The focus group discussions offered key insight into the impact of the pandemic on the mental health needs of children and families and the challenges that they experienced (and continue to experience) in accessing care. Focus group results confirm and illuminate data from the CDC, Georgia Student Health Survey, and Rural Health Innovation Hub that the pandemic, and situations caused by the pandemic, placed a unique strain on the mental health of children and families in the state. While being forced to quickly pivot to a new way of learning and working created an opportunity to connect with those in their household, the feelings of isolation, uncertainty, and loss took a toll on many.

The findings support that schools are viewed (by both youth and caregivers) as entities that, in addition to providing an education, should be equipped to promote mental wellness, provide quality behavioral health services, or help families navigate the system in identifying needed supports. Schools are a centralized location for youth, and as such, it would be ideal for every school to integrate some level of SBMH services. However, due to limited staff capacity, insufficient financial resources, or other reasons, schools may struggle to provide robust behavioral health services directly. What is more, school counselors are an untapped and overworked resource – considering the mandated counselor-to-student ratio in Georgia is one counselor to every 450 students. (see Figure 8) The American School Counselors Association’s

**Figure 8: Student-to-Counselor Ratio by School District (Source: National Association for College Admission Counseling)**

![Map of Georgia showing student-to-counselor ratio by school district.](chart.png)
recommended ratio is one counselor to every 250 students. Despite being educationally qualified, the daily responsibilities (e.g., guiding registration, assisting with college applications, mental health crisis management) of school counselors (for so many students) may prevent them from providing or helping families to navigate them. Further, there was an overwhelming concern from caregivers about not knowing what the school offers. Forging sound partnerships with community-based providers and organizations is the next step for schools – it circumvents the barriers schools may face in providing behavioral health services directly and strengthens the referral process. Further, increasing promotion of the services and supports available within schools or through school partnerships would provide caregivers a concrete starting point when supports are needed.

Additionally, stigma serves as a major hurdle to seeking and receiving behavioral health services. The findings revealed that caregivers are apprehensive about the children in their care being labeled by the school. However, schools are charged with the responsibility of recognizing behaviors that inhibit learning and, when deemed appropriate, referring the student for evaluation. A caregiver’s fear of labeling can be rooted in the stigmas associated with having an IEP or 504 plan. These stigmas may include the caregiver feeling guilt or regret for their child’s learning differences or concerns about how their child will be perceived by their instructors (or other school personnel) and peers (e.g., negative perceptions may result in bullying). Special (and/or inclusive) education is intended to be a resource and pathway for youth to receive needed services and supports through school. Developing campaigns that seek to reduce stigma among caregivers is a step toward minimizing fears of labeling. Further, addressing culture- and other identity-related factors in these campaigns can begin to tackle attitudes and beliefs that negatively impact the perception and dialogue surrounding seeking needed behavioral health services and supports.

Stigma may also play a critical role in the reported gender differences in the perception and dialogue surrounding mental health. The findings support that youth who identify as female were typically more comfortable talking about mental health and taking necessary actions to receive mental health services and supports compared to their male peers. Further, the 2022 Georgia Student Health Survey data shows a stark contrast between male and female student (grades 6-12) responses to mental health-related questions, with female students experiencing mental health challenges more than their male peers:

- Girls (52 percent) were twice as likely as boys (27 percent) to report experiencing intense anxiety, worries, or fears that get in the way of daily activities.
- Girls (13 percent) were twice as likely as boys (7 percent) to report self-harm.
- Girls (15 percent) were twice as likely as boys (8 percent) to report suicidal ideation.

Interestingly, “school performance and grades” was the second highest reason for suicidal ideation among boys and girls, which corresponds with the findings of this research – academic performance significantly impacts the mental health of youth. However, across the above-mentioned mental health data, the higher rates reported by girls may indicate that they more readily recognize certain mental health challenges or that they feel more comfortable disclosing these struggles in a survey. This suggests that more mental health awareness campaigns that specifically target adolescent males may be helpful in increasing recognition of mental health challenges and seeking mental health supports. Further, the prevalence of mental health challenges among girls should not be ignored. Creating more outlets for youth to process their emotions, discuss mental health, and learn more about healthy coping mechanism could reduce poor mental health outcomes (e.g., self-harm, suicidal ideation).

Separate from stigma and services and supports through schools, several factors rose to the top that serve as barriers to care, including limited insurance coverage or uninsurance, insufficient provider availability, difficulty identifying providers that accepted their insurance and that were accepting new patients, poor coordination, and inadequate crisis supports (especially in rural communities). The recent passage of the Mental Health Parity Act (MHPA) should help mitigate several of the identified challenges. The parity component of the law requires insurers to cover behavioral health services at the same level as physical

education can take place in the general classroom, resource room, or a specialized school, but typically students are separated from their peers. Inclusive education addresses the needs of children with disabilities or learning differences, but students are able to learn alongside their peers.
health services in hopes of minimizing experiences with limited coverage for behavioral health needs. Further, the law requires the state to implement a Behavioral Health Care Workforce Database, allowing for a survey to be attached to the licensure and renewal process for behavioral health professionals. The survey will capture needed data regarding the workforce, including location, specialty, insurance accepted, demographic profile, and more. The collection of this data provides an opportunity to identify shortages and develop targeted strategies to increase and diversify the workforce, and to explore pathways to ease the process of identifying local providers. Another relevant component of the MHPA is the creation of the Multi-Agency Treatment for Children (MATCH) team. Building on existing SOC infrastructure (LIPTs, BHCC, IDT), the MATCH team has the potential to help increase access to community-based services and supports for children with complex and unmet treatment needs. The team is also intended to help strengthen interagency collaboration (working with existing state and local infrastructure) and coordination to better serve youth and families across the state.

Similar to the MHPA, the recent passage of Georgia Behavioral Health and Peace Officer Co-responder Act is a step forward in addressing crisis support needs in Georgia. The law requires CSBs to pilot a co-responder program – a partnership between CSBs and law enforcement that utilizes peace officers and behavioral health professionals on behavioral health crisis-related emergency calls. Understanding the overlap between the pilot and other models, as well as current data on 911 calls, 988 and Georgia Criss and Access Line calls, and emergency room visits for children in behavioral health crisis, will help Georgia build and sustain crisis supports that meet the needs of children and families in Georgia.

While recent legislation is intended to begin tackling challenges related to limited insurance coverage, provider availability, care coordination, and crisis supports, integrated care models are increasingly recognized as a strategy to increase mental health care access for children. Integrated care (or collaborative care) models leverage primary care providers to address behavioral health needs by providing warm hand-offs or scheduling joint visits between the patient, primary care provider, and a behavioral health specialist. The specialist is able to diagnose, treat, or refer patients to additional resources. Identifying, piloting, and implementing integrated care models can better position Georgia to detect and treat behavioral health needs among children and strengthen care coordination and case management.

This research has potential limitations. A number of the participants reside in metro Atlanta counties, and the majority of youth participants identified as female. As such, the findings may not adequately depict the mental health needs of youth that live in counties outside of metro Atlanta. More specifically, the mental health needs of adolescent males may extend beyond what emerged in the focus group discussions. Key considerations for future research include identifying and engaging partners to help with recruitment. Ensuring that these partners have successful outreach strategies for rural communities and gender-specific out-of-school activities (e.g., Boy Scouts, recreational sports teams) can help increase the number of caregivers and youth that live outside of metro Atlanta, as well as increase the number of adolescent males engaged.

In summary, caregivers and youth encountered a myriad of challenges when seeking mental health services and supports. Strengthening SBMH services and awareness of such services holds the greatest potential in giving caregivers a tangible entity to tap for help. However, there is room to make strides in reducing stigma surrounding seeking and receiving mental health services. And the state has begun to carve a path forward by prioritizing access to mental health services and supports during the 2022 legislative session. We offer the following recommendations to address stigma and to continue improving and strengthening access, coordination, the behavioral health workforce, and awareness of available services and supports:
State leadership and agencies

- Continue to expand the Georgia Apex Program’s reach in rural and underserved communities.
- Track and promote SBMH services and supports in the state.
- Via funding and training, encourage schools to start and grow quality SBMH programs and better leverage school counselors to provide behavioral health services to any student in need.
- Allocate more funding to support the implementation of SBMH workforce pipeline programs, including paid practicum placements and reimbursement for supervised training of emerging professionals.
- Increase state funding to expand reach of mental health awareness (i.e., Youth Mental Health First Aid, including the importance of confidentiality) training for teachers, school counselors, and staff (e.g., administrative faculty, coaches, other extracurricular advisers) and to increase understanding of community-based mental health resources.
- Develop awareness campaigns to promote community-level mental health resources, including CSBs, and to reduce cultural- and identity-based stigma (e.g., Black, Hispanic, adolescent males).
- Ensure full implementation of the Behavioral Health Care Workforce Database and develop strategies to address identified provider shortages and diversify the workforce.
- Explore alternative licensure pathways to increase the behavioral health workforce, including identifying opportunities to make the process less burdensome and costly, and where appropriate minimize licensing barriers for foreign-trained behavioral health professionals.
- Adopt a standard of cultural competency training and requirements for behavioral health professionals and paraprofessionals.
- Continue to expand broadband infrastructure to increase universal access to tele–behavioral services regardless of income or location.
- Expand the COVID-19 Emotional Support Line to continue connecting children and families to community-level resources.
- Allocate more funding to strengthen crisis support and intervention services, including continued implementation of 988 and mobile crisis services for children and adolescents.
- Leverage evidence-based integrated care models (e.g., Integrated Care for Kids) to reduce expenditures and improve quality of care for children and adolescents.

Schools

- Actively and frequently promote existing SBMH and community-based behavioral health services and supports to students and caregivers.
- Leverage existing training and resources (e.g., Sources of Strength, Teen Mental Health First Aid, 4-H, Georgia Campaign for Adolescent Power and Potential, Community Resiliency Model, Free Your Feels (FYF) campaign), including afterschool and summer learning programs, to develop teen-led or -focused mental health support programs and initiatives, including those that support healthy educator-student relationships (e.g., promoting strategies to minimize oversharing of student mental health challenges through FYF).
- Explore opportunities to expand available SBMH services and supports, including leveraging school-based health centers and telehealth programs and integrating Certified Peer Specialists–Youth and –Parent into SBMH programs.
- Consider mechanisms to reduce staffed counselors’ academic demands to create time for counselors to serve as a navigator for and/or to provide mental health supports.

Higher education institutions

- Track and publish demographic data for students enrolled in behavioral health fields and develop outreach and other strategies to attract a more diverse applicant pool.

Insurers (public and private)

- Simplify the process for beneficiaries to identify local mental health providers and ensure that provider network information is accurate and indicates whether providers are accepting new patients.