Dear Policymaker, Child Advocate, and Friend,

Welcome to our January 2019 edition of All about Kids: Factsheets on Georgia’s Children. Throughout this book, you will find an array of data and research on topics across the spectrum on child policy. Our goal with this collection is to provide you with one easy-to-use reference guide that you can refer to as you develop and contribute to the policies affecting children in our state.

The nature of child policy is a fluid and expansive area of study. So while this book is fairly comprehensive, we are continuing to develop additional factsheets. That is why we have included a pocket in the back of this book where you can add new documents as we create them.

If you find a particular area of child wellbeing that you feel is missing, please let us know, and we will see if we can address it in the next iteration.

At Voices for Georgia’s Children and Georgia Statewide Afterschool Network, we work hard to be responsible and helpful advocates for the next generation. We hope you agree with us that the best way to figure out how to help our children and youth is to assess relevant data and to work with those who have expertise in the various fields affecting children. As we know, children are about 30 percent of our population, but 100 percent of our future.

Thank you for all you do for the children and youth of our state (and for the rest of us too!).

Most sincerely,

Erica, Katie, Polly and Melissa

Erica Fener Sitkoff  
Executive Director  
Voices for Georgia’s Children  
efenersitkoff@georgiavoices.org  
404-521-0311

Katie Landes  
Director  
Georgia Statewide Afterschool Network  
klandes@georgiavoices.org  
404-521-0355

Polly McKinney  
Advocacy Director  
Voices for Georgia’s Children  
pmckinney@georgiavoices.org  
678-427-5945

Melissa Haberlen  
Research and Policy Director  
Voices for Georgia’s Children  
mhaberlen@georgiavoices.org  
404-521-0311
Acknowledgements

Voices for Georgia’s Children would like to thank the Governor’s Office, the Georgia General Assembly, and State Agency Leadership, all of whom have committed years of hard work to ensure that Georgia’s children are healthy and safe. Voices would also like to express gratitude to all those who helped in the development of these factsheets by sharing their data, perspectives, expertise and time.

About Voices for Georgia’s Children

Voices for Georgia’s Children seeks to help all children thrive through research and analysis, public education, convening, and engagement with decision-makers. Our work is framed in a holistic “whole child” perspective that allows us to identify how different policies impact children and to propose solutions that benefit children on multiple levels.

For more information, visit www.georgiavoices.org.

About Georgia Statewide Afterschool Network

The Georgia Statewide Afterschool Network (GSAN) is a public-private collaborative that envisions a day when all communities in Georgia have the resources to provide exceptional afterschool programming. Our mission is to advance, connect, and support quality afterschool programs to promote the success of children and youth throughout Georgia.

For more information, visit www.afterschoolga.org.
# Table of Contents

## Early Care and Learning

<table>
<thead>
<tr>
<th>Topic</th>
<th>Revision Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building Blocks of Brain Development</td>
<td>07/2018</td>
</tr>
<tr>
<td>Georgia’s Pre-K: Midpoint in Early Learning</td>
<td>05/2018</td>
</tr>
<tr>
<td>Quality Early Learning in Georgia</td>
<td>07/2018</td>
</tr>
<tr>
<td>The Economics of Early Care in Georgia</td>
<td>07/2018</td>
</tr>
<tr>
<td>Farm to Early Care and Education</td>
<td>10/2018</td>
</tr>
<tr>
<td>Georgia’s Summer Transition Program</td>
<td>07/2018</td>
</tr>
<tr>
<td>School Readiness in Georgia</td>
<td>07/2018</td>
</tr>
<tr>
<td>Child and Parent Services (CAPS)</td>
<td>12/2018</td>
</tr>
</tbody>
</table>

## Afterschool

<table>
<thead>
<tr>
<th>Topic</th>
<th>Revision Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demand for Afterschool in Georgia</td>
<td>10/2015</td>
</tr>
<tr>
<td>The Landscape of Afterschool in Georgia</td>
<td>12/2017</td>
</tr>
<tr>
<td>Quality Afterschool: What it is &amp; Where Georgia is Heading</td>
<td>09/2018</td>
</tr>
<tr>
<td>What are the Georgia Afterschool &amp; Youth Development Quality Standards?</td>
<td>09/2018</td>
</tr>
<tr>
<td>A Snapshot of 21st CCLC in Georgia</td>
<td>09/2018</td>
</tr>
<tr>
<td>Support for Afterschool in Georgia</td>
<td>10/2015</td>
</tr>
</tbody>
</table>

## Physical and Mental Health

<table>
<thead>
<tr>
<th>Topic</th>
<th>Revision Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Navigating Healthcare for Children</td>
<td>07/2017</td>
</tr>
<tr>
<td>How Medicaid and PeachCare Money Work</td>
<td>12/2018</td>
</tr>
<tr>
<td>Two Ways to Get More Kids Covered</td>
<td>12/2018</td>
</tr>
<tr>
<td>Access to Dental Care in Georgia</td>
<td>12/2018</td>
</tr>
<tr>
<td>School-Based Health Centers: Maximizing Access to Quality Care</td>
<td>01/2017</td>
</tr>
<tr>
<td>School-Based Health Centers in Georgia</td>
<td>12/2018</td>
</tr>
<tr>
<td>School-Based Health: What’s Happening in Georgia</td>
<td>11/2018</td>
</tr>
<tr>
<td>Georgia Network for Educational &amp; Therapeutic Supports (GNETS)</td>
<td>12/2018</td>
</tr>
<tr>
<td>Recommendations of the Commission on Children’s Mental Health</td>
<td>11/2018</td>
</tr>
<tr>
<td>Behavioral Health Workforce Analysis</td>
<td>12/2017</td>
</tr>
<tr>
<td>Georgia’s Crisis in Child &amp; Adolescent Behavioral Health</td>
<td>12/2018</td>
</tr>
<tr>
<td>Snapshot of Child and Adolescent Behavioral Health</td>
<td>12/2018</td>
</tr>
<tr>
<td>Youth Suicide in Georgia</td>
<td>11/2018</td>
</tr>
<tr>
<td>Substance and Non-Substance Disorders</td>
<td>12/2017</td>
</tr>
</tbody>
</table>
### Physical and Mental Health cont.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Revision Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse in Georgia</td>
<td>12/2018</td>
</tr>
<tr>
<td>Autism Spectrum Disorder in Georgia</td>
<td>12/2018</td>
</tr>
<tr>
<td>Learning Disabilities in Children</td>
<td>12/2018</td>
</tr>
<tr>
<td>Child Food Programs in Georgia</td>
<td>11/2018</td>
</tr>
</tbody>
</table>

### Protection and Safety

<table>
<thead>
<tr>
<th>Topic</th>
<th>Revision Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Welfare Improvements in Georgia</td>
<td>12/2018</td>
</tr>
<tr>
<td>Family First Prevention Services Act</td>
<td>12/2018</td>
</tr>
<tr>
<td>Child Sexual Abuse in Georgia</td>
<td>12/2018</td>
</tr>
<tr>
<td>Childhood Trauma – Discussion and Policy Solutions</td>
<td>12/2018</td>
</tr>
<tr>
<td>Maltreatment and Brain Development</td>
<td>12/2017</td>
</tr>
<tr>
<td>Homelessness and Children in Georgia</td>
<td>12/2018</td>
</tr>
</tbody>
</table>

### Juvenile Justice and Effective School Discipline

<table>
<thead>
<tr>
<th>Topic</th>
<th>Revision Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Juvenile Justice Update</td>
<td>12/2018</td>
</tr>
<tr>
<td>Juvenile Justice Roadmap</td>
<td>12/2018</td>
</tr>
<tr>
<td>Juvenile Detention Alternatives Initiative (JDAI)</td>
<td>12/2018</td>
</tr>
<tr>
<td>Positive Behavioral Interventions and Supports (PBIS)</td>
<td>12/2018</td>
</tr>
</tbody>
</table>

### Budget and Workforce

<table>
<thead>
<tr>
<th>Topic</th>
<th>Revision Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Census 2020</td>
<td>12/2018</td>
</tr>
<tr>
<td>How Federal Dollars are Used by Georgia</td>
<td>12/2018</td>
</tr>
<tr>
<td>Title IV-E</td>
<td>12/2018</td>
</tr>
<tr>
<td>Turnover Rates and Average Salaries of Child-Serving Workers</td>
<td>12/2018</td>
</tr>
<tr>
<td>Federal Poverty Guidelines</td>
<td>1/2019</td>
</tr>
</tbody>
</table>
Two-Generation “2Gen” Approach

2Gen: An Overview

The two-generation (2Gen) approach to policy and programs disrupts generational cycles of poverty and poor outcomes by taking the whole family into account - focusing on the needs of the entire family, rather than on children or parents alone. Any policy, program, or service for parents or children, including those for early care and education, health, child welfare, and juvenile justice, can use a 2Gen approach.

2Gen policies address multiple areas that allow the whole family to change and thrive:

- Health and Well-being
- Economic Stability
- Social Supports
- Postsecondary Education & Employment
- Early Childhood Education & Development
- 2Gen Whole Family Approach

Economic Impact of 2Gen Approaches

Nearly 50% of children in the United States belong to families with low income.

A $3,000 increase in a parents’ income when their child is young is associated with a 17% increase in their child’s future earnings.

Children with as little as $499 in an account designated for college are more likely to enroll and graduate.
2Gen Models in Georgia

Department of Early Care and Learning
The Department of Early Care and Learning (DECAL) is leveraging Childcare and Parent Services (CAPS, subsidized childcare) to:

- Connect parents currently pursuing workforce training or postsecondary education with child care and family supports
- Connect parents of young children in the child care system with workforce training and postsecondary education
- Offer grants to communities to develop or expand promising 2Gen practices

Department of Juvenile Justice
The Department of Juvenile Justice’s (DJJ) multi-organization Parenthood Project strives to enhance relationships between youth committed to secure placement who are parents and their children. Parenthood Project includes:

- Nurturing Parenting parent skills training
- Storybook Moms and Dads, where a youth-parent is recorded reading a children’s book aloud and the book/recording are sent to their child
- Angel Tree, which provides Christmas gifts for children on behalf of their parents

Network of Trust School Health Program
The Network of Trust school health program in Albany works with pregnant teens to promote the health of moms and babies, as well as:

- Develop parenting skills
- Increase mother’s self-esteem
- Increase rates of school attendance and graduation

Sources: https://tinyurl.com/2GenReferences

Rev. 12/2018
A child’s brain develops at a remarkable pace between birth and age eight. Missing key milestones during this crucial period can lead to developmental delays. It is critical that everyone knows what to expect during each stage of a child’s early development since early detection and intervention can help kids stay on track.

<table>
<thead>
<tr>
<th>0-1</th>
<th>1-2</th>
<th>2-3</th>
</tr>
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<tbody>
<tr>
<td>![Heart] Seek and respond to attention.</td>
<td>![Question Mark] Learn difference between familiar adults and strangers.</td>
<td>![Man] Learn to share and respect the rights of others, but can’t resolve peer conflicts on their own.</td>
</tr>
<tr>
<td>Develop trust, love, and security when adults respond appropriately.</td>
<td>![People] Begin to develop self-confidence and some independence, but still seek adult support.</td>
<td>![Feeling Good] Begin to show a sense of satisfaction in their own abilities and preferences.</td>
</tr>
<tr>
<td>![Communication] Communicate emotions through sounds, facial expressions, and body movements.</td>
<td>![Voice] Develop the ability to communicate, listen, and follow simple instructions.</td>
<td>![Response] Rapidly develop new vocabulary and respond appropriately in conversation.</td>
</tr>
<tr>
<td>![Sound] Start to learn about sounds and words and become aware of their bodies.</td>
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Sources: https://tinyurl.com/y8vgrww9
Building Blocks of Brain Development

3-4
- Become more comfortable interacting with adults and play cooperatively with other children.
- Begin to identify more complex emotions, like frustration, jealousy, and enthusiasm.
- Able to engage in organized activities and problem-solve to achieve tasks.

4-5
- Begin to form and maintain friendships with peers and seek to please adults.
- Distinguish positive and negative emotions and identify what causes them.
- Distinguish between real life and fantasy and begin to use imagination.

5-6
- Begin to understand other points of view.
- Express feelings and ideas verbally and maybe even through artwork.
- Begin to use comparative adjectives and answer who, what, and why questions.

6-8
- Become concerned with others’ opinions and seek approval from adults and peers.
- May view self based on school performance, appearance, and ability to make friends.
- Begin to understand time and sequencing and develop judgment of right and wrong.

Sources: https://tinyurl.com/y8vgrww9
Georgia’s Pre-K Program is a voluntary, free program available to all of Georgia’s four-year-olds regardless of parental income. Approximately 1.6 million Georgia students have been served by Georgia’s Pre-K since it began in 1992. The program continues to be nationally recognized for its success.

80,874 kids enrolled in Georgia’s Pre-K in the 2016-17 school year. Representing 60% of all four-year-olds in Georgia.

Georgia’s Pre-K operates in all of the state’s 159 counties in 1,871 locations which operate 3,863 Pre-K Classes

Approximately 47% are located in a public school system
53% are located in private centers

Georgia is one of only ten states and D.C. that provide high-quality care to more than 50% of 4-year-olds.

Demand is Still High

Of Georgia’s 4-year-olds are not currently enrolled. Some receive supplemental forms of care, while others receive no care at all.

At the end of the 2017-18 school year, there still were 4,030 kids on the waitlist.

Georgia’s Pre-K Improves Outcomes

In 2011, the Georgia General Assembly began a multi-year evaluation led by the Frank Porter Graham Child Development Institute. So far, the study has found that children enrolled in the Georgia Pre-K Program:

- Are more prepared for Kindergarten compared to four-year-olds in other forms of care
- Earn higher grades and retain more of what they learn
- Spanish speaking children showed growth in both English and Spanish

Children in Georgia’s Pre-K showed significant growth across all learning domains including:

- Math Skills
- Language & Literacy Skills
- Social-emotional Skills

These gains happened for all students, regardless of gender and income differences and are sustained through the end of first grade.
**About Georgia’s Pre-K**

Administered by Bright from the Start: Georgia Department of Early Care and Learning

- **Full day program**
- **Maximum of 22 kids per class**
- **Operates 180 days a year**

Required to use the Georgia Early Learning and Development Standards (GELDS)

- **Hearing, vision, and dental screenings are required**
- **Required to have a lead teacher and assistant teacher**
- **All Pre-K lead and assistant teachers must meet credential requirements**

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**QUALITY RATED**

574 of the 1,871 centers are Quality Rated, a voluntary, quality rating system for early and child care centers.

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**Funding Georgia’s Pre-K**

$354 MILLION

GA Lottery dollars were allocated to Georgia’s Pre-K in 2017

- $4,255 was spent per child

For the 80,874 children enrolled in the 2016-17 school year

Although spending per child has risen since the recession, recent spending lags behind 2002 levels by more than $1,400 per child.*

*Adjusted for inflation

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In 2016, the Georgia General Assembly approved a $34 million increase for Pre-K salaries. Despite recent increases, Pre-K teacher salaries are lower than similar professions. Assistant teachers make $15,873/year. The salary for lead teachers for the 2018 school year range from:

- 2-yr Degree: $21,500
- 4-yr Degree: $27,000
- 4-yr Degree & Certified: $36,000
- Masters Degree: $40,000

Research shows a significant factor in an early childhood teacher’s decision to leave the profession is **low pay.**

High turnover rates have been linked to lower program quality and shown to negatively impact a child’s social and emotional development and relationships between teachers, children, and parents.

In comparison, the average wage for Kindergarten teachers in Georgia is:

$53,410

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Sources: https://tinyurl.com/y799skms
Increased child care subsidies
Voluntary center-based home visiting services
Health screenings, assessments, and referrals
Additional professional development for early childhood educators
Support to get 100 percent of child care programs Quality Rated

Although the elements of quality early care will vary by age, quality early learning should:

- Have low child-teacher ratios
- Implement individualized instruction
- Employ qualified and well-trained teachers
- Ensure a clean and safe environment
- Engage and support families
- Promote proper physical, social, and emotional development
- Support academic growth particularly in language and literacy
- Provide supports for dual-language learners
- Have low child-teacher ratios
- Implement individualized instruction
- Employ qualified and well-trained teachers
- Ensure a clean and safe environment
- Engage and support families
- Promote proper physical, social, and emotional development
- Support academic growth particularly in language and literacy
- Provide supports for dual-language learners

WHAT IS QUALITY?

The standards define the desired content and outcomes for early learning that are aligned with K-12 standards. The standards support children’s individual rates of development, approaches to learning, and cultural contexts.

Early Education Empowerment Zones (E³Zs)

This three-year pilot was federally funded as a part of the Early Learning Race to the Top grant and successfully improved the quality of early education through targeted services. The four selected regions serve as models for other communities across the state. After a tremendous impact, the state is now continuing the investment.

Services provided to E³Zs include:

- Increased child care subsidies
- Voluntary center-based home visiting services
- Health screenings, assessments, and referrals
- Additional professional development for early childhood educators
- Support to get 100 percent of child care programs Quality Rated
Quality Rated is a voluntary quality rating and improvement system for early and school-age care programs administered by DECAL. Quality Rated is meant to assess, improve, and communicate the level of quality of a child care program.

To become Quality Rated, programs must submit a portfolio with self-reported information and receive a site visit by independent experts. Based on their star rating, programs receive a tiered reimbursement package that includes training, materials, and equipment or financial bonuses.

Quality Rated is a three-star rating system that awards programs a star rating based on standards.

Benefits for Parents and Families

Quality Rated helps parents and families find high-quality child care so they can make the most informed choice for their child.

Parents can use the FREE, online tool to access information about specific programming including safety and inspection reports, teacher credentials, and ages served. To find Quality Rated programs in your area, visit www.QualityRated.org.

Benefits to Georgia

Regardless of their rating, all programs that participate are committed to improving the quality of their program by going above and beyond Georgia’s licensing standards. At a community and state level, Quality Rated creates a shared understanding of quality learning and a commitment to achieving it. By 2020, all childcare centers receiving child care subsidies (CAPS) must be quality rated.

Of approximately 5,000 state licensed and monitored child care programs, over 1,500 are Quality Rated and more than 2,000 are in the process of becoming Quality Rated.

Percentage of Licensed Programs that are Participating in Quality Rated Per County

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Statewide Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-24%</td>
<td>508</td>
</tr>
<tr>
<td>25-49%</td>
<td>764</td>
</tr>
<tr>
<td>50-59%</td>
<td>891</td>
</tr>
</tbody>
</table>

For more information about Voices for Georgia’s Children, go to www.georgiavoices.org/a-solid-start. For more information about GEEARS: Georgia Early Education Alliance for Ready Students, go to www.geears.org.

Revised on 8/1/18

Sources: https://tinyurl.com/ycby5d3e
The Economics of Early Care in Georgia

Quality early care is critical to Georgia’s economy — it generates jobs and revenue, while equipping kids with the tools they need to be the workforce of tomorrow.

**Early Care in Georgia’s Economy**

$$\text{Annual Earnings} + \text{Economic Activity} = \text{Economic Impact}$$

<table>
<thead>
<tr>
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<tr>
<td>Annual Earnings</td>
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<tr>
<td>Economic Activity</td>
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<tr>
<td>Economic Impact</td>
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</tr>
</tbody>
</table>

The early care industry generates $2.5 billion in annual earnings and $2.2 billion in additional economic activity. This translates to a $4.7 billion annual investment in the Georgia economy.

**Investing in Early Care Creates Jobs**

Georgia’s Early Care Industry employs 67,507 people who work in a variety of jobs including:

- Teachers
- Administrators
- Kitchen Staff
- Office Staff
- Drivers

Additionally, every 100 jobs in early care generates an additional 26 jobs in other industries.

**Early Care Supports Georgia’s Parents**

494,000 or 65% of Georgia’s children under the age of six have parents in the labor force.

Parents with children enrolled in Early Care Programs have been shown to:

- Miss fewer days at work
- Earn more income to support the family
- Stay employed at higher rates

**$24 Billion**

Georgia parents taking advantage of early care programs earn approximately 24 billion.

By 2022, the Child Care Industry is expected to be one of the 20 fastest growing industries in Georgia.
Early Care Brightens Our Children’s Futures

How Early Care Benefits Children

- School Readiness
- Behavioral and Social Development
- Health and Well-being

These benefits lead to:

- Lower retention rates/repeated grades
- Reduced dependency on public welfare systems
- Lower involvement in the criminal justice system
- Improved long-term health

All of which reduces public spending in the long run.

For every dollar spent on early child care...

- up to $8.60 is returned in benefits to society.

Creates the Workforce of Tomorrow
Quality early care has been shown to increase:

- Third grade reading proficiency
- High-school graduation rates
- College attendance

Therefore better preparing Georgia’s youngest learners for the jobs of tomorrow.

Children who are in enrolled in early care programs have the potential to gain between $9,166 and $30,851 more in lifetime earnings than other adults their age who did not receive similar care.

Why should Georgia invest in its youngest learners?

1. Investments made at the start of a child’s life accumulate throughout their entire lives.

2. Young children under the age of eight have the greatest capacity for change. Interventions are often more effective at this age and can have lasting impacts for years to come.

3. Early education gives young children skills they continue to build on throughout the continuum of their education.

Sources: https://tinyurl.com/yda5vuyy
Farm to Early Care and Education

Research shows Farm to School initiatives improve children’s health and nutrition. Most of these programs start in K-12 school districts, but we can reach children earlier with Farm to Early Care and Education.

Farm to Early Care and Education has been shown to:

**Increase**
- Fruit and vegetable consumption by 20-30%
- Healthy food consumption at home
- Willingness to try new foods by 34%
- Vitamin A, C, and E intake
- Motor skills

**Decrease**
- Body Mass Index (BMI) by 15%
- Likelihood that parents pack unhealthy snacks for their children

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**Programs that Work**

- Nutritional Education for Parents
- Meal Planning Services
- Curriculum Where Kids Touch and Taste Food
- Gardening with Kids
- Fruit and Vegetable Boxes

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**Agriculture and Georgia’s Economy**

Farm to ECE can have a significant positive impact on the state’s economy.

Agriculture is the **#1** industry in Georgia.

That’s approximately **$73.3 BILLION** contributed to the state’s economy.

In 2016, there were **383,600** agriculture jobs in Georgia.

That’s **1 in 7** Georgians.

In 2017, farms covered **9.3 million** acres in Georgia.

That’s **25%** of all the land in Georgia.

For sources, please see: [https://tinyurl.com/FTECERefferences](https://tinyurl.com/FTECERefrances)
Georgia's Summer Transition Program

Georgia's Summer Transition Program, a six-week intensive academic program, supports high risk children with successful early transitions through the Rising Kindergarten and Rising Pre-K Programs.

Rising Kindergarten Summer Transition Program

Bright from the Start: Georgia Department of Early Care and Learning (DECAL) offers the Rising Kindergarten Summer Transition Program to children registered to enter Kindergarten in the fall who:

1. Did not participate in Georgia’s Pre-K Program or Head Start during the school year and/or
2. Need additional help in preparing for Kindergarten and
3. Whose family is at or below 85% of the state median income

This Summer, the Rising K Summer Transition Program serves up to

- 2,384 children
- 121 locations
- 51 counties
- 149 classes

- 34% are located in a public school system
- 66% are located in private centers

Rising K Program Has:

- Maximum of 16 kids per classroom
- A lead and assistant teacher per class
- Full day program operating for six weeks
- Provides/assists in coordinating care before and after school as needed through CAPS

Transition Coach

A notable difference between Georgia’s Pre-K Program and the Summer Transition Program is the requirement of a half-time transition coach for every class. The transition coach is responsible for:

- Actively seeking out students who would benefit from the program and meet the enrollment priorities
- Working with families to collect eligibility documentation
- Facilitating at least one family or parent engagement activity per week based on parents’ needs
- Connecting families with community resources
- Planning kindergarten transition activities
Rising Pre-K Summer Transition Program

DECAL runs the Rising Pre-K Summer Transition Program to support children registered to enter Georgia’s Pre-K Program or Head Start in the fall. To qualify, families must primarily speak Spanish at home.

This Summer, the Rising Pre-K Summer Transition Program serves up to 826 children at 47 locations in 22 counties, which operate 59 classes of which approximately 27% are located in a public school system & 73% are located in private centers.

Although similar to the Rising K program, the Rising Pre-K Program differs in the following ways:

- Maximum of 14 children per classroom
- Teacher training to work with Dual Language Learners (DLLs)
- Both English and Spanish are used for instruction and behavior management
- At least one teacher AND the transition coach must be fluent in Spanish

An estimated 17% of Georgia’s 3 & 4 year olds are DLLs, with the vast majority speaking Spanish.

Research from the Frank Porter Graham Child Development Institute indicated that:

1. Spanish-speaking DLLs are less likely than their peers to enroll in early care, directly affecting school readiness skills.
2. Both the English and Spanish Language skills of participating children increased during the program.
3. The program helped children become more comfortable with school routines and overcome their shyness and dependence.
4. While children made significant gains, a meaningful gap remained between DLLs and their peers.

Combined, the Rising K and Pre-K Summer Transition Programs are offering:

- 208 classes at 146 program sites in Summer 2018.
- The total budget* for both of the 2018 Summer Transition Programs are: $5.1 MILLION
  - Approximately $1,575 being spent PER CHILD

*budget funded by the Georgia Lottery and federal dollars

For more information about Voices for Georgia’s Children, go to www.georgiavoices.org/a-solid-start/. For more information about the Summer Transition Program, go to www.decal.ga.gov/Prek/SummerTransitionProgram.aspx. Sources: https://tinyurl.com/yb3uovtr
Children entering Kindergarten with school readiness skills are more likely to experience academic success and better lifetime well-being than their peers.

What is School Readiness
A child’s readiness for school includes:

- Detection and appropriate care for potential physical or mental disabilities
- Emerging social and interpersonal skills
- Evident early literacy and language skills
- Possession of a general knowledge about the world

School readiness is influenced by a child’s development, their family, community, and schools, and the services they receive. Children from low income families, whose parents did not graduate high school, or do not speak English at home are less likely to have readiness skills. Multiple studies of Pre-K programs, including Georgia’s Pre-K, show that participation in Pre-K can greatly improve school readiness skills, particularly in high-risk populations.¹

Georgia’s Commitment to School Readiness
The following programs run through Bright from the Start: Georgia Department of Early Care and Learning (DECAL) are two of several programs Georgia has to increase early readiness skills so its students can enter Kindergarten prepared to learn.

Georgia’s Pre-K Program
Approximately 1.6 million Georgia students have been served by Georgia’s Pre-K since it began in 1992.
Evaluations have found that children enrolled in the Georgia Pre-K Program²:

- Are more prepared for Kindergarten compared to four-year-olds in other forms of care
- Earn higher grades and retain more of what they learn
- Spanish speaking children showed growth in both English and Spanish
- Growth in all learning domains including:
  - Math Skills
  - Language & Literacy Skills
  - Social-emotional Skills

Children in Georgia’s Pre-K showed significant growth across all learning domains including:

Summer Transition Programs
DECAL offers both the Rising Kindergarten and Rising Pre-K Summer Transition Programs as additional supports for high risk children including:

- 208 classes at 146 program sites
- 6 week, intensive summer program
- A transition coach in each class to help families
- Child’s family must be at or below 85% of the state median income

Fast Facts

For more information about Voices for Georgia’s Children, go to www.georgiavoices.org/a-solid-start/.

¹² https://tinyurl.com/ydyv2kh7
Sources: https://tinyurl.com/yb3uovtr
The Childcare and Parent Services (CAPS) program offers low-income families subsidies to pay for quality child care, afterschool and summer programs for children up to age 12 and for children up to age 17 with special needs. CAPS is federally funded through the Child Care and Development Fund (CCDF) and is administered by the Department of Early Care and Learning (DECAL).

The purpose of CAPS is to:

1. Provide access to high quality and affordable early learning, afterschool and summer environments for low-income families.
2. Increase positive school readiness outcomes.
3. Assist families in achieving and maintaining self-sufficiency by providing financial supports for child care costs.

**WHO IS ELIGIBLE FOR CAPS?**

To qualify for entry into the CAPS program, family income must not exceed 50% of the state median income.

For example, a family of four cannot initially make more than $36,601 a year, and can continue to receive a CAPS scholarship until their income reaches $62,221.

To qualify for the very low income priority group: A family of four cannot make more than $25,100 a year.

**PRIORITY GROUP ELIGIBILITY**

Because CAPS scholarships are limited, children in the following situations are given priority:

- Child Protective Services
- Custody of the Division of Family and Children Services
- Domestic violence situations
- Disabled
- Enrolled in Georgia’s Pre-K Program
- Participating in or transitioning from TANF
- Experienced a natural disaster
- Lack fixed, regular and adequate housing
- Very low income as defined by CAPS
- Grandparents raising grandchildren
- Minor parents
- Need to protect
Parents who receive CAPS must complete 24 hours a week of approved activities to stay eligible for the CAPS scholarship.

Approved activities can include:

- **Employment**: Paid employment or volunteering at Head Start/Early Head Start facilities
- **Education**: Participation in middle or high school, GED programs, vocational training programs, and associate degree programs*
- **Job Search**: Parents who lose their job or stop attending state-approved training or education programs may be authorized for up to 13 weeks of job search.**

*For parents enrolled with the Technical College System of Georgia (TCSG): every credit hour equals two hours towards the required 24 hours a week of approved activities. For example, if a parent is enrolled in a class that counts as 3 credit hours with TCSG, they earn 6 credit hours a week towards the required 24.

**Parents who meet eligibility requirements for certain priority groups may be authorized with job search as their state-approved activity for the entire 12-month eligibility period.

---

**CHANGES TO THE CHILD CARE DEVELOPMENT FUND FOR 2019-2021**

Georgia received an extra **$93 million** in CCDF funds for FY 2019-2021.

As of September 17, 2018, parent fees were significantly reduced, not to exceed **7%** of family income.

All CAPS sites must be Quality Rated by the end of 2020.

Sources: [https://tinyurl.com/CAPSReferences](https://tinyurl.com/CAPSReferences)
Demand for Afterschool in Georgia

282,453 or 16% of Georgia’s school-aged children participated in afterschool programs in 2014¹

but

Nearly 600,000 or 40% more children would enroll if a program was available in their community²

That’s a 14% increase in the demand for afterschool programs since 2004³

45% of programs say they must at least double capacity to serve all the kids in their community who need afterschool⁴

And Over 300,000 or 18% of Georgia’s children are alone and unsupervised between the hours of 3pm and 6pm

THE TOP FIVE AFTERSCHOOL PROVIDERS:

Public Schools  Religious Organizations  Private Schools  YMCAs  Boys and Girls Clubs
<table>
<thead>
<tr>
<th>WHY DO WE NEED MORE PROGRAMS:</th>
<th>WHAT PARENTS SAY:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>19%</strong> of juvenile violent crimes occur during school days between: 3pm and 7pm&lt;sup&gt;5&lt;/sup&gt;</td>
<td><strong>78%</strong> of Georgia's parents say that afterschool programs help parents keep their jobs&lt;sup&gt;9&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>45%</strong> of students attending 90 days or more at a 21st CCLC afterschool program improved math and reading test scores&lt;sup&gt;6&lt;/sup&gt;</td>
<td><strong>90%</strong> of Georgia's parents are satisfied with their child’s afterschool program&lt;sup&gt;10&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>90%</strong> of students in a 4-year afterschool program graduated high school&lt;sup&gt;7&lt;/sup&gt;</td>
<td>About <strong>2.5 MILLION working parents are overly stressed by afterschool concerns, bringing stress to the work place, lessening productivity</strong>&lt;sup&gt;11&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>25%</strong> fewer absences for students who are in afterschool programs for two years&lt;sup&gt;8&lt;/sup&gt;</td>
<td><strong>80%</strong> of parents were less worried about their child’s safety when in afterschool&lt;sup&gt;12&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

**CONTACT US** | For more information on afterschool in Georgia go to [www.afterschoolga.org](http://www.afterschoolga.org)
The Landscape of Afterschool in Georgia

The Georgia Department of Education (GaDOE) and the Georgia Division of Family and Children Services (DFCS) FUND 567 do not have any state funded programs but IN PARTNERSHIP WITH:

Visit the Georgia ASYD Website: www.georgiaasyd.org
Visit GSAN’s Website: www.afterschoolga.org

FOR MORE INFORMATION:

These programs serve over 57,000 young people each year – ranging from Pre-K to high school.

68 COUNTIES are served by more than 1 program

66 OF 159 COUNTIES do not have any state funded programs
Georgia's afterschool and youth development programs provide thousands of youth – from kindergarten through high school – with a safe and enriching place to go after the school day ends. High quality afterschool programs keep Georgia's young people on track to succeed in school, careers, and life – but what does high quality mean?

### High Quality Afterschool and Summer Learning Programs:

- **have flexible, well-rounded daily schedules with activities that are well organized, appropriate, and allow for learning new skills**
- **build upon what young people are learning during the school day**
- **are safe and clean and reflect the needs and interests of all youth**
- **nurture positive relationships and promote a respectful environment**
- **provide opportunities for physical activity and to practice healthy habits**
- **need great staff and volunteers and should support their growth and development**
- **have a clear mission, defined goals, and good financial management**
- **need to always be improving – data collection and analysis is key**
- **engage families and communities in the program**

### Why Does Quality Matter:

**The ABCs: Attendance Behavior and Coursework**

Participation in high quality afterschool programs can increase attendance, improve behavior and raise student achievement.

**Closing the Achievement Gap**

For low-income students who consistently participated in high-quality afterschool programs from kindergarten through fifth grade, the achievement gap in math scores between those students and their high-income peers was eliminated by fifth grade.

**Better Health**

One Georgia study shows that the prevalence of obesity decreased for children participating in afterschool programs compared to those who did not participate.

**Confidence and Self-Efficacy**

Students in afterschool programs develop better work habits, have more self-efficacy in the classroom and have better attitudes about school.

**Productive Parents**

Parents report that they have less stress, fewer unscheduled absences and more productive work time when their children are enrolled in afterschool programs.

**Minimizing Risks**

The hours between 3:00 p.m. and 6:00 p.m. on school days are the most likely periods for juvenile crime and experimentation with drugs, alcohol, cigarettes and sex.
WHERE IS GEORGIA HEADING:

GEORGIA AFTERSCHOOL & YOUTH DEVELOPMENT (ASYD) QUALITY STANDARDS

The Georgia ASYD Quality Standards is a collaborative project that is funded and endorsed by the Georgia Division of Family and Children Services, the Georgia Department of Education, the Georgia Department of Public Health and the Governor’s Office for Children and Families. These standards are research-based best practice guidelines that delineate the critical components of high quality youth development programs. When adopted by afterschool and youth development programs, the standards can be used as a framework for the design and implementation of high quality programs for youth from elementary through high school.

GEORGIA AFTERSCHOOL & YOUTH DEVELOPMENT (ASYD) CONFERENCE

The bi-annual Georgia ASYD Conference, hosted by the Georgia Division of Family and Children Services, the Georgia Department of Education, and the Georgia Department of Public Health, is an opportunity for afterschool programs across the state to come together. Through interactive workshops, afterschool professionals can learn best practices in positive youth development and organizational practices, network with their peers, and better understand how to utilize the Georgia ASYD Quality Standards.

For more information on the Georgia ASYD Quality Standards and Conference go to www.georgiaasyd.org

QUALITY RATED SCHOOL AGE PROGRAM

The Georgia Department of Early Care and Learning’s Quality Rated is a voluntary quality improvement system for child care and afterschool programs to achieve higher levels of quality. Afterschool programs have a specially tailored process to complete Quality Rated that reflects the population they serve.

Quality Rated can support afterschool programs with technical assistance, free training, minigrants, bonus packages for receiving a star rating, and marketing materials.

For more information on Quality Rated go to www.qualityrated.org

CONTACT US | For more information on afterschool in Georgia go to www.afterschoolga.org
What are the Georgia Afterschool & Youth Development (ASYD) Quality Standards?

The ASYD Quality Standards are based on research from a variety of fields including education, child development and psychology, organizational psychology, business management and public health. Each standard aims to encourage positive short-term and long-term outcomes in youth based on best practices found through this research.

EVIDENCE-BASED, RESEARCH-DRIVEN:

The ASYD Quality Standards are designed especially for programs that:

- Serve children and youth between ages 5 and 18
- Serve youth who attend regularly and over a long period of time
- Are well-established
- Offer youth a range of enriching experiences

SELF-ASSESSMENT, NOT PUNISHMENT:

Programs can utilize this as a tool for quality awareness and improvement, facilitating important conversations and setting goals among staff.

DESIGNED ESPECIALLY FOR PROGRAMS THAT:

- Serve children and youth between ages 5 and 18
- Serve youth who attend regularly and over a long period of time
- Are well-established
- Offer youth a range of enriching experiences

A TOOL FOR CONTINUOUS IMPROVEMENT:

Studies show that programs that use a continuous quality improvement system are likely to see improvements in the quality of instruction delivered by staff members and even retention levels of short-term staff.

Georgia joins 38 other states, including Arkansas, Florida, Nebraska, and Indiana, which also have quality standards for their afterschool programs.
The Anatomy of the ASYD Quality Standards

**QUALITY ELEMENTS**

9 Georgia’s standards are organized into nine categories called “Quality Elements”

- **Programming & Youth Development**
- **Linkages with the School Day**
- **Environment & Climate**
- **Relationships**
- **Health & Well Being**
- **Staffing & Professional Development**
- **Organizational Practices**
- **Evaluation & Outcomes**
- **Family & Community Partnerships**

Each of these nine quality elements includes a series of related standards or best practices, as well as indicators to help programs understand what successful implementation looks like.

The Standards Promote Education, Families and Health

**SUPPORTING EDUCATORS AND STUDENT LEARNING**

- **Keep** open and frequent lines of communication between program staff and school faculty
- **Utilize** and base activities on Georgia state academic standards
- **Offer** hands-on activities that further engage students in content from the school day
- **Incorporate** homework help and tutoring
- **Teach** students skills that will help them become academically successful, such as time management and teamwork

**STRENGTHENING FAMILY PARTNERSHIPS**

- **Hold** orientations for families to learn about the program
- **Encourage** families to visit and observe the program
- **Share** positive information and constructive feedback with families regularly through written notes, phone calls and face-to-face conversations
- **Ask** families for feedback about how to improve the program

**ENCOURAGING HEALTHY LIFESTYLES**

- **Prevent** bullying and harassment
- **Teach** healthy eating and cooking choices and offer healthy snacks
- **Incorporate** physical activity
- **Communicate** with and provide resources to families about health

**FOR MORE INFORMATION:**

Visit the Georgia ASYD Website: [www.georgiaasyd.org](http://www.georgiaasyd.org)
Visit GSAN’s Website: [www.afterschoolga.org](http://www.afterschoolga.org)

IN PARTNERSHIP WITH:
A Snapshot of 21st CCLC in Georgia

The 21st Century Community Learning Centers (CCLC) Program is the only federal funding stream dedicated to afterschool, before school, and summer learning.

28,000 kids participated in 21st CCLC in Georgia in 2018

In 2018, Georgia awarded over $39 MILLION for 21st CCLC programming

Out of the 237 program sites that serve Georgia’s children:

- 71% are located in schools
- 24% are located in community based organizations
- 5% are located in institutions of higher education

165 of the programs operate over the summer

Demographics of students served by 21st CCLC in Georgia:

<table>
<thead>
<tr>
<th>AGE</th>
<th>Pre-K</th>
<th>Elementary</th>
<th>Middle</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>164</td>
<td>6,195</td>
<td>4,310</td>
<td></td>
</tr>
</tbody>
</table>

Racial Makeup:

- African American: 67%
- Caucasian: 33%
- Hispanic: 18%
- Asian: 9%
- Other/Not Reported: 5%

67% of 21st CCLC sites are in urban areas
33% of 21st CCLC sites are in rural areas
87% are eligible for free or reduced lunch
Georgia’s 21st CCLC programs offer students the equivalent of at least 45 additional school days. 21st CCLC programs attempt to enroll students who previously did not meet state standards.

Of those who participated in 21st CCLC:

- **75%** improved/maintained an A, B, or C in their English grades
- **80%** improved/maintained an A, B, or C in their math grades

21st CCLC not only provides programming for kids, but for families as well. In the 2018 school year, 30,297 parents attended 1,717 events ranging from:

- GED Prep
- Movie Nights
- Sporting Events

73% of eligible programs were not funded for the 2016 – 2017 school year.

9 out of 10 children who participated in 21st CCLC in Georgia increased homework completion.

8 out of 10 children who participated in 21st CCLC in Georgia improved classroom behavior.

96% of parents are satisfied with their child’s 21st CCLC program.

88% of children are satisfied with their 21st CCLC program.

To learn more about Georgia Afterschool & Youth Development please visit [www.georgiaasyd.org](http://www.georgiaasyd.org).

To learn more about Georgia’s 21st CCLC program please visit [www.gadoe.org](http://www.gadoe.org).

In partnership with:
Support for Afterschool in Georgia

PARENT SATISFACTION WITH AFTERSCHOOL PROGRAMS HAS Risen IN THE LAST DECADE:

PARENTS SATISFIED WITH THEIR CHILD’S AFTERSCHOOL PROGRAM

<table>
<thead>
<tr>
<th>OVERALL</th>
<th>SAFE ENVIRONMENT</th>
<th>QUALITY OF CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>2009</td>
<td>2014</td>
</tr>
<tr>
<td>82%</td>
<td>87%</td>
<td>90%</td>
</tr>
<tr>
<td>2009</td>
<td>73%</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>89%</td>
<td>86%</td>
</tr>
<tr>
<td>70%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td></td>
<td>70%</td>
</tr>
<tr>
<td>2014</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PARENTS REPORT A RANGE OF BENEFITS OF AFTERSCHOOL PROGRAMS:1

- 70% Reduction of risky behavior
- 64% Gain workforce skills
- 59% Excites children about learning
- 79% Peace of mind for parents at work
- 78% Help working parents keep jobs

SUPPORT EXTENDS BEYOND JUST PARENTS WHO ARE SERVED BY AFTERSCHOOL PROGRAMS:

OVER 200 ORGANIZATIONS are involved as partners, supporters or local leaders in afterschool including:7

- US Department of Education
- United Way of America
- National Association of School Psychologists
- National Education Association

92% of working mothers say afterschool programs are important in 20125

82% of school superintendents say afterschool programs are important in 20115

88% of parents in Georgia support public funding for afterschool programs1

CONTACT US | For more information on afterschool in Georgia go to www.afterschoolga.org
Each child comes with his or her own needs, desires and challenges, which means that a child's well-being is a moving target. It's fluid, crossing systems, conditions and time, and engages an array of people, places, services, and systems which children traverse frequently. Often, kids find themselves navigating multiple conditions and situations at the same time, needing varying levels of support and care from each.

Making sure that every child in our state has access to high quality medical care is essential in order to prevent illness and injury, assess needs, address those needs, and improve the chances of a long and successful life.

**Wellchild**
Good child health relies on prevention, screening, and early intervention. Regularly scheduled checkups, often called well-child visits, from shortly after birth through the teen years, allow a doctor to keep a child's general health and development in check.

**Newborns**
Good prenatal care, early developmental screenings and interventions can minimize the occurrence and outcomes of many developmental delays and disabilities. This sets the stage for a child to have the most healthy future possible.

**Behavioral Health**
In Georgia, an estimated 21% of children from 2-17 need some sort of behavioral health services. That can mean everything from grief counseling, to substance abuse treatment, to psychiatric medication to therapeutic intervention for autism.

**State Custody**
Medicaid covers care for approx. 14,000 kids in Georgia’s child welfare system and for most of the 1400 or so children under supervision by the Georgia Department of Juvenile Justice. Behavioral Health services, among others, are key to helping children through tough times, improving public safety and reducing recidivism.

**Pre-existing Conditions**
Thousands of Georgia children encounter significant health obstacles as a result of pre-existing conditions, such as cancer, asthma, sickle cell anemia, and developmental disabilities.

**Incidental**
Life happens, and that means dealing with things like cavities, broken arms, colds and concussions. Such conditions, though not pre-existing, can easily consume a family's time and income.

**Sources available:** https://tinyurl.com/ybywhcc6
### Georgia Families CMO
- **No. of Children Served:** 1,316,200²
- **Ages Served:** 0 to 18
- **Key Requirements:** Children in foster care, youth receiving adoption assistance, etc.

### Georgia Families 360 CMO
- **No. of Children Served:** 24,000²
- **Ages Served:** 0 to 26
- **Key Requirements:** Aged, blind, and disabled. (SSI deeming waivers)

### Fee For Service
- **No. of Children Served:** 60,331¹
- **Ages Served:** All

### Peachcare
- **No. of Children Served:** 237,011²
- **Ages Served:** 18 and under (Eligible until 19th birthday)
- **Key Requirements:** Previously uninsured for 60 days, family income is equal to or less than 247% of the federal poverty level (that's about $62,004 for a family of 4)

---

1. Number of children served represent ever enrolled during FY15
2. Number of children served represent ever enrolled during FY17

---

200,000 of Georgia’s children remain uninsured.

**How Georgia’s Doing**

<table>
<thead>
<tr>
<th>Department of Behavioral Health &amp; Developmental Disabilities (DBHDD)</th>
<th>Department of Community Health (DCH)</th>
<th>Department of Education (DOE)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program &amp; Children Served</strong></td>
<td><strong>Program &amp; Children Served</strong></td>
<td><strong>Program &amp; Children Served</strong></td>
</tr>
<tr>
<td>Social security beneficiaries, uninsured children that require behavioral health services, developmental disability waivers (e.g., Katie Beckett waiver)</td>
<td>Children receiving special education services that are in the state’s Children’s Intervention Services in Schools State Medicaid Plan and who are enrolled in Medicaid.</td>
<td></td>
</tr>
</tbody>
</table>

**How Medicaid and Peachcare Money Work**

- 32.5% $3,257,019,997 Georgia Dollars
- $10,204,127,983 *SFY 2017
- 67.5% $6,947,107,986 Federal Government Match

**Medicaid and Peachcare in Georgia**

Voices for Georgia’s Children
**Medicaid**

**WHAT IS IT?**
Medicaid is a jointly funded, Federal-State health insurance program for low-income and needy people.

**HOW IS IT FUNDED?**
Medicaid is financed through a combination of federal and state funds. The federal dollars vary from year to year based on facts like the per capita income.

**WHAT DOES IT COVER?**
It covers children, pregnant women, the aged, blind, and/or disabled people.

**WHO CAN GET IT?**
All Georgia Medicaid beneficiaries must be US citizens or legal residents for 5 years.

---

**PeachCare**

Also known as Georgia’s Children’s Health Insurance Program (CHIP)

**WHAT IS IT?**
CHIP is a federal assistance program that helps states provide insurance for low-income children whose families make too much to allow them to qualify for Medicaid coverage, but make too little to provide the insurance on their own.

**HOW IS IT FUNDED?**
As of October 1, 2015 the federal government pays 100% of Georgia’s CHIP costs. This includes service and administrative costs.

**WHAT DOES IT COVER?**
In Georgia, CHIP covers children of families earning at or below 252% of the federal poverty level (FPL) (that’s at or below $61,110 for a family of four)

**WHO CAN GET IT?**
In Georgia, CHIP covers primary, preventive, specialty, dental and vision care for enrolled children ages 18 and under. In addition, the insurance covers hospitalization, emergency room visits, prescription medications and mental health care.
TWO WAYS TO GET MORE KIDS COVERED

In Georgia, 93 percent of kids have health coverage, many thanks to Medicaid and the Children’s Health Insurance Program (CHIP), known as PeachCare for Kids. While clearly this is good news, nevertheless, Georgia still has the 4th highest number of uninsured children in the nation.

GEORGIA CAN DO TWO THINGS TO COVER MORE THAN 50% OF ELIGIBLE KIDS:

Guarantee enrollment for children for 12 continuous months to ensure that temporary surges in family income like seasonal overtime don’t wreak havoc and cause kids to lose coverage. Continuous eligibility also enables Georgia to better measure the quality of care children receive.

Use SNAP (Supplemental Nutrition Assistance Program) eligibility data to automatically enroll eligible children. This would allow tens of thousands of Georgia’s children to gain coverage while reducing the administrative burden on the state to collect and review previously verified data.

WHAT’S AT RISK WHEN KIDS DON’T HAVE HEALTH INSURANCE?

• Children do not receive the check-ups needed to identify life-threatening conditions.

• Children who take prescribed medications for chronic conditions, such as asthma or ADHD, are forced to suddenly stop taking them.

• Delayed medical visits can change routine health care into crisis health care.

• Doctors and hospitals are forced to either provide care at no cost or deny services.

Sources available: https://tinyurl.com/y7qv6zv4
Revised: 12/2018
## Access to Dental Care in Georgia

### Kids and Dentists Face Major Challenges

<table>
<thead>
<tr>
<th>Availability of Care</th>
<th>Transportation</th>
<th>Medicaid Reimbursement for Services</th>
<th>Language</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dentists</strong> 1 per 2,143 Georgians</td>
<td><strong>On average, Medicaid/CHIP eligible kids have to travel 15 more miles for dental care than their non-Medicaid peers</strong></td>
<td><strong>Reimbursement as a % of fees charged</strong></td>
<td><strong>Medicaid patients are required by federal law to have access to translation services arranged for and paid for by the provider</strong></td>
</tr>
<tr>
<td><strong>Hygienists</strong> 1 per 1,721 Georgians</td>
<td></td>
<td><strong>Medicaid</strong> 47.4% <strong>Private</strong> 80%</td>
<td><strong>Of dental schools in the US report that students were not adequately prepared to manage Limited English Proficient patients</strong></td>
</tr>
<tr>
<td><strong>123 Counties in Georgia have a dental care shortage</strong></td>
<td><strong>59% Of Georgia’s counties are at high risk for health transportation barriers</strong></td>
<td></td>
<td><strong>38%</strong></td>
</tr>
<tr>
<td><strong>72% Medicaid or PeachCare</strong> Georgia ranks 14th out of the 16 southern states in the percent of dentists accepting Medicaid or PeachCare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>14%</strong> children in Georgia did not have dental care in the last 12 months.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1,330,000 children in Georgia did not have dental care in the last 12 months.
**Benefits of Improved Dental Health**

<table>
<thead>
<tr>
<th>Improved health outcomes</th>
<th>Cost savings for kids, families and the state</th>
<th>Improved education and life outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Link between poor oral health and:</td>
<td>Reduction of future dental visits and related costs</td>
<td>Improved attendance</td>
</tr>
<tr>
<td>- Trouble eating and speaking</td>
<td>- One study found that preventive dental care could save Georgia $51.1 million annually in Medicaid costs</td>
<td>- Improved academic performance</td>
</tr>
<tr>
<td>- Diabetes</td>
<td></td>
<td>- Improved self-esteem and employability</td>
</tr>
<tr>
<td>- Pain</td>
<td></td>
<td>- Reduced pain and suffering</td>
</tr>
<tr>
<td>- Pre-term low birth weight</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Policy Recommendations**

**Increase dental workforce in shortage areas throughout Georgia by:**
- Continue to expand dental hygienists practicing in settings such as schools and nursing homes.

**Incentivize and increase Medicaid acceptance rates among dentists by:**
- Increasing Medicaid reimbursement rates for dental services like exams, cleanings, fluoride, sealants, and treatment of caries.
- Reducing administrative barriers that hinder dentists from accepting Medicaid.

For sources please visit [https://tinyurl.com/y9wuf2u5](https://tinyurl.com/y9wuf2u5)
School-Based Health Centers: Maximizing Access to Quality Care

School-Based Health Centers (SBHCs) are primary care centers within schools that provide convenient, accessible, and comprehensive health care services to children, families, and school personnel. There are currently 2,315 SBHCs in the United States.

More than 8,000 children, families, and school personnel currently benefit from services at 38 SBHCs in Georgia.

<table>
<thead>
<tr>
<th>Number of SBHCs per state</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

WHAT COMPREHENSIVE HEALTHCARE SERVICES LOOKS LIKE

- **Physical Health**
  - Well-child visits
  - Preventive screenings
  - Immunizations
  - Chronic disease management

- **Behavioral Health**
  - Preventive screenings
  - Treatment services
  - Address social disorders

- **Dental Health**
  - Oral exams
  - Education
  - Screenings
  - Treatments
  - Sealants

- **Counseling & Education**
  - Dangerous behaviors
  - Social & emotional health
  - Healthy eating & active living
  - Sexual & reproductive health

Revised on 1/14/17. For sources please visit [https://tinyurl.com/ycagttz9](https://tinyurl.com/ycagttz9)
Increased access to primary, oral, and behavioral health care.

Increased use of mental health and substance abuse services.

Decreased emergency room use and hospitalization for children with asthma.

Decreased prescription drug use.

Increased attendance and GPA for students utilizing mental health services.

Decreased drop out rates and school discipline referrals.

Decreased cost of:
- Pediatric health care for Medicaid, PeachCare, and private insurers.
- Emergency room use and hospitalizations.
- Pharmacy and transportation costs.
- Time away from work for parents.

Children in Georgia are currently uninsured: 200,000

Don’t receive the behavioral health services they need: 60%

Of counties don’t have a licensed social worker or psychologist: 51%

Children in Georgia stay home sick more than six days each year: 190,000

Georgia’s current rank in overall child well-being: 39th

A PROBLEM OF ACCESS: THE NEED FOR SCHOOL-BASED HEALTH CENTERS

THE BENEFITS OF SCHOOL-BASED HEALTH CENTERS
SUCCESS IN GEORGIA

Whitefoord SBHC

✓ 50% reduction in average cost per child to Medicaid for children with SBHC access.

✓ Annual expense per Medicaid-covered child decreased from $2,360 to $899.

Lake Forest SBHC

✓ 50% of the students referred to the SBHC returned to class afterwards.

✓ 10% reduction in absenteeism in the first year.

✓ 44% reduction in the number of students sent home sick.

SBHCs in Georgia

More than 8,000 children, families, and school personnel currently benefit from services at 38 SBHCs in Georgia.

STATE FUNDING FOR SBHCs

37% of states currently provide funding for SBHCs.

Grants provide another funding opportunity for SBHCs.

Current SBHC grants in Georgia:

• NIH Grant - To study the impact and benefits of SHBCs in suburban and rural areas of Georgia.

• PARTNERS for Equity in Child and Adolescent Health - Allocates planning grants to communities in Georgia. 36 have been awarded since 2010.

For more information on Planning Grants, visit: http://bit.ly/2jtPGSQ

Revised on 12/5/18. For sources please visit https://tinyurl.com/y9rb3egb
Revised on 11/27/18. For sources please visit https://tinyurl.com/y87jj6q6

* DeKalb and Chatham Counties’ Mobile Medical Unit serve 4 schools.
GNETS: AN OVERVIEW

A network of programs designed to provide comprehensive educational and therapeutic support services to students with severe emotional and behavioral disorders. These students receive services either in their neighborhood school or in a separate GNETS facility. GNETS, originally the Georgia Psychoeducational Network, was created by the Georgia General Assembly in 1972 after a three year pilot project in Athens. The network of programs grew to 24 by 1976, and was renamed GNETS in 2007.

STUDENTS IN GNETS
More than 3,000 students are served by GNETS.

Students are referred to GNETS by their local school system through the IEP process.

GNETS programs serve students with behavioral disabilities like:
- Autism
- ADHD
- and other mental health needs

EXIT CRITERIA

Students return to their school when they meet exit criteria developed on entry.

However, exit criteria can be vague and standards can be set higher than would be for general students.

For example

Criteria for some GNETS students require that they maintain physical self-control 100% of the time.

RACIAL MAKEUP

<table>
<thead>
<tr>
<th>Race</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>54%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>41%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>4%</td>
</tr>
<tr>
<td>Other/Mixed</td>
<td>1%</td>
</tr>
</tbody>
</table>

DISABILITIES OF STUDENTS IN GNETS

<table>
<thead>
<tr>
<th>Disability</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional and behavioral disorder</td>
<td>1,807</td>
</tr>
<tr>
<td>Autism</td>
<td>566</td>
</tr>
<tr>
<td>Other impairment</td>
<td>329</td>
</tr>
<tr>
<td>Other disability</td>
<td>171</td>
</tr>
<tr>
<td>Significant developmental delay</td>
<td>155</td>
</tr>
<tr>
<td>Intellectual disability</td>
<td>70</td>
</tr>
</tbody>
</table>

Revised on 12/15/18. For sources please visit https://tinyurl.com/yd299vyq
The Georgia Department of Audits conducted a performance audit of GNETS in 2010 and found the following outcomes. There is no current data available to demonstrate improvement from the 2010 findings.

**COST OF EDUCATION**

- **$14,000** Average cost per GNETS student.
- **$9,938** Average cost per general education student

**DISTANCE FROM COMMUNITY**

The maximum distance some school districts have set for their students to travel to GNETS programs is significantly longer than the typical commute of their neighborhood peers.

**FY 18 GOVERNANCE AND FUNDING**

- **$65 million** state dollars
- **$73 million** GNET funding
- **$8 million** federal dollars

**Glossary of Related Terms**

**EBD - EMOTIONAL AND BEHAVIORAL DISORDERS**

- An inability to build or maintain satisfactory interpersonal relationships.
- An inability to learn which cannot be adequately explained by intellectual, sensory, or health factors.
- A consistent or chronic inappropriate type of behavior or feelings under normal conditions.
- A displayed pervasive mood of unhappiness or depression.
- A displayed tendency to develop physical symptoms, pains, or unreasonable fears associated with personal or school problems.

**IEP – INDIVIDUALIZED EDUCATION PROGRAM**

- A written plan detailing a student’s present level of academic achievement, measurable annual goals, duration of special education services, student placement, etc.
- IEPs are developed by teams of personnel familiar with the student.

**OTHER TERMS**

- **EPSDT – Early & Periodic Screening, Diagnostic, and Treatment**
- **RESA – Regional Educational Service Agency**

Revised on 12/15/18. For sources please visit https://tinyurl.com/yd299yq
## Recommendations of the Commission on Children’s Mental Health

After a number of years examining the various needs of the child and youth population in Georgia, a recurring theme emerged from a number of legislative study committees and at least one administrative reform commission (Child Welfare Reform Commission, 2016): the need for the state to strengthen its focus on children’s mental and behavioral health. To address such concerns, Governor Nathan Deal appointed the Commission on Children’s Mental Health in June of 2017. The following are the recommendations adapted from the report of that commission, released on December 11, 2017. The full report can be found at [http://bit.ly/2yiMmgB](http://bit.ly/2yiMmgB). In the SFY 19 budget, over $20 million was allocated to support all eight recommendations of the Commission. More on the budget can be found at [https://tinyurl.com/ydd3nhz4](https://tinyurl.com/ydd3nhz4).

### A

**Challenge to be Addressed**

Need for better coordination and collaboration among school systems, mental health providers, and other community stakeholders

**Desired Impact**

Increased access to a continuum of behavioral health care for children and families

**Target Ages**

Pre-K through 12th grade

**Increase access to behavioral health services for Georgia’s school-aged children by sustaining and expanding the Georgia Apex Program (GAP) for school-based mental health.**

### B

**Fund Supported Employment/Supported Education programs for youth and emerging adults with severe mental illness.**

**Challenge to be Addressed**

Need for access to employment and recovery opportunities for individuals with severe mental illness

**Desired Impact**

Sustained and increased access to supports for employment and related recovery activities

**Target Ages**

Ages 16 to 26

### C

**Provide support for the development and implementation of additional levels of support within the behavioral health continuum of care for youth with the highest levels of need.**

**Challenge to be Addressed**

Gaps in the continuum of care for children with behavioral health needs; need for additional levels of care, enhanced workforce training, and awareness of emerging conditions

**Desired Impact**

Youth at the highest level of need would be able to access more appropriate urgent and responsive care, such as those requiring specialized foster services centered around care coordination

**Target Ages**

Ages 4 to 26

### D

**Strategically increase telemedicine infrastructure capacity for child-serving, community-based, behavioral health provider organizations in order to improve access to children’s behavioral health services.**

**Challenge to be Addressed**

Significant difficulties in accessing behavioral health services, especially in rural areas, for children and families; lack of widespread flexible infrastructure for telemedicine

**Desired Impact**

Increased access to children’s behavioral health services, especially in rural areas

**Target Ages**

Ages 4 to 26
<table>
<thead>
<tr>
<th>Challenge to be Addressed</th>
<th>Desired Impact</th>
<th>Target Ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invest in <strong>coordinated training</strong> for priority areas of interest and concern for the child-serving workforce. This may include additional clinical training in evidence-based practices, including trauma-informed care, and may also include administrative practices that support the delivery of high quality behavioral health services across service settings.</td>
<td>Advance the planning, coordination, and delivery of behavioral health workforce training</td>
<td>Staff members of clinical providers, state agencies, and stakeholder groups in need of training</td>
</tr>
<tr>
<td>Fund expanded provider training, fidelity monitoring, technical assistance, and evaluation for evidence-based <strong>High Fidelity Wraparound (HFW)</strong>.</td>
<td>Increased access to HFW for providers which will help more youth remain in their communities</td>
<td>Ages 5 to 21</td>
</tr>
<tr>
<td>Support multi-pronged early intervention and prevention approaches to combat the <strong>opioid crisis</strong> among Georgia’s youth and emerging adults.</td>
<td>Decreased opioid misuse, abuse, and overdose deaths</td>
<td>Ages 10 to 25</td>
</tr>
<tr>
<td>Support a multi-pronged <strong>suicide prevention</strong> approach, including the expansion of prevention programming and expansion of Georgia Crisis and Access Line (GCAL) hours, to reduce rising suicide rates among Georgia’s youth and emerging adults.</td>
<td>Reduced suicide attempts and increased access to service referrals through GCAL</td>
<td>Ages 10 to 24</td>
</tr>
</tbody>
</table>

Sources: https://tinyurl.com/y9gw4ppc
Revised 11/27/18
Voices for Georgia’s Children conducted an analysis of Georgia’s child and adolescent behavioral health workforce* in order to inform strategic decisions aimed at improving the preparation, practice, and support of the workforce. The following represent key findings and recommendations from that analysis. For the full report please visit https://bit.ly/2DGii58.

<table>
<thead>
<tr>
<th>FINDINGS</th>
<th>RECOMMENDATIONS</th>
</tr>
</thead>
</table>
| Lack of a strategic, integrated and formal approach to our education, training, and licensure:  
• Lack of sufficient opportunities  
• Lack of system connectivity  
• Difficult path to licensure | Pilot a training program that ensures the workforce has a path from degree to licensure with relevant evidenced based therapy training  
Expand residency and post-degree certification opportunities |
| Graduates lack certain skills, training, and confidence  
• Evidence-based therapies  
• Administrative skills | Streamline trauma training of existing workforce and child serving systems  
Offer scholarships or sponsor cohorts of practitioners to be trained in targeted therapies and obtain CEUs |
| Lack of consistent, reliable, and quality data on the demographics and practice settings of the currently active behavioral health workforce | Implement a Minimum Data Set (MDS) Survey to collect data on the workforce at licensure renewal  
Compile an annual report from data collected in the MDS Survey with geographic and demographic data  
With available data, map the distribution of the workforce |
| Administrative burdens and other barriers to effective practice hinder providers’ ability to practice in and relocate to Georgia:  
• Lack of clarity around telehealth  
• Inadequate non-emergency medical transportation  
• Lack of evidence-based standards for Medicaid reimbursement rates  
• Lack of connectivity between crisis care and follow up care | Implement tele-consultation, -supervision, -learning, and tele-therapy demonstration projects to determine effective models for improving access to care and cost analysis for expansion  
Conduct research on setting evidence-based reimbursement rates, including a full business model cost analysis in targeted settings  
Improve integration of Georgia’s Crisis and Access Line (GCAL) with the systems that provide follow up care (e.g., care coordination services within Care Management Organizations) |
| The array for Georgia’s APRNs is more limited than comparable states | Research expanding the authorization of Psychiatric Nurses to fully leverage their education, training and capabilities |
| Lack of clarity about license reciprocity with other states | Create a publicly available list of licensure reciprocity standards and the states from which Georgia accepts licenses for incoming professionals (particularly salient to support Military spouses) |
| Incentive programs are available, but only for some practitioner types and providers often face eligibility and administrative barriers | Expand the professions in loan reimbursement programs offered by the state to include additional mental health professionals |

*The analysis covered core behavioral health providers including psychiatrists, pediatricians, psychologists, psychiatric nurses, social workers, marriage and family therapists, and professional counselors.

Sources: https://tinyurl.com/yd5d42k2

Revised 12/12/17
Georgia’s Crisis in Child & Adolescent Behavioral Health

THE PROBLEM:

60% of children who need behavioral health services do not receive them.

Behavioral Health is at the core of the majority of the problems we see in education, juvenile justice and child welfare. And the challenges don’t stop there — they continue into adulthood.

76 of 159 COUNTIES do not have a licensed psychologist

52 of 159 COUNTIES do not have a licensed social worker

Currently, 1 School Psychologist for every 2,475 students

Needed: 1 School Psychologist for every 1,000 students

Currently, 1 School Nurse for every 1,088 students

Needed: 1 School Nurse for every 750 students

Approx. 75% of children who receive services, receive them in schools.
ALARMING STATS:

* 2 in 10 children have one or more emotional, behavioral, or developmental conditions.

- Suicide is the 2nd leading cause of death among youth age 9 to 17.
- Children with disabilities are twice as likely to be suspended increasing the risk of grade repetition and dropping out.
- Preschoolers are expelled more than three times as often as K-12 students, often due to behavior issues.
- Approx. 50-70% of youth in the juvenile justice system have a need for behavioral health services.

WHY WE NEED BEHAVIORAL HEALTH SERVICES:

Untreated behavioral health illness in children and adolescents can lead to:

- A higher usage of health care services
- Higher poverty rates
- Much lower rates of employment in adulthood

WHAT WE NEED:

1. All children and adolescents have access to behavioral health services
2. Schools are equipped to meet the need early and effectively
3. Georgia has the workforce to help children and adolescents with behavioral health needs

WHAT NEXT:

We need to fully implement Georgia's comprehensive three-year state plan for child and adolescent behavioral health and continue to fund the recommendations from the Children's Commission on Mental Health.

Sources available at: https://tinyurl.com/yarnoke5
Revised on 12/4/18
Snapshot of Child and Adolescent Behavioral Services in Georgia

Telehealth Behavioral Health Pilot in Lamar County Schools (DPH lead, interagency participation)

Counties with schools trained in PBIS (DOE)

Child Advocacy Center Location

County with parent and peer support specialists

SBHCs with behavioral health services

Project AWARE locations

Project Apex (DBHDD): Community Service Board (CSB) providing school-based services

DBHDD Resiliency Support Clubhouse locations

School districts using the Georgia Partnership for Telehealth network

Sources for this factsheet available at: https://tinyurl.com/ybkwvut2
Revised on 12/5/18
# Current Child & Youth Behavioral Health Projects in Georgia

## Early Childhood

**Project LAUNCH**

Increases access to mental health services for children ages 0-8 in childcare and early education settings, through parental supports, early behavioral health screenings, and trainings for early identification of autism. Funding: Federal Grant; 5-years.

## School-Based Access

**Project Apex**

Increases school-based behavioral health capacity through Community Service Boards (CSBs). CSBs develop partnerships with local schools to provide behavioral health services. Funding: DBHDD State Funds.

**Project AWARE**

Builds capacity of state and local educational agencies to increase awareness of mental and substance abuse issues through student screenings and school staff trainings (e.g., Youth Mental Health First Aid). Funding: Federal Grant; 5-years beginning in 2014.

**SBHCs**

School-Based Health Centers: Improve children’s access to health services. 10 SBHCs provide mental and behavioral health services through on-site services in partnership with community providers. Funding: Foundation grants for start-up costs, insurance billing for sustainability.

**PBIS**

Positive Behavior Intervention Supports in schools: Facilitates positive school climate and timely identification of behavioral health needs for students. A network of 1100+ schools and programs representing 50% of Georgia local educational agencies continue implementation with fidelity. Funding: DOE state funds PBIS specialists in each Regional Education Support Area.

## Telehealth & Telemedicine

**DPH**

Department of Public Health: Identified need for mental and behavioral health tele-health services. DPH is leading an interagency pilot to augment on-site school-based health services with behavioral health via tele-health. Funding: DPH state funds provided equipment.

**GPTH**

Georgia Partnership for Telehealth: 49 schools have tele-health equipment to be used for behavioral health services through the GPTH network. Funding: GPTH grant; school budget for staff time; Medicaid.

## Out-of-School Time

**Club Houses**

Mental Health Resiliency Club Houses: DBHDD supports six clubhouses statewide to provide supportive services, e.g., educational, social, and employment support geared to engage youth and assist them in managing behaviors and symptoms.

**ASYD**

After School and Youth Development Quality Standards: A tool designed to help ensure afterschool and youth development programs and provide environments that benefit youth socially, emotionally, and academically. Funding: DFCS, DOE, DECAL.

## Parent & Child

**Specialists**

Parent and Peer Support Specialists: Certified specialists assist parents and families of children with emotional and behavioral challenges by identifying and connecting them to community resources. Funding: DBHDD state budget for training; DBHDD and DCH are currently working to revise the GA State Medicaid plan to allow for services to be covered by Medicaid.

**CPP**

Child Parent Psychotherapy: Recent evidence based intervention for children ages 0-5 who have experienced at least one traumatic event and are experiencing behavior, attachment, and/or mental health problems. Funding: Grant; 1-year.
Youth Suicide in Georgia

GEORGIA YOUTH SUICIDES, AGES 5 TO 17

Source: Georgia Bureau of Investigation, Child Fatality Review Unit

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>32</td>
</tr>
<tr>
<td>2013</td>
<td>36</td>
</tr>
<tr>
<td>2014</td>
<td>30</td>
</tr>
<tr>
<td>2015</td>
<td>51</td>
</tr>
<tr>
<td>2016</td>
<td>51</td>
</tr>
<tr>
<td>2017</td>
<td>43</td>
</tr>
</tbody>
</table>

BREAKDOWN OF 2017 YOUTH SUICIDE DATA

Source: Georgia Bureau of Investigation, Child Fatality Review Unit

- Method:
  - Gunshot: 56%
  - Hangings: 5%
  - Overdose: 2%
  - Other: 2%

- Age:
  - 5 to 9: 37%
  - 10 to 14: 33%
  - 15 to 17: 65%

- Race:
  - White: 67%
  - Black: 33%
  - Hispanic: 19%
  - Asian: 12%

- Gender:
  - Male: 67%
  - Female: 33%

GEORGIA STUDENTS WHO REPORT CONSIDERING OR ATTEMPTING SUICIDE, GRADES 6 TO 12

Source: Georgia Department of Education, Georgia Student Health Survey 2.0

<table>
<thead>
<tr>
<th>Year</th>
<th>Considered Suicide</th>
<th>Attempted Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>48,566</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>51,625</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>54,769</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>57,913</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>61,057</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>64,201</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>78,969</td>
<td></td>
</tr>
</tbody>
</table>

For sources please visit https://tinyurl.com/y7h26v7l

If you or someone you know is considering harming themselves, please call Georgia Crisis and Access Line (GCAL), 1-800-715-4225

Revised 11/21/18
### WARNING SIGNS OF SUICIDAL BEHAVIOR

These signs may mean that someone is at risk for suicide. Risk is greater if the behavior is new, or has increased, and if it seems related to a painful event, loss, or change. Risk is also greater with the presence of multiple warning signs.

- Talking about wanting to die or kill oneself
- Seeking or having lethal means, such as firearms or medication, to kill oneself
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped or being in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Displaying extreme mood swings
- Putting affairs in order or saying goodbye
- Sudden cheerful mood after depression
- Losing interest in enjoyable things
- Difficulty dealing with life issues

### CHILD POPULATIONS AT RISK FOR SUICIDE

Suicide is a complex human behavior with no single determining cause. The following groups have demonstrated a higher risk for suicide or suicide attempts than the general population:

- American Indians and Alaska Natives
- People bereaved by suicide
- People in justice and child welfare settings
- People who intentionally hurt themselves
- People who have previously attempted suicide
- People with medical conditions
- People with mental/substance use disorders
- People who are LGBT

<table>
<thead>
<tr>
<th>Comprehensive Prevention Strategies</th>
<th>Example Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify and assist persons at risk</td>
<td>Gatekeeper training, suicide screening, teaching warning signs, referral to professional help</td>
</tr>
<tr>
<td>Increase help-seeking</td>
<td>Self-help tools and outreach campaigns</td>
</tr>
<tr>
<td>Ensure access to effective treatment</td>
<td>Safety planning, evidenced-based treatment, and reducing financial, cultural, and logistical barriers to care</td>
</tr>
<tr>
<td>Support safe care transitions and organizational linkages</td>
<td>Formal referral protocols, interagency agreements, cross-training, follow-up contacts, rapid referrals, and patient and family education</td>
</tr>
<tr>
<td>Respond effectively to individuals in crisis</td>
<td>Mobile crisis teams, walk-in crisis clinics, hospital-based psychiatric emergency services, and peer-support programs</td>
</tr>
<tr>
<td>Provide for immediate and long-term post-vention</td>
<td>Protocols to respond effectively and compassionately after a suicide, supports for people bereaved by suicide</td>
</tr>
<tr>
<td>Reduce access to means of suicide</td>
<td>Educate families, distributing gun safety locks, changing medication packaging, and installing barriers on bridges</td>
</tr>
<tr>
<td>Enhance life skills and resilience</td>
<td>Skills training, mobile apps, and self-help materials</td>
</tr>
<tr>
<td>Promote social connectedness and support</td>
<td>Social programs for specific population groups</td>
</tr>
</tbody>
</table>
# Substance and Non-Substance Disorders

**Substance Use Disorder**
Recurrent use of substances that causes clinically and functionally significant impairment and failure to meet major responsibilities

**Non-Substance Disorder**
Behavioral addictions that lead to significant psychosocial and functional impairments

## SUBSTANCES USED BY YOUTH

<table>
<thead>
<tr>
<th>Substance</th>
<th>Type of drug</th>
<th>Physical form</th>
<th>Consumption</th>
<th>Impact on Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ALCOHOL</strong></td>
<td>Depressant</td>
<td>Liquid</td>
<td>In beverages</td>
<td>Impaired brain functioning; increased risk of cancer; weakened immune system; decreased heart health and functioning; damage to the liver and other organs; and increased risky behaviors</td>
</tr>
<tr>
<td><strong>COCAINE</strong></td>
<td>Stimulant</td>
<td>Fine, white powder</td>
<td>Snorted, smoked, or injected</td>
<td>Impaired brain functioning; decreased appetite; damage to nose, intestines, and bowels; increased alertness, insomnia, anxiety, and erratic behavior; increased risk for heart issues; and increased risk of infectious diseases</td>
</tr>
<tr>
<td><strong>MARIJUANA</strong></td>
<td>Psychoactive</td>
<td>Greenish, gray mixture of dried, shredded leaves, stems, seeds, or flowers; or resin</td>
<td>Smoked or eaten</td>
<td>Decreased coordination and reaction time; hallucinations, anxiety, panic attacks and psychosis; problems with mental health, learning, and memory; and damage to the respiratory system</td>
</tr>
<tr>
<td><strong>OPIOIDS</strong></td>
<td>Pain relievers, depressants, and stimulants</td>
<td>Tablet, capsule, or liquid</td>
<td>Swallowed or injected</td>
<td>Drowsiness, nausea, constipation, and confusion; slowed breathing and death; and increased risk of infectious diseases</td>
</tr>
<tr>
<td><strong>TOBACCO</strong></td>
<td>Stimulant</td>
<td>Cigarettes, cigars, bidis, hookahs, snuff, or chew</td>
<td>Smoked, shorted, chewed, or vaporized</td>
<td>Increased blood pressure, breathing, and heart rate; greatly increased risk for cancer; and increased risk for chronic bronchitis, emphysema, heart disease, cataracts, and pneumonia</td>
</tr>
</tbody>
</table>

* Legislation passed in 2017 that expanded the conditions for which cannabis oil can be prescribed to include Tourette's syndrome, Autism Spectrum Disorder, Epidermolysis bullosa, Alzheimer's disease, Human immunodeficiency syndrome, Autoimmune disease and Peripheral neuropathy.
### PREVALENCE OF USE IN GEORGIA

Youth Risk Behavioral Surveillance System; Substance Abuse and Mental Health Services Administration

### NON-SUBSTANCE DISORDERS

<table>
<thead>
<tr>
<th>Description</th>
<th>Impact on Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pathological Gambling</strong></td>
<td>Addiction to regulated and non-regulated gambling and betting that causes significant problems in a child’s life. Pathological gambling is formally recognized and can be clinically treated.</td>
</tr>
<tr>
<td></td>
<td>Loss of means to protect well-being (e.g., money, school materials, food, etc.); stress and guilt associated with loss and debt; damaged relationships; and increased risk for mental health disorders, crime, substance use, and risky behaviors</td>
</tr>
<tr>
<td><strong>Problematic Internet Use</strong></td>
<td>Encompasses gambling, internet enabled sexual behavior, online gaming, and excessive internet use that causes youth to neglect other areas of life important to healthy development and functioning.</td>
</tr>
<tr>
<td></td>
<td>Pain and numbness in hands and wrists; dry eyes or strained vision; back aches and neck aches; severe headaches and sleep disturbances; and pronounced weight gain or weight loss</td>
</tr>
</tbody>
</table>

### Georgia High School Student Use of Substances, 2013

- **Cigarettes**: Past Month 13%, Ever 40%
- **Alcohol**: Past Month 28%, Ever 59%
- **Marijuana**: Past Month 20%, Ever 36%
- **Cocaine**: Past Month 7%, Ever 5%
- **Pain Relievers**: Past Month 0%

*Represents past year use of non-medical pain relievers. DFCS reports an 81% increase in children entering the foster care system due to substance abuse between FY13 and FY17. Further, juvenile courts that operate a family treatment court report a 31% increase in the number of caregivers with opioid use disorder between FY14 and FY16.

Note: Data not available for past month use of cocaine or lifetime use of non-medical pain relievers.

For sources please visit: https://tinyurl.com/y9uruywq

Revised 12/18/17
Substance Abuse in Georgia
What You Need to Know & What Georgia Needs

Opioids are a class of drugs used to reduce pain. They can generally be classified in three categories:

- **Prescription opioids** can be prescribed by doctors to treat moderate to severe pain, but can also have serious risks and side effects. Common types are oxycodone (OxyContin), hydrocodone (Vicodin), morphine, and methadone.

- **Fentanyl** is a synthetic opioid pain reliever. It is many times more powerful than other opioids and is approved for treating severe pain, typically advanced cancer pain. Illegally made and distributed fentanyl has been on the rise in several states.

- **Heroin** is an illegal opioid. Heroin use has increased across the U.S. among men and women, most age groups, and all income levels.

While opioids provide pain relief, they also cause physical dependence, respiratory depression, and euphoria.

In 2017 the opioid epidemic was responsible for 49,068 overdose deaths in the US, an increase from 42,249 in 2016. On average, 115 Americans die every day from an opioid overdose.

**Opioids and Georgia’s Children**

- Neonatal Abstinence Syndrome (NAS) is the set of withdrawal symptoms that a newborn can experience when the mother used or abused drugs during pregnancy.

- The long-term effects of NAS may include learning disabilities and delayed motor skills.

- Between 2010 and 2014, there were 1,365 Inpatient hospitalizations with a diagnosis of NAS. The average hospital charge for families with cases NAS was $52,856 per baby.

- Between 2012 and 2016, the percent of entries into foster care related to substance abuse increased by 61 percent.

- In 2017 drug abuse was the second leading cause for children entering foster care in Georgia.

- In rural areas like Gilmer and Carroll counties, 70 to 80 percent respectively of all cases of children being removed from homes were due to substance abuse.

Recent evidence and research results have confirmed that the onset of addiction is a pediatric disease. In more than 9 of 10 cases addiction originates or is triggered by substance use before the age of 21, a period of rapid growth and development of the brain. Because of the vulnerability of the youth brain at this time, any use of alcohol, nicotine, marijuana, prescription drugs or other substances is risky. Research indicates that it is no longer possible to dismiss adolescent experimentation with substance use in any form as unavoidable or harmless rites of passage.
More About Georgia and Opioids
Deaths Related to Drug Overdose and Motor Vehicle Crashes, Georgia, 2007 – 2017

Georgia ranks in the top 11 states nationwide with the most prescription opioid overdose deaths.²

- Recent data from the Georgia Department of Public Health indicates that deaths related to drug overdose surpassed deaths due to motor vehicle crashes in 2014.
- Opioid overdose death rates including heroin in Georgia increased significantly in Georgia – from 0.6 to 5.5 per 100,000 persons – between 1999 and 2014.
- The rate of increase in opioid deaths in Georgia was much higher than the rate of increase of opioid deaths in the U.S. Sales of opioids also quadrupled in the U.S. between 1999 and 2014. Similar to national trends, deaths related to opioid overdose continue to rise in Georgia.
- The health care costs associated with opioid misuse in Georgia alone were estimated at $447 million in 2007 with estimated per-capita costs at $44. Given the increase in overdose deaths and misuse of opioids in Georgia over 11 years, some estimates indicate that health care costs associated with opioid misuse in Georgia have increased by 80 percent since 2007.

Georgia’s Response

1. At the request of Governor Nathan Deal, the Georgia Pharmacy Board changed a rule removing naloxone, an emergency drug used to reverse opioid overdoses, from the dangerous drug list and rescheduled it as an exempt drug. Additionally Governor Deal directed the Department of Public Health (DPH) to issue a standing order to allow naloxone to be dispensed over-the-counter by pharmacists across the state.

2. Following the Senate Study Committee recommendation, the aforementioned executive orders from Governor Deal were put into permanent law allowing for the sale of naloxone over-the-counter at pharmacies across the state.

3. Additionally, the committee recommends increasing funding and improving mechanisms to address neonatal abstinence syndrome (NAS), as well as improving provider education and training around prescribing opioids, especially for pregnant women, and educating patients on prescription drug use.

4. The Senate Study Committee also recommended increasing funding and wider promotion of substance abuse education with a focus on opioid use in schools and restoring some public health funds. This can be accomplished by creating and expanding prescription drug education programs which should target teens, young adults and parents.

5. The study committee supports efforts to improve the utility of Georgia’s Prescription Drug Monitoring Program by: (1) mandating reporting by all prescribing physicians; (2) increasing funding to expand the ability of Georgia Drug and Narcotics Agency (GDNA) to review and make data available; and (3) developing an application that will allow the system to update its information every 24 hours. A number of new policies addressing these areas will be put into effect in 2019.

6. In the FY 19 budget, Governor Deal allocated approximately $3.5 million towards decreasing the opioid epidemic in Georgia. $800,000 of this is upon recommendation from the Commission on Children’s Mental Health and is a vital start to opioid abuse prevention and intervention.

For sources please visit: https://tinyurl.com/y8oao8e3

Revised 12/5/18
Autism and Autism Spectrum Disorder (ASD) are used interchangeably to describe a group of complex disorders of brain development that impact how people communicate, interact, and behave. Behaviors associated with ASD can be evident in children as early as 18 months. These difficulties present themselves in a range of behaviors and in varying severity.

DIAGNOSIS OF ASD

The most recent edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is the primary tool for diagnosis of ASD. In order for a child to be diagnosed with ASD, the DSM-5 requires that they demonstrate a combination of:

Deficits in social communication and interaction:
- Social-emotional reciprocity
- Nonverbal communicative behaviors used for social interaction
- Developing, maintaining, and understanding relationships

Restricted and repetitive patterns of behavior:
- Repetitive motor movements, use of objects, or speech
- Insistence on sameness; inflexible adherence to routines
- Highly restricted, abnormally intense, and fixated interests
- Hyper- or hyporeactivity to sensory input; unusual interest in sensory aspect of environment

SYMPTOMS AND ISSUES ASSOCIATED WITH ASD

Developmental symptoms of ASD are related to problems with communication, social interaction, and repetitive behaviors. Other physical and medical issues can also be associated with ASD:

- Seizure disorders
- Gastrointestinal disorders
- Pica (eating disorder)
- Genetic disorders
- Sensory integration dysfunction
- Sleep dysfunction
- Other mental health issues

PREVALENCE OF ASD IN GEORGIA

Births: 1 in 64
Females: 1 in 181
Males: 1 in 39

Factors Related to Apparent Increase in Prevalence
- Increasing awareness of autism – symptoms are noticed more by parents and doctors which leads to increased diagnoses
- Expanding diagnosis criteria – conditions for diagnosis now include a broader range of symptoms, behaviors, and disorders
- Reduction in stigma associated with ASD – has led to increased diagnoses, especially in minority communities
# TREATING THE CORE SYMPTOMS OF ASD

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ABA</strong></td>
<td>Applied Behavioral Analysis&lt;br&gt;Leverages principles like positive reinforcement to teach skills and reduce challenging behaviors in a highly structured setting</td>
</tr>
<tr>
<td><strong>VB</strong></td>
<td>Verbal Behavior Therapy&lt;br&gt;Teaches communication by motivating children to learn language through the connection of words and their purposes</td>
</tr>
<tr>
<td><strong>PRT</strong></td>
<td>Pivotal Response Treatment&lt;br&gt;Aims to develop language skills and positive social behaviors through play-based and child-initiated activities</td>
</tr>
<tr>
<td><strong>ESDM</strong></td>
<td>Early Start Denver Model&lt;br&gt;Utilizes relationship-based teaching practices to teach skills to very young children from ages 12 to 48 months</td>
</tr>
<tr>
<td><strong>Floortime</strong></td>
<td>Floortime&lt;br&gt;Engages children at their level of activity (e.g., floor) to model positive communication, cognitive, and social practice</td>
</tr>
<tr>
<td><strong>RDI</strong></td>
<td>Relationship Development&lt;br&gt;Leverages positive reinforcement to help with relationship building, social connections, and emotional bonds</td>
</tr>
<tr>
<td><strong>TEACHH</strong></td>
<td>TEACHH Autism Program&lt;br&gt;Builds on the strengths and difficulties of children with ASD to support achievement of educational and therapeutic goals</td>
</tr>
<tr>
<td><strong>SCERTS</strong></td>
<td>Social Communication/Emotional&lt;br&gt;Promotes child-initiated communication to help children master the ability learn and apply skills in a variety of settings</td>
</tr>
</tbody>
</table>

## STATE ACTIVITIES ON ASD

In 2018, the state legislature appropriated **$10.7 million** towards services for children ages 0 to 21 with ASD.

A collaboration between four of Georgia’s state agencies has begun to lay the framework for a more comprehensive state approach to caring for youth with ASD. These state agencies include the **Departments of Community Health, Public Health, Behavioral Health and Developmental Disabilities**, and **Human Services**. Together, this interdepartmental collaboration has identified current challenges, barriers, and opportunities facing those seeking and providing care for ASD. Two major barriers that have been identified are the lack of access to evidence-based treatments (i.e., certain foundational treatments are not billable through Medicaid) and limited capacity of the current provider workforce, especially in rural areas of the state. Proposed solutions include leveraging existing infrastructure, opening codes for certain treatments, phasing in multiple access points, investing in early intervention, and expanding the network of qualified providers. Priority has also been placed on supporting and developing the workforce that serves individuals with ASD.

### Behavioral Analysts in Georgia

<table>
<thead>
<tr>
<th>Certification</th>
<th>Statewide Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBA – Doctoral</td>
<td>52</td>
</tr>
<tr>
<td>BCBA – Master’s/Graduate</td>
<td>393</td>
</tr>
<tr>
<td>BCaBA – Bachelor’s</td>
<td>30</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>475</strong></td>
</tr>
</tbody>
</table>

**BCBA**: Board Certified Behavioral Analyst  <br>**BCaBA**: Board Certified Assistant Behavioral Analyst

For sources please visit: [https://tinyurl.com/y89cpaz9](https://tinyurl.com/y89cpaz9)  <br>Revised 12/5/18
Learning Disabilities in Children

The symptoms of learning disabilities are a diverse set of characteristics which affect development and achievement. All children can exhibit some of these symptoms at some point in their development. However, a person with a learning disability has a cluster of these symptoms which do not disappear as s/he grows older.

### SPECIFIC LEARNING DISABILITIES (SLD)

Specific Learning Disabilities affect the understanding or use of language, written or spoken.

**50%**

of all disabled children have a SLD.

Children with specific learning disabilities may have difficulty:

- listening
- thinking
- speaking
- reading
- writing
- calculating

### 5 MOST COMMON LEARNING DISABILITIES

**Dyslexia:** disorder that impedes the student’s ability to read and comprehend a text

**Attention Deficit/Hyperactivity Disorder (ADHD):** chronic condition marked by persistent inattention, hyperactivity, and sometimes impulsivity

**Dyscalculia:** severe difficulty in making arithmetical calculations, as a result of brain disorder

**Dysgraphia:** deficiency in the ability to write, primarily handwriting, but also coherence

**Processing Deficit:** problems with the processes of recognizing and interpreting information taken in through the senses.

**15-20%**

of the national population has some symptoms of dyslexia.
Dyslexia

Dyslexia is a language-based learning disability which results in difficulties with specific language skills including reading, writing, and pronouncing words. It is classified as a specific learning disorder (SLD) under the Individuals with Disabilities Act. It can affect:

- speech and language delays
- reading comprehension and word recognition
- spelling and vocabulary development
- social and emotional development

**Dyslexia and intelligence are NOT related.**

Research shows when teachers are trained in early dyslexia identification and intervention 90% of children with dyslexia can be educated in a regular classroom.

**POLICY RECOMMENDATIONS**

- Screen for potential language deficiencies prior to age six (e.g. remembering letters of the alphabet or rhyming).
- Provide training for ALL new teachers through the schools of education, relating to identifying dyslexia/reading problems and knowing how to teach students reading skills.
- Embrace the Cox Campus’ “Read Right from the Start” program that provides instruction to existing teachers on how to teach reading.
- Work with the new Sandra Dunagan Deal Center for Early Language and Literacy to ensure training for teachers on identification of dyslexia and how to teach dyslexic students.

Sources: [https://tinyurl.com/GALearningDisordersReferences](https://tinyurl.com/GALearningDisordersReferences)
**Child Food Programs in Georgia**

| Food insecurity affects over 500,000 children of who live in the state of Georgia. | Nearly 130,000 children in high school in Georgia are either obese or overweight. |

When given access to adequate nutrition, the impact is clear: children perform better in school, are healthier, and have the chance to become productive adults. However, children who are not provided adequate, healthy food often underperform in school, are less likely to receive a secondary education, and are more likely to experience mental health problems. These children are also at greater risks for health issues later in life like diabetes, high blood pressure, hypertension, heart disease, arthritis, and some types of cancer.

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**Children under 18 with limited or uncertain access to adequate food**

- **523,470**
- **20.9%**

**Children in Georgia who are overweight or obese**

(Overweight is at or above 85th percentile of healthy BMI, and obese is at or above 95th percentile)

- **2 to 4-year-olds on WIC**
  - 13.0%
- **10 to 17-years-old**
  - 18.4%

**Yearly Cost to the US Economy**

- **Cost of Hunger: $167.5 billion**
- **Cost of Obesity: $14.1 billion**

* Women, Infants, and Children (WIC) program

For sources please visit [https://tinyurl.com/yb29zzcl](https://tinyurl.com/yb29zzcl)  
Revised 11/15/18
<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
<th>Children Impacted in GA*</th>
</tr>
</thead>
<tbody>
<tr>
<td>CACFP Child and Adult Care Food Program</td>
<td>Provides aid to child and adult care institutions and family or group day care homes for the provision of nutritious foods. Programs that can receive CACFP include child care centers, afterschool care programs, day care homes, emergency shelters, and adult day care centers.</td>
<td>143,990</td>
</tr>
<tr>
<td>NSLP National School Lunch Program</td>
<td>Provides nutritionally balanced, low-cost or free lunches to children in public and nonprofit private schools and residential child care institutions.</td>
<td>1,211,207</td>
</tr>
<tr>
<td>SBP School Breakfast Program</td>
<td>Provides cash assistance to states to operate nonprofit breakfast programs in schools and residential childcare institutions.</td>
<td>649,924</td>
</tr>
<tr>
<td>NSLP/SBP Seamless Summer Option</td>
<td>Provides that same meal service that is available during the regular school year in order to reach hungry kids in the community during the summer. This program is provided through either the NSLP or SBP.</td>
<td>138,301</td>
</tr>
<tr>
<td>SFSP Summer Food Service Program</td>
<td>Provides reimbursement for healthy meals and snacks served to children from low-income areas during periods when schools are closed for vacation.</td>
<td>88,446</td>
</tr>
<tr>
<td>SMP Special Milk Program</td>
<td>Provides milk to children in schools and childcare institutions who do not participate in other federal meal service programs. SMP is also available to children in half-day pre-kindergarten and kindergarten programs where school meal programs are not available.</td>
<td>99,606 half-pints served</td>
</tr>
<tr>
<td>SNAP Supplemental Nutrition Assistance Program</td>
<td>Provides nutrition assistance to low-income individuals and families.</td>
<td>382,000</td>
</tr>
<tr>
<td>WIC Women, Infants, and Children</td>
<td>Provides supplemental food assistance, health care referrals, and nutrition education for low-income pregnant, postpartum, and breastfeeding women, infants, and children up to age five.</td>
<td>189,696</td>
</tr>
</tbody>
</table>

* All data represents average daily participation for 2017, except for SNAP data. SNAP data is from 2015 and represents the number of households with children receiving SNAP.
Georgia’s Division of Family and Children Services (DFCS) has made major improvements in recent years to stabilize the state’s child welfare system, reach more children and families, and support its workforce. Through new practice models and statewide initiatives, DFCS has increased retention of its staff, improved the efficiency of case management, and enhanced its ability to gather feedback from constituents and staff. Most of all, such improvements support strides the agency has made to improve child safety and well-being.

### IMPROVING CHILD SAFETY

The DFCS Strategic Plan lays out 6 indicators for measuring improvements to child safety. Comparing baseline data from July 2017, improvements have been made for all 6 indicators.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Indicator</th>
<th>July 2018 Baseline</th>
<th>FY 18 Actual</th>
<th>July 2019 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce recurrence of maltreatment</td>
<td>Number of times a child suffers a confirmed case of abuse or neglect with 12 months of a previous incident</td>
<td>8%</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Reduce reentries into foster care</td>
<td>Percentage of youth in foster care who were in care for a different reason 12 months prior</td>
<td>7.5%</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td>Reduce maltreatment of children in foster care</td>
<td>Number of substantiated reports of maltreatment received in a 10,000 day period</td>
<td>1.084</td>
<td>.671</td>
<td>.75</td>
</tr>
<tr>
<td>Train and educate OFI staff annually on mandated reporter requirements</td>
<td>Number of OFI staff who have completed the mandated reporter training</td>
<td>100%</td>
<td>98%</td>
<td>100%</td>
</tr>
<tr>
<td>Reduce sleep-related deaths for children who are currently receiving or previously received from services from DFCS</td>
<td>Number of sleep-related deaths for children who are currently receiving or previously received from services from DFCS</td>
<td>63</td>
<td>35</td>
<td>56</td>
</tr>
</tbody>
</table>

### SERVICE PROVISION IMPROVEMENTS

Implementation of new service delivery and practice models, like Solution-Based Casework (SBC), resulted in major improvements to the efficiency and accuracy of case processing. For example, between 2014 and 2016, the on-time completion of cases improved for both food stamp cases and child welfare investigations.

Other improvements include:

- Increased percentage of children in foster care placed with relatives from 19 to 29 percent in FY 2017
- Decreased rate of error in food stamp determinations
- Decreased number of overdue child welfare investigations
In 2015 and 2016 DFCS renewed its focus on employee safety, the development of career paths, and providing enhanced training for staff. Coupled with the hiring of 180 eligibility workers and over 700 Child Protective Services staff, these efforts led to a decrease in workforce turnover rates and average caseloads.

- **5% increase in DFCS employee satisfaction between 2015 and 2017**
- **11% increase in entry level salary for economic assistance case managers**
- **19% increase in salary for child welfare case workers**

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**Turnover Rates**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>36%</td>
</tr>
<tr>
<td>2018</td>
<td>27%</td>
</tr>
</tbody>
</table>

**Average Caseloads**

<table>
<thead>
<tr>
<th>Year</th>
<th>Caseload</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>24</td>
</tr>
<tr>
<td>2018</td>
<td>18</td>
</tr>
</tbody>
</table>

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Source: DFCS Office of Legislative Affairs and Communications. (2018). Revised 12/19/18
Family First Prevention Services Act (FFPSA)

Family First Prevention Services Act: An Overview

The Family First Prevention Services Act (FFPSA) changes the child welfare system by allowing States to use Federal funds under Title IV of the Social Security Act to support families and prevent foster care placements. There are two main components of the act:

1) optional foster care prevention services and programs, and
2) required changes to congregate care.

Foster Care Prevention Services and Programs

FFPSA allows states the option to use existing Title IV-E funds for prevention services and programs to keep families together and prevent children from entering foster care.

Eligibility is not dependent on family income

SERVICES AND PROGRAMS

- Mental Health services
- Substance abuse prevention and treatment services
- In-home parenting programs

WHO IS ELIGIBLE?

- Children who are candidates for foster care, but who can safely remain at home
- Children in foster care who are pregnant or parenting
- Parents or kin caregivers of the children

How does a state obtain funding for services or programs?

- State must maintain a written prevention plan for child and collect data on programs and services administered.
- Services or programs must be trauma-informed.
- Services or programs must be based on promising, supported, or well-supported practices.
Congregate Care

FFPSA limits foster care payments for group homes (NON-foster family placements) to 2 weeks. This is REQUIRED beginning October 1, 2021. However, states can accelerate the effective date to as early as 2019 and Georgia chose to target 2020. Children will have to be placed in foster homes for all placements longer than 2 weeks UNLESS the child is place in one of the following:

- A Qualified Residential Treatment Program (QRTP).
- A setting specializing in providing prenatal, postpartum, or parenting supports for youth.
- If a child is 18, a supervised setting in which child is living independently.

Qualified Residential Treatment Program (QRTP)
QRTPs must meet the following requirements:

- Use a trauma-informed treatment model
- Registered or licensed nursing and clinical staff onsite
- Facilitates family outreach and participation
- Documents family integration into the treatment process
- Provides discharge planning and family-based supports for at least 6 months after discharge
- Licensed and accredited by one of the following:
  - The Commission on Accreditation of Rehabilitation Facilities
  - The Joint Commission on Accreditation of Healthcare Organizations
  - The Council on Accreditation
  - Other nonprofit accrediting organization approved by the Secretary

IMPORTANT CONSIDERATIONS FOR GEORGIA

- Georgia has notified the HHS Administration for Children and Families that it intends to implement in September 2020. The date a state chooses as its effective date for congregate care changes also determines the date in which prevention funds become available.
- States will define eligible “candidates” for preventive services. Gathering and analyzing data on Georgia’s current child welfare population may help the state determine how broadly to define candidates for purposes of FFPSA.
- Offering state funding to providers now to meet the requirements of evidence-based programs or QRTP may help providers make necessary transitions in time to comply with the law.
- The Federal Government will provide 50% of the funding for prevention services and programs until October 1, 2026. Beginning October 1, 2026, Federal funding will equal the Federal Medical Assistance Percentage, which is currently 67.62% in Georgia.

Sources: https://tinyurl.com/FFPSARefferences

Rev. 12/2018
Child Sexual Abuse in Georgia

Child sexual abuse is the exploitation of a child for the sexual gratification of an adult or caregiver. Sexual abuse includes:

<table>
<thead>
<tr>
<th>Touching Offenses:</th>
<th>Non-touching Offenses:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fondling</td>
<td>Child Pornography</td>
</tr>
<tr>
<td>Sodomy</td>
<td>Indecent Exposure</td>
</tr>
<tr>
<td>Rape</td>
<td></td>
</tr>
<tr>
<td>Intercourse</td>
<td></td>
</tr>
<tr>
<td>Masturbation</td>
<td></td>
</tr>
</tbody>
</table>

- **Approximately 1 in 10 children** is sexually abused by the time they turn 18.

- A report of alleged child abuse is made in Georgia every **4.6 minutes**.

Child sexual abuse happens in various settings, but most occurs in the victim’s own home. **84%** of children under age 12 and **71%** of children aged 12 to 17 are abused at home.

**Who are the Perpetrators?**

People who sexually abuse children look just like everyone else. Abusers can be neighbors, religious leaders, teachers, family members, or anyone who works with children.

- **90%** of children know their abuser
- **One-third** are abused by family members.
- **ONLY 10%** of children who experience sexual abuse are abused by complete strangers.

**DID YOU KNOW?**

- Gay individuals are not more likely to sexually abuse children than straight individuals. In fact, most men who abuse boys self-identify as straight.
- There is absolutely no research that says a transgender person is more likely to sexually abuse children than someone who is not transgender.
- Although men are consistently shown to commit the majority of child sexual abuse, women are the abusers in approximately 11% of cases.

Approximately **62%** of children who are sexually abused DO NOT tell anyone about it. Many children are afraid of getting in trouble, worried about what people will think of them, or simply do not understand what is happening to them.
# Victims of Child Sexual Abuse

**Children and youth who are more at risk of being sexually abused:**

- Females
- Youth with physical, emotional or cognitive disabilities
- Children living in single parent households
- Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth

**Children who have been sexually abused are more likely to:**

- Show physical aggression
- Experience behavioral health problems
- Attempt suicide
- Become delinquent
- Perform poorly in school
- Abuse alcohol or other drugs
- Become pregnant

---

# Labeling Youth as Sexual Predators

Juveniles represent **one-fourth** of all sex offenders known to police and **one-third** of known offenders against other juveniles.

**40-80%** of juveniles sex offenders have *themselves been victims of sexual abuse*. These children are often responding to their own trauma.

However, the likelihood that juvenile sex offenders will reoffend later in life is relatively low with a 7-13% recidivism rate within five years. In addition, interventions for juvenile sex offenders have shown to be particularly effective.

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# How Can I Help?

1. Encourage community members to learn how they can prevent child sexual abuse. For example, consider taking a Darkness to Light Stewards of Children training. Learn more at www.d2l.org.

2. Educate adults, youth, and children about the harm caused by treating others as sexual objects.

3. Develop relationships with your local, state and federal representatives, and educate them about child sexual abuse and exploitation.

If you suspect that a child is being abused, call the Division of Family and Children Services at **1-855-GACHILD** immediately to report.

Sources: https://tinyurl.com/yd4mmkhp
Trauma is another way of referring to a person’s emotional and physiological responses to Adverse Childhood Experiences (ACEs), such as:

- Being threatened or held captive
- Caregiver mental illness
- Chronic neglect
- Exposure to parental separation
- Exposure to violence
- Family economic hardship
- Parental alcohol or drug use
- Sexual or Physical abuse or assault
- Removal from home
- Witness to injury or murder

Research shows that ACEs can affect a child’s perception of their environment, perception of their role in their environment, and brain development.

Prevalence of ACEs in Georgia

In a 2016-2017 survey, 44.6% of guardian-responses indicated a child having one or more ACEs. That's over 1 million of Georgia's children.

Responses to Trauma

<table>
<thead>
<tr>
<th>Positive Stress Response</th>
<th>Tolerable Stress Response</th>
<th>Toxic Stress Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characterized by brief increases in heart rate and mild elevations in hormone levels - normal and essential to development</td>
<td>Activates body’s alert systems to a greater degree and is the result of more severe, longer-lasting difficulties</td>
<td>Occurs when a child experiences strong, frequent, and prolonged adversity</td>
</tr>
</tbody>
</table>

The Impact of Trauma

Children with ACEs are at increased risk of negative outcomes in multiple areas of their lives

<table>
<thead>
<tr>
<th>Health</th>
<th>Behavioral Health</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance use (alcohol, tobacco, and other drugs)</td>
<td>Mental illness and behavioral health challenges</td>
<td>Decreased concentration (attention, organization, and activity levels)</td>
</tr>
<tr>
<td>Risk-taking behaviors (sexual promiscuity, gang membership, and violent crime)</td>
<td>Psychiatric disorders</td>
<td>Decreased memory</td>
</tr>
<tr>
<td>Economic Hardship (unemployment, poverty, and homelessness)</td>
<td></td>
<td>Decreased language ability</td>
</tr>
</tbody>
</table>

For full report, further readings, and sources please visit [https://tinyurl.com/yb7akj7h](https://tinyurl.com/yb7akj7h) Revised 12/5/18
Policy Solutions

The following recommendations address childhood stress from a variety of points. In order to adequately tackle childhood trauma, policies must focus on a child’s developmental needs from birth. In addition, an adequate support system for each child should be at the center of any child policy platform.

Furthermore, policies should focus on community-based services, including programs that work to eliminate the underlying causes of childhood trauma, such as efforts made to reduce domestic and neighborhood violence, substance abuse, and poverty. Cohesive policies that attack childhood trauma from several different angles, all the while fostering a supportive environment for children, will see the most success in reducing both its individual and societal costs.

For more policy recommendations under each category please see the full report at the link below.

Early Care and Learning
- Counter childhood trauma by creating an environment where the effects of toxic stress are buffered with appropriate supports helping children adapt and enhancing child cognitive and social development.

Early Intervention
- Increased access to health care and home visiting support helps to prevent threats to healthy development and also provides early diagnoses, appropriate care, and intervention when problems emerge.

Parental Health
- Addressing parental mental and behavioral health can prevent or minimize a child’s exposure to traumatic environments.

Afterschool and Summer Learning Programs
- Increase funding and prevalence for quality afterschool and summer learning programs like the Boys and Girls Clubs and YMCAs, to increase access and ensure affordability.

Foster Youth Care
- Maximize implementation of the federal Family First Prevention Services Act.
- DFCS and CMOs should develop procedures that enable continuity of behavioral health and primary care while youth are in foster care and after their transitioning out of the system.

Juvenile Justice and School Discipline
- Juvenile courts must work to provide environments that are safe and services that do not increase the level of trauma that youth and families experience.
- Public Safety Officers who engage with children should also be given child development and trauma awareness training.

Workforce and Systems Development
- Caregivers and child-serving professionals should receive training on the effects of trauma and stress on children and youth, so that they can respond appropriately to behaviors and initiate effective interventions.

Nutrition
- Increased funding for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).
Brain development is impacted by both our genetics and our experiences. As children grow, their brains develop basic functions first (breathing) before progressing to more sophisticated functions (complex thought).

### Early Brain Development
- Before and after birth neurons are created and form connections.
- The brainstem and midbrain develop first, governing functions necessary for life like heart rate, breathing, eating, and sleeping.

### Young Child Brain Development
- Formation of synapses occurs at a high rate.
- Higher function brain regions (governing emotion, language, and abstract thought) develop gradually and at different rates throughout childhood and adolescence/early adulthood.
- By age 2, a child has formed 100 trillion synapses.
- Synapses are eliminated as experiences deem them unnecessary (pruning).
- Protective layers form on cells to ensure clear and quick transmission of information across synapses (myelination).
- By age 3, a child’s brain is 90 percent of its adult size.

### Adolescent Brain Development
- Prior to puberty there is a growth spurt in the areas of the brain governing planning, impulse control, and reasoning.
- While these areas develop, teenagers can act impulsively, make poor decisions, and take increased risks, all normal behaviors for this stage.
- More pruning and myelination occurs in the teenage years.
- Growth and transformation of the limbic system.

### HEALTHY BRAIN DEVELOPMENT

**Neuron** – the basic cell that allows communication between the brain and the body.

**Brain Stem** – the part of the brain that regulates vital functions (heartbeat, etc.).

**Mid Brain** – the part of the brain that regulates vision, hearing, motor control, sleep, arousal, and temperature.

**Synapse** – the connection between neurons that carry messages.

**Pruning** – the shedding of unnecessary connections between neurons.

**Myelination** – the strengthening of necessary connections between neurons.

**Limbic System** – a network of brain structures that governs emotions and memory.

### OTHER FACTORS IMPACTING DEVELOPMENT

#### Responding to Stress
- The timing and type of stress determines the impact on the brain.
- **Positive Stress** – moderate, brief, and generally normal part of life.
- **Tolerable Stress** – more severe and long-lasting difficulties; can be damaging unless the stress is time-limited and buffered by relationships with adults that help the child adapt.
- **Toxic Stress** – strong, frequent, and prolonged activation of body’s stress response system that disrupts healthy development.

#### Sensitive Periods
- Windows of time in development when certain parts of the brain may be more susceptible to certain experience (e.g., strong attachments to caregivers formed during infancy).

#### Memories
- Systems of neurons that have been repeated and strengthened.
Trauma-induced changes to the brain can result in varying degrees of *cognitive impairment* and *emotional dysregulation* that can lead to a host of problems, including difficulty with attention and focus, learning disabilities, low self-esteem, impaired social skills, and sleep disturbances.

– Child Welfare Information Gateway, Supporting Brain Development in Traumatized Children and Youth

### EFFECTS OF MALTREATMENT

#### On Behavior, Social, and Emotional Functioning

- Permanent fear response to certain triggers, even when they pose no actual threat
- Fear response is automatically triggered without conscious thought
- Destabilization of emotion and stress regulation
- Diminished executive functions like memory, attention, impulse control, etc.
- Delayed developmental milestones
- Decreased response to positive feedback or rewards
- Social interactions made more difficult

#### Damage to the Brain

- Prefrontal Cortex
- Orbitofrontal Cortex
- Hippocampus
- Corpus Callosum
- Amygdala
- Cerebellum

Trauma-informed care and evidence-based practices

Family-centered practice and case planning, including parent-child interaction therapy

Individualized services for children and families

Child advocacy centers offering interviews, assessments, and services in a child-friendly environment

For sources please visit https://tinyurl.com/y84242rc

Revised 11/12/18
The primary piece of federal legislation focused on addressing the needs of homeless people in the United States. It was first signed into law in 1987, and has since been amended and reauthorized several times. Economic Problems
- Child and family poverty
- Employment issues
- Lack of health insurance
- Lack of affordable housing

System Involvement
- Involvement with foster care or the juvenile justice system
- Transitioning out of foster care and residential or institutional facilities

Family Problems
- Abuse/neglect and trauma
- Single or youth parents
- Mental illness
- Substance abuse

Population At Higher Risk
- Racial/ethnic minorities and LGBTQ youth are disproportionately affected by child homelessness

The section of the McKinney-Vento Homeless Assistance Act dealing with problems faced by homeless children and youth with enrolling, attending, and succeeding in school. This program requires state education agencies to ensure that each homeless child and youth has equal access to the same free and appropriate public education as their peers.

In FY 2017, the Georgia Department of Education sub-granted $2,082,366 in 48 school districts.

EXAMPLES OF MCKINNEY-VENTO PROGRAMS

**BARTOW COUNTY**
The district’s McKinney-Vento program engages parents, school staff and community partners through the Bartow “Give A Kid A Chance” program. It provides back to school supplies, haircuts, hearing, vision and dental screenings, books and other resources to McKinney-Vento students.

$43,858

**ATLANTA PUBLIC SCHOOLS**
Atlanta Public Schools has partnered with the Atlanta Housing Authority (AHA) to provide 50 housing vouchers to children and families that are identified as homeless based on the McKinney-Vento definition of homelessness.

$93,698

**CHATTOOGA COUNTY**
The district’s Homeless Liaison worked closely with Family Connection as well as 20 community agencies and numerous community volunteers to provide school supplies, food, and hygiene products as well as informational resources to approximately 400 McKinney-Vento Students.

$42,298

Homeless children and youth are defined as individuals who lack a fixed, regular, and adequate nighttime residence. In FY 2017 approximately 39,677 students in Georgia were considered Homeless.

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DISPARITIES IN THE MAKEUP OF HOMELESS STUDENTS

- Black: 57% Homeless Students, 37% All Students
- Hispanic: 41% Homeless Students, 29% All Students
- White: 10% Homeless Students, 15% All Students

MCKINNEY-VENTO COUNT OF HOMELESS STUDENTS IN GEORGIA*

- FY 08: 15,700
- FY 09: 20,000
- FY 10: 24,000
- FY 11: 28,000
- FY 12: 32,000
- FY 13: 36,000
- FY 14: 40,000
- FY 15: 44,000
- FY 16: 48,000
- FY 17: 52,000

* Data most likely underreported, other estimates suggest that there were between 45,000 and 74,000 homeless youth in Georgia in 2013

POLICY RECOMMENDATIONS

- Increase public awareness of the scope and impact of homelessness on children and families.
- Improve program design and service delivery to meet unique needs of homeless children and families.
- Inform state and local policies and plans to address the needs of homeless children and families.
  - Increase the availability and equitable distribution of quality and affordable housing.
  - Support policies, including rent subsidies, which protect families and children from unsafe housing, hardship, baseless evictions, and unjustified fees and penalties.
  - Identify and disseminate successful models of interagency coordination across child welfare, homelessness, and housing networks.
  - Improve access to educational opportunities that will ensure success for children and youth who are homeless.
  - Prevent youth who age out of foster care and unaccompanied youth from becoming homeless.
  - Collect data on housing status to increase knowledge of the scope of homelessness.

For sources please visit https://tinyurl.com/y85r6nwm
Revised 12/10/18
In 2012, Governor Nathan Deal reappointed the Special Council on Criminal Justice Reform. He asked members to study Georgia’s juvenile justice system and craft recommendations that improve public safety and decrease costs. With the help of the Pew Center on the States, a non-partisan research organization, the Council produced a sound set of research-based recommendations. These recommendations were combined with previous legislative efforts led by Representative Wendell Willard, chairman of the House Judiciary Committee. The resulting legislation reorganizes, revised and modernized Title 15, Chapter 11 of the Official Code of Georgia Annotated, a section of our law known as the juvenile code.

### SYSTEMS CHANGE AND NEW APPROACH

**New mandate for juvenile courts and DJJ**

To improve public safety and decrease costs by preserving and strengthening family relationships in order to allow each child to live in safety and security

**Examples of new policies and practices**

- Increased use of evidence-based programs
- Treating youth in the community rather than in secure facilities
- Juvenile Justice Incentive Grant Program

### SIGNS OF PROGRESS FROM 2013 TO 2016

<table>
<thead>
<tr>
<th>Metric</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in secure confinement</td>
<td>36%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduction in secure detention</td>
<td>11%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduction in overall commitments to DJJ</td>
<td>46%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase in child population ages 10 to 16</td>
<td>2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secure</td>
<td>1,797</td>
<td>1,600</td>
<td>1,283</td>
<td></td>
</tr>
<tr>
<td>Non-Secure</td>
<td>682</td>
<td></td>
<td></td>
<td>597</td>
</tr>
</tbody>
</table>

OVERVIEW OF GEORGIA’S JUVENILE JUSTICE PROGRAMS

<table>
<thead>
<tr>
<th>Program</th>
<th>Administered by</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>JJIG</td>
<td>Juvenile Justice Incentive Grants</td>
<td>Criminal Justice Coordinating Council</td>
</tr>
<tr>
<td>CSG</td>
<td>Community Services Grant</td>
<td>Department of Juvenile Justice</td>
</tr>
</tbody>
</table>

FUNDING OF JJIG AND CSG

<table>
<thead>
<tr>
<th></th>
<th>Initial*</th>
<th>FY 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>JJIG State</td>
<td>$5 million</td>
<td>$7.8 million</td>
</tr>
<tr>
<td>JJIG Federal</td>
<td>$1 million</td>
<td>$700,000</td>
</tr>
<tr>
<td>CSG State</td>
<td>$1.6 million</td>
<td>$3.4 million</td>
</tr>
<tr>
<td>Total</td>
<td>$7.6 million</td>
<td>$12 million</td>
</tr>
</tbody>
</table>

Cost Savings of JJIG and CSG

- Cost per year for out-of-home placement: $90,000
- Number of youth diverted in FY 17 with a successful outcome: 1,388
- Potential cost to taxpayers in FY 17: $125 million
- Actual cost to taxpayers in FY 17: $12 million

IMPLEMENTATION OF JJIG AND CSG

Between JJIG and CSG, all of Georgia’s counties are eligible to receive evidence based services

In FY 17
- 98% of Georgia’s at-risk youth population resided in a JJIG or CSG served county
- 1,388 youth diverted from out-of-home placements with a successful outcome
- 75% of youth served through JJIG and CSG were minorities

Over 8,000 youth have received evidence-based services through JJIG or CSG since FY 14

FY 17 JJIG AND CSG OUTCOMES IN GEORGIA

- Out-of-Home Placements: 49% Reduction in out-of-home placements compared with FY 12 baseline
- Program Completion: 65% Successful completion rate for youth in JJIG and CSG programs
- School Engagement: 93% Youth who were actively enrolled in or had completed school

Revised 11/29/17
A "Child in Need of Services" under Georgia law means a child who is in need of care, guidance, counseling, structure, supervision, treatment, or rehabilitation AND meets one of the following criteria:

• Habitually truant from school
• Habitually disobedient of the reasonable commands of his or her parent/guardian/legal custodian
• Runaway
• Committed an offense applicable only to a child
• Wanders or loiters about the streets, highway, or any public place, between the hours of 12:00 A.M and 5:00 A.M.
• Disobeys the terms of supervision contained in a court order which has been directed to such child, who has been adjudicated a CHINS
• Patronized any bar where alcoholic beverages are being sold, unaccompanied by his or her parent/parent/guardian/legal custodian, or who possesses alcoholic beverages
• Committed a delinquent act and is in need of supervision but not in need of treatment or rehabilitation

Juvenile Justice Roadmap

The passage of the comprehensive Juvenile Justice Reform Act of 2013 updated Georgia’s forty-year-old juvenile justice statute, resulting in improved responses to young offenders. To date, this thoughtful and data-driven approach has reduced recidivism, saved taxpayer dollars, improved public safety and helped misbehaving youth get back on track to success.

Below you will see two diagrams illustrating pathways for:
1. Children in Need of Services (CHINS) Process
2. Delinquency Process

Also, for convenience, please find a short glossary of juvenile justice terminology on the last page.

Georgia CHINS Process

Complaint
Made by a child’s parent, guardian/legal custodian, DFCS employee, school official, law enforcement officer, guardian ad litem or an attorney

Temporary Custody
Law enforcement can exercise temporary custody over the child for up to 12 hours

Notify Court
If notified, it is then charged with determining the child’s placement

DJJ Custody
If a youth is placed in a secure or nonsecure DJJ facility (for no longer than 24 hours), then
1) a DAI must be conducted
2) one of the following must apply: child is alleged runaway, habitually disobedient; and/or failed to appear

DFCS Custody
If a youth is placed in foster care, the child is required to have a case plan.

Released to Parents/Guardian or Legal Custodian

Within 72 Hours

Continued Custody Hearing
The court must determine whether there is probable cause to believe that the child has committed a status offense or is otherwise in need of services. The hearing must decide placement and next steps.

Released to Parents/Guardian or Legal Custodian

Within 5 Days

A “Child in Need of Services” under Georgia law means a child who is in need of care, guidance, counseling, structure, supervision, treatment, or rehabilitation AND meets one of the following criteria:

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• Habitually disobedient of the reasonable commands of his or her parent/guardian/legal custodian
• Runaway
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• Patronized any bar where alcoholic beverages are being sold, unaccompanied by his or her parent/parent/guardian/legal custodian, or who possesses alcoholic beverages
• Committed a delinquent act and is in need of supervision but not in need of treatment or rehabilitation
Within 3 months (and every 6 months until the disposition is complete)

**Review Hearing**
The court must periodically review the case as long as the disposition order is in effect.

**Disposition Hearing**
Within 3 months (and every 6 months until the disposition is complete)

**Adjudication Hearing**
If youth is held in state custody: the petition must be filed within 5 days of Continued Custody Hearing
If youth is released or not held in state custody: the hearing must be held within 60 days of filing the petition.

**Court Issues Summons**
This goes to the child, parent/guardian/legal guardian, DFCS, or other public agencies or necessary parties. The summons requires the person to come to court for the adjudication to participate in the hearing.

**PLACEMENT**
**DJJ Custody**
For up to 72 hours, for the purpose of allowing time to arrange for another appropriate placement.

**DFCS Custody**
For the purposes of foster care placement

**NEXT STEPS**
**Order a CHINS Petition and schedule an adjudication hearing.**
If youth is held in state custody: the petition must be filed within 5 days of Continued Custody Hearing
If youth is released or not held in state custody: the petition must be filed within 30 days of Continued Custody Hearing

**Refer to a community-based risk reduction program**
If youth is held in state custody: the hearing must be held within 10 days of filing the petition.
If youth was released or not held in state custody: the hearing must be held within 60 days of filing the petition.

**Potential dispositions include:**
remain at home with or without conditions; probation; community service; restitution; or after or evening school programming.
Under no circumstances may a disposition order for a child in need of services place the child in a DJJ facility.

**There is no probable cause.**
Released to Parents/Guardian or Legal Guardian

**There is probable cause that the child committed a status offense or is in need of services.**
The court must decide to place in least restrictive custody.

**For up to 72 hours, for the purpose of allowing time to arrange for another appropriate placement.**

**For the purposes of foster care placement.**

**Under no circumstances may a disposition order for a child in need of services place the child in a DJJ facility.**

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Georgia Juvenile Justice Process

Complaint
Citizen of Law Enforcement Investigation

Temporary Detention or Release to Parents/Guardians

Detention/Probable Cause Hearing
Must be held within 72 hours if detained or 48 hours if no arrest warrant. Youth have the same right to bail as adults.

Petition Filed
By anyone with knowledge of facts. Within 72 hours if detained or, if not detained, within 30 days of receipt of complaint.

Adjudication
If detained, must be within 10 days of when petition is filed or within 60 days if not detained. Court finds whether allegations in petition are sure beyond a reasonable doubt.

Predisposition Investigation
Court may schedule a disposition on a later date to allow time to investigate appropriate placements or outcomes.

Disposition Hearing
If youth is detained, no more than 30 days after adjudication. Judge decides outcome of case.

Dismissal
Charges dismissed.

Informal Adjustment
Diversion to alternative programs. Probation officer may monitor child. Discretion to proceed to adjudication is retained until program completion.

Dismissal
Charges dismissed.

Dismissal
Charges dismissed.

90 Day Short Term Placement
Judge may order a stay in a YDC for up to 90 days.

Commitment to DJJ
For up to two years, DJJ has discretion on placement.

Probation
Child remains with parent/guardian at home. Probation officer assigned to supervise while in community.

Restitution/Fines
Court may determine amount.

Other
Mandatory school attendance or completion, community service, counseling, suspension, or prohibit issuance of driver’s licence.

Post-Disposition
A youth has the right to appeal case. Upon motion of DJJ and after a hearing, the court may extend DJJ custody for up to 2 years.

Superior Court Jurisdiction
Prosecutorial Discretion
No Juvenile Court Jurisdiction
Juveniles 13-17 who have committed one of the “seven deadly sins.” Murder, rape, armed robbery with a firearm, aggravated child molestation, aggravated sodomy, aggravated sexual battery and voluntary manslaughter.

Criminal Proceedings in Superior Court
Trial as adult.

Transfer Hearing
A juvenile court hearing to consider transfer of the proceedings if the child is over 13 and the crime is punishable by death or life imprisonment.
Definitions

Adjudication Hearing: Fact-finding proceeding to determine whether the facts alleged in the petition or other pleadings are true. This is the juvenile court equivalent to a trial in civil cases. Standard of proof is clear and convincing evidence in dependency, CHINS (Children in Need of Services) and TPR (Termination of Parental Rights) proceedings; standard is beyond a reasonable doubt in delinquency proceedings.

Case Plan: Document developed in a dependency case by DFCS, in conjunction with parents/guardian/legal custodians and child (when appropriate), which states the reasons a child is brought into protective custody and the exact steps which must be taken by everyone involved to alleviate the conditions of dependency and allow the parent to provide a safe and stable home for the child.

Community-based risk reduction program: Programming that allows a youth adjudicated with a delinquent offense to remain in their home community and receive cognitive behavioral treatment to reduce their risk of recidivating in the future. These are also uses in CHINS cases as well during custody hearings. (O.C.G.A. 11-14-414).

Detention Assessment Instrument (DAI): A standardized and validated tool, required prior to detention, that measures the youth’s risk to reoffend and risk to flee before court proceedings occur. The DAI was implemented in 2000 to provide greater structure and consistency, focus the use of detention resources on high risk youth, reduce inappropriate detention by identifying youth who can be safely released, and establish a basis for DJJ to monitor detention assessment operations. The DAI is completed by DJJ staff at the time a youth is arrested or picked up by law enforcement.

Disposition Hearing: Proceeding to determine what placement is best suited to the protection and physical, mental, and moral welfare of a child adjudicated dependent, delinquent, or “child in need of services.”

Guardian ad litem: Officer of the court who is appointed to represent the best interest of the child in abuse and neglect proceedings, custody proceedings, and sometimes in delinquency or unruly proceedings. May be an attorney or layperson. Often referred to as “G.A.L.”

Informal Adjustment: An informal adjustment is given by a Judge as an alternative to a formal petition in juvenile court. If conditions are met, the Judge is able to informally adjust and erase the case from the youth’s record.

Least Restrictive Custody: The level of custody which safeguards the child’s best interests and protect the community (i.e. release to parent, foster care, other court-approved placement that is not secure, or secure residential facility).

Nonsecure Facility: Nonsecure residential facilities are community residential facilities that provide 24-hour care in a residential setting that are not hardware secured. These nonsecure community residential programs include group homes, emergency shelters, wilderness/outdoor therapeutic programs, and other placements that provide 24-hour care in a residential setting.

Post-Disposition: Treatment that is received after the case has been disposed of.

Predisposition Investigation: A predisposition investigation, or PDI, is ordered by the court to get more information from a youth and family in order to determine what services or assistance is needed to help a youth move forward and stay out of the juvenile justice system.

Probation: Probation is the release from detention, subject to a period of good behavior under supervision.

Prosecutorial Discretion: Prosecutorial discretion is the authority of an agency or officer to decide what charges to bring and how to pursue each case.

Secure Facility: Secure facility is defined as a hardware secure residential institution operated by or on behalf of DJJ and shall include a youth development center or a regional youth detention center.

Transfer Hearing: A hearing in juvenile court to determine whether jurisdiction over a juvenile case should remain in juvenile court or be transferred to adult court. In Georgia, these are commonly referred to as “440 cases” which encompass the most serious offenses such as murder rape, aggravated assault, etc.

Regional Youth Detention Center (RYDC): Regional Youth Detention Centers provide temporary, secure care and supervision to youth who have been charged with offenses or who have been adjudicated delinquent and are awaiting placement. In addition, youth who have been committed to the custody of DJJ are sometimes placed in an RYDC while awaiting treatment in a community program or a long-term facility.

Youth Development Campus (YDC): A Youth Development Campus provides secure care, supervision and treatment services to youth who have been committed to Department of Juvenile Justice custody for short- and long-term programs. Every YDC provides education, vocational programming, health and mental health treatment, food services, resident counseling, substance abuse treatment/counseling and family visitation.

Rev. 12/2018
OVERVIEW OF JDAI

History

The Juvenile Detention Alternatives Initiative (JDAI) was developed by the Annie E. Casey Foundation in December of 1992. It was developed in response to the growing number of youth being held in secure detention across the country for non-violent acts. It currently operates in 40 states, including Georgia.

Purpose

To help jurisdictions reduce their reliance on secure detention while ensuring public safety through the establishment of more effective and efficient systems that accomplish the purposes of juvenile detention.

Objectives

- To eliminate the inappropriate or unnecessary use of secure detention
- To minimize failures to appear and incidence of delinquent behavior
- To improve conditions in secure detention facilities
- To redirect public finances from building new facility capacity to responsible alternative strategies
- To reduce racial, ethnic, and gender disparities

Strategies

- Collaboration between major juvenile justice agencies, governmental entities, and community organizations
- Use of accurate data to diagnose the system’s problems and identify real solutions
- Objective admissions criteria and instruments to replace subjective decisions that inappropriately place children in custody
- Alternatives to detention to increase the options available for arrested youth
- Case processing reforms to speed up the flow of cases so that youth don’t languish in detention
- Reducing the use of secure confinement for “special” cases like technical probation violations
- Deliberate commitment to reducing racial disparities by eliminating biases and ensuring a level playing field
- Improving conditions of confinement through routine inspections

HISTORY OF JDAI IN GEORGIA

In 2015, a state-level committee was established by Governor Nathan Deal and the Georgia Criminal Justice Reform Council to improve the delivery of juvenile justice services and expand JDAI efforts throughout Georgia. The committee, called the State Steering Committee for JDAI, consists of juvenile court judges and representatives from stakeholder organizations. While some communities instituted JDAI as far back as 2003, state rollout of JDAI began in 2016 after an initial phase of assessment.

For sources please visit https://tinyurl.com/y7rmb28e  
Revised 12/10/18
IMPLEMENTATION OF THE JDAI IN GEORGIA

Currently, five counties in Georgia are JDAI sites and all of these have completed JDAI Readiness and System Assessments. As of 2017, two additional counties have completed JDAI Readiness and System Assessments.

JDAI NATIONWIDE OUTCOMES

As of 2016, there were 197 JDAI sites in the United States, representing 300 local jurisdictions and 10 million youth ages 10 to 17. The youth living in areas working on JDAI represents approximately 30 percent of the total youth population. Recent data gathered from these sites suggests the following trends for JDAI involved areas:

<table>
<thead>
<tr>
<th>Trend</th>
<th>Indicator</th>
<th>Pre-JDAI Baseline</th>
<th>2016 Data</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced reliance on juvenile detention</td>
<td>Average Daily Population (ADP)</td>
<td>8,780</td>
<td>4,964</td>
<td>-43%</td>
</tr>
<tr>
<td></td>
<td>Annual Admissions</td>
<td>188,948</td>
<td>95,939</td>
<td>-49%</td>
</tr>
<tr>
<td>Reduced commitments to state custody</td>
<td>State Commitments</td>
<td>17,457</td>
<td>7,432</td>
<td>-57%</td>
</tr>
<tr>
<td>Reduced juvenile crime</td>
<td>Felony Petitions</td>
<td>79,391</td>
<td>48,770</td>
<td>-39%</td>
</tr>
<tr>
<td></td>
<td>Delinquency Petitions</td>
<td>42,562</td>
<td>29,770</td>
<td>-31%</td>
</tr>
<tr>
<td>Remaining challenges with racial equity</td>
<td>Percent of ADP that are youth of color</td>
<td>75%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>and overrepresentation of youth of color</td>
<td>Percent of annual admissions that are youth of color</td>
<td>70%</td>
<td>76%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percent of state commitments that are youth of color</td>
<td>70%</td>
<td>83%</td>
<td></td>
</tr>
</tbody>
</table>

For sources please visit https://tinyurl.com/y7rmb28e
Revised 12/10/18
Positive Behavioral Interventions and Supports (PBIS)

PBIS is an evidence-based, data-driven framework proven to reduce disciplinary incidents, increase the sense of safety, and support improved academic outcomes in schools.

PBIS schools apply a multi-tiered approach to prevention, using disciplinary data and principles of behavior analysis to develop schoolwide, targeted, and individualized interventions and supports to improve school climate for all students.

**Tier 1**: Standards-based instruction, universal screening, progress monitoring, and direct behavioral instruction provided to all students

**Tier 2**: Designed for students who are accessing but not responding to Tier 1 supports

**Tier 3**: Intensive/Individualized support systems provided for students who exhibit patterns of severe or extreme behavior

**Tier 4**: Designed for students who do not respond to Tier 3 supports

---

**Georgia Schools Trained in PBIS**

<table>
<thead>
<tr>
<th>Year</th>
<th>Schools Trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>80</td>
</tr>
<tr>
<td>2010</td>
<td>182</td>
</tr>
<tr>
<td>2011</td>
<td>240</td>
</tr>
<tr>
<td>2012</td>
<td>290</td>
</tr>
<tr>
<td>2013</td>
<td>392</td>
</tr>
<tr>
<td>2014</td>
<td>466</td>
</tr>
<tr>
<td>2015</td>
<td>566</td>
</tr>
<tr>
<td>2016</td>
<td>851</td>
</tr>
<tr>
<td>2017</td>
<td>1117</td>
</tr>
<tr>
<td>2018</td>
<td>1361</td>
</tr>
</tbody>
</table>

**Climate Star Rating of Georgia PBIS Schools**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 3 Stars</td>
<td>19%</td>
</tr>
<tr>
<td>4 or 5 Stars</td>
<td>81%</td>
</tr>
</tbody>
</table>

For sources please visit [https://tinyurl.com/yblkmcy4](https://tinyurl.com/yblkmcy4)  
Revised 12/4/18
Georgia Highlights

<table>
<thead>
<tr>
<th>School District</th>
<th>PBIS Started</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lee County Schools</td>
<td>2008</td>
<td>• Average office discipline referrals per day reduced by 35%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Out-of-school suspension days reduced by 24%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Discipline incidents resulting in office referral reduced by 58%</td>
</tr>
<tr>
<td>Murray County Schools</td>
<td>2008</td>
<td>• Discipline events reduced by 45%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Discipline actions reduced by 37%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Graduation rate increased by 14%</td>
</tr>
<tr>
<td>Griffin-Spalding Schools</td>
<td>2009</td>
<td>• Out-of-school days reduced by 30%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Bus referrals reduced by 53%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Graduation rate increased by 10%</td>
</tr>
<tr>
<td>Gwinnett County Schools</td>
<td>2010</td>
<td>• 2 schools recognized for best practices with PBIS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 5 schools highlighted for interested international educators</td>
</tr>
<tr>
<td>All Georgia PBIS Schools</td>
<td></td>
<td>• 24% reduction in office discipline referrals from initial training year to 2016</td>
</tr>
</tbody>
</table>

For sources please visit [https://tinyurl.com/yblkmcy4](https://tinyurl.com/yblkmcy4)
Census 2020
What You Need to Know and Why It Is Important for Kids

What is the census?
The census is a count of all people living in the United States (not just citizens). The data are used for congressional seat allocation and the drawing of legislative district boundaries.

What do I need to know about the census?
The census is:

- **Required**: The U.S. Constitution mandates the census be taken every 10 years.
- **Confidential**: It is illegal to disclose or publish any information that identifies an individual or business.
- **Convenient**: Households will submit their information either online or regular mail.

Why is an accurate count important?
Nearly 300 government programs depend on census data for a total of more than $600 billion in funding annually, including:

- Children’s Health Insurance (Medicaid/PeachCare)
- Special Education
- Head Start
- Foster Care Support
- School Nutrition
- Supplemental Nutrition Assistance Program
- Housing Assistance

When children are undercounted, they are denied a full voice in policy decision making and the resources needed to thrive.

Next census: April 1, 2020

<table>
<thead>
<tr>
<th></th>
<th>Su</th>
<th>Mo</th>
<th>Tu</th>
<th>We</th>
<th>Th</th>
<th>Fr</th>
<th>Sa</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2020</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<tr>
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<td></td>
<td></td>
<td></td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Next census: April 1, 2020</td>
<td></td>
<td>13</td>
<td>14</td>
<td>15</td>
<td>16</td>
<td>17</td>
<td>18</td>
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<td></td>
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<td>19</td>
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<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
<td>29</td>
<td>30</td>
</tr>
</tbody>
</table>

Which children are at risk of not being counted?

- Under the age of 5
- Children of color
- Live with grandparents or non-parental caregivers
- Live in poverty
- Live in households with limited English proficiency or literacy
- Living with immigrant parents

More than a million children nationwide are at risk of not being counted in the 2020 census.
How Can You Help?

- Ask lawmakers for adequate resources for the census to ensure all kids are counted
- Advocate for the work of the Complete Count Committee to continue into the next administration
- Share information with friends, colleagues, and groups you’re involved with about why the census matters

Road to the 2020 Census
Key Dates to Remember

2019

- **January - February:**
  - Open 40 area census offices

- **June - August:**
  - Open remaining 208 area census offices

- **August:**
  - Conduct in-field address canvassing

2020

- **March 23rd:**
  - Internet self-response begins
  (Households can self-respond through July)

- **April 1: Census Day!**

- **Mid-April:**
  - All nonresponding homes receive final letter and paper census form

- **May 13th through July:**
  - Non-response door-to-door visits begin

- **December 31:**
  - Deliver apportionment counts to President

2021

- **March 31:**
  - Complete delivering redistricting summary files to all states

For more info: https://census.georgia.gov
Rev. 12/2018
In State Fiscal Year 2019, federal funds will go to 9 state agencies serving Georgia’s children.

<table>
<thead>
<tr>
<th>STATE AGENCY</th>
<th>SFY 2019 Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCH: Department of Community Health</td>
<td>$3,513,203,456</td>
</tr>
<tr>
<td>DHS: Department of Human Services</td>
<td>$504,646,705</td>
</tr>
<tr>
<td>DPH: Department of Public Health</td>
<td>$289,358,731</td>
</tr>
<tr>
<td>DBHDD: Department of Behavioral Health and Developmental Disabilities</td>
<td>$21,841,356</td>
</tr>
<tr>
<td>DECAL: Department of Early Care and Learning</td>
<td>$404,798,159</td>
</tr>
<tr>
<td>DOE: Department of Education</td>
<td>$2,098,482,487</td>
</tr>
<tr>
<td>CJCC: Criminal Justice Coordinating Council</td>
<td>$2,718,014</td>
</tr>
<tr>
<td>DOD: Department of Defense</td>
<td>$18,414,513</td>
</tr>
<tr>
<td>DJJ: Department of Juvenile Justice</td>
<td>$8,417,741</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$6,861,881,162</strong></td>
</tr>
</tbody>
</table>

Federal Funding by Policy Area

- **63.1%** Health and Human Services
  - DBHDD: Department of Community Health
  - DHS: Department of Human Services
  - DPH: Department of Public Health

- **0.4%** Public Safety
  - CJCC: Criminal Justice Coordinating Council
  - DOD: Department of Defense
  - DJJ: Department of Juvenile Justice

- **36.5%** Education
  - DECAL: Department of Early Care and Learning
  - DOE: Department of Education

Personal Communication. Governor’s Office of Planning and Budget. (December 18, 2018). Revised 12/19/18
## STATE PROGRAMS RECEIVING FEDERAL FUNDING

### Health and Human Services

<table>
<thead>
<tr>
<th>Agency</th>
<th>Program(s)</th>
<th>Funding (in $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DBHDD</td>
<td>Community Mental Health Services Block Grant, Medical Assistance Program (Medicaid)</td>
<td>$4,329,050,248</td>
</tr>
<tr>
<td></td>
<td>Sub. Abuse Prevention and Treatment Block Grant</td>
<td></td>
</tr>
<tr>
<td>DCH</td>
<td>Medical Assistance Program (Medicaid)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>State Children’s Insurance Program</td>
<td></td>
</tr>
<tr>
<td>DHS</td>
<td>Medical Assistance Program (Medicaid), Social Services Block Grant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Title IV-E: Adoption Assistance and Foster Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Title IV-B: Promoting Safe and Stable Families</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Title IV-D: Child Support Enforcement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CAPTA, Child Care, and SNAP</td>
<td></td>
</tr>
<tr>
<td>DPH</td>
<td>Infants and Toddlers with Disabilities Grant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maternal and Child Health Services Block Grant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive Health and Health Services Block Grant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Women, Infants, and Children Program</td>
<td></td>
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<tr>
<td></td>
<td>Immunization and Vaccines for Children Grant</td>
<td></td>
</tr>
</tbody>
</table>

### Public Safety

<table>
<thead>
<tr>
<th>Agency</th>
<th>Program(s)</th>
<th>Funding (in $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CJCC</td>
<td>Temporary Assistance for Needy Families Block Grant</td>
<td>$29,550,268</td>
</tr>
<tr>
<td></td>
<td>Juvenile Justice and Delinquency Prevention</td>
<td></td>
</tr>
<tr>
<td>DOD</td>
<td>STARBASE, National Guard Youth Challenge and Job Challenge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>United States Department of Agriculture</td>
<td></td>
</tr>
<tr>
<td>DJJ</td>
<td>Education</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Residential Substance Abuse Treatment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Title IV-E: Foster Care</td>
<td></td>
</tr>
</tbody>
</table>

### Education

<table>
<thead>
<tr>
<th>Agency</th>
<th>Program(s)</th>
<th>Funding (in $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DECAL</td>
<td>Child and Adult Care Food Program, Child Care and Development Block Grant, Child Care Development Fund, Head Start</td>
<td>$2,503,280,646</td>
</tr>
<tr>
<td></td>
<td>National School Lunch Program</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Race to the Top: Early Learning Challenge Grant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>State Administrative Expenses for Child Nutrition</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Team Nutrition Grants</td>
<td></td>
</tr>
<tr>
<td>DOE</td>
<td>21st Century Community Learning Centers, Career and Technical Education, Charter Schools</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Child Nutrition Discretionary Grants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Comprehensive Literacy Development</td>
<td></td>
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<td></td>
<td>Education for Homeless Children and Youth</td>
<td></td>
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<td></td>
<td>Education for Migrantary Children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>English Language Acquisition State Grants</td>
<td></td>
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<tr>
<td></td>
<td>Fresh Fruit and Vegetable Program</td>
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<tr>
<td></td>
<td>Grants for State Assessments and Related Activities</td>
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</tr>
<tr>
<td></td>
<td>Maternal and Child Health Services Block Grant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mathematics and Science Partnerships</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Migrant Education Coordination Programs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>National Assessment of Educational Progress</td>
<td></td>
</tr>
<tr>
<td></td>
<td>National School Lunch Program</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Race to the Top: Early Learning Challenge Grant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rural Education</td>
<td></td>
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<tr>
<td></td>
<td>School Breakfast Program</td>
<td></td>
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<td></td>
<td>School Improvement Grants</td>
<td></td>
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<tr>
<td></td>
<td>Special Education Grants</td>
<td></td>
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<tr>
<td></td>
<td>Special Education Grants to States</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Special Milk Program for Children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>State Administrative Expenses for Child Nutrition</td>
<td></td>
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<tr>
<td></td>
<td>Student Support and Academic Enrichment Program</td>
<td></td>
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<td></td>
<td>Subsance Abuse and Mental Health Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supporting Effective Instruction State Grant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Title I Grants to Local Education Agencies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Title I Neglected and Delinquent Children and Youth</td>
<td></td>
</tr>
</tbody>
</table>
TITLE IV-E

The Federal Foster Care Program, also called Title IV-E, helps provide safe and stable out-of-home care for children until they are able to safely return home, placed permanently with adoptive families or placed in other planned arrangements.

In FY 2018, the Department of Human Services received $100,143,079 and the Department of Juvenile Justice received $1,495,178 of federal funding for Title IV-E.

Funding activities include:
- Monthly maintenance payments for daily care and supervision of eligible children.
- Administrative costs to manage the program at the state level.
- Training of staff and foster care providers.
- Title IV-E Child Welfare Education Program provides stipends for competitively selected MSW and BSW senior students to prepare them for competent professional child welfare practice.

TOP REASONS A CHILD IS IN FOSTER CARE

- Neglect
- Drug Abuse
- Inadequate Housing
- Abandonment
- Incarceration

FAMILIES FIRST PREVENTION SERVICES ACT

The Family First Prevention Services Act reformed Title IV-E to fund prevention services to families who are at risk of entering the child welfare system.

The changes will help keep children safely with their families and avoid the traumatic experience of entering foster care, emphasizes the importance of children growing up in families, and helps ensure children are placed in the least restrictive, most family-like setting appropriate to their needs.

NEW PREVENTION ACTIVITIES

- 12 months of mental health services & substance abuse treatment
- In-home parent skill-based programs
- Mandatory prevention plan for a child to remain safely at home
- No time limit for family reunification
- Trauma-informed services*

*Must be modeled after the California Evidence Based Clearinghouse for child welfare

Sources: https://tinyurl.com/TitleIVERefences

Rev. 12/2018
### Turnover Rates and Average Salaries of Child-Serving Workers*

#### Social Services Specialist (DFCS)
- **Voluntary Turnover**: 22.9%
- **Entry Level**: $29,202.69 (856 workers)
- **Working Level**: $34,421.12 (1,944 workers)
- **Advanced Level**: $36,903.06 (333 workers)
- **Supervisor**: $42,000.63 (630 workers)

#### Economic Support Specialist (DFCS)
- **Voluntary Turnover**: 14.3%
- **Entry Level**: $25,721.95 (586 workers)
- **Working Level**: $27,540.39 (1,824 workers)
- **Advanced Level**: $32,620.57 (407 workers)
- **Supervisor**: $35,647.10 (379 workers)

#### Registered Nurse (DPH)
- **Voluntary Turnover**: 15.3%
- **Entry Level**: $37,275.32 (72 workers)
- **Working Level**: $47,647.87 (676 workers)
- **Advanced Level**: $65,221.40 (247 workers)
- **Supervisor**: $81,898.18 (8 workers)

#### Registered Nurse (DJJ)
- **Voluntary Turnover**: 13.1%
- **Entry Level**: $49,445.76 (75 workers)
- **Working Level**: $54,802.92 (11 workers)
- **Advanced Level**: $57,928.56 (17 workers)

#### Corrections Officer (DJJ)
- **Voluntary Turnover**: NA
- **Entry Level**: $27,938.04 (812 workers)
- **Working Level**: $30,942.24 (756 workers)
- **Advanced Level**: $35,454.96 (158 worker)
- **Supervisor**: $37,948.44 (183 workers)

#### Social Services Program Coordinator (DJJ)
- **Voluntary Turnover**: NA
- **Entry Level**: $31,555.92 (77 workers)
- **Working Level**: $36,248.28 (25 workers)
- **Advanced Level**: $37,145.52 (44 workers)
- **Supervisor**: $43,845.96 (10 workers)

#### Probation/Parole Specialist (DJJ)
- **Voluntary Turnover**: 15.5%
- **Entry Level**: $28,297.92 (80 workers)
- **Working Level**: $31,743.72 (374 workers)
- **Advanced Level**: $35,634.36 (72 workers)
- **Supervisor**: $39,110.28 (85 workers)

#### Probation Officer (DJJ)
- **Voluntary Turnover**: NA
- **Entry Level**: $33,129.00 (80 workers)
- **Working Level**: $37,881.72 (41 workers)

#### Pre-K Teachers (DECAL)
- **Voluntary Turnover**: Retained 82%

<table>
<thead>
<tr>
<th>Position</th>
<th>Lead Teacher (2 yr degree)</th>
<th>Lead Teacher (4 yr degree+)</th>
<th>Lead Teacher (Certified T4)</th>
<th>Lead Teacher (Certified T5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-K Teachers (DECAL)</td>
<td>$21,449.86 (32 workers)</td>
<td>$27,315.60 (920 workers)</td>
<td>$35,820.73 (2,833 workers)</td>
<td>$40,343.04 (2,833 workers)</td>
</tr>
</tbody>
</table>

*All positions and salaries from DFCS and DPH represent FY17. All positions and salaries from DJJ represent FY16. DECAL teacher salaries represent the required minimums for the 2017-2018 school year.*

Revised 12/4/18
For sources please visit: https://tinyurl.com/ybw3dfb6
Increased funding could provide salary increases and strengthen recruitment and retention efforts for these positions that play an important role in the lives of children.

Note: FPL (Federal Poverty Level) for a family of 4 in FY17 (100%: $24,600 and 200%: $49,200)
## 2019 Federal Poverty Guidelines

<table>
<thead>
<tr>
<th>Family/Household Size</th>
<th>100%</th>
<th>200%</th>
<th>400%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 person</td>
<td>$12,490</td>
<td>$24,980</td>
<td>$49,960</td>
</tr>
<tr>
<td>2 people</td>
<td>$16,910</td>
<td>$33,820</td>
<td>$67,640</td>
</tr>
<tr>
<td>3 people</td>
<td>$21,330</td>
<td>$42,660</td>
<td>$85,320</td>
</tr>
<tr>
<td>4 people</td>
<td>$25,750</td>
<td>$51,500</td>
<td>$103,000</td>
</tr>
</tbody>
</table>

Source: Department of Health and Human Services

## Federal Program Eligibility based on Federal Poverty Guidelines

Certain federal programs use the federal poverty guidelines to determine eligibility. The following chart details specific programs and the maximum yearly income a family of 4 can earn to remain eligible.

<table>
<thead>
<tr>
<th>Program</th>
<th>Maximum Yearly Income (Family of 4)</th>
<th>Maximum % of Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childcare and Parent Services - Low Income Priority Group</td>
<td>$25,750</td>
<td>100%</td>
</tr>
<tr>
<td>Supplemental Nutrition Assistance Program</td>
<td>$33,475</td>
<td>130%</td>
</tr>
<tr>
<td>Women, Infants, Children</td>
<td>$47,638</td>
<td>185%</td>
</tr>
<tr>
<td>Medicaid (Children up to 1 year)</td>
<td>$52,788</td>
<td>205%</td>
</tr>
<tr>
<td>Medicaid (Children ages 1-5)</td>
<td>$38,368</td>
<td>149%</td>
</tr>
<tr>
<td>Medicaid (Children ages 6-18)</td>
<td>$34,248</td>
<td>133%</td>
</tr>
<tr>
<td>PeachCare (Children 0-18)</td>
<td>$63,603</td>
<td>247%</td>
</tr>
<tr>
<td>Marketplace (Health Insurance) Premium Tax Credit</td>
<td>$103,000</td>
<td>400%</td>
</tr>
</tbody>
</table>
### Federal Program Definitions

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Childcare and Parent Services (CAPS)</strong></td>
<td>The Childcare and Parent Services (CAPS) program offers low-income families subsidies to pay for quality child care, afterschool and summer programs for children up to age 12 and for children up to age 17 with special needs.</td>
</tr>
<tr>
<td><strong>Marketplace (Health Insurance) Premium Tax Credit</strong></td>
<td>Individuals and families with incomes at 100 - 400% FPL, that purchase health insurance through the Health Insurance Marketplace, can receive federal premium tax credits to reduce their monthly insurance premium payments.</td>
</tr>
<tr>
<td><strong>Medicaid</strong></td>
<td>Medicaid in the U.S. is a joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid also offers benefits not normally covered by Medicare, like nursing home care and personal care services.</td>
</tr>
<tr>
<td><strong>Peachcare for Kids™</strong></td>
<td>PeachCare for Kids™ provides medical coverage for individuals under age 19 whose parents earn too much to qualify for Medicaid, but not enough to pay for private coverage.</td>
</tr>
<tr>
<td><strong>Supplemental Nutrition Assistance Program (SNAP)</strong></td>
<td>SNAP offers nutrition assistance to millions of eligible, low-income individuals and families through electronic benefit cards.</td>
</tr>
<tr>
<td><strong>Women, Infants, Children (WIC)</strong></td>
<td>Women, Infants, and Children provides supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk.</td>
</tr>
</tbody>
</table>

Sources: [https://aspe.hhs.gov/poverty-guidelines](https://aspe.hhs.gov/poverty-guidelines)