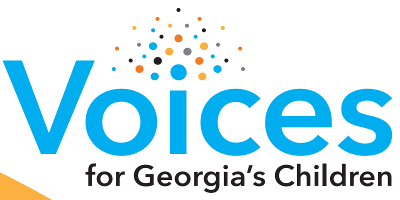
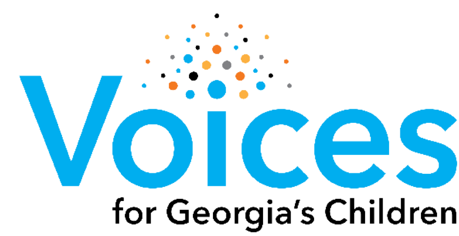


# ALL ABOUT KIDS:

## Factsheets about Georgia's Children

January 2023



Dear Policymaker, Child Advocate, and Friend,

Welcome to our 2023 edition of All About Kids: Factsheets on Georgia's Children. Throughout this book, we offer an array of data and research on topics across the spectrum of child policy, all designed to be easy-to-find and easy-to-use as you work on policies and legislation for children and families. We hope that you will find this helpful.

We at Voices for Georgia's Children (Voices) and the Georgia Statewide Afterschool Network (GSAN) are at your disposal to assist with any child-related policy work or questions you may have!

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

Most sincerely,
Caitlin, Katie, Polly and Melissa

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## 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 believes every child can thrive when given the opportunity. Through research and analysis, public education, and convening and engaging with decision-makers, we advance laws, policies, and actions that improve the lives of children — particularly those furthest from opportunity. Our work is framed in a holistic "whole child" perspective that allows us to identify how different policies impact children and propose solutions that benefit children on multiple levels.

For more information, visit 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 afterschoolga.org.

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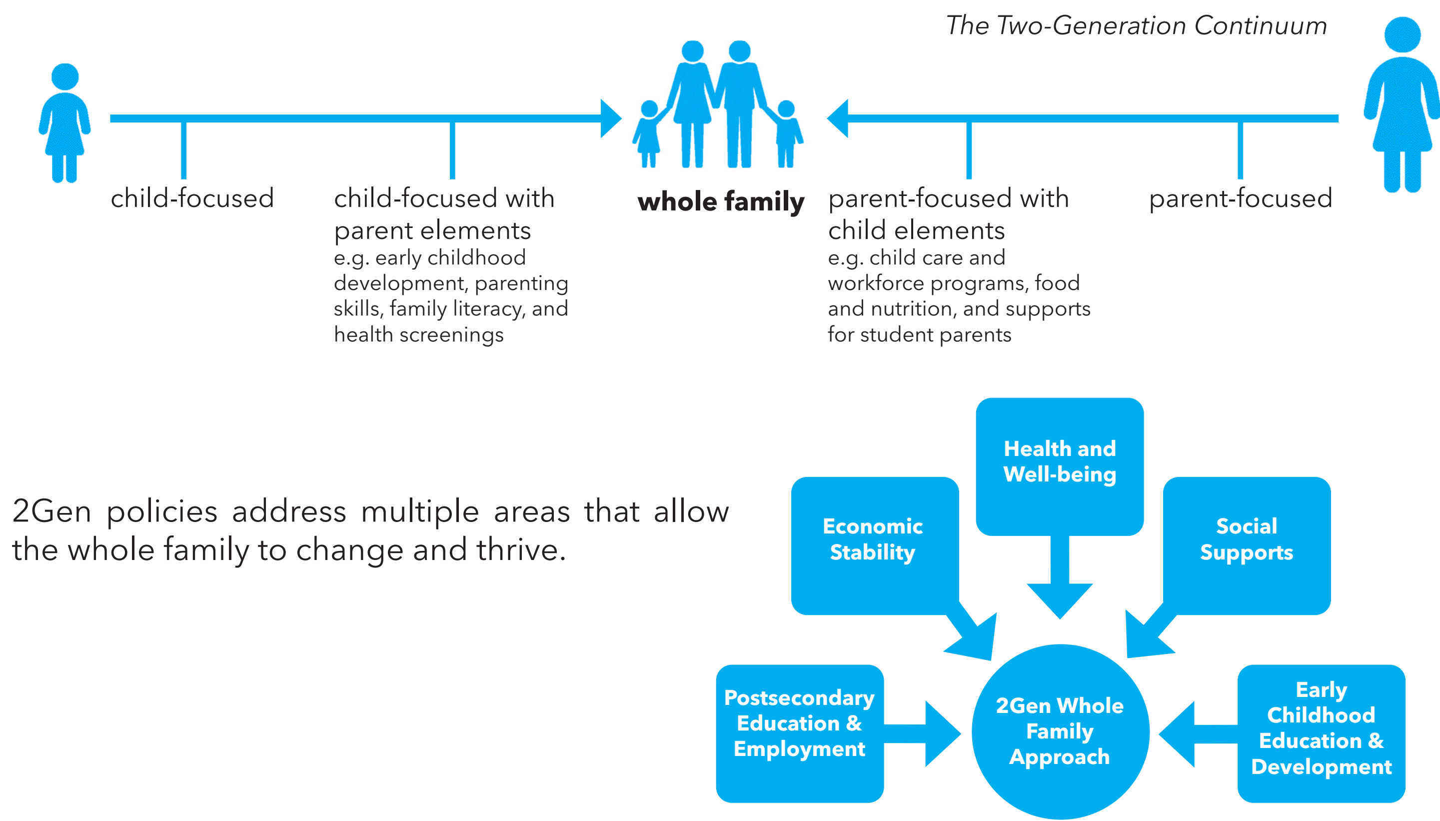
# Two-Generation "2Gen" Approach

## 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 separately.[1] 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.

## Impact of 2Gen Approaches

Improving access to childcare could address an estimated **$1.75 billion** economic loss to the state by reducing missed work and increasing economic opportunities for parents of young children.[2]

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.[3]

Children with college savings between **$1 and $499** are **3 times** more likely to go to college and **4 times** more likely to graduate.[4]

**Household income below 100% of the federal poverty level. See HHS Poverty Guidelines for more info.*

# 2Gen Models in Georgia*

## Department of Early Care and Learning (DECAL)

DECAL's Childcare and Parent Services (CAPS) program:[5]

Provides access to high-quality and affordable early learning for families with low incomes

Helps young learners achieve school readiness for greater academic gains in the long-term

Assists families in achieving stability and self-sufficiency by providing financial support for childcare

DECAL also supports select technical colleges with Two-Generation Innovation Grants, which connect children from low-income families with quality early learning and helps their parents receive the training and education they need for well-paying jobs.

## Quality Care for Children

Quality Care for Children's Boost Child Care Initiative aims to increase the success of low-income parents and their children. Boost Child Care Initiative includes:

Increasing state investment in child care subsidies to improve Georgia's workforce

Eliminate the Childcare and Parent Services (CAPS) eligibility gap

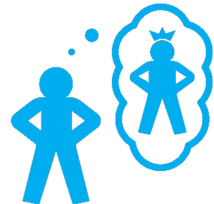
Extending subsidy eligibility to parents attending college

*Note: The Quality Care for Children's Boost Child Care Initiative is not affiliated with the Georgia Statewide Afterschool Network BOOST Grant.*

## Network of Trust School Health Program

The Network of Trust school health program in Albany works with pregnant teens and young mothers to:[6]

Promote healthy moms and babies



Increase mother's self-esteem

Increase rates of school attendance and graduation

The Network of Trust also works to decrease the rate of child abuse.

**This is not a comprehensive list of 2Gen models in Georgia. Other examples include Home Visiting, Child Care Access Means Parents in School (CCAMPIS), and Nana grants.*

Rev. 07/2022
Sources: https://bit.ly/3AdBQu5

# INSERT BANK TAB: EARLY CARE AND LEARNING

# Early Childhood Developmental Milestones

A child's early years are critical for later health and development.[1] Missing key milestones during this crucial period may indicate developmental delays. It is critical to know what to expect during the early stages of a child's development, since early detection and intervention can help kids stay on track. Between birth and age 5, a child's brain develops more than at any other time in life.

**95% of brain growth happens before kindergarten.[2]**

## THE FIRST YEAR OF LIFE[3]

### 0-3 months

- Holds head up when on stomach
- Begins to smile
- Learns to briefly calm self (e.g., brings hand to mouth and suck on hand)

### 3-6 months

- Copies movements and sounds
- Begins to babble
- Rolls from stomach to back

### 6-9 months

- Begins to sit with support
- Plays peek-a-boo
- Knows familiar faces

### 9 months to 1 year

- Crawls and pulls to stand
- Uses simple gestures (e.g., shakes head, waves)
- Responds to simple spoken requests

## THE SECOND YEAR OF LIFE (AGES 1 TO 2 YEARS)

mama
cat
dada

- Knows several words
- Points to show something is interesting
- Plays simple pretends

## THE THIRD YEAR OF LIFE (AGES 2 TO 3 YEARS)

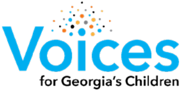
- Finds objects that are hidden
- Engages in conversation
- Begins to run
- Follows instructions with 2-3 steps

## THE FOURTH YEAR OF LIFE (AGES 3 TO 4 YEARS)

- Cooperates with other children
- Dresses self
- Sings songs or poems from memory
- Plays roles (e.g., parent, teacher, animal)

*Note: It is important to remember that children may develop skills on slightly different timelines. Therefore, developmental milestone achievements may not fully align with the provided time frames and may be met at slightly different times.*

**www.georgiavoices.org**



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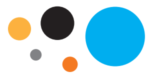


# Quality Early Learning in Georgia

Quality early care and learning are essential to the growth and development of Georgia's youngest learners. Multiple studies have shown how quality early care and learning impact outcomes for young children in their early years and well beyond.

## WHAT IS QUALITY?[1]

### Elements of quality early care 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

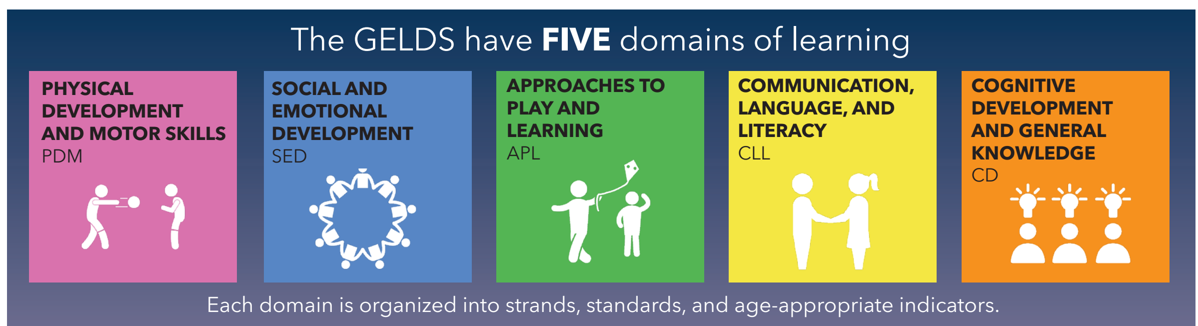
Provide supports for dual-language learners

## QUALITY INITIATIVES IN GEORGIA

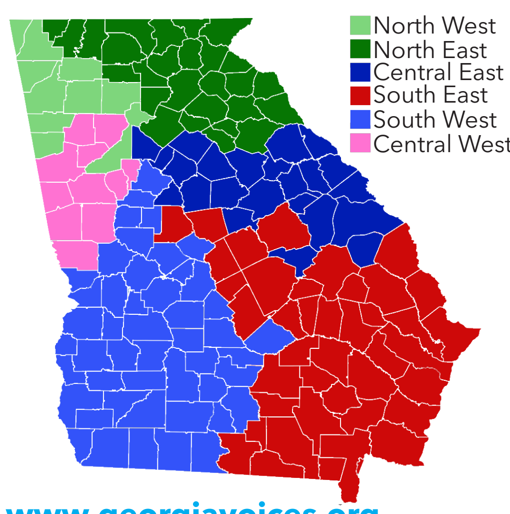
### Georgia Early Learning and Development Standards[2]

The Georgia Early Learning and Development Standards (GELDS) are a set of high-quality, research-based, appropriate, attainable standards that are flexible enough to support individual rates of development, approaches to learning, and cultural context for children from birth to age five. The GELDS promote quality learning experiences for children and address the question, "What should children from birth to age five know and be able to do?" The GELDS are aligned with the Georgia Standards of Excellence (GSE) for K-12, as well as the Head Start Early Learning Outcomes Framework and the Work Sampling System.

The GELDS are a continuum of skills, behaviors, and concepts that children develop throughout this time of life, divided by age group.




### Early Education Community Partnerships Team[3]




DECAL is continuing its investment in community outreach and engagement through the Early Education Community Partnerships (EECP) Team. This team is composed of six Community Coordinators assigned to each DECAL administrative region of the state. These Community Coordinators share information about DECAL resources and collaborate with community organizations to improve learning outcomes for young children.

The EECP Team also engages with local stakeholders to coordinate the delivery of available services for young children and their families, with priority given to efforts that expand access to high-quality care through Georgia's Quality Rated Child Care system. Specific efforts led by regional Community Coordinators include working with community stakeholders to align systems for children ages birth to 8, fostering public awareness of early education services, serving as a local resource and referral for all DECAL programs and services, and convening regional birth-to-eight teams and child care engagement networks.

## QUALITY RATED[4]

**Quality Rated is a voluntary tiered 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.

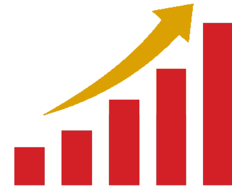
To become Quality Rated, programs must score well on portfolios with self-reported information and classroom observations conducted by trained assessors. Star rated programs receive packages with training, materials, and equipment.

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

## Benefits for Parents and Families

QualityRated.org is a trustworthy resource that helps families find high-quality child care and Pre-K programs.

Parents can use the **FREE, online search tool** to access information about specific programming, including safety and inspection reports, weekly rates, and ages served. To find Quality Rated programs, 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.

Of the **4,450** state eligible child care programs, more than **2,855** are Quality Rated.[5]

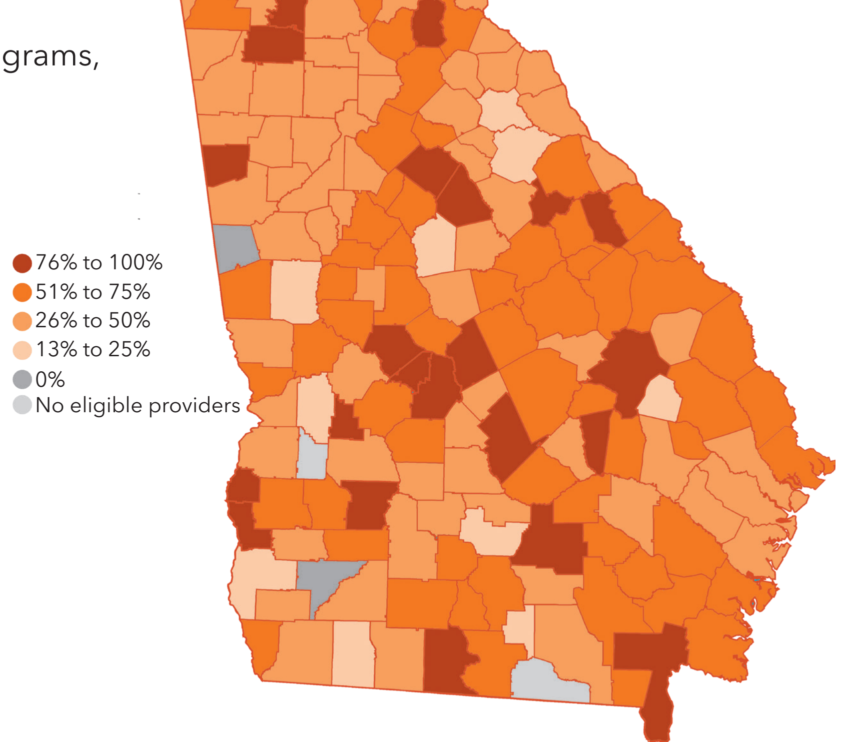
**Star Rating Statewide Count**[6]

**1,128** ★

**1,190** ★★

**537** ★★★

### Percentage of Eligible Programs that are Quality Rated per County

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Sources:bit.ly/3HRdJWC

# Childcare and Parent Services

The Childcare and Parent Services (CAPS) program assists families with low-income with the cost of child care while they work, go to school or training, or participate in other work-related activities.[1] Subsidies can be used 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.[2]

The purpose of CAPS is to:[3]

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

## FUNDING FOR CAPS[6]

CAPS is funded by state and federal dollars.

### Federal Funding

Federal funding is provided from the Child Care and Development Fund (CCDF) and is administered by the Department of Early Care and Learning (DECAL). Georgia typically receives approximately **$230 million** in federal child care subsidy funds. However, with available pandemic-related federal stimulus funding available, DECAL has been able to increase funding for CAPS by **$165M** for a limited time. DECAL used these funds to support an expansion of CAPS priority and eligibility populations, increase provider payment amounts and eliminate family fees to temporarily reduce the financial burden on families, as well as increase the tiered reimbursement that quality rated providers receive (see below for more details).

### State Funding

In State Fiscal Year 2022, Georgia appropriated and made available approximately **$56 million** for CAPS.

## PRIORITY GROUP ELIGIBILITY

Because CAPS scholarships are limited, children in the following situations are given priority:[5]

- Child Protective Services
- Custody of the Division of Family and Children Services
- Domestic violence situations
- Disability status
- 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
  (e.g., family with substantiated Child Protect Services case closed within the last 12 months, caregiver other than biological or adoptive parents has taken over full-time care of child)
- Student parent (effective as of May 1, 2022)

While federal and state funding temporarily allowed DECAL to expand priority groups and serve additional families, continued, and increased, investments are crucial to reaching eligible but not served individuals. For example, the limited funding for the state's child care subsidy program means that it is only able to support a small percentage of the children and families who qualify for it (appropximately five to seven percent in 2022).[4]

## INCOME ELIGIBILITY

To qualify for entry into the CAPS program, family income must not exceed 50% of the state median income.[7]*

For example, a **family of four** cannot initially make more than **$76,443** a year.

To qualify for the Very Low Income priority group, a **family of four** cannot make more than **$41,625** a year.[8]

*This threshold was set at 85% of the SMI November 1, 2022 through December 15, 2022, due to funding from the American Rescue Plan Act and expanded CAPS to serve 10,000 additional children. Families currently enrolled in CAPS are not affected by these changes and can still remain in the program as long as their income does not exceed 85% SMI and they meet other eligibility requirements.

## PARENT APPROVED ACTIVITIES

Parents who receive CAPS must complete 24 hours per week of approved activities to stay eligible for the CAPS scholarship.[9]

Approved activities can include:[10]

**Employment**
Paid employment or volunteering at Head Start or Early Head Start facilities

**Education**
Participation in middle or high school, GED programs, vocational training programs, technical college, technical credits, associate degree and bachelor's 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 per 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 per week towards the required 24.[11]

***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.[12]

## CHANGES TO THE CHILD CARE DEVELOPMENT FUND (CCDF)

In FY 2022, CCDF mandatory and matching federal funds totaled approximately **$73.5 million**,* which included an approximate $17 million permanent increase authorized by the American Rescue Plan Act.[13]

As of September 17, 2018, parent fees were significantly reduced, not to exceed **7%** of family income.[14]

All providers serving children receiving CAPS subsidies are required to participate in Quality Rated.[15]

*The $73.5 million appropriation does not include pandemic-related one-time funding amounts for DECAL.

Rev. 12/2022
Sources:

# Georgia's Pre-K Program

Georgia's Pre-K Program has served more than **1.8 million students** since it began in **1992**.[1] This voluntary, free program is open to all four-year-olds in Georgia, regardless of parental income. The program continues to be nationally recognized for its success.

## 2021-2022 Participation

During the 2021-2022 school year, Georgia's Pre-K had:[2]

**73,177** students in **3,762** classes operating in **159** counties in **1,838** locations

At the end of the year, **2,592 kids** were on the waitlist.[3]

Georgia's Pre-K programs are located in both public school systems (**45%**)[4] and private centers (**55%**).[5]

## Program Structure[6]

Maximum of 22 kids per classroom

Full day program that runs 180 days per year

Lead and assistant teachers must meet credential requirements

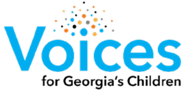
Curriculum is based on the Georgia Early Learning and Development Standards (GELDS)

## Program Highlights

**8th in the nation**

In 2020-2021, Georgia ranked **8th** best in the nation for access to pre-k for four-year-olds.[7]

**More than half** of Georgia's pre-k providers are *Quality Rated*, a voluntary, quality rating system for early and child care programs.[8]



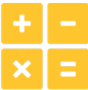
## How Georgia's Pre-K Program Improves Outcomes

From 2011 to 2015, the Georgia Department of Early Care and Learning and the Frank Porter Graham Institute conducted a multi-year evaluation to understand the short- and long-term benefits of Georgia's Pre-K. The study followed children from Georgia's Pre-K through third grade and found children:[9]

**Are more prepared for kindergarten** compared to four-year-olds who did not attend a Georgia Pre-K program.

**Sustain gains made in pre-k** through kindergarten and first grade.

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 were shown to be sustained through the end of first grade.

## Funding for Georgia's Pre-K Program

Georgia's Pre-K Program is funded by the Georgia Lottery. **$401 million** lottery dollars were allocated to Georgia's Pre-K for FY23.[10]

Research shows **low pay** is a significant factor in an early childhood teacher's decision to leave the profession.[11] **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.[12]

In 2016, the Georgia General Assembly approved a $34 million increase for pre-k salaries. Georgia's current pre-k salaries are as follows:

| Assistant Teacher[13] | 4-year degree, Lead Teacher[14] | 4-year degree & certified, Lead Teacher[15] | Master's Degree, Lead Teacher[16] |
|---|---|---|---|
| **$16,190.35** | **$38,820.73** | **$38,820.73** | **$43,343.04** |

Rev. 07/2022
Sources: bit.ly/3HL6K1k

# School Readiness in Georgia

Children entering kindergarten with school readiness skills are more likely to experience **academic success** and better **lifetime well-being** than their peers.[1]

## What is School Readiness?

A child's readiness for school includes:[2]

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, family, community, schools, and the services to which they have access.**

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.[3] Environmental exposures, such as health risks, financial strain, conflict, and neighborhood safety, impact a child's future opportunities – including school readiness and grade promotion.[4] 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.[5]

## Georgia's Commitment to School Readiness

Georgia Department of Early Care and Learning (DECAL) administers several programs to increase early readiness skills so students can enter kindergarten ready to learn, including:

### Georgia's Pre-K Program

**MORE THAN 1.8 MILLION**

students have been served by Georgia's Pre-K Program since it began in 1992.[6]

Children in Georgia's Pre-K program showed significant growth across all learning domains, including:[8]

Math skills

Language and literacy skills

Social-emotional skills

Evaluations have found that children enrolled in the Georgia Pre-K program:[7]

- Are more prepared for kindergarten compared to four-year-olds in other forms of care.
- Have increased cognitive development and improved educational outcomes in later grades.

Dual language learners in Georgia's Pre-K program showed growth across all skills in English and most skills in Spanish.[9]

### Summer Transition Programs[10, 11, 12]

DECAL offers both Rising Kindergarten and Rising Pre-K Summer Transition programs as additional supports for high-risk students, including:

**387** classes at **294** program sites

**6-week** intensive summer program

Child's family must be **at or below 85% of the state median income**

A **transition coach** is in each class to help families

**Low student-to-teacher** ratio

www.georgiavoices.org

# Georgia's Summer Transition Program

Georgia Department of Early Care and Learning, Bright from the Start's Rising Pre-K and Rising Kindergarten Summer Transition Programs (STP) are **intensive six-week academic programs** to support children and prepare them for pre-k and kindergarten.

## Rising Kindergarten Summer Transition Program

**Eligibility Requirements for Rising Kindergarten:**[1]

1. Child did not attend a Georgia's Pre-K or Head Start program during the 2021-2022 school year, **OR**
2. Child attended a Georgia's Pre-K or Head Start program, but did not attend the entire school year, **OR**
3. Child attended a Georgia's Pre-K or Head Start program the entire school year and falls into one of the following priority groups:
    - Child identified as needing additional academic support
    - Dual language learner (home language is a language other than English)
    - Foster care placement
    - Child's family is without permanent housing (homeless as defined by McKinney-Vento Homeless Assistance Act)
    - Child has an Individualized Education Program (IEP)

### 2021-2022 Participation[2]

**3,816** children at **237** locations in **61** counties which operate **315** classes

These programs are located in both public school systems (**35%**) and private centers (**65%**).

### Program Structure[3]

Maximum of 12 kids per classroom

Full day program

A lead and assistant teacher per class

Provides/assists in coordinating care before and after school as needed through CAPS

### Transition Coach[4]

Summer transition program requires a half-time transition coach for every class, who is responsible for:

Identifying students who would benefit from the program and meet the enrollment requirements

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-Kindergarten Summer Transition Program

**Eligibility Requirements for Rising Pre-Kindergarten:**[9]

1. Child is attending Georgia's Pre-K or Head Start in Fall 2022, **AND**
2. Child's home language is Spanish

### 2021-2022 Participation[5]

**720** children at **57** locations in **20** counties which operate **72** classes

These programs are located in both public school systems (**26%**) and private centers (**74%**).

### Program Structure[6]

Maximum of 10 kids per classroom

Instruction is provided in both English and Spanish

Teacher training to work with Dual Language Learners (DLL)

At least one teacher AND the transition coach must be fluent in Spanish

### Dual Language Learners

An estimated **24%** of Georgia's **3 & 4-year-olds** are DLLs, with the vast majority speaking Spanish.[7]

Research from the Frank Porter Child Development Institute indicated that:[8]

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 **increased independence**.
4. While children made significant gains, **a meaningful gap remained between DLLs and their peers**.

**In 2022, the Rising K and Pre-K Summer Transition Programs combined hosted:**

**4,536** children at **294** locations

**The total budget* for both Summer Transition Programs is: $10.8 MILLION.**

Approximately **$2,380**

being spent **PER CHILD**

*budget funded by the Georgia Lottery and federal dollars

Rev. 05/2022
Sources: bit.ly/3jjaBbK

# Farm to Early Care and Education

Georgia's Early Care and Education (ECE) programs serve more than **330,000 children**, many of whom may consume **1-3 meals** and **2 snacks** a day onsite.[1]

## Why Farm to Early Care and Education?

Research shows Farm to School initiatives improve children's health and nutrition.[2] Most of these programs start in K-12 schools, but children can be reached earlier with Farm to Early Care and Education (FTECE).

**Top Reasons Providers Choose to Participate in FTECE**

- Teach children where food comes from and how it is grown
- Improve child health
- Provide children with experiential learning

## STRATEGIES THAT WORK

Parent education and engagement[3]

Meal planning and preparation[4]

Curriculum where kids touch and taste food[5]

Gardening with kids[6]

Fruit and vegetable boxes for home consumption[7]

## FTECE SUPPORTS

- Fruit and vegetable consumption, some of which may increase vitamin A, C, and E intake[8]
- Healthy food consumption at home[9]
- Willingness to try new foods[10]
- Development of motor skills[11]
- Fosters life skills, social skills, and self-esteem[12]
- Promotes physical activity[13]
- Reduced diet-related diseases among children[14]
- Reduced food waste

## FTECE and Agriculture

FTECE benefits children, as well as **supports Georgia farmers**. FTECE encourages childcare providers to:

- Purchase and serve fresh, nutritious, local foods for their children
- Host on-site farmers markets for parents and staff
- Develop partnerships with local farms for experiential learning

## VOICES RECOMMENDATIONS

- Allocate funding to reimburse ECE programs when meals incorporate local foods.
- Develop and fund a pilot for ECE providers to purchase larger quantities of food from local farmers.

www.georgiavoices.org

Rev. 05/2022
Sources: bit.ly/3BOV0XI

# Evidence-Based Home Visiting Program

Georgia's **Evidence-Based Home Visiting (EBHV) Program**, under the Georgia Department of Public Health, provides new parents the supports they may need when having a baby. EBHV gives at-risk pregnant women, new moms, and families with children 0-5 years old the skills they need to raise healthy children.[1] The overall goals of home visiting programs are to:[2]

- increase healthy pregnancies,
- improve parenting skills,
- improve child health and development,
- strengthen family connectedness to community support, and
- reduce child abuse and neglect.

**In 2021, 22,863 home visits were conducted for 1,925 Georgia families.**[3]

## ELEMENTS OF AN EVIDENCE-BASED HOME VISIT[4]

Weekly to monthly visits, based on the families' needs

Screening for developmental delays, parent depression, and domestic violence

Visits last 1 to 1.5 hours

Making referrals to community resources

Answering questions about child development

Encouraging perinatal and well-child visits

Promoting engaged, positive parenting practices

Supporting parents' education and employment goals

## WHO IS ELIGIBLE FOR EBHV?[5]

To be eligible, parents must be in need of ongoing support and meet some of the following criteria:

- Low-income
- First-time parent
- Younger than 21 years old
- Lack employment or stable housing
- Low educational attainment
- Lacking access to prenatal care
- Experienced child abuse or neglect
- History of, or ongoing, substance abuse or mental health challenges
- Is receiving or has received special education services
- Has veteran or active military members in the family

## FUNDING FOR EBHV[6]

The federal Maternal, Infant, Early Childhood Home Visiting (MIECHV) program is the primary funding source for home visiting; additional funding streams include Title V, Child Abuse and Neglect Prevention, and other state dollars.

## EFFECTIVENESS OF THE 2020 GEORGIA HOME VISITING PROGRAM[7]

**Outcomes after receiving home visiting services:**

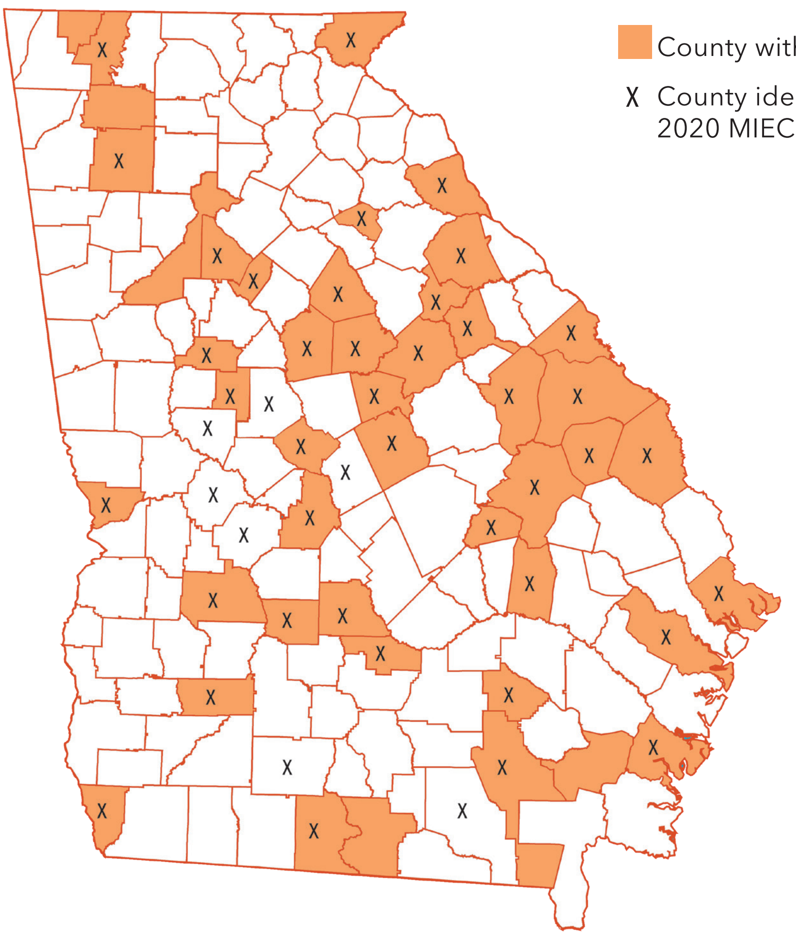
**For children:**

- **99%** had *no reports of maltreatment*
- **97%** *spent quality time* with a caregiver (e.g., read a story, sang songs)
- **90%** were *screened for developmental delays* at the appropriate time
- **100%** of those referred to early interventions services for developmental delays *received services in a timely manner*

**For primary caregivers:**

- **92%** *received postpartum care*
- **94%** were *screened for depression*
- **89%** were *using safe sleep practices*
- **96%** were *screened for intimate partner violence*
- **74%** *maintained health insurance* for at least 6 months of the year

## GEORGIA HOME VISITING PROGRAM COUNTY COVERAGE BY PROGRAM TYPE*




*This chart is a non-comprehensive list of the Georgia Department of Public Health EBHV programs across the state.[8]

## RECOMMENDATIONS

- Create and fund an interagency workgroup (overseen by DPH) to map current state home visiting efforts, identify national best practices, and develop and execute a strategic plan to increase the availability of home visiting throughout the state.
- Continue to fund existing Georgia home visiting programs at current levels; this includes (pending passage of the proposed federal MIECHV reauthorization) setting aside funds for a possible state match for MIECHV-funded programs.

Rev. 11/2022
Sources: bit.ly/3v5xv92

# Insert Bank Tab: Quality Out-of-School Time

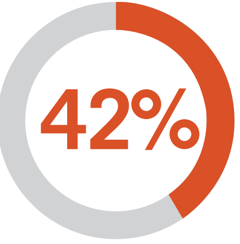
# Demand for Afterschool in Georgia

**327,853** or **18%**

of Georgia's school-aged children participated in afterschool programs in 2020[1]

*but*

**633,481** or **42%**

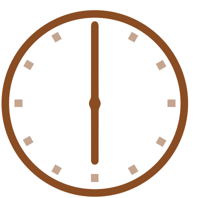


more children would enroll if a program was available in their community[2]

That's a **16%** increase in the demand for afterschool programs since 2004[3]

**33%** of children in afterschool are from low-income households[4]

**238,265** of Georgia's children are alone and unsupervised between the hours of



**3pm** and **6pm**[5]

## THE TOP THREE ROADBLOCKS TO AFTERSCHOOL PROGRAM PARTICIPATION

Programs are too expensive — 55%

No safe way to get their child to and from programs — 52%

Lack of available programs — 35%

Percentage of parents reporting they did not enroll their child in an afterschool program because of these reasons[6]

## WHY WE NEED MORE PROGRAMS

**19%** of juvenile violent crimes occur during school days between:

**3pm** and **7pm**[7]

of students attending 90 days or more at a 21st CCLC afterschool program improved math and reading test scores[8]

**90%**

of students in a 4-year afterschool program graduated high school[9]

fewer absences for students who are in afterschool programs for two years[10]

## WHAT PARENTS SAY

**70%**

of Georgia parents say that afterschool programs help parents keep their jobs[11]

of Georgia parents are satisfied with their child's afterschool program[12]

**79%**

of Georgia parents agree that afterschool programs provide working parents peace of mind[13]

**87%**

of Georgia parents report their child's afterschool program provides a safe environment[14]

**CONTACT US** | For more information on afterschool in Georgia go to **www.afterschoolga.org**


REFERENCES:

[1-6] Afterschool Alliance. America After 3PM (2020). Retrieved December 8, 2020 from http://www.afterschoolalliance.org/AA3PM

[7] Office of Juvenile Justice and Delinquency Prevention. Statistical Briefing Book "Juvenile Violent Crime Time of Day" Retrieved from https://www.ojjdp.gov/ojstatbb/offenders/qa03301.asp

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[9] Jay Smink. Expanding Minds and Opportunities: the Power of Afterschool and Summer Learning for Student Success. "A Proven Solution for Dropout Prevention: Expanded Learning Opportunities" Retrieved from https://www.expandinglearning.org/expandingminds/article/proven-solution-dropout-prevention-expanded-learning-opportunities

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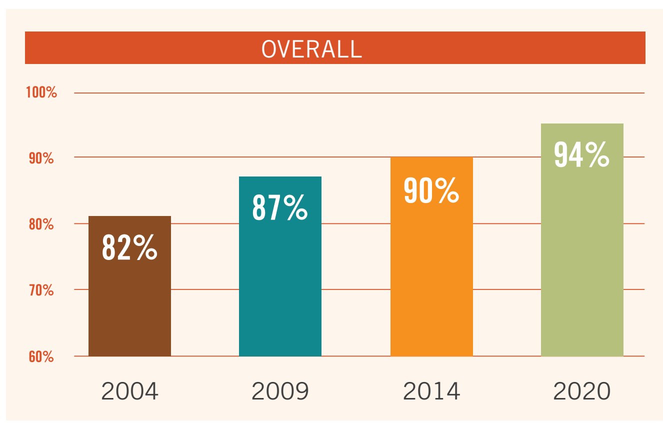
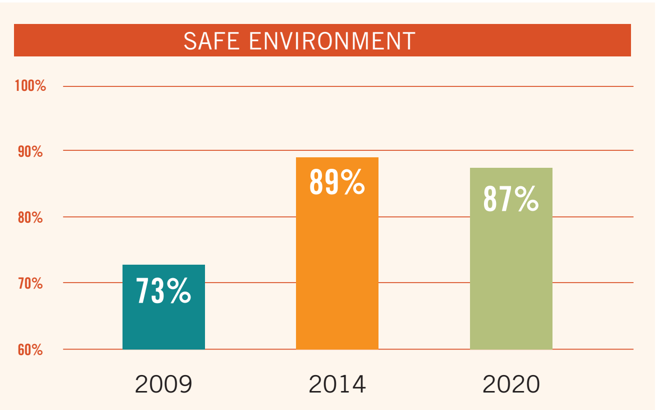
[11-14] Afterschool Alliance. America After 3PM (2020). Retrieved December 8, 2020 from http://www.afterschoolalliance.org/AA3PM

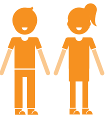
# Support for Afterschool in Georgia

## GEORGIA PARENT SATISFACTION WITH AFTERSCHOOL PROGRAMS[1]




## GEORGIA PARENTS REPORT A RANGE OF BENEFITS OF AFTERSCHOOL PROGRAMS[2]

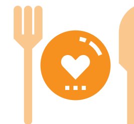


**91%**
Interacting with peers and building social skills

**70%**
Building life skills

**71%**
Engaging in STEM or computer science learning opportunities

**79%**
Peace of mind for working parents



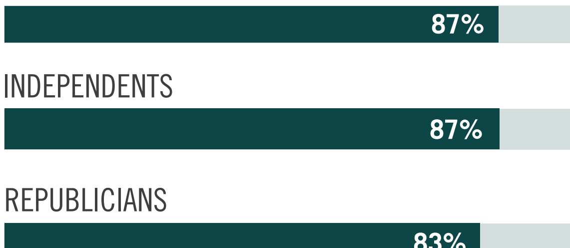
**83%**
Receiving healthy snacks and meals

## SUPPORT EXTENDS BEYOND JUST PARENTS WHO ARE SERVED BY AFTERSCHOOL PROGRAMS[3]

**86%** of parents in Georgia support public funding for afterschool programs

**77%** parents agreed nationally that Congress should provide additional funding for afterschool programs to operate during virtual school days due to the COVID-19 pandemic

Strong support for public funding for afterschool across the political spectrum



**CONTACT US** | For more information on afterschool in Georgia go to **www.afterschoolga.org**

**REFERENCES:**
[1-3] Afterschool Alliance. America After 3PM (2020). Retrieved December 8, 2020 from http://www.afterschoolalliance.org/AA3PM

# The Landscape of Afterschool in Georgia

The Georgia Department of Education (GaDOE) and the Georgia Division of Family and Children Services (DFCS) **FUND 276** afterschool and summer learning organizations serving **1146** program sites across the state.

In 2021,

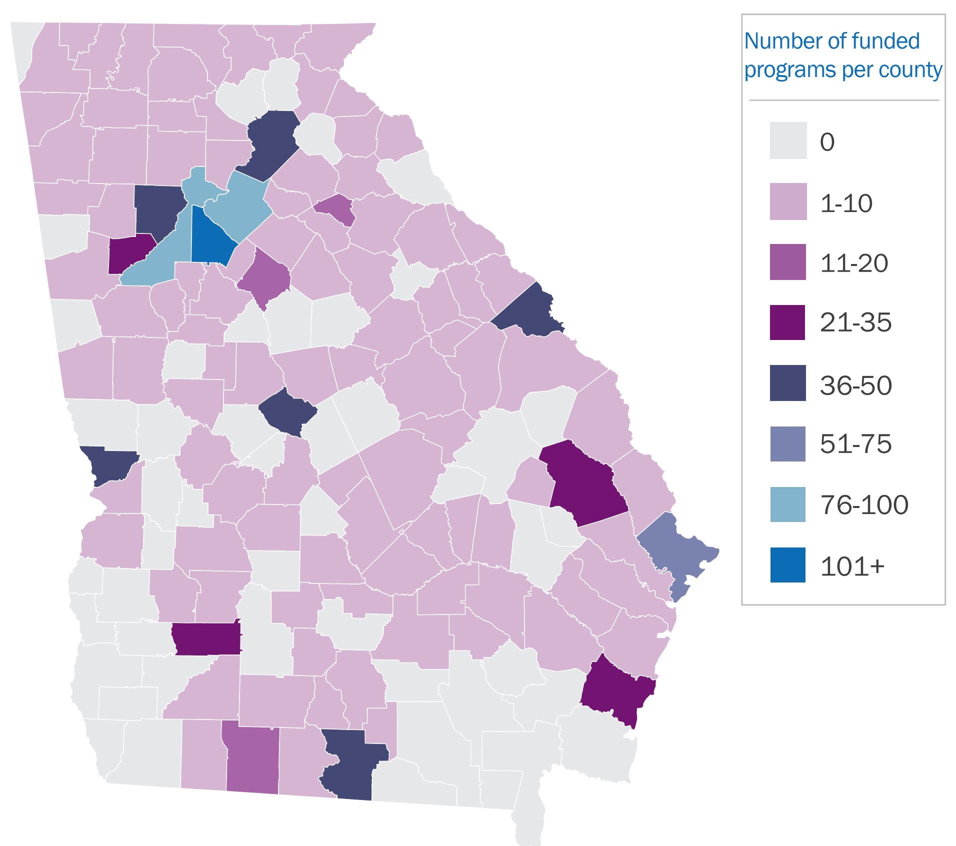
**$83.4 MILLION in FEDERAL FUNDING**

— *and* —

**$4.7 MILLION in STATE FUNDING**

has been invested in these programs to serve young people ranging from

**Pre-K** to **High School**




**83 COUNTIES** are served by more than 1 program

*but*

**44 OF 159 COUNTIES** do not have any government funded programs

Visit GSAN's Website
**www.afterschoolga.org**

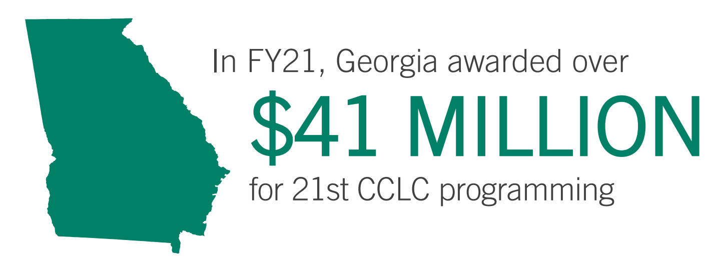
**Sources:**

1. Georgia Statewide Afterschool Network. Building Opportunities for Out Grantee Master Site List. Collected and processed by GSAN.
2. Georgia Department of Education. 21st Century Community Learning Centers (CCLC) Sites. Open Records Request (July 2022). Processed by GSAN.
3. Georgia Division of Family & Children Services. Out of School Services Program Sites. Professional Communication (April 2022). Processed by GSAN.
4. United Way of Greater Atlanta. Learning Loss Sites. Professional Communication (September 2022). Processed by GSAN.

# 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.

**16,680** kids participated in 21st CCLC in Georgia in FY21.



In FY21, Georgia awarded over **$41 MILLION** for 21st CCLC programming

Out of the **331** program sites that serve Georgia's children:

**58%** are located in schools

**40%** are located in community based orginizations

**2%** are located in institutions of higher education

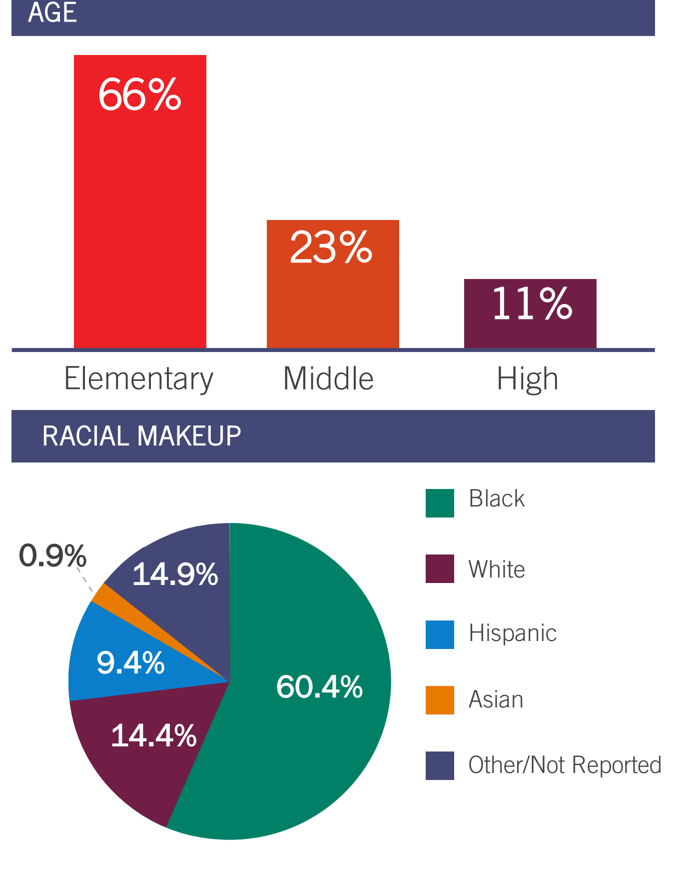
**115** of the programs

operate over the summer

**66%** of 21st CCLC sites are in urban areas

**34%** of 21st CCLC sites are in rural areas

**Demographics** of students served by 21st CCLC in Georgia:




**89%** are eligible for **free or reduced lunch**

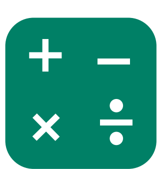
Georgia's 21st CCLC programs offer students the equivalent of at least…

**additional school days**

21st CCLC programs attempt to enroll students who previously did not meet state standards.

**OF THOSE WHO PARTICIPATED IN 21st CCLC:**

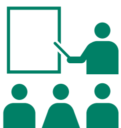
**75%** improved/maintained an A, B, or C in their English grades



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

*Due to the COVID-19 public health emergency, this data was not collected for FY20 and FY21. This academic data is from FY19.*

21st CCLC not only provides programming for kids, but for **families** as well. In the 2020 - 2021 school year, **11,519 parents** attended **1,049 events** ranging from:



GED Prep

Movie Nights

Sporting Events

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

**9** out of **10** children who participated in 21st CCLC in Georgia improved classroom behavior

of **parents** are satisfied with their child's 21st CCLC program

of **children** are satisfied with their 21st CCLC program

For more information, visit GSAN's website: **www.afterschoolga.org**

To learn more about Georgia's 21st CCLC program please visit **www.gadoe.org.**

**SOURCES**


1. Nita M. Lowey 21st Century Community Learning Centers, *2020 - 2021 Executive Summary*. Retrieved from https://www.gadoe.org/School-Improvement/Federal-Programs/Pages/21st-Century-Community-Learning-Centers.aspx
2. Georgia Department of Education, *FY21 21st CCLC Sites Open Records Request* Oct 1, 2020
3. Georgia Department of Education, *FY21 21st CCLC Student Demographics Data Collection Request* Oct 20, 2020
4. Georgia Rural Definitions. Census Urban Areas. Retrieved from https://www.ers.usda.gov/webdocs/DataFiles/53180/25565_GA.pdf?v=0

# Quality Aftershool: What it is & Where Georgia is Heading

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[1]:

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:

High quality afterschool and summer learning programs support academic acceleration. Students have opportunities to develop positive relationships with caring adults and peers, foster cooperative learning, and develop good decision-making skills. Regular participation leads to:

**Improved School Day Attendance**

**Gains in Reading and Math**

**Improved Work Habits and Classroom Behavior**

**Increased Graduation Rates[2,3]**

**Cognitive, Social, and Emotional Development[4]**

**Improved Health and Nutrition[5]**

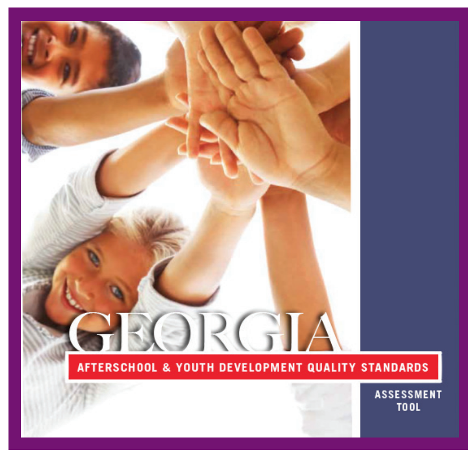
**Development in Positive Decision-making Skills, Self-control, and Self-awareness**

**Reduction in Risky Behaviors Such as Substance Use and Misuse[6,7]**

## WHERE IS GEORGIA HEADING:

### GEORGIA AFTERSCHOOL & YOUTH DEVELOPMENT (ASYD) QUALITY STANDARDS

A collaboration between the Georgia Statewide Afterschool Network (GSAN) and GUIDE, Inc., the Georgia Afterschool & Youth Development (ASYD) Initiative is supported by the Georgia Division of Family and Children Services and the Georgia Departments of Education, Public Health, Early Care and Learning, and Behavioral Health and Developmental Disabilities. The Georgia ASYD Quality Standards, released in December 2015, are Georgia's first quality standards for afterschool programming and provide a framework for afterschool providers to evaluate and continuously improve the quality of their programming. The Georgia ASYD Initiative provides training, coaching, and resources to providers across the state to support their quality improvement journey.




### GEORGIA AFTERSCHOOL & YOUTH DEVELOPMENT (ASYD) CONFERENCE

The biennial Georgia ASYD Conference serves youth development professionals across the state of Georgia. Hosted by The Georgia ASYD Initiative, this engaging conference provides three dynamic days of research-based best practices; information, tools and resources framed by Georgia's ASYD Quality Standards; over 70 workshops to choose from; and opportunities for networking and partnership formation.

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

### QUALITY SUPPORTS

GSAN brings free to low-cost training opportunities and technical assistance that supports more robust and formalized quality improvement practices. Through curated resources from the most respected and well-known leaders of youth development experts in the state, toolkits, activity guides, and content specific resources are made easily accessible and downloadable to youth program providers. Professionals have the opportunity for collaboration and quality improvements through peer learning cohorts led by subject matter experts throughout the year and Quality Coaches are also engaged to support youth programs.

For more information on Quality Supports in Georgia, go to **www.afterschoolga.org**

1. Georgia Afterschool and Youth Development Quality Initiative. Quality Standards. Retrieved from https://georgiaasyd.org/quality-standards/
2. Afterschool and Summer COVID-19 Response: Helping to Meet Students' Learning Needs. (2020). Afterschool Alliance. Retrieved from http://afterschoolalliance.org/documents/AA%20Helping%20to%20Meet%20Student%20Learning%20Needs.pdf
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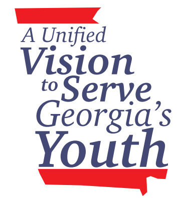
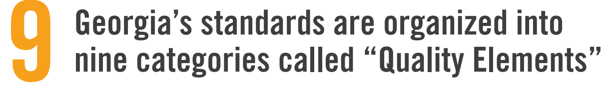
# What are the Georgia Afterschool & Youth Development (ASYD) Quality Standards?



The Georgia ASYD Quality Standards, released in December 2015, are Georgia's first quality standards for afterschool and summer learning programs and provide a framework for programs and professionals to evaluate and continuously improve the quality of their programming. The Georgia ASYD Initiative provides training, coaching, and resources to providers across the state to support their quality improvement journey.

## The Anatomy of the ASYD Quality Standards




**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

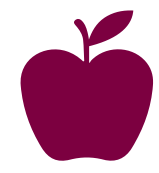
Family & Community Partnerships

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.

### EVIDENCE-BASED, RESEARCH-DRIVEN:

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.

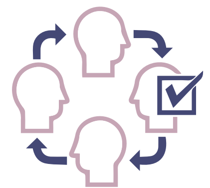
### DESIGNED ESPECIALLY FOR PROGRAMS THAT:



- 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

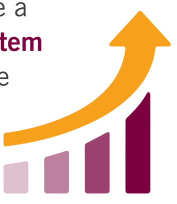
### SELF-ASSESSMENT, NOT PUNISHMENT:

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



### 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.



Visit the Georgia ASYD Website: **www.georgiaasyd.org** | Visit GSAN's Website: **www.afterschoolga.org**

# Afterschool Issues

## Afterschool Supports Healthy Lifestyles

Georgia ranked **24th in the nation for childhood obesity** (2020-2021).[1]
Of children aged 10 – 17 years old:[2, 3]

| 17% | 16.8% | 20.8% | 12.7% |
|---|---|---|---|
| OVERWEIGHT | OBESE | MALES WERE OBESE | FEMALES WERE OBESE |

**360,210** of Georgia's children were food insecure – lacking reliable and regular access to food in 2020.[4]

**Hungry children are likely to have:**[5]

- Lower grades
- Higher rates of absenteeism and tardiness
- Higher chances of repeating a grade

**Youth lack physical activity opportunities:**

- **27%** of children ages 6 - 11 and **16.8%** of children ages 12 - 17 are physically active for at least 60 minutes daily[6,7]
- **60.4%** live near a park or playground area[8]
- **41.2%** of high school students spend three or more hours a day playing video games or using a computer[9]

## Impact of Afterschool

Afterschool and summer learning programs are critical partners in supporting the health of Georgia's youth by providing access to nutritious foods, keeping kids physically active, and promoting healthy habits.

### GEORGIA PARENTS IN 2019[10]

**83%** said their child's afterschool program offers a healthy meals and/or snacks

**86%** said their child's afterschool program offers opportunities for physical activity

### Meals Served in 2019

**120,039** youth served daily by Child and Adult Care Food Program (CACFP)[11]

**112,495** youth served daily by Summer Nutrition Programs[12]

Youth who actively participate in high quality afterschool programs show less prevalence of obesity when compared to their non-participating peers.[13]

**Afterschool provides opportunities for:**[14]

- Snacks and meals
- Nutrition education
- Additional time for physical activity
- Safe space and materials
- Structured activities
- Adult support
- Team sports leading to:
  - conflict resolution skills
  - decreased stress
  - improved communication

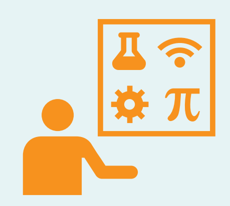
**Regular physical activity and healthy eating leads to:**[15]

- Strong bones and muscles
- Improved cardiorespiratory fitness
- Reduced symptoms of anxiety and depression
- Decreased likelihood of serious health conditions as an adult (heart disease, Type II diabetes, and cancer)
- Higher academic achievement
- Improved classroom behavior
- Improvement in indicators of cognitive skills (concentration, memory, and verbal skills)

For references, go to **www.afterschoolga.org/afterschool-issues**.

# Afterschool Issues

## Afterschool Builds Georgia's STEM Workforce



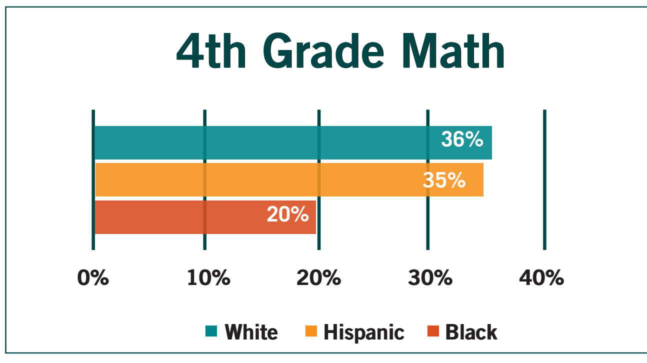
STEM careers in Georgia are expected to grow **13%** by 2027.[1]

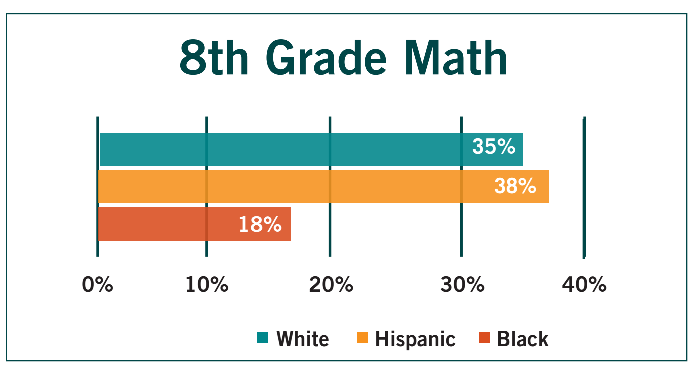
Georgia students performing at or above the National Assessment of Education Proficiency in math (2022):[2]

**34%** OF 4TH GRADERS

**24%** OF 8TH GRADERS

### INEQUITIES IN OPPORTUNITIES LEAD TO RACIAL ACHIEVEMENT GAPS IN GEORGIA




**Proficiency Percentages in Georgia Math Assessments in 2022[3]**

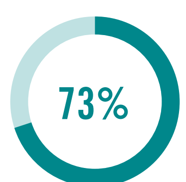
Historical inequities in educational opportunities, systemic barriers, and significantly fewer opportunities have resulted in unequal outcomes and continue to prevent a significant number of Georgians from reaching their full potential.[4, 5]

## Impact of Afterschool

Afterschool and summer learning programs are helping close the opportunity gap - which often results in a skills gap - by offering additional time and opportunities for students to experience hands-on STEM learning.

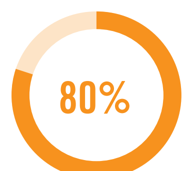
### NATIONAL STEM OUTCOMES

**Survey of 1600 youth from 160 programs [6]**

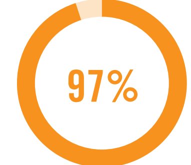



Students that have a more positive STEM identity (strongest indicator of pursuing a STEM career)

**Afterschool program serving 25,000 youth [7]**

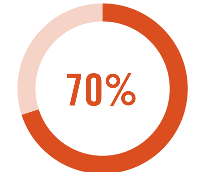



Students that reported the program was the most important source of support for pursuing a career




Students that said it taught them to set high goals and expectations of themselves.

**National program [8]**




Students that pursued post-secondary education and careers in STEM fields.

### Afterschool provides opportunities for: [9]

- Enriching STEM activities such as computer science, coding, and robotics
- Critical foundational skills
- Communication skills
- Working collaboratively
- Fostering confidence
- Exposure to career pathways

### Regular participation leads to: [10, 11]

- Significant gains in math achievement
- Positive results in reading achievement
- Increase in STEM knowledge and skills
- Higher chances of graduation
- Higher chances of pursuing a STEM career

For references, go to **www.afterschoolga.org/afterschool-issues**.

# Afterschool Issues

## Afterschool Improves Literacy in Georgia

**6 out of 10 children (63%)**
completing third grade in Georgia were not prepared to meet the literacy challenges of the next grade level (2021)[1]

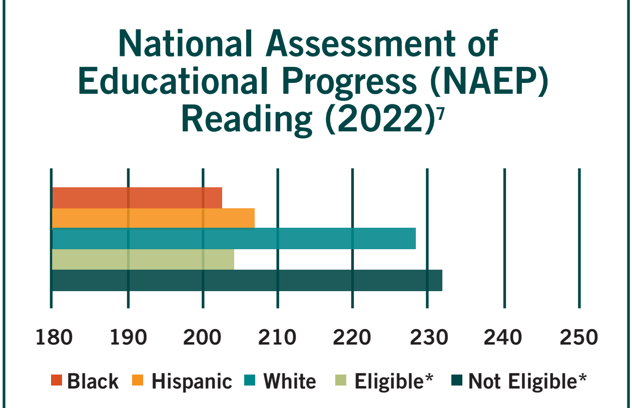
**This leads to a cycle of low literacy**[2, 3]

- Struggle with learning and fall behind
- Discipline problems
- Perform poorly in 8th grade math
- Higher chances of becoming teen parents
- Higher chances of dropping out of high school
- More likely to spend time in prison
- Struggle with unemployment
- Poor health & shorter life expectancy

**1 million Georgia adults** have low literacy and earn 30% less than adults with a HS diploma[4]

Costs the state **$1.26 billion** in social services and lost tax revenue annually[5]

**72%** chance of being at lowest reading level for children with parents with low literacy levels[6]




Average scores of Georgia students.
*Free or Reduced Lunch (indicator of family income)

**SUMMER IS CRUCIAL**

**2-3 months** reading skills loss for low income children[8]

**2/3** of the achievement gap in reading between low and middle income children by 9th grade due to summer learning loss[9]

## Impact of Afterschool

Afterschool and summer learning programs provide students with the additional supports they need to help build a strong foundation in literacy, including reading, writing and critical thinking skills.

**7 out of 10 parents** report that their children's programs provide opportunities for reading or writing and homework assistance.[10]

**21st CCLC programs in Georgia** — **77%** of regular attendees improved their grade or maintained an A, B, or C grade in ELA (2019)[11]

**One 21st CCLC program served 60 students** — **100%** of regularly attending middle school students increased at least one letter grade in ELA & 97% promoted to next grade[12]

**Afterschool provides opportunities for:**[13, 14]

- Project based learning opportunities
- Strong literacy foundation
- Group activities
- Peer-to-peer learning
- Critical thinking skills
- Communications skills

**Regular attendance lead to:**[15, 16]

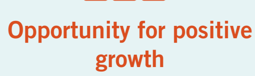
- Significant gains in reading skills
- Improved grades
- Improved attendance
- Improved attitude towards school
- Higher chances of graduation

For references, go to **www.afterschoolga.org/afterschool-issues**.

# Afterschool Issues

## Afterschool Supports Safer Communities

**Adolescence (ages 10 – 19) is a vital time in building cognitive, social, and emotional skills.[1] Marked by:**



Opportunity for positive growth

Possibility of recovery from negative childhood experiences

Increased sensitivity to their environment[2]

In 2019, more than **10,615 Georgia youth** were under the supervision of the Georgia Department of Juvenile Justice (DJJ) and approximately **1,357** of these youth were confined.[3]

- Georgia is **1 of only 3 states** that processes 17 year olds through the adult system regardless of offense
- High cost of youth confinement at **$91,000 per bed per year**[4]
- **50% of screened youth** referred for a more thorough mental health assessment[5]
- Disproportionate responses to misbehaviors in schools and in public safety for similar offenses

Black youth are more than **5.6 times as likely** to be detained or committed to youth facilities compared to White youth.[6]

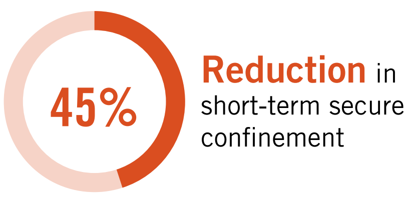
Youth from low income families are **4 times as likely** to be disciplined compared to their peers.[7]

Implicit biases related to race, gender, ethnicity, geography, and income have pushed countless youth into the juvenile justice system, and increased their likelihood of involvement with the justice system as an adult.[8]

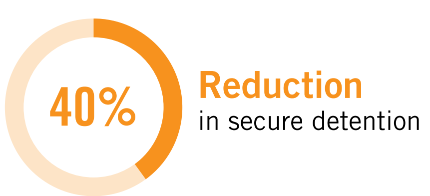
## Georgia Juvenile Justice Reform Act of 2013

In 2013, the Juvenile Justice Reform Act was passed with the aim to improve public safety, decrease costs, and preserve and strengthen family relationships to allow youth to live in safety and security. Strategies implemented include increased use of evidence-based programs, treating youth in the community rather than in secure facilities, and utilizing the Juvenile Justice Incentive Grant Program to decrease recidivism.

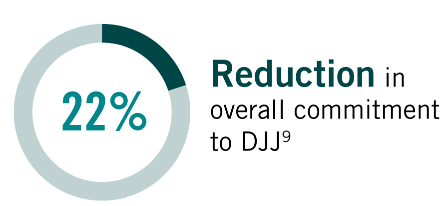
### GEORGIA 2013 – 2018 STRATEGY RESULTS




**Reduction** in short-term secure confinement




**Reduction** in secure detention




**Reduction** in overall commitment to DJJ[9]

More than **10,000 youth** have received evidence based treatment programming in their home communities.[10]

## Impact of Afterschool

All high quality afterschool and summer learning programs can serve as prevention programs and those that use evidence-based and trauma-informed practices can also support intervention and diversion.

### Afterschool provides:

- Safe and supervised environments
- Enrichment activities
- Opportunities to build positive decision-making and social-emotional skills
- Meaningful relationships with caring adults and peers[11]
- Protective factors that contribute to positive developmental experiences
- Mitigation of the effects of risk factors[12,13]

### Regular participation leads to:

- Reduction in crime and juvenile delinquency[14]
- Decreased reports of misconduct in school and disciplinary incidents
- Reduction in risky behaviors such as substance use and misuse[15,16]
- Self-control and self-awareness
- Increased school attendance
- Improved work habits and classroom behaviors
- Gains in reading and math
- Increased graduation rates[17,18]

## Recommendations

Afterschool and summer learning programs keep youth safe, provide necessary developmental supports, build protective factors, and provide opportunities for positive relationships thereby decreasing a young person's chances of interacting with the juvenile justice system. To ensure these supports are available to all young people GSAN makes the following recommendations:

**Create incentive grants for afterschool programs to use trauma-informed practices** and evidence-based programs to build protective factors.

**Expand state funding to afterschool and summer learning programs** to increase access and ensure affordability.

**Expand trauma-informed training** to afterschool and youth development professionals.

**Strengthen partnerships at all levels** between community-based afterschool programs, mentoring programs, school districts, juvenile courts, and other community partners to align services for young people.

**Increase funding and accessibility of evidence based wraparound models** to keep youth in their homes, placements, and communities.

**Expand trauma awareness and implicit bias training** for public safety officers and law enforcement personnel that engage with children in any way.

**Expand the jurisdiction of juvenile courts to encompass children under 18** and eliminate provisions that automatically transfer (without juvenile court approval) certain youth to adult courts.

**Increase funding and accessibility of behavior aide services and extend them to afterschool and youth development professionals**, in addition to families and classroom teachers, so they can help youth learn behavior modification techniques, supervise behaviors, and de-escalate situations.

For more information on afterschool in Georgia, go to **www.afterschoolga.org.**
For references, go to **www.afterschoolga.org/afterschool-issues.**

# Afterschool Issues

## Afterschool Addresses the Impact of COVID-19

COVID-19 stay-at-home orders and school closures impacted the lives of **10 million Georgians,** including Georgia's over **1.7 million students.**[1,2]

### COVID-19 IMPACT ON YOUTH

A majority of Georgia's students have experienced adjusting to distance learning and using **online resources.**

In Metro Atlanta, about **21,000 fewer students in ELA** and **29,000 fewer in math** are on track for grade-level proficiency.[3]

**A nationwide survey of school-aged kids:**

**27%** reported feelings of anxiousness

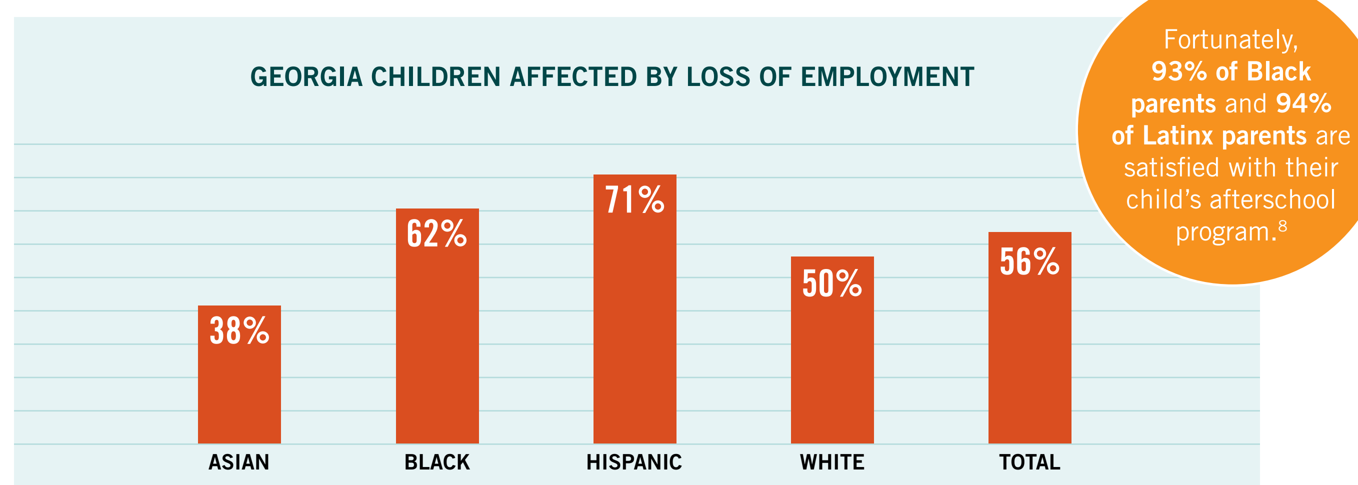
**23%** reported feelings of stress

**22%** reported feelings of unhappiness[4]

In Georgia, **24% of adults reports** being in households with children who felt down, depressed or hopeless for most of the week.[5]

**The virus disproportionally impacted youth of color and youth from low-income households.**

**73%** of programs serving the majority of children from **higher-income families** were open, compared to just **38%** of programs serving the majority of children from **low-income families** in summer of 2020.[6]

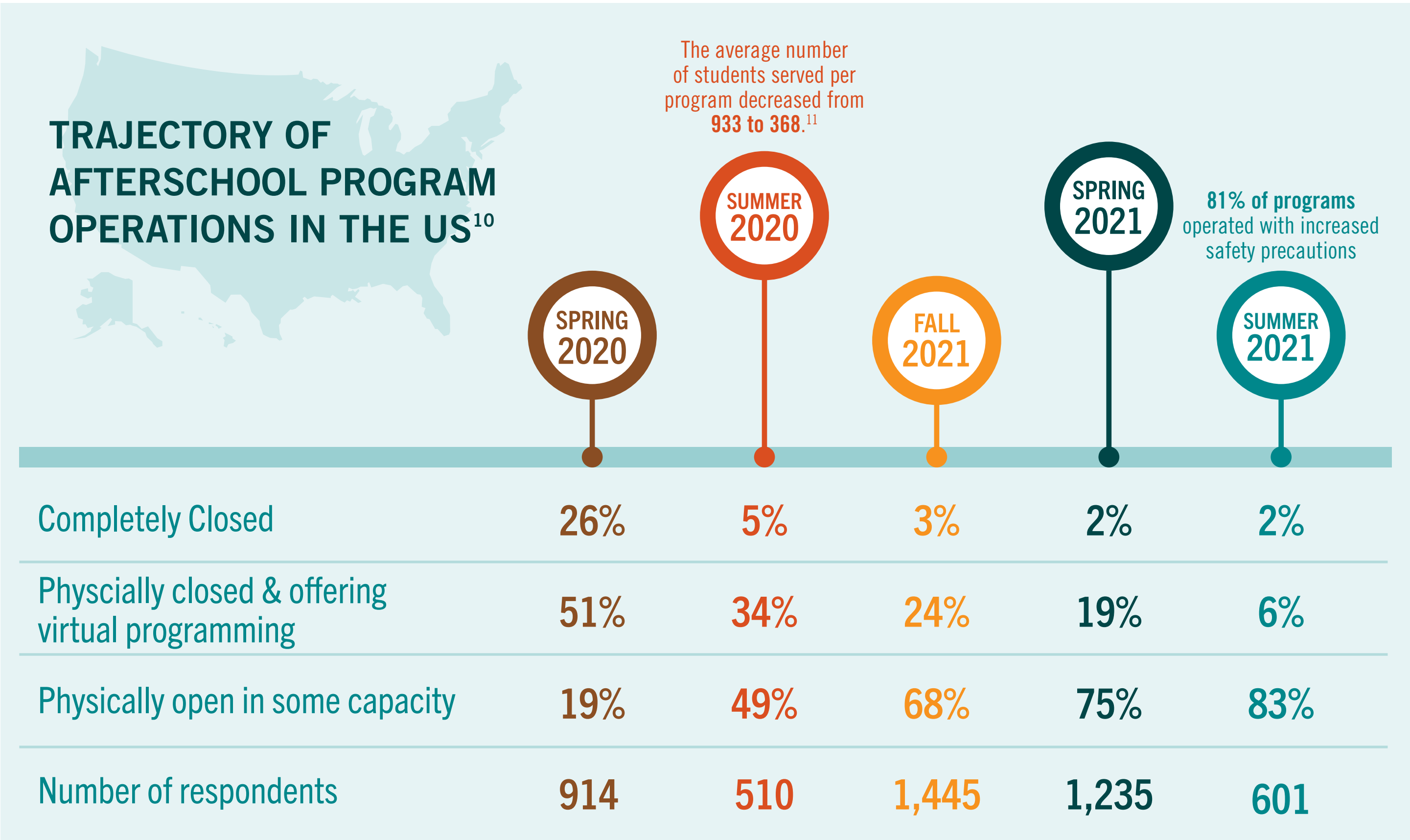



Fortunately, **93% of Black parents** and **94% of Latinx parents** are satisfied with their child's afterschool program.[8]

56% of Georgia households with children lost some form of employment income by November 2020. This number increases to 62% among Black households and 71% among Hispanic households.[7]

## COVID-19 Impact on Afterschool and Summer Learning Programs

In 2020, the Georgia Department of Labor business layoff and closure numbers reported **569 losses** from afterschool or childcare programs.[9]




| | SPRING 2020 | SUMMER 2020 | FALL 2021 | SPRING 2021 | SUMMER 2021 |
|---|---|---|---|---|---|
| Completely Closed | 26% | 5% | 3% | 2% | 2% |
| Physcially closed & offering virtual programming | 51% | 34% | 24% | 19% | 6% |
| Physically open in some capacity | 19% | 49% | 68% | 75% | 83% |
| Number of respondents | 914 | 510 | 1,445 | 1,235 | 601 |

### Future Concerns

**57%** of program providers are concerned about being able to hire enough staff, while **51%** are concerned about funding and their long term future.[12]

## Impact of Afterschool

In Georgia, for every child in an afterschool program, 2 more are waiting to get in, with **238,265 children alone and unsupervised** after school.[13]

**Afterschool Programs stepped up to support youth, families, and communities by[14]:**

- Providing a safe and well-supervised learning environments
- Providing childcare for essential workers
- Offering positive and supportive relationships
- Supporting adolescent brain development and social emotional learning

### BY SUMMER 2020

**53%** of programs adapted to support students for full-day virtual learning[15]

**95%** of summer programs were able to open in some capacity[16]

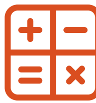
**53%** of programs provided some form of meal assistance[17]

**52%** of programs connected families with community resources[18]

# Summer Learning in Georgia

## Why Summer Learning?

**Summer can be a time of great opportunity but many youth – especially those from disadvantaged backgrounds – lose access to resources available during the school year, do not have access to programs in their community, and suffer summer learning loss.**

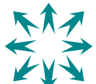


Most students lose **2 months of math skills** & low-income students lose an additional **2-3 months of reading skills**[1]

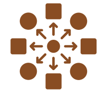
**2/3 of the achievement gap** in reading between low and middle income children by 9th grade is due to summer learning loss[2]

Only **1 in 7** students qualifying for free or reduced lunch receive summer meals[3]

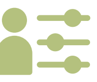
**High quality summer programs can stem learning loss, close educational and opportunity gaps and:**



**Broaden students' horizons**



**Include a wide variety of activities**

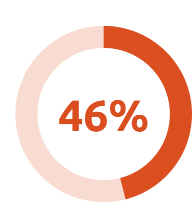


**Help youth build skills**

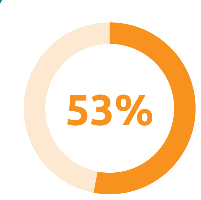
**Foster cooperative learning**

**Promote healthy habits**[4]

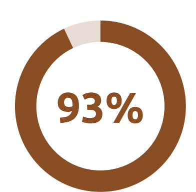
## Summer Learning by the Numbers[5]



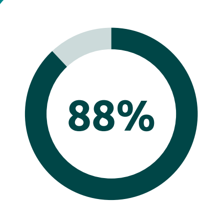

46% of Georgia families report that their child participated in a summer program in 2019




53% of Georgia families would have enrolled their child in a summer program if one were available




93% of Georgia parents are satisfied with their child's structured summer experience

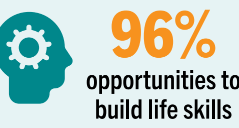



88% of Georgia parents support public funding for summer learning opportunities

## What do Georgia parents look for in a summer program?[6]

99% safety of environment

99% knowledgeable and caring staff


96% opportunities to build life skills

91% physical activity opportunities

83% opportunities to experience the outdoors

81% prevent learning loss

## Barriers to summer program enrollment[7]

Family does other things during the summer

40%

Programs are too expensive

36%

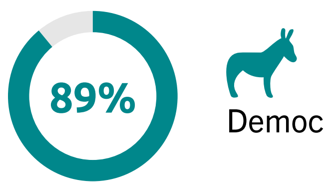
Issues with location or transportation

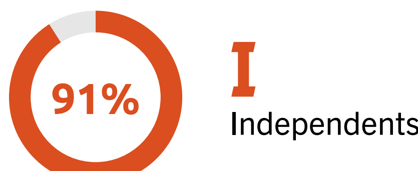
20%

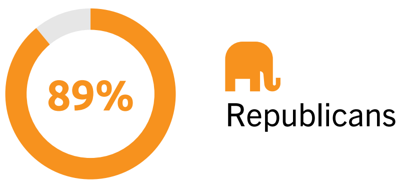
No summer programs available in their community

13%

## Support for summer learning is strong and bipartisan in Georgia[8]


89% Democrats


91% Independents


89% Republicans


1. Cooper, H., Nye, B., Charlton, K., Lindsay, J., & Greathouse, S. (1996). The Effects of Summer Vacation on Achievement Test scores: A Narrative and Meta-Analytic Review. Review of Education Research, 66 (3), 227-268.
2. Alexander, K. L., Entwisle D. R., & Olson L. S. (2007a). Lasting Consequences of the Summer Learning Gap. American Sociological Review, 72, 167
3. Hunger Doesn't Take a Vacation: Summer Nutrition Status Report. (August 2020). Food Research and Action Center. Retrieved from https://frac.org/wp-content/uploads/FRAC-Summer-Nutrition-Report-2020.pdf
4. Catherine H. Augustine, Jennifer Sloan McCombs, John F. Pane, Heather L. Schwartz, Jonathan Schweig, Andrew McEachin, and Kyle Siler-Evans. Learning from Summer: Effects of Voluntary Summer Learning Programs on Low-Income Urban Youth. RAND Corporation. (September 2016). Retrieved from https://www.rand.org/pubs/research_reports/RR1557.html
5. America After 3 PM. Afterschool Alliance (2020) http://afterschoolalliance.org/documents/AA3PM-2020/GA-AA3PM-Summer-2021-Fact-Sheet.pdf
6. Ibid.
7. Ibid.
8. Ibid.


For more information on afterschool in Georgia, go to **www.afterschoolga.org.**

# The Building Opportunities in Out-of-School Time (BOOST) Grants Program

The Building Opportunities in Out-of-School Time (BOOST) grants program is a collaborative partnership between the Georgia Department of Education and the Georgia Statewide Afterschool Network. Funded through the American Rescue Plan Act, BOOST allocates $85 million in grants to afterschool and summer learning in Georgia. The three-year grants, renewed annually, are awarded to organizations that operate comprehensive out-of-school time (OST) programming year-round, over the summer months, or after school during the academic year, with the goal of providing evidence-based afterschool and summer enrichment programming for youth most impacted by the COVID-19 pandemic.

## Intended Impacts

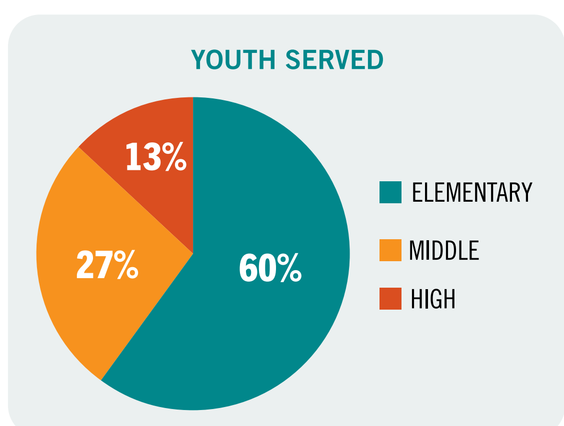
**BOOST grants support youth's academic acceleration, connectedness and well-being, utilizing a whole child approach to:**

**Expand access to serve more youth**, with an emphasis on children and communities most impacted by the pandemic.

**Reduce barriers**, such as lack of transportation and enrollment costs, to ensure access for all.

**Increase programmatic quality** and expand or enhance supports and services offered.

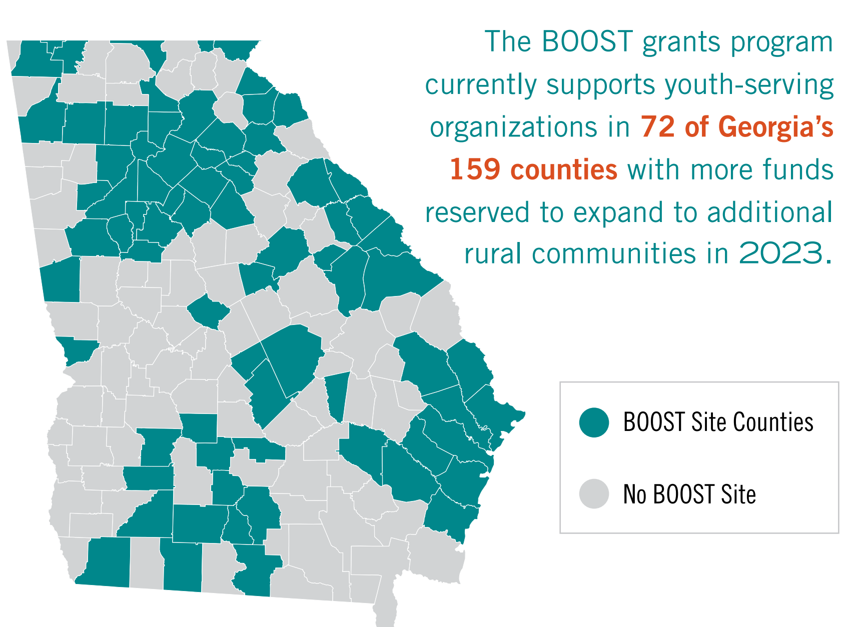
In 2021, Georgia awarded over **$27 million** to support 101 grantees who collectively served **over 72,000 youth** via afterschool and **over 78,000 youth** via summer programming.



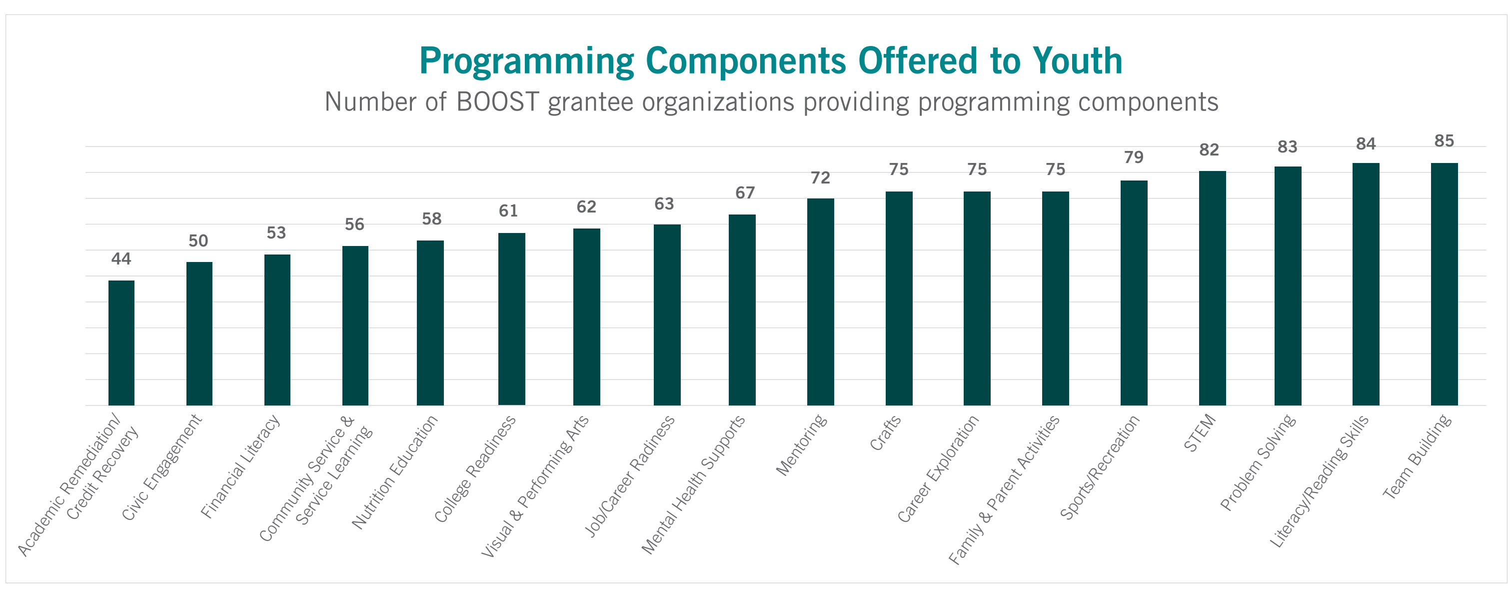

### Target Populations

- Youth receiving free or reduced-price lunch
- Youth with disabilities
- Youth experiencing homelessness
- Youth experiencing foster care
- English language learners
- Migratory youth

The BOOST grants program currently supports youth-serving organizations in **72 of Georgia's 159 counties** with more funds reserved to expand to additional rural communities in 2023.

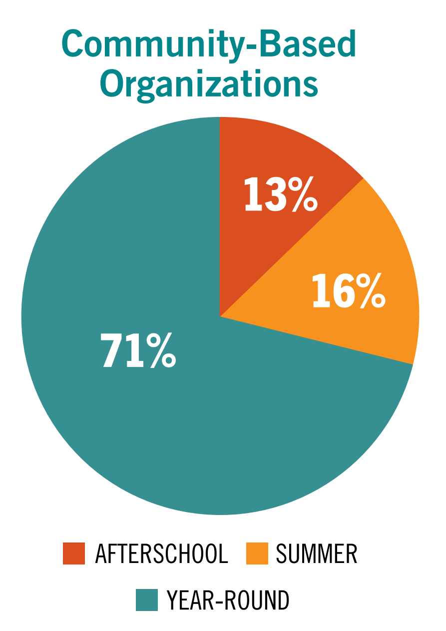


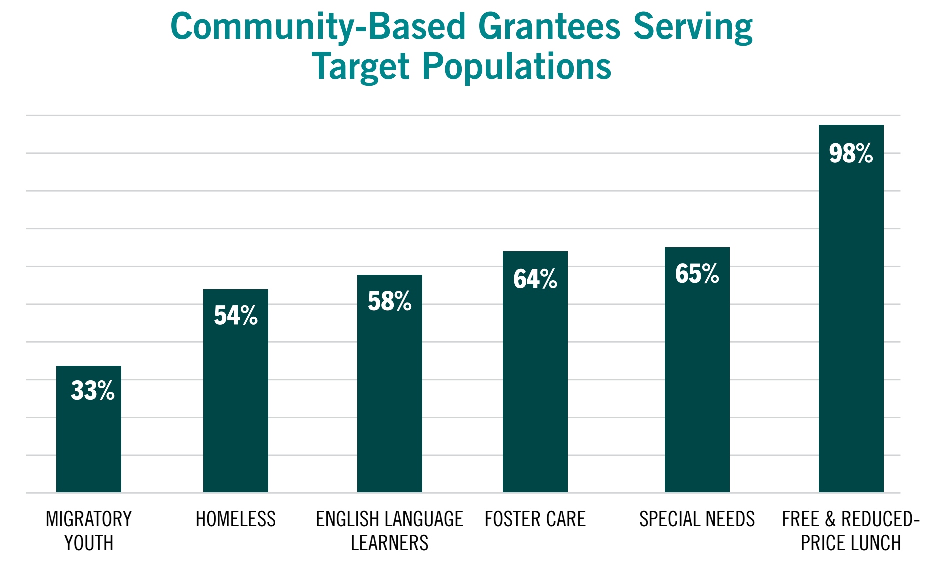
# Grantee Composition




## COMMUNITY-BASED ORGANIZATIONS

**97 community-based organizations** that collectively serve over **74,000 youth annually.**




## STATEWIDE ORGANIZATIONS

**4 statewide organizations** that serve youth year-round and collectively serve over **89,000 youth annually.**

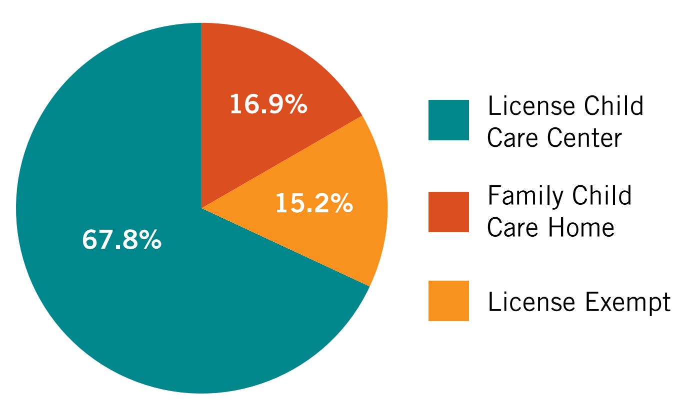
# The School-Age Help and Relief Effort (SHARE) Grants Program

The Georgia Department of Early Care and Learning's SHARE Grant funded through the Coronavirus Response and Relief Supplemental Appropriations Act (CRRSA), helped support child care providers caring for and supporting school-age children (ages 5–12 years) throughout the school year and those providing summer academic and social enrichment programs for school-age youth.

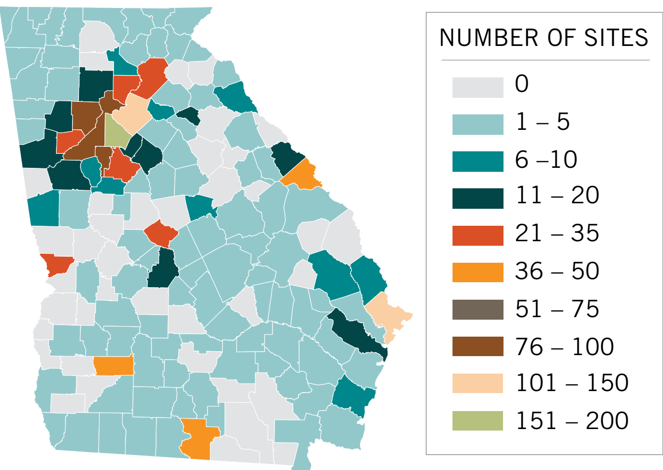
As of February 2022, over **$3.7 million** was awarded to over **1,350** grantees.

| School-Age Capacity Range (Licensed & License-Exempt Centers) | Payment Tiers |
|---|---|
| 1-25 | $1720 |
| 26-50 | $2150 |
| 51-100 | $2795 |
| 101-200 | $3440 |
| 201 and greater | $4300 |
| All Family Child Care Learning Homes | $1075 |

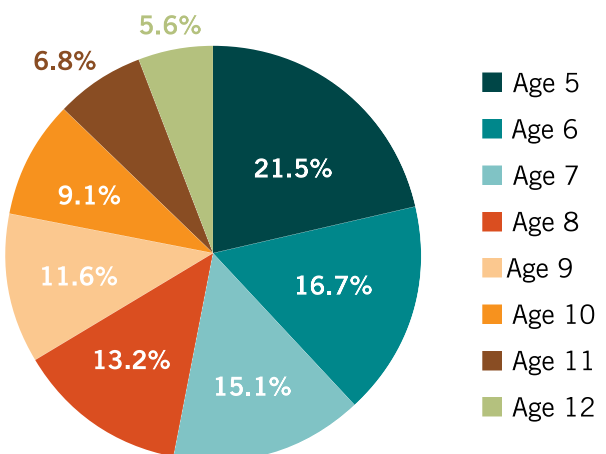
Analysis of SHARE grant recipients includes data from **1,382** applications.



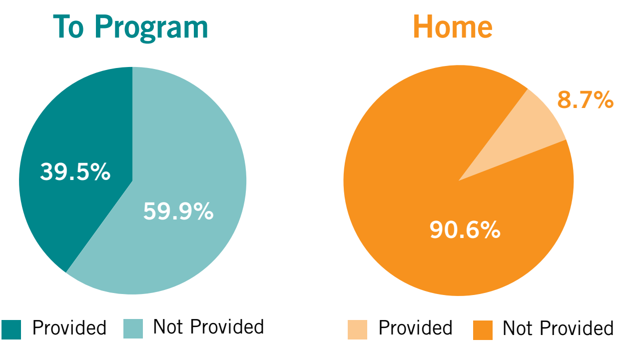

SHARE Grants were provided to programs in **122** out of **159** Georgia counties.



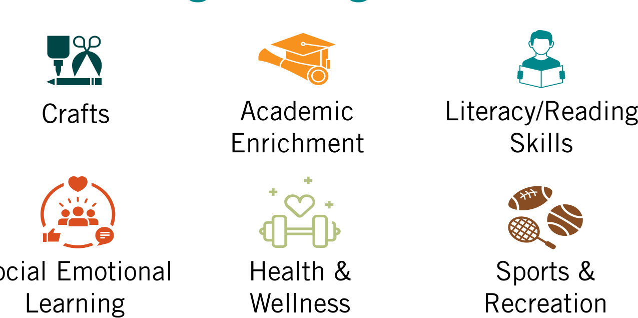

Collectively, these sites served **48,067 school-age youth** in March 2021.



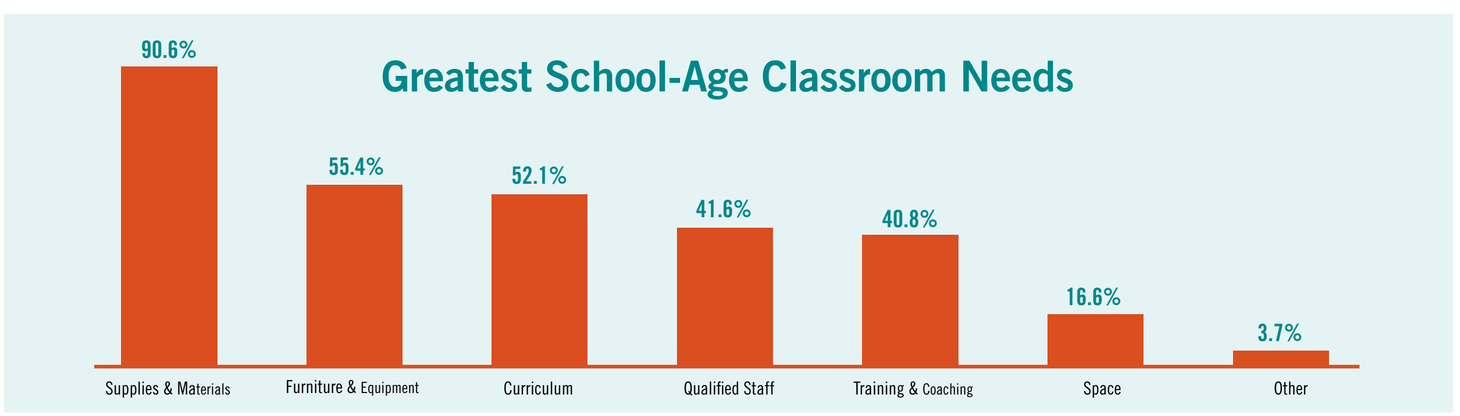
## Transportation Services



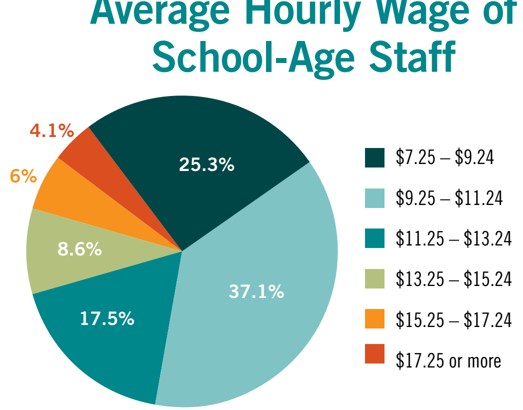

## Most Commonly Provided School-Age Programming Content



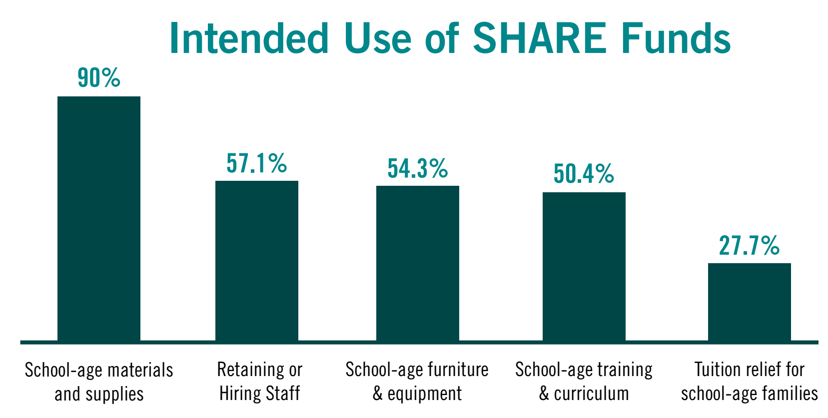

## Greatest School-Age Classroom Needs




## Average Hourly Wage of School-Age Staff




## Intended Use of SHARE Funds

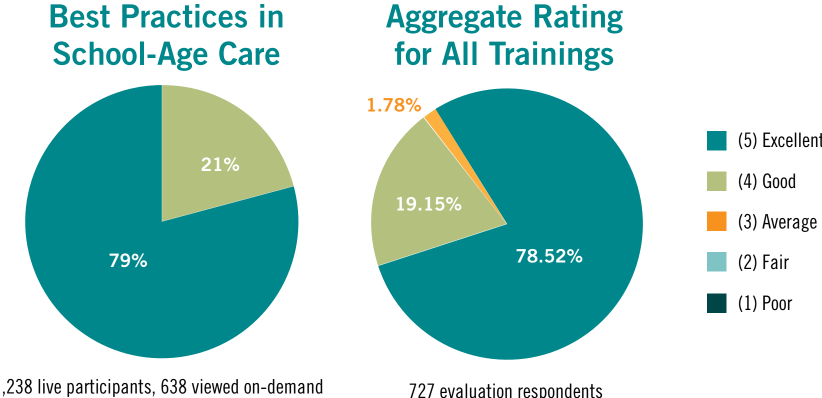



## Quality Supports Provided to Grant Recipients

All SHARE grant recipients attended a required Best Practices in School-Age Care training and had the opportunity to attend 4 additional trainings focused on developing high quality activities and environments and building resiliency in youth. Recipients were also provided opportunities to participate in Small Group Coaching focused on the Georgia ASYD Quality Standards.

- Over 2,000 professionals attended virtual trainings
- Small Group Coaching provided to 50 participants from 39 programs through 8 cohorts (1 cohort for family child care centers)
- Coaching participants received 5 coaching sessions aligned to the Georgia Afterschool & Youth Development (ASYD) Quality Standards and created an action plan utilizing the ASYD Self-Assessment tool
- External evaluations were completed using the School-Age Program Quality Assessment for 10 programs

### Best Practices in School-Age Care / Aggregate Rating for All Trainings



# Afterschool & Summer Learning Programs Supporting the Behavioral Health Needs of Georgia's Youth

**The 2017-2018 National Survey of Children's Health:**
**24%** of Georgia's youth aged **3 – 17** years had one or more mental, emotional, developmental, or behavioral problem.[1]

---

## High Quality Afterschool and Summer Learning Programs

Provide supportive environments & incorporate healthy habits into routine[2]

Offer protective factors that improve youth outcomes & mitigate the effects of risk factors[3, 4]

Help overcome Adverse Childhood Experiences & reduce chances of developing substance use disorders[5]

Promote positive behavioral factors like positive decision-making skills, self-control, and self-awareness[6]

Provide opportunities to learn from mentors[7]

Lead to improved work habits and classroom behavior, gains in reading and math, and increased school attendance and graduation rates[8, 9]

**These programs are an ideal opportunity to foster positive behavioral health, which increase a child's sense of well-being, supports healthy relationships, and enables children to achieve their full academic potential.[10,11]**

## Spring 2019 Behavioral Health Round Table Discussions

Georgia Statewide Afterschool Network hosted
**5 Behavioral Health round table discussions with**
**37 Afterschool & Summer Learning providers**
to identify strategies, tools, and resources to address program challenges in supporting youth's behavioral health needs.

## What We Heard

### Behavioral Health Issues Observed

- Attention seeking behavior
- Defiant behavior and testing boundaries
- Physical and verbal altercations

### Obstacles to Supporting Youth

- Lack of behavioral health knowledge, understanding, and training
- Program capacity stretched too thin
- Lack of access to a list of referral services and organizations

### Resources Needed

- Training and professional development
- Education and awareness
- Vetted master list of services, partners and referral organizations

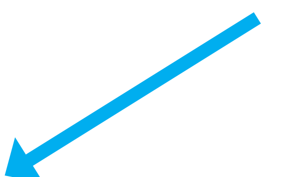
### Successful Strategies

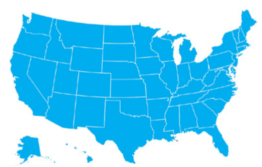
- Raise awareness and knowledge
- Include families in services and intervention methods
- Offering youth choice, nurturing relationships, supportive age appropriate environments, and enriching activities

**For references, go to www.afterschoolga.org/afterschool-issues/**

# INSERT BANK TAB: PHYSICAL HEALTH

# How Medicaid and PeachCare Money Work

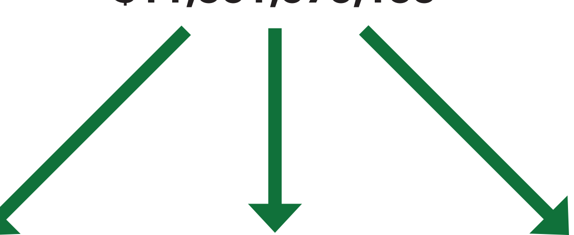




**Georgia Dollars:**[2]
**$3,170,826,744**

**Federal Match:**[1]
**$8,190,749,389**

**Total Amount:**[3]
**$11,361,576,133**



## Fee for Service

State pays providers directly per service (DCH manages physical health care/costs, DBHDD manages behavioral health care/costs)

**CHILDREN SERVED**[4]
Primarily children that are blind or disabled, including those enrolled in Katie Beckett

**AGES SERVED**[5]
Blind, disabled: ALL
Katie Beckett[6]: 0 until 19

**KEY REQUIREMENTS**[7]
Disability, income limits

## Georgia Families 360° Managed Care

State pays Care Management Organization (CMO) per member per month to manage care/costs

**CHILDREN SERVED**[8]
Children in foster care, receiving adoption assistance, and in some juvenile justice programs

**AGES SERVED**[9]
Foster Care: 0 until 26
Adoption Assistance: 0 until 18
Juvenile Justice: While in custody

**KEY REQUIREMENTS**[10]
In foster care or receiving adoption assistance, juvenile justice eligible while in state custody in certain programs

## Georgia Families Managed Care

State pays CMOs per month to manage care/costs

**CHILDREN SERVED**[11]
Children under age 19 with income limits per the chart below as well as newborns born to mothers enrolled in any Medicaid program

**AGES SERVED**[12]
0 until 19
Newborns: 0 until 13 months

**KEY REQUIREMENTS**

Medicaid Income Limits[13]

| AGE | FPL[14] | INCOME (for 4)[15] |
|---|---|---|
| 0 until 1 | 210% | $58,275 |
| 1 until 6 | 154% | $42,735 |
| 6 until 18 | 138% | $38,295 |

PeachCare Income Limits[16]

| AGE | FPL | INCOME (for 4) |
|---|---|---|
| 0 until 18 | 247% | $68,543 |

# THE FACTS ABOUT MEDICAID AND PEACHCARE

## Medicaid

*1,509,485 children served*[17]

**WHAT IS IT?**
Medicaid is a jointly funded, Federal-State medical assistance program for low-income individuals and families.

**HOW IS IT FUNDED?**
Medicaid is financed through a combination of federal and state funds. The federal dollars vary year to year based on facts like the per capita income. Georgia's federal financial participation matching rate for Medicaid is 66.02% for the Federal Fiscal Year 2023.[18] In 2020, the Families First Coronavirus Response Act (FFCRA) authorized a 6.2 percentage point increase to the federal Medicaid match rate to offset the economic impact of the pandemic and to prevent coverage loss. The enhanced federal match rate will expire at the end of the quarter in which the public health emergency ends.[19]

**WHO DOES IT COVER?**
It covers chidren, pregnant women, the aged, blind, and/or disabled people. All Georgia Medicaid beneficiaries must be citizens or legal residents for 5 years.

**WHAT DOES IT COVER?**
In Georgia, Medicaid covers primary, preventive, specialty, dental, and vision care. In addition, the insurance covers hospitalization, emergency room visits, prescription medications, mental health care, and non-emergency medical transportation.

## PeachCare for Kids®

*Georgia's Children's Health Insurance Program (CHIP)*

*217,398 children served*[22]

**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?**
Federal matching funds are available to subsidize more than 75 percent of the benefit cost less premiums with the remaining percentage coming from the state. The percentage of federal matching funds is adjusted annually. Georgia's enhanced federal financial participation matching rate for CHIP is 76.21% for the Federal Fiscal Year 2023.[20]

**WHO DOES IT COVER?**
In Georgia, CHIP covers children of families earning at or below 247% of the federal poverty level (FPL) -- that's at or below $68,543 for a family of four.[21]

**WHAT DOES IT COVER?**
In Georgia, CHIP covers primary, preventive, specialty, dental, and vision care. In addition, the insurance covers hospitalization, emergency room visits, prescription medications, and mental health care.

Rev. 07/2022
Sources: bit.ly/3WfytLR

# Two Ways to Get (and Keep) Kids Covered

**Georgia has 176,000 kids who lack health insurance.** That makes us **4th highest** in the number of uninsured kids in the nation.[1] As of the drafting of this factsheet, the Public Health Emergency is slated to end January 2023, ending the continuous coverage requirement and potentially putting hundreds of thousands of children and families at risk of losing health care coverage.[2]

## Coverage Win for Georgia's Kids

In 2021, the Georgia General Assembly passed legislation requiring the state to implement Express Lane Eligibility (ELE) for the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF). This allows the state to use SNAP and TANF eligibility data to automatically enroll or renew eligible children in Medicaid or PeachCare for Kids® (PeachCare). **This should allow close to 70,000 of Georgia's previously uninsured children to gain coverage.** ELE implementation began in October 2022.

## Ways Georgia Can Insure More Kids and Keep Them Covered

**In addition to Express Lane Eligibility for SNAP/TANF, use all other available data to renew coverage for children on Medicaid/PeachCare (known as "ex parte" renewals).** This markedly reduces the paperwork burden on families and the state, by having the state use already verified data in its posession (e.g., Georgia Department of Labor, Internal Revenue Service (IRS), Georgia Department of Driver Services), to process renewals before requiring families to submit any additional data. This could significantly reduce the number of children who are eligible for Medicaid, but unnecessarily lose coverage due to the burden of complicated Medicaid renewals.

**Guarantee Medicaid/PeachCare for children for 12 continuous month.** This prevents kids from losing coverage due to temporary surges in family income, such as seasonal overtime.

## BENEFITS TO CHILDREN'S HEALTH INSURANCE COVERAGE

Children receive the check-ups needed to identify developmental delays or conditions that can become life-threatening when left untreated

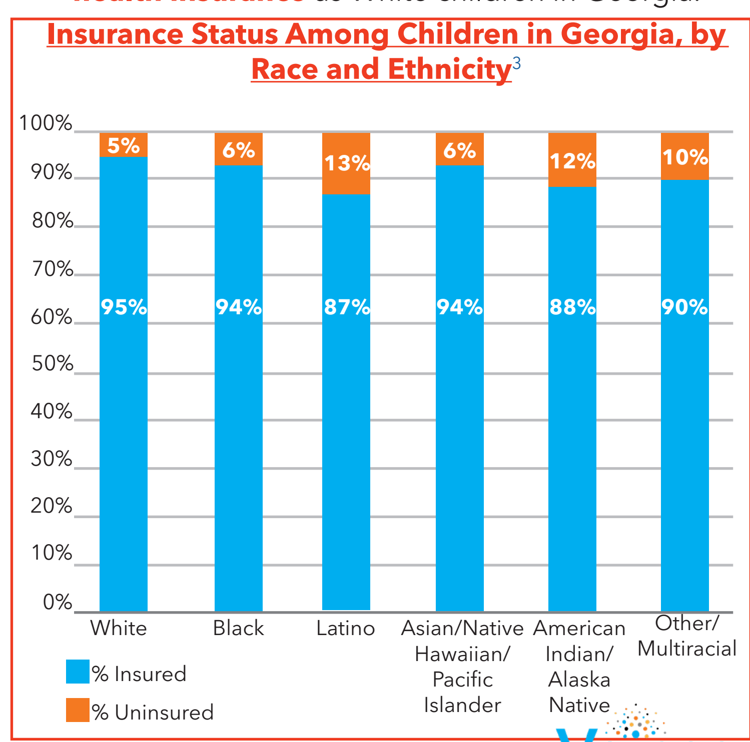
Children with chronic conditions, such as asthma or ADHD, have the medications they need

Children receive routine health care, which can prevent a health care crisis

Doctors receive reimbursement for services provided, supporting financial stability

## WHO DOESN'T HAVE HEALTH INSURANCE IN GEORGIA?

Latino children are **almost 3x as likely to lack health insurance** as White children in Georgia.

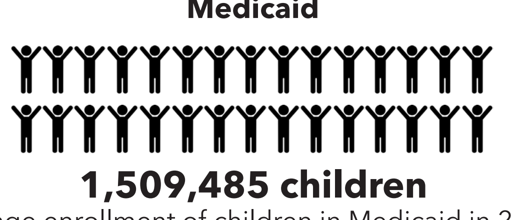


# How are Georgia's Children Covered?

Most children in Georgia who have health insurance are covered through their parent's employer-sponsored insurance or through Medicaid or PeachCare, public coverage offered by the state.

## Public Insurance

### Medicaid



**1,509,485 children**

average enrollment of children in Medicaid in 2021[4]

### PeachCare for Kids®*

**217,39885 children**

average enrollment of children in PeachCare in 2021[5]

*Created in 1998, PeachCare for Kids® is the name of Georgia's State Children's Health Insurance Program.

## Private Insurance

### Employer-Sponsored Insurance

**1,220,300 children**[6]

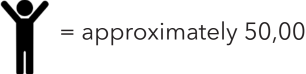
### Individual / Small Group Marketplace

**107,500**[7]

## Uninsured

**176,000**

**Georgia children do not have health insurance**[8]




Rev. 11/2022

Sources: bit.ly/3jny0sk

# Benefits of School-Based Health Centers

School-Based Health Centers (SBHCs) place critically needed health-related services directly in schools to reduce access to barriers for children, families, and school personnel.[1,2]

**School-Based Health Center**

Offers primary care services through a staffed primary care provider (e.g., nurse practitioner or physician assistant)

**Comprehensive School-Based Health Center**

Offers primary care, behavioral health and other expanded services, including health education, dental, and vision services

## The Need for School-Based Health Centers in Georgia[3,4,5,6]

**176,000**
children in Georgia do not have health care coverage

**130,000**
children, on average, in Georgia stay home sick more than 6 days a year. Chronic conditions (e.g., asthma) and other health-related challenges (e.g., dental pain) are likely causes of chronic absenteeism.

**45%**
of children 3-17 struggle to, or are not able to, access needed mental health treatment and counseling

## THE BENEFITS OF SCHOOL-BASED HEALTH CENTERS[7]

**More than 100,000** children, families, and school personnel currently benefit from services at **102** SBHCs (growing from two in 2013) in Georgia.

### Health[8,9]

**Increased:**

- Access to primary, oral, and behavioral health care
- Use of mental health and substance abuse services
- Access to the flu vaccination

**Decreased:**

- Emergency room use and hospitalization for children with asthma
- Prescription drug use

**How This Looks in Georgia:**

- Turner SBHC initiated Halls to Health, a program that addresses childhood obesity and student emotional health.
- Tiger Creek SBHC offers services to the entire community, including adults.
- Albany Area Primary Health Care SBHC offers eye exams and glasses to all students within the Dougherty County School System.

### Education[10,11,12]

**Increased:**

- Attendance and GPAs for students utilizing mental health services

**Decreased:**

- Drop out rates and school discipline referrals
- Faculty and staff absences due to illness

**How This Looks in Georgia:**

- Turner SBHC prioritizes school staff wellness and utilized state grant funding to reduce barriers to healthy lunches for teachers.

### Cost Savings[13]

**Decreased:**

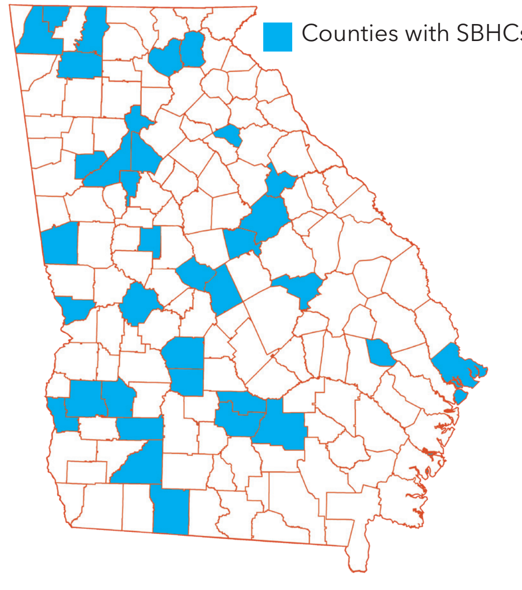
- Drop out rates and school discipline referrals
- Faculty and staff absences due to illness

**How This Looks in Georgia:**

- Whiteford SBHC reported a 50% reduction in average cost per child to Medicaid for children with SBHC access, and a 62% reduction in annual expense per Medicaid-covered child.

## Sustaining School-Based Health Centers

**SBHCs can quickly become self-sustaining when start-up funds are available. Georgia has allocated $125 million of federal funding to support planning and startup of new SBHCs.**




### Funding for SBHCs

**17** states and Washington, D.C. have an ongoing funding mechanism to support SBHCs.[14]

Philanthropic partners provide another funding opportunity for SBHCs.

Current SBHC grants in Georgia:

- **NIH Grant** to study the impact and benefits of SBHCs in suburban and rural areas of Georgia[15]
- **PARTNERS for Equity in Child and Adolescent Health**: allocates planning grants to communities in Georgia. 46 have been awarded since 2010.[16]
- **The Georgia Department of Education's Office of Whole Child Supports**: offers SBHC planning grants to expand school-based health services to rural communities[17]
- **Medical College of Georgia**: supports a SBHC in a middle School in Athens, GA[18]

### Recommendations to Strengthen School-Based Health Centers

- Continue to increase state funding to Federal Qualifed Health Centers to support the development and expansion of school-based health services throughout the state, especially in high-need, rural areas.
- Ensure that school-based health centers are comprehensive and facilitate access to behavioral health services.
- Ensure effective telehealth practice and outcomes, including emphasis on quality control, maintaining pandemic-related telehealth flexibilities, and provider reimbursements (e.g., insurance reimbursement for consultation and services provided via telephone, video chat, and the like).

# School-Based Telehealth in Georgia

A school-based telehealth (SBTH) program uses telecommunications technology to connect children in need of acute or specialty care services to a healthcare provider at a distant site.[1]

## THE NEED FOR SCHOOL-BASED TELEHEALTH

More than

**130,000**

children in Georgia stay home sick more than 6 days a year.[2]

**65**

counties do not have a pediatrician.[3]

**115,000**

children live in households that do not own a vehicle.[4]

## BENEFITS OF SCHOOL-BASED TELEHEALTH

Increased children and families' access to health education, especially for the management of chronic health conditions (i.e. diabetes and asthma)[5, 6]

Reduced barriers to healthcare in rural communities[7, 8]

Reduced student absenteeism due to illness[9]

## BARRIERS TO IMPLEMENTATION

Engaging and sustaining relationships with healthcare providers or specialists

Insufficient training or staff capacity

Lack of continuity in care

Lack of oversight and access to technical assistance

Low program enrollment due to parental concerns about privacy and lack of understanding about telehealth

## SCHOOL-BASED TELEHEALTH MODELS*

**Private Providers**

**School-based Telehealth Program**

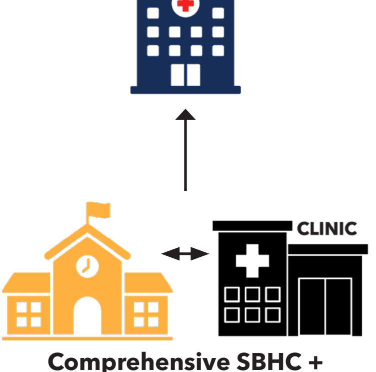
**Provider Network**

**School-based Telehealth Program**

**FQHC/Local Hospital**

**School-based Telehealth Program**

**FQHC/Local Hospital**




**Comprehensive SBHC + School-based Telehealth Program**

**Likelihood of Success**

*all models require equipment valued at a minimum of $10,000*

## GLOSSARY OF TERMS

**Federally Qualified Health Center (FQHC)**

A Federally Qualified Health Center is an outpatient clinic that qualifies for specific reimbursements under Medicare and Medicaid. Health centers provide a comprehensive set of health services including primary care, behavioral health, chronic disease management, preventive care, and other specialty, enabling, and ancillary services, which may include radiology, laboratory services, dental, transportation, translation, and social services.

**School-Based Health Centers (SBHCs)**

School-Based Health Centers place critically needed services like medical, behavioral, dental, and vision care directly in schools to reduce access barriers for children, families, and school personnel.

**Telehealth**

Telehealth refers to a broad scope of remote healthcare services, including nonclinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.

**Telemedicine**

Telemedicine involves the use of electronic communications and software to provide clinical services to patients without an in-person visit

## RECOMMENDATIONS* FOR SUCCESSFUL SCHOOL-BASED TELEHEALTH PROGRAMS

### FOR POLICYMAKERS

- Continue to ensure quality, streamline school access to qualified telehealth providers and develop and encourage best practices.
- Increase opportunities for telehealth programs to be implemented within a comprehensive health system, including state funding for comprehensive school-based programs throughout the state.
- (Medicaid) Expand health care locations able to conduct presumptive eligibility to include SBHCs or SBTH programs.

### FOR DISTRICTS OR SCHOOLS

- If possible, develop a school-based telehealth program within an existing or planned school-based health center.
- Engage and enlist the support of key stakeholders before planning begins.
- Allocate time and resources to continously market the program and recruit and enroll students.
- Ensure an adequate number of trained personnel to provide services and manage the program's administrative components.
- Ensure all children, regardless of insurance status, are served through the SBTH program.

**for an in-depth look at these recommendations, refer to https://tinyurl.com/SBTHinGAReport*

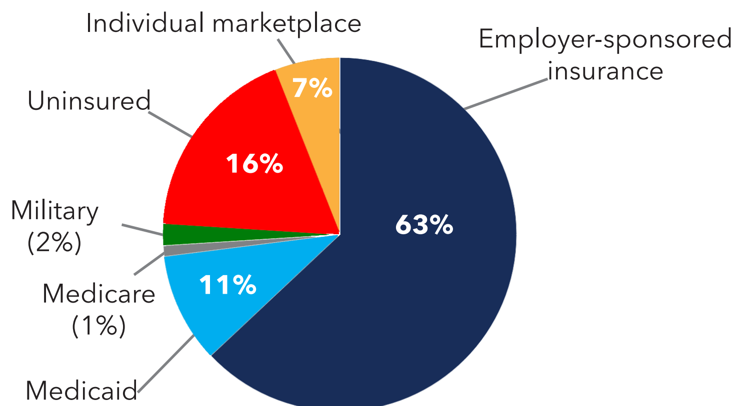
Rev. 11/2022
Sources: bit.ly/3G3qvPl

# Healthcare Coverage for Parents and Caregivers

The impact of parents' health on their child is lifelong and severe. It can have a long-lasting impact on cognitive ability and socio-emotional development, and can significantly deteriorate a family's financial situation.

## HOW GEORGIA PARENTS AND CAREGIVERS ARE (OR ARE NOT) COVERED[2]

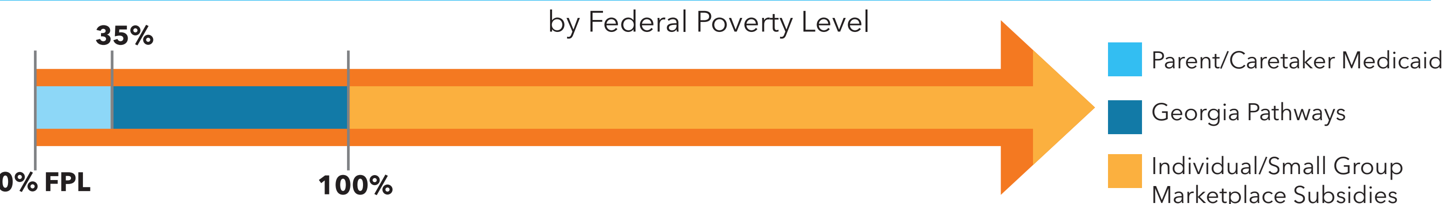
Nearly **one in six** Georgia adults with child dependents, or 345,100 people, lack healthcare coverage.[1]




### WHO IS UNINSURED?

- **39%** of Hispanic or Latino adults[3]
- **39%** of unemployed adults[4]
- **23%** of working adults with incomes less than 138% FPL ($38,295 for a family of four)[5]

## COVERAGE SUBSIDIES AVAILABLE FOR GEORGIA PARENTS AND CAREGIVERS




Pregnant Women Medicaid (see below) is also available for pregnant women and new moms who have incomes up to 220% FPL.

### Medicaid

Parent/Caretaker Medicaid is for people with child dependents whose incomes are 35% of the federal poverty level, or **$7,836/year for a family of four**.[6] This is the only way for parents/guardians to receive Medicaid if they are not pregnant, aged, blind, or disabled.**

**Supplemental Security Income (SSI) is available for adults with certain disabilities.

### Subsidized Coverage on the Individual/Small Group Marketplace

Subsidies are available on healthcare.gov for parents/guardians regardless of household income. Prior to the American Rescue Plan and Inflation Reduction Acts, subsidies were capped at 400% FPL. The average marketplace premium in Georgia is $394/month.[7]

### Georgia Pathways

Provides coverage for people whose incomes are below 100% of the federal poverty level, or **$26,200/year for a family of four**, and that are ineligible for other types of Medicaid. Individuals are required to report 80 hours per month of qualifying activities.

As of the drafting of this factsheet, Georgia Pathways implementation is paused.

### Employee Sponsored Coverage

In Georgia, less than half of private-sector employers offer employer-sponsored coverage, but most people who have employer-sponsored coverage make more than 400% FPL, or **$104,800/year for a family of four**.[8]

**Fewer than 15%** of people who make less than 100% FPL have employer-sponsored coverage.

## EXTENDED MEDICAID COVERAGE FOR NEW MOMS

In 2022, Georgia extended coverage for new moms under Right from the Start Medicaid for Pregnant Women from six months postpartum to up to 12 months. This extension will improve the health of both mother and baby. Georgia's pregnancy-related death rate is one of the highest in the nation and **Black women are 2.3x more likely to die from pregnancy-related complications than White women.**[9]

Rev. 11/2022
Sources: bit.ly/3jleZqN

# Access to Dental Care in Georgia

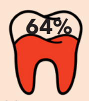
Poor oral health is one of the leading causes of school absenteeism in Georgia.[1]

**26%**
of children in Georgia did not have a dental check-up in the last 12 months.[2]

That's more than **590,000** children.

## WHO IS AT RISK OF POOR ORAL HEALTH?

Untreated tooth decay is **50% more common** in children in families with low-income compared to children in families with higher income.[3]



Hispanic children have a higher prevalence of tooth decay compared to non-Hispanic children.[4]

Children in rural communities have a higher prevalence (60%) of tooth decay compared to children in urban communities (48%).[5]

## Major Challenges Facing Kids and Dentists

### Availability of Care

**22**
counties in Georgia have no dentists.[8]

**Dentists**
**1 per 2,053** Georgians[6]

**Hygienists**
**1 per 2,227** Georgians[7]

Georgia has **190** dental care shortage areas.[16] Federal regulations stipulate that in order to be considered as having a shortage of providers, a designation must have a population-to-provider ratio that meets or exceeds 5,000 to 1 or 4,000 to 1 for areas with unusually high needs.

### Public Insurance Challenges

On average, Medicaid and PeachCare beneficiaries had to travel **15 more miles** for dental care than their non-Medicaid peers.[9]

**28%** of Georgia dentists accepted public insurance (Medicaid or PeachCare) in 2017.[11]

Children with fee-for-service Medicaid* (33%) are **less likely** to receive dental care compared to children in managed care.[17]

Medicaid reimburses **63.1%** of fees charged. Private insurance reimburses about **80%** of fees charged.[10]

### Language Barriers

Medicaid patients are required by federal law to have access to translation services arranged and paid for by the provider.[12,13,14]

**38%** of dental schools in the U.S. report that students were not adequately prepared to manage Limited English-proficient patients.[15]

*Fee-for-Service covers children who are legally blind or have a disability. Managed care covers children who are in foster care, some juvenile justice programs, or their family's income does not exceed program limits.

## BENEFITS OF IMPROVED DENTAL HEALTH

### IMPROVED HEALTH OUTCOMES

Routine dental care is linked to:

- Improved eating and speaking[18]
- Improved diabetes outcomes[19]
- Reduced dental pain[20]
- Improved pregnancy outcomes, including fewer low birthweight babies[21]

### COST SAVINGS FOR KIDS, FAMILIES, AND THE STATE

- Reduction of future dental visits and related costs[22]
- Reduction in emergency department visits for non-traumatic dental problems[23] [24]

### IMPROVED EDUCATION AND LIFE OUTCOMES[25] [26]

- Improved attendance
- Improved academic performance
- Improved self-esteem and employability
- Reduced pain and suffering

## Policy Recommendations

**Increase dental workforce in shortage areas by:**

- Educating and raising awareness about the ability of dental hygienists to practice in settings such as schools and nursing homes.
- Encouraging local public health clinics to provide dental services.

**Increase access to dentists for children on Medicaid by:**

- Increasing Medicaid reimbursement rates for dental services like exams, cleanings, fluoride, sealants, and treatments of caries.
- Reducing administrative barriers that hinder dentists from accepting Medicaid.
- Establishing goals to increase dental access for Fee-for-service member children (i.e., a minimum percent of children receiving services annually).
- Monitoring the number of dental providers that are accepting new patients and actively participate in Medicaid Fee-for-Service and CMO dental networks.

**Increase access to dental services in schools by:**

- Leveraging comprehensive school-based health services as a vehicle for providing dental care.

Rev. 12/2022
Sources: bit.ly/3GcI9CE

# Vaccines and Vaccine Safety

**Vaccines save lives!** Prior to vaccinations, diseases injured or killed thousands of children. The development of vaccines created an opportunity to completely eliminate such diseases.

## HOW DO VACCINES WORK?

Vaccines build immunity to a disease by imitating an infection which causes the body to create antibodies and defensive white blood cells.[1] The defensive white blood cells remain in the body and fight the disease if the body encounters it in the future.[2]

## WHY SHOULD CHILDREN GET VACCINATED?

Vaccines protect against **25+** serious, and often life-threatening, diseases in the U.S.[3] The majority appear on the recommended childhood immunization schedule. Vaccines protect **everyone**, but especially those most vulnerable immune systems, including:[4, 5]

Newborns

People with Cancer / Weak Immune Systems

Transplant Patients

## VACCINE SAFETY

Vaccines are safe. While there can be side effects, they are usually minimal (e.g., slight discomfort and redness at the injection site).[8] Serious side effects such as allergic reactions are extremely rare.[9] The benefits of vaccines significantly outweigh the risks.[10]

## SO WHAT'S THE CONCERN?

Despite ample evidence of vaccines being safe and effective, some parents are choosing to not vaccinate their children. When children are not vaccinated, they are at risk of life-threatening diseases including diseases that were once rare or completely eradicated.[11]

## VACCINES AVAILABLE TO CHILDREN

**Diphtheria***
**Hepatitis A***
**Hepatitis B***
**Hib***
**Human Papillomavirus** (HPV)
**Influenza** (Flu)
**Measles***
**Meningococcal** (Meningitis)*
**Mumps***
**Pertussis*** (Whooping cough)
**Pneumococcal Disease***
**Polio***
**Rotavirus**
**Rubella***
SARS-COV-2 (COVID-19)
**Tetanus**
Tuberculosis
**Varicella** (chickenpox)

*Vaccines that are required for school or childcare attendance in Georgia.[6]

**Bolded** vaccines appear on the Child and Adolescent Immunization Schedule[7]

## VACCINES DO NOT CAUSE AUTISM

Since 2003

**9**

studies from the Centers for Disease Control (CDC) confirmed the mercury-based ingredient thimerosal is not linked to autism.[12] The CDC stresses vaccines are safe, necessary to save lives, and there is no link between vaccines and autism.[13]

A study of more than

**95,000**

children found that the measles-mumps-rubella (MMR) vaccine did not increase a child's risk of autism.[14]

| VACCINE-PREVENTABLE ILLNESSES | |
|---|---|
| Polio | • Poliovirus spreads from person to person via contact with an infected person's feces; a less common spread can occur through sneezing or coughing[15]<br>• Lives in infected individual's throat and intestines but can enter the brain and spinal cord and result in paralysis or death[16]<br>• Vaccine developed 1955[17]<br>• Some common ways to contract poliovirus are through contaminated food and unsanitary water[18] |
| Tetanus | • Serious disease caused by a baterium, called Clostridium tetani, that produce toxins[19]<br>• Some common ways to contract the bacteria that causes tetanus are through contaminated wounds and burns[20]<br>• Causes muscle stiffness and spasms, paralysis, and breathing problems[21]<br>• Treatment usually requires hospitalization[22]<br>• Vaccine first introduced in late 1940s[23]<br>• Tetanus has an approximately 11% fatality rate, and an even higher fatality rate among unvaccinated persons at 22%[24] |
| Influenza | • Respiratory illness caused by a virus[25]<br>• Every year since 2010, between 12,000 and 48,000 children under the age of 18 have been hospitalized by the flu[26]<br>• Vaccine licensed for all civilians in the U.S. during 1945[27] |
| Hepatitis A | • Liver infection caused by hepatitis A virus[28]<br>• Can be contracted from contaminated food, drinks, stool or sexual contact[29]<br>• Vaccine developed in 1995[30] |
| Hepatitis B | • Liver infection caused by the hepatitis B virus[31]<br>• Spread when blood and other bodily fluids of an infected person enter an uninfected person[32]<br>• Vaccine first became commercially available in 1981 in the U.S.[33]<br>• Some common ways to contract the hepatitis B virus are through sexual contact, mother to child during pregnancy, sharing needles, and needle sticks[34] |
| Rubella | • Spreads through sneezing and coughing[35]<br>• Especially dangerous to pregnant women and fetuses[36]<br>• Vaccine first available in 1969[37] |
| Hib | • Haemophilus influenzae type b is a bacteria that infects the lining of the brain[38]<br>• Harms the immune system and causes brain damage and hearing loss and is sometimes fatal[39]<br>• Prior to vaccine development, Hib was the leading cause of bacterial meningitis for children under age five[40]<br>• Can cause severe infections of the lining of the brain and spinal cord (meingitis) and the bloodstream[41]<br>• Vaccine first licensed in 1987[42] |
| Measles | • Very contagious and can be contracted through airborne particles. The virus can stay active for up to 2 hours in the air or on objects[43]<br>• Especially serious for young children[44]<br>• Vaccine first available in 1963[45] |
| Pertussis | • Highly contagious and sometimes deadly for infants[46]<br>• Known for uncontrollable, violent coughing which makes it difficult to breathe[47]<br>• Vaccine developed in 1930s and used widely by the mid-1940s[48] |
| Pneumococcal Disease | • Bacterial disease that results in ear and sinus infections, pneumonia and sometimes meningitis[49]<br>• Especially dangerous for children and can affect the brain and spinal cord[50]<br>• Vaccine first used in U.S. in 1977[51] |
| Rotavirus | • Spread through hand-to-mouth contact[52]<br>• Symptoms include severe diarrhea and vomiting which can lead to severe dehydration requiring hospitalization[53] [54]<br>• Vaccine was approved by the FDA in 2006 and a second was introduced in 2008.[55] |
| Mumps | • Contagious disease with most common outbreaks occurring among groups of people who have prolonged, close contact (e.g., sharing eating and drinking utensils, kissing, heavy breathing, sports, close quarters with a person who has mumps)[56]<br>• Symptoms include salivary gland swelling, fever and aches and fatigue[57]<br>• Vaccine licensed in the U.S. in 1967[58] |
| Chickenpox | • Can be serious or even deadly for infants, adults and immunosuppressed[59]<br>• Symptoms include itchy rash, blisters, and fever[60]<br>• Vaccine first licensed for use in the U.S. in 1995[61] |
| Diphtheria | • Can cause difficulty breathing and lead to heart failure, paralysis or even death[62]<br>• Vaccine was developed in the early 1920s and widely used by the 1930s [63]<br>• Most commonly spread from person to person through coughing or sneezing[64] |

| Human Papillomavirus | • Spread primarily through skin to skin contact (e.g., sexual contact[65], cut, abrasion, or small tear in skin)[66]<br>• Most infections go away on their own, some can cause certain types of cancer in both men and women[67]<br>• Children can receive the vaccine (administered in two doses) around ages 11-12, or around 15 (administered in three doses)[68]<br>• Nearly all men and women will get HPV at some point in their lives[69] |
|---|---|
| Tuberculosis | • A bacteria spread through the air (cough, speak, sing) from one person to another[70]<br>• Symptoms can include a cough lasting three weeks or longer, chest pain, and coughing up blood[71]<br>• Can be detected through two tests: a blood test or a skin test[72] |

## WHY HAVEN'T I HEARD OF SOME OF THESE DISEASES?

Because vaccines **WORK!**
Many of these diseases have been wiped out or are very rare, thanks to vaccines!

# Benefits of Physical Activity

Research overwhelmingly shows that physical activity, both structured and unstructured, has a positive impact on academic performance, classroom engagement and productivity, social-emotional development, physical health, and fitness.[1, 2] Early Childcare and Education (ECE) programs and K-12 schools play a critical role in providing unstructured (e.g., recess, free play) and structured (Physical education (P.E.) teacher-led) physical activity opportunities.

## WHERE GEORGIA STANDS

**16.4%** of youth ages 10-17 are **overweight**.[4]

**18%** of youth ages 10-17 are **obese**.[5]

Approximately **1 in 4** middle and high school students do not meet the recommended 60 minutes of physical activity.[6]

## TERMS TO KNOW[10]

**Body Mass Index:** Found by dividing a person's weight in kilograms by the square height in meters. For children, weight status is determined by using age- and sex-specific percentile for BMI.

**Overweight:** A BMI at or above the 85th percentile but below the 95th percentile.

**Obese:** A BMI above the 95th percentile.

## PHYSICAL ACTIVITY RECOMMENDATIONS, BY AGE

- 0-12 months: Daily activities with adult[7]
- 12-36 months: At least **30 minutes** unstructured daily, **60 minutes** structured daily[8]
- 6 to 17 years: **60 minutes** or more of physical activity each day.[9]

## IMPACT OF PHYSICAL ACTIVITY AND PLAY

Both structured and unstructured movement impact the following areas:

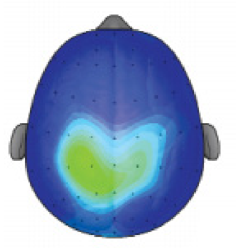
### Learning and Academic Performance

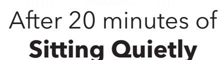
**Improved** grades and standardized test scores[11]

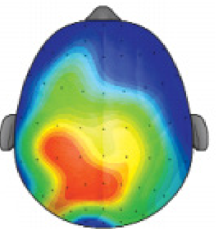
**Higher** recall rate of vocabulary words (compared to those without recess)[12]

**Higher** grades for students performing below grade level[13]

**Average composite of 20 students' brains taking the same test after sitting quietly or taking a 20 minute walk.**







After 20 minutes of **Sitting Quietly**

After 20 minutes of **Walking**

*Reprinted with permission of Dr. C.H. Hillman*[3]

### Classroom Engagement and Productivity

**Helping** stay on-task in the classroom[14]

**Decreases** inappropriate behaviors, such as distracting other students[15]

**Promotes** executive function growth (e.g., planning, organization, flexibility) among young children[16]

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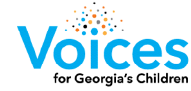


## IMPACT OF PHYSICAL ACTIVITY AND PLAY, CONT.

### Social and Emotional Development

**Increases** opportunity for development of social, intrapersonal, and communication skills, especially for young children[17, 18]

**Increases** brain development in areas associated with attention, information processing, storage, retrieval, coping, and positive affect[19]

**Promotes** self-regulation and fosters coping techniques among young children[20, 21]

### Physical Health and Fitness

Increases opportunity for development of cognitive and motor skills[22]

Builds strong bones and muscles[23]

Reduces the risk of developing health conditions (e.g., heart disease, Type 2 diabetes)[24]

### Win for Georgia's Kids

In 2022, with the signing into law of House Bill 1283, Georgia took important steps to safe-guard recess for students. House Bill 1283:[25]

- Ensures that Georgia's kindergarten through fifth grade students have access to recess
- Encourages schools to provide an average of 30 minutes a day

### Recommendations

- Ensure that neither physical activity nor recess opportunities are withheld for disciplinary reasons
- Design built environments utilizing elements that encourage physical activity for youth and adults
- Increase access to afterschool and summer learning programs that support healthy and active lifestyles through opportunities for formal and informal physical activity and recreation

# Youth E-Cigarette and Tobacco Use in Georgia

E-cigarettes are electronic devices that heat a liquid and produce an aerosol or mix of small particles in the air for people to inhale. E-cigarette aerosol usually contains nicotine, flavorings and other chemicals.

## FACTS ABOUT TOBACCO AND E-CIGARETTE USE

Using nicotine in adolescence can harm the parts of the brain that control attention, learning, mood, and impulse control.[1]

Young people who use e-cigarettes and smokeless tobacco (chew or dip) are more likely to smoke cigarettes in the future.[2]

E-cigarettes are known by many different names. They are sometimes called "e-cigs," "e-hookahs," "mods," "vape pens," "vapes," "carts," "tank systems," and "electronic nicotine delivery systems."[3] [4]

Using an e-cigarette is sometimes called vaping or JUULing.[5]
JUUL is a brand of e-cigarette. A single JUUL pod (the liquid nicotine refill) contains as much nicotine as an entire pack of cigarettes (20).[6]

**Consequently, JUUL and other vaping devices can potentially be more addictive.**

## TRENDS AMONG GEORGIA HIGH SCHOOL STUDENTS

**Nearly 80%**

said a friend or family member is the reason why they started to vape[7]

**1 in 4**

reported that they had ever used e-cigarettes[8]

### Frequency at which Georgia high school students consume nicotine:

3.4% were daily e-cigarette smokers[9]

10% say they have smoked e-cigarettes within the past 30 days[10]

3% smoked cigarettes in the past 30 days[11]

5% say they smoked other tobacco products (e.g., cigars, smokeless tobacco, hookah)[12]

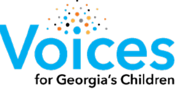
### High school students' perceptions about e-cigarettes:

**One in four** believed e-cigarettes were more acceptable in society than cigarettes.[13]

**26.6%** reported that they believed e-cigarettes are less addictive than cigarettes.[14]

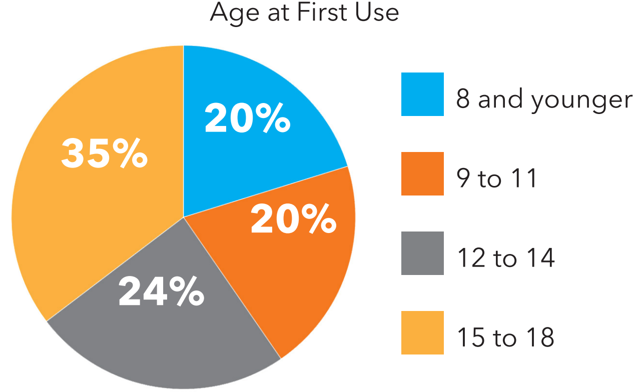
**44%** believed that there is little to no risk in smoking one or more packs of cigarettes a day.[15]





## AGE AT FIRST USE OF CIGARETTES AMONG GEORGIA STUDENTS (6TH-12TH GRADE)[16]

**23,995 (6%)**
reported that they have smoked a cigarette in the past




## HOW YOUTH ARE ACQURING AND USING E-CIGARETTES AND TOBACCO

**84%**
are purchasing e-cigarettes at a gas station or convenience store[17]

**24%**
of high school students report using alcohol, drugs, tobacco, or drugs at home, school, friend's house, or in a car[18]

### Recommendations

- **Increase tax on tobacco products.**[i]
  - To combat youth access to cigarettes, raise the tobacco tax from 37 cents to the national average of $1.91.
- **Ban flavored e-cigarette products, including disposable devices and refillable pods.**
- **Include vaping in the Smoke-free Air Act.**
- **Invest in youth-centered smoking cessation programs.**

[i] Georgia's General Assembly passed legislation in 2020 that applies a 7% excise tax to vape products and raises the legal smoking age from 18 to 21.[19]

# Overview of Federal Child Food and Nutrition Programs in Georgia

**When given access to adequate nutrition, the impact is clear:** children are healthier and perform better in school.[1] However, children who are not provided adequate, healthy food often perform poorly in school and are more likely to experience mental health problems.[2] 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.[3]

## CHILD HUNGER IN GEORGIA

Food insecurity affects approximately

**360,210**

of Georgia's children under the age of 18.[4]

## PROGRAMS DESIGNED TO SUPPORT HEALTHY AND ADEQUATE CHILD NUTRITION

| Program Description | Enrollment in Georgia^ |
|---|---|
| **Child and Adult Care Food Program (CACFP)**<br>Reimburses for nutritious meals. Child care programs, afterschool care programs, child care homes, emergency shelters, and adult care centers can be CACFP eligible.[5] | 108,420 average daily attendance[6] |
| **National School Lunch Program (NSLP)**<br>Provides nutritionally balanced, free or reduced-cost (based on a sliding scale) free lunches to children in public and nonprofit private schools, and residential child care institutions.[7] | 694,147 total participation[8] |
| **School Breakfast  Program (SBP)**<br>Provides cash subsidies to public or non-profit private schools and residential child care institutitions to provide meals that meet federal nutrition requirements. Meals are provided to eligible children for free or at a reduced cost.[9] | 481,991 total participation[10] |
| **Seamless Summer Option (SSO)**<br>Provides the same meal service that is available during the regular school year to hungry kids in the community during the summer. This program is provided through either the NSLP or SBP.[11] | 112,495 average daily participation[12] |
| **Summer Food Service Program (SFSP)**<br>Reimburses for healthy meals and snacks served to children from low-income areas during summer months when school is not in session.[13] | 56,900 average daily attendance[14] |
| **Supplemental Nutrition Assistance Program (SNAP)**<br>Provides a nutrition-designated electronic benefit card to supplement food budgets of individuals or families with low-income.[15] | 301,000 households with children[16] |
| **Women, Infants, and Children (WIC)**<br>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.[17] | 202,200 total participation[18]<br>*This is only 49% of the number eligible for WIC.* |

*^Pandemic-related USDA waivers, which provide increase program flexibility and reduce barriers, may be a factor in the decreased participation compared to previous years (e.g., required applications, universal meals)*

# Child Food and Nutrition Programs: Household and Academic Settings

Food insecurity affects approximately **360,210** of Georgia's children under the age of 18.[1] When given access to adequate nutrition, the impact is clear: children are healthier and perform better in school.[2] On the other hand, children who are not provided with adequate, healthy food often perform poorly in school, are more likely to experience mental health problems, and are at greater risks for health issues later in life.[3]

The federal government funds seven food and nutrition programs which support children and adults within academic settings, afterschool programs, care facilities, and at home. Such programs have proven to support child health and development, all while addressing long-standing inequities (e.g., food insecurity, disparate chronic health outcomes).[4, 5]

## What Should Children and Youth Be Eating?

The *Dietary Guidelines for Americans 2020-2025* is published by the United States Department of Agriculture. The guidelines provide advice on what to eat and drink to meet nutrient needs, promote health, and prevent chronic disease, and are broken down by life stage:[12]*

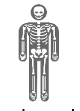
| AGES | VEGETABLE (CUP/DAY) | FRUIT (CUP/DAY) | GRAINS (CUP/DAY) | PROTEIN (CUP/DAY) | DAIRY (CUP/DAY) |
|---|---|---|---|---|---|
| 2 to 8 years old | 1 to 2.5 | 1 to 2 | 3 to 6 | 2 to 5.5 | 2 to 2.5 |
| 9 to 13 years old | 1 to 2.5 | 1.5 to 2 | 5 to 9 | 4 to 6.5 | 3 |
| 14 to 18 years old | 2.5 to 4 | 1.5 to 2.5 | 6 to 10 | 5 to 7 | 3 |
| *Servings vary on each child and their individual caloric intake. | | | | | |

## Nutritious Foods Support

Immune system responses[6]

Eyesight[7]

Cognitive Development[8]



Bone health[9]

## Nutritious Foods Protect Against[13]

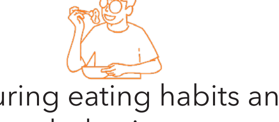
Dental cavities

Heart disease

Chronic illness (e.g., type 2 diabetes, obesity)

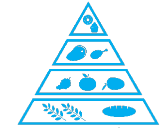
Iron deficiency

## Benefits of Nutrition Education[10, 11]



Nurturing eating habits and behaviors

Empowering individuals by increasing nutrition and health knowledge



Supporting individuals in informed decision-making about food and beverage consumption

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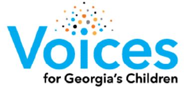

## Nutritious Food for Households

Two federally-funded feeding programs provide food purchasing benefits as well as nutrition education to participating households.

| PROGRAMS DESIGNED TO SUPPORT CHILD NUTRITION | | | |
|---|---|---|---|
| *Program and Participant Eligibility Criteria* | *Food Benefits* | *Health & Nutrition Resources* | *Enrollment in Georgia* |
| **Supplemental Nutrition Assistance Program (SNAP)**<br>*Georgia*[14]<br>• Resident of the state of Georgia<br>*Non-citizen Individuals*<br>• Lived in the United States for at least 5 years, or<br>• Receives disability-related assistance or benefits, or<br>• Children under 18<br>*Income*[15]<br>• Lives at or below 130% of federal poverty income guidelines, depending on household status and deduction calculations | • Monthly benefits to purchase fresh fruits, vegetables, and frozen, canned, and shelf stable items[16] | • Nutrition education[17] | 301,000 households with children[18] |
| **Women, Infants, and Children (WIC)**<br>*Women, Infants, and Children*[19]<br>• Pregnant, breastfeeding, and non-breastfeeding postpartum women<br>• Infants and children up to age five<br>*Income*[20]<br>• Living at or below 185% of the federal poverty income guidelines<br>• Participating in another assistance program may make an applicant automatically income-eligible for WIC (e.g., SNAP, Medicaid)<br>*Nutrition Risk*[21]<br>• Applicants must be determined to be at "nutrition risk" by a health professional or a trained health official | • Nutritionally balanced food packages[22]<br>• WIC Farmers Market Nutrition Program vouchers[23] | • Breastfeeding supports[24]<br>• Healthcare referrals[25]<br>• Nutrition education[26]<br>• Immunization screenings[27] | 202,200 total participants[28]<br>This accounts for roughly 49% of those who are eligible for WIC |

## POLICY RECOMMENDATIONS TO SUPPORT SNAP AND WIC

**State Only:**

- Strategically engage community organizations and benefit enrollment staff to understand and eliminate barriers to SNAP and WIC
- Ensure state agencies are fully leveraging data to ease enrollment for all eligible households (e.g., Adjunctive Eligibility - using Medicaid or SNAP data to facilitate WIC enrollment)
- Explore and enact opportunities to leverage virtual tools to support physicians in WIC program operations (e.g., electronic prescription, referral systems, electronic health data contracts)
- Explore an extension of the WIC FMNP farmers' market season

**State and Federal:**

- Increase culturally and linguistically inclusive resources within SNAP and WIC

**Federal Only:**

- Leverage technology to increase access to, utilization of, the WIC FMNP for farmers and WIC participants (e.g, remote trainings, electronic WIC FMNP benefits)
- Increase culturally inclusive foods within WIC food packages

## Nutritious Food for Early Education, School, & Afterschool

Five federally-funded feeding programs provide nutritionally balanced meals and snacks to children within early care and education programs, schools, and afterschool programs. Eligibility for participation is based on income, from 130% of the federal poverty line (free) to 185% of the federal poverty line (reduced priced).

**PROGRAMS DESIGNED TO SUPPORT HEALTHY AND ADEQUATE CHILD NUTRITION**

| *Program and Description* | *Enrollment in Georgia* |
|---|---|
| **Child and Adult Care Food Program (CACFP)** Reimburses for nutritious meals. Child care programs, afterschool care programs, child care homes, emergency shelters, and adult care centers can be CACFP eligible.[38] | 108,420 average daily attendance[37] |
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| **Summer Food Service Program (SFSP)** Reimburses for healthy meals and snacks served to children from low-income areas during summer months when school is not in session.[30] | 56,900 average daily attendance[29] |
| *Pandemic-related USDA waivers, which provide increase program flexibility and reduce barriers, may be a factor in the decreased participation compared to previous years (e.g., required applications, universal meals)* | |

## POLICY RECOMMENDATIONS

**State Only:**

- Ensure state agencies are fully leveraging data to ease enrollment for eligible students (e.g., Direct Certification - using Medicaid data to facilitate NSLP enrollment)
- Leverage available data to strategically recruit CACFP-eligible programs (e.g., low-income, low food access areas)

**State and Federal:**

- Provide funding for transportation grants to fund innovative approaches and mobile meal trucks to increase summer meal access
- Promote local food procurement by connecting food systems to child care programs and simplifying procurement processes for CACFP operators

**Federal Only:**

- Increase food access by changing the area eligibility requirement from 50 percent to 40 percent of the children eligible for free or reduced-price meals
- Streamline CACFP program requirements, reduce paperwork, and maximize technology to improve program access (e.g., streamline CACFP and SFSP applications, virtual monitoring)
- Allow all CACFP participant programs to be reimbursed for an additional meal (typically a snack or supper), as was previously allowed
- Increase nutritious food access for family child care homes and afterschool programs by allowing them to receive a higher reimbursement rate (regardless of location)

# INSERT BANK TAB: BEHAVIORAL HEALTH

# Crisis in Child and Adolescent Behavioral Health

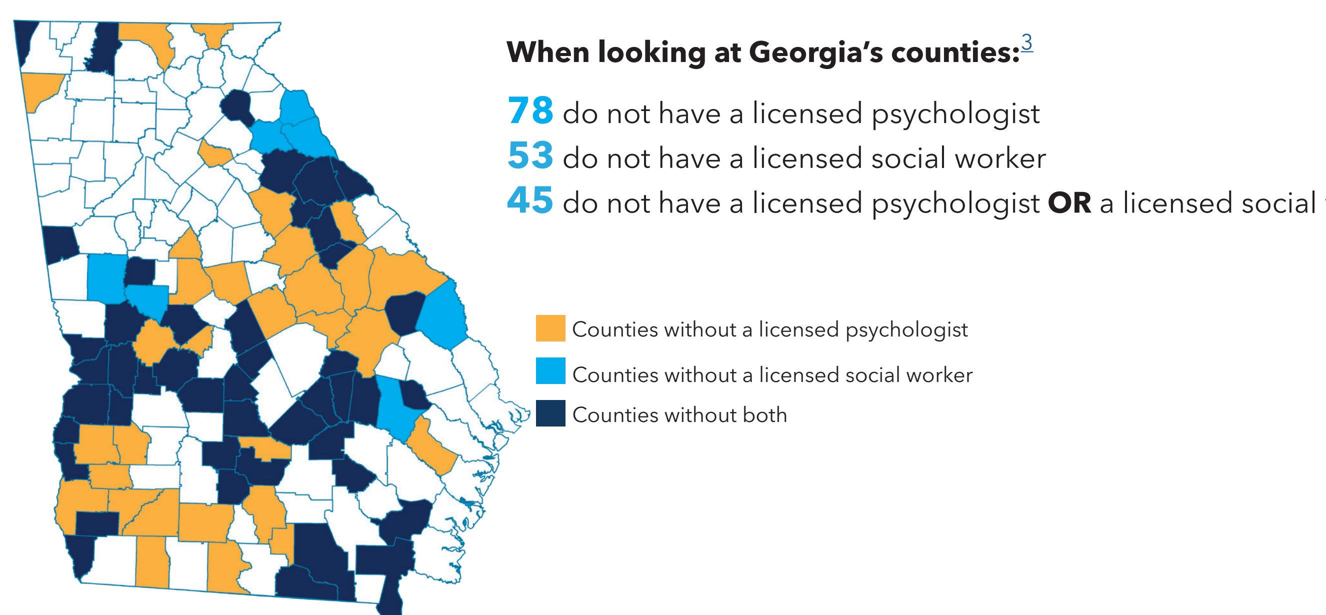
Many children and youth face behavioral health challenges. Nationally, 2 in 10 children have one or more emotional, behavioral, or developmental conditions.[1] Undiagnosed, untreated, or inadequately treated conditions can result in poor immediate and lifelong outcomes, including significant impact to a child's education. Children with Attention-Deficit / Hyperactivity Disorder (ADHD), autism, or developmental delays are **twice as likely to be chronically absent** compared to kids without these conditions.[2]

## Youth Behavioral Health in Georgia

### Georgia Kids in Crisis

- In Georgia, **suicide is the 3rd leading cause of death** among youth ages 10-17.[10]
- **45%** of children ages 3-17 struggle to or are not able to access needed mental health treatment and counseling**.**[11]
- **Approximately 70% of youth** in Department of Juvenile Justice long-term facilities have a mental health diagnosis severe enough to require ongoing treatment.[12]

### Accessing Behavioral Health Services in Georgia




### The Role of Schools

**Schools often serve as the primary point of access to behavioral health services and supports.**

| | What We Have: | What We Need: |
|---|---|---|
| Social Workers[5, 6, 7] | 1 for every 2,043 students | 1 for every 250 students |
| School Psychologists[8, 9] | 1 for every 2,269 students | 1 for every 500 students |
| School Nurses[4] | 1 for every 1,017 students | 1 for every 750 students |

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## WHY WE NEED BEHAVIORAL HEALTH SERVICES

Untreated behavioral health illness in children and adolescents can lead to:[13] [14]

Drug and alcohol abuse

Violent or self destructive behavior

Low educational attainment

Lower rates of employment in adulthood

### Recommendations

- Sustain and expand support for the Georgia Apex Program to continue advances in school-based mental health.
- Ensure full implementation of the Behavioral Health Care Workforce Database and develop strategies to address identified provider shortages and diversify the workforce.
- Allocate more funding to strengthen crisis support and intervention services, including continued implementation of 988 and mobile crisis services for children and adolescents.

## WHAT NEXT?

We need to fully implement Georgia's comprehensive three-year System of Care State Plan for child and adolescent health and support the work of Behavioral Health Innovation and Reform Commission to develop policy which can improve children's behavioral health outcomes.

Rev. 11/2022
Sources: bit.ly/3hGDxKd

# Snapshot of Health and Behavioral Health Services and Supports in Schools and Afterschool Settings

At least one school with Georgia Apex Program (school-based mental health services)[1]

Limited on-site health services[2]

Comprehensive SBHCs[3] (includes behavioral health services)

Project Aware*[4]

Telehealth services[5]

Medical Mobile Unit[6]

DeKalb: 10 schools
Chatham: 22 schools
Fulton: 27 schools

Prevention Clubhouses[7]

DBHDD Mental Health Resiliency Clubhouses[8]

Schools trained in Positive Behavioral Interventions and Supports[9]

School districts using telehealth**[10, 11]

*Please note that some services and supports are only available in a certain school district or school and are not countywide.*

Georgia Department of Education (GaDOE) and Regional Educational Service Agencies (RESAs) coordinated **1,304** Mental Health Awareness Trainings (MHAT) for **32,444** educators and school staff, including:[12]

- Trauma 101
- Brain 101
- Trauma to Resilience
- Secondary Traumatic Stress
- Psychological Safety

*Please note this list is not comprehensive.*

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## SCHOOL-BASED ACCESS

| Program | Description |
|---|---|
| **Georgia Apex Program** | Increases school-based behavioral health capacity through partnerships between community-based providers and local schools and school districts. Both develop partnerships with local schools to provide behavioral health services. Funding: DBHDD state funds[13] |
| **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. Grantees will assist in developing a statewide framework to provide training to school and community professionals to identify students with mental health needs and connect youth and families to community resources.[14] *Project Aware is currently partnering with Bibb, Hall and Houston County Schools for grant period 2020-2025. During the previous grant period (2014-2019), Muscogee, Newton, and Spalding County Schools received funding.* |
| **Youth Mental Health First Aid** | Provides individuals who interact with youth with skills for helping an adolescent who is experiencing a mental health or addiction challenge or is in crisis[15] |
| **Sources of Strength** | Targets strengthening multiple sources of support, changing social norms and school culture. This program is designed to prevent suicide, violence, bullying and substance abuse by encouraging connections between peers and adults.[16] |
| **School-Based Health Centers (SBHCs)** | Improve childrens' access to health services. 102 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[17], and the Georgia Department of Education[18] |
| **Positive Behavior Interventions and Supports (PBIS)** | Facilitates positive school climate and timely identification of behavioral health needs for students. A network of 1,400+ schools and programs representing 62% of Georgia local educational agencies continue implementation with fidelity. Funding: DOE state funds PBIS specialists in each Regional Educational Service Agency[19, 20, 21] |

## Telemedicine & Telehealth

| Program | Description |
|---|---|
| **School-based Telehealth (SBTH)** | Provides children and families with access to needed primary, acute, and specialty care on a school campus through telecommunication technologies |
| **Georgia Partnersip for Telehealth (GPTH)** | 172 schools have telehealth equipment to be used for behavioral health services through the GPTH network. Funding: GPTH grant; school budget for staff time; Medicaid[22] |

## Out-of-School Time

| Program | Description |
|---|---|
| **Clubhouses** | Mental Health Resiliency Club Houses: 13 clubhouses statewide, supported by DBHDD, to provide supportive services, e.g., educational, social, and employment support geared to engage youth and assist them in managing behaviors and symptoms[23]<br><br>DBHDD supports three prevention clubhouses that were designed to provide prevention services to youth ages 12-17 at high-risk for alcohol and drug abuse to address challenges they face in their communities. They are located in Norcross, LaGrange, and Dawsonville. The Clubhouses use peer mentors, evidence-based programming, and interactive activities to build coping, decision-making, and life skills.[24] |

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Sources: bit.ly/3FKb1zf

# School-Based Mental Health Programs: How They Work and Succeed

School-based mental health programs increase much-needed access to mental health support by eliminating barriers to care such as transportation, provider availability and proximity, and cost.

## THE NEED FOR SCHOOL-BASED MENTAL HEALTH

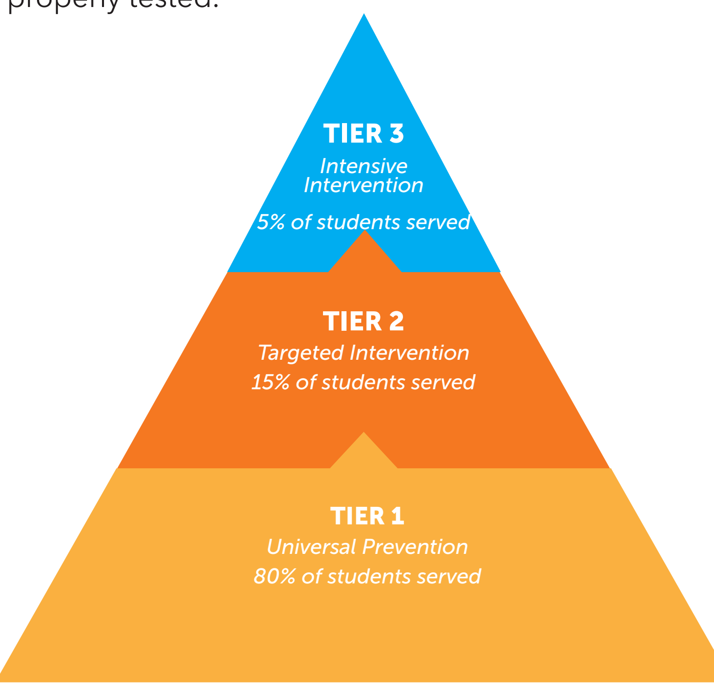
Nearly
**73,000**
students in 6th through 12th grade reported having seriously considered attempting suicide.[1]

**45% of Georgia's children**
aged 3-17 had difficulty accessing or were unable to access needed mental health treatment and counseling.[2]

**1 in 6**
children aged 2 to 8 years old has a diagnosed mental, behavioral, or developmental disorder.[3]

### Multitiered System of Supports

Comprehensive school-based mental health increases the chance that teachers and clinicians will **identify students with untreated mental health needs and avoid misdiagnoses**. Students who appear to have a mental health disorder but are actually experiencing another challenge (e.g., family instability, severe hunger, trouble with vision) are more likely to be properly tested.




### Challenges Providers Experience

Limited qualified workforce who will accept the salary (lower than other jobs in the field)

Clinician burnout (i.e. from heavy caseloads and secondary trauma)

Blurred roles in schools and extra demands on clinicians' time (hindering billable time, which is important for program sustainability)

Lack of transportation for afterschool and summer services

Stigma around mental health treatment

Limited parental involvement

### Factors that Boost Program Success

Using *both* insurance billing and grant funding (This allows programs to be comprehensive, providing interventions in all three tiers.)

School buy-in

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## Recommendations

### State Agencies and Leadership

- Extend telemedicine reimbursement provisions to support increasing access (including summer services) and family engagement.
- In addition to Express Lane Eligibility for SNAP/TANF, use all other available data to renew coverage for children on Medicaid/PeachCare (known as "ex parte" renewals.
- Share school-based mental health program outcomes annually.
- Support integrated school-based health (physical and mental health).
- Reimburse school-based mental health services consistently.
- Simplify/streamline insurance billing.
- Explore reasonable alternatives to the state salary schedule such that state behavioral health professionals are competitive in their field.
- Consider mobilizing school counselors, school psychologists, and school social workers to provide therapeutic services by allocating funding to hire more of each profession to reduce the student to professional ratio.Develop awareness campaigns to promote community-level mental health resources, including CSBs, and to reduce cultural- and identity-based stigma (e.g., Black, Hispanic, adolescent males).

### Providers

- Increase peer-to-peer support opportunities for youth and families (e.g., sources of strength program, establishing family federation chapters).
- Support clinicians to ease the burden and prevent burnout (e.g., secondary trauma supports, billing programs to minimize administrative burdens).
- Promote free clinical supervision toward licensure and incentives, like federal loan forgiveness.
- Partner with afterschool and summer learning programs.
- Partner with Regional Education Service Agencies (RESAs), School Climate Specialists, and school Positive Behavioral Interventions and Supports (PBIS) coordinators.
- Continue to use telehealth to enhance access to services.

### Schools

- Work with providers to submit community plans to draw down federal funding (e.g., HRSA grants).
- Leverage district and school-level funds to support program costs.
- Include providers in school meetings and groups (e.g., staff meetings, student support teams) and leverage providers for teacher trainings and professional development.

## Additional Resources:

Supporting Children's Mental Health in Georgia Schools: How Three School-Based Mental Health Providers Serve Students, Voices for Georgia's Children

Youth Behavioral Health in Georgia Two Years into the COVID-19 Pandemic: Perceptions of Need, Services, and SYstem of Care Obtained through Youth and Caregiver Focus Groups, Voices for Georgia's Children

Behavioral Health Needs in Afterschool & Summer Time: Equipping Programs to Support Georgia's Youth, Georgia Statewide Afterschool Network

Rev. 11/2022
Sources: bit.ly/3jkgaGG

# Child and Adolescent Behavioral Health Workforce

Georgia – through cross-agency collaboration efforts, the work of partners, and recent policy and practice changes – has made steady progress in reducing barriers to behavioral health services and supports.

## Recent Accomplishments

- Created a school-based mental health workforce pipeline program that provides school-based graduate training opportunities (within Georgia Apex programs).
- Embedded trauma training into the practicum program of five schools of social work and one counseling program, in partnership with the Interagency Directors Team and System of Care State Plan (training students, as well as supervising licensed providers).
- Passed key legislation to help alleviate provider shortages, allowing Georgia to enter into interstate compacts for physicians to practice medicine and psychologists to practice telemedicine in the state, and requiring equal reimbursement for telemedicine services among insurers.
- Passed the **Mental Health Parity Act** (MHPA), requiring the creation of the Behavioral Health Care Workforce Database, the development of a cancelable loan program for behavioral health professionals, and a study reimbursement rates for child and adolescent behavioral health services across public and private insurers (i.e., Medicaid, PeachCare for Kids, State Health Benefit Plan) and medical necessity denials.

## Mental Health Parity Act (MHPA)

The Mental Health Parity Act (MHPA) improves access to behavioral health services beyond the components that strengthen the workforce. Other provisions include:

- Ensuring limitations for behavioral health services are no greater than those for physical health services;
- Requiring care management organizations to spend 85% of premium revenues on medical claims and efforts to improve quality of care;
- Creating the Multi-Agency Treatment for Children (MATCH) team, which has the potential to help increase access to community-based services and supports for children with complex and unmet treatment needs; and,
- Increasing training and support for co-responder programs.

## CHALLENGES FACING THE CHILD AND ADOLESCENT BEHAVIORAL HEALTH WORKFORCE

### The Access Challenge

Despite these improvements, access to behavioral health services and supports remains a challenge for Georgia's children and families.

### Factors Affecting Access to Needed Mental Health Care

Stigma

Difficulty navigating the behavioral health system

Lack of insurance or time off

Cost

Lack of transportation

## Select Workforce Challenges

**72** Georgia counties do not have a psychiatrist[1]

**25%** of Georgia adults reported unmet behavioral healthcare needs[2]

**67%** of youth with major depression reported not receiving mental health services[3]

More than **96%** of Georgia's counties are designated as Mental Health Professional Shortage Areas (MHPSAs)*

*Mental health shortage area designations are based on the number of providers relative to the population; the population to provider ration must be at least 30,000-to-1 (20,000-to-1 if there are unusually high needs in the community.

### Additional Workforce Challenges

- Graduates lack certain skills, training, and confidence in evidence-based therapies and administrative skills.[6]
- Psychiatric nurses have a more limited scope of practice than in comparable states.[7]

## The Cultural Competency Challenge

If families can overcome these hurdles, then they face a second, major barrier – **the lack of adequate, appropriately trained and culturally and linguistically competent behavioral health professionals**.

### Georgia's Increasingly Diverse Population

**14%** of Georgia's residents speak a language other than English at home[4]

Asian and Hispanic populations have increased by **53% and 32%**, respectively, while White individuals make up barely over half of the population

More than **10%** of Georgia's population is foreign-born, which is an almost 40% increase from 1990[5]

### Recommendations

#### Scope and Practice Environment

- Encourage the practice of combining primary health and mental health care in one setting and ensure payer reimbursement for such integrated care.
- Streamline insurer provider certification, prior authorization, and billing practices and increase reimbursement rates to encourage more providers to accept public and private health insurance and maintain employees.
- Expand authorization and capacity of psychiatric nurses to include additional prescriptive abilities and the ability to practice independently.

#### Education and Training

- Expand and standardize culturally responsive care training for the behavioral health workforce.
- Develop a registered behavior technician (RBT) program within the Technical College System of Georgia to help meet the state's need for a larger autism and behavioral health workforce.
- Intentionally encourage, recruit, and support diverse and rural students to pursue mental and behavioral health careers (e.g., Georgia Department of Education's Georgia HOSA (Health Occupations Students of America)).

#### Support

- Create a subcommittee of the Healthcare Workforce Commission to identify ways to integrate foreign-trained health professionals into Georgia's healthcare workforce, including creating a licensure pathway and allowing temporary licenses.
- Dismantle barriers to licensing for behavioral health professionals, including funding to support required supervised hours.
- Increase funding to support additional staffing within the Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Therapists.

### In-Depth Child and Adolescent Behavioral Health Workforce Resources

- An Analysis of Georgia's Child and Adolescent Behavioral Health Workforce
- Sustaining Georgia's Child and Adolescent Workforce Through Supervision
- Licensing Barrier for Foreign-Trained Behavioral Health Professionals
- Whole Child Primer, 3rd Edition

Rev. 12/2022
Sources: bit.ly/3G8N1r4

# Youth Suicide in Georgia

**Suicide was the third leading cause of death for Georgia children aged 5-17 in 2021.[1]**

## GEORGIA YOUTH SUICIDES, AGES 5-17

*Source: State Child Fatality Review Panel*

| Year | Suicides |
|---|---|
| 2021 | 86 |
| 2020 | 55 |
| 2019 | 60 |
| 2018 | 63 |
| 2017 | 43 |
| 2016 | 51 |
| 2015 | 51 |
| 2014 | 30 |
| 2013 | 36 |
| 2012 | 32 |

### BREAKING DOWN THE 2021 DATA[2]

**RACE**

| White | Black | Other |
|---|---|---|
| 55% | 29% | 16% |

**GENDER**

| Male | Female |
|---|---|
| 67% | 33% |

**AGE**

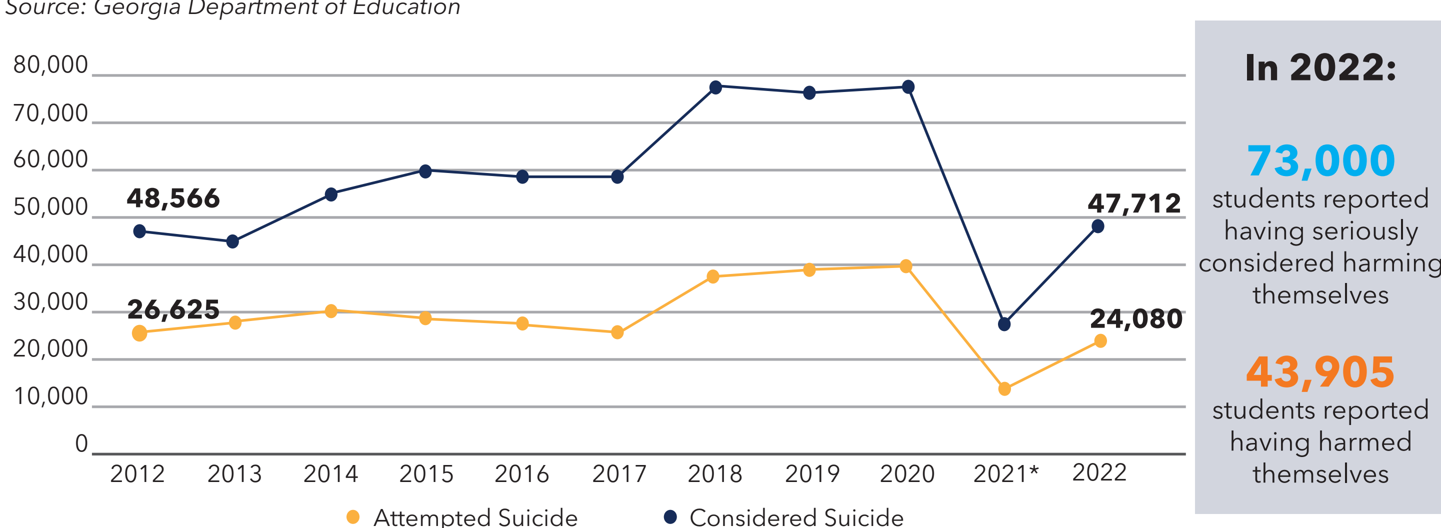
| 5 to 9 | 10 to 14 | 15 to 17 |
|---|---|---|
| 1% | 34% | 65% |

**METHOD**

| Firearm | Hanging | Other |
|---|---|---|
| 47% | 46% | 7% |

## GEORGIA STUDENT HEALTH SURVEY

*Source: Georgia Department of Education*




**The Georgia Student Health Survey was not administered during the 2020-2021 school year. Instead, GaDOE developed a brief Student Wellness Survey to highlight non-academic barriers to learning.*

The number of children in Georgia who visited emergency rooms for reasons related to suicide **nearly tripled** between 2008 and 2021.[3]

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## 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.[4]

- 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

## PROTECTIVE FACTORS TO PREVENT SUICIDE

According to the Centers for Disease Control and Prevention, protective factors buffer individuals from suicidal thoughts and behaviors.[5]

- Ongoing quality healthcare for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support
- Family and community support and connection
- Development of strong skills for non-violent conflict resolution and problem solving
- Cultural and religious beliefs that discourage suicide and support instincts for self-preservation

| Comprehensive Prevention Strategies | Example Activities |
|---|---|
| Identify and assist persons at risk | Gatekeeper training, suicide screening, teaching warning signs, referral to professional help (e.g., 988 Suicide and Crisis Lifeline, MyGCAL Line and App) |
| Increase help-seeking | Self-help tools and outreach campaigns |
| Ensure access to effective treatment | Safety planning, evidenced-based treatment, and reducing financial, cultural, and logistical barriers to care |
| Support safe care transitions and organizational link-ages | Formal referral protocols, interagency agreements, cross-training, follow-up contacts, rapid referrals, and patient and family education |
| Respond effectively to individuals in crisis | Mobile crisis teams, walk-in crisis clinics, hospital-based psychiatric emergency services, and peer-support programs |
| Provide immediate and long-term post-vention | Protocols to respond effectively and compassionately after a suicide, supports for people bereaved by suicide |
| Reduce access to means of suicide | Educate families, distributing gun safety locks, changing medication packaging, and installing barriers on bridges |
| Enhance life skills and resilience | Skills training, mobile apps, and self-help materials |
| Promote social connectedness and support | Social programs for specific population groups |

*Source: Suicide Prevention Resource Center*

Rev. 10/2020
Sources: bit.ly/3BPW7Gx

# Youth Substance Use and Non-Substance Disorders

**Substance Use Disorder**[1]
Recurrent use of substances that causes clinically and functionally significant impairment and failure to meet major responsibilities

**Non-Substance Disorder**[2]
Behavioral addictions that lead to significant psychosocial and functional impairments

## SUBSTANCES USED AND MISUSED BY YOUTH

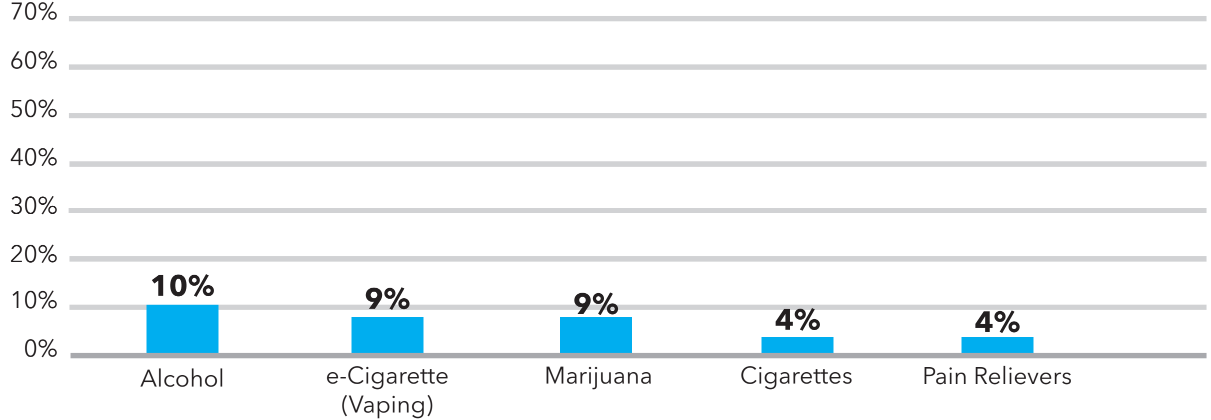
| | | | Impact on Health |
|---|---|---|---|
| **Alcohol** | Type of Drug: | Depressant | Impaired brain functioning; increased risk of cancer; weakened immune system; decreased heart health and functioning; damage to the liver and other organs; and increased risky behaviors [3, 4] |
| | Physical Form: | Liquid | |
| | Consumption: | In beverages | |
| **Cocaine** | Type of Drug: | Stimulant | Impaired brain functioning; decreased appetite; damage to nose, intestines, and bowels; increased alertness, insomnia, anxiety, and erratic behavior; increase risk for heart issues; and increased risk for infectious diseases [5, 6] |
| | Physical Form: | Fine, white powder | |
| | Consumption: | Snorted, smoked, or injected | |
| **Marijuana*** | Type of Drug: | Psychoactive | Decreased coordination and reaction time; hallucinations, anxiety, panic attacks and psych osis; problems with mental health, learning, and memory; and damage to the respiratory system [7, 8] |
| | Physical Form: | Greenish, gray mixture of dried, shredded leaves, stems, seeds, flowers; or resin | |
| | Consumption: | Smoked or eaten | |
| **Opioids** | Type of Drug: | Pain relievers, depressants, and stimulants | Drowsiness, nausea, constipation, and confusion; slowed breathing and death; and increased risk of infectious diseases [9, 10] |
| | Physical Form: | Tablet, capsule, or liquid | |
| | Consumption: | Swallowed or injected | |
| **Tobacco** | Type of Drug: | Stimulant | Increased blood pressure, breathing, and heart rate; greatly increased risk for cancer; and increased risk for chronic bronchitis, emphysema, heart disease, cataracts, and pneumonia [11, 12] |
| | Physical Form: | Cigarettes, cigars, bidis, hookahs, snuff, or chew | |
| | Consumption: | Smoked, snorted, chewed, or vaporized | |

** Legislation passed in 2017 and 2018 that expanded the conditions for which cannabis oil can be prescribed to include post-traumatic stress disorder, intractable pain, Tourette's syndrome, Autism Spectrum Disorder, Epidermolysis bullosa, Alzheimer's disease, Human immunodeficiency syndrome, Autoimmune disease and Peripheral neuropathy.*

| NON-SUBSTANCE DISORDERS | What It Is | Impact on Health |
|---|---|---|
| **Pathological Gambling** | A formally recognized and treatable addiction to regulated and non-regulated gambling and betting that causes significant problems in a child's life | 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 |
| **Disordered Eating** | Serious and sometimes fatal disorders (i.e., Anorexia Nervosa, Bulimia Nervosa, Binge-Eating) that involve a disruption in an individual's eating behaviors and thoughts about food and body weight.[13] Common behaviors may include being extremely restrictive in the amount and type of food consumed or binge-purge cycles, which involve binge eating followed by purging episodes through vomiting, laxatives, diuretics, fasting or excessive exercise[14] | Bone and muscle deterioration; brittle hair and nails; low blood pressure; slowed breathing and pulse; lethargic or sluggish; development of acid reflux disorder; worn tooth enamel; chronically inflamed and sore throat; and damage to major organs, including possible multi-organ failure[15] |

## Did You Know?

- **Alcohol, marijuana, and tobacco products** are the most commonly used substances among adolescents.[16]
- More than **17,000** Georgia high school students reported using marijuana in the last 30 days.[17]
- Georgia has the **5th highest** marijuana possession arrest rate in the nation and a Black person is **3 times more likely** to be arrested for possession than a White person.[18]
- In the 2022 Georgia Health Student Survey, **26% of girls** and **11% of boys** reported avoiding food, vomiting, or using laxatives to lose weight in the last 30 days.[19]
- In the last month, Georgia students say they have used the following substances:[20]




*The Georgia Student Health Survey is offered annually. "The last month" refers to the month prior to the students completing the survey. This measure is used to assess alcohol and drug use among youth and can be compared to national data from the Youth Risk Behavior Surveillance System (YRBSS).*

# Opioid Misuse in Georgia

## WHAT ARE OPIOIDS?[1]

Opioids are a class of drugs that act in the nervous system to produce feelings of pleasure and pain relief. They can be generally classified into three categories:[2]

| Prescription Opioids | Fentanyl | Heroin |
|---|---|---|
| Can be prescribed by doctors to treat moderate to severe pain, but can have serious risks and side effects.<br><br>Common types are:<br>• oxycodone (OxyContin)<br>• hydrocodone (Vicodin)<br>• morphine<br>• 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.<br><br>Illegally made and distributed fentanyl has been on the rise in several states. | Heroin is an illegal opioid.<br><br>Heroin use has increased across the U.S. among men and women, most age groups, and all income levels. |

***Addiction*** (termed substance dependence by the American Psychiatric Association) is defined as a **brain disease** that leads to compulsive substance use despite harmful consequences.[3]

## OPIOIDS AND GEORGIA'S CHILDREN

Opioid misuse and addiction can negatively impact children and adolescents' lives in multiple ways. Parental misuse, during pregnancy, or otherwise can lead to unintended consequences for their children, including health challenges at birth, inadequate supervision, or other experiences which could negatively affect a child's short- or long-term wellbeing. Youth opioid misuse may result in addiction, potentially impacting a child's academic performance, brain development, or life span.

### Impact of Parental Misuse

Neonatal Abstinence Syndrome (NAS) is a set of clinical withdrawal signs and symptoms present in a newborn infant who was exposed to illegal or prescription drugs while in the mother's womb.[4]

**762**
confirmed cases of NAS in Georgia in 2017, and **20%** were attributed to opioids.[5]

More than
**1 in 3**
infants with NAS were born to mothers 25–29 years of age.[6]

**43%**
of children who entered foster care in 2021 did so due to parental substance abuse.[7]

### Youth Misuse

In 2022, among middle and high school students:

Nearly
**20,000**
reported taking a prescription drug painkiller that was not prescribed for them, within the last 30 days.[8]

Approximately
**9,200**
reported using heroin within the last 30 days.[9]

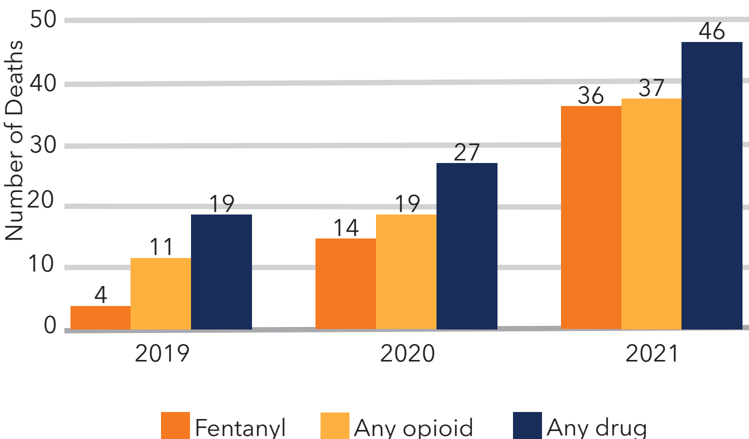
## OPIOID DEATHS AMONG ADOLESCENTS (AGES 10-19) IN GEORGIA

**From 2019 to 2021:**[10]

- **236% increase** in opioid overdose deaths
- **800% increase** in overdoses involving fentanyl
- Fentanyl overdoses rose to **78% for adolescents**, compared to 53% for adults

**In 2021, 80% of all overdose deaths among adolescents involved opioids.**[12]

**Overdose Deaths Among Adolescents by Drug Type, Georgia, 2019-2021**[11]




Opioid-involved overdoses accounted for **7,954** emergency department visits and **2,822** hospitalizations.

## SELECT EXAMPLES OF GEORGIA'S RESPONSE

- In 2017, a standing order was developed allowing pharmacists across the state to dispense naloxone/ Narcan, an opioid overdose reversal drug.[13]
- The Opioid and Substance Misuse Unit is implementing a sustainable, collaborative, and multi-disciplinary approach, by forming eight workgroups and one supporting committee on Multi-cultural Inclusion: Prevention Education; Maternal Substance Use; Data and Surveillance, Prescription Drug Monitoring Program, Treatment and Recovery; and Control and Enforcement; Harm Reduction and Hospice. Each workgroup outlined strategic next steps for the state.[14]
- The Criminal Justice Coordinating Council (CJCC) received funding from the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to create the Georgia Opioid Affected Youth Initiative competitive grant opportunity that supports strengthening opioid misuse and overdose data collection, overdose prevention training, treatment and recovery services and more.[15]
- Secured $636 million from the multi-state opioid settlement with three major pharmaceutical distributors to strengthen state and local prevention efforts.[16]

## Recommendations

- Increase state funding for treatment and prevention efforts, including youth-focused opioid misuse awareness campaigns and evidence-based positive youth development and resilience programs (e.g., Strengthening Families, Prevention Clubhouses).
- Ensure annual collection and reporting of opioid-related data, including NAS/Neonatal Opioid Withdrawal Syndrome (NOWS), youth misuse, and fatal and non-fatal overdoses.
- Leverage internet-based learning networks (e.g., Maternal Health ECHO) to provide healthcare providers consultation, training, and collaboration opportunities for treating NAS/NOWS, pregnant women with opioid misuse challenges, and to increase awareness of family-centered treatment and recovery support services.
- School Districts: Allocate a portion of Elementary & Secondary School Emergency Relief (ESSER) funding to provide Screening, Brief Intervention, and Referral to Treatment (SBIRT) training to teachers, school nurses, and counselors to increase identification of youth opioid misuse and improve access to services and supports.

# Autism Spectrum Disorder

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.[1] **Behaviors associated with ASD can be evident in children prior to two years old, however most signs and symptoms begin to appear between 2-3 years old.**[2] Therefore, early intervention services are crucial, as they are more effective when they are provided early in life.[3] Additionally, early diagnosis and intervention for autism have long-term positive effects on symptoms and skills.[4] Unfortunately, accessing early intervention and autism services can be difficult, with barriers including the availability of qualified and adequately trained professionals, the lack of transportation, and gaps in healthcare coverage.

## Diagnosing Autism Spectrum Disorder

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:[5]

**Persistent deficits in social communications and interactions:**

- Ability to engage in social interactions between two or more people
- Nonverbal communicative behaviors used for social interaction
- Developing, maintaining, and understanding relationships

**AND**

**Restricted and repetitive patterns of behaviors, interests, and activities:**

- 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

## Autism Spectrum Disorder in Georgia

**49,303**

children in Georgia, ages 3-17, were diagnosed with autism in 2019-2020[6]

**Factors related to apparent increase in prevalence**:[7]

- Improved diagnosis criteria
- Environmental influences, such as parental age at conception, prematurity, and birth weight
- Increased awareness and earlier screenings

### Behavioral Analysts in Georgia[8]

Applied Behavior Analysis is an evidence-based therapy used for people with autism and other developmental disorders that supports language and communication, attention and memory, and behavior concerns.[9]

| CERTIFICATION | Doctoral (BCBA) | Master's/Graduate (BCBA) | Bachelor (BCaBA) | Total |
|---|---|---|---|---|
| STATEWIDE COUNT | 79 | 1,178 | 60 | **1,317** |

**BCBA**: Board Certified Behavior Analyst
**BCaBA**: Board Certified Assistant Behavior Analyst

## POLICY RECOMMENDATIONS

- Increase workforce capacity to serve, and availability crisis services and supports for, individuals with dual diagnoses (i.e., behavioral health disorder and intellectual/developmental disability).
- Require public and private insurers to allow ABA therapy upon autism diagnosis from primary care physician or child psychiatrist while waiting for a psychological evaluation.
- Develop a registered behavior technician (RBT) program within the Technical College System of Georgia to help meet the state's need for a larger autism and behavioral health workforce.
- Review, and if necessary, strengthen policies, procedures, state licensing provisions and quality monitoring of residential treatment and respite care for children and youth with behavioral health conditions, including serious emotional disturbance, substance use disorders, and autism.
- Assess gaps in coordination of services through Babies Can't Wait (Department of Public Health) and Preschool Special Education Program (Georgia Department of Education), then structure and fund programs adequately.
- Encourage schools to partner with community providers of autism services to increase availability of supports in academic settings.
- Promote early identification educational opportunities for new and existing child care workforce members to better serve infants and young children aged 0-4 and their caregivers.

Rev. 11/2022
Sources: bit.ly/3PJxRM5

# Babies Can't Wait

Babies Can't Wait (BCW) is Georgia's early intervention program available to children ages zero to three years old with disabilities and developmental delays. Through BCW, a team of multidisciplinary healthcare professionals assesses, educate, and implement a family service plan to help ensure children receive every opportunity to fulfill their potential.[1]

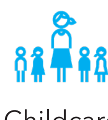
A child's brain develops extremely rapidly from birth to age three. **This is a critical window of opportunity to detect and address developmental delays before they become significant barriers to healthy development.** BCW staff work closely with physicians and healthcare providers to identify children showing signs of developmental disabilities or delays, so that needed supports can be provided early on – and long-term development challenges can be prevented or mitigated.

## WHO QUALIFIES FOR SERVICES?

Babies Can't Wait serves children from birth until age 3 who have a diagnosed developmental delay or chronic health condition that results in a developmental delay.[3] BCW services provide support and resources to assist family members/caregivers to enhance children's learning and development in the child's natural environment (e.g., home or community setting).[4, 5]

Anyone can refer a child to Babies Can't Wait including, but not limited to::[6]

Parents



Childcare Providers

Doctors

A free developmental evaluation is available to families to determine eligibility for services and supports under the program.[7]

## HOW THE PROGRAM IS FUNDED

babies can't wait receives federal funds from the Office of Special Education Programs, Individuals with Disabilities Education Act, and state funds, and is housed within the Georgia Department of Public Health.

## HOW SERVICES ARE PAID FOR[2]

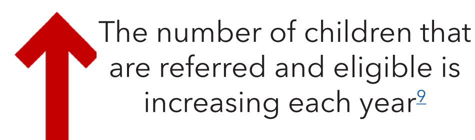
First, services are billed to the child's health insurance (where applicable and with parent permission)

A sliding fee is determined based on income and family size

BCW program serves as a payor of last resort, if needed

## CHILDREN SERVED BY BABIES CAN'T WAIT

**26,000**
children were served in FY 2021-2022[8]



The number of children that are referred and eligible is increasing each year[9]

It's likely that more children are in need of services than BCW can currently serve, given existing constraints.

## STEPS TO RECEIVE EARLY INTERVENTION SERVICES[10]

1. Referrals can be made by anyone including but not limited to a pediatrician, family member, care provider, or a parent/guardian for assessment. Assessment of children must start within 45 days of referral.

2. Intake is conducted by BCW Service Coordinators (SC) and/or BCW Intake Service Coordinators (ISC) to assess potential delays or diagnoses. Early Intervention Coordinators (EIC) and Service Coordinators ensure that children receive assessments and services in a timely fashion and align with the care plan; they also ensure that timely and complete data is collected.

3. The Individualized Family Services Plan (IFSP) team, which includes parent/guardian, service provider(s), Service Coordinator(s), and anyone the family deems necessary, create an IFSP based on the child's needs.

4. Children and families receive services for conditions based on their IFSP up until their 3rd birthday. Services are provided by BCW local agency staff and contracted providers (Physical Therapists, Occupational Therapists, Speech Language Pathologists, Special Instructors, and other BCW contracted providers.

5. The child's progress is evaluated every six (6) months or as needed based on the needs of the child and the concerns of the IFSP team. BCW Service Coordinators work with providers and families to determine if additional services are recommended[11]

6. Transition plans begin at 27 months. BCW Service Coordinators help families develop a plan to determine which next step will support the child's developmental needs after they have exited the BCW program. Options for next steps include private therapy services, private childcare, preschool special education classroom, Head Start/Early Head Start, or staying at home. This includes creating an educational plan to compare all transition options.

## CHALLENGES TO THE SUCCESS OF THE BABIES CAN'T WAIT PROGRAM

While Babies Can't Wait is implemented in all 18 public health districts, the program has encountered challenges with having enough contractors, particularly in rural areas of Georgia, to meet all the service needs of the children enrolled. **Understaffing ultimately results in children/families receiving delayed services or not receiving the recommended services.**

## RECOMMENDATIONS TO STRENGTHEN THE BABIES CAN'T WAIT PROGRAM

- Work closely with local agency staff, stakeholders, and community partners to assess and address staff/ program recruitment and retention issues.
- Streamline coordination and follow-up coordination/communication between referral source (e.g., physician) and program staff across the state
- Continue to recruit providers to serve in all districts at numbers that meet the demand for services.
- Continue to offer telehealth as a platform for providing services to parents/caregivers where possible.
- Continue to explore whether there are early intervention services provided by the state which could be billed to Medicaid and/or private insurance (e.g., provider-to-provider consultations to coordinate services). If feasible, this would allow greater flexibility for IDEA Part C grant funds to support case management.

*Babies Can't Wait is a federally regulated program under the Individuals with Disabilities Education Act, specifically, Part C of the law. The program is to be a statewide, coordinated, multidisciplinary inter-agency system that provides early intervention services for infants and toddlers, and coordinates developmental, educational, and community supports for those children. However, eligibility criteria may vary state to state.*

Rev. 11/2022
Sources: bit.ly/3FJ2A7B

# INSERT BANK TAB: PROTECTION AND SAFETY

# ACEs and Childhood Stress

Adverse Childhood Experiences (ACEs), or early negative experiences, can lead to negative impacts later in life, such as **poor mental and physical health, lower academic achievements, and substance abuse**. In the research discussed here, ACEs refer to these experiences:[1]

- Homelessness
- Involvement in child welfare system
- Medical trauma
- Natural disasters
- Neglect (physical/emotional)
- Discrimination (including racism and sexism)
- Community violence

ACEs, along with other negative life events, can cause high levels of stress, or toxic stress, which can also have long-term effects on a child's development.[2]

## IMPACT OF ACEs

Children with ACEs are at increased risk of negative outcomes in multiple areas of their lives:[4, 5]

- Poor health, including mental health
- Substance abuse

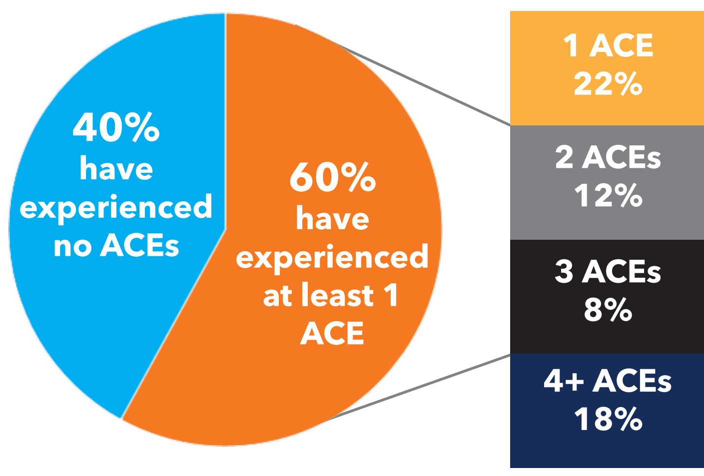
- Depression
- Risky behavior
- Difficulty concentrating or making decisions

- Poor academic achievement
- Employment problems

## PREVALENCE OF ACEs IN GEORGIA[3]

**Nearly 3 in 5 surveyed Georgians reported having experienced at least one ACE.**

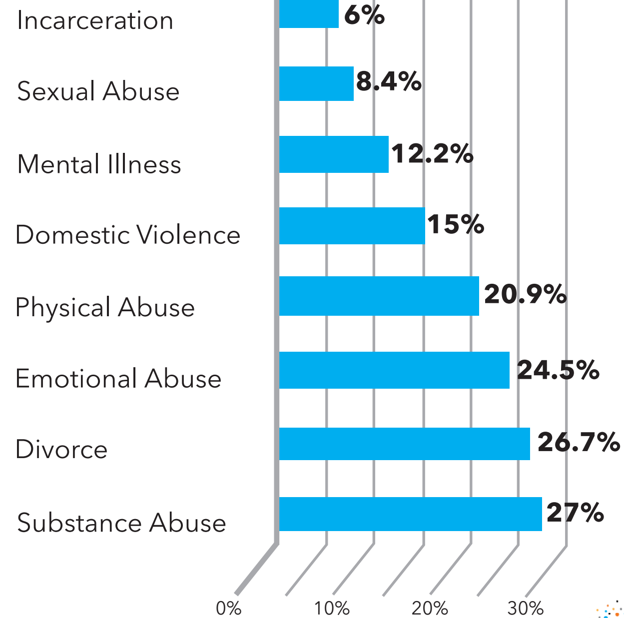
In 2016 and 2018, Georgia collected data from adults about ACEs they experienced as children. (ACEs not included in this research are experiencing neglect and having a family member attempt or die by suicide.)[6]




### DATA ON DISPARITIES

While the likelihood of having four or more ACEs did not vary significantly by race or ethnicity in Georgia, White respondents were about **8 times** as likely to have experienced no ACEs as Black respondents, according to 2016 BRFSS data.

**ACEs Among Adults 18 Years and Older, Georgia Behavioral Risk Factor Surveillance System, 2020**[7]




**In 2020, 14.3% of Georgians surveyed reported having experienced at least four ACEs.***

* The Department of Public Health is analyzing updated data, which is expected in December 2022.

## POLICY RECOMMENDATIONS

**These recommendations build protective factors around families.** In order to adequately tackle ACEs and toxic stress, an adequate support system for each child should be at the center of any child policy platform.

### Early Care and Learning

- Create an environment where the effects of toxic stress are buffered with appropriate supports to help children adapt and enhance cognitive and social development

### Early Intervention

- Increase access to health care and home visiting support to promote healthy development and provide early diagnoses, appropriate care, and intervention when problems emerge

### Parental Health

- Address parental mental and behavioral health to minimize, or even prevent 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
- Develop procedures that enable continuity of behavioral health and primary care while youth are in foster care and after they're transitioning out of the system

### Juvenile Justice and School Discipline

- Provide environments that are safe and services that do not increase the level of trauma that youth and families experience
- Train Public Safety Officers who engage with children in child development and trauma awareness

### Workforce and Systems Development

- Train caregivers and child-serving professionals on the effects of trauma and stress on children and youth to ensure they respond appropriately to behaviors and initiate effective interventions

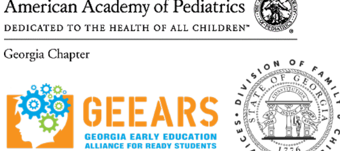
### Nutrition

- Increase funding for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

### Stable Housing

- Improve Georgia's renter protection laws to reduce incidents of unsafe housing and eviction (FFPSA)

Thanks to these partners for their collaboration on this factsheet:



Rev. 11/2022
Sources: bit.ly/3YB6LLb

# Family First Prevention Services Act

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. Georgia began phased implementation of FFPSA in Fall 2021.[1] There are two main components of the act:

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

Family First services will be offered in Chatham, Cherokee, DeKalb, and Richmond counties in the beginning of 2023. Services will include Multisystemic Therapy and Functional Family Therapy, two evidence-based treatments to address behaviors of youth at risk for out-of-home placement.[2,3]

## Foster Care Prevention Services and 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

Eligibility is **not** dependent on family income

### SERVICES AND PROGRAMS

that are eligible for reimbursement for Title IV-E funds

Mental health services

Substance abuse prevention and treatment services

In-home parenting programs

For more details on who is eligible for these services and programs, see the definition for candidacy on Blueprint for Family First. The Prevention Plan identified BSFT, FFT, MST, HFA, and PAT for inclusion in 5 year plan.

**How does a state obtain funding for services or programs?**

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

Half of the cost of prevention services, training, and related administrative tasks can be covered by Title IV-E funds.

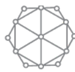
*If Georgia postpones the effective date of congregate care changes, it must also delay requesting prevention funds until the same date.*

## Congregate Care

Starting September 30, 2021, FFPSA limits foster care payments for group homes for up to two weeks only. Although FFPSA limits federal reimbursement for foster care maintenance payments for group homes, the limitations do not currently impact the ability to place youth in group homes if it is determined to be the most appropriate placement.[4]

### Qualified Residential Treatment Programs

QRTPs must meet the following requirements:[5]


Use a trauma-informed treatment model

Have a registered or licensed nursing and clinical staff onsite

Facilitate family outreach and participation

Document family integration into the treatment process

Provide discharge planning and family-based supports for at least 6 months after discharge

Be licensed and accredited by one of the following:

- Commission on Accreditation of Rehabilitation Facilities
- Joint Commission on Accreditation of Healthcare Organizations
- Council on Accreditation
- Other nonprofit accrediting organization approved by the Secretary

Meet the treatment needs of children as determined by an assessment within 30 days of placement

# 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.[1]

In FY 2023, the Department of Human Services received $92,141,472 and the Department of Juvenile Justice received $5,311,353 of federal funding for Title IV-E.[3]

Funding activities include:

- Monthly maintenance payments for daily care and supervision of eligible children[4]
- Administrative costs to manage the program at the state level[5]
- Training of staff and foster care providers[6]
- 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

## FOSTER CARE SYSTEM IN GEORGIA

**11,438**
kids are in Georgia's foster care system[2]

### Top Reasons a Child is in Foster Care[7]

- Neglect (47%)
- Caregiver drug abuse (43%)
- Inadequate housing (20%)
- Caregiver's inability to cope due to illness or other reason (11%)
- Parental incaration (10%)
- Physical abuse (10%)
- Child's behavioral health condition (10%)

A child can be removed from the home for more than one reason.

## FAMILY FIRST PREVENTION SERVICES ACT[8]

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* include:

12 months of mental health services and 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 an approved Title IV-E Prevention Services Clearinghouse activity.

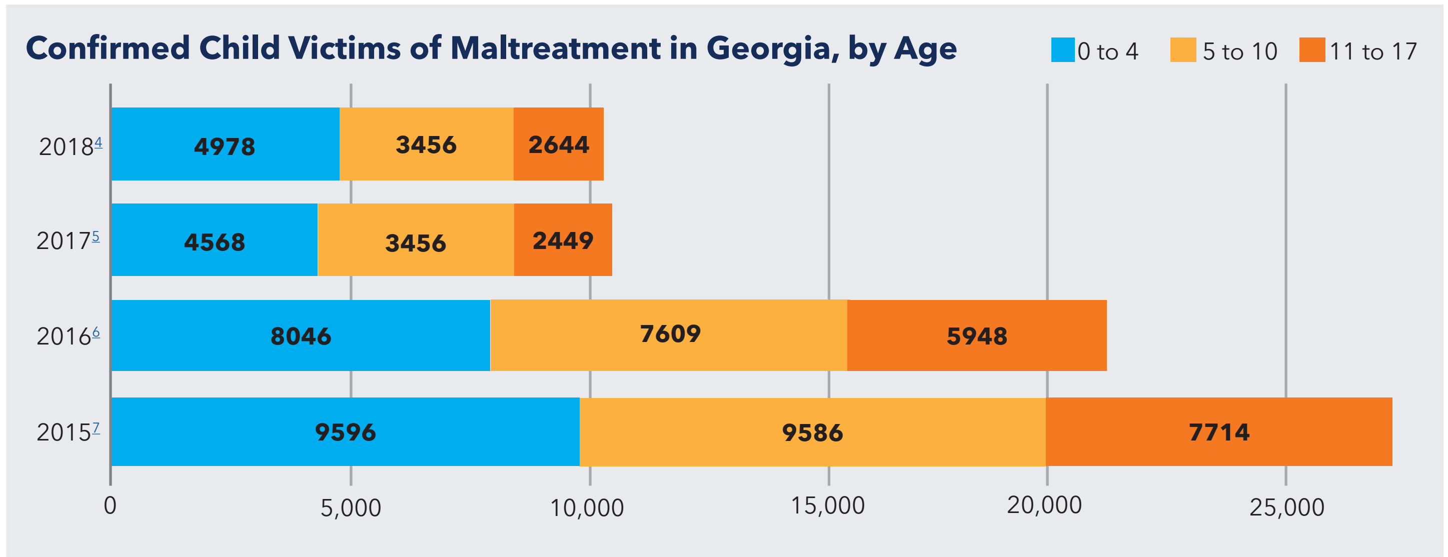
# Child Maltreatment's Impact on Brain Development

Brain development is impacted by both our genetics and our experiences. As children grow, their brains develop basic functions first (e.g. breathing) before progressing to more sophisticated functions (e.g. complex thought).[1]

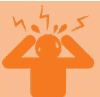
Child maltreatment includes all types of abuse and neglect of a child under the age of 18 by a parent, caregiver, or other person in a child-serving role (e.g., minister, teacher, etc.). There are four common types of abuse: physical, sexual, emotional, and neglect.[2]

## Effects of Maltreatment on Behavior, Social, and Emotional Functioning[3]

- 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
- Delayed developmental milestones
- Diminished executive functions like memory, attention, impulse control, etc.
- Decreased response to positive feedback or rewards
- Social interactions made more difficult




## 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[8]

**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[9]

**Toxic Stress** - strong, frequent, and prolonged activation of body's stress response system that disrupts healthy development[10]

**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)[11]

**Memories**

Systems of neurons that have been repeated and strengthened[12]

> 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

## POLICY AND PRACTICE CONSIDERATIONS

Prevention and early intervention remain the most effective methods for minimizing the effect of maltreatment on development. Other promising trends include:[14]

Trauma informed care and evidence-based practices

Individualized services for children and families

Promotion of evidence-based practices

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

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

## HEALTHY BRAIN DEVELOPMENT[13]

### Early Brain Development

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

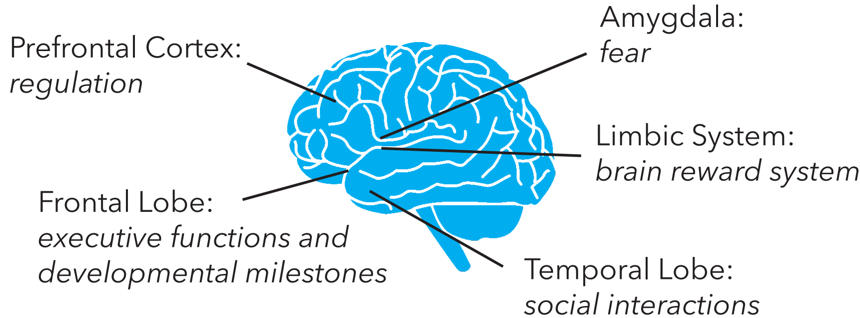
### Young Child Brain Development

- Formation of synapses occur at a high rate
- Higher function brain regions (governing emotion, language, and abstract thought) grow rapidly in the first three years
- By age two, a child has formed 100 trillion synapses
- Synapses are eliminated as experiences deem them unnecessary (i.e. pruning)
- By age 3, a child's brain is nearly 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
- Limbic system grows and transforms

## PARTS OF THE BRAIN




## TERMS TO KNOW

**Amygdala**: brain's emotional reaction center associated with behavioral function and survival instincts (e.g. fight or flight)[15]

**Neuron**: a unique type of cell found in the brain and body that is specialized to process and transmit information[16]

**Brain stem**: one of the four major parts of the brain. It monitors basic, vital functions such as heartbeat, body temperature, and digestion. The brain stem is the first part of the brain to develop.[17]

**Midbrain**: the part of the brain that regulates auditory and visual processing, motor control, arousal, and alertness[18]

**Synapse**: the site between neurons where the transmission of messages occurs[19]

**Pruning**: the selective elimination or "weeding out" of non-essential synapses based on a child's specific experiences[20]

**Myelination**: the strengthening of necessary connections between neurons[21]

**Limbic System**: a network of brain structures that governs emotions and memory[22]

# Homelessness and Children in Georgia

Homeless children and youth are defined as individuals who lack a fixed, regular, and adequate night time residence.

**31,768**

K-12 students in Georgia were homeless in 2021.[1]

Approximately

**36,000**

children under age six were homeless in 2019, with more than 1,500 served in Early Care and Education environments.[2]

Being homeless doesn't always mean sleeping outside. Of the students who reported experiencing homelessness, **72%** said they were staying with extended family or friends. [3]

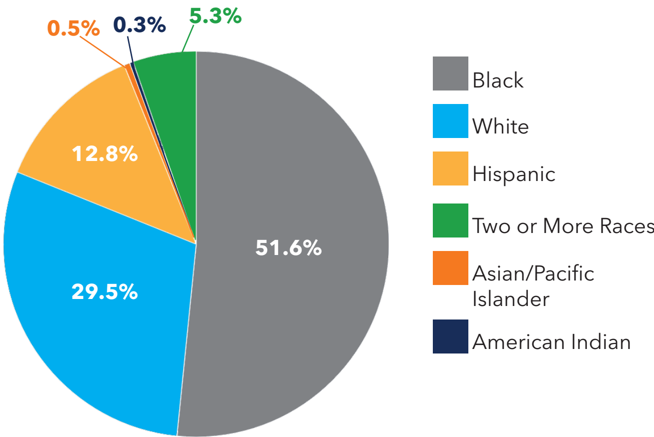
## COVID-19 AND HOMELESSNESS IN GEORGIA

The COVID-19 pandemic has increased housing insecurity in Georgia, which directly impacts children. As of July 2022, **more than one in seven** Georgia families with children were late on their rent or mortgage payment, according to the U.S. Census Household Pulse Survey.[4] As of July 2022, approximately 67% of Georgia families with children reported that they were "very likely" to have to leave their current home in the next two months due to eviction.[5]

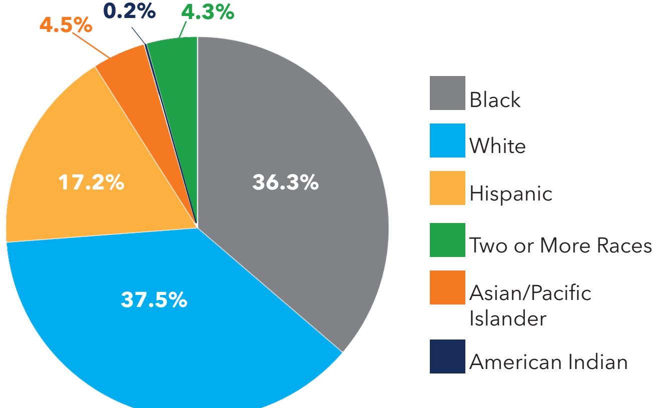
## WHO IS HOMELESS IN GEORGIA?

Black students make up a disproportionate amount of Georgia's homeless student population.[6]

### HOMELESS STUDENTS, BY RACE AND ETHNICITY




### NON-HOMELESS STUDENT POPULATION, BY RACE AND ETHNICITY




**In FY21, 20% of foster care placements cite inadequate housing as a reason for removal of a child from the home.**

## IMPACT OF CHILD AND YOUTH HOMELESSNESS

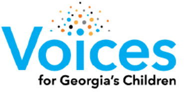
Georgia has a growing population of students experiencing homelessness. These students are more likely to:

- be suspended
- miss school
- fall far behind in reading and math

## RISK FACTORS FOR CHILD AND YOUTH HOMELESSNESS

- Child and family poverty
- Employment issues
- Lack of health insurance
- Lack of affordable housing
- Abuse/neglect and trauma
- Single or youth parents
- Mental illness
- Substance abuse
- LGBTQ+ youth
- Involvement with foster care or the juvenile justice system
- Transitioning out of foster care and residential or institutional facilities





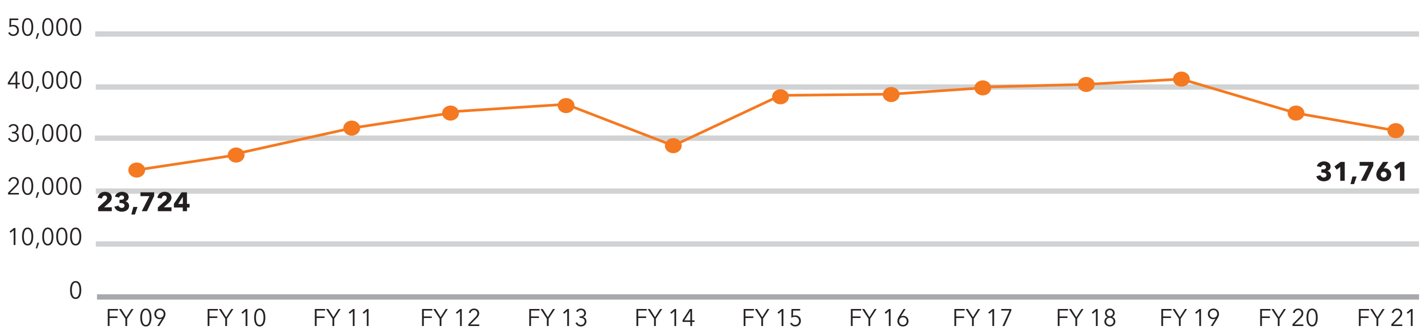
## MCKINNEY -VENTO HOMELESS ASSISTANCE ACT

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 been amended and reauthorized several times.

## MCKINNEY -VENTO EDUCATION FOR HOMELESS CHILDREN AND YOUTH PROGRAM

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

## MCKINNEY-VENTO COUNT OF HOMELESS STUDENTS IN GEORGIA*




**The COVID-19 pandemic may have impacted data collection and homelessness may be higher than recorded.*

**In FY 21, the Georgia Department of Education subgranted more than $3.1 million for homelessness initiatives in 46 school districts.**[7]

## EXAMPLES OF 2020-2021 MCKINNEY-VENTO PROGRAMS[8, 9]

*All are Grant Year 2020/21 examples.*

### CARROLLTON CITY SCHOOLS

The Carrollton City School District combined its efforts with community to provide McKinney-Vento youth with school supply boxes and assistance for families in transition.

**$54,801**

### COBB COUNTY

The district used American Rescue Plan funds to identify and support 1,454 students to remain in their schools of origin at a 42% success rate.

**$104,157**

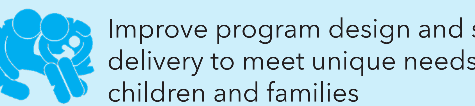
### MUSCOGEE COUNTY

The district dedicated a week to allow students to attend college and career fairs, complete financial aid application, conduct scholarship searches, and prepare for college admission tests. They also used funds to deliver school supplies and uniforms to homes, shelters, and hotels and granted parents access to the on-campus store and computer lab.

**$86,193**

## 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:

- Expand funding for and awareness of Find Help Georgia, a DFCS needs-based triage system for family support services that links families with DFCS-partnered, local organizations to help find resources for housing, food access, and other basic needs. Increase the availability and equitable distribution of quality and affordable housing.
- Improve Georgia's renter protection laws to reduce incidents of unsafe housing and eviction.
- Increase the availability and equitable distribution of quality and affordable housing and support policies, including rent and mortgage subsidies, which protect families and children from unsafe housing, hardship or baseless evictions, and untenable fees and penalties.
- Support policies that facilitate housing opportunities for people with past evictions, criminal histories and mental health issues.
- Improve access to educational opportunities that will ensure success for children and youth who are homeless.
- Create and fund community-based resources, such as drop-in centers and job-training, to 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.
- Conduct more research to identify interrupters of multi-generational homelessness.

# Child Sexual Abuse

Child sexual abuse is the exploitation of a child for the sexual gratification of an adult or caregiver. Sexual abuse includes both touching and non-touching offenses.[1]

**Touching Offenses:**

- Fondling
- Sodomy
- Rape
- Intercourse
- Masturbation

**Non-touching Offenses:**

- Child pornography
- Indecent exposure

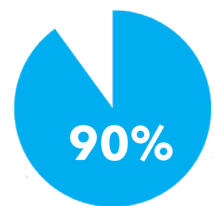
Approximately **1 in 10** children is sexually abused by the time they turn 18.[2]

Of the children removed from their home in 2021,* **3%** were for reasons of sexual abuse.[4]

Child sexual abuse is often underreported.[3] As such, these data points likely underestimate how frequently this occurs.

## Who are the Perpetrators?

People who sexually abuse children look just like every one else. Abusers can be neighbors, religious leaders, teachers, family members, or anyone who interacts with children.[5, 6]




of children know their abuser

**One-third** are abused by family members.

The majority 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.[7]

## DID YOU KNOW?

- The sexual preference of a perpetrator **does not** make them more likely to sexually abuse children.[8]
- There is **no research** that says a transgender person is more likely to seuxally abuse children than someone who is not transgender.[9]
- Although men are consistently shown to commit the majority of child sexual abuse, **women are also abusers**.[10]
- In 2018, Georgia **mandated** age-appropriate sexual abuse and assault awareness education for all students K-9.[11]
- Georgia's Child Sexual Abuse and Exploitation Prevention **Technical Assistance Resource Guide** (TARG) outlines sexual abuse prevention strategies.[12]

## Who are the Victims?

Children and youth who are more at risk of being sexually abused:[13]

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:[14]

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

*A child may be removed for more than one reason.*

## Labeling Youth as Sexual Predators

Juveniles represent **one-fourth** of all sex offenders and **one-third** of known offenders against other juveniles.[15]

**40-80%** of juvenile sex offenders have *themselves been victims of sexual abuse*. These children are often responding to their own trauma.[16]

Juvenile sex offenders are unlikely to commit another sex offense later in life.[17] Studies universally confirm that juvenile sex offense recidivism is relatively low with an estimated rate of 7%.[18] In addition, interventions for juvenile sex offenders have shown to be a particularly effective.[19]

## 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.

Rev. 12/2022
Sources: bit.ly/3G8ojHt

# Childhood Lead Poisoning

Lead is a heavy metal found in the earth's crust that does not break down in the environment.[1] When someone inhales or swallows lead, they can suffer serious health consequences, up to and including death.[2]

In 2021, 91,648 of Georgia's children were screened for lead poisoning. Of those, **3,209 children** had **lead poisoning measuring 3.5 µg/dL or more.**[3]

## What is Childhood Lead Poisoning?

Georgia law requires, and the Centers for Disease Control and Prevention (CDC) recommends, intervention for children with a blood lead level presence of 3.5 µg/dL (micrograms per deciliter).[4,5] Children's bodies absorb lead more easily, affecting brain and other physical development in organs and the nervous system.[6] Children under age 6 are at the greatest risk of lead poisoning.[7] Even low levels of lead can result in:

Speech, language, and behavioral problems

Learning disabilities and Attention-Deficit / Hyperactivity Disorder

Lower IQ

Nervous system damage

Higher levels of lead - also called elevated blood lead levels - can cause coma, convulsions, intellectual disabilities, developmental disabilities, seizures, and death. Elevated blood lead levels can require expensive medical treatment and exacerbate health conditions.[8] Prenatal exposure can cause miscarriage, premature birth, and damage to baby's brain, kidneys, and nervous system.[9]

**DISPARITIES ON LEAD EXPOSURE**

According to 2021 Georgia Department of Public Health data, childhood lead poisoning is more prevalent in Asian, Black, and Multiracial children than White children.[10]

## Where is Lead Found?

### Water

This can be caused by corrosion of plumbing materials (e.g. pipes and fixtures). Homes, schools, childcare programs, and other buildings built before 1986 are more likely to have lead pipes, fixtures and solder.[11]

### Soil

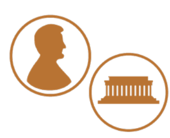
Yards and playgrounds may become contaminated from exterior lead-based paint flakes, industrial sources, or even contaminated sites. Also, lead is naturally occurring and can be found in high concentrations in some areas.[14]

### Paint

Older homes and buildings are more likely to have lead-based paint. While the use of lead in residential paints was banned in 1978, lead is present in many buildings built prior to that date.[12]

### Small metal objects

Which can be swallowed by children.[15]



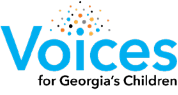
### Toys and Other Items

May be present in those imported from other countries.[13]

### Herbal or folk remedies

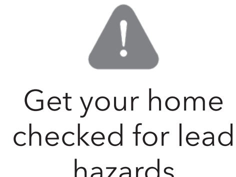
Greta and azarcon, which are traditional Hispanic medicines, as well as other traditional medicines from India, China, Bhutan and others can contain lead.[16]





## PROTECT YOUR FAMILY

Have your child tested



Get your home checked for lead hazards

Test your water

Clean regularly

Remove shoes or wipe off soil before entering house

## Wins for Georgia's Kids

- In 2022, Georgia signed into law a lower lead poisoning threshold, which aligns with the most current CDC recommendation, of 3.5µg/dL.[17, 18] Additionally, this legislation supports the Georgia Department of Public Health in:
    - hiring additional lead inspectors statewide to investigate cases of lead exposure;
    - educating families on exposure reduction; and,
    - engaging with property owners to reduce and eliminate lead sources.

- The Clean Water for Georgia Kids Program supports schools and early care and education (ECE) programs through testing, communications, and providing low-cost recommendations on how to remove lead from drinking and cooking water. This program is funded by Environmental Protection Agency and free to participants.[19]

**There is still work to do.**

## POLICY RECOMMENDATIONS

- Explore and establish funding opportunities to support ECE programs in lead pipe and fixture mitigation and remediation efforts.
- Expand Georgia law to include blood lead level monitoring and mitigation strategies for women of childbearing age (DPH) and children under six years of age.
- Develop and implement multi-year lead test and mitigation strategies in built environments and drinking water at schools, childcare facilities, and other non-home locations where children spend time.* Explore federal and other public or private funding mechanisms to cover costs.
- Expand partnerships to increase blood lead level testing sites (e.g., clinics, labs, point of care). (DPH)
- Encourage Care Management Organizations (CMOs) to increase well-child visits and mandatory Medicaid child lead screenings.** Ensure that Medicaid / DCH is accurately monitoring and reporting lead screening. (DCH)
- Assess and address built environment for each child whose blood lead level is equal to or greater than the CDC action level, especially for children under 3 years old. (DPH, GEPD)

*Lead testing and mitigation strategies for drinking water may consider the Georgia Lead Poisoning Prevention Act of 1994, which addresses lead-based paint.

**Medicaid federally requires that every state provides at least 80% of Early and Periodic Screening, Diagnostic and Treatment recipients with timely medical screens, including lead screening for under age six.[20] Federal data show that from 2015 to 2019, Medicaid lead screening rates steadily declined in Georgia (from approximately 108,000 to 96,000) for ages 0-6.[21] Note: Medicaid reported that this data was incorrectly reported so numbers will vary.[22]

# Swimming Pool Safety

## THE IMPORTANCE OF SWIMMING POOL SAFETY

Drowning is the **sixth** leading cause of unintentional death for children ages 1-17 years old in Georgia.[1] In 2021, 31 children in that age group drowned,[2] and there were 153 emergency room visits drowning and submersion.[3] **Most drownings of children ages 1 to 4 happen in swimming pools.**

## WATER-RELATED INJURIES IN THE U.S.

While the biggest threat to children around unexpected, unsupervised access to water is drowning, every year thousands of children are treated in the emergency room for non-fatal water-related injuries.[4]

**Estimated ER-Treated Injuries**

| | Younger than 5 | 5-14 years | Total <15 years |
|---|---|---|---|
| Average | 4,800 | 1,400 | 6,200 |
| 2020 | 4,400 | 1,300 | 5,800 |
| 2019 | 5,100 | 1,200 | 6,300 |
| 2018 | 4,900 | 1,500 | 6,400 |

*Source: U. S. Consumer Product Safety Commission: National Electronic Injury Surveillance System*

## SWIMMING POOL RULES AND REGULATIONS

The Georgia Department of Public Health (DPH) is responsible for ensuring public swimming pools are clean, healthy and safe. In addition to **adult supervision**, there are laws in place regarding fencing, pool drains, and clean water that are critical to pool safety.

### Public Pool Barriers[5]

- All outdoor swimming pools and spas shall have a barrier (e.g., fence, safety cover, wall, building wall, or a combination) which completely surrounds or covers the pool or spa, and obstructs access.
- Top of the barrier should be at least 4 feet high.
- Pedestrian access gates should be self-closing and self-latching; other gates should have a self-latching device.

### Public Pool Drains[6]

- Suction outlets must have been tested and meet approved standards.
- The main drain must be visible through the water from the pool edge.
- All drain covers and grates must meet appropriate standards.

### Clean Water

Children, 3 years and younger, and those not toilet-trained, are required to wear a swim diaper in a public swimming pool.[7]

## HOWEVER, IT IS IMPORTANT TO KNOW:

Swim diapers are not leak proof. Diarrhea-causing germs may be delayed from leaking into the water for a few minutes, but these germs still contaminate the water.[8]

## WHY POOL INSPECTIONS ARE IMPORTANT

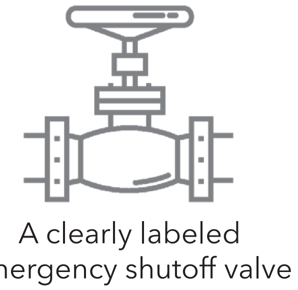
Germs that cause water illnesses can be spread in recreational settings when swallowing water that has been contaminated with **fecal matter**.[9] Appropriate levels of disinfectants kill most germs within minutes, but some can survive for days.[10]

| Germ[11] | Symptoms Can Include: | Time It Takes to Kill or Inactivate Germs in Chlorinated Water[12] |
|---|---|---|
| *E.coli* O157:H7 Bacterium | Watery or bloody diarrhea, fever, abdominal cramps, nausea, and vomiting[13] | Less than 1 minute |
| Hepatitis A virus | Fever, fatigue, loss of appetite, nausea, vomiting abdominal pain, dark urine, diarrhea, clay-colored stool, joint pain, jaundice[14] | About 16 minutes |
| *Giardia* Parasite | Diarrhea, gas, greasy stools that tend to float, stomach or abdominal cramps, upset stomach or nausea/vomiting, dehydration (loss of fluids)[15] | About 45 minutes |
| *Crypto* Parasite | Watery diarrhea, stomach cramps or pain, dehydration, nausea, vomiting, fever, weight loss[16] | About 10.6 days |

** 1 part per million (ppm) free chlorine at pH 7.5 or less and a temperature of 77°F (25°C) or higher. Source: CDC[8]*

## SWIMMING POOLS IN GEORGIA

The Georgia Department of Public Health (DPH) is the state agency that ensures public swimming pools are clean, healthy and safe. To ensure minimum standards are met, DPH regularly inspects public swimming pools. Public swimming pools must have:[17]



A clearly labeled emergency shutoff valve

A trained operator perform a minimum of 2 weekly visits and document conditions

Regular collection of water samples to test

## DPH's 7 PREVENTION STEPS FOR HEALTHY AND SAFE SWIMMING[18]

- **Closely supervise children in the water.**
- **Don't swim when you have diarrhea.**
- **Shower before you enter the pool.**
- **Don't swallow the water you swim in.**
- **Do not urinate in the water and always report fecal matter.**
- **Don't swim if pool drain covers are missing, broken, or can't clearly be seen.**
- **Report hazards to your local health department or environmental health office.**

Rev. 11/2022
Sources: bit.ly/3BLuw9F

# INSERT BANK TAB: JUVENILE JUSTICE AND SCHOOL DISCIPLINE

# Juvenile Justice Update

## Juvenile Justice Reform Act of 2013

In 2012, members of the Special Council on Criminal Justice Reform studied Georgia's juvenile justice system and crafted recommendations to improve public safety and reduce costs. These recommendations and resulting legislation, the Juvenile Justice Reform Act of 2013, reorganized, revised, and modernized Title 15, Chapter 11 of the Official Code of Georgia Annotated, a section of our law known as the Juvenile Code.

In addition to improving public safety and reducing costs, the new code aimed to strengthen family relationships in order to allow each child to live in safety and security.

Policies and practices include:

- Increased use of evidence-based programs
- Treating youth in the community rather than in secure facilities
- Juvenile Justice Incentive Grant Program, which aims to reduce recidivism

**DJJ Mission Statement:** Adopted in 2020, the Georgia Department of Juvenile Justice transforms young lives by providing evidence-based rehabilitative treatment services and supervision, strengthening the well-being of youth and families, and fostering safe communities.[1]

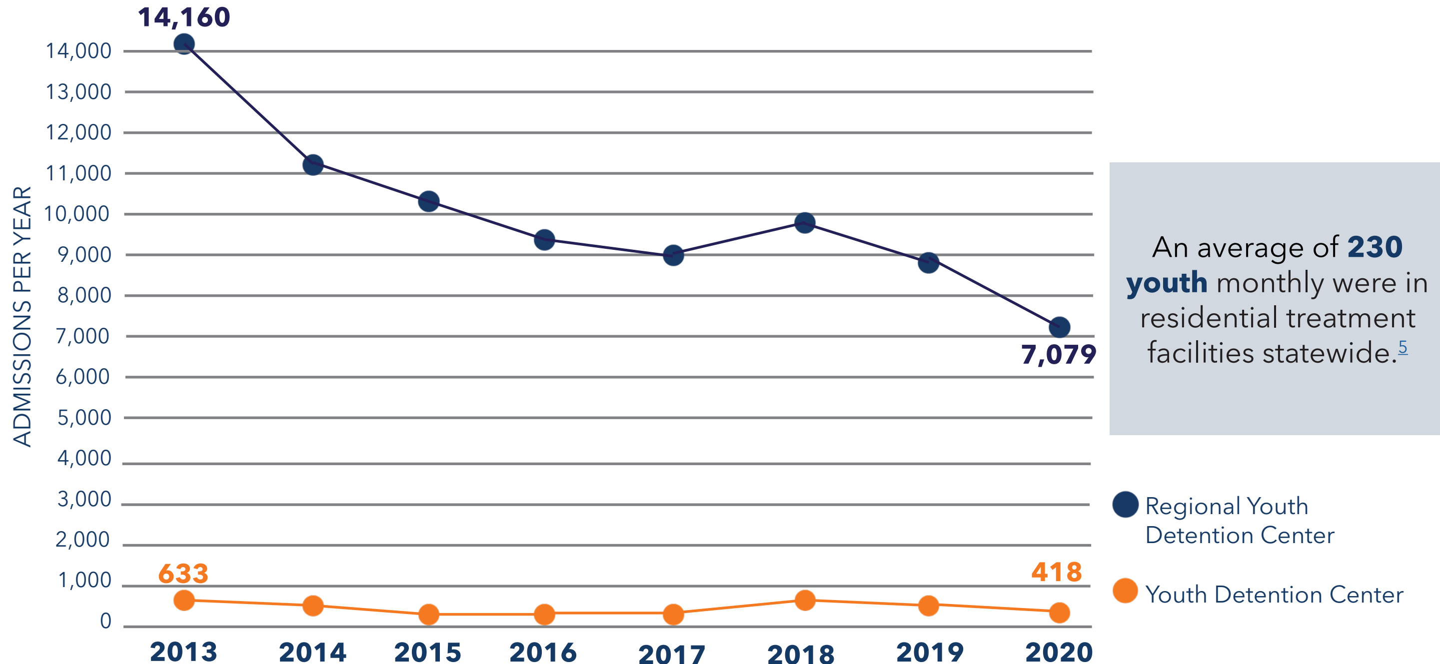
### Signs of Progress from 2013 to 2019[2]

## Georgia Youth in Secure Residential Facilities

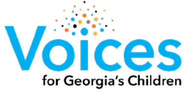
The Department of Juvenile Justice has two secure residential facilities for juveniles in custody:

Regional Youth Detention Centers (RYDCs) provide temporary, secure care and supervision to youth who have been charged with offenses or who have been adjudicated delinquent and are awaiting placement.[3]

Youth Development Campuses (YDCs) provide secure care, supervision, and treatment services to youth committed to DJJ custody for the short and long-term.[4]





## SUPPORTING HIGH-RISK YOUTH ON PROBATION

| | Grant | Administered by | Purpose |
|---|---|---|---|
| JJIG | Juvenile Justice Incentive Grants | Criminal Justice Coordinating Council | To maximize the impact on public investment on public safety by reducing the number of out-of-home placements of youth through the use of evidence-based programs. |
| CSG | Community Service Grant | Department of Juvenile Justice | |

## FUNDING OF JJIG AND CSG

| | | Initial* | Current |
|---|---|---|---|
| JJIG | State | $5 million | $7.8 million[6] |
| | Federal | $1 million | $300,000[7] |
| CSG | State | $1.6 million | $2.1 million[8] |
| | **Total** | **$7.6 million** | **$12 million** |

*JJIG was initially funded in 2013 and CSG in 2014

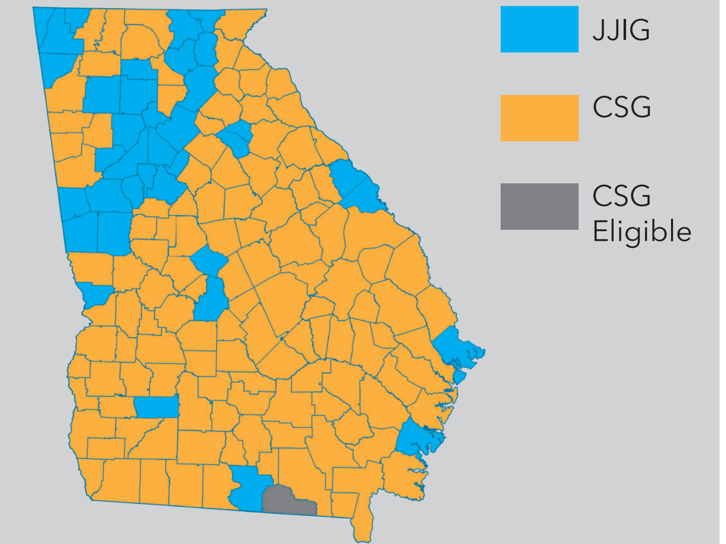
## COST SAVINGS OF JJIG AND CSG

| | |
|---|---|
| Cost per year for out-of-home placement | $90,000+ |
| Number of youth diverted in FY21with a successful outcome | 936 |
| Avoided cost of detaining youth in FY21 due to diversion | $84.2 million |

## IMPLEMENTATION OF JJIG AND CSG

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

- These grants provide funding and technical support for juvenile courts to deliver evidence-based treatment programming for juvenile offenders in their home communities.
- 70% of youth served through JJIG and CSG in FY19 were Black. Black youth made up 52% of juvenile arrests in 2019.[9]




**More than 12,000** youth have received evidence-based services through JJIG or CSG from FY14 to FY21.[10]

## JJIG and CSG OUTCOMES IN GEORGIA[11]

**Out-of-Home Placements**

**78% JJIG**
**69% CSG**

Reduction in out-of-home placements in 2021 compared with FY21 baseline

**Program Completion**

**72% JJIG**
**81% CSG**

Successful completion rate in 2021 for youth in JJIG and CSG programs

**School Engagement**

**95% JJIG**
**91% CSG**

Youth who were actively enrolled in or had completed school in 2021

**In FY21, JJIG served 821 and CSG served 438 at-risk youth across Georgia.**

## JJIG and CSG EVIDENCE-BASED PROGRAMS

| PROGRAM | DESCRIPTION |
|---|---|
| Botvin LifeSkills Training | Group-based intervention that addresses the social and psychological factors that contribute to substance use, deliquency, and violence |
| Brief Strategic Family Therapy | Individual-based family intervention that addresses adolescent behavior problems, family functioning, and prosocial behaviors |
| Connections Wraparound | Individual-based family intervention for probated youth that addresses emotional and/or behavioral problems, and uses youth and family teams to coordinate services |
| Multidimensional Family Therapy | Individual-based family intervention that addresses substance abuse, deliquency, and behavioral/emotional problems, while promoting positive attachments to pro-social supports |
| Multi-Systemic Therapy | Intensive individual-based family intervention that addresses the environmental factors that impact chronic and/or violent youth offenders |
| Aggression Replacement Training | Group-based intervention that addresses aggression and violence by improving moral reasoning and social skill competency |
| Functional Family Therapy | Individual-based family intervention that addresses deliquency, violence, substance use, and/or disruptive behavior disorders by reducing risk factors and increasing protective factors |
| Thinking for a Change | Group-based intervention that addresses the criminogenic thinking of offenders by developing, problem-solving, and social skills |

JJIG Program    JJIG and CSG Program

## OTHER SERVICES AND PROGRAMS

| PROGRAM | DESCRIPTION |
|---|---|
| Youth Tracking Program | Tracking services provides intensive surveillance and monitoring allowing juvenile offenders to remain at home pending further court action |
| High Intensity Team Supervision | Community-based, in-home detention placement alternative for community supervised youth |
| Georgia Interstate Compact for Juveniles | Processes incoming and outgoing supervision transfer from other states, as well as the return of runaways, accused delinquents, absonders or escapees |
| Adult detention facility monitoring | Annual inspection by DJJ at the 173 adult detention facilities that temporarily hold or detain juveniles |
| Gang Prevention | Specialized gang training for employees to serve in the Community Security Risk Group, which enhances the identification, tracking and support to DJJ gang-affiliated youth that enter the Georgia juvenile justice system |

# Georgia Juvenile Justice Process for Delinquency Cases

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.

Georgia classifies offenders as juveniles if they are under the age of 17. It is one of only three states that processes all 17-year-olds as adults (see Raising the Age of Juvenile Court Jurisdiction factsheet). **Superior Court has jurisdiction over juveniles 13-17 who have committed certain violent felonies, including murder, rape, armed robbery with a firearm, aggravated child molestation, aggravated sodomy, aggravated sexual battery, and voluntary manslaughter.**

A child may come into contact with the juvenile justice system through a delinquency or a Child in Need of Services (CHINS)* complaint. The following is a map of the delinquency process.

**Complaint**
Citizen or law enforcement investigation

**Complete a Detention Assessment Instrument (DAI)**

**Release to Parents/Guardians or Legal Custodian**

**Temporary Detention**
Child can be held for 2 business days if there is no warrant.
Child can be held for 5 business days if there is a warrant.

**Informal Adjustment**

Within 30 days

**Superior Court**

Superior Court has jurisdiction over a child if indicted in Superior Court or transferred from Juvenile Court

**Detention/Probable Cause Hearing**

**Superior Court**

Declined prosecution in Superior Court*

Within 72 hours

**Deliquency Petition**

**Transfer Hearing**
Transferred if certain conditions are met

Within 5 days if in custody

Within 60 days if released

**Investigation**

**Adjudication Hearing**

*Prior to indictment, the district attorney can decline prosecution in Superior Court and cause the petition to be filed in juvenile court.

**Disposition Hearing**

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

**Commitment to DJJ**
For up to 2 years, DJJ has discretion on placement, but youth are typically placed in YDC.

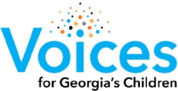
**Probation**
Child remains with parent/guardian at home. Probation officer assigned to supervise while in community.

**Restitution/Fines**
Court may determine amount.

**Other**
Mandatory school attendance or completion, community service, counseling, suspension, or prohibit issuance of driver's license.

**Post-Disposition**

*For more information regarding the CHINS process, see the Georgia Juvenile Justice Process for Children in Need of Services factsheet.



# Terms to Know:

**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 deliquency dependency and CHINS (Children in Need of Services); standard is beyond a reasonable doubt in delinquency proceedings. (OCGA 15-11-181; OCGA 15-11-441; OCGA 15-11-582)

**Community-based risk reduction program**: Programming designed to identify children and families at risk of future court-involvement for the purpose of developing and implementing intervention actions or plans and providing services and resources. (OCGA 15-11-38)

**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 or court intake staff at the time a youth is arrested or picked up by law enforcement.

**Disposition Hearing**: Proceeding to determine which 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". In Delinquency and CHINS cases, the disposition proceeding will also determine if the child is in need of treatment, rehabilitation, or supervision and may include community service and/or restitution. (OCGA 15-11-210; OCGA 15-11-600; OCGA 15-11-442)

**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." (OCGA 15-11-2(35))

**Informal Adjustment**: An informal adjustment is the disposition of a case other than by formal adjudication and disposition. (OCGA 15-11-2(39)) It often involves referral to a community-based risk reduction program.

**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 obtain 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. (OCGA 15-11-590) During this time, a Guardian Ad Litem ma be appointed to represent the best interest of the child.

**Probation**: Probation is the release from detention, subject to a period of good behavior under supervision of a course officer. (OCGA 15-11-601)

**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. (OCGA 15-11-561)

**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.[1]

**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.[2]

Rev. 11/2022
Sources: bit.ly/3jj07sP

# Georgia Juvenile Justice Process for Children in Need of Services (CHINS)

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: (O.C.G.A . 15-11-2)

- 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

Under Georgia law, a parent, guardian, legal custodian, children meeting certain criteria may be brought before the court as a Child in Need of Services (CHINS). In these cases, services are provided in an attempt to divert the child away from delinquency*. The following is a map of the CHINS process.

**Complaint**
Child's parents, guardian or legal custodian, a DFCS employee, school official, law enforcement officer, guardian ad litem, or attorney

**Released to Parents/Guardians or Legal Custodian**

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

**Division of Family and Children Services**
If a youth is placed in foster care, the child is required to have a case plan.

72 hours

**Department of Juvenile Justice**
If a youth is placed in a secure or nonsecure DJJ facility (for no longer than 24 hours), then:
1) a DAI must have been conducted,
2) statute criteria must apply (e.g., child is "alleged runaway, habitually disobedient, and/or failed to appear at a scheduled hearing")

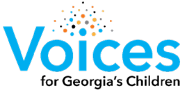
24 hours

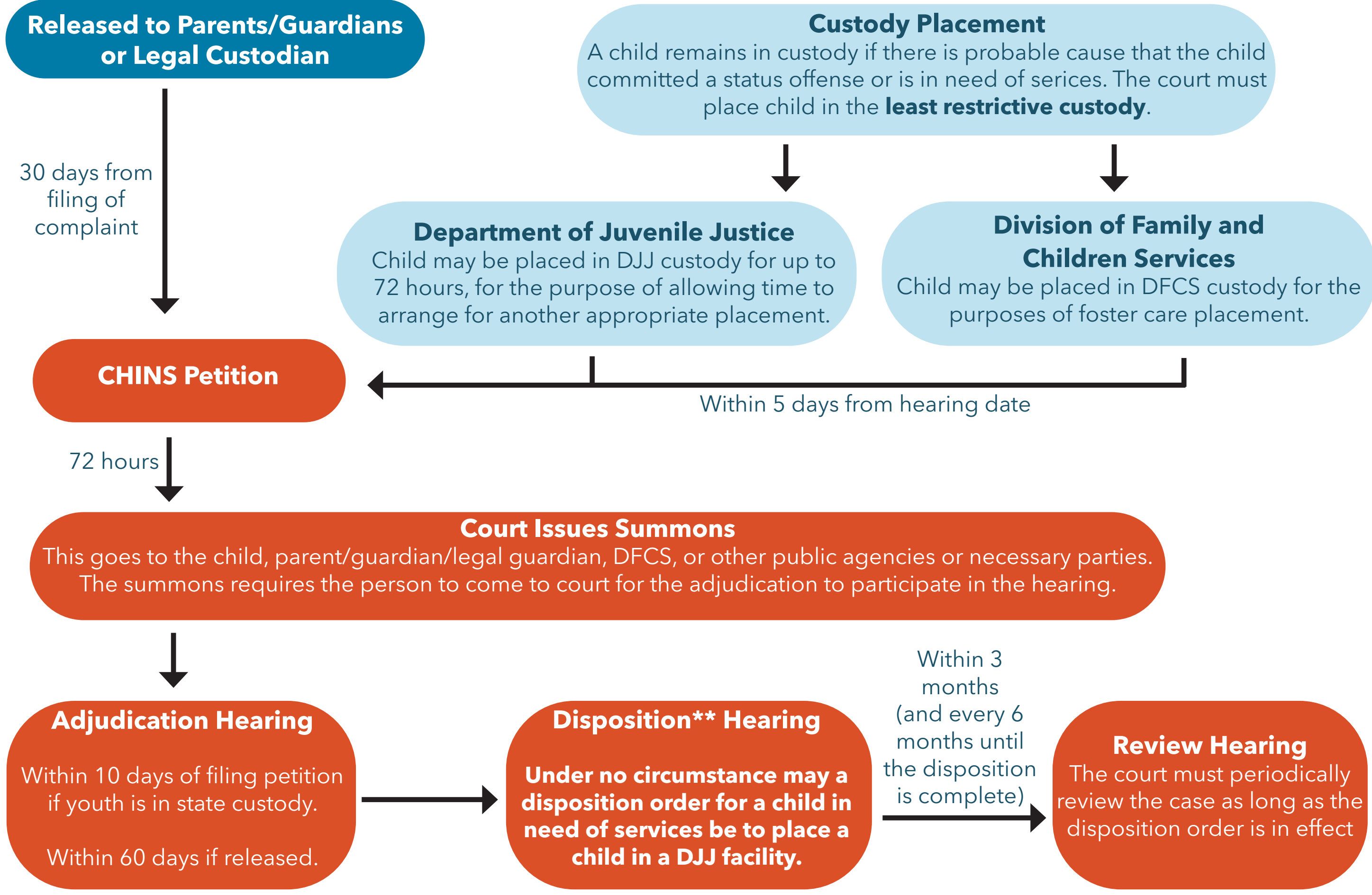
**Continued Custody Hearing**
The court must determine whether there is probable cause to believe that the child has committed a status offense or is otherwise in need of services. This hearing must decide **custody placement** or **release**. (See next page for expanded process.)

**Jump to CHINS Petition on p. 2**

**Jump to Custody Placement on p. 2**

*For more information regarding the delinquency process, please visit our Georgia Juvenile Justice Process for Delinquency Cases factsheet.






**Potential dispositions include: remain at home with or without conditions; probation; community service; restitution; or after or evening school programming. These are often a condition of probation.

## Terms to Know:

**Case Plan:** If a child is alleged or adjudicated to be a child in need of services and is placed in foster care, the child shall be required to have a case plan which addresses the child and parents' strengths and needs, the problems contributing to the child's behaviors, identification of the least restrictive placement for the child, and an assessment of services availabile to the child.

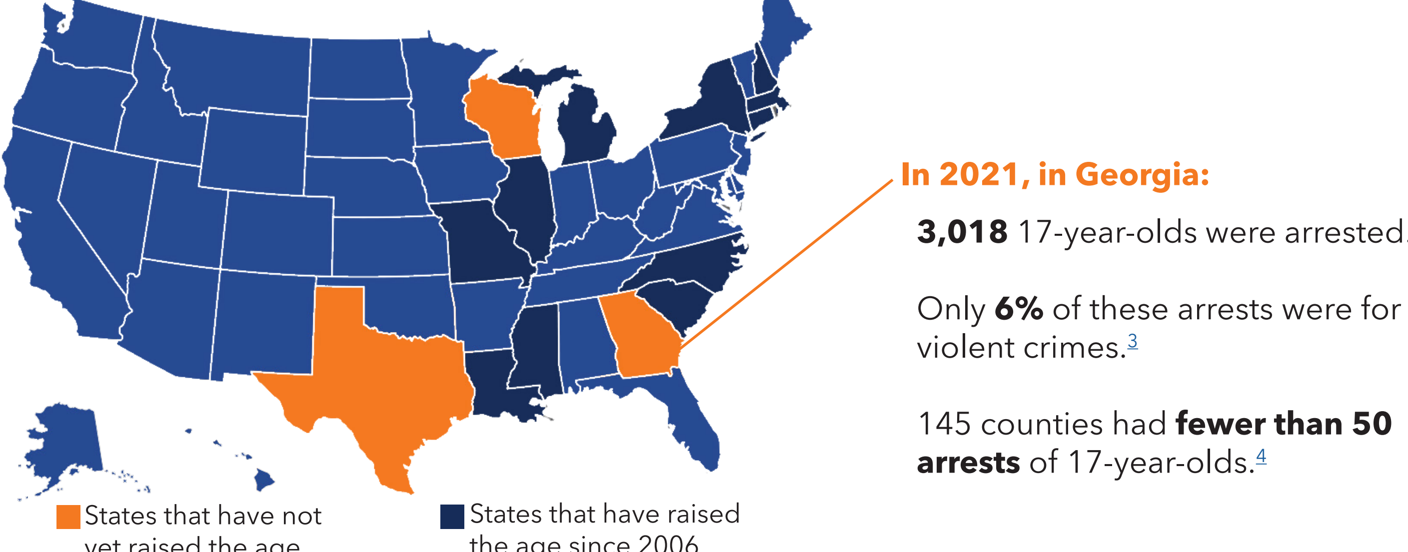
**Least Restrictive Custody**: The level of custody which safeguards the child's best interests and protect the community (i.e. release to parent, foster care, other court-approved placement that is not secure, or secure residential facility). (OCGA 15-11-404)

**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. (OCGA 15-11-2(49))

**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. (OCGA 15-11-2(67))

# Raising the Age of Juvenile Court Jurisdiction

Georgia is **one of only three states** (along with Texas and Wisconsin) that processes all 17-year-olds as adults in the criminal justice system, sending them to adult court rather than through the juvenile justice system.[1]




**In 2021, in Georgia:**

**3,018** 17-year-olds were arrested.[2]

Only **6%** of these arrests were for violent crimes.[3]

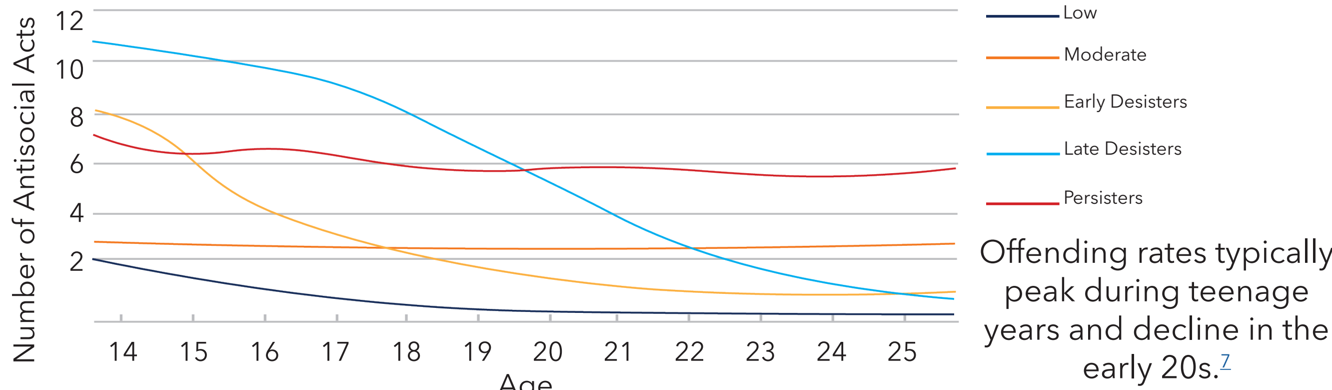
145 counties had **fewer than 50 arrests** of 17-year-olds.[4]

**If Georgia raises the age of juvenile court jurisdiction to 18, youth as young as 13 charged with certain violent felonies may still be tried as adults. Such crimes include murder, rape, armed robbery committed with a firearm, aggravated child molestation, aggravated sodomy, aggravated sexual battery, and voluntary manslaughter.**

## WHY RAISE THE AGE OF JUVENILE COURT JURISDICTION?

A growing body of research shows 17-year-olds are still in the **adolescent phase** of brain development, a fundamentally different stage than that of an adult. Executive function skills, which allow for self-control, regulating emotions, and understanding different points of view,[5] are not yet fully developed. When compared to adults, 17-year-olds are:[6]

- less capable of impulse control
- less able to regulate their emotions
- less able to consider the consequences of their actions
- more easily influenced by their environment
- more likely to change course if given the right support




Offending rates typically peak during teenage years and decline in the early 20s.[7]

The U.S. Supreme Court* finds adolescents are **more capable of change** than adults and should be given the **opportunity to rehabilitate**.[8]

**Graham v. Florida* (2010)

## JUVENILE VS. ADULT CRIMINAL JUSTICE SYSTEMS

Juvenile courts and juvenile court-ordered plans take a more holistic approach to rehabilitation when compared to the adult criminal justice system. By using a youth's naturally high capacity for change and growth, we can **redirect behavior** into more healthy and socially positive outcomes. In short, responding to a 17-year-old's misbehavior in **developmentally appropriate ways** can reduce the likelihood that the child will commit offenses as an adult.[9]

The juvenile justice system makes use of:

- Mental health treatment/substance abuse counselors
- Evidence-based programs that aid in social skills development, cognitive restructuring, problem-solving skills, and crisis management
- Career development and job readiness training
- Education opportunities
- Diversion programs
- Accountability courts

**Juvenile courts prepare youth for adulthood while recognizing they are still children.**

### REDUCING DETENTION RATES WHILE IMPROVING PUBLIC SAFETY

Evidence-based alternatives to detention have been proven to reduce the likelihood of criminal activity.[10] By employing these strategies, Georgia has seen a **42% reduction** in juvenile incarceration since 2013.[11]

Georgia's Juvenile Justice Incentive Grants (JJIG) and Community Service Grants fund the delivery of evidence-based programs proven effective for juveniles: Functional Family Therapy, Thinking for a Change, Aggression Replacement Training, Multisystemic Therapy, Botvin LifeSkills Training, Brief Strategic Family Therapy, and Connections Wraparound.[12] Together these grants make these therapies available to juvenile court jurisdictions encompassing 99% of Georgia's at-risk youth population.[13]

#### JJIG IN 2021

Served **1,259** youth at moderate or high risk to reoffend[14]

**71%** successfully completed their evidence-based programs[15]

**93%** were actively enrolled in or had completed high school.[16]

**66%** reduction in out-of-home placements in JIIG-participating counties.[17]

#### CSGs IN 2021

Served **438** youth at moderate or high risk to reoffend[18]

**74%** successfully completed their evidence-based programs[19]

**91%** were actively enrolled in or had completed high school.[20]

**69%** reduction in out-of-home placements in JIIG-participating counties.[21]

## OUTCOMES FROM RAISING THE AGE

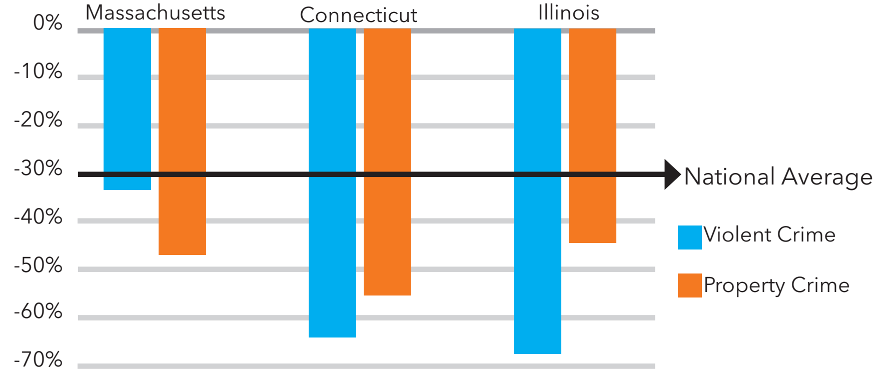
States that have recently raised the age as part of their juvenile justice reform efforts have experienced **no** or **minimal cost increases** while lowering arrest and detention rates.

### NORTH CAROLINA: OUTCOMES FROM YEAR TWO

- As of **December 2019**, 16 and 17-year-olds in North Carolina go into the juvenile court system.[22] [23]
- The number of criminal complaints received dropped by **5.4%** from 2020 to 2021.[24]
- **91%** of offenses committed by 16 and 17-year-olds were non-violent; more than half were minor offenses.[25]

## RAISING THE AGE: EFFECT ON JUVENILE ARRESTS

Connecticut, Illinois, and Massachusetts have seen significant drops in juvenile arrests after raising the age up to 18.[26]




## FAST FACTS

- Nationally, youth are **36 times** more likely to commit suicide in an adult facility than a juvenile facility.[27]
- In 2020, the average daily caseload of youth in Georgia receiving mental health services was **656**.[28]
- From 2014-2018, more than **8,000 youth** have received individual or group therapy through evidence-based models delivered by the Georgia juvenile justice system.[29]
- Data show lower level offenders, when confined with higher level offenders, emerge from incarceration **more inclined** to conduct criminal activity.[30]

## PREPARING FOR THE FUTURE

The Georgia Department of Juvenile Justice (DJJ) is the 181st school district in the state. **Georgia Preparatory Academy** is the middle and high school within the DJJ school system with 29 campuses across the state in detention and transitional centers. An online version of the Georgia Preparatory Academy is available for youth under DJJ supervision who are unable to return to public high school. Additionally, **Pathway to Success** is an adult education program that offers GED instruction and testing. The **Connections Graduate Program** focuses on re-entry, work skills development, and post secondary options.[31]

# Gang and Youth Violence Prevention

**Approximately 40% of gang members in the United States are 18 years old or younger.[1]**

### What is a gang?

Georgia law states a “criminal street gang” is any organization, association, or group of three or more persons who engage in criminal gang activity (e.g., rape, racketeering, criminal tresspass, or any offense that involves violence, use of a weapon, or possession of a weapon, among others).

A gang can be established by a common name or identifying signs, symbols, tattoos, graffiti, attire, or other distinguishing characteristics.[2]

### What is youth violence?

Youth violence is the intentional use of force or power by 10- to 24-year-olds to threaten or harm others.[3] Committing youth violence increases the risk for:[4]

Academic challenges and school drop-out

Substance use

Depression

Suicide

Behavioral and mental health conditions

**Most youth who commit violence lack positive supports from parents, schools, peers, and their community.**

### RISK FACTORS

Risk factors for youth violence and gang membership include:[5]

- Child abuse and neglect
- Academic problems or school discipline issues
- Parent-child separation/Lack of parent involvement
- Poverty
- Housing instability
- Aggressive, violent, or delinquent behavior
- Youth alcohol or drug use
- Mental health conditions
- Exposure to community violence
- Parental substance abuse and/or parental criminality
- Racial prejudice

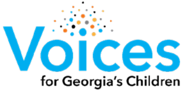
### PROTECTIVE FACTORS

Protective factors against youth violence and gang membership include:

- Parental involvement
- Family support system
- Coping and interpersonal skills
- Positive social connections
- Peer support
- Academic achievement
- Reducing alcohol and drug use

**The more risk factors a young person experiences, the greater their chance of committing youth violence, including through gang membership;[6] however, exposure to protective factors reduces this chance.[7]** Given this, prevention strategies are aimed at increasing these crucial supports in a youth’s life: security, connectedness, and safety.

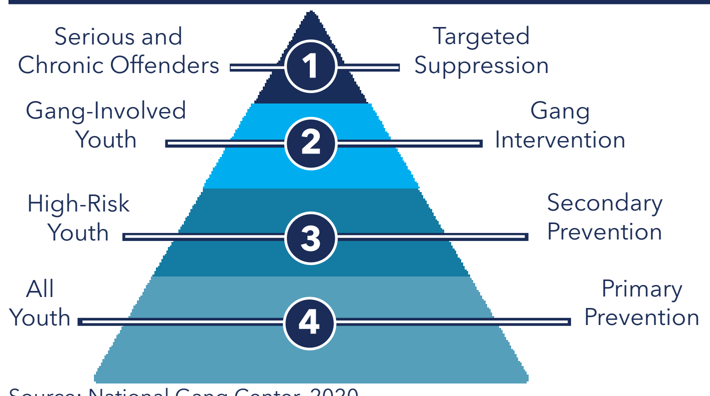




## PREVENTION STRATEGIES

| STRATEGY | APPROACH | GEORGIA PROGRAMS AND SUPPORTS EXAMPLES |
|---|---|---|
| Promote family environments that support healthy development | • Early childhood home visitation<br>• Parenting skill and family relationship programs | DPH and DFCS home visiting and parental skill-building, and Strengthening Families Georgia |
| Provide quality education early in life | • Preschool enrichment with family engagement | Georgia Pre-K, Head Start, CAPS, and Quality Rated Child Care |
| Strengthen youth's skills | • Universal school-based programs | Georgia Apex Program, Youth Mental Health First Aid and Teen Mental Health First Aid (tMHFA), Positive Behavioral Interventions and Supports, and comprehensive school-based health centers. |
| Wrapping children who are at risk of becoming gang-involved with an array of supportive services | • Cognitive behavioral treatment | Cobb County Juvenile Court R.I.S.I.N.G. Program diverts participants from the juvenile justice system by offering a specialty court that has been developed based on an accountability court structure. |
| Connect youth to caring adults and activities | • Mentoring programs<br>• Afterschool programs | Boys and Girls Club, 21st Century Community Learning Centers, DBHDD's Prevention Clubhouses, DFCS's Afterschool Care Program, YMCAs, and 4-H |
| Create protective community environments | • Modify the physical and social environment<br>• Reduce exposure to community-level risks<br>• Street outreach and community norm change | Community-oriented policing, afterschool programs and community centers like the @PromiseCenter, Front Porch Community Resource Center, Juvenile Detention Alternatives Initiative, norms change programs like CureViolence (happening in some Southwest Atlanta neighborhoods) |
| Intervene to lessen harms and prevent future risk | • Treatment to lessen the harms of violence exposures<br>• Treatment to prevent problem behavior and further involvement in violence<br>• Hospital-community partnerships | Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); DJJ's evidence-based programs for cognitive restructuring, problem-solving, and crisis management; DJJ's Georgia Preparatory Academy, Pathways to Success and Connections Graduate Programs, offering educational and vocational opportunities; and mental health and substance abuse treatment through DJJ |

## MULTI-TIERED SYSTEM OF SUPPORTS FOR GANG AND YOUTH VIOLENCE PREVENTION AND INTERVENTION




Source: National Gang Center, 2020

**Tier One**: Targeted enforcement and prosecution through a gang accountability court. May account for 4-8% of offenders.

**Tier Two**: Intensive treatment, like group therapy, family therapy, mentoring, and cognitive-behavioral therapy.[8]

**Tier Three**: Less intensive levels of the same interventions as used for Tier Two.

**Tier Four**: Primary prevention strategies, like school-based programs, mentoring, and afterschool programs.[9]

## RECOMMENDATIONS

### PREVENTION

- Ensure that training on trauma-informed care and implicit/explicit bias is provided to all stakeholders who engage with children in any way (e.g., law enforcement, school resource officers, school faculty and staff, child care and afterschool providers, DJJ staff, child welfare and foster care settings.)
- Increase the number of mental health and social work professionals in schools.
- Expand federal and state funding to afterschool and summer learning programs to increase access and ensure affordability.
- Ensure that school codes of coduct are evidence-based, trauma-informed, free of bias, and include input from local child-serving stakeholders (i.e. mental health providers, social workers, juvenile courts).

### INTERVENTION

- Increase funding for restorative programs for children and youth (e.g., Children in Need of Services (CHINS), Juvenile Incentive Grant Program, and Community Service Grants Program).
- Strengthen partnerships between community-based afterschool programs, school districts, juvenile courts, and other community partners to align services for young people through Local Interagency Planning Teams or truancy prevention programs.
- Promote the use of mentoring and apprenticeships programs (e.g. partner with local chambers of commerce, rotary clubs, chapters of 100 Black Men, Big Brothers Big Sisters, or other civically focused organizations).

### RESTORATION

- Raise the maximum age of juvenile court jurisdiction up to 18.
- Expand and develop effective juvenile gang accountability courts, including wraparound services that support the youth and the youth’s family.
- Increase access to evidence-based practices for mental and behavioral health in schools.
- Increase access to educational and work remediation.

# Juvenile Detention Alternatives Initiative

The Juvenile Detention Alternatives Initiatives (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 39 states, including Georgia, and is housed within the Council of Juvenile Court Judges.[1]

The purpose of the JDAI is to reduce secure confinement through the use of alternatives that ensure public safety while accomplishing the objectives of secure confinement.[2]

## Objectives of JDAI

- To eliminate the inappropriate or unnecessary use of secure detention
- To minimize failures to appear and incidents 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 of JDAI

- 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

## JDAI NATIONWIDE OUTCOMES[3]

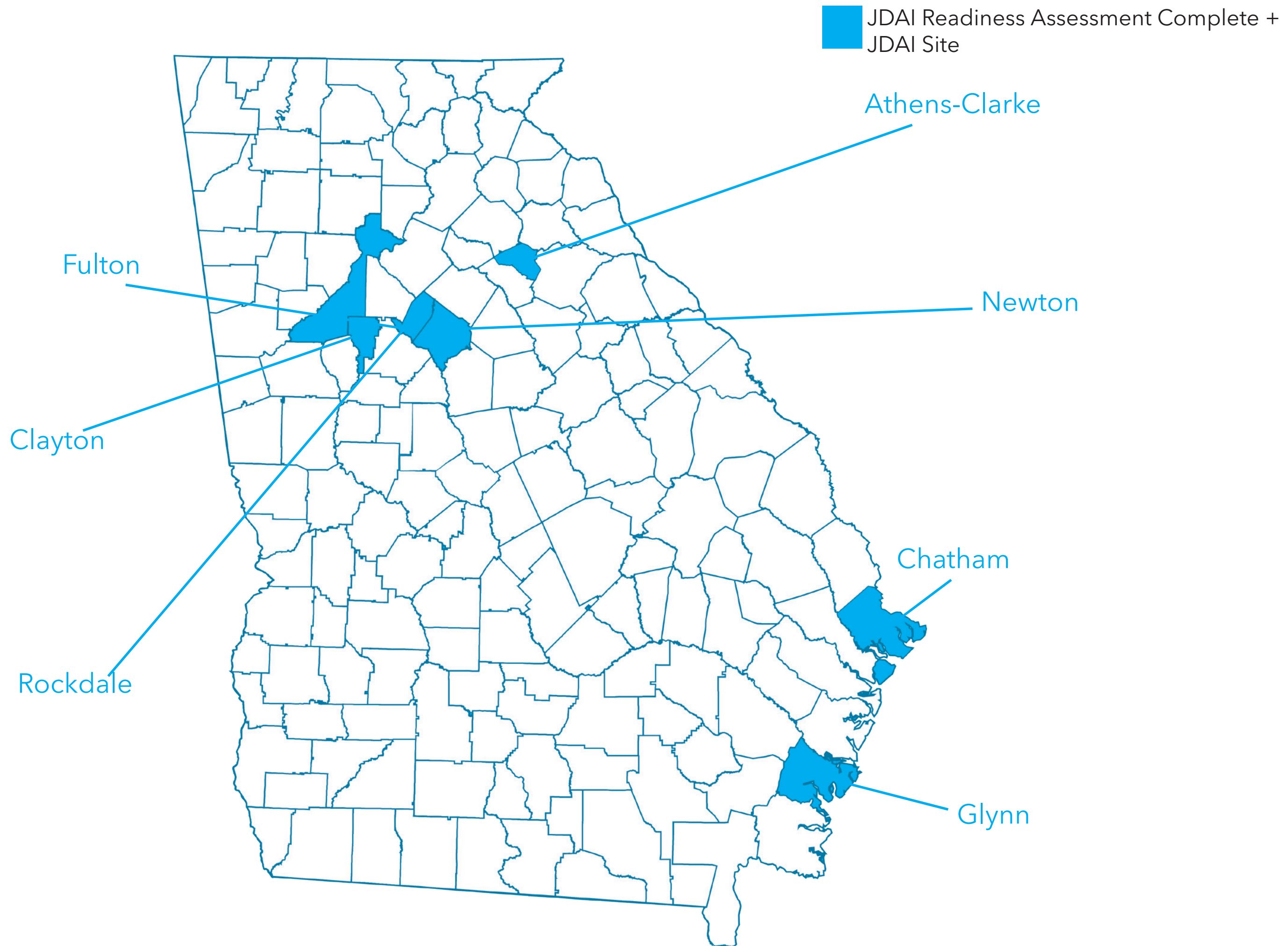
As of 2016, there were 197 JDAI sites in the United States, representing 300 local jurisdictions and 10 million youth ages 10 to 17. Recent data gathered from these sites suggests the following trends for JDAI-involved areas:

| Indicator | Pre-JDAI Baseline | 2016 Data | % Change | Trend |
|---|---|---|---|---|
| Average Daily Population (ADP) | 8,780 | 4,967 | -43% | Reduced reliance on juvenile detention |
| Annual Admissions | 188,948 | 95,939 | -49% | |
| State Commitments | 17,457 | 7,432 | -57% | Reduced commitments to state custody |
| Felony Petitions | 79,391 | 48,770 | -39% | Reduced juvenile crime |
| Delinquency Petitions | 42,562 | 29,770 | -31% | |
| Percent of ADP that are youth of color | 75% | 80% | | Remaining challenges with racial equity and overrepresentation of youth of color |
| Percent of annual admissions that are youth of color | 70% | 76% | | |
| Percent of state commitments that are youth of color | 70% | 83% | | |

## THE JDAI IN GEORGIA

In 2015, former Governor Nathan Deal and the Georgia Criminal Justice Reform Council established the State Steering Committee for JDAI. The committee consisted of juvenile court judges and representatives from stakeholder organizations and was tasked with improving the delivery of juvenile justice services and expanding JDAI efforts throughou the state. While some communities instituted JDAI as far back as 2003, statewide rollout of JDAI began in 2016 after an initial phase of assessment.[4]

Seven counties in Georgia are JDAI sites and all have completed JDAI Readiness Assessments.[5]

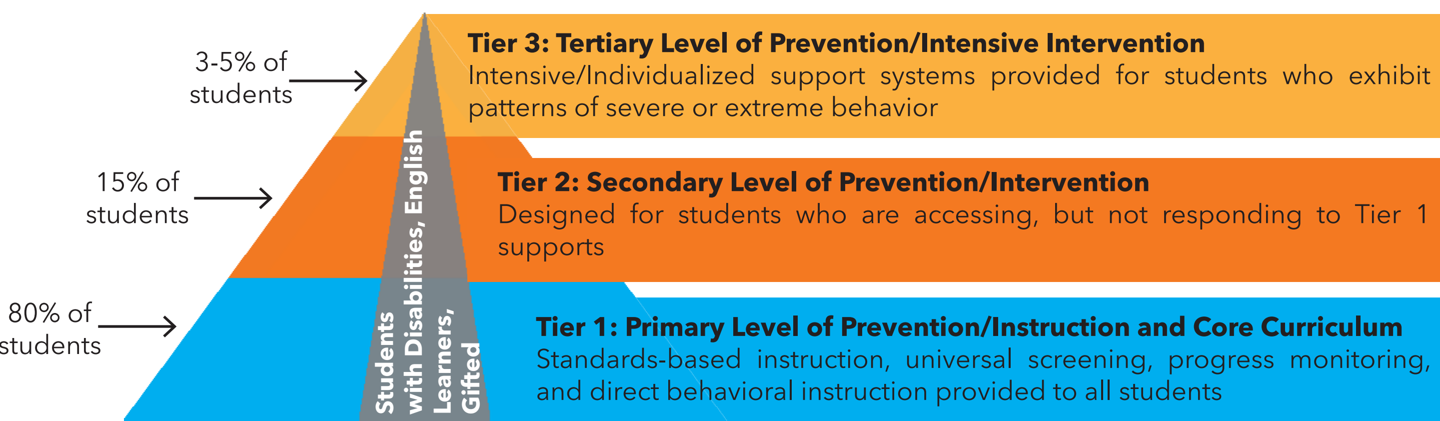



Rev. 11/2022
Sources: bit.ly/3YD6OWX

# Positive Behavioral Interventions and Supports

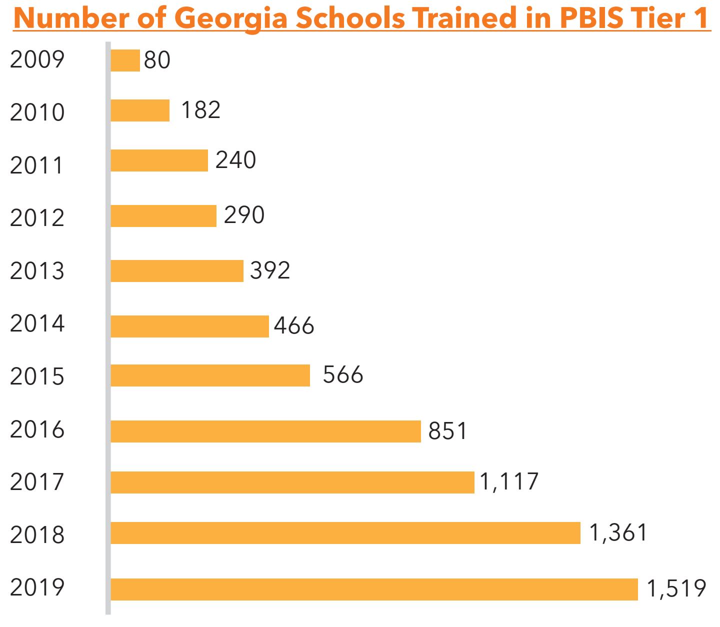
Positive Behavioral Interventions and Supports, or PBIS, is an evidence-based, data-driven framework proven to reduce disciplinary incidents, increase the sense of safety, and support improved academic outcomes in schools.[1]

PBIS schools apply a multi-tiered approach (pictured below[2]) 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. In turn, teachers and staff enjoy a more welcoming environment where they may focus on instruction as opposed to discipline.[3]

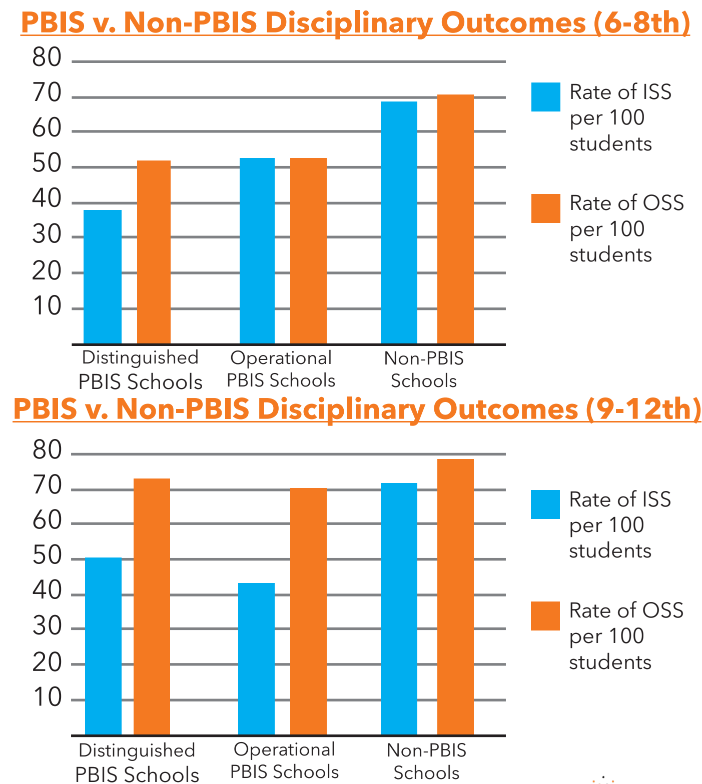



## PBIS in Georgia

In 2007, the Georgia Department of Education (GaDOE), Division for Special Education Services, established the Positive Behavior Support Unit to provide professional learning and technical assistance in tiered behavioral supports to address the high rates of exclusionary disciplinary practices used in Georgia K-12 schools, including the disproportionate rates of suspension of students within disabilities.[4] In PBIS-trained schools, **11,746 fewer students** were assigned out-of-school suspension in 2018 than in 2014.[5]




The GaDOE is backlogged due to the COVID-19 pandemic and has not prepared reports for 2019 to present. GaDOE reported that, as of September 15, 2022, 1,424 schools were trained in PBIS and seeking support from GaDOE.



Voices for Georgia's Children

# INSERT BANK TAB: BUDGET AND WORKFORCE

# State Agency Salaries for Child-Serving Workers

Child-serving state agency workers help Georgia's children and families get support for their **most basic needs**.

## Child-Serving Agency Entry-Level Salaries

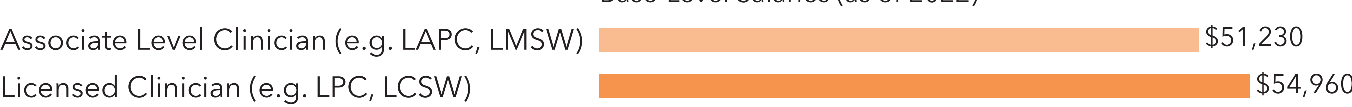
**$65,000**
$60,000
$55,000
$50,000
$45,000
$40,000
$35,000
$30,000
$25,000
$20,000
$15,000
$10,000
$5,000
$0

- DBHDD Associate Level Clinician (e.g. LAPC, LMSW)
- DBHDD Licensed Clinician (e.g. LPC, LCSW)
- DFCS Child Welfare Worker w/Bachelor Degree
- DFCS Child Welfare Worker w/Masters Degree
- DFCS Food Stamps and Family Medicaid Worker
- DECAL Pre-K Teacher (with a 4-year degree)
- DJJ Probation Officer
- DJJ Corrections Officer
- DJJ Probations Specialist
- DPH Registered Nurse

## Department of Behavioral Health and Developmental Disabilities

Clinicians and social workers at Community Service Boards (CSBs), which are safety net mental health providers based in communities, provide direct services to youth in the community and sometimes in schools. These services include individual, group, and family therapy. The following salary information is specific to DBHDD (hospitals and community-based providers) and does not include the CSBs. However, many CSBs use the state salary structure, through their respective average starting salaries will likely vary.

Base-Level Salaries (as of 2022)[1]

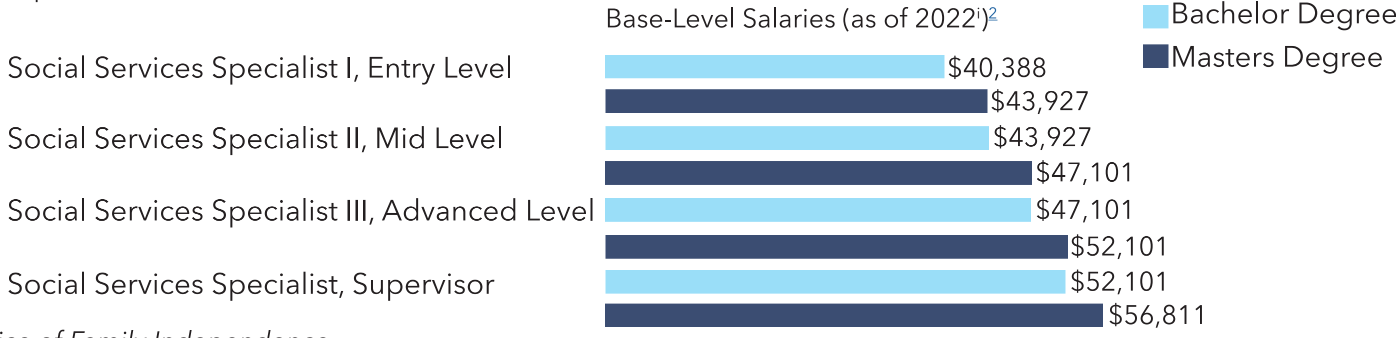



*Note: These salary increases are a result of funding approved by the Georgia state legislature during the 2022 legislative session to adjust for cost-of-living and/or provide pay increases to state agency employees, teachers, and nurses.*

## Department of Human Services, Division of Family and Children Services (DFCS)

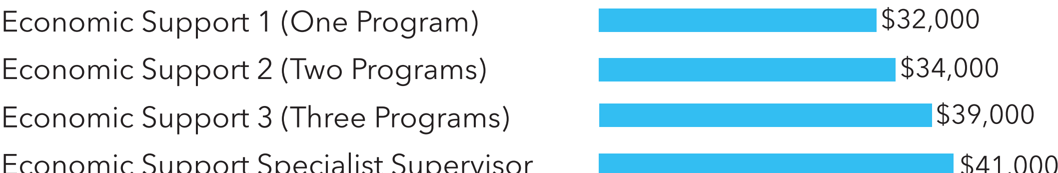
*Child Welfare*

Child welfare workers provide investigative and comprehensive case management for children experiencing abuse or neglect. They assess safety concerns, identify physical, educational, and behavioral needs of the child, parents, and foster parents, and ensure these needs are addressed.



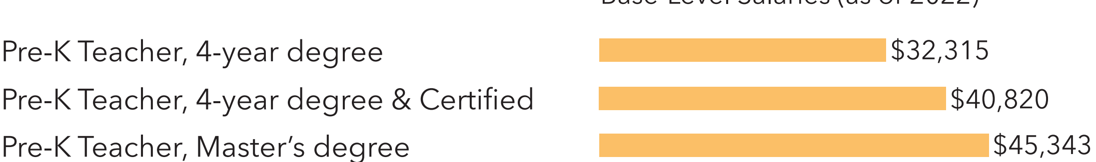

*Office of Family Independence*

Office of Family Independence workers process SNAP/Food Stamp and Family Medicaid cases. They determine applicant eligibility and process applications.




## Department of Early Care and Learning

Georgia Pre-K teachers teach 4- and 5-year-old children, 5 days a week, 180 days per year. The school-day is 6.5 hours, and sometimes longer to provide before- and after-school care.




## Department of Juvenile Justice (DJJ)

DJJ staff are responsible for youth under DJJ supervision, both in detention facilities and on probation in communities.

Base-Level Salaries (as of 2022)[5]

Probation Officer I, Entry Level $37,130

Juvenile Corrections Officer I, Entry Level $37,730

Juvenile Probation Specialist, Entry Level $42,000

## Department of Public Health (DPH)

DPH Registered Nurses provide nursing care, including for populations with special needs during natural disasters and emergencies.

[i] Salaries were effective April 1, 2022

[ii] Amounts shown reflect the midpoint salary ranges for the positions listed.

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Sources: bit.ly/3v37uqW

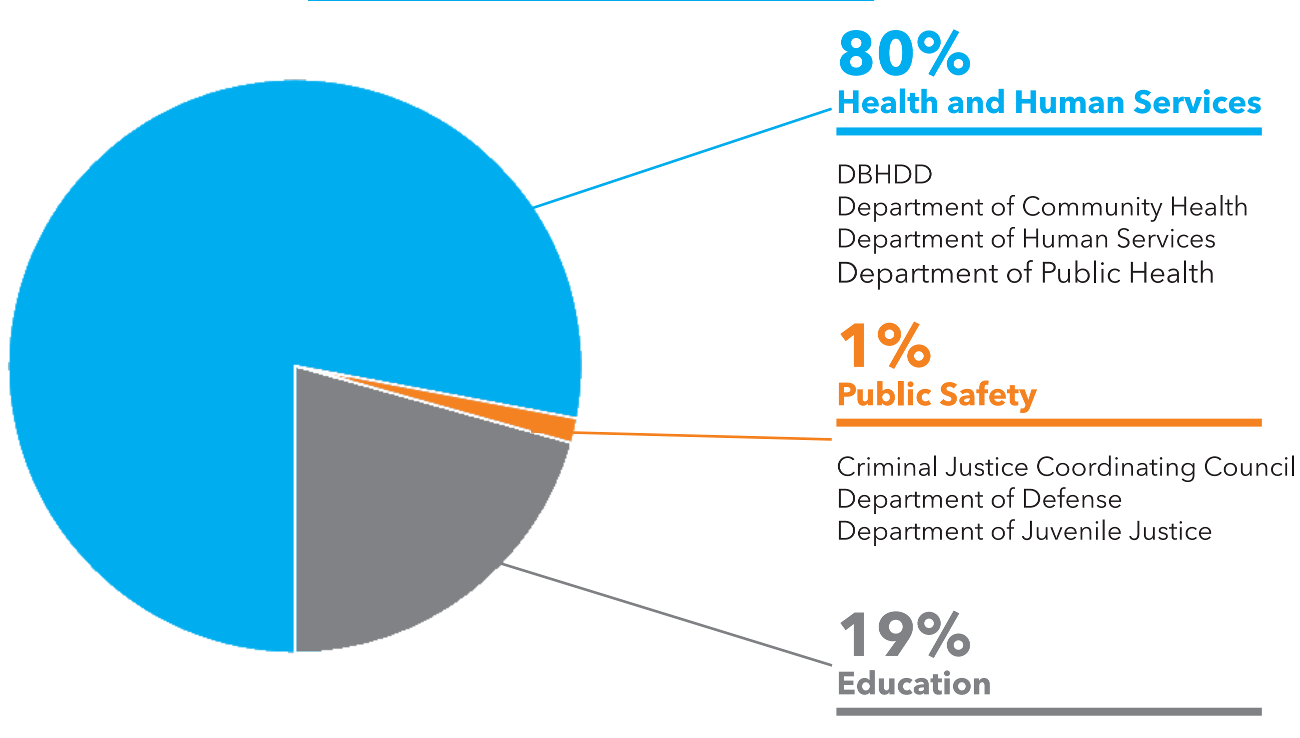
# How Federal Dollars are Used in Georgia

**In State Fiscal Year 2023,[1] federal funds* will go to nine state agencies serving Georgia's children:**

| | STATE AGENCY | SFY 2023 BUDGET |
|---|---|---|
| DCH | Department of Community Health | $9,473,345,840 |
| DHS | Department of Human Services | $1,066,499,726 |
| DPH | Department of Public Health | $395,951,809 |
| DBHDD | Department of Behavioral Health & Developmental Disabilities | $149,263,138 |
| DECAL | Department of Early Care and Learning | $475,649,841 |
| DOE | Department of Education | $2,096,148,714 |
| CJCC | Criminal Justice Coordinating Council | $101,677,799 |
| DOD | Department of Defense | $93,371,709 |
| DJJ | Department of Juvenile Justice | $10,760,962 |
| | **TOTAL** | **$13,865,669,538** |

*Reported budget totals do not include Federal COVID-19 relief funds.

## Federal Funding by Policy Area



| COVID-19 Relief Funding Allocations[2] | | | |
|---|---|---|---|
| **Active Grant Program** | **Funding Source** | **Description** | **Budget** |
| Capital Projects Fund | American Rescue Plan Act (ARPA) | Provides grants to support broadband infrastructure projects. Approximately 70,000 locations are estimated to be served by funded projects.[3] | $250 million |
| Coronavirus State and Local Fiscal Recovery Funds | ARPA | Addresses negative economic impacts of the public health emergency, and increases investment in water, sewer, and broadband infrastructure. | $4.8 billion |
| Georgia Investments in Housing Grants | ARPA | Supports nonprofits that are 501(c)(3) or 501(c)(19) tax-exempt organizations who provide affordable housing and aid individuals experiencing homelessness. | $100 million |
| Governor's Emergency Education Relief Fund | Coronavirus Aid, Relief, and Economic Security (CARES) Act/Coronavirus Response and Relief Supplemental Appropriations (CRRSA) Act) | Provides support through grants to local educational agencies (LEAs), institutions of higher education (IHEs), and other education related entities with emergency assistance. | $47 million |
| Homeowner Assistance Fund | ARPA | Aids homeowners who have experience financial hardship due to the pandemic with mortgage payments, homeowner's insurance, utility payments, and other specified purposes. | $354 million |
| Improving Neighborhood Outcomes in Disproportionality Impacted Communities | ARPA | Supports projects that promote improved health and safety outcomes (e.g., green spaces, recreational facilities, sidewalks). | $250 million |
| Judiciary Grant | ARPA | Used to combat violent crime and help support the Georgia judiciary's recovery from COVID-19 with funding to address court backlogs in cases with a primary focus on serious violent felonies. | $110 million |

## STATE PROGRAMS RECEIVING FEDERAL FUNDING

### Health and Human Services — $ 11,085,060,513

| Agency | Programs | Programs |
|---|---|---|
| **DBHDD** | Community Mental Health Services Block Grant<br>Medical Assistance Program (Medicaid) | Sub. Abuse Prevention and Treatment Block Grant |
| **DCH** | Medicaid Assistance Program (Medicaid) | State Children's Insurance Program |
| **DHS** | Medicaid Assistance Program (Medicaid)<br>Social Services Block Grant<br>Temporary Assistance for Needy Families<br>CAPTA, Child Care and SNAP | Title IV-E: Adoption Assistance and Foster Care<br>Title IV-B: Promoting Safe and Stable Families<br>Title IV-D: Child Support Enforcement |
| **DPH** | Infants and Toddlers with Disabilities Grant<br>Maternal and Child Health Services Block Grant<br>Temporary Assistance for Needy Families | Preventive Health and Health Services Block Grant<br>Women, Infants, and Children Program<br>Immunizations and Vaccines for Children Grant |

### Public Safety — $ 205,810,470

| Agency | Programs | Programs |
|---|---|---|
| **CJCC** | Temporary Assistance for Needy Families<br>Family Violence Prevention and Services Act<br>Edward Byrne Memorial Justice Assistance Grant<br>Residential Substance Abuse Treatment for Prisoners<br>Paul Coverdell Forensic Science Improvement Grants* | Juvenile Justice and Deliquency Prevention<br>VOCA Victim Assistance Formula<br>VOCA Victim Compensation Formula<br>Sexual Assault Services Formula Grant<br>STOP Violence Against Women Formula Grant |
| **DOD** | STARBASE<br>National Guard Youth Challenge and Job Challenge | United States Department of Agriculture |
| **DJJ** | Education<br>National School Lunch Program<br>Re-Entry/2nd Chance | Residential Substance Abuse Treatment<br>Title IV-E: Foster Care |

**denotes grants that do not benefit children but contribute to the total federal funds received*

### Education — $ 2,574,798,555

| Agency | Programs | Programs |
|---|---|---|
| **DECAL** | Child and Adult Care Food Program<br>Child Care and Development Block Grant<br>Child Care Development Fund<br>Head Start<br>National School Lunch Program | Preschool Development Grant<br>Race to the Top: Early Learning Challenge Grant<br>State Administrative Expenses for Child Nutrition<br>Team Nutrition Grants |
| **DOE** | 21st Century Community Learning Centers<br>Career and Technical Education<br>Charter Schools<br>Child Nutrition Discretionary Grants<br>Comprehensive Literacy Development<br>Education for Homeless Children and Youth<br>Education for Migratory Children<br>English Language Acquisition State Grants<br>Fresh Fruits and Vegetables Program<br>Grants for State Assessments and Related Activities<br>Maternal and Child Health Services Block Grant<br>Mathematics and Science Partnerships<br>Migrant Education Coordination Programs<br>National Assessment of Educational Progress | National School Lunch Program<br>Race to the Top: Early Learning Challenge Grant<br>Rural Education<br>School Breakfast Program<br>School Improvement Grants<br>Special Education Grants<br>Special Education Grants to States<br>Special Milk Program for Children<br>State Administrative Expenses for Child Nutrition<br>Student Support and Academic Enrichment Program<br>Substance Abuse and Mental Health Services<br>Supporting Effective Instruction State Grant<br>Title I Grants to Local Education Agencies<br>Title I Neglected and Delinquent Children and Youth |

**Some grants/programs benefit populations other than children*

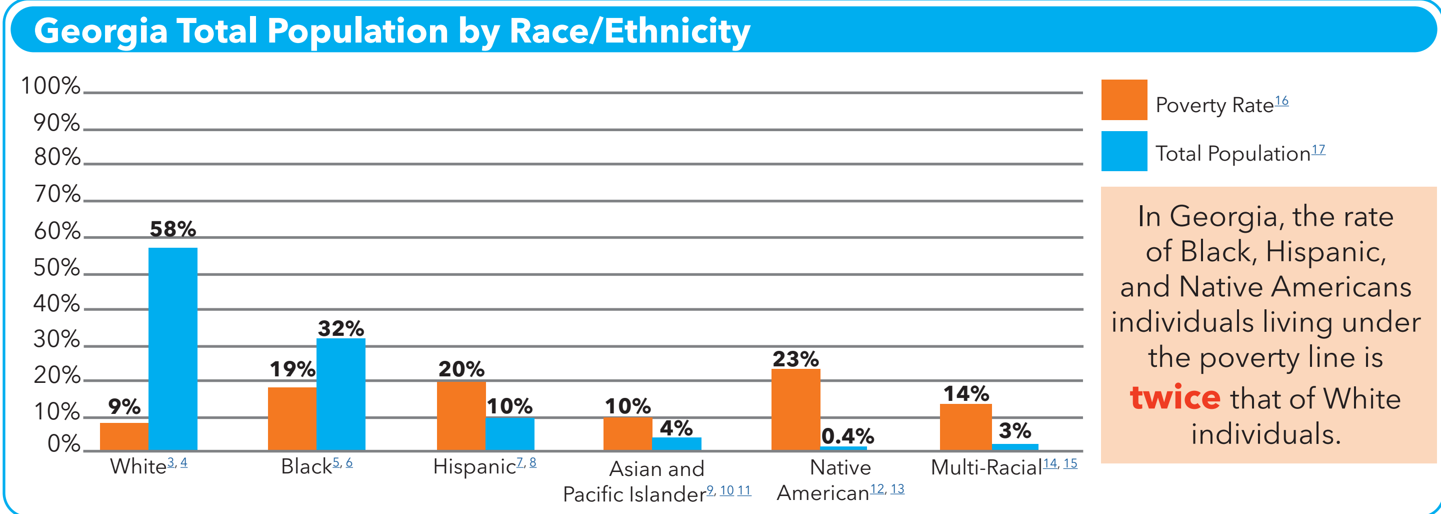
# 2022 Federal Poverty Guidelines

The U.S. Federal Poverty Guidelines determine financial eligibility for certain federal programs. The poverty guidelines are published in January by the U.S. Department of Health and Human Services, and are designated by the year in which they are issued (i.e. guidelines issued in January 2022 are the 2022 poverty guidelines).[1]

## 2022 Federal Poverty Guidelines[2]

| Family/Household Size | 100% | 200% | 400% |
|---|---|---|---|
| 1 person | $13,590 | $27,180 | $54,360 |
| 2 people | $18,310 | $36,620 | $73,240 |
| 3 people | $23,030 | $46,060 | $92,120 |
| 4 people | $27,750 | $55,500 | $111,000 |

## Georgia Total Population by Race/Ethnicity




In Georgia, the rate of Black, Hispanic, and Native Americans individuals living under the poverty line is **twice** that of White individuals.

## Federal and State 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.

| Program | Maximum Yearly Income (Family of 4) | Maximum % of Guidelines |
|---|---|---|
| Childcare and Parent Services - Low Income Priority Group | $41,625[18] | 150%[27] |
| Supplemental Nutrition Assistance Program | $36,075[19] | 130%[28] |
| Pregnancy Medicaid | $61,050[20] | 220%[29] |
| Women, Infants, Children | $51,338[21] | 185%[30] |
| Medicaid (Children up to 1 year) | $58,275[22] | 210%[31] |
| Medicaid (Children ages 1-5) | $42,735[23] | 154%[32] |
| Medicaid (Children ages 6-18) | $38,295[24] | 138%[33] |
| PeachCare (Children 0-18) | $68,543[25] | 247%[34] |
| Marketplace (Health Insurance) Premium Tax Credit | $111,000[26] | 400%[35] |

## Federal and State Program Definitions

**Childcare and Parent Services (CAPS)**: 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. *See Voices' CAPS factsheet for more details*

**Marketplace (Health Insurance) Premium Tax Credit**: Individuals and families with incomes at 100 – 400% FPL who purchase health insurance through the Health Insurance Marketplace, can receive federal premium tax credits to reduce their monthly insurance premium payments.

**Medicaid**: 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. *See Voices' How Medicaid and PeachCare Money Work factsheet for more details*

**Peachcare for Kids™**: PeachCare for Kids™ is a comprehensive health care program for uninsured children (under age 19) living in Georgia, whose parents earn too much to qualify for Medicaid, but not enough to pay for private coverage. *See Voices' How Medicaid and PeachCare Money Work factsheet for more details*

**Supplemental Nutrition Assistance Program (SNAP)**: SNAP offers nutrition assistance to millions of eligible, low-income individuals and families through electronic benefit cards.

**Women, Infants, Children (WIC)**: 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. During 2022, Georgia WIC is transitioning benefits from paper vouchers to an electronic benefit transfer (EBT) card.

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Sources: https://bit.ly/3QjzW0C