



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**

November 2022

PREFERRED CITATION

Newton, B., Kelley, L., & Haberlen DeWolf, M. (2022). 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. [Link]

ACKNOWLEDGEMENTS

Voices for Georgia's Children would like to say a special thank-you to the Georgia Department of Behavioral Health and Developmental Disabilities for giving us the opportunity to conduct this research; the Georgia Rural Health Innovation Center, VOX ATL, the Carter Center, and Dr. Karyn Korsah (Morehouse School of Medicine Child and Adolescent Psychiatry Fellow) for your thoughtful contributions to the research design, implementation, and analysis; and the caregiver and youth focus group participants for generously sharing their time and knowledge.

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EXECUTIVE SUMMARY

This report captures findings from 12 two-hour virtual focus groups conducted during April and June 2022 with 44 caregivers and 32 youth, representing 31 counties (rural and urban) from around Georgia. Staff from Voices for Georgia's Children and the Georgia Rural Health Innovation Center facilitated caregiver focus groups comprising various caregiver types (e.g., parents, foster parents, legal guardians). Youth trained in research methods and focus group facilitation, along with staff from Voices for Georgia's Children and VOX ATL, conducted focus groups that included youth aged 12-18. This method, known as the Youth Participatory Action Research approach, empowers youth to research and seek solutions to issues that affect them and their communities. Youth and caregivers were diverse in geography, race, age, and insurance coverage.

Prior to the pandemic, Americans were already struggling with unmet mental health needs. In 2019, approximately 40 percent of American adults with serious mental illness and 60 percent of youth with major depression did not receive mental health care.¹ Georgians were no exception to this reality, as one-quarter of the state's adults and two-thirds of youth reported unmet mental health care needs as of 2019.²

As COVID-19 spread across America and quarantine protocols were put in place, there were significant increases in the number of adults and youth reporting mental health issues.³ In June 2020, American adults reported symptoms of anxiety and depressive disorders at three and four times the rate reported in June 2019, respectively. In the same 2020 survey, 13 percent of adults surveyed reported that they began or increased substance use to cope with stress or emotions related to the pandemic.⁴ Similarly, youth in Georgia reported feeling depressed at a 14 percent higher rate in 2021 than those surveyed in 2019.⁵

Moreover, the pandemic affected Black, Indigenous, and People of Color (BIPOC) familiesⁱ in specific ways related to social determinants of health. COVID-19 exacerbated the financial instability, housing insecurity, and shortages of food that BIPOC communities were already disproportionately experiencing before the pandemic.⁶ Although BIPOC communities experienced higher rates of depression and anxiety during the pandemic, data shows

that these communities received treatment at lower rates than white communities.⁷

Many factors are involved in how communities access mental health care. Lack of transportation, insufficient insurance, stigma, cost, and general confusion over how to navigate the mental health care system can all contribute to an inability to access care. One major challenge is a shortage of mental health providers. In 2019, there was one mental health provider to 690 residents in the state, and almost all of Georgia's counties were classified as Mental Health Professional Shortage Areas.^{8,ii} Further, as Georgia's population becomes more diverse, additional barriers are appearing surrounding language, identity, and cultural competence. Georgia has made steady progress in improving available mental health services and supports. By building state and local infrastructure to assist with planning and coordinating behavioral health services for adults and youth, Georgia has remained dedicated to implementing the System of Care (SOC) framework. Despite these improvements, there is still much more work to be done.

The following findings are based on the experiences of, and perceptions shared by, caregivers and youth that participated in focus groups. As most data surrounding the effects of COVID-19 on mental health exists solely on a national level or in quantitative forms, these findings add invaluable context in understanding the unique needs of Georgia's caregivers and youth.

- i. Social determinants of [behavioral] health (SDoH) are the economic, social, and political conditions that influence a person's behavioral health risks and outcomes over the course of a lifetime, including health care access and quality, education access and quality, social and community context, economic stability, and neighborhood and built environments. (Centers for Disease Control and Prevention)
- ii. Mental health shortage area designations are based on the number of providers relative to the population; the population-to-provider ratio must be at least 30,000-to-1 (20,000-to-1 if there are unusually high needs in the community).

KEY FINDINGS

Isolation, uncertainty, and drastic lifestyle changes resulting from the COVID-19 pandemic exacerbated mental health issues in both caregivers and youth.

Caregivers said that the pandemic led to increased responsibilities at home and work, separation from community, and financial uncertainty that significantly increased their stress and anxiety. For youth, separation from friends and activities disrupted their social lives, while virtual learning left many students struggling to keep up with schoolwork. Notably, many caregivers said that the pandemic improved their mental health and/or their children's mental health in some ways by removing the pressures of in-school learning and being able to spend more time together as a family. Youth remarked that the pandemic allowed them more time to sleep and more freedom to do things during the school day.

Access to mental health care before and during the pandemic was extremely limited due to a shortage of providers, inadequate insurance coverage, high costs, and insufficient information.

Caregivers living in rural communities reported having limited, if any, options for mental health care, resulting in long commutes to seek treatment. Lengthy wait times for appointments and complicated transitions were common experiences described by those initiating treatment. Regarding insurance, caregivers reported poor coverage, high premiums, and limited provider options, which frustrate the process of finding quality providers. In addition, an overall lack of information makes navigating the mental health care system difficult for families. While telehealth can be an effective alternative to in-person care, caregivers noted that limitations on broadband access and rules surrounding out-of-state care reduce the benefits of telehealth.

Identity, family characteristics, and social status create barriers to seeking and receiving mental health care.

Youth reported being hesitant to discuss mental health with parents as a result of cultural norms that frown upon or do not accept mental health issues as a legitimate problem – some even fear being ostracized. Both caregivers and youth said that a lack of diversity among mental health care professionals also discourages people from seeking mental health care, as they often seek treatment from those with whom they can relate.

I think a lot of us (children of immigrants) mentioned previously, that... our identity makes it more difficult for us, I guess, to seek mental health care because of the stigma around it and maybe not having really anybody nearby or close that we can talk to.

Youth, Age 16, Henry County

I am now connected more with my family [in] understanding their particular needs and being able to champion for them when it comes to their medical needs.

Caregiver, Fayette County

I [learned] that in Dekalb County, there's only one pediatric psychiatrist in the whole county and...they are always booked. And so, he's only seen once a month because of the availability of the one pediatric psychiatrist.

Caregiver, Dekalb County

[W]e don't have enough black providers to serve that community. And there may be some hesitancy, unless you're able to see somebody who can look like you and relate to you... whether it's specific issues to a particular community or [the ability] to relate [to] a life experience.

Caregiver, Camden County

School-based mental health (SBMH) care is limited due to administrative demands, training deficiencies, and shortages of school guidance counselors.ⁱⁱⁱ Focus group participants believed that school counselors are either focused on academic demands, lack proper training, or are simply overwhelmed by the needs of their students. Overall, caregivers viewed school as a key setting where youth mental health needs should be addressed but felt that most schools fall woefully short in this area.

[The] counselors at my school... their primary purpose is not necessarily to counsel students. It's primarily to do class changes and decide whether or not you should take dual-enrollment classes and all of that.

Knowledge of local mental health resources varies. Better communication and awareness of those that do exist was identified as a critical need. Focus group participants had some knowledge of behavioral health resources outside of schools and primary care. Caregivers identified community service boards (CSBs) and residential treatment facilities as behavioral health resources; however, access to these options may be limited based on location and type of care needed (immediate or intensive care versus less intensive treatment). For both youth and caregivers, Certified Peer Specialists and peer groups provide personal support by connecting them with others through shared experiences and may be used to bolster SBMH. Still, some participants were unaware of available resources in their community and were unsure where to begin should they need care. Further, there are very few, if any, local resources for youth in most communities.

[W]e have a ton of schools but [there are] a ton of kids in them. And we just recently got one counselor in every single school, and that was a huge deal. But [my daughter's school] has 400 kids to one counselor, and so they're just completely overwhelmed.

Caregiver, Camden County

Youth, Age 17, Paulding County

I don't know of any, other than me seeking out help through the school to find out, to ask for a resource for a therapist that was covered under my insurance, I wouldn't have even been able to find that.

Caregiver, Fulton County

I learned about mental health from GCAPP, the Georgia Campaign for Adolescent Power and Potential. And it's just being within the youth council and having the opportunity to be a moderator and participate in teen summits where we're focusing on mental health.

Youth, Age 17, Clayton County

iii. School counselors are school district employees who typically offer students academic guidance (e.g., class schedules, addressing educational needs) and mental health support (through 504 and Individualized Educational Programs) and who provide administrative support to the school. They are distinct from community mental health providers, who provide in-school mental health treatment for students through partnerships such as the Georgia Apex Program.

Based on these findings, Voices for Georgia’s Children offers the following select recommendations for different audiences. A comprehensive list of all recommendations can be found on page 24.

State leadership and agencies

- Continue to expand the Georgia Apex Program’s reach in rural and underserved communities.
- Track and promote SBMH services and supports in the state.
- Via funding and training, encourage schools to start and grow quality SBMH programs, and better leverage school counselors to provide behavioral health services to any student in need.
- Allocate more funding to support the implementation of SBMH workforce pipeline programs, including paid practicum placements, and reimbursement for supervised training of emerging professionals.
- Increase state funding to expand reach of mental health awareness (i.e., Youth Mental Health First Aid, including the importance of confidentiality) training for teachers, school counselors, and staff (e.g., administrative faculty, coaches, other extra-curricular advisers) and to increase understanding of community-based mental health resources.
- Develop awareness campaigns to promote community-level mental health resources, including CSBs, and reduce cultural- and identity-based stigma (e.g., Black, Hispanic, adolescent males).
- Adopt a standard of cultural competency training and requirements for behavioral health professionals and paraprofessionals.

Schools

- Actively and frequently promote existing SBMH and community-based behavioral health services and supports to students and caregivers.
- Leverage existing training and resources (e.g., Sources of Strength, Teen Mental Health First Aid, 4-H, Georgia Campaign for Adolescent Power and Potential, Community Resiliency Model, Free Your Feels (FYF) campaign), including afterschool and summer learning programs, to develop teen-led or -focused mental health support programs and initiatives, including those that support healthy educator-student relationships (e.g., promote strategies to minimize oversharing of student mental health challenges through FYF).

Higher education institutions

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

Insurers (public and private)

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

Our research found that there is an urgent need to improve access to behavioral health care for Georgia’s families to cope with both prepandemic and COVID-19-related behavioral health needs. Youth and caregivers’ insight is invaluable in that it provides a community-level perspective to state agencies, nonprofits, and community-based service providers as they work to enhance access to and quality of mental health care in the state. These proposed recommendations should assist Georgia with improving mental health outcomes for youth and families by allowing for a more accessible and efficient System of Care.

INTRODUCTION & BACKGROUND

Prior to the COVID-19 pandemic, America was struggling with an increasing prevalence of behavioral health challenges and limited access to care. In 2019, 39 percent of adults and 60 percent of youth with serious mental health concerns reported that they were not receiving treatment.⁹ In Georgia, 25 percent of adults reported unmet health care needs, and 67 percent of youth with major depression reported that they were not receiving mental health services in 2019.¹⁰

After the pandemic began and communities started to quarantine, there were significant increases in the number of adults and youth experiencing mental health challenges. In the United States, adults reported symptoms of anxiety disorder at three times the rate and depressive disorder at four times the rate in 2020 as they did in 2019.¹¹ Additionally, 13 percent of adults surveyed reported that they began or increased substance use to cope with stress or emotions related to the pandemic.¹²

Like adults, youth suffered the effects of the pandemic on their mental health. In Georgia, approximately 14 percent more students reported feeling depressed and 16 percent more students experienced intense anxiety in 2021 compared to 2019.¹³ⁱ Youth, however, were affected by the pandemic in ways that differentiated their experience from those of adults. Teens already struggling with the common issues of self-esteem and pressure associated with adolescence found themselves isolated from their peers and cut off from mental health services.¹⁴ In addition to the direct impact of isolation on youth, economic hardships resulting from COVID-19 contributed to parental anxiety and depression. Adults with children reported depression, anxiety, and financial insecurity at higher rates than the rest of the population, and family stress can reduce a child's sense of well-being and, in some cases, lead to abuse.¹⁵

Key Terms

Black, indigenous, and people of color (BIPOC) includes Black people of any ancestry, native inhabitants of North America (including Native American, First Nations, and Native Alaskans), and people of color, which includes all people who are not white (i.e., Black, East Asian, Latin, South Asian, Hawaiian and other Pacific Islander, and more).¹⁶

Behavioral health includes the emotions and behaviors that affect a person's overall well-being and may include the treatment of mental illnesses, such as depression or anxiety, as well as substance misuse and other self-harming, risk-taking, or addictive behaviors.¹⁷

Social determinants of [behavioral] health (SDoH) are the economic, social, and political conditions that influence a person's behavioral health over the course of a lifetime, including: (see **Figure 1**)¹⁸

- Health care access and quality
- Education access and quality
- Social and community context
- Economic stability
- Neighborhood and built environments

i. State-level data comparing the mental health needs for adults before the pandemic began and during the pandemic is not yet available through the Substance Abuse and Mental Health Services Administration (SAMHSA). While some 2020 data is available, SAMHSA cautions against comparing this data with previous years' data due to changes in methodology resulting from COVID-19. State-level youth data were calculated using a statewide Student Mental Health Survey

Figure 1: Social Determinants of Health
(Source adapted from: CDC)¹⁹



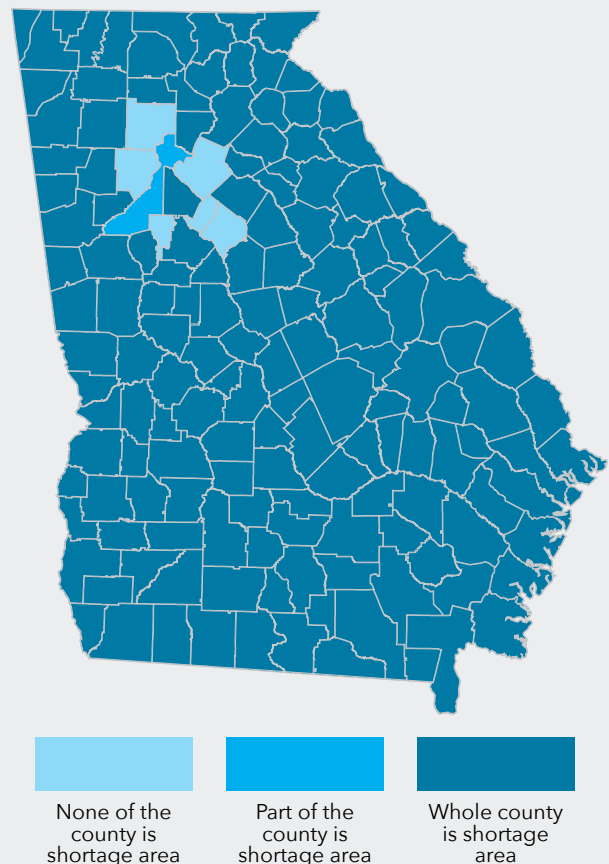
Social determinants of health (SDoH) played a major role in how individuals and families experienced the pandemic. For example, families that had trouble accessing financial resources, nutritious food, stable housing, and health care prior to the pandemic were even harder hit by these challenges during the pandemic, making them also more susceptible to worse health and behavioral health outcomes.²⁰

According to the Centers for Disease Control and Prevention (CDC), racism and other forms of discrimination are also key factors in SDoH, as they prevent equal access to a myriad of SDoH for BIPOC communities while also increasing their risk of chronic stress. Consequently, BIPOC communities suffered particularly poor physical and behavioral health outcomes during the pandemic. Notably, Hispanic and Black adults in the United States reported higher frequencies of depression, anxiety, and substance abuse during COVID-19 than their white counterparts.²¹ In a nationwide June 2020 survey, Black and Hispanic respondents reported either starting or increasing substance use to cope with COVID-19-related stress and recent suicidal thoughts at two times the rate of white respondents.²² And while communities of color may have experienced mental health issues at a higher rate, national data shows that they received less treatment. In 2021, over 40 percent of Black, Hispanic, Asian, and Native American adults in the United States reported an increase in mental health issues since the start of COVID-19; however, less than 27 percent received treatment.²³

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

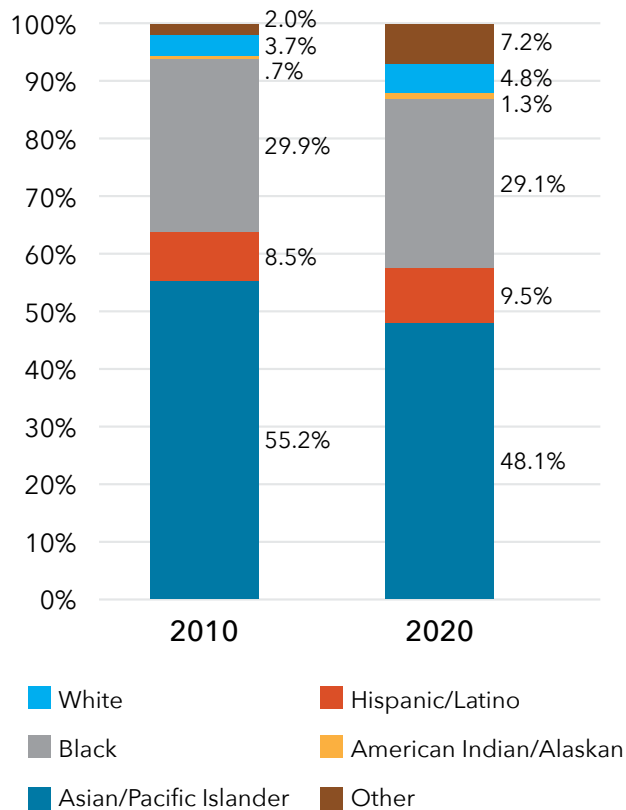
Several factors may inhibit children and families' access to needed mental health care, including stigma, difficulty navigating the behavioral health system, lack of insurance coverage or time off, cost, lack of transportation, and more (see [Barriers to Health Care for Georgia's Children](#)). Families that are able to overcome the aforementioned hurdles must then tackle a second, major barrier – the lack of available behavioral health providers.ⁱⁱ In 2019, Georgia only had one mental health care provider for every 690 people living in the state, and the pandemic has only increased pressure on what was already a strained system.²⁴ **More than 96 percent of Georgia's counties are designated as Mental Health Professional Shortage Areasⁱⁱ (MHPSAs).** Provider shortages often lead to long waitlists or commutes, and this is particularly true for rural residents.²⁵ And while the provider shortage is most apparent in rural counties, even metro Atlanta counties, such as DeKalb and parts of Fulton, are also designated as a MHPSA (see **Figure 2**).²⁶

Figure 2: Mental Health Professional Shortage Areas, by County, 2022
(Source: Rural Health Information Hub)



What is more, Georgia is becoming increasingly diverse and has seen significant growth in the BIPOC community (see **Figure 3**).²⁷ Notably, the BIPOC population increased by 7.2 percent while the white population decreased by 7.1 percent from 2010 to 2020.²⁸ As such, barriers may be heightened for children and families seeking culturally responsive care (e.g., bilingual clinicians, familiarity with culture, religious affiliation) or services related to other identities (e.g., gender identity, sexual orientation) due to the lack of diversity among the behavioral health workforce.²⁹ A 2020 comparison showed the percentage of white psychologists to be higher than the percentage of the white population, while the percentage of BIPOC psychologists was less than the population percentage of every other race and ethnicity in the United States (see **Figure 4**). In Georgia, only 14 percent of psychiatrists identified as “Black or African American alone,” while Black individuals make up approximately 30 percent of the state population.³⁰

Figure 3: Race and Ethnicity in Georgia: 2010 v. 2020³⁵

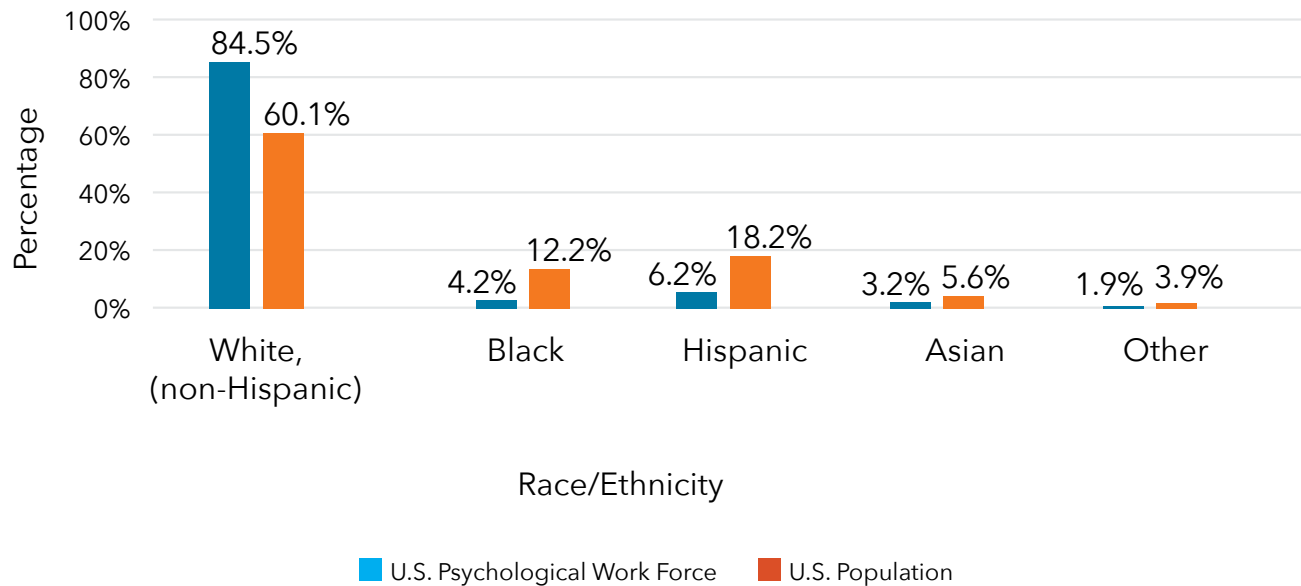


While access to behavioral health services remains challenging for Georgia’s children and families, the state has taken significant steps over the last 20-plus years to confront this issue.

- In 1990, to help the state start to implement the [System of Care \(SOC\)](#)ⁱⁱⁱ framework, Local Interagency Planning Teams (LIPTs) were created to coordinate local services for children and adolescents with severe behavioral health disorders.³¹
- In 1999, Georgia was the first state to successfully ensure Medicaid reimbursement for services rendered by Certified Peer Specialists (CPSs).³² Peer support, both formally trained and certified (CPS) and informal, offers an opportunity for adults and young adults with lived experience to provide support services to youth and adults battling behavioral health challenges.
- In 2009, the [Behavioral Health Coordinating Council \(BHCC\)](#) was created to make systemic improvements to improve behavioral health service delivery and outcomes. One year later, the Interagency Directors Team (IDT) for children’s behavioral health was created as a working group of the BHCC, responsible for implementation of SOC at the state level.³³
- In 2015, the Department of Behavioral Health and Developmental Disabilities (DBHDD) initiated the [Georgia Apex Program](#), which creates partnerships between community-based providers and schools to provide SBMH services (i.e., mental health promotion, early and intensive intervention). The Georgia Apex Program began as a pilot, serving 104 schools and approximately 2,400 students, and has expanded to serve 731 schools and nearly 11,000 students.³⁴

iii. SOC is an organizational framework defined as “a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.” (Stroul, Blau, & Friedman, 2010)

Figure 4: U.S. Psychological Workforce v. U.S. Populations by Race and Ethnicity: 2020³⁶



- In 2022, the Georgia legislature passed the [Mental Health Parity Act](#) to improve access to behavioral health services in the state by ensuring limitations for behavioral health services are no greater than those for physical health services, among other provisions. As a part of its implementation, the state is currently developing a service cancellable loan program for Georgia’s emerging behavioral health professionals, prioritizing those working with underserved youth or communities.³⁷ The law has several other potentially helpful components, including the creation of the Behavioral Health Care Workforce Database to collect needed data on the available behavioral health workforce in the state, and the creation of a Multi-Agency Treatment for Children team to better support children with complex mental health needs.

The findings from this report are intended to support policymakers, advocates, and child- and family-serving organizations in understanding the mental health needs of children and families throughout the pandemic and the challenges they experienced in navigating the behavioral health system. Much of the available data about the impact of COVID-19 on behavioral health is national. Community focus groups provide unique insight into the systems and circumstances that directly impact them. As such, engaging youth and caregivers in focus groups provided an opportunity to better understand the experiences of children and families in Georgia and to leverage these findings to propose policy opportunities to mitigate key pain points described. Further, the research methods used to conduct this study allowed Voices for Georgia’s Children (Voices) to empower youth (facilitators) to harness their own experiences in order to conduct meaningful research to inform advocacy and policy change.

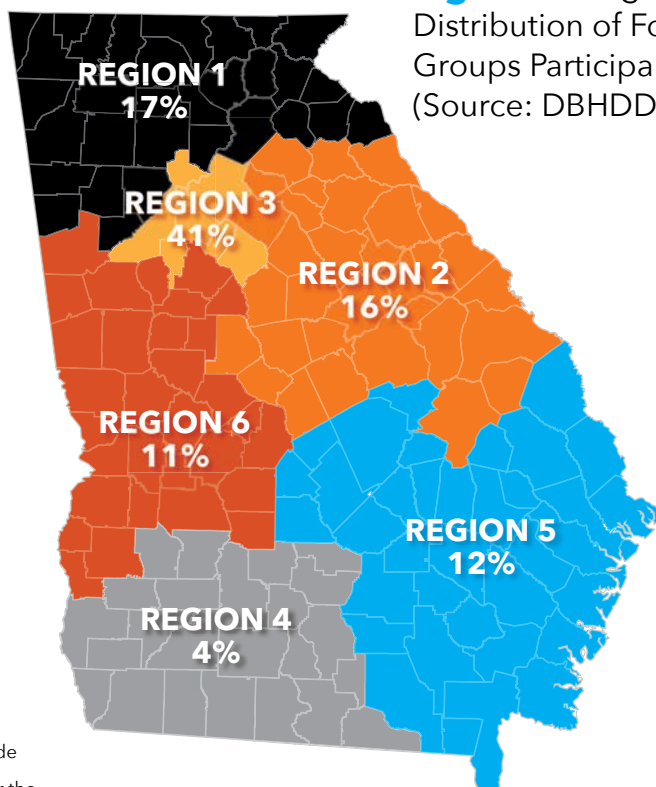
METHODS

From April 2022 through June 2022, Voices conducted 12 two-hour virtual focus group sessions with youth and caregivers to understand youth mental health needs throughout the pandemic and to capture barriers and facilitators to navigating the behavioral health system. The work was carried out by researchers at Voices in partnership with VOX ATL (who helped design and facilitate the youth focus groups) and the Georgia Rural Health Innovation Center (GRHIC) at Mercer University (who helped design and facilitate the caregiver focus groups). Overall project guidance was elicited through regular “Planning Team” meetings, consisting of all research partners, DBHDD leadership, and staff from the Carter Center Mental Health Program.

Leveraging social media networks and targeted partner outreach (e.g., Georgia Rural Health Innovation Center, Family Connections Partnership, DBHDD Regional Service Administrators), Voices invited Georgia teens and caregivers to participate in focus groups to discuss behavioral health needs, services, and experiences related to navigating the behavioral health system. To ensure a diverse group of participants, focus group participants were selected based on their geography (residents representing each DBHDD region, (see **Figure 5**), health insurance type, and racial/ethnic background. A total of 76 (44 caregivers and 32 youth) registrants were selected to participate in one of 12 focus groups (six caregiver and six youth sessions). The caregivers included biological parents, foster parents, adoptive parents, legal guardians, and grandparents raising grandchildren. While ages of the children in their care ranged from 4 months to age 19, the mental health needs or mental health service experiences referred to regarded children 3 years of age or older. Youth focus group participants were aged 12 to 18 (all 18-year-old participants were still enrolled in high school). A total of 31 counties were represented, with the following regional distribution (based on DBHDD regional community services map): Region 1 (17 percent), Region 2 (16 percent), Region 3 (41 percent), Region 4 (4 percent), Region 5 (12 percent), and Region 6 (11 percent). The participants were diverse in race/ethnicity and insurance type: Black, non-Hispanic (46 percent); white, non-Hispanic (34 percent); Hispanic (7 percent); American Indian/Alaskan Native, non-Hispanic (1 percent); Asian, non-Hispanic (5 percent); 2 or more races, non-Hispanic (7 percent); insurance status: private (41 percent); Medicaid (29 percent); PeachCare (3 percent); uninsured (5 percent); unsure (22 percent) (see **Figure 6** for additional youth demographics).

The moderator’s guide^{iv} for caregiver focus group sessions was developed by the Planning Team, and each of the six caregiver sessions was facilitated by at least two researchers from Voices and the GRHIC. For the youth sessions, Voices employed a **Youth Participatory Action Research (YPAR) approach, which empowers youth to leverage research practices and ethics to explore and understand issues that affect their lives, communities, and entities that are intended to serve them and to identify potential solutions** (see **Figure 7**).³⁸ Voices partnered with VOX ATL – an Atlanta-based nonprofit that supports teens in leveraging various media (e.g., poetry, podcasts, roundtable discussions, surveys) to increase youth voice and impact – to promote an opt-in opportunity for teens to facilitate the youth focus group sessions. The six teens who elected to serve as youth researchers were trained by the Voices research team in focus group best practices and research ethics. The youth researchers then developed, with support from the Planning Team, the moderator’s guide, recruitment material, and supplemental focus group session tools (e.g., slide deck, Jamboard). The youth researchers facilitated approximately two virtual sessions each (for a total of six youth-facilitated sessions), via Zoom, in pairs, joined by at least two adults (i.e., one from Voices and one from VOX ATL).

Figure 5: Regional Distribution of Focus Groups Participants (Source: DBHDD)³⁹



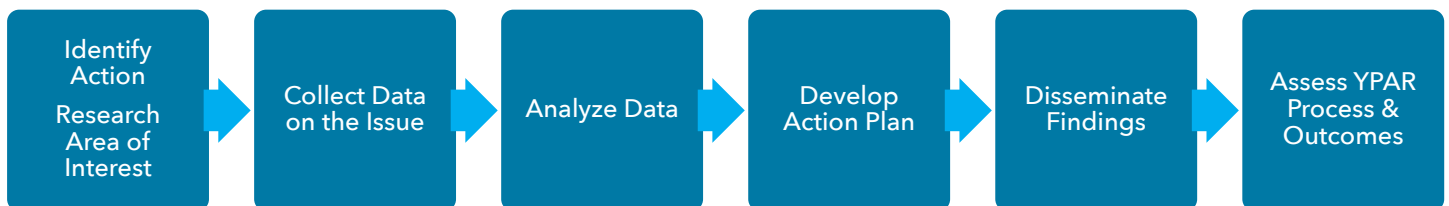
iv. A moderator’s guide serves as the outline of the focus group discussion. The guide is usually developed through a collaborative process between moderators and stakeholders to ensure the desired information is collected. It includes a script for the moderator and questions to guide the discussion with focus groups participants.

Figure 6:

Youth Focus Groups
Participant Demographics

| | White, non-Hispanic | Black, non-Hispanic | Asian, non-Hispanic | Hispanic | 2 or more races, non-Hispanic | Total |
|---------------------------|---------------------|---------------------|---------------------|----------|-------------------------------|-------|
| Total (aged 12-18) | 5 | 20 | 2 | 2 | 4 | 32 |
| Gender | | | | | | |
| Female | 5 | 15 | 2 | 2 | 3 | 27 |
| Male | - | 4 | - | - | - | 4 |
| Nonbinary | - | 1 | - | - | - | 1 |
| Age | | | | | | |
| 12 | - | - | 2 | - | - | 2 |
| 13 | - | - | - | - | - | 0 |
| 14 | 1 | 5 | - | - | - | 6 |
| 15 | 3 | 1 | - | 1 | 1 | 4 |
| 16 | 3 | 5 | - | 1 | - | 9 |
| 17 | - | 4 | 2 | - | 2 | 8 |
| 18 | - | 3 | - | - | - | 3 |

Figure 7: YPAR Process (Source: Adapted from Cook & Krueger-Henney, 2017)



FINDINGS

Georgia caregiver and youth behavioral health focus group findings were consolidated and presented by the following key themes that emerged from discussions with both groups: impact of the pandemic on child and family mental health, access to mental health services and supports, impact of individual and family characteristics on seeking or receiving mental health care, SBMH, and knowledge of community mental health resources.

Impact of the Pandemic on Child and Family Mental Health

Parents and caregivers described the pandemic as being stressful due to increased demands at home and at work. Disruptions in child care and in-person learning left many parents facing the hard task of juggling multiple new roles (e.g., caregiver, educator), while still trying to maintain work responsibilities. All caregivers reported feelings of anxiety, uncertainty, isolation, and loss. Caregivers who depicted themselves as more extroverted found it difficult to deal with the changes in how they communicated with their work associates and social groups. Community divisions also contributed to the sense of loss as disagreements over COVID-19 protocols regarding isolation and vaccination caused ruptures in relationships between families and friends. These divisions were compounded by racial trauma^v (see [Childhood Trauma Report](#)) surrounding the death of George Floyd and subsequent protests and related violence.

[Because] of the afterschool hours change, and I have to fight through traffic to get [to the daycare] on time, and it was just really stressful on me, and I feel like that definitely impacted my relationship with my son, where I'm putting that energy towards him, when it's not his fault.

Caregiver, Black, DeKalb County

There was a judgmental aspect of, "Are you doing it my way, or are you doing it the other way?" And in figuring out who to be with is like, "Are you on my team? Are you on the other team."

Caregiver, White, Gwinnett County

The first thing that came to my mind was the divide between Black and White, I feel like, became so grand. So when I think of community, the first thing I thought about were police killings, the news publicizing. It wasn't just COVID.

Caregiver, Black, Henry County

Although almost all caregivers reported negative effects of COVID-19 on their mental health, a few caregivers pointed out several positive aspects of the pandemic, remarking that they were able to "slow down" and focus on caring for their families during this time. Several caregivers noted that the pandemic brought their families and their communities closer together. They spoke of neighborhood children playing together for the first time and parents becoming more engaged in their children's education. One parent said that the time away from in-person learning was good for her child, who struggled with learning disabilities and bullying at school.

v. Racial trauma, or race-based stress – often experienced by individuals who have also developed historical trauma – occurs when Black, Indigenous, and other people of color experience or witness events of racism or racial discrimination (e.g., police brutality, hostile or violent xenophobic behaviors, inhumane immigration practices).

I am now connected more with my family [in] understanding their particular needs and being able to champion for them when it comes to their medical needs.

Caregiver, Fayette County

Both caregivers and youth reflected on how separation from school impacted youth mental health. Parents spoke about their children feeling frustrated with virtual learning, losing social skills, and missing out on significant life events. Youth reported feelings of isolation, lacking a sense of normalcy, and loss rooted in missing social experiences (e.g., prom, graduation, forming new relationships in the transition from middle to high school). They discussed missing the connection with their friends at school, and some also said that virtual school was difficult for “hands-on” learners, which was evident by the decline in their grades. Academic performance is closely related to youth mental health, with youth participants reporting that their mental health is negatively impacted if they are not performing well in school. In general, however, the teens agreed that they enjoyed having more time outside of school for activities, self-care, and catching up on sleep.

COVID affected me by putting me behind on schoolwork because I didn't get to learn in person.

Youth, Age 15, Bibb County

For me it just felt really isolating. It was difficult at first not being with people after I'd been with everybody, or been around people, for a majority of my life every day since pre-K. It was just difficult being isolated like that, and lonely.

Youth, Age 17, Henry County

I could get more sleep and do the things I love at home.

Youth, Age 14, Richmond County

COVID gave me the opportunity to get to know myself better.

Youth, Age 16, Carroll County

Further, the transition from virtual schooling back to in-person learning had varying effects on youth mental health. Focus group participants reported that their mental health (e.g., social anxiety, anxiety, and depression) worsened once education was back in person due to perceived learning and social skill loss. However, several youths acknowledged that new changes to in-person school policies, such as incorporating a certain number of digital days (i.e., virtual school days) per semester, is a welcome change and supports their mental health.

[The year before] we didn't have yearbook signings, we didn't have the eighth-grade end of year party or anything, so we missed out on a lot of things. And to just be thrown back into high school just like, "All right, we're back to school, let's go back. We're all going to be great," yeah, it was stressful.

Youth, Age 16, Bartow County

I would add for our family... the most challenging part for one of our children who has a lot of anxiety and has really struggled with not wanting to go to school ... we really had to work with her and a guidance counselor at school and a therapist and with this not wanting to go to school. So I think that somehow made it worse for her.

Caregiver, Cherokee County

I feel like a lot of the children got behind so bad because we were not able to have that face-to-face instruction. And I think that hurt us a lot. And now they're expecting us to keep pushing the kids to keep growing, but it's like a big chunk of their life where they didn't even learn what they were supposed to learn. So now we got to try to move forward. It's just, I don't know. That's depressing.

Caregiver, Clarke County

Just not having those constant connections really hurt her friendships, and to the point where, when she finally was able to see her friends again, I guess those relationships just weren't the same anymore. And I know that's impacted her pretty negatively throughout the school year.

Caregiver, Houston County

Access to Mental Health Services and Supports^{vi}

Across the state, caregivers expressed that there are limited mental health resources within their communities. Further, caregivers highlighted challenges that inhibit their ability to efficiently secure mental health treatment and support for the children that they care for, including high costs, poor coordination between providers, difficulty identifying providers that accept their insurance or other coverage barriers (e.g., Medicaid renewal), and a general lack of providers and local crisis services. Poor case management, care coordination, and communication between providers rose to the top of the list of concerns, with many caregivers sharing experiences of the onus being on them to figure out the process of identifying a provider with the skills needed to meet the needs of the child in their care. Caregivers faced with the task of finding a provider are usually met with the reality that there are very few providers in their area, which leads to extensive wait times for an available appointment or long commutes to receive services. This unfortunate reality is magnified for caregivers living in rural communities, especially if they are in need of crisis supports and services. Caregivers shared that if there is a need to switch providers, the transition rarely goes smoothly and there is very little follow-up from the original provider to ensure that it was successful. Nearly all the caregivers perceived a lack of information surrounding insurance coverage, referral sources, crisis assistance, and follow-up care as a barrier to mental health services and supports. Not only did they have issues finding this information on their own, but they also relayed that their general practitioners often did not have adequate information and insurance providers were little help.

Everybody you talk to says you need to do different things. There's waitlists everywhere, and it's kind of up to all of us to kind of figure out what our system of care is going to be or what would be effective. It doesn't feel like you have either a point person or anything that's easily understandable.

Caregiver, Dekalb County

For me, I'm the system of care. I am the one that holds it together. I have to coordinate the therapist and the doctors. Actually, we have three doctors, so I have to coordinate all of them and I have to coordinate with the schools and I have to coordinate with the case workers. I am the one that keeps everybody in the know and I'm the one that has to pursue it. If there's any questions, I have to follow up with them.

Caregiver, Clarke County

There's a lack of care just generally in mental health, especially with children in the school system, in the county, in the community. There's more physical health places. It's easier to find urgent care for your body. It's easier to find [emergency rooms], doctors, clinics for the body. I think mental health facilities, and resources, and information should be just as accessible.

Caregiver, Dekalb County

I know for me, there's a big difference with the access. Rural, we only had one provider in the county and then they closed. And then there's a clinic now in the county that only has certain days to see kids.

Caregiver, Muscogee County

It costs so much money to get care unfortunately. We have insurance but the copays are astronomical. We have two kids going to therapy each week. ... Why can't it be easier for parents to get the proper help for their children in crisis?

Caregiver, White, Camden County

Having crisis-level services within proximity is helpful also, and those are really based on population. So if you're not in, really, honestly, a metro area, whether that's Macon or Columbus or Atlanta - or [if you are] where we are, Southeast Georgia, then you're probably going to be in a pretty tough spot.

Caregiver, Camden County

vi. Youth perceptions regarding access to care were limited to SBMH resources and peer groups (see [School-Based Mental Health](#)).

Caregivers described difficulties with both private and public insurance. While some reported being unable to find quality providers who accepted Medicaid and PeachCare for Kids (Georgia's Children's Health Insurance Program), others with private insurance believed that public insurance provided more opportunities for mental health care. Medicaid renewal was also an issue during the beginning of the pandemic as local Division of Family and Children Services offices were closed, and limited internet access prevented some from renewing online. Other caregivers expressed their concerns regarding exceeding the income levels for public insurance but not being able to afford the premiums offered by the marketplace – which ultimately impacts their ability to access needed care or results in them absorbing high costs.

Then the family that's stuck in the middle where you might just be over the threshold, but you still do not have the financial means to get there. And that's the group that's often really lost. It's like you really have to prove your inability to afford anything to even be eligible. And even if you are eligible, whatever [it] costs you may not still be able to afford.

Caregiver, Fayette County

Many caregivers reported that telehealth services were beneficial throughout the pandemic; however, caregivers in rural communities, and those with young children or multiple children needing care, experienced challenges due to limited broadband access, inability to coordinate services with few devices, and difficulty keeping the child engaged for appointments. Families utilizing mental health providers in a neighboring state found difficulties navigating complex telehealth rules and were, in some cases, informed that they are ineligible for telehealth services because they reside in Georgia.

We actually use Florida [providers] because we're the last exit, Georgia-Florida, so we do a lot in Florida. And our kids are being helped by that. But what I will say is this: Because we live in Georgia, they cannot do any type of telehealth videos or anything like that with our kids. ... They have to be in person.

Caregiver, Camden County

We really didn't understand or either have the technology to assist for telehealth, then some families [were] having barriers with internet, like they didn't have internet or couldn't really afford it. And then, by me being here in Southwest Georgia, in certain counties, the broadband was a problem.

Caregiver, Dougherty County

Impact of Individual and Family Characteristics on Seeking or Receiving Mental Health Care

Seeking Mental Health Care

Caregivers and youth shared how several identities (e.g., race/ethnicity, culture, gender, sexual orientation) and family characteristics (e.g., religious/spiritual affiliation, parental mental health challenges) have affected the perception, dialogue, and search regarding mental health supports and services. Among youth participants, several mentioned they were comfortable talking about their mental health with their siblings; however, the level of comfort in discussing mental health with their parents varied. Youth's comfort with talking to their parents generally correlated with their parents' openness about navigating and managing their own mental wellness and diagnoses. Youth attributed their family's cultural background and religious beliefs as the primary reasons if they did not feel comfortable talking about their mental health with their caregivers. Several youths shared that within their culture – most common among youth who identified as Black, Hispanic, first-generation American – mental health is a controversial topic. Some even shared that they witnessed family members being ostracized due to their mental health challenges or the overall negative narrative associated with those family members.

Similarly, caregivers shared that acknowledging mental health challenges and seeking mental health services is stigmatized within many communities, and particularly communities of color. Several caregivers also discussed how their own perceptions of mental health evolved as they learned more about it, which also led to them expanding how they define mental health. Both youth and caregivers discussed how racial identity may impact one's decision to seek care due to the lack of diversity in the behavioral health field and the likelihood of having a provider who can relate to the experiences of the individual seeking care. Youth participants highlighted that this sentiment also applies to members of the lesbian, gay, bisexual, transgender, queer (LGBTQ+) community. Another factor that youth believe may impact one's decision to seek care is gender identity. There was a consistent perception that youth who identify as female are more likely to seek care than their male counterparts. Many teens mentioned that their male peers were inclined to feel shame surrounding seeking mental health care.

I'm Mexican, and I find that Hispanic communities, even in the United States, tend to be very, like, conservative about mental health, and it's a very taboo topic in my family. I have a lot of family members who have mental health issues as a result of trauma from sexual assault and growing up and crossing the border that families often don't address. And it's just, "Oh, your aunt is a little eccentric, or oh, she's in the hospital? She got an injury," but in reality it's a facility.

Youth, Age 15, Gwinnett County

With African Americans, there's so many different aspects of trauma and we're more likely to have experienced trauma. So, when you go to your parents, not everyone has been able to heal their trauma. So, they won't understand how to deal with your trauma. So, you just end up having to sit with your problems.

Youth, Age 17, Dekalb County

Growing up, I was suicidal badly. But with me telling some people ... some people find out, because then I never told anybody. But, like, when you see the change in the child, and then you try to tell. ... I would try to tell the adults, they'll be, like, "Nothing's wrong. I don't see nothing wrong with you." They'll brush it off. So they'll be like, "That's not really a[n] illness. It's you just feeling pity upon yourself."

Youth, Age 18, Black, Lamar County

I know that my foster mom understands these sort of things because she has done training and things like that, and I've been living with her for about three, going on four, years, and she understands the mental health issues I have.

Youth, Age 15, Two or more races, Clarke County

A lot of the mental health challenges I've had have stemmed from systemic racism and things like that. So when I reach out to get a therapist, I usually look for someone who looks like me, because it's really hard to relay experiences that you've had with someone who hasn't really been through that. And I also feel like gender identity plays a huge role because if you're a part of the LGBT community, it's going to be really hard to relay everything about how you're feeling if your therapist already has biases and doesn't really like people of the LGBT community. So, I think race and gender identity and sexuality have huge roles.

Youth, Age 16, Black, Fulton County

I know working in mental health, Caucasian and African Americans tend to access it more. And then all the other minorities essentially do not get the services, because it's more frowned upon, [in] those different cultures and ethnic groups. They handle stuff within their group or not at all.

Caregiver, Muscogee County

I also think gender identity plays a role generally into seeking mental health care. I think [with] women and young girls, there tends to be more openness about mental health among young women and girls, but boys and men, I think face more – there's more stigma and shame when it comes to mental health issues.

Youth, Age 15, Two or more races, Gwinnett County

Receiving Mental Health Care

In terms of receiving care, most of the youth did not report any stark differences. However, some youth and caregivers mentioned the importance of the provider understanding the connection between one's cultural background and the behaviors exhibited. Further, caregivers shared how family characteristics impacted the quality of care that they received. Caregivers who identified as single parents or foster parents reported a negative shift in how providers treated them once they became aware of their family structure. Some caregivers even reported that when they attempted to reach out for supports and services, the child's behavioral challenges or mental health challenges were dismissed, and certain behaviors were even considered to be a result of parenting issues or normal teenage angst.

Being a single mom or divorced mom, I've also been told many times or been turned away because my daughter's issues were just parenting issues.

Caregiver, Clarke County

I know about my child, identifying as a foster kid, at the beginning, definitely, we would walk into medical clinics and just be treated differently, if even it was just a temporary case where maybe she wouldn't be there long. And so we were definitely looked at differently when it comes to that.

Caregiver, Camden County

The way that I see it treated here is it's almost a mentality of, well, you're on that insurance, which means that you already have a hard life. So you better go ahead and toughen up, because your problems are less than. They don't matter as much, and you don't need as much attention. That is the attitude that I generally have seen.

Caregiver, Cherokee County

School-Based Mental Health

Both caregivers and youth spoke extensively about SBMH and their desire for schools to be a strong connector to behavioral health resources. Although most schools employ at least one school counselor, parents and youth expressed that there were not enough to serve students effectively. There was also a consensus between both youth and parents that school counselors were more focused on meeting academic requirements than on mental health – that they were only there as college counselors or making sure students were passing tests and not trained to handle the complex mental health needs of some students, particularly in crisis situations. Several teens shared concerns surrounding school counselors repeating their confidential conversations to other school employees. While some caregivers and youth referenced being able to tap into needed services through their child’s school, others indicated that there was little to no school-based support. Caregivers heard talk of increased mental health support in schools, but there seemed to be little follow-through by the schools.

I remember asking [the school] for information on counseling or therapists, if they had any people that they recommended since I had no place to start other than therapists in my area with your insurance. And it was just like a blanket document of, “Here [is] a list of people, call them.” None of which I found to be very helpful information. So I feel like there is a lack of, again, accessibility to the information to make better choices for your children.

Caregiver, Cobb County

Based on my experience, I don’t think that [school counselors] are adequately trained to diagnose or evaluate. I think they’re just checking boxes on a form that’s [a] template and slapping labels on kids, not really understanding the big picture.

Caregiver, Clayton County

There’s too much for [school counselors] to do. ... I can’t imagine how hard it must be for them. I’m sure there’s a lot of kids on 504s and with IEPs and with issues. [The school has] allowed [my daughter] to, like, leave the classroom before a meltdown or go on a walk, and [the school has] little places that [my daughter] can go to, but there’s just not a lot of support.

Caregiver, Dekalb County

I’ve been a school counselor and I’ve had the mental health training. And so with many of the guidance counselors with schools, some of them have some mental health training, some of them do not. Plus the role of a counselor in a school varies with each school and whoever the administrator is. If the principal assign[s], they do counseling; some they do don’t do any counseling whatsoever. It’s all the administrative and the paperwork.

Caregiver, Muscogee County

Both caregivers and youth felt that schools were not forthcoming with the SBMH resources that were currently available. Parents of children with disabilities expressed dissatisfaction with a perceived categorization of their children. They felt as if the school system was quick to label a child as needing special education instead of addressing the specific needs of the child or connecting them with resources. Other caregivers mentioned Individualized Educational Programs (IEPs) and 504^{vii} plans as a way to access mental health services for students but remarked that the process of obtaining such plans was burdensome.

I've helped other families walk through [the process of obtaining an IEP or 504 plan]. And it feels like on purpose there are challenges for families to apply, to even learn what that is. I've tried to engage a principal before at our previous school throughout the pandemic to bring in speakers who can share more information on it. And it's kind of like a "no-no" area. And the people who are there, the counselors, the parent liaisons, again, I feel like there are some services that ... [it] doesn't feel like they're trying to share what those services are as a parent.

Caregiver, Dekalb County

While teens and parents mentioned school counselors and some in-school mental health education as a resource, they seemed to favor peer support in the form of student-led mental health organizations (such as Youth Advisory Council and SBMH clubs) or simply talking to their friends. One parent mentioned that the school put a "buddy system" in place for her daughter so she has a designated peer to talk to if she is experiencing mental health difficulties during the school day. Additionally, caregivers and youth talked about the benefits of CPSs^{viii} and offered them as a solution to the shortage of mental health care supports in schools for both kids and parents. Aside from peer support, caregivers and youth viewed third-party mental health services, such as the Georgia Apex Program and Summit Health Care, that provide on-site, clinical mental health treatment in schools, as beneficial resources for students and families.

I am a parent, a CPS-P parent, which is a Certified Peer Specialist-Parent. So, I come with that lived experience of knowing about having a child with a mental health diagnosis. So, being able to connect with someone with that lived experience is very important.

Caregiver, Floyd County

Another resource is honestly just student-led organizations and clubs. My school ... has a club called Minds Matter and another club called Girl Up, and they collaborate with other clubs in the school like Gay Straight Alliance and Girl Up and African American Student Association, Asian American Student Association. ... So I think other schools could also start that up.

Youth, Age 15, Gwinnett County

I learned about mental health from GCAPP, the Georgia Campaign for Adolescent Power and Potential. And it's just being within the youth council and having the opportunity to be a moderator and participate in teen summits where we're focusing on mental health.

Youth, Age 17, Clayton County

We have what is called Apex therapy services that are in the schools. That way it's easier for the kids to be accessed at school. That way if they're having a difficult day there, the parents don't have to take so much time off from work, that once every couple of months they have a family session, but the kid can also have their therapy session at the school.

Caregiver, Dodge County

I think there should be on-site mental health counselors because, again, school counselors, they don't actually help. They just relay what we tell them to our parents. ... I think there should be on-site mental health counselors for anyone who needs it. Well, not counselors, therapists.

Youth, Age 16, Fulton County

vii. IEPs and 504 plans are education plans that enable students with disabilities to receive personalized education assistance or accommodations, based on the type of disability. To qualify for an IEP, a student must have one or more of 13 specified disabilities that must affect the child's education performance and/or ability to learn and benefit from the general education curriculum, leading to the need for specialized instruction. A 504 plan includes any disability that interferes with the child's ability to learn in a general education classroom. Section 504 has a broader definition of a disability than IEP – that the disability must substantially limit one or more basic life activities, such as learning, and may often be temporary.

viii. Certified Peer Specialists-Parent and -Youth are individuals with lived experience who have been trained to support individuals with behavioral health (i.e., mental health and substance use disorder) challenges.

Knowledge of Community Behavioral Health Resources

Despite the lack of information on mental health resources from schools and primary care providers, parents and caregivers were aware of a variety of options existing outside of schools. Community service boards (CSBs)^{ix} were one of the most mentioned resources among the caregivers. Some individuals praised the efforts of their CSB, while others viewed them as a last resort. One caregiver described the community support individual (CSI; also referred to as the behavioral health clinical case manager) working with her child as being extremely helpful when she was experiencing anxiety. Another caregiver commented that the process of getting checked in, seen by a doctor, and getting medication at a CSB was too lengthy and that calling 911 resulted in more immediate attention. Of note, many caregivers did not mention CSBs, suggesting they were either unaware or there was no CSB in their community.

We are blessed in this community to have a CSB that does offer the resources that it offers and does put in place as much as it can and is continuing trying to grow and meet needs for families.

Caregiver, Laurens County

Here in Gwinnett County, we have something called Viewpoint Health. That is the community behavioral health where folks go that don't have resources. And that might mean they don't have insurance. Maybe they just don't have the finances to seek private mental health care. So that's the safety net level.

Caregiver, Gwinnett County

[The community support individual] has helped greatly, especially if it's on a day that [my daughter's] anxiety's real high about something that's coming up and she doesn't know how to handle her situation, or she's just having bad anxiety about that. If she can talk to her CSI worker, it helps calm her nerve. It helps calm her, and she can get through whatever she's having her anxiety about.

Caregiver, Dodge County

We do have [Narcotics Anonymous, Alcoholics Anonymous] with parents of children with addictions and we do have Gateway [CSB]. We have a counseling center for adults that is based on a sliding scale.

Caregiver, Camden County

[There were instances of] individuals not knowing where to go, because issues started coming up in households where issues may not have existed before, and so now we have just a wave of people seeking [behavioral health care], but they don't really know where to go because the schools were not even prepared to deal with the influx.

Caregiver, Richmond County

Another helpful local resource that both caregivers and youth identified was peer support groups, such as Mental Health America chapters and Alcoholics Anonymous (for those seeking help with substance use disorder support). Although one caregiver noted that these resources do not have a lot of programming for youth, another mentioned that the Federation of Families for Children's Mental Health chapter in their community was helpful with connecting families and youth to mental health resources. Another caregiver said that her local chapter of Family Connection, part of a statewide network that promotes the health and well-being of families, was a good way for her community to share resources. One parent mentioned the benefit of having peer support in the form of a CPS to support the siblings and other family members of youth who have a mental health disorder. Youth also discussed afterschool programs, Boys and Girls Clubs, and the Georgia Campaign for Adolescent Power and Potential (GCAPP) as places to connect with peers and seek information relating to mental health outside of school. Regarding informal resources, both caregivers and youth said that social media such as Facebook and TikTok were potential places to connect with peers or online support groups but also acknowledged that spending time on social media could be detrimental to mental health.

ix. CSBs are created in OCGA §37-2-6 et seq. as public corporations and instrumentalities of the state to provide services for mental illness, intellectual/developmental disabilities, and/or addictive diseases. There are 22 CSBs across Georgia with Boards of Directors appointed by the governing authorities of the counties within the CSB area.

As part of Georgia's Public Safety Net, CSBs serve eligible persons with serious mental illness, intellectual/developmental disabilities, and/or addictive diseases who have no insurance and limited to no means to pay for treatment. CSBs also serve persons with Medicaid. Individuals with other insurances are served based on the CSB's capacity and local need.

We do what they call a Family Connections, where a group of people come together and share their different resources. (Caregiver, Camden County) Social media, although sometimes it's harmful when it comes to mental health, it does provide an outlet for some people.

Youth, Age 16, Gwinnett County

The other side of that would be family support. You know, there are support groups for parents; there's nothing for siblings. So helping my younger child, who's traumatized by all this, realistically understand and cope and be able to meet people who understand has been pretty much impossible.

Caregiver, Clarke County

Our police department does have the co-responder program, and they do address mental health issues. However, and they'll tell you straight up when they come out, that they have more resources for adults than for minors, because the minor can't choose to go into a program or something. We have that. DFCS, we've had to get DFCS involved to get help for my daughter. Yeah, those are the only real community programs that I see that touch the youth population.

Caregiver, Clark County

Government agencies were also recognized as potential mental health resources. Several caregivers remarked that the most expeditious way to access mental health care is to call the police. One caregiver who had personal experience with the police co-responders said that the responders were helpful, but they were limited as far as the services they could provide, especially for minors. This same parent also recalled having to involve the Division of Family & Children Services (DFCS) to get help for her child and stated that the police and DFCS were the only community resources that assist youth. Several caregivers were also aware of the new 988^x mental health crisis line, though one caregiver was unsure of its exact purpose.

Here, they have a new 988, I believe it is, support that I'm not sure what all they cover, but it is supposed to be a mental health support.

Caregiver, Cherokee County

I don't know if it's successful, but the police. That's been the most helpful way, at least where I used to work, to help people get the resources they needed. ... It was the way to get them to the hospital, to the ER, to get them [involuntarily committed] when they were trying to hurt themselves or when they were running in the streets, doing whatever, or when they were high on whatever.

Caregiver, Houston County

Residential treatment facilities (such as Lighthouse Behavioral Wellness Center and Peachford Hospital) were also a topic of discussion, as many participants had firsthand experience with emergency and inpatient treatment. Most individuals, however, reported that individual counseling through private therapists was their primary professional resource for mental care.

For them at the hospital, it was great. [My son] did very intense, all-day partial hospitalization program for five days, all day long. There was a psychiatrist there that worked with his meds. She called me every day when [my son] was there. Then after he completed that, he went to their step-down program, which was called IOP, and it was intensive outpatient.

Caregiver, Camden County

Another person is also my therapist, obviously. She specializes in adolescent mental health. That's very helpful. And she helps me not feel as if my experiences are trivial.

Youth, Age 15, Gwinnett County

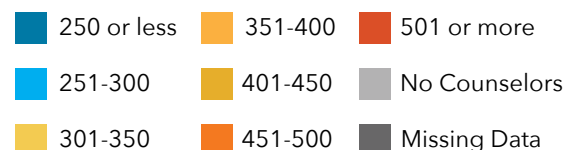
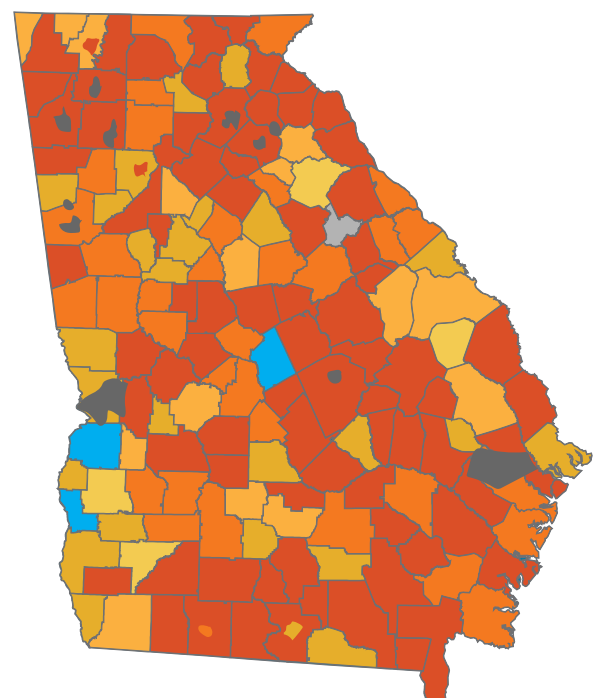
x. 988 is a direct line connecting callers to trained mental health counselors who can address their immediate needs and connect them to ongoing care.

DISCUSSION & RECOMMENDATIONS

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

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

Figure 8: Student-to-Counselor Ratio by School District (Source: National Association for College Admission Counseling)⁴⁰



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

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

Stigma may also play a critical role in the reported gender differences in the perception and dialogue surrounding mental health. The findings support that youth who identify as female were typically more comfortable talking about mental health and taking necessary actions to receive

mental health services and supports compared to their male peers. Further, the 2022 Georgia Student Health Survey data shows a stark contrast between male and female student (grades 6-12) responses to mental health-related questions, with female students experiencing mental health challenges more than their male peers:⁴¹

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

Interestingly, “school performance and grades” was the second highest reason for suicidal ideation among boys and girls,⁴² which corresponds with the findings of this research – academic performance significantly impacts the mental health of youth. However, across the above-mentioned mental health data, the higher rates reported by girls may indicate that they more readily recognize certain mental health challenges or that they feel more comfortable disclosing these struggles in a survey. This suggests that more mental health awareness campaigns that specifically target adolescent males may be helpful in increasing recognition of mental health challenges and seeking mental health supports. Further, the prevalence of mental health challenges among girls should not be ignored. Creating more outlets for youth to process their emotions, discuss mental health, and learn more about healthy coping mechanism could reduce poor mental health outcomes (e.g., self-harm, suicidal ideation).

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

xi. *Special education* is an individual-centered teaching style that responds to the needs of children with disabilities or learning differences. Special education can take place in the general classroom, resource room, or a specialized school, but typically students are separated from their peers. *Inclusive education* addresses the needs of children with disabilities or learning differences, but students are able to learn alongside their peers.

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

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

While recent legislation is intended to begin tackling challenges related to limited insurance coverage, provider availability, care coordination, and crisis supports, integrated care models are increasingly recognized as a strategy to increase mental health care access for children. Integrated care (or collaborative care) models leverage primary care providers to address behavioral health needs by providing warm hand-offs or scheduling joint visits between the patient, primary care provider, and a behavioral health specialist.⁴³ The specialist is able to diagnose, treat, or refer patients to additional resources.⁴⁴ **Identifying, piloting, and implementing integrated care models can better position Georgia to detect and treat behavioral health needs among children and strengthen care coordination and case management.**

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

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

State leadership and agencies

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

Schools

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

Higher education institutions

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

Insurers (public and private)

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

CONCLUSION

Access to needed mental health services and supports has been a long-standing challenge for children and families, but the pandemic created unique strains that have exacerbated this need. Fortunately, Georgia has made significant investments to build and sustain an infrastructure to better support the mental health of children and families. Further, the recent passage of the MHPA and other behavioral health access-related legislation well-positions the state to make more progress in meeting the mental health needs across the state. State policymakers and child- and family-serving systems can reflect on processes and program structures to identify and reduce critical barriers to behavioral health services and supports. Engaging youth and community voice in research and policy discussions that impact them and considering their input when implementing policy and practice changes to the systems upon which they rely on will greatly improve the lives of children and families in Georgia.

"I enjoyed that we all shared our experiences and thoughts freely and even got inspiration from others as to ideas and ways to advocate mental health in my community."

"It was very comfortable and I could tell that my experiences and my voice was valued."

"I liked how we all got the chance to voice our truths and opinions."

"I want to say in terms of mental health, I really like meetings like this because I really hope that they can change the conversation and also make mental health help and advice accessible to everyone. And I think it's really good that teens are being able to talk about this and adults are actually listening."

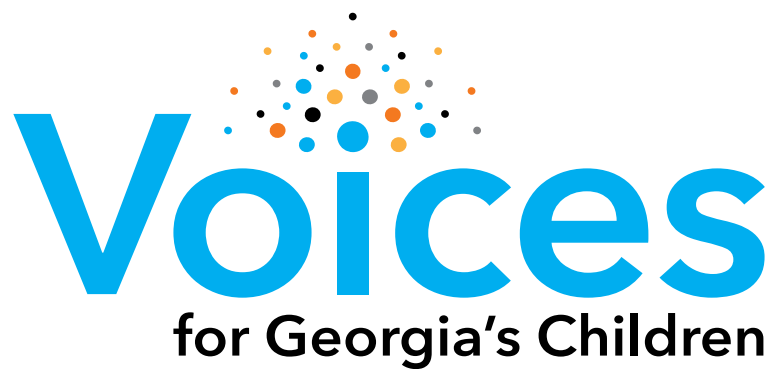
"I just want to say that this has been a really interesting experience and that I really appreciate it, and things like this should maybe be done more, because this is important."

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