UNDERSTANDING THE LANDSCAPE:
MENTAL HEALTH ACCESS FOR AFRICAN AMERICAN AND LATINX CHILDREN AND YOUTH IN THE STATE OF GEORGIA
Acknowledgement and Citation

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# Table of Contents

- Acknowledgment and Citation 02  
- Executive Summary 04  
- Background 06  
  - Purpose 07  
  - Methodology 07  
  - Overview 08  
- Georgia Environment 09  
  - Overview 09  
  - Key significant geographic areas of need and gaps in services 11  
- Current services available in Georgia 13  
  - Overview of health insurance in Georgia compared to the United States 13  
  - Existing services 14  
  - Key gaps in services 21  
  - Identified barriers to services 21  
  - Rural and Urban variations 22  
- Evidence based and promising practices strategies for target populations 23  
  - Evidence based practices 23  
  - Promising practices 24  
  - Key stakeholders working in this field 25  
  - Novel approaches or best practices available in Georgia 26  
  - Capacity development of those who are working in policy and advocacy 27  
- Workforce Development 30  
- Specific COVID/pandemic related issues 31  
- Provider perspectives 32  
  - Key issues in Georgia 33  
  - Challenges serving/reaching target population. 35  
  - Existing areas where there are gaps in services. 39  
  - Suggestions for improving the environment in GA 42  
- Individual perspectives 45  
  - Personal experiences 46  
  - Telehealth/telemedicine 50  
  - Strides/Positive experiences in mental health service use 52  
  - Challenges/Barriers to accessing services 52  
  - Suggestions for improving services in the state 59  
- Conclusions 63  
- Recommendations 64  
  - Workforce development 64  
  - Community education about behavioral health services 65  
  - Creative therapies and funding 65  
- References 66
Executive Summary

Healthcare Georgia Foundation partnered with the Multicultural Development Institute, Inc., to cultivate this White Paper discussing mental health equity for the African American and Latinx communities in urban and rural Georgia. The purpose is to examine how mental health equity is defined, resources available and implemented, and access for behavioral health services throughout the state of Georgia. Thorough research of these issues also informs conclusions about the current state of mental health equity in Georgia and recommendations for future research and funding.

The methodology used includes primary and secondary data to discuss key issues in mental health equity, barriers to access and/or gaps in services. Secondary data was collected from existing research such as demographic data from the United States Bureau of the Census (U.S. Census) and the Georgia Department of Public Health, insured or uninsured rates, evidence-based strategies, and promising approaches. The primary data was collected using three focus groups including:
(1) a provider focus group,
(2) an African American group with youth and their parents/caregivers, and
(3) a Latinx group with youth and parents/caregivers.
This group was divided into two groups, one session was held in English and one in Spanish.

Situation

Georgia is experiencing disparities in mental health prevalence and access to care. Georgia has a mental health ranking of 49 out of the 50 states for healthiest state (United Health Foundation, 2021). The top 3 prevalence rates for depression are 17-year-olds with the highest prevalence at 18.5%, followed by 15-year-olds at 17.2% and 16-year-olds at 16.9. Racial prevalence is 13.8% for Latinx and 14.0% for African Americans. Latinx and African Americans have higher prevalence and severity rates, about 68% (NIMH, 2019).

In Georgia, improvements have been made, such as increasing mental health providers by 22 percent. While the number of providers increased, so did mental distress from 2011 to 2019 by 26 percent (United Health Foundation, 2021). A few other key factors point to the need for greater understanding of mental health equity within the state of Georgia

- The uninsured rate in 2020 was significantly higher for Georgia than for the U.S overall (13.4% and 9.4% respectively) (United Health Foundation, 2021).
- 19- to 25-year-olds are the most uninsured group in Georgia, with an uninsured rate of 13.7% in 2017 and an increase to 14.3% in 2018 (Berchick, Barnett, & Upton, 2019).
- Income inequality in Georgia impacts the insurance rate. White households in Georgia, on average, have higher median incomes than the U.S, while the Latinx communities have a higher median income than African Americans (Guzman, 2020).
- The Latinx community is concentrated in the following counties: Echols, Stewart, Chattahoochee, Gwinnett, Hall, Gordon, and Whitfield (County Health Rankings, 2020).
There are a wide range of existing services, however most of them do not focus on African American or Latinx young adults. There is greater prevalence of services in metro areas such as Atlanta, Augusta, Savannah, and Albany, with significantly fewer mental health providers serving the rural parts of the state. There are some unique programs that try to target these audiences, in particular ViewPoint Health, a Georgia state-funded Community Service Board, has a division that works specifically with Latinx audiences but these services are limited. Most of the service providers in rural parts of the state are Community Service Boards (CSBs) which serve multiple counties and do not always have a consistent presence in the county, which limits the options for mental health services for residents in those communities. There are 23 CSBs which serve the 159 counties in the State of Georgia under the guidance of the Georgia Department of Behavioral Health and Developmental Disabilities.

Key challenges, gaps, and barriers

Through the review of the literature, maps of service areas and key areas of need, the key challenges and gaps in services included:

- The highest prevalence of poor mental health is located in rural areas which also suffer from lower rates of mental health services and insurance access.
- There is a lack of cultural and linguistic competency in mental health care for both African American and Latinx youth.
- Latinx youth reside in rural areas in greater levels than in urban areas. Again, these are locations with fewer mental health service providers and less choice options for individuals.
- There is a lack of youth voices in treatment, and there is not enough peer support.
- Latinx young adults need providers who understand their culture, language, and beliefs (Barrera & Longoria, 2018).
- Misdiagnoses is an issue for many African American and Latinx individuals due to misinterpretation of cultural cues.
- African Americans need providers to understand racism, systemic racism, and trauma (Trent, Dooley, & Dougé, 2019).
- Almost 50% of young people want to learn how to help themselves and their peers (Mental Health America, 2020).

Barriers to services included the following:

- African American and Latinx communities have a mistrust of medical providers (Copeland & Snyder, 2011).
- Both communities experience discriminatory treatment or ineffective care, as well as cultural stigmas and general attitudes toward psychiatric disorders and mental health services (Woods-Giscombe et al., 2016).
- There is a lack of quality mental health services that are culturally aware and sensitive for both African American and Latinx communities (Corrigan et al., 2017).
- There is a lack of services which provide cultural adaptation including language, awareness of cultural differences and expectations and potential traumas for Latinx communities (Corrigan et al., 2017). This is often true for African American communities as well.
- Latinx residents often fear of being deported or immigration status being called into question when seeking these services which outweighs the need for help for some (Corrigan et al., 2017).

Partnering with trusted community sources like barbershops and churches is another promising practice that is being investigated. Policy Advocacy is essential as well because it can improve cultural and linguistic workshops, training, and laws.
Recommendations

Based on the variety of research and evidence review in the White Paper, several recommendations are presented at the end of the paper including:

- Increased funding for cultural and linguistically representative researchers to support researching promising practices to move them to evidence-based models, continuing to examine barriers and understand ways to change the systems. Research into workforce development is also needed.

- Peer support is needed to help encourage and support young people, particularly in these vulnerable communities.

- Mentoring programs can provide pathways for young African American and Latinx youth to enter the field of mental health and increase the number of providers in the field who are similar to the target audience.

- Loan forgiveness also provides models to increase the number of African American and Latinx mental health providers.

- Addressing licensing of foreign professionals to help reduce communication concerns and anxiety for Latinx individuals seeking care.

- Community education about behavioral health services and mental health and wellness helps to reduce stigma and increase awareness for recognizing needs and connecting resources.

- Specialized training for existing mental health providers to help meet the unique needs and challenges for these providers.

- Linguistic barriers can be reduced to help expand the options for Latinx individuals.

- Creative therapies and funding will allow more mental health providers to provide culturally appropriate and supportive care to African American and Latinx communities.

Background

Impetus behind the project

An October 24, 2020, Washington Post feature article about an 11-year-old, mentally ill, Black boy named Ahav, who lives in suburban Atlanta with his single mother Kelli and younger brother Analiel describes the critical issues we address in this paper. Ahav experiences visual and auditory hallucinations and the delusion that a “man in his body” tells him to hurt himself and his family. Due to “his mental illness, his family’s poverty, his age, his size, his race and a pandemic that was eroding the already fragile systems that had been keeping him stable,” Ahav experiences multiple complications with healthcare, law-enforcement, and education systems including frustrations with Medicaid, noting the lack of access to in-patient treatment for Ahav, who had seven ER visits between April and October 2020. In addition to the costs associated with accessing care (even with Medicaid), the article discusses the importance of a culturally responsive therapist and crisis and trauma trained police officers. The article closes with Analiel just released from the hospital stabilized, Ahav experiencing symptoms, and his mother resolved to continue bearing the burden of care alone, despite the failings of the system. In the end, the focus is on Kelli’s persistence in helping her sons survive.

WARNING: The link to the full article for Ahav’s story is below. This article describes real episodes of emotional disturbance and physical violence. Accordingly, reader discretion is advised.

https://www.washingtonpost.com/nation/2020/10/24/black-child-mental-illness-pandemic/
Healthcare Georgia Foundation engaged the Multicultural Development Institute, Inc. to develop an equity White Paper to help support the Foundation with its due diligence relative to Mental Health equity and health disparities among African American and Latinx youth in the state of Georgia. The White Paper includes key information to examine the intentionality of serving these communities, how equity is understood in the Georgia mental health system, and how equity is being considered in the planning and execution of behavioral health services.

The process would include primary and secondary research about existing behavioral health services that are available in Georgia for these two communities; the barriers to accessing services with an emphasis on children and families who are either uninsured or underinsured; the gaps in service access and delivery; the demographics of the population; and the evidence-based strategies and/or promising approaches for African American and Latinx children/youth and their families.

The behavioral health workforce would also be addressed, in particular any development opportunities for individuals at all levels of service including those in the first access points to enter the behavioral health system for children and youth. And it will address training opportunities relative to equity and implicit bias among the workforce.

Finally, the paper will provide recommendations to the Foundation on programmatic and direct services, systems approaches and communications strategies to address stigma and policy opportunities that seek to address equity and reduce disparities that could be incorporated into future program design for the Foundation.

As a primary part of the project, a research team was developed with the two principal investigators pulling together two additional research assistants to create a research team. The research team worked collaboratively to develop the summary White Paper. This report was prepared using a meta-analysis of existing research as well as primary data collection from key stakeholders. First, the principal investigators met to discuss and develop the key focus areas for the White Paper and the key areas for investigation and research. A thorough literature review was conducted to include information about each of the key areas identified by the principal investigators. Three virtual convenings were held with key informants: African American/Black, Latinx, and mental health providers to also provide firsthand experience.

Guided by the key focus areas outlined by the principal investigators, the research team conducted a thorough literature review. During the literature review process, the research team met each week to discuss the updated literature and summaries as well as any key areas of overlap or discord between the articles and research resources identified. Often these meetings resulted in identification of additional avenues for research. In addition to peer reviewed articles, the research team also reviewed key stakeholder reports, summary documents, and key products from mental health agencies throughout the state. This information was all consolidated in summary annotated bibliographies which have then been used to prepare this final written report.

The literature review informed the development of the focus group question route. The focus groups were scheduled with the assistance of key community organizations who had connections to the target populations. Mental health providers and advocates were recruited to participate through an electronic email message and flyer sent out through the Georgia Behavioral Health Planning and Advisory Council, the Behavioral Services Coalition, Behavioral Health Services Coalition, and the Georgia Department of Behavioral Health and Developmental Disabilities. The Georgia Latino Alliance for Human Rights (GLAHR) and the Georgia Parent Support Network (GPSN) assisted in recruiting young adults and parents for the individual focus groups.
Each of the three focus groups was held via Zoom at times that were identified as the best opportunity for each of the target groups. Prior to conducting the focus groups, the research team held a training session to ensure that all members of the team were prepared to moderate and to take notes during the focus groups. The training session lasted one hour and included opportunities for each of the team members to practice moderating the question route. All focus groups were transcribed for analysis.

Finally, information from each of the areas was integrated to prepare the final report which integrated the information from the literature review, environmental scan, and focus groups.

**Overview**

This paper is organized in several key sections. The first section will review the current environment in Georgia. This section will include a review of mental health prevalence nationally and in Georgia. Specific discussion of depression in the target communities both nationally and within the state of Georgia will also be examined. Mental health prevalence within the African American and Latinx communities in Georgia will also be discussed. Within this section key geographic areas of need will also be reviewed, including areas of coverage and gaps in services or high areas of need.

The second section of this paper will focus on the current services available in Georgia, including an overview of health insurance coverage for residents in the state. Existing services throughout the state will also be discussed in this section. Barriers to service access and comparisons between urban and rural areas will also be examined. Rural areas for the purposes of this paper are defined as counties with populations less than 35,000. The population includes both incorporated and unincorporated towns and cities within the designated 108 rural Georgia counties (Georgia Office of Rural Health).

In the third section of the paper, evidence-based practices for target populations will be reviewed and discussed. This will include both evidence-based and promising practices as well as other key stakeholders who are investing and working within this area. Workforce development opportunities will be examined and discussed in the fourth section of the paper. This will include a review of capacity development opportunities, language issues, and opportunities for building capacity within the existing workforce as well as strengthening and building the workforce.

Section six will review specific COVID/pandemic related issues. Sections seven and eight will review the feedback and guidance from providers in the state and from individuals in each of the target populations. The paper will conclude with a summary conclusion and recommendations which will summarize all the key findings and produce some specific recommendations for future actions by philanthropic groups as well as research organizations.
Georgia Environment

Overview

The National Institute of Mental Health defines depression as experiencing a minimum of two weeks feeling depressed, including loss of interest, no pleasure in daily activities, challenges with eating, sleeping, self-worth, or concentration.

Broad mental health prevalence.

Georgia has its challenges with mental health ranking 49 out of the 50 states for healthiest state (United Health Foundation, 2021). With this low ranking, improvements have been made, such as increasing mental health providers by 22 percent. While the number of providers increased, so did mental distress from 2011 to 2019 by 26 percent (United Health Foundation, 2021).

Depression

Major depression is the leading mental health disorder in the United States (NIMH, 2019). The National Survey on Drugs and Health from 2017 provided data on the adults and youth-related to depression. For adults, major depression is the most common mental disorder in the U.S. 17.3 million (7.1%) adults had one major episode. More common in women (8.7%) than males (5.3%). The highest prevalence for the age group 18-25 with 13.1% (NIMH, 2019). African Americans and Latinx had a prevalence rate of 5.4 compared to Whites at 7.9, yet adults reporting two or more races had a prevalence of 11.3. In the past year, 64% had severe impairment due to depression. For the youth, major depression affects 3.2 million (13.3%) adolescents from 12-17—higher among females (20%) than males (6.8) (NIMH, 2019). The top 3 prevalence rates are 17-year-olds with the highest prevalence at 18.5%, followed by 15-year-olds at 17.2% and 16-year-olds at 16.9. Racial prevalence is 13.8% for Latinx and 14.0 for African Americans. The highest prevalence is 16.9 for two or more races. 71% had severe impairment with their depression episode. The age groups of 15-17 and 18 to 25 have the highest prevalence rate for depression. Latinx and African Americans have a higher prevalence rate and severity rate about 68% (NIMH, 2019). The data above are national data on depression in the United States.

Prevalence among the target populations.

The Online Analytical Statistical Information System (OASIS) reported the number of youths and young adults who had hospital discharges due to mental and behavioral disorders from 2015 to 2019. The prevalence was the highest amongst the age range of 15 to 19 years old with a total of 27,439 for White and Black people being discharged with the total of 869 Latinx people being discharged (GDPH, 2021). There is a higher prevalence in females with 15,893 than males at 11,546 (GDPH, 2021). The racial breakdown was 6,270 White males with 8,883 White females compared to 4,150 Black males to 5,453 Black females compared to 381 Latinx males to 488 Latinx females (GDPH). This data correlates to the national data of women having a higher prevalence rate than men. The age range of 20 to 24-year-olds was 22,043 for White and Black individuals being discharged, with 405 Latinx individuals being discharged. There is a slightly higher prevalence in men with 11,785 than females at 10,258. The racial breakdown was 5,640 White males to 5,449 White females compared to 5,257 Black males to 4,121 Black females compared to 223 males to 182 Latinx females (GDPH, 2021). The data provides evidence that the age group of 15 to 19 years old’s is the most at risk, with females having the higher prevalence but the age group 20 to 24-year-olds are at risk, but males have a higher prevalence in Georgia.
Another study conducted by the Georgia Department of Public Health for the Youth Risk Behavior Surveillance system provided in 2013 provided the following data. That 28% of high school students between the ages of 14-18 were depressed and/or suicidal, 14% seriously considered attempting suicide in the past 12 months, 12% made a plan to attempt suicide, the annual suicide rate for ages 14–18 from 2008–2012 is 4.7% (GDPH, 2018). It was also shown that males have a suicide death rate in Georgia, four times the average in the United States. From 2008 to 2012 sixty-four students experienced self-inflicted injuries, 9% actually attempted suicide in the past 12 months, and 3% made a suicide attempt that was treated at the hospital (GDPH, 2018). This data provides evidence that high schoolers need mental healthcare in Georgia.

Access to health insurance is critical for access to mental health services. The 2018 U.S. Census provided information about the uninsured rate in the U.S. The data stated that the uninsured rate for the U.S. in 2017 was 8.7%, and in 2018 it was 8.9%. In Georgia, the uninsured rate in 2017 was 13.4%, and in 2018, it was 13.7% (Berchick, Barnett, & Upton, 2019). It can be concluded from this data that the uninsured rate is increasing for both the United States and Georgia. The age range with the highest insured rate in the United States is 19 to 25-year-olds at 89% (Berchick, Barnett, & Upton, 2019). In 2017 the uninsured rate for ages 0 to 18 years old was 5% and in 2018 was 5.5%. In 2017 for ages 19 to 25 years old, it was 13.7%, and in 2018 it was 14.3%. Ages 19 to 25 was among the most likely to be uninsured, with a coverage rate of 85.7 percent and an uninsured rate of 14.3 percent (Berchick, Barnett, & Upton, 2019). The evidence concluded that the uninsured rate increased as age increased. The government has tried to decrease the uninsured rate for people between the ages of 19 to 25 with the Affordable Care Act to protect young adults and eliminate burdens on businesses and families. This included offering dependent child coverage until age 26 (CMS, 2021). This means that children can be dependent on their parents’ insurance until they are 26 years old. They can qualify if they are married or unmarried while having the same benefits coverage as their parents while not paying more (CMS, 2021). The uninsured rate in the United States and Georgia has to be addressed to increase access to mental health services.

A challenge for Georgia is that people avoid care due to cost and being uninsured. The 2020 U.S. Census data provided evidence that 13.4% of residents in Georgia were uninsured compared to 9.4% in the United States (United Health Foundation, 2021). Statista conducted a telephone survey to determine the uninsured rate for Adults in Georgia from 2001 to 2016. The data provides evidence that in 2001 the total population for ages 19–64 years old was overall 30% uninsured and earns less than 200% of the federal poverty level (Elflein, 2019). Whites were uninsured at 26%, Blacks at 25%, and Latinx at 44%. In 2010, the uninsured rate for the same age group was 36%, with Whites at 33%, Blacks at 31%, and Latinx at 48%. In 2012, the uninsured rate for the same age group was 32%, with Whites at 27%, Blacks at 28%, and Latinx at 44%. In 2014, the uninsured rate for the same age group was 24%, with Whites at 19%, Blacks at 21%, and Latinx at 37%. In 2016, the uninsured rate for the same age group was 19%, with Whites at 15%, Blacks at 14%, and Latinx at 32% (Elflein, 2019). In conclusion, from 2001 to 2016, the total population of uninsured people decreased. Whites decreased from 26% to 15%. Blacks from 25% to 14%. Latinx from 44% to 32% in Georgia. Often the uninsured rate is connected to income.

According to the U.S. Census, the median household income for the United States from 2015–2019 was $62,843 compared to Georgia at $58,700 (Guzman, 2020). Household income separated by race and ethnicity provided the following data: the non-Hispanic White median households had an income of $68,785 in the United States compared to Georgia at $67,955. The Hispanic median household had an income of $51,811 in the United States compared to Georgia at $49,897. The African American median household had an income of $41,935 in the United States compared to Georgia at $44,670. The White household has an income higher than the United States median household income while Hispanics have a higher median household income than the African Americans. This data reflects the income inequality in Georgia.
Income inequality and uninsured rate are high in Georgia. In 2018, out of all cities in the United States, three of Georgia’s cities made it to the national top 25 cities with the highest uninsured rate. The cities are Valdosta, with an uninsured rate of 19.2%, Gainesville with an uninsured rate of 16.4%, and Dalton with an uninsured rate of 16.1% (Elflein, 2021). All of these uninsured rates are higher than the U.S. and Georgia’s uninsured rate. When comparing Georgia to the United States in 2019, Georgia ranks 48 out of 50 states for the highest uninsured rate of 13.4% (Szilagyi, 2020). Georgia not expanding Medicaid probably influenced the ranking. Changes in the uninsured rate in Georgia from 2010 to 2019 was 6.29% (Szilagyi, 2020). In 2019 the uninsured rate by race and ethnicity were Whites at 10.23%, African Americans at 13.32%, and Hispanics at 32.35% (Elflein, 2021). This data coincides with a CDC survey that was done in 2019 asking if people over 18 had insurance. Whites said yes with a rate of 87.6%, African Americans at a rate of 81.5%, and Hispanics at a rate of 40%. Whites said no with a rate of 12.4%, African Americans at a rate of 18.5%, and Hispanics at a rate of 60%. Overall for the age range of 18 to 24 years old, 80.6% had insurance, and 19.4% didn’t (Elflein, 2021). Latinx has the highest uninsured rate in Georgia for 2019, while 20% of people aged 18 to 24 years old are uninsured. In 2019 a study provided evidence that 2.9 million adult workers between the ages of 19 to 25 years old were uninsured (Elflein, 2020). The study also looked at the different types of insurance in Georgia. Employers’ insurance was the most common at 48.9%, Medicaid at 17.3%, Medicare at 12.6%, Non-group at 5.6%, and other public insurance at 2.2% (Elflein, 2020). This information is essential because an American Community Survey in Georgia provided evidence that young adults under 26 have the worse health outcomes than adolescents, including increased rates of injury and mental illness (Conway, 2020). Georgia’s uninsured rate in 2019 for ages 19 to 25 years old was 24.40%. This is important because young adults face changes to their insurance coverage at 19 years old because they don’t qualify for public coverage anymore. The uninsured rate for 19-year-olds is 14.3% which is 4.8% higher than 18-year-olds. The uninsured rate increases for ages 19 to 21 and 24 to 26 years old. 26-year-olds have the highest uninsured rate at 18.3% (Conway, 2020). This information is vital to understanding mental health access in Georgia for the African American and Latinx communities.

Key significant geographic areas of need and gaps in services

To identify the key areas of need, the research team examined the areas of the state that had the highest population rates for the target audience, the highest rates of poor mental health (County Health Rankings, 2020), and the areas with the highest rates of uninsured individuals. Feedback from the focus groups with providers and individuals was triangulated with this information to provide a more comprehensive picture of the current environment. The map below was created using data from the County Health Rankings and the Georgia Department of Public Health OASIS data system. As can be seen in the map below, in general, residents in rural areas and South Georgia counties in particular, tend to have a higher average number of poor mental health days than those in the urban centers.
A similar pattern can be seen in the maps below, with the counties with a higher percentage of African American/Black and Latinx populations being more prevalent in South Georgia rural counties. African American communities have higher rates of concentrations in the following Georgia counties, Clayton, Dekalb, Rockdale, Fulton, Calhoun, Early, Clay, Baker, Washington, Hancock, Bibbs, and Richmond (IndexMundi, n.d). Chattahoochee, Echols, Gwinnett, Gordon, Hall, Stewart and Whitfield are the Georgia counties with the highest proportions of Latinx per population. (IndexMundi, n.d).

It is interesting to note in the map on the left, which shows the prevalence or access to care, that the urban centers tend to have a lower ratio of people to providers (more providers to serve the population). This means that the rural counties where there may be a much greater need for care, also have a much lower level of access to care. There is overlap in services for areas close to Metro Atlanta but deficient service availability in rural areas that are predominately African American or Latinx. In the map below from the County Health Rankings website, counties in deeper blue color have a lower ratio of providers to individuals. This means in those counties that there are more people per provider than in the light blue counties.
In addition, the following graphic from Voices for Children (2021), shows the disparity between rural and urban areas with regards to types of clinicians to serve the demands of the community, particularly for youth.

According to the U.S. Census, the average uninsured rate for the nation reached 9.2 percent in 2019, higher than the 8.9 percent in 2018 (Szilagyi, 2020). In 2019, Georgia was listed among other states with the highest uninsured rate in the country at 13.41%, ranking 48 out of the 50 states (Szilagyi, 2020). A demographic breakdown reveals that in 2019, 7.41% of children were uninsured, 15.48% of adults were uninsured, 13.32% of Black individuals were uninsured and 32.35% of Hispanics were uninsured (Szilagyi, 2020). Data from the American Community Surveys (ACS) between 2018-2019 examined the uninsured rate among young adults ages 19-34 throughout the 50 states (Conway, 2020). In 2019, 15.6% of young adults between the ages of 19-34 were uninsured, higher than the uninsured rate for children under the age of 19 (5.7%) working-aged adults between the ages of 35-64 (11.3%) and adults 65 and older (0.8%) (Conway, 2020).

In 2019, the percentage of young adults between the ages of 19-34 who were uninsured were highest among five southern states, including Georgia at 23.7% (Conway, 2020). The Affordable Care Act (ACA) gave the option for states to expand their Medicaid eligibility for those whose income-to-poverty ratio fell below a certain threshold. Leading up to January 1, 2019, 32 states and the District of Columbia chose to expand their Medicaid eligibility, while 18 states chose not to expand their Medicaid eligibility. Young adults, after they age out of coverage under CHIP or their dependent coverage status, have the opportunity to access Medicaid if they meet specific income criteria. In 2019, the uninsured rates for young adults between 19-34 that lived in states that did not expand their Medicaid was 10.5% higher at 22.3%, compared to states that did expand Medicaid at 11.8%, Georgia is among the states that did not expand.

Georgia’s Counties

- 78: Do not have a licensed psychologist
- 53: Do not have a licensed social worker
- 45: Do not have a licensed psychologist OR a licensed social worker

Counties without a licensed psychologist
Counties without a licensed social worker
Counties without both

Current services available in Georgia

Overview of health insurance in Georgia compared to the United States
Beginning January 2020 and ending in June 2020, the Commonwealth Fund conducted a Biennial Health Insurance survey. These findings are a part of a survey that has been conducted since 2001, measuring whether or not people have insurance, if they do, what is the gap in coverage from the previous year, and how high out-of-pocket costs and deductibles are impacting their insurance usage (Collins, Gunja, & Aboulafia, 2020). The Commonwealth Fund found that during the first half of 2020, 43.4% of adults were inadequately insured (Collins, Gunja, & Aboulafia, 2020). High uninsured rates were reported among people of color, small business workers, people with low incomes, and young adults (Collins, Gunja, & Aboulafia, 2020). According to the survey findings found by the Commonwealth Fund, the percentage of young adults between the ages of 19–34 who were uninsured was 28%, the percentage of Black individuals who were uninsured was 24%, and Latinx individuals at 40% (Collins, Gunja, & Aboulafia, 2020).

Existing services

There are a variety of mental health service providers within Georgia. More than could be completely listed within this report, when considering all of the range of mental health providers and types of care. The Georgia Collaborative ASO and the Georgia Department of Behavioral Health and Developmental Disabilities provides a comprehensive searchable list of DBHDD approved providers at:

https://providersearch.beaconhealthoptions.com/#/provider/home/277

This site provides a comprehensive list of providers who are approved for reimbursement for various services in each county throughout the state. This paper will discuss later the barriers that individuals and providers discuss regarding access to available, insurance covered care in all areas of the state.

The first table on the next page shows some of the largest mental health providers throughout the state that include services for youth and young adults, including the services provided and geographic areas covered. There were representatives from many of these providers who participated in our provider focus group (discussed later in this paper). These private services make up a fraction of facilities in this community, but do not serve as an overall depiction of the number of services available. Below is a snapshot of the services in Georgia that were a part of the listening sessions and other services available throughout the state of Georgia that serve this particular demographic.

In addition to independent mental health services and organizations, Resilient Georgia has been working with eight (8) cities and the surrounding counties across Georgia to assemble a succinct trauma-informed public and private behavioral health system. These cities focus on trauma informed wellness and care, Adverse Childhood Experiences (ACEs) and child sexual abuse prevention training, as a starting point to transform systems and procedures across public and private sectors. The regional coalitions are based out of Athens, Augusta, Macon, Savannah, Albany, Columbus, Rome, Thomasville, Clayton, Cobb, Gwinnett, Valdosta, and surrounding areas. Within these coalitions are partners in the perspective counties that support Resilient Georgia’s mission. These coalitions are described in the second table below.
# Providers Throughout Georgia

(sample, not a comprehensive list)

<table>
<thead>
<tr>
<th>Organization</th>
<th>Description</th>
<th>Counties Served</th>
<th>Demographic Served</th>
<th>Latinx or African American populations specifically?</th>
<th>Specialty Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viewpoint Health</td>
<td>Community behavioral health center</td>
<td>Atlanta, Lawrenceville, Newton, Norcross, Rockdale</td>
<td>Children, adolescents, and young adults</td>
<td>No</td>
<td>Autism outpatient services, Adolescent Crisis Stabilization Unit, Zero Suicide Initiative</td>
</tr>
<tr>
<td>Chris 180</td>
<td>Mental and behavioral services</td>
<td>Atlanta, Dekalb, Adamsville, Gwinnett</td>
<td>Children, young adults, and families</td>
<td>No</td>
<td>Individual therapy, Aggression Replacement, Play Therapy</td>
</tr>
<tr>
<td>Family Ties</td>
<td>Home based counseling and community integration services for children and families</td>
<td>Cobb, Clayton, Coweta, Dekalb, Forsyth, Fulton, Gwinnett, Hall, Henry, Rockdale</td>
<td>Families and children</td>
<td>No</td>
<td>Telemental Health, Medicaid Funded Mental Health Services, DFCS Services, School Based Mental Health Services</td>
</tr>
<tr>
<td>Marvelous Light Consultants</td>
<td>Home based counseling and community integration services for children and families</td>
<td>Dekalb, Fulton, Clayton, Henry, Rockdale</td>
<td>Children and families</td>
<td>No</td>
<td>Substance Abuse Treatment Services, Community Behavioral Health Treatment Services, Family Preservation Services</td>
</tr>
<tr>
<td>Achieving Recovery Through Resilience, Optimism, and Wellness (ARROW)</td>
<td>Specialized program for young adults having a hard time readjusting into everyday life</td>
<td>Grady Hospital</td>
<td>Young adults between 18-30</td>
<td>Yes, Latinx</td>
<td>Cognitive Behavior Therapy (CBT) for psychosis, Family Therapy, Low-dose medication management</td>
</tr>
<tr>
<td>Clinic for Education, Treatment, and Prevention of Addiction (CETPA) (now a part of Viewpoint Health)</td>
<td>Providing evidence-based, culturally, and linguistically appropriate substance abuse, mental health counseling, and prevention services with priority to the Latino community</td>
<td>Gwinnett, Rockdale, Newton</td>
<td></td>
<td></td>
<td>Direct clinical services, intervention services, prevention services</td>
</tr>
<tr>
<td>Unison Behavioral Health</td>
<td>Create health and wellness in our communities by providing quality mental health, substance abuse, and developmental disability services</td>
<td>Barrow, Bartow, Bryan, Camden, Chatham, Clarke, Clayton, Dekalb, Effingham, Elbert, Fulton, Glynn, Gordon, Greene, Henry, Jackson, Liberty, Long, Madison, McIntosh, Morgan, Muscogee, Oconee, Oglethorpe, Rockdale, Walton Oglethorpe, Rockdale, Walton</td>
<td>Children and Families</td>
<td>No</td>
<td>Home-based Services, Pharmacy, Residential Program</td>
</tr>
<tr>
<td>Organization</td>
<td>Description</td>
<td>Counties Served</td>
<td>Demographic Served</td>
<td>Latinx or African American populations specifically?</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<td>------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>CSB Middle Georgia</td>
<td>Providing those served with quality innovative behavioral healthcare in a recovery-based environment</td>
<td>Bleckley, Dodge, Johnson, Laurens, Montgomery, Pulaski, Telfair, Treutlen, Wheeler, Wilcox counties in Georgia Burke, Emanuel, Glasscock, Jefferson, Jenkins, Screven</td>
<td>Children and Adults</td>
<td>No</td>
<td>Children/Youth Services, Adults Mental Health Services, Nursing Services</td>
</tr>
<tr>
<td>Middle Georgia Behavioral Services</td>
<td>Provides integrated treatment for drug and alcohol and co-occurring mental health issues.</td>
<td>Appling, Atkinson, Bacon, Baldwin, Barrow, Bibb, Bleckley, Brantley, Bryan, Bulloch, Burke, Butts, Camden, Candler, Carroll, Charlton, Chatham, Chattahoochee, Clarke, Clay, Clinch, Coffee, Columbia, Coweta, Crawford, Crisp, Dodge, Dooly, Effingham, Elbert, Evans, Fayette, Glasscock, Glynn, Greene, And Many More</td>
<td>Individuals, Couples, and Families</td>
<td>No</td>
<td>Mental health services for children, adolescents, and families, medication services, drug, and alcohol treatment</td>
</tr>
<tr>
<td>Pineland BH/DD CSB</td>
<td>A public, not-for-profit community-based organization that helps children, adolescents, adults, and seniors who have mental illness, developmental disabilities, and addition challenges to live more full and productive lives</td>
<td>Clayton, Dekalb, Douglas, Fayette, Fulton, Gwinnett, Henry, Rockdale</td>
<td>Adults</td>
<td>No</td>
<td>Outpatient Counseling center, community integration services, child, and adolescent outpatient services</td>
</tr>
<tr>
<td>River Edge Behavioral Health Center</td>
<td>A leading resource for mental health and substance use disorder treatments and supports for individuals with intellectual and development disabilities.</td>
<td>Cherokee, Clayton, Cobb, Dekalb, Fayette, Fulton, Gwinnett, Henry, Newton, Rockdale</td>
<td>Youth, adults, and families</td>
<td>No</td>
<td>Mental illness recovery, substance use disorder recovery, intellectual and developmental disabilities support</td>
</tr>
<tr>
<td>Arise Counseling Services</td>
<td>A comprehensive continuum of care for adolescents and adults suffering from mental health and substance use disorders.</td>
<td>Coweta</td>
<td>Youth, Adults, and older adults</td>
<td>Yes, African American and Latinx</td>
<td>Substance Use, Anger Management, Domestic Violence</td>
</tr>
<tr>
<td>Highland Psych</td>
<td>A team of talk doctors to help clients get unstuck, building deeper and more satisfying relationships.</td>
<td>Dekalb and Fulton</td>
<td>Youth, adults, and older adults</td>
<td>Yes, African American and Latinx</td>
<td>Anxiety, Depression, and Relationship Issues</td>
</tr>
</tbody>
</table>
covered three areas of behavioral/mental health:
across a number of behavioral health challenges
of the review was to identify promising interventions
benefited from in the behavioral health setting. The goal
intervention's teens and young adults (12-26) have most
Foundation, to address existing evidence on the
review, at the request of the Colorado Health
In 2018, Academy Health conducted a systematic
State organization or NAMI affiliate (NAMI, 2021).
dered in school, community, and health care settings
together with mental health
delivered in school, community, and health care settings
of the continuum of care

Resilient Georgia Supported
Coalitions

Athens Northeast GA

<table>
<thead>
<tr>
<th>Coalition Focus</th>
<th>Coalition Geographic Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma-informed behavioral health continuum of care</td>
<td>Barrow, Clarke, Jackson, Madison, Oconee, Oglethorpe</td>
</tr>
</tbody>
</table>

Partners
- Athens Area Community Foundation
- Envision Athens
- Sole to Soul Therapy & Consulting

<table>
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</thead>
<tbody>
<tr>
<td>Cherokee, Cobb, Dekalb, and Fulton</td>
<td>Couples, family, and relationship counseling</td>
<td>Yes, African American and Latinx</td>
<td>Substance Use, Continuing care, Intensive outpatient program</td>
</tr>
<tr>
<td>Clarke, Cobb, Fulton, Morgan, Oconee</td>
<td>Individuals, couples, and families</td>
<td>Yes, African American</td>
<td>Depression, Anxiety, Relationship Issues</td>
</tr>
<tr>
<td>Savannah</td>
<td>Children, Youth, adults, and older adults</td>
<td>Yes, African American and Latinx</td>
<td>Depression, Anxiety, Testing and Evaluation</td>
</tr>
</tbody>
</table>

Coastal Georgia

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</thead>
<tbody>
<tr>
<td>Provide mental health counseling to Elementary, Middle, and High School Students</td>
<td>Bryan, Chatham, Effingham</td>
</tr>
</tbody>
</table>

Partners
- America’s Second Harvest
- Deep Center
- The Front Porch
- Youth Intercept
- Savannah Chatham County Public School System
- Georgia Southern University - School of Public Health and Department of Education and Instruction
- Savannah/Chatham CASA - Court Appointed Special Advocates
- Savannah Police Department - Training/Professional Development and Behavioral Health Unit
- 1. Joseph’s /Candler Health System - the African American Health Information and Resource Center (HERO Database)
- Chatham County Government
- Frank Callen Boys and Girls Club
- Parent University
- Savannah Feed the Hungry
- Bryan County Schools
- Effingham County Schools
- Front Porch Improv
- Georgia State University - Child Welfare Collaborative

Below is a sample of some of the current
conclusions. Below is a sample of some of the current
organization where there is preliminary evidence of
Promising practices, according to the U.S.  Department
of Health and Human Services (2003) is a program,
which is a program, to address existing evidence on the
review, at the request of the Colorado Health
In 2018, Academy Health conducted a systematic
State organization or NAMI affiliate (NAMI, 2021).
### Resilient Middle Georgia

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Empower the surrounding cities and counties to help with challenges related to empathy and bravery in the building of resilience in individuals, families, and the community</td>
<td>Baldwin, Bibb, Crawford, Hancock, Houston, Jasper, Jones, Monroe, Peach, Pulaski, Putnam, Twiggs, Washington, Wilkinson</td>
</tr>
</tbody>
</table>

| Partners | | |
|---------| | |
| ABC Breathe | Baldwin County Family Connection |
| Partnership-Family Connection | Bibb County School District |
| Bright from the Start DECAL | Central Georgia Technical College |
| Southern Center for Choice Theory | Community Healthcare Systems, Inc. |
| The Center for Collaborative Journalism at Mercer University | Mercer Family Therapy Center |
| Community in Schools of Central Georgia | Justice Partnership, DA’s Office |
| Crisis Line & Safe House of Central GA | Washington County Family Connection |
| Family Counseling Center of Central Georgia | First Baptist Church of Christ |
| First Choice Primary Care | Georgia Rural Health Innovation Center |
| Griffith Family Foundation | Habitat for Humanity Macon |
| Healthy Communities Navient | Hospice Care Options |
| Houston County Health Department | Houston Family Connections |
| Jones County Family Connection | Loaves and Fishes Ministry |
| Macon-Bibb County Health Department | Macon Headspace and One World Link |
| Macon Housing Authority | Macon Public Defender Office |
| Macon Volunteer Clinic | Medical Center Navient Health |
| Mercer University School of Medicine | One Macon Program Director for Region 6 |
| Middle GA Regional Library | Office of Congressman Sanford Bishop |
| River Edge Behavioral Health School | North Center Health District DPH |
| | Pulaski Family Connections |
| | Bibb County School District |
| | Macon AIM |
| | Navient Health |
| | The Comfy Place, LLC |
| | Bibb Community |
| | Community Health Works |
| | Middle GA State |
| | Mercer University |
| | Bibb Mt. Zion Baptist Church |
| | Crescent House, Navicent |

### Resilient Chattahoochee Valley

<table>
<thead>
<tr>
<th>Coalition Focus</th>
<th>Coalition Geographic Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing awareness and knowledge about ACES, trauma, and resilience for the outcomes of children between the ages of 0-16</td>
<td>Chattahoochee, Clay, Harris, Macon, Marion, Muscogee, Quitman, Schley, Stewart, Talbot, Taylor, Webster</td>
</tr>
</tbody>
</table>

| Partners | | |
|---------| | |
| 211: United Way of the Chattahoochee Valley | Boys and Girls Clubs of the Chattahoochee Valley |
| Bradley-Turner Foundation | Chattahoochee Council, Boy Scouts of America |
| Columbus Alliance for Battered Women dba Hope Harbour | Columbus Consolidated Government Columbus GA 2025 |
| Columbus Health Department – West Central Health District | Community Foundation of the Chattahoochee Valley |
| Easter seals West Georgia | Enrichment Services Program, Inc./Head Start, Early Head Start |
| The Family Center | Feeding the Valley Food Bank |
| Ferst Readers, Inc. of Muscogee County | Georgia Department of Public Health West Central Health District |
| Girls Scouts of Historic Georgia, Inc. | Girls Inc. of Columbus and Phenix-Russell |
| Greater Columbus Georgia Chamber of Commerce | Home for Good: A Program of United Way of the Chattahoochee Valley |
| Mercer University School of Medicine | Mercy Med of Columbus |
| Mill District Studios | Muscogee County School District |
| New Horizons Behavioral Health | Open Door Community House, Inc |
| Parents as Teachers | Piedmont Columbus Regional |
| Rivertown Pediatrics | St. Francis-Emory Healthcare |
| The Salvation Army | United Way of the Chattahoochee Valley |
| Valley Healthcare System | Twin Cedars Youth and Family Services, Inc. |
| YMCA of Metropolitan Columbus, GA | |
In 2018, Academy Health conducted a systematic review with the goal of identifying promising interventions for effective mental health programs for those who need it. The review was to identify promising interventions for teens and young adults (12-26) who have most benefited from in the behavioral health setting. The goal was to explore the ways program coordinators could reduce barriers to participation in recreation programs that offer several opportunities for individuals with mental illness (Hutchinson & Fenton, 2018). The study could be helpful for the production of safe and inclusive environments, as well as beneficial program components that influence the production of programming relevant for people who experience mental illnesses (Hutchinson & Fenton, 2018). According to the literature, engaging in recreation has been shown to improve health and well-being (Hutchinson & Fenton, 2018). The process of recovery involves the journey to recovery, the type of mental health services available, how to talk about mental health, how to recognize mental health symptoms in teens and young adults, and supports available (Gerlach, 2018).

### Partners

- Adoptive and Foster Parent Association GA
- Colquitt County Family Connections
- GA Department of Behavioral Health & Developmental Disabilities
- Mitchell County Family Connection
- Open Door Adoption Agency
- Southwest Public Health District (Child Health Program staff)
- Thomas County Family Connections
- Thomas University School of Social Work
- Thomasville First United Methodist Church Williams Family Foundation of GA

### Coalition Geographic Area

- Colquitt County School System
- Dental Associates of Southwest GA
- Hands and Hearts for Horses
- Never Lost (CASA)
- Southeast Georgia RESA
- Thomas County DFCS
- Thomas County School System
- Thomasville Police Department
- Thomasville Community Resource Center

### Rome–Floyd

**Coalition Focus**

- Increase awareness and provide necessary resources to integrate trauma informed care

**Coalition Geographic Area**

- Colquitt, Decatur, Early, Grady, Miller, Seminole, Thomas

**Partners**

- Family Connection County Collaboratives: Haralson Family Connection, Murray County Family Connection, Paulding Family Connection, Pickens County Family Connection, Polk Family Connection, Walker County Family Connection, Whitfield Family Connection/Children & Families First Department of Public Health: WIC, local health centers
- DJJ and Family Court Circuits in Region 1 – Formerly the Northwest System of Care
- Georgia Family Connection Partnership (GaFCP)
- Georgia HOPE
- Highland Rivers
- North Georgia colleges and universities
- United Way of Chattanooga
- Rome-Floyd County Commission on Children and Youth
- Regional Prevent Child Abuse Chapters & Prevent Child Abuse Georgia

**Coalition Geographic Area**

- Bartow Collaborative, Inc
- Catoosa County Family Connection
- Chattooga Family Connection
- DADE FIRST-Family Connection
- Fannin County Family Connection
- Gilmer County Family Connection
- Family Connection Gordon
- DECAL – regional representatives/offices
- GED and WIOA program providers
- Global Impact
- Local & Regional DFCS
- Primary Healthcare
- United Way of North Georgia
- Local School Systems and Boards of Education (County, City)

### Aligning Community Systems for Resilience Initiative

**Coalition Focus**

- Create a more trauma informed community and system of care in Clayton County

**Coalition Geographic Area**

- Clayton

**Partners**

- Clayton Center Community Service Board
- Clayton County Chamber of Commerce
- The Rock Church
- Clayton County Department of Public Health
- Clayton County District Attorney’s Office
- Clayton County Schools
- GCAPP Youth Advisory Council
- Clayton State University
- United Way of Greater Atlanta
- Flint River Boys and Girls Club
- Various non-profits: Hearts to Nourish Hope, Sisters Empowerment Network, & Rainbow House

**Coalition Geographic Area**

- The Clayton Collaborative Authority (Georgia Family Connections)
- Clayton County Commissioners
- Clayton County Department of Juvenile Justice
- Goodwill
- Clayton County Family Connections
- Clayton County Public Library
- Solid Rock Academy
- Department of Family and Children Services
- Housing Authority of Clayton County
- Thomasville/Vashti Center

- Clayton County Chamber of Commerce
- The Rock Church
- Clayton County Department of Public Health
- Clayton County District Attorney's Office
- Clayton County Schools
- GCAPP Youth Advisory Council
- Clayton State University
- United Way of Greater Atlanta
- Flint River Boys and Girls Club
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The review was conducted by the Academy Health Foundation at the request of the Colorado Health Foundation, to address existing evidence on the promise of interventions for behavioral health challenges that includes some type of mental illness to experience a good quality of mental health services. This study’s aim was to discover the promising practices for reducing suicidal behavior, depression/anxiety, substance use, and suicide attempts.

Universal approaches for reducing depression and anxiety disorders, bipolar disorder, schizophrenia, and decreasing stigma, the signs and symptoms of mental illness, offer several opportunities for individuals with mental illnesses. This study's aim was to discover the promising practices for reducing suicidal behavior, depression/anxiety, substance use, and suicide attempts. The study revealed that a welcoming and supportive environment, empathetic leadership, and valuing the participants' choices are important in developing a trauma-informed community throughout the county, by providing training and resources to organizations that work with children who are at risk for ACEs.

Literature, engaging in recreation has been shown to offer several opportunities for individuals with mental illnesses. This study's aim was to discover the promising practices for making recreation programming relevant for people who experience illness. A study conducted by Hutchinson & Fenton (2018), could be helpful for the production of safe and inclusive environments, as well as beneficial program components that influence the production of safe and inclusive environments, as well as beneficial program components that influence the production of safe and inclusive environments.

A study conducted by Hutchinson & Fenton (2018), aimed to increase mental health awareness and reduce the stigma surrounding mental health and validating mental health conditions. The presentation is made up of scripted interactive dialogue centered around the mental health condition and the family member of a person with a mental health condition. There is a great need for mental health services among Black men, as only four percent of therapists are Black, according to the American Psychological Association (Today, 2021). The Confess Project, initially started in Little Rock, Arkansas, is a nonprofit organization that engages with other barbers in barbershops, including those in Little Rock, Little Rock, Little Rock, and Little Rock, to direct their clients. The initiative understands the barriers to participation in recreation programs that could be helpful for the production of safe and inclusive environments, as well as beneficial program components that influence the production of safe and inclusive environments, as well as beneficial program components that influence the production of safe and inclusive environments.
A literature review was conducted to assess the realities of accessing mental health services. Specifically, for African American and Latinx individuals between the ages of 18-25 that have used mental health and/or behavioral health services. While analyzing this demographic’s experiences with using these services, academics, clinicians, and mental health professionals noted the gaps present and recommendations for a more well-rounded care. Across the literature, there were two overall gaps mentioned: lack of cultural competence in mental health care and the incorporation of the voices of the youth who are using these services into the curriculum of these programs.

African Americans and Latinx individuals have noted in their respective focus groups or interviews that within the services they receive, there is a crucial element missing from their care and that is a provider who understands them completely. For Latinx individuals, it’s been asserted that it is very important for mental health providers to have a working understanding of the beliefs and perceptions minority ethnic individuals have about mental illness from a cultural context (Barrera & Longoria, 2018). Racial and ethnic minorities are often misdiagnosed because mental health professionals aren’t able to interpret certain “cultural cues” of these group’s mental illness. It is further imperative to understand cultural variables, as people from different cultures, like Latinx, present their symptoms in a unique way, as well as communicate about their problems and their decision-making process through the lens of their cultural beliefs and values (Barrera & Longoria, 2018). When treating African Americans, it is important to acknowledge the ways racism has impacted their relationship with the medical community and the ways in which this impact has ongoing effects (Trent, Dooley, & Dougé, 2019). Instituting intentional interventions for African Americans can begin to undo the harmful cycle of racism. These can look like creating a culturally safe environment where the providers are sensitive to the racism that was experienced, assess patients for stressors, assess patients who reported experiencing racism for mental health conditions, and so much more (Trent, Dooley, & Dougé, 2019).

A report conducted by Mental Health America argued that leaders need to immediately engage young people in the discussion around resources and the support needed to adequately take care of their mental health (Mental Health America, 2020). The report called to action clinicians, teachers, school administrators, and healthcare systems to address trends in youth mental health, especially considering the effects of the pandemic on youth engagement (Mental Health America, 2020). This perspective is important to tackle, as it calls for an internal reconstruction of the nature of youth mental health services and its effectiveness. A survey conducted by Mental Health America, of over 1,900 14- to 24-year-olds, revealed that access to mental health professionals and mental health breaks in the school or work environment were among the most requested resources to support their own mental health (Mental Health America, 2020). Less than 25% of young people think trained adults would be beneficial in helping them with their mental health challenges, whereas almost 50% of young people would prefer to help with their own mental health (Mental Health America, 2020). Additionally, young people want the support to make a difference in their own mental health, learning more about mental health, connecting with mental health communities, and being trained to support their peer’s mental health concerns as well (Mental Health America, 2020). Ultimately, there is a gap not only in services, but the quality of services for youth mental health for the youth that are using them.

While investigating the utilization of mental health services by African Americans and Latinx individuals between the ages of 18-25, barriers to accessing these services were also investigated. Barriers to services suggests that while trying to use these services, these two groups have had a difficult time either pursuing these services and/or remaining there. Between these two groups, several barriers have surfaced across the literature, some overlapping and others specific to each group. In the literature, both African American and Latinx individuals have communicated that mistrust of medical providers, discrimination when seeking care, and quality of services were barriers to them seeking care. Across the literature, mistrust of the medical community has been the most prevalent barrier. The mistrust of the medical community for African American and Latinx individuals is often rooted in the adversarial relationship with the medical community and the ways providers often communicate about their problems and their decision-making process through the lens of their cultural beliefs and values. Additionally, the stigmatization of mental illness and the perceived lack of support for their peer’s mental health concerns have been barriers to accessing mental health services. These barriers need to be addressed to ensure that African American and Latinx individuals receive the care they need.
Discrimination when seeking medical care was another barrier that affected both groups. Discrimination has been explored in the literature either from the medical provider when providing the mental health services or perceived discrimination from peers about mental illness. In a study conducted by Woods-Giscombe et al., their research revealed African American women perceived their mental illness would be immediately met with medication versus treatment, putting this group on edge and discouraging them from going altogether (Woods-Giscombe et al., 2016). Other examples of discrimination in the mental health care system have been experienced as discriminatory and racist attitudes via mental health service providers (Cénat, 2020). Discrimination or stigma associated with mental illness or seeking mental health care is often experienced by individuals within the same demographic group. Help-seeking behaviors are often thwarted for some Latinx individuals as the perception of seeking mental health services are associated with persons who are severely disturbed versus individuals who can still function despite a number of stressors (Villatoro & Aneshensel, 2014) Further, in this depiction of mental illness many Latinx communities associate it with suffering from being “loco” or crazy, implying that these people are dangerous to the community and experiencing an incurable disease (Barrera & Longoria, 2018). Likewise, from another study conducted with African Americans, community members expressed that the reluctance to seek help for mental illness came from concerns about being labeled crazy or dangerous, as well as concerns around the perceived lack of anonymity (Haynes et al., 2017).

African American and Latinx individuals both experience a lack of quality mental health care services when they do seek to use it. The lack of quality mental health services is both a deterrent to seeking mental health services and decreases the likelihood of retention to these services. This lack of quality in mental health care services are present in the lack of cultural adaptation, like including services in other languages, like Spanish, having more sensitive providers who are aware of cultural differences, cultural expectations, and other realities that their clients experience (Corrigan et al., 2017). Other culturally specific barriers for the Latinx community have been immigration concerns. Fear of being deported or immigration called into question when seeking these services outweighs the need for help in certain scenarios. Undocumented immigrants fear seeking help because of possible ICE reprimands or possibly being deported (Corrigan et al., 2017). Other barriers have been identified as religious influences on the need for mental help. For instance, some Latinx individuals might believe they don’t need these services because the ministry and God will take care of it. (Corrigan et al., 2017).

**Rural and Urban variations**

While the effects of mental illness are similar, the barriers to accessing these services vary in urban and rural communities. In urban communities, barriers to service typically revolve around mental health stigma, lack of cultural and linguistic competency, and a distrust of the medical community. These barriers most often affect how often individuals go to these services and feel like they are welcomed to do so. Barriers for mental health service use in rural communities, also includes stigma around mental illness, while additionally including a lack of accessibility, availability, and acceptability (RHI Hub, 2021). Rural Americans travel further to provide and receive services, are less likely to have insurance benefits for mental health care, are less likely to recognize mental illness, and understand their care options (Thomas, Macdowell, & Glasser, 2012). Rural areas typically experience chronic shortages of mental health professionals and are highly unlikely to have specialty providers available in these rural areas (Thomas, Macdowell, & Glasser, 2012). Further, rural communities have fewer trained professionals to work competently in rural areas and an urban model is often used as a framework in a rural context.
Evidence based practices (EBP) is the application of research findings in everyday patient care practices, integrating the patient’s unique perspective of their needs and preferences. EBP, as it pertains to mental health service use, engages several approaches that have proven to be beneficial and are suggested to be implemented into future mental health program designs.

In an article by Munson and Jaccard (2018), these authors address critical theories that can drive a more effective mental health service utilization among young adults (Munson & Jaccard, 2018). The authors suggest that treatment of mental disorders and the intricacies of engagement have to be dually approached for healing and recovery to take place. It’s also been asserted that building a repository of the determinants of mental health service use is necessary to help focus on the efforts that will help increase engagement (Munson & Jaccard, 2018). The authors further argue that the execution of these efforts is just as important in the tackling of constraints on mental health service engagement. To employ these characteristics of EBP in mental health service utilization, the article implemented science-based principles of communication and attitude theory. A top-down communication style was used, where a source communicates messages or information to a target audience with the intention of presenting information that can shape this target’s behavior, belief, or attitude. In the top-down communication conceptualization, there are five components that impact its effectiveness. The source, the message, the medium in which the message is being communicated, the audience, and the context in which the communication is occurring in (Munson & Jaccard, 2018).

Munson & Jaccard (2018) point out a number of factors that are key in EBP and are particularly relevant to work with African American/Black and Latinx young adults. Some of these factors include: the power relationship between the source and target, source likeability, and the confidence with which sources state their position (Munson & Jaccard, 2018). Further, in mental health service research, client and provider race/culture matching has shown that race matching between case managers and clients yields greater service engagement (Munson & Jaccard, 2018). Communication needs to consider the cultural context when developing the content, style, and timing. A well thought out, culturally sensitive, and strong argument has been proven to be more effective, producing more attitude, belief, and attitude change (Munson & Jaccard, 2018).

In an article written by Drake and colleagues (2001), the authors note there are number of mental health interventions currently present (Drake, et al, 2001). A number of suggestions have been made to consider in line with EBP in mental health services. These considerations have been streamlined from the Evidence-Based Practices project, a collaboration between the Robert Wood Johnson Foundation, the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration, The National Alliance for the Mentally Ill, and a number of other mental health research centers, state mental health authorities in New Hampshire, Maryland, Ohio, North Carolina, and Texas (Drake et al, 2001). The considerations are taking a more comprehensive look at medication prescriptions, the incorporation of self-management training, incorporating family psychoeducation, building an assertive community, and building an integrated treatment plan for co-occurring substance use disorders (Drake, et al, 2001). Further, the authors assert that treatment plans should include helping individuals with life skills in addition to treatment plans, developing skill building as it pertains to independence, employment, satisfying relationships, and fostering a good quality of life (Drake, et al, 2001).
The authors argue that the overarching areas of implementation in routine mental health services that need to be attended to are issues surrounding organizational structure and commitment, resource development, and clarity of roles and responsibilities (Drake et al, 2001).

In the Summer of 2021, Dr. Pierluigi Mancini through the SAMHSA funded National Hispanic and Latino ATTC and PTTC centers released the Hispanic and Latino Evidence Based Programs eCompendium. The eCompendium supports the notion that prevention and intervention programs should consider cultural responsiveness and cultural humility in the use of established EBPs when appropriate. The categories in the eCompendium identify EBPs that may be more likely to be appropriate for Latino communities. The eCompendium also raises awareness of the need for more culturally responsive research and practice. The purpose of the eCompendium is to assist and inform service providers, directors, administrators, and education leaders in the selection of research evidence-based programs that are likely to be better suited to the participant population and community needs. The eCompendium is available to anyone and can be accessed by visiting The National Latino Behavioral Health Association.

Promising practices

Promising practices, according to the U.S. Department of Health and Human Services (2003) is a program, strategy, or activity that has worked in at least one organization where there is preliminary evidence of effectiveness, but not enough to support generalizable conclusions. Below is a sample of some of the current promising practices in the area of mental and behavioral health services for African American and Latinx communities.

A study conducted by Hutchinson & Fenton (2018), assessed the promising practices for making recreation programming relevant for people who experience mental illnesses. This study’s aim was to discover the program components that influence the production of safe and inclusive environments, as well as beneficial recreational experiences for adults living with mental illness (Hutchinson & Fenton, 2018). According to the literature, engaging in recreation has been shown to offer several opportunities for individuals with mental illnesses to experience a good quality of mental health (Hutchinson & Fenton, 2018). The goal of this study was to explore the ways program coordinators could reduce the barriers to participation in recreation programs that could be helpful for the production of safe and inclusive environments (Hutchinson & Fenton, 2018). The study was conducted in Nova Scotia and the remaining Canadian provinces and territories. Findings from the study revealed that a welcoming and supportive environment, empathetic leadership, and valuing the participants’ choices are important in developing effective mental health programs for those who need it (Hutchinson & Fenton, 2018).

The Confess Project, initially started in Little Rock, Arkansas, is a nonprofit organization that engages with barbers across the country in an effort to connect with men of color and raise awareness about mental health (Today, 2021). The Confess Project has now expanded to other barbershops in Louisville, Indianapolis, New Orleans, and Atlanta. The organization provides a 12-month curriculum to barbers as they get trained on active listening, how to use positive language to address the stigma surrounding mental health and validating clients’ emotions and concerns. Additionally, the barbers also learn about mental health resources in their area, to direct their clients. The initiative understands that finding and accessing mental health services can cause confusion and there is already an existing relationship between barbers and their clients. The founder, Lorenzo Lewis understands that the need to address mental health among Black men is great, as only four percent of therapists are Black, according to the American Psychological Association (Today, 2021).

Compartiendo Esperanza is a bilingual 90-minute presentation aimed to increase mental health awareness in Latinx communities. The presentation is made up of two individuals, a person living with a mental health condition and the family member of a person with a mental health condition (NAMI, 2021). There is a scripted interactive dialogue centered around the
Mental health efforts and interventions are being supported by a number of organizations and stakeholders across the state of Georgia. Some of the examples can be seen in the list of collaborative efforts being funded by Resilient Georgia in the section above on existing services. Federal organizations support mental health efforts by being a sounding board of resources and connections to specialized services, working in partnership with the state to address mental health. The federal government supports the government by providing mental health block grants (MHBG), these grants support states in building their community mental health services. Federal funding in research provides opportunities for the study of mental health disorders that may not be available elsewhere. These are agencies like the Substance Abuse and Mental Health Services Administration (SAMHSA), National Institute of Mental Health (NIMH). These agencies lead the way in research, grant administration, and public education about these findings. This information provides the opportunity for a deeper understanding of mental health and where further research and improvements can be made (Mental Health America, 2021).

In addition to the many federal organizations involved with mental health efforts there are many philanthropic organizations that fund scholarships, grants, host conferences and help develop policies. There is the Hogg Foundation for Mental Health that is located in Austin, Texas. This foundation offers scholarships, fellowships while working to eliminate “health disparities in racial and ethnic minority populations and persons with limited English proficiency (Grantwatch, 2012). In 2011, The Robert Wood Johnson Foundation distributed a policy brief that discussed the high rates of uninsured or underinsured people with mental illness and how better policies and increased insurance coverage could improve patient care. The Empire Health Foundation in Washington State is rolling out the model for payment reforms for primary care and behavioral health services. The belief is with better integration comes improved care. The Maine Health Access Foundation has given over forty grants totaling 10 million dollars over the course of ten years to create coordinated care between primary care providers and behavioral health providers (Grantwatch, 2012). The New York Community Trust gave an $85,000 grant to a hospital in Brooklyn to study the “effects of using electronic medical records on care for patients with mental illness.” Lastly, the Bristol–Myers Squibb Foundation has started a Well-Being Initiative to help veterans and active-duty members with mental health (Grantwatch, 2012).

Interventions that focus on populations at a high risk for behavioral challenges that includes some type of cognitive behavioral therapy (CBT) are promising approaches for reducing depression and anxiety symptoms in teens and young adults. Universal interventions that seek to improve skills and increase knowledge about the social factors that contribute to substance use in teens and young adults can lead to reductions in illicit drug use. Psychosocial interventions, like dialectical behavior therapy (DBT) delivered in school, community, and health care settings are promising strategies for reducing suicidal behavior among teens and young adults (Gerlach, 2018).

Key stakeholders working in this field

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Inside Philanthropy (2020) reports that while the number of organizations that fund mental health work is limited, there are a few grant makers who are working in this area. Often they are smaller organizations and the focus is often on research. Some of the active funding organizations they mentioned include (a full list can be found on Inside Philanthropy’s website: https://www.insidephilanthropy.com/grants-for-mental-health):

- A Little Hope focusing on bereavement for youth;
- American Legion Child Welfare Foundation focusing on overall well-being for children;
- American Psychological Association focuses on a wide variety of issues related to mental health and reducing stigma and many other issues;
- Baird Foundation supports mental health organizations in general
- Baxter International Foundation focuses on quality healthcare for underserved populations throughout the U.S. including a range of mental health causes.
- Carter Center focuses on grants related to equity and policy and reducing stigma and discrimination related to mental health.
- Klingenstein Third Generation Foundation provides funding for postdoctoral programs in child and youth ADHD and depression.
- Mental Health Foundation focuses on reducing stigma, increasing access to quality care, and building a better understanding of mental wellness.
- Morrison and Foerster Foundation supports mental health organizations at the local, national and international levels.
- Stranahan Foundation focuses on increasing access to care, mental health education, alternative care methods, preventative measures and extending research.

GRANTMAKERS IN HEALTH
Grantmakers in Health is a nonprofit organization that focuses on supporting foundations and corporate giving programs focus on improving health overall. They currently provide conferences and educational sessions for philanthropic and corporate programs on a range of behavioral health and health equity issues (among many other health related topics). Providing key educational components can help philanthropic and corporate funders have a better understanding of behavioral health and health equity needs in general, overall best practices, and other key factors related to developing and implementing funding to help improve mental and behavioral health access (Grantmakers in Health, 2020). All of these organizations above are needed to push research, influence policy, and give funding to improve mental health in the United States.

Novel approaches or best practices available in Georgia

In 2019, Georgia state officials launched a mobile app named MyGCAL to access via text and chat the Georgia Crisis and Access Line’s (GCAL) services. GCAL is a full-time hotline for people in need of mental health treatment. This app offers free and confidential access to people struggling with mental illness and other behavioral health issues. The app is compatible with Apple and Android smartphones and it is geared toward younger Georgians who are more comfortable with texting versus speaking over the phone. However, officials show concern that they may be missing the demographic of Georgians under the age of 25 who may more likely want to chat online. The push for this app was sparked after Governor Brian Kemp made a visit to two high schools in Gwinnett County and Dawson County, speaking to educators and health officials about the need for improve mental health care. Kemp added that his aim is to be proactive, promoting mental health awareness and removing the stigma (Bluestein, 2019).
Policy advocacy is a complex process of activities that when performed effectively will help influence decision makers. The process includes helping organizations develop key strategies that are focused on vision and concise in content; training staff and volunteers on the skills necessary to approach and recruit individual and organizational advocates; and identify potential partners to build local, state, and national networks.

Georgia policy and advocacy work. Voices for Georgia’s Children (Voices) is an independent, “non-partisan catalyst for systemic change” (Georgia Voices, 2021). Through much of their work, Voices advances laws, policies, and actions that improve the livelihoods of children in Georgia (Georgia Voices, 2021). Voices has identified that one of the crises affecting child and adolescent behavioral health is that 41% of children ages 3-17 struggle to access mental health treatment and counseling (Georgia Voices, 2021). There have been some significant findings and policy recommendations from the work that Voices has done in recent years.

Schools often serve as the primary point of access for behavioral health services, and there is a disproportionate number of students to the number of services available (Georgia Voices, 2021). Voices points out that there is currently 1 social worker for every 2,475 students, when there needs to be 1 for every 250 students, there is 1 school psychologist for 2,475 students, when there needs to be 1 for every 700 students, and there is 1 school nurse for every 1,088 students, when there needs to be 1 for every 750 students (Georgia Voices, 2021).

A snapshot of health and behavioral health services and after school supports reveal that school-based mental health programs increase access to mental health support, by eliminating barriers like provider availability, proximity, cost, and transportation (Georgia Voices, 2021). Nearly 80,000 students in grades 6-12 have reported having considered attempting suicide. Providers have expressed that they also face challenges in their experiences, such as clinician burnout, stigma around mental health treatment, limited parental involvement, and lack of transportation for afterschool and summer services (Georgia Voices, 2021).

Voices conducted an analysis of Georgia’s child and adolescent behavioral health workforce, highlighting findings, recommendations, and key partners. These findings highlight the lack of strategic training and licenses, lack of coordination between crisis care and follow up care followed with recommendations to pilot training program that ensures that behavioral health professionals are being properly trained in evidence-based and therapy training, while also improving the integration of Georgia’s Crisis and Access Line (GCAL) to provide follow up care. Potential key partners have been identified as state agency university partnerships, GCAL, and State Agencies (Georgia Voices, 2021).

Voices has released a full report about Sustaining Georgia’s Child and Adolescent Behavioral Health Workforce Through Supervision with many partners to include Georgia Department of Behavioral Health and Development Disabilities, Georgia State University’s Center of Excellence for Children’s Behavioral Health, CHRIS 180, Georgia HOPE, Georgia Pines, Metropolitan Counseling Services, Motivo, Serenity Behavioral Health System and University of South Carolina John H. Magill School of Mental Health Certificate Program (Sustaining Georgia’s child and adolescent behavioral health workforce through supervision – Voices for Georgia’s children, 2021, March). This was very influential in learning how essential clinical supervision is for licensing, what can help retain employees and supervisors, and cultural competency and funding changes. There are different hourly requirements for licensed and certified specialists that are offered free to the learning associates. In Georgia, over one-fourth of counties lack licensed psychologist or licensed social workers and a report by the Kaiser Family Foundation reports that Georgia has 87 mental health care professional shortage areas (KFF State Health Facts September 2020). The disparity increases with rural areas, and the only counties not lacking are in Metro Atlanta. The main problem has been the lack of enough experienced clinical supervisors.

The various organizations are offering different types of supervision including third-party telesupervision, agency-based supervision, and university pipe-line programs (Sustaining Georgia’s child and adolescent behavioral health workforce through supervision –
Voices for Georgia’s children, 2021, March). The third-party telesupervision is beneficial because people have more clinicians to choose from, zero travel, and more access to resources. The disadvantage includes group sessions and not always one on one, technical difficulties, and feedback. Ways to incentivize supervisors include giving them stipends, decreasing caseload, and paying them for the losing billable hours. Organizations can retain associates by offering loan forgiveness programs and paying back supervision costs if they do not complete their contracts.

Voices also notes that there is no consensus on conducting cultural competency training between the Georgia Board of Professional Counselors, Social Workers, and Marriage and Family therapists. Cultural and linguistic competency is essential for dealing with the adverse effects of mental illness in children and adolescents. Having one diverse curriculum teaching the same thing may help increase professionals’ cultural competency while increasing results with clients (Sustaining Georgia’s child and adolescent behavioral health workforce through supervision – Voices for Georgia’s children, 2021, March). Funding of $24 million dollars was created in 2017 for the Georgia Apex Program for school-based mental health (SBMH) and $8.4 million in 2019 to increase funds for Apex and create a four-year Behavioral Health Reform and Innovation Commission. Getting more practitioners into the field though is critical and may need to include creating a repayment program for a behavioral health professional with state and federal loans and creating more pipe-line programs in schools would further expand the impact and support increasing the workforce (Sustaining Georgia’s child and adolescent behavioral health workforce through supervision – Voices for Georgia’s children, 2021, March). If organizations, state, and federal agencies work together, then increasing behavioral health professionals is achievable.

Other establishments such as the Georgia Child Advocacy Leader Lab is a consortium of organizations and advocates dedicated to policy development through investments in research, evaluation, advocacy, and lobbying, in addition to supporting local leaders across the state in advocacy initiatives (Georgia Voices, 2021). Local policy forums are held in various parts of Georgia, in Savannah, Dublin, and Albany, in partnership with school-based forums with the Carter Center and Georgia Appleseed (Georgia Voices, 2021). In addition to the recommendations listed above, other recommendations from these forums included: creating awareness surrounding the impact on children and youth among school resource officers, coordinating major school-based health initiatives for the web-based Georgia School-Based Health Hub, and applying youth voices surrounding their quality of life and suicide prevention PSAs (Georgia Voices, 2021).

Cultural and linguistically appropriate workshops and intensive training opportunities need to be made available to the general public and nonprofit organizations to increase capacity of advocates at all levels and these organizations would be perfectly positioned to carry that out.

A Ways and Means Committee analysis, Left Out: Barriers to Health Equity for Rural and Underserved Communities, released on July 14, 2020, (downloaded on June 6, 2021) describes issues relevant to health equity and summarizes public submissions that provided input on barriers to optimal health for residents of underserved communities. The report presents several issues, in addition to the workforce development issue addressed earlier, that can be used as guidance in the development of policy issues for behavioral health in the state of Georgia. They are:

🌈 Georgia ranks 42nd in state health system performance, according to the Commonwealth Fund’s State Health System Performance Scorecard. (Sources: Kaiser Family Foundation Population Distribution by Race/Ethnicity, Life Expectancy at Birth, Median Annual Household Income, Primary Care Health Profession Shortage Areas and Status of State Medicaid Expansion data; World Population Review 2020 Maternal Mortality Rate by State data; United States Census Bureau QuickFacts.)

🌈 Racial health inequities persist among Black, American Indian/Alaska Native, Latinx, and Asian residents across the nation. Nationwide, 36 percent of all counties are at least 25 percent non-White. In Georgia, 77 percent of all counties (123 of 159 counties) are at least one-quarter non-White. (Sources: County-level estimates retrieved from the American Community Survey 2018 Race datafile)
Higher income correlates with lower mortality and better health outcomes. In Georgia, the median annual household income is $56,183, which is 6.9 percent lower than the U.S. median annual household income of $60,336. In 134 of Georgia’s 159 counties (84.3 percent of Georgia’s counties), the median annual household income is below the U.S. average. (Sources: State-level estimates retrieved from Kaiser Family Foundation Median Annual Household Income 2017 datafile; County-level estimates retrieved from the United States Census Bureau 2014–2018 Median Household Income in the United States by County datafile.)

During a recent virtual town hall about access to behavioral health care in Georgia and policy advocacy, there was discussion about the issues of mental health parity and health care and health insurance access for everyone. In 2019 Governor Kemp wanted to reform mental health policies and created the Behavioral Health Reform/Innovation Commission as HR-514. Georgia’s focus is on mental health parity. Parity is people with mental health, and substance use conditions receive the same level of health insurance benefits- and access to services- to people with physical health conditions. Parity is important because it improves health outcomes, prevents homelessness, reduces costly interventions, helps rural areas with reimbursement, and reduces people in rural areas from only receiving mental health care in jail. Many of these were issues that were discussed in the provider and individual focus groups that the research team conducted (see sections below). Policy advocacy is essential for increasing access and reaching the vulnerable population such as children, youth, and rural areas (Carter Center, 2021).

The state of Georgia counts with strong behavioral health advocates like the Georgia Mental Health Consumer Network, the Georgia Council on Substance Abuse, the Carter Center Mental Health Program, the Georgia Parent Support Network, NAMI, Mental Health America of Georgia; the Center for Victims of Torture; Georgia Budget and Policy Institute, Voices for Georgia’s Children, American Counseling Association of Georgia; American Foundation for Suicide Prevention (AFSP), Georgia Chapter and Georgians for a Healthy Future. They play a vital role in the development and implementation of public policy to promote an informed, healthy, and strong community.

The following policies have been enacted to help address issues of parity in mental health in Georgia:

- Georgia Senate bill 80 deals with prior authorization, and that critical because it determines if treatment is denied or delayed.
- Georgia House bill 163 increases access to Medicaid by automatically enrolling children who are receiving SNAP benefits.
- Georgia House bill 272 ensures that 17-year-olds are treated in the juvenile justice system and not as adults.

According to the Federal Communications Commission, 10 percent of U.S. residents lack access broadband – a trend that the Joint Economic Committee found to be more pervasive across communities of color.

Approximately 7.6 percent of Georgia residents lack broadband access, compared to 6.5 percent of residents across the U.S. In 24 of Georgia’s 159 counties (15.1 percent of Georgia’s counties), at least half of all county residents lack broadband access. (Sources: Federal Communications Commission (FCC) 2019 Fixed Broadband Deployment datafile.)
Mental health research is one of the tools for making improvements in mental health service efficacy. Partnerships among mental health organizations allow for these studies to capture a more extensive population, reaching a broader audience. Partnerships that have been examined in the literature range from universities, community health organizations, law enforcement, and budding faith-based organizations. Universities often partner with mental health studies in the state they are located in, having access to research that can be disseminated to communities in their vicinity. Community health organizations like the Tri-County Rural Health Network partner with mental health services to disseminate accurate information to its community members, and train community health workers to facilitate aid as well. Law enforcement and mental health have a very unique relationship, as most urgent mental health crisis calls are responded to by law enforcement. Partnerships like the Police Mental Health Collaboration (PMHC), partner with community mental health services to better assist with these mental health crises and monitors the effectiveness of the assistance and training they have received from these relationships. Lastly, faith-based organizations are beginning to partner with mental health organizations. Faith-based organizations like Community Health Interstate Partnership (CHIP), located here in Atlanta, Georgia, merge mental wellness and faith communities in collaboration with one another to assure that people with mental and addictive illness have all the tools they need to live well.

Workforce Development

The same Ways and Means Committee analysis referenced earlier, ‘Left Out: Barriers to Health Equity for Rural and Underserved Communities’ (2021) addresses issues of workforce shortage as follows:

The Health Resource and Services Administration (HRSA) designates geographic regions as health professional shortage areas (HPSAs) if they lack health care providers. Counties in Georgia exhibit an average Mental Health HPSA score of 14.9 compared to the national average of 15.5 (on a scale of zero to 25, where 25 denotes an extreme HPSA shortage), Seventy-two percent of Georgia’s counties (114 of 159 counties) are designated as mental health HPSAs. (Source: Health Resources & Service Administration HPSA Mental Health Datafile)

When it comes to cultural and linguistically responsive clinicians the numbers are even worse. More than 60 million people of Hispanic origin live in the United States, accounting for almost 18 percent of the total U.S. population and making Hispanics the nation’s largest ethnic or racial minority, according to 2020 U.S. Census data. By 2060, the U.S. Hispanic population will reach 119 million people, representing more than 28 percent of the population, according to Census projections.

Yet there are only about 5,000 psychologists in the United States who are Hispanic, representing 5 percent of all psychologists, an increase from 3 percent a decade ago, according to U.S. Census data. In a nationwide APA survey, only 5.5 percent of psychologists, who may be Hispanic or another race or ethnicity, said they can provide services in Spanish, making them a rare commodity (Hamp, A; Stamm, K; Lin, L, & Christidis, P. 2016).

The full breakdown of psychologists by race and ethnicity according to the APA report Demographics of the U.S. Psychology Workforce (Lin, L, Nigrinis, A., Christidis, P, & Stamm, K., 2015) is: Asian (4.3 percent), Black/African American (5.3 percent), Hispanic (5.0 percent) and other racial/ethnic groups (1.7 percent), accounted for approximately 16.4 percent of active psychologists.

In contrast for social workers, the most common race/ethnicity among licensed social workers is White, which makes up 65.8% of all licensed social workers. Comparatively, there are 17.4% of the Black or African American ethnicity and 11.3% of the Hispanic or Latino ethnicity. (Zippia, 2021).
Georgia is working hard to increase access and educational, developmental opportunities in many different capacities. Youth development is available through the Mental Health America of Georgia offers Kids on the Block and Leadership Empowerment and Access Program to help children, youth, and young adults learn, discuss and empower each other related to mental health (Mental Health America of Georgia, 2021). Georgia offers many workforce development opportunities. The Georgia Department of Behavioral Health and Developmental Disabilities provides yearly conferences through the Georgia School of Addiction and bicultural peers.

Studies to provide training and networking opportunities. Georgia Department of Behavioral Health and Developmental Disabilities offers different prevention training courses, including youth drinking and mental health and school safety (Georgia Department of Behavioral Health and Developmental Disabilities, 2021). The University of Georgia secured a grant to fund project BE-AHEAD to help qualified students in their counseling psychology, school of counseling, or mental health counseling to gain experience while working in medically underserved and diverse communities (Daigle & Calhoun, 2019).

Some workforce development strategies include:

- Earlier outreach to students in the Middle School and High School years.
- Provide temporary licensing to foreign clinicians whose academic work and experience can be verified and measured for competency to practice under supervision for a period of time until they can sit for their state license exam.
- Increase the number of Certified Peer Specialists (CPS) and the Certified Addiction Recovery Empowering Specialists (CARES) including bilingual and bicultural peers.
- Targeted outreach to undecided students in Bachelor degree programs with emphasis on bilingual students.
- Modify current state license rules that limit licensed clinicians’ ability to transfer to Georgia and receive reciprocity from the State’s Licensing Board.
- Provide loan forgiveness programs for clinicians working in rural Georgia or serving those with limited English proficiency.

Specific COVID/pandemic related issues

The Coronavirus Disease 2019 (COVID-19) pandemic has unearthed a number of concerning issues, especially for minorities in the United States (U.S.) COVID-19 has perpetuated racial trauma in Black, Latinx, and Asian communities across the U.S. Specifically for Black and Latinx communities, during COVID-19 there were targeted statements made toward the Black and Latinx communities by political figures placing blame on individuals without consideration of the systemic/structural drivers of these inequities (Liu & Modir, 2020). For instance, on April 10th, 2020, U.S. Surgeon General Jerome Adams addressed Black and Latinx communities saying, “We need you to step up” and to avoid alcohol, tobacco, and drugs during the pandemic (Liu & Modir, 2020). During COVID-19, there has been a lack of access to protective resources and care for those who were financially vulnerable. Black and Latinx communities have shown a deficit in well-resources hospitals, available testing, and housing that allows for safe social distancing and quarantining efforts (Liu & Modir, 2020). Undocumented populations, including undocumented Latinx individuals, also have to consider the possible fear of getting tested for COVID-19 or seeking medical services in general, for the fear of exposing them to immigration authorities.
Further, the vast majority of essential workers, who don’t have the option of staying home during the pandemic, are people of color (Liu & Modir, 2020). In New York City alone, Black, Latinx, and Asian communities make up more than 70% of the essential workforce that comprised of cleaning services, health care, transit, and postal employees. Further, structural racism and the U.S justice system disproportionately imprisons Black and Latinx populations. Black and Latinx people make up 56% of the U.S. incarcerated population, and so because of COVID-19 shifting through prisons across the country, these communities additionally are impacted at disproportionate risks of infection (Liu & Modir, 2020).

### Provider perspectives

The research team held one listening session with providers throughout Georgia. Providers were recruited to participate in the focus group via email messages sent through the Department of Behavioral Health and Developmental Disabilities as well as through several key support organizations. There were 20 providers who participated. The participants included both men (6) and women (14) and represented 15 different agencies. There were 6 participants who were primarily focused on serving the Latinx population in the state. Providers worked in both rural and urban communities.

The providers discussed a dramatic increase in the demand in recent years. This was true both for the African American/Black young adults/youth and the Latinx community. Several providers indicated that they are seeing more caregivers and in particular more adult males accessing services voluntarily and seeking out services. Several providers specifically discussed seeing this emerging as a new pattern with African American/Black men. Much of the increased demand is related to increasing stress and parents are seeing more challenges among youth who are home more due to the pandemic.

**Despite cultural constraints:**

Providers are reporting more Black and Latinx men voluntarily seeking services

*For the Latinx community, we have been seeing an increase of people are asking for referrals for counseling and mental health services. Parents are sharing issues with the related to mental health, anxiety disorders, depression, PTSD, and some of the suicidal issues as well. The pandemic has exacerbated everything for the parents and for the children. And basically, for the immigrant community, there is no safety net. And there’s a lot of issues about access to mental health services, which is the biggest issue for our community.*

*I would like to say that I’ve seen a great increase too in referrals, especially with young black males, a lot of trauma.*
Providers all discussed the importance of being able to connect individuals to services when they cannot provide services directly themselves due to insurance, geographic, or other limitations (type of services needed, etc). Most of the providers indicated that they do not currently have a waiting list but that they are seeing a steady, consistent, high need for care. While providers reported not having a waiting list, some did report having limited space for individual counseling and clients may need to wait additional time for an appointment.

One of the major challenges facing African American/Black families and individuals right now has been the increased stress and social injustice and violence (including multiple high profile police shootings in the state as well as nationally). In addition to this trauma, the pandemic has created an environment where parents are home more with their youth. Several providers indicated that they had seen an increase in children coming in for care due to behavioral health concerns because parents were seeing more behavior issues with children home more and were more proactive about seeking out supports when they were unsure of how to help youth adjust to being at home and out of contact with peers.

The pandemic has exacerbated and brought to light more and more of the challenges facing young people in the African American/Black and Latinx communities. Many providers discussed they are seeing an increase not just in individual needs and requests for services but also family members of existing clients seeking counseling and supports and asking for assistance. Providers that work with specific programs are finding ways to provide extended resources to family members and connecting family members to the services and supports that are needed.

One of the key issues for the Latinx families was the issue of immigration status and the impact this has on willingness to seek out services and their ability to access and utilize mental and behavioral health services. The pandemic has highlighted challenges that have been in place before but with an added complexity of the lack of a financial safety net for individuals and families.

There is a correlation between the impact of immigration status and the willingness to seek, to access and to use mental health services for Latinx young people.
One of the issues for many of the providers in Georgia has been the development and rebuilding of services as in-person services were not available and the transition to remote services had to be developed and implemented. The expansion and development of more community-based outreach and services, particularly in African American/Black communities, has also been an issue in Georgia and something that the providers recognized has been a new area of focus for them.

The focus has just been just dramatically shifted. We had a lot of in-house group support here. We had a Young Adults Program on site, and all of that fell away as well. So we've got a major rebuild to do, but there's some opportunities that happen there too, so we're able to finally reach out to people in a way that we had never done before. The expansion of community services has been a real gain for us, and I hope that we maintain that as well.

A key issue in some of the communities and echoed by all of the providers was the lack of insurance and the affordability of health care for both African American/Black and Latinx communities. Approval for mental and behavioral health care can be very challenging, particularly for the young people that have Medicaid. The application services are typically online which can be a challenge and providers mention they often have staff who are assigned specifically to help individuals apply for public benefits so that they can have the insurance needed to access care.

According to providers, discrimination continues to be a challenge for accessing and utilizing care. This includes issues such as the need for translation for language access, lack of bilingual providers offering services and the role of children serving as translators for parents, so the issues of confidentiality and medical information are significant in the community.

The demand is huge, and especially for people that are undocumented, children that are documented. They have few organizations that have counseling services but not for people that have acute symptoms.
One of the challenges that we have here in Georgia, and one of my roles is, I want to communicate to these churches that there are services out there, many of them which would be maybe a relief and maybe would settle some of their concerns.

I’ve had a family to come in and to bring their faith-based materials with them and say, “I want counseling, but I want it from this perspective. So this is what you need to weave into the work that you’re doing with our youth or our family.”

The programs are not fitting their needs. I think we need to concentrate on that more. While we’re willingly getting them down, we need to have something to help them.

Once people are able to engage in services, we are able to support them, but there’s often a lot of conversation. Even those referral phone calls, when they call, we find that our receptionist is doing rapport building on the phone, because we have to establish this safety. She may take 15 or 20 minutes on one referral phone call, which she is supposed to be taking three minutes to fill out a sheet of paper, but we have to establish this safety with persons in these communities in order for them to even trust us to take the next step.

Programs often do not fully fit the needs of young African American/Black or Latinx communities, so the challenge is to keep young people engaged and provide supports.

Given history within the African American/Black community and immigration concerns in Latinx community: Establishing trust and rapport is KEY.
Some of the providers indicated that while their numbers were often very high (particularly in hospital situations), the clients have declined since the beginning of the pandemic so they are looking at ways to change their outreach and doing more direct connection in the community to be able to do direct service. They are now starting to see an uptick in the acuity of the clients they serve. One of the challenges they have faced is that providers are not readily trained to do video sessions using the specific technology, and clients do not always have access to the technology be able to participate in these sessions either. Providers also had to develop skills to be able to help clients get phones set up and how to use the technology to be able to participate in the sessions. Providers are exploring and learning what remote technologies and what processes work best in this new environment, often this means regularly changing and updating processes until they find the one that works the best.

Providers discussed that they have definitely lost a lot of people that are still trying to reconnect with and particular services and supports that can only be offered in person and on site.

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Providers discussed that they have definitely lost a lot of people that are still trying to reconnect with and particular services and supports that can only be offered in person and on site.

While telehealth is an increasing option for expanding services, often individuals do not have the technology needed to utilize telecounseling which can become another barrier. For rural communities with large populations of immigrants for whom Spanish is the second language and English is very limited and where resources are limited, it can be a significant challenge to meet the needs of the individuals and families. In addition, many rural African American/Black communities, internet access and technology tools are limited and stretched thin already with digital school. Some providers said that because of the particular challenges for their communities, they continued face to face appointments throughout the pandemic to ensure that the individuals continued to receive care.

Engagement is the number one thing that they’re tasked with. And to try to engage somebody whose family is anxious about COVID and doesn’t want you coming to the house, and the worker is anxious about COVID prior to vaccines. That’s been probably the most difficult thing for us is to keep this very small focused team able to do what their responsibility is, which was just to engage with clients, which is always challenging with somebody who’s experiencing psychosis about 10 times harder when there’s many barriers in the way.

Mainly they using smartphones, the best technology for telecounseling. It had become also another barrier having clients not being able to have access to computers or technology or have no knowledge about how to use technology. That’s two big issues around Northwest Georgia.

And then also there’s a lot of Guatemalan communities around Northwest Georgia, and they speaks only... Their first language is indigenous. Spanish is the second language, and the English, obviously, is super limited. In terms of availability, maybe pre COVID I think there’s a little bit more accessibility in terms of tele-health for most people general, we all know everyone doesn’t have a computer, everyone doesn’t have stable wifi ever so there’s always a challenge.
In addition, some providers indicated that they were experiencing resistance to the use of telehealth among adolescents. They indicated that they felt that the high demand from 13-18 year olds was often related to adolescents who did not want to be active participants in the experience and so they would miss virtual sessions. Some adjustments included shortening sessions and finding innovative ways to keep them engaged in services. Several providers mentioned the impact of zoom fatigue on young people who were managing virtual school and also virtual mental health sessions. It was a significant challenge for many of the providers.

Language and cultural issues are an issue for both the African American/Black and Latinx communities. Providers reported that while individuals are starting to reach out despite stigma, they are still hesitant and participation is sometimes limited. Individuals are looking for providers who look and sound like them as well as providers who understand their culture. Having a provider who speaks their language made a huge difference in individuals accessing services in their community.

I think there's still stigma, certainly in the African American community, around accessing mental health. That remains there. Or we will get where people will access the services, but they're tentative. They're hesitant. They're limited about how much participation they will have or very concerned about the provider, so, "I will come to this service, but I don't want a white clinician."

We do have a therapist in our office who is lovely, and she is from the part of the Latinx community, and she's a wonderful therapist, but we've had discrimination where people don't want to work with her specifically because her accent.

While language issues are a challenge in many areas of the state, ViewPoint Health has a specific clinic in Norcross that provides core services and the center is bilingual so all services can be accessed in either Spanish or English. A few other providers indicated that they do have a few providers who are bilingual and that they try to meet other needs via the language line.
We are part of ViewPoint Health, which is a large community service board so we provide core services. We don’t have a waiting list, we can’t have a waiting list. Typically, if someone calls they will be seen the same week, but sometimes the next day or two days later individuals start individual family counseling and group counseling, and our center is bilingual. So all of those services are either in Spanish or English.

A key issue for all providers, both urban and rural, was transportation. Many individuals who need services have reported issues with transportation to accessing services, they tell the providers that they cannot come into the office because they do not have transportation. In the metro areas, even where there is public transportation, often individuals report challenges with accessing care.

Another key challenge for providers and clients both are the challenge of utilizing insurance and accessing public health benefits so that they will be able to access the care without the fear of the financial impact of accessing care. Providers are expanding staff responsibilities to be able to help clients apply for public health benefits. Coverage areas are another issue that some providers mentioned, they are limited in regards to who they can serve based on residency. Some of the providers can only serve individuals within a certain county catchment area.

With us at Grady, if they reside within DeKalb or Fulton, we can provide them with services through a grant that we have. But if they don’t reside within either one of those counties, then we have to try to refer them out elsewhere. So it just leaves a lot of them stuck trying to figure out where else to go.

Payment structures are also an issue for many providers. Service eligibility is frequently tied to insurance or other funding streams. Several of the providers mentioned the variety of funding mechanisms that impacted who they could serve including grant funding, DBHDD funding, private funding, private pay, and other mechanisms. One of the providers reported that their agency does not receive any funds to provide mental health services to low income community members and they are finding that many individuals do not have bank accounts or credit cards, they only have a very limited amount of cash to pay for services.
So the biggest... Many barriers with treating the Hispanic population, but I think the biggest one is immigration status and being able to financially afford care, to even access it, that's a huge barrier because being part of a CSB, we have to work within the bounds of the state mandates. So in order to access DBHDD funds, someone has to have some type of legal immigration status. And if they don't, then they can't access those services. They have to pay out of pocket. So you're talking about an individual who's undocumented who might have a really low wage job.

For the other outpatient clinics as well and Apex, and most of CNA services work the same way. They'll have a sliding scale and for the ones that can pay and most of the centers, at least on this round, they have insurance. So they also have any... I think they operate in the same sliding scale that ATL does. So they have even a reduced cost for undocumented clients that can't afford the higher rate.

Coordination among agencies continues to be a struggle, providers discussed the challenges of working within the fragmented system where there is no flow between discharge and outpatient services. Barriers to clinics being able to coordinate services more seamlessly during this transition. It is a challenge for both providers and individuals to find and access resources.

We struggle, because it's very fragmented system. There's no flow between people that are being discharged and how they're going to receive outpatient services and then preventing clinics working in it in another way. It's very complex, the healthcare system, and I feel that is challenging for us as providers to find resources.

Existing areas where there are gaps in services.

There are currently few organizations in Georgia that provided mental health services for people that have limited English proficiency or in other languages (particularly Spanish). Providers mentioned knowing of only a couple of agencies that hire bilingual staff and provide some key services, but they also discussed the significant increase in the demand and need for this particular type of service and outreach. There were a couple of agencies in Norcross and only one of them was the only participating agency that discussed having active bilingual services available for individuals. Marketing and resources in Spanish is also a gap in services that is needed, as well as finding qualified Spanish speaking clinicians. Finding clinicians in rural areas is particularly challenging.

I agree with you on that when we place advertisements, particularly for bilingual and by that we are open to almost any language because there are people from everywhere who needs services, but I know that particularly Spanish speaking clinicians, it's really difficult for us to get a response. It's not even for us to find a person who's qualified, it's really to get a response period. So I think that is an area where demand and need are not in line.

The population is bigger every year, and it's not enough bilingual and bicultural services with the competencies and sensibility to support this community. And it's not the Latinx, but also the pan-Asian community and other immigrant communities around Georgia.
Some of the providers in suburban areas also mentioned that they are seeing an increase in calls from rural communities where individuals are trying to access services but do not have the same availability as in the urban and suburban areas. There is a big demand in the rural areas but not as many options. This need is being somewhat addressed with the increase in Telehealth options, but transportation remains an issue. Providers also discussed how often clients had limited options for different types of services or providers.

For the Northwest Georgia, we have a center in Dalton. That’s a community that also is really remote from a lot of services around mental health transportation is a huge issue, because they’re lacking of public transportation to remote areas around Northwest Georgia. Telehealth services is something that had been offered. There’s a lot of clients that have no knowledge about how to use technology, and that became another barrier.

Obviously, any place that has a decent sized city, there’s better access to providers. In the state of Georgia it’s the perimeter of the state for the most part, except for maybe down where Columbus is, maybe over where Villa Rica is. There’s a little bit more there, but for the most part on the perimeter of the state of Georgia, their resources are very, very limited.

Metro you can pretty much find anything just around the corner, but for our rural families they really struggle with we tried them once before and it didn’t really go well, who else can we pick from, there’s a, disconnect there. What we also struggle with is for our Spanish speaking families, we don’t have a lot of Spanish speaking options as far as providers and therapists, psychiatrist. There might be someone who speaks Spanish, but they may not understand their culture and that’s where we struggle with helping families feel culturally accepted by having appropriate therapist and psychiatrist involved, especially for our families that are not centrally located to Metro areas.

The providers also discussed that there are challenges with Telehealth related to HIPAA issues and using specific technological services to provide counseling and health related sessions. This required getting both individuals seeking services and providers educated on how to use the technology and set up with accounts to use the system. Providers are having to learn new technology as well as provide the counseling and support services. Agencies are trying to keep the biggest portion of the burden on the provider rather than for the patients. For some providers, they are also reporting that some conditions (like psychosis) do not respond as well to telehealth interventions, particularly when they are symptomatic, so they are having to rely on hybrid methods utilizing both in person and virtual options.

“The gift and the curse of Telehealth.” And the other side of that coin is what some people have mentioned is not having smartphones or computers. Or having those devices, but not being able to keep Wi-Fi services on at home. Or having those devices, but it’s one device for the whole family, and mom or dad has to work. So this device is kind of traveling. That supports but doesn’t eliminate barriers, presents barriers itself.
I’m still doing intakes in person. Cause I feel like folks with psychosis, they do better if they meet you in person first versus meet you on a screen, especially if they’re very symptomatic.

There are not a lot of alternative resources within rural communities which produce many challenges for individuals in these areas (which also have the highest demand and highest rates of African American and Latinx populations). In addition, if an individual’s needs are severe enough, there may not be any provider within the vicinity of where they live that is capable of providing the service they need. Some of the providers mentioned that while on the DBHDD site it is listed that a county is served by a particular agency, that agency may not actually have any staff located in that particular county or in that county on a regular basis.

Some of the providers also discussed the increasing need for psychiatry hours and services in these communities. Often individuals can find counseling services but not psychiatry services. Providers are seeing a greater need for psychiatry services and providers who can prescribe medications. Some of the providers indicated that while there are enough CORE services, that there are not always enough special or specific services in some communities, such as access to psychiatry and intensive family intervention.

And there appears to be a dearth of psychiatric nurse practitioners as well. So it’s not just psychiatrist, it’s psychiatric nurse practitioners or other people who can prescribe psych meds. In terms of services, the service that we probably have the highest demand for right now needed and accessible. Coordination with early education centers is also a gap and a need perceived by the providers. To be able to more quickly and timely get assessments completed so that developmental delays can be identified earlier.

And then we do face some of these other barriers to services and accesses that we’ve already talked about. But really being able to go where people are, to let them know what’s available, to support them, and schools and community centers are really some of the best places to be able to do that.

As we work hand in hand with Department of Juvenile Justice and Probation. But being in schools a little bit more informing individuals of maybe mental health or behavioral health and being proactive with talking about it. One other thing with the shortage of that teenage at a young Americans or the youth group with them not having a credential so forth and so on. I think more mentoring programs where you don’t have to have necessarily those credentials or that education, but a mentoring program.

Providers discussed that the limited number of providers serving rural areas mean that individuals often exhaust the options within their community looking for mental health providers who are the right fit and right resource for their particular needs.
The increasing use of telehealth is a recognized need and game-changer where providers are able to reach more people and address the demand in areas that were previously more difficult to reach. Expanding this service as well as increasing ways to help provide technology to individuals to be able to best utilize this resource was a key recommendation for improving the environment.

As mentioned previously, for communities with large immigrant populations where the primary language is indigenous, the providers have to translate a lot of materials for families to be able to access all benefits and that is a significant burden on agencies and individuals to ensure that the individuals have access to all the services that they need.

Increasing the Telehealth options also has provided the opportunity for providers in rural areas to meet more need because they are not having to spend as much time traveling. It has been challenging for staff to transition to the new model, however as they have adjusted they are experiencing benefits of being able to meet more needs in some ways. Several providers mentioned that not having to drive significant distances allowed them time to see more clients.

Now on the one hand, like in my role, I can be in your county today and be across the state a 30 minutes later, whereas before I’m going to have to drive three or four hours to get there and just go to one of those locations. So from my perspective, it’s been awesome, but to a lot of our staff who are working hands-on directly with families, it’s been somewhat difficult, initially. Then, as people began to understand how to work Zoom and even work their smartphones, like Mr. Maurer mentioned, then it became easier. Now I think people or families, at least what I’m hearing from our teams, are that families are beginning to get a little Zoom burnout, and they’re missing the hands-on while at the same time, as we talked about, they’re scared about getting sick.

I have found that I’ve been able to schedule a lot more appointments if I’m not driving in between, because we cover Rockdale and Newton, but at the same time we have one client in Hall County, client and Fulton County, and then a client in Clayton County because there are no programs there we just absorb those. It is easier accessing clients, which before it was a barrier driving and traffic.

Several of the providers indicated that they are seeing an increasing need of providers who understand LGBTQ issues, particularly within African American/Black and Latinx communities. This was in conflict sometimes with the cultural perspectives of the communities as well as with the faith-based perspectives in some families and communities.

There is a need in African American/Black and Latinx communities for providers who understand both the culture of the community AND LGBTQ issues (which are often in conflict with each other).

And with the youth community, we have seen a lot of LGBTQ issues with and the culture. Our Latinx, Hispanic community have strong gender roles and strong genders ideas around the role of the female and the men. Or young people that identify themselves differently, they struggle a lot with their parents and their community. And especially the church around them, the spiritual leaders that they had, also have the same constructs and concepts on around gender roles. That has been a big issue that had created a lot of mental health issues within the youth community as well.
I also add that I’ve seen, basically, the intersection between faith and sexuality or sexual preferences being a part of the LGBTQ community serve as a barrier to seeking care for African American young people, because there’s a fear that they won’t be accepted. Or one identity that their therapist may identify with more than the other and so just not feeling like they’ll receive care as far as who they are as a whole person and an individual.

In our case is that, as the information is out and people are more aware, the parents and the children have ways to voice out these issues. It’s not that it have increased, it’s just that people are more aware and they’re more disclosing these issues to us and their parents and their school teachers. It’s something that we have seen. And also the mental health providers share that with us, like children that have issues related to gender roles and how the parents react to their transitions and the decision-making through their youth years, which is the years they’re living with the parents.

As seen in the comments in previous sections, improved partnerships with key stakeholders (early education, schools, community centers, etc) will be key to improving services in Georgia. This is particularly true in African American communities where relationships with trusted organizations is critical. In addition, some providers mentioned the importance of developing supportive housing and employment to provide additional supports to the families. The individuals needing housing support do not fit homeless criteria because they are not homeless by definition but they are not safe in the environment they are living in.

I see that as an issue with a population that we serve, most of them young adults, but they live at home. And most of the time the home is the trigger or the stress of the environment, because our clients are getting more self-sufficient and empowered, especially when they get a job and the dynamics of the relationship with the parents or whoever they’re living with is changing, and there’s causing more conflict.

I’ll always put a pitch in for some sort of supportive housing that might be targeted toward our younger population. We use Covenant House and some others, but frequently whether they’re housed with family or not. Where they are is probably the biggest challenge that we experience, that and supported employment.

Yeah, and also the lack of housing and affordable housing, to me, has really increased the mental health symptoms in our clients. The anxiety level is a good question. It’s really affecting their mental health. I hope that we can find some solutions to this housing situation, this housing crisis.

Our number one challenge is transportation, but within transportation is homelessness because it’s unfortunately not uncommon for people when they come... When they’re honest about who they are to be rejected by family and then be faced with homelessness. It’s also not uncommon for people who have substance abuse issues to be faced with homelessness.
Making health care more affordable and comprehensive is one of the primary issues for the providers when discussing how to improve the environment in Georgia. Addressing social determinants would also help make accessing mental health services more attainable for individuals. All of the providers indicated that it was hard to prioritize one aspect (social determinants, cost, etc) over others because they are all key issues in making mental health services more accessible and utilized. Now the affordability of mental health access is also connected to the internet accessibility. Providers are trying to find new and novel ways to provide ways to support families with this challenge.

Some of the providers discussed that the services that are currently available just are not designed for the target audience we are discussing now. That the programs do not fit everyone’s needs and that providers and systems need to able to adjust them to meet individual needs and continue to keep individuals engaged in mental health support services.

Improving the system in Georgia also includes increasing the number of providers and the availability of a range of providers who are qualified to meet the populations needs. This includes addressing the limited resources in certain communities. Often providers reported struggling with how to handle situations where they did not feel qualified to address a client’s challenges but there was not another available option. Providers included the idea of peer support youth in the importance of workforce development. The importance of peer support was echoed by several of the providers. For some of the providers they discussed finding a way to build the bridge by intentionally hiring young clinicians who could better build rapport with the young people they are serving.

There is, of course, less resources and really reduced number of providers. And we frequently have as providers, those ethical dilemmas, when sometimes you feel the pressure of having to take in clients who are not really on the scope of your competence or the age group that you work with because there is nobody else. So sometimes I have made some... We refer between colleagues and sometimes when I have to say no, when that is outside of my scope of competence, I’m being ethically competent that I’m paying attention to that. But on the other hand, I’m like, “who else is going to serve this client then?” And then this creates a huge problem, too.

And then there’s also the bandwidth with the bandwidth we have tried our best to do some community resources and getting internet companies to provide them that, cause I know there was a grant for some extended to, or some other internet companies to provide them that bandwidth too.

I think one of the things that we have noticed, and it’s a workforce development issue. There’s a greater need for certified peer youth. We have a lot of youth that want that support, but there aren’t enough peers to support the demand.
Education in general was also a key theme among the providers for ways to improve the environment and access to care in Georgia. This includes educating parents, caregivers, and youth about the resources available, how to identify and deal with mental health, and developmental skills. In addition, some providers discussed working with more youth to identify career paths to bring them into the field first as peers and then as trained certified clinicians.

Expanding the services available in the state of Georgia is another area suggested by many of the providers. Currently some of the more creative therapies cannot get licensed in the state of Georgia. Increasing the availability of creative therapies like equine, drama, and play therapy would be very beneficial in the state.

**We need to continue to do better is promoting and training and education. It’s my biggest piece of the younger Latino and African American community as a whole. When we go to the high schools and we educate about mental health, I like to see it more of a hands-on, I’m a CNA clinician, but it’s more of a preventative side. I would love to see more trainings, free trainings of course, in the daycares. I would love to see the daycares, I would love to see parents learning, I would love to see maternity clinics when they’re teaching them, but the resources are there for the community. Younger mothers, what to teach them, how to deal with mental health, what to expect, teach them about developmental. Just little mental skills for kids and all of that.**

Expanding the services available in the state of Georgia is another area suggested by many of the providers. Currently some of the more creative therapies cannot get licensed in the state of Georgia. Increasing the availability of creative therapies like equine, drama, and play therapy would be very beneficial in the state.

**We have a huge workforce shortage of therapists and counselors, but yet we have this untapped market of creative therapists, equine, our drama, even play that cannot get licensed in the state of Georgia. Therefore, they can’t provide services in CSPs and in private practices because they can’t bill.**

**Individual perspectives**

Two separate focus groups were held with young people and their parents to gather feedback about the mental and behavioral health system and care in Georgia for African American/Black youth and Latinx youth. One focus group focused on the African American/Black youth and families and the second focus group focused on Latinx youth and families. Two different community organizations assisted with recruiting individuals and families to participate in the focus groups. All participants received a $25 gift certificate for participating in the focus group. The Georgia Parent Support Network and the Georgia Latino Alliance for Human Rights both helped to recruit for the focus groups. There were 14 youth and parents who attended the African American/Black focus group, 9 women and 5 men. There were 20 youth and parents who attended the Latinx focus group, including 10 men and 10 women. All of the participants had lived experience with trauma and the mental health system in Georgia. For both groups, the participants lived throughout Georgia including approximately half of all participants residing in rural areas in the state (in particular northwest and southwest Georgia). In both focus groups, trauma was a significant issue for both groups.
Every treatment I've received, I've been pretending. I've always been pretending because I feel like I have to build a relationship before I can be open with them but I never get a chance. I don't ever get a chance to do that because I always have to change providers or something. Like for insurance or my parents just can't afford it. So I never really like build a relationship with a person. But just being introverted in general, I'm not really open so I just pretend. But I feel like if I got the chance to build a relationship with them, then I could be [open].

Every time, every year, they get again a new therapist. They have to start all over again with the relationship again to know that person. With my daughter, [...] since she’s been bullied so much, she's not open with anybody.

Family members and significant others (girlfriends and boyfriends) normalized treatment and reduced the stigma.

A girlfriend motivated him. She would normalize the conversation about mental health, his family does not talk about it. She would talk to him about it all the time and that helped him make a decision. His mother would also say it was important to speak with someone and that helped him.

Personal experiences

Some of the participants indicated that they moved while receiving services for their children. The services moved with them, however they also indicated that their case workers were able to provide them more local resources as well.

One of the African American participants was actively working as a certified peer specialist working with youth. She discussed how she was able to build on her own life experiences to support others and in addition she still continually seeks out more services that can help her now. Many of the Latinx participants talked about the role that their support networks played in getting them into therapy and into treatment.

Consistency in service providers was discussed by several of the participants. They indicated that they had to regularly change therapist due to a variety of issues including changing insurance coverage, clinicians moving or changing positions, or changes in caseloads. These disruptions in providers caused the individuals to feel like their relationships and progress was limited or challenged due to the lack of ability to form longer lasting relationships.

For African American/Black youth and families, getting referrals to trusted services was very important to the families.

When he went to therapy he saw several of his friends that were also receiving help and it helped him normalize it.

Relationships with providers were key for both African American and Latinx communities, however both experienced much disruption in relationships with providers.
African American and Latinx participants also indicated that having providers who understood them and were flexible with them was very important. They wanted providers who they could connect with in multiple ways. They wanted providers who they felt took the time to connect to them and make connections to them. They want providers who will connect with them and help them develop ongoing solutions.

For Black/African American participants, having a provider who understood their community and culture and who looked like them was often more important than language issues. For the Latinx participants, language and culture were both very important. Several of the participants discussed feeling discriminated against, particularly when they were working with clinicians who were different from themselves. Having a clinician and system that understood the individuals culture and built connection to the individual was seen as extremely important and critical.

“Don’t like be too, I want to say that too professionally, because it scares me. It would be you don’t really care a little bit, and my therapy is my providers, I paid. They real chill, they’ll stay how I talk and they don’t get pressed when I start talking real fast. For you might hurt when I start talking fast little, many go. I get frustrated. I really get frustrated myself.

I was with her for years, she was very calm, laid back to talk about pretty much anything. But I think it was very important for me to feel comfortable within my sessions instead of just feeling like I was in a professional office setting 24/7.”

So, I need for my providers to be within the area, I feel like I want my daughter to get her healing from within the community, if it all possible. That’s very important and it is important that the provider looks like her because of her individual experiences in life. I feel like if it’s somebody that looks like her, sounds like her she can relate better to them. Now, they can speak as many languages as they can but as long as they can speak English, I’m okay with that.”

Community and culture was critical for African American communities; Language and culture were very important to Latinx communities.
Discrimination due to not understanding community and culture was a significant issue for both African American and Latinx participants. Participants indicated working both with ongoing therapists as well as having worked with crisis teams and hospitals and peer support. The variety of experiences provided the opportunity to discuss the mental health system broadly. Several of the providers discussed having to be strong advocates for themselves with the organizations they were seeking support from, particularly when there were frequent changes in clinicians.

Several of the participants discussed the importance of obtaining legal guardianship for older youth (16–18-year-olds) who are at risk of psychiatric hospitalizations so that they can continue to advocate for and know about the young person’s mental health services and needs.

One of the critical first steps that many of the African American and Latinx participants discussed was recognizing the need for help and learning to ask for help. They had to learn to ask for help, to receive it, and to advocate for themselves with family, friends, and the mental health system. For African American participants this often meant contradicting cultural expectations and norms. For the Latinx participants, they reported being dismissed often when they sought help or assistance. In one case, they requested assistance from the school but was told they did not provide resources and they did not give her any resources to contact.

So, kind of just getting comfortable with just accepting that it’s okay to ask for help. So not necessarily on the therapy end, like I said, I’ve always pretty much been comfortable. It’s other people. But when I did get with my crisis intervention team, this time around, they came with services like actual jobs, all that. That was a little bit harder for me because even when they would go out to the house ready to help, I’m like, no, it’s fine. I can do it. Like, it’s this cool, and just realizing, they’re there to help.
From Mexico, she thought it was part of the change. It was difficult to find help. She went to the school and was told that they could not help her. They only taught and did not have a referral. That she had to find the resources. She did not speak English.

One of the participants discussed her family’s experience with the Georgia Crisis Line during a recent crisis with her daughter and during a time when she needed a provider that accepted Medicaid.

You know, I did this last time that my daughter went into the hospital. I knew that if I didn’t find a Medicaid provider, I might’ve been out of pocket paying money myself. And, I knew I wasn’t going to have that kind of money that they charge per day for hospitalizations. So I called the crisis line and they told me that there was a hospital in Gainesville, which I didn’t even know. So they said, “We can come out.” Traffic was so bad that day, “Or, you can take her.” So I took her. So I really thank God for the crisis line, cause they, directed me to the right place, the right time and the people in the hospital were great. Absolutely wonderful.

Some of the participants reported very traumatic experiences with hospitalization and a lack of clear understanding from clinicians about what hospitalization would involve. The participants indicated that for this reason they were often very cautious about how open they were when receiving treatment. The participants also indicated that they felt that sometimes they were not provided enough support and resources when they were discharged from the hospital.

Hospitalizations could be very traumatic due to a lack of clear communication and understanding of what was involved.

We just went to go see a therapist and they ended up telling my mom I had to be there for 72 hours and so my parents were freaking out because they couldn’t get me out. That was crazy because they didn’t inform my mom about that at all before we got there so I was kind of just stuck there and for me, it was so traumatic because I feel like people go there... I know I had an incident where my councilor encouraged me to go to the hospital and be evaluated and when I got there, I waited a very long time. They never had a psychologist or whatever meet with me. They had a nurse meet with me and they said, “Okay well we’re just going to admit you.” There wasn’t like a lot of information and I was texting my friend and that’s how I found out they don’t let you leave when you want and when I text my friend and I told her that, I decided that it wasn’t going to be a good idea for me to stay and then, when I left, they gave me a paper and they gave me like three different coping mechanisms and then they just sent me on my way.

Another thing is, I have friends and relatives that have been hospitalized and their experiences from what they tell me have been very traumatic and I think, sometimes, clinicians aren’t very honest about what happens at the hospital and what it’s like for people there. So just knowing that it can be very scary. I won’t share that with the clinician. Depending on if I think that they’re going to try to send me to the hospital.
Several of the Latinx participants indicated that their history with mental health services was multigenerational with parents who utilized mental health services or worked in the mental health field. This helped to normalize seeking treatment and to make it more accessible. Several of the participants also indicated that they began their interaction with the mental health system when they were adolescents.

*my mother began a career in social services and social work in New York City. And so I was introduced to mental health services around my teenage years. And after my parents experienced a divorce, that was the first time I began seeking therapy.*

I did therapy when I was younger. I was 12 when I first did therapy. And I did it throughout until I was like 14.

**Telehealth/telemedicine**

Several of the participants indicated that in rural areas, telemedicine made a significant difference in their ability to access and utilize care. This was the case for both African American and Latinx young adults and families. For African American participants, comfort and video conference burnout was a major factor, as well as internet access. For Latinx participants, those issues existed but also language issues continued to be an issue. Some of the participants indicated that telehealth made it easier to schedule meetings, but for others it was more challenging.

Several participants talked about how through therapy either themselves or their children had made significant strides including greater independence and more positive outlooks. Some of the participants indicated telemedicine made it much easier to access care while for others it added to the challenge.

**Strides/Positive experiences in mental health service use**

In general, the participants indicated very positive interactions with and experiences with the mental health services. One of the participants talked about the value of a good counselor, one who would consistently make referrals to other supports and services as she needed during their time working together.

*Telemedicine has significant benefits for access in rural areas but also can have significant limitations and challenges for creating change.*

*I've actually been using telehealth services... well before this month but I feel like it was not as effective because there's so many distractions in my room and stuff and I get really anxious about things and just knowing I have other things to do that I could be doing instead of being on there virtually. I feel like it's just better in person. It's just not as effective on the computers and stuff.*

I just want to say with telemedicine, it's easier to get my daughter to come out of the room, to sit and talk than it would be for her to get dressed and for me to push her, come on, you got to go because, having to make her go get in a car is harder. It's easier to have her come out of the room.
I think they were understanding, very patient, kind, resourceful. If I needed other services outside of their scope of practice, they would do well with connecting the other places. I had a counselor about two years ago. She connected me to black women’s wellness center downtown for physicals and that type of thing. So, that’s kind of been the positive part about it. When you do find a good councilor, they do refer you other places when you need it.

Several of the Latinx participants indicated that their history with mental health services was multigenerational with parents who utilized mental health services or worked in the mental health field. This helped to normalize seeking treatment and to make it more accessible. Several of the participants also indicated that they began their interaction with the mental health system when they were adolescents.

Like I thought I was never going to make it. I thought I was going to like forget it. I can’t do it. I can’t do it. So they got me in school. I’m working. I’m working on my depression. I’m working on my anxiety. It’s helped me a lot where I was before. Because I was so down to the point that I wanted to just like leave this world. I didn’t want to do nothing. No eating. No sleeping. I couldn’t do it but with the service I’ve gotten now, it’s like I’m doing better than I was before. So yeah, it helped me a lot and I’m thankful for my services because without them, I don’t know where I’d be at today. That’s all I got to say.

I was four years old when I got into the system and ever since then, I’ve been in the system. I’m 23 now. So four... yeah, it’s been far away. But, as I’ve been in the system, it developed me to a better person.

It is important to have it but its not easy to access.

In the Latinx group, several of the participants talked about their positive experiences in therapy but also mentioned that they felt like they had greater access and resources in the metro area than in rural parts of the state. Part of this was finding the right therapist and the right cost. In addition, these participants discussed wanting to continue the treatment and engagement and to help others like themselves.

Now I can see the importance of it if there is something that I can close this with. Now I can see the importance of it and I hope that eventually, in the future, I may be able to do something else just for keeping up with this, because I’m sure there’s still some things that are not completely cured, but I’m working on it as much as I can on myself.

I didn’t have a problem with it, but the thing is, I don’t think that I could have found this kind of help in Tifton, especially as a minority in Tifton. I did find a place in Decatur. It was a little bit far away from work, but it’s okay. Luckily, I had a job where they open up the space for... I could drive there, but I don’t know what would have happened because I really did need the therapy when I got it right. The place where I went to, it charged me only $15.
The authors concur that, for Latinx communities, issues of privilege also play a role as it does in the general community. It was clearly evident that those who participated in the focus groups who were acculturated and assimilated into general culture were more knowledgeable about the behavioral health system and were more informed about how to access services. A clear indication that education about behavioral health services works Those who were recently arrived immigrants or first generation were less knowledgeable about the behavioral health system and how to access it, in many instances due to language barriers.

**Challenges/Barriers to accessing services**

One of the challenges that many of the individuals and families faced in accessing services was understanding services, resources and funding and ensuring that the best options were selected. Some families faced having to make a decision for care that had to be changed later due to insurance and payment issues. Some participants recalled having issues and disruptions to services because providers did not want to accept Medicaid or indicated that Medicaid paid too slowly so they would discontinue services. This had led to disruption of services for several of the participants. Advocating for providers to continually petition and request Medicaid payment was a challenge for both participants and clinicians. Participants indicated that often they struggled to find providers because providers would say they do not take Medicaid and the challenge is actually that they do not want to take Medicaid. Cost was an issue that was discussed by all of the participants in both of the focus groups.

> **So now, this third visit that she’s going to have on Wednesday. I’m going to say, *I call Medicaid.* And they say that you can bill under this address, and I think that what she’s probably going to say, *We have to discontinue services because Medicaid pays too slowly.* They just don’t get the money and I get it, that she needs to pay her bills and everything too. I’m just hoping that she’ll make this one exception for my daughter. That’s all I’m hoping I’m liking, but can you just please?**

> **And Medicaid denies a lot of services, so I had to have the therapists keep petitioning Medicaid in order for them to okay it....It made me feel like that Medicaid wasn’t enough in order to have services that my daughter needed. So it, it made me feel intimidated. That’s what it did. It made me feel intimidated, cause my insurance is low income based.**

So, we stayed at Georgia Behavioral Health because she had a stay in, in a psychiatric hospital that had used all the... What’d you call it? Deductible monies and everything. So, I didn’t understand, if I had a known what I know now, I would’ve changed it from Georgia Behavioral Health and put her with a Medicaid provider because what happened? She established a relationship with the Georgia Behavior psychiatrist. Then, when the next year rolled around, it was like I had to pay all this money out of pocket. So, that was the dilemma.
Some of the Latinx participants indicated that they only reason they were able to utilize care was because they had Medicaid which paid for it, however the hours limitations were one of the caveats and challenges they experienced. This often led to interruption of services. The ability to access care utilizing Medicaid or insurance was seen as a key factor for many of these respondents.

Even when using private insurance participants reported challenges due to the confusion associated with insurance and different protocols and forms as well as finding a provider that would take their insurance.

High deductible and out of pocket costs were also challenges to participants when they were discussing finding and staying with providers. The affordability factor impacted accessing both sessions with clinicians and also accessibility of medications and being able to ensure consistent access to and use of appropriate medications. Some of the participants reported trying to negotiate with providers so that they could afford the treatment and sessions. Some providers were willing to provide a discount when the individual was paying in cash.

Having to consistently change providers was one of the challenges mentioned by several of the participants. Having to regularly re-establish relationships or contracts with therapists was a significant challenge for families and for successful treatment. African American participants in particular mentioned the importance of establishing a relationship with a provider. The changes occurred due to changes in insurance or due to changes in prices or locations where services were offered.

“Can you just pay us in cash? Go in your bank account?” because my deductible on my insurance is so high, I still end up paying so much so I don’t know, it’s a catch 22.

SP has searched for her son, 14 year old, for emotional help. It was difficult to find. If the insurance covers or not or if self pay very expensive. She also wants help for her but it was expensive ($100/session). Therapy or rent type of decision.

Yeah and then even like affording medications. I know when I was younger and I received services, I would be on and off different medications because my parents couldn’t afford it. So that too. Lack of funding.
Yeah and then even like affording medications. I know when I was younger and I received services, I would be on and off different medications because my parents couldn’t afford it. So that too. Lack of funding.

Throughout this two-year journey, her therapist has changed two or three times because what I’m finding out is people have these little, I call them short term contracts, these therapists. You’ll have them for a minute, those establish a good relationship with your child. And then they’ll be like, “Oh, I’m gone. You have to find somebody else.” That’s been very heartbreaking to me and traumatizing because when she came out of the hospital, this last time like a month ago, she didn’t have a therapist. I had to scramble and find one. So I went on the website and I found a company called Focus Forward. They say they took Medicaid as well, that’s why I picked them. I never had a consistent service. I would go to different places like every year because they would increase prices or my insurance would change or my parents couldn’t afford it in general. So, just like funding because I could never really build a relationship with any of those people that I had relationships with when I was younger and right now, I’m not receiving services anymore.

Consistency of care was a key issue for establishing relationships and successful treatment.

I think when I was younger, as far as DFCS, it was just difficult because you have a new person every couple of months and it’s kind of hard to get used to someone but, for the most part, I’ve had pretty amazing experiences with clinicians. So yeah.
Some participants in the Latinx focus group pointed out that often the locations that specialize in specific treatments may lose funding or the therapists are not permanent (interns or temporary) and so there is a lot of turnover and a lack of stability. Constantly changing providers can create more trauma and more challenge for individuals rather than providing support.

Transportation was a significant issue for some of the participants because the mental health service locations were out of the area and so finding transportation to and from appointments were a challenge. Consistent with the transportation issues, location was a key consideration for many of the participants when they were looking for and selecting providers. Individuals want to utilize therapist that are within their communities whenever possible, in part for convenience due to the other demands but also due to the desire for understanding of connection and community.

Cultural sensitivity and discrimination were two barriers that participants also discussed by both African American and Latinx participants. Some of the participants indicated that they or their families had struggled with finding providers who understood them and their cultural backgrounds. Having a provider who looked like them and who fully understood them was very important to many of the participants. Participants indicated that having providers who were more like them also helped to ensure that the provider would have a better sense of the experiences they live with, in particular some of the trauma they have experienced. Race and gender were both discussed as key criteria for important characteristics for African American participants.

It’s like a cultural difference like as a black woman having a provider that might be white or just non-black in general. So there was a time where I had a counselor that left the facility I was at and they didn’t have any other black women, so it made it difficult to like kind of connect with someone that wasn’t a black woman. Also, some facilities, they don’t really specialize in sexual orientation or stuff like that. So it makes it somewhat difficult to open up about those things because you don’t know if they’re going to judge you just because they don’t offer those type of services.
I think the only barrier would be like, a cultural sensitivity, just because I did attempt to go to them before starting at the initial place that I decided that I’m seeing now. So yeah, just a little bit of a culture difference. Everybody was pretty much nice, but I did have an issue with the therapist there, like the first day before even having an official session. It just was a little bit of kind of like a conflict, not necessarily with me, but with my family members who I brought.

My first time seeking counseling after being diagnosed with depression, I went to a non-African American person and I think, more so cultural differences. They couldn’t really identify with me and my coping mechanisms. So basically, I could talk about the most horrific thing that happened to me but speak about it regularly like this and the provider was like, “I don’t know how to help you.” So then, I chose after that to choose a provider that was kind of more in my cultural background, African American woman and she was able to kind of just see through some of my coping mechanisms and help me better.

For the Latinx participants, finding a provider who could understand the immigrant community was really important. They needed to not only understand the language but also the community. Many of the Latinx participants struggled to find providers who understood their immigrant community and other parts of their needs as well. Both Latinx and African American/Black respondents often discussed wanting a provider of the same gender as well as culturally and racially similar.

Language consideration was also very important to the Latinx respondents. Often when searching for a provider they were limited to search services that had to be conducted in English and only provided referrals to English speaking counselors which was not helpful to the individuals. It is important to note that respondents want providers who understand the culture as well as the language.

He called United Way 211. They did not have services in Spanish. Referred to English speaking counselor. He could not explain in English what he could have had in Spanish.

Even though they can speak the language she believes that they need to know the culture. Variety in countries that can cause problems or a situation. Sometimes culture influences how the situations happen between countries. Understand concepts differently.

Important that they look like me, language and identify I the area. Priority for DACA. Gives more attention to those in DACA and may be more helpful. LGBTQ or POC. That they can explain the options.
In addition to cultural and language issues, many of the participants in both groups discussed the importance and the challenge of finding providers who understood them culturally and who also understood LGBTQ challenges and this was very important to the individuals. The African American participants also reported challenges finding providers who understood both their community and culture and LGBTQ issues.

For some of the providers, cultural sensitivity included recognition of the value and importance of religion and the church in accessing and utilizing care. Finding a provider who shares their religious beliefs was something that was important to many of the participants.

Some of the participants discussed the challenges accessing care as they transitioned from a youth to an adult. They wanted and needed support as they were aging out of foster care or transitioning off of their parents insurance and into their own payment process.

Some of the participants also mentioned struggling to find the right type of provider and clinician. In particular, participants struggled to find a psychiatrist as well as a counselor and often they would not be located at the same facility which made accessing care more difficult.
Stigma was still a significant issue for many of the participants in accessing mental health and behavioral health services. They discussed struggling to help change the perspective in their community and to normalize seeking out help and support. In the Latinx focus group, participants talked about how seeing peers in treatment helped to normalize it and provide them motivation for seeking treatment on their own. Stigma was a significant issue for the Latinx participants as well. However, it is important to note that many in the Latinx focus group discussed how pervasive stigma is within the community. Many of the participants indicating that there was stigma associated with even entering the buildings and accessing care.

Among the Latinx focus group respondents, the issue of identification and being able to provide proof of residency for accessing care. Several of the participants indicated that they were asked to show identification prior to being able to access care, and this limited their ability to utilize services.

For people to work it out, I feel like everybody should come together and pull together for the community about the stigma.

I feel like there’s a lot of stigma in our culture about therapy and when I did feel like I needed help, I didn’t want to seem like I had too many problems or that I was just doing it for attention. I feel like that’s what a lot of Latino parents think. So I just always pushed it under the rug and never really sought out for help. I just kept telling myself that I would be fine and that it would just get better as I got older.

I don’t want to say like a playground, but it should be [inaudible] somewhere where we can go and engage with other people who are going through the same things that we’re going through, or maybe used to sympathize with somebody else who’s going through a different thing.

A lot of... I know my grandparents, they told me not to tell people our business. Not to speak about certain things. We’re supposed to keep stuff at home. We’re supposed to go to church and pray. So when you do end up in crisis or in psychosis or in the hospital, they’re shocked. They think you’re being dramatic because they ignored all of these warning signs.

You need a social and stuff like that in order to get a paper from them. So after having a lot of back and forth with them I told them, “Please just let me pay whatever I need to pay. I just need to get this done because it’s part of my probation. I’m on probation. I want to get these done so I don’t get in trouble.” I don’t know how what happened, but the $50 that are paid, that was all that I ended up paying at the end. And they were able to release my information to my PO, whatever they did they think of my mental health.
Suggestions for improving services in the State of Georgia.

Some of the suggestions from the participants included focusing on youth services, youth led groups like Youth Move. The suggestion was to expand programs like that beyond the metro Atlanta area to reach a broader part of the state. And to include within that type of program, supports to help young people transition to adulthood and adult services.

Transition services were discussed by several participants as well. Services that would help young adults with mental and behavioral health issues to successfully transition to independence focusing on work, life skills, money management.

I actually worked for a place called UMFS.org. They help you transition to adulthood for becoming an emerging adult. So I started at the age of 16 through, now it’s 16 to 26 and we will teach you, the real world, basic school of life about, you paying your bills, how to manage your money, get you a job, [inaudible 01:25:21], how to get a job, how to dress for it. You know, be over all an adult.

Peer support services was also a strong recommendation from many of the participants because the importance of peers and engaging with each other was discussed as very important to many of the participants. Support systems in general were also considered very important and critical. Support systems typically included community members, teachers, friends, family, and church.

The teachers are so understanding. So they’ve been a huge support system for me and it’s so nice because they’re so understanding now that we’re doing online school and stuff.

But now, it’s to the point that my support system is getting stronger and they never give up on me. They ain’t never going to give up on me. Even though they want to but they see something in me that I don’t see in myself.

My support system basically was my mom. My mom, my grandma, and my grandfather. They all three supported me.

More cultural and linguistic responsive awareness and training was recommended for clinicians, particularly those in hospital settings. This included recommendations for how various challenges manifest differently in different cultures and populations. Taking time to fully assess individuals was also cited as critically important.
I feel things can be a lot of times overlooked and women, especially to the Black women, I definitely think things like ADHD a lot of times are easily pointed out more in young men just because they could be. I don’t like to stereotype, but a lot of times it’s seen, or as the symptoms are seen, as you know, over activity. As for a lot of girls, most of them, a vast symptom is pretty much just be suppressed, it kind of just blend in.

In addition to more culturally sensitive providers, some of the participants indicated that having a single place to contact, where language was not an issue, and a direct connection to appropriate services could be made.

Some of the Latinx participants indicated that they were not comfortable searching through the currently available methods which are less personal and often do not have culturally appropriate providers.

And the resources, personally, I don’t know if there are many resources available, and it’s maybe just because I’m very, in a way close-minded to looking or expanding, but I haven’t found any resources or anything that makes me feel comfortable in searching.

A center for youth and families. And in that center they could refer people to other providers throughout the state closer to their home. Even if it was somewhere else that it would cover a large service area. Serve the parents and entire family at an affordable cost.

A hotline located in a some organization or mental health provider would be good to have direct contact with one person. If someone calls they can be directly referred to an appropriate provider.

INCREASING MEDICAID COVERAGE AND THE SPEED AT WHICH THEY REIMBURSE PROVIDERS AND INDIVIDUALS WAS SOMETHING CITED BY SEVERAL PARTICIPANTS.

I just want to say Medicaid needs to pay people faster or they need to reimburse me. I would be just as satisfied with being reimbursed, I’ll find her somewhere to go and I’ll pay it if I could just be reimbursed because I need them keep the money coming, recycling it so I can use it for the next appointment. I can figure out a way to do that. If, I can just know that I’m going to be reimbursed.

I agree with [name redacted] that the therapists do need to be educated on the condition of the child before they can understand what they’re dealing with. They need to, yeah. The therapist have to know about the child’s health condition. That way they can be aware of which direction to go when they come at the child.
Participants discussed the need for more affordable providers throughout the state. Finding providers who operate on a sliding scale or had other affordable rates was a challenge for many participants, particularly when they did not have insurance. This may include receiving supports from providers that are working with youth as they begin to age and move off of their parents insurance, or for youth within the DFCS system having mental health service be one of the transition supports in place.

Finding ways to address and improve the stigma related to seeking care was a key recommendation from the participants. Stigma is still very much an issue in the African American community as well as the Latinx community. Providing education to individuals about mental health, services offered, resources, and general support is a key recommendation from the participants. Provides in the Latinx group also discussed the importance of education to normalize treatment. The importance of educating parents was discussed by many participants, this was emphasized so that participants could understand both their child’s actions and needs as well as the resources and supports as well. Some of the participants also indicated that the addressing the stigma could include improving the locations where treatment is provided and the marketing that is brighter.

I know when I didn’t have insurance, it was very difficult. Especially paying out of pocket, it got to the point where I had to stop seeing my therapist because it got too expensive. I know that there was a place on camp creek. I think Odyssey where they have a grant where your copay is $20 so that was good, but other than that, I didn’t really find any other places that had a reasonable, affordable

When I was in DFCS, I don’t really remember them connecting me to mental health services when I aged out. Like maybe job readiness programs and stuff, like that but nothing towards mental health. So, I think for me, the biggest problem was not being able to afford mental health services when I wasn’t insured.

Both Latinx and African American participants discussed the need for:

- More affordable providers throughout the state
- Increasing Medicaid coverage
- Increasing speed of Medicaid reimbursement

So, if there is a way that clinicians can educate or speak with older black people. Because they really don’t believe in depression and anxiety.

mental health is something we are still learning that we all need when she is open about her issues and what makes her toxic the community places you in a box that labels you by your mental health issues to define you as person. We need to normalize it and we all have traumas that we need to talk about.

When she sees the news about suicide due to bullying, it would focus on teaching parents that it’s nothing wrong with seeking mental health services for their children. Parents are in denial. Parents don’t want to accept or are ashamed. Social media can help. If we don’t have the money they should advocate for their children. Focus on educating the parents.
Just bettering their knowledge in general because I know, personally my family, well my African American side of my family, they don’t really believe in seeking services for mental health and I know my dad’s side, they love to say, “You’ll grow out of it.” And stuff. So just like increasing their awareness on mental health in general would be so much better.

Greater responsiveness and use of CIT trained offers (crisis incidence trained officers) was one of the recommendations from some participants. They discussed requesting them when parents had to call for support, however they are not often dispatched as needed.

So my mom always asks for... I don’t know what it’s called. CI something. What is it? Do you guys know what it’s called? CIA, CIT something. Trained officers. They’re supposed to know how to deal with people with mental health. They never send them. Ever. Never. Every time she asks, they never send them so it ends up just being them coming and leaving because there’s never a CIT trained or whatever it’s called.
Conclusions

This paper provides a broad overview of the current environment in Georgia, best practices and promising practices for providing services for African American/Black and Latinx young adults, youth, and their families, the critical nature of the workforce shortage, and feedback directly from providers and clients throughout the state of Georgia. There were several key findings from this extensive review of data, research literature, and qualitative data.

Individuals from both target populations have had very positive experiences in the mental health system and would like to see care more widely accessible.

Cost and insurance continue to be a barrier to service for individuals in both target populations.

There is a significant need for and desire for more education and awareness work to be done in the target communities to help reduce the stigma to admitting mental health needs and seeking care. This includes education on identification and supporting individuals.

More providers are needed throughout the state, but not just any providers. More investigation is needed to understand the balance of types of providers needed (psychiatrist, psychologist, counselors, etc) in different areas and regions. Increasing coordination and collaboration across providers may also be helpful.

Rural areas are in particular need for more providers, even when one provider is present, this does not give enough option and choice for individuals in the area needing services.

Telehealth provides access for many individuals that was not there previously. While it is not the best fit for everyone, it does provide a way for many individuals to have a greater array of options to accessing care particularly in rural areas.

The current pandemic has increased the amount of trauma and stress on many individuals and is increasing the demand and need for mental health services throughout the state. This is particularly true for these target populations who often have greater challenges with basic living necessities (housing and food) in addition to mental health and medical issues.

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There is a significant amount of need for services in the more rural areas of Georgia.

Many rural counties have a high proportion of the population who is African American/Black or Latinx.

Individuals in rural communities in Georgia report on average more poor mental health days per month.

There are fewer options for mental health and behavioral health services in rural communities in Georgia.

African American/Black and Latinx individuals prefer to utilize services from providers who are more like them and who can understand their culture and life experiences.

The target populations have higher rates of mental and behavioral health needs and experience a higher amount of stigma to admitting mental health needs and seeking treatment.

Latinx individuals prefer providers who speak their language and understand their specific cultural background.

African American/Black individuals prefer providers who look more like them and who can understand their culture and the specific traumas they have experienced.

Both target populations report high levels of trauma and a high level of need for mental and behavioral health services.
Recommendations

Based on the conclusions and the research conducted, there are several recommendations that we have been able to develop that could help to improve the access and availability of mental and behavioral health services in Georgia.

**Workforce development**

More work needs to be done to increase the entire continuum of the behavioral health workforce and specifically to increase the diversity of the workforce to ensure that there is access to providers who understand the target populations culturally and can address their linguistic needs.

**Researchers**

Providing funding to support researchers to investigate workforce development issues will help in this area. Advocating and supporting research into the best methods to recruit and retain minority professionals in the field is a critical need. We must also increase the number of culturally and linguistically responsive researchers and research participants.

**Peers**

Developing a path for peer support specialists is a significant need. These peers can provide much needed support and advocacy when individuals may be in crisis or are struggling to find treatment. Often these peers may also continue their education into employment. Training bilingual peers is the fastest way to address the linguistic barrier for individuals with limited English proficiency in need of behavioral health services.

**Mentoring programs**

Setting up mentoring programs to help individuals who are interested in pursuing a career in mental or behavioral health fields have been shown to have a significant impact on minority individuals entering and remaining in these fields.

**Loan forgiveness**

These programs may provide loan forgiveness for specific individuals who go into mental/behavioral health fields or who choose to work in communities that are underserved (i.e. rural areas).

**Immigrant professionals / licensing issues.**

Addressing the limitations that many individuals face in transferring education, training and licensing from other countries, or from other states, to increase their ability to support and serve clients, would help to improve the workforce.
Community education about behavioral health services

As mentioned earlier, education to reduce stigma is extremely important to improving access to care for individuals throughout the state. This training should be available for multiple groups and focus on a variety of areas.

General population

Training the general population on how to recognize mental health challenges, to identify when a person is in crisis, and how to support friends and families in accessing and participating in care. Some of this training and education is currently available but needs to be continued and expanded.

Immigrants and refugees

Training both for immigrants and refugees on the range of services and resources that are available in the state and county is one way to help address the barriers and challenges. In addition, specialized training to reduce the stigma among immigrant and refugee families is very important and needs to be conducted more specifically than the generalized community training – it must be tailored to the cultural expectations and it must be provided in the language that they understand.

Creative therapies and funding

Providing ongoing support and advocacy both for creative therapies and creative funding streams can help increase accessibility for all audiences. This can include equine, art, and play therapies.

Specialized training

Training for key first responders on how to respond in crisis and how to recognize mental health crisis is another area where more information and training is needed. This can help reduce the trauma and struggles that many individuals are facing.

Linguistic barriers

There are many ways that the linguistic barriers can be addressed including by providing some language specific services where individuals can search for culturally and linguistically appropriate providers in a single location rather than having to search in a different language or sort through a number of providers who are not appropriate due to language differences. One example would be partnering with the United Way 211 information line by adding a language appropriate section to their directory. Another suggestion is to partner with community-based organizations like the Latin American Association and the Center for Pan Asian Community Services to host a ‘warm line’ in their language(s) with appropriate behavioral health referral and education resources.

Developing novel funding mechanisms and expanding the number of providers and agencies who utilize a sliding scale system so that clients can find services that best meet their needs and are affordable.
References


Resilient Georgia. Regional Coalition Grantee Summary Reports. 2021


