A photograph of a person sitting on a couch with their hands clasped in their lap. To the right, two hands are reaching out towards them, one above the other, in a gesture of support or offering. The image is framed by a large orange curved shape at the top and bottom.

# Sustaining Georgia's Child and Adolescent Behavioral Health Workforce Through Supervision

March 2021

## **ACKNOWLEDGEMENTS**

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# EXECUTIVE SUMMARY

Over the last six years, ensuring that children and families have access to behavioral health services has been a central public health priority for Georgia policymakers. Georgia has made admirable progress in that time -- from the creation and expansion of the Georgia Department of Behavioral Health and Developmental Disabilities' (DBHDD) Georgia Apex Program (Apex) for school-based mental health (SBMH), to implementation of the Interagency Directors Team's System of Care State Plan, to two governor-initiated commissions to improve the delivery of behavioral health services (one of which resulted in an unprecedented \$24 million increased investment in children's behavioral health). In fact, the National Survey of Children's Health reported that the percentage of children in Georgia aged 3-17 with an emotional, developmental, or behavioral problem who were able to access treatment from a mental health professional increased from 41 percent in 2016 to 57 percent in 2018.<sup>1</sup> While this is encouraging, it remains that about 43 percent, or approximately two out of five children, were unable to access the mental health services they needed.<sup>2</sup>

One of the most apparent barriers to accessing care is the limited number of behavioral health providers practicing in the state. Forty-five counties in Georgia have neither a licensed psychologist nor a licensed social worker.<sup>3</sup> Moreover,

among practicing behavioral health professionals, levels of quality and cultural competency vary greatly, particularly among those practitioners accepting insurance -- public and private. Voices for Georgia's Children's (Voices) 2017 [Analysis of Georgia's Child and Adolescent Behavioral Health Workforce](#) found that a **critical pain point for emerging behavioral health professionals, and possibly a major contributor to workforce shortages and turnover, is a lack of access to clinical supervision that effectively supplements their academic learnings, allows them to attain and maintain licensure, and assists them in translating theory into practice.** Additionally, despite the known impact of providers' cultural competency on the outcomes of their behavioral health clients<sup>4</sup>, cultural competency training is not a standard requirement for acquiring or maintaining licensure in Georgia.

In order to identify potential solutions, Voices conducted key informant interviews with a diverse sample of behavioral health provider agencies to explore clinical supervision models and ways providers can support and retain emerging professionals through supervision and other related policies. Through these interviews, we identified the following supportive factors for, and challenges to, providing quality clinical supervision and increasing provider cultural competency and employee retention:

- **Telesupervision, or clinical supervision through remote communication methods, is a helpful mechanism** for increasing productivity and access to diverse supervisors, supporting cultural competency learning, and eliminating the burden on senior staff to provide clinical supervision.
- **Incentives such as loan repayment programs attract and retain employees;** however, many agencies find it difficult to use established federal loan repayment programs.
- **Disincentives for leaving a position, such as repayment of the cost of supervision, also help to retain employees.**
- **Incentives and supports for supervisors**

**such as providing a small stipend, or reducing the productivity requirement** helps compensate for the time taken from providing billable services.

- **Cultural competency training and requirements vary greatly across agencies**, suggesting lack of a common, baseline proficiency across providers.

Additionally, together with DBHDD and the Center of Excellence for Children’s Behavioral Health at Georgia State University (COE), Voices garnered the following from interviews with representatives of the University of South Carolina about the John H. Magill School Mental Health Certificate Program for budding SBMH providers:

- University-pipeline programs that partner with a state’s behavioral health agency can increase the state’s access to students and recent graduates through coordinated internships and grow provider expertise in critical areas of need (e.g., child and adolescent services and SBMH).

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## NEXT STEPS

Based on these findings, Voices suggests the following next steps for Georgia to increase access to quality supervision and retain more qualified, culturally competent, licensed behavioral health professionals:

### **Increase the use of loan repayment programs by behavioral health agencies and professionals.**

- DBHDD, behavioral health provider associations, and agency associations should explore barriers to loan repayment program enrollment and identify opportunities to promote and support enrollment in federal loan repayment program.
- Georgia’s General Assembly should develop and fund state loan repayment programs for behavioral health providers.

### **Leverage telesupervision to increase workforce productivity and access to diverse supervisors.**

- Behavioral health agencies should consider using telesupervision to increase clinicians’ productivity and time for billable services, and support employees by increasing access to diverse supervisors and cultural competency learning.

### **Adopt a universal standard of cultural competency training and requirements.**

- Behavioral health care provider boards (e.g., Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Therapists; Georgia Board of Psychology; Georgia Composite Medical Board) should consider adopting mandatory cultural competency training requirements for licensed providers.
- Behavioral health agencies should consider adopting cultural competency training as a requirement for both clinical and non-clinical staff and discuss key tenets in agency-based clinical supervision sessions.

### **Build on relationships with higher education institutions to improve the workforce pipeline from universities to employers.**

- DBHDD, with support from the COE, should continue to formalize the design for and launch a statewide school-based behavioral health professional internship program through Apex, based on South Carolina’s John H. Magill School of Mental Health Certificate Program.

Implementing these next steps could help increase access to high-quality clinical supervision opportunities, improve consistency in training, and encourage newly licensed providers to remain in this field in the state—all of which strengthen Georgia’s child and adolescent behavioral health workforce. Such an impact has the potential to increase access to needed services and ultimately improve child and adolescent behavioral health outcomes in the state.

# INTRODUCTION

Ensuring children and families have access to quality, timely, and culturally competent behavioral health services is essential for minimizing the adverse effects of mental illness, such as poor physical health, poor social and family relationships, poor academic and employment outcomes, and substance misuse.<sup>5,6,7</sup> Recognizing the lifelong impact that poor mental health can have on children, Georgia policymakers have increased their focus on child and adolescent behavioral health services and supports. In 2015, the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) developed the [Georgia Apex Program](#) (Apex) for school-based mental health (SBMH). In 2017, the Interagency Directors Team for children’s behavioral health launched a new [System of Care State Plan](#), and based on recommendations from the Commission on Children’s Mental Health, Gov. Nathan Deal and the Georgia General Assembly invested an unprecedented additional \$24 million in children’s behavioral health. In 2019, Gov. Brian Kemp and the legislature built on this investment with a \$8.4 million increase in funds for Apex and the creation of a four-year Behavioral Health Reform and Innovation Commission to identify further opportunities to improve access to and delivery of behavioral health services.

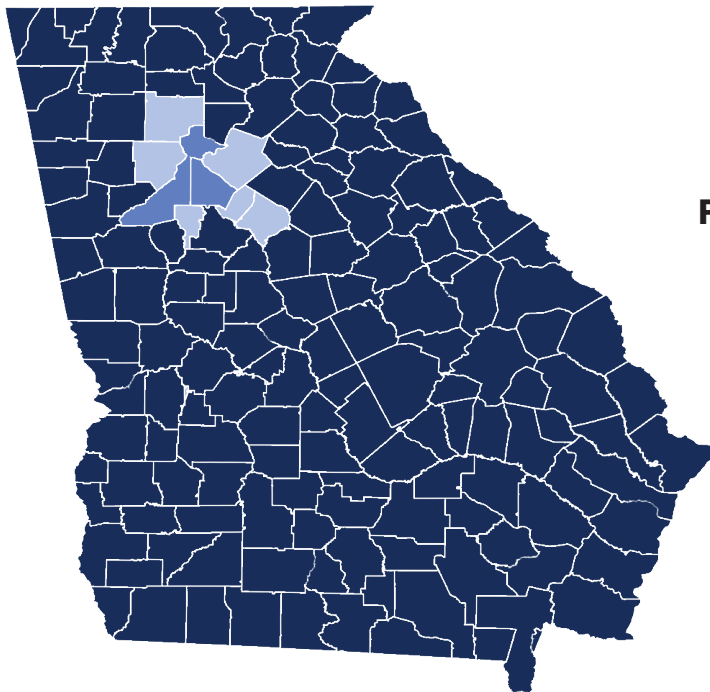
While the recent investments in children’s behavioral health have certainly helped reduce barriers to access, two out of five children in Georgia, aged 3-17, with an emotional, behavioral or development problem still have trouble accessing the mental health services that they need.<sup>8</sup> Many factors can limit a child’s access to mental health treatment, including lack of insurance, cost, difficulty identifying services and navigating the system, and transportation challenges (see [Barriers to Healthcare for Georgia’s Children](#)). However, a general lack of provider availability is one of the most significant barriers to accessing behavioral health care throughout the state. In fact, over one-fourth (45 of 159) of Georgia’s counties do not have a licensed psychologist or a licensed social worker.<sup>9</sup> Further, according to the Health Resources and Services Administration, there are 95 Mental Health Care Health Professional Shortage Areas in Georgia (see [Figure 1](#)), which impacts nearly all (96 percent) of Georgia’s counties and half of its residents.<sup>10</sup> The disparity in provider access is more evident in rural communities, which make up the bulk of the state.<sup>ii</sup> In fact, the only counties that are not considered a Mental Health Care Health Professional Shortage Area are in metro Atlanta. Additionally, for children and families that

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

ii Health Resources and Services Administration refers to the U.S. Census Bureau or the Office of Management and Budget to define rural populations at fewer than 50,000 people. Retrieved from <https://www.hrsa.gov/rural-health/about-us/definition/index.html>

FIGURE 1



### MENTAL HEALTH CARE HEALTH PROFESSIONAL SHORTAGE AREA BY COUNTY IN GEORGIA<sup>14</sup>

- None of the county is a shortage area
- Part of the county is a shortage area
- Entire county is a shortage area

are marginalized as a result of their race, ethnicity, country of origin, religion, sexual orientation, or gender identity, **typical access barriers such as provider shortages may be magnified by the lack of diversity and cultural competency among the available behavioral health provider workforce.** This increases the possibility that these children and families will experience less culturally responsive care, and even misdiagnosis or inadequate treatment.<sup>11,12,13</sup>

In 2017, Voices for Georgia’s Children’s (Voices’) Analysis of Georgia’s Child and Adolescent Behavioral Health Workforce found that emerging behavioral health professionals experience great difficulty in satisfying the clinical supervision requirements to become a licensed professional in the state. The most common challenge cited was access to qualified supervisors; this was particularly difficult for professionals in rural communities, because agencies often had limited staff and high caseloads, leaving little time to provide adequate supervision. Accordingly, addressing the barriers to clinical supervision holds great promise for reducing Georgia’s mental health provider short-

ages, as well as strengthening providers’ cultural competency, and thus improving care for all Georgians.

DBHDD has prioritized identifying and reconciling pain points in the path to licensure for children’s behavioral health professionals and engaged Voices to explore the clinical supervision models of several provider agencies. In 2020, Voices interviewed representatives of five behavioral health provider agencies - CHRIS 180, Georgia HOPE, Serenity Behavioral Health Systems (BHS), Georgia Pines, and Metropolitan Counseling Services (MCS) - to learn more about their supervision programs, provider retention strategies, and university partnerships. We also interviewed representatives of Motivo, a third-party behavioral health telesupervision vendor that connects therapists to remote clinical supervisors, and the University of South Carolina, which, in partnership with the South Carolina Department of Education, developed the John Magill Certificate Program to recruit and train recent graduates who are school-based behavioral health professionals.

TABLE 1

INTERVIEW PARTICIPANTS

Organization Name	Organization Type	Area(s) Served
CHRIS 180	Private, non-profit provider	Metro Atlanta
Georgia HOPE	Private, for-profit provider	North Georgia, West Georgia, Metro Atlanta
Serenity BHS	Community service board (CSB)	East Georgia
Georgia Pines	Community service board (CSB)	South Georgia
MCS	Private, non-profit provider	Metro Atlanta, North Georgia
Motivo	Third-party telesupervision provider	Nationwide (all states allowing live video-conference supervision)
University of South Carolina	University	Statewide - South Carolina

Note: The behavioral health provider agencies were selected for interviews based on their diversity in geography and public vs. private structure, as well as their well-defined training, internship and/or clinical supervision models. The size of the agencies and the total number of clients served varies – from six to 503 staff members, serving 275 to 7,500 clients.

CLINICAL SUPERVISION IN GEORGIA

Georgia’s behavioral health system is composed of several licensed and certified professions. This brief focuses on licensed (and associate) professional counselors, licensed master’s social workers, licensed clinical social workers, and licensed (and associate) marriage and family therapists.<sup>iii</sup> Clinical supervision is central to behavioral health professionals’ path to licensure. While the specific requirements vary depending on the license type that the individual

is seeing (see the Appendix), the purpose of clinical supervision is consistent – oversight and support for associate-level behavioral health professionals (hereinafter referred to as associates), such that they are well-equipped to translate theory into practice and provide high-quality therapy to their clients. **Supervision provides an opportunity for associates to engage with more experienced practitioners to discuss cases, treatment strategies, self-care, navigating biases, and ethics.**



The number of years of clinical supervision required for a behavioral health license range from one to three, with a total of 1,000 – 3,000 required hours, depending on licensure type. Additionally, most professions require a practicum or internship experience, of at least 600 hours, during school. In absence of this practicum experience, the associate must complete an additional year of direct, supervised experience.

**Identifying and securing supervision can be challenging, and although clinical supervision is a licensing requirement, opportunities are limited.**<sup>15</sup> The associate has to consider a variety of factors, including that the supervisor: meets the requirements set by the licensing board, can help them meet the needs (e.g. clinical, setting, cultural) of the population they serve, meets the cost/contract requirements outlined by the providing agency, and has a schedule that aligns closely enough with the associate’s.

iii Report does not include psychiatrist and psychologist. We primarily focused on masters-level professionals (LCSWs, LPCs, LMFTs, etc.) because Georgia has greater geographic distribution of degree programs that align with these professions – leading to a larger number of graduates in these fields.



# FINDINGS

Findings suggest that increasing telesupervision opportunities, free agency-based supervision, promotion of loan repayment opportunities, and university partnerships can reduce barriers experienced by emerging professionals during their path to licensure, as well as help with retaining providers long-term. Interview findings are organized by three avenues to increase access to clinical supervision: third-party telesupervision, agency-based supervision, and university pipeline programs.

## THIRD-PARTY TELESUPERVISION

Telesupervision is an innovative approach to clinical supervision that leverages a Health Insurance Portability and Accountability Act compliant audio-visual platform to facilitate sessions between an associate and an experienced professional. Approximately 300 providers in Georgia are currently utilizing Motivo, a secure platform that connects therapists to experienced clinical supervisors and allows for tracking and documentation of accrued supervised hours. Virtual platforms like Motivo afford associates the opportunity to strategically select their supervi-

sor, whereas in traditional supervision delivery models, an associate may select their supervisor based on location. A telesupervision model allows the associate to focus on factors that advance their practice goals; for instance, they may have the ability to select a supervisor who is experienced in serving a specific population that the associate seeks to serve.

Motivo supervision can be procured individually or through a larger entity contract (agency, institution and/or university). They offer three methods of supervision: group (up to eight associates) at \$45 per hour per associate, dyad/triad (one supervisor to two-three associates) at \$55 per hour, and individual (one-to-one) at \$65 per hour. Larger entities, such as CHRIS 180 and Georgia Hope, receive a discount on group supervision--\$150 per hour, for a group of six. Motivo has access to over 600 qualified supervisors (see [Appendix](#) for supervisor requirements) across all of the behavioral health professions. The supervisors are independent contractors, and Motivo facilitates compensation for the services rendered.

All of the providers interviewed offer telesuper-

vision in some capacity and consistently reported that this modality: greatly increased access to qualified supervisors in various specialty areas; reduced time lost due to travel; and eased access to resources. However, some providers encountered difficulties, such as trouble maintaining engagement with supervisees, less effective role playing and other learning techniques, technical problems, and the inapplicability of some feedback given due to the work culture/environment.

## PROS AND CONS OF TELESUPERVISION

### PROS:

- Increases access to qualified supervisors
- Reduces time lost due to travel
- Eases access to resources

### CONS:

- Makes it difficult to engage all supervisees (at the same time) in group sessions
- Limits the delivery of traditional learning techniques
- Experiences occasional technical difficulties
- Limits the applicability of feedback given due to work culture

## AGENCY-BASED SUPERVISION

Both non-profit and private community-based providers employ associates who are seeking licensure, as well as unlicensed (e.g., interns and case managers) behavioral health professionals. Providers accept interns who are fulfilling their graduate program's practicum requirements and often these students are hired as permanent staff after graduation. Interview findings related to agency-based clinical supervision are grouped by the following themes: supervision arrangement, supervision as a retention mechanism, supervisor incentives and supports, funding, and cultural competency training.

### *Supervision Arrangement*

Agencies offer supervision on an individual level, dyad/triad, group,<sup>iv</sup> or combination of more than one of these, at minimum of one hour per week, until the supervisee acquires required hours (see the [Appendix](#)). Only licensed clinicians certified by a national association<sup>v</sup> are able to provide the supervision.

Serenity BHS only offers individual supervision on a weekly basis. Georgia HOPE and MCS offer individual sessions weekly and at least one group session per month, while Georgia Pines alternates between individual and group sessions (e.g. individual sessions weeks 1 and 3; group sessions weeks 2 and 4). Both MCS and Serenity BHS sessions are provided in person or virtually (agency-based telesupervision), depending on the associates' needs. CHRIS 180 primarily uses the dyad/triad structure to provide supervision weekly; however, new hires are assigned to group supervision sessions for the duration of their probationary period (90 days). While the staff capacity at CHRIS 180 allows for the majority of their associates to receive supervision within the agency, they do not have as many certified licensed marriage and family therapists (LMFTs) on staff, so the agency uses Motivo to provide supervision for associate marriage and family therapists (AMFTs). Georgia HOPE has recently engaged Motivo to facilitate some

<sup>iv</sup> Group supervision is not required for licensure; in fact, the licensing board often specifies a maximum percentage or number of group supervised hours that can count toward licensure.

<sup>v</sup> Supervising LPCs must have a National Board of Certified Counselors (NBCC)-approved clinical supervisor credential or a Licensed Professional Counselors Association of GA (LPCAGA)-certified professional counselor supervisor credential; supervising LMFTs must have an American Association for Marriage and Family Therapy (AAMFT)-approved supervisor credential

SNAPSHOT OF AGENCY-BASED SUPERVISION CHARACTERISTICS

TABLE 2

	Georgia Hope	MCS	Georgia Pines	Serenity BHS	CHRIS 180
Cost to the associate-level (assoc.) provider?	No	No	No	No	No
Cost to the agency (assoc. per year)	\$1,000	\$5,000	\$12,480	\$1,800-\$3,600	\$3,120
Employs and pays associate-level providers	Yes	Yes*	Yes	Yes	Yes
Contract obligations	No	1-year contract	1-year contract	2-year contract	No
Supervisor incentives (compensation)	No	Yes <sup>+</sup>	Yes <sup>++</sup>	Yes <sup>+++</sup>	No
Support provided for supervisors <sup>++++</sup>	Yes	Yes	Yes	Yes	Yes
No. of qualified supervisors	4	3	4	3	2
Use of telesupervision	Yes <sup>-</sup>	Yes	Yes	Yes	Yes
Cultural competency training	Yes <sup>**</sup>	Yes <sup>***</sup>	Yes <sup>^</sup>	Yes <sup>***</sup>	Yes <sup>^</sup>

\* The hourly rate is for clinical hours only; no compensation for administrative work

+ Reimbursement of \$92 per hour plus a small administrative stipend

++ Reduce supervisors’ productivity requirement by 20 percent; fund travel for supervisor certification training

+++Provides a small stipend to supervisors

-Georgia Hope contracts with Motivo to provide telesupervision for 38 groups; Georgia Pines is piloting telesupervision with one of six groups.

\*\* Developed an equity, diversity, and inclusion training plan; contract with Motivo for racial trauma and social justice training to be included in clinical supervision sessions

\*\*\*Agency-wide training offered annually (Serenity BHS) or multiple times throughout the year (MCS)

of their group supervision, allowing them to offer over 38 group (a max of six associates per group) telesupervision sessions every month. Georgia Pines is also beginning to venture into telesupervision by piloting Motivo with one of their six supervision groups.

The supervision arrangement dictates certain components of the supervision style:

- Individual supervision – individual case review, assistance with developing individual treatment plans, identification of opportunities for personal growth, and productivity.
- Group supervision<sup>vi</sup> – de-identified (e.g.,

presented as a scenario) case reviews; discussions around ethical, legal and moral obligations; and recent and relevant research, training and/or continuing education (CE) opportunities; and the importance of and guidance on incorporating self-care.

*Supervision as a Provider-Retention Mechanism*

**Retention of providers is often a major concern, especially for agencies in rural communities, with national data reporting turnover rates among the behavioral health workforce as high as 70 percent per year.<sup>16</sup>** Several factors impact retention: compensation, op-

vi Many of the group supervision topics (e.g. ethics, self-care, relevant research) are also discussed in individual sessions, especially if an agency only offers individual supervision.

portunity for advancement, caseload size, and mentoring.<sup>17</sup> Consequently, the majority of the agencies interviewed<sup>vii</sup> have established policies that provide incentives and disincentives to help

## LOAN REPAYMENT

In addition to supervision, loan repayment eligibility is a major incentive to new providers, particularly in rural areas. Both Georgia Pines and Georgia HOPE promote the National Health Service Corps Loan Repayment Program, which provides student loan debt relief for licensed mental health professionals that agree to work in a designated Health Professional Shortage Area (HPSA) for a minimum of two years. Licensed professionals are eligible to receive loan repayment program funding for a maximum of two funding cycles. Because 150 of Georgia's counties are considered Mental Health Care Professional Shortage Areas, federal loan repayment programs could benefit behavioral health professionals across the state.

retain associates long term. **Every agency provides supervision at no cost to the associates.** Agencies also typically offer full-time positions once the associate becomes licensed or provide a salary increase if they are already employed full-time with the agency. Three of the agencies interviewed use contracts of one- to two-year

obligations to encourage employee retention; two of these agencies also require the employee pay back the cost of supervision (e.g., at the rate of \$120 per hour) if the contract is broken. MCS specifies that the associate is not able to take their caseload if they leave prior to completing the training program.

These contract obligations (along with loan repayment programs) have provided agencies with some success in retaining newly licensed professionals. However, despite these efforts, private practice is often more appealing due to significantly higher compensation. The agencies' retention rates vary from 60 percent to 98 percent.<sup>viii</sup> Though not mentioned in these interviews, other factors, like office climate and supports, may impact an organization's retention rate.

### *Supervisor Incentives and Supports*

Many clinicians consider providing supervision to be a part of their responsibilities. Still, incentives and supports for supervising professionals can be a valuable tool for agencies to ensure that they have enough supervising clinicians on staff, and prevent burnout among supervisors. Collectively, provider agencies offer a range of incentives such as reimbursement for the cost of training to become a certified supervisor,<sup>ix</sup> a small stipend<sup>x</sup>, monthly support meetings<sup>xi</sup>, a reduction in productivity requirements<sup>xii</sup>, and sponsored CE opportunities<sup>xiii</sup> to encourage clinicians to supervise emerging professionals. Provider agencies have also leveraged telesupervision opportunities to allow agency-based clinicians more time to provide reimbursable services.

### *Funding Supervision*

Supervision is a necessary cost for agency-based providers and is not billable through health

vii Serenity BHS (two-yr contract); Georgia Pines and MCS (one-year contract)

viii MCS's supervision model is designed as a training program. Program participants are expected to secure full-time employment elsewhere upon completion of the program.

ix CHRIS 180 covers the cost of training to become a certified supervisor.

x MCS has also been able to procure funding from philanthropic partners and client pay to reimburse supervisors at \$92/hour and provide a small administrative stipend. Serenity BHS also provides supervising clinicians with a small stipend.

xi MCS and Serenity BHS both hold a mandatory, monthly meeting for supervisors to discuss any challenges

xii Georgia Pines reduces the productivity requirement for clinicians that provide supervision, recognizing that time spent supervising associates has a direct impact on the time available to serve clients.

xiii Georgia Pines and Georgia HOPE offer supervisors paid time-off to participate in CE opportunities or host them on-site; Georgia HOPE offers 42 hours of CE every year; Georgia Pines hosts CE approved lunch and learns



insurance (public or private payers). **The average cost of supervision to the agencies per supervisee was \$5,040 per year**, with the lowest agency cost being \$1,000 per supervisee per year and the highest agency cost at \$12,480 per supervisee per year.

While provider agencies seldom have a single funding mechanism that directly supports supervision activities, most are able to blend revenue streams to cover costs and sometimes provide a small stipend for supervisors. The majority of the agencies<sup>xiv</sup> revenue comes from state funding, grant funding, and insurance billing (Medicaid, Medicare, or private). CHRIS 180 also receives funds from local school districts for their school-based mental health services, and philanthropic foundations. MCS does not receive any state funding, but generates revenue through grants, individual donations, client pay (through a sliding-fee scale), and facilitated trainings.

### *Cultural Competency Training*

Cultural competency, increasingly referred to as cultural humility, is a major factor in whether children and families, regardless, of race, religion, and sexual orientation, receive effective behavioral health services. Unlike other health care services, behavioral health diagnosis and treatment rely heavily on how a sole behavioral health professional interprets behaviors. Knowledge of various cultural inferences, or consistently learning and considering how a client's behavior may be influenced by cultural norms and factors, reduces implicit bias and thus, the likelihood of related error in diagnosis and treatment.<sup>18,19</sup> Further, culturally centered interventions delivered by well-trained providers and/or practitioners reflecting the diversity (including the ability to speak the native language) of their patients has shown to improve treatment adherence, reduce perceived stigma, and increase treatment seeking behaviors.<sup>20</sup> Identifying opportunities to improve cultural competency training among behavioral health professionals could improve mental health outcomes.

**Currently, the Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Therapists does not have a CE require-**

### **ment for cultural competency training.<sup>xv</sup>**

Therefore, it is up to individual providers and provider agencies to facilitate this learning and development (should they choose to do so), and as a result, cultural competency training varies significantly among behavioral health agencies:

- Georgia HOPE has an equity, diversity and inclusion (EDI) training plan, which has resulted in the development of two EDI taskforces; hiring an EDI consultant to conduct an agency-wide assessment and provide recommendations; and hiring a supervisor through Motivo who will address racial trauma and social justice in clinical supervision sessions.
- Serenity BHS requires all staff to participate in annual cultural humility training, and addresses applicability in supervised sessions, as needed.
- Georgia Pines utilizes supervised sessions to identify cultural considerations on an individual client basis, and discuss how to best serve that client.
- MCS provides a mandatory weekly two-hour training session for their associates, that also serves as an opportunity to provide cultural competency training (typically one to three times a year depending on clients' needs).
- CHRIS 180 incorporates cultural competency into supervision sessions by discussing blind spots, biases and how their own experiences may influence interactions with clients. The agency has also recently partnered with Motivo for a three-month intensive virtual consultation around race and culture, and has implemented weekly on-site discussions guided by a local consultant.

All of the agencies leverage online resources (webinars, online training, professional organization/university-facilitated training) to supplement their agency-based cultural competency training.

While it is important that agencies are able to tailor some of the content of cultural competency training opportunities to the populations they typically serve, with Georgia's increasing-

xiv CHRIS 180, Georgia HOPE, Georgia Pines, and Serenity BHS

xv Providers must complete 35 CE hours, comprising a minimum of five hours of ethics training and 15 hours of core training (specific to the license type). Cultural competency training may count toward core training, but selection of this type of course is up to the licensee's discretion.

ly diverse makeup in race, ethnicity, national origin, sexual orientation and gender status, **it is critical that general standards regarding cultural competency training be adopted for all behavioral health professionals.** This helps strengthen client-professional interactions and improves quality of services and treatment for children and families, as well as ensures that behavioral health professionals feel supported and equipped to interact with their clients. Additionally, behavioral health agencies, universities, and the state, must work together to increase diversity within the workforce.

## UNIVERSITY-PIPELINE PROGRAMS

Many behavioral health agencies in the state (including those interviewed for this report) have established mutually beneficial partnerships with universities in which the university refers students and/or recent graduates to the provider agencies for placement.<sup>xvi</sup> Graduate programs are often in need of placements for students for their practicum experiences, where the students gain clinical experience as interns with the agency. In some cases, the intern is hired as staff after completing their practicum experience and can begin acquiring their clinical supervision hours for licensing. Georgia Pines and Georgia HOPE have a continuous cycle of student interns after having connected with several universities and completed the school's process (e.g., application, memorandum of understanding) to become a practicum site. At all of the agencies, interns are placed in one department or rotate across multiple areas, gaining experience in assessments, therapy, case management, crisis intervention, and more. In many cases, interns become full-time staff and remain with the agency throughout the licensure process.

### [John H. Magill School Mental Health Certificate Program - South Carolina](#)

With the recent creation and continuous expansion of Apex, which supports SBMH services, DBHDD has recognized the need and opportunity to create university partnerships focused on the development of Georgia SBMH professionals. Using one of our neighboring states (and

national leader in SBMH), South Carolina, as a model, DBHDD, with support from the COE, is designing a SBMH university-pipeline program to launch in Georgia.

In fall 2018, the South Carolina Department of Mental Health (SCDMH), with support from the University of South Carolina's (USC's) School Behavioral Health Team and in partnership with the South Carolina Department of Education, created the John H. Magill School Mental Health Certificate Program (see [Figure 2](#) for a snapshot of the core competencies and corresponding requirements), to reduce the recruitment gap for SBMH professionals. The SCDMH, through the state's 16 mental health centers (similar to Georgia's Community Service Boards), provides SBMH services in over 700 of 1,293 public schools, and has committed to ensuring that every student in a South Carolina public school will eventually have access to mental health services. Given that this goal requires more SBMH providers, the SCDMH allocated \$63,000 in funding to support the first cohort of this program, which equates to seven intern placements (\$9,000 per center, per intern). Each intern is compensated at \$11 per hour and is fully immersed into SBMH programs.

Key certificate program requirements include:

- 600 internship hours, including exposure and understanding of SCDMH's policies, procedures and the role of SBMH professionals in school culture, and training in the agency's electronic health record.
- A minimum of 150 clinical hours, which entails observing; leading or co-leading individual, family or group therapy; shadowing Positive Behaviors Intervention and Supports (PBIS) meetings; training in clinical assessment and crisis intervention; and participating in interdisciplinary meetings.
- 30 hours of professional development, involving additional training in SBMH evidence-based treatments, multi-tiered systems of support, and other components.
- A minimum of two hours/month of supervision.

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xvi Georgia HOPE, Georgia Pines, and CHRIS 180 have created internship programs for graduate students/recent graduates. CHRIS 180's program markets their program through their website and students can apply separately from their academic institutions.

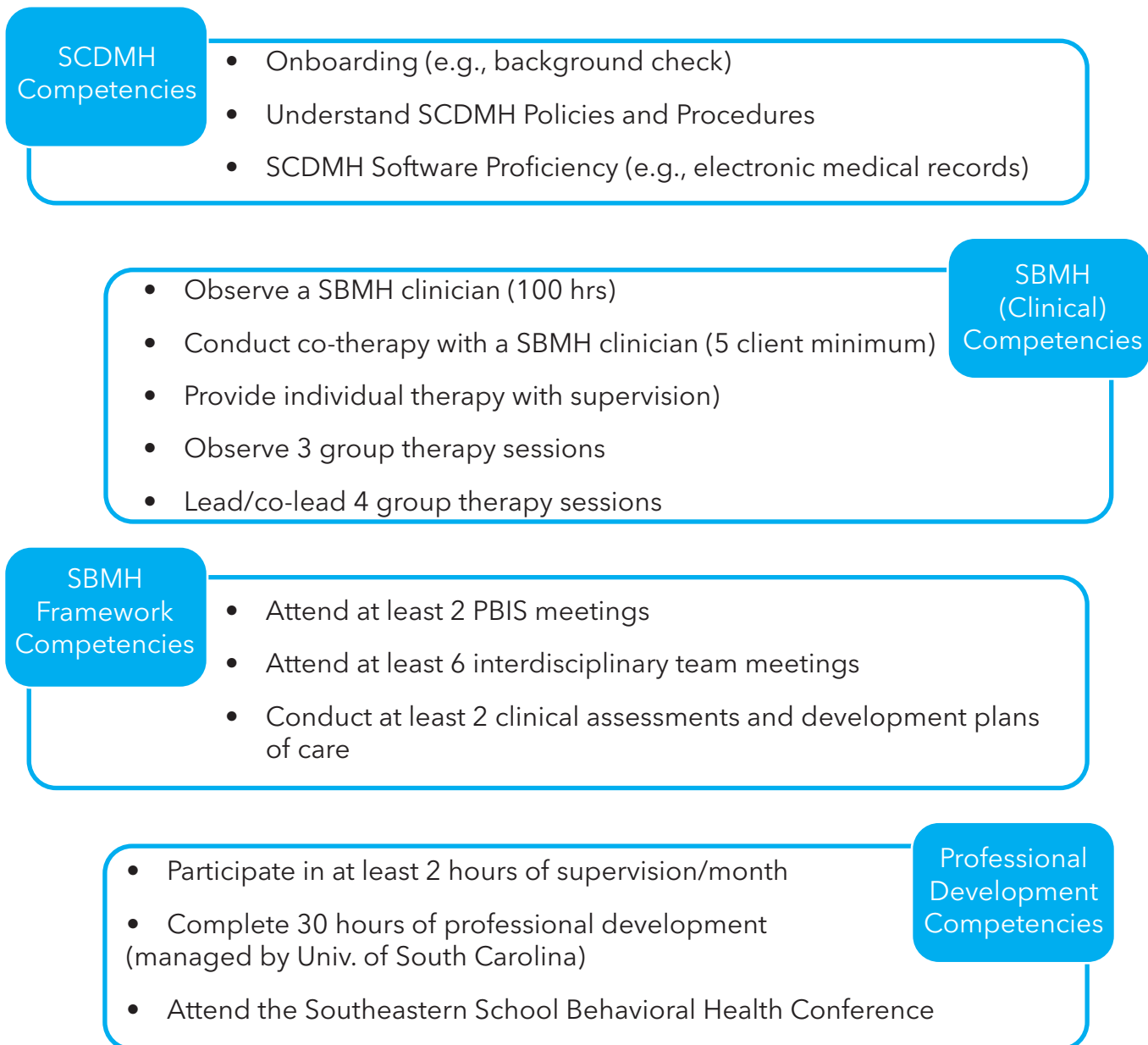
xvii Five graduates to date, two participants did not complete the program requirements

**Program staff recruit students through career fairs hosted by colleges and universities throughout the state.** Graduates of the program are offered a full-time position with the SCDMH, waiving the three to five-year experience requirement for new hires. Additionally, Magill graduates<sup>xvii</sup> are often hired at a higher band (and pay) level (e.g., Human Services I vs II).

Though relatively new, the Magill Certificate Program provides a promising model for Georgia to replicate to increase the recruitment and training of high-quality SBMH professionals.

**FIGURE 2**

**PROGRAM STRUCTURE FOR DEVELOPING SBMH PROVIDER CORE COMPETENCIES**



# CONCLUSION AND NEXT STEPS

Development and retention of qualified professionals is a challenge for Georgia's behavioral health workforce that directly affects the children and families in need of their services. However, our research confirms that while barriers related to clinical supervision (and attaining licensure status), cultural competency, and retention exist, so do a number of innovative strategies to circumvent these barriers.

Voices recommends the following next steps for Georgia's behavioral health provider agencies, state agencies, and policymakers:

## Behavioral Health Provider Agencies

- Provide agency-funded telesupervision opportunities to increase access to diverse expertise and eliminate the burden of providing clinical supervision from senior agency providers.
- Provide associate-level incentives (e.g., loan repayment) and disincentives (e.g., repayment of the cost of clinical supervision) to help attract and retain behavioral health professionals.
- Offer incentives and supports for supervisors to compensate for the time taken from providing billable services.
- Consider implementing mandatory, agency-wide cultural competency training.

## State Agencies and Policymakers

- DBHDD, provider associations and behavioral health agency associations should explore barriers to loan repayment program enrollment, and determine innovative ways to promote and support widespread participation in existing

federal loan repayment opportunities (e.g., developing a tool or other resources to help agencies identify if they qualify for and register as an approved site, and enroll employees).

- DBHDD, behavioral health professional associations, and the General Assembly should explore opportunities to develop and implement state loan repayment programs, like the Physicians for Rural Assistance Program, Georgia Physician Loan Repayment Program, Dentists for Rural Areas Assistance Program, Physician Assistant Loan Repayment Program, and Advanced Practice Registered Nurse Loan Repayment Program.
- The Georgia Board of Professional Counselors, Social Workers, and Marriage and Family Therapists should consider adopting a mandatory cultural competency training requirement for licensed professional counselors, licensed clinical social workers, and licensed marriage and family therapists, to ensure that Georgia's behavioral health workforce is better equipped to meet the needs of their increasingly diverse clients.
- Building upon the research already initiated, DBHDD and COE should formalize the design for and launch **through Apex** a statewide school-based behavioral health professional internship program, based on South Carolina's model.

**If individual behavioral health provider agencies and the state work together to broadly implement the aforementioned steps, Georgia will undoubtedly move closer to producing and maintaining the qualified behavioral health workforce that its children and families deserve.**



# APPENDIX

## CLINICAL SUPERVISION REQUIREMENTS, BY PROVIDER TYPE

LICENSE TYPE	PRACTICUM/ INTERNSHIP EXPERIENCE	REQUIRED SUPERVISED HOURS/YEARS	DIRECT CLINICAL HOURS/ SUPERVISED HOURS SPECIFICATIONS
<b>Licensed Professional Counselor (LPC)</b>	Yes, 600 hours	Three years or four years (3,000 hours)	<ul style="list-style-type: none"> <li>Two years of direct, supervised experience is provided by a LPC<sup>+</sup></li> </ul>
LPC applicant with specialist degree	Yes, 600 hours	Three years	<ul style="list-style-type: none"> <li>At least one year of directed, supervised experience must be provided by a LPC</li> </ul>
LPC applicant with doctoral degree	Yes, 750 hours	One year, if the applicant did not complete a practicum/internship within their degree program	<ul style="list-style-type: none"> <li>Directed, supervised experience provided by a LPC</li> </ul>
LPC applicant with rehabilitation counseling degree	Yes, 600 hours	Two years or four years*	<ul style="list-style-type: none"> <li>A minimum of one year of the supervision must be provided by a certified rehabilitation counselor or a supervisor who is a licensed professional counselor</li> </ul>
<b>Licensed Master Social Worker (LMSW)</b>	Not Required	Zero**	<ul style="list-style-type: none"> <li>None</li> </ul>
<b>Licensed Clinical Social Worker (LCSW)</b>	Not Required	Three years (3,000 hours)	<ul style="list-style-type: none"> <li>At least 2,000 hours must be in practice of clinical social work</li> <li>At least 120 supervised hours, of which no more than 50% may be group supervision</li> <li>At least 50% of supervised hours must be provided by a qualified LCSW</li> </ul>
LCSW applicant with doctoral and master degrees in social work	Not Required	Two years (2,000 hours), completed within six years of graduating	<ul style="list-style-type: none"> <li>Submit documentation of 80 supervised hours, of which no more than 50% was group supervision</li> <li>At least 50% of supervised hours must be provided by a qualified LCSW</li> </ul>
<b>Licensed Marriage and Family Therapist (LMFT)</b>	Yes, 500 hours	Three years	<ul style="list-style-type: none"> <li>A minimum of 2,500 direct clinical hours</li> <li>200 hours of supervision provided by a LMFT, LPC, LCSW, psychiatrist, or psychologist**</li> </ul>
LMFT applicant with an active Associate Marriage and Family Therapist (AMFT) license	Not Required	Two years	<ul style="list-style-type: none"> <li>2,000 hours of direct clinical experience</li> <li>100 hours of supervision provided by a LMFT, LPC, LCSW, psychiatrist, or psychologist, of which no more than 50% may be group supervision</li> <li>A minimum of five hours of such supervision must have been obtained concurrent with each 100 hours of direct clinical experience</li> </ul>
LMFT applicant with a doctoral degree	Yes, 500 hours	Two years (1,500 hours)	<ul style="list-style-type: none"> <li>A minimum of 1,000 direct clinical hours</li> <li>Provided by a LMFT, LPC, LCSW, psychiatrist, or psychologist</li> </ul>

\* In absence of the required practicum or internship hours, an additional year of clinical supervision is required.

\*\* An applicant seeking LMSW licensure can practice up to 1 year under direction and supervision, while waiting to take the competency exam.

+ Supervising LPC must have a National Board of Certified Counselors (NBCC) Approved Clinical Supervisor credential or a Licensed Professional Counselors Association of GA (LPCAGA) certified professional counselor supervisor credential.

\*\* Supervising LMFT, LPC, LCSW, psychiatrist or psychologist must be licensed and in good standing for a minimum of 3 years; or have a American Association for Marriage and Family Therapy (AAMFT) Approved Supervisor credential, or a Georgia Board Approved Marriage and Family Therapy Supervisor credential.

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