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Provisional Behavioral Health Licenses to Full Licenses: Analysis of Nebraska Behavioral Workforce Data 2009–2019

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There is a need to recruit and to retain behavioral health providers especially when providers are moving from the provisional licensing status to a full licensure status. This study estimated the rates of conversion of provisional licenses to full licenses among provisionally licensed psychologists, mental health practitioners, master social workers, and alcohol and drug counselors (ADCs) in Nebraska and examined potential associations among demographic characteristics and license conversion rates. Nebraska's behavioral health licensure data (2009–2019) was obtained from the Health Professional Tracking Service (HPTS) program that was established as a joint effort between Nebraska Department of Health and Human Services, Human Services Office of Rural Health and University of Nebraska Medical Center. The rate of conversion from provisional to full license during the most recent years ranged from 44% for ADCs to 75% among social workers. Compared to individuals of older age, individuals of younger age are more likely to convert among ADCs ($p = .0028$). Moreover, compared to individuals living in urban areas, rural practitioners are more likely to convert among social workers ($p < .0001$). With behavioral health problems on the rise across the country, it is urgent that behavioral health professional shortage areas begin to close the workforce gap. Increasing conversion rates from provisional to full licenses will be a part of this solution.

Public Health Significance Statement

The research estimates the conversion rates of provisional licenses to full licenses among provisionally licensed psychologists, mental health practitioners, master social workers, and alcohol and drug counselors in Nebraska. Increasing conversion rates from provisional to full licenses will be a part of this solution.

Keywords: workforce, provisional license, rural

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Background

Behavioral health issues are highly prevalent in the United States. According to the latest national survey, in 2018, approximately 47.6 million (1 in 5, 19.1%) adults (age 18 years and older) had any mental illness (AMI) in the U.S. and an estimated 9.2 million adults (3.7%) had both AMI and at least one substance use disorder (Substance Abuse and Mental Health Services Administration, 2019b). These numbers are even more striking considering the prevalence of mental health disorders in rural states and the lack of behavioral health providers to provide services. According to the 2018 National Survey on Drug Use and Health data, in Nebraska, only 45.0% of adults (age 18 years and older) who had AMI received mental health care (Substance Abuse and Mental Health Services Administration, 2019a). Also, past-month binge alcohol use among young adults aged 18–25 in Nebraska is significantly higher than the national average (42.3% vs. 38.1%; Centers for Disease Prevention and Control, 2017). Among all adults, binge drinking was reported highest in two rural regions—Two Rivers Public Health Department district (Dawson, Buffalo, Gosper, Phelps, Kearney, Harlan, and Franklin Counties; 23.2%) and Northeast Public Health Department district (Cedar, Dixon, Wayne, and Thurston Counties; 23.0%; Nebraska Department of Health and Human Services, 2019b).

It is well documented that the U.S. has a widespread shortage of behavioral health providers. As of June 30, 2020, there were a total of 5,530 behavioral health professional shortage area (HPSA) designations in the U.S., requiring an additional 6,329 practitioners to remove such designations. Of the 5,530 behavioral health HPSA designations, 3,205 were in rural communities, 1,875 were in nonrural communities, 448 were in partially rural communities, and two had an unknown rural–urban status. The shortage of behavioral health providers and rural–urban disparities can also be observed across individual states. According to the most recently available data on behavioral health workforce, in 2019, 91 of Nebraska’s 93 counties were designated as federal behavioral health HPSAs (Health Resources and Services Administration, 2021).

Contributing to behavioral health care workforce shortages are issues related to the recruitment and retention of providers, especially in rural areas. Gifford et al. (2010) identified barriers associated with keeping providers in rural areas of Alaska: pay, lack of

quality education and training, and lack of supervision all contributed to shortages in behavioral health providers (Gifford et al., 2010). McCarthy et al. (2016) found that challenges in education and training along with limited quality supervision and administrative requirements were barriers faced by behavioral health providers in the state of Washington. New Mexico faces some of the highest shortages of behavioral health providers in the U.S. Legislators in that State enacted the Health Care Work Force Data Collection, Analysis, and Policy Act in 2011 to study and address the issue of workforce capacity. A lack of resources, a dearth of behavioral health providers representative of the population served, limited access to providers working in public settings, and difficulties finding quality supervision and education emerged as issues impacting the ability to provide behavioral health services (Altschul et al., 2018).

Nebraska has also focused on addressing the behavioral health care workforce shortage. Nayar et al. (2017) found that Nebraska has a lower proportion of all categories of behavioral health professionals compared to national estimates (Nayar et al., 2017). To address the emerging issue of rising behavioral health concerns and the lack of behavioral health providers to deliver services, the Behavioral Health Education Center of Nebraska (BHECN) was designated by the Nebraska legislature to recruit, retain, and increase competency of the state's behavioral health workforce. The overall purpose of BHECN is to improve access to behavioral health care across the state of Nebraska by developing a skilled workforce. BHECN examines the licensure data and provider and facility survey data to estimate the supply of psychiatrists, advance practice registered nurses (APRNs) practicing psychiatry, physician assistants (PAs) practicing psychiatry, psychologists, licensed independent mental health practitioners (LIMHPs), licensed mental health practitioners (LMHPs), and licensed alcohol and drug counselors (LADCs). Since the inception of this program, the analysis revealed a severe shortage of behavioral health care providers in the state (Behavioral Health Education Center of Nebraska, 2020). Compared to the national average, Nebraska had fewer psychiatrists per 100,000 residents (7.9 vs. 14.8). The disparity is even more significant for rural areas with only 2.7 psychiatrists per 100,000 residents. Similarly, the supply of psychologists in the state is much lower than the national average (19.1 vs. 29.6 per 100,000 residents) and in rural counties with only 8.8 psychologists per 100,000 residents. For all other provider

types, we observe similar patterns of provider shortage in rural communities.

BHECN was also created to address the behavioral health care workforce shortage by developing best practices to increase the Nebraska behavioral health care workforce. Figure 1 presents a diagram to explain the opportunities to enhance behavioral health workforce development. During the high school and undergraduate program phases, individuals can be introduced to the field of behavioral health professionals, encouraging them to pursue a degree in a given profession (e.g., psychologist). Similar to many other states, Nebraska uses a two-tier system for behavioral health licensing for psychologists, mental health practitioners (MHPs), master social workers (MSWs), and alcohol and drug counselors (ADCs). Other behavioral health professions, such as psychiatrists, PAs, and nurses, do not have the provisional licensee process. As detailed in Table 1, psychology students would typically complete the American Psychological Association (APA) accredited doctoral degree and pursue an APA accredited 1-year internship program to obtain a provisional license. Similar licensing requirements regarding degree, internship completion, and a provisional licensing period exist for other behavioral health care professions in the state (Nebraska Department of Health and Human Services, 2019a, 2021a, 2021b).

There is a need to recruit and to retain behavioral health providers, especially when providers are moving from the provisional licensing status to a full licensure status. It is often desirable to have a full license over a provisional license because the individual with a full license can practice to the maximum scope of work for a given profession and the organization that hires the full licensed individuals can bill for their services with less oversight needed. This study characterized the rates of conversion of provisional licenses to full licenses among provisionally licensed psychologists, behavioral health practitioners, Certified Master of Social Worker (CMSW), and ADCs in Nebraska and examined potential associations between demographic characteristics and license conversion rates among provisionally licensed behavioral health professionals in Nebraska.

Method

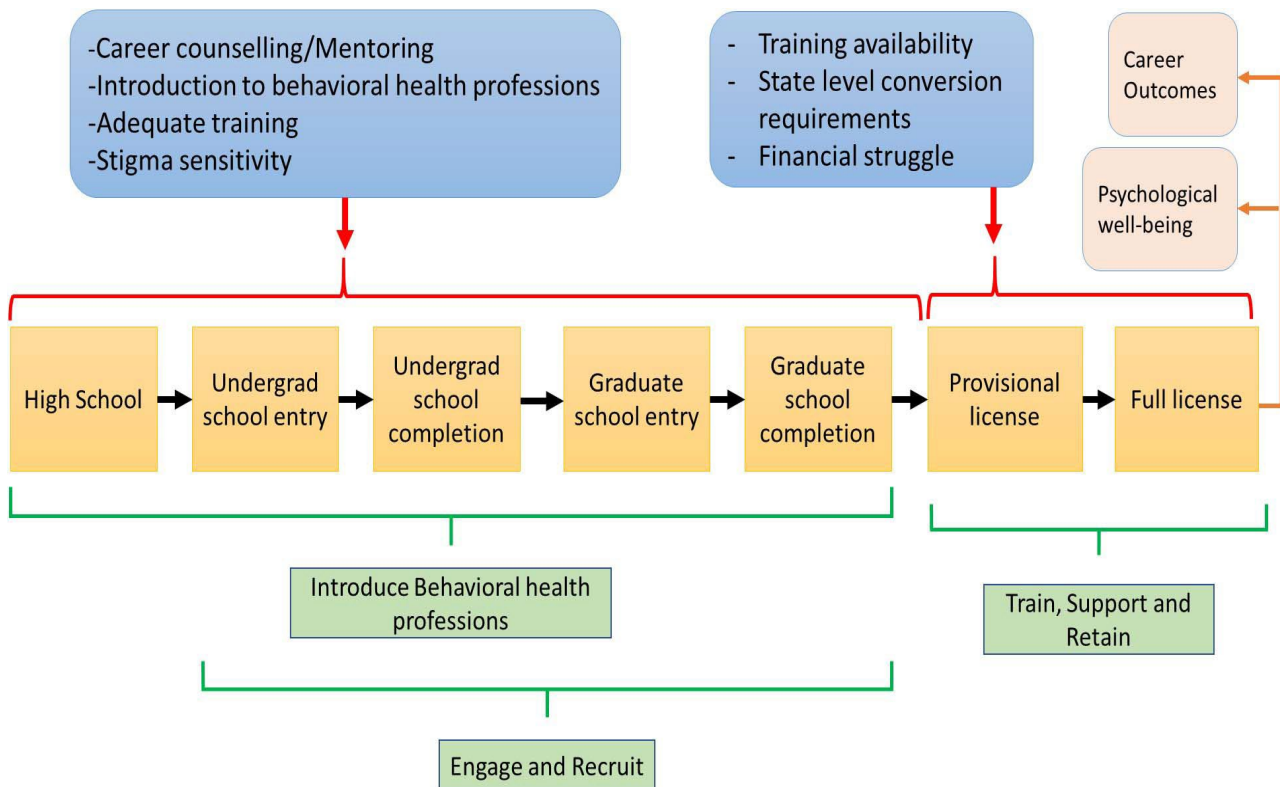
Data

Nebraska's behavioral health licensure data (2009–2019) was obtained from

the Health Professional Tracking Service (HPTS) program that was established as a joint effort between Nebraska Department of Health and Human Services, Human Services Office of Rural Health and University of Nebraska Medical Center (UNMC). The State of Nebraska licenses, certifies, and registers various professionals and occupations, including health care providers. There are four types of provisional behavioral health credentials issued by the state of Nebraska: provisional license as a psychologist, provisionally licensed mental health practitioner (PLMHP), provisional certification as a master social worker (PCMSW), and provisional LADC.

Figure 1

The Behavioral Health Workforce Pipeline Model



Note. See the online article for the color version of this figure.

Table 1. Provisional and Full Behavioral Licensure Requirements in Nebraska (7-9)

Provider	Education	Internship	Training	Exam
Provisional psychologist	APA accredited doctoral degree Demonstration of equivalency for nonaccredited programs	APA accredited 1-year internship: • At least 1,500 hr within 24 months • 4 hr supervision per week	N/A	N/A
Psychologist full license	N/A	N/A	1 year registered supervised postdoctoral experience • At least 1,500 hr including 1,000 of direct service hours earned within 24 months	Two exams: National EPPP NE Jurisprudence Exam
Provisional Licensed Mental Health Provider (PLMHP)	Master's or doctoral degree in a therapeutic mental health discipline	Minimum 300 clock hours of direct contact under qualified supervision	N/A	N/A
Full Licensed Mental Health Provider (LMHP)	N/A	N/A	Postdegree 3,000 hr of supervised experience in mental health practice • Minimum 1,500 direct service hr • Weekly 1 hr. supervision	Mental health practice exams for discipline: NCE or NCMHCE National Marriage & Family Therapy Exam ASWB Clinical Level Exam
Provisional CMSW	Master's or doctoral degree from an approved social work program	Meet PLMHP internship hours for PLMHP	N/A	N/A
Full CMSW	N/A	N/A	3,000 hr of postdegree experience in the practice of social work with provisional CMSW license • Under the supervision of a full CMSW • Meet additional clinical experiences & supervision for LMHP	ASWB Clinical Social Work exam
Provisional LADC (PLADC)	High school diploma or its equivalent 270 clock hours of education related to the	Supervised practical training with 300 hr in counselor core functions in a work	N/A	N/A

	knowledge and skills of alcohol and drug counseling 40 hr Continuing Ed (20 hr alcohol/drug specific) each biennial renewal	setting		
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Note. APA = American Psychological Association; EPPP = Examination for Professional Practice in Psychology; PLMHP = provisionally licensed mental health practitioner; LMHP = licensed mental health practitioners; NCE = National Counselor Examination; NCMHCE = National Clinical Mental Health Counseling Examination; ASWB = Association of Social Work Boards; CMSW = Certified Master of Social Worker; LADC = licensed alcohol and drug counselor. To practice clinical social work in Nebraska, provisional and full CMSWs must also obtain a PLMHP/LMHP license. The CMSW credential is necessary for Social Workers to obtain a PLMHP/LMHP license; Ed = education; IC & IR = International Certification and Reciprocity Consortium

Data Analysis

A descriptive analysis characterized the yearly conversion rates from provisional to full licenses for provisionally licensed psychologists, MHPs, MSWs, and ADCs. Starting in 2009, provisional licenses issued each year were followed until December 2019. Rates in percentages along with mean and median durations of conversion were computed for each provider type. For reporting rates, only those years were taken into account that had a complete follow-up time based on the validity period of each provisional license type (i.e., 2 years for psychologists, 5 years for behavioral health providers, MSWs, and ADCs). Therefore, for licensed psychologists, the analysis period for conversion ended in 2017; for MHPs, MSWs, and ADCs, the analysis period for conversion ended in 2014.

In addition, we compared gender, age, and residential location between those who converted and those who did not by using chi-square and Fisher's exact tests. For psychologists, the analysis included those who obtained a provisional license in 2017 ($n = 16$). For MHPs ($n = 304$), CMSWs ($n = 63$), and ADCs ($n = 92$), data for 2014 was used. For behavioral health practitioners, MSWs, and ADCs, the analysis included those who obtained a provisional license in 2014 ($n = 304$, $n = 63$, and $n = 82$, respectively). The significance of $p < .05$ was used. All statistical analyses were conducted using SAS

9.4 (SAS Institute Inc., Cary, NC).

BHECN Meetings

BHECN coordinates and hosts various conferences and meetings with academic programs that develop behavioral health workforce in the state. There are 23 programs that educate students to become psychologists, MHPs, CMSWs, and ADCs. Two meetings were held in 2020 to review the results of the conversion data analysis with administrators and faculty of these programs. We solicited their input to understand the barriers and recommendations to improve the conversion rates. Their input was used to discuss the implications of the study.

Results

Conversion Rates

Psychologists

A provisional psychology license is valid for 2 years from the date of issue (i.e., may take about 2 years before most individuals move from the provisional to full license status). Therefore, the data cutoff for percent conversion is 2017 for Figure 2a. From 2009 to 2019, the number of provisional licenses issued each year exhibits an uneven trend with a peak in 2019 when 39 provisional licenses were issued. The lowest number (16) of licenses was issued in 2017. Between 2009 and 2017, the 2-year rates of conversion from provisional to full licenses range between 36% and 68%, with 2015 displaying the highest conversion rate.

Mental Health Practitioners

A MHP provisional license is valid for 5 years from the date of issue (i.e., it may require approximately 5 years before most individuals move from the provisional to full license status). From 2009 to 2019, the number of provisional mental health practitioner (PLMHP) licenses issued each year exhibits an overall increasing trend with a slight dip in 2017, when 271 licenses were issued. The lowest number (235) of licenses was issued in 2010. Between 2009 and 2014, the 5-year rates of conversion from provisional to full licenses ranged between 47% and 58% with 2014 displaying the highest conversion rate.

Certified Master of Social Work

A MSW provisional license is valid for 5 years from the date of issue. From 2009 to 2019, the number of provisional MSW licenses issued each year exhibits an overall increasing trend with a slight dip in 2017 when 73 licenses were issued. The lowest number (36) of licenses was issued in 2009. Between 2009 and 2014, the 2-year conversion rates over 5 years from provisional to full licenses ranged between 65% and 75%, with 2014 displaying the highest conversion rate.

Alcohol and Drug Counselors

ADC provisional license is valid for 5 years from the date of issue. From 2009 to 2019, the number of provisional ADC licenses issued each year seems constant with dips and rises over time. The lowest number (65) of licenses was issued in 2011. Between 2009 and 2014, the 5-year rates of conversion from provisional to full licenses ranged between 44% and 60%, with 2009 displaying the highest conversion rate.

Comparison of Gender, Age, and Residential Location

Table 2 summarizes the comparison between those who converted into full license and those who did not in terms of gender, age, and residential location. The proportion of females among those who converted into full license ranged from 54.5% among ADCs to 78.9% among MSWs. There was no statistically significant association by gender for any professional group when comparing the individuals who converted into full license to those who did not. The average age of those who converted to full license ranged from 33.1 years (*SD*: 8.1) among MHPs to 35.5 years (*SD*: 8.7) among ADCs. The average age of those who did not convert ranged from 32.5 years (*SD*: 7.8) among MSWs to 41.8 years (*SD*: 38.8) among ADCs. Among MHPs and ADCs those who did not convert were, on average, significantly older than those who converted (MHPs: 35.6 vs. 33.1; ADCs: 41.8 vs. 34.4). All of the psychologists resided in urban Nebraska. Of the 304 MHPs, 235 (77.3%) lived in urban Nebraska, 60 (19.7%) lived in rural Nebraska, and 9 (3.0%) left Nebraska. Similarly, the majority (74.4%) of ADCs lived in urban Nebraska. The opposite pattern was observed for MSWs. Of the 63 MSWs, only 20 (31.7%) lived in urban Nebraska and 40 (63.5%) lived in rural Nebraska. Also, we

observed a statistically significant association between the place of residence and conversion status for MSWs. A larger proportion of MSWs who converted lived in rural areas compared to those who did not convert.

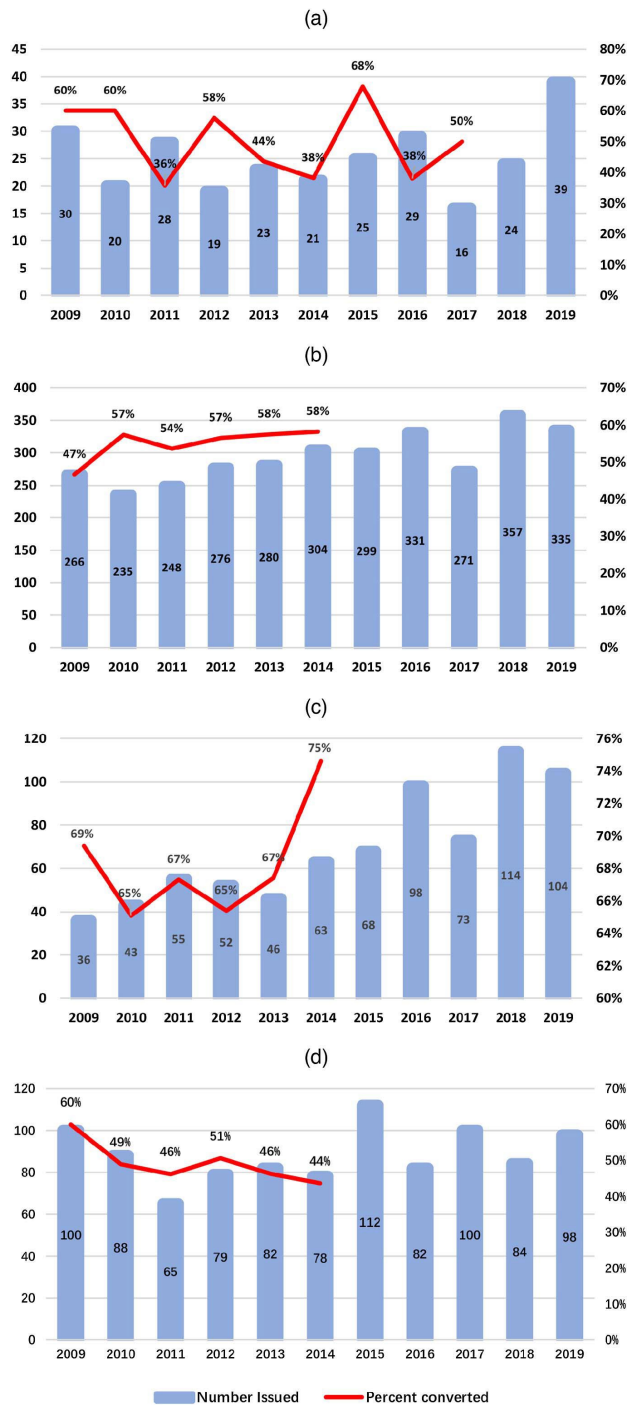
Discussion

Summary

This study characterized conversion rates from provisional to full licensure for psychologists, MHPs, MSWs, and ADCs in Nebraska. It also examined the potential associations among demographic characteristics and license conversion rates among provisionally licensed behavioral health professionals in Nebraska. There is a lack of data on national rates of conversion for the behavioral health professions in this study, making it difficult to discern if Nebraska rates are above, below, or similar to other states. However, the conversion rate from provisional to full licensure is a topic of concern, as there is a dearth of fully licensed behavioral health professionals in Nebraska remains in line with the nation in reports. An increase in efficiency from provisional to full licensure in Nebraska will help close the gap in the workforce shortage. This will lead to a larger number of fully licensed individuals who can practice at their highest scope within the discipline.

This study tracked provisional licenses issued and percent converted to full licenses from 2009 to 2019 in Nebraska. The MHP and MSW provisional licenses were issued at increasing rates over the past decade, while the psychologist and ADC provisional license remained mostly constant over the past 10 years, with occasional decreases. For MSW licenses, conversion rates were proportionally much higher for rural practitioners than urban. In the urban setting, 55% did not convert, while only 5% in a rural location did not convert. One possible explanation for this is the lack of administrative or other nonclinical roles for MSWs outside of urban areas, making the conversion to a licensed MSW more appealing and/or necessary to obtain employment in rural areas. For MHPs and ADCs, there were no statistically significant differences in conversion to full licensure based on urban versus rural location. Because all licensed psychologists resided in urban Nebraska, they were not included in the analysis to determine conversion differences based on location.

Figure 2. Number of Provisional Licenses Issued Each Year and 2-Year Conversion Rates for 2009–2019



Note. (a) Psychologists. (b) MHPs. (c) CMSWs. (d) ADCs. MHP = mental health practitioners; CMSW = Certified Master of Social Worker; ADC = alcohol and drug counselor. See the online article for the color version of this figure.

Table 2. Characteristics of Individuals Who Converted to Full License Those Who Did Not

Variable	Psychologist			MHP			MWS			ADC		
	Convert number (%)	Did not convert number (%)	p value	Convert number (%)	Did not convert number (%)	p value	Convert number (%)	Did not convert number (%)	p value	Convert number (%)	Did not convert number (%)	p value
Gender												
Male	2 (40.0%)	3 (60.0%)	.2995	30 (61.2%)	19 (38.8%)	.7494	4 (66.7%)	2 (33.3%)	.6071	7 (43.8%)	9 (56.3%)	.5784
Female	8 (72.7%)	3 (27.3%)		162 (63.5%)	93 (35.5%)		45 (78.9%)	12 (21.1%)		36 (54.5%)	30 (45.5%)	
Age (M, SD)	35.3 (6.1)	34.3 (9.4)	.7987	33.1 (8.1)	35.6 (9.7)	.0165	32.2 (7.2)	32.5 (7.2)	.893	34.4 (9.1)	41.8 (11.3)	.0028
Location												
Urban NE	10 (62.5%)	6 (37.5%)	.967	148 (63.0%)	87 (37.0%)	.6416	9 (45.0%)	11 (55.0%)	<.0001	27 (46.6%)	31 (53.4%)	.3690
Rural NE	0 (0.0%)	0 (0.0%)		37 (61.7%)	23 (38.3%)		38 (95.5%)	2 (5.0%)	7 (35.0%)	13 (65.0%)		
Left NE	0 (0.0%)	0 (0.0%)		7 (77.8%)	2 (22.2%)		2 (66.7%)	1 (33.3%)		0 (0.0%)	0 (0.0%)	

Note. MHP = mental health practitioners; MSW = master social worker; ADC = alcohol and drug counselor; NE = Nebraska.

Understanding the disparity between rural and urban social work licensure conversion rates could be an area of potential future research, as rural, fully licensed social workers may be able to provide insight into how they overcame barriers to obtaining supervision. Similarly, social workers who did not complete licensure could provide information on the reasons why they did not. While this study would be specific to social work professionals, the information obtained could help inform workforce efforts for the entire behavioral health workforce.

One reason why conversion rates were not often above 65% is that provisionally licensed practitioners sometimes receive their full licenses in other states. This occurred in states where the requirements are different for full licensure. Because some funders may not pay for services provided by provisionally licensed practitioners, agencies may not be reimbursed while a practitioner is on a provisional basis. This creates a financial barrier and a disincentive to hire provisionally licensed practitioners and makes it difficult

for provisionally licensed practitioners to practice independently. If a provider can receive full licensure more rapidly in another state, they may relocate for financial reasons. In other states surrounding Nebraska (i.e., Missouri, Kansas, South Dakota, Iowa, Wyoming, and Colorado), the required postgraduate training hours for full psychologist licensure vary from 1,500 hr to 2000 hr, similar to or slightly more than that of Nebraska (1,500 hr). For full MHP licensure, the requirements in Nebraska and surrounding states are similar (postdegree 3,000 hr of supervised experience) except that Colorado and South Dakota require 2000 hr while Kansas requires 4,000 hr (American Counseling Association, 2010). An additional barrier in Nebraska is the credentialing process at Managed Care Organizations (MCOs) who provide Medicaid and Medicare services in the state. Each MCO has its own credentialing process, making it difficult for new graduates to begin work (Blue Cross and Blue Shield, 2021; Nebraska Total Care, United Health Care, 2019). The individual cannot work on a licensed basis before this is complete, so workers can be lost to a state where this process can be completed more quickly. It also creates a situation in which newly graduated and provisionally licensed practitioners may need to find employment doing work outside of the behavioral health field.

Limitations and Future Directions

This report is the first of its kind in the state and one of few in the country to characterize the conversion rates among behavioral health professionals. It covers many professions and provides valuable insights into the workforce situation for behavioral health providers. However, some limitations are noted. Collection of additional demographic data may be informative to understand the characteristics associated with obtaining full licenses including location (urbanicity) of those obtaining full licensure. Because provisional licenses for some professions last for 5 years, we only have conversion data for half of the data that was collected. Five more years of data could provide 10 years of conversion information, which would provide clearer understanding of the time trend associated with conversion rates. Additionally, this data was limited in the sense that there was no qualitative information to accompany the statistics to understand why some MHPs are not going from provisional to full licensure. For instance, in addition

to knowing how many licenses are converted per profession, a full snapshot of the issue may include qualitative data on how the practitioner chose their location, what challenges they experienced as they gained their full license, and how the process could be improved from their perspective. Therefore, a future direction of this research may be a focus group and a survey of practitioners to better understand the nature of these barriers and if there are more present that have not been considered.

There is currently no data to demonstrate the connection between obtaining full licensure and staying in a rural area to practice. We do know that initiatives such as loan forgiveness, tax credit incentives, and reciprocity policies can help with recruitment and retention of professionals, but currently there is no data around obtaining full licensure as a way to retain behavioral health professionals (Altschul et al., 2018; Covino, 2019; Oregon Health Authority, 2016; Vermont Agency of Human Services, 2017).

Conclusion

Growing the behavioral health workforce in Nebraska and other rural states will continue to be a conversation for years to come. Solutions for the distant future will involve today's youth. The development of interest and recruitment through an appropriate need-based mentoring of the rural high school and graduate students may aid in curtailing the deficiency of behavioral health providers. In a study conducted in Nebraska, high school students expressed the need for basic mentoring about career possibilities, while college students needed mentoring specific to achieving career goals. Figure 1 illustrates the possible means to influence the recruitment and retention of behavioral health providers at various stages of the educational process (workforce pipeline). Early introduction to behavioral health professions and career counseling or mentoring, as soon as high school, will increase engagement with the behavioral health professions. It is also critically important to continue to advocate for policy and regulation changes to remove the barriers to licensing in order to incentive these students to choose behavioral health careers.

With behavioral health problems on the rise across the country, it is urgent that mental HPSAs begin to close the workforce gap. Increasing conversion rates from

provisional to full licenses will be a part of this solution, and eliminating the barriers to conversion as recommended should be emphasized moving forward.

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