Proposed Change to the Entry Level Standard to become a Registered Psychologist in the Province of Nova Scotia

Report submitted to the Nova Scotia Board of Examiners in Psychology
Prepared by the Entry Level Committee[1]

Mar 5, 2011[2]

The Nova Scotia Board of Examiners in Psychology (NSBEP or the Board) requested that the Entry Level Committee (ELC) convene "to explore the merits of moving to the doctoral level for entry to practice psychology in Nova Scotia" (Wilson, 2009). This report presents to the Board the results of the task undertaken, with two main sections: (1) the ELC Description and Process and (2) the "deliverables" of the Committee's work, including (2a) a chart using a Decision Tree format to summarize the information gathered, (2b) a table that details the "Merits, Barriers, and Consequences" of changing the entry level standard, in terms of Supporting and Contrary Arguments to the three options the ELC arrived at, and (2c) a discussion of some of the issues and empirical literature[3] that may clarify and/or elaborate on the issues raised in the table contents. Appendices contain relevant but primarily data oriented information.

SECTION 1. ELC: Description and Process

Mandate of the ELC. At its first meeting, the ELC members posed two questions: What is the Board's rationale for the proposed change to entry level and what is the mandate of the ELC? The following was the Board's response to those requests:

> The NSBEP announced at its AGM, in March, 2006 its intension to move towards the doctoral level as the entry level educational qualification for registration to practice psychology in NS. The current standard is "a doctoral, master's or equivalent degree in psychology that is acceptable to the Board" as set out in The Psychologist's Act (2000). The Board has considered this change to the standard in light of several issues and factors and, "in collaboration with the Association of Psychologists of NS, is establishing a committee to examine the question of whether NSBEP should be moving to the doctoral level for entry to practice psychology in NS. … The Entry level Committee has been asked to explore the merits of moving to the doctoral level for entry to practice psychology in NS. The committee has also been charged with identifying barriers to such a change and any unidentified consequences that may results from such a change." (Allan Wilson, Registrar, NSBEP Website & in APNS Newsletter announcement, June 2009).
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> Three major reasons the NSBEP is considering this change are (1) the doctoral degree is the standard for licensure in the vast majority of jurisdictions in North America; (2) the Agreement on Internal trade (AIT) recently put into effect the requirement "that mobility then becomes based on the least onerous entry to practice standard," with the results that provinces have no capacity to protect the public from practitioners

[1] The ELC thanks Matthew Wagner, Assistant to the Registrar, for his help with data gathering efforts.
[2] November 19, 2010 –first draft.
[3] The ELC thanks Brad Peters, Psych. (Cand. Reg.) for initially collecting much of the literature review material for APNS, who subsequently, with thanks, provided it to the ELC.

> that they earlier had the right (mandate) to decline to register or to require they take upgrading or additional supervision, for example. NS also becomes a "source" site of registered psychologists who can move to other provinces and become registered where they otherwise would be considered ineligible; and (3) the observation by the NSBEP that there are more serious valid complaints (and higher costs) associated with these complaints filed and processed against M' level trained psychologists in the province. These issues are inter-related and to maximize the protection of the public, resolving all of them would require raising the entry level standard to the doctorate.
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> It is important to note that no existing registration of existing psychologists at neither the master's level, nor anyone in a master's level course within a to-be-determined suitable length of time would be affected or lose their license as a result of this change.

ELC composition. The ELC convened Sept. 25 2009 at the request of the Registrar of the Board. Prior to this meeting, a call for interest in participating in this committee was sent out to NSBEP registrants (via the APNS Spring, 2009 Newsletter and the NSBEP website). A representative and moderate-sized group (maximum of 8 members) was selected by the Registrar to give voice to as many NSBEP constituencies as possible. Dr. Maureen Gorman (NSBEP representative) agreed to act as Chair. She was in Health/Geriatric Psychology in a city hospital until Dec, 2009 and now is in full time private practice (PP). Master's trained psychologists were Mr. Brad Peters (Cand. Reg.)., in PP (city-based); Mr. Steve Gleich in Community Mental Health (rural-based), and Ms. Beth MacInnis who works as a school psychologist in a rural school board district. Doctoral trained psychologists include Drs. Julia Holt in PP (city- and rural-based), Rick MacGillivray in PP (city-based), Lisa Price from Acadia University and in PP part time (rural-based), and Michael Ross from Community Mental Health (city-based) who also does some PP. Dr. Ross is the representative of the Association of Psychologists in Nova Scotia (APNS) on the ELC. Additional communication was received from psychologists across NS, both rural- and city-based, all of which has been considered in the writing of this report. With regret, the ELC accepted the resignation of Mr. Peters on December 12, 2009. In his letter of resignation he stated that while "honored and privileged" to be involved with the ELC Mr. Peters found the "intended purpose set forth by NSBEP at odds with what I believe to be a logical progression of thought on the matter" (full letter available to NSBEP directors upon request).

Overview of timeline of ELC activities. The ELC met at the NSBEP office on nine occasions between Sept. 25, 2009 and June 9, 2010 and the tenth and final in-person meeting was Nov. 15, 2010, each for 1.5 hours (meeting date Agendas & Minutes on file with NSBEP). The ELC identified important stakeholder groups for inclusion in a consultation process, such as Universities, the Government Departments of Health and Education, employers, and consumers, in addition to the primary stakeholder group of psychologists throughout NS. After some data collection efforts (e.g., surveys of employers of psychologists regarding number of positions, vacancies, and education level; tabulation of complaints information), the ELC then determined that the next step was to undertake a series of open meetings or consultations with the psychologists' group, with two purposes in mind: (1) to present the findings of the ELC to date and (2) to receive input and feedback from those in attendance. The ELC decided to restrict the meetings to registered psychologists (i.e., not the general public or other professional groups) in this first wave of consultation with respective stakeholders. Four, 2-hour meetings occurred in

Wolfville, Yarmouth, Halifax & Truro (on May 10, 11, 13, 19, respectively). A meeting arranged for Sydney had to be cancelled because of insufficient advance notice of attendance.[4] (Please see Appendix B for the presentation slide show for the Truro meeting, as this one incorporated all of the information added as a result of feedback received from each prior presentation.) The Board received additional written responses after each meeting, from those who attended as well as from registrants responding to information given to them by colleagues in attendance. These letters are on file in the NSBEP office and are available for perusal by Board members. Their contents are considered in Section 2 of this report, both in the content of Table 1 and in the discussion.

A "Decision Tree" format was used to attempt an initial "sort" and consolidation of all of the information gathered by the ELC (pages 4-7). The Decision Tree consists of five levels of response to the question: Should the NSBEP change the entry level standard to the doctoral-only level (affirmative or negative)? Levels 1 and 2 are immediate responses "yes" or "no" and within the "yes" response two alternate options emerged: Yes, doctoral only; and Yes, with a 2-tier system. Level 3 is the presentation of specific arguments made for or against the respective choice made; and some assessment of whether or not this is a negative or positive argument (for the practice of psychology) and/or an opportunity for further consideration or future development. Level 4 further extends to the results and/or consequences of Level 3 arguments in terms of the ameliorating and/or mitigating factors that can modify these consequences. Level 5 includes the decision points or follow-up options for consideration by the NSBEP. At the ELC meeting in June, 2010, the summary discussion and a draft of a decision tree model was discussed.

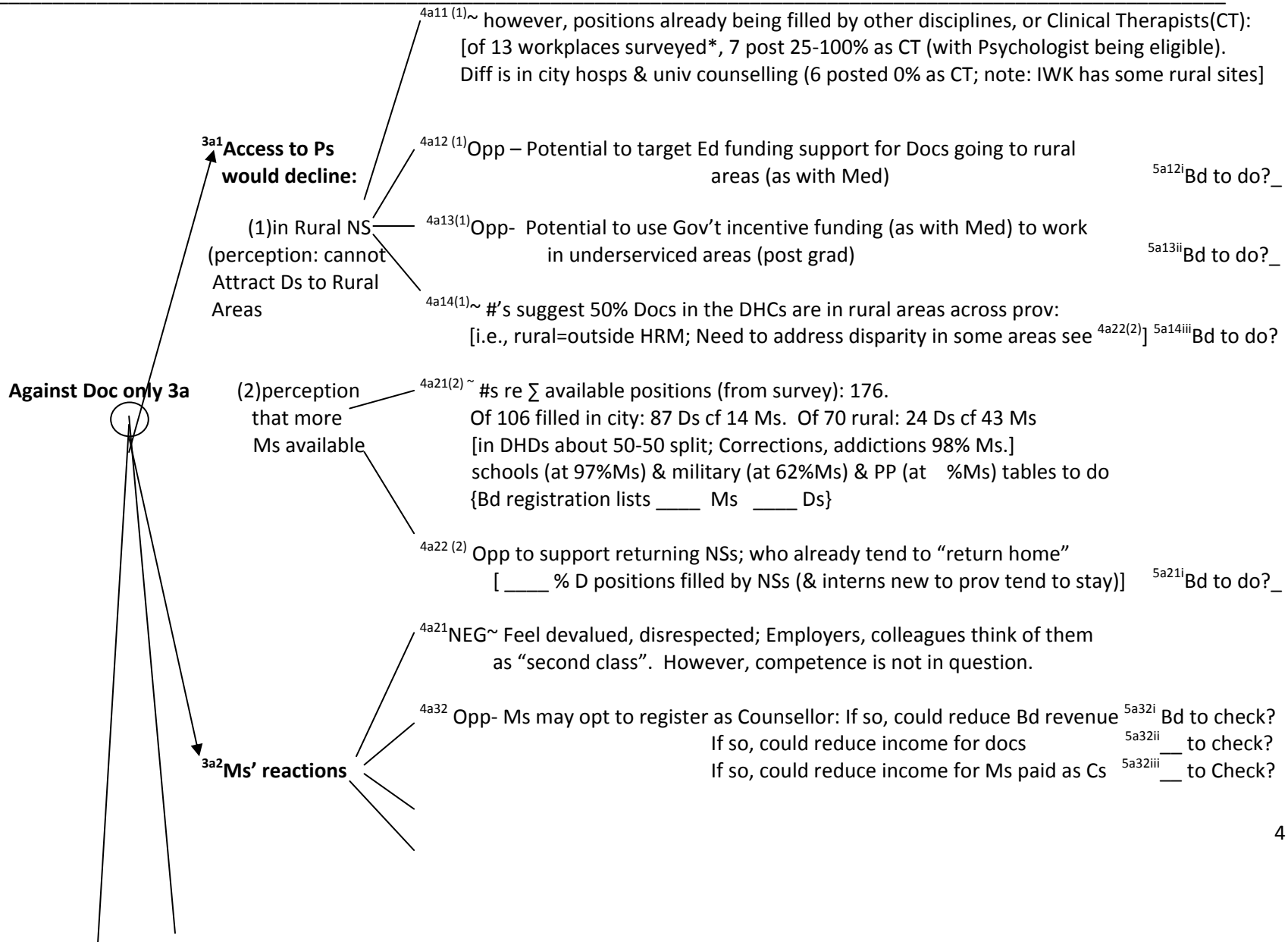
Mr. Gleich stated during the June meeting that he was resigning from the ELC because he believed he had done all he could do on the ELC and would not be able to continue into a next phase of the ELC work. However, he indicated he would consider contributing as "consultant" or reviewer of reports. The resignations of two of the three master's trained psychologists on the committee contributed to a decision to cease the active work of the ELC, as the viability of continuing without them was called into question. The ELC agreed to writing this report, documenting the work completed to date, with completion targeted for the Fall of 2010. The ELC met in November, 2010 to consider the "final" content of the report in the form of the Decision Tree, Table 1 (pages 8-16), and the literature review/discussion. Feedback during this meeting suggested that further revision was necessary in order to be more inclusive of ELC members' viewpoints and to de-emphasize the non-empirical literature[5]. The targeted date for completion of these revisions was Jan 10 (to the ELC) and Jan 14 for submission of the report to the NSBEP. It was expected that discussion of the report would be held at the joint APNS-NSBEP meeting January 21.

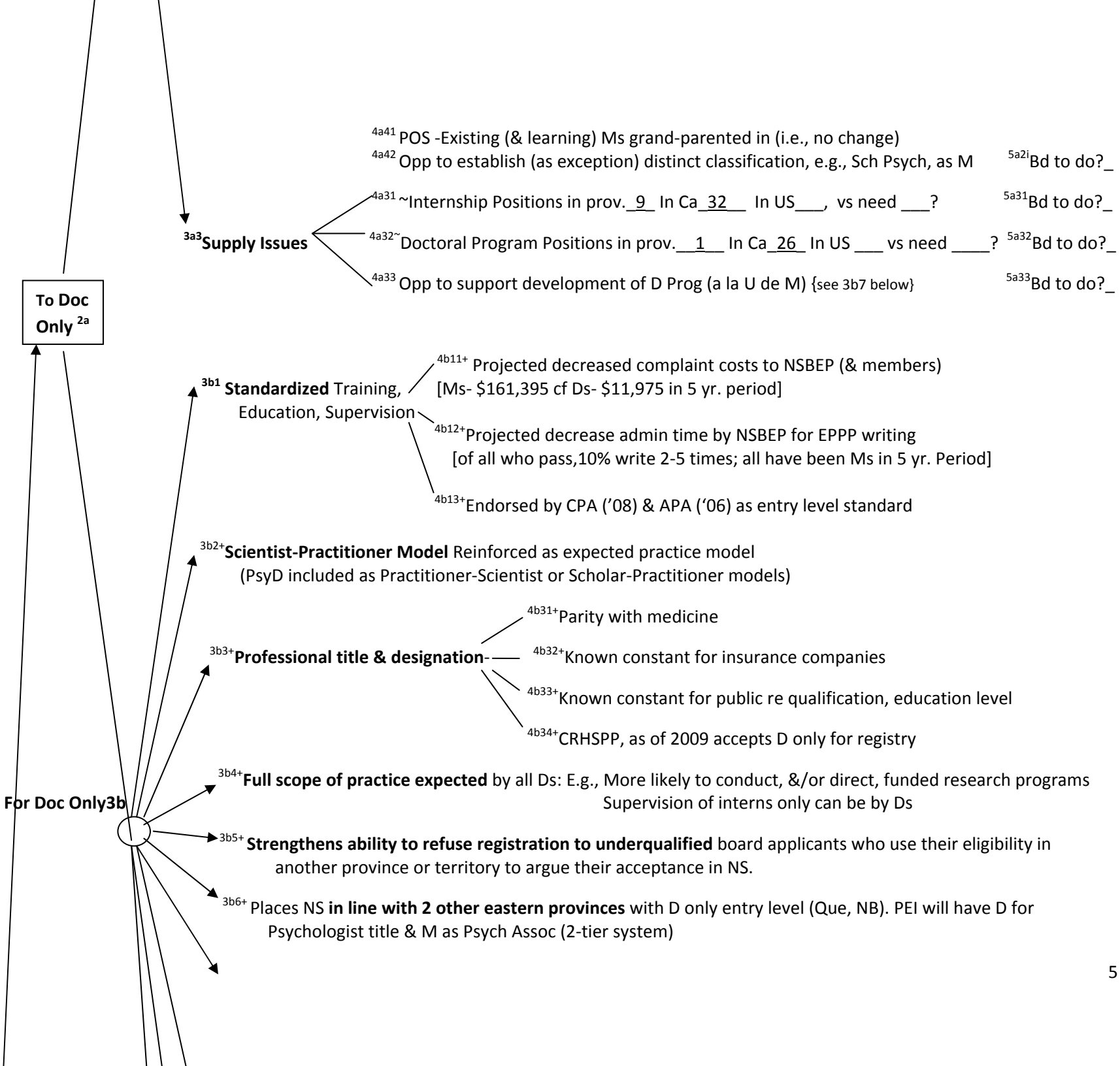
The ELC considers that it has fulfilled a good part of its mandate, in presenting to the NSBEP this report with information upon which it may base its decision to proceed or not to proceed

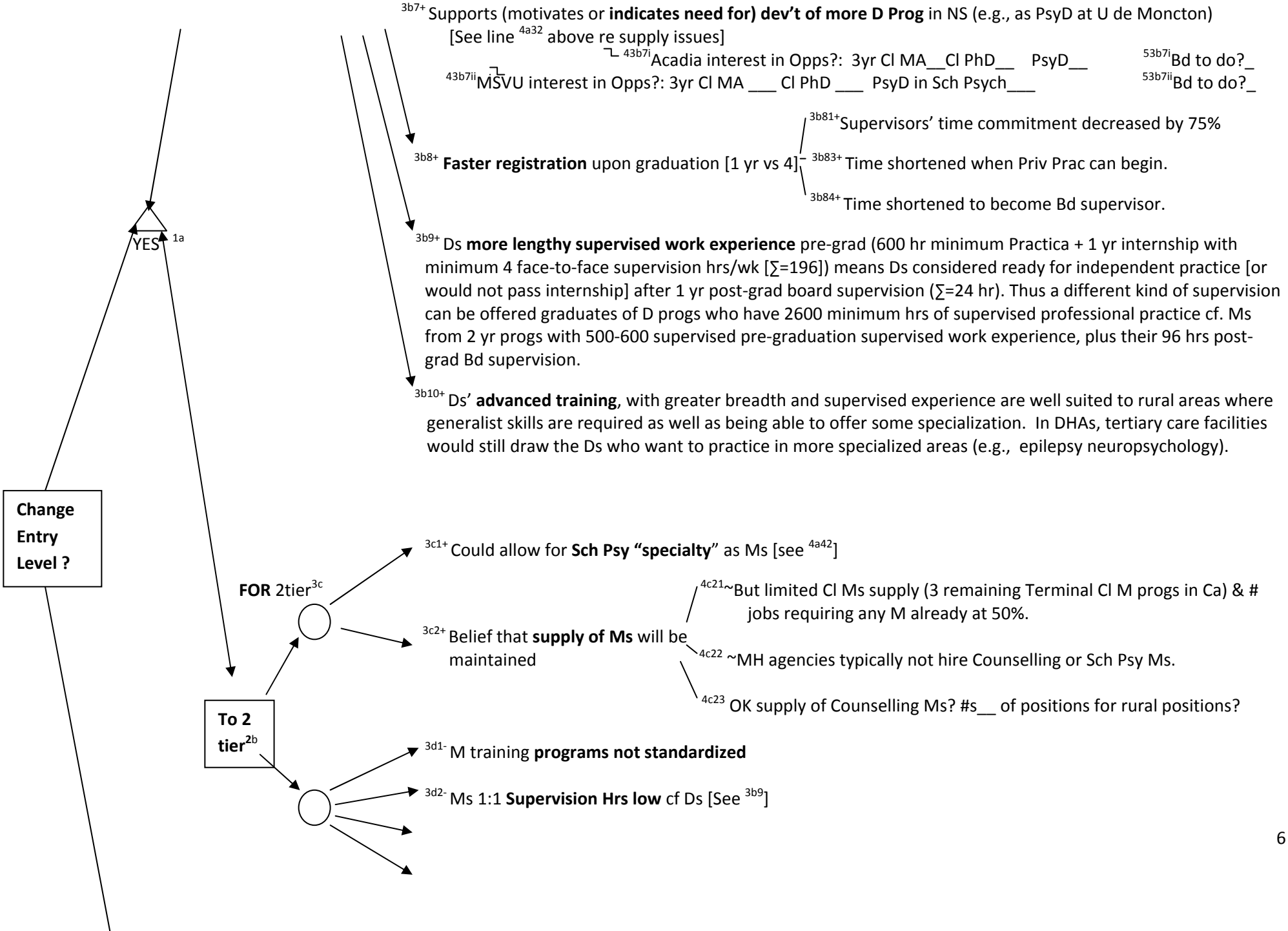
[4] The ELC understands that the APNS had held a workshop in Sydney a few weeks earlier and that "20 plus" psychologists discussed the proposed change. No written report was received but informally we understand the consensus was that the entry level change will occur and that school psychologists will remain a "distinct Ms" group.

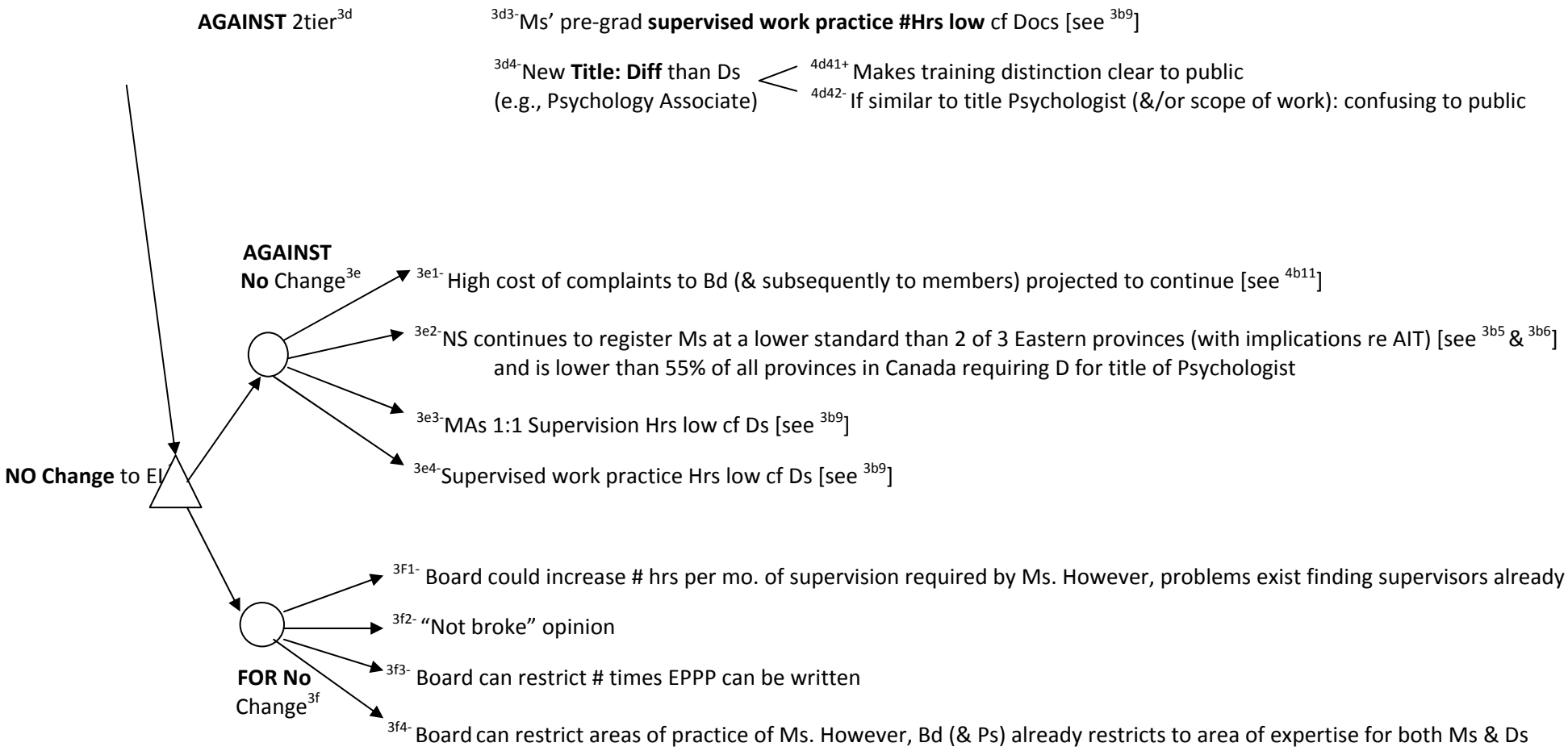
[5] Please see Appendix C for non-empirical literature review.

QUESTION	LEVEL 1:	LEVEL 3:	LEVEL 4:	LEVEL 5:
	Responses	Arguments + / - ~(equalizing) or Opportunity (Opp)	Consequences, Results thereof + or -; ~ or Opp; Facts & Options	Outcomes (OCs), Consequences for Board's consideration




4a41 POS -Existing (& learning) Ms grand-parented in (i.e., no change)
4a42 Opp to establish (as exception) distinct classification, e.g., Sch Psych, as M
5a2i Bd to do?_
3a3 Supply Issues
4a31 ~Internship Positions in prov._9_ In Ca_32__ In US___, vs need ___?
5a31 Bd to do?_
4a32~ Doctoral Program Positions in prov.__1__ In Ca_26_ In US ___ vs need ____?
5a32 Bd to do?_
4a33 Opp to support development of D Prog (a la U de M) {see 3b7 below}
5a33 Bd to do?_
To Doc Only 2a
3b1 Standardized Training, Education, Supervision
4b11+ Projected decreased complaint costs to NSBEP (& members) [Ms- $161,395 cf Ds- $11,975 in 5 yr. period]
4b12+ Projected decrease admin time by NSBEP for EPPP writing [of all who pass,10% write 2-5 times; all have been Ms in 5 yr. Period]
4b13+ Endorsed by CPA ('08) & APA ('06) as entry level standard
3b2+ Scientist-Practitioner Model Reinforced as expected practice model (PsyD included as Practitioner-Scientist or Scholar-Practitioner models)
3b3+ Professional title & designation
4b31+ Parity with medicine
4b32+ Known constant for insurance companies
4b33+ Known constant for public re qualification, education level
4b34+ CRHSPP, as of 2009 accepts D only for registry
For Doc Only3b
3b4+ Full scope of practice expected by all Ds: E.g., More likely to conduct, &/or direct, funded research programs
Supervision of interns only can be by Ds
3b5+ Strengthens ability to refuse registration to underqualified board applicants who use their eligibility in another province or territory to argue their acceptance in NS.
3b6+ Places NS in line with 2 other eastern provinces with D only entry level (Que, NB). PEI will have D for Psychologist title & M as Psych Assoc (2-tier system)


[3b7+] Supports (motivates or **indicates need for) dev't of more D Prog** in NS (e.g., as PsyD at U de Moncton)
[See line [4a32] above re supply issues]
[43b7i] Acadia interest in Opps?: 3yr Cl MA__Cl PhD__ PsyD__
[53b7i] Bd to do?_
[43b7ii] MSVU interest in Opps?: 3yr Cl MA ___ Cl PhD ___ PsyD in Sch Psych___
[53b7ii] Bd to do?_
[3b8+] **Faster registration** upon graduation [1 yr vs 4]
[3b81+] Supervisors' time commitment decreased by 75%
[3b83+] Time shortened when Priv Prac can begin.
[3b84+] Time shortened to become Bd supervisor.
[3b9+] Ds **more lengthy supervised work experience** pre-grad (600 hr minimum Practica + 1 yr internship with minimum 4 face-to-face supervision hrs/wk [∑=196]) means Ds considered ready for independent practice [or would not pass internship] after 1 yr post-grad board supervision (∑=24 hr). Thus a different kind of supervision can be offered graduates of D progs who have 2600 minimum hrs of supervised professional practice cf. Ms from 2 yr progs with 500-600 supervised pre-graduation supervised work experience, plus their 96 hrs post-grad Bd supervision.
[3b10+] Ds' **advanced training**, with greater breadth and supervised experience are well suited to rural areas where generalist skills are required as well as being able to offer some specialization. In DHAs, tertiary care facilities would still draw the Ds who want to practice in more specialized areas (e.g., epilepsy neuropsychology).
YES [1a]
Change Entry Level ?
FOR 2tier[3c]
[3c1+] Could allow for **Sch Psy "specialty"** as Ms [see [4a42]]
[3c2+] Belief that **supply of Ms** will be maintained
[4c21] ~But limited Cl Ms supply (3 remaining Terminal Cl M progs in Ca) & # jobs requiring any M already at 50%.
[4c22] ~MH agencies typically not hire Counselling or Sch Psy Ms.
[4c23] OK supply of Counselling Ms? #s__ of positions for rural positions?
To 2 tier[2b]
[3d1-] M training **programs not standardized**
[3d2-] Ms 1:1 **Supervision Hrs low** cf Ds [See [3b9]]


AGAINST 2tier[3d]
[3d3-]Ms' pre-grad **supervised work practice #Hrs low** cf Docs [see [3b9]]
[3d4-]New **Title: Diff** than Ds (e.g., Psychology Associate)
[4d41+] Makes training distinction clear to public
[4d42-] If similar to title Psychologist (&/or scope of work): confusing to public
AGAINST No Change[3e]
[3e1-] High cost of complaints to Bd (& subsequently to members) projected to continue [see [4b11]]
[3e2-]NS continues to register Ms at a lower standard than 2 of 3 Eastern provinces (with implications re AIT) [see [3b5] & [3b6]]
and is lower than 55% of all provinces in Canada requiring D for title of Psychologist
[3e3-]MAs 1:1 Supervision Hrs low cf Ds [see [3b9]]
[3e4-]Supervised work practice Hrs low cf Ds [see [3b9]]
NO Change to El
[3F1-] Board could increase # hrs per mo. of supervision required by Ms. However, problems exist finding supervisors already
[3f2-] "Not broke" opinion
[3f3-] Board can restrict # times EPPP can be written
FOR No Change[3f]
[3f4-] Board can restrict areas of practice of Ms. However, Bd (& Ps) already restricts to area of expertise for both Ms & Ds

with the change in entry level standard. Whilst not completing all the extended tasks it might have done, the ELC's proposed "next steps" (with original timeline), that were presented in the open information meetings, illustrate some of the activities that the NSBEP may wish to consider doing:

(1) Focused consultation groups (psychologists) (May, 2010)
(2) (perhaps) Developing (from feedback & input) a survey to go to all registrants. (out & return by mid June. 2010)
(3) Determining what other stakeholder groups are involved (not necessarily but possibly employers, government departments, other service provider groups, consumer groups?, university program folks) (by end June) and modifying survey accordingly & sending out (&/or maybe consultation or in person meetings) (by end Aug, 2010);
(4) (Other) Stakeholder consultations
(5) Collating feedback from all sources (by end Sept, 2010).
(6) Any other steps? (by ELC)
(7) Reporting to NSBEP & to the registrants (released after the Board has considered the recommendations)
(8)The ELC dissolves as is.
(9) A new committee established to carry out the Board's wishes

Thus the ELC decided to conclude after "Step 1". It is noted that the Board considered the concerns that arose in some of the received correspondence (many of which were in response of the open meetings) to be of sufficient immediate importance to request the Registrar to offer clarifications on some apparent misunderstandings (in Fall, 2010, APNS newsletter –vol 22, #3). From this clarification statement, it is understood that the NSBEP has already made one vital decision should it go forward with a change to doctoral-only training, and that is, it will not change the professional standing of any current psychologist, and will not cause any to lose title or function. It is further understood that the NSBEP will need to articulate a grace period for those students already engaged in training at the master's level, so as not to personally harm or disadvantage practitioners and trainees.

SECTION 2.

This part of the report presents the findings of the ELC's work in terms of the arguments supportive of and contrary to the three options presented in the above-mentioned Decision Tree Chart (see Table 1, pages 9-16) and a discussion of these points accompanied by some empirical literature, in terms of supply and demand issues, and of training issues. The literature includes relevant articles published from 2000 only. Please note that no attempt has been made to conduct a critical review of the research methodology as it is beyond the scope of this report.

The ELC identified three possible options for the Board to consider, including: (1) Option One: to "maintain the status quo" and continue registering master's trained individuals as independent practitioners of psychology (i.e., psychologists); (2) Option 2 is "two-tier registration", meaning to register master's trained psychologists with a different title than Psychologist, such as Psychological Associate; and (3) Option 3 is doctoral-only registration, meaning to discontinue the registration of master's trained individuals (using a pre-determined start date) .

General Issues. In addition to the supply and demand, and training issues, there were a few general issues discussed at the meetings and by the ELC. Concern was raised by some practitioners attending the meetings (or who wrote to the Board/ELC) that the change in entry

Entry Level Committee: Summary of Consultation with Committee Members, Registrants & Supportive Data:

Options:	Supportive Input	Contrary Input	Comments
Option One: **Maintain Status quo**	a) Psychology positions will be lost to other disciplines if Psychology moves to doctoral-only registration	Psychology positions are already being lost to other disciplines (for example, a drop in Master's-level Psychology positions in Truro Hospital; in some public sector settings, psychology positions have been taken by social workers)	Some loss of positions may well happen, but this is health-care-wide trend (e.g. LPN's taking over some BScN duties); NS positions lost already are not primarily PhD.
	b) Psychology services may be less available to rural areas	Rural positions are currently split almost 50/50 between PhD & Master's practitioners in Department of Health facilities. In 5/8 District Health Authorities, there are more PhD than Master's practitioners; in Addictions, Corrections and Schools, the opposite holds true	Master's employment is proportionately higher in rural than urban areas, where PhD predominates; there is, however, some regional disparity.
	c) MA /MSc people feel devalued by doctoral-only requirement	Registration of current Master's people as psychologists certifies value; competency is also addressed for both PhD and Master's practitioners by the NSBEP complaint process.	Current Master's practitioners will be unaffected by change in terms of title and privileges; Any proposed change should reflect the anticipated future needs of the profession
	d) Distinction of school Psychology versus clinical Psychology would remain irrelevant as far as licensure is concerned:	Only NS and Manitoba have option of terminal Master's in clinical Psychology: the MS/MSc training model is arguably obsolete.	Doctoral-only registration would also eliminate any difference in qualification for clinical and school psychology. Whether school psychology is or ought to be considered distinct is not an issue on which there is any obvious consensus. The MRA agreement does not suggest any distinction in core competencies.
	e) The standard entry to practice degree for school Psychology is the Master's Degree; Master's training in school Psychology is available at 6 universities	The trend in the U.S. (& UBC) is towards 3-year Master's degrees for school Ψ; MSVU is a tough 2 year program (10 full credits in 2 years; 16 courses + 1 full credit for thesis and 1 for 500 hour internship) that would be potentially amenable to upgrading to PsyD	A heavier course content is becoming necessary to have adequate coverage for practice in school; implies that questionable adequacy of 2-year Master's training; Switch to 4-year PsyD is likely more attractive to candidates & faculty than switch to 3-year MA. There is question of whether the remuneration of school psychologists would support the investment in a 4-year degree.
	f) Loss of educational opportunities in Psychology.	There are fewer options for Master's training: only two terminal masters programs in clinical Psychology and only two without option for doctoral training	See 1(d); Atlantic Provinces: 2 new PsyD programs, 2 fewer MS/MSc programs in last two years

		in school Psychology, in Canada	
Options:	**Supportive Input**	**Contrary Input**	**Comments**
Option One: **Maintain Status quo** ***(continued)***	g) Federal Psychologists will keep title-governed jobs, will lose those jobs if title denied	Current Master's practitioners would keep titles and jobs under a doctoral-only act	There is some concern about who might fill such roles as Master's people leave, and no obvious way to access such information. The Federal Government does employ doctoral-level psychologists.
	h) Master's Psychologists might choose to register as counselors, not as Psychologists; since about half psychologists registered are Master's, potential loss of revenue to NSBEP	There are considerable advantages to the title of Psychologist; the grandparenting provision allows all Master's practitioners the option of registration as psychologists;	NSBEP cannot control who does or does not choose to apply for registration
	i) Least immediate change required (the least expensive, effortful option);	The dispute over an appropriate entry to practice degree has continued to come up and will likely continue to do so in future if not resolved; problem is a divisive one for profession.	This option does not consider the immediate national pressures brought about by mandated liberalized trade (e.g., the AIT agreement), as well as the CPA aspiration for the profession, or trends in education of practitioners.
	j) Validates worth of Master's training	Does not recognize that Master's degrees are not uniform; some universities award Master's standing to failed doctoral candidates rather than successful completers of a coherent program leading to readiness for practice	There is no mechanism by which the comparability of Master's programs can be evaluated (since there is no standardization/accreditation of Master's programs in Canada). (The same can be said of non-accredited doctoral programs.)
	k) Would not strain NSBEP supervisory resources especially in school psychology: few doctoral Psychologists available to supervise new candidates for school Psychologists positions		If doctoral-only option were chosen, some bridging mechanism would be necessary for supervision, most likely involving grandparented Masters-trained psychologists
	l) Would not contribute to obsolescence of existing Master's programs at Acadia, MSVU	Some members of Acadia Department have twice sought change to doctoral (PsyD, PhD); switch might provide impetus to this change; MSVU would likely be amenable to switch to PsyD	The trend in clinical psychology suggests terminal Master's degree (two left in Canada) is already becoming obsolete. There has not been unanimity among Acadia faculty on doctoral change There are other applications of psychology training at the masters level, including Counseling Psychology, School Psychology, Community Psychology, and Industrial/Organizational Psychology (some of which may not be subject to licensure in Nova Scotia.)
	m) Would be popular with a number of psychologists	Master's practitioners are not uniformly adverse to change from status quo; status	No choice is likely to be popular with all psychologists; no poll has been taken on

		quo would be unpopular with a number of psychologists	willingness to accept change to status quo
Options:	**Supportive Input**	**Contrary Input**	**Comments**
Option One: **Maintain Status quo** ***(continued)***	n) Master's training ensures an adequate number of graduates for NS needs	See 1(a) and (b); Acadia University produces on average not more than six graduates per year, and MSVU approximately eight.	No evidence that two-tier or doctoral-only provinces or states lack sufficient psychologists (US data suggests an over-abundance at least in some states). The lack of Canadian experience with doctoral-only registration precludes a definitive comment on the impact of doctoral-only standards on access to psychological services in Canada, but there is no evidence that 2-tier registration in Canada has had any negative effect on supply or access, and no U.S. evidence of harm to the profession or public by either doctoral or two-tier registration.
	o) Master's programs are equivalent to doctoral in preparing practitioners	EPPP first-try mean scores 2004-210 and pass-fail ratios suggest preparation is not equal: in the last 10 years: Master's EPPP mean ≈ 100 points lower than PhD; failure rate 25% (PhD = 0%);	Very few respondents made this argument in meetings; coursework, internship and supervision requirements for Master's and PhD/PsyD programs do not suggest equivalence of training (although no program can disprove equivalence of talent). Those who have successfully completed the NSBEP candidate registration and gained full registration with NSBEP all eventually passed the EPPP.
	p) Several jurisdictions have the current NS arrangement: Alberta, Newfoundland, Nova Scotia and NWT	7/10 provinces have either 2-tier/ differential titles or doctoral-only; 6/10 reserve title "psychologist" for doctoral practitioner. Saskatchewan legislation permits doctoral practitioners to use title of "doctoral psychologist"	Memorial University change to PsyD is likely to make Master's obsolete in NFLD. Eight Canadian provinces allow for a registration option for those trained at the Masters level , , although not, in several cases, with the title "psychologist." Ontario is currently proposing a return to Doctoral-only registration according to ACPRO.
	q) PhD programs cost too much; Maritime Provinces Higher Education Council would have to approve a competitor doctoral program to Dalhousie; & there is already a slight shortage of CPA accredited internship	Doctoral programs are expensive but popular with professors (provide research assistants); PsyD's are less expensive but less popular with professors; the prospect for a growth in government-supported internships is likely to improve with a	See 1(l); A change to two-tier registration would avoid this problem; change to a doctoral-only model would require an adequate period of notice to allow educational institutions to adapt. The Departments of Health & Wellness and

	sites in Canada	larger number of doctoral graduates	Education would have to support more internship placements. Some university psychology departments may be reluctant to switch to doctoral training without a substantial increase in resources. NSBEP and APNS should take a proactive role in advocating for PsyD programs in Nova Scotia.
Options:	**Supportive Input**	**Contrary Input**	**Comments**
Option One: **Maintain Status quo** ***(continued)***	r) Lack of opportunities for existing practitioners to upgrade to doctoral level	The Dalhousie PhD program has enrolled Master's graduates and practitioners.	It would seem reasonable for NSBEP and APNS to advocate for universities to make available part-time options for upgrading, should doctoral-only registration be established (as in Quebec).
	s) Some psychologists feel that the present system is working and so should not change	The ELC committee conducted no in-depth analysis of whether the current system is or is not working apart from statement of personal opinion.	Presumably this question would require an operational definition of "working."
Option Two: **Two-tier registration**	a) Several provinces have this option: BC, Ontario, Manitoba, & PEI. Saskatchewan allows differentiation by use of "doctoral psychologist"	Future Master's practitioners face loss of opportunity to practice with the title "psychologist" and might therefore lose access to Federal Government/ Corrections jobs; different provinces allow different levels of independence to Master's practitioners;	No cross-provincial consistency in Master's designation & privileges; Manitoba has 2 levels of function within the Master's designation with separate government certification for school Psychologists; Ontario has some discrepancy in function for two tiers but not as originally intended; A title other than "psychologist" is the norm for Master's in 2-tier provinces (except Saskatchewan, where a change from doctoral-only registration was legislated against the intent of the licensing body (personal communication).
	b) Would clarify distinction of qualifications to public while preserving licensure status to Master's practitioners	Calling grandfathered Masters practitioners "Psychologists" and new Masters practitioners "Psychological Associates" is going to create new confusion, and imply lesser qualification for future Master's practitioners with the same training as current Master's ones.	The public has no way of distinguishing qualification level if title of psychologist granted to both Master's and PhD/PsyD levels; The public frequently assumes that psychologists are "doctors" (and some do not know the difference between psychologists and psychiatrists)
	c) Would protect the public from graduates of dubious Master's programs who have attained title of psychological associate elsewhere and relocate to NS under new AIT	Would not protect public from those graduates, under the title Psychological Associate	Registration of a second tier would require a national mechanism for accreditation of MS/MSc programs and internships that does not now exist, and is unlikely given expense (there are some accredited

	legislation		Master's-level programs in the US)
	d) Would readily establish a category for school practitioners	Would overlook the perceived need and trend in school psychology for extended or intensified training at Master's level & undermine impetus by university to seek doctoral training for school psychology	The "distinctiveness" of school psychology from other applications of clinical psychology is an unresolved issue.
Options:	**Supportive Input**	**Contrary Input**	**Comments**
Option Two: **Two-tier registration (Continued)**	e) Would be cost effective: allow Master's psychologists access to public sector positions & preserve psychology in a tight money era	Decrease in funding of Psychology positions is not specific to degree and the greater decrease in funded positions appears to have occurred at MS/MSc level	It is arguably more difficult to support the unique contribution of Psychology at the Master's level (compared to other masters-trained clinical professions), such that these positions are more vulnerable to loss through "generic clinician" hiring model, and more susceptible to the expectation that they perform similar functions as other professionals (e.g., intake, "one-session" therapy).
	f) Would allow graded levels of expertise in the profession analogous to different levels within medicine (e.g. physicians vs. registered nurses vs, LPNs, etc.)	Other professions have distinct titles and prescribed domains of function at the different levels of licensed practice; NSBEP would have to establish licensure requirements at every level of the grade	The introduction of a technology wing of psychology was implied at the Halifax meeting, from a cost effectiveness and function-limiting area, as was the argument that the title psychologist be restricted to the doctoral level. (Recalls old category of "psychometrist"). See 2a, 2b. Profession would be arguably better positioned to propose multi-level registration once title "psychologist" was settled. Technology-level training at the bachelor's level has been the norm in nursing, occupational therapy, kinesiology and physiotherapy, although there are recent changes towards the Master's level for physiotherapists (although not assistants) Master's practitioners may be reluctant to accept redesignation of their level of training as that of a technician.
Options:	**Supportive Input**	**Contrary Input**	**Comments**
Option Two: **Two-tier registration (Continued)**	g) Allows for delineation of limits of competence according to qualification rather than self-report: There is question as to whether Master's training provides adequate insight into	Regulations already exist that mandate practitioners to recognize and observe limits of competence; the PP directory tells us nothing about the asserted competence of public-sector	It has been suggested that this "range of expertise" is related to a supposed greater mobility of MS/MSc-trained psychologists, although we are aware of no data to support such a claim. There has also been

	or recognition of limits of competence (mean number of areas of competence in the APNS Private Practice Directory for 2009-2010 is *higher* for Master's practitioners than PhD/PsyD ones).	psychologists.	criticism that using the APNS directory is inappropriate since not all private practice psychologists may list in that directory. The private practice directory represents over 28% of NSBEP registered psychologists, including academic, public sector and out-of province registrants. While NSBEP needs to recognize the limitations of the directory as an instrument for drawing such inferences, the sample size and convenience (as the only voluntary listing of self-reported expertise available) renders it useful as an illustration of this concern.
	h) The increase in number of Master-trained practitioners in other health professions serves to lessen the distinctiveness of psychologists also trained at the master's level.		The lack of distinctiveness may arguably have contributed to the development of the generic mental health therapist model, in which psychological interventions are provided by people lacking exposure to what psychologists would see as fundamentals of human learning, development and psychopathology. (See 2c)
Option Three: **Doctoral-only Registration**	a) Protects profession & public from inadequately-trained practitioners (including those trained extra-jurisdictionally). Exemptions to the AIT apply to specific programs (once approved by AIT "officials"); It is the lowest common denominator (of entry standards) that is the default for all provinces to have to accept.	Some Master's do not perceive this problem as significant, and some were not convinced that a change to doctoral only registration was the only means of addressing concerns arising from AIT.	Failure to provide that protection will allow practitioners with standards currently considered inadequate to practice in NS with unfettered right to the title and functions of Psychology in NS.
	b) Potential of exclusive doctoral model to achieve "function" laws: protection of profession & public in areas of psychological expertise (e.g., Quebec law governing qualification for the function of psychotherapy by all professions)		Under title laws public can access psychological services under other names without adequate quality control; function laws ensure quality control of services regardless of provider. Profession should support this trend.
Options:	**Supportive Input**	**Contrary Input**	**Comments**
Option Three: **Doctoral-only Registration (continued)**	c) "APA" experience shows potential for equivalence of Psychology with psychiatry in a range of health care roles	Even with a doctoral model, APA has run into difficulties (e.g., Oregon governor vetoed bill granting greater equivalence to psychology)	It is difficult to assert equivalence with psychiatry or general practice in medicine, when Master's training is lesser in duration, range and supervision than either GP or psychiatry training,

	d) Credentialing of programs and internships allows greater predictability and quality of training		Lack of accreditation renders Master's programs and practicum settings difficult to assess qualitatively (see 3c).
	e) Range of coursework and practicum/internship experience of PhD/PsyD more fully prepares independent practitioners (e.g., the Dalhousie calendar states PhD is 5 yrs: 13 required courses with 3 half-credit electives, 3 seminar courses (research, teaching & Psych Inquiry) and Clinical Rounds, Case Conference & mandatory colloquia; 600 min practicum hrs; dissertation; 3 comprehensives (research projects) & 1 year clinical internship)	Some Master's practitioners argue otherwise, that doctoral training makes no difference	Master's programs may not provide courses in neuropsychology, psychopathology, specific psychotherapies (other than survey courses covering a range of psychotherapies) & other essential skills of independent practice, typically gained through the more extensive supervised practice during internship and the often greater number of practica hours (many programs requiring 700-1000 hours).
	f) Predicts a lower rate of serious and costly complaints to NSBEP, and a lesser degree of vulnerability to public	Many of the most costly complaints can be traced to a relatively few Master's practitioners; Ethics coursework is similar at Master's and PhD/PsyD levels, so ethical conduct should be similar	The doctoral internship provides supervised exposure to ethical decision-making in practice to a substantially greater degree than the NSBEP monthly supervision requirement
	g) Eliminates public confusion about qualification of psychologist practitioners; many patients assume their psychologist is "Doctor." (see 2g)	Practitioners are already required to ensure that public understands one's level of qualification	It is unreasonable to expect the public to read the degrees/licenses on the wall or understand the vagaries of variable registration requirements.
	h) Prepares profession for new challenges (e.g., prescription privileges, admission privileges, option to refer to psychiatry)	U.S. trend suggests slow progress towards Rx and other privileges despite doctoral predominance	There might be benefits to the profession speaking with a single voice on these and other issues.
	i) It makes sense to have different titles for doctoral and Master's trained practitioners given the substantial difference in training: distinction by title best informs public of difference: public has a right to know		Distinction of qualification by title is the rule in medicine, the public's main model of health care
Options:	**Supportive Input**	**Contrary Input**	**Comments**
Option Three: **Doctoral-only Registration (continued)**	j) Potential to raise the profile and availability of PsyD option: time-limited, clinically-focused doctoral training, appealing to practice-minded psychologists who may be reluctant to choose the open-ended, academically focused PhD		Provinces switching to doctoral-only have pioneered PsyD programming: Quebec, NB; few other provinces offer PsyD in Canada (only one); in the mainly doctoral U.S., both universities and free-standing school offer a wide array of PsyD choices
	k) Resolves this issue for all time, and		Experience suggests that the status quo will

	supports a unified profession able to speak with a single voice; the divisiveness of this issue has undermined the unity of the profession		not settle this issue.
	l) Doctoral training is the growing consensus of the profession: 48/50 U.S. states have doctoral-only requirement for title psychologist; 31 states have doctoral-only registration; 15 states have two-tier in which Master's practitioners get titles of "Associate " or "Assistant"; 3 states have "School Ψ" Title; Quebec and New Brunswick have just changed to doctoral-only; Ontario is initiating move towards doctoral-only entry level.	Several provinces have not changed, and (albeit under cabinet direction) Saskatchewan has switched back to two-tier. Manitoba Government has established a certification that allows for Masters-level school psychologists separate from other Master's practitioners who can be registered as psychological associates with the Psychological Association of Manitoba.	See 1(p), 2(a)
	m) Allows best protection of any prospective change option to currently-practicing and soon-to-practice Master's graduates, in that it preserves title & privilege of independent practice on a permanent basis.	Leaving things as they are would allow that protection as well	Change to doctoral training offers no real negative impact and minimal chance of harm to currently-practicing and soon-to-practice Master's graduates; gives adequate notice of the change to future psychologists of the training they should seek

qualifications to the doctoral level implied that masters-trained practitioners were perceived as being deficient or inferior in competence to practice, relative to doctoral practitioners. The inference, at least in part, appeared to arise from the Board's use of observed differences between master's and doctoral trained psychologists on EPPP scores and Board complaints in its rationale for the proposed change and the ELC's subsequent examination of these data. At no time did either the ELC or NSBEP state this rationale or express agreement with it. The ELC encourages the Board, however, to reassure the psychological community that the decision about changing entry to practice standards is based solely on the considerations otherwise stated in this report, primarily the needs of the profession and our clients, rather than on the inferred competence of individuals.

A related general issue is the utility of the EPPP and complaints data that compared master's and doctoral trained practitioners. The committee had a number of discussions and, as noted in Table 1, some members of the committee questioned whether there was sufficient evidence to warrant switching from the status quo based solely on "the more serious valid complaints (and higher costs)" against master's level practitioners. One member noted, "attempting to infer useful information about the competency of groups of psychologists on a very small and non-representative sample[6] of psychologists is not good science". A similar argument was made against using the EPPP data to "prove" anything, because (a) the mean scores were not tested for significance of difference[7] and the fact that, even though no doctoral candidate had failed the EPPP (data since 2005), and 26 percent of master's candidates wrote the exam more than once, all fully registered psychologists have met the standard by passing the EPPP. Thus, if the Board proceeds with the change to the doctoral level, its further use of the EPPP and the complaints data may or may not yield any more helpful information, supporting or not supporting the need for the proposed change. For example, it remains to be seen whether or not more detailed analyses of the data (two suggestions included tracking the number of complaints per person and determining the psychologists' area of practice since some areas may be more prone to litigious action than others) and/or whether or not surveying all of the psychologists in private practice about their areas of practice and training would show supporting or non-supporting findings.

The perception of some psychologists that competency is questioned by the Board led to the further clarification that the Board's greater concern regarding preparedness to practice is with the Agreement on Internal Trade (AIT); that is, required registration of individuals because they are registered elsewhere in Canada but whom the Board considers inadequately trained. The prospect that it is largely master's trained individuals whose programs have not been recognized by the NSBEP, in concert with the existence of accredited programs of doctoral training that provides a recognized standard of quality, has been a significant impetus to the Board's proposed change. Whereas the ELC recognizes that the Board's primary purpose is in the protection of the public, the ELC approached the question in terms of how best to address the needs of the profession and its consumers, thus, in part, fulfilling its mandate to consider the impact of such a change on these stakeholders. Clearly, doctoral level programs provide an advanced level of

[6] In addition, at the request of the ELC in the Fall of 2010, to try to determine the pattern of complaints across North America, the Board conducted a survey of the Association of State and Provincial Psychology Boards (ABSPP), asking for their breakdown of complaints by level of training. With only four of its 60 members responding, the data were considered insufficient to include in this report.

[7] (means = 581 [n=69, SD=58] & 641 [n=46, SD=43] for master's and doctoral scores, respectively; see Appendix B for specific findings).

training. Whether master's level training (for school, clinical, counselling, etc,) and subsequent four years of supervision is adequate for independent practice remains an open question, although the committee did agree that master's and doctoral training are not equivalent in this respect [that is, readiness to practice], and that master's practitioners may not be adequately trained in the breadth and depth of knowledge and skills necessary for unrestricted practice in Psychology.

Competency is used in discussion of this issue. Mode of acquiring expertise may be the more appropriate term (and avoids the confusion with the aforementioned, incorrect interpretation that the Board believes that master's trained psychologists in NS are incompetent). The argument was put forward that "competency" is also considered to be dependent on stage of training and experience, scope of practice and work environment. For example, some individuals with master's' degrees indicated to the committee that they have many opportunities to receive informal supervision or consultation in the school or health setting where they work. The committee also agreed that the level of training typically obtained in a master's school psychology program, is extensive, albeit within a limited scope of practice.

The issue of title and scope of practice arose in discussion in consideration of the NSBEP's observation that throughout many provinces and states in North America, the doctoral degree is standard for entry level registration. In Canada, there are a number of provinces where individuals with a master's degree can practice independently with the title Psychologist (Alberta; Newfoundland, NL; NS and North West Territories) or Psychological Associate (British Columbia, Ontario, Prince Edward Island[8] and Manitoba in some cases). Saskatchewan registers those master's trained with the title of Master Psychologist (and Psychologist for those doctoral trained). Quebec and New Brunswick (in 2011) accept only a doctoral degree for registration. There is some speculation that NL will shift to doctoral-only now that their PsyD program is in place. Some ELC members questioned whether it is enough of a reason to switch from the status quo solely because other provinces may be doing so. Others contend that if NS changes the entry level requirement to doctoral-only, we would avoid becoming a stepping stone for registered master's practitioners who want to migrate to other Canadian jurisdictions.

Practical Considerations for the "greater good of psychology as a profession". Some ELC members and psychologists in the community strongly support a shift to doctoral-only registration for the "greater good of psychology as a profession". As noted in Table 1 (Option 3k, p. 16), it might be argued that such a switch would unify the profession and place it in a better position to raise its profile and lobby for privileges specific to the profession, for example (Option 3h, p. 15). However, the challenge is to understand fully how the change to doctoral-only registration would affect psychology in NS on a practical level. The ELC identified the following practical considerations, including (a) the apparent fall in status of Psychology over the past ten-to-twenty years, with its impact on the jobs and institutional support for the profession, and (b) the declining number of psychologists employed in rural hospitals at either level, and especially at the master's level. A third consideration (c) is our ability to comply with Canadian law and to have some kind of cooperative relationship with other provinces (e.g., as is addressed by the NSBEP in every transfer interviews). A fourth practical consideration is (d) access to training and is discussed in the Training Issues section below.

[8] Soon to come into effect.

Consideration (a) suggests that changes in the practice (and training) of psychology over the past 20-30 years in NS warrants a brief review to place the proposed change in historical perspective. At the time of the original Psychologists' Act in 1980, hospital-based Psychology Departments advocated and supported the interests of the profession and the needs of psychologists. Since then, the advent of the program service delivery model has gradually transformed Psychology Departments, from autonomous and independent entities, to affiliated practice groups. This shift in models also has led to a loss of autonomy and identity for the profession, in addition to a loss of collegial support, reduced opportunities and less informal mentorship being available to practitioners at differing levels of training. Over the past 10 years or so, psychology positions have been lost to generic clinical therapists in a number of hospital-based mental health programs. The increase in clinical therapist positions is speculated to be directly related to the shift to program models.

A radical practice change in NS involves the shift to service delivery in private practice settings. In 1980, the typical career track of most clinicians and school psychologists was in the public sector. As many as 50 percent or more of practicing psychologists now work part time or full time in the private sector; fully 25 percent of licensed resident practitioners are listed in the APNS Private Practice Directory. The ELC sees the effect of this change as increasing the need to ensure the continuing competence of independent practitioners, in the absence of the institutional and collegial supports that still would be offered psychologists in a hospital-based setting that would help ensure skill enhancement. Professional isolation and lack of opportunity for peer consultation may well occur in a solo private practice as is recognized in the NSBEP's prohibition of solo private office within two years of registration.

Given the Mutual Recognition Agreement (MRA) in 2002 and more recent pressures for common standards through the AIT, it is becoming increasingly obvious that Psychology functions not only in a provincial setting, but also in a national one. NSBEP will have to consider this national perspective, including its responsibility to share in making decisions that ensure the qualifications of practitioners' nation-wide. Making a decision that ignores NS's specific needs and perspectives would be inappropriate, but equally inappropriate would be the failure to consider the welfare of the profession in the country as a whole.

Supply and Demand Issues

One of the biggest concerns raised by a number of psychologists in our meetings was how changing to doctoral-only registration might affect the service delivery of psychology throughout NS, particularly in the rural areas. Fully addressing rural needs regarding psychological practice is beyond the scope of this report. However, the ELC did conduct an informal survey of psychologists working in the public sector (please see Table 2, pages 20, 21) and gleaned some information from the 2010-2011 APNS Private Practice Directory (PPD); see page 22 for discussion of this information). Table 2 data suggest that there are relatively higher numbers of master's level psychologists (than doctoral) working in both rural and urban areas at Corrections, Addiction Services and DND facilities. With just two of 69 school psychologists in NS being doctoral level, School Psychology is almost exclusively practiced by those with master's level training (in both rural and urban areas). Doctoral-level representation in district health authorities (DHAs) is higher than master's level, in five of the eight districts (or 6 of 9 if the NS

Table 2
Results of Informal Survey of Number of Psychologists in Public Sector Workplaces
March-April 2010 & Oct 2010

Health Districts –*Rural*

Workplace	Total	D	M	Current	Duration	CT posting
SWHA –Yarmouth	10	2	7	1	2-6	50%
CEHHA – Truro	9	1	8	1	6-12D/1-6M	50%
SSHA –Bridgewater	5	3	2	0	3-4D, 3-4M	50%
CHA – Amherst	4	1	3	0	n/a	100%
CBDHA – Sydney	11	7	4	2D	12-24D/var.M	0%
AVDHA- Kentville	13	9	4	0	2-12D/1-2M	25% (temp. only)

Corrections *Rural*

Workplace	Total	D	M	Current	Duration	CT posting
Community/parole	2	0	2	0	9-12 mos.	0%
Spring Hill Inst.	10	0	8	2	indefinite	25%
Nova Institution	4	1	3	0	2-12+ months	0%

Health – Addictions Services *Rural*

Workplace	Total	D	M	Current	Duration	CT posting
AS – Northern	15 CT	-----	2	0	varies	100%

Military (Oct 2010) *Both*

Workplace	Total	D	M	Current	Duration	CT posting
Stadacona	9.5	2	7	.5	n/a	n/a
Valley	1	1	0	0	.	100%

Health – Capital District *City but IWK & NSH etc. covers some rural areas*

Workplace	Total	D	M	Current	Duration	CT posting
QE2	17	14	1	2D	1-6 mos.	0%
NSH, MH, Foren.	22	18	3	1	n/a	0%
IWK	60	50	8	1 D/1M	varies widely	0%

University Counselling Centres *City*

Workplace	Total	D	M	Current	Duration	CT posting
Dalhousie	7	5	2	0	n/a	0%

Table 2 continued

Private Practitioners (from 2010-2011 APNS Directory)

Workplace		**Total** *(N:107)*	**D (n=52+1?no degree FT HRM)**	**M (n= 54+1?no degree FT HRM)**
HRM	FTE	*64 +1*	27 + 1 both Rural & HRM	32 + 4 both Rural & HRM
HRM	PT	*16*	12 *	4
Rural	FTE	*17*	6	11[9]
Rural	PT	*9*	6	3

School Boards *Both City & Rural*

Workplace	**Total**	**D**	**M**	**Current**	**Duration**	**CT posting**
English	67	2	65	0	n/a	n/a
French	2	0	2	0	n/a	n/a

n/a = not available
D = PhD/PsyD
M=MA/MS
CT = Clinical Therapist
Current = current vacancies
Duration = estimated # months for vacancies to be filled

[9] Appears there are more advertising Ms working full time in pp in rural areas & more advertising Ds doing part time work in city.
There is not a substantial difference in the number of Ds & Ms working in the rural areas: (12 + one .5 Ds and 14 + four .5 Ms [13 compared with 18 individual psychologists])

Hospital and its satellite clinics and the QEII are considered separate programs, which they themselves do, although both are Capital Health-CH facilities). Of all the DHAs, only the QEII is strictly urban. The IWK operates separately from the CH and its 60 psychologists work throughout the province. The perception of some psychologists is that doctoral level practitioners are not attracted to these types of positions (i.e., school, addictions, military, corrections) and/or rural areas, contributing to the concern that eventually psychological services may no longer exist in particular sectors (i.e., if the standard goes to the doctorate-only). The survey supports this to some extent, in that particular geographic areas are not attracting as many doctorates as master's psychologists (i.e., the 3 geographic areas that have, on average, 4.5 times the number of master's psychologists as doctoral psychologists) and in rural Corrections facilities (with 12 of their 13 psychologists) and rural Addictions facilities (with both of their practitioners) are master's trained. Otherwise, the remaining rural areas are staffed by 20 doctoral practitioners compared to 15 master's practitioners in areas outside of the HRM. The ELC did not, however, survey whether there are differential preferences for practice locale according to degree, or assess to what extent the employment of master's level practitioners reflects employer preference (perhaps that master's practitioners cost less) rather than practitioner preference.

Literature from US sources contends that rural areas are underserved by mental health (MH) professionals and that 20 percent of the rural population is vulnerable or at risk for MH problems (because of such factors as poverty, old age, chronic illness), (in Jameson & Blank, 2007; citing 2001 and 1990's data). One such study in 1998 reported that in population areas of 1500 to 20,000, there were no psychiatrists and in about half of those areas there were no psychologists (master's or doctoral level) or social workers. Jameson and Blank (2007) noted that areas with populations less than 2500 also had no general practitioners and that one-third of rural areas lack any health care services, necessitating travel for both outpatient and inpatient care (citing a1999 study). They described their difficulties defining "urban metropolitan" and "non-metropolitans areas" (rather than a more typical rural-urban breakdown), which they based on population numbers and proximity to "urban" areas. The ELC experienced similar difficulties, before (somewhat arbitrarily) deciding to define a rural area as being outside of Halifax Regional Municipality (HRM). The ELC agrees that a consensus definition "that fully captures the demographics, cultural, and economic aspects of rurality" (Jameson and Blank, 2007, p. 284) is elusive. What can be gleaned from this study is, perhaps predictably (at least when extrapolating from US data), that rural areas tend to be underserviced and, in terms of medical care in NS, it is well known that medical care is grossly underserviced by family doctors and psychiatrists (at least) in "rural" NS. Information we gathered and feedback we received[10] indicated some disparities in service by urban-rural breakdown (but not in all communities or districts); however, the NSBEP may want to redefine the rural-urban demarcation used by the ELC to more fully explore service delivery issues across NS for this proposed change or for any other question it wants to ask in future.

Some discussion of **other professions and their potential influence** on the practice of psychologists is deemed appropriate, both to gain a wide-lens view of psychology within the health care system (and what the growing trends and changes in models of health care delivery may be), as well as to address the needs of future psychologists (see Option 3m- p. 16; Option

[10] See page 23 and 24 for more detailed discussion or rural-urban data.

1b- p. 9) and perhaps to see how psychology can benefit from the experience of other disciplines. A Canadian study shows a trend with respect to general practitioners increasingly providing MH services, which in turn, is related to the supply and demand issues of psychological services (Watson et al., 2005). They note that this is a similar trend to that observed in the US. Watson et al.'s study of population MH services usage in Winnipeg showed that general practitioners (GPs) reported an increase in their MH treatment rates from 1992 to 2001, for both "major and minor" mental illnesses, from 15 to 31 percent. In 2001, 45 percent of those diagnosed with a mental illness saw only their GP, on an average of 9 and 7 times a year (for major and minor illnesses, respectively). This occurred with the average number of GP visits remaining stable from 1992 10 2001. Those with low socio-economic-status received the highest rate of service from their GP; 24 percent of billings in 2000-2001 were "psychosocial" in nature (meaning problems other than mental illnesses). Watson et al. concluded there was evidence of an increase in prevalence of mental illness over this nine year span and that of those seeking mental health care, occurring in the context of a shift to a "community shared care" model, that "most receive services via primary care".

One issue of supply if going to a doctoral-only or to a two-tier system is the argument that the doctoral psychologist would not want to practice in the public sector (urban or rural), as Jameson and Blank (2007) suggest, because of the more competitive fee rates a private urban psychologist can demand (in the US at least). The data from the work survey (Table 2) suggest that in NS, many doctoral-level psychologists choose the public-sector despite the apparent remunerative rewards of PP. The ELC collected some information to try to address this question of private practice providers, by doctoral and master's training, while obtaining a breakdown by urban-rural areas and by full or part time (FT, PT) status[11], using the 106 psychologists who advertised in the 2010-2011 APNS Private Practice Directory (PPD). The ELC recognizes that the PPD is not a randomized sample of NS psychologists or of private practitioners, and thus is not necessarily representative of either group; however, it is 28 percent of all the psychologists in NS and over 40 percent of all those doing private practice (given that about half of registered psychologists are in PP on a FT or PT basis). These data show about equal numbers of doctorates and master's in private practice across NS. They also lend support to the idea that more master's psychologists work in PP, FT, in rural areas and that more doctorates work FT in PP in urban areas (almost 2:1). There are twice as many doctorates in PT rural private practice and a 3:1 ratio of doctorates to master's in PT private practice in the city (please see Table 2, pages 21, 22).

Training Issues.

The fourth practical consideration, referred to above (d) is access to training. Fully addressing rural needs regarding psychological practice and training is beyond the scope of this report (see discussion in Appendix C in which there is recognition of the challenges of working in a rural setting which may impact the supply of "rural" psychologists.) Briefly, however, one finding of note reported by Jameson and Blank (2007) suggests that going to a doctorate-only entry

[11] Full /part time breakdown was based on the statement of at least 4 days of office time. Accuracy of this data can be questioned.

presents an opportunity to launch government lobby campaigns to increase incentives to interns placed to "high need" areas (see Option 1b,e,f -p. 9, Option 1l- p.10; Option 3d- p.15; Option 3j- p. 16, for items relevant to government, interns and/or high needs areas). For example, the University of Nebraska has been "successful" in attracting 24 interns to a "rural track" internship and 33 percent have stayed on to work in the area. In NS, the retention rate of interns in or near their internship site is at least comparable, thus supporting this recruitment strategy that appears already to be working in NS, and which is recognized as such by program sites and the Dept. of Health. One of the challenges for any change to doctoral-only status in the province would be the provision of more internship sites in rural as well as urban areas. There currently are nine internship "slots" in NS, two in the Valley Regional DHA, and seven in the HRM area (including some rural satellite clinics).

The paucity of doctoral programs in the province begs the question whether the status quo actually blocks the enhancement of clinical training in NS; for example, some department members at Acadia have twice tried and failed to get a doctoral program asters while our sister provinces are establishing PsyD programs (Quebec, New Brunswick, NL; and Manitoba, respectively). On a more positive note, since the 1980's, Acadia and Mount St Vincent Universities have established well respected (and now only) clinical and school Master's programs (respectively) in NS and Dalhousie now has an accredited clinical doctoral (PhD) program. A second major change was the restructuring of the master's program at St. Mary's University as an Industrial-Organizational program (rather than clinical), leaving only the one clinical master's program (Acadia) and one School psychology program (MSVU). Therefore, whilst recognizing that NSBEP is not responsible for the training opportunities of psychologists (future or existing), the ELC strongly urges the NSBEP to look at available training modalities in Psychology in NS, in order to facilitate and/or support those psychologists wishing to upgrade and/or begin training towards becoming a psychologist in NS.

The ELC recognizes that the psychologists most affected (immediately) by the proposed change are the master's' trained psychologists, who have been clear in expressing their concerns and/or fears that there will not be sufficient retraining or upgrading opportunities for those who can do this. One of the ways the Board can help, on the training issue, is to support and encourage the NS government to fund more doctoral programs or more students in the existing one. On a national level, the typical standard for doctoral training has been the PhD (and see Cohen and Caputo, 2006, below), following the scientist-practitioner modal, with an emphasis on the training of expert researchers as a major component of clinical training (i.e., equal to the clinical practice training). Notwithstanding the findings of the APA Vail Conference in 1966 regarding the limitations of this training modality for clinical practitioners, Canada made no appreciable movement towards PsyD training until very recently. Practice-minded students who wanted doctoral-level training had two choices: learn to be a researcher too, in the relatively open-ended PhD format, or go to the U.S. The shift seen in some provinces already recognizes the need for a clinical-intervention-focused doctoral mode of training, rather than the combined researcher-clinician PhD model for the clinical practitioner (analogous to the medical degree as a practitioner training degree for physicians). MSVU has structured a school program that is unusually heavy for the master's level, while informally expressing an interest in restructuring to PsyD. The ELC cannot say whether a switch to doctoral-only training would lend impetus to the upgrading of existing master's clinical and school programs in Psychology. It might equally be

argued that such a switch would lead to the loss of these two existing programs, if unwilling or unable to afford the transition to doctoral programs.

Hays-Thomas (2000; citing Duer & Hays-Thomas, 2005) raised most, if not all of the issues, pro and con, about doctoral/master's registration that are being presented in this report. They address Option 1a (page 9) where Hays-Thomas questioned whether or not there were sufficient numbers of "behavioural health care providers" who would be available in the near future and she examined the four different kinds of master's program in the US. She estimated that in 2000, there were 6000 "health service providers" from 270 two-year applied terminal master's programs. The master's programs in the US are defined by their outcomes: (1) "terminal", meaning "ready for work" upon graduation; (2) pre-doctoral, meaning that following completion the expectation was they would go on to doctoral work; (3) doctoral, meaning completion of the master's blended into/during doctorial program; and (4) consolation, meaning the master's was received if one cannot complete the doctorate.

Cohen and Caputo (2006) released data on their CPA Panel on Accreditation Survey of the Council of Canadian Departments of Psychology (CCDP) about master's programs, looking to "better understand the needs of master's psychologists" and to know how many terminal master's programs exist in Canada (see Option 1e- p. 9). Of the 19 programs that responded, 5 (26%) were considered terminal programs (i.e., students graduated "with qualifications for registration as a psychologist or psychological associate in an area of professional psychology", such as school, clinical or counselling), as in US category (1) above; 7 (37%) were programs "that graduates used to obtain registration as a psychologist or psychological associate, even though the programme was not intended to train registered practitioners"; 5 (26%) programs accepted students into a master's programme and required separate application into the doctoral programme, similar to US category (2) above; and 5 (26%) accepted students directly into a doctoral programme with a baccalaureate degree and "accord these students a master's degree if they completed a requisite body of work and, for some unanticipated reason, could not complete the doctoral degree" (i.e., as in the Consolation master's US category 4 above). The overlap of kinds of programs in Canada is reflected in the more than 100% total in these responses. Cohen and Caputo make the point of distinguishing a psychology degree from a program, the latter having an "organized and comprehensive training component" and which clearly those seven programs not intending to graduate practitioners are not doing (i.e., providing professional and/or competent training; see Option1j-s- p. 10,11; Option 2c- p. 12, Option 3a,3d- p. 14,15). Cohen and Caputo encourage master's programs to obtain accreditation from the Council on Applied master's Programs in Psychology (CAMPP) and other groups as well as for students to consider enrolling in departments other than psychology, such as the Educational Psychology program in the Faculty of Education at the University of Edmonton, or with counselling programs if a doctorate is not wanted (see Option 1j- p. 10). Similarly, the School Psychology program at the Mount St. Vincent's University is not housed under the Psychology Dept. Where graduates find they do not have sufficient psychology content in their program they are encouraged to register (when available) with the most appropriate professional group (e.g., in Manitoba school psychologists have their own organization). The position of CPA remains that a common entry level across Canada is the best way to serve needs of students and the public and in 2008 they affirmed the "best way" was the doctoral degree. Cohen and Caputo reported that in 2006 there were 14000 psychologists in Canada and about half were in Quebec, which now has the doctoral

level standard and which has also opened new PsyD programs. They suggested that these programs offer a way to help "harmonize" the mid-career upgrading of interested master's and/or of students entering university with psychology as a career in mind, and which the ELC thinks could serve as one model for NS.

Again, using the experience of other professions is thought to add to this discussion of arguments heard by the ELC. The medical profession in Great Britain showed that their physicians benefit from obtaining "higher degrees", which was encouraged as a way to counterbalance professional isolation and burnout that had been identified in independent practitioners (Lynch and Gallen, 2005). They found that when general practitioners go for more education, they benefit from the professional development, and it also boosts their self-confidence. This increase is thought to come from a "broadened knowledge base and increased skills" that they then use to "explore more deeply into one's own discipline" and leads to their conducting more research. In an APA study, reported by Corley and Yeatmen (2000), master's (M) and doctoral (D) graduates were asked about the adequacy of their program preparation and their job satisfaction one year after graduating. While not directly measuring self-confidence, this may be considered a general reflection of the graduates' self-confidence and knowledge/skills base. The APA study further delineated a separate group of graduates coming from master's programs holding membership in the CAMPP. Of pertinence to this ELC report, 85 percent and 89 percent of the two master's groups (master's and CAMPP, respectively) reported that their program "adequately prepared" them for their job (D graduates were not asked this question). Around two thirds got their job of first choice in all three groups (66%, 61%, 68% for M, CAMPP, and D, respectively). By definition, all the CAMPP schools have an applied emphasis but there was no explanation offered for why more of the master's group were in counselling (29% cf. 16% CAMMP), and more of the CAMMP group were in clinical psychology (50% cf. 21%). At one year follow-up, more master's trained psychologists were doing doctoral work than CAMMP (27% cf. 13%). More CAMMP graduates were satisfied with their training than master's graduates and more had full time employment. It can be speculated that the value of accreditation is in its offering a "better", more satisfying training program asters and that the master's graduates believed they were in need of further training (and so go on to the D level training). It may also be that the master's and CAMMP graduates had self-selected to academic and applied programs, respectively.

Concluding Statements

In the process of conducting its work, the committee itself quickly became aware of the obvious differences of opinion and perspectives of its members, as would (and should) be expected given the kind of question before the committee, and the varied qualifications and work settings represented on the committee. The variances are obvious in Table 1. What can be agreed upon, however, is that the issue in question is a contentious and difficult one. Indeed, the loss of two master's trained committee members speaks to the apparent un-reconcilable differences between those, in this case, who believed the process was flawed from the start and/or that there was no justifiable rationale to pursue the question in the first place, and those that did not.

The ELC members' experience of conflicting views was echoed among those who addressed the committee, in person or in writing. In the wider psychology community, some practitioners expressed reluctance to give opinions in a climate of acrimony and recrimination. Some participants took offense to the perceived disrespect paid to them during the open meetings. At the same time, the ELC heard a good deal of positive input and openness/willingness to address this question head on, fairly and with due consideration for difference of opinion. Awareness of the potential of this issue to divide psychologists, as it has divided them for the past thirty years, and to still seek a future in which these divisions are mended and unity among psychology as a profession achieved will be one of the most important endeavours undertaken by the NBSEP.

In addition to the points made throughout the report, each of which the Board will need to assess on a pro and con basis, the following ones are all considered sufficiently important to restate for the Board's due consideration of the proposed change to entry level:

1) The ELC does not see raising the question of changing the status quo as an evaluation or review of the abilities or competence of practitioners at the master's and doctoral levels.

2) The ELC process included looking at current levels of service (e.g., Workplace Survey, statistics re complaints to the Board) but the principle focus was not (and ought not to be) on the "past." Thus, the ELC also considered the future of Psychology in NS. The Board would benefit from knowledge gained by conducting more exhaustive analyses of these data and/or more comprehensive surveys as suggested on page 22 in order to best plan for the future.

3) The Board is encouraged to consider the proposed change to entry level in the context of current service delivery models that represent changes to the practice of psychology and to mental health service delivery in NS. Psychology has shifted from a largely public-sector environment in which collegial support and institutional professional development was the norm, in the early 1980's, to a substantial increase in those now in private practice. Changes to the mental health service delivery model in terms of increased generic "therapist" positions (some of which appeared to replace unfilled psychologist positions) led to speculation by some that there would be reduced access to psychological services in some rural or institutional settings. One ELC member suggests that perhaps with doctoral only registration there would be fewer psychologists filling these generic positions, but that it may also be the case that if psychologists declined such jobs and institutions wanted to be seen as offering a range of professional services, they might be encouraged to create psychology positions, thereby increasing access to our profession.

4) The Board is encouraged to participate in the discussions and lobbying efforts, likely in concert with the APNS, to involve the Universities and relevant Government departments (Health and Wellness, and Higher Education) as stakeholders in the pursuit of providing more post-graduate training opportunities and as appropriate, be involved in the planning and development of such programs (albeit the ELC recognizes that training is not the responsibility of the NSBEP).

5) As in point (4), the Board is encouraged to be pro-active, as appropriate, in advancing the increasing numbers of professional scope of practice areas under consideration and/or already implemented in some jurisdictions (e.g., prescription privileges). These new areas

correspond to recognition of psychology's expertise in areas previously considered to be outside the realm of our science (such as physical medicine), and where the limitations of the traditional medical service delivery model become more evident.

6) The Board is encouraged to continue to work on provincial and national levels to arrive at one standard of entry level to maintain compliance with the MRA and the AIT and to support a national as well as a provincial perspective on the development of the profession.

7) The "next steps" taken by the Board may be those already delineated on pages 3 and 8, in addition to others identified by the Board, if it decides to move forward with the change.

In summary, the ELC concluded that the profession of psychology in NS will benefit from having a final decision- one that credits the perspectives of all and gives due consideration for the interests of all. That decision must address not just where we are, but where we as a profession need to go from here.

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Appendices

Appendix A	Meetings: Agendas and Minutes – on file with NSBEP
Appendix B	ELC Presentation to Members (Power Point slide show)
Appendix C	Discussion of Non-Empirical Literature Pertaining to Registration Issues of the Entry Level Standard

NSBEP Entry Level Committee Meeting

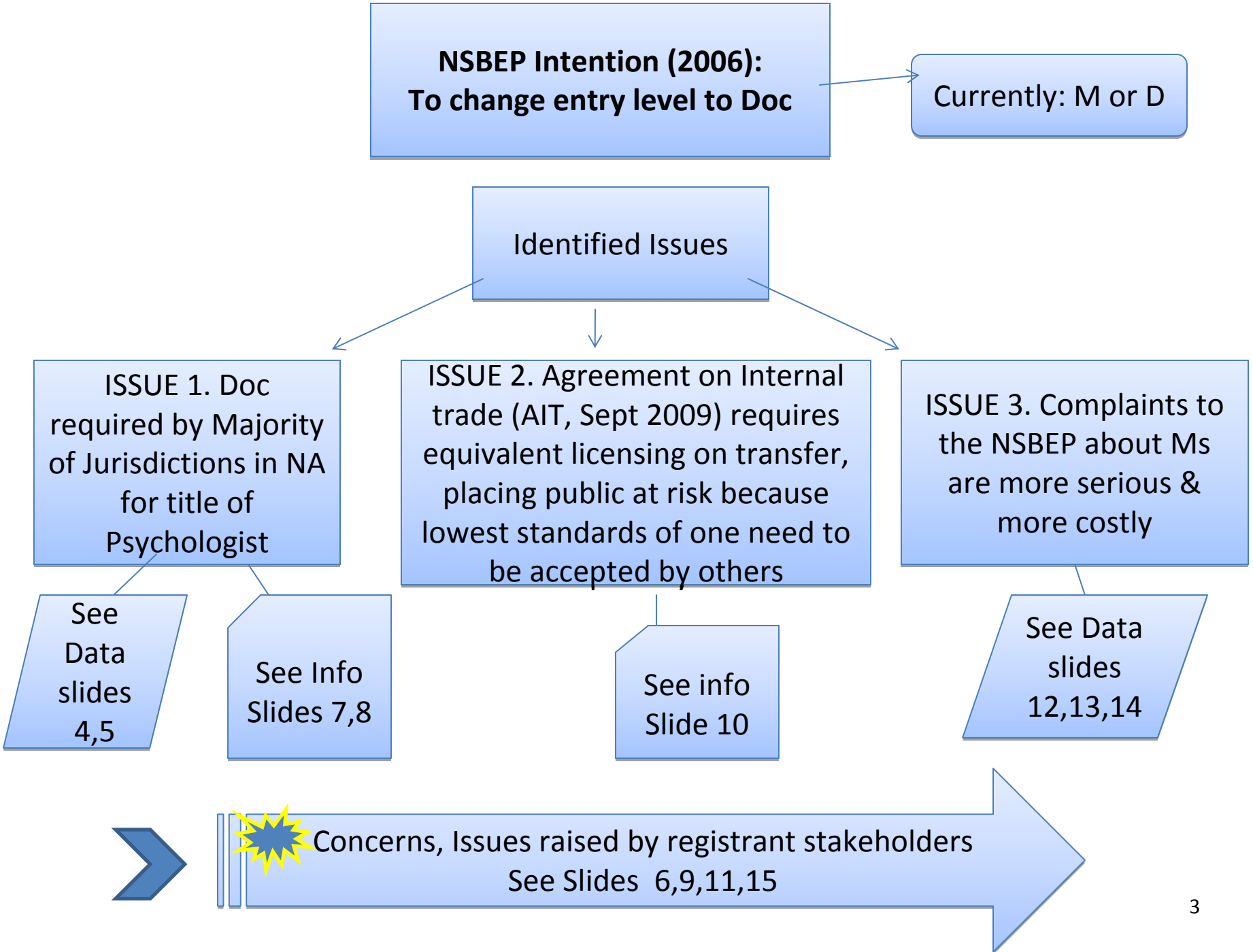
Truro NS

May 19, 2010

7-9 pm

Agenda

- Welcome & Introductions 7-7:10
- Review of Meeting Agenda 7:10-7:15
- Overview of ELC mandate 7:15-7:25
- Presentation of work to date 7:25-7:45
- “Talking Points”: Group Discussion; Feedback; Input 7:45-8:20
- Developing a Vision for the Practice of Psychology in Nova Scotia 8:20-8:55
- Next Steps…. & Concluding Comments 8:55-9:00


NSBEP Intention (2006):
To change entry level to Doc
Currently: M or D
Identified Issues
ISSUE 1. Doc required by Majority of Jurisdictions in NA for title of Psychologist
ISSUE 2. Agreement on Internal trade (AIT, Sept 2009) requires equivalent licensing on transfer, placing public at risk because lowest standards of one need to be accepted by others
ISSUE 3. Complaints to the NSBEP about Ms are more serious & more costly
See Data slides 4,5
See Info Slides 7,8
See info Slide 10
See Data slides 12,13,14
Concerns, Issues raised by registrant stakeholders
See Slides 6,9,11,15

ISSUE 1. Doc required by Majority of Jurisdictions in NA for **title** of Psychologist

CA:
- D 55% as title
- D only: Que '06 NB'11
- Both M & D: AB NWT NL NS SK (SK -title of Psych't for D & M Psych't for M)
- 2-tier: M as Psych 'I Assoc: BC Ont Man PEI (Man & Ont Ms may be supervised & reports co-signed)

US:
- D 96% as title
- D only: 31/50 states
- Both: 1
- 2-tier: M as Assoc or Assis title: 15 states.
- 'Sch Psych't title: 1 as M, 1 as M or D & 1 as D only

See Slide 6

D =Doctorate M=Masters

2010 **Registration** Options for Psychology Masters Degrees in Canada

PROVINCE	REGISTRATION OPTION
Alberta	Registered Psychologist
British Columbia	Psychological Associate
Saskatchewan	Registered Psychologist
Manitoba	Psychological Associate*
Ontario	Psychological Associate
Quebec	Not eligible for Registration
New Brunswick	Registered Psychologist**
Prince Edward Island	Registered Psychologist
Nova Scotia	Registered Psychologist
Newfoundland	Registered Psychologist
NorthWest Territories	Registered Psychologist

*In Man there are 2 levels of registration for those with Masters Degrees: Psychological Associates (Supervised Practice) & Psychological Associate (Independent Practice).
****** After July 1st, 2011 NB will require new registrants to have a Doctoral degree.

From Issue 1. Slide 4

Scope of practice whether M or D is same

M list more areas of practice than D (in PP Dir)

? D tend to specialize more when Area is same as M

?

Sch Psych & Clin Psych not same practice prep (courses e.g.,)

BC Act states no diff between D, M

Issue 1. Doc required by Majority of Jurisdictions in NA for title of Psychologist

Background Info:

CPA (2008) & APA (2006) affirm doc as min ed requirement for practice as a professional psychologist:

- Involves "sequential, organized, supervised pro'f experience" i.e., is standardized & accredited as such

Most Doc Clinical programs are accredited (in Ca n=26)

No Masters programs are accredited nor standardized

Supervision in D prog:
Ca: 1 yr predoc internship & postdoc supervision that varies 1-2 yrs:
Total combined supervised work experience = ~2624 Total hr (including 1 yr FTE internship)

Ave 700 hr pr + ~1900 hr FTE Int (incl 220 hr dir sup) + 24 hr Bd sup

(In US: 2 yr FTE, 1 is predoc internship & 1 postdoc work exper.)

Supervision in M prog:
Total combined supervised work experience = ~600-700 Total hr.

500-600 hr pr + 96 hr Bd sup

Issue 1. Doc required by Majority of Jurisdictions in NA for title of Psychologist

Doc programs aim to produce psych'ts whose knowledge base, clinical skill & scientific-mindedness are consistent, predictable & readily interchangeable:

- EPPP is a standardized test of foundational knowledge "that should be acquired by any candidate"

NSBEP DATA: 07/05 to 03/10

8 Ms, 0 Ds wrote twice

7 Ms, 0 Ds wrote 3-5 times.

		N	Ave	St Dev
All		120	570	
Taken once		92	627	
Taken 2+ times		13	543	
M Pass rate	76%	69	581	58
D Pass rate	100%	46	641	43

See Slide 9

Coursework?

From Issue 1. Slide 8

Perhaps NSBEP needs to limit # times EPPP can be taken, to increase likelihood less well prepared candidates will not eventually pass.

?

In practice

Remains that Ms prepared more likely in this group

?

ISSUE 2. Agreement on Internal trade (AIT, Sept 2009) requires equivalent licensing on transfer placing public at risk because lowest standards of one need to be accepted by others

Ms in NS can register and transfer to another jurisdiction that would not otherwise register them as Psych (title)

Experience in NWT where 100's of psych's registered there but do not live or practice there (AB accepts them)

Ms registered outside but otherwise not meet our criteria can transfer in

Exemptions may be applied for by province on individual program basis (i.e., to not have to accept a transfer from a particular school)

From Issue 2. Slide 10

*Re **Supply & Demand**:*

- *Fewer D want to work in rural areas*
- *Employers want M because can pay less*
- *Pay scale does not compensate study costs*

In Practice

'09-11 CUPE Pay Scale (start & top)

M = 58,000 & 77,000

D = 65,000 & 92,000

Dif: 7,000 & 15,000

About 50% outside of HRM are D

HRM & Valley hosp require D for Internship Training Programs & for Tertiary level Specialties not found in rest of NS.

Of 11 Current Vacancies:

	%D	Time*D	Time*D/M	%CT**
5 Rural:	33	.5-2yr	.1-var	37.5
6 City:	80	.1-2y	var	0

*Est Time to fill **Clinical Therapist

ISSUE 3. Complaints to the NSBEP about M's are more serious & more costly

NSBEP

REGISTRANTS	Total #	%
DOCTORAL	234	47
MASTERS	267	53

Valid complaints* 07/04 - 10/09

against	n**	%∑ C	%'valid'	Costs
M	12	11 (of 29)	41	$67,000
D	6	9 (of 20)	30	$12,000

See Slides 14,15

Area

	ParCap	Cus&Acc
M	2/12	2/12
D	0/6	0/6

•Any complaint not dismissed and resulted in any of the following dispositions: Counsel; Caution; Reprimand; Undertaking; Hearing.
Where appropriate, NSBEP may Attempt to resolve the matter informally, if the complainant agreeable to this option.
** n= total complaints. 11 different M & 6 different D

Master's Level		**Doctoral Level**	
Service/Disposition(s)	*Cost*	*Service/Disposition(s)*	*Cost*
Treatment / Sent to suspension hearing; result – undertaking.	$2213	*Treatment /* Caution with Undertaking: breach of confidentiality	$1556
Treatment / Hearing: guilty of professional misconduct (sexual misconduct) – removed from Register.	$9239	*Treatment /* Counsel & Caution: failure to obtain informed consent, maintain appropriate boundaries & provide continuity of care	$3694
Service: Psychoeducational Assessment Undertaking: issues relating to professional competence, fitness to practice, and interpersonal relationships	$10,100	*Treatment & Cus & Accesss Assessment /* Caution: failure to obtain parental consent & to use adequate asset methods to reach conclusions and make recs re paternal access.	$3615
Service: Parental Capacity Assessment Hearing:guilty of professional misconduct on a number of charges (e.g., conclusion without stating any evidence to support it; lack of informed consent, failure to use currently accepted clinical and scientific guidelines in selection of data collection methods). Psychologist chose to resign.	Cost Investigation $16, 081 Cost Hearing $34, 497	*Service: Treatment* Caution: breach of confidentiality	$900
Service: Cus & Acc: Hearing found psych't guilty of prof'l misconduct: wrote a recommendation to the Court without seeing any individuals & not collecting adequate data to arrive at opinion; conclusion not supported by current professional and scientific evidence; failed to acknowledge limitations of assessment methods, data or conclusions. Psychologist chose to resign.	Cost Investigation $16, 081 Cost Hearing $34, 497	*Service: Treatment* Caution: Failure to maintain adequate record keeping	$900
Service: Treatment Counsel: boundary crossings	$1310	*Service: Treatment* Counsel: boundary crossings	$1310
Service: Treatment Caution & Undertaking: violation of Section 22 (1) of Psychologists Act, of Code of Ethics re integrity in relationships, respect for the dignity of persons& of Standard of Professional Conduct re being [not] responsive to the regulation and discipline of governing bodies.	$1269		
Service: Treatment Hearing found psych't guilty of professional misconduct # of charges: did not use adequate assessment methods in diagnosing & not acknowledge limitations of assessment methods & data used to reach the opinions; provided a diag without informing client of the diag thus failed to obtain informed consent; failed to ensure the client was referred for treatment and/or made aware of the need for treatment; misled the public by presenting certifications and membership in associations as evidence of qualifications.	Cost Investigation $4201 Cost Hearing $51, 000		

Service: Psychoeducational Assessment Caution & Counsel with Undertaking: Inappropriate intervention and failure to follow-up, to maintain appropriate boundaries; to use appropriate procedures	$1423		
Service: Custody & Access Assessment Counsel: Failure to maintain relevant and up to date techniques in conducting psychological practice.	$2700		
Service: Treatment Caution and Counsel: failure to obtain parental consent; dual relationship, failure to use adequate assessment; to remain objective and unbiased: info obtained from only one parent Psychologist sanctioned.	$900		
Service: Parental Capacity Assessment Counsel: # of minor factual & proofreading errors in report; incorrect procedural errors in documentation	$900		
	$161,395		$11, 975

Table 1. Breakdown of complaints against M and D Individuals (n= 11 & 6, respectively) by Service, Issue(s) & Cost

From Issue 3 Slide 6

M work in High Risk Areas more than do D.

D in Hosp have other ways problems are handled.

In Practice

Ps working in 'high risk' area:
(from APNS PP directory):

			∑
Parental Capacity	M: 7	D: 2	9
Custody & Access	M:	D:	
Legal/Court:	M: 4	D: 10	14

working in 'low risk' setting?

				∑
Hosp	M	D	~90%?	151
School	M 97%	D		67

?higher risk in speciality areas given higher outputs (# reports/yr)

'risk' defined by # complaints filed from area

Group Discussion: Questions for Feedback, Input

Considering licensing options:
How will our profession and the people we serve presently and 10 years from now be affected:

- Assuming that all new registrants will require a doctoral degree?
- Assuming a 2-tier system with psychologist/psychological associate designations?
- What about school psychologists (designations, exemptions, etc.)? [included here as needing discussion but is not the focus

Questions, Cont'd

i.e., the foregoing questions are looking to help determine

How the profession of psychology can best

- Ensure an adequate and comparable level of competence among practitioners?
- advance the welfare of the profession and the people we serve, in matters of scientific and clinical scope and expertise, as well as law and public policy?
- promote the ability of the public to make informed decisions about the qualifications of practitioners?
- promote unity among psychologists?

Questions, cont'd

[The following is included for completeness of issues in need of discussion. However, these questions are not the focus of discussion at this point, because of time constraints]

Given that the Canadian Department of Industry's Agreement on Internal Trade (AIT)) exists:

- How do we best deal with demands placed upon us from issues related to the mobility of psychologists' licensure between Provinces?
- and between Provinces and States (e.g., Association of State and Provincial Psychology Boards' (ASPPB) Agreement on Reciprocity)?

What is your vision for the practice of Psychology?

“Next Steps"

(1) Focussed consultation groups (psychologists)

(2) (perhaps) Developing (from feedback & input) a survey to go to all registrants

(3) Determining what other stakeholder groups are involved (not necessarily but possibly employers, gov't depts, other service provider groups, consumer groups?, university program folks)

(4) Stakeholder consultation

(5) Collating feedback from all sources

(6) Any other steps?

(7) Reporting to NSBEP & to the registrants (released after the Bd has considered the recs)

(8)The ELC dissolves as is.

(9) A new committee established to carry out the bd's wishes

A vision statement for Psychology in Nova Scotia

Psychology in Nova Scotia is envisioned as follows, guided by its commitment to the principles of competence, accessibility, uniqueness (distinctiveness), and equity with medical practice. Specifically,

• every registered psychologist is adequately trained and educated for independent practice upon certification;

• members of the general public, in choosing a psychologist, can assume comparable levels of training and education among them;

• psychologists speak with a unified voice to advance the welfare of the profession and the people we serve, in matters of scientific and clinical expertise, law and public policy;

• psychological practice provided by registered psychologists (within psychology's scope of science and technology), holds equal value to the practice of medicine, and similar status in the field of health care as physicians, dentists and chiropractors.

A vision statement for Psychology in Nova Scotia

The future of Psychology in Nova Scotia is envisioned by its commitment to the following goals and principles:

•That every registered psychologist shall be adequately trained and educated for independent practice upon certification;

•That members of the general public, in choosing a psychologist, can assume comparable levels of training and education among any practitioners bearing the title of psychologist;

•That psychologists will speak with a unified voice to advance the welfare of the profession and the people we serve, in matters of scientific and clinical expertise, law and public policy;

•That psychologists will advocate that within its scope of science and technology, psychological practice holds equal value to the practice of medicine, and will pursue the same status in the field of health care as physicians, dentists and chiropractors.

APPENDIX C

Discussion of Non-Empirical Literature Pertaining to

Registration Issues of the Entry Level Standard

This review contains supplementary literature that is descriptive and/or subjective in nature. It is included in this report because it is considered important to provide the historical context and some background to the issues raised in the report. It also speaks to the apparent intensity of the emotional response the ELC witnessed with respect to the Board's proposed change in entry level, to doctorate-only. No attempt has been made to critically review this literature.

Supply issues relate to the general concern that a doctoral-only standard would lead to reduced numbers of psychologists in practice in Nova Scotia (NS), thus reducing access to psychological service, especially in rural areas. This is not a new concern, and it has been asserted that all psychologists avoid rural areas, not just doctoral trained psychologists. Jameson and Blank (2007) argued that the "cultural richness of graduate training" cannot be replicated in rural settings thus leading to lower job satisfaction for those who practice there. They believed that rural psychologists face cultural barriers and a lack of respect for the professional judgment of clinicians (where rural folks rely more on informal resources such as self-help and/or religious organizations), which may contribute to this lower degree of satisfaction. They quoted a 2002 study that found 65 percent of 192 full time master's psychologists in a non-metro area suffered from at least a moderate level of burnout (using Maslach's burnout scale, 69% experienced the most frequent symptom, Emotional Exhaustion). [Jameson and Blank identified the need for and strongly advocated for peer and social support systems for rural psychologists.]

Jameson and Blank (2007) cite Hargrove (1991) who contended that clinical psychologists are drawn to urban centres because there is a (presumed) better match for their increased specialization through doctoral training programs, and which do not train them for the breadth of problems one sees in the more rural areas (see Table 1, O1b). However, one NS doctoral psychologist, in a letter to the ELC after attending an ELC presentation, suggested that the opposite may be true, at least as far as doctoral training goes, as follows:

> In rural outpatient mental health, I had to be able to serve arsonists and autistic persons, anxiety disorders and accident victims - and that is just the letter "A"! Any condition, any letter of the alphabet, could walk in the door, and I had to be ready. In contrast, in my urban hospital work, I had many specialists to call upon. A two-year program cannot possibly prepare a person for the real demands of a rural practice. …I had undergone 8 separate 600-hour practica, and in addition had a full year of predoctoral internship - this represents over 10 times the training of a master's degree. In my opinion, competent rural practice demands more training, not less." *(ELC note, 4800 total practica hours likely includes master's level practica.)*

The following literature suggests what else the NSBEP may look at regarding future planning for the profession, particularly with regard to ensuring the supply of "rural" psychologists. Jameson and Blank (2007) advocated for a "generalist" training model that includes "skills for rural" practice. In NS there are several internship programs that serve as rural training sites (i.e., the

Valley Regional Hospital, some IWK and Capital Health Mental Health Clinics). The Clinical Master's program at Acadia University also includes rural setting practica. Future planning could involve the establishment of consortia internship programs that include several hospitals in designated parts of the province. Also, liaison opportunities with the University de Moncton (U de M) which has established a doctoral program recently and is looking to establish practica and internship sites for its students could be pursued as well. (On verbal communication from its placement program director, U de M students are typically fully bilingual and would be desirable student and eventually staff members at any NS facility.) Newfoundland's Memorial University recently started a PsyD program and is another site that trains doctoral candidates that could help increase the supply of doctoral psychologists in NS (see Table 1 O1f).

The potential disparity in earnings for rural versus urban practitioners has been cited as a deterrent for doctorates to move to (and work in) rural areas (Jameson & Blank, 2007). In NS, (as noted within the Report) this argument is not valid; about as many doctorates as master's psychologists work in the District Health Authority (DHA) facilities in both rural and city areas; and as such are paid on a fairly equal basis, albeit stratified by degree and experience (i.e., doctorates are paid more than master's). The Military, Addictions, Correctional Services and School Boards are located in both rural and city areas and are also governed under their same respective legislation (federal or provincial); thus, for example, a school psychologist in Glace Bay would receive the same salary as one in Liverpool, or in Halifax. Whereas master's trained psychologists are paid less than doctorates in these facilities, commensurate with education, they can (and do) charge the same rates as doctorates in private practice; with some adjustment across the province, whether doctoral or master's trained, according to "the going market rate" (e.g., apparently lower in rural regions). Insurance company differentials, in the US at least, favour doctoral psychologists (according to Jameson & Blank) but this does not apply in NS. Although some insurance policies place a cap on fees allowed, or they may not allow payment to candidate registered psychologists, these limitations apply to both doctoral and master's degree psychologists.

It appears in NS at least, that under-representation of doctorates in the schools, prisons, addictions, military (less so in this category), and in community mental health programs may have explanations other than money or perceived prestige (and see page 4, end of second paragraph and start of last paragraph). Doctoral under-representation may be more a function of the employers' hiring practices (e.g., the increasing tendency in mental health centres and addictions to advertise for "clinical therapists") and to the paucity of available degree program choices (i.e., no doctoral program in eastern Canada for school psychology). Self-selection also is a factor regarding where a doctoral or master's trained psychologist would choose to work. Not only do DHA facilities (major hospitals) advertise for doctorates as a matter of policy, the expectations are that they supervise practica students and interns (often from 2 to 4 direct hours a week per student/intern) and that they conduct research (and are given 20% relief time to do so). It can be speculated that those who prefer to work in direct client care all or nearly all of the time, would more likely apply to advertised generic clinical therapist positions, where, by definition, they are placed on a somewhat equal footing as social workers, nurses, and others in terms of what, and how they perform their every day functions. Likewise, those who intend to launch a funded research program and participate in accredited clinical training programs would not apply for generic positions. Within the mental health system, Jameson and Blank (2007) note that psychologists (doctoral or master's) "move quickly" to supervisory or administrative positions,

which also may not be attractive to clinicians wanting to do direct clinical care. No data have been gathered by the ELC; anecdotally, in NS at least, both psychologists and other professionals have taken management positions and both master's and doctoral psychologists appear to do so.

There are several other changes occurring at the systems level that some purport adversely affects access to psychological services, and the belief is that doctoral-only standard will exacerbate this situation. One such change relates to the generic therapist position and the apparent increase in advertised clinical therapist positions in the mental health system in NS, as opposed to specific disciplines. Some professionals believe that the term "clinical therapist" is simply a convenient title used to facilitate hiring one or another of the disciplines, with the intention of using that successful applicant in the role of the discipline one is trained in. For the reasons discussed already, some NS psychologists believe generic positions would not appeal to doctoral psychologists and thus there would be a decreased number of psychologists in therapist positions in the future. However, there is one known case, of a doctoral psychologist (in NS), who recently displaced a long un-filled social worker position by virtue of the position being advertised as clinical therapist. The suggestion has also been made that the shift in the system means that all disciplines must assume the same roles (effectively do the same job). Jameson and Blank (2007) described the change slightly differently, saying they noticed an (apparent) increasing tendency to see social workers and/or clinical therapists do the work that clinical psychologists train so well for (see Table 1 O1a,g). This relatively new model of care, a generic service provider model, appears to be independent of or is outside the influence of a change in the entry-level standard. Jameson and Blank (2007) noted another systems change, involving a shift to an "integrated care" model (and which they note is lacking in US rural health service delivery). Of relevance to this review, is the finding that increasingly, physicians are doing more mental health (MH) treatment regardless of how many MH specialists are available. Not surprisingly, Jameson and Blank (2007) advocated for better training for psychologists in the "integrated" care model.

Hays-Thomas (2002) recognized that most master's degrees are granted to those who enter doctoral programs (i.e., those who complete the doctorate as well as those who receive a consolation type master's degree), rather than in "terminal" master's programs. Hays-Thomas advocated for an integrated but distinct 2-tier system, referring to "behavioural health care providers" as an example of a master's level title. In their 2005 article, Duer and Hays-Thomas identified (seemed to lament) the transfer of psychology training at the terminal master's level to the counseling realm: because it is now "curricular for Ms licensures related to counseling not psychology, because Organized Psychology declined to formulate the scope of practice and specify licensing standards". With respect to the argument of training equivalence between master's and doctorate programs, the change Duer and Hays-Thomas described seems to highlight the difference between counseling and clinical master's programs (see Table 1 O1o) in that the counseling education programs do not provide the same scientific basis and foundation that the clinical psychology programs do, thus they see it as "a loss to the discipline as a whole if Ms psychologists and their training were to be stripped of their psychological roots and be forced into the field of counseling by default" (p. 127).

Levant, Moldawsky, & Stigall (2000) supported the doctoral entry level in their response to the Hays-Thomas' article (2000); they used the US Veterans' Affairs Department's establishment of

the doctoral degree in 1996 as a requirement for employment[1] as recognition of the value of this standard. They cite a 1974 report that exemplified the essence of the difference between doctoral and master's training involving the first graduating class of Rutgers' University Professional Psychology Doctoral program. Informal interviews of graduates after the program's first two years (i.e., "most" of the 20 master's clinical and 16 school psychologists) described themselves as

> "being awed by what they learned. They did not know what they did not know, and 2 years in a doctoral program brought up their perception of the vastness of information they needed to acquire and the sense that now, as doctors, they did not know very much. In other words, they acquired some humility about the complex nature of our field and how much they had grown in the space of 2 years" (p. 346).

Levant et al. (2000) stated that "It is very hard to tell folks that they are not very well prepared with just a master's degree". APA President Cantor seems not to share this belief, as she declared in her 1999 address that the master's "is a liability to the future of professional psychology and a threat to the public's safety." Cantor further relegated master's trained psychologists to the level of "trained technicians" (see Table 1 O2f). In 2000, APA President Strickland may have attempted to redress this message by stating that if master's trained psychologists are not allowed to practice as psychologists, the (American) "system loses a cadre of educated well-trained clinicians, practitioners". She stated there were three times more masters than doctorates in the US and that there were other organizations representing scientific research (i.e., the American Psychological Society) and applied psychology (the American Institute of Applied and Preventive Psychology). Perhaps not surprisingly, Cantor's message was not well received, as demonstrated in Yeatts' several unpublished articles about master's psychologists being as competent as doctoral psychologists (2004, 2006). Yeatts proposed that "abolishing" the registration of master's prepared psychologists is unethical in "not protecting trainees or trying to resolve the conflict". He sees "the future for Ms threatened as barriers to the marketplace are created by psychologists who claim psychology is a doctoral profession". His belief was that the master's entry level would be abolished so that doctoral psychologists could maintain a certain desired status and he used the inability for some master's to be reimbursed by third party payers to show how this had been achieved. Levant et al. (2000) also found that some master's psychologists have the perception that the only motivation to get master's psychologists "out of the competition" was for the "economic gain of the doctors."

Yeatts (2006) cited literature from the 1980's to demonstrate the equitable competence of, employer demand for, and satisfaction with master's psychologists, compared with doctoral psychologists (particularly in North Carolina and Tennessee) as well as Employee Assistance Program (EAP) agencies that hire more masters than doctorates in two of three types of EAPs surveyed. A study by NIMH in 1987 showed that 89 percent of their agencies hired masters' level staff, although psychologists, counselors, and social workers were not differentiated. Hays-Thomas (2000, published 2002) labeled the doctoral psychologists "elitist" because the momentum comes from researchers and those who want parity with psychiatry (similar to Yeatts' contention, see Table 1 O3c). She stated that the PsyD is a non-research degree so the distinction between it and a master's degree is diminished accordingly. Furthermore, in Texas, the EPPP cutoff is lower for masters than for doctorates; Hays-Thomas questioned why a master's trained psychologist reaching the cutoff level for doctorates would not be granted that higher license.

[1] The US VA also requires employees and interns to be US citizens and staff to have doctorates and internships from APA accredited institutions.

She does not, however, explain why Texas uses a lower cutoff for the master's trained psychologists. In his 2006 article, Yeatts reiterated his position that doctoral psychologists have formed a "guild" against the evidence which he purports shows there is "no measurable difference" in psychotherapy outcomes as a function of education. For example, "well documented studies" have found that competency in conducting Cognitive Behaviour Therapy is related to the expertise of the therapist, not to his or her education degree (Barber et al., 2007). Yeatts believes there is "more applied" training at the master's level than doctoral which is scientist-practitioner based. Apparently in support of his position, Yeatts stated that although Wilhelm Wundt supported the doctoral standard at the turn of the 20th Century, it was not an applied profession at the time.

Recently the ASPPB reported (October, 2010) on the practice areas that psychologists are increasingly getting into and for which the authors believe they are not necessarily trained in as a specialty. This issue speaks to the need for more (and/or different?) coursework and training. Levant et al. (2000) anticipated this need and advocated the expansion of

> "the scope of psychological practice into such diverse areas as health psychology (and its related aspects such as psychology in primary care, psychoneuroimmunology, and applied psychophysiology), neuropsychology, rehabilitation psychology, forensic psychology, feminist psychology, child and family psychology, multicultural psychology, geropsychology, business and industry consultation, and psychopharmacology. In addition, public sector care is recently being seen anew, as an area rife with possibilities for an expanded scope of practice, such as in the correctional systems, and in the federal (VA), state, and community mental health centers, which serve those diagnosed with long-term mental illness (Levant et al.,1999)" (p. 347).

Levant et al. (2000) believed that because the need for "education and training to provide such comprehensive services requires a very substantial commitment on the part of both the educational institution and the psychologist in training, the doctoral degree will continue to be recognized as the appropriate educational credential for independent practice" (p. 348) (see Table 1 O3e). They reiterated Stozall's 1994 statement that a double standard means that a lower standard replaces a higher one, leading to diminished regard for the discipline and declining resources for doctoral education and training. According to Levant et al. (2000), "In the final analysis, acceptance of a double standard is a retreat from insistence on the highest quality of education and training for professional practice and substitution of less well-prepared psychologists to serve the public" (p. 348). While not endorsing the generalizability of the statement to currently practicing master's trained psychologists in NS (see Table 1 O1c), the Canadian government's imposition of the AIT does reflect this reality in terms of the NSBEP's very limited power to prevent "less well-prepared psychologists" who have been granted registration elsewhere from providing service to the NS public (see Table 1 O3a). Levant et al. (2000) advocated that the NA Association of Master's in Psychology would provide master's psychologists a route to independent practice, with licensing as master's counselors and marriage and family therapists, a move encouraged by the APA practice directorate in 1998 (see Table 1 O1h). Alternatively, APA President DeLeon in 2000 also suggested that master's psychologists could form their own professional organization outside Psychology which he believed "would serve the unique needs of both groups", as similarly suggested by Cohen and Caputo (2006), and Levant et al. (2000). Levant et al. suggested that advanced specialization could occur at the post-doctoral level.

Appendix C

Dr. D. Cotton (2010), President of the College of Psychologists of Ontario (CPO), addressed the implications of the AIT with her membership, identifying the differences in titles and standards across Canadian provinces and territories as a major issue of lack of consistency and clarity in facilitating ease of mobility (see Table 1 O3l). For example, a master's psychologist registered in NS can go to Ont. and be registered as a Psychologist, whereas a master's psychologist registered in Ont. would be called a Psychological Associate there and would need to be registered anew in NS. The CPO, however, has been able to maintain the right to refuse registration to transferring psychologists who do not "demonstrate knowledge of matters applicable to the practice of psychology in Ontario". Dr. Cotton stated the CPO's task force on "the future of psychology registration" is considering changing the Psychologist Act of 1991 back to doctoral only registration and is clear it is only one option among others but which were not described (see Table 1 O2a). The reasons for such consideration include the fact there are "few master's educational programs" (as in NS and across Canada, see Table 1 O1l), few psychology departments in hospital settings (not the same case in NS where psychologists continue to be hired in the major hospitals), with more psychologists going into private practice, and the impending establishment of the Registry of Psychotherapists and Mental Health Therapists (see O1h). NS regulatory legislation is pending for the Certified Counsellors who tend to be from Master's in Counselling or Education programs , suggesting that the master's trained psychologists who choose to opt out of NSBEP (or CPO) can maintain status (or obtain status) as a regulated health professional (see Table 1 O1h).

Bieschke, Fouad, Collins and Halonen (2004) promoted the scientist aspect of psychology as the value-added component that psychologists offer in the delivery of health services, regardless of setting. This article is summarized to suggest a way to compare and contrast the training of the master's and doctoral psychologists and secondarily to suggest a framework for research competency. Their task force examined the "scientist's" core competency needs, upon reaching "agreement that a scientific approach to psychological practice (wherever it is practiced) is a critical core competency for all psychologists and serves to distinguish psychologists from other health-care providers" (p. 716). The group identified the proficiencies required for a scientifically-minded psychologist while recognizing that not all psychologists will conduct original research. Being informed consumers of scientific knowledge is considered the minimum expectation of practitioners but insufficient to claim competency as a "Scientifically-Minded Psychologist". Five proposed subcomponents of the core competency of scientifically-minded practice include "the ability to 1) access and apply appropriately and habitually current scientific knowledge; 2) contribute to knowledge; 3) critically evaluate interventions and their outcomes; 4) practice vigilance about how sociocultural variables influence scientific practice; and 5) subject work routinely to the scrutiny of colleagues, stakeholders, and the public" (p. 716). Contributing scientifically may include publishing in peer-reviewed journals, giving presentations, informing researchers about one's practice (e.g., when interesting questions are communicated informally or formally), maintaining a shared practice database, peer supervision, and doing community and psychoeducational work. No distinction was made in the article between master's and doctoral trained psychologists in terms of what they do or not do. However, when it came to educational training opportunities the authors asserted that "training at the professional level of competence should occur in doctoral training programs, where students develop identities as scientifically minded psychologists" (p. 720) (see Table 1 O3d,e) and would most efficiently be "infused in existing content-based courses" (rather than separate courses).

Appendix C

The authors adopted the position that "learning is a lifelong process", so it would be the responsibility of the training programs to instil within their students "a commitment to continuous improvement".

Bieschke et al.'s (2004) task force also identified some possible training methods, including "role models, research teams, clinical supervision with a scientific focus, mentorship, teaching science as a creative enterprise, supervision in hypothesis testing and applying research knowledge, collegial consultation, and alternative models to just reading and taking a test (e.g., to actually applying scientific knowledge)" (p. 720). Preferred competency assessment techniques are considered "authentic" ones that "employ real-world tasks and ask trainees to engage in meaningful activities that are task relevant, as well as allow for evaluation of effective performance;" including "criterion-based measurement, case simulation, practice portfolio assessment, 360-degree evaluation, dissertation and research projects, American Board of Professional Psychology (ABPP)-like case presentations, evaluation of work samples, examinations, self-assessment strategies, and peer evaluations" (p.720).

At least on two occasions, NS psychologists recommended to the ELC that the NSBEP consider expanding its review outside of North America (NA). The British system of registration and professional practice was suggested as one to explore. A visit to the British Psychological Society (BPS) website and to a (Welsh) University website yielded the following information and represents the understanding taken from those sites. The information, however, is not accompanied by any concrete sense of time lines beyond the three year undergraduate degree required for anyone who wishes to go on to practice as a psychologist. There appears to be a number of routes to becoming a practitioner, based on an intensive undergraduate degree which is exclusively related to psychology (reference to an honours degree is made but it is not clear if this is an additional undergrad year as it is in NA). The website information states that about one-fourth of psychology undergraduates continue their studies but do not say how many go into professional practice fields. The practice regulator in Britain is the Health Professionals Council (HPC), and is required: "In order to offer services to the public as a psychologist in one of the seven applied areas regulated by the HPC, you need to complete an HPC approved programme of training. The areas of psychology regulated by the HPC are Clinical, Counselling, Educational, Forensic, Health, Occupational and Sport and Exercise Psychology." Postgraduate training is required for registration with the HPC but what it specifically requires is not clear in these websites and may reflect the individualized content of the seven areas mentioned above. The UK also has the designation of Chartered Psychologist, which is a voluntary registration conferred by the BPS. As well, the BPS grants membership to any psychology graduate but only those with chartered status can use the title of Chartered Psychologist. The Chartered Psychologist must "achieve the Graduate Basis for Chartered Membership (GBC) and then undertake further Society-accredited training before being eligible for entry onto the List of Chartered Psychologists". While not legally required, the BPS recommends it as a way to "guarantee [the public] that the person is properly trained and qualified, and is answerable to an independent professional body". The BPS accredits honours degrees and suggests it is the "easiest way to achieve the GBC"; or when a degree is not a psychology one or is not accredited, the GBC can still be obtained by taking "conversion courses". Again, the time frame is not well delineated in the website information. The website states that

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> CPsychol is awarded to all academic and practitioner psychologists who have met the Society's high standards for education and training. It is the gold standard that shows a commitment to the continued development and promotion of the discipline. In addition to the approved undergrad degree and post graduate training, a chartered psychologist must also agree "to follow the Society's Member Conduct Rules and be guided by the Society's Code of Ethics and Conduct.

It appears that the chartered status is part marketing tool and part peer quality assurance, as evidenced by the following testimonials(?) of those who have lent their experience to the website "brochure":

> I achieved chartered status with the Society as soon as it became available, and since then I have never doubted that it has been important to my career progression. Chartered status is a way that many professions define their highest standard of professional achievement, and employers, clients and the wider public alike similarly recognizes and respects Chartered Psychologists. CPsychol is also the hallmark of peer recognition for professional practice amongst psychologists, and it demonstrates personal and professional commitment to maintaining high standards, and to your continuing professional development.

> As an independent Occupational Psychology consultancy, we have to work hard to Attract and secure clients. I sought Chartered Psychologist status when I joined the centre, as it's really important to demonstrate to clients that your professional body has evaluated what you do and decided that you are competent to practice independently. Potential clients look to the Society as it is the trusted body of psychology in the UK, so having Chartered Psychologist status and links to the Society is vital for us as a professional organization.

The culture of a university system based on intensive (and much more independent) undergrad training and education that is the foundation (preparation) for continuing education of all kinds forms the basis of the developing British system of regulating its practitioners. The Chartered status appears to be a combination of what already exists in NA with credentialing and registrations as health service providers in Canada[2] and the US, and the more collegial benefits of state and provincial associations. In the absence of a pre-existing strong independent regulatory body for psychology, the HBC fulfills a rudimentary regulatory function that serves to protect the public (as does the NSBEP). The mixture of functions and goals of the British system as well as the education systems would not appear to map well on to the NA education system or to how our regulatory/affiliative associations are organized. However, exploring the nature by which the BPS tracks and/or evaluates the Chartered Psychologist on an ongoing basis and/or initially approves him/her, could be helpful in the development of continuing competency measures in NS.

[2] The CRHSPP organization has recently moved to a doctoral only requirement for membership (in 2009), thus removing an opportunity for Masters trained psychologists (those not grand-parented in) to proclaim practice competence and/or experience, which removes it from playing a role for Masters' psychologists if some form of the British system were to be adopted.