Proceedings of the Summit on Master’s Training in Psychological Practice

December 2-4, 2016

American Psychological Association
750 First Street, NE
Washington, DC 20002
Acknowledgements

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*** The conclusions outlined in this report have not been approved by the APA Council of Representatives and do not constitute APA policy. ***
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Executive Summary

The American Psychological Association (APA) held a Summit on Master’s Training in Psychological Practice on December 2-4, 2016, at the APA Headquarters located at 750 First Street, NE in Washington, DC. The purpose was to explore whether the APA should embrace the training of psychological practitioners at the master’s level. Discussions primarily centered on identifying key considerations of this issue, potential solutions and their impacts, areas of consensus, and concerns. Sponsored by the APA Minority Fellowship Program (MFP) and developed in conjunction with the APA Board of Director’s subgroup on master’s training and APA executive staff (i.e., the Master’s Summit Planning Group), funding was also made possible (in part) by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Attendees included key stakeholders and leaders with relevant experience in training and certification representing universities, independent/private practice, state associations, non-profit organizations, hospitals, and medical centers and a broad group of stakeholders across APA. Andrew Dailey, MDiv, MS, Director of the APA Minority Fellowship Program, and Frank Worrell, PhD, Professor and Director, School of Psychology at the University of California Berkeley, served as moderators for the Summit. It included keynote presentations, plenary discussions, and four concurrent breakout groups that convened on the last two days. An agenda and an attendee listing can be found in the Appendix of this report.

Organization of the Summit

The Summit was organized around four distinct workgroups: Marketplace and Workforce, Regulatory and Licensure, Quality Assurance and Accreditation, and Scope of Practice. Providing a foundation and framework for each of the aforementioned workgroups, four plenary session presenters focused on key topics which were addressed throughout the final two days of the Summit. The topics and presenters included:

- “Overview and History and Current State of Master’s Level Practice in Psychology”–Linda Campbell, PhD, Professor, Department of Counseling and Human Development, University of Georgia;
- “Marketplace and Workforce Issues”–Ramani Durvasula, PhD, Professor of Psychology, California State University of Los Angeles;
- “Quality Assurance and Accreditation Issues”–Jacqueline Wall, PhD, Director, Office of Program Consultation and Accreditation, Education Directorate, APA;
- “Regulatory and Licensure/Scope of Practice Issues”–Stephen DeMers, PhD, Chief Executive Officer, Association of State and Provincial Psychology Boards (ASPPB).
For the final two days of the Summit, the four distinctly assigned workgroups met concurrently. Each group was to focus on six key areas which included:

1. Considerations
2. Potential Solutions and Actions
3. Impact and Consequences of Actions
4. Broad Areas of Consensus
5. Areas of Concern
6. Questions/Items for Future Consideration

On days two and three, after the workgroups met, the full group reconvened for the workgroup reports followed by discussion. A summary in chart form of the individual workgroup discussions for both days can be found in Appendix E.

Conclusions
A key outcome was the development of a consensus statement presented on the next page.
**Consensus Statement**

We recognize the expertise in science, clinical practice and leadership offered by psychologists. Our responsibility is to address the shifting demographics and behavioral health needs of the U.S. population. We need to bring additional scientifically informed and culturally and linguistically responsible practitioners to all populations, including underserved populations, using approaches distinct from those offered by other behavioral health practitioners.

We believe this can be accomplished by the development of a complementary model of training and credentialing for master’s level practitioners in psychology. This alliance and integration in the field of psychology that includes both doctoral and master’s level practitioners who are committed to the scientifically driven practice of psychology will greatly expand the reach of our field in the coordinated delivery of behavioral health services.

The behavioral health workforce would benefit from the inclusion of master’s level psychology practitioners in the following ways:

- The standard of training should include clinical and cultural proficiency and should be grounded in the science of psychology as a recognized and regulated part of our profession.
- This master’s level of training should include access to a level of regulation/licensure that permits them to be competitive with other master’s level providers of behavioral health services.
- The master’s practitioner in psychology should be integrated within the field of psychology.
- Having training embedded in psychological science and evidence based models of behavioral health treatment, practitioners with a master’s in psychology should be distinguished from other master’s level providers of behavioral health services.
Overall Areas of Consensus

- APA should embrace both the training of psychological practitioners at the master’s level and accreditation for master’s degree training programs. APA should also advocate for licensing and consistent titling of master’s trained individuals with the understanding that there are both benefits and challenges.
- It is important to affirm and maintain the doctoral degree as the entry level for psychologists and to enhance the “value added” of psychologists.
- Clearly distinguishing the master’s level psychological practitioner from the psychologist is critical in order to define the unique identity of the master’s level psychology practitioner as compared with other master’s level providers. This definition should also include a broader focus to reflect psychology as a health profession and be operationalized.
- Embracing master’s level trained practitioners provides an opportunity to meet the increasing needs of underserved and marginalized populations which will ultimately serve the public interest. Currently, there are not enough psychologists from diverse backgrounds in the field or in the pipeline.
- Determining a proper title for the master’s level practitioner is important and needs further consideration. It should not be demeaning or divisive. The words “licensed” and “psychology/psychological” should be included in the title.
- Emphasis should be placed on the training and cultivation of scientifically informed and culturally and linguistically responsible practitioners.
- APA should develop a model act for master’s level practice/licensure.
- There is a need to examine existing data and collect additional data to address questions about delineating scope of practice, licensure, credentialing, etc. In particular, we can address questions such as: What is the current scope of practice for doctoral and master’s level practitioners in different states? In what settings are professionals practicing? What kinds of services are they offering, and to what clientele? Which clinical services do we claim as psychology?
- It is expected that some psychologists may be concerned about APA supporting master’s psychology practitioners. As such, APA should utilize change management strategies to understand the perspectives of concerned psychologists and collaboratively work through potential barriers.
- It will be important to investigate the workforce impact of this initiative, including to what extent community access to psychological services is enhanced (especially for underserved), quality and safety are improved, and health disparities are reduced.
- The economic/financial impacts of this initiative should be further reviewed. Impact could be expected for the Association, for practitioners, for health care delivery systems, for state/federal behavioral health systems, and others.
At the conclusion of the Master’s Summit, Dr. Worrell thanked the participants for their diligent work on this issue and for developing a consensus statement that represents multiple constituencies and stakeholders in psychology and beyond. He also informed them that the report on the Summit will be shared with the APA Council of Representatives at their next meeting. Mr. Dailey also thanked the participants and encouraged them to move forward on this issue in the same spirit of collaboration that was evident during the Summit.
Introduction and Background

On December 2-4, 2016, the American Psychological Association (APA) held a Summit on Master’s Training in Psychological Practice, at the APA Headquarters located at 750 First Street, NE in Washington, DC. The summit was sponsored by the APA Minority Fellowship Program (MFP) and developed in conjunction with the APA Board of Director’s subgroup on master’s training and APA executive staff (i.e., the Master’s Summit Planning Group). Funding for this conference was made possible (in part) by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Attendees included 34 key stakeholders and leaders with relevant experience in training and certification representing universities, independent/private practice, state associations, non-profit organizations, hospitals, and medical centers. This group also constituted a broad group of stakeholders across APA. A total of 13 APA staff were in attendance representing APA’s Public Interest, Practice, and Education Directorates. Andrew Dailey, MDiv, MS, Director of the APA Minority Fellowship Program and Frank Worrell, PhD, Professor and Director, School of Psychology at the University of California Berkeley both served as moderators for the Summit. The individual areas of expertise and diverse perspectives were vital to a judicious examination of the benefits and challenges related to the training of master’s level psychological practitioners. Appendix A contains an attendee listing.

This Summit was convened to explore whether the APA should embrace the training of psychological practitioners at the master’s level. Discussions primarily centered on identifying key considerations of this issue, potential solutions and their impacts, areas of consensus, and concerns. The Master’s Summit included keynote presentations, four concurrent breakout groups that convened on the last two days, and plenary discussions. Leaders from the broad spectrum of psychological practice had the opportunity to work with others who have varying viewpoints on master’s training. Therefore, the Master’s Summit Planning Group sought participants who were deemed
as having open minds and who were willing to work with other stakeholders in the spirit of inclusion and collaboration. A full meeting agenda can be found in Appendix B.

Organization of this Report
To capture the critical points and summarize key findings, these proceedings have been organized by each day of the Summit reflecting the key agenda items and activities. These include (1) Introduction and Background: Organization of this report; (2) Summary of Day One: Welcome, Networking, Overview of the Summit, and Facilitators Meeting; (3) Summary of Day Two: Welcome and Importance of the Summit; Framing the Workgroup Discussions: Opening Plenary Session, and Convening of the Workgroups; (4) Summary of Day Three: Workgroup Discussions and Reports; and (5) Conclusions. Since this document references numerous acronyms, a listing with hyperlinks has been provided in Appendix C.

Day One: Friday, December 2, 2016
Welcome, Networking and Overview of the Summit
The Master’s Summit convened with a dinner for the attendees in the Spire Conference Center at the American Psychological Association. Following the dinner, Andrew Dailey, director of the Minority Fellowship Program, led a networking exercise designed to foster creative collaboration and decision-making among the participants while promoting a relaxing and enjoyable atmosphere. Each group of about four individuals was asked to develop a list of ten items or experiences they had in common. The groups engaged in lively conversations as they endeavored to learn more about each member. The members of each group then introduced themselves and reported their list to the other attendees. At the conclusion of the networking exercise, Mr. Dailey encouraged the participants to employ the same skills they used to collaborate on their lists when working together to address the topics during the remainder of the Summit.

Mr. Dailey provided an overview on the background of the Summit. He described the process of developing the idea for the Summit, securing permission from APA’s Executive Management Group, proposing the Summit to SAMHSA, and working with the planning group and the MFP Training Advisory Committee to develop the details of the meeting. He closed the evening by providing logistical details for the weekend and answering questions from the stakeholders.
Facilitators Meeting
Following the dinner, networking, and overview of the Summit, the facilitators met with the planning group to discuss their role and responsibilities. Dr. Linda Campbell provided the group with details regarding expected deliverables for days two and three as well as the overall flow for the workgroup sessions and opportunities to report to the larger group and receive feedback at the end of each day. She provided the facilitators with sample questions that could be used to encourage discussion; however, she emphasized that the questions were not required to be used and the facilitators were free to use their judgment when conducting their workgroup sessions. Questions from the facilitators were addressed, additional logistical details were discussed, and then Dr. Campbell adjourned the meeting.

Day Two: Saturday, December 3, 2016
Welcome and the Importance of the Summit
Cynthia Belar, PhD, APA Interim Chief Executive Officer (CEO) welcomed the group to the Summit as well as to the APA headquarters building. We know that master’s level education and training psychology is one the fastest growing sectors in all of higher education, according to Dr. Belar. She asserted that many people in master’s level psychology engage in psychological fields ranging from research, program administration, publishing, personnel services, and supervised practice. They work in many roles to serve societal needs; in fact, some of them work at APA. Dr. Belar then stated that APA as a whole has not focused on the master’s segment. She acknowledged concerns expressed by some individuals that the inclusion of master’s level practitioners might diminish APA’s focus on the doctoral degree as the primary entrance to practice as a psychologist. However, Dr. Belar believes that this is far from the truth and she commended the group for their undertaking here at the Summit.

Antonio Puente, PhD, 2017 APA President and an alumnus of the Minority Fellowship Program, also welcomed the group. He briefly shared information about APA’s financial and membership status, and he then asserted that the association is currently positioned to tackle important issues in unchartered waters. Dr. Puente related his experiences as a professor of psychology at the University of North Carolina at Wilmington to the work of the Summit. He described the department’s efforts to determine to relationship between their master’s and doctoral programs as well as the future expiration of North Carolina’s license for master’s level psychological associates.

Lastly, Dr. Puente shared that we need to satisfy this large gap that has been a part of our history which is, “Can we preserve the doctoral degree in psychology and find a place for master’s training that satisfies the need for behavioral health care and other forms of training?”
He challenged the group to move forward with an open mind and to work beyond the Summit as we approach APA’s 125th anniversary.

**Framing the Workgroup Discussions: Day Two Plenary Session**

In order to provide a foundation and framework for each of the four workgroups, four plenary session presenters focused on key topics that would be addressed throughout the final two days of the Summit. Below is brief overview of each plenary presentation:

“Overview and History and Current State of Master’s Level Practice in Psychology”

*Linda Campbell, PhD*

*Professor, Department of Counseling and Human Development*

*University of Georgia*

Dr. Campbell’s presentation focused on where we have been and where we are going with master’s level practice using what she termed as a “database” approach. As a foundation for her presentation, Dr. Campbell first referenced a document that she and her colleagues (Deborah Baker, JD and Stephen DeMers, PhD) prepared specifically for the Summit (Appendix D). In examining the history and current state of master’s level practice in psychology, she reinforced that the role of master’s training and practice has been the subject of numerous conferences and task forces beginning in 1952-1953, during which there were 10 conferences. In subsequent years, at least 30 additional study groups have considered the subject and raised important earlier questions, including:

- **Professional titles**: What should master’s graduates be called?
- **Training programs**: Should APA develop a model curriculum? What should it include?
- **Accreditation**: Should APA develop procedures to recognize master’s training programs with appropriate standards?
- **Certification**: Should APA credential or certify graduates of master’s training programs? How would that status function differently from accreditation?
- **Levels of supervision**: Should master’s graduates be supervised? Is so, by whom? What entity would determine the status of supervision? How long should the supervision be?

In 1999, 23 states offered limited licensure or registration for practitioners with a master’s degree, and in 2016, 15 states had this category. Dr. Campbell noted that since 1999, approximately 10 states have eliminated master’s level psychology licensure, whether
supervised or independent practice. She also noted that, in 1999, Vermont and West Virginia were the only independently licensed states for master’s practice. Both states allow for master’s level licensure in psychology with the same scope of practice as doctoral level.

Dr. Campbell presented information on various professions and their respective entry levels. Health professions are generally moving toward doctoral level entry, but for mental health professions, licensure is typically at the master’s level. All of the mental health professions typically require a doctorate to teach at the university level. A comprehensive summary chart entitled “The State of the States on Psychology Licensure” can be found on the last page of Appendix D. For the purposes of our discussion during the summit, Dr. Campbell clarified that this meeting is intended to focus on master’s level practice in psychology, not counseling.

“Marketplace and Workforce Issues”
Ramani Durvasula, PhD
Professor of Psychology
California State University, Los Angeles

In this presentation, Dr. Durvasula—with the input of her colleagues, Drs. Sally Robles, Kellye Hudson, Rachel Navarro, Carlen Henington and Torrey Wilson—provided a response to the report, National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013 – 2015 (U.S. Department of Health and Human Services, 2016). This report presents national projections of U.S. supply and demand for behavioral health practitioners in 2025, with 2013 data serving as a baseline.

Dr. Durvasula’s initial response was that the report presented multiple shortcomings and raised more questions than answers. She posited that the report appeared to have been based on a central assumption that everyone who has mental health issues also has access to mental health services. However, the demand will be greater than the supply. Below are key areas of concern and disagreement Dr. Durvasula raised in her presentation:

- **Use of workforce modeling:** The report is based upon two perspective scenarios using workforce modeling. First, the HRSA Workforce Simulation Model (HWSM) was used to address supply and demand for each behavioral health category referenced in the report. To calculate supply, workforce decisions for future behavioral health professionals are simulated based on provider characteristics (demographics), profession and specialty, and features of the local or national economy (wages, unemployment rate). Demand for services is based on individual characteristics of the U.S. population (demographics, socioeconomics, health behavior, and health status). The second model uses findings from the SAMHSA 2013 National Survey on Drug Use
and Health to estimate current workforce shortages and projected needs. Both models are based on the theory that twenty percent of persons with mental health and substance abuse conditions did not receive services in 2013. Dr. Durvasula believes this to be a significant limitation of the HRSA report. These numbers are derived from workforce modeling and thus may not adequately address nuanced needs within the population (e.g., geography, language, aging, etc.).

- **Behavioral health provider categories**: The report suggests that national demand for the nine categories of behavioral health providers listed below are projected to grow due to the aging and growth of the U.S. population. It is important to note that the groups highlighted in bold/asterisk* below on this list are heterogeneous in nature, have unique challenges when focusing on master’s level psychology, have different routes/mechanisms for training and are most relevant to the Summit discussion. These include:

  - Psychiatrists
  - Behavioral health nurse practitioners
  - Behavioral health physician assistants
  - **Clinical, counseling, and school psychologists (doctoral)***
  - Substance abuse and behavioral disorder counselors
  - Mental health and substance abuse social workers
  - **Mental health counselors***
  - School counselors*
  - **Marriage and family therapists***

- **Supply and demand**: A key conclusion in the report is that the national demand for services is much higher than the current supply of providers. One question that remains unanswered was, “Who do we need to fill these roles?”

- **Integrated behavioral health**: As more people enter into the mental health pipeline, particularly with an integrated care approach, mental health professionals will see more individuals with health conditions such as diabetes, heart disease, and HIV/AIDS. Dr. Durvasula asserted that it is critical to prepare a workforce for evolving settings such as integrated behavioral/primary care (e.g., health management, health “coaching,” school based services, campus based services, etc.). Often these are short term targeted models that address issues such as caregiving and adherence to psychotropic medications. She encouraged psychologists to examine business trends and stay ahead of the curve to address the known, probable, and unknown needs in integrated behavioral health.
• **Cultural and linguistic response:** According to Dr. Durvasula, the HRSA report did not give attention to the awareness and need to be culturally, linguistically and demographically responsive. She reminded the group to remain mindful of access to services and train a workforce that can fill the need for accessible, affordable, and culturally/linguistically/demographically responsive services. This includes an allowance of the vocabulary of emotion to be stated in a native tongue.

• **Training considerations:** Dr. Durvasula exhorted psychologists to move away from silo-based training. There is often an assumption that master's level clinicians need to be trained with other master’s level clinicians and doctoral level clinicians need to be trained with other doctoral level clinicians. Instead, she encouraged overlaps in psychology workforce training.

According to Dr. Durvasula, a more expansive workforce is needed to meet the anticipated demand, and psychologists must give greater consideration to training the workforce to practice integrated care. Further, it is imperative to train master’s level clinicians to be responsive to the needs of our populations, particularly those who are underserved and disenfranchised, thereby creating a more diverse mental health workforce. Finally, Dr. Durvasula reminded the group that many people in communities are desperately in the need of mental health services, and it is imperative that psychology practitioners are in the position to provide these services. She affirmed, “*Before we get too far into the mud, we as psychologists need to lift our faces to the sky in terms of making sure that we reach those who need services.*”

**“Quality Assurance and Accreditation Issues”**

*Jacqueline Wall, PhD*

*Director, Office of Program Consultation and Accreditation*

*Education Directorate*

*American Psychological Association*

Dr. Wall defined accreditation as a process that is ultimately designed to protect the public, and achieves its goals as a system of evaluation, through emphasizing quality assessment and improvement. In the U.S., educational, human services, and healthcare programs and institutions undergo accreditation review. Although accreditation is unique to each of these three sectors, there are similarities in the processes used across them. Accreditation generally consists of a process that is voluntary and done through peer-review. The process consists of an internal examination by an entity with a subsequent external review. After the external review occurs, a body of persons that includes pertinent subject matter experts (SMEs) and
public representatives examines the results of information collected through the entire evaluation process from which an accreditation decision about the entity is derived.

Dr. Wall summarized the history, structure, and function of accreditation in higher education. Accreditation began in the late 19th century as a voluntary process to articulate qualifications for student entry into colleges and universities and evolved into the formation of regional groups of higher education administrators to evaluate secondary education practices. The process began to expand in 1944 with the Servicemen’s Readjustment Act, providing educational funding for servicemen towards the end of WWII.

Over time, the U.S. Department of Education (USDE) has honed its actions in higher education to focus on those that promote access to education and the accountability of academic institutions and programs. The Higher Education Act (HEA; 1965) and subsequent amendments, such as those in 1992 that included provisions designed to strengthen the gatekeeping triad for student loan guarantees and financial aid (i.e., state licensing bodies, accreditation associations, and the federal government), enhanced the practice of accreditation. The 1992 amendments also authorized the National Advisory Committee on Institutional Quality and Integrity (NACIQI), an entity that serves to evaluate accrediting bodies.

The Higher Education Opportunity Act (2008), another amended piece of the HEA, authorized the U.S. Secretary of Education to publish lists of accrediting agencies that it recognizes. These recognized accrediting bodies provide ratings of educational quality and allow students to access federal funding.

In addition to the U.S. government’s involvement in accreditation, there is a private recognition body of educational quality, the Council for Higher Education Accreditation (CHEA). CHEA provides recognition of accrediting agencies. A voluntary membership organization with more than 3,000 institutions represented, CHEA was founded 20 years ago and focuses on the following criteria for accrediting bodies:

- Advancement of academic quality by requiring the demonstration of how standards are met;
- Demonstration of accountability by requiring accredited entities to provide consistent and reliable information about quality and achievement;
- Encouragement of self-scrutiny to improve processes;
- Use of decision processes that contain a system of checks and balances to ensure fairness;
- Demonstration of ongoing self-review of accreditation practices; and
Possession of sufficient resources to maintain the accrediting entity.

In the U.S., these two national entities direct higher education accreditation via the following recognition practices:

- Regional associations, which normally review entire institutions;
- National associations that primarily evaluate career, vocational, and trade schools; and
- Specialty and programmatic accreditors that examine individual programs of study (e.g., medicine, dentistry, teaching, etc.).

According to Dr. Wall, in the area of health service that incorporates mental health processes and function, eight bodies that accredit programs at different educational levels and represent about 2,300 programs exist. Four of these accreditors—American Psychological Association Commission on Accreditation (APA-CoA), Psychological Clinical Science Accreditation System (PCSAS), Council for the Accreditation of Counseling and Related Programs (CACREP), and Commission on the Accreditation for Marriage and Family Therapy Education (COAMFTE)—evaluate doctoral programs. Two accrediting bodies—APA and the Accreditation Council for Pharmacy Education (ACPE)—are currently recognized by USDE. All of the above accrediting bodies will likely be impacted if either of the current bills that are in congressional committee related to higher education (Higher Education Reform and Opportunity Act [2015] and Higher Education Innovation Act [2015]) is passed.

Each of these bills would expand access to federal monies for different types of accrediting bodies. One bill would move decision-making to the states (e.g., establishing an educational system aligned with a federalist approach), and both bills may subject those accrediting educational entities receiving government funding to greater scrutiny. Irrespective, Dr. Wall in her final comments emphasized that the need for processes demonstrating the supported value of educational offerings is becoming the norm in the accreditation world.

“Regulatory and Licensure/Scope of Practice Issues”
Stephen DeMers, PhD
Chief Executive Officer
Association of State and Provincial Psychology Boards (ASPPB)

Dr. DeMers first emphasized that he was not speaking on behalf of ASPPB and that his presentation is based upon a long history of involvement with psychology licensing, his experiences as an appointee to the Kentucky Board of Psychology, and his 20-year connection with accreditation programs in clinical and school psychology programs. He affirmed his
support for the doctoral standard as the entry level for psychologists, and that psychologists should have a doctorate degree from an accredited program. Dr. DeMers shared that APA’s avoidance of the master’s level has created a vacuum and may have been a mistake. He expressed his pleasure that APA is now addressing a long overdue issue. He recounted that almost half of the states had some form of credentialing in psychology at the master’s level but with little or no guidance from a national association about what should be in a core curriculum. When making credentialing decisions, licensing boards rely on connections with national associations for guidance in areas such as ethics codes, program approval, quality assurance, and training. Academic programs have frequently been doing what they believe is best without association guidance or oversight. In relation to master’s training, Dr. DeMers asserted that APA has been somewhat missing in action.

Many APA members and others in the psychology community are faculty in terminal master’s training programs. They may also work simultaneously in doctoral programs. Dr. DeMers clearly stated that he is glad that APA is now examining how licensing boards or other entities can determine if a master’s program in psychology meets standards of quality to prepare students for a practice career. He asserted that he is in favor of a practice credentialing, especially for someone in the mental health and health workforce with a master’s degree, but they should not be called psychologists. They should be given another title with a defined scope of practice. Although APA does not control state legislatures, the Association should not remain silent. In this case, psychology practitioners need to have overall standards and levels of scope and practice.

Dr. DeMers emphasized that the above scenario should not be a threat to psychologists because there are not enough students at the doctoral level who can meet the increasing needs. Because the demand for practitioners is so high, we should not drive away people who are seeking master’s degrees. Regarding concerns about behavioral analysts and other fields encroaching upon psychologists’ scope of practice, Dr. DeMers believes that it is “much better to have them in the tent than out of the tent.” If a psychology board is involved in regulating behavioral analysts, psychological practitioners, and psychologists, then the regulatory structure will be strengthened. It may also help address other issues, such as from whom a master’s psychological practitioner will seek guidance on a complicated case. If a master’s level practitioner in psychology must become credentialed in professional counseling because they have not been accepted or recognized by their home profession, then the last person they might want to come to their aid would be a psychologist. Dr. DeMers closed his presentation by insisting that psychology must somehow find a seat at the table.
Convening of the Workgroups

Katherine Nordal, PhD, Executive Director of APA’s Practice Directorate, provided instructions for the workgroups who convened on the final two days of the Summit. Attendees participated in one of four workgroups which included a facilitator; a recorder for summarizing group discussions, feedback, and suggested actions; and an assigned MFP staff support member. Table 1 below depicts the assignments for each workgroup.

Table 1: Summit Workgroup Assignments

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<th>Marketplace and Workforce</th>
<th>Regulatory and Licensure</th>
<th>Quality Assurance and Accreditation</th>
<th>Scope of Practice</th>
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<td>Jo Linder-Crow, Facilitator</td>
<td>Catherine Fiorello, Facilitator</td>
<td>Cindy Juntunen, Facilitator</td>
<td>Tim Cavell, Facilitator</td>
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<td>Elena Eisman, Recorder</td>
<td>Katherine Nordal and Deborah Baker, Recorders</td>
<td>Jacqui Wall and Jim Díaz-Granados, Recorders</td>
<td>Cathi Grus, Recorder</td>
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<td>Janice Haskins, MFP staff support</td>
<td>Andrew Dailey, MFP staff support</td>
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<td>Cynthia Gomez</td>
<td>David McAllister</td>
<td>Sara Jo Nixon</td>
<td>Lori Thomas</td>
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<td>Martin Heesacker</td>
<td>Antonette Zeiss</td>
<td>Jane Stafford</td>
<td>Torrey Wilson</td>
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<td>Jana Martin</td>
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<td>Jerrold Yeo</td>
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<td>Sally Robles</td>
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</table>

* Drs. Linda Campbell, Frank C. Worrell, and Antonio Puente floated between workgroups

Dr. Nordal provided further instructions to the workgroups to help guide their discussions for the final two days of the Summit. Specifically, on Day Two, the workgroups were to focus on three key areas: Considerations, Potential Solutions and Actions, and Impact/Consequences of Actions. At the conclusion of Dr. Nordal’s instructions, the stakeholders were released to their workgroups.

At the end of Day Two, after the workgroups met concurrently, the full group reconvened for the workgroup reports followed by discussion. Dr. Frank C. Worrell facilitated the reporting and discussion period.
It is important to note that the Marketplace and Workforce group developed and presented a draft consensus statement for discussion and consideration by the large group. After reading the statement, the large group responded with applause and agreed that it was comprehensive in nature and reflective of the key considerations generated by the remaining workgroups. The consensus statement can be found in the next section.

To prepare for the next day and provide a structure for the overall summit proceedings, a matrix conceptualized by the Summit Planning Committee was completed to synthesize information captured by each group’s assigned recorder. Each workgroup was given a completed matrix summary to be used as a foundation for the continued group work on the following day (Appendix E).

**Day Three: Sunday, December 4, 2016**

As participants reconvened for the final day of the Summit, Dr. Worrell instructed the workgroups to now turn their attention to three additional areas which built upon previous discussions: *Broad Areas of Consensus, Areas of Concern, and Questions/Items for Future Consideration*. After the concurrent workgroup session concluded, the full group reconvened for workgroup reports and discussion. Appendix E reflects a summary of the individual workgroup discussions for both days.

At the end of the day, the consensus statement was reviewed in greater detail by the full group, and additional revisions were applied. The consensus statement is provided on the following page.

Finally, the full group also attempted to propose a title for the master’s level practitioner in psychology. After considerable discussion, the attendees could not reach consensus on one title. However, they did agree on the importance of having a title and discussed possible considerations—*Licensed Psychology Practitioner, Licensed Psychological Provider* and *Licensed Psychology Associate*—which could be used as a working title until a final one is designated. The group did reach consensus that the words “licensed” and “psychology/psychological” should be included in the title, particularly given the current marketplace.
Consensus Statement

We recognize the expertise in science, clinical practice and leadership offered by psychologists. Our responsibility is to address the shifting demographics and behavioral health needs of the U.S. population. We need to bring additional scientifically informed and culturally and linguistically responsible practitioners to all populations, including underserved populations, using approaches distinct from those offered by other behavioral health practitioners.

We believe this can be accomplished by the development of a complementary model of training and credentialing for master’s level practitioners in psychology. This alliance and integration in the field of psychology that includes both doctoral and master’s level practitioners who are committed to the scientifically driven practice of psychology will greatly expand the reach of our field in the coordinated delivery of behavioral health services.

The behavioral health workforce would benefit from the inclusion of master’s level psychology practitioners in the following ways:

- The standard of training should include clinical and cultural proficiency and should be grounded in the science of psychology as a recognized and regulated part of our profession.
- This master’s level of training should include access to a level of regulation/licensure that permits them to be competitive with other master’s level providers of behavioral health services.
- The master’s practitioner in psychology should be integrated within the field of psychology.
- Having training embedded in psychological science and evidence based models of behavioral health treatment, practitioners with a master’s in psychology should be distinguished from other master’s level providers of behavioral health services.
Summary of Workgroup Discussions and Reports

Upon reviewing the summary matrix of the workgroup discussions provided in Appendix E, it is important to note that common threads and similarities existed across all four groups. This reinforced intersectionality and similar positions adopted among the key topical areas (i.e., Marketplace and Workforce, Quality Assurance and Accreditation, Regulatory and Licensure, and Scope of Practice), all of which will be addressed in the Conclusions section of this document.

Andrew Dailey, MFP director, informed the group that the consensus statement, Summit agenda and participant list would initially be shared with the APA Board of Directors and Council Leadership Team in January, 2017. A draft of the Summit proceedings would be shared with the planning group and the participants for review/input. The final Master’s Summit proceedings would be made available to the Board of Directors and Council of Representatives in February. The proceedings will also be forwarded to SAMHSA and become available on MFP’s portion of the APA website in March, 2017.

Conclusions

We can agree with certainty that we are now in a new healthcare environment and that there is uncertainty as to what exactly that will entail, as shared by Dr. Susan H. McDaniel, 2016 APA President, in her written welcome message to Summit participants. The fact that master’s level clinicians are central to the mental health delivery system will not change. What does this mean for training master’s level psychological practitioners? Should APA embrace them? If so, what is required to ensure that they are properly trained and launched into the workforce?

Over two and one-half days, Summit participants engaged in lively and creative conversations examining the benefits and challenges related to the training of master’s level psychological practitioners and considerations for the future.

While Appendix E in this document presents a summary of the small group discussions, following is a summary of general conclusions as well as those deemed more specific to the four key topical areas assigned to the workgroups: Marketplace and Workforce, Regulatory and Licensure, Quality Assurance and Accreditation and Scope of Practice.
**Overall Areas of Consensus**

- APA should embrace both the training of psychological practitioners at the master’s level and accreditation for master’s degree training programs. APA should also advocate for licensing and consistent titling of master’s trained individuals with the understanding that there are both benefits and challenges.
- It is important to affirm and maintain the doctoral degree as the entry level for psychologists and to enhance the “value added” of psychologists.
- Clearly distinguishing the master’s level psychological practitioner from the psychologist is critical in order to define the unique identity of the master’s level psychology practitioner as compared with other master’s level providers. This definition should also include a broader focus to reflect psychology as a health profession and be operationalized.
- Embracing master’s level trained practitioners provides an opportunity to meet the increasing needs of underserved and marginalized populations which will ultimately serve the public interest. Currently, there are not enough psychologists from diverse backgrounds in the field or in the pipeline.
- Determining a proper title for the master’s level practitioner is important and needs further consideration. It should not be demeaning or divisive. The words “licensed” and “psychology/psychological” should be included in the title.
- Emphasis should be placed on the training and cultivation of scientifically informed and culturally and linguistically responsible practitioners.
- APA should develop a model act for master’s level practice/licensure.
- There is a need to examine existing data and collect additional data to address questions about delineating scope of practice, licensure, credentialing, etc. In particular, we can address questions such as: *What is the current scope of practice for doctoral and master’s level practitioners in different states? In what settings are professionals practicing? What kinds of services are they offering, and to what clientele? Which clinical services do we claim as psychology?*
- It is expected that some psychologists may be concerned about APA supporting master’s psychology practitioners. As such, APA should utilize change management strategies to understand the perspectives of concerned psychologists and collaboratively work through potential barriers.
- It will be important to investigate the workforce impact of this initiative, including to what extent community access to psychological services is enhanced (especially for underserved), quality and safety are improved, and health disparities are reduced.
• The economic/financial impacts of this initiative should be further reviewed. Impact could be expected for the Association, for practitioners, for health care delivery systems, for state/federal behavioral health systems, and others.

Following is a summary of areas of consensus that are more unique to each workgroup.

**Marketplace and Workforce**

- While considering a recognition and acceptance of master’s level practitioners, there must also be an effort to enhance the value proposition of doctoral level practice and training so that the two are distinct.
- The current psychology workforce has not adequately responded to the changing demographic composition of the country.
- The focus on the scientific underpinnings of practice is one of the major things that distinguishes psychology as a behavioral science profession.

**Regulatory and Licensure**

- Stronger collaborative relationships should be developed with other professional mental health provider groups at the master’s level (e.g., Massachusetts Mental Health Coalition, National Mental Health Liaison Group, Coalition for Patient’s Rights) as well as expanding and/or enhancing existing relationships, including those focusing on licensure.
- Consider a staged rollout of the new licensure category, paying special attention to the protection of current applied psychology programs.

**Quality Assurance and Accreditation**

- Quality assurance and accreditation are necessary to assure high quality training and an increased qualified workforce to meet public health needs.
- Quality assurance mechanisms should be addressed in five areas: (1) accreditation of programs; (2) core areas of study; (3) establishment as a health provider; (4) identification of skills at different levels; and (5) core value added of a doctorate degree.
- In initial discussions, the Quality Assurance and Accreditation workgroup identified three separate models for moving toward accreditation at the master’s level: (1) MPCAC serves as the accreditor; (2) APA provides material support to and collaborates with MPCAC; and (3) APA serves as the sole accreditor for master’s level training of practitioners. In an approach that would involve compromise, be conciliatory in nature, and protect students currently in the pipeline, the workgroup proposed one possible three phase roadmap to be considered by APA leadership.
1. APA works towards developing credentialing and accreditation standards for master’s level education and training, essentially developing its own process as an independent partner alongside the Master’s in Psychology and Counseling Accreditation Council (MPCAC) and ASPPB.

2. APA and MPCAC work toward transitioning APA as the sole accreditor for master’s level education and training.

3. An APA commission focused on master’s level education and training is established as the sole recognized accreditor for master’s level training and education.

Figure 1: Proposed Roadmap for APA Master’s Level Credentialing and Accreditation

Scope of Practice

- The differences in the scope of practice between a psychologist and a master’s trained psychological practitioner should be clearly defined and articulated. A review of the currently defined scopes of practice for other mental health professionals considering equivalency and a review of existing competency models would be beneficial in this process. It was noted that the work of Drs. Margo Jackson and Michael Scheel should be a starting point. In particular, two articles published in The Counseling Psychologist Journal include *Quality of Master’s Education: A Concern for Counseling Psychology*, The Counseling Psychologist (2012) and *Integrating Master’s Education in Counseling Psychology for Quality, Viability, and Value Added* (2013).

- In developing a Model Scope of Practice Act for master’s level providers, the benefits to the field of psychology and psychologists as well as the conceptual basis must first be clearly articulated. Practice should be based on what psychology does well (e.g., scientific mindedness).
Closing of the Summit

At the conclusion of the Master’s Summit, Dr. Worrell thanked the participants for their diligent work on this issue and for developing a consensus statement that represents multiple constituencies and stakeholders in psychology and beyond. He also informed them that the report on the Summit will be shared with the APA Council of Representatives at their next meeting. Mr. Dailey also thanked the participants and encouraged them to move forward on this issue in the same spirit of collaboration that was evident during the Summit.
References


Appendix A:
Attendee Listing
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Appendix B:

Meeting Agenda
# Agenda

## APA Summit on Master’s Training in Psychological Practice

750 First Street, NE-Washington, DC

## Friday, December 2

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<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tr>
<td>6:30pm-7:30pm</td>
<td>Dinner</td>
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<tr>
<td>7:30pm-8:30pm</td>
<td>Welcome, Networking, and Overview of the Summit</td>
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<tr>
<td></td>
<td>Andrew Austin-Dailey, MDiv, MS</td>
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<td>Director, Minority Fellowship Program</td>
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<td>8:30pm-9:30pm</td>
<td>Facilitators’ Meeting</td>
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<td>Spire Boardroom</td>
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## Saturday, December 3

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<td>8:55am-9:00am</td>
<td>Welcome and Importance of the Summit</td>
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<td>Cynthia Belar, PhD, ABPP</td>
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<td>9:00am-9:55am</td>
<td>Framing the Workgroup Discussions</td>
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<td>“History and Current State of Master's Training”</td>
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<td></td>
<td>Linda Campbell, PhD</td>
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<td></td>
<td>Professor</td>
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<td></td>
<td>Department of Counseling and Human Development Services</td>
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<td></td>
<td>University of Georgia</td>
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<td></td>
<td>“Marketplace and Workforce Issues”</td>
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<td></td>
<td>Ramani Durvasula, PhD</td>
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<td></td>
<td>Professor of Psychology</td>
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<td>California State University Los Angeles</td>
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<td>“Quality Assurance and Accreditation Issues”</td>
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<td></td>
<td>Jacqueline Wall, PhD</td>
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<td></td>
<td>Director, Office of Program Consultation and Accreditation</td>
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Agenda
APA Summit on Master’s Training in Psychological Practice
750 First Street, NE-Washington, DC

“Regulatory and Licensure / Scope of Practice Issues”
Stephen DeMers, PhD
Chief Executive Officer
Association of State & Provincial Psychology Boards

9:55am-10:00am
Spire Multipurpose Room
Instructions for Workgroups
Katherine Nordal, PhD
Executive Director
Practice Directorate
American Psychological Association

10:00am-10:15am
Break

10:15am-12:00pm
Conference Room 201
Conference Room 5035
Spire Multipurpose Room
Conference Room 203
Workgroup Discussions
Marketplace and Workforce
Quality Assurance and Accreditation
Regulatory and Licensure
Scope of Practice

12:00pm-1:00pm
Spire Multipurpose Room
Networking Lunch

1:00pm-3:15pm
Conference Room 201
Conference Room 5035
Spire Multipurpose Room
Conference Room 203
Workgroup Discussions
Marketplace and Workforce
Quality Assurance and Accreditation
Regulatory and Licensure
Scope of Practice

3:15pm-3:30pm
Break

3:30pm-5:00pm
Workgroup Reports and Discussion
Moderator: Frank Worrell, PhD
Professor and Director, School Psychology
University of California Berkeley

6:30pm
Ruth’s Chris Steak House
724 9th Street, NW
Washington, DC 20001
(202) 393-4488
Gallery Place Metro Station

Dinner
Agenda
APA Summit on Master’s Training in Psychological Practice
750 First Street, NE-Washington, DC

Sunday, December 4

8:00am-8:55am  Breakfast
Spire Multipurpose Room

8:55am-9:00am  Instructions for Workgroups
Spire Multipurpose Room
Katherine Nordal, PhD
Executive Director
Practice Directorate
American Psychological Association

9:00am-12:00pm  Workgroup Discussions
Conference Room 201
Marketplace and Workforce
Spire Boardroom
Quality Assurance and Accreditation
Spire Multipurpose Room
Regulatory and Licensure
Conference Room 203
Scope of Practice

12:00pm-1:00pm  Networking Lunch
Spire Multipurpose Room

1:00pm-3:00pm  Workgroup Reports and Discussion
Conclusions and Next Steps
Closing
Spire Multipurpose Room
Moderator: Frank Worrell, PhD
Professor and Director, School Psychology
University of California Berkeley
Appendix C:
List of Acronyms
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<td>Council for the Accreditation of Counseling and Related Educational Programs</td>
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<td>CAPP</td>
<td>Committee for the Advancement of Professional Practice</td>
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<td>Counsel of Counseling Psychology Training Programs</td>
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<td>CECP</td>
<td>Committee on Early Career Psychologists</td>
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<td>Council for Higher Education Accreditation</td>
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<td>Commission on the Accreditation for Marriage and Family Therapy Education</td>
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<td>Health Service Psychology Education Collaborative</td>
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NP: Nurse Practitioner
PA: Physician Assistant
PCSAS: Psychological Clinical Science Accreditation System
SAMHSA: Substance Abuse and Mental Health Services Administration
SMEs: Subject Matter Experts
SPTA: State, Provincial or Territorial Association
Appendix D:

History and Current State

of

Master’s Level Practice in Psychology
APA Minority Fellowship Program

Summit on Masters' Training in Psychology

December 2-4, 2016

Presented by Linda Campbell, Ph.D.

Prepared by Linda Campbell, Ph.D., Deborah Baker, J.D., and Stephen DeMers, Ph.D.
History and Current State of Masters’ Level Practice in Psychology

The role of Masters’ training and practice has been the subject of numerous conferences and task forces beginning in 1952-1953 during which there were 10 conferences. In subsequent years, at least 30 additional study groups have considered the subject and raised important questions including the following:

- **Titles:** What should masters’ graduates be called?
- **Training Programs:** Should APA develop a model curriculum? What should it include?
- **Accreditation:** Should APA develop procedures to recognize masters’ training programs with appropriate standards?
- **Certification:** Should APA credential or certify graduates of masters’ training programs and how would that status function differently from accreditation?
- **Levels of Supervision:** Should masters’ graduates be supervised? Is so, by whom and what entity would determine the status of supervision?

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<td></td>
<td>Vermont</td>
</tr>
<tr>
<td></td>
<td>West Virginia</td>
</tr>
</tbody>
</table>

---

B. Limited Licensure or Registration for Master’s Degree in Psychology (Under Supervision)

23 Alabama, Alaska, Arkansas, California, Delaware, Iowa, Kansas, Kentucky, Maine, Michigan, Minnesota, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas & Wyoming

15 Alabama, Alaska, California, Kansas, Kentucky, Maine, Maryland, Michigan, Nebraska, New Mexico, North Carolina, Oregon, Tennessee, Texas & Wyoming

1. VT and WV were the only independently licensed states for master’s practice in 1999. Both states allow for master’s level licensure in psychology with same scope of practice as doctoral-level licensed psychologists.

The other three states include a separate psychology licensure for master’s level individuals with the potential for independent practice.

In Kansas, licensed clinical psychotherapists are independent providers whereas master’s level psychologist is supervised and may not practice independently. A master’s level psychologist may apply for licensure as a clinical psychotherapist after 2 years (4000 hours) supervised experience.

In Kentucky, licensed psychological practitioners are independent providers whereas licensed psychological associates are supervised. A licensed psychological associate may be eligible for licensure as a psychological practitioner upon completion of the equivalent of five (5) full-time years of professional experience under the supervision of a board-approved licensed psychologist. A licensed psychological practitioner may perform certain functions within the practice of psychology independently but may not provide supervision. A licensed psychological associate may perform certain functions within the practice of psychology only under the supervision of a licensed psychologist approved by the board but shall not practice independently.

In Oregon, a (supervised) psychologist associate-resident may apply for independent status after completion of 3 years of supervised experience (plus a year-long, full-time internship) at a demonstrated high level of professional proficiency.

2. Since 1999, approximately 10 states have eliminated the master’s level psychology licensure category (supervised or independent practice) – Arkansas, Delaware, Iowa, Minnesota, Nevada, New Hampshire, North Dakota, Oklahoma, Pennsylvania and South Carolina.

3. Maryland and Nebraska are the only new states to adopt supervised master’s level practice since 1999.

4. There are no states of which we are aware that offer a limited license to I/O graduates at the master’s level.
<table>
<thead>
<tr>
<th>Health Professions and Their Respective Entry Levels²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiology</td>
</tr>
<tr>
<td>Chiropractic</td>
</tr>
<tr>
<td>Clinical Laboratory Sciences</td>
</tr>
<tr>
<td>Dentistry*</td>
</tr>
<tr>
<td>Medicine*</td>
</tr>
<tr>
<td>Nursing</td>
</tr>
<tr>
<td>Advanced Nursing Practice (CNP, CNS, CRNA, CNM)</td>
</tr>
<tr>
<td>Occupational Therapy*</td>
</tr>
<tr>
<td>Optometry</td>
</tr>
<tr>
<td>Osteopathic Medicine</td>
</tr>
<tr>
<td>Pharmacy*</td>
</tr>
<tr>
<td>Physical Therapy*</td>
</tr>
<tr>
<td>Podiatry</td>
</tr>
<tr>
<td>Psychiatry</td>
</tr>
<tr>
<td>Psychology*</td>
</tr>
<tr>
<td>Speech/Language Pathology</td>
</tr>
</tbody>
</table>

*These professions are inclusive of other levels of licensure (i.e. Physicians Assistants, Physical Therapist Assistants, and Dental Hygienists) that have different entry level requirements.

### Mental Health Professions and Their Respective Entry Levels

<table>
<thead>
<tr>
<th>Profession</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed Professional Counselors (LPC)</td>
<td>Master’s Level</td>
</tr>
<tr>
<td>Licensed Mental Health Counselors (LMHC)</td>
<td>Master’s Level</td>
</tr>
<tr>
<td>Licensed Clinical Social Workers (LCSW)</td>
<td>Master’s Level</td>
</tr>
<tr>
<td>Social Worker</td>
<td>Bachelor’s Level</td>
</tr>
<tr>
<td>Licensed Marriage and Family Therapists</td>
<td>Master’s Level</td>
</tr>
<tr>
<td>Behavioral Analysts</td>
<td>Master’s and Bachelor’s Level</td>
</tr>
</tbody>
</table>

**Note of Comparison of Health and Mental Health Professions:**

- No other mental health profession has doctoral and master’s level entry to licensure.
- There is no licensed doctoral level practice in social work; however, the Ph.D. doctorate and DSW Practice Doctorate is accepted as long as the social worker also earned an MSW degree.
- There is no licensed doctoral level practice in counseling.
- There is no licensed doctoral level practice in MFT (except for those who also are licensed as a psychologist).
# The State of the States on Psychology Licensure

## States (+ D.C.) with Doctoral Licensure: 34

<table>
<thead>
<tr>
<th>Arizona</th>
<th>Delaware*</th>
<th>Illinois</th>
<th>Massachusetts</th>
<th>Montana</th>
<th>New York</th>
<th>Pennsylvania*</th>
<th>Utah</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arkansas*</td>
<td>Florida</td>
<td>Indiana</td>
<td>Minnesota*</td>
<td>Nevada</td>
<td>North Dakota</td>
<td>Rhode Island</td>
<td>Virginia</td>
</tr>
<tr>
<td>Colorado</td>
<td>Georgia</td>
<td>Iowa*</td>
<td>Mississippi</td>
<td>New Hampshire</td>
<td>Ohio</td>
<td>South Carolina*</td>
<td>Washington</td>
</tr>
<tr>
<td>Connecticut</td>
<td>Hawaii</td>
<td>Louisiana</td>
<td>Missouri</td>
<td>New Jersey</td>
<td>Oklahoma</td>
<td>South Dakota</td>
<td>Wisconsin</td>
</tr>
<tr>
<td>D.C.</td>
<td>Idaho</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Bolded states** below are those that have MA-level licensure for independent practice: Kansas, Kentucky, Oregon, Vermont, West Virginia

## States with Doctoral Licensure and MA Licensure—**independent practice**: 2

<table>
<thead>
<tr>
<th>Vermont</th>
<th>Psychologist-Masters (no delay before independent practice)</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Virginia</td>
<td>Psychologist (5 years of experience before independent practice)</td>
</tr>
</tbody>
</table>

## States with Doctoral licensure and two levels of MA level licensure/practice (potential for independent practice): 3

<table>
<thead>
<tr>
<th>Kansas</th>
<th>Licensed Clinical Psychotherapist (independent) Master Level Psychologist (supervised) After 2 years (4000 hours) supervised experience as MLP can apply to be independent licensed clinical psychotherapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kentucky</td>
<td>Licensed psychological practitioner (Independent) Licensed Psychological Associate (supervised)</td>
</tr>
<tr>
<td>Oregon</td>
<td>Psychologist Associate (Independent) Psychologist Associate-Resident (supervised) After 3 years of supervised experience (plus potential year-long internship), resident may apply for independent status.</td>
</tr>
</tbody>
</table>

## States with Doctoral licensure and supervised MA level registered professional: 4

| California | Registered Psychological Assistant |
| Maryland | Psychological Associate |
| Nebraska | Registered Psychological Assistant or Psychological Associate |
| Wyoming | Certified Psychological Practitioner (after 5 years, supervision drops to weekly consultation with 1 hour/face-to-face per month) |

## States with Doctoral Licensure and MA licensure—**supervised practice**: 8

<table>
<thead>
<tr>
<th>Alaska*</th>
<th>Licensed Psychological Associate (in 1998, independent scope of practice was repealed) (verified with ASPPB)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>Psychological Technician</td>
</tr>
<tr>
<td>Maine</td>
<td>Psychological Examiner</td>
</tr>
<tr>
<td>Michigan</td>
<td>Limited Licensed Psychologist</td>
</tr>
<tr>
<td>New Mexico</td>
<td>Psychologist Associate</td>
</tr>
<tr>
<td>North Carolina</td>
<td>Licensed Psychological Associate</td>
</tr>
<tr>
<td>Texas</td>
<td>Licensed Psychological Associate</td>
</tr>
<tr>
<td>Tennessee*</td>
<td>Psychological Examiner (Supervised) Certified Psychological Assistant (supervised)</td>
</tr>
</tbody>
</table>

* indicates states that used to have MA level licensure for independent practice but no longer have that license. i.e.) as of December 2013, Arkansas no longer issues the psychological examiner license which had independent practice rights.

**September 2015 -- APA PRACTICE**
Appendix E:
Matrices of Workforce Discussions
## Summary Matrix of Workgroup Discussions: Marketplace and Workforce—December 4, 2016

<table>
<thead>
<tr>
<th>Considerations</th>
<th>Potential Solutions/Actions</th>
<th>Impact/Consequences of Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Marketplace</strong> and <strong>Workforce</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Consider that this training is already happening in the “Real World”: public health focus, the payer community, rural services, economics, market share, competency and public safety, professional identity, etc.</td>
<td>1. Collaborate with MPCAC to address credentialing and accreditation standards.</td>
<td>1. This would be a cultural change for the field that could result in membership loss for APA.</td>
</tr>
<tr>
<td>2. Reaffirm that the doctoral level is the entry level for a psychologist.</td>
<td>2. Develop a value proposition for doctoral psychologists that show distinct expertise, skills and training at the doctoral level.</td>
<td>2. There could be strong reactions from practitioners, training councils, students, CoAs as well as possible strong reactions from other professions including those from other licensing areas, etc.</td>
</tr>
<tr>
<td>3. Consider that we haven’t made a strong enough case for the value of psychology at the doctoral level to make it distinct enough from what a master’s level individual might do.</td>
<td>3. Communicate about the value of adding a master’s level psychology provider (or other title), while possibly expanding doctoral training to include skills needed in changing marketplace (i.e., leadership, business practice, etc.).</td>
<td>3. On a positive note, this change could reduce the threat of decreased funding for doctoral programs and might increase APA membership if master’s level students were accepted as full members.</td>
</tr>
<tr>
<td>4. Consider the importance of recognizing the fears related to a potential loss of market share, change of identity for psychologists.</td>
<td>4. Collect and Supply Data: where psychologists work, what the career and work expectations of students and early psychologists are (where they want to see themselves, salaries they hope to earn), current client needs, assess current linguistics, geographic info, etc.</td>
<td>4. Could clarify for consumers and other groups as to exactly what psychology is and what psychologists do by clarifying degree, title, and scope of practice.</td>
</tr>
<tr>
<td>5. Consider we need to make a strong case for the value of pursuing a doctorate degree and what constitutes appropriate levels of training and competencies for the master’s and doctorate in order to distinguish the two.</td>
<td>5. Begin to define the title and the scope of practice of for the master’s level in psychology.</td>
<td>5. Data collection and analysis is expensive, so funding must be considered.</td>
</tr>
<tr>
<td>6. Consider how we leverage the science of psychology to help distinguish a master’s degree in</td>
<td>6. APA and SPTAs should examine the regulatory and licensure implications for this shift and for the master’s level.</td>
<td>6. Some economic impact on the current workforce, essentially people who are now in practice.</td>
</tr>
</tbody>
</table>
### Summit on Master’s Training in Psychological Practice

#### Summary Matrix of Workgroup Discussions: Marketplace and Workforce—December 4, 2016

<table>
<thead>
<tr>
<th>Considerations</th>
<th>Potential Solutions/Actions</th>
<th>Impact/Consequences of Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>psychology distinct from other master’s level mental health providers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Don’t make the assumption that when we bring in new master’s level individuals they will necessarily want to focus on culturally based or responsive work.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Consensus, Concerns, and Questions/Parking Lot: Marketplace and Workforce

<table>
<thead>
<tr>
<th>Broad Areas of Consensus</th>
<th>Concerns</th>
<th>Questions/Items for Future Consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. While considering a recognition and acceptance of master’s level practitioners, there must also be an effort to enhance the value proposition of doctoral level practice and training so that the two are distinct.</td>
<td>1. How to retain a focus both on serving an increasingly diverse population and also creating an increasingly diverse group of practitioners to meet all the needs.</td>
<td>1. Is there a set of “core” practice skills we should be focusing on regardless of level?</td>
</tr>
<tr>
<td>2. NOTE: A combined consensus statement has been developed with the input of all 4 working groups.</td>
<td>2. How to position this in a way that is viewed as being a complement to psychologists rather than competition.</td>
<td>2. What does it mean to fully “embrace” this proposition?</td>
</tr>
<tr>
<td>3. How to ensure that a shift like this doesn’t assume that the master’s degree is just a “safe harbor” for less capable students; understanding that some individuals simply don’t wish to seek a doctoral degree but may be extremely capable students.</td>
<td>3. What do we train psychologists to do that is distinct to the doctoral level and that reflects the shifting needs of the population and the healthcare delivery system?</td>
<td>3. What do we train psychologists to do that is distinct to the doctoral level and that reflects the shifting needs of the population and the healthcare delivery system?</td>
</tr>
<tr>
<td>4. How do we position ourselves so the master’s and doctoral degree is connected to our science base? How can this distinguish us?</td>
<td>4. How do we position ourselves so the master’s and doctoral degree is connected to our science base? How can this distinguish us?</td>
<td>4. How do we position ourselves so the master’s and doctoral degree is connected to our science base? How can this distinguish us?</td>
</tr>
<tr>
<td>5. Concern/Questions for doctoral programs with extensive master’s level training programs: Is there a difference between what is produced at both levels?</td>
<td>5. Concern/Questions for doctoral programs with extensive master’s level training programs: Is there a difference between what is produced at both levels?</td>
<td>5. Concern/Questions for doctoral programs with extensive master’s level training programs: Is there a difference between what is produced at both levels?</td>
</tr>
<tr>
<td>Broad Areas of Consensus</td>
<td>Concerns</td>
<td>Questions/Items for Future Consideration</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. Fiscal concern for independent licensed psychologists, will APA endorsing the number of master's level practitioners make any difference? What is the base and identity of APA?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. Explore BA to MA, BA to PhD pipeline professional development model for students dedicated to underserved communities (NIH build initiative).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8. Explore organizational support for supporting MA level students dedicated to underserved communities.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Additional Questions/Comments from the Large Group During the Day One Report Out:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>9. What is the impact of including master’s level psychology practitioners as a measure of patient health outcomes? <strong>Initial Response:</strong> The group discussed this and viewed it as having a positive impact on patient care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10. Public health needs are currently great so there is an increased demand for master’s level psychology practitioners and mental health professionals.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11. Be sure to address the cultural and linguistic needs of underserved communities.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12. Provide the data first, with the ultimate goal of creating a diversified workforce, because it's easy to be presumptive. Some of this data already exist.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13. It was mentioned that “where you train is usually where you practice.”</td>
</tr>
</tbody>
</table>
# Summit on Master’s Training in Psychological Practice

<table>
<thead>
<tr>
<th>Considerations</th>
<th>Potential Solutions/Actions</th>
<th>Impact/Consequences of Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality Assurance and Accreditation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. It was the workgroup consensus that APA should embrace the training of psychological practitioners at the master’s level.</td>
<td>1. Titles for master's trained psychology providers – Multiple Possibilities for Title/Identity: o Psychology Associate o Associate Psychologist o Licensed Specialist in Behavioral Health o Psychology Practitioner o Behavioral Health Scientist o Behavioral Health Specialist o Mental Health Specialist o Behavioral Health Practitioner</td>
<td>1. Increased qualified workforce to meet public health needs. 2. Increased employment opportunities for faculty and students.</td>
</tr>
<tr>
<td>2. Accreditation is necessary to assure high quality training and good service to the public.</td>
<td>2. Need to develop criteria for Health Services Psychologists (HSPs) to cross the curriculum.</td>
<td>3. Maintain consistency and build upon the psychology education pipeline (career ladder).</td>
</tr>
<tr>
<td>3. What quality assurance mechanisms would be appropriate? Three (3) possible models are described on the last two pages of this table.</td>
<td></td>
<td>4. May open opportunities for groups that are under-represented in psychology.</td>
</tr>
<tr>
<td>4. Core areas of study should be established.</td>
<td></td>
<td>5. Leverage the science of psychology.</td>
</tr>
<tr>
<td>5. Establishment of psychology as a health service provider.</td>
<td></td>
<td>6. Expand the representation at the state level.</td>
</tr>
<tr>
<td>6. Importance of identifying the skills at different levels and the value added of a doctorate degree.</td>
<td></td>
<td>7. Any change may positively or negatively impact APA membership numbers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8. May lead to a need for additional field placement sites.</td>
</tr>
</tbody>
</table>
### Summit on Master’s Training in Psychological Practice

**Summary Matrix of Workgroup Discussions: Quality Assurance and Accreditation—December 3-4, 2016**

<table>
<thead>
<tr>
<th>Broad Areas of Consensus</th>
<th>Areas of Concern</th>
<th>Questions/Items for Future Consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Overarching Group Consensus:</strong> There is a need to develop practitioners to meet public health needs, including the provision of culturally and linguistically diverse services.</td>
<td>1. Costs are not known and could be substantial.</td>
<td>1. Are there some titles that would be more favorable than others? For example, they would not imply secondary status?</td>
</tr>
<tr>
<td>2. APA embraces both the training of psychological practitioners at the master’s level and accreditation for education and training programs.</td>
<td>2. The change may privilege programs that lead to credentials and have unintended consequences for current forms of graduate training (e.g., counseling psychology doctoral training).</td>
<td></td>
</tr>
<tr>
<td>3. The recommended roadmap to achieve accreditation for master’s level training is found on page 3 of this document. The three phases of the road map are titled #3, to #2 to #1. Following this strategy would provide some protection to students who are currently in the training pipeline. Plus, this would be a plan to integrating the model across time.</td>
<td>3. Process may erode the entry level for practitioners at the master’s level.</td>
<td></td>
</tr>
<tr>
<td>4. APA should develop a model act for master’s level practice.</td>
<td>4. Resources needed to complete accreditation (e.g., staff and member volunteers).</td>
<td></td>
</tr>
<tr>
<td>5. There should be consistent titling. Titling should be carefully considered to represent the qualifications of the education and training received.</td>
<td>5. Possible resistance to change.</td>
<td></td>
</tr>
<tr>
<td>6. There is more added value and benefits than cost to developing accredited training at the master’s level.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Proposed roadmap for consideration—A process of compromise and is conciliatory in nature.

1. APA works towards developing credentialing and accreditation standards for master's level education and training, essentially developing its own process as an independent partner alongside the Master's in Psychology and Counseling Accreditation Council (MPCAC) and ASPPB.
2. APA and MPCAC work toward transitioning APA as the sole accreditor for master's level education and training.
3. An APA commission focused on master's level education and training is established as the sole recognized accreditor for master's level training and education.
### Additional Key Considerations

**CoA – MPCAC versus APA – M**

<table>
<thead>
<tr>
<th></th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Model 1: APA - M</strong></td>
<td>Highest level quality control</td>
<td>Cost (short-term)</td>
</tr>
<tr>
<td></td>
<td>Branding</td>
<td>Internal Resistance with APA Membership</td>
</tr>
<tr>
<td></td>
<td>Existing structure/expertise/experience</td>
<td>Duplication of existing process (MPCAC)</td>
</tr>
<tr>
<td></td>
<td>Less confusing</td>
<td>Identifying who will perform the function (HR cost)</td>
</tr>
<tr>
<td></td>
<td>Trustworthy</td>
<td>Less curriculum flexibility</td>
</tr>
<tr>
<td></td>
<td>Comport with APA policy</td>
<td>Timeline is 3-5 years</td>
</tr>
<tr>
<td></td>
<td>Consistency and unity of training</td>
<td>Title and Identity</td>
</tr>
<tr>
<td></td>
<td>Career ladder preparation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Revenue</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintain control</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emerge as a leader</td>
<td></td>
</tr>
</tbody>
</table>

**Model 2: MPCAC**

APA collaborates with MPCAC in a 5 yr. planning process with goal of eventual absorption

- MPCAC has developed standards
- Name recognition—not many people familiar with MPCAC
- Quality standards consistent with competency benchmarks
- Disrupts consistency in education/training and complicates an easy career ladder
- Has applied to CHEA
- No outcome data
- Has accredited programs
- Goals are different
- Title and Identity

**Model 3:**

Parallel to Counseling Model

Pros and cons similar to Model #2

<table>
<thead>
<tr>
<th>Professional Organization</th>
<th>Counseling</th>
<th>Psychology</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA</td>
<td>APA</td>
<td>MPCAC</td>
</tr>
<tr>
<td>CACREP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASCB</td>
<td></td>
<td>ASPPB</td>
</tr>
<tr>
<td>Considerations</td>
<td>Potential Solutions/Actions</td>
<td>Impact/Consequences of Actions</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td><strong>Regulatory and Licensure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. How would master’s level psychology practice be uniquely defined so that it is appropriately captured in licensure?</td>
<td>1. Embracing master’s level training and practice in psychology with the expectation that such individuals will be eligible for licensure at the independent practice level.</td>
<td>1. Anticipate strong reactions within the APA member community to this proposed change.</td>
</tr>
<tr>
<td>2. What should be the relationships between psychology licensure at master’s level and other mental health master’s level license categories?</td>
<td>2. Revising the APA Model Act for State Licensure of Psychology.</td>
<td>2. Anticipate strong reactions from other accrediting bodies and professional organizations serving other master’s level providers.</td>
</tr>
<tr>
<td>3. How is ASPPB already capturing these concepts in its policies and materials?</td>
<td>3. Collaborating with ASPPB on implementation issues.</td>
<td>3. There may be unintended consequences.</td>
</tr>
<tr>
<td>4. The title “licensed psychologist” ought to continue to be a doctoral-level category. The master’s level licensure category ought to reflect psychology without using the title “psychologist.”</td>
<td>4. Looking at other existing models like school psychology, nursing, etc. that have negotiated similar hierarchical licensure categories.</td>
<td>4. Academic departments under pressure to increase enrollment in master’s level programs.</td>
</tr>
<tr>
<td>5. There continues to be concerns about how to define added value of licensed psychologists; this will not adversely impact the opportunities for practice for them.</td>
<td>5. Defining the unique identity of master’s level psychological practitioners as compared to other master’s level mental health providers. Such definition would focus on psychology defined more broadly as a health profession.</td>
<td>5. Internship shortage exacerbated or development of new internship models for master’s level licensure.</td>
</tr>
<tr>
<td>6. How will this kind of change be implemented at the individual state level? How would this be impacted by the political climate moving towards an anti-regulatory environment?</td>
<td>6. Need to “upgrade” what it means to be a psychologist to broaden beyond the practitioner role to include training on health care delivery, business practices and how the system works.</td>
<td>6. Ensure that resources are maintained to support doctoral level and earmark a proportion of new revenue to the master’s level practitioner training.</td>
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<tr>
<td>7.</td>
<td>7. Distinguishing the master’s level psychological practitioner from the psychologist to include a review of the following resources:</td>
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<tr>
<td></td>
<td>o APA competencies and benchmarks documents on developmental levels</td>
<td>1. Anticipate strong reactions within the APA member community to this proposed change.</td>
</tr>
<tr>
<td></td>
<td>o CCPTP (counseling psych. training council) master’s level competencies</td>
<td>2. Anticipate strong reactions from other accrediting bodies and professional organizations serving other master’s level providers.</td>
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<tr>
<td></td>
<td>o MPCAC standards</td>
<td>3. There may be unintended consequences.</td>
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<td>4. Academic departments under pressure to increase enrollment in master’s level programs.</td>
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<td>5. Internship shortage exacerbated or development of new internship models for master’s level licensure.</td>
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<td></td>
<td>6. Ensure that resources are maintained to support doctoral level and earmark a proportion of new revenue to the master’s level practitioner training.</td>
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# Summit on Master’s Training in Psychological Practice

## Summary Matrix of Workgroup Discussions—Regulatory and Licensure—December 3-4, 2016

<table>
<thead>
<tr>
<th>Considerations</th>
<th>Potential Solutions/Actions</th>
<th>Impact/Consequences of Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. How will this affect existing challenges associated with opening the psychology practice act?</td>
<td>O NASP competencies</td>
<td></td>
</tr>
<tr>
<td>9. What are the perspectives of state psychological associations and state psychology licensing boards? Other stakeholders?</td>
<td>8. Developing stronger collaborative relationships with other professional mental health provider groups at the master’s level. Utilize current relationships and consider additional collaborative efforts focused on the master’s licensure issue. Examples: MA Mental Health Coalition, National Mental Health Liaison Group, Coalition for Patients’ Rights.</td>
<td></td>
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<td></td>
<td>9. Avoid titles that may be seen as demeaning or divisive such as psychological extenders or psychological assistants.</td>
<td></td>
</tr>
<tr>
<td>Broad Areas of Consensus</td>
<td>Areas of Concern</td>
<td>Questions/Items for Future Consideration</td>
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<tr>
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</tr>
<tr>
<td>1. Message has to be that there is tremendous need; psychology wants to create more providers, expand the marketplace.</td>
<td>1. Licensing law will need title, curriculum and standards as we wait for accreditation of master’s programs.</td>
<td>1. What would be the membership status in APA for master’s level practitioners?</td>
</tr>
<tr>
<td>2. Embracing master’s level training and practice in psychology with the expectation that such individuals will be eligible for licensure at the independent practice level.</td>
<td>2. Portability across states.</td>
<td>2. What would be the impact on the APA Practice Organization advocacy agenda, etc.?</td>
</tr>
<tr>
<td>3. Defining the unique identity of master’s level psychological practitioners as compared to other master’s level mental health providers. Such a definition would focus on psychology defined more broadly as a health profession.</td>
<td>3. Portability from LPC, LMHC, etc. licensure to psychology master’s level licensure.</td>
<td>3. What is the perceived impact on status of psychologists relevant to prescription privileges, physician definition?</td>
</tr>
<tr>
<td>4. Distinguishing the master’s level psychological practitioner from the psychologist: Review APA competencies and benchmarks documents on developmental levels, CCPTP master’s level competencies, MPCAC standards, and NASP competencies.</td>
<td>4. Route for those with master’s degree who have previously not been able to be licensed? Be mindful of not creating “orphans”, i.e., students who are already in programs or practitioners who are in states that don’t have access to licensure at the master’s level. For example, those who are in counseling psychology master’s programs.</td>
<td>4. Internship/practicum issues: As numbers increase at the master’s level, might some resources be shifted to support master’s training and endanger the availability of doctoral level internships?</td>
</tr>
<tr>
<td>5. Developing stronger collaborative relationships with other professional mental health provider groups at the master’s level. Utilize current relationships and consider additional collaborative efforts focused on the master's licensure issue.</td>
<td>5. Question for quality assurance and accreditation workgroup: Consider a progressive implementation: attend to those programs (counseling psychology) that are endangered by regulation issues (CACREP) related to counselor licensure. Which accrediting body can APA use for master’s training programs... must it be APA through DOE? If so, what would be the role, if any, for MPCAC?</td>
<td>5. Will need significant resources for the clinical training of master’s level folks... where will those supervisors come from? Will there be a requirement for “internship” at the master’s level for licensure?</td>
</tr>
<tr>
<td>6. Should master’s level training/licensure be limited to Health Service Psychologists (HSPs) only?</td>
<td>6. What are the core competencies for master’s level?</td>
<td>6. What is the scope of practice related closely to titles and the definition of master’s level practice in psychology?</td>
</tr>
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### Summit on Master’s Training in Psychological Practice

**Summary Matrix of Workgroup Discussions—Regulatory and Licensure—December 3-4, 2016**

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<td>Examples: Massachusetts Mental Health Coalition, National Mental Health Liaison Group, Coalition for Patient’s Rights.</td>
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<td>6. Suggest titles that are inclusive such as licensed psychological practitioner, psychological services provider, and psychological associate. Avoid titles and language that may be seen as demeaning or divisive, such as “extender”, “assistant,” etc.</td>
<td></td>
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<tr>
<td>7. Consider staged rollout of new licensure category, paying special attention to protection of current counseling psychology programs.</td>
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<tr>
<td><strong>Scope of Practice</strong></td>
<td><strong>Considerations</strong></td>
<td><strong>Potential Solutions/Actions</strong></td>
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<tr>
<td><strong>1. What will be gained? Lost?</strong></td>
<td>1. Data is critically needed to delineate what the scope of practice would be and exactly where does master’s stop and doctoral training begin. Practice should be competency focused as well as focused on public good.</td>
<td>1. How much control does APA have to impact scope of practice at the state level?</td>
</tr>
<tr>
<td><strong>2. Psychologists need to have a voice in the preparation of master's trained individuals in their work settings/roles.</strong></td>
<td>2. Recommendations for process to delineate and responses to questions that existing data might address:</td>
<td>2. Proposed legislation can be modified in a way that makes it different than intended – jeopardize the scope of practice for psychologists in the effort to define the scope of practice for master's level practitioners.</td>
</tr>
<tr>
<td><strong>3. Threats to doctoral psychology by not embracing master's level training for psychology practice.</strong></td>
<td>o Where are people doing psychological practice?</td>
<td>3. Creating a scope of practice or supervision requirements that is too limiting to be attractive to employers.</td>
</tr>
<tr>
<td><strong>4. Doctoral psychology is not sufficiently meeting societal needs and training is also not addressing the broader needs (e.g., population health; psychology’s responsibility to the public good, etc.).</strong></td>
<td>o What are they doing?</td>
<td>4. Difference between doctoral and master's trained individuals might not be seen as very distinct. Again, there is a need to operationally define the differences.</td>
</tr>
<tr>
<td><strong>5. Shift to team-based care offers chance to define clearer roles for doctoral vs. master’s trained individuals.</strong></td>
<td>o What are we claiming as psychology?</td>
<td>5. Consequence of not taking action: What is the future of doctoral psychology? Will we remain relevant as a profession?</td>
</tr>
<tr>
<td><strong>6. Competencies for master's level trained individual (based on serving the public good): health service focus, service delivery (reference existing competency models at master's level, MPCAC standards).</strong></td>
<td>3. Review current defined scopes of practice for other mental health professions to consider equivalence and look at existing competency models. Use this data to inform a larger conversation about scope of practice based on needs to be served.</td>
<td></td>
</tr>
<tr>
<td><strong>7. Focus on using evidence-based practice, not producing more prescriptive curriculum, creating uniformity in requirements; not “mini-doctorates”. Practice should be</strong></td>
<td>4. Develop curricular resources.</td>
<td></td>
</tr>
<tr>
<td><strong>Scope of Practice</strong></td>
<td>5. Develop plan for state and association governance, stakeholder advocacy and education.</td>
<td></td>
</tr>
<tr>
<td><strong>Considerations</strong></td>
<td>6. Consider consequences of opening up state laws and psychology board rules.</td>
<td></td>
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<tr>
<td><strong>Potential Solutions/Actions</strong></td>
<td>7. Articulate the differences in scope of practice between psychologists and master's trained psychological practitioners. Looking at what the scope would look like.</td>
<td></td>
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<tr>
<td>based on what psychology does well (e.g., scientific mindedness).</td>
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<tr>
<td>8. Should the scope of practice for master's level trained individuals in psychology be similar to or different from other master's level trained mental health providers? RESPONSE: It should be similar scope as well as distinct because of its strength of emphasis on science, evidence and psychological principles.</td>
<td></td>
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<tr>
<td>9. What is the conceptual basis for proceeding (e.g., psychology trains people better)? Use that to guide decisions about scope of practice.</td>
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**Summit on Master’s Training in Psychological Practice**  
**Summary Matrix of Workgroup Discussions: Scope of Practice — December 3-4, 2016**

### Broad Areas of Consensus, Areas of Concern, and Questions/Parking Lot

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<th>Broad Areas of Consensus</th>
<th>Areas of Concern</th>
<th>Questions/Items for Future Consideration</th>
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<td>1. This is an opportunity to better serve those who are marginalized and underserved.</td>
<td>1. Independent practice of psychology by master’s level psychology practitioners represents a potential threat to the marketplace viability of psychologists.</td>
<td>1. Impact on movements related to CACREP accredited programs.</td>
</tr>
<tr>
<td>2. We support APA taking steps toward recognizing master’s psychology training/practice, understanding there are both benefits and challenges. It is no longer tenable for APA to ignore this issue. It is time for APA to take a leadership role.</td>
<td>Other areas of concern:</td>
<td>2. Managing “change process” if movement goes forward.</td>
</tr>
<tr>
<td>3. There is a need to articulate the benefits of proceeding with the development of a model scope of practice act; why/how would this benefit psychology and psychologists.</td>
<td>o Accreditation</td>
<td><strong>Pre-considerations</strong> (generated by individual group members as an orientation exercise):</td>
</tr>
<tr>
<td>4. Reviewing extant scope of practice acts to identify what is already out there; looking for gaps/needs that could be addressed.</td>
<td>o Marketplace</td>
<td>1. Embrace master’s trained individuals to benefit and strengthen the communities we live and work in.</td>
</tr>
<tr>
<td>5. Develop a model scope of practice act for master’s trained individuals in psychological practice.</td>
<td>o Reimbursement</td>
<td>2. Move forward; make sure we can serve and benefit our communities, particularly underserved.</td>
</tr>
<tr>
<td></td>
<td>o Getting support from psychologists</td>
<td>3. Not producing enough doctoral trained individuals from diverse backgrounds; master’s trained individuals may be more reflective and we should have some say.</td>
</tr>
<tr>
<td></td>
<td>o Impact on students about to enter the workforce</td>
<td>4. <strong>Embrace</strong>: address underserved, meet needs and encourage collaboration.</td>
</tr>
<tr>
<td></td>
<td>o Licensing</td>
<td>5. <strong>Embrace</strong>: benefit to society; would be a long process to do so. Psychology well suited to integrate research and practice this should be disseminated to other providers.</td>
</tr>
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<td></td>
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<tr>
<td>0 Define competencies for master’s trained individuals.</td>
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<tr>
<td>0 Develop curricular resources to foster development of these competencies.</td>
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### Summit on Master’s Training in Psychological Practice

**Summary Matrix of Workgroup Discussions: Scope of Practice — December 3-4, 2016**

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<td>Principles that are important to include in a model practice act:</td>
<td></td>
<td>6. Achievement of higher quality standards based on training at the doctoral level. Focus on safety and quality – team-based models can enhancement improvement.</td>
</tr>
<tr>
<td>a. Title should be different than “psychologist” but not something that is demeaning.</td>
<td></td>
<td>7. “See” individuals trained at the master’s level which serves the public interest; important to enhance competence of master's trained individuals.</td>
</tr>
<tr>
<td>b. Training would be driven by the Health Service Psychology Education Collaborative (HSPEC) competency model that includes a focus on evidence-based practice. This adds value in the marketplace as compared to other currently licensed master’s practitioners.</td>
<td></td>
<td>8. More providers yielding more effective care. This might address student debt by promoting master’s degrees then practice and perhaps later go for doctoral degree; could promote sense of community and job satisfaction.</td>
</tr>
<tr>
<td>c. Consider integrated care skills as a core competency.</td>
<td></td>
<td>9. Do not assume that independent practitioners are not integrating with other practitioners including those at other levels of training. Must not ignore concerns of those who are not as ready to change.</td>
</tr>
<tr>
<td>d. Scope is at a minimum consistent with other master's practitioners but limited from psychologists.</td>
<td></td>
<td>10. Markets needs are valid but with questions as to whether master’s level training would truly improve access/reduce disparities and potential financial impacts need to be considered.</td>
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### Summit on Master’s Training in Psychological Practice  
Summary Matrix of Workgroup Discussions: Scope of Practice —December 3-4, 2016

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**Additional Questions/ Comments from the full group during the Report Out on Day One:**

- Will this group be making recommendations about the parameters of skills and practices?
  - *Initial Response: Many of the psychologists in this group train master’s level practitioners. On Day Two, the group will explore some recommendations to present in terms of looking at other models, etc. The challenge is that those models are fairly limiting because they focus on general psychology requirements at the master’s level and not training practitioners.*

The following articles serve as resources:

- **Quality of Master’s Education: A Concern for Counseling Psychology?**  

- **Integrating Master’s Education in Counseling Psychology for Quality, Viability, and Value Added.**  