

OPA Member Toolkit for CPBAO Consultation Feedback on the Proposed Changes to Training and Accreditation Standards

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Acknowledgements

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Clarification Statement

The OPA would like to note that the following information is not meant to imply masters-qualified applicants, or applicants from other provinces, cannot practice ethically and competently in Ontario. Rather, our goal is to demonstrate that there is a higher risk involved with less training. This is why masters associates in Ontario have historically undergone additional post-graduate training under supervision before autonomous practice.

Disclaimer

This document was developed by members of the Ontario Psychological Association Board of Directors to support professional dialogue. Every effort has been made to ensure the accuracy of the information presented; however, unintentional errors or omissions may occur.

CALL TO ACTION

We strongly encourage members to participate in the consultation process. Submit your feedback to the CPBAO before the consultation deadline, **December 9, 2025**. Encourage colleagues, students, and the public to advocate for high-quality, safe, and accountable mental health care in Ontario.

Constructive, evidence-based feedback is vital to ensuring that Ontario's regulatory standards continue to protect the public while supporting high-quality psychological care. Our position is not directed at College Council members or individuals who entered through alternate pathways, but at safeguarding the integrity of the profession. Our position is one of concern about system-level implications and the importance of ensuring that changes are grounded in research, training requirements, and public-safety evidence. Every route into psychology must meet rigorous standards to protect the public and preserve confidence in our field. Thoughtful engagement from practitioners across all backgrounds and training routes is essential to achieving a regulatory model that is fair, practical, and safe for Ontarians.

Overview: What's Happening

Background: Why Is CPBAO Proposing Drastic Changes that Lower the Standards of Training and Accreditation?

The College's proposed reforms did not arise in isolation. Over the past several years, external pressures from the Office of the Fairness Commissioner (OFC), federal mobility agreements such as the Canadian Free Trade Agreement (CFTA), and Ontario's pending As-of-Right legislation have all emphasized reducing perceived barriers to registration and improving interprovincial mobility of health professionals. The OFC has repeatedly rated the College as "moderate-to-high risk" for fairness, citing lengthy and complex entry pathways compared with other jurisdictions. In response, the CPBAO appears to be attempting to "modernize" its system by aligning with the lowest common denominator across provinces rather than preserving Ontario's historically high standards. However, while the intent of these frameworks is to promote access and mobility, we believe the current proposals go far beyond that mandate, effectively dismantling core quality training and safeguards that have defined psychological regulation in Ontario for decades.

The CPBAO has proposed sweeping regulatory changes that would:

- Reduce supervised clinical training requirements from approximately 3,000+ hours to about ~300 hours before the supervised practice year, approximately a 75% reduction.
- Eliminate the oral examination, the last independent assessment of competence before autonomous practice.
- Allow accreditation of academic programs by CPBAO, despite CPBAO having no prior accreditation experience. Of note, no Canadian master's program in psychology is CPA-accredited. Deregulating into an unaccredited landscape means Ontario could no longer verify quality through an independent standard.
- Eliminate psychologist and psychological associate titles and collapse all registrants under a single label of *psychologist*, regardless of training depth or breadth.

These changes effectively eliminate a professional regulatory system grounded in rigorous, accredited, and independently verified training with one that prioritizes volume and expediency over quality and safety.

Other changes that have already been passed by the college, and regrettably did not require consultation include:

- Removing distinct practice areas (e.g., neuropsychology, forensic, rehabilitation psychology).
- Changing the Jurisprudence and Ethics Examination into a low-stakes “no-fail” e- module.
- Allowing unlimited attempts at the EPPP.

The concurrent rollout of these changes jeopardizes public safety by weakening training requirements and eliminating safeguards that ensure competence. In the absence of these protections, the burden falls on the public to recognize and report harm, an unrealistic expectation for many vulnerable clients.

Why This Matters

Public Safety & Quality of Care

Ontario’s psychologists and psychological associates routinely manage high-risk and complex cases, including severe depression, suicidality, PTSD, psychosis, acquired brain injury, neurodivergent diagnostic evaluations, forensic assessments, and workplace disability claims. These professional responsibilities require extensive diagnostic and clinical reasoning skills, cultivated through years of supervised practice, and advanced coursework. Drastically reducing the scope and depth of training means new practitioners will likely be unprepared for the complexity and accountability of real-world practice. Below, we expand on some of the most important reasons why the college proposal is short-sighted and why it matters that we respond robustly.

CPBAO cites a lack of evidence of increased harm caused by lowering standards; however as pointed out by members on the college council, an absence of evidence is not evidence of absence. Relying on discipline data requires patients to know they are harmed and take the steps to report. However, an OPA member

reviewed the list of registrants referred to the Discipline Committee of the CPBAO between June 2023 and May 2025 and found that Alberta transfers to Ontario were statistically over-represented among Ontario discipline referrals ($p = .022$), even with small sample sizes, which suggests that there are real-world safety risks tied to reduced training and oversight.

- 25% of discipline referrals in the data sample from 2023 through spring 2025 appeared to involve Alberta-trained, master's-level entrants, though they likely represent only 2–3% of registrants, which is an 8–12x overrepresentation. 50% of all referrals in this sample involved non-standard or externally trained entrants.
- In contrast, Ontario-trained doctoral psychologists, who constitute the vast majority of registrants, accounted for 25% of discipline referrals, a figure far below their proportion in the profession.
- While the absolute numbers are small, the proportional disparities are notable. This pattern suggests that reduced training intensity and limited supervision are potentially associated with greater disciplinary risk.
- It should be noted that many of the allegations involved serious boundary violations, sexual misconduct, or the exploitation of vulnerable clients, underscoring the public-safety consequences of insufficient clinical preparation and ethical training. Taken together, these findings indicate that lowering Ontario's entry-to-practice requirements would increase, not reduce, risk to the public.

Across several jurisdictions, there are increased discipline rates among minimally trained practitioners. Although only ~5% of Québec psychologists have master's degrees, they represented ~60% of discipline cases from the available data between 2022–2025 - an over-representation of about 28x ($p < .001$). Additional data would be required to determine whether this represents a stable risk pattern, but this is a cause for *pause* and further examination of data.

Alberta's 2022–2025 disciplinary data show that 69% of publicized discipline decisions against master's-level clinicians involved graduates of counselling-focused master's programs (MEd, MC, MACP, or MA in Counselling Psychology), credentials that fall short of Ontario's current eligibility standards but are now transferable under interprovincial mobility laws. In these cases, insufficient knowledge and "professional incompetence" are frequently cited in discipline judgments. This does not imply all

master's-trained practitioners pose elevated risk, only that, in this dataset, the relative rate of discipline was higher in master's clinicians with these specific types of degrees that traditionally focus less on diagnosis and assessment than degrees in clinical psychology. This raises concerns regarding the large variability in quality of programs deemed acceptable for registration, and the transferring of clinicians interprovincially.

It should be noted that several non-accredited online programs focus on graduating large volumes of applicants from counseling psychology programs. In Ontario, graduates of these programs typically register successfully as psychotherapists. Given that psychotherapists or counsellors are not currently regulated in Alberta, these individuals register with the College of Alberta Psychologists and are then eligible to transfer their titles and work within Ontario. Data suggests that these counselling programs may be insufficiently preparing students for practice in the field of psychology.

Workforce & System Implications

The assumption that reducing training quality and quantity will improve access is not fully supported by available evidence. There are important findings published by the Canadian Institute for Health Information (2025) that refute this assumption:

In Alberta (where low-bar entry exists), 49% of adults with a diagnosed mental-health disorder reported "unmet needs" (defined as people who had a diagnosed mental health disorder and felt that they needed mental healthcare but their need was only partially met or not met in the past 12 months), which is *the highest in Canada* ([CIHI, 2025](#)) vs. 41% nationally and 33% in Quebec. ***Alberta should not be the model for psychology in Canada.*** Psychology must remain grounded in rigorous training, accountability, and evidence-based standards - not in the erosion of professional safeguards.

Quebec, which *strengthened* standards to the doctoral level in 2007, has *higher public trust and lower unmet need rates* than provinces with lower entry thresholds. This tells us that public needs can indeed be met while retaining high standards.

The Quebec government recognized that more psychologists were needed in the public sector, and instead of reducing standards for professional entry, they provided bursaries to psychologists who remained in the public sector following graduation ([Canadian Press, 2023](#)). This model aligns with what has been offered to physicians in Ontario.

Quebec also has the highest raw number of psychologists in the country, despite having a doctoral-only pathway, thereby *challenging the notion that higher educational standards preclude registration and access*. This is not to say that master's level clinicians should not be allowed to practice in the field, rather, it's to reinforce that lowering educational standards is not a requirement for increasing access and outcomes.

Economic Cost of Poor Quality Care

Preventable diagnostic error in mental health leads to poorer outcomes, increased hospitalization, and wasted resources (see Bradford et al., 2024 for review).

Relatedly, research also demonstrates that clinical experience and training are effective predictors of diagnostic accuracy (Brammer, 2002; Garb, 2005; Spengler et al. 2009).

Misdiagnosis of psychiatric disorders carries large direct financial consequences. For example, U.S. insurance claims studies report that misdiagnosed bipolar patients treated for depression had ~\$6,000 USD (~\$8,000 CAD) higher annual costs compared to correctly diagnosed bipolar patients (McIntyre et al., 2022), due largely to ineffective pharmacotherapy, emergency visits, and recurrent episodes requiring care (Kilbourne et al., 2004). When applied nationally across large patient populations, these costs scale into the hundreds of millions to billions annually.

The Organisation for Economic Co-operation and Development (OECD) reports that unsafe, ineffective, or delayed care consumes 13% of total health expenditures across high-income OECD countries (OECD, *The Economics of Patient Safety*, 2020). This includes inappropriate prescribing, ineffective treatments, preventable hospitalizations, and disability expenditures. In Ontario, with an \$81–\$90B annual health budget (Ontario Budget 2024; FAO 2024), even 13% represents \$11–\$12B in avoidable spending.

Small changes in accuracy produce large fiscal effects. If even 1% of diagnostic spending shifts toward preventable error or inappropriate treatment, the result is hundreds of millions in wasted spending, much of it recurring annually. In highly prevalent disorders (depression/anxiety/PTSD), even modest misdiagnosis rates drive large downstream costs via disability claims, hospitalizations, relapse, and polypharmacy.

Mental-health-related disability claims already represent a massive financial load for the government. Sun Life data show that mental illness is the #1 cause of long-term disability (LTD) claims in Canada, representing roughly 40% of claims overall and up to ~45% among women. The Canadian Life and Health Insurance Association (CLHIA) similarly identifies mental health conditions as a leading driver of disability costs and productivity loss nationwide. Introducing large numbers of diagnosticians with substantially reduced training hours may increase risks of diagnostic error or inappropriate treatment, which in turn drives higher costs. It is particularly concerning that decision-makers would consider adding providers with substantially less training while simultaneously removing the supervision and examinations required to ensure competent practice and public safety.

Equity and Access through Quality

Access and equity are not achieved by lowering competence thresholds. Instead, Ontario has made measurable progress in diversifying psychology programs while retaining high training standards:

- **TMU:** Runs an ongoing Diversifying Psychology initiative, aimed at recruiting individuals from marginalized backgrounds.
- **University of Guelph:** Diversity rose from 20% (2018) to 83% (2025) in incoming cohorts.
- **Windsor:** 70% of incoming doctoral students identified as diverse (2024 cohort).
- **UOttawa:** Up to 67% of admissions spaces are prioritized for BIPOC candidates under rebalanced scoring rubrics.
- The **American Psychological Association** Center for Workforce Studies cited that racialized psychologists increased 166% between 2000–2019 in America, while maintaining advanced-entry standards (APA, 2021)
- Provincial and Federal research grants include specific funding opportunities and measures that prioritize, are exclusively designated for, or support

Indigenous Peoples, BIPOC, or racialized minority groups, intended to enhance access to research programs and graduate studies.

Of note, CPBAO does not collect race or ethnicity data, which can make it difficult for them to monitor improvements in diversity of their registrants. Nonetheless, per a review of the CPBAO registry, the majority of psychologists speaking Spanish, Urdu, Farsi, Arabic, Hebrew, and Punjabi are doctoral psychologists, thereby reinforcing that a doctoral standard does not inhibit diverse recruitment.

- It should also be noted that CPBAO cited a desire to increase registration of international psychologists (including those from the United States). Per public data, approximately 300 registrants from international jurisdictions arrived between 2022-2024, and over 85% of them held doctoral degrees. Unfortunately, many international healthcare providers who immigrate to Canada have reported feeling as though they are practicing below their qualifications and experience; lowering standards will likely make us less appealing to strong international registrants (Covell, Neiterman, & Bourgeault, 2015).

It is important to note that the OPA heard from several BIPOC members who stated that, while increasing diversity is a critical need, the assumption from stakeholders that lowering standards is the best way to do so is both offensive and inappropriate.

The Real Issue: High-Quality vs. Low-Quality Training

A debate about degree type may be less effective than focusing on training quality and oversight, given that the CFTA exists and allows people to train elsewhere and register in Ontario with a masters degree (outside the psych associate pathway). Reducing standards threatens the principle of public protection, transparency, and accountability in Ontario's healthcare system.

Category	Current High-Quality, Accredited Training	Proposed Low-Quality, Reduced Training
Supervised Practice	2,200–3,000+ hours + 1-year residency (or 4 years supervised work experience in PA)	300 hours, 1 placement
Accreditation	CPA/APA/PCSAS or equivalent, independent oversight	Self-accredited by CPBAO (who have no experience with accreditation)
Evaluation of Competence	Written + oral exams, ethics exam,	EPPP only, unlimited attempts, no oral, no-fail JEE
Scope Preparation	Complex diagnostics, supervision, leadership, integrated therapy, program evaluation, research knowledge and contributions to advancement in mental health and psychological understanding	Narrow clinical exposure; limited supervision
Public Confidence	Recognized nationally and internationally	Risk of lost mobility and recognition

CONCERNS RELEVANT TO EACH PROPOSAL ITEM

CPBAO as an Accreditor of Graduate Programs:

- A regulator must remain independent and impartial when evaluating applicants. If the same body that licenses psychologists also certifies the programs they come from, it becomes impossible to enforce neutral standards across all institutions.
- The Canadian Psychological Association (CPA) and American Psychological Association (APA) already conduct rigorous, internationally recognized accreditation of psychology doctoral programs and internships.
- It is a dual role for a regulator to simultaneously serve as the licensing authority and the accrediting body. Doing both creates conflicts of interest, wastes resources, duplicates existing systems, and undermines public trust in the fairness and neutrality of licensure.
- Current accredited programs consistently demonstrate increased base-knowledge for professional psychological practice as shown in EPPP pass rates. Between January 2020 and December 2024, first-time EPPP candidates from APA- or CPA-accredited doctoral programs (N = 17,748) achieved a 75% pass rate on their first attempt, compared to 45% among candidates from non-accredited or otherwise unaccredited doctoral programs (N = 2,274, ASPPB; Weiss, 2025).
- Currently graduates of distance-learning programs are able to register in Alberta, whereas this is not permitted in Ontario. CPBAO and CPA have historically ensured that registrants learn and work during training with patients at least partly in-person, to ensure appropriate oversight and immersion in clinical activities.
- Removal of the Oral Exam:
 - Eliminating the oral exam removes the only direct assessment of real-time clinical reasoning and ethical judgment.
 - This removes a key quality-assurance tool precisely when entry requirements are being lowered.
 - Multiple studies in health-care education show that knowledge-based assessments alone (e.g., multiple-choice examinations) are limited in their ability to reliably identify practitioners who lack the ability to apply knowledge, make ethical judgments or respond dynamically in high-risk situations. For example, a scoping review of clinical reasoning

assessment found that MCQs and other written tools alone do not cover the full domain of clinical reasoning competency (Daniel et al., 2019), and the Institute of Medicine concluded that 'knowing is not enough; we must apply' (Cuff, 2014). This underlines the importance of using more than one assessment modality, including oral exams, simulations or structured interviews, to evaluate real-time decision-making and professional reasoning.

- As more clinicians register through As of Right and CFTA pathways, the roster of supervisors and their associated experience will be considerably varied. The oral exam provides a final assessment using specific and consistent criteria for all registrants prior to autonomous practice.
- The oral exam will be especially crucial given that *for profit masters programs* will be incentivized to pass and graduate students *irrespective of skill level*, and their students may now be more likely to register with CPBAO. The exam serves as a final opportunity to independently assess competence and uphold the quality of those entering the profession to protect the public.
- Other high-stakes professions have oral/competency assessments:
 - Physicians: Royal College clinical exams & OSCEs
 - Lawyers: Bar admission courses and character/competency evaluations
 - Psychiatrists: oral exam component in specialty certification
 - Many U.S. psychology boards: structured oral, jurisprudence interviews, or supervised practice evaluations before independent practice
 - Ontario would stand out as lowering, not aligning, with national (e.g., New Brunswick, BC, Saskatchewan, Manitoba, Nova Scotia, PEI) and international standards.

- **Reduction of Required Clinical Training:**

- These changes break alignment with the majority of national and North American standards. This pushes Ontario far below every major psychology jurisdiction in Canada, the U.S., the U.K., Australia, and much of Europe. Ontario would become an international outlier in minimum training for regulated psychologists. Being known for having

the lowest standards is unlikely to attract high quality international professionals.

- Meta-analyses and competency-based training literature consistently find that skill acquisition in psychotherapy requires repetition, supervision, feedback loops, and diverse patient encounters (Hill & Lent, 2006; Beidas & Kendall, 2010; CPA, 2023; APA CoA, 2022).
- The APA Commission on Accreditation, CPA accreditation standards, and HSTP competency frameworks all consider extensive supervised practice non-negotiable because clinical reasoning and ethical decision-making develop over time, not from coursework alone.
- Reducing practicum hours means registrants enter the supervised practice year under-prepared, forcing workplace supervisors to teach basic competencies rather than refine developed skills.
- The Dunning-Kruger Effect (1999) research shows that people with lower ability tend to overestimate their performance because they lack the metacognitive ability to accurately appraise what competent performance looks like. Poor performers not only make mistakes, they lack the ability to recognise their mistakes (Knof et al., 2024).
- Research across health-professions education shows that global self-assessment (i.e., a learner's judgment of their overall competence) often correlates poorly with measured performance (e.g., Davis et al., 2006; Eva & Regehr, 2011; Gabbard et al., 2021; Hill & Lent, 2006; Rahmani, 2020). In psychotherapy training, there is also evidence that less experienced therapists frequently misjudge their competence compared to supervisor ratings or observed skills (see Bennett-Levy & Sburlati, 2014).
- Based on public information, the minimum number of clinical hours being considered in one practicum, would be less than the total number of practicum hours required of Occupational Therapists (~1000 hours) and even hairstylists (3020 practical hours), neither of which are authorized to communicate diagnoses. These are a stark contrast to the minimum of approximately 300 hours required in several psychology masters programs, which could now be considered as sufficient for entry to the profession.

Changes Already Passed by CPBAO

There are also a number of changes that are not being included in public consultation because the college has already passed these motions. These are also concerning and are part of the larger picture:

- Allowing **unlimited attempts on the EPPP** increases the likelihood someone unqualified will *pass by chance*.
 - Ironically, Alberta is moving to reduce the number of attempts to three, as it recognizes that unlimited attempts are not in the public's best interest and that placing limitations "adds to the integrity of test outcomes" (CAP Annual Report, 2023).
 - Unlimited attempts do not increase fairness and equity, as the EPPP costs roughly ~CAD \$933, meaning only students with significant means can afford to take the test multiple times.
 - Quarterly results reported in *The CAP Monitor* (2020–2024) show consistently weak outcomes, with pass rates ranging from 41% to 68% across 19 reporting periods (N = 2,806). The weighted mean pass rate was 52.6% (median = 51%, mode = 50%, SD = 6.8%). By contrast, data from the ASPPB 2025 Report for Ontario's CPA-accredited doctoral programs over the same period show a calculated weighted mean first-attempt pass rate of 96.9% (N = 355 candidates across 15 programs; median and mode = 100%, SD = 4.2%; data calculated by Dr. J. Weiss).
- **Turning the JEE into a low stakes, no fail, e-module** ensures that no one can fail, even though the risks of not understanding the laws and regulations of the profession can have catastrophic outcomes.
 - If there is no possibility of failure, the JEE stops functioning as an assessment of readiness to move forward toward autonomous registration. If everyone passes by default, then candidates who do not understand key legal requirements may still enter practice, particularly if the oral exam is removed.
 - Questions will be posted online, traded in group chats, or sold. This happens regularly within un-proctored, no-fail systems. Once leaked, the JEE becomes a formality, not a safeguard.

- Awareness of relevant jurisprudence and ethical decision-making guidelines are of particular relevance as Ontario seeks to expedite the registration of professionals from other jurisdictions. Indeed, CAP has only recently passed a requirement for ethics courses to be taught by psychologists starting in 2026.
- **Removal of areas of competence (AOC)** eliminates accountability for practicing outside competence.
 - AOCs create a clear regulatory boundary. If a practitioner works outside declared competence and harms a patient, the College and involved parties can take action more easily. Without AOCs, there is no declared scope, making it harder to discipline unsafe practice.
 - AOCs require clinicians to meet specific training and practice standards before authorization. For example, declaring competency in forensic psychology required supervision by an experienced forensic psychologist and completion of a designated number of forensic cases and assessments. These changes are particularly concerning in neuropsychological and forensic domains, where professional expertise is often relied upon in medical and legal contexts.
 - Dunning-Krueger research has demonstrated that people often overestimate their ability. Although expecting a psychologist to practice strictly within one's area of competence is aspirational, AOCs function as a critical safeguard. Eliminating them increases the likelihood of practitioner overreach, particularly in high-stakes clinical situations, where inadequate training and oversight can elevate risk and ultimately generate more complaints, not fewer.
- **Collapsing of Titles.**
 - Doctoral-level psychologists in Ontario currently complete 3,000–4,500 hours of supervised training, with an additional 10-15 courses on topics such as advanced assessment and psychometrics, research methods, supervision, intervention, and complex case management. They also complete CPA accredited practicum and residency placements, ensuring high quality of supervision and exposure to a variety of complex cases.

- Psychological Associates in Ontario currently follow an apprenticeship model in that they complete a master's degree and then engage in 6000 hours of supervised training during a 4 period after completion of their degree.
- However, when completing a master's degree outside of Ontario and seeking to transfer their title received in another province, individuals are not required to undergo extensive supervised practice training even if their training and supervision process has been materially different.
- Several online and unaccredited counselling programs accepted in other jurisdictions that do not regulate psychotherapy focus predominantly on interventions, rather than psychopathology, assessment, and differential diagnosis, during their two years.
- Some argue that a common title of "psychologist" for current psychologists, psychological associates, incoming MA-level psychologists from out of province, and new registrants under the proposed reforms, would suggest singular or equivalent training pathways and place the onus on vulnerable patients to understand the different training psychological providers may have. When distinct titles exist, it becomes the responsibility of the provider to properly reflect their title and answer questions the patient may have, thereby ensuring greater transparency.
- Title distinctions are used in jurisdictions across the USA and Europe. They are often accompanied by variations in scope and specialization, as well. With an influx of online and unaccredited doctoral programs, particularly within the domains of counselling and education which do not focus on diagnostic assessment and complex intervention, reliance on the prefix of "Dr." alone may not provide transparent distinction.
- It should also be noted that OPA heard from a number of current Psychological Associates and psychologists who expressed concern that merging psychological associates with newly trained master's-level psychologists under one title could diminish the value of their training, extensive supervision, and professional title. As described, Psychological Associates undergo advanced training to prepare themselves for the role of working with the same scope as psychologists.

Summary:

With the elimination of the oral exam, unlimited EPPP attempts, and a no-fail JEE, the core safeguards that have long protected the public and upheld professional standards in psychology are being dismantled. Coupled with the removal of CPA accreditation requirements, these changes risk transforming psychology from a rigorously evaluated, evidence-based profession into one where virtually anyone can gain entry regardless of their competence, preparation, or ethical grounding.

These lowered standards will open the door to high-cost, profit-driven programs that prioritize enrollment over quality, admitting anyone who can afford their fees, including those who may never have set foot in a classroom or participated in a genuine clinical setting. Psychology must not become a pay-to-enter profession. Under these proposals, completing a single practicum and one year of supervised practice would be deemed sufficient to practice independently.

Once licensed, these minimally trained individuals could move freely across the country under the CFTA, further weakening provincial oversight and **putting Canadians at real risk**. The public deserves assurance that those who call themselves psychologists are skilled, accountable, and ready to provide safe, competent care.

Appendix A

Evidence-Based Talking Points for Members

Here are some helpful talking points to consider when engaging with the public or media about what is happening.

Public Safety Must Come First

"Every Ontarian deserves care from a fully trained professional who has demonstrated competence through rigorous, independently verified standards. A single practicum, no-fail online ethics review, and no declared area of competency do not meet that threshold."

This is not about our jobs or elitism but genuine concern for public safety.

"Diagnostic errors have serious consequences. Especially in the field of forensic evaluations (fitness to stand trial, risk assessments), medical-legal claims (insurance, workplace accommodation), child and youth assessments (autism, ADHD, learning disorders), and neuropsychological evaluations (brain injury, dementia). Not only will less trained individuals be able to diagnose, but there will also no longer be areas of competency to safeguard the public. Someone with limited training can determine independently that they are competent to do neuropsychological assessments, which usually require years of advanced training."

"When diagnostic competence is uneven, the consequences aren't theoretical - they affect courts, hospitals, schools, and disability systems. Inconsistent diagnostic quality leads to contradictory reports, challenges to expert credibility, and increased legal and clinical liability."

High-Quality Training Reduces Harm and Cost

"Psychologists' and psych associates' advanced training in differential diagnosis prevents costly misdiagnoses that strain the healthcare system and employers alike."

Align with the Highest Standards, Not the Lowest

Ontario should not mirror Alberta's model, where unmet mental-health needs are highest nationwide, but follow provinces like Quebec's, BC and NS whose evidence-based path toward higher quality, accountability, and equity."

Access Through Capacity, Not Compromise

Expanding accredited programs, permitting registration during post-graduate supervision periods, and supporting well-trained international psychologists will increase capacity without sacrificing safety.

Protect Public Trust

The titles *psychologist* and *psychological associate* signal to the public that the clinician has undergone the most rigorous mental-health training available. Diluting that standard risks confusion and erosion of trust.

What is a Psychologist?

"Psychologists/PAs are not the entire mental-health workforce. We are advanced diagnosticians, science-practitioners, and leaders in the mental health field. Ontario already has thousands of regulated therapists to meet moderate-need demand (CRPO is registering thousands a year). Rebranding the workforce as "psychologists" doesn't add capacity; it changes the label, not the workforce. The number of people available to deliver therapy remains the same, but now the public can no longer tell who has advanced diagnostic and supervisory training.

"Ontario's mental-health system works because different regulated professions serve different needs. If everyone is a "psychologist" then referrers, insurers, and clients can't distinguish the level of training or appropriate referral pathway. Other professions will rightly ask for expanded scopes (e.g., counsellors diagnosing), creating regulatory chaos and inter-professional friction. Further, costs will increase

within the sector as those with limited credentials achieve new titles and charge rates aligned with advanced doctoral providers."

These changes will reduce the number of students pursuing advanced doctoral or residency-level programs, yet Ontario's hospital systems rely on these students for low cost care and cutting-edge research.

When the bar for entry is lowered, you do get *more people with the legal right to diagnose*, but not necessarily people trained to do it well.

Appendix B

Quick Facts

- **Clinical Training Gap:** 3,000+ vs 300 hours before supervised practice year = 10× less supervised practice.
- **Discipline Disparity:** Alberta-trained, master's-level entrants likely represent only ~2–3% of CPBAO registrants, but accounted for ~25% of referrals to the Discipline Committee in a recent sample - an 8–12× proportional overrepresentation, based on publicly posted Decisions & Reasons. Quebec samples showed a 28x higher discipline rate amongst masters level registrants compared to doctoral.
- **Across ASPPB jurisdictions,** accredited doctoral programs average roughly 70–80% first-attempt pass rates, compared with ~45–55% in non-accredited or minimally supervised pathways.
- **Quarterly data from *The CAP Monitor* (2020–2024)** show Alberta's EPPP pass rates ranging from 41% to 68% (weighted mean = 52.6%, N = 2,806), whereas Ontario's CPA-accredited doctoral programs reported a weighted mean first-attempt pass rate of 96.9% over the same period (N = 355 across 15 programs).
- **Economic Impact:** OECD data show that unsafe/delayed care wastes about 13% of health budgets (OECD, 2020), and mental illness already drives ~40–45% of disability claims in Canada (Sun Life, 2020;), so rising misdiagnosis or ineffective treatment creates hundreds of millions to billions in recurring costs.
- **Access Reality:** Alberta's unmet-need rate = 49% (vs 33% in Quebec, 41% nationally). See [CIHI](#).
- **Diversity Progress:** Ontario doctoral cohorts have achieved major improvements in diversity, which has been achieved *without lowering standards* (based on reported and self-identifying data from students).

Ontario's reputation for excellence in psychology has been earned through decades of rigorous, evidence-based standards. We must not abandon that legacy for a model that prioritizes numbers over quality. Other provinces are watching, and many provinces, *including the association for psychologists in Alberta*, have signed a letter indicating they are concerned about these changes.

Appendix C

Alternatives Ideas For Discussion and Consultation

We encourage members to share their alternative ideas for how to meet the needs of Ontarian's without compromising public safety.

Some examples might include:

- Pushing for a robust and comprehensive masters pathway (2-3 years) that is CPA accredited and requires at minimum of two assessment and treatment-focused practicum placements in different settings along with two or three formal years of supervised practice.
- Create title distinction for masters and doctoral level psychologists
- Creating a doctoral pathway that will greatly expand doctoral registrants through PsyD programs. Grandfathering in current PAs.
- Create a transitional registration category (e.g., *Qualifying or Provisional Psychologist*) for candidates who have successfully completed the JEE and EPPP but are still accruing the post-masters practice hours required for registration. This would drastically expand the number of active registrants, ensure appropriate supervision by qualified providers, and prevent master's-level clinicians from registering temporarily with other colleges such as the CRPO.
- Broaden access to essential coursework by allowing students in related doctoral programs, such as EdD programs in child development or counselling, to enroll in the diagnostic and assessment courses required for CPBAO registration. This change would immediately expand the pool of doctoral-level candidates ready for licensure, without major cost or structural overhaul.
- Implement an expedited pathway for internationally trained psychologists, prioritizing applicants from jurisdictions with comparable standards (e.g., the United States). Increasing the frequency of the Jurisprudence and Ethics Examination (JEE) would further support this process and reduce registration delays.
- Longer term options could include OPA and CPA working to target high school students from marginalized communities who have an interest in sciences, psychology, and mental health, to help them secure volunteer positions, network, and apply for university programs in psychology.

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