Continuing Professional Development for Clinical Psychologists
This is dedicated to Pam Gray and Adrian Turner for patiently tolerating this book’s intrusion into their lives, for their support and understanding.
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Foreword

The importance of continuous professional development (CPD) cannot be understated. There are clear moral obligations, and emerging regulatory requirements, that make CPD an integral and everyday part of daily activity for professionals in health and social care. Easy words, difficult to do! Help is here, however, and can be found in this thoughtful and very interesting book. The book is a first in many ways. It takes and describes what should be commonplace activity but surrounds it with essential and helpful information, some research-based evidence and very helpful advice.

In reflecting on ‘a career for life’ it struck me that there are important milestones and ‘aha’ moments as one makes progress as a professional. The first probably appears following qualification as a professional. For a brief moment you are filled with confidence and a mission to succeed. This is very quickly followed by anxiety and doubt when faced with clinical encounters never previously experienced. Confidence and knowledge is challenged and uncertainty sets in. This is when CPD can make its first impact and no better than through well-constructed clinical supervision and a programme for new staff, subjects well dealt with in this book.

The second comes when trying to make sense of complex clinical situations. The temptation is to take the best evidenced-based assessment and intervention, surround it by well-constructed case notes and make sure that everyone in the team is properly informed and engaged. This is all good practice and to be applauded, but there are other skills that should be sharpened and honed to equal measure and they belong to more subtle processes. Hills (2004) takes some of the foundations of modern education and offers a succinct view of the relationship between implicit knowledge – that which grows from personal experience and
explicit knowledge – that which grows from the acquisition of knowledge. He argues that ‘the value of explicit knowledge lies not in its ownership but in its application. If explicit knowledge is the basis of the human intellect, then the implicit kind is surely the basis of human intelligence.’ In other words, it is important to consciously use your implicit knowledge, do not let it be overwhelmed by explicit knowledge or clever science.

It is arguable that when clinicians are at their best it is because they have responded to the implicit understanding of what good interventions can offer in the practice setting and can locate this within explicit knowledge. They will have gained implicit understanding from various life experiences and their properly supervised clinical practice. Through this, good clinicians gain capability. Explicit knowledge asks for different but nonetheless essential detail. However, where implicit understanding becomes drowned out by explicit knowledge, poor practice will surely follow. The best CPD is sensitive to this and it is dealt with sensibly here. Authors in this book offer well-balanced solutions to this complex conundrum.

Finally, those with well-found experience have a duty to continue to be immersed in CPD (showing by example)! I have always taken the view that you are never too old to learn. I have an example from my own experience. Despite a number of years of clinical experience, my assessment and questioning techniques, as well as my capacity to listen, had not been assessed ‘in vivo’ by other expert practitioners for some time. I took the opportunity to observe and then participate in some systemic family work in a local mental health service. Their model was theoretically rigorous and demanded that clinical work was properly supervised and recorded on video and audiotape. When asking questions of people or families a small earpiece allowed observers in a separate room to encourage me to re-phrase or ask questions differently. While somewhat disconcerting, this was a tremendous opportunity to hear others comment on my performance and say (live and in my ear!) such things as ‘they cannot understand that question’ or ‘it’s clear that you were not listening to that answer.’ It was disconcerting to be exposed to this but very informative. I am convinced that it helped me to listen better and frame questions more purposefully than I had done for some time.

It is plain from this that I believe that any clinical psychologist’s skills can be constantly improved and developed no matter how long in the tooth! I have little doubt that this book will be immensely helpful in the debate on CPD. I welcome its thoughtful approach and have little doubt that it will offer considerable support to those in
practice and those who will craft continuous professional development programmes.

Tony Butterworth
March 2005

REFERENCE

Notes on Contributors

**Tony Butterworth** has had an extensive career in the NHS and Higher Education sector. He was most recently Dean of School and then Pro Vice Chancellor at the University of Manchester and then moved to be the Chief Executive of the Trent NHS Workforce Development Confederation. He chairs several national committees relating to research and to workforce development, and has just become Director of the Centre for Clinical and Academic Workforce Innovation at the University of Lincoln.

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**Derek Milne** is Director of the Newcastle University Doctorate in Clinical Psychology, where his input includes teaching and supervising the ‘evaluation’ aspect of the course and preparing the trainees for CPD. He has had a career-long interest in staff development and its evaluation and has published books on *Training Behaviour Therapists* (1986: based on his PhD) and on *Evaluating Mental Health Practice* (1987). Subsequently there has been a steady stream of related books and scientific and professional papers, some 100 in total. His current specialism is staff development.

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Laura Golding and Ian Gray
Chapter 1

What a Difference a Day Makes

Laura Golding and Ian Gray

The majority of applied psychologists, indeed NHS professionals in general, know that their continuing professional development is important. They take it seriously. But for some, when they hear the phrase ‘continuing professional development’ this is met by a yawn and then a groan. They think ‘log books’. They tot up the number of hours they have spent on activities that could ‘count’ as CPD and then they worry about whether these are the right ‘type’ of activities. They worry about where they will find the time, and the resources, to pursue CPD activities.

Having completed a first degree in psychology, and then a three-year doctorate in clinical psychology, most clinical psychologists feel as if they have learned enough on qualifying and want to be allowed to get into practice. However, many do want to attend conferences, read about new developments in their area of specialty and keep up to date. But, how many of us construe these activities as being the means to maintaining and improving our professional competence – about CPD? For many members of the profession, until very recently, CPD was just that. It was the pursuit of such activities, driven largely by a self-motivation to keep up to date and pursue areas of personal and professional interest. We cherry-picked courses and conferences according to individual preference inspired, perhaps, by a spate of referrals of a particular type or by the latest trend for a particular therapy or intervention. This was not about looking coherently at our service needs balanced against our own development needs as professionals. This was not about engaging in CPD activity as part of a coherent whole, as part of a multiprofessional NHS-wide commitment to maintaining and improving competence. It was a largely piecemeal, haphazard and uneconomical process.
Now though, the context has changed. Over the past few years, the need for all NHS professionals to undertake CPD activities regularly, based on needs identified through a systematic appraisal process, has become mandatory (Department of Health, 1998, 1999b). For applied psychologists, this was reinforced by the British Psychological Society’s members’ vote to make CPD activity mandatory for all chartered psychologists holding practising certificates in 2000 (BPS, 2003). This will become a legal requirement when the statutory regulation of all applied psychologists comes into place. With the Society’s rejection (BPS, June 2005a), of the current proposals for statutory regulation by the HPC, the when and the how of statutory regulation remains uncertain. The context has changed from one of voluntary cherry picking to mandatory, systematic selection of CPD activity. The day after we qualify as clinical psychologists, just when we thought we had done with formal learning, our life long learning begins – what a difference a day makes . . .

What is CPD?

Within the NHS, the terms ‘continuing professional development’ and ‘life long learning’ often seem to be used interchangeably. The Department of Health’s consultation paper, ‘Clinical Governance in the New NHS’ clarifies this by defining CPD as ‘a process of lifelong learning for all individuals and teams which meets the needs of patients and delivers the health outcomes and healthcare priorities of the NHS and which enables professionals to expand and fulfil their potential’ (DoH, 1999a). For the purposes of this book, the term continuing professional development is used to describe the activities we undertake that maintain and improve our professional competence (Miller, 1990).

This notion is developed further by the Professional Associations Research Network which highlights the wide applicability of this notion of CPD to any professional group: CPD is ‘any process or activity that provides added value to the capability of the professional through the increase in knowledge, skills and personal qualities necessary for the appropriate execution of professional and technical duties, often termed competence’ (Professional Associations Research Network, www.parn.org.uk).

The Health Professions Council’s literature on CPD makes the link between this process of CPD and registration: ‘CPD is learning that develops your knowledge and skills beyond the minimum’ required to achieve registration (HPC, 2003). The HPC is ‘developing a system
to link re-registration to continuous professional development’ (HPC, 2003). The HPC estimates that a system linking CPD to re-registration is likely to be in place in 2006.

**CPD for All**

Within the NHS, we are familiar with the notion of individuals completing their pre-qualification training fit for award, fit for practice and fit for purpose (QAA, 2003). The trick then, throughout our careers, is to ensure that we remain fit for purpose as our clinical training becomes a distant memory and the context in which most of us work, the public sector, constantly changes. This is achieved through our CPD activity. Regularly undertaking CPD activity of an appropriate type and quality should keep us safe to practice and fit for purpose throughout our careers.

Whether you have just qualified or have been qualified for 30 years and are the manager of a large psychology service, CPD is for you. CPD is, in fact, a great leveller. No matter where you are in the hierarchy, it is just as important – no one is immune from having to maintain and improve their competence. So, although the type of CPD activities that a newly qualified clinical psychologist may undertake will differ greatly to those undertaken by an experienced psychology manager and clinician, the importance to both is the same. We all need to ensure that we are fit for purpose, safe to practice and up to date throughout our careers. This book aims to set out the context for this need and provide readers with the research and relevant literature in the area as well as practical information about how to go about meeting our CPD needs throughout our careers.

**Continuing Professional Development for Clinical Psychologists: A Practical Handbook**

The changing context and hugely increased emphasis and importance placed on CPD within the NHS in recent years have meant that we have much to do in this area. We need to know about the best ways to go about meeting our individual CPD needs, and the needs of our services. We also need to know if what we are doing is effective. We need to link in with our colleagues in other professions and do some of our CPD activities with them. It seemed to us, that there is much to say on this subject and that this is about the right time to say it.
So, this book is a collection of edited chapters written by clinical psychologists, and others, who have expertise in professional issues and continuing professional development. It is aimed, primarily, at clinical psychologists working in the UK but is relevant reading for all applied psychologists working in healthcare as well as other health professionals, especially those who work in mental health. Here we aim to provide readers with an accessible, practical self-help guide to all you need to know about your own continuing professional development and that of the services and organizations you work in. The book has a clear practical focus throughout and aims to be a practical ‘how to do it’ handbook at a time when statutory regulation and other healthcare developments mean that undertaking CPD activity has renewed importance.

Chapter 2 asks ‘CPD, Why Bother?’. It takes us through a thorough look at what CPD is, its context in wider society and why it is important. It sets the context for why we do, indeed, need to bother about meeting our CPD needs in the most effective and systematic way possible. This is then followed, in Chapter 3, by a comprehensive overview of the policy context to the need for CPD in the NHS and the profession. This includes an overview of the relevant NHS legislation, the implications of statutory regulation, the role of the Health Professions Council and the impact of Agenda for Change and the NHS Knowledge and Skills Framework.

Chapter 4 explores the many practical issues involved in meeting CPD needs. This includes everything you need to know about undertaking CPD activities in local services including suggestions of funding sources for CPD activity, ways of doing CPD for free, finding out what CPD activities or materials are available through a comprehensive checklist to use when organizing conferences and courses. The next three chapters explore the CPD needs of members of the profession at different stages of their careers – newly qualified, transition to management and service manager level. These chapters discuss the literature and issues relevant to each career stage and describe examples of good practice within the UK where CPD initiatives are meeting identified needs.

Chapter 8 looks at evaluating CPD activity. In recent years, so much emphasis has been placed, within the NHS, on the need to undertake CPD activity but much less on the effectiveness of these activities and the overall process. Chapter 8 addresses the rarely discussed issue of outcome, drawing on examples from the research on supervision. This is followed by Chapter 9 which looks at the work of the British Psychological Society in relation to CPD for applied psychologists. The
Society has been engaged in a great deal of activity in this area for several years as the moves towards statutory regulation become mandatory for all. This chapter looks at the Society’s work and the additional role of the Division of Clinical Psychology and the Division’s guidance to members regarding CPD. Chapter 10 addresses the multi-professional context in relation to CPD. As a profession, we are often seen as being parochial when it comes to education and training within the NHS. In fact, the evidence suggests that we are engaged daily in work with members of a range of other health professions, including in our CPD activity (e.g., Golding, 2003). It is essential that our thinking and work around CPD is set within a wider multi-professional context and that we join our colleagues from other professions, as appropriate, in meeting some of our CPD needs jointly. This chapter looks at the work of some of the other major professional groups in this area and discusses the implications for us as a profession. Chapter 11 discusses in some detail the Knowledge and Skills Framework (KSF) and the joint work of the Society and Amicus (BPS June 2005b) to facilitate its implementation within the family of applied psychology. It links the KSF to the wider NHS CPD context and discusses the far-reaching implications of this new framework. The book ends with a chapter looking at the way forward in CPD for clinical psychologists and a guess at what is ahead in terms of the policy context. We provide lists of useful addresses and websites to enable readers to pursue the ideas and issues raised in this book further.

REFERENCES


Chapter 2

CPD: Why Bother?

David Green

Introduction

Continued professional development. The very phrase has a reassuring ring to it. It sounds like just the sort of activity that ought to be being undertaken in our universities and hospitals, where committed and competent healthcare professionals demonstrate their enduring commitment to become even more competent at their jobs. If ever there was an uncomplicated ‘good thing’ that deserves widespread public support, helping qualified doctors, nurses, clinical psychologists and their ilk keep up to date in current good practice is surely it! So why would the introductory chapter of a fine volume such as this start by sounding a loud and deliberately cautionary note? Because there is a lot more to the case for, and against CPD, than immediately meets the eye.

Definition

If investment in the continued development of clinical psychologists is to be justified certain essential components of the educational process must work and be seen to work. First the individual psychologist must find a way to recognize specific skills deficits that need to be remedied or identify developmental opportunities to expand their professional competence. Then she needs to seek out an appropriate training experience that will result in demonstrable changes in her capacity to perform her duties. Now she has to generate enough energy and enthusiasm to complete her chosen course of study. However staying the educational course is not an end in itself. The raison d’être of CPD is improving the quality of patient care by incorporating lessons
learned on Fancy Dan residential training events in the everyday good practice of health professionals. Finally, of course, there are economic realities to be considered. The cost/benefit sums must add up. We would be unwise to assume that achieving any of these elements is a straightforward business.

**Self-Appraisal**

Clinical psychologists undergo an extensive, and expensive, basic training during which they receive a constant flow of feedback designed to shape up their evolving skills. Surely we are entitled to assume that once qualified these characters will be equipped with the self-knowledge and theoretical awareness to allow them to critically appraise their own professional performance? They are psychologists after all. There is not much in the way of empirical evidence expressly concerned with the self-assessment skills of clinical psychologists, but research conducted with members of other health disciplines strongly suggests that we should take professionals’ claims to know their own training needs with a substantial pinch of salt.

When medical students enter training we would perhaps anticipate that, lacking prior experience on which to anchor their judgements, the novice doctors might make judgements of their competence that vary somewhat from the appraisals made by their course tutors. (Gordon, 1991). However we would expect the degree of this divergence to diminish over the course of medical training. In fact the opposite seems to be the case (Wooliscroft et al., 1993). On average self-appraisals of students’ performance moved away from, not closer to, the opinions of their educational mentors. This was not a result of staff and students using different criteria for judging professional competence. When medical students appraised their classmates, their views tended to converge with those of the tutors over time. The mismatch only came when students held a mirror up to themselves. Furthermore other studies suggest that neither the introduction of self-directed learning into the medical curriculum (Tousignant and DesMarchais, 2002) nor the accumulation of post-qualification experience (Tracey et al., 1997) do much to improve doctors’ capacity to appraise their own competence.

This makes psychological sense. Actors and observers have importantly different perspectives on the way they interpret their world (Jones and Nisbet, 1972). We are all prone to the ‘above average’ effect and tend to view our own achievements through somewhat
rose-coloured glasses (Alicke et al., 1995). Under most circumstances this is a highly adaptive stance to adopt and looking on the bright side can bestow significant health benefits (Snyder, 2000; Taylor et al., 2000). However the self-same systematic positive bias that protects patients can turn into a dangerous liability when employed by those charged with their care.

Marteau and colleagues (1989) reported an intriguing study investigating nurses’ assessment of their ability to resuscitate patients after cardiac arrest. The researchers asked nurses of varying levels of seniority and experience to gauge their own competence and provide a measure of their confidence in their own ability. Actual performance in life-support skills was then assessed against operationalized procedural standards. The nurses used a manikin to demonstrate how they would respond to a real patient who had lost consciousness following a heart attack. The results of this study are not reassuring. All nurses overestimated their competence. None got the procedure entirely right. Furthermore the mismatch between confidence and competence was most marked in the more experienced staff group. How could this happen? Apparently most nurses in this setting would only infrequently be called upon to administer life-support. As sadly these emergency interventions may not have resulted in the patient’s survival even when conducted properly, there was limited opportunity for collecting feedback on ineffective performance. We shall return to the pivotal role of feedback shortly.

Added to this suggestion that the more we progress in our careers the less capable we are of making a clear-eyed assessment of our abilities, is the repeated finding that it is the least capable members of any training cohort that are likely to have the most positively distorted view of their own capabilities (Kruger and Dunning, 1999) This has been described as a dual-handicap in that the learner is not only performing relatively poorly but does not appreciate that his work is substandard. As a consequence he lacks any motivation to improve. This persistent pattern has proved highly resistant to change probably because it is highly adaptive in terms of enhancing self-esteem under conditions of threat.

Another psychological trick we tend to employ to maintain our professional self-esteem involves favourably comparing our current capability with the way we formerly practised. So an experienced child clinical psychologist might shake her head in disbelief at how insensitive to picking up clues of potential sexual abuse she was earlier in her career. Nowadays of course she is on top of her game. This apparently reassuring developmental trajectory (‘from chump to champ’ as
described by Wilson and Ross, 2000) may boost practitioner morale but relying on the wisdom of hindsight has its costs. Do we have to wait until tomorrow to recognize what we could be doing better today?

The trouble is that it seems to take a lot for us to shift our established views of our own abilities (Ehrlinger and Dunning, 2003). We have our cherished theories of what we are (and are not) good at, and make generalized assumptions about how well we perform that seem to rely surprisingly little on the actual results of our efforts. These ‘chronic’ self-views may lead to unwise CPD decisions. The complacent will fail to take remedial action to correct their professional failings. The pessimistic may never take up the training opportunities that could help them achieve their full occupational potential. Women’s attitudes to a career in science are arguably a case in point (DeBacker and Nelson, 2000).

So the headline message from this brief and selective literature review is clear enough. Self-appraisal of our professional competence is neither easy nor straightforward. Those who most need to improve their skills are probably those who are least equipped to recognize their training needs. Furthermore the Great and Good of our trade are likely to be at least as prone to self-delusion as the rest of us!

Has clinical psychology therefore fallen at the first fence in the CPD steeplechase? Not necessarily. First let us not overstate our fallibility. The correlations between self-appraisals and objective measures of performance across a range of domains are consistently positive albeit weakly (Mabe and West, 1982). Second it behoves psychologists of all professions to pay heed to research findings suggesting ways to develop self-assessment skills (Gordon, 1992). We need to take the time and care needed to examine systematically the evidence that should inform our judgements (Parboosingh, 1998). Crucially this means being prepared to seek out the opinions of all those who can offer a legitimate and credible commentary on our working lives. It is not only (or indeed necessarily) a psychologist’s supervisor or line manager who is in a position to pass judgement on her professional competence. Several other important voices need to be heard – the defining principle of 360 degree feedback (Goodge and Burr, 1999). If it makes sense for trainee doctors undertaking placements in obstetrics to be evaluated by their patients and colleagues not only in medicine but also nursing and allied health professions (Joshi et al., 2004), it is not hard to envisage a comparable process that could be initiated by a clinical psychologist working in say a community mental health team. If, or as research findings would suggest, when these opinions differ significantly from the practitioner’s own appraisal of his or her performance,