

ASPPB Guidelines for Continuing Professional Development

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ASPPB Task Force on Maintenance of Competence and Licensure (MOCAL)

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Task Force Charge and Process

In June 2001, ASPPB published its *Guidelines for Continuing Professional Education*. In 2009, in light of the competency movement and other recent developments in the field, the ASPPB Board of Directors determined that the guidelines should be updated. The Board appointed a task force on the Maintenance of Competence and Licensure (MOCAL) with the following charges:

1. Revise and update the *ASPPB Guidelines for Continuing Professional Education* (June 2001) with input from member boards and other interested stakeholders.
2. Study the role that regulatory bodies in psychology can have in assuring that licensed/registered psychologists maintain their competence.
3. Make recommendations to regulatory bodies on how to implement maintenance of competence/licensure procedures.

The MOCAL Task Force has been working since then through conference calls, in-person meetings, and a larger work group meeting. Draft *ASPPB Guidelines for Continuing Professional Development* were submitted to the ASPPB Board of Directors and to the ASPPB membership, and were posted for comments on the ASPPB website. The larger work group took into account all the comments that had been received and made further suggestions for the Task Force to consider. The document that follows is the result of those efforts.

Introduction

These *Guidelines* address the broad concept of Continuing Professional Development (CPD). Not only is it expected that psychologists will continue to update their knowledge throughout their careers, but also that they will maintain and enhance their existing knowledge, skills and professional competencies. Further, it is anticipated that psychologists will maintain their competencies based on published advances in theory, practice and empirical research. Participation in continuing education is one way that psychologists maintain and enhance their knowledge and skills; however, it is not the only way, nor is it necessarily the most effective way.

CPD, as described in these *Guidelines*, is intended to continue and update the training of psychologists in their current areas of practice. The development of specialist competencies, or competencies in new areas (e.g., from general clinical to neuropsychology), is expected to be undertaken through a much more comprehensive, structured process beyond what would ordinarily be required for licensure renewal. On the other hand, CPD is *not* “business as usual”; rather, it is intended to maintain and build on existing competencies throughout a psychologist’s career, and to keep knowledge and practice up-to-date.

Assuring that psychologists maintain their competence serves the public protection mandate of psychology licensing boards and colleges. Consequently, appropriate CPD encompasses more than training in ethics and laws; it also addresses the knowledge, skills, and attitudes necessary to maintain and enhance competent practice.

Adapting the definition of “competency” found in the Oxford Dictionary to the practice of psychology, Kaslow, Dunn & Smith (2008) described competency as “an individual’s capability and demonstrated ability to comprehend and perform certain tasks appropriately and effectively and in a fashion that is consistent with the expectations for an individual qualified by education, training, and credentialing. It is not an absolute or static process, but rather a dynamic process that entails continual professional development”(p.19).

Epstein & Hundert (2002) described competence as including the “habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and

community being served” (p. 226). Further they noted that competence involves “habits of mind that allow the practitioner to be attentive, curious, self-aware, and willing to recognize and correct errors” (p.228).

Consumers assume that professional regulatory organizations are ensuring that licensees maintain their competence to practice. However, one consumer advocacy group has recommended that regulatory organizations “go beyond imposing mandatory continuing education (CE) to require ...periodic *assessment* of knowledge, skills, and clinical performance; development, execution, and documentation of an *improvement* plan based on the assessment; and periodic *demonstration* of current competence” (Swankin, LeBuhn & Morrison, 2006, p. iii).

For our purposes, at a minimum, competence is understood to comprise knowledge, skill, judgment and attitudes, which when integrated, result in appropriate and effective action being taken in a particular situation (Rodolfa, Bent, Eisman, Nelson, Rehm & Ritchie, 2005). Further there is an expectation that these components must be continuously refreshed and updated in order to maintain competence. These *Guidelines* are intended to assist psychology regulatory boards and colleges in meeting their mandate to assure consumers that licensees are competent to practice.

Continuing Professional Development (CPD)

CPD stands as a professional and ethical obligation of every psychologist. In psychology, the traditional way of defining this ongoing professional development has been in terms of Continuing Education (CE), which usually refers to formal learning activities conducted in classroom or workshop settings. CPD is a broader concept, referring to the continuing development of the multi-faceted competencies needed for quality professional performance in one’s area of practice. For the professional practice and regulation of psychology, those areas of competency have been identified by a national sample of psychologists as Scientific Knowledge; Evidence-Based Decision Making/Critical Reasoning; Interpersonal and Multicultural Competence; Professionalism/Ethics; Assessment; and Intervention/Supervision/Consultation (ASPPB, 2010). An emerging area of competence that has been identified as important is Interprofessional Collaborative Practice (e.g., Spring, 2011).

CPD activities have as their foundation a continuing learning process, starting during graduate training and continuing as long as the practitioner is engaged in professional activities. The shaping, reshaping and development of a psychologist involves responding to changing societal and individual needs, in the context of evolving science, technologies, and professional activities (World Federation of Medical Education, 2003). CPD is essential to maintain professional competencies, to remedy gaps in knowledge and skills, and to enable professionals to respond to the challenges of rapidly growing knowledge and technology as well as changing practice requirements and structures in which that practice occurs.

In psychology the content of CPD should be based on evidence-based practice where possible. Evidence-based practice refers to the importance of integrating scientific knowledge, professional experience, and client characteristics into professional practice. The American Psychological Association (APA, 2005) provides a broad definition of evidence-based practice:

Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences. This definition of EBPP closely parallels the definition of evidence-based practice adopted by the Institute of Medicine (2001, p. 147) as adapted from Sackett and colleagues (2000): "Evidence-based practice is the integration of best research evidence with clinical expertise and patient values." The purpose of EBPP is to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention (p.1).

An examination and understanding of two other issues in the field of professional psychology is critical to the development of CPD guidelines that jurisdictions can use to help ensure the ongoing competence of their licensees. They are: self-assessment, and outcome assessment of CPD. These two issues are briefly presented here and are discussed in detail in Appendix E.

Self-Assessment

A key assumption in much of adult education and continuing professional education is that the professional accurately determines what knowledge and skills he or she needs

to acquire or enhance, and then plans and selects appropriate methods to acquire or to enhance the needed knowledge and skills (Wise, 2010).

Research suggests that there are weaknesses to relying on self-assessment to determine professional development needs (Kruger & Dunning, 1999; Eva & Regehr, 2005). Those who are objectively more competent in their professional activities, especially those in the top quartile, tend to underestimate their competence relative to their peers. However, they were more accurate in assessing their absolute score on a performance test. Of greater concern, those who are objectively less competent overestimate their competence, especially those individuals whose competence falls in the bottom quartile. In addition, these less competent individuals may not benefit from observing a competent model (Kruger & Dunning, 1999); it seems that they do not recognize competence when they see it. They may not have the knowledge and expertise necessary to evaluate their competence adequately (Dunning, Heath & Suls, 2004).

It may be possible to increase the accuracy of self-assessment. Providing additional training in the knowledge and skills required for one's work increases the accuracy of self-assessment of competency (Kruger & Dunning, 1999). Providing objective feedback through tests and measures or feedback from peers may also improve the accuracy of an individual's self-assessment of competency (Dunning et al., 2004). Self-assessment may itself be a competency or even a meta-competency (Hatcher, 2011).

Outcomes

There are related but somewhat different meanings of the term "outcome" with respect to this report: (1) measuring and enhancing outcomes of CPD activities and (2) enhancing client/patient outcomes through monitoring progress. Both are important in developing and administering CPD programs and in attempting to ensure that the eventual outcome of CPD is competent professional practice.

Measuring and Enhancing CPD Outcomes

There are many ways that the effectiveness of CPD activities can be measured. One widely cited model for evaluating training outcomes is that of Kirkpatrick (1967); this model is discussed in Appendix E. More specifically for this report, one of the more

useful schemes for evaluating the effectiveness of CPD activities was developed by Milne, James, & Sheikh (2006). Their proposed system is as follows:

1. What is the right thing to do? This is the judgment about what needs to be learned and is guided by sources such as theories of psychopathology and mechanisms of change, clinical guidelines, treatment manuals, and professional consensus. However, there is limited consensus in the practice or academic communities as to what practitioners need to know to maintain or enhance their clinical or applied skills.
2. Has the right thing been done? Basically, this refers to whether there is a good match between knowing what the right thing is to do and what has actually been presented.
3. Has it been done right? This addresses whether the activity has been presented skillfully using an effective method. There is considerable research and theory in clinical, cognitive, and industrial/organizational psychology; medicine; educational settings; human resources; and adult learning that should inform the development and administration of CPD activities.
4. Did it result in the right outcomes? Outcomes can be roughly broken down into affective outcomes (satisfaction), acquisition of knowledge (subjective opinions or objective measures), transfer of knowledge and skills into the workplace (Sitzmann, Ely, Brown, & Bauer, 2010), and in the practice arena, the impact of the activity on client/patient care and on outcomes. In psychology, there is little empirical research on CPD outcomes, with the exception of surveys of participants' views regarding the value of the activities (Neimeyer, Taylor & Wear, 2009).
5. Was the CPD context right? This refers to whether the professional environment can serve as a booster or a barrier to introducing new learning into direct client care, e.g., peer and administrative support, practice opportunity (Brown & Sitzmann, 2011).

It is clear that more research aimed at systematically evaluating the utility of different methods of CPD delivery on transfer of new learning into practice, and the effects of this new learning on outcomes, is needed.

Enhancing practice outcomes through monitoring client/patient progress

There is one model of evaluating outcomes that bypasses many of the complexities detailed above. Michael Lambert and colleagues note in a series of publications that, while there has been an increased emphasis on quality assurance by policy makers and insurance carriers, less than one-third of practitioners systematically assess their own treatment outcomes to evaluate the quality of their work. A number of studies have shown that direct monitoring of clients'/patients' progress can dramatically improve outcomes, particularly in those clients/patients who are at risk for intervention failure (e.g., Lambert, 2010; Duncan, 2011).

In summary, in spite of the fact that there is little direct research on effective methods of CPD, much can be extrapolated from research in non-clinical settings, indicating that assessment in applied settings on ongoing client or patient progress offers a promising tool to enhance the effectiveness of service delivery. Research on effective methods of CPD is necessary to provide knowledge of what CPD methods actually can change psychologists' behavior. The Task Force therefore is recommending that CPD credit be given for monitoring client/patient progress. (A more detailed review of the professional literature on outcomes is available in Appendix E.)

Rationale for the Guidelines

CPD is part of a pattern of lifelong learning that begins with graduate training in psychology. It is **not** a substitute for the basic academic education and training needed for entry to the field of psychology, nor can it be the primary vehicle for career changes from one recognized specialty area (e.g. clinical, counseling, or school psychology) to another whose practice requires different training and different skill sets (e.g., neuropsychology, forensic, or consulting psychology).

Currently 52 jurisdictions of ASPPB's 64 member jurisdictions (See Appendices A & B) recognize the need for continuing professional development by requiring that continuing education be taken as one component of licensure renewal. These *Guidelines* are being written in part to provide a strong rationale for mandating CPD across jurisdictions.

The public believes and expects that licensed professionals remain current and competent in their areas of practice (Finlayson & Dewar, 2001). The public also believes professionals are required to demonstrate evidence of continued competency in order to maintain licensure (Neuberger, 2000). Competence is a cornerstone of ethics codes for psychologists, and psychologists are expected to practice only in their areas of competence and in a “competent” manner (APA, 2002; CPA, 2000). Research suggests that one-time continuing education workshops or classes do very little to ensure continued competence, and continuing education classes seem to have very little impact on how people practice (O’Brien, Freemantle, Oxman, Wolf, Davis, & Herrin, 2007). Research also has demonstrated that professionals are inaccurate when assessing what they need in the way of education and training to help them continue to practice competently (e.g., Krueger & Mueller, 2002; O’Brien et al., 2007). In other words, the systems for continuing education that jurisdictions have put in place to help ensure public protection and continued competence of their psychologists, may be inadequate, or at least have not been demonstrated to ensure continuing competence.

An important function of regulatory bodies is to investigate complaints and implement educative and disciplinary measures as appropriate. The association between continuing education and the prevention of disciplinary actions has not been established, and indeed, has been questioned (Rodolfa, Schaffer & Webb, 2010). Further, there does not seem to be an association between the presence of formal, public disciplinary actions or malpractice claims and professional competence (Reid, Adams, McGlynn & Mehrotra, 2010).

What **has** been demonstrated to contribute to ongoing maintenance of competence, enhanced orientation to lifelong learning, CPD, and ultimately public protection, is variety in the kinds of learning activities in which professionals engage (Hojat, Veloski, Nasca, Erdmann, & Gonnella, 2006; Hojat, Valoski, & Gonella, 2009), especially if the variety of activities focuses on one content area (Institute of Medicine, 2010); activities that continue over time (Jameson, Stadter, & Poulton, 2007); and activities that include ongoing feedback and formal follow-up (Grant, Chambers & Jackson, 1999, as cited in WFME, 2003). Further, it has been suggested that professional isolation can be a barrier to maintaining one’s competence (Courtney & Farnworth, 2003), and that individuals who practice in isolation from others run the risk of becoming less aware of current practice standards (Lewkonja, 2001). Systematically monitoring one’s own practice has also been demonstrated to improve client/patient outcomes (Babins-

Wagner, 2011; Lambert, 2010). (A more detailed discussion of these factors can be found in Appendix E.)

Purposes for the *Guidelines*

These *ASPPB Guidelines for Continuing Professional Development* are meant to assist jurisdictions by providing recommendations for implementation of a program of mandatory CPD that uses the research about continuing professional development to create a mechanism for licensees to maintain their competencies and continue a process of lifelong learning. They are meant to assist jurisdictions to identify their licensees' areas of practice at initial licensure and at each renewal period thereafter, thus providing a framework for each licensee's continued professional development. These *Guidelines* are based on a model of competencies identified by the ASPPB Practice Analysis (2010) that have been deemed necessary for professional practice in psychology, and they encourage evidence-based activities, a continuing professional development plan, and assessment of outcomes. While these *Guidelines* themselves are not evidence-based (the evidence for what actually works in CPD is not robust), they are informed by the evidence that is available.

Implementing a program of mandatory CPD will help create consistency in professional standards across jurisdictions. Mandated CPD also contributes to public protection by setting standards for continuing professional competence, and mandated CPD identifies and makes transparent a jurisdictional commitment to ensuring the highest ethical responsibilities for its licensees. The delivery of high quality psychological services and the commitment to the highest professional ethical standards must be the driving force for each psychologist's participation in CPD activities; but jurisdictions can help provide a structure that facilitates this very important commitment.

ASPPB Guidelines for Continuing Professional Development (CPD)

The following *Guidelines* are intended to assist jurisdictions in developing CPD requirements for their licensees/registrants. ASPPB supports the effort to achieve mobility in licensure and believes that greater standardization of CPD requirements will contribute to that effort. A sample of these *Guidelines* written in regulatory language is available in Appendix G.

Continuing Professional Development Plan

To optimize the value of CPD activities, psychologists should proceed in a thoughtful and self-reflective manner. To that end, it is recommended that each psychologist create a professional development plan at every license renewal cycle. The plan should be informed by a combination of self-reflection on the psychologist's own practice experience, input from peers and mentorship groups, and developments reported in the professional and research literature. The plan should be developed at the beginning of the licensure renewal cycle and should include areas of focus identified by the self reflection, proposed CPD activities, timelines for completion of those activities, and means to evaluate the impact of the CPD activities on the psychologist's practice. The psychologist should attest to its completion on the licensure renewal form. The professional development plan would serve as a tool for the psychologist's own use and could be modified during the licensure renewal cycle. The plan should be available for audit by the regulatory body. (A sample professional development plan is included in Appendix F.)

In light of the current debate regarding the value of self-assessment in the maintenance of competence, these *Guidelines* do not include a formal recommendation for self-assessment. Research has found that those who are less competent overestimate their competence as compared to evaluations by peers or by objective measures, but the accuracy of self-assessment may be improved with further training (Sitzmann, et al., 2010). It is hoped that future research will provide a self administered, structured, objective tool that can assist in informing a licensee's approach to appropriate continuing professional development.

Areas of Practice

It is recommended that at initial licensure and at each renewal period, jurisdictions require their licensees/registrants to identify their areas of practice. (Appendix C includes a recommended structure for identifying area of practice.)

Credits

The Task Force recognizes that most practitioners currently acquire more than the credits required by their licensing boards and colleges for license renewal, and these *Guidelines* in no way are meant to discourage this practice. These *Guidelines* present the number of suggested CPD credits required for licensure renewal, but they do not propose that practitioners limit their CPD activities overall.

It is recommended that jurisdictions require 40 *credits* of CPD every two years. The concept of *credits* replaces the concept of *hours*, since many of the recommended activities do not have an hourly component. Forty (40) credits are recommended because that is the modal number of hours of CE jurisdictions currently required, and we see no justification to change that number. Licensure renewal periods differ among jurisdictions; however, every two years is also the modal figure. If jurisdictions have a different licensure renewal period, it is recommended that the number of credits be adjusted accordingly, e.g. that there be 20 credits every year, or 60 credits every three years.

Mandated Credit Areas

The Task Force considered what, if any, credit areas should be *mandated* for licensure renewal. After considering a number of suggested areas, our aim was to be able to give some direction about what we considered important, not only at entry to practice, but throughout one's professional career. Additionally, the Task Force thought it important to allow flexibility to jurisdictions in deciding on appropriate areas for required CPD and to psychologists in their overall plans for obtaining CPD. Even though we did not find any reliable evidence to support the relationship of specific CPD credits in ethics and enhanced competence, the task force feels it is important for psychologist to remain updated in this area. Therefore, the Task Force recommends that 3 credits in Ethics, Risk Assessment, and/or Jurisdictional Rules and Regulations be required for each renewal period. These credits may be obtained through various activities, e.g., ongoing peer consultation, sponsor approved CE workshops; but it is recommended that there

be an evaluation component to the CPD in order to obtain these credits.

Mode of Delivery

One aim of these *Guidelines* has been, as much as possible to utilize the evidence there is about how adults learn, what ensures knowledge retention, and what contributes to ongoing competency. Although the research is limited, we know that people have different learning styles, that reducing isolation contributes to the likelihood of changes in practice and to keeping current, and that content conveyed by various methods is more likely to be retained.

Further, task force members determined that flexibility was key in terms of helping ensure that psychologists are able to take advantage of the variety of ways that people learn and thus how CPD credits can be earned. The Task Force did not find any evidence that a particular amount of in-person CPD is beneficial or that a particular amount of electronically mediated CPD is problematic. Given advancements in technology and issues of accessibility, the task force decided not to put any limit on the number of credits that can be earned by electronically mediated CPD.

CPD Activities

It is recommended that the following 10 activities, with associated credits, constitute the range of CPD activities. A psychologist can meet the CPD requirements with any combination of these activities as long as they add up to at least the recommended 40 credits. Most of the activities have caps or maximums (and one, Peer Consultation, has a minimum) on the credit values allowed, thus it will generally be necessary to be involved in more than one of the activities to reach 40 credits. Table 1 identifies each activity with its associated number of credits (based on 40 credits every two years). A more thorough description of each activity follows Table 1. Appendix H contains a table of the activities, rationale for each activity and the activity's relationship to the competencies identified in the Practice Analysis (ASPPB, 2010).

CPD Activities and Credit Values
TABLE 1

CPD Activity	Maximum # of Credits Allowed each Renewal Period	Value of Credits by Activity
Professional		
1. Ongoing Peer Consultation (including but not limited to case consultation, journal clubs, research groups; mentoring)	Minimum 10*/ Maximum 20 (*If this activity is chosen, a minimum of 10 credits is required)	1 hour = 1 credit
2. Practice Outcome Monitoring (assessing client/patient/patient outcomes via protocol)	20	1 client/patient = 1 credit
3. Professional Activities (including but not limited to serving on psychological association boards or committees, editorial boards of peer reviewed journals related to psychology, scientific grant review teams or board member of regulatory body)	10	1 year = 10 credits
4. Conferences/Conventions (attendance time as distinguished from CE credits)	5	1 conference day = 1 credit
Academic		
5. Academic Courses (taking courses from a regionally accredited institution, a graduate-level course for credit that is related to psychology)	20	1 credit course = 7 credits 2 credit course = 14 credits 3 credit course = 20 credits

<p>6. Instruction (teaching a course related to psychology in a regionally accredited institution, full day sponsor-approved or half-day sponsor-approved workshop presentation; only counts first time teaching or presenting)</p>	<p>20</p>	<p>1 course = 20 credits 1 full day workshop = 10 credits ½ day workshop = 5 credits</p>
<p>7. Publications (peer-reviewed articles, book chapters or editor or coeditor of peer reviewed journal)</p>	<p>10</p>	<p>1 publication = 10 credits</p>
<p>Continuing Education</p>		
<p>8. Approved Sponsor Continuing Education (any activity provided by approved sponsor organizations defined in CPD guidelines)</p>	<p>30</p>	<p>1 hour = 1 credit</p>
<p>9. Self-directed learning related to one's professional activities (readings, videos, electronically mediated presentations, unsponsored activities)</p>	<p>5</p>	<p>1 hour = 1 credit</p>
<p>Board Certification</p>		
<p>10. Board Certification (can count for 100% of required CPD in the year that certification is awarded)</p>	<p>40</p>	<p>Certification awarded = 40 credits</p>

Documentation requirements for each activity are defined in Table 2.

Professional

1. *Peer Consultation*: “Peer Consultation” refers to a structured and organized system of interaction with colleague(s) designed to help broaden professional knowledge and expertise and reduce professional isolation. Meeting with colleague(s) in research groups, journal clubs, and case consultations, with a structured, organized format, in person or electronically mediated, that focuses on professional practice would count for up to 20 credits, with a minimum of 10 credits (if this activity is chosen then a minimum of 10 hours of peer consultation is required to meet the CPD requirements) per renewal cycle, one hour of peer consultation being equal to one credit.
2. *Practice Outcome Monitoring*: “Practice Outcome Monitoring (POM)” refers to the periodic application of outcome assessment protocols with clients/patients, in order to monitor one’s own practice process and outcomes. POM of ongoing therapy clients/patients should include repeated measures. POM can help assess whether or not one’s approach to practice is effective and whether that effectiveness can be enhanced. Participation in an organization’s (e.g., business, hospital, healthcare, etc.) quality assurance program that focuses on monitoring client outcomes is another means of evaluating one’s practice that could be included in this category. POM involves the use of a standardized assessment tool. Practice Outcome Monitoring counts for up to 20 credits every two years, with one client/patient outcome assessment (or series of assessments as appropriate to the practice endeavor) being equal to one credit.
3. *Professional Activities*: “Professional Activities” refers to ongoing participation in professional associations and other professional organizations. This helps to ensure that the public service work of the profession is supported and helps to reduce professional isolation. Service on regulatory boards, within professional psychological associations (boards, and committees - with the exception of professional lobbying activities for psychology), and scientific grant review teams for one full year would count for up to 10 credits for the two-year renewal cycle.

4. *Conference/Convention*: “Conference/Convention” refers to attending, in person, professional conferences/conventions related to psychology in order to interact with colleagues and participate in the social, interpersonal, professional, and scientific activities which are part of the milieu of conferences and conventions. These credits are in addition to attaining continuing education credits at conferences and conventions from Approved Sponsor Continuing Education addressed below. These credits are for activities for which the attendee does not earn approved sponsor continuing education. Attendance at conferences/conventions would count for up to 5 credits every two years, with one conference day being equal to one credit.

Academic

5. *Academic Courses*: “Academic Courses” refers to taking, for credit, a graduate-level course related to psychology from a regionally accredited institution, either in person or electronically mediated. Coursework could be in a variety of areas, but must be demonstrated to relate to psychology and to help manage the professional, scientific, business or administrative aspects of one’s profession more effectively. Taking the equivalent of one semester-long one credit course would count for 7 credits; taking the equivalent of one semester-long two credit course would count for 14 credits; and taking the equivalent of one semester-long three credit course would count for 20 CPD credits every two years. The maximum number of credits allowed for this category is 20 credits every two years.

6. *Instruction*: “Instruction” refers to teaching, for the first time, in a regionally accredited institution, a semester-long graduate or undergraduate course related to psychology. It also refers to presenting, for the first time, a day long (6 hours) approved sponsor workshop or a half-day (3 hours) approved sponsor workshop that relates to the practice of psychology. This kind of activity is seen as a means to advance one’s own competencies as well as to educate others. Either of these activities may be taught in person or may be electronically mediated. Teaching a semester-long (or equivalent) course for the first time counts for 20 CPD credits every two years. Presenting a day-long workshop for the first time counts for 10 CPD credits, and presenting a half-day workshop for the first time counts as 5 CPD credits every two years. The maximum number of credits allowed for this category is 20 credits every two years.

7. *Publications*: “Publications” refers to authoring book chapters, editing or co-editing a book, authoring peer-reviewed articles, or editing or co-editing a peer-reviewed journal. This activity would benefit both the psychologist who does the writing and the intended audience. “Publications” must be related to the profession of psychology and counts for up to 10 credits every two years.

Continuing Education

8. *Approved Sponsor Continuing Education*: “Approved Sponsor Continuing Education” refers to attendance at any activities provided by approved sponsor organizations described in the Compliance and Enforcement section below. “Approved Sponsor Continuing Education” would count for up to 30 credits every two years, with one hour of workshop being equal to one credit.

9. *Self-Directed Learning*: “Self-Directed Learning” refers to reading books, or scientific journals, listening to tapes or reviewing electronically mediated presentations or other professional learning activities on one’s own. “Self-Directed Learning” would count for up to 5 credits every two years, with one hour spent on this activity being equal to one credit.

Board Certification

10. *Board Certification*: “Board Certification” refers to earning certification from the American Board of Professional Psychology (ABPP). ABPP certification requires psychologists to demonstrate to the satisfaction of experienced peers, through a structured and well-formulated process, that they are competent in intervention, assessment, and consultation in their area of practice. Additionally, psychologists are examined on ethical and legal issues, scientific bases for their services, supervision/teaching/management, interpersonal interactions, individual and cultural diversity, and professional identification. This level of examination and scrutiny is considered the “gold standard” and serves as the best indicator our profession currently has of assuring that licensed psychologists are maintaining their professional competence. A single, voluntary board encompassing all of the recognized specialties is considered to be the appropriate designator for board certification. Currently, the only organization recognized by the Council of Specialties, an independently incorporated non-profit organization representing and

supporting the development of specialties in psychology, is the American Board of Professional Psychology (ABPP). Being awarded an ABPP counts for all 40 credits required for the two-year renewal period.

Assignment of Number of Credits

The Task Force used several methods in determining the number of credits to be assigned (maximums, and minimums where applicable) to each activity. The total allocation of 40 credits was based on the modal number of hours required by licensing boards for CE during each two-year renewal cycle. The initial allocations of activity credits were developed through a consensus approach among the Task Force members. However, allocations were adjusted after consideration of input received from surveys of ASPPB's member jurisdictions and from the APA Continuing Education Committee. The steps taken to arrive at the current number of credits for each activity are described more thoroughly in Appendix I.

Sponsorship and Verification

If the CPD activity requires sponsorship, it must be provided by an approved sponsor. Qualifying programs include those offered by the American Psychological Association or any of its sponsors approved through the American Psychological Association Sponsor Approval System (APA, 2005), the Canadian Psychological Association Approval of Sponsors of Continuing Education for Canadian Psychologists (CPA, 2005), the Academies of the Specialty Boards of the American Board of Professional Psychology, the Association for Psychological Science, the National Association of School Psychologists, Association of State and Provincial Psychology Boards, regionally accredited educational institutions that offer graduate training in psychology or related fields, accredited medical schools, Category I Continuing Medical Education (CME) of the American Medical Association, the Canadian Medical Association, the American Bar Association, and the Canadian Bar Association. Courses offered by non-psychology organizations must be relevant to the practice of psychology.

An organization, association, person, or entity must assume full responsibility for the program(s) offered and provide qualifications acceptable to the licensing board or college or its designee if so requested. Providers/sponsors are responsible for assuring the educational quality of the material presented, and are responsible for measuring achievement of the stated educational goals and objectives of the CE program. The

educational programs must be specifically applicable and pertinent to the practice of psychology and offer content that is post-graduate in nature, accurate, objective, timely, and where available, evidence-based. Finally, providers/sponsors should be held accountable for meeting all applicable local, state, provincial, and federal standards, and for the payment of any applicable provincial, state, or federal taxes or fees.

Approved sponsors must provide demonstration of acquisition of the knowledge, skills or attitudes consistent with the program's objectives. Surveys of participants' satisfaction are not sufficient to meet this requirement. The delivery method of the CPD may be in person or electronically mediated as long as provided by an approved sponsor.

Table 2 contains the recommended types of documentation and verification jurisdictions can use for each type of CPD activity. For more details of each activity see descriptions above.

CPD Sponsorship and Verification
Table 2

Continuing Professional Development Activity	Maximum # of Credits Allowed each Renewal Period (2 years)	Value of Credits by Activity
<p>1. Ongoing Peer Consultation</p> <p>Documentation/Verification - Required documentation would be a completed Ongoing Peer Consultation Form with indication of structured program of consultation, regularly scheduled meetings, with attester's signature. Attester must be the designated recorder and attestation should include dates, nature of consultation, number of hours, recorded on the verification form. Minimum of 10 credits per renewal cycle is required if this activity is chosen to satisfy renewal requirements.</p> <p><i>Completed Verification Form (Appendix D) (must provide evidence that it is a structured program of consultation with regularly scheduled meetings and nature of consultation).</i></p>	<p align="center">Minimum of 10 credits Maximum of 20</p>	<p align="center">1hour=1 credit</p>

<p>2. Practice Outcome Monitoring</p> <p><u>Documentation/Verification</u> -. Documentation includes completed verification form identifying type of assessment protocol, frequency of use with each client/patient and a copy of the protocol(s).</p> <p><i>Completed Verification Form (Appendix D) (must include number of times protocol(s) was administered to each client/patient a copy of protocol(s) used).</i></p>	<p>20</p>	<p>1 client/patient = 1 credit</p>
<p>3. Professional Activities</p> <p><u>Documentation/Verification</u> – External verification of participation in activity (e.g. editorial page of journal, letter from organization verifying appointment and participation)</p> <p><i>Completed Verification Form (Appendix D) (along with documentation from professional organization)</i></p>	<p>10</p>	<p>1 year=10 credits</p>
<p>4. Conferences</p> <p><u>Documentation /Verification-</u> <i>Conferences/Conventions-Copy of registration materials.</i></p>	<p>5</p>	<p>1 conference day= 1 credit</p>

<p>5. Academic courses</p> <p><u>Documentation/Verification</u> –<i>Course transcript</i></p>	<p>20</p>	<p>1 credit course = 7 credits 2 credit course = 14 credits 3 credit course = 20 credits</p>
<p>6. Instruction</p> <p><u>Documentation/Verification</u> - Instruction- documentation from university or workshop.</p> <p><i>Documentation of first-time presentation from workshop or institution (e.g., announcement, course catalog, registration materials); attestation from psychologist stating first time presenting</i></p>	<p>20</p>	<p>1 course= 20 credits 1 full day workshop = 10 credits ½ day workshop = 5 credits</p>
<p>7. Publications</p> <p><u>Documentation/Verification</u> -Publications must be peer-reviewed only.</p> <p><i>Publications-copy of first page of article or book chapter</i></p>	<p>10</p>	<p>1 publication= 10 credits</p>

<p>8.Approved sponsored Continuing Education</p> <p><u>Documentation/Verification</u> -Appropriate documentation from sponsor.</p>	<p>30</p>	<p>1 hour=1 credit</p>
<p>9. Self-directed learning</p> <p><u>Documentation/Verification:</u> Self-directed learning (reading, videos-involves an unsponsored activity).</p> <p><i>Self-Directed Learning- Verification Form completed. Completed Verification Form (Appendix D)</i></p>	<p>5</p>	<p>1 hour=1 credit</p>
<p>10. ABPP Certification.</p> <p><u>Documentation/Verification</u>-Verification from ABPP stating date certification was awarded.</p>	<p>40</p>	<p>Certification awarded= 40 credits</p>

Compliance and Enforcement

Record Keeping

Licensees should retain copies of accepted documentation of CPD, including proofs of attendance (e.g., certificate of attendance, university course transcript), course outlines, verification forms, and published CE content and presenters for at least two (2) licensing cycles.

Each jurisdiction has the authority to accept CPD documentation from the ASPPB Credentials Bank and to consider this documentation as primary source documentation. Licensees should refer to the specific category to ascertain what documentation is

required. Some of the categories will require using a customized verification form (Appendix D-1). Licensees may use the CPD log (Appendix D) to maintain records of completed CPD. Some jurisdictions may wish to have all licensees send in a completed CPD log with each renewal.

Attestation

As part of the renewal process, the licensee should be required to sign an attestation of completion of the mandated CPD. The attestation and/or penalty of perjury statement should be part of the license renewal form. Licensees should be informed of the disciplinary implications of falsely signing the renewal statement.

Audit

All psychologists are subject to audit to ensure compliance with CPD requirements. It is recommended that at least 5 to 10% of licensees be audited each renewal cycle. Auditing of all licensed psychologist board/college members and any licensees/registrants who have been subjected to a board or college action is advised for every renewal cycle during their tenure or disciplinary period.

Exceptions

Psychologists who are licensed during the first year of the biennial renewal period must obtain 20 credits of CPD. Any psychologist licensed during the second year of the biennial renewal period will **NOT** be required to obtain any CPD credits to renew his/her license for the first time.

Situations may arise in which it is appropriate to modify the CPD requirements for certain licensees. These modifications should be developed at the individual jurisdictional level. The board or college has the authority to issue a waiver of required CPD or to be more flexible regarding what content areas are required for CPD. If a license/registration has been in inactive status for more than one year, the psychologist should be required to complete 20 CPD credits prior to reactivating the license.

Sanctions

Further disciplinary action should be considered when licensees continue to practice psychology while failing to comply with mandated CPD.

Failure of CPD Audit: While many times CPD audits will occur during licensure renewal periods, the Task Force is focused on sanctions for failing a CPD audit rather than consequences for failing to renew one's license. Failing a CPD audit occurs when the board/college deems that the licensee has not completed the required credits in the required time frame. In these cases, a disciplinary action (letters of concern or reprimand, fines...) should be pursued. Additionally the licensee should have no more than 3 months to complete the required CPD and the CPD completed for this purpose should not count towards the next reporting cycle. Further, the licensee should be audited in the next reporting period. However, depending on the severity of the infraction, a formal and public disciplinary action may be deemed necessary that could include more stringent consequences.

Appeal: The licensee shall have 30 days to appeal the decision made as a result of the CPD audit. After 30 days, discipline should be pursued per Board/College authority.

Multiple Licenses

Psychologists must meet the specific CPD requirements for each jurisdiction in which he/she is licensed. CPD credits earned in one jurisdiction should transfer to other jurisdictions.

APPENDIX A

Current Jurisdictional Mandated CE

For more information regarding individual jurisdictional requirements for Continuing Professional Development (Continuing Education), please visit the ASPPB website at <http://www.asppb.org/HandbookPublic/Reports/default.aspx?ReportType=ContinuingEducation>

APPENDIX B

Board Contact Information

For information on how to contact a psychology licensing board in the U.S. and/or Canada, visit the ASPPB website at

<http://www.asppb.net/i4a/pages/index.cfm?pageid=3395>

APPENDIX C

Declaration of Psychological Practice Form

Declaration of Psychological Practice
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All licensee applicants are asked to state their areas of practice in psychology. The declaration will be considered in the context of the competences identified in the educational preparation and experience of the applicant.

A. Check the appropriate area(s) of psychological practice* below:

1. Clinical Psychology		8. Family Psychology	
2. Counseling Psychology		9. Industrial-Organizational Psychology	
3. School Psychology		10. Clinical Neuropsychology	
4. Forensic Psychology		11. Professional Geropsychology	
5. Behavioral & Cognitive Psychology		12. Psychoanalytic Psychology	
6. Clinical Health Psychology		13. Other (specify)	
7. Clinical Child Psychology			

*Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP) recognized areas of practice

B. Once you have indicated your area(s) of practice, use the corresponding numbers above to identify the activities and services you intend to provide and the clients to whom you will provide these services.

Clients	Administration	Consultation	Assessment/ Evaluation**	Intervention/ Treatment***	Research	Other (specify)
Infants						
Children						
Adolescents						
Adults						
Elderly						
Families						

Groups						
Organizations						
Other (specify)						

C. You declare you are competent to provide services in:

English	
French	
Spanish	
Other languages (list)	

Applicant's Signature

Date

APPENDIX D

OVERALL CPD LOG

CPD Category	Description of Activity Completed	Date Completed	# of Credits Awarded	Total Allowed Credits Earned for Category
1. Peer Consultation (up to 20 credits allowed)				
1. Peer Consultation (up to 20 credits allowed)				
Total Credits				
2. Practice Outcome Monitoring (up to 20 credits allowed)				
2. Practice Outcome Monitoring (up to 20 credits allowed)				
Total Credits				
3. Professional Activities (up to 10 credits allowed)				
3. Professional Activities (up to 10 credits allowed)				
Total Credits				
4. Conferences/Conventions (up to 4 credits allowed)				

4.Conferences/Conventions (up to 4 credits allowed)				
Total Credits				
5.Academic Courses (up to 20 credits allowed)				
5.Academic Courses (up to 20 credits allowed)				
Total Credits				
6. Instruction (up to 20 credits allowed)				
6. Instruction (up to 20 credits allowed)				
Total Credits				
7. Publications (up to 10 credits allowed)				
7. Publications (up to 10 credits allowed)				
Total Credits				
8.Approved Sponsor CE (up to 30 credits allowed)				
8.Approved Sponsor CE (up to 30 credits allowed)				
Total Credits				

9. Self-directed learning (up to 4 credits allowed)				
9. Self-directed learning (up to 4 credits allowed)				
Total Credits				
10. ABPP Certification (can count for all required CPD in the renewal period in which that certification is awarded)				
Total Credits				
Total Renewal Credits				

APPENDIX D-1

CPD Verification Form

CONTINUING PROFESSIONAL DEVELOPMENT (CPD) VERIFICATION FORM

Name:	
Address:	
Telephone Number:	
Email:	Date:
Identify below the type(s) of CPD completed. Attach any available documentation regarding each type as verification (see Sponsorship & Verification Table for details).	
CPD Activity Completed	Peer Consultation
Dates of meetings	
Nature of Consultation	
Number of hours	
Person Attesting to meetings (attached a signed attendance log attesting to your presence)	
CPD Activity Completed	Continuous Practice Outcome Measure
Dates of meeting(s)	
Client/Patient ID	
Number of Protocol administrations with each client/patient	

Attach protocol used for each client/patient	
CPD Activity Completed	Professional Activities
Name of association/regulatory body	
Date of appointment	
Duties	
Attach verification documentation from organization	
CPD Activity Completed	Self-Directed Learning
Name of Activity (name of video/article)	
Mode of Delivery (online; reading; video)	
Applicability to Practice	

APPENDIX E

Further Information about Self-Assessment & Outcomes

Self-Assessment

Approaches to CE and CPD often assume that a psychologist is able to accurately assess his or her own abilities and deficits in order to select appropriate CE or professional development activities (Wise, 2010). Some jurisdictions with mandatory CE requirements or “quality assurance” programs have explicitly included self-assessment as a key component of these programs (College of Psychologists of Ontario, 2010).

Despite the reliance on self-assessment, there has been conflicting evidence regarding its value. Kruger & Dunning (1999) found that people overestimated their abilities in many social and intellectual domains and that this was particularly so for people who scored in the lower quartiles on objective measures of performance. They found, however, that improving the skills of research participants helped them recognize the limitations of their abilities and improved the accuracy of their self-appraisals.

Their research also indicated that incompetent individuals are less able to recognize competence in others and so may not benefit from an opportunity to observe the performance of a competent individual. In contrast, the authors found that those whose performance fell in the top quartile underestimated their performance relative to their peers. However, they were more accurate in assessing their absolute score on a performance test (Kruger & Dunning, 1999).

Based on their comprehensive review of the self-assessment literature, Dunning et al. (2004) cited several concerns. One such concern was that people might not have the knowledge and expertise necessary to assess their competence adequately.

Another concern was that the common educational practice of massed training (a one day workshop, or two or three successive days), while appearing to promote the rapid acquisition of skill and self-confidence, does not necessarily promote the retention of skill. This finding is similar to the learning literature of the 1960’s that demonstrated the differential outcomes of massed versus distributed practice and concluded that the latter resulted in longer term retention of learning. Dunning et al. recommended providing

long-term evaluations of retention and transfer to assess the actual benefits of an educational or training program. To improve the accuracy of self-assessment of competence, they recommended watching tapes of one's performance in the company of a faculty member, undergoing peer assessment with clear standards, being provided with more frequent feedback and taking standardized testing.

Eva & Regehr (2005) also considered why a number of studies have found poor correspondence between self-assessment ratings and objective or external ratings of competence. They concluded that people are least accurate in making summary judgments (summative evaluations) of their own abilities. In order for individuals to identify and redress gaps in their knowledge or skill they would need to obtain and act upon reliable and valid external evaluations of their performance rather than self-assessment.

In a wide-ranging review, they noted that only the health professions emphasize self-directed learning. This is in contrast to models of the development of expertise that suggest that learners do better when there are expert tutors available to provide assistance and direction, when a broad overview of the material to be learned is provided, and when there is an opportunity to actively work on a problem before receiving a solution.

Eva & Regehr (2005) argued that the type of self-assessment that may be more valuable to self-regulation is "reflection-in-action," an ongoing self-monitoring process during performance of a task. They described this as effortful, guided problem solving which involves repeatedly assessing one's self-efficacy in a situation, addressing emergent problems and continuously monitoring one's ability to effectively solve the current problem.

Based on these studies, it seems that a capacity for accurate self-assessment of competence should not be presumed, but may be developed as a result of appropriate training to develop the particular competence. Attempting to solve a problem on one's own, with the availability of an instructor for guidance, may improve the self-assessment of competence. Additionally, frequent feedback, peer evaluation and objective testing may also improve the accuracy of self-assessment of competence. These elements should all be considered in any program intended to foster continuing professional development.

In the meantime, it is recommended that licensees routinely seek out peer feedback and opportunities to receive feedback through external evaluation. The current evidence indicates that both of these approaches foster the development of competence and also improve the accuracy of self-assessment.

Outcomes

There are related but somewhat different meanings of the term “outcome” with respect to this report: (1) measuring and enhancing outcomes of CPD activities and (2) enhancing client/patient outcomes through monitoring the individual’s progress. Both are important in developing and administering CPD programs and attempting to ensure that the eventual outcome of CPD is competent professional practice. This appendix will address each of these questions.

Measuring and Enhancing CPD Outcomes

There are many ways that the effectiveness of CPD activities can be measured. However, there is limited consensus on information that practitioners need to know to maintain or enhance their skills, whether CPD activities are in fact integrated into their practices, or if integrated, whether the new learning is effective in positively affecting client/patient improvement. This section will address each of these questions.

One of the more comprehensive schemes for evaluating effectiveness of CPD activities was developed by Milne et al. (2006). This appendix will follow their framework, beginning with examining the basis for deciding what type of CPD is needed, and then proceeding through several steps to finally examining the context in which new learning is to be implemented.

What Is The Right Thing To Do?

Milne et al. (2006) say that this is the judgment about what needs to be learned based on such sources as individuals’ assessments of their own needs and interests, theory, clinical guidelines, treatment manuals, and professional consensus. Once out of graduate school, for most psychologists no one guides them as to coursework and professional development, and rarely is there close supervision. The current structure

for psychologists consists in most jurisdictions of a mandated number of CE hours without specifying the particular content (with the exception of ethics and a few other topics in some jurisdictions), and it is presumed that the psychologist's selection of CPD activities is largely based on the self-assessment of needed knowledge and skills, availability of CPD activities, and the necessity to meet licensing board mandates. Recently, Neimeyer, Taylor, and Wear (2010) found that there were significant differences in psychologists' CPD activities based on their workplace settings. This indirectly supports the idea that psychologists chose CE experiences on the basis of their professional needs even though there was no direct measure of what specific education or training was needed. These authors also found that program convenience and cost was important, so self-assessed need was clearly not the sole determinant of psychologists' choices.

While it is certainly important that psychologists pursue CPD activities they feel are important to their own development, there are several drawbacks to CPD being based solely on psychologists' choices. As discussed in other sections of this report, there is a great deal of evidence that self-assessment as a determinant of CPD needs is quite fallible. Green (2006) indicates that self-appraisal in medical students tends to get less accurate over time, that as nurses have more experience there is more discrepancy between competence and confidence, and that often the least capable professionals have the most positively distorted assessment of their own abilities. Graesser (2010) notes that in selecting CPD activities, practitioners tend to avoid areas that are difficult for them and choose to focus on what they already know. Also, Lambert (2010) has found that most clinicians do not systematically monitor treatment outcomes, and without such monitoring they underestimate negative outcomes. A logical extension of his findings suggests that without systematic feedback, psychologists will find it difficult to objectively appraise their own knowledge, skills, and educational needs, meaning that they will have difficulty choosing CPD activities that could most benefit them and their clients/patients.

Also, psychologists generally do not follow prescribed assessment or treatment protocols, so without firm benchmarks as to "correct" intervention, it is difficult, if not impossible, to know what the "right" thing is. Aspirational treatment guidelines developed by various APA work groups have attempted to provide guidance, and the APA initiative on treatment guideline development, still in the beginning stage as of this writing, is one step toward establishing guidelines that individual psychologists can use

to inform their work. The most recent work in this area is documented at APA Access (Access/pubs/newsletters/access/2012/01-04/index.aspx).

In summary, there is a great deal of information, but no current consensus, on guidelines for the treatment of various disorders or the determinants of effective treatment. Lacking that, practitioners use their own judgment as to what paths to choose for their own continued development. While practitioners' self-assessed needs probably are quite useful in determining their choices, there is little objective evidence that they are making the choices that would most enhance their competencies. More problematically, at least using evidence from other professions, the practitioners most in need of guidance seem to be the ones least likely to believe they need it.

Has The Right Thing Been Done?

Milne et al. (2006) ask whether there is a good match between knowing what the right thing is to do and the material that has been presented. There are some studies that evaluate the fidelity of the CPD activity to theory or empirical evidence, as shown by the delivery of services that are true to the content of the training program. One promising project is the Resiliency and Disease Management Initiative in Texas, which has established evidence-based treatment guidelines for children, offered training in those treatments, and monitored their implementation (Jensen-Doss, Hawley, Lopez, & Osterberg, 2009). Additionally, Steinfield and colleagues have implemented an evidence-based anxiety and depression treatment program and tracked its implementation (Steinfield, Coffman, & Keyes, 2009). One can make a reasonable assumption that if these trainings were developed from a model, and the model intervention was implemented, then the training accurately reflected the model and was successful in translating the approach into practice. Sponsors of continuing education programs would do well to demand that providers explicate the theoretical, empirical, and/or professional consensual bases of their offerings, and demonstrate that, in fact, the provider has accurately and effectively translated these bases into the program content. This is largely an issue of quality control by providers. At this time, we know of no research that has directly examined this question across a wide range of CPD activities.

Has It Been Done Right?

Milne et al. (2006) ask whether the activity has been presented skillfully using an effective method of delivery. By effective method one can refer to research on what works and what does not work in CPD activities, ranging across self-directed learning, supervision, peer or professional consultation, or more formal courses or workshops. There is considerable research in clinical, cognitive, and industrial/organizational psychology; educational settings; human resources; and adult learning that should inform the development and administration of CPD activities. Unfortunately, as noted by Neimeyer et al. (2009), while psychology has been at the forefront of developing theory and practice in training, learning and methods of skill acquisition, very little of this theory or its practical applications has found its way into the design of CPD programs.

There is a wide variety of research on whether current methods of CPD delivery are effective in producing the various outcomes mentioned above in fields other than those directly involving clinical practice; very little of this research has been used to shape approved CPD activities in psychology.

A brief overview of some of this research is presented below that should illustrate the kinds of empirical findings that could, and should, guide CPD program development and implementation. For convenience, this report will list selective findings and conclusions gleaned from one or more of these sources; the ones selected seem to us to be the ones most relevant to CPD for practitioners. Moreover, there is considerable overlap between these authors from different fields, which would seem to emphasize the importance of some of the conclusions. However, we did not attempt to integrate the findings, but opted to simply list them. Finally, all of the following are taken from multidimensional, complex articles or books, so any listing, while we hope it will be useful, will necessarily be oversimplified (but, we hope, not distorted).

Conclusions and recommendations from Brown & Sitzmann (2011) regarding training and employee development:

- Formal vs. informal settings. Formal instruction seems superior to informal if the information is complex.

- Transfer of training into the workplace. The relationship between learning outcomes and application in the workplace is not necessarily strong, so steps need to be taken to enhance the transfer.
- Transfer of learning outcomes into the workplace is particularly strong if there is high similarity between the training and the jobs to be performed.
- Transfer of learning into the workplace is facilitated if:
 - a. The work environment is supportive.
 - b. There is opportunity to put the new knowledge and skills into practice.
 - c. There is post-training evaluation of transfer.
 - d. There are interactive activities during training.
- Training should not be an isolated event. Its effectiveness is enhanced if there are pre-training and post-training activities as well.
- Training is enhanced if the learning is multidimensional, including cognitive, affective, and skill components.
- For older trainees, it may be useful for the experience to be slower paced and to show work examples.
- Lectures are useful in order to transmit knowledge. They are particularly helpful when combined with discussion, problem-solving tasks, case studies, modeling, simulation, and games. It is also helpful if learners have the opportunity to explore resources, probably because this fosters independent inquiry.
- Feedback alone may not be enough to alter behavior (also see Graesser and “practice outcome monitoring” below).

Conclusions and Recommendations from Graesser (2010) regarding the seven principles of adult learning:

- Learning experiences should be spaced over time.
- It is useful to interweave worked examples with problem solving exercises.

- Combining graphics with verbal descriptions enhances learning.
- It is important to connect and integrate abstract and concrete representations of concepts.
- Use quizzes to promote learning.
- Help students allocate time effectively.
- Ask deep, explanatory questions.

Information from Graesser, Halpern, & Hakerl (2008) regarding principles of learning (selected items):

- Ground concepts in perceptual motor performance.
- Present material in verbal, visual, and multimedia forms.
- Use testing to enhance learning.
- Space studying and testing to produce long-term better retention.
- There are benefits for repeated testing when students expect a final exam.
- Producing answers is more effective than simply recognizing answers.
- Outlining, integrating, and synthesizing information works better than more passive strategies.
- Stories and examples tend to be remembered better than facts and abstract principles.
- Multiple and varied examples are helpful.
- Students benefit from feedback, particularly immediate feedback.

- Challenges make learning and retrieval effortful and enhance long-term retention.
- Information presented should not overload working memory.
- Complex lessons should be broken down into manageable parts.
- There are more benefits in constructing mental models than memorizing isolated facts.
- Deep reasoning and learning is stimulated by problems that present obstacles to goals, conflict, and contradictions.
- Cognitive flexibility improves with multiple viewpoints that link fact, skills, procedures, and conceptual principles.
- Material should be pitched at the right level for learner's skill or knowledge (Goldilocks Principle).
- Most students need training in self-regulated learning.
- Learning and motivation are enhanced when content is anchored in real world problems that matter to the learner.

Conclusions from Bloom (2005)

- Interactive techniques were most effective in changing physician behavior and enhancing patient outcomes, including audit, feedback, academic detailing/outreach, and reminders.
- Clinical practice guidelines and recommendations of opinion leaders were less effective.
- Didactic presentations and distributing printed information was reported to have minimal beneficial effect.

Hojat et al. (2009) support the idea of experiencing a range of learning activities, including continuing medical education, attending conferences, reading, home study, etc.

Sitzmann et al. (2010) provides information regarding training for accurate self-assessment of knowledge:

- Give feedback on performance.
- Self-assessment is particularly useful if students get feedback on the accuracy of their self-assessments during the learning process so they can calibrate their assessments. This helps them learn their strengths and weaknesses.
- Have students compare their level of knowledge and performance with their peers in order to enhance their motivation to learn.
- Have students practice using relevant knowledge and skills.
- Learning to evaluate one's own knowledge and skills is helpful in developing lifelong learning habits.

Information gleaned from Cochran Collaboration reviews (e.g., Davis, 2001; Davis et al., 2006; Jamtvedt, Young, Kristoffersen, O'Brien, & Oxman, 2010; Oxman, Thomson, Davis & Haynes, 1995):

- Feedback on performance is valuable if the feedback is proximal in time to decision making. There are a variety of methods of feedback (e.g., 360-degree feedback, peer comparison), and the empirical support for these methods varies from study to study.
- Reminders given before a decision is to be made are significantly but minimally useful. For example, some type of reminder of the various assessment instruments helpful in a custody evaluation report could be useful if given soon before the assessment is to take place.
- Educational meetings combined with feedback are helpful; meetings help to increase the value of feedback.

- Educational meetings can be helpful when attendance is higher, there are mixed didactic and interactive elements, when at least some of the learning requires active participation on the part of the recipient, and when outcomes are more serious.
- Educational meetings alone do not seem to be effective in changing professionals' complex behaviors.
- At times, intense feedback combined with practice audit is useful, but the effect on quality of care is small.
- Audits and feedback are more useful when the feedback is intensive and adherence to recommended practice (e.g., treatment guidelines) is low.
- Multifaceted programs generally produce better practice outcomes, but there are many interactions among various factors.
- It has been shown in medicine that if a practice audit turns up deficiencies in performance, targeted interventions can improve performance.

Conclusions and Recommendations from the Committee on Planning a Continuing Health Care Professional Education Institute (2010):

- CPD activities should bring together diverse health care disciplines to enhance team-based health care.
- It is important to have learners identify problems and apply solutions.
- Best learning comes from interactive experiences that involved feedback.
- It is most useful to have multiple learning experiences over time on the same topic.
- Simulations may be helpful.
- Learning is enhanced if it is in the context of client/patient care and deals with clinical or applied questions.

- It is important to teach students the nature of biases and to learn self-reflection.
- Experiential learning using such methods as needs assessment and role-play may be helpful.
- Ongoing feedback is useful.
- Simulate the clinical setting.

In summary, this is a survey of some of the literature applicable to CPD and adult learning. However, it should be apparent that the majority of CPD experiences, particularly as mandated by licensing boards in psychology, have not integrated what is known about effective CE into their programs.

Did It Result In The Right Outcomes?

Outcomes can be roughly broken down into affective outcomes (satisfaction), acquisition of knowledge (subjective opinions or objective measures), transfer of knowledge and skills into the workplace, and the impact of the activity on patient or client care and ultimately on outcomes (Brown & Sitzmann, 2011). There is a long history of evaluating treatment outcomes (e.g., Lambert & Hawkin, 2004), most of which has been designed for research or developed to provide agency feedback on overall effectiveness (Battle, Imber, Hoehn-Saric, Stone, Nash & Frank, 1966; Kiresuk & Sherman, 1960), and most of which only indirectly applies to CPD outcomes. There is a much briefer history on developing measures that may be useful to the individual practitioner (e.g., Cone, 2000; Lambert, 2010), and few formal CPD programs that specifically address the use of these measures. As noted by Neimeyer et al, (2009), there is a paucity of CPD outcome research in psychology, so we are left with extrapolating results of research from other professions or fields to attempt to enhance CPD programs for psychologists.

There are a variety of ways to categorize outcomes. One useful model is the taxonomy proposed by Kirkpatrick (1967). The four-outcome levels framework includes:

1. "Reactions" to CPD, (e.g., satisfaction with the program, opinions about the acceptability of the material). Such reactions, however, may have a minimal or even non-existent relationship with the next three levels. For example, Warr, Allan, and Birdi (1999) found that in an organizational setting, positive reactions

to a training program were unrelated to later job behavior. Unfortunately, many purveyors of CPD programs rely heavily on such reactions to judge a program's effectiveness. This would be akin to asking undergraduate students how much they learned in a course, assigning grades on the basis of their opinions, and then expecting them to apply the knowledge gained. Such positive reactions may be effective in promoting business and must reflect some learning; however, this has not been objectively documented to be helpful in professionals' skill development or improving client outcomes.

2. The second level of outcome is defined as the acquisition of declarative or procedural knowledge, behavioral change such as increased competency, or change in attitude. As discussed above, relying on self-assessment at this level is hazardous, suggesting that objective measures of change are desirable.

3. Even if there is objectively documented learning at level two, it is critical that the enhanced competence gained from CPD transfer to the workplace. Kirkpatrick labels this as "results". Again, the assumption is that if the new learning transfers into the workplace, this will enhance client outcomes. In the practice monitoring adherence to treatment guidelines, generally carried out in research settings, but currently difficult if not impossible to implement in general practice settings, is probably the "gold standard" for monitoring this level of CPD results. Other measures could include practice audits. Of course, if one can demonstrate new learning has been put into practice in the workplace, decades of outcome research into methods of assessment and treatment would suggest a positive impact on treatment outcomes. The work of Jensen-Doss et al. (2009) and Steinfield et al. (2009) serve as good examples of this outcome level.

4. Kirkpatrick's fourth outcome level, system change, seems more possible in organizational settings, e.g., higher morale, less staff turnover, than in independent practice settings. In mental health organizations, this could include fewer complaints, fewer errors, higher compliance with administrative and clinical regulations, etc.

As previously stated, unfortunately, in psychology, there is little empirical research on CPD outcomes with the exception of surveys of participants' views of the value of such activities (Neimeyer et al., 2009). A survey of APA Practice Organization members indicated that generally psychologists were satisfied with their CE experiences, felt the

quality of offerings was good, felt they had learned a considerable amount, and felt that what was learned translated into their practices. The authors were clear that there was no direct assessment of outcomes and further note the discrepancy in the literature between perceived and measured outcomes in psychology. They also stated that the lack of theoretically informed work on studying and offering CE is puzzling. In the practice arena most of the evidence on levels of new learning, translation of learning into practice, and effects on clients/patients is based on self-report rather than on objective assessment (Neimeyer et al., 2009).

Neimeyer et al. (2009) suggest that studies of CE outcomes can be broken down into four categories: (1) overall satisfaction, (2) levels of new learning, (3) translation of learning into practice, and (4) impact of learning on service effectiveness. This is quite similar to Kirkpatrick (1967). They go on to note that there is little research in psychology on the latter two; however, it might be more usefully stated that most of the sound research on CPD in psychology is in the first category, since most of the evidence on levels of new learning, translation of learning into practice, and effects on clients/patients is based on self-report. We have evidence from training in I/O psych that self-assessment of knowledge gained appears to be more strongly related to satisfaction with the experience than with actual cognitive learning. Findings in medicine (Davis et al., 2006) summarized in a review of 725 articles, showed “weak or no associations between physicians’ self-rated assessments and external assessments” (p.1100). Also, people who have lower rated external assessments are the least accurate in self-assessment (Tracey, Arrol, Barham & Richmond, 1997). Tracey and colleagues found correlations between physicians’ self-assessed level of knowledge of three major disorders with formal knowledge assessment to be about .20, suggesting that physicians have great difficulty assessing their level of knowledge accurately. Finally, it is discouraging to see that people who need the most help and who know the least are the least aware of needing it (Gruppen, 2010). Gruppen referred to a general finding of professionals, in his example college professors, where 94% rated themselves above average. He and others have referred to this as the “Lake Woebegeon” effect, where there is no one below average.

Laying aside the assumption that enhanced competencies will enhance client outcomes, it is also possible to think of another outcome level, that of specific client outcomes. Kirkpatrick (1967) may have included this level under “results” but this is not clear. There is no reason to expect, however, that acquired cognitive or behavioral

competencies will necessarily translate directly into improved client outcomes, even if they do translate into enhanced client care. There are many variables affecting client outcomes, including, for example, the nature and level of a client's illness/distress, motivation or willingness of the client to comply with recommendations, efficacy of the treatment model, aspects of family or other environmental factors that either support or undermine treatment, client financial resources, client/psychologist match, etc. Therefore, while improved outcomes is clearly the ultimate goal of CPD, direct measurement of this goal is complicated and contaminated by many factors other than psychologist competence and transfer of knowledge into the workplace.

In spite of the complications of using patient or client outcomes as a measure of CPD effectiveness, there are an increasing number of innovations in outcome measurement that show great promise in improving results of treatment. First, it is important to present a bit of background on the impetus for these developments. This discussion will involve CPD only insofar as practitioners can be motivated and taught to systematically monitor client/patient progress; it does not gauge the effectiveness of the various methods of offering CPD on the outcome categories outlined by Kirkpatrick (1967) or Niemeyer et al., (2009).

Golding & Gray (2006) note that after graduate school, psychologists face a lack of supervision, some larger degree of professional isolation, and some loss of peer support. They suggest that learning to evaluate one's own outcomes should be part of the graduate program curriculum to help ensure that competent provision of services will continue in spite of reduced oversight. Similarly, Epstein, Siegal, & Silberman (2008) note that in medicine, practitioners get little objective, external feedback, so they fall back on "internal data" to judge their knowledge and competence. These authors discussed how subcortical regions of the brain, particularly those involved in emotions and reactions to threat, are involved in processing of information beneath conscious awareness even though such processes directly affect reasoning and decision-making. This internal data is, of course, subject to a variety of sources of bias such as noticing only external information that is consistent with one's self image. Riso (2011) notes that we may ignore important cues from our patients, selecting out information that confirms our preconceived belief that psychotherapy is effective (confirmation bias).

Daniel Kahneman, in *Thinking, Fast and Slow* (2011), reviews findings in cognitive psychology and related fields in straightforward, everyday language, brilliantly

summarizing the effects of “fast thinking” (automatic, non-reflective, reflexive thinking and reactions) on our thinking and decision-making, introducing biases of which we are unaware. There is no evidence that practitioners are more immune to these biases than anyone else. In a review in *The Atlantic*, Maria Popova (2011) suggests that Kahneman’s book will forever change the way one thinks about thinking. Even more problematic, a number of authors (Kruger & Dunning, 1999; Dunning et al., 2004; Gruppen, 2010) have shown that practitioners who are least competent are the ones most likely to inflate their image of themselves as competent. And those who are incompetent may not be able to use more competent individuals as role models since they may not have the knowledge to assess competence in others.

One attempt to help practitioner’s remedy this lack of feedback and avoid the types of biases noted above may be called “practice outcome monitoring”. In her APA Presidential Address, Carol Goodheart (2011) outlined an attempt to help practitioners remedy this lack of feedback and avoid the type of biases noted above called “practice outcome monitoring” or “practice based evidence.” The popularity of outcome monitoring has gathered considerable momentum in the last few years. Katherine Nordal, Executive Director for Professional Practice of the American Psychological Association, strongly endorsed individual practitioner’s use of outcome measures in that it benefits patients, practitioners, third party health insurance carriers, and policy makers (Nordal, 2012). Practitioner newsletters have endorsed this practice (e.g., Riso, 2011) and there have been several workshops that have focused on monitoring, including a series of online presentations by the Psychotherapy Networker (2011) and the APA (Doucette, 2011).

The impetus for outcome assessments reflects not only the importance of demonstrating the effectiveness of psychological interventions, but, more importantly for this report, enhancement of the individual practitioner’s effectiveness. It is the impact on individual practitioners that led us to recommend awarding CPD credit for conducting outcome assessments.

Lambert and colleagues note in a series of publications that, while there has been an increased emphasis on quality assurance by policy makers and insurance carriers, less than one-third of practitioners systematically assess their own treatment outcomes (e.g., Lambert, 2010, Lambert & Hawkin, 2004; Shimowka, Lambert & Smart, 2010.) However, Whipple and Lambert (2011) indicate that a minimum of 5-10% of patients in

psychotherapy get worse during therapy, and 30-50% of others may fail to improve. The situation seems even worse for children and adolescents. They have also found that it is rare for psychologists to predict or even note deterioration. For example, in one study involving 550 patients, therapists predicted one percent would have a negative outcome, while, in fact, seven percent of them did (Hannan, Lambert, Harmon, Nielsen, Smart, Shimokawa, & Sutton, 2005). In light of these findings, the issue of biases discussed above, and the ambiguity of assessing psychotherapy outcomes, the lack of systematic assessment on one's own outcomes would seem to represent a serious deficiency in our practice

A number of studies have shown that direct monitoring of patients' progress can dramatically improve outcomes, particularly in those patients who are at risk for treatment failure. A wide array of measures have been developed specifically for therapists to administer to patients to track progress session by session, allowing for recognition of problems and need for changes in the treatment on an on-going basis. As noted above, the APA has reviewed many of these measures and has put a searchable database of researched measures on the APA website (under My APA, for members only). Some of these are aimed at specific problem areas, e.g., depression (Beck, Steer & Brown, 1996), others at a range of symptoms (Derogatis & Fitzpatrick, 2004), some at more general levels of functioning (Lambert, 2010; Whipple & Lambert, 2011), and others at more global estimates of functioning and the quality of the therapeutic alliance (Anker, Duncan & Sparks, 2009; Anker, Owen, Duncan & Sparks, 2010; Anker, Sparks, Duncan, Owen & Stapnes, 2011; Duncan, 2011). Below we will give an overview of several of these instruments.

Lambert (2010) has developed a questionnaire called the Outcome Questionnaire-45 (OQ-45). It is a 45-item patient survey, administered at each session that covers the status of symptoms, interpersonal functioning, social role functioning, and changes in quality of life. It has been well standardized and been shown to be exceedingly effective in identifying therapy that is "off-track," and is effective in predicting and averting treatment failure. Duncan and colleagues have developed the Partners for Change Outcome Management System (Anker et al., 2009; Anker et al., 2010; Anker et al., 2011; Duncan, 2011). They developed two four-item scales, one focused on the same areas as noted above in the OQ-45 and the other focused on the therapeutic alliance (quality of the therapeutic relationship and agreement with the therapist on the goals and methods of treatment). They have shown dramatic improvement in treatment

effectiveness when the measure is used collaboratively with the client or patient. In this collaboration, the patient becomes the “educator” or at least provides motivation for the therapist’s new learning and approaches. Finally, Pinsof (2011) authored the Systemic Therapy Inventory of Change (STIC), a measure designed to track what he terms client systems from “multi-systemic, multi-dimensional perspectives”, suitable for individuals, couples, and families. His is also a collaborative model, using the STIC at each session for assessment, planning, and monitoring change. Babins-Wagner (2011) has further demonstrated that such measures not only enhance overall treatment outcomes in a clinical setting, but also can be integrated seamlessly into ongoing agency procedures.

It appears that while some authors believe that feedback alone can be helpful (Lambert, 2010; Duncan, 2011), to be maximally useful it should be combined with collaboration between the practitioner and the patient on the ongoing assessment of the therapy and the patient’s functioning. Several authors (e.g., Lambert, 2010; Pinsof, 2011) have taken a second step in not only identifying patients in danger of deterioration but also developing a “decision tree” of recommended interventions depending on the major dimensions involved in impending failure, e.g., symptoms, interpersonal relationships, ruptures in the alliance. This can help guide the practitioner to a variety of interventions that could be helpful in averting failure or enhancing outcomes.

Based on the findings discussed above, Epstein et al. (2008) suggest that learning to evaluate one’s own outcomes should be part of the graduate program curriculum to help ensure that competent provision of services will continue in spite of reduced oversight. In support of the feasibility of this suggestion, Brown & Sitzmann (2011) have shown that there is research that suggests that under certain conditions, students can learn to be more accurate in their self-assessments.

In summary, in spite of the fact that there is little direct research on effective methods of CPD, much can be extrapolated from research in non-clinical settings, and assessment in clinical settings on ongoing patient progress offers an exciting tool to enhance the effectiveness of service delivery. The first may provide knowledge of what CPD methods change therapists’ behavior. The second does not necessarily lead practitioners to be better therapists, but it does help them provide better therapy (Lambert, 2011). The Task Force therefore is suggesting that CPD credit be given not only for seminars or workshops on integrating these methods into practice, but also to practitioners who demonstrate that these methods have been integrated into their practice.

APPENDIX F

Professional Development Plan

EVALUATION OF CURRENT AREAS OF PRACTICE AND/OR SERVICES PROVIDED

List your current areas of practice or the services you provide.

Identify any differences between your current and desired levels of knowledge or skill. Please consider both areas requiring improvement and areas where enhancement is desired. Having identified these differences, you should begin to think about how these might be addressed through continuing professional development. Please describe these differences and carry them forward to be addressed in your *Professional Development Plan*.

Areas of Practice/Services Provided	Differences Between Current and Desired Levels of Knowledge and Skill
Example:	Example:
Consultation with School Teams regarding children with learning disabilities	None
Rehabilitation therapy with elderly	Not familiar with newest versions of intelligence measures with national norms
Assessment of children with LD	Confusion regarding consent to treatment, capacity, etc. How does capacity to consent to treatment differ from capacity to handle own financial affairs
Counseling for families of elderly stroke victims	None
Bereavement Counseling	Continue to update knowledge
Chronic pain work with individuals	Consider expanding to group work – need more experience

PROFESSIONAL DEVELOPMENT PLAN

A *Professional Development Plan* is created to address any differences between the current and desired levels of knowledge, skill or experience identified through the above exercise.

Differences Identified Above	Developmental Plan to Address Differences	Time Line	Course, Workshop, Activity
Example:	Example:	Example:	
Become familiar with newest versions of intelligence assessment measures, including national norms	Discuss with peers Review journal articles	June 2012	
Improve understanding of ‘capacity’ and ability to consent to treatment	Get copy of relevant legislation Discuss areas of confusion with colleague	Immediate	
Obtain experience with chronic pain groups	Review recent literature in psychoeducation and support groups Arrange to co-facilitate two series of groups with colleague	December 2012	
Continue to update knowledge for bereavement counseling	Look for workshop, conference or new journal articles	Ongoing	

APPENDIX G

Regulatory Language Sample

Continuing Professional Development Requirements.

During each two year period commencing on _____, of each even numbered year:

A licensed psychologist shall be required to complete not less than 40 credits of continuing professional development related to the licensee's professional practice; The required number of hours of continuing professional development for a psychologist who first becomes licensed during the two year period shall be decreased to 20 for one year and less than a year, no CPD will be required. All licensed psychologists are required to have at least 3 credits in the areas of Ethics, Risk Assessment and/or Jurisdictional Rules and Regulations every two years.

Each licensee shall be required to complete a Continuing Professional Development Plan available at (jurisdictional website) at the beginning of each renewal period. The plan shall serve as a guide for the psychologist regarding continuing professional development and should be available to the licensing board in the event the psychologist's continuing professional development is audited;

Each licensee shall be required to provide the Board with a document available at (jurisdictional website) stating his/her intended areas of practice;

Credit for Continuing Professional Development shall be recognized in accordance with the following:

Peer Consultation

A maximum of 20 credits per two-year period shall be recognized for regular and ongoing peer consultation. Peer consultation includes research groups, journal clubs, and case consultation groups that have a structured, organized format, meet regularly, and focus on psychological activities related to one's practice. This activity requires a minimum of 10 hours participation, in order to be creditable, with one hour or peer consultation equal to one hour of credit. Required documentation is a contemporaneous

log with a list of dates attended, topics discussed, location, identification of participants, and number of hours. The log must be attested to by the individual who is designated as the recorder of the peer consultation group.

Practice Outcome Monitoring (POM)

A maximum of 20 credits per two-year period shall be recognized for Practice Outcome Monitoring (POM) with one patient/client series of assessments being equal to one credit, if properly documented. This activity includes the regular application of outcome assessment protocols with clients/patients in order to monitor one's own practice process and outcomes. POM of ongoing services should include repeated measures and involve the use of a standardized assessment tools. Participation in a hospital or health care system's formal quality assurance program (QA) that focuses on monitoring client/patient outcomes would also be included in this category. Required documentation includes a contemporaneous log with client ID #, date of assessment, assessment protocol, and outcome of assessment.

Professional Activities

A maximum of 10 credits per two-year period shall be recognized for Professional Activities such as serving on psychological association boards or committees, editorial boards of peer reviewed journals, scientific grant writing teams or a board member on a regulatory body. One continuous year of such service equals 10 credits. Required documentation is written verification from board or committee chair.

Conferences/Conventions

A maximum of 5 credits per two-year period shall be recognized for attendance at professional Conference/ Conventions related to psychology, which are not part of formal Approved Sponsored Continuing Professional Development. One day equals one credit. Required documentation is a copy of the registration materials.

Courses

A maximum of 20 credits per two-year period shall be recognized for completing and passing a graduate-level course related to one's area of psychological practice from a

regionally accredited educational institution. Passing the equivalent of one semester-long one credit course would count for 7 credits; passing the equivalent of one semester-long two credit course would count for 14 credits; and passing the equivalent of one semester-long three credit course would count for 20 CPD credits. Required documentation is a transcript showing the course taken and the passing grade.

Instruction

A maximum of 20 credits per two-year period shall be recognized for teaching a graduate or undergraduate course related to psychology in a regionally accredited institution. A maximum of 10 credits per two year period shall be recognized for teaching a 6 hour long approved sponsor continuing professional development workshop and a maximum of 5 credits every two years shall be recognized for teaching a 3 hour long approved sponsor continuing professional development workshop. These credits (for courses and workshops) apply only for the first time teaching or presenting. Required documentation is a copy of the presentation announcement or course catalog noting the course taught and instructor, or registration materials indicating the presentation; and an attestation from the psychologist stating that the course or workshop is being presented for the first time.

Publications

A maximum of 10 credits per two-year period shall be recognized for publications related to psychology as long as the publications are contained in a peer-reviewed article or a book chapter. Required documentation is a copy of the first page of the journal article, or book chapter.

Approved Sponsor Continuing Education

A maximum of 30 credits per two-year period shall be recognized for Approved Sponsored Continuing Education. This refers to participation in any activity provided by approved sponsor organizations described below. Required documentation is an official certificate of attendance/participation issued by the CE presenter/sponsoring organization and includes date, title, location, and number of hours.

Self-directed Learning

A maximum of 5 credits per two-year period shall be recognized for self-directed learning directly related to the practice of the psychologist. Acceptable activities include use of audiotapes, videotapes, books, and journals and activities from non-approved sponsors. Each hour of self-instructional activity qualifies for one (1) CPD credit. Required documentation is an attestation that contains a description of the activity, the subject material covered, the dates, and number of hours involved.

Board Certification

A maximum of 40 credits in a two-year period shall be recognized for the successful completion of the board examination of the American Board of Professional Psychology. Documentation from ABPP must be submitted to the Board.

Approved sponsors of continuing education include the American Psychological Association or any of its sponsors approved through the American Psychological Association Sponsor Approval System (APA, 2005), the Canadian Psychological Association Approval of Sponsors of Continuing Education for Canadian Psychologists (CPA, 2005), the Academies of the Specialty Boards of the American Board of Professional Psychology, the Association for Psychological Science, the National Association of School Psychologists, Association of State and Provincial Psychology Boards, regionally accredited educational institutions that offer graduate training in psychology or related fields, accredited medical schools, Category I Continuing Medical Education (CME) of the American Medical Association, the Canadian Medical Association, the American Bar Association, and the Canadian Bar Association. Courses offered by non-psychology organizations must be relevant to the practice of psychology.

The delivery method of the continuing education may be in person or electronically mediated as long as provided by an approved sponsor

Each licensee shall be responsible for maintaining records of completed qualified professional education for a period of four years after the close of the two-year period to which the records pertain.

Each licensee shall attest, on his/her biennial license renewal application, that he/she has satisfied the continuing professional development requirements. Documentation of these activities should be retained by the licensee and not sent to the Board unless so requested. False attestation of satisfaction of the continuing professional development requirements on a renewal application may subject the licensee to disciplinary action, including revocation.

The Board will audit a ____ percent sample of the renewal applications. Licensees whose applications are audited will be required to document the completion of their Continuing Professional Development activities.

If an audited licensee attests to completion of the required CPD in the appropriate timeframe but does not present acceptable documentation of the attested CPD, a disciplinary action will be pursued. The licensee will have no more than three months from the time of the failed audit to present acceptable documentation of the required CPD. These CPD credits shall not be used by the licensee for documentation of CPD requirements for subsequent reporting cycles and the licensee will be audited in the next reporting cycle. Should the licensee fail to present documentation of the required CPD within that 3 months, the license will be considered lapsed.

Appeal: The licensee shall have 30 days to appeal the decision made as a result of the CPD audit. After 30 days, discipline should be pursued per Board/College authority.

Further disciplinary action should be considered when licensees continue to practice psychology while failing to comply with mandated CPD.

APPENDIX H

Rationale for the Activities

CPD Activity	Primary Rationale	Competencies Addressed
<p>Peer Consultation:</p> <p>Interaction with colleagues can be extremely valuable and should be encouraged. Professional isolation can be a danger and is more likely to occur when a psychologist is practicing solo.</p>	<p>Reduction in professional isolation</p>	<ul style="list-style-type: none"> • Scientific Knowledge • Evidence-Based Decision-making/Critical Reasoning • Interpersonal & Multicultural Competence • Professional Ethics • Assessment • Intervention/ Supervision/ Consultation
<p>Practice Outcome Monitoring:</p> <p>Periodic filling out evaluation forms, having specific goals mapped out and then checked by the client/patient and practitioner when they have been attained, and other more formal mechanisms of evaluation are available for internally monitoring one's own practice.</p>	<p>Systematically monitoring one's own practice</p>	<ul style="list-style-type: none"> • Evidence-Based Decision-making/Critical Reasoning • Intervention/ Supervision/ Consultation
<p>Professional Activities:</p> <p>In order to overcome isolation and to ensure that the public service work of the profession is supported, professionals are encouraged to participate in their professional associations at all</p>	<p>Reduction in professional isolation</p>	<ul style="list-style-type: none"> • Scientific Knowledge • Professional Ethics

<p>levels.</p>		
<p>Conferences/Conventions:</p> <p>Interacting with colleagues and participating in the variety of social, interpersonal, professional and scientific activities that are part of the milieu of conferences and conventions can be enhancing to professional development.</p>	<p>Variety in the kinds of learning activities</p>	<ul style="list-style-type: none"> • Scientific Knowledge
<p>Academic Courses:</p> <p>There are many areas that benefit psychologists with regard to obtaining additional information that relates to their profession and the practice of psychology. These areas could range from refresher courses in areas of established practice to business training to help with management of the business-related aspects of practice.</p>	<p>Activities that occur over time</p>	<ul style="list-style-type: none"> • Scientific Knowledge • Evidence-Based Decision-making/Critical Reasoning • Interpersonal & Multicultural Competence • Professional Ethics • Assessment • Intervention/Supervision/Consultation
<p>Instruction:</p> <p>The effort of preparing for a course or workshop and teaching it for the first time is substantial. The updated knowledge gained from these endeavors can significantly add to one's professional development.</p>	<p>Activities that occur over time</p>	<ul style="list-style-type: none"> • Scientific Knowledge • Evidence-Based Decision-making/Critical Reasoning • Interpersonal & Multicultural Competence • Professional Ethics • Assessment

		<ul style="list-style-type: none"> • Intervention/Supervision/Consultation
<p>Publications:</p> <p>Publications are an example of an area with benefits for both the psychologist who does the writing and for the intended audience. When one produces a publication, a great deal of knowledge is obtained from the literature review, from the science that has been included in the publication itself, and the feedback given by the publishers. The Identification of new ideas is critical to the continuing freshness, growth and development of the field and that is also true for the growth and development of professionals within the field.</p>	<p>Activities that include formal feedback</p>	<ul style="list-style-type: none"> • Scientific Knowledge
<p>Approved Sponsor CE:</p> <p>The opportunity for psychologists to take various approved sponsor CE, not only from other psychologists, but also from individuals in professions related to the psychologists' fields of endeavor, will continue to be an important and mainstream aspect of Continuing Professional Development.</p>	<p>Variety in the kinds of learning activities</p>	<ul style="list-style-type: none"> • Scientific Knowledge • Professional Ethics • Assessment • Intervention/Supervision/ Consultation

<p>Self-directed learning:</p> <p>It is valuable to read books and scientific journals, listen to tapes, or in other ways gain knowledge on one's own</p>	<p>Variety in the kinds of learning activities</p>	<ul style="list-style-type: none"> • Scientific Knowledge • Professional Ethics • Assessment • Intervention/Supervision/ Consultation
<p>Board Certification:</p> <p>Board Certification requires much time, effort, work and demonstrated competence in a specialty area that is scrutinized and evaluated by other expert psychologists within the same area. Psychologists are required to demonstrate to the satisfaction of experienced peers, through a structured and well-formulated process, that they are competent in intervention, assessment, and consultation in their area of practice. Additionally, psychologists are examined on ethical and legal issues, scientific bases for their services, supervision/teaching/management, interpersonal interactions, individual and cultural diversity, and professional identification. This level of examination and scrutiny is considered the "gold standard" and serves as the best indicator our profession currently has of assuring that licensed psychologists are maintaining their professional competence. As with medicine, a single, voluntary board encompassing all</p>	<p>Activities that include formal feedback</p>	<ul style="list-style-type: none"> • Scientific Knowledge • Evidence-Based Decision-making/Critical Reasoning • Interpersonal & Multicultural Competence • Professional Ethics • Assessment • Intervention/Supervision/ Consultation

of the recognized specialties is considered to be the appropriate designator for board certification.		
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APPENDIX I

Assignments of Credits

The decision to assign a certain value to each activity was initially determined on a rational, rather than on an empirical, basis. The process utilized to obtain the current credit recommendations involved seven steps.

1. Each member of the Task Force individually assigned a percentage value to each of the activities listed, reflecting the maximum value that activity should contribute to a two-year quotient of CPD activities;
2. The committee determined that 40 credits every two years would be recommended, in keeping with the modal number of CE hours required by jurisdictions
3. Each individual assigned a maximum number of credits for each activity, based on the requirements of 40 credits every two years.
4. A consensus conference was used to arrive at the initial allocations, using both a credit and percentage basis considered appropriate for each of the several categories of CPD activity.
5. The psychology regulatory Boards and Colleges in the United States and Canada were surveyed for their views on the proposed credit allocations and on the appropriate maximum allocations for each activity.
6. In addition, input was received from a survey jointly conducted by the American Psychological Association's Continuing Education Committee, and the American Board of Professional Psychology asking practicing psychologists about their current CPD activities, and their estimates of future CPD activities.
7. The MOCAL committee reviewed the number of credits for the various activities in light of the results of both surveys as well as from other input received. In addition, the committee assessed various combinations of activities to ensure that practitioners and academicians could readily obtain the required number of credits. Caps were maintained for the total number of credits for each type of activity to require psychologists to utilize more than one activity for professional development and to reduce the potential for professional isolation.

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