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# Peer Consultation Groups: The Future of Continuing Education?

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An ongoing requirement for mental health clinicians is to receive continuing education. The American Association for Marriage and Family Therapy, like many professional organizations, includes this as an expectation in their codes of ethics: "Marriage and family therapists pursue knowledge of new developments and maintain their competence in marriage and family therapy through education, training, and/or supervised experience." (AAMFT, 2015). In this paper, "continuing education" speaks to the accrual of ongoing education, training, and/or supervised experience.

Mental health clinicians are by no means the only profession that requires continuing education. The systems and constituents that many professions serve evolve over time, and new short-term and longitudinal research studies provide feedback as to how to most effectively meet the needs of consumers. Continuing education requirements invite professionals to hone their skills, adapt to the needs of clientele, and reflect on how professional work impacts the professional individual and community at large.

## The Oversight of Continuing Education

Continuing education is one of many strategies by which the public are protected from receiving services from ill-prepared, uninformed, and/or unethical individuals and companies. In the United States, the oversight of professional development, which includes regulations, consumer protection practices, and continuing education requirements, happens on a state level. Massachusetts professions are shepherded by the Division of Occupational Licensure, "an agency within the Office of Consumer Affairs and Business Regulation, is responsible for oversight of 32 boards of registration." (Commonwealth of Massachusetts, 2022). These 32 boards of registration are responsible for providing licensure—an educational and occupational process by which individuals are deemed to be effective for serving the public—and regulatory standards for almost 600,000 professionals in over 150 professions in our state.


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One of the 32 boards of registration is the Board of Registration of Allied Mental Health and Human Services Professionals, which oversees regulations for marriage and family therapists, mental health counselors, behavioral analysts, educational psychologists, and rehabilitation counselors. (Note: On January 1, 2023, the Board of Allied Mental Health will be overseen by the Department of Public Health.)

The development of a bureaucratic system to oversee licensure requirements created a marketplace for individuals and businesses to administer continuing education; these individuals and businesses, as a representation of the capitalistic elements of continuing education, are referred to as "vendors". Vendors submit outlines of continuing education programs to bureaucratically-approved oversight organizations (NEAFAST for licensed marriage and family therapists) to vet and ensure that the content of said continuing education events match the standards for best practices of the profession that the oversight organization serves. In general, there are four types of vendors.

For some context, in 1994 the Board of Allied Mental Health enlisted the help of separate entities that would be responsible for certifying continuing education activities acceptable to meet license renewal requirements, which included that LMFTs and LMHCs receive 30 hours of continuing education every two years. The Massachusetts Association for Marriage & Family Therapy was chosen as the entity for MFT's. MAMFT published a request for proposals to subcontract the administration of its CE program. FDA/CE Certifications, directed by Michael Vickers was chosen by MAMFT to design and implement the CE program. In December 2018, upon the retirement of Michael Vickers, the Board of Registration directly authorized the New England Association for Family and Systemic Therapy, NEAFAST, the successor organization to MAMFT, to continue its LMFT certification program.

NEAFAST chose to continue the same regulatory guidelines that FDA/CE had proposed, including the criteria for approving continuing education programs, forms for CE vendors to apply for approved CEs for LMFTs, and processes for granting CE credits to participants (Gibson & Kobel, 2018).

NEAFAST evaluates continuing education programs along the rubric of three content categories and its connectedness to the practice of family and systemic therapy:

1) Professional practice activities, education events that engage within the legal, economic, regulatory environments, as well as self-of-therapist exploration.

2) Family and systemic therapy activities, which includes education that addresses the methods, theory, research, training, and supervision of couples, family, and systemic therapy.

3) Other relevant clinical activities. This includes a wide diversity of specific content areas, such as mood disorders, anxiety and PTSD, and a host of family and relational processes.

In order to meet the variety of professional needs of marriage and family therapists, including the acknowledgment that many MFTs in our state work largely and specifically with individuals, these three categories are broadly and loosely defined.

NEAFAST has developed processes to meet the standard established by the Board of Allied Mental Health, which is similar to most statewide regulatory boards. We are collaborating with more vendors to ensure that a wider variety of continuing education options are approved for LMFTs in Massachusetts, as shown by our quantitative and financial growth of our continuing education program in 2022.

But are we, or any of the thousands of organizations in our position, actually enhancing the practice of family and systemic psychotherapy with our current continuing education structures?

How do we know that continuing education is effective, both for the development of the professional and, more importantly, for the complex needs of the families and systems that we serve?

Do our current continuing education structures meet these needs? And if not, what are characteristics of continuing education programs that lead to second-order change: in the case of our profession, the ability for clinicians to ethically and effectively implement the materials they learn into their therapeutic practice?

**What is Effective Continuing Education?**

There are a myriad of theories that describe factors to effective continuing education. For instance, Chickering and Gamson (1987) propose seven features of effective learning, including encouraging collaboration between students, giving meaningful and timely feedback, and communicating high expectations. Ajzen (1991) and Sniehotta (2009) describe the theory of planned behavior as a way to assess intentions, attitudes and bias, and perceived behavioral control of the learner. According to this theory, an effective educational event would enhance positive attitudes toward the subject matter, the ethical implementation of the skills learned within the professional practice, and the overall process of learning and continuing education and implementing, as well as a subjective feeling of mastery of content. Michie, van Stralen, and West (2011) designed the behavioral change wheel, which suggests that capability, the "psychological and physical capacity to engage in the activity concerned", and opportunity impact motivation, which leads to behavioral change, creating a feedback loop where the behavioral change leads to more capability, motivation, and opportunity.

Assessing the effectiveness of continuing education is complicated research; while educational theories are important, there are numerous variables that might disrupt the data, including, but

not limited to the stage of professional development of the learner, the financial and temporal limitations of the learner, and the numerous ways that a learner may integrate new information into their larger body of knowledge.

Louise Forsetlund and colleagues (2021) evaluated 200 worldwide studies, involving over 28,000 healthcare professionals, that discuss the effectiveness of continuing education programs. These programs had a high variety in terms of content, number of participants, length and frequency of meetings, the type of interaction between educator and learner, and education practices. The studies in the literature review also communicated a high variance in effectiveness. They suggest the following:

1) Continuing education programs that have strictly didactic practices, where there's a clear delineation between presenter (or lecturer) and learner, are typically not effective.

2) One-time educational meetings are unlikely to improve practice for "highly complex behaviors"; the utilization of systems theory into our psychotherapeutic perspective automatically adds complexity to our work.

3) Programs that have fewer participants, more sessions over a longer duration of time, a shorter time for follow-up may have larger effects.

4) Experiential trainings, where learning objectives and interventions are practiced as part of the learning experience, may have larger effects.

One of the primary sources that Forsetlund and colleagues use is Mansouri and Lockyer's 2007 evaluation of continuing education in medical professions, which used a similar process as Forsetlund, but had fewer studies. Mansouri and Lockyer categorized continuing education events by type of education event (workshop, lecture, small group activity, etc.), participant numbers, length, both of the continuing education event and the time between events, and the number of sessions. They assessed for three markers of success: physician knowledge, physician performance, and patient outcome. They determined:

1) Case-based training, long-term workshops where the content progresses over the duration, and interactive small groups have the highest success rate, while auditing, workshops, and detailed comments in written feedback, had the lowest success rate.

2) The only successful strategy that improved physician performance was individual training; NEAFAST will produce an entirely separate article about the necessity for better supervision practices in a future journal issue.

3) Interactive small groups were the only continuing education model that improved patient outcome.

How can NEAFAST use this research to design continuing education for the psychotherapy community in New England that leads to more effective learning experiences?

**Peer Consultation Groups: The Future of Continuing Education**

Assessing ongoing therapist competency is a challenging process. While we are grateful for the existence of regulatory boards, especially as they protect the public from people unethically practicing therapy, the quantification of biannual continuing education hours (30 CEs every two years for LMFTs in Massachusetts) has created an industry that's invested in producing a high volume of continuing education events, often with characteristics that the research suggests doesn't lead to effective outcomes, such as one-time, 1-3 hour training events, didactic learning, large audiences, and minimal followup. Evaluation forms commonly assess the performance of the presenter at the expense of exploring how the learner might implement the educational experience into their ongoing practice. These characteristics reinforce the power differential between educator and learner; virtual platforms have contributed to the likelihood of the disengaged learner.

NEAFAST is responsible not just for ensuring that the continuing education programs submitted to us meet appropriate content standards; we are also responsible to develop continuing education that is informed by research, which suggests that small groups meeting over extended amounts of time and discussing, in an egalitarian manner, the intricacies and challenges of our profession, are the most effective strategies. NEAFAST has revamped its mission statement to reflect this position: *NEAFAST provides stewardship for the art and science of systemic psychotherapy practice in New England by investing in supportive creative programming using collaborative platforms for cooperative grassroots professional development.*

While at this stage we cannot inform regulatory standards, we can begin to explore alternative designs that are informed by research, as well as by the interest of practitioners.

In good news, these systems already exist: peer consultation groups, defined by Miu, et al (2022) as goal directed group of professionals that "receive guidance on problematic cases, discuss ethical and professional issues, and process countertransference concerns" were a much more common form of continuing education (Miu, et al, 2022).

Quite a bit has been written about the effectiveness of peer consultation groups. Nobler (1980) writes that peer consultation groups have similar developments as therapy groups, moving from discomfort and uncertainty about the function and role of the group, to a greater willingness to take risks, and ultimately, a greater sense of intimacy. Counselman and Weber (2004) define ten important characteristics of effective peer consultation groups:

1) The tasks of leadership are shared, so that everyone has equal responsibility for the group.

2) A directional, goal-oriented focus that finds the balance that focuses as equally as possible content and process.

3) A clear contract of expectations, understood by all participants, and a discussion about

contract violations

4) A culture of respect, openness, and curiosity that capably addresses emotional processes around shame, competition, avoidance, and aggressiveness.

5) Attendance to present, in-the-moment responses and interactions.

In the last two years, NEAFAST has developed three peer support groups—Moving Toward Antiracism, Next Steps Toward Antiracism, and Stop, Breathe, Write. However, these groups have addressed exclusively to self-of-therapist and self-care issues.

In 2023, NEAFAST will add two six-month peer consultation groups as continuing education programs to join our Moving Toward Antiracism groups. These groups will be closed, semi-structured, content and process-oriented, and ongoing, and will offer continuing education units for participants.

Couples Therapy 101, facilitated by Jeremiah Gibson, LMFT, will explore Karl Tomm's Patterns in Interpersonal Interactions as a strategy to help couples therapists focus exclusively on the process of the relational dynamic. Participants will learn from the wisdom of Tomm and his collaborators at the Calgary Family Therapy Centre, the experiences of each participant in practicing the model in the consultation group, and case studies that participants process with the group.

Family Therapy with Young Children, facilitated by Howard Wolfe, LMFT, will intersect the work of Rudolf Dreikurs, rooted in Adlerian Family Therapy, with Stanley Greenspan's Floortime Approach. Participants will be invited to share cases that encourage learners to invite parents and others in adult subsystems to be agents of change through their transmission of values, and explore transference and countertransference issues that arise throughout the family therapy process.

The leadership team of Skeetz Edinger, Ike Gallinsky, Miranda Hughes, Katherine Manners, David Wood have met with me and Howard for the last several months to discuss how NEAFAST can develop processes for peer consultation groups to be successful, with this research in mind. We are eager to write more about how these structures and future peer consultation groups can help therapists engage in their professional development in a more holistic way so that we can have a deeper understanding of how to navigate the complex systems that we address in systems therapy, explore self-of-therapist issues and biases in safe, supportive structures, and build more collaborative relationships with other professionals and, most importantly, the populations we serve.

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