APS Position Statement

Psychology Peer Consultations in Organisations

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Table of Contents

Statement of purpose

This paper describes the position of the Australian Psychological Society (APS) on peer consultation/clinical supervision of psychologists working in organisations. It refers to the 2018 Psychology Board of Australia (PsyBA) peer consultation standards for fully registered psychologists, while highlighting the importance of quality peer consultation/supervision and identifying its best practice implementation in the organisational context.

Definition

Supervision is an historically critical aspect of lifelong psychological practice. With this in mind, in 2010, AHPRA, through the PsyBA, sought to delineate supervision from the "line management" that can be provided to psychologists by re-defining it as peer consultation (Leonard, 2015). This position paper also seeks to distinguish peer-to-peer supervision from that which might be provided to a psychologist in training (e.g., student, intern, registrar).

Accordingly, while the term supervision is often used in organisational settings, in line with the PsyBA definition, "peer consultation" will be used across this position paper to describe clinical supervision that is either the formal provision of "intensive relationship-based education and training that is case-focused and supports, directs and guides the work of supervisees" (Milne, 2007, p440) or the participation of peers of equal or similar experience in such relationship-based education and training.

By either means, peer consultation may be conducted in pairs or small groups, is reflective and has three core functions:

1. Normative: to address legal, organisational, professional and ethical responsibilities
2. Formative: to educate and develop knowledge and clinical skills, and
3. Restorative: to support the personal well-being of practitioners (e.g., minimising the risk of vicarious traumatisation, compassion fatigue or burnout) (Proctor, 1986).

The importance of quality peer consultation

Peer consultation is an internationally established practice across a range of industries and professions. These include law, medicine, psychology, social work and nursing.

It is a central quality assurance plank of clinical and corporate governance within health care organisations (Victorian Healthcare Association (VHA), 2008). Clinical governance requires that all parties involved in health care delivery - from members of governing bodies, to managers and clinicians - are accountable to clients and the community for assuring the delivery of safe, effective and high quality services.

High quality peer consultation is integral to Australian mental health policy and practice frameworks [e.g., the 2014 National Clinical Supervision Competency Resource (Health Workforce Australia, 2014, 2012 NSW Health Education and Training Guide on Clinical Supervision & 2015 Victorian Department of Health and Human Services Clinical Supervision Skills Review Tool for implementing the National Resource]. When driven by a systemic commitment from organisations and practitioners, peer consultation yields important benefits.

Health service delivery and client benefits

Peer consultation is important in promoting good contemporary, evidence-based practice and reducing risk adverse events in healthcare (Centre for Substance Abuse Treatment, 2014; VHA, 2008). Its benefits to the client include increased practitioner adherence to a treatment model (Schoenwald, Sheidow & Chapman, 2009),

strengthening of the therapeutic alliance and an increased client retention rate (Bradshaw, Butterworth, & Mairs, 2007).

Although noted to be scant in nature, research findings have also identified quality peer consultation to be associated with client outcomes (Wrape, Callahan, Ruggero & Watkins, 2015). Thus, it has been suggested that supervisors account for up to 16 per cent of the variance in client outcome (Callahan, Almstrom, Swift, Borja & Heath, 2009). In one notable quantitative investigation, Bambling, King, Raue, Schweitzer and Lambert (2006) randomly assigned clients with a diagnosis of major depression to supervised or unsupervised practitioners for eight sessions of problem-solving treatment. They found that clients who were treated for depression by a supervised practitioner were more likely to have a positive treatment outcome than those who were being treated by a practitioner who was not receiving peer consultation.

Staff and organisational benefits

Peer consultation is also critical to the maintenance of an effective workforce. Various findings have shown it to be associated with staff:

- clinical capacity and insight (VHA, 2008)
- perceived effectiveness (Livni et al, 2012) and
- capacity to effectively prioritise workloads (VHA, 2008).

The provision of a high quality peer consultation program reflects management's commitment to staff welfare (White & Winstanley, 2010) and optimal service delivery outcomes. It has been identified as a key tool for monitoring risk to practitioner mental health (Victorian Auditor General's Office, 2018). It is associated with:

- reduced staff absenteeism and turnover (VHA, 2008) which translates to improved service delivery. In client services, for example, this means improved continuity of client care
- enhanced staff relations; regular peer consultation improves staff relationships and relieves the negative effects of social isolation (VHA, 2008)
- improved staff confidence and performance (Livni, Crowe & Gonsalvez, 2012; VHA, 2008) and
- protection of staff at higher risk for vicarious traumatization, compassion fatigue and burnout staff due to the challenging nature of their work (Figley, 2003).

The risks of poorly implemented or no peer consultation

The absence of, or inadequacies in, peer consultation has the potential to expose organisations to reputational risk; for example, via the perception that it is ignorant of, or indifferent to, the professional and clinical needs of staff or promotes service delivery that is not guided by best practice. Deleterious effects that may accrue to psychology practitioners from sub-optimal peer consultation being superficial and ineffectual and, even, being a forum for bullying and abuse (Gray et al, 2001; McHugh, 2018).

Effectively implementing high quality peer consultation in organisations

In Australia, psychologists must annually engage in a minimum of 10 peer consultation hours to maintain their registration status (Guidelines for continuing professional development; PsyBA, 2015). This mandated minimum is aimed at ensuring psychologists maintain and update their skills and that members of the public seeking psychological services are protected and receive the best possible service.

Based on the available literature, the APS recommends that for the effective implementation of high quality peer consultation, the following principles be adopted. Their implementation requires a systemic approach involving practitioner and organisational commitment.

Psychologist commitment

The effective implementation of peer consultation requires that psychologists:

1. Seek peer consultation with other registered psychologists. Typically, the supervisor is a peer or more senior psychologist experienced or knowledgeable in an aspect of practice relevant to psychologist's work and CPD learning plan (PsyBA, 2015).
2. Are aware that there are benefits in accessing peer consultation with psychologists in other settings and, albeit as an exception, non-psychologists (e.g., psychiatrists) when the learning explicitly relates to their learning plan or the need for support in dealing with a particular issue better addressed by another profession (PsyBA, 2018). Consultation with non-psychologist peers must be clearly linked to the goals of the psychologists' CPD learning plan, giving an explicit rationale as to why peer consultation by a non-psychologist is appropriate in the particular instance.
3. Abide by the APS ethical guidelines on supervision (APS, 2014).
4. Take personal responsibility for professional decisions and consultation provided to other psychologists.
5. Take action to resolve unsatisfactory peer consultation. Where possible, if a psychologist is in an unsatisfactory peer consultation arrangement, they have the responsibility to address the matter first with their peer consultant(s) and then at the appropriate level in the organisational chain of management.
6. Maintain appropriate peer consultation records, organisational and personal records (Roufeil, 2014).
7. Where they are providing supervision, actively deploy using a competency-based approach (O'Donovan, Halford & Walters, 2011, PsyBA, 2018). This requires that an explicit framework and method of peer consultation practice are in place and that there is a consistent evaluative and outcome-based approach to peer consultation. Since 2013, the PsyBA requires all supervisors of psychologists seeking registration and internships to successfully complete training in competency-based peer consultation and to update their training every five years (see Guidelines for supervisors and supervisor training providers, PsyBA, 2018).

Organisational commitment

The commitment of the organisation is critical to the operation of best practice peer consultation. Organisations delivering best practice should:

1. Include peer consultation in all relevant workforce policies with the clear expectation that all psychology staff engage in it.
2. Articulate protocols that confirm the arrangements necessary for the sustainable implementation of high quality peer consultation across all services, as follows:
    - mode and frequency - that is, by regular face-to-face consultation or, where there is difficulty accessing a supervisor face-to-face, by a digital platform (e.g., MS Teams, WebEx, Zoom or Skype) alone or in combination with occasional in person arrangements
    - ideal number of participants [see the APS (2011) peer consultation network guidelines]
    - location (within or external to the organisation)
    - frequency (not less than monthly)
    - duration (usually 60 minutes)
    - practices around confidentiality and record keeping and
    - record storage requirement which must be kept and securely stored for a period of time consistent with pertinent legislation and organisational protocols.

3. Demonstrate support for peer consultation at all levels of management, such that it is accepted as a prominent feature of the organisational culture.
4. Build peer consultation into core organisational and program budgets so as to resource appropriately trained and experienced practitioners.
5. Provide resourcing that permits appropriate time allocation for peer consultation. Where peer consultation cannot be provided within the existing organisational workforce, the organisation is obliged to meet the costs incurred by psychologists who are consequently required to access external peer consultation.
6. Ensure that individuals locally identified as peer consultants are appropriately educationally skilled for their role and undertake their own peer consultation.
7. Make sure that peer consultation occurs as part of a nested structure whereby less senior psychologists are supported by more experienced psychologists, who are in turn supported by the most senior psychologists of the organisation.
8. Acknowledge that, while a minimum of 10 hours of peer consultation per annual cycle is mandated for all psychologists by National Law, psychologists early in their career, new to an area of practice or work, or working with complex and/or high risk clints may require more than the stipulated minimum requirement.
9. Implement programs of continuous evaluation to ensure that the quality and efficacy of local peer consultation arrangements are able to be demonstrated and regularly reported. It is recommended that this process incorporate evaluative tools to demonstrate the effects of peer consultation [e.g., a supervisor rating scale (see O'Donovan et al., 2010) or pre and post-peer consultation questionnaires (see Horne, 2006)].
10. Maintain a dedicated information management system to monitor the peer consultation characteristics listed under point 2 above.
11. Instigate procedures to address any problems with peer consultation, with the expectation that management are receptive to, and supportive of, staff who experience problems in obtaining suitable peer consultation.

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