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How Psychologists view and engage with competence in their practice.

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Abstract

The purpose of this study was to gain insight into how psychologists view and engage with competence and identify the factors that they determine as supporting or inhibiting competent practice. To date, few studies have examined the elements psychologists identify as shaping the development of their professional competence. It is hoped by doing so, strategies can be implemented that develop, maintain, and enhance competence and encourage active participation in the Continuing Competence Programme (CCP). Having an agreed definition of the qualities required to be competent is essential to evaluate, improve, and ensure quality assurance in psychological practice. Ten psychologists from the clinical and industrial organisational scopes participated. Semi-structured interviews were used; questions were designed to act as prompts and to ensure no relevant themes were overlooked. The interviews were recorded then transcribed and analysed using thematic analysis. Results indicated that while the participants understood the meaning of competent practice, how they relate that to their practice and how this influences their participation in the CCP varies. The participants discussed the value of, and the challenges associated with, achieving, demonstrating, and measuring competence and the consequences this has on their practice, their clients and themselves. They also identified factors that encourage, develop, and maintain competence and those factors that are threats to competence. It is essential to understand how an individual perceives competence as this will determine how they view and engage with competence in their practice. Understanding this will assist with competency development, maintenance, measurement and demonstration across the professional lifespan.

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"Every discipline develops standards of professional competence to which its workers are subject…Every scientific community is a society in the small, so to speak, with its own agencies of control."

(Kaplan, 1964)

1. Introduction

As psychology is brought into line with other health care professions, and with the expectation of increased competency requirements and public demand, it is important to examine how core competencies are currently identified and measured. Before evaluating or changing existing core competencies research needs to ascertain how those working in the field of psychology, construct, view, and engage with competence. Within psychology there are numerous specialities and while all employ knowledge from the same foundation they vary greatly in practice. For this reason, focusing on clinical and Industrial Organisational (IO) psychology will provide a broad overview of the practitioners' perspectives. It is also noted that within these two areas of psychology crucial progress has been made in the advancement of core competencies.

This study was prompted by my understanding that while competence is a core value of the profession of psychology, the emphasis was on the "foundational competencies" (Rodolfa, Bent, Eisman, Nelson, Rehm, & Ritchie, 2005, p. 351), knowledge, ethics, and reflective practice, (the foundations of the practice of psychology), with less regard for the essential domains of professional relationships, supervision, administration, and self-care and how to assess for these. These "functional competencies" (Rodolfa et al., 2005, p. 350) are the necessary activities

for the day-to-day practice of psychology. For a profession that is considered a science of thought and behaviour and promotes healthy relationships, encourages self-reflective practices in others, and works with some of the most vulnerable demographics, it is of great value to actively support, encourage, and emphasise the significance of these elements.

As a student, through undergraduate and Masters papers, I felt my understanding of competent practice was limited and insufficiently supported. My experiences with self-reflection had only been through supervising the efforts of primary school aged children. My education and experiences as a middle class, white Australian female meant my cultural competence, when it came to appreciating, and wanting to embrace, the bicultural views unique to New Zealand culture, recognising the multicultural and diverse perspectives of practice, and understanding where my culture placed me, was, I felt, inadequate. While the ethics of practice are clearly outlined, the practice of supervision, self-reflection, and self-care were not. For these reasons I was curious as to how those practicing in the field, and therefore had experience with the elements of competence, viewed and engaged with them in their practice.

When this study began the New Zealand Psychology Board (NZPB) were reviewing the Continuing Competence Programme (CCP), looking to refine the way in which the participants engaged with the requirements of the core competencies. While the NZPB are committed to the current CCP process they have since simplified the steps required to complete the documentation. This documentation was considered by many to be unnecessarily onerous and not accurately capturing competence, thus limiting engagement with it. While this study reflects psychologists' participation with the then requirements of the NZPB it goes beyond this, revealing their

interpretation, development, and engagement in competent practice and as such is still relevant, regardless of changes to the CCP.

Thesis structure;

Following on from the introduction, the literature review will provide an overview of key topics related to the study. This will include, definitions, historical background, the role of competencies, a discussion on competent practice, and critical considerations of competent practice. The method section will discuss the approach taken, a description of, and the reason for using, Thematic Analysis. An outline of the data collection, including participant demographic and recruitment will be included. The analysis and discussion will follow. Finally, the conclusion, limitations, and suggestions for future directions will complete the study.

Background.

Defining competence;

Defining the qualities that are required to practice psychology successfully (and how to achieve these qualities is difficult), as is a consensus of the meaning of competence. Competence is a broad construct not easily defined (Elman, Illfelder-Kaye & Robiner, 2005). For this reason, insight into how an individual interprets competence is essential in understanding how they view, engage with and incorporate the principles of competence.

Many words are used to describe competence including; knowledge, skill, expertise, attitude, experience and capability (Hodges & Lingard, 2012). The term competence is also used in many ways and the concept of competence has been debated and examined to such an extent that arriving at a definition that encompasses the many terms is difficult. Thus, as a concept it has proved complex. Le Deist &

Winterton (2005) note that among researcher's, competence may be referred to in a functional sense, using 'competencies' for the plural; others refer to 'competency' when discussing vocational competence, and at times the words competence, competency and competencies are used interchangeably. To date there is no one statement that reconciles the different uses and meanings of competence.

The NZPB (2015) describes competence as the relationship between four elements; knowledge, skill, judgement and diligence. They acknowledge that all four components are necessary to practice as a psychologist and fulfilling this requires ongoing revision and adjusting to achieve the desired performance. However, whether this definition sufficiently captures the meaning of competence from the view of practicing clinicians, and whether this is the definition that psychologists understand to mean competence is uncertain.

Masterpasqua (1989), defines competence as the integration of personal characteristics and the capacity to complement the explicit and implicit beliefs we hold about the ability to meet demands and challenges that are influenced by an individual's "adaptive cognitive, emotional, behavioural and social attitudes". Interpretation of competent practice by practitioners and their engagement with current competence requirements will benefit not only education and assessment but may also bring into focus areas involving attitudes, beliefs and values.

The history of competence in psychology;

Historically, competency guidelines have their roots in the area of education (Markus, Cooper-Thomas, & Cronquist, 2005). Through the efforts of this discipline, other health professions and the achievements of industrial-organisational psychologists to employ the concepts of competencies, the field of psychology has

recognised the value of identifying, and assessing of competencies, and engaging in ongoing training (Rubin et al. 2007). In 1973, David McClelland proposed personal competencies as an alternate approach to psychometric tests of trait and intelligence as a better measure of occupational performance (Athey & Orth, 1999; Markus, Cooper-Thomas & Allpress, 2005). He suggested basic principles that included observing what it is that people do to be successful; the belief that competencies can be developed and improved on over time, as opposed to traits that are considered innate and fixed; that competencies be transparent allowing practitioners to understand what is needed to achieve competency; and finally, competencies should relate to "meaningful outcomes" (Athey & Orth, 1999) that inform the practice of psychology. These principles have guided the competency movement and laid the foundation for reflection on knowledge, skills and performance.

Initially, completing a doctorate in psychology was considered sufficient to ensure competent practice (Rodolfa et al. 2013). Thus, standardising the doctoral training programmes was at the forefront of the competency movement in psychology with a focus on readiness to practice (Bourg, Bent, McHolland & Stricker, 1989; DeMers, 2009). To begin with, the priority was what was being taught, this emphasis shifted during the 1960's when attention was placed on what was being learned (Stiers et al., 2014). Roberts, Borden, Christiansen, and Lopez, (2005) observe that competence at the beginning of independent psychological practice is only the start of competent practice, the link between graduation and practice needs solid and ongoing emphasis on the demonstration of competence, with a focus on a life-span model of competence in practice.

Originally the educational model of competence in psychological practice focused on self-study and improving education with little to no regard for ethnic or

gender diversity, self-reflection or personal development (Peterson, Peterson, Abrams & Stricker, 2006). From here, there was a progression from knowledge-based to competency-based models as a means to evaluate advancement through these programmes (Rubin et al., 2007). Roberts et al. (2005) note that further development concentrated on psychology in practice, with a growing importance placed on diversity, ethics, self-assessment, supervision and the professional life-span.

From 2000 on advancements were made in defining competent psychological practice and the methods for assessing this. The movement towards a competencies based profession gained momentum in more recent times, as a result of, 'The Competencies Conference: Future Directions in Education and Credentialing in Professional Psychology' held in Arizona, in 2002 (Kaslow, 2004; Kaslow et al. 2004). Representatives from diverse groups were present, including education, training, public interest, research and credentialing (Rubin et al. 2007); they formed eight work groups to give particular attention to eight competency domains, 1) ethical and legal issues, 2) individual and cultural diversity, 3) scientific foundations and research, 4) psychological assessment, 5) intervention, 6) consultation and interprofessional collaboration, 7) supervision and 8) professional development. It was agreed that there were particular foundational competencies that were relevant to all the domains; ethical practices, individual and cultural diversity, critical thinking, knowledge of self, interpersonal and relationship skills, fitness for the profession and professionalism. At this time, a cube model for competency development was created (Rodolfa et al., 2005). This outlined the foundational competencies that underpin the practice of psychology and included the functional competencies required to practice in different contexts and with different groups (Humphreys, Crino & Wilson, 2017).

The focus has since shifted to the importance of clinical supervision as a means to enhance and maintain competence (Falender et al., 2004) and the American Psychological Association (APA) developed a guide outlining the necessary competencies for competent practice as a psychologist (APA, 2015).

Competent practice;

Roe (2002), describes competent practice as having two key features that define it. Firstly, it is associated with a clearly defined type of work to be fulfilled in a specific setting. Secondly, that this work incorporates knowledge, skills and ways of thinking. Examples of this are a teacher creating a lesson plan, a lawyer drawing up a contract, an architect designing a bridge or a clinical psychologist delivering behavioural therapy. Competence is usually gained during the process of practicing this work, as opposed to the knowledge and skills required that are attained during one's education. Thus, in attempting to describe the qualities of a competent psychologist, consideration must be given as to whether the focus should be on the knowledge that students require to become competent or the skills psychologists should demonstrate that determine competent practice (Roe, 2002). Or perhaps we should be considering the combination of both elements.

Eraut (1998), argues that understanding attributes of competent practice becomes more difficult when we consider that judgements are involved and that degrees of competence may differ between contexts. In one situation the distinction may be clear as to whether a person is competent or not competent, in another, competence can be considered on a continuum (Pearson, 1984), encompassing those that know how to do something at one end (newly qualified) to those that know how to do it well at the other. Furthermore, borrowing the analysis and investigations into

the meaning of competence from other professions is not sufficient for determining competence in detail within a specific occupation (Le Deist & Winterton, 2005). To have significance the understanding of competence must be centred around the particular profession under analysis. For this reason, this current research is centred around factors that practicing psychologists consider necessary to be considered competent.

When considering what it is that makes a psychologist a competent practitioner, an agreement must be reached as to what the required qualities of a proficient practitioner, are and what are deemed as important principles of practising psychology. Roberts, Borden, Christiansen, & Lopez (2005), suggest a number of principles of competence, they include different competencies such as the significance of competence and sensitivity required when working with diverse and multicultural communities and the lack of appropriate evaluations of cultural competence that currently exist. Adding to the difficulty of defining competence is the development of practice from recent graduate to the widely experienced. Roberts et al. suggest that the foundation of competence be considered developmental. They argue that the assessment of competence varies as it develops and matures, and additionally describe the changes and development that occur in supervision over time and with experience. They believe that the methods and practice of self-assessment should begin early in one's training and continue as the career progresses and other models of self-assessment and evaluation involving multiple perspectives should be developed. These views provide a basis and direction for the advancement of psychology, moving beyond a reliance on a single form of assessment, highlighting the importance of particular forms of competence (such as cultural competence), and considering competence as developmental across the professional life-span.

Solely having the appropriate skills and knowledge is inadequate to be judged competent (Rodolfa et al., 2005). To be considered competent requires demonstrating through actions that indicate critical thinking and judgement in a manner that is consistent with standards, guidelines, values and ethical considerations as set out by the profession. A summary of the components of competence by Proctor (1991) state that competency is comprised of knowledge, performance and outcome; what an individual brings to the role, how they perform that role and what they achieve in the role.

In more recent times, Epstein and Hundert (2002), describe competencies as "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.227). They further detail competency as more than isolated competencies, and consider it a union of the knowledge base, skills, values, ethics, attitudes along with clinical reasoning, emotions and reflection necessary to appropriately benefit the individual or community being served. This integration of scientific, clinical and ethical judgement assists practitioners to make decisions and problem solve. The significance of some of these more personal or individual variables may be overlooked when it comes to understanding what makes a competent practitioner, however, arguably, the influence they have is no more or less important than skills and knowledge. The importance of these aspects when considering competence may be overlooked as a consequence of challenges in defining and measuring them. In fact, capturing the technical, emotional and cognitive characteristics of competence and their influence on practice is difficult and therefore does indeed tend to be disregarded.

As stated, the foundations of competence are built on clinical skill, knowledge, the acquisition and use of this knowledge, effective communication, patience, attentiveness, self-awareness and critical thinking (Epstein & Hundert, 2002). The cognitive aspects of knowledge, that is evidence based and the judicial use and application of this core knowledge, is the basis for competence. This knowledge is usually acquired during academic education, research and reading and other forms of didactic instruction (Barnett, Doll, Younggren, & Rubin, 2007). Knowledge can also include the use of meaningful personal knowledge gained through experience. The cognitive aspects must also include recognising one's gaps in the knowledge, the ongoing acquisition of knowledge, problem solving, and the use of resources (supervisors, colleagues, publications,). Included in the foundation of competence are the skills of effective communication, patience and attentiveness which are the building blocks of the client/practitioner therapeutic relationship and have a significant effect on client outcomes. It is through practicums, training, clinical supervision and professional development that these skills are developed and maintained (Barnett et al., 2007). The foundations of competence also depend on the capacity to be aware of one's own emotional and cognitive biases, thinking and emotions, the ability to recognise mistakes and correct them, and critical thinking. These attitudes, values, and judgement should be developed through both acquiring knowledge and skill and, an awareness on how personal, social and situational difficulties may affect competence to practice. It is these "habits of mind" (Epstein & Hundert, 2002), along with moral function that are difficult to capture and evaluate but are essential to competent practice.

Previous analysis of the competency practices of registered psychologists have mostly focused on their background in education and training, their role and

responsibilities within the practice and how they apply their knowledge to practice without due consideration given to how they regard self-reflection, identity, interpersonal and relationship skills (Donovan & Ponce, 2009) and the application of them in competent practice. As the competency movement continues to shift from a knowledge based one, to one with increasing emphasis on reflection, awareness, relationships, individual and cultural diversity, and management and administration, there needs to be ongoing discussion around the qualities required for successful practice (Roe, 2002). Consideration must also be given to competence as a developmental process, throughout the career life-span, from new graduate to near retirement and, the part supervision plays in competent practice and, with particular reference to New Zealand, as a cultural issue. Furthermore, to consider competence as isolated requirements rather than the sum of its parts is to do a disservice to the individual and community being served and the practice of psychology.

Competence and the different specialities;

Capturing competent psychological practice from a global point of view has its difficulties as the practice of psychology is as diverse as the population it provides for. Defining qualities that are universal among the various practices and specialities of psychology and describing those qualifications that are specific to the different scopes is challenging. Gaultier, (2002), Humphries, Crino, and Wilson (2017) and Roe (2002) acknowledge differences in the length of curriculum and content of psychology courses among countries, the route to registration, the influence of governing parties and professional bodies, demographics, ethical, cultural and social practices, and the impact and constraints of regulations and legal requirements along with employment opportunities and the different settings in which psychologists

practice. This may mean that, though all draw knowledge from the same foundations, the qualities of a competent psychologist may vary and have differing priorities from country to country.

Roe (2002) and Barnett et al. (2007) also recognise the difficulty of defining the qualities required to practice competently which arises when attempting to determine the differentiation between the specialities. New Zealand recognises four scopes of practice; clinical, counselling, general and educational psychology though all psychologists practice as a specialist in some form, whether in health, community, neuropsychology, child, older age, sport, forensic, organisational, youth or adult psychology. All have differing settings, roles, client requirements and behaviours and problems to be addressed, and knowledge required. Identifying the common and unique qualities required for the many specialities needs to be addressed to ensure standardisation across the board (Roe, 2002). Currently there is no standardised way of making a distinction between the specialities (other than the qualifications required to enter them), making it problematic when seeking to "identify the common and unique qualifications" (Roe, 2002, p.193) required to practice competently and the boundaries that ensure competent practice. Hence there is a need for core competencies across the various domains with specific guidelines for the different branches and populations psychology services (Kaslow et al., 2004).

The role of competencies;

Though competence is an individual's responsibility, it is often thought of as a requirement dictated by others. A regulated process is often considered threatening and can be resented, yet when presented as self-responsibility the importance of it is often overlooked (Bargagliotti, Luttrell, & Lenburg, 1999; Lenburg, 2000). Managing

to ensure competence through the required competencies while encouraging individual pride in ability and professional enhancement is not straightforward.

Competencies are designed to provide a standard to maintaining, broadening and improving a psychologist's knowledge and expertise; they are constructed to improve performance. They bring in to focus a practitioner's strengths and identify learning needs that require developing and further knowledge. They require self-reflection, self-assessment, the setting of goals, and the opportunity to develop new skills with a view to enhancing current and future practice. Without standards that define, self-assess, evaluate and regulate (Rodolfa et al. 2013) the practice of psychology, there is the risk of the profession not meeting the requirements of the diverse individuals they serve.

The NZPB (2015) consider core competencies as the minimum requirement to practice as a psychologist. With the current core competencies emphasising the measurement of basic skills and core knowledge. While they act as a guideline for the minimum standard, the board states that psychologists should aim for the highest level of competence achievable. Given the diversity of competencies and elements of competence, achieving competence is aspirational, though unclear. Competence must be considered a dynamic process that develops over time, enhances practice, promotes ongoing learning and leads to professional development.

It has been suggested by Epstein and Hundert (2002) that there may be other areas of professional practice that are overlooked or are insufficiently considered when examining competency, these include ongoing learning, interpersonal and communication skills, the consolidation of knowledge into practice and professionalism. These skills of attitude and judgement are difficult to assess using frameworks such as the CCP and may be better assessed through outcome measures.

As recently as November 2014, at the 5th International Congress on Licensure, Certification and Credentialing of Psychologists, a working group, called the International Project on Competence in Psychology (IPCP) was formed to identify the benchmark competencies relevant for a global model of competence. The group does not focus on optional competencies that may be pertinent to specific countries and specialities. Rather, they are defining the core competencies that are considered essential to be an effective practicing psychologist from an international point of view. These critical considerations of competence form the foundations of competent practice and are the elements that contribute to competency.

Critical considerations of competence in the practice of psychology.

Reflection;

Self-reflection is critical for improvement and is essential for positive change. It is crucial for the development and maintenance of competence across the professional life-span. It is necessary for identifying ongoing learning requirements, assists in integrating knowledge; linking new to existing, and it aids in the understanding of one's own beliefs, values and attitudes and their influence on one's behaviours (Mann et al., 2009).

Dewey's (1933) early description of reflection as "active, persistent and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusion to which it tends" (p. 9) brings to mind our own understandings of critical thinking and its relevance to reflective practice. Bouad, Keogh, and Walker (1985) defined reflection as a universal term to describe the activity in which one examines their knowledge and experiences with a view to an improved understanding and growth, while in 1999, Moon described

reflection as analysis of one's knowledge while seeking an alternative views or further insight and applying this to complex ideas.

In 2004, Moon stated that in more recent times ideas about reflection and the importance of reflection had grown and spread throughout many professions and disciplines as part of their education programmes and ongoing professional learning. As a result of this burgeoning interest the term "reflective practice" (Schön, 1983) was introduced to describe the use of reflection as a means of exploring one's knowledge and experiences in order to understand or learn from situations. In doing so, the participant assesses their own performance, feelings, thinking, and responses with the view to generate alternate perspectives (Kam-shing, 2006). While the idea of reflective practice is to learn from the experience, for this to be practiced efficiently requires the knowledge of the theoretical foundations and the support to practice it (Jarvis, 1992).

Reflective practice was initially developed through nursing and teaching programmes (Nelson, 2012) and is now applied over many professions including the practice of psychology. Consequently, reflection and reflective practice have become a fundamental quality of a competent practitioner.

Clinical supervision;

An essential element of competent practice is supervision (Falender et al., 2004). Supervision aids in the practice of reflection, assists in maintaining professional and ethical standards and creates time for "review, reflection, conceptualisation, and planning of interventions" (NZPB, 2010). Supervision requires attention to all factors that may impact a person's ability to practice competently,

including personal and professional issues, knowledge, ongoing education and skill, and continues throughout the professional life-span.

Along with reflective practice, supervision provides an opportunity to demonstrate and maintain competence, to consider alternative perspectives, indicate gaps in knowledge, and highlight the positive. Ideally the supervisee/supervisor relationship is collaborative, develops goals and appropriate task to achieve them, encourages and supports reflective practice, and provides ongoing, and valid feedback (Falender & Shafranske, 2014). While clinical supervision is a core competency, it is also considered a professional competence that is intended to ensure lifelong professional development.

Self-care;

The nature of a psychologist's work, and the challenges and stressors faced in life, create a vulnerability to the effects of distress and burnout (Barnett, Doll, Younggren & Rubin, 2007). Failing to maintain one's competence in the face of such stressors may result in professional competence being impaired. Attention to burnout, that is job related stress, and distress associated with such domains as substance abuse/dependence, relationship difficulties, financial strain, and depression, in oneself and others, is essential in preventing the compromise of occupational function and subsequently impairment of practice (Smith & Moss, 2009).

On-going self-care should be regarded as a preventive plan of action, though research indicates that there is a lack of emphasis on the importance of self-care and its direct relationship to competence (Barnett & Cooper, 2009; Smith & Moss, 2007). Rather than just addressing distress, burnout, and impaired practice when it becomes apparent, more emphasis should be placed on preventive strategies. Education in

undergraduate programmes and ongoing formal training in the importance of self-care in oneself and others is essential.

Smith and Moss (2007), discuss the impediments that exist in intervention (fear of termination, breakdown of professional relationship, loss of licence, loss of friendships, rejection of help, and being unsure of the severity of impairment creates a barrier to intervention), the difficulties in addressing impairment, and the lack of training and guidelines that create barriers in what should be considered a core competency. They suggest a concise definition of burnout, distress, and impairment, and the provision of guidelines and resources that assist psychologists in identifying impairment and intervening when necessary will go a long way to ensure competent practice and creating a culture of self-care.

Psychologists have a responsibility to themselves and others; failing to ensure their own well-being may put themselves, their clients, and the profession at risk. Bearing in mind the risk factors and challenges associated with psychological practice a greater emphasis on awareness, self-reflection, and support may prevent impairment. As Barnett, Johnston, and Hillard, (2006) illustrate, "Self-care is not an indulgence. It is an essential component of prevention of distress, burnout, and impairment. It should not be considered as something 'extra' or 'nice to do if you have the time' but as an essential part of our professional identities" (p. 263).

Current study.

Competence is a key principle that underpins the practice of psychology. Yet there is little information on how psychologists view and engage with competence in their practice and how this supports or inhibits competent practice. Previous research has focused on a variety of topics associated with competence, mostly related to the

definition, assessment and measurement of competence. A search of the literature reveals articles such as Donovan and Ponce (2009) which describes the identifying and measurement of core competencies. Roe (2002), suggests a model of competence, Fouad et al. (2009) consider the benchmarks for competence required for entry into practice and Kaslow et al. present a toolkit for assessing competence. Nelson (2007) and Rubin et al. (2007) review the history of the assessment of competence from education, training through to practice and go on to discuss the developing competencies and implications of them. Other articles consider alternative models for assessment, Leigh et al. (2007) review and compare assessments used in nursing, dental and medical with current practices of assessment in psychology. However, to date, few studies have examined the elements psychologists identify as shaping the development of their professional competence.

Within the fields of medical practice, dentistry, and nursing, competence as a practitioner has been looked at, but to date very little emphasis or consideration has been placed on the understanding of competence within psychological practice. By exploring the way psychologists in practice perceive competence and through identifying the factors that psychologists determine as supporting or inhibiting competence, strategies that encourage, develop and maintain competence and promote engagement with competencies can be developed. This research aims to enhance our understanding of the skills, knowledge, and attitudes required to perform competently. Hence the aim of the present study is to address the lack of research regarding the understanding of, and engagement with, competence from the psychologists' point of view.

2. METHOD.

Approach;

The aim of qualitative research is to explore and make sense of specific social experiences. As ideas, opinions and perceptions are difficult to evaluate through quantitative methods a qualitative approach was more appropriate in understanding an individual's engagement and views of competency. Denzin and Lincoln (2005) describe qualitative research as involving "… an interpretive naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them" (p. 3). In other words, the researcher wishes to discover the attitudes, motives and behaviours of the individuals being studied in their environment (Ten Have, 2004). This emphasis of observation and experience underpins qualitative research and the 'finding out about' is central to this. In qualitative inquiry (Creswell, 2007), the priority is on insight into the meaning the particular issue holds for the participants, rather than the meaning the researcher may bring. It is person-centred, requires commitment to the participant's point of view and accepts there are numerous and diverse realities (Vaismoradi, Turunen & Bondas, 2013). The aim is to produce knowledge that reflects an individual's reality and subjectivity and gain some understanding of its impact.

The process of identifying themes within the participant's understandings was used to address the gaps in the current literature. It was hoped that this would allow for additional investigation of the research question; how psychologists view and engage with competence in their practice. For this reason, the most appropriate method for analyzing the material is thematic analysis (TA). Although there has been some criticism of this particular method due to the lack of clear guidelines, Braun and

Clarke (2006) have delineated a series of phases through which researchers must proceed in order to develop a TA that will produce a clear and transparent study. Braun and Clarke's (2006) method of TA was employed as the approach provides a direct and well-defined clarification of what TA is and how it is executed.

This study seeks to generate phenomenological data that would create an understanding of the meaning of competence in practice. According to Smith (1995), TA's objective is to reveal an interpretive phenomenological understanding of an individual's experience, this links with qualitative research. It is not designed to test theory or prove or disprove hypotheses and uses a primarily inductive approach. It illustrates an endeavour to explore competence using a phenomenological methodology in an attempt to construct an understanding of what being competent means using the participant's individual experiences of competent/incompetent practice and their meaning.

Thematic Analysis;

Thematic analysis involves searching for themes that are revealed as being important to the description of the phenomenon (Daly, Kellehear, & Gliksman, 1997). Unlike content analysis whereby the data is systematically searched for patterns and frequency of words (Vaismoradi, Turunen & Bondas, 2013), thematic analysis describes the data in detail, identifies emerging themes, allows us to consider the themes within their context and at times interprets aspects of the issue; put simply it is a method of arranging qualitative data (Braun & Clarke, 2006; Attride-Stirling, 2001). It moves beyond tallying a phrase or word count and takes into account "identifying and describing both implicit and explicit ideas" (Guest, MacQueen & Namey, 2012, p. 10). McLeod (2011) describes themes as more than content or a person's response

to a particular question. Rather they are a repeating pattern that emphasises their experience of the world, conveying meaning about a specific topic or issue. It is uncovering or unravelling these meanings that reflect a reality that is central to thematic analysis.

While thematic analysis has its roots in grounded theory and resembles its principles of concepts and categories (Corbin & Strauss, 1990) it does not require the involved coding features necessary in grounded theory nor does it solely focus on recurring statements as seen in content analysis, rather it is flexible and direct while also providing an intricate and comprehensive account of the data (Braun & Clarke, 2006; McLeod, 2011). The aim of thematic analysis is to develop a set of themes and associated traits that through ongoing analysis act as guides to further analyse the data (Tuckett, 2005).

Data Collection and Analysis.

Within the practice of psychology in New Zealand there are a number of scopes of practice as defined by the NZPB (see Appendix A for details). While all have a common foundation in knowledge they vary greatly in practice; for this reason, focusing on clinical and IO psychology, though broad, will provide an overview of the practitioner's perspective in these two branches. It is also noted that these two areas of psychology have focused on advancing core competencies in recent times (Rubin et al., 2007).

Selection criteria was based on purposeful sampling (Palinkas, Horwitz, Green, Wisdom, Duan & Hoagwood, 2015; Tuckett, 2004). This requires the identification and selection of individuals, that are familiar with and have knowledge relevant to the phenomenon being studied (Creswell & Plano, 2011). Bernard (2002)

notes the relevance of participants willingness and availability to participate. He also comments that participants need skill to express articulately and reflectively their opinions and experiences.

As the aim of the study was to ascertain how psychologists understand, define and view competence, participants were selected on the basis they were currently registered as either a clinical or I/O psychologist and had practiced for a minimum of 5 years. The pool of participants was initially generated through suggestions by my supervisor, my own contacts and approaching psychologists, that while they had no connection, were considered to have a particular interest in the area. In the first instance the prospective participants were contacted via an introductory email with an attached information sheet outlining the study (see Appendix B). Those that were able to participate were asked to nominate a time and place that suited them to be interviewed. Before the interview began participants were asked to read and sign a consent form (see Appendix C). All interviews (see Appendix D) were done in confidentiality. At the completion of the interviews the participants were given a $40.00 voucher as a token of appreciation for their time.

Data was collected via voice recording and notes at the time of the interview. Interviews were conducted face to face and later transcribed by the author. All interviews took between 45-75 minutes. Using voice recording as a means of collecting data allows the interviewer to focus on the interviewee, ensures descriptive validity and allows the interviewer to refer back to the interview at a later date. The recordings were transcribed, and the data analysed using thematic analysis. All identifying information was removed.

Participants;

Ten psychologists were interviewed, made up of seven clinical and three I/O psychologists. Marshall (1996); Mason (2010) state that a suitable sample size is one that answers the research question sufficiently. As the research develops and data and themes start to reach saturation point, that is the point where more data does not necessarily mean more information or that new information does not add more to the overall story, it will become apparent how many participants are required. A small sample size allows an in-depth and detailed study of the phenomenon. It provides a richness that may not be achieved with large sample sizes and as Braun & Clarke (2006) state the time-consuming reading and rereading of the data is not always practical.

The psychologists varied in years of experience, but all had at least five years working as a registered psychologist. The participants areas of expertise varied also, encompassing clients ages and associated issues ranging from pre-schoolers to the older age group for clinical psychologists and various domains of organisational psychology for IO psychologists. Two of the clinical psychologists currently worked for a District Health Board (DHB), four of the clinical psychologists were in private practice, and one was currently in administration. Two considered themselves to be at the end of their professional life-span, the other clinical psychologists considered themselves to be mid-career. Three of the clinical psychologists worked primarily with children, one worked with teenagers, and the rest with adults (the under 65's for the most part). One taught at a university and was involved in research while also practicing. One worked part-time, having worked full-time for a number of years, and the remainder of the participants worked full-time. Two clinical psychologists

reported working with the Maori population regularly and one considered the demographic of her population to be increasingly Asian.

Of the IO psychologists, one was five years post study, the other two had worked in IO for many years. The IO psychologists worked in a number of domains. One worked part-time in private practice, while also working as a consultant assisting employees back to work after illness or injury. Another worked privately while also promoting health, physical and mental, in organisations. The third IO worked for a large organisation as a team leader, predominantly in education.

Ethical considerations;

Prior to the commencement of the study ethical approval for low risk research was gained from Massey University.

The process;

As mentioned, for this study Braun and Clarke's (2006) approach to TA was employed. Braun and Clarke (2006) encourage a reflexive and active approach throughout the process, their analysis encourages an organic and flexible strategy with coding naturally developing as the analysis progresses. The process does not require one step to be completed before moving on to the next rather it is designed to be a recursive process. Braun and Clarke (2006), phases of thematic analysis were used as a framework in the current study as it provides a methodical approach to TA. An inductive TA was used to identify themes in the transcriptions. Coding was done manually, highlighting potential patterns in the text and using post-it notes to mark relevant segments.

1. **Familiarisation of data by reading and re-reading the data and noting initial ideas.** The data collected for this study was initially read through looking for possible patterns and ideas. During repeated reading of the data and listening to the recordings of the collected interviews notes were taken and ideas marked down.
2. **Generating initial codes.** Initial codes were generated from the data; these codes were determined to be the most interesting or relevant to the research question. This stage required organising the data into meaningful groups and, at times, returning to stage one to confirm and clarify themes it also involved the identification of repeated patterns/themes. Segments of data from individual transcripts were photocopied and collated using index cards. It was important at this stage not to ignore contradictions or inconsistencies that appeared within the data set as these may be relevant to the story as a whole.
3. **Searching for themes.** Once all the data had been collected and initially coded the codes were sorted in to potential themes.
4. **Reviewing potential themes**. At this point a thematic map was generated, using post it notes on a board, as a visual aid, grouping similar data together resulting in a map depicting six main themes. It was also at this stage that relevant sub themes emerged and some data reduced or discarded.
5. **Defining and naming themes**. Initial theme names were considered and as the process continued they were at times reviewed and modified. After consultation with my supervisor themes and sub themes were agreed upon.
6. **Producing the report**. Once the final themes were decided the analysis was written up using examples that were relevant to the research question, captured the main points, and provided evidence of the themes within the data.

3. ANALYSIS AND DISCUSSION.

This study provided a description of how a group of psychologists view and engage with competence in their practice. The findings illustrate the value of, and the difficulties associated with, developing, achieving, demonstrating, and measuring competence and the consequences this has on their practice, their clients and themselves, and identifies factors that encourage, develop and maintain competence. Participants identified reflective practice and supervision as core to their competence, and continuing education, ongoing learning, and self-care as key to maintaining competence. Alongside the analysis will be a discussion that considers the current research relevant to the themes, reviews the findings, and evaluates the study.

What is competence?

"The most important thing in your circle of competence is not how large the area is, but how well you've defined the area."

(Buffett, n.d.)

As a broad construct;

Verbally describing competence as a broad concept proved somewhat more difficult for participants than explaining it as it relates to the practice of psychology. As indicated by the following examples the meaning of competence is often uncertain and not easily expressed,

"I get stuck around that word competence and just what the hell it means." (Clin.)

"I think the whole idea of competence is a questionable word in itself..it's got too much space to allow all sorts of people to get in there and create their own definition and meaning of it. Competence has different meanings for

everybody, even if you look up dictionaries, how it's defined is very loose." (Clin.)

A person may practice in a competent manner but trying to find words that capture that proved problematic, for this reason having a clear definition of it as a general concept may assist in guiding the development of competence. As one IO participant defined it,

"I think of it has having three particular components to it; one being the component of knowledge which they carry, the second part being the skills which they have which they bring to the job that's distinct from the knowledge, and the third being the attitude with which they do the job. I see these as being the components of competence." (IO)

Or as described by a clinical psychologist,

"*Well I guess as a profession you have a sense of what is defined as your role and what you're doing. I guess being competent means that you are meeting the basic requirements of what that profession decides is the requirements I suppose."* (Clin.)

These two descriptions of competence demonstrate the different perspectives, interpretations, and difficulty of defining competence. One indicates a construct that is multi-layered, the other outlines competence as simply the requirements to do the job as set out by the profession. Hence the need for a precise, concise definition of competence.

As a psychologist;

Overall the participants explanation of competence as it relates to the practice of psychology were within the suggested definitions of competence as described by the NZPB (2015). For some participants knowledge was the key to competence,

> *"For me I've got to have the knowledge, I've got to have the theoretical understanding and I've got to know what's happening in research."* (Clin.)

For others it was having the knowledge and the ability to demonstrate that,

> "*it means demonstrating and having the skills and proficiency to practice in a way that meets the clients' needs. It's not just knowing it but demonstrating it."* (Clin.)

Another participant viewed competent practice as knowing the limits of their knowledge,

> "*competence for me is knowing the limits of your skill and your knowledge and not practicing beyond those."* (Clin.)

Having a clear definition of competence is vital in acting as a guideline as there are a number of ways to explain competence leaving competence open to interpretation. As Kitchener and Anderson (2011) comment "it is easier to require psychologists to be competent than it is to define what competence means" (p. 88).

Having knowledge of the definition and requirements of competence make it easier for the participants to adhere to, and aspire to competence, as both a standard and a goal. Epstein and Hundert's (2002) definition of competence as they applied it to medicine is as relevant to the practice of psychology. They describe competence as "the habitual and judicial use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served" (p. 226). This definition captures the

components of competence required to be considered a competent psychologist; critical thinking, self-awareness, professional judgement, and reflective practice carried out within the ethical principles, values and guidelines of the profession. Competence is also developmental, depending on the stage of practice an individual is at, and context dependent (Kaslow, 2004). Kaslow comments that competence varies according to the setting and situation as the application and execution of competencies differs dependent on the environment. As one participant explained it,

> *"If you can show that you are demonstrating the core competencies as we have prescribed them, then yes you are competent. If, however, you are going beyond that, so if you've set up as some sort of a specialist doing the specialist part incompetently then you're incompetent.*" (Clin.)

The implication being that one may be competent in one area or setting and not another.

Demonstrating Competence.

Self-reflection;

Self-reflective practice and self-awareness were the foundations of demonstrating, maintaining and evaluating competence for all participant's.

> *"It's constantly being aware of what you're doing and how you're doing it and recognising that if something's not quite right then you have to follow that up."* (Clin.)
>
> *"Self-reflection is something I've built into my day-to-day work for my own learning. What's gone well today? What's hasn't gone well? What would I do differently tomorrow?"* (IO)

The ability to engage in reflection assisted in ensuring they stayed relevant, evaluated their practice, and learnt from their experiences,

> *"You need to be looking at what you're doing all the time and just check in on what's going on so that you can improve and provide the best support".* (Clin.)

One participant considered self-reflection not only as an opportunity to examine their practice but to review their formulations and interventions, as part of their functional competency. Fouad et al. (2009) describe functional competencies as the principal functions that a psychologist performs, these include assessment, diagnosis, and intervention and are an integral element of competency.

> *"It's part of how you shape your formulation and whether you are happy with the intervention strategies that you're choosing to use".* (Clin.)

Overall participants recognised self-reflection as critical for improvement and essential for positive change,

> *"for me it's a given because if you can't, at the end of that session, the end of every session essentially, if you can't…when you're sitting making the notes, reviewing what was covered, what happened in the session, what you're going to do next, where things are stuck, that's self-reflection."* (Clin.)

This ties in with the CCP's description of self-reflection as an overview of practice with the aim of highlighting areas of competence that need improving. This capacity to reflect is considered essential for professional competence (Mann, Gordon, and MacLeod, 2009). It is also through reflection that an understanding of one's identity is developed and understood, as recognising how our values, beliefs and attitudes impact competent practice is essential to being a competent practitioner,

"*You have to be aware of your own beliefs, world views, because you're dealing with diverse individuals and that's where self-reflection lies. So, you've got to be able to question and ask of self, what am I thinking, expecting around this?"* (Clin.)

Past studies (Jennings & Skovholt, 1999; La Torre, 2005; Lenburg, 2000) have shown that effective psychologists are both reflective and self-aware and use these qualities for active learning and professional growth. It is central to development and enables practitioners to build on their knowledge and skill (Bennet-Levy, Thwaites, Chaddock, and Davis, 2009). Kaslow (2004) describes reflective practice as the ability to think critically, assess situations, and make, modify and evaluate decisions using professional judgement. It does require an element of self-awareness; an accurate view of one's current behaviour and knowing where one is to enable reaching a goal. Without self-reflection, ongoing learning, enhancement of competence and improvement in practice is unattainable.

An issue that arose with self-reflection is the ability to effectively self-reflect. Participants commented that there was a lack of meaningful training to prepare them for effective self-reflection, they commented that they were unprepared to self-reflect having never been trained in self-reflective behaviour,

"*I think we're crap at self-reflection, training doesn't prepare you to be doing self-reflection. We have no skill in self-reflection I don't think",* (Clin.)

"we need to be trained in how to do self-reflection. I think you do need to have the capacities to reflect on yourself, but I don't think we're trained in doing that", (Clin.)

"we're really good at reflecting on our clients and formulating and figuring stuff out but training and self-reflection is very variable", (Clin.)

> *"I used to supervise a lot of students as well, and I was always most worried about the ones that didn't have that natural self-reflective capacity and they don't get any in their training."* (IO)

From the participants comments it appears the overall view is that the ability to self-reflect is not necessarily innate and requires training. While all understand the relevance and importance of self-reflection it was felt that education in the practice is inadequate at a training level and insufficient as an ongoing learning option. Roberts et al. (2005) suggest that self-reflection/assessment should be taught and practiced throughout training with the objective being to develop the necessary skills and habits required to self-reflect effectively as a psychologist. Self-reflection practices could be implemented alongside the current curriculum, teaching it, and providing opportunities to practice it, throughout academic education.

Participation in the NZPBs requirements for competency involve self-reflection. The self-reflective review is a means of evaluating competent practice and is considered central to achieving, maintaining and enhancing competency and as such is a form of self-assessment. Participants indicated that they struggled with what they felt were the demands of carrying out the self-reflective review,

> *"lots of people were spending enormous amounts of time on their self-reflective review. They turned that into this major exam effectively and they would write screeds and screeds and screeds and get really angry about it and actually pretty much lose sight of what the process was about."* (IO)

In their desire to be competent, they acknowledged that they were at times overly critical of their capabilities. This was apparent in their approach to the self-reflective review,

> *"what's happening is that self-reflection, it creates an anxiety and you'll see it amongst clinical psychologists or any psychologist around the country. It generates an anxiety about whether I am or not and that anxiety is actually debilitating then from being able to just let go, so it's actually harmful."* (Clin.)

Participants commented that they felt they lacked the skill to effectively undertake a self-reflective review and were unprepared for completing one. For something that is such a necessary and requisite element of demonstrating and measuring competence and improving the quality of practice the self-reflective review was talked about as being difficult and onerous task. Rather than being approached as an opportunity to enhance the quality of their practice it appears to have become a function to prove a practitioners' competence mostly as a result of the formula and requirements around the self-reflective review. It is one thing to participate in the self-reflective review and another to use it as a tool to enhance competence.

While there are many merits to self-reflection the accuracy of it depends on the individual (Mann, Gordon & Macleod, 2009) and as clinical competence is linked to this ability to self-assess and choose learning opportunities. It is important that we do not place too much reliance on it as an accurate demonstration or measure of competence. A study by Davis et al. (2006) on health workers noted that their ability to self-assess was poor. They suggested that alongside self-reflection competence be considered using observation, feedback, portfolios, less general and more practice based specific learning, and training in the skill of self-assessment. Approaching the assessment of competence in practice from a more holistic view, might result in …

The aim of self-reflection is to enhance competence (Lenburg, 2000) and as such is a vital part of the CCP but to be effective it requires a change in approach,

attitude and practice. By allowing the practitioner to take more responsibility for this type of self-assessment they may engage to a greater extent with less resentment. Lenburg also notes that taking responsibility for self-reflection as a self-assessment within a specific framework, encourages motivation and active engagement with self-improvement with less hostility. Self-reflection that focuses less on criticism and failure and more on pride in performance may go a long way towards changing attitudes and motivate practitioners to take responsibility for their own self-reflection and as a result improving their competence.

Supervision;

Participants also recognised supervision as a means to demonstrate competence. Clinical supervision is recognised as a career long and significant element of competent practice. It was through supervision they practiced reflection and felt supported in their practice,

> *"Supervision, it's kind of a main place that you're doing your reflective part of your practice and I guess having somebody else reflecting back to you and having some sense of benchmark I suppose or a sense of comparison."* (Clin.)

They reported that supervision was key to their professional competence, ongoing development and performance.

> *"I think the two ways that I use supervision in relation to competence I guess is the difficult ones where you've got a particular problem or there's been a roadblock, or you maybe feel like you're reaching the limits of your competence and those are the ones that I would discuss."* (Clin.)

Participants expressed the view that supervision is both a formal and informal activity. The formal being the time allocated to discuss work practices, decisions and

reflection, to demonstrate competence, enhance development and ensure safety and welfare of clients,

"Formally by checking things out in supervision and using supervision", (Clin.)

"Supervision is quality assurance and quality improvement. It's the supportive aspect and mentorship". (Clin.)

Alongside formal supervision is the more informal support provided by talking to colleagues and peers which the participant's felt was just as valuable in terms of reassurance, ideas and feedback,

"Informally by accepting feedback, of which psychologists are not backward in coming forward, if they don't agree with something that you do" (Clin.)

"I have my mentor kind of supervisor and then I also do a peer supervision process as well. Then there's all the informal stuff that you do when you go along to a conference and you chat to other people about how they're doing things and what they do. There's that side of it as well which is a little less regular but still important." (IO)

Some participants who work within a public health setting were assisted in supervision, over and above their clinical supervisors, through auditing, mentoring and observation ensuring that competence was not only met but maintained and improved,

"We don't just rely on people's clinical supervisor, we have professional supervisors for our services. I have eight professional supervisors who don't do the kind of traditional supervision, but they do the auditing and they do the mentoring and they do the sitting in the same service and hearing what the psychologist says and all that bit of it." (Clin.)

Some of the participants reported that they used supervision for assistance with personal issues that may relate to or impact on their ability to practice competently,

> *"This actually gives people permission to address these kind of issues because some people come from a background of saying well, you know, personal issues have no place in supervision. It should all be about this. All these things need to be really addressed in supervision. It's not personal therapy but it's personal to the extent that it impacts on your ability to do your job. Different people use that to different amounts."* (Clin.)

For some it was a matter of offloading, for others it was a need for ideas and support with personal issues, a form of therapy as one participant put it,

> *"If there's stuff going on in my life that has the potential to make me not do my job as well I use supervision for that stuff as well, which I don't know, maybe some people would have their own therapy or their own avenues of doing that, but for me supervision has that kind of dual purpose of the technical stuff, but also the background."* (Clin.)

The value of this to competent practice may be underestimated, not only does it act as a sounding board but is a form of self-care and a tool to alleviate stress and monitor well-being. As indicated by the participants, supervision covers a complexity of issues, some directly relating to client work, and others on variables that influence client work (such as personal issues). The Guidelines on Supervision (NZPB, 2010) support this by acknowledging that one of the functions of supervision is to "...focus on the emotional wellbeing of the client in their family, whanau or community context."

Supervision was understood by the participants as an opportunity to facilitate self-assessment (Falender & Shafranske, 2012), evaluate practice, develop and maintain competence, and ensure lifelong learning. Underpinning this was the importance of the supervisee/supervisor relationship and the expectations that were attached to that. Previous research (Bernard & Goodyear, 2014; Ellis, 2010; Falender & Shafranske, 2004; Falender & Shafranske, 2007,) indicates that one of the cornerstones of competence is the supervisory relationship. As one participant put it,

> *"Supervision builds your competence because it builds your confidence I think if you have somebody that you respect."* (IO)

This relationship provides an opportunity to practice skills required to develop, monitor and maintain competence. As Ellis (2010) describes it "good supervision is about the relationship" (p. 106), he also suggests that supervisee outcomes are directly associated with the supervisory relationship. As such, a good supervisory relationship can only enhance competence.

Falender and Shafranske (2008) describe supervision as a "distinct professional activity" that is promoted through the development of a shared alliance designed to increase and reinforce the supervisees' knowledge and skills, while supporting self-efficacy; in addition, it is conducted ethically, competently and professionally. While this definition describes a fairly structured process of supervision it was evident that the participants engagement with supervision was less regulated, with greater emphasis on the relationship and the opportunity to discuss their practice with another colleague. However, some participants suggested that competence may not be assured through supervision as *"hiding"* one's competence was not difficult,

> *"The kind of supervision that psychologists understand, does not require that you present everything to the supervisor, so you can cherry pick and you could hide your competence in front of a supervisor really easily."* (Clin.)

Supervision at the present time does not seem to be clearly defined for either the supervisee or the supervisor and although supervision is addressed during training and internship, the ongoing value of supervision as a method of demonstrating and maintaining competence does not appear to be sufficiently captured in the current competencies framework.

At the time of interviewing, the changes to the CCP regarding the use of supervisors and the self-reflective review had not taken place, though participants did have views on the proposed changes. While some anticipated that the process would become less time consuming and would benefit from the supervisors input,

> "*Really you've got to do supervision, which you're doing anyway, and you've just got to record the activities that you do, which you do anyway. So, I feel that like it's been a really big improvement in terms of reducing the time aspect",* (Clin.)
>
> *"I mean the new competencies I think are probably a better fit in that sense because I feel like they are more about… because it's partly about what activities do you do and then also what does your supervisor think. I mean there are all sorts of issues with that as well, but I do think they at least have some personal contact with you, know how you talk about clients, hopefully watch some videos of you or have some idea of how you interact with clients or people. So, I think that will capture it a better way and be less time consuming in that sense, less about ticking the boxes."* (Clin.)

One participant felt that their supervisor was not the ideal person to be overseeing their reflective practice and goals,

> *"I'm a little bit concerned with the way that the new competency process is shaping up to have such a heavy reliance on your supervisor. Maybe I haven't got the right supervisor, but I would say my peers are a better place to connect that my supervisor is."* (IO)

Others expressed concern that it may change the supervisor/supervisee relationship,

> *"So, while I can see why the supervisor is in a strong position, actually I don't agree that's then the person who knows how to call it because I think that's unfair and that's unreasonable and it would get in the way of the supervisory relationship. Supervision is about being able to discuss things you don't know, things you're not good at without fear of repercussion, so it will really change the nature of supervision."* (Clin.)

This change places the supervisor in a greater role of assessment with increased accountability on the supervisory relationship to ensure competent practice, and as such suggests that there are concerns that the relationship may become more evaluative rather than reflective and supportive. Therefore, some participants may not see it as an effective means of enhancing competence.

Threats to competence.

"To know one's own limitations is the hallmark of competence."

(Sayer, n.d.)

Apart from their understanding of the term and requirements of competence the participants also understood competence by describing what competence was not,

as Kitchener and Anderson (2011) put it, “competence is sometimes easier to identify in its absence...” (p. 88).

> “*It’s not stepping outside and doing stuff that you don’t have the knowledge or capacity to do.”* (Clin.)

For many this meant not practicing outside your area of knowledge or expertise, having the insight to know your boundaries and the ability to refer a client on,

> “*The biggest thing for me, if I feel like someone is lacking in competence, is the kind of person like I said who doesn’t know what they don’t know,”* (Clin.)
>
> *“That’s where you get in to trouble when you say I could try that, and you may not have the proper education or supervision or whatever.”* (Clin.)

This ethical consideration of competent practice aligns with the principles and values of The Code of Ethics (NZPsS, 2012, p.16) which states that “Psychologists recognise the limits of their competence and provide only those services for which they are competent, based on their education, training, supervised experience, or appropriate professional experience.” These same indications were also considered a threat to competence when not adhered too and are open to interpretation. A loose definition of the boundaries of competence, and as judging where one’s boundaries lie is fundamentally the responsibility of the practitioner, may mean a psychologist extends their practice slightly and gradually until they are practicing outside of their competence (Barnett et al., 2007). Several participants had witnessed practitioners that had moved outside a scope of practice or expertise and lacked awareness as to the gravity of their activities,

> *“In terms of competence what worries me most, is the ones that don’t even realise they are getting off track or don’t have the awareness to know that there is a lack in their knowledge base.”* (Clin.)

Participants felt that in doing so, these practitioners may endanger the public and potentially damage the reputation of psychology. Again, assessing for this is difficult as those that continue to practice outside of their expertise and knowledge may lack the self-awareness required to adequately reflect and may be unaware of what they do not know. As Barnett et al. (2007) suggest, prior to extending one's area of practice, psychologists should be obliged to seek advice from someone competent in the field to ensure they have the appropriate skills and knowledge required to practice, that is, seek supervision from an expert. Further defined guidelines that limit self-judgement would also be useful in reducing the dangers associated with moving beyond one's scope of practice.

Other threats to competence noted by the participants were the personal, social, and situational factors that influence competent practice.

> *"All of us have got stuff at home that's going to get triggered or be difficult or impact on our ability to practice, all of us and there are no exceptions."* (Clin.)

These concerns are supported by Barnett, Younggren, Doll and Rubin (2007) who examine the "challenges and stressors" that may negatively affect a psychologists' ability to practice competently and the consequences of not adequately addressing them. They further point out that all psychologists are exposed to stressors (both personal and professional) by the very nature of the work they do; as such it was argued that they must practice self-care, watch out for signs of burn-out and stress and find a balance between their personal and professional lives before it impairs competence. This is also supported by Roe (2002) who notes that personal, social and situational factors influence performance; therefore, being a competent practitioner does not necessarily guarantee competent practice as factors such as fatigue, health,

motivation, leadership, and availability of tools and information all impact performance,

> *"How can I manage the impact on my practice? I think personally it has a really big impact on competency with personal issues."* (Clin.)

Barnett and Cooper (2009) comment that psychologists have a responsibility to themselves and those they serve to attend to any impairment to prevent placing themselves, their clients, and the profession at risk. There is also a responsibility on colleagues, supervisors, and peers to be aware of the signs of stress in others and take a proactive approach to assist them in addressing the issues and ensuring competence is maintained.

The Code of Ethics (2012) states "Psychologists have a responsibility to monitor their ability to work effectively in order to avoid conditions that could result in impaired judgement and interfere with their ability to practice safely" (p. 16). The American Psychological Association Ethics Code (APA, 2017, p. 3) also acknowledges the challenges that may be experienced by psychologists and how this might impact their ability to function professionally by stating "Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work." This recognises the number of ways in which physical and mental health might compromise competence; unfortunately, by the time impairment is evident professional competence may already be negatively affected.

Another issue that participants felt was a threat to competence was the inability to translate information into a formulation,

> *"The most common way for me to know that somebody is not working at a very competent kind of level is that they show themselves as being unable to really develop good formulations. I work with clinical psychologists, what you*

find is they come along with an awful lot of information about this person but often the skill of actually taking that information and integrating it into something which sounds like a psychological formulation or a conceptualisation doesn't happen." (Clin.)

"I read the psychologist report and it doesn't have a formulation." (Clin.)

This skill, that one participant coined *"thinking like a psychologist",* or as another put it "*psychological mindedness",* is a difficult concept to assess. According to Kaslow (2004) it is the ability to use a psychological and scientific approach to thinking critically, problem solving, and developing a case formulation by integrating theory, research and assessment. Assessing this may only be achieved through outcome measures or observing a psychologist's mode of practice. It may be that this is a skill that can be identified and resolved before registration and as such is the responsibility of the training programme. It is also a skill that without a level of insight and reflection, and clinical supervision, a person may not be aware they are lacking.

It appears from participants' comments that the basis of incompetence in practice is a lack of self-awareness, that even with supervision and self-reflection may never be resolved. While some skills, such as converting client information to a formulation, may be teachable others are not and no amount of practical experience will overcome them.

Measuring competence.

The role of the Board;

The Continuing Competence Programme (CCP) provides a guideline to assist practitioners in ensuring competent practice and acts as a process or measure to confirm for the board that competence is achieved and maintained. For the

participants the role of the board and its guidelines went hand in hand with being a competent practitioner,

"acting in a way described by the board," (Clin.)

"using the core competencies as a guideline so that you can practice professionally and ethically." (Clin.)

It was felt that the explicit requirements of the board act as a framework and following them provides direction,

"acting in a way that a psychologist, as understood by the board, should act," (IO)

"in practice we look specifically at the prescribed set of competencies that the board has prescribed, and look for evidence that in fact those are being translated into day-to-day activities of psychologists." (Clin.)

The CCP is designed to act as a minimum requirement and all practitioners should endeavour to achieve beyond that and enhance their ongoing competence.

Participants concerns were that fulfilling the requirements of the CCP did not necessarily translate to clinical practice and may not be a true measure of quality,

"*at the moment we have core competencies that if you tick the boxes then you are competent and that might not necessarily translate into clinical practice."* (Clin.)

"I don't think any board can capture all the requirements to be a competent practitioner," (Clin.)

"So, whether somebody is completing their paperwork, I mean I guess it's a rough estimation of quality, but it's not like a real measure of quality." (Clin.)

As Barnett et al. (2007) comment "...licensing boards typically require documentation that renewing psychologists spent a minimum number of hours in

professional development activities. This is hardly adequate, as assessing competence by counting hours in continuing professional development is akin to evaluating services by counting client hours. In both cases, it is the outcome of these hours rather than the number that is important" (p. 512). While participants understood the value in the CCP as a guideline they suggested that it may fail to sufficiently safeguard against incompetence,

> *"it's that gut feeling that you have, and some people just don't have that or don't know when they're doing the wrong thing."* (Clin.)

A concept that is difficult to measure and assess.

Participants acknowledged the part the CCP plays in acting as a measure of competence but also held the view that as a framework it was unable to satisfactorily capture and ensure all elements of competent practice. While the participants recognised the elements of competence as determined by the board; (knowledge, skill, judgement and diligence), they also noted that the less tangible characteristics such as attitude, beliefs, insight/self-awareness, and interpersonal functions such as the ability to relate to others and form relationships (Kaslow, 2004), played an important role in being a competent practitioner also,

> *"There's no mention of how you might be managing relationships."* (IO)
>
> *"I don't think the current competencies capture the personal qualities."* (Clin.)

These qualities of competence are difficult to capture and while the current competencies as defined by the NZPB assess for knowledge and basic skill, it was felt that they may understate the relevance of these other important areas of professional practice (Epstein & Hundert, 2002). While knowledge and skill are necessary for competence they are not a sufficient marker on their own. As attributes play a key part

in competence participants argued that they should be considered a major feature of competency standards, without them competence is viewed from a narrow perspective.

For some participants engaging in the CCP was felt to be an insufficient means of determining competence,

> *"It can't be measured by a pen and paper exercise that you fill in once a year, but it could be measured by feedback from users or something like that, so there could be other ways of measuring it."* (Clin.)

For several participants, a point system for assessing competence felt more equitable used alongside the current CCP with its focus on self-reflection and supervision.

> *"We shouldn't just be keeping a little log, we should be accruing points that we're either in peer supervision, we're going to conferences, we're doing reading or whatever."* (Clin.)

> *"Actually, it should be keeping documents about all the courses we do to accrue points. We should be keeping a record of the other supervision we're in and some vehicle of what's covered in that."* (IO)

It was felt that accruing points by attending continuing education and professional development opportunities, undertaking practice assessments, lecturing, speaking at conferences, publishing research, and participation in supervision, in a manner similar to that used in other fields, such as architecture, law, and medicine may cover areas of competence outside that of the current CCP. A potential issue with this is the question as to what quality these educational opportunities are, are they effective, and do they improve psychologists' competence. Another issue that arises is that it relies heavily on the psychologists judgement to ensure that all areas of practice

are covered. Barnett et al. (2007) suggest that accruing points runs the risk of one area of practice becoming the focus of collecting points to the detriment of other equally important areas. While this may seem like a simple solution, does the accumulation of hours and the accruing of points by attending professional development opportunities adequately indicate competence?

"Psychology is a science, but it is also an art. We'll lose the art of it." (Clin.)

Participants also expressed the view that with a competencies-based framework, the necessary pushing of boundaries and moving forward, may limit or potentially inhibit change,

"There's no room for innovation, there's no room for trialling things, there's no room for difference of opinion." (Clin.)

As it is a fairly structured way of representing competence it may not allow for innovation, development, flexibility and alternate views, ultimately impacting the public and the progress of psychology,

"One of the real dangers with a competencies-based approach is when the competencies are defined as doing what we do now and then you get into a real conflict between what we do and what we could do and probably should do." (Clin.)

"I think it's hugely important that we don't overplay what competency frameworks and so on can actually provide and do and that they are part of the puzzle rather than the whole puzzle or part of the solution rather than the whole solution." (IO)

An example is using a method in a flexible and innovative manner, this could be construed as being incompetent as it is not strictly conforming to the prescribed manner of use. Rather than limiting the progress of psychology through structured and

limiting frameworks, encouraging thinking outside the box, and alternate ways of doing and viewing, may help to promote psychology. Through the use of professional judgement, consultation with experienced colleagues, and alongside ethical practice, pushing the boundaries of the current framework and looking forward, can be considered an advancement for competence in the practice of psychology and positive for the public.

Outcome as a measure of competence;

While the CCP acts as a competency framework for measuring competent practice it is only one part of a bigger picture of competence. Most participants felt that self-assessment and self-directed learning may not be an adequate measure of evaluating competence and a focus on an external assessment may need to be considered (Davis et al., 2006). Competency, to this point in time, has been conducted through self-assessment by the practitioner and measured by others in the profession (supervisor and Board), but the voice of the consumer is largely absent in our current measures of competency. It was suggested by some that this current emphasis on accountability to the board (rather than the public) limits the true representation of a practitioner's competence,

> *"At the moment you're accountable to the board, not to the public, not your clients."* (Clin.)
>
> *"It's sort of a limitation in a sense, competency structures are one part of the story and they're a part which gets focussed on a whole lot."* (Clin.)

Currently the CCP does not include outcomes as a measure of competence which most participants indicated that, alongside the formal structure of the CCP, were the best evidence of competence,

"one of the best indications of competence would be if a psychologist became much, much better at measuring outcome, because in the end that's what really counts." (Clin.)

"*I think competent clinicians have high rates of success, good outcomes, they have high rates of satisfaction with therapy, high rates of referral of friends, family, colleagues. That would all to me indicate a competent clinician."* (Clin.)

Roberts et al. (2005), suggest that measuring clinical skill be achieved through observation and evaluation using a number of methods including that of clients, supervisors, self and peers. They also emphasise the value of defining and assessing attitudes and values alongside knowledge through observation, simulations, and work samples. By doing so a broader picture of competence may emerge.

In addition to the CCP, using client feedback can assist in meeting the needs of the consumer, individualise care, decrease drop-out rates, and aid in identifying failing cases (Miller, 2010). Measuring outcomes alongside the CCP as a routine part of client care may significantly benefit both psychologists and their clients. Nordal (2012) contends that the use of outcomes as a measure can direct choice of treatment, highlight areas that require further professional training, and assist clients in acknowledging improvements. This would complement self-reflection and assist with the role of supervision. As one participant stated;

"Maybe we should be presenting some outcome data on client satisfaction." (Clin.)

Competence across the professional lifespan.

Maintaining competence;

Maintaining competence requires ongoing learning and training in order to develop and expand expertise, keep up-to-date with changes and developments in the profession, and improve and enhance practice (Roe, 2002). Participants acknowledged the importance of maintaining competence through ongoing education and lifelong learning,

> "*It is I guess the life-long learning kind of thing, which ties back into the drive. It's an ever-changing process, there's some things that don't change, but there's a lot that does. I think that's one of the things that for me, I've practiced for 20 years and for me it's one of the things that made it such a rewarding career was learning something. If I wasn't going to a conference or reading a book or a journal article I was learning something from my clients."* (Clin.)

> *"I think we should be required to show new learning and gaining of knowledge, so I think we should be required to do that."* (IO)

All participants felt that a curiosity or passion for more knowledge was essential for enhancing and maintaining their practice. Therefore, this indicates that competency is not fixed, rather it is ongoing and relies on an individual's attitude and development. As described by one participant,

> *"By being curious and maintaining learning and encouraging others to do that."* (IO)

This may consist of refreshing and extending current skills by attending specific courses, programmes, conferences, or workshops, or participating in self-directed learning, coaching, mentoring, and involvement in research.

"I guess what in terms of maintaining my competence, what's important to me, I guess it's checks and balances. It's about making the most of opportunities to update the knowledge and that's never as much as you would like, but more than that it's about recognising that you have to keep talking about it, particularly when you're in private practise." (Clin.)

For some participants, part of maintaining competence, while broadening and extending their knowledge, was looking for reassurance by attending ongoing education opportunities,

"Now my approach to ongoing education is I will go to specific topic things if it's relevant to what I do and see a lot of, but I tend to go to conferences where I can pick and choose from a whole range of things to get a broader thing. But even then, I think what's most valuable for me about going to ongoing education kind of stuff is reassurance really that nothing's changed dramatically." (Clin.)

Participants acknowledged that maintaining competence also required engaging in self-reflection/self-assessment, supervision, and the CCP.

"So, supervision is for me a really crucial part of maintaining that competence and going along to seminars and courses and keeping updated with the general stuff as much as you can." (Clin.)

When considering the maintenance of competence, it is important to reflect on whether the goal is to simply meet the requirements of the CCP or to maintain and further one's competence. Some of the participants went beyond the compulsory supervision, reflection and education by engaging in group peer supervision, enrolling in specialised ongoing learning courses, participating in research, and seeking regular advice from colleagues. Those participants working in IO attended group supervision,

> *"the peer group that I meet with is really good at holding each other accountable. I would say may peers are more aware of what I'm working on professionally than my supervisor is. We're really good at challenging each other and picking holes in each other's plans"* (IO)
>
> *"I do peer supervision. I have a really, really good group that meet once a month for peer supervision"* (IO)

These participants were involved in mentoring programmes and took part in regular networking opportunities, with one participant describing a monthly group supervision that not only focused on peer supervision but also required each participant to bring a tool/knowledge to share thus educating and benefiting the group and enhancing their competence,

> *"We bring a tool. So, we bring knowledge to put into the pool so that we're all sharing collectively and getting benefit out of each session."* (IO)

Some clinical psychologists participated in research, volunteer and community work, and sitting on boards,

> "*I do work in research and lecturing, some people volunteer for community involvement, sitting on boards, but that's time consuming and people are doing it out of the goodness of their hearts. It does contribute to your overall competence because you're developing a whole lot of knowledge in an area, but it's not captured in any way."* (Clin.)

Though these activities maintain and strengthen competence they are not acknowledged as adding to one's overall competence. These activities also suggest that competency is not just externally regulated but internally regulated as well, as evidenced by the participants going over and above the requirements of the CCP and actively looking to enhance their practice.

From new graduate to retirement;

As stated in the Code of Ethics (NZPB, 2012) psychologists are required to "keep themselves up to date with relevant knowledge, skills, techniques and research methods, through the reading of relevant literature, peer consultation, and continuing education and training activities, in order that their service or research activities and conclusions are sound" (p. 6). Though this maintenance is life long, it is also developmental, and tasks associated with different points of the professional life-span, when beginning a career, mid-career and as retirement approaches, may differ.

Thus, competence needs to be built upon from new graduate to experienced practitioner. New skills and practices evolve and a practice that may have been relevant 20 years ago may now be superseded. Psychologists must constantly assess their abilities and continue developing new skills and keep up-to-date with any changes or advancements through professional development and ongoing education. New research, the addition of new technologies, and new interventions means that the practice of psychology is constantly changing (Barnett et al. 2007).

Most participants were concerned that the development of competence across the professional lifespan was not captured or considered sufficiently under the current requirements,

> *"I would expect enormous developmental changes and I think there's nothing that reflects that. There's no guidelines."* (Clin.)
>
> *"There's a lack of guidelines around how much practice is enough and what type of trainings in professional activities is enough."* (Clin.)

They indicated that competence came with different expectations with regards to the demonstration, assessment and maintenance of competence, from new graduate to experienced practitioner,

> *"I know that coming out as a new grad and feeling competent is crazily different from mid-career say where you have a wealth of experience to draw on and you can be more relaxed about it, as long as you've got the capacity to still know your limits. But I think late career it becomes different again, like I'm kind of heading towards that now and I'm thinking my biggest competency issue that I have to keep in mind is am I getting stale? Am I just doing the things I've always done because they know they work and am I potentially doing a disservice to the people I see because of it?"* (Clin.)

Participants were of the opinion that while it is expected that developmental changes occur throughout training, the progression of the development of competence as the career advances does not seem to be sufficiently represented, leaving practicing psychologists adrift.

Rodolfa et al. (2013) observe that the development of competence does not finish at the start of independent practice and is a dynamic process and clinicians should aim to increase their levels of competence across the professional life-span (Donovan & Ponce, 2009). Responsibilities increase, opportunities in research become available, teaching, leadership all impact/assist the development of competence as the career progresses. It was felt by participants that no acknowledgement or consideration was given for the wealth of experience, as a result of many years of competent practice, that had been accumulated. As Barnett et al. (2007) comment, "competence relies on experience as much as on formal training" (p. 514).

In addition to changing expectations and developing competence, participants also noted that supervision needs, and specific competencies, change as experience develops,

> *"I do definitely think there's a case for having different kinds of ways of monitoring competency in different stages of your career definitely. Supervision is another thing that changes dramatically and I guess again I'm getting to the stage now where the mentors are going to start dying off and I'm going to be the mentor. So how do I shift my requirements to reflect that and that's where I guess I've gone back...because peer supervision I found really useful early career. Not so much mid-career, but I'm going back to that now with that recognition that we're all seniors now."* (Clin.)

Roberts et al. (2005) suggest that as skills and understanding increase, supervision changes are to be expected; the supervisory relationship changes and supervisees are able to take increased responsibility for their development within supervision (Stoltenberg, 2005). The NZPB (2010) also acknowledge that "the nature of the supervision relationship may change as the career advances" (p. 2). Participants proposed that for this reason different methods of assessment are needed at each developmental level and guidelines around the changes in supervision requirements need to be clearer.

> *"It would be nice to have some guidelines, wouldn't it? It would be nice to think that actually if you're a new grad for the first three years you need supervision. Once you're more than ten years' postgraduate you may have supervision three to four weekly. Once your 20 years postgraduate maybe it's a monthly basis and maybe there's room for peer groups in provision*

alongside individuals. There ought to be some agreed developmental changes." (Clin.)

This suggests that the need for oversight of competency reduces as the experience increases. While the NZPB does recognise the increasing skill level and understanding, participants felt it did not reflect the needs of the practitioners when it comes to the developmental changes in needs and support, or sufficiently describe the levels of competence across the professional lifespan.

Self-care;

Participants noted another factor to maintaining competence was self-care, "*Certainly, one of the biggest things for clinical psychologists is certainly if there is any kind of trauma or difficulty in their own personal life most of us would take a break or step aside for a bit. In private it's slightly harder, it's not like anyone pays you to take leave, but you have to make that call and the supervisor would support that. Yes, I think it makes an enormous difference actually if you are struggling with difficulties in your own life. I guess one of the biggest things as a clinical psychologist is learning how do I manage that?"* (Clin.)

As previously discussed, being aware of the risk factors that may lead to incompetent behaviour, monitoring oneself and engaging in self-care practices assist in the maintenance of competent practice. Smith and Moss (2009) identified a number of occupational risks associated with burnout that may result in incompetent practice. These included high occupational demands; long working hours, compassion fatigue, challenging paperwork and administration duties, and negative client behaviour. In addition to these factors are the personal influences such as financial strain,

relationship issues, illness, substance abuse and non-work-related stress that contribute to poor work performance. If these factors are ignored or untreated they may lead to practitioner distress, negative patient care, and incompetence (Barnett et al., 2007; Kitchener & Anderson, 2011; Smith & Moss, 2009). To prevent this occurring and ensure competence Baker (2007), suggests educating in recognising the signs of professional impairment in oneself and others should begin at training and continue across the professional life-span. Participants comments indicate that competency is affected by outside influences, thus it can be enhanced or reduced by a myriad of factors. They also argue that maintaining self-care requires both self-reflection and the input of others (peers, colleagues, supervisor); the interpersonal and intrapersonal elements of competency, and the time to be competent.

To maintain competence also requires an environment that satisfies personal needs and provides support,

> *"In a public health service, you need leadership support, management support, a good space to do your work in, systems that help you in terms of just recording your information. You need a supportive team because actually psychologists probably deal with the most complex, high risk people."* (Clin.)

One participant considered time as a significant factor in the ability to maintain competence,

> "*the really important thing that psychologists need, is time. You need time to sit down and formulate. You need time to look up the literature. You need time to develop treatment plans. You need time to score neuropsych tests. You need time."* (Clin.)

The importance of time as a factor to maintain competence is possibly overlooked. Having the time to attend supervision, and ongoing learning, to practice self-

reflection, and self-care, formulate patient plans, and manage administration tasks requires the support of others and organisations.

These social, situational, and personal factors influence performance (Roe, 2002) and while a person may be considered competent to practice, they may not always perform to the best of their ability. Competence is not enough to guarantee satisfactory performance. Barnett et al. (2007) note that all psychologists are vulnerable to professional and personal factors that result in distress and may affect competence. Whether in private practice or in the public health service, support, supervision, workshops, and continuing education programmes, and ongoing self-care requires a preventive and a multi-layered approach, from the individual to the organisation.

Culturally competent.

> "Cultural competence can be applied to ALL individuals, because human interaction is anchored in a cultural context. Indeed, everyone has a culture and is part of several subcultures, including those related to age, ethnicity, gender, sexual orientation, race, socioeconomic class, religion/spirituality, national origin, socioeconomic status, language preference, ideology, geographic region, neighborhood, physical ability/disability, and others"
>
> (Comas-Dias & Caldwell-Colbert, 2006).

Competence in cultural diversity;

Essential to competent practice is the ability to work with a diverse population of individuals that may have many cultural identities. All participants recognised this diversity as a bi-cultural and multicultural issue in New Zealand, and also identified

the influence their own beliefs, biases, assumptions, and values have on their practice and professional relationships. As it is described in the Code of Ethics (NZPB, 2012), "Psychologists respect diversity, and recognise that a person lives and develops within their social, cultural and community groups." It is not enough that the individual keeps this in mind, the profession as a whole needs to consider the impact of culture on the professional relationship, the use of assessments, the best outcome for the client, and the assessment of cultural competency (Roberts et al., 2005). Cultural competency requires a deeper understanding at a graduate level and an ongoing and supportive framework throughout the career. From participants comments, it is clear that self-reflection plays a role in being culturally competent.

> *"I define cultural competence as having an awareness of cultural diversity but at the same time recognising my own culture and what I bring to the situation. So, having the ability to adapt the way I work and being culturally sensitive at the same time, so always checking the perceptions and the attitudes, so making sure that I can bring the skills needed to achieve, while acknowledging my own culture and recognising the impact that has on the situation."* (IO)
>
> *"Having an understanding that not everyone thinks the way that you do and that other cultures have different norms, ways of thinking, expectations."* (Clin.)
>
> *"There are three elements to cultural competence, awareness, knowledge and skills. Being aware of your own bias, being aware that other people may have different views, different ways of looking at the world, is really important. Knowing how to extract those views as well and to draw them out from other people rather than to place them on, your views on to other people. The*

questioning skill is really, really important and I think a core competency for all psychologists to draw out people rather than just tell." (IO)

"Cultural safety for me is about dealing with the individual and being open to what they bring and who they are and not imposing all your own crap on them." (Clin.)

All participants understood that their culture did not necessarily fit with their clients' culture,

"I guess it means the first thing I always think about is recognising that I am a Pakeha psychologist in a predominantly Pakeha service and that I am using a western model to work with this person." (Clin.)

They also recognised that they may lack cultural competence when it came to working with specific groups or individuals outside of their own,

"I don't nearly have enough education in that area and that makes me quite anxious if I have a Maori client or a Pacific Island client because I don't tend to. I think that in private practice you are with your white middle class, European, population generally but I also find it a little bit anxiety provoking that I am getting more Asian clients now. I would really like to do a lot more awareness in cultural competency with some of these specific populations. But I'm also aware that I don't have the ongoing experience of working with those populations to keep that going." (Clin.)

For this reason, participants sought cultural supervision or ongoing education when required. Those in DHB's had cultural support provided within the system, particularly when it came to Maori and Pacific clients,

"I think it's important and I think that we're lucky in that our organisation provides quite a lot of support around it, so we have Maori Pacific staff that

we would not begin working a case with without having them as part of that case. I imagine that that's a pretty rare luxury that we have." (Clin.)

"In a DHB it's more readily available. If you were in a situation where you were seeing say a Maori, or even Asian, obviously they're a big part of our population now, that you could have some guidance around what's appropriate for understanding what's happening or what things might mean." (Clin.)

For those in private practice seeking cultural supervision has ensured competence,

"I've been really lucky that I've had good people around me, so I could seek their supervision and have the relationships with senior Pacific Island leaders who were able to help me." (IO)

"You might consult out to get it, you might bring in a cultural consultant or someone who has more expertise in the area." (Clin.)

For some participating in workshops that offered education assisted in ensuring and maintaining their cultural competence,

"*I go to a kind of cultural training network in Auckland that anybody can go to that's run through ADHB but they have it at Royal Oak and I try to go to that as much as I can."* (Clin.)

"There's this wonderful thing called the teleNetwork which I get emails for constantly and they have these newsletters and workshops and things that they run." (Clin.)

As discussed previously, *"knowing what you don't know"* (conscious incompetence, Morell, Sharp & Crandall, 2002), is a significant part of competence and is particularly applicable to cultural competence. Once you are aware of this you can seek to fill gaps through supervision or training.

Cultural competence for participants was also about being aware of assumptions,

> *"I guess what I do think has been useful is asking questions when I'm working with people and also not making assumptions about, you've ticked the Maori box on this form, so therefore you're going to want a million different things. I think with any ethnicity there's huge variation."* (Clin.)

> *"The first part of cultural competence is not assuming. It's not assuming that the person lives with all the cultural stereotypes. Making no assumptions, actually is around asking. Being curious, being respectfully curious of this person and how they see the world and particularly being prepared to address that from their cultural point of view...but more generally to be culturally safe I think is actually about knowing enough but not assuming."* (Clin.)

Clinicians must avoid making assumptions on the basis of culture and group characteristics to prevent stereotyping and approach with an informed and educated perspective. To do this requires reflection and self-awareness together with one's knowledge and support and applying it to the situation effectively, appropriately and in a useful manner.

New Zealand's population continues to grow and diversify. There are increasing numbers of elderly, and individuals that identify as gay, lesbian, bisexual or transgender or are members of ethnic minority groups, are disabled, live with chronic conditions, or are socio-economically disadvantaged (Yali & Revenson, 2004) and require culturally safe and informed practice. Consequently, there will be a greater requirement for psychologists to be both culturally competent and sensitive to the changing population. There is a need to not only be sensitive to cultural

differences but to also be skilled to meet the needs of this culturally diverse population (Guarnaccia & Rodriguez, 1996).

Cultural competence has been regarded historically as a speciality competence (Barnett et al. 2007) but it is hoped that as our population diversifies cultural competence will be considered a fundamental competence and that all psychologists will understand the importance of developing a culturally competent service. There is a need to not only be sensitive to cultural differences but also skilled

"I guess try and get a bit of information is obviously helpful and we work exclusively with families so you've got that resource to use in terms of I guess asking questions about how this works in a cultural sense. I guess those are the main resources we have and then it's just being open and aware that that's a limitation in your understanding of what's happening and trying to I guess reflect that within your understanding of the process and the intention that you're using." (Clin.)

Telehealth.

Telehealth or computer-based assessments and interventions were only touched upon by participants,

> *"I supervise a rural psychologist who is in an extremely isolated part of New Zealand and travels around in a fortnight all these towns. She's got all sorts of self-help type things where she's directing people to and she's quite good at just going in and finding out what they've done and telling them how brilliant they were to get onto that. It seems to be working reasonably well,"* (Clin.)
>
> *"I used to share an office with a guy, we were both doing our intern year. I hadn't seen him for 30 something years. He was in Brisbane and what he was doing was developing computer programmes, computer therapy programmes.*

So, you go in and you type in I'm depressed, how long have you felt that way? And it has all this response stuff," (Clin.)

However, they appear to be a direction in which the health profession is heading. Public demand and the increasing use of telecommunications to deliver health care services means that computer-based consultations, assessments, interventions, management, support and video appointments may become an area of practice within psychology (Glueckauf, Pickett, Ketterson, Loomis, & Rozensky, 2003; Jerome et al., 2000). This will provide a convenient and less costly service for those populations that are isolated, confined, housebound or time poor. As a result of these rapid developments, psychology will need to develop guidance for practice, clearly defined competencies that outline the knowledge and skills required to practice in this area, and specific assessments of competence around the use of technology in delivering mental health services.

Areas that psychologists need to be competent in are evolving, in ways that we would not necessarily have expected a few decades ago, therefore, principles around competency need to be flexible enough to incorporate and cover new domains in psychology.

Conclusion.

How an individual understands competence will influence how they view and engage with competence in their practice. Understanding this will assist with competency development, maintenance, measurement and demonstration. The responsibility for competence rests mainly on the individual in ensuring they take the requisite measures to meet the minimum standards required, while these standards

may be met, they do not guarantee quality services. Competence cannot be assumed to have been achieved simply through education and training.

It was clear from the participants in this study that competency is influenced by multiple factors, some within the person, some interpersonal, and some organizational, and these all relate and contribute to one another. Participants argued that competency is an ongoing process, and that it is related to, but no the same as, how well you practice, as other things can compromise that. While participants agree that skills and knowledge are important, they argued that self-reflection and attitude are very relevant to competent practice and these encourage life-long learning.

Participants identified the ability to self-reflect adequately, have a high level of self-awareness, and the opportunity to participate in appropriate, quality supervision as essential requirements for demonstrating competence. It was felt that for these factors to succeed and support competence, greater emphasis is required at the training level, and through ongoing education.

In addition to supervision as a means to demonstrate competence, participants also felt that it provided an avenue for maintaining competence, ensured safe and competent practice and acted as a monitor for self-care. Self-care, or lack thereof, was considered both a threat to competence and a significant means to maintaining competent practice. Due to high occupational demands associated with burnout and personal influences that may contribute to poor work performance, monitoring oneself and engaging in self-care practices is necessary to prevent incompetence (Smith & Moss, 2009; Kitchener & Anderson, 2011). To prevent impairment in oneself and to recognise the signs in others it was argued that it is necessary to promote self-care during training and for this to continue across the professional life-span.

Along with the personal and professional factors that may negatively affect competent practice, participants also recognised that practicing outside of your scope of expertise and not being aware of your boundaries of knowledge may endanger the client, the public, and potentially the reputation of psychology. It was felt that those that had moved beyond their level of expertise, often lacked self-awareness and the ability to self-reflect accurately, making assessment for this situation difficult.

All participants recognised the role of the CCP as a guideline for measuring competence. They discussed self-regulation, peer regulation and Board regulation. Though participants fulfilled the requirements of the CCP they were concerned that the current emphasis on accountability to the NZPB, rather than the public, limited an accurate account of competence. Most participants indicated that the requirements may not necessarily translate to practice, may not be a true measure of quality, and may not sufficiently guard against incompetence. It was felt that the less clearly defined characteristics of interpersonal skills, attitude, self-awareness, and beliefs are difficult to capture and the current means of assessing was considered inadequate on their own for determining competence. It was suggested by participants that accruing points by attending continuing education and professional development opportunities, undertaking practice assessments, lecturing, speaking at conferences, publishing research, and participation in various forms of supervision, may cover areas of competence outside that of the current CCP.

While the CCP does not include outcome as a measure of competence, most participants pointed out that alongside the CCP outcome as a measure was the best indicator of competence. By broadening the framework of the CCP participants were of the opinion that a more accurate description of competence may result. Doing so

would also include the voice of the consumer, which the participants argued for, rather than relying on the profession to monitor itself.

Psychologists need to attain, demonstrate, and maintain competence in order to provide consistently appropriate and safe practice. They should only work within the boundaries of their expertise, and when considering working with new populations, in new settings, or employing new skills and techniques should endeavour to expand their competence. Competence should be kept up-to-date and psychologists should be aware of factors that threaten competence in themselves and others. The ongoing issue remains; how does one develop competence, how do you determine when someone is competent, how do you measure competence, and how much competence is sufficient?

It is not easy to define psychology and as a result we risk failing to keep up with other health professions in delineating what psychologists know and are capable of. Participants acknowledge that there are specific elements to psychology, which means factors involved in competent practice are unique, as are the barriers, (such as compassion fatigue). This is clearly a work in progress, and will require time, effort and commitment.

Limitations;

This study adds to the limited research available on how psychologists understand and engage with competence. However, more research with a greater number of participants would be valuable. Although this study centred around psychologists from IO and Clinical, further research involving other scopes and Maori psychologists would capture a richer experience of competence in New Zealand. All participants had five or more years of practice, this limits the knowledge gained from

new graduates and their engagement with competence. Further research that focuses on specific elements of competence such as cultural competence, competence around the use of technology as a platform for delivering psychology, the relevance of self-care to competent practice, and alternate measures of competence would be useful in going forward.

Future Directions;

The challenge is to develop a consistent definition of competence and active engagement with it. As individuals may interpret competence in various ways, there is a risk that different clinicians may approach and engage with competence differently. For psychologists, having a clear definition of competence and how it relates to practice may promote a deeper understanding and engagement with competency requirements. This may assist in preventing interpretations while encouraging innovation and progress.

It may be that future consideration is given to increased training, prior to practice, for both self-reflection and supervision (for both supervisee and supervisor) with the continuation of ongoing formal education. Alongside these two essential elements, ongoing learning that addresses self-care as a lifelong consideration in oneself and others, and the implementation of guidelines and resources that assist psychologists in recognising distress, burnout, and impairment in colleagues and facilitate intervention, will go towards reducing impairment and promote safety and maintenance of competence over the professional lifespan.

If we consider competence as a developmental concept that increases over time with different expectations at different points of the career, then assessment should reflect this. Developing a method to assess for evaluating competence over the

professional life-span that captures the changes and acknowledges the many ways in which competence is enhanced and maintained as professional maturity is gained is worth considering. It is also worth understanding that the professional life is an ongoing developmental progression and as such the elements of competency; self-reflection, self-care, critical thinking, and continuing education, act as a model of prevention. This means that deficits or early warning signs may be picked up earlier, reducing risk and the possibility that a psychologist's competence to practice becomes jeopardised.

There is a need to pay greater attention to diversity with regards to assessing cultural competence. Currently there is neither a clear definition or measurement for cultural competence, this needs to be remedied to ensure safe practice and competent clinicians. Courses that are culturally based must be considered as fundamental to the education of trainee psychologists as any other, as cultural diversity is an area of human behaviour that requires specific knowledge and skills (Whaley & Davis, 2007). There is an opportunity at the present time to not only re-examine cultural competence but also reconsider the concept and expand the idea of multi-culturism in the practice of psychology in New Zealand.

As a relatively new domain of practice and with the increase in internet-based assessments and on-line delivery of psychology, there is a need for specific training in the specialised knowledge and skills required, the development of competence, and the assessment of competence in providing this service.

Currently psychology does not have the methods to reliably assess the combination of knowledge, skills, and attitudes required to competently practice, and yet this integration of professional behaviours is what comprises competence. Competence is dynamic and evolving and this should be reflected in measures of

competence. While it may be a challenge, adopting a more holistic, multi-measure framework that involves a parallel process of self-reflection, supervision and feedback alongside external evaluations, work samples, and outcome measures, may strengthen the current measurements in ensuring competence

"The education of the doctor which goes on after he has his degree is, after all, the most important part of his education"

(Billings, 1894, as cited in Nelson, 2006).

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Appendix A.

New Zealand PSYCHOLOGISTS BOARD
Te Poari Kaimātai Hinengaro o Aotearoa

SCOPES OF PRACTICE AND QUALIFICATIONS under the HPCA Act 2003 For psychologists registered in New Zealand

SCOPES OF PRACTICE AND PRESCRIBED QUALIFICATIONS

1. **"Psychologist"** - A psychologist within a general scope is defined as rendering or offering to render to individuals, groups, organisations or the public any psychological service involving the application of psychological knowledge, principles, methods and procedures of understanding, predicting ameliorating or influencing behaviour, affect or cognition. Such practice is undertaken within an individual's area and level of expertise and with due regard to ethical, legal, and Board-prescribed standards.

   The following qualifications are prescribed for registration in the Psychologist scope of practice;

   A minimum of a Masters degree in Psychology from an accredited[1] educational organisation, or an equivalent qualification. Eligibility for a general scope of practice requires a Board approved practicum or internship involving 1500 hours of supervised practice.

2. **"Intern Psychologist" -** An intern psychologist within a special purpose scope is defined as rendering or offering to render to individuals, groups, organisations or the public any psychological service involving the application of psychological knowledge, principles, methods and procedures of understanding, predicting ameliorating or influencing behaviour, affect or cognition. Such practice is undertaken within an individual's area and level of expertise and with due regard to ethical, legal, and Board-prescribed standards.

   An Intern Psychologist scope of practice may be granted to applicants:

   - who have completed formal academic studies that have provided them with the foundation competencies required for safe practice in a supervised internship setting and who are enrolled in a Board-accredited post graduate diploma or doctoral course of studies.

3. **"Trainee Psychologist" -** A trainee psychologist within a special purpose scope is defined as rendering or offering to render to individuals, groups, organisations or the public any psychological service involving the application of psychological knowledge, principles, methods and procedures of understanding, predicting ameliorating or influencing behaviour, affect or cognition. Such practice is undertaken within an individual's area and level of expertise and with due regard to ethical, legal, and Board-prescribed standards.

   A Trainee Psychologist scope of practice may be granted to applicants:

   - who have completed formal academic qualifications that have provided the foundation competencies required for safe practice in a supervised setting and who are entering board-approved supervised practice for the purpose of achieving full registration.

[1] "Accredited" here and in subsequent references means accreditation of the educational organisation, or an educational course, by the New Zealand Psychologists Board for the purpose of registering psychologists.

VOCATIONAL SCOPES OF PRACTICE AND PRESCRIBED QUALIFICATIONS

4. **"Clinical Psychologist" -** Clinical Psychologists apply psychological knowledge and theory derived from research to the area of mental health and development, to assist children, young persons, adults and their families with emotional, mental, developmental or behavioural problems by using psychological assessment, formulation and diagnosis based on biological, social and psychological factors, and applying therapeutic interventions using a scientist-practitioner approach. Such practice is undertaken within an individual's area and level of expertise and with due regard to ethical, legal, and Board-prescribed standards.

   The following qualifications have been prescribed for registration as a psychologist in the Clinical Psychologist scope of practice;

   A minimum of a Masters degree in Psychology from an accredited educational organisation and an accredited Postgraduate Diploma in Clinical Psychology, or equivalent qualification. Eligibility for a clinical psychology scope of practice shall require a Board approved practicum or internship involving 1500 hours of supervised practice.

5. **"Counselling Psychologist" -** Counselling Psychologists apply psychological knowledge and theory derived from research to the area of client empowerment and enhancement, to assist children, young persons, adults and their families with personal, social, educational, and vocational functioning by using psychological assessments and interventions, and preventative approaches that acknowledge ecological, developmental and phenomenological dimensions. Such practice is undertaken within an individual's area and level of expertise and with due regard to ethical, legal, and Board-prescribed standards.

   The following qualifications have been prescribed for registration as a psychologist in the Counselling Psychologist scope of practice;

   A minimum of a Master's degree in psychology from an accredited educational organisation and an accredited Postgraduate Diploma in Counselling Psychology, or equivalent qualification. Eligibility for a counselling psychologist scope of practice shall require a Board approved practicum or internship involving 1500 hours of supervised practice.

6. **"Educational Psychologist" -** Educational Psychologists apply psychological knowledge and theory derived from research to the area of learning and development, to assist children, young persons, adults and their families regarding their learning, academic performance, behavioural, social and emotional development, by using psychological and educational assessments and applying interventions using systemic, ecological and developmental approaches. Such practice is undertaken within an individual's area and level of expertise and with due regard to ethical, legal, and Board-prescribed standards.

   The following qualifications have been prescribed for registration as a psychologist in the Educational Psychologist scope of practice;

   A minimum of a Masters degree in psychology[2] from an accredited educational organisation and an accredited Postgraduate Diploma in Educational Psychology, or equivalent qualification. Eligibility for an educational scope of practice shall require a Board approved practicum or internship involving 1500 hours of supervised practice.

7. **"Neuropsychologist" -** Neuropsychologists apply scientific understanding of the relationship between the brain and neuropsychological function within applied clinical contexts. This approach forms the basis for the assessment, formulation, and rehabilitation of people who

have sustained brain injuries or other neurological conditions. Neuropsychologists work with people of all ages who have neurological problems such as traumatic brain injury, stroke, epilepsy, toxic and metabolic disorders, brain tumours, and neurodegenerative diseases. Such practice is undertaken within an individual's area and level of expertise and with due regard to ethical, legal, and Board-prescribed standards.

The following qualifications have been prescribed for registration as a psychologist in the Neuropsychologist scope of practice;

A minimum of a Master's degree in Psychology from an accredited educational organisation and an accredited Postgraduate Diploma in neuropsychology, or equivalent qualification. Eligibility for the Neuropsychologist scope of practice shall require a Board-approved practicum or internship involving no less than 1500 hours of supervised practice.

. [2] A Master's degree in Education may be considered equivalent to a Master's degree in psychology where its content is sufficiently educational psychology in nature.

Appendix B.

How do psychologists understand competence~~y~~ in their practice?

My name is Kristin Taylor and I am conducting a research project for my Master of Arts~~s~~ at Massey University. My supervisor is Dr.~~,~~ Angela McNaught.

The aim of ~~this~~ my research is to explore how psychologists understand competence within their practice and how this influences their practice of psychology. I am particularly interested in ~~different scopes of practice and~~ how competence is understood within the different ~~se~~ scopes of practice, and how this translates into practice. You will be aware that the New Zealand Psychologists' Board is currently reviewing its CCP requirements however, this project is in no way connected with the B~~b~~oard. I am only interested in your personal understandings of competence and the consequences of this for your practice. ~~This project is in no way connected with the Psychologists Board.~~

The project involves interviewing registered psychologists with more than ~~5~~ five years' experience who are currently engaged in the practice of psychology. I expect the interview to take approximately 45-60 minutes. ~~This~~ It will be audio recorded for later transcription. ~~I would like for Tthe interviews will to take place between the 1st and the 30th of August.~~ At the end of the interview, as a token of my appreciation for your time, you will receive a $40.00 petrol~~grocery~~ voucher.

Your information will be kept confidential at all times. You will be given a pseudonym and your recordings and transcripts will be held o~~i~~n a secure password protected device for a minimum of ~~5~~ five years after which ~~they~~ both recordings and transcripts will be destroyed. If you decide to participate you have the right to not ~~-~~answer any particular question and to raise any queries you may have about the study at any time during participation. At the end of the study a summary of the projects findings will be ~~provided~~available.

If you would like to participate please contact me on kristintaylor30@hotmail.com or on my mobile 0211 548 249. If you have further questions please feel free to contact me ~~on the above email~~ or my supervisor ~~on~~ at a.mcnaught@massey.ac.nz~~,~~ or on 414-0800 extn 43106.

Thank you for your time.

Kristin Taylor

Appendix C.

How psychologists understand competence in their practice?

PARTICIPANT CONSENT FORM

I have read and understood the information sheet. Any questions I have had have been answered to my satisfaction, and I understand I may ask further questions at any time.

I understand that if I wish to receive a summary of the results I can include my email address at the bottom of this form.

I agree to participate in this study under the conditions set out in the information sheet.

Signature _____ Date _____

Full Name (printed) _____

Email Address (for summary of findings):

_____

Appendix D.

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Q: As a general focus how would you describe competence?

A: In general, because I'm a clinical psychologist, so for me as a clinical psychologist what do I think competence is? At the end of it, for me, it means being able to do a good job. It means being up to date with literature, so it does mean having good knowledge. It does mean knowing what works. It does mean building a really good relationship with a client. It means being able to work out what that client, what is it they're most wanting, needing from the therapy because it varies enormously. Then being able to I guess given, you know, because they have reasonable knowledge or understanding of how therapy works, I can help that to happen to enable what it is that they're most wanting from therapy to happen, so that we get a good outcome.

Q: So using the knowledge that you're constantly updating first of all to assess, diagnose?

A: Yes.

Q: So that's competence for you in practice?

A: Yes. I guess for me I've got to have the knowledge, I've got to have the theoretical understanding and I've got to know what's happening in research and I have to have the ability to build the relationship in order to run the two together. Without one or the other I would think I wasn't competent or wasn't able to do a good job.

Q: So it's a union of a number of different…

A: Yes, and then it coming together in order to get that good outcome at the end of the therapy.

Q: When you think of competency in practice do you see one that appears more important to you than others?

A: That's a really good question. Do I think it's more important? I don't know if I do think it's more important hierarchy I guess. I think one can't happen without the other, so if you haven't got theoretical knowledge and understanding I think building the relationship on its own isn't going to go anywhere. But if you can't build the relationship, then there's not much point having a theoretical understanding because you can't do anything with it. I feel like they're both integral to competence.

Q: No matter how much knowledge you have?

A: No, you can't…

Q: If you haven't got the relationship…

A: No, you're never going to get anywhere.

Q: And vice versa?

A: Yes and I think some people do have one or the other.

Q: Yes and I'm sure sometimes with different clients, even if you have all the knowledge, you just can't build that relationship at times, I don't know.

A: Yes, it's going to be more difficult.

Q: More of a challenge.

A: Yes, but that's I guess learning that actually it's the ability to always be striving to learn how to manage it better. So you should always be having a way forward. So you never ultimately be not able to…

Q: To practise with a client.

A: Yes, even if that's to terminate but you want to terminate well.

Q: Yes, best practice.

A: Yes, always to be able to do it well. I mean ultimately for me I think the person coming in the door has got to have a good experience. They've got to go out feeling like that was okay, or feeling like in fact that was incredibly helpful. Certainly not wanting it to be negative, damaging in any way whatsoever. You could have those to be able to do that, so for me alongside each other.

Q: What part does then this self-reflective review come into it for you?

A: Good. I didn't mention it actually did I? For me it's a given because if you can't, at the end of that session, the end of every session essentially, if you can't… when you're sitting making the notes, reviewing what was covered, what happened in that session, what you're going to do next, where things are stuck, that's self-reflection. I guess you could look at material you've covered in a session and plan the next session without thinking how it went, you could do that, but again you're going to come unstuck because self-reflection is what enables you to work with the relationship or work with difficulties that are occurring, so interestingly maybe actually would have to have all three components up there in reality.

Q: Yes because that is an important part of being a competent practitioner.

A: Yes.

Q: I guess it's not just after you've seen a client and you're writing up the notes and things, it may be working with your supervisor or down the line a bit.

A: Yes, I think you need to be not just saving it for supervision though. Someone like me is once a month so you have to be doing it all the time thinking that didn't go so well. Why might that be? Or yes, that works, that was good. What was so good about that? If you didn't do that, I guess in the early days you do less of it because you're still trying to just get through the sessions and remember what to do and manage it. Supervision I guess helps you practise self-reflection from really early on, so you're socialised into self-reflection really early in your training process.

Q: So it becomes just a natural part of…

A: Yes, I think some people are better at it than others. So not all clinicians are really great at self-reflecting and not all are probably really good at building relationships and not all are really that good at having knowledge, so it varies. Hence I think we talk about competence.

Q: So if we're talking about someone that may not be good with, you feel isn't very self-reflective, which could potentially be a dangerous practice or an unhealthy practice, how do you know that person? How do you know that someone is not a competent practitioner?

A: You're making a judgement aren't you I guess ultimately, and again it is where there's difficulties, at the moment we have core competencies that if you tick the boxes then you are competent and they might not necessarily translate into clinical practice. But it's interesting because there's the move at the moment and one of the propositions is that more onus goes onto the supervisor obviously because the supervisor is the one dealing face-to-face, hearing the psychologist's ability to self-reflect, hearing what their knowledge is, hearing their ability to form relationships, sometimes seeing it if they're preparing video work.

So while I can see why the supervisor is in a strong position, actually I don't agree that that's then the person who knows how to call it because I think that's unfair and that's unreasonable and it would get in the way of the relationship, the supervisory relationship. Supervision is about being able to discuss things you don't know, things you're not good at without fear of repercussion, so it would really change the nature of supervision. How do I know if someone's competent? I mean if they're not open, I get most of it, so maybe it's also if they're not open to…

Q: Transparent with their practice?

A: Yes or to thinking about something differently or to increasing their knowledge or to try things out in their therapy sessions or to reflecting out loud about the relationship or about themselves. If they're not open to doing those things it would bother me, and it would bother me because then I think that's going to have an impact on their practice. I'm holding the view actually that without ability to form relationships, good knowledge and theoretical understanding and that ability to reflect, then it's going to be hard to do your job.

Q: Those same people I guess, even if they have a good supervisor, if they're not being honest with themselves then they're not being honest with their supervisor, then it's going to be hard to pick up for people I would imagine.

A: You might pick it up but again you can't, it doesn't really change it, so that's probably the difficulty. It would be unlikely a supervisor wouldn't pick it up, but your ability to change that… I mean clinicians can just change supervisors if they find that too hard or too [09.38].

Q: There are ways around.

A: Yes or if you're the supervisor you just stop supervising the people that you don't find…

Q: Live up to…

A: Yes what you're needing or wanting from another therapist, so an enormous amount of personal judgement.

Q: Yes there is isn't there? And it does put a lot of onus on the supervisor if the changes, the recommended changes…

A: Yes, well it could, it certainly could do. I guess I'm really hoping it doesn't [10.12] clinicians and my choice; my personal choice is I stopped supervising people. I say this is not a good match for me, this isn't working for me and I haven't had to do that very often in my career actually, but I can do it if I have to because that's my integrity that's then on the line.

Q: Yes it does, it reflects on you, absolutely.

Measuring competencies in the field. Do you feel we should have different measurements for different scopes of practise?

A: Yes (laugh).

Q: At the moment there really isn't.

A: They're so similar aren't they? It's ridiculous. I mean I think yes, why would we bother training…

Q: Because we all come from the same knowledge base.

A: Yes and then we specialise and if there isn't a difference then why would we ever bother to specialise? So there must be some differences and they must or they ought to be reflected in core competency, it's never going to happen in New Zealand, but it ought to. So an educational psychologist, I guess you've still got to form a relationship, so does health, so does counselling, so does clinical, so there must be core and then I guess there's specialist areas though around knowledge and practise.

Q: I guess particular knowledge and again they sound the same, it would have to be about particular knowledge. You can't I guess, my feeling is, you can't base your competence purely on, your review purely on what interests you when you're going forward. It has to be on what's relevant, important, based on your strength and areas where you're not so strong. It can't just be I'm interested in this so this is what I'll do my…

A: Yes although you see it's hard I guess because over time often people do become more specialist and I guess there's also this interesting question around slightly across competency isn't there? So for example, I work with adults, so clinical psychologist works with adults theoretically 18 to 65, but I don't always stick within that. On occasion I see slightly older and occasionally, pretty rare, that I might see slightly younger. Now is that within my area of competence? [13.31] kind of say no because I don't have the theoretical knowledge or understanding of the relationships at that younger… older spectrum I don't know, for some reason I think we can get away with it more. They're still adults aren't they, not adolescence, although theoretically there is a difference.

I guess sometimes we think we can have enough competence for other reasons that we might slightly step out of our scope as a clinician. Should everyone be able to do that? Because as a clinical psychologist again sometimes I might see someone in a health area, someone who has cancer or something. Now I don't have specialist theoretical knowledge around cancer, so I certainly do think I've got some obligation to be somewhat up to speed to have enough knowledge going in, but a clinical psychologist might be able to see that person who is post-cancer.

Q: That would be for a specific reason and rather than more of the health side of it, so to fit into your scope.

A: Yes. So I guess if you're going to step outside your scope, you have an obligation to be informed. Scopes have got viaduct and if you train as a health psychologist presumably you have a huge interest in health issues, but then broader clinical issues and clearly there would be an overlap, but you must have that education. So I do think there's got to be general areas of competencies, the relationships and the original understanding and our self-reflection, that you've got to back that with all

the skill and the knowledge for that particular area. So I would certainly hope that a health psychologist is really good, way more than a clinical psychologist.

Q: Yes, for their specific scope.

A: Yes and the practise that goes with that. Educational psychologists are always getting far more testing around ability or disability, far more than a clinical psychologist, and particularly around educational functioning. You've got to have specialist skills within each of those scopes and counselling psychologists, similarly, I have to assume that they will have less psychopathology…

Q: Yes than a clinical psychologist would see…

A: Yes they might deal with the more mild to moderate but I wouldn't be that keen if you've got so much psychopathological knowledge or skill to then work with someone who is chronic or severe.

Q: So if you're a competent practitioner you'd refer them?

A: Yes.

Q: You have to know at what point to do that.

A: Yes and therein I guess is the issue, is that you're so reliant on individual therapists and their supervisors sharing and that's my view. It certainly isn't anyone else's and it certainly isn't out there. The board's view is that you can do anything if you wish, seriously (laugh).

Q: So regulation isn't a focus?

A: No and actually mostly the board would like you to be really good at self-reflection and so long as you can self-reflect that really [17.22] currently.

Q: And if you see in the review to come out, that's the big thing, is self-review, self-reflective review, that's really the only thing they talk about.

A: Yes and you could keep a little log of the activity. So you can keep a little log…

Q: Which diminishes as you go to…

A: Yes it diminishes, you know, updating knowledge, it diminishes that, highlights self-reflection and there's no mention of how you might be managing relationships. They do think it's hierarchical, the board, I don't share that view. That's the board, but the board has another agenda don't they? Their agenda is that we are all one and the same and we are not going to allow any specific psychologist to think they're any different from another, and certainly not any better than another.

Q: If that's the case though you would think that you would finish your undergraduate and then everybody goes along and does the same papers and from there you can just choose where you want to go, but that's not the case. There's deployments in different things, there's clinical psych, they've brought in the masters of clinical - all sorts of…

A: Exactly, so trying to hold it up as being a more extensive psychopathological knowledge and ability to deal with more serious cases, you would think would be possible but the board does not recognise that clearly. It just is not a shared belief system. It is by most clinical psychologists but not at general scope or educational [19.10].

It's so interesting and it's so interesting for you of course because there's some political, cultural agenda about why New Zealand cannot do that. So Britain can do it. I assume, I don't know much about America, but America can do it. But New Zealand can't. So there's something about small population needing to be one and the same.

Q: Do you think it's really New Zealand culture?

A: Yes I do.

Q: I'm an Australian and the New Zealand culture is very much like that. There's the tall poppies, there's the we're all the same, we're all treated equal.

A: Yes I think it is really cultural, really cultural and clinical psychologists aren't seen as the tall poppies.

Q: Regardless of the work they've had to do to get there (laugh).

A: It does seem kind of logical when you are one why that would be, but for the others that's no justification and they do not and cannot allow… and I do, I think it's cultural, culturally that the whole profession of psychology cannot allow the tall poppies to be tall poppies. You've got to hold them into the masses and keep pulling them back into the masses.

Q: And yet the competencies or being a competent practice is for the benefit and best practise for the public.

A: Yes.

Q: But then that's not taken into consideration when they…

A: No. The interesting thing for me is that I was part of the - when did the HPCA come in?

Q: 2003.

A: So in 1990 I was part of one of the first working parties and we were looking at trying to get… we weren't calling them [21.14] of practice but in that day we were trying to get clinical psychologists registered separately from psychologists in 1990 when it started. There was working parties and meetings and it came through in 2003. So that's a cultural issue and that's about tall poppies.

Q: Thank you for that.

A: It's interesting. I don't know how it happens in Australia.

Q: I've only looked a little bit at theirs. I was looking more at theirs through the occupational therapists and things like that. I was just having a look because I know they're undergoing a lot of change with their competencies requirements.

A: Health practitioner.

Q: Yes, health practitioners, so we look at that. So a high level of competence is required to be a good practitioner. What about the influences, say social, situational, how they influence your competence? When I say that I think of situational or the tools that are available for you, how the business is managed?

A: Right, in order to be a competent clinician?

Q: Yes, the outside influences.

A: Yes interesting you're asking me because I'm a private practitioner, so part of the move to be a private practitioner for most of us, may not all but most of us, is that actually you have so much more control over what [23.09] is for a start. So you are removing yourself from others, putting restrictions or rules around things you cannot do. So how much do I think that influences competence? I'm not sure. Again you see I probably think the onus still comes back to the clinician mostly, not completely. In private practice obviously we contact the clients outside 9 to 5 because I work outside 9 to 5 for a start and you can contact us outside 9 to 5 whereas I think the DHBs are pretty strict that that would be unacceptable.

For one clients are not allowed what we would call private numbers outside the DHB so you would be breaking all the results. So does that make you less competent? Although the DHB is set up, they have a system that helps to manage that but does that make it hard? I guess sometimes. Does it make you more competent though? I don't know if it makes you less competent. It just makes it harder sometimes to be able to work in a way that you're used to, you have freedom in private practice and you have enormous responsibility clearly because you're not then relying on others.

Q: Do you have the same access do you feel to any tools and knowledge and whatever?

A: Yes if you need it. So certainly if you need crisis cover you have as much access to it as…

Q: If you were working for…

A: Yes, so it's interesting, it doesn't make you more competent. I don't know what I think about that. Does it make you more competent? I think you can be a highly competent therapist in very difficult situations working under quite a lot of constraints on you, like within a DHB, but I still think you can be a highly competent clinician. It must make some difference but I'm not sure if it makes a lot.

Q: And whether it's positive or negative.

A: Yes.

Q: What about personal influences, your own energy levels or health, motivations?

A: I think that's really big.

Q: So much more situational…

A: Yes, situational factors. Certainly one of the biggest things for clinical psychologists is certainly if there is any kind of trauma or difficulty in their own personal life most of us would take a break or step aside for a bit. In private it's slightly harder, it's not like anyone pays you to take leave, but you have to make that call and the supervisor would support that. Yes, I think it's makes an enormous difference actually if you're struggling with difficulties in your own life. I guess one of the biggest things as a clinical psychologist is learning how do you manage that? How do you manage your life so that it doesn't…

Q: Has the least impact.

A: Yes, both ways I think.

Q: That's a strong requirement for a good competent practice.

A: I think it is a really strong requirement. What do you think [26.55] situation is how do you best manage that? Are you someone who needs to work just a few hours every day? Are you someone who needs to do and have stronger admin roles, a little less face to face [27.13]. Those personal circumstances I think can have an enormous [27.21].

Q: You have to know yourself pretty well.

A: Yes can be open too I guess, for me it's that openness to discussing it and supervision and in private we also… we don't get to choose [27.36] and DHBs not so much because I find that's internal. So you need to have a supervisor who you can talk to about that stuff and be able to say we actually, you know. Like you did with me, you know, something comes up with a kid or there are some issues with children.

Q: A bit of flexibility.

A: Yes so how can that be, have not too much, how can I manage the impact on my practice in what I'm doing? So I think personally it has a really big impact on competency with personal issues.

Q: And social issues? So support networks, all of those things, I guess that comes under personal for you?

A: Personal for me yes and why am I thinking that's more than situational? Because I guess I think that ability to form a relationship is really strong, it's a strong component of being competent with a therapist, whereas if there are situational constraints on you I guess generally you try and problem solve your way around them.

Q: But if you can't develop that relationship in the first place then it doesn't matter what constraints are there or not.

A: No, and all of us are human. All of us have got stuff at home that's going to get triggered or be difficult or impact on our ability to practice, all of us and there are no exceptions.

Q: No, we're all human.

Cultural competence. How do you define cultural competence with regard to Maori culture?

A: That is big and really hard, really hard. Look, ideally for me, in an ideal world, which doesn't exist, but I would like that we had lots of Maori psyches, all highly competent and available to work with Maori. That would actually be my ideal, given it doesn't exist.

A: But that would be my ideal so that there was good choice for Maori people to see either Maori clinicians or not and a range of Maori clinicians, so it isn't just one Maori and you can see the one Maori clinician we have and you've got to get on, because it is about good match.

Q: Do you feel like there's a potential for harm if a Maori isn't seen by a Maori clinician?

A: Potential for harm? I think it depends a lot on the client themselves enormously how much they identify culturally, how much they want to

have access to someone from that same culture. I'm not someone who assumes just because you are therefore you have to, but I think it would be really nice to have choice wouldn't it in New Zealand? It would be nice to have choice and it would be nice to think that we could certainly offer Pacifica and Maori people, given they're a big proportion of our population, that they could have a choice, whereas actually they're just [31.13]. Given that is the reality then there certainly is an obligation on us as clinicians to be as knowledgeable as we can be and to I guess make sure we know enough about protocol so that actually yes, we can form a reasonable relationship if you're in that division that you need to or have to.

Q: Do you ever seek cultural assistance if you're in a situation like that?

A: Yes and again more so in DHB that's more readily available. In private obviously you have to agree but differently just to get it but you still get cultural supervision. If you were in a situation where you were seeing say a Maori, or even Asian, obviously they're a big part of our population now, that you could have some guidance around what's appropriate for understanding what's happening or what things might mean.

Q: I guess the way we assess, obviously the western model of assessing, and the conclusion we might come to might be completely different to assessment and conclusion by someone from the same culture and a different understanding.

A: Yes.

Q: Again talking about having Maori and Pacific Islander clinical psyches, do they need to be educated in a different way?

A: Well…Yes, a very westernised model.

Q: We don't look really in any depth at the health models of the Maori culture.

A: I know and western culture is very individualised, it's not whanau based. I think it's a good question. Ideally if you have very intact strong cultural groups they develop, education, seek support from within. We don't though so that's never gonna happen. So you can still… I guess what is an advantage though is if you educate within the western system you use that within your own cultural group and you then have the knowledge and skills to be moving between the two but you're so strongly immersed within your own culture you work…

Q: That's right, you already have that.

A: …within your own cultural group. So I guess actually the advantage would possibly be if you can do both wouldn't it, to succeed within the western education system (laugh).

Q: Is what it comes down to.

A: It does and then actually go back within the cultural groups and work with them however that might look.

Q: So using that knowledge but your own skills, cultural skills and cultural knowledge.

A: Yes and again that becomes very difficult because then how do your cultural standards know they're being measured. So if you're a clin psyche, if you're a Maori clin psyche, you've trained within our system and then you're back within your own culture, you're still going to be assessed by that western system in terms of cultural competence.

Q: Yes so that's another avenue.

A: Yes, I mean measuring competencies is extremely difficult.

Q: New Zealand is a very bicultural, at least bicultural society but there's only one competency programme.

A: Yes I know.

Q: How would you deal with straight cultural competence in practise if you are dealing also with gender or sexuality, there's all of those aside from bicultural [35.30].

A: So same thing though, you see for me I guess your core competencies are around areas of knowledge, knowledge research based, building relationships and self-reflection. So whatever presents, whoever presents, you've got some obligation to get enough knowledge and skill behind you. You might consult out to get that; you might bring in a cultural consultant or someone who has more expertise in the area because you've got to get it somehow. Then you've got to have all the really core strong skills to build a relationship with whoever is in front of you.

Q: I guess that also means you have to be very aware of your own beliefs, world views, the whole… because you'll be dealing with diverse individuals.

A: Yes, big time and that's where self-reflection lies. So you've got to constantly be able to question and ask of self. What am I thinking, expecting, around this?

Q: I don't know if you've ever considered this, but I'm wondering whether the characteristics of the current competence take into account the life span, the professional lifespan. So from a new graduate…

A: No, not at all.

Q: …through to retirement and clearly there's going to be a lot of life changes in that period of time and who knows whether a fairly new graduate is at the same level as someone who has retired or whether that person is. So how do you define that or is competence covered, does that cover this?

A: I don't think it does under the current measure of competency. I don't think there's any room in there for… they're saying if you reflect on what your own strengths and weaknesses are you set your goals accordingly, but it would be nice to have some guidelines wouldn't it? It would be nice to think that actually if you're a new grad for the first three years you need supervision [37.47]. Obviously once you're more than ten years postgraduate you may have supervision three to four weekly. Once you're 20 years postgraduate maybe it's a monthly basis and maybe there's room for peer groups in provision alongside individuals. There ought to be some agreed developmental changes.

Certainly I've been to lots of learning workshops, conferences in those years and you certainly expect it to be less over time. Not none, but less than. I would expect enormous developmental changes and I think there's absolutely nothing in it that reflects that. There's no guidelines, it is just a mass of, let's just all say what we think we're good at, what we're not so good at, we'll give you the names to consider and at the end of it, so long as you reflect sufficiently, we'll say you're competent.

Q: Everybody knows how to practise self-reflection effectively.

A: Yes but if not actually they'll pedantically teach you anyway from the board point of view. You can tell I really like the current programme (laugh).

Q: The more I've read it's interesting to say the least.

A: It is interesting.

Q: I've asked you about priorities and competencies and you felt…

A: Yes I definitely, the three broad areas for me.

Q: There's none that were more critical than others.

A: No.

Q: How do you actually demonstrate your competence in practice?

A: It is hard because on the whole we demonstrate it by outcome and that's very unfair and unreasonable because a lot can influence outcome. But if you are competent you've got to get a reasonable proportion of good

outcomes. It's not all but I think that's what I was kind of eluding to earlier. So your client, even if there isn't a fantastic outcome, at least the experience has been positive and/or reasonable, it hasn't been harmful.

So I think competent clinicians have high rates of success, good outcomes, they have high rates of satisfaction with therapy into the [40.32], high rates of referral of friends, family, colleagues. That would all to me indicate a competent clinician. But if you're not getting good outcomes, if you're not getting people being very happy and if you're not getting lots of referrals coming in then it's going wrong.

Q: It's a good indicator (laugh).

A: Do we measure it a lot through? No, we don't. Unless it's that ProCare [41.05]. That's a good aspect of ProCare. You're really gnarly on client satisfaction and outcome.

Q: Heaps of people…

A: I don't know if they're doing anything with their data of course, but they at least collect it. So their clients get to comment on how happy they were with their therapist. I don't know if that, I can't remember if they do it after every session or after their four or five, they only get four or five. They do enough measures to look at outcomes. so are they getting better? Are they happy with their therapist? So actually they're measuring that data themselves aren't they?

Q: I guess if you're aware that they're measuring it you would presumably work harder.

A: It does depend what you're doing with the data. If you're feeding it back in.

Q: Yes using it as a chance to review.

A: It would be good if they didn't wouldn't it? Because then you would presume therapists would be wanting to be on their game more.

Q: Are there areas you feel need changing?

A: I really dislike the current system phenomenally. I think it's become a pedantic exercise in teaching clinicians how to self-reflect, I really do. I think it has become nothing more than that and actually the more you can actually [42.48] actually you get that proper feedback that you've done a great job. If you are less able to use self-reflective language in the current system you are punished for that. It's really obvious - I supervise about 20 clinicians and two people I supervise, one is probably one of the most ethical, competent clinicians ever [43.18] that wouldn't be my [43.21] had to resubmit it one year because she did not follow protocol. I don't know, what does that say? What is that message?

Q: When it's telling you it's self-reflection…

A: Yes because she didn't follow… now I have to admit it was worse than that in the first year because there was no format, there was no format that she was very severely punished for using a format that was muted as a possibility. So punished by having to re-submit, so the implication is not incompetent enough to be censured or suspended, but incompetent enough to be asked to resubmit. Seriously? So it's seeing those sorts of anomalies…

Q: Priority…

A: Yes, put on the ability to follow that format in the manner they require you to do it, so that currently is the measure of competence. I really disagree with that. I think that has got nothing to do with competency.

Q: We need to go back and see what other countries are doing.

A: Yes, it is definitely not the same. I actually do think we should do a point system. I think we should be required to show new learning and gaining of knowledge, so I think we should be required to do that. We shouldn't just be keeping a little log, we should be accruing points that we're either in peer supervision, we're going to conferences, we're doing reading or whatever…

Q: The law does, the legal fraternity do.

A: Almost every other professional group so we should be keeping those points. We should be keeping some kind of record and accountability of supervision processes, so that we are regularly in supervision, how often it is. With some production and maybe the supervisor and the therapist are recording or fully count how much self-reflection is going on and how do I think we should measure relationships? Maybe we should be presenting some outcome data on client satisfaction, but actually it should be keeping documents about all the courses we do to approve points. We should be keeping a record of the other supervision we're in and some vehicle of what's covered in that. But again maybe it's ticking boxes; it doesn't have to be arduous. Then maybe we should be collecting over the course of the year client satisfaction forms or randomly every…

Q: Yes randomly…

A: Boy that would be fun and meaningful wouldn't it?

Q: Yes, we'd have a lot more meaning.

A: Rather than your ability to self-reflect, according to their rules and [46.05]…

Q: That's right, so it's not the focus.

A: Yes and do I think that's self-reflection? No, I don't think it's self-reflection. That is not self-reflection. That is the ability to do as you're told and to write what you're told in the manner you're told. That's all that measures. Some people are really good at doing that and some people aren't so good at that.

Q: And it does not mean that they're not competent.

A: Exactly. I also had a clinician who got given clear feedback that the language used was not self-reflective enough and the suggestions made were you need to be thinking and feeling more than telling. So what did that measure? Seriously what did that measure?

It has been such an interesting process to be part of for the last five years. I obviously get see a lot of the feedback after it's collected and some people produce documents of 20 to 30 pages for God's sake and others…

Q: A small piece this size (laugh).

A: Pretty much and that - is that any more competent…

Q: That's right, than someone that can…

A: Now in fact there doesn't seem to be enormous correlation between those who have necessarily presented two or three pages more than one, but that seemed to meet the okay standard than those presenting 20 pages but that shouldn't be occurring. There should not be people writing - no you don't and it's not required.

I had really experienced clinicians in tears over the whole [47.54] but then most ridiculous thing I've ever seen because it's so incomprehensible what is actually being required of you, other than to write what you've been told, that goes against the grain.

Q: It does of self-reflection, of the definition of self-reflection.

A: So the whole process is complicated. You've got to actually get the exact nuance they want in the manner they want in order to be told you're [48.23] and they didn't put out a format the first year, so they're punished severely, the person who didn't… and then they developed a format the second year that strongly suggested you… well I actually didn't. I continued to use the first format (laugh).

Q: And you didn't get censored?

A: No, some people did though that were still using it because within our practice that's where she's at and most people did it and it was fine, but others got criticised for it, particularly towards the end of the 5th year. So things have become really unstuck within the board itself and the idea of it, that there is an inconsistency and then how do they equate those who have been through their competency who then have complaints laid against them by the general public? How does that work? So you've actually got, in your practising certificate because you've halved your random one and five years audit and then if there's - oh hello, two or three complaints about your practice, how…

Q: Has that not come up?

A: I don't know. I've not seen anything [49.39] but I do wonder because we do have a number of complaints to the board obviously in a year. So I guess no one's asked or it's certainly not been published, how many of those people with complaints against them had passed the audit process.

Q: Yes, had current certificates of practise.

A: I bet every one of them has.

Q: Yes, I think so.

A: And the ones who were not granted had to re-submit or have some - I don't know, I've never met anyone who actually didn't get one. That was a possibility, that it would be withheld until you met the criteria. I didn't see that happen but [50.23] on that one, what they would have made you do.

Q: I'll keep that in mind (laugh).

A: Or they didn't audit once a year. So obviously they're in complete disarray so they've only re-audited the very few who were on their list as [50.44] and again, probably good, very competent clinicians who they had no issues with but they didn't fill out a form correctly, so they were the only ones that were audited. So who knows what will transpire.

Q: That's right. We know it's going to be self-reflection.

A: Yes and we know that the onus will probably pass to the supervisors because they board don't carry it.

Q: That's right.

A: I'm very cynical; I don't think there will be a good outcome. You'll have to keep a log of your practice but that won't be accrued, won't be allocated points, and it won't actually count for anything. You won't have to submit any record of supervision. All clinicians who I supervise, and that the

current audit all submitted sheets of their hours of supervision, not required. So you're not required to submit it, documentation of any record of your supervision. According to their rule so it's not even normal self-reflective review.

Q: I'm sure you're not the only person that feels this way.

A: Yes it will be interesting to know if that's the case or if it relates right back to the whole starting point, which is in New Zealand there is no room for difference. Is that the root for the whole argument in the first place and that is why it's turned into this ridiculous self-reflective review according to our rules and criteria?

Has that all come from the basis that we cannot allow clinical psychologists to accrue their points, because that's what they're trained to do and that will disadvantage some of our other clients or health clients? I would assume they want to keep out [52.58], I can't see why they wouldn't.

Q: I'm sure that has to be part and parcel across the board for everybody. You have to be up to date.

A: I guess because we're all, according to the board, one and the same we can have this ridiculous, meaningless competence measure. For me they're consistent, they are completely consistent so I'm not thinking it's gonna change in a hurry [53.27] and I registered in 1990.

Q: Is that right?

A: Practicing 25 years but I did work in the UK and it was very different for me there. Really, really different. So even back in… I registered in the UK about '92 and even then, so 1992 I had to register under the Charter of Clinical Psychologists so they have always had…

Q: The difference, yes.

A: …sorted out in Britain and the requirements to be a Chartered Clinical Psychologist was very individualised and different from being an educational psychologist. I don't even know if they had health psychologists there. Counselling psychology was just developing and it was a separate scope and check this out, it came under the umbrella of clinical psychology - under the umbrella. Counselling psychologists had to be supervised by clinical psychologists so there's this really radical approach. Culturally the British system is way more hierarchical so they didn't have any issues with it. So you've got a whole culture that, you know.

Q: That is their culture that is hierarchical.

A: Yes, so really interesting. It's very developmental within Britain so you have as a new grad, I can't remember what their terms are, they have assistant psychologists, psychologists, they have senior psychologists but they're called A grades and B grades I think, so they even separate out developmentally the whole profession as hierarchical, which I'm not saying is all good but it has its place.

Q: Because ultimately it's for the public so it has to be.

A: But also here within clinical psychology you talk about the developmental phases there is no great enormous respect for experience.

Q: That's right and that has to count for something.

A: You would have thought but actually I'm as likely to get challenged by someone five years postgrad as… there isn't a sense that because I'm 25 years postgrad I might know a little bit. There's no sense of that whatsoever in New Zealand and that would never occur in England.

Q: No, the respect would be there.

A: It's the way it is. It is the way we operate as a culture here, for better or worse. Good to know and think you can have a voice, but there is a real lack of sense of respect for experience or maybe wisdom.

Q: And it's a lack of respect for the public?

A: Ultimately yes.

Q: Ultimately for the public because that's what it should really be about.

A: Yes and ultimately that's exactly… how they are supposed to work out who are competent clinicians, more experienced clinicians, they have no idea. I really feel for the public.

Q: Yes because there's no grading, they don't understand what's required to be a clinical psychologist or what they actually do separate to a counselling psychologist…

A: Or a registered psychologist, general scope, they have no idea. Again the British system, for better or worse, is just incredibly clear. So it's really, really clear who you are seeing, in what way they're qualified, how senior they are…

Q: What their level of experience is.

A: Yes. It's very interesting; you're opening a can of worms (laugh). It is such an interesting can of worms though I've got to admit. I know, the feedback form, well clearly for all of us who did first time round that was

so upsetting for the board that it actually had to then ask for another round because they just couldn't deal with it.

Q: They didn't get the answers they wanted.

A: Exactly, that's exactly what happened and that's a joke, it is though isn't it? Let's have a really big review and leave you all high and dry having no idea what's going to happen and then say oh my gosh, we don't quite know what to do with all of this, so now we're going to put it out there again because we just have no idea. We've got so much [58.32] and of course they haven't said that but it has been the issue.

Q: Yes they wouldn't have done it another time, trying to get different answers.

A: I know.

Q: That's been fantastic.

[End of recording 58.41]

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Q: What does competence mean in a general idea to you?

A: Okay so not so much the professional…

Q: No, just general.

A: I guess it's doing things safely with a degree of expertise and confidence about it.

Q: When you bring that down to your own practise what does it mean to you specifically?

A: I think probably, if I'm really honest, it's about not stuffing up really, competence. I think also for me it is very much about making sure that you're doing things within the limits of your expertise. I think that's what always comes to mind for me in terms of competence. It's not stepping outside and doing stuff that you don't have the knowledge or capacity to do.

Q: Talking about that - stepping outside your knowledge of what you've been practising in, would that alert you to someone that was not competent if they were going outside of their area of expertise?

A: Yes, absolutely. I've probably come across that on a number of occasions during my career watching people do that and I guess it's what I would say as being incompetent as that they're doing things that they don't have the capacity to do.

Q: Ultimately competence is about public safety, but also best interests.

A: Yes.

Q: So if you've got someone practising outside it would be…

A: Yes.

Q: What do you see as priorities in competence?

A: Obviously it starts with knowledge. There has to be a base of knowledge but I think once that basic knowledge is there it's about maintaining it and then it's about experience of applying that knowledge. I think that's a huge part of competence that probably when you're first learning is right in the forefront of your mind, but can fade I think for people.

Q: The experience?

A: The importance of it. I think the danger at my stage of the career is that you can kind of get into that, you know, I've done it all before so it's all easy and I don't really need to think about it too much. But I think the experience you continue to get is still just as crucial in terms of maintaining competence as well as updating the knowledge, but it is more recognising that having applied that knowledge and done it before does point you in the right direction in the future as well.

Q: So you would say that the experience is critical to competent practise?

A: Yes.

Q: How does that influence your practise?

A: I guess what in terms of maintaining my competence, what's important to me, I guess it's checks and balances. It's about making the most of opportunities to update the knowledge and that's never as much as you would like, but more than that it's about recognising that you have to keep talking about it, particularly when you're in private practise. You need to keep talking to others about what you're doing to make sure that you're on the right track. So supervision is for me a really crucial part of maintaining that competence, going along to seminars and courses and keeping updated with the general stuff as much as you can, although that's pretty hard. I sort of read the titles and think oh yeah, I'll read that one one day but books and stuff like that again are important.

I think also it's constantly being aware of what you're doing and how you're doing it and recognising that if something's not quite right then you have to follow that up with either checking in with someone and going back to the literature, or finding something that you've done before that is relevant to that situation. It's the experience part I guess.

Q: Would you call that self-reflective review?

A: Yes.

Q: So that's one of the competencies and with the new lot that are coming out it's quite strong on that self-reflective review, so that would be self-reflective review and do you think that's a critical element of competence?

A: I think it is and I guess that was one of the things that I really liked about the changes to the continuing competence was the idea that that's important. However I have to say that the formalisation of that hasn't kind of worked for me because I think it's something that I do all the time anyway. Although I was quite enthusiastic about the idea of having this nice little plan and structure and ticking things off, the reality is it doesn't kind of work like that for me, which is unusual because……I thought I

wouldn't be that sort of person but in reality it's a constant process for me, rather than something that I sit down and do once a year and then tick off at the end.

Q: That's really what self-reflective review is isn't it? It's something that over time you're going over and it's not something that I guess can be particularly structured.

A: Yes, I think it's good to have points in the diary that you do formally do that, yes the process of writing it into their sort of formal structure for that has been a bit challenging at times, but as I say it's the ongoing, in between that is just as important to me.

Q: What part does supervision then play for you? You mentioned that talking to others when you've got a particularly tricky situation or just feedback?

A: Yes I think I use supervision in a couple of ways that I think is important. I have my mentor kind of supervisor and then I also do a peer supervision process as well. Then there's all the informal stuff that you do when you go along to a conference and you chat to other people about how they're doing things and what they do. There's that side of it as well which is a little less regular but still important. I think the two ways that I use supervision in relation to competence I guess is the difficult ones where you've got a particular problem or there's been a roadblock or you maybe feel like you're reaching the limits of your competence and those are the ones that I would discuss.

But the other side of it that I think that is really important for me is the whole general background stuff and I guess that's probably more about maintaining your competence in terms of the capacity that you have. So if there's stuff going on in my life that has the potential to make me not do my job as well I use supervision for that stuff as well, which I don't know, maybe some people would have their own therapy or their own avenues of doing that, but for me supervision has that kind of dual purpose of the technical stuff, but also the background.

Q: Absolutely, one of the things I was going to ask was while competence is critical for good practise, other issues such as the social, your personal and even situational issues might impact on competence. So when you were talking about things that might be going on for you in your life, so personal issues, I guess you might consider things like health issues and for some people it might be motivation or whatever, so those things are going to impact. So when it comes to situational factors and I'm thinking say if someone who works in a DHB and they've got a lot of tools available, they get a lot of input, that sort of thing. Working for yourself do you find situational factors an issue at all?

A: The nice thing about private practise is that you can pick and choose the work that you do, whereas you can't do that in the DHB system.

Because of that I guess you can manage your workload a lot easier so I think you can, if you know you've got quite a few difficult people, you can cut back and you can see a few less people while you get that balance back. Or if the person who is ringing you up you know is not a case that is best dealt with in private practise you can refer them on or push them away.

So you do have a lot more autonomy and control over the kinds of work that you do in private practise, however the downside of it is, as you say, you don't have that support structure in place. You don't have the colleagues on tap and you don't have that sense of working in a team that you might have in the DHB. So you do have to be quite careful I think that you're not in your own bubble and that those personal factors are… because there's no one else there to pick up on it happening as there would be in a big place that you had. So you do have to be a lot more mindful about that and that's why I think it's probably become more of a focus in my supervision than maybe it would have been otherwise.

Q: Again that comes back to self-reflective review doesn't it?

A: Yes.

Q: Do you think that self-reflective review is actually a good marker of competence? Some people have more insight than others.

A: I guess what comes to mind thinking about that is that I'm always most worried about… because I used to supervise a lot of students as well, and I was always most worried about the ones that didn't have that natural self-reflective capacity. I mean most clin psyche students anyway are way the other way, you know, too self-reflective and too hard on themselves and there's that side of it. But the ones that worried me most were the ones that just didn't have that awareness and I guess if I think about working with other professions there are some professions who are less good at that. They don't get it in their training or they don't have a natural tendency towards that kind of thing.

In terms of competence that's what worries me most, is the ones that don't even realise they're getting off track or don't have that awareness to know that there is a lack in their knowledge base that… one of the things that stands out to me most in the terms of competence is I remember when I was working in a multi disciplinary team I had a social worker who came to me and said - look I don't know why you make such a fuss about this, this psychometric testing thing that you do, I could do that if I wanted to. That was kind of like a red rag to a bull to me, but that's the epitome I guess of what we're talking about there. She didn't have the capacity to reflect on how inappropriate that was. That was very challenging, dealing with that (laugh).

Q: I can image after all your years of study and knowing it inside out before you use it.

A: Yes that was a real turf war situation. It wasn't about the psychometrical testing, it was about she wanted to be doing therapy with some of the more challenging clients in the team and others in the team felt that there wasn't the competence there to be doing that. But because she was much older than me she felt threatened and challenged by that, but it came out as I could do psychometric testing if I wanted to.

Q: So with self-reflection the idea is it shows you your strengths but also it shows gaps in learning and knowledge and things like that. I guess for some people it may be that attending workshops and conferences and those sorts of things, maybe they attend them more on an interest base than a needs base and so then you're missing the point of actually gaining the necessary knowledge, do you know what I mean?

So some other professions actually have a point system when it comes to what you attend and it kind of has to fit with your reflective review that you're attending appropriate things because you might be a child psychologist but hey, I'm interested in older aged people so heck, I've got gaps here, I'll just go and attend those. Is it enough to just get a general, interspaced?

A: The self-reflective review has been really good for me. It's forced me to make choices because I think psychologists in New Zealand are notorious for being generalists. I think that's changing these days, but we all like to have the idea that we can do everything still and I think that as I've got through my career I've actually been forced to confront the fact that I'm never probably going to have enough knowledge in some areas to be doing that work now. I'm constantly rung up to see adolescents and so a while ago I drew a line in the sand and said that I'm not going to see anyone younger than 17 and they need to be able to either not be at school so already started university or haven given away school so that they're kind of moving into that adult phase.

I realised from seeing a couple of 15, 16 year olds that I just didn't have the expertise… well it was actually more the experience of dealing with that population. So now I don't go to the adolescent stuff any more because I've chosen not to work in that area. However it took me a long while to kind of give that away and I thought no, maybe I should be enhancing my competence in this area so that I can see these people and maybe I should be going to those sorts of conferences, maybe I should be trying harder to know more about this, but I realised that the amount of people that I was going to see was never going to warrant the investment. So it was pragmatic to say right, I'm going to draw my line in the sand. I'm not going to see anyone under 17 and I'm going to refer them on to people who can do that stuff better than me.

Now my approach to ongoing education is I will go to specific topic things if it's relevant to what I do and see a lot of, but I tend to go to conferences where I can pick and choose from a whole range of things

to get a broader thing. But even then, I think what's most valuable for me about going to ongoing education kind of stuff is reassurance really that nothing's changed dramatically. There's a few little new things that kind of seep in occasionally and I think oh yes, I'd like to try that. But more often it's knowing that I'm still up with the game and hearing it all come back at me and thinking yes, I can do that, if that makes sense. So it's more reassurance…

Q: Yes it's confirmation that you're on the right track still.

A: Yes so it's quite rare now that I will go to something that's not relevant to what I'm doing whereas in the past I would have. I would have gone to all sorts of things that were interesting but I don't now see the benefit of doing that if I'm not going to then go and apply it and use it because it fades.

Q: Yes, if you're not using it constantly.

A: Having said that though, because I work at the medical school and get all their emails and stuff through, every now again there will be something that's happening out there that I get a notice about and I'll go along and attend a lecture or go to a presentation about something that's just interesting, rather than directly relevant. Having said that actually I don't have time so most of the things I go to are really relevant as well. Same with trolling through the journals and that, there will be one thing and oh, that looks interesting. I might kind of dip into it and have a look at it but really I only have time to go to the things that… like it will be that sounds new, that I'll make the time to go and actually…

Q: Look further.

A: For the rest of us it's just reassurance - yes the same things are still being researched, yes nothing much has changed. Oh actually, maybe they're doing something [18.59], better keep an eye on that one. So while I'm interested, it's not a luxury that I think many of us have.

Q: No, not with time factors.

A: But there will be stuff at conferences that you'll just chance upon. Oh this is really interesting and you've got an hour to fill and it is. I think that's important because it does stimulate you to think about things differently. So a mix I think is the ideal.

Q: I guess if you're doing that, that's sort of global competency isn't it because you're thinking a little bit outside of your particular speciality and looking at psychology globally in a sense, rather than just a specific competence for your particular…

A: Yes so I think if we had a system like the doctors do where they have to get their points and that - I've always been a little bit resistant to that

because I think it does take away some autonomy. The thing I really like about the system that they're trying to put in place now is that there's a degree of trust and respect and I think largely the profession is pretty good at figuring this stuff out, but it does still bother me that there might be some cowboys out there that are not… as I say, there's a small percentage that don't have that awareness that maybe in a system like that would probably be able to pick up where things are going wrong. But whether the vast majority of people should conform to that system for that small minority I'm not sure.

Q: You're a clinical psychologist and then we have other specialities such as the IO, educational and then looking at putting counselling psychologists, do you feel that there are specific competencies related to your particular field of expertise?

A: As opposed to some of those other specialities?

Q: Yes.

A: Yes but I'm not sure how to best describe that. I think that clinical psychologists, as I say, have traditionally been generalists but we do have additional competence in terms of dealing with the more complex cases and the more severe ends of the mental health… and I guess one of the things that concerns me a little bit about the increasing specialisation is that we just need to be all really clear what we do and what we don't do. I think a lot of clinical psychologists would have the capacity to do any of those other scopes, whereas I wouldn't say the reverse would apply and that's what's a little bit tricky about it. Clinical psychologists are seen as being a bit high and mighty or arrogant because of that, but I think it is that the training has been so broad based and general and a lot of the foundations we can then go and apply to those other areas.

I remember there was a big debate when I was training about the neuropsychologists and I was always absolutely adamant that I was a screener for neuropsychological stuff. Having said that I had quite a degree of competence and was writing reports for the courts about neuropsychological stuff, so I was probably one of, at the time, the more experienced in that area but I would have never said I was a neuropsychologist. I would never have assumed the level of competence that someone who has done specialist training in that area has. So I think that's an example of knowing your limits.

In fact maybe I probably undersold my competence in that area at the time because compared to maybe other clinical psychologists I was probably doing a lot more than they were, but I still never felt that I could call myself a specialist in that area.

Q: Do you think the competencies then acknowledge that sort of speciality, saying neuropsychologist, or are they very broad just to put everybody…

A: That's the tricky thing about them and I think that's kind of yet to be worked through. I think something like the counselling scope for example, I don't call what I do counselling but it probably looks like it to other people. Whereas does a counselling psychologist see what they do as being different from what I do and I guess again I don't want to get into turf wars because I think that's not helpful at all. What I want to do is be able to have a good understanding of what those specialities provide in addition to what I have so that I can access their help and assistance and direct people in that way.

So if I think a counselling psychologist has got some additional skills from what I've got and that this person in front of me could benefit from that I want to be able to have that pathway really clear. The same with industrial organisations, I actually do a lot of work in corporations, and see a lot of individuals but also do group work in those settings as well, but I'm not an industrial organisation psychologist. Again I'm quite removed from what they do now but I remember back when they were… because they had a course at Canterbury at the same time as I did, what they did looked nothing like what I do.

I don't know if it's changed but I think that that's probably the most important thing with the sub-specialities that are coming out, is that group of people has to be really good at communicating what it is that they do that might be different from the rest of us, so that we can embrace them rather than feel like they're just kind of splitting the pie in a way that doesn't necessarily help.

Q: Do you think a particular job description for each, like the requirement and then as you say a really good description about what it is that they do would be sufficient?

A: Yes and I think that that has to go right through from us, psychologists as a group, right through to the public. I remember that was one of the things why I was so drawn to the college of clinical psychologists as opposed to the psyche society, you know, the more general thing, was that the clin psyches were saying hey we have to identify what it is about us that we do so that the public knows and everyone is clear about that. So in the early days of the college a lot of emphasis was put into coming up with materials that we could use to disseminate to various professionals in the public about what it a psychologist is so I'd really like to see those other specialties start to do that with us and then out to other health professionals and the public.

I guess health psychology is another one that's coming along now and I've been involved in that programme.

Q: That's growing.

A: And do teach for them but I still actually don't know how competent they are in some of the areas that, you know, I mean I'm probably closer to that programme than most people would be, but I still don't have a clear sense of what level of competence they would have say if a psychotic person walked into the room. So the students that I have been teaching or supervising in that I know, clearly know, that if someone with schizophrenia walks in it's out of their territory, but I don't know whether the other students coming out of that programme would necessarily have had that. So that's a good example of competence. I wouldn't see a health psychologist as being competent to deal with…

Q: Psychopathology.

A: Yes, but maybe they are trained on some level to think that they are, I'm not sure.

Q: Do you think the competencies could be changed to show that, by having specific competencies for specific specialities or areas of expertise?

A: See again I think it comes back to personal responsibility. I mean I guess even as clinical psychologists I know that the training that I did was very heavily focussed on mental health and the areas that I worked in as a student were high levels of psychopathology, but not every psychology student has that experience or that basic foundation there. So I would say rather than make it formal again like that it's about having those basic principles and knowing your limits of working within the strengths and weaknesses that you have of aiming to address weaknesses if they are an important part of your practise. I think it's those basic principles that are more important.

Q: That is competence - knowing.

A: Yes so rather than it being okay, a clinical psychologist has to have done x number of hours in this area to call themselves [28.58] we're going to tie ourselves in knots. But if we come back to the basic principles, which is what determines competence, which is being confident that you have enough experience to deal with someone who is psychotic, that's the key.

Q: So even within clinical psychologists, if we look at you are the clinical psychologists, some more specialised in 17 and under, some within the adulthood, some in the older age groups and each group is quite different to another group. Even within clinical psychologists competence requires you to, as you've done, draw the line and define what area, because I guess it could be very easy being a clinical psychologist and moving between all of them in a way.

A: Yes and I think it's determined largely early in your career.

Q: Yes of course, where you end up.

A: Where you're working.

Q: Rather than where your interest is?

A: That's right. I know when I first started my training I always assumed that I would end up being a child and family psychologist. I mean lots of people do, but I had one placement in child and family service in my second year so by the time I got out of my training I was like, oh actually, I can't go and apply for a job in child and family now and that was then. Had I wanted to and had I been quite determined I'm sure I probably would have but it is largely determined by what happens early in your career.

In fact I must admit that that placement actually put me off so I guess where I didn't have the motivation to go back and fill in those gaps, but what I did get was from the placements that I was in, was an area of expertise that I think has been quite difficult in New Zealand and that is in acute psychiatry. It wasn't until I moved to Auckland that I realised quite how rare that experience was and I felt duty bound actually because I came up here to Auckland to look for a job and I had four or five places clambering for me because of that acute psychiatry experience that psychologists up here just didn't have at that stage.

While it made me feel really valued and useful I probably wouldn't necessarily have been stuck in that area if I hadn't perceived that actually I did have a bit of a duty to pay back here as well.

Q: And there was a lot of opportunity available.

A: Yes and honestly it was almost embarrassing that I could offer so little and they could be so grateful and that was the scarcity of the knowledge that they needed. I mean that was a long time ago now and that's all changed, but it surprised me that again there wasn't a lot of clinical psychologists here in Auckland able to fill those gaps and I guess that points to that competence thing that most people wouldn't have felt competent to go and work in those settings with the experience that they had.

So that shows me I guess that people are regulating that, they're not putting themselves into positions that…

Q: No, that's right, into situations that they may not be competent.

A: Yes that they're not competent to fill.

Q: If we're talking about the professional lifespan from new graduate through to retirement, do you think competencies cover that sufficiently

and do you think they should be different for a new graduate than they are for someone who has been practising for 30 years?

A: Yes I do actually because I know that coming out as a new grad and feeling competent is crazily different from mid-career say where you have a wealth of experience to draw on and you can be more relaxed about it, as long as you've got the capacity to still know your limits, I think that's the crucial point. But I think late career it becomes different again, like I'm kind of heading towards that now and I'm thinking my biggest competency issue that I have to keep in mind is am I getting stale? Am I just doing the things I've always done because they know they work and am I potentially doing a dis-service to the people I see because of it?

So I think that - I don't know if I'm going to be doing this job in another 20 years time, it seems like a long time to be doing it, but if I am, if I'm still sitting here in my private practise in 20 years time I'm going to be really, really conscious of the fact that I could be a dinosaur.

Q: But only if you're not keeping up to date and as you say you keep up to date, you're aware of your gaps.

A: Yes and I actually think probably what I will end up doing is specialising in older people just to make sure that I'm still on track (laugh). So I do definitely think there's a case for having different kinds of ways of monitoring competency in different stages of your career definitely. Supervision is another thing that changes dramatically and I guess again I'm getting to that stage now where the mentors are going to start dying off and I am going to be the mentor. So how do I shift my …requirements to reflect that and that's where I guess I've gone back… because peer supervision I found really useful early career. Not so much mid career, but I'm going back to that now with that recognition that…

Q: Yes it's your peers.

A: We're all seniors now (laugh).

Q: But seniors I guess that are still practicing that aren't sort of more in academia and things like that.

A: Yes.

Q: The cultural part of competence where we come from a very western-based model of education for psychology, do you feel that there is a potential for harm because of that? The majority of psychologists are women, white, seeing a variety of people, but if we're just talking about the bicultural society of New Zealand, so the Maori and the Pakeha, do you feel that there's a potential for harm with the model that we've based

our education on and the white European westernised model treating Maori?

A: Yes and I think again in the course of my career we've come such a long way in understanding and compensating for that. I don't nearly have enough I think ongoing education in that area and that makes me quite anxious if I have a Maori client or a Pacific Island client because I don't tend to. I think that in private practise you are with your white middle class, European, population generally but I also find it a little bit anxiety provoking in that I am getting more Asian clients now.

I would really like to do a lot more awareness in cultural competency with some of those specific populations. But coming back to what we were talking about with the adolescents, I've had to recognise that I can't keep up with all of that, there just aren't the opportunities in private practise for me to be able to and I'm really grateful of anyone who does provide that sort of thing. But I'm also aware that I don't have the ongoing experience of working with those populations to keep that current.

So conscience wise I will go for any opportunities I have to increase my competence in those areas, but I think I am much more… again coming back to those basic principles of recognising that it could be something I don't have competency in and coming back to the basic level of respect and empathy and understanding of that and recognition that if I'm missing the mark here or if there's something that's not working for you about the way I work, those are what I rely on as markers for competence. So the openness to acknowledging that there's a problem I think is my basic insurance policy if that makes sense.

Q: Would you seek assistance, outside assistance?

A: Definitely. I would address it with the person first.

Q: Because not necessarily all Maori want a Maori psychologist.

A: That's right. With the ones that it has been an issue with and there haven't been many, but the ones where I've felt hey look I'm not the right person here for you, I've been really upfront with them about that and some of them have said no, actually this is fine, this is good. I can get that elsewhere but what you give me is something I can't get from them. So I think having that basic insurance policy of checking in, finding out, knowing that I'm wobbling so checking if that's going to be a problem or not, has worked for me. But I think it is, yes, it is that I do have that anxiety about that as a potential barrier to competence with these people.

Q: You say you're starting to see a lot more Asian population. Is there anywhere you can go to have supervision or support?

A: There's this wonderful thing called the teleNetwork which I get emails for constantly and they have these newsletters and workshops and things that they run, but I've never got to one. I've tried valiantly and never actually been able to make it a priority and get to them, but it's continually in my list of competency things as I want to get to that. I want to look more into it and I do gather information about it, but again I have to fall back on that insurance policy of saying is this working for you? Is there something I'm missing? That works mostly and if it doesn't people don't come back and in private practise there is that…

Q: That's an indication.

A: …thing that goes on is that if you're not doing it for your clients they won't come back and often that will be in the first few sessions so if you're not hitting the mark or there is some competency missing there for that person, they will move on and I'm absolutely fine with that. There doesn't have to be a big fuss about it, there's no me feeling hard done by or regretful or guilty about that, it's just that…

Q: That's what it is.

A: Yes I'm not the right person for…

Q: For that yes, okay. I'm sure we've been over this, but is the current method of measuring competencies sufficient, the current one that we have?

A: I like the idea of what they're proposing, the relaxing of it a little bit.

Q: And the increase in the supervision?

A: Yes. Again states of career probably come into play there. I don't think you need the same level of supervision as you do early career so I haven't quite looked at what the mechanics of that are in terms of what they're proposing, so I'm not sure whether that's going to work or not. But they have to be pragmatic about it; they have to be proposing something that people can do. I think if they get too inflexible about it it's not going to work, people just won't do it.

Q: It becomes too hard, too time consuming.

A: Yes so I think again if they stick with their basic principles, which I agree with, and have some degree of flexibility in how they do it and have that high trust model that they have indicated they will, I think that that's going to work well for the majority, but I think there probably will always be some people who slip through the cracks and it's not enough for. I mean that's unfortunate but I think that's a little bit about communal responsibility as well, if you hear of someone that is a bit dodgy and that's the way I would rather have it. I would rather be able to have a

mechanism by which I could quietly and carefully say I'm not sure about this person.

Q: How can you tell if someone's not competent?

A: I guess again the only real times that I've had that in my career haven't been with my profession. They've been with other professionals that I have questioned their competence and it was an absolute nightmare to try and do anything about it. It really kind of spurned me in terms of I was appalled at the inadequacies of the professional systems to deal with those situations. They were all inappropriate relationships with clients, which you'd think would be the thing that would have most people to deal with it because it's so obvious.

In the one case, the worst case of it, it was drawn to the attention of every single person that it could be and it still continued. In that case the particular professional involved was so vulnerable, emotionally fragile, that it was allowed to continue, which was horrific to me because I was dealing with the patient. I had the patient to deal with, so I guess I was a bit more invested in it, but it was a terrible situation whatever way you looked at it and the way that it dragged on for so long was awful.

So again in terms of what I would pick up on nowadays it would probably be people who are close to burn out would be the ones that I would be most wanting to have some vehicle by which to address that, particularly if it's not someone I know well. So it would be burn out and it would also be people practising outside of competence. If I hear of people who are doing stuff that I know they're not qualified to do, that would be the other main thing. I'd really like to have some way of dealing…

Q: An anonymous…

A: Yes I wouldn't want those people to be called and have a disciplinary committee, but I'd want someone to be able to go in there and say have you thought about this? Or maybe you could do that because otherwise that's where you're heading. That's what I'd like to see.

Q: Sort of an audit of the practice outside of the official audit of the competencies.

A: Yes, because how do you find out who someone's supervisor is? That's not something that you can easily do, which would be the best way of addressing it, having a quiet word to their supervisor and saying… which is what you would do in a system where you all know each other but again in private practise you don't and you don't have those systems in place to be able to have a quiet word. So the equivalent of a quiet word would be, I think, the best way of dealing with the small percentage of problems that might arise and I think the vast majority of people would do well with the system that they're proposing.

[End of recordings 46.19]

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Q: As a general focus how would you describe competence?

A: So for me I guess it means staying true to my training and keeping up with…

For me it means staying true to your training but also keeping up to date and developing your skills in terms of what's current. I guess in terms of that training it means really for me not drifting. I think the longer that you're in practise the more you kind of… you listen to your intuition, you kind of rely more on the art side of practise and it's easier to drift from the science part. So for me the competence stuff is really around a structure for the science and making sure that what you're doing is evidence based and that you're not drifting.

Q: So you feel it's quite strongly knowledge, education…

A: Yes.

Q: And ongoing training or keeping up to date.

A: Yes.

Q: How does that translate then into your actual practise?

A: You mean on a practical level?

Q: Yes.

A: I guess I'm a little bit different to probably some of the people that you interview, and it's one of the reasons I'm quite interested in competence. So I do a little bit of private practise, and I mainly work in research and lecturing, so I work three days or three and a half days really. One day is lecturing and teaching GPs about mental health and then two days is a research project and then half a day is doing private practise. I guess for me it's about thinking about the things that… being competent…

So for me I guess competence means… sometimes I feel like it means documenting or showing that I'm competent.

I guess sometimes I feel like it's kind of a documentation process almost, because the things I do are all a little bit diverse I've had to kind of, in my own mind, I've kind of structured my private practise so that I'm seeing clients, because both of my roles at the university are around child development, so I see mainly kids in private practise so I feel that I am, you know, that my different areas of competence feed into each other. I think sometimes the competency stuff at the moment has this, or previously, has this kind of structure to it that is very much about face-to-face client contact, but I don't think necessarily takes into competence that people have in teaching or research areas. Even though, if you asked them, you know, the science evidence base is so important, it doesn't actually, the work that you might do in that area isn't captured anywhere in the competencies.

So sometimes for me it feels like a kind of, I guess a time consuming process of showing somebody that I'm competent. I mean the new proposed competencies I think are probably a better fit in that sense because I feel like they are more about… because it's partly about what activities do you do and then also what does your supervisor think. I mean there are all sorts of issues with that as well, but I do think they at least have some personal contact with you, know how you talk about clients, hopefully watch some videos of you or have some idea of how you interact with clients or people. So I think that will capture it a better way and be less time consuming in that sense, less about ticking the boxes.

Q: Are there priorities in competence? Do you have priorities in competence?

A: For me?

Q: Yes for you.

A: My priorities are kind of around - this is going back to the drift stuff again, around the kind of ethical boundaries and insight I guess. Like I feel like I'm in… one of my first supervisors saying to me ethics is that gut feeling that you have and some people just don't have that or don't know when they're doing the wrong thing. I think sometimes for me competency is about doing all sorts of things that help you to remember that, those sorts of ethical boundaries and those effective ways of practising, rather than going oh I'm gonna do this, here's this young person I've seen once, they seem like they're anxious, I'll do this intervention with them. Than kind of go well hold on, what's the latest evidence based around how we formulate anxiety. Not kind of drifting and missing these steps along the way I guess.

Q: So tailoring it?

A: Yes and I guess always going back to your training in terms of the overall structure of working with somebody and then pulling in what's the

more recent evidence base. So there's that aspect of it. I guess the other - I'm just thinking about times that… and it doesn't happen very often, I mean if there's a criticism of competence stuff I guess it's that there are very few people, but occasionally you come across them, who you think really struggle with competence issues. I have a lot to do with doctors and I think they're very good at only getting people through - for instance they wouldn't get past their consultancy exams, they just have these kind of cool interaction issues and lack of insight.

I think partly clinical training programmes do a good of that too, but I think there's the odd person who you come across, but the reality is that most people are practising to the best of their ability and actually in a fairly, if not very, competent way. I think sometimes the standards or the standards that we've had, are kind of very… there's lots of people for instance who have not, over the years have not passed their competencies for ticking the box reasons, but actually in reality their practise is great. So I feel like this new system will capture that a little bit better.

Q: What part then in being a competent therapist or practitioner does self-reflective review play for you?

A: I think you do that in supervision anyway. I mean I just don't know that that setting yearly goals and… I mean I don't know. There's nothing that I've ever done in a prior competency process that has been like a revelation to me.

Q: It's common sense you feel?

A: I think that it's stuff that you do anyway. I mean I guess there's some value in setting aside a time to set goals and be structured about it, but I don't know that the value is enough to offset how much time and stress that puts on people, worrying about whether they're going to pass or whether they're going to be able to practise and just the sheer amount of time that it takes. I mean it's very time consuming and particularly if you're part-time like I am, there's been times when the kids were little where I just thought I'm not even going to bother getting my practical certificate this year because I'd like to do maybe a day of private practise but what's the point? By the time I've paid for all of these conferences and workshops that I need to go to and supervision and childcare and all the other stuff and all the time that goes into it, then it's very difficult.

I think the competency stuff, I mean in general, whatever the standard is, that particular standard that you use, it's really if you're part of a public health system or a public sector organisation like corrections or something like that and you're kind of okay, then your competency stuff almost happens without you doing anything. You go to a multi disciplinary team meeting every week anyway, you have a clinical director who you consult with as well as supervision that's paid for and there will be, although the budget is decreasing, there will be some

allocation for training in some way and in-house trainings that happen all the time in organisations.

So I think it's a little bit harder in private practise to do that and I guess this is where I think we've kind of… university competence stuff is interesting because a lot of the professional development stuff that I do at the university like going to conferences, that doesn't count really. Maybe it does but they're so vague and you get no feedback. When I've tried to talk to them about, you know, I'm writing these articles; can I use that tool as my competence? It's kind of like well you put it in and then we'll evaluate you rather than…

Q: So not a structure that says if you've attended this… so do you mean more like, I'm thinking in the legal profession, that they have a point system.

A: Exactly and doctors have that too, medical doctors. I can see an argument for both sides, but I think in my situation where this stuff isn't automatic, then a points based structure or system would be easier for me. I don't necessarily think that means that the whole profession has to go that way, but I do think that for me it would be clearer because then I could make an informed decision. I could say okay, I've got this amount of time to devote to… and this amount of money over the next year. Is it worth me practising?

My personal belief is that a lot of the stuff that I do in the research world does inform, in terms of psycho-education with clients, you know, it's really interesting for people to understand what happens at what age and working with young people. I certainly don't think it's a completely separate thing, it's not like I'm working as an accountant three days a week and then doing a day of private practise. I don't think there's really any structural recognition of that how that relates.

Q: So the current competencies don't cover that?

A: I don't think they do.

Q: Too broad?

A: Yes I think in some ways… well even just the way that they're… I guess the current competencies are the ones that have been around for the last five years, but the new proposed ones…

Q: They're quite heavy on self-reflection, supervision?

A: Yes, I do think that the previous ones have been… over the last year when I wrote mine I did try and have bits from, you know, I'm writing this paper on maternal depression and how does that relate to this? But I don't know… I never got audited, so I don't know what the…

Q: What part that played?

A: Yes and so I feel like it would be nice to have… if you're interviewing a range of different psychologists in different roles it would be interesting to know whether organisational psyches feel the same, I know they have different competencies anyway, but I do feel like it's an improvement. I guess with the new competencies again they don't really capture that stuff, but at least it's a less time consuming process to do it. Because really you've just got to do supervision, which you're doing anyway, and you've just got to record the activities that you do, which you do anyway. So I feel like it's been a really big improvement in terms of reducing the time aspect. I don't really think it's probably done much for the other issue that I have with it, which is how do different aspects of practise fit into this?

Q: Which is where I was going to lead next. In your particular expertise, are there specific competencies for your area? What needs to be changed to do that, to capture what you do as opposed to what an IO does or what an educational psyche does.

A: Do you mean for me in terms of as a clinical psychologist? Or me as an individual clinical psyche in my role?

Q: For clinical psychologists.

A: I think the actual competencies themselves are good. There are so many of them anyway they kind of cover everything I think. Whether you'd put more emphasis on some or not, I mean it's not structured in that way that it's… it's not a hierarchy or anything. My issue really has been with how that's been evaluated and I guess just with the idea, which I know is a hard one and I think that the psyche board has probably struggled with, is how do you evaluate someone's competence anyway? What was the question again?

Q: Does anything need to be changed?

A: With the competencies themselves?

Q: Yes, for specific areas. Like for your specific area of competence…

A: I guess the only thing that for me in particular, if I look at the competencies and think well do these adequately assess and tap into the things that I feel are competence and strengths in my role. I guess the only thing I would say is kind of the stuff I touched on earlier, which is I mean there's some stuff in the competencies about scientist practitioner stuff and understanding the evidence base and being on top of the literature really, but if I was to go to them in the old system and say, but look I've published five papers on mental health stuff this year. They would say that doesn't…

Q: No, it doesn't tick the boxes.

A: Yes, where is this captured in here? I don't think that that's a competency that everybody has to have. I don't think that if you're a psychologist and in full-time practise that you should have to go and do your own research and I think it's really important obviously all psychologists have to have a Masters or a PhD and you have to be able to understand the research and read it and integrate that into your practise, but I don't think you need to do it yourself. But then the other side of that is that for people like me that are and want to maintain their clinical practise as well, it's like you're kind of doing double up. You're doing double professional development, you're doing double competencies really and not getting any… and that's hard when you're part-time anyway.

Q: Clearly if you're doing your own research you're having to read and research the latest anyway.

A: Yes exactly, you're right. That's a good example because what part of that… if I write a paper, what part of that counts towards my competencies? Only the literature review. I mean I've read these six papers which I reviewed for this, but actually the hours of data analysis and actually discovering new exciting stuff isn't captured anywhere. I mean if I was to change it then I guess then there would be… I mean Angela and I have talked about the idea of - I think the UK has this - specific scopes of practise for academic psychologists, and I guess that's partly where - I mean I don't know if that would fix things for me because then I'd just have to have two scopes of practise (laugh) and maybe it would be more complicated. But I guess at least then it would be clearer in my mind.

Q: Yes, what you specifically have to do.

A: Yes and I think it would be really interesting. For instance there's lots of clinical psyches who have morphed into more health psyche areas and into IO stuff. I think oh gosh, I wonder at what point do they… like do they maintain their clin psyche scope, even though they're mainly working in an organisational style? At what point do they change that over almost in terms of which competencies they actually best match and do they maintain to, I don't even know about that but that would be interesting. If it was an academic scope that would be a bigger question to answer because there are obviously lots of clin psyches who work in academic areas. I wouldn't want people to have to have two psyches.

Q: As part of competence, if we're talking about people moving outside of the area they've trained in, competence means using characteristics of the competencies to have good practise. If they're moving outside of their area, does that mean that…

A: And are they doing it in a really kind of…

Q: Yes that's right. Have they done the diploma, have they retrained, have they…

A: I think that's interesting because…

Q: …an interest based theme and they've gone into it.

A: And I think sometimes there's a (interruption)… leading to different scopes of practise. It's interesting because I think there's almost this kind of idea that if somebody said I trained in organisational psyche, but now I'm working in a clinical area, people would be kind of… But if a clin psyche said I tried in clin psyche and now I'm working in an organisational area…

Q: Yes it's just accepted.

A: Yes, but there's a whole kind of defined scope of practise.

Q: It is, it's a whole defined scope of practise so does that need different regulations to say a clinical practice?

A: Yeah it's interesting, but then I guess one of the tricky things is, especially with a workforce the size of New Zealand's psychologists, the more prescriptive you become then it becomes harder for people and that's one of the things that I was complaining about earlier, is it's hard to have such prescriptive things about competence - not around competence but around proving it, showing it, demonstrating it, because it just takes so much time. That's also a time consuming process for the board and if you're grading academic scope and other scopes and everything's all specified.

I don't know, maybe it is… it does become too prescriptive for people and too kind of restrictive, I don't know. I mean I guess part of it and this is where even though I'm saying earlier I wish it was more of a prescriptive kind of points based system, you think well actually the benefits of kind of a self-reflective process is that it allows… you don't have to have as many guidelines and for instance that shift from if you work on site, working more in an organisational area, then that would be captured by your self-reflective review because you're identifying areas that you're working in, areas that you need to develop more, so it is partly captured.

Q: Yes I can see that.

A: Whereas the new system of is your supervisor happy with you and what activities have you attended this year?

Q: But do the activities necessarily… you could go to anything that just interests you, rather than a needs based and is that showing competence?

A: Yes, well you're right because what they've taken out is that kind of, you know, I mean the aspect I did like about the old system was this idea of identifying really your areas of weakness or areas that you work with and that you need to develop.

Q: So attending workshops and conferences and assistance around that, rather than I've attended this, this, this, this and they may be interest based rather than a needs base.

A: Or even convenience based and cost based. I mean I choose a lot of my trainings based on if they're on days that I'm actually working anyway so I already have childcare, because otherwise it costs me hundreds of dollars more. Obviously within that I choose the things that are relevant to me, but there's not that many a year that you can choose from. So once you're saying I'd really like it to be on a Monday, Wednesday or a Thursday in Auckland for a cost that I can afford, yeah, you are more restricted.

Q: So a high level of competence is required for a good practise. What sort of personal or social situational factors influence competence? So if I'm thinking situational - if you're working for a DHB or something, they've got all the tools provided, that sort of thing. If you're working on your own you may not have the same situational things available for yourself. Social I guess I'm thinking of support and personal would be health, motivation.

A: Yes definitely. I think… for me in particular?

Q: Yes.

A: The situational one that I've already mentioned of private practise versus being in the public sector and specifically how that impacts. For instance I work mainly with young people and I really like doing cognitive assessments, but I do feel like I could hire someone else's tools and I could set it up, but actually if I could find some way to get them into public services and get that for free then I would try and do that instead. So I guess you do, in that way, you lose areas of competence because you're not doing them.

But it's interesting, that idea of competence in areas of strengths and weaknesses because I think you can become… that's what inevitably happens as people develop in their careers is that you become more and more specialised. I had one of my placements for my internship in older adults. I wouldn't have a clue what to do there now and psyche assessment for dementia and yet technically I guess I'm still qualified to do that. If a job with older adults came up and I applied for it and they

gave it to me you'd develop your competence. I guess what they're relying on really is that self-reflection to say this is an area that is a weakness for me or that I need to develop again.

I think that balance between going I'm more experienced and I'm specialising, and on the other hand I'm losing areas of competence.

Q: And that is competence in itself because you're aware of the areas that you are competent in and there are other areas that you may not be.

A: Yes.

Q: Do you think the self reflective review is actually an accurate depiction of competence because some people certainly wouldn't have the same insight and may just do it as a matter of course, rather than actually looking and thinking what's gone wrong or what could I do differently?

A: That's why I think the old system didn't work as well as it could have. I think that's something that you hope that all psychologists have anyway, that level of insight and I guess awareness. That's what makes a good practitioner in any area, not just psychology, but knowing what you don't know. I think the issue with the self-reflective review is that it's time consuming and it became very much about how you worded it, was it a goal or an outcome? Was that your action plan, or whatever it was called, but I think with good supervision you do that stuff anyway. That's where I think them placing it more in a supervision setting and of course then you're relying on people having good supervision. I do think you can do that at a much more accurate and meaningful way in supervision than you can…

Q: Doing it yourself?

A: Yes and getting caught up in the logistics of it.

Q: The language, the structure and that was really more important than the actual self-reflective review.

A: Exactly yes.

Q: Do you think the competencies capture the professional lifespan, so from new graduate right through to retirement age?

A: No I don't think they do. That's a really good question. No. Well in some ways they do because their core competency is that (interruption). In some ways there are core competencies that regardless of what setting you're in, where you are, then most of them, you're going to have them anyway. In particular I think that psychology is a workforce dominated by women and young women and most of them have children and I think - and it's just me being egotistical because that's the stage that I'm at - but I do think that it doesn't particularly… there's lack of guidelines around

how much practise is enough and what type of trainings in professional development activities are enough.

I don't think it tailors very well for… and I think there's a lot of psychologists who are very good psychologists who let it go. I think it's the same… my sister's a teacher and I think teaching doesn't look after teachers very well either in that sense. The reality is I think you're allowed three years consecutive without a practising certificate and then you can just get it again fine, but any more than that there's additional training and stuff that's required. That's actually not that much time for…

Q: No, for a family situation or the situation you're in.

A: Yes if you have multiple children and a lot of psychologists are quite focussed on having a good early start with their kids and that kind of thing. So I think that's one life stage that it doesn't cater that well for. I think it probably caters very well for new grads who have got lots of time to put into all of the… and just have a lot of time. Even if you think about you've got two people who work full-time and you've got someone who's been working for 10 or 15 years and someone who is in their first year, the client case load of that new grad is going to be less, the workplace, which they should be, is more supportive of this kind of stuff. Whereas if you're in a senior role you're going to be doing all sorts of other stuff and it's going to be harder to do all this kind of stuff.

Q: Should the competencies take that into consideration, experience?

A: I guess if you're relying more on the supervision aspect but I guess what would take that into consideration would be similar to what I was saying in terms of academic stuff, would be thinking about different activities. So there might be a senior psyche in a DHB who spends a lot of their time, maybe they're a psychology advisor, so they might only spend half their time or less in a clinical role, but they're doing a whole lot of professional stuff for the work force. That's not in there anywhere in the same way that research papers isn't in there. So I do think anything… I think it caters well for when you qualify, when you've just passed your exam…

Q: Working full-time.

A: Yes. I do think probably the other area of the workforce that it doesn't cater that well for is I guess retirement and semi-retirement, anything that's part-time.

Q: So the other end of the scale there.

A: Yes but I guess that's true of any profession that requires a practising certificate or some area of competence. So you can't say oh well, you work part-time so therefore you only have to be half competent; you still have to be competent (laugh). There's the aspect of how you do the competence and then there's the aspect of how easy the process is. I

actually think the process has been very time consuming and very difficult and hard to work out in advance, so I think that's put people off. If you're going to say you still have to do all these competency things, which you should do anyway and be aware of your competence and work to develop it, then at least the process should be clear cut, straightforward and less time consuming.

Q: Cultural competence. If we talk about cultural competence but specifically for Maori culture, how would you define that and how do you practise it?

A: I think that's an interesting one. I trained in Otago and I don't think that's a particular strength of the Otago training programme, particularly because of the demographic in Dunedin. My first job out was in Manukau for an adult CMHC and I specifically chose that because I felt like it was an area that I wanted to develop and I feel that most of what I've learned about competence I've learned from people in the team. At Counties and also when I worked at ADHB, we had cultural advisors on our teams and I feel like that's the stuff that I've kind of learned the most and has stuck with me.

I guess for me it means specifically working with Maori families or young people or older, individual clients. I guess it means the first thing I always think about is recognising that I am a Pakeha psychologist in a predominantly Pakeha service and that I am using a western model to work with this person. I think as much as I would like to be an expert, I think it's like all areas of competence, that recognising what you don't know is the most important thing.

For instance when I was at ADHB we did a Te Reo, like a three month Te Reo course which I've retained almost nothing from, but sometimes I can impress my kids with the odd phrase. But I don't know that that skill particularly has helped me with anything because I don't feel confident enough to use it. I feel like I'm being a twit, even though I think maybe it is useful in some settings. But I guess what I do think has been useful is asking questions when I'm working with people and also not making assumptions about you've ticked the Maori box on this form, so therefore you're going to want a million different things. I think within any ethnicity there's huge variation.

Q: Like their involvement in…

A: Exactly and somebody's ethnicity in the same way as a child's gender is actually at the end of the day almost the least defining feature when you put all the other stuff and experiences in there. I guess for me working with young people, the biggest aspect has really been, and this is not something I do because I'm not the expert in it, but I do think recognising how much that young person is connected to their culture or not and how much that plays a part in what's happening for them. I do think that's really important.

Q: Do you seek supervision for cultural competence at times?

A: When I worked in the DHBs definitely and again that's par for the course because it's built into the system. But yes I definitely did in that setting because it's there and has so much expertise. To be honest and this is an awful statement, but I don't think I've seen any Maori young people in private practise. I've seen a reasonable number of Indian families and Asian families.

Q: It applies then again, it doesn't matter what ethnicity, gender, sexuality, religion, it's always, cultural competence has got to be considered and you've got to look at your own.

A: Yes but I do think it's something that, you know, I go to a kind of cultural training network in Auckland that anybody can go to that's run through ADHB but they have it at Royal Oak and I try and go to that as much as I can. But that's predominantly, or it seems to have quite a lot of presenters around Asian mental health issues, which has been really useful for me because that's primarily the kind of other culture that I see in my client base. But I do think it's that same issue, I feel like my specific knowledge and skills in working with Maori and Pacific families, because of the setting that I work in, is declining really.

Q: It is a very western-based model that our education is and it doesn't…

A: I feel that theoretically and again if I was thinking about evaluating my cultural competence a lot of the research that I do is kind of mental health/public health population health and so I have a lot of extra knowledge I guess about inequities in different health areas, but I don't feel like that gets ticked off in any way, but I do feel like I've developed things that I think do help with my cultural competence. For instance being really careful to think about when you're publishing work that might explain different inequities that you're doing it in a useful way but it's not just another article out there that's saying, oh look, Maori and Pacific are worse off, you know, that it's actually productive in some way.

Q: Yes, it's going to be beneficial.

A: Yes exactly and that it has some kind of pathway to change.

Q: Resolving or…

A: Exactly and I think that's something that has shifted or that's important to my view of cultural competence but I don't think is captured in the clinical psyche scope. I don't necessarily think it has to be.

Q: But just to have that option would be…

A: Yes.

Q: Do you think then there is potential for harm, if practising as a psychologist from a western-based model and having someone culturally very different? I'm thinking if you have say a Maori who is very involved with their culture and a Pakeha assesses and diagnoses and is treating them, if they were seen by a Maori psychologist the assessment and the diagnosis might be completely different.

A: I agree. Yes I think culture is the biggest and most important factor in that sense and I think there are lots of other factors like that. For instance I try and not work with young men, adolescent men, because I think there's lots of issues that they need to talk about that they don't want to talk about with a woman who is 15 years older than them, who looks like their mother. I would follow the same kind of process in my mind that I would in that situation where if you put it out on the table and people know that they have options and you do your best to help them find those options if they would prefer to see somebody else, whilst also recognising that sometimes, for some people, it isn't an issue in the same way that for some people. If they're going to get a smear test it's really important that they see a female doctor. Other people don't care and they're happy to see a male.

I know that's probably not the best analogy but I do think it doesn't necessarily have to be an issue, but I think the important thing is being aware that it could be an issue and talking about it with your client and their family because if you don't put it out there and you don't recognise it, then I think it's a problem.

Q: That's part of competent practise isn't it and being competent is being given choices?

A: Yes. It's the same kind of thing that I would always - if I think people meet criteria for public services I would always say I think…

Q: There's options.

A: Exactly because I think you need to have that awareness and have other options.

Q: …someone is lacking in competence?

A: The biggest thing for me, if I feel like someone is lacking in competence, is the kind of person like I said who doesn't know what they don't know. So somebody who is new to a team and puts up their hand for the riskiest kind of, trickiest referral, without recognising that they might want to get settled into the team first. I think partly that's that kind of lack of insight and you see that, that's one example of it, but you'll see it in lots of interactions. So often those people have interpersonal difficulties when they're working with families and they'll put peoples back up and they'll say the wrong thing and within a team relationships are difficult.

It doesn't happen - I don't think I've ever worked with anybody who I've felt at their core was incompetent in that way. I've certainly worked in situations where I think that the situation has meant that somebody is at risk of not doing their best work, either because they're so overworked or burnt out or that kind of thing. But I've never personally worked with anyone who I think has got major issues with their competence.

Q: How would you demonstrate global competence?

A: Global competence. What do you mean?

Q: Talking about competence on a level where it's not just within your specific domain but looking at bigger issues maybe. I guess with you doing quite a bit of research that would be… is it specifically for New Zealand or is it things that can translate to…

A: Oh global as in international?

Q: Yes.

A: So you mean how would somebody be competent to practise anywhere?

Q: No, no. Globally as part of a community.

A: …similar to the academic research stuff that contributes to wellbeing for communities. I think that a lot of psychologists are involved in community organisations. That's something as well that you think about somebody, we were talking earlier about working part-time or after psychologists have children and take time out, most of those people aren't twiddling their thumbs. A lot of them are involved in things, community organisations or Plunket and they might be doing something that helps young mums or doing stuff that's kind of community minded because you wouldn't get into a helping profession if you weren't that sort of a person anyway. Yet that's not captured in any way, you know, the kind of volunteer aspect, but then how do you evaluate that?

That's kind of a tricky one as well, but it would be nice if there was some area of competence that allowed for and maybe that is a way, that more sort of global competence that allowed for these other things that people do that actually do contribute to aspects of their competence. For example if you think about the same way that my research work has been acknowledged that it's useful for [150915_0020.WMA 01.42]. People who volunteer for community involvement, it will give them information and connections and networks and that is useful for their clinical work but it's not actually one-on-one clinical practise.

Q: That I guess comes down to if it was a point system then your academic and your research would be covered and those sorts of things such as

volunteer work and community work would also have some, be covered some way.

A; Yes sitting on boards and things like that, specially now there's so many NGOs, often psychologists are kind of involved in some way in them, but that's time consuming and people are doing it out of the goodness of their heart. It does contribute to your overall competence because you're developing a whole lot of knowledge in an area, but it's not captured in any way. That's a really good question. That's kind of a nice way rather than being how much research hours do you do, how much community - to actually have it in a more global way.

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Q: In a general sense what does competence mean to you?

A: It means the ability of psychologists or whatever, other professionals, to be able to do their work well. I think about it as having three particular components to it; one being the component of knowledge which they carry, the second part being the skills which they have which they bring to the job that's distinct from the knowledge, and the third being the attitude with which they do the job. I see those as being components of competence.

Q: Is there any of those that you've outlined there that you would say are critical or a priority?

A: I think they're all critical. It's an 'and' not an 'or' really.

Q: So equal weight.

A: Yes I think so, pretty much.

Q: How do those translate to your practice?

A: In what way?

Q: Just in general, those competencies, how do you demonstrate them in practise?

A: By working in a knowledgeable way with a good set of skills and with an attitude, which is an attitude which is respectful and a supportive attitude, which works with strengths, works with the person's strengths and looks at being a really collaborative kind of an approach. The knowledge I think sort of speaks for itself. For me the knowledge is around actually having the knowledge there and then doing the process of translating that into a form which the particular person you're working with can use, so that's sort of what it's about.

So you've obviously got to have the knowledge there yourself and the skills around doing what you do in a way which is skilful and using the appropriate sort of skills for the person that you're working with. In the kind of work I do different people have very, very different learning styles, very different ways of thinking about the world and the skills

which I need to use to work well with them varies person to person, even if they have what you might call the same diagnosis or even very similar formulations of the situation.

Q: When you're talking about strengths you're talking about your clients' strengths or your own strengths?

A: Yes, obviously both are important.

Q: So if we're talking about a practitioner's strengths and the way you're aware of those is through self-reflection, what sort of priority does that take in your competencies, the self-reflection?

A: Obviously it's a big part. It's one of the four competencies, which the board talks about isn't it? It is very important because otherwise, unless you're self-reflecting you're fairly unlikely to know where you're at with the various competencies so it's important.

Q: So with the new ones that are coming out, the updated, the self-reflective review is quite a big… that's something they've prioritised or looked at along with the supervision.

A: You're talking about the competency, continuing competency programme, which is actually quite different from competency?

Q: Yes I am. So there's CCP so with that they're looking at updating the self-reflective review.

A: Are they updating it? I don't think they are, they're just prioritising it.

Q: Yes prioritising it along with the supervision I guess, asking to increase the supervision. So are they things that you felt needed to be looked at?

A: I supervise quite a lot of people and also in my former role, which was the professional leader of psychology for a DHB, I got to be really aware that lots of people were spending enormous amounts of time on their self-reflective review. They turned that into this major exam effectively and they would write screeds and screeds and screeds and screeds and get really angry about it and actually pretty much lose sight of what the process was about, which actually is about thinking about where you're at and planning for the future.

So this year what I did with around about 12 or 13 people that I supervise, I set up a process with them whereby we actually spent a supervision session and doing that self-reflective review partly based on the literature which shows that actually most people are actually very poor at self-reflecting and that the outcome of self-reflection is improved quite a lot by feedback. So what we do with this process would be to look at each of the competencies as defined by the board, we'd get people to reflect on where they were at, where their [05.18] and we

would think about what are your learning objectives for this year and then we'd develop a plan related to those objectives.

It was still primarily a self-reflective review but it was a facilitated self-reflective review really.

Q: Feedback plays a big part really in self-reflection.

A: It does. Well it improves it a lot.

Q: It does, it improves it, yes. You were saying that self-reflection on its own wasn't necessarily an adequate or an appropriate way of… people were doing it not wrongly, but making it a more difficult thing than it needed to be?

A: Yes, making it a much, much bigger task than probably what it could usefully be, both in terms of the opportunity cost of the time or whatever, but also in terms of actually I think people lose sight of what it's all about. Quite often I would get to read through people's self-reflect reviews or whatever and it would be I've done this, I've done this, I've done this, I've done this, I've done this, a lot of it not actually about their practise but about the things they've done in their organisation.

Q: So not insight, looking more at…

A: Turning it into an exam as I say, give me a tick because I've done these things.

Q: So it may not always be an adequate sign of competence?

A: You mean…?

Q: What they've put in, what their claimed as their self-reflective review, may not be an appropriate indicator, an indication of competence.

A: I think you've got to be really careful because the way that our competency programme is set up is actually much more aimed… I always think these things as there's quality improvement, which is starting from here and getting better. Then there's quality assurance, which is saying are we good enough right now, is what you're doing. They're quite different tasks. The kind of competency structure which has been developed by CCP I think really very much more is the kind of competency structure you use for quality improvement, rather than necessarily quality assurance because people are reflecting on their own practise and the literature is all there, which shows us that actually there's very, very, very little correlation between people's self-assessed competency and their externally assessed kind of competency.

So if you were wanting to set up a competency assurance, a quality assurance programme, you wouldn't base it on self-assessment. I

suppose you could say from that point of view that bringing the supervisors a little more closely into that process brings you a whole lot… well brings in a little more of that kind of quality assurance kind of a thing. But you're walking a really thin line there because if you do then in a sense you may end up tipping it so that people start to treat your supervision in the same way as a lot of interns do; oh God I can't say what I'm really doing because I'm being judged.

Q: That's not really the role of supervisor.

A: No. When the board first set up the CCP process they talked about it being a high trust model and that's really good. So one way of thinking about that is what they've said was we'll start off from the basis that people are reasonably competent practitioners and will use this to help them to improve their competence, rather than we're going to make absolutely sure that you are absolutely doing everything which one would hope of a competent practitioner and make sure that the box is ticked.

Most of the time when you do that kind of honest connectivity it doesn't really tell them a lot. There's an expression in the NHS in Britain about hitting the target but missing the point. When you get into that kind of boxed in kind of activity you can so much do. So I think our CCP is a really, really useful process for making people, to do that quality improvement, well when it's working right it is. What it isn't really is a way of sort of absolutely ensuring the quality of psychologists. Personally I think that's okay because we do have other mechanisms…

Q: Of picking up when there's a problem?

A: Yes and I mean hopefully supervision is about picking up and addressing those issues as they come up.

Q: If people are being honest in supervision as you say.

A: Being honest yes and if you mess up the ability for them to be honest then you actually stop them from doing that. Hopefully also, well there are other mechanisms like the complaints processes and so on which actually help with quality assurance, a little further down the line than we would like and there's potentially a fairly good process for trying to do that quality assurance work.

Q: Another point was how do you recognise someone who isn't competent in practise and how do you measure that?

A: Could I just say one more thing about that facilitated CCP process? I'm actually quite a believer in practice-based evidence and so I've actually done an evaluation of how people found that whole process and it has shown some really, really positive results. Most people have found it has been really useful in terms of they looked at things like has it helped to

make the process take its time and there was very strong support for that. Has it changed the quality of your self-reflective review, because it could have gone either way, and the vast majority of people are saying it actually improved the quality of the self-reflective review. Has it helped you complete it in a more timely fashion and yes it has.

There was some qualitative bits in the evaluation as well and one of the comments, which one of the people made, was something along the lines of this has taken a process which I was dreading into something which has really been quite fun and quite enjoyable.

Q: I guess that's what you want because you want them to be able to interact and look forward to doing it, because it's only going to assist their practise, which then benefits the public.

A: Yes see it as not a punishment for being a professional.

Q: A common theme that I've come across just in other interviews was the time taken to do this was almost overwhelming - not overwhelming, but it was a lot of time to do and for some of them they might be part-time workers, that sort of thing, they felt that it was over and above.

A: Yes but that's also a reflection of the obsessive nature of psychologists too because people end up taking far, far more time than what it actually really requires and actually hopefully a process like the one, the facilitation process, of taking about… I think it does sharpen up people's thoughts a lot because of cutting out some of the dross. That feedback process which goes on there helps, but it also I think just gives people permission not to spend hours and hours doing it.

Q: Is a narrative type of self-reflection a better idea than say one that requires a certain language and a certain format or structure? That really describes your self-reflection if it's your own language doesn't it and your own narrative?

A: I think there's probably something between the two extremes which works reasonably well and I think the structure is quite good of that, in the same way that we're doing a structured interview here and that if you just let me rave for an hour or two about competency then we would probably both end up pretty lost. So have a structure I think is quite useful but not having the structure so tight that it does become for instance like BOT's competency review, which is a series of boxes or the medical one which is that you've been to so many conferences so you get points for each thing that you've done. I think those are extraordinarily unhelpful kinds of tools for either, for quality assurance or quality improvement, particularly as people get to know the quality of [15.28] in the medical setting and they get to know the quality of the paper and [15.35] setting, but I don't think there's any other impact on quality in those often.

So yes, I think it's a pretty good approach and it's probably pretty good for psychologists as well in that we are quite narratively orientated but actually some structure really helps that because like everybody else we will focus on some things and less look at some of the darker corners really.

Q: Because the idea is that it's to highlight strengths or weaknesses or gaps in your knowledge or skills.

A: Yes.

Q: I was just asking you about someone who may not be competent, how do you recognise that and how do you measure that?

A: The most common way for me that I know that somebody is not working at a very competent kind of level is that they show themselves as being unable to really develop good formulations. I work in a clinical, well I work mostly with clinical psychologists who are working in clinical fields, and so what you find is that they can come along with an awful lot of information about this person, which is a skill. But often the skill of actually taking that information and integrating it into something which sounds like a psychological formulation or a conceptualisation doesn't happen. Then you start to see that's when both the skill of that integration approach and the knowledge of that, well the breadth of psychological knowledge, which helps you to be able to draw that together, isn't there.

Q: Isn't that just experience?

A: No, absolutely not.

Q: It's an innate… it's something that you have or you don't or you can learn?

A: I think people learn it, they certainly do learn it, but they don't necessarily learn it just by being in the job longer. A colleague of mine used to talk about, well have you had ten years of experience or have you had one year of experience ten times? You do find some people have been in the job for a long time, but still are actually functioning less and you hope that in turn would function better really in terms of those kinds of things. So it is teachable, but it's not innate.

Q: Is there a way of measuring that?

A: I've never tried to measure it sort of qualitatively because it's a hugely qualitative thing. I sometimes think about it as thinking like a psychologist and I don't know that I've ever really come across a satisfactory way of taking the construct as sort of complex as that, sort of global as that and actually making it into a number. There are things which could be good indications, and probably one of the best

indications actually would be if a psychologist became much, much better at measuring outcome, because in the end that's what really counts. That's sort of the limitation in a sense and maybe we'll talk about this or not, I don't know, but competency structures are one part of the story and they're a part which gets focussed on a whole lot. This isn't only in psychology, it's actually the whole world managerialism really, that we're very, very good at focussing on is this person doing the right thing and much less good at saying yes, and what's the outcome of what they do. They're not necessarily all the same.

Q: I guess if you're in private practice as opposed to say working for a DHB where your outcomes might be more obvious, they have feedback, that sort of situation, if you're in private practice your outcomes… only you may be the person that really knows so there's not a way of as you say looking at that or other people being aware because ultimately it is the outcome that is the measure of competence.

A: Yes but interesting because it's not anywhere in our competency framework as in what are you outcomes. Actually, although you would sort of think that within something like a DHB setting or a corrections setting or whatever, that there would be solid outcome measurement, there isn't. A couple of complications, one being that there are outcome measures which are collected and they're in a sense very, very global and of course they're the outcomes for the client, which is the outcome of the input of the multi-disciplinary team rather than any particular individual.

So there's no specific kind of psychology kind of an outcome measurement tool, which is being used very widely. Some people have developed their own for their own field in their space, but it's as specific as that.

Q: Is there room or is there the ability to develop something?

A: I think there is. If you think that people find the whole competencies framework challenging they find an outcomes framework even more challenging really. There's endless different reasons for why you may not get a good outcome in all sorts of situation.

Q: It might not actually indicate your competency in a particular situation, but I guess if you were seeing a poor outcome fairly regularly with a particular person then alarm bells might ring and you might have to have a discussion.

A: Yes and again maybe it actually helps with quality and an improvement even more than quality assurance in that if people start to look at their own outcomes and start to see that that worked well with this kind of person, but not that kind of person and all my outcomes are good with young males but awful with young females, or great with people who look like me and terrible with people who don't, that kind of thing. Then

you can start to say what do I need to do about that? If we don't measure we don't see. We can self-reflect but self-reflection will take us where we look.

Q: If you're looking at people who may not… the outcome may not be good with groups dissimilar to themselves or whatever, should then there be more specific sort of competence around your particular area of expertise? You may work predominantly with early adulthood, say to 17, childhood, but feel that you're still competent enough to work with adults. That then takes you out of something that you're very competent at. Is there room there for competence around that?

A: Quite a lot of disciplines do that and so they have a general competency framework and they have what they have a credentialing framework, which is where you're credentialed to particular areas and some areas are [24.17] credential to do particular procedures but then in other areas it's [24.22] to a particular client or service. I'm not entirely sure that it's a good idea for psychology because again it adds a different layer, which may not actually improve things immensely.

Also there's a lot of people who do actually cross over a lot of kinds of areas and who experiences across a lot of kinds of areas because the next step on from saying well, your credential in this area is saying only people can work in this area. Take neuro-psych for instance, which is one of the areas where people have long said well only people who have got PhDs and a neuropsychological course and have done specific kinds of training should be doing any neuropsychology. You can't even say it's fine if you live in Auckland, it's vaguely possible if you live in Auckland. If you live in Timaru or Gisborne…

Q: Where there's not the services.

A: There's not the potential and it maybe not what you need because a lot of the time people, when they're needing a neuropsychological assessment they're not needing somebody who can identify the whole of this particular area of the corpus callosum, they're needing somebody who can tell you this person's got these kinds of deficits, this is how you go about actually trying to help them to minimise the impact of those, either in their life or in their therapy.

Q: So rather than the anatomy, the knowledge about the anatomy, the knowledge about the psychopathology or…

A: Or the difference between the high, high specialisation and the sort of intermediate level of knowing enough and being comfortable about… knowing enough and knowing enough to be able to make some good solid grounded understandings and then what to do about that.

Q: Yes and that's competent practise.

A: Yes, knowing enough, so there is that interim level.

Q: Clinical psychs, you see them moving into other areas. Some of them end up doing IO, into health and things like this. Health psychologists cannot in the same way work as a clinical psychologist. Is there a parameter that defines each of those specialities? I'm thinking more specifically about health and the new one, counselling psychology.

A: You have families, like if you're talking about clinical health and counselling psychology, then they're a family of skills, which are very similar in some ways. They're a family of expertise, background knowledge and so on, which is very, very similar but there is also a specialism within in. For instance, I do a lot of teaching, both with clinical psychologists and health psychologists and some people think health psychologists should be able to apply for any job that a clinical psychologist does. Personally I think that's a race to the bottom of the pool. We actually get more strength out of having relatively distinct niches, even though we use a lot of very similar techniques we also use some different things and we have expertise in different areas.

The difference between somebody who has health psych training and somebody who has clinical psych training - an awful lot of it is the same but there's quite a different emphasis within that training. So in some ways it's a little bit like saying you're confident as a psychologist with young adults and therefore you should also be able to work with the elderly, and you probably can, but it may not be ideal. So I think there is a strength, and it's actually having strong niches and being strong in those. I think about it as a sports team sometimes, that it's good to have different people who can play different kinds of games in a sports team.

Q: Is there a need then for particular competencies around the different area of expertise?

A: I talked about the family there, there's the family of those ones and then there's the organisational psychologists and academic psychologists, they're a very diverse group. We have completely different competencies there; they're a different family in a way. It depends on the question you're asking - if you're saying do we need specific competencies between the people who work providing therapeutic care within a health setting? Probably not. If we're saying therefore anybody who has got psych in their job title should be able to work in any field they want to work. Probably not.

I suppose one thing for me is that a lot of the work I do now, probably half the work I do, some people might say that's IO work. I've been working in leadership and management or leadership in particular in the health sector for the best part of 20 years now.

Q: So that combines doesn't it - the IO and the health?

A: That's right. One of the things that I've always believed very strongly is that part of what we do as psychologists is treat the organisations we work with as a client, whether you're an IO psychologist or whether you're a clinical psychologist. Part of what you're doing is actually helping to change the system so that it actually can work better for your clients and for society. So I've always taken that view, right through my career. Some people might say that I'm not an IO psychologist and therefore I shouldn't be doing that kind of work, I don't have those competencies, but I don't know.

Q: It's through experience.

A: That's often the case.

Q: Rather than through actual study. I mean you would have also have gained the knowledge.

A: I think that's the problem trying to bind it too tightly in terms of you've got to have this name but there are limits on that, getting rid of the scopes of practise for instance would be a very, very foolish idea because you'll find a lot of people who would love to be able to say yes, I'm a clinical psychologist who actually did a weekend course in additional therapy once.

Q: Yes like cosmetic surgeons and plastic surgeons.

A: Yes. It was a very long answer to a short question (laugh).

Q: Do you feel the current methods of - and I know we've sort of covered this already, are the current methods of measuring competence sufficient?

A: As of this CCP?

Q: Yes.

A: I think on the whole they're pretty good. Again if we think about it in terms of outcomes, one of the outcomes is the number of people who come up with complaints against them and it's not hugely high.

Q: Is the process pretty straightforward if a practitioner wants to lay a complaint or say I'm worried about this person? Is it anonymous and straightforward and taken fairly…

A: I think so and is taken very seriously by the board. Very punishing of people who get complained against. I don't know if there is a way of making it not punishing really because it is just such a huge thing and it carries so much fear and it carries so much of a sense of shame. Any of us would hate to go through that.

Q: I guess it keeps you on your toes in that sense. You don't want to be in that position, but also you do it because it's the right thing to do anyway, be a competent practitioner.

A: I've got to say that most of the times when I've been involved in complaints processes, helping other people through complaints processes, there's been more of a little vindictiveness on the part of the person making the complaint.

Q: There is that possibility isn't there?

A: There sure is. For instance within the corrections field it's very well recognise that it's one of the approaches which the lawyers will take is there's been a complaint against this psychologist and then they can say you've been complained against as a way of trying to weaken their competence. I sort of think we're there by the grace of whoever your preferred deity is, for any of us really, but there's absolutely no guarantee. You could be the most competent practitioner and you could still… notwithstanding that I think the rates of complaint against are pretty low. For me that's sort of an outcome and probably it is about right, there are certainly more competent psychologists around, but it's probably about right.

Q: You were talking a little while ago about the families, sort of groups. Would defining them improve the public's understanding of what they're getting and what you do and things like that? I think at the moment it's kind of loose in a way.

A: Yes it would.

Q: I mean why see a clinical psychologist as opposed to a counselling psychologist?

A: The step beyond that is that many people who come to see us are not quite sure of the difference between a psychologist and a psychiatrist and a counsellor and CBT therapist so yes, there is good scope for trying to improve that public awareness. There is a thing called The Future Psychology Initiative which I've involved with at the moment. Its overarching goal is to help to make psychology robust, resilient and relevant into the future. There's five streams of action which we're looking at within that and one of those actions is the advocacy of the public. One of the strategies within that is helping to define better, make psychology defined better. There's also similar work happening within the New Zealand College of Clinical Psychologists as well, which is also around actually helping to better define what clinical psychology is about and what it does.

It's something which people have been talking about for decades partly I think because of the nature of psychologists, haven't necessarily got very far with and also partly because it's not most people's interest

really. How may people know the difference between a cardiologist and a cardiac surgeon? So we can do what we can do in that direction. One of the things is that most people actually have a fairly positive kind of a view of what psychology is.

Q: Certainly more so now I would say than going back a bit.

A: Possibly yes.

Q: A more positive view.

A: Yes. I used to do some teaching with high school students who were coming into a health setting and being able to talk about - well one of the things I would quite often start off with was asking them about what films have you seen about psychology? So they come up with things like *Sixth Sense* and *The Sopranos* and things like that. So they had a really, really clear idea of that. Sometimes I'd notice the physios or the OTs who were there as well thinking nobody makes a film about an OT (laugh).

Q: That's true - not as exciting.

A: And they do hugely useful work. So I think that kind of thing means that we do have some cachet with the public.

Q: My son thought I was learning to read minds when I first started. It was useful for a while (laugh).

A: Until he found out (laugh).

Q: Being competent, is there scope for variation in the competencies along the professional lifespan? So from new graduate to retirement, what's required around a new gradate say to someone who has been practising 20 years to someone who is now coming to the end of their practise.

A: It sure is and actually the document, the board's competency document, was very largely informed by a DHB competency structure which had the sort of competencies you'd expect of a trainee, of a new graduate, of a psychologist, of a senior psychologist and a consultant psychologist, with a bit of working around effectively what the board has gone with the full knowledge and agreement of the people who, like yourself, who are involved in developing that.

Q: Was this after the HPCA Act back in 2003? Was that when you were on the working charity?

A: I can't quite remember. I can't remember if it was before then or after then. No, I don't really know. If you had a look in the front of the document - sorry the DHB document started to be developed; in its major form it started being developed around about 2001. It was

completed initially around about 2003, but had been in development there and so it was possibly the… it may not have been quite the finished product, which was in the news to inform the board. I mean both of them come from the Canadian document as well to some degree and so on as well. They were both informed by some overseas work in this field.

Q: They have in the UK a hierarchy don't they?

A: Yes. It makes sense but the board have made this a sort of requirement, perhaps part related to that kind of thing, saying you'll have one person with ten years experience and another person with ten times the same year of experience. We can hope for more but what we can ask for is that people are as confident as you would be as a practitioner.

Q: Regardless of where you are in your professional lifespan?

A: Yes so that's their benchmark and so even if somebody has been working as a psychologist for 20 years, well we can't necessarily say you should be the same as every other psychologist who has worked for 20 years. We can only say that you should be good enough to be functioning as well as we would hope a new psychologist would function. Within the DHB structure for instance it's useful to have those different competencies because it helps you, particularly in the old days, it helps to define when you have… when somebody is functioning at a meritorious level, the various meritorious levels I suppose. We produce that for helping them to… back in the days when you had the scales for senior psychologists and consultant psychologists then you could use it to help to identify if somebody was working at that level.

Q: You could compare to a cohort in a way?

A: Yes or a benchmark against that. It was a document that's very large in terms of there's a lot of information and nobody on earth would probably meet all of the criteria for all those levels and so its much more globally this is what a consultant psychologist looks like and this is what a senior psychologist looks like, rather than saying you've got to tick every box.

So there's plenty of scope for that, I'm just not sure it's within the board's framework. It probably is a little bit dependent on the kinds of services that people read about. For instance I suspect, I'm not absolutely sure, but I suspect corrections - they have a very strongly developed psychologist, senior psychologist kind of structure and I'm pretty sure that they will have a competencies document which does reflect each…

Q: Each measure.

A: Yes and as I say that DHB one is accepted, it's actually in the contract, in one of the employment contracts and it's accepted throughout by all the DHBs. It doesn't carry a whole lot of weight any more because they

got rid of the scales, senior scales and so on. So in the places where it is still in that sense used, it's about having the title of senior or consultant psychologist and getting paid a truckload more.

Q: If we can talk about cultural competence. We're educated in a very western-based model. This is a very at least bi-cultural society and even more so with Asian and Pacific Islander. Is there the potential for harm with being educated in a western based model acting as a practitioner say for Maori or culturally different groups?

A: Sorry, is there a potential for what?

Q: Potential for harm if we are using our western-based model to act as a practitioner with other groups.

A: Yes there is potential for harm. There's also potential for great good. When it's practised well, psychology has a lot to offer people from all groups because when we talk about culture we also need to talk about sub-culture and we also need to talk about age. We also need to talk about…

Q: Sexuality, religion…

A: Onus etc., and if I was only to be able to work with white middle-aged guys then I suspect I wouldn't be able to hopefully do less good in the world really. It's sort of interesting tracking over time the concept of cultural competence and how it changes and the word… that's often reflected in the words which get used for it. You find there's a swirl of words as to if you use that one word in one context then somebody there will shoot you down for using that word. If you use another word in another context then somebody will shoot you down for that, because you should have been using the word you used in the first context. It clearly is hugely important to be able to behave competently, culturally competently.

Q: How do you do that?

A: Several planks really. The first part of cultural competence is not assuming. It's not assuming that this person lives with all the cultural stereotypes, which I might get even if I felt like I knew a culture really well. The second is almost the opposite but it's not quite - that it's actually at least knowing the enough that I could make some assumptions, but then in a sense starting from that basis then try and not to make them as much as I can. The third is really around… well the making no assumptions, actually is around asking. What is associated with that is the one about being curious, respectfully curious of this person and how they see the world and particularly being prepared to address that from their cultural point of view as well.

Perhaps another of the planks is really them being prepared to take my basis of western knowledge or whatever and negotiating with that person a way of actually making it useful to them. I sort of see the heart of most of what I do as a clinical psychologist in effect as being taking what we've learnt from studies with rats, studies with people, studies with societies, all this weird stuff which psychologists do, and translating that into a form which this particular person who is sitting in front of me can use. So that's the scientist part of what we do but it's also the practitioner part is taking the science and applying…

Q: Applying it appropriately.

A: Yes and that works the same in a sort of a cross-cultural kind of a thing of I have to take this western model, be aware it's a western model, and then figure out with the person what out of this is useful and what isn't? Or how can we make it so that it's both useful and acceptable and appropriate? That's one big branch of cultural competence and there are some of the more formal kinds of parts, which might be how many [52.15] you know or whether you can do your mahi and those kinds of things, which apply in a particular cultural context. But more generally to be culturally safe I think is actually about knowing enough but not assuming.

Q: Have you in practise or do you in practise seek supervision, cultural supervision?

A: Here yes.

Q: There have been times when you've needed to discuss it?

A: Yes and been really lucky that I've had really good people around me so I could seek that supervision and have the relationships with [53.06] and with senior Pacific Islands' leaders who were able to help me. Actually more often or not the sort of advice which they've given being fairly practical people, is sort of along the lines of ask the person what's right for them.

Q: I think we've pretty much covered everything. One other thing is outside of having a high level of competence for your practise, factors such as personal factors, social factors and situational factors influence competence, how aware or how do they impact competence? So I'm thinking say if you work in Corrections or DHB, so situationally, you've got a lot of tools at your disposal that you may not have in private practise. How does that affect competence? Then personal things like health or families or motivation, they're all going to affect your competence, so these are things we have to consider as practitioners. Do people do that sufficiently themselves?

A: That's sort of recognised within the HPCA structure.

Q: With the self-reflection?

A: Well no, the HPCA, the Act itself, is the difference between your competence and your fitness to practise. It treats those two things a little bit differently. Just an example of how it treats them differently is that if a health professional has concerns about the fitness to practise of a health professional then they actually are obliged to refer that to the appropriate body. If they have concerns about the competency of another psychologist or another health professional then they have as an option to refer that to the body, they can try and do so in some other way, they sort of have an obligation to try and address it. But for instance as a supervisor if I'm concerned, say a colleague of mine a little while ago was concerned that one of her older colleagues was actually getting far enough into dementia that it was becoming difficult for them to practise and so she actually had an obligation to report that.

If I sort of feel like somebody has gone off their game because of something they don't know or whatever, I don't necessarily have to rush off to the board and report that, I can try and address it in some way. If I feel that somebody is behaving a bit marginally ethically, which is sort of a competency issue, then I can try and address that in some other way rather than necessarily going to the board.

Q: I guess if you know their supervisor or something there may be a way of speaking to them.

A: That's right yes.

Q: It's not always going to be easy to know who is supervising who and things like that though is it?

A: No. Like a lot of other conflict resolutions you start off with the person and try and address it with them first and then take it up the line. Unfortunately a lot of the time our people don't, they go to the highest thing they can.

Q: Right, jump from here to here.

A: Yes, so they can avoid the conflict themselves. So confidence obviously is affected by things like personal factors, and institutional seating or organisation seating of someone and sometimes it does create a conflict for people. That conflict can go in many directions really. Often people feel that actually the organisation rules and so on can make it quite difficult for people to practise competently.

Q: Constraining do you think?

A: Yes and so then people have… I'll give you a very recent nice example. The local district health board here, ADHB, has established a rule that if there is any kind of belief that somebody may have been a victim of

sexual abuse, then that needs to be reported. Now the heart is good, it's to try and stop it being swept under the carpet, the only problem is if this was 20 years ago the person involved has died or whatever and also the way of reporting actually means that it ends up being broadcast effectively to anybody in the health system. It becomes almost like a big red flag on the front of the file, which is hugely, hugely disrespectful and very, very difficult as a practitioner, you know, that's something which you need to deal with very… to deal with that competently it needs to be done very sensitively. So that's an example of an organisational process which gets in the say of competent practise.

Q: So that's within the ADHB?

A: Yes. Who knows how it will play out? I mean there is a certain amount of work being done on trauma.

Q: It could put people off coming and, you know, 20 years down the track you may not want to do anything about it but they may not feel they can talk.

A: That's right. As I said, good intentions I think, but very problematic. So it can be a kind of organisation thing, which can really constrain someone. So obviously all those things need to be really addressed and in supervision I have this really brain dead model for supervision, which I use, which sort of defines what the areas of supervision are. This is relevant believe it or not. It's called quadrant model and it's four different quadrants in terms of the kinds of things which supervision is about. So it's not a model of how you do supervision in a sense, it's a model of what supervision is about.

The first of those models is obviously about clinical cases, so you're looking at clinical casework - I've got this person [01.01.16] and what should I do about it and is what I'm doing okay? The second one is about general clinical issues much more generally and that can be things like, I've got… I find that when I'm working with people that are dysphoric or [01.01.42] more than depressed and I really struggle with them or I find that when I'm working with people that have an addiction problem I don't think I do as well as I possibly could and that kind of thing. It's also your ethical issues might come up and you're like - lots of different ethical issues. Some obviously will come up around a particular case, but often they can come up [01.02.10].

The third component, which in this model is around actually organisational issues. A lot of that is around how is the organisation helping or hindering me from doing what I need to do? Like conflict within teams or the kind of resource limitations that we were talking about like the issue which I just talked about. There was one which came up with supervision with somebody in AHB because they were really, really concerned about that and they had a client who was in exactly that situation and they knew that if they did that, you know, if they followed

the procedure then they would just completely… that person would lose trust and it would effectively end their therapy.

The final component is actually the personal. It's not personal therapy but it's personal to the extent that it impacts on your ability to do your job. Different people use that to different amounts. Some people use it quite a lot, like they do use it I think, well probably not a quarter, an eighth of what they do. Other people use it very rarely probably because they've got their own good resources outside and they've got other resources they have. It could be a reflection of the trust or the way supervision is set up or whatever, I don't know. I think mostly it's more about other resources.

So effectively if you think about it in terms of your question this is my way of trying to ensure that I am able to help protect the competency of people or develop the competency of people and maintain it, both when there are organisational challenges and when there are personal challenges and factors. So I pretty much, I do very much see it as part of that.

Q: So you're saying it's a big part of your supervision and a big part of the competence is personal and organisational?

A: Yes. This is actually quite a developmental model so if we look at early career people often what you find is that a lot of it is around the case. Quite a lot of it is around the general, the general stuff. Only a little bit of it often is around the organisation. So particularly with interns because generally they're not… well there will be conflicts and so on with people on the staff, but it's generally quite a small part. Then as I say the personal is quite a variable [01.05.31], so that's early career. Later on in people's career often what you find is that there's actually quite a lot less of the case supervision.

Q: Yes, that comes with experience.

A: Yes, there's often still a fair amount of the more general kind of clinical issues. There's often much more of the organisation and then the personal dependent on the person. That's partly because often and hopefully by that stage people are moving into where they are actually, as I said before, they're treating the organisation as the client. So in a sense it's a different kind of a case issue. It's not only that they've pissed off more people, but they can deal with it.

Q: No, but the relationship has changed.

A: Yes so a lot of it is about how do I help the organisation to grow in this way. How do I have influence in this kind of a situation to make things better? I suppose as part of our earlier conversation that's part of my OI kind of a background in a sense as well as working with a lot of people in how do you influence these organisations to do what they need to do.

Q: Is this a fairly standard thing or this is your way of looking at supervision?

A: It's my lovely way of thinking of supervision. It's sort of in the process of moving towards publication and it's been written up in a reasonably formal kind of short form and it's being used in training workshops. So it's a nice one, it just makes huge sense to people and a little like I was saying before about how the facilitation process that I talked about gives people the permission to address, well it gives them permission to not spend days and weeks and months doing the CCP. This actually gives people permission to address these kinds of issues because some people come from a background of saying well, you know, personal issues have no place in supervision. It should all be about this. Supervision is quality assurance and they're making sure you're doing the right things with your clients.

Q: Without looking at the impacts and everything else that influences it.

A: Yes. The Ministry of Health has a definition of supervision, which talks about two things. It talks about basically quality assurance and quality improvement. It talks about the training development role; these aren't the words it uses. It talks about… I think they call it the normative role in the sense the accountability kind of a role. That's what it says; this is what supervision is for. If you look at most other places in the world and look at what people who write about supervision say they include a third one, which is support. It's the supportive aspect and the mentorship.

Q: That's got to be a huge part of it.

A: It has.

Q: Do you find that that's not part of the New Zealand model of supervision?

A: It depends on what discipline you're looking at. If you look at nursing it's not so, if you look at psychology it very much is so and many of the other disciplines don't do supervision, well they don't do formal supervision. Nobody does formal supervision the way that psychologists do.

Q: I think we've covered everything. Is there anything you want to add?

A: It's a little bit recapping but I think it's hugely important that we don't overplay what competency frameworks and so on can actually provide and do and that they are part of the puzzle rather than the whole puzzle or part of the solution rather than the whole solution and the outcomes is definitely another [01.10.29]. One of the real dangers with a competencies-based approach is when the competencies are defined as doing what we do now and then you get into a real conflict between what we do and what we could do and probably should do.

Q: Can you explain that a little bit?

A: I haven't asked you anything about your background or anything like that. I don't know what your experience has been in terms of other disciplines before training in psychology or anything like that?

Q: No.

A: You haven't?

Q: No.

A: One of the real drives at the moment in a lot of psychotherapy is what they call fidelity. Are you doing it the way Marcia [01.11.47] says you should do it? Are you doing CBT exactly the way which Judith Beck says it should be done and we will measure you as to whether you are doing it precisely this way, precisely the way it says in the book, or not. We will make the assumption that if you're not doing it that way then it won't work as well as what it should.

Now that sort of defies the logic of being a professional who is responding to the needs of the individual person, which is not only about the problem which they're facing, it's also about who they are as a person. Now competency framework can very, very quickly become, are you doing it the way the book says? A lot of it is at the higher level, sort of more meta-process rather than what are you doing in your therapy room in this particular situation? But it can very, very quickly slide down to that and the limiting factor of that and there is quite a large literate involving that, you've probably looked at some of it around competencies framework, is how it can really ossify practise into right now as we do it right now, so that if people stop either being able to be flexible or being able to be innovative.

Q: Yes, so to tailor it.

A: Yes. But also to innovate because innovation says that you're no longer demonstrating fidelity to the approach, which Marcia says, then if that then becomes a competency issue if you're not doing exactly what the book says then you're not doing it right. Therefore you're incompetent and then that stops us being able to grow and develop and/or be flexible. There is a really important document, which came out as long ago as I care to remember. It's often known as the MAS Document, which stands for Management Advisory Services. It was in the UK and the context of it was that it was that it was a place… well a management consultant was hired by the NHS, the National Health Service there, to effectively tell them why they didn't need psychologists.

Effectively what he came back with was saying, actually you do need psychologists and this is why. He said within mental health there are

three levels of function. The first one is level one and that's the kinds of skills, which everybody should have. Anybody who is working in this field should be able to ask decent questions. Anybody should be able to connect with people. Anybody should have a few skills, which are human skills and some specific kinds of skills, good listener, being able to help people to work through didactic [01.15.22]. The sort of stuff that you'd hope anybody that you would come across if you were struggling who would help.

The second level, called number two, is the ability to do [01.15.42] therapy. The ability to take fairly simple and straightforward, well not necessarily simple and straightforward, but take a fairly standard kind of approach and apply that well. Do it so that you can, you know, do relaxation training, do fairly mid-level CBT, being able to take somebody's report record and being able to apply any of those kinds of fairly straightforward kinds of approaches in a sensible and reasonably consistent way. There's heaps and heaps of people who can do that and can do it very well and they can make a huge difference in an awful lot of people's lives.

The third level, which he talked about, was really the level, which integrated therapy knowledge and the theoretical, psychological theoretical basis in a way, which was able to tailor the therapy to the individual needs of the person in a way that made sense.

Q: So this is that innovative is it?

A: Yes it can be. I mean you can innovate probably anywhere in there but it's integrative and particularly integrative of the knowledge of say therapies but also the knowledge of psychological theory. A lot of the time I think when I'm doing a lot of my work I'm using what I learnt in stage 2 social psychology as much as I'm learning from a lot of my postgraduate stuff really, particularly working in South Auckland and most of the people who I worked with who were young people with psychotic disorders. Many, many, many of the challenges they were facing were of a social nature more than anything else and they were working in family systems that were supportive of anything but their health and friendship networks and so on. So social psychology kind of stuff was as important to me as knowing a lot about early intervention for psychosis.

Now if I'd just gone through and learned the manualise stuff about how to do early intervention for psychosis then I wouldn't necessarily have the integrative kind of background, which allowed me to do that. If you get the thinking, which can be driving the competencies kind of thing, it doesn't always, but it can be as you've heard I'm mostly pretty positive about it as an approach, I think it's a really useful approach, and when that gets into fidelity or even bypassing that, it can actually leave us stuck here. And not even just stuck there, as you pointed out losing that ability to innovate.

So that's my one thought about if we… I think the competencies approaches are really, really strong and really, really useful but the unintended consequence of them if they become too all consuming can be that kind of ossification of loss of innovation and loss of ability for flexibility. There's more there which we could talk but you've probably heard enough from me.

Q: I've really enjoyed it, it's been great, and I will take this if that's okay. With reference to this article you were saying they had this in the NHS, so they clearly kept the psychologists. So he was able to show them the need.

A: He certainly was quite convincing. I could send you an article, which talks about that a little bit more if you'd like?

Q: I'd appreciate it; that would be great. I could see very easily that this could happen, to stay at level 2 and being quite comfortable. People being quite comfortable with being there.

A: There's a lot of work at the moment on stepped care approaches which is where you have different professionals but effectively what it means is that everybody's got these, but we increase the number of people who can do that, possibly with supervision and support from psychologists and other highly skilled people. There are a lot of really highly skilled people who are not psychologists as well. Then the psychologists and those other highly skilled people are doing this.

Now what tends to happen a lot of the time is you've got people there and you've got people there and so many people in the middle. In Britain recently there's been this whole big thing increasing access to psychological therapies or AAPT programme, which has cleared up a lot of people to be in that middle zone, often supervised and led by psychologists. It has hugely increased the number of people who are getting access to psychological therapies because a lot of people don't need…

Q: No, the high level.

A: They can benefit from a small amount of lower level stuff.

[End of recording 01.22.48]

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Q: As a general definition could you tell me how you would describe competence?

A: For general psychologists?

Q: In a broad sense.

A: For general psychologists competence is about being aware of your area of expertise, what you do have knowledge and skill in and practising within those limits and feeling comfortable and confident that you're doing the right thing, that you've got a sort of a sound educational underpinning or research underpinning behind what you're doing. It is backed by research; it is okay to practice in the way that you're practising, or doing what you're doing.

So competence for me is about knowing the limits of your skill and of your knowledge and not practising beyond those.

Q: If we then look at that specifically for the field that you work in, what would you say are priorities in competence, specifically in IO?

A: What do you mean? Could you give me an example?

Q: Competence as you say is knowledge, so it's an educational underpinning, knowing your limits, those sorts of things. So when you're thinking about those things are they a priority or is there a critical, some more critical than others when you're considering those and applying them to your practice?

A: For the work that I'm doing right now I need to be aware of things like diversity, is that the type of thing that you're looking for?

Q: Yes.

A: So I need to be aware of things like diversity and the different approaches and lenses that people look at the world through and aware of my own bias around that, because I look at the world in a particular way so I mainly look after leadership development. Just because I think in a certain way of what leaders should or shouldn't do doesn't make it right or wrong, so I need to be aware and open to those different perspectives.

I need to be competent in understanding the impact that I can have on people so the professional impact, like the professional coaching or advice that I'm giving, because I'm working with leaders that then take action based on what I've said. So I need to be really aware of the follow through impact and make sure that it's done in a respectful way and a safe way.

Q: You were talking about attitudes and bias and you considering yourself that because of who you are and where you're from, it may be quite different to another, someone else that you're educating. If we think of the cultural side of that you mentioned the bias and attitude, so would that be a big thing you'd consider? If you're working with someone who is culturally quite different, say Maori, from a different background, are these things that you consider and you're aware of?

A: Gosh this is taking me back. There are three elements to cultural competence, awareness, knowledge and skills. Being aware of your own bias, being aware that other people may have different views, different ways of looking at the world, is really important. Knowing how to extract those views as well and to draw them out from other people rather than to place them on, your views on to other people. The questioning skill is really, really important and I think a core competency for all psychologists to draw out people rather than just tell.

In leadership development it's got to feel right for that person, it's got to sit well with them and they've got to see themselves doing it. If I keep telling them what they're supposed to do and it's not right for them and it doesn't sit well, it's never going to wash, it's never going to go down well. So by asking questions they come up with their own way of leading or motivating or delegating or whatever it may be, that's right for them and within their worldview.

Q: So you're sort of tailoring it to… once you learn about them you can tailor it to what is going to work?

A: Yes, it has to be and it's got to be realistic for them and something they think they can do.

Q: You were talking about knowledge, so I guess that's keeping up to date with the latest research. Do you feel it's enough to say you're a competent practitioner by demonstrating the basics of competence, just the minimum of maybe reading or minimum of attending workshops? Do you think really to be competent it needs to be much bigger, more involved?

A: I probably have personal views on that in that I want to always grow and develop and I always want to… I'm hungry to learn more and hungry to learn about different perspectives and just expand my knowledge in the more diverse places and I can get that from the better and broader my worldview grows and the greater my appreciation grows for different

perspectives. I think bare minimum is unacceptable for me personally. I would not feel comfortable doing the bare minimum. I have to seek as much information as I can from as many different sources as I can, from as many different places.

So I get information from Twitter, from LinkedIn, from my peers, peer supervision and my supervisor. I'm the president of the IO Psych Committee, so we have a guest speaker come along once a month but all of these sources are continually feeding and growing my knowledge. I think if I ever stopped that I would question my own level of comfort with my competence.

Q: Talking about people that may not be competent, how do you recognise someone that isn't a competent practitioner or competent in their field?

A: That's tough. In my area it would be someone who is telling, someone who is forcing their perspective on other people without asking those critical questions. That would I guess raise my suspicions, alarm bells would ring. Hang on, what are they doing and why are they doing it that way? Why do they think their way is the right way?

Q: Within the competencies, the continuing competency development, do you think there is a way of measuring people who aren't competent?

A: I think you probably need to get some feedback from the people that work most closely with them. Whether that's their supervisor, I'm not entirely sure if they see the work that that individual is doing on a day-to-day basis, or whether it's their line manager or the people that have received the service that they provide. I think people who have been witness to their practice are probably best placed to comment on someone's competence.

However, those people are also unaware of what competence should be and what a highly competent person versus a lacking in competence person, what is the actual difference between those two things? I don't think it's necessarily something that should just be a self-assessment. I'm not entirely sure that your supervisor that you choose is 100 per cent sure or aware of what you're doing anyway, so I'm not sure that that's the full picture either.

Q: If we're talking about self-assessment, self-reflective review is quite a big part of competence. How much time do you spend doing self-reflective review? Is it a process throughout the year or is it something at the end or periodically?

A: Self-reflective review is something that I've built into my day-to-day work for my own learning because I teach, I don't like the word teach, but because my role revolves around leadership development I ask people to be self-reflective and to do things that will work for them, whether it's ten minutes a day just to reflect on what have you learned today? What's

gone well? What hasn't gone well? What would you do differently tomorrow? Or journaling or whatever it may be, whatever works for an individual. Ten minutes mindfulness practice or meditation just to clear the head and think clearly, because I ask people to do that I do that myself.

It's not necessarily… I'm not being self-reflective specifically about psychology competence; it's more about me in general and my role and my day-to-day work. It's reflecting on what have I done today? What am I doing today? What good questions have I asked? What good questions have been asked of me? What could I do more effectively tomorrow? So it's not specifically about psychology.

Q: When it comes to registering and you have to do your self-reflective review, do you think they capture well competence?

A: I was in the first round to go through the self-reflective review, the formal process, for CCP. I was in the first round, which was a few years ago now I think, maybe five years ago, four years ago, and the process was a little rusty back then. Annually when I get the reminder to pay for my registration, yes okay I need to do this reflective review, and I critically look at what are my areas of weakness? What are the areas that I want to develop? I do that in conjunction with looking at my role as well, so what are the opportunities that I have that lend themselves to developing in a particular area?

I guess I go through that process and the peer group that I meet with on a monthly basis is really good at holding each other accountable. So we all do it at the same time and we all check on each other and I would say my peers are more aware of what I'm working on professionally than my supervisor is. So my supervisor is someone that I go to for more specific questions, whereas with them they know what I'm working on across the year a bit more clearly. We're really good at challenging each other and picking holes in each other's plans.

It is quite a formal process. When I submitted mine to the registration board they said I'd gone overboard because I'd provided them with my diary of all the different development activities and all of that sort of thing. It's nice to see the processes changing because it was a little bit of a logistical nightmare for me to pull that information together because I'd got peer review notes in some places and diary over here and then the IO psych stuff that I'm doing, the guest speaker notes. It's all in different places so to pull it all together was quite a big job.

Reviewing my competence is something that I do on a daily basis and then on an annual basis, in conjunction with looking at what are my goals for my role as well as what are my goals as a psychologist.

Q: With the changes to the competencies, supervision is going to be a bigger part of that. How do you see that impacting you? Do you supervise anyone?

A: I do peer supervision. I have a really, really good group that meet once a month for peer supervision. We call it the lab and a big focus of that peer supervision is not only reflection on the last month, but we also bring a tool. So we bring knowledge to put into the pool so that we're all sharing collectively and getting benefit out of the session, otherwise you kind of go along and question what is the value of picking apart the last month, but we're getting value from educating each other as well as sharing any difficult things that we've experienced over the last month.

I think my peers are far more familiar with what I'm working on and how I'm developing much more than my supervisor. My supervisor is specific issues and I actually have different supervisors for different purposes. I have a supervisor that I go to for academic type queries and ethical things and legal things and so on, but then I have supervisors that I go to for commercial things and conflicts of interest.

So there's different people that are knowledge experts that I would tap into as needed. I'm a little bit concerned with the way that the new competency process is shaping up to have such a heavy reliance on your supervisor. Maybe I haven't got the right supervisor, but I would say my peers are a better place to connect than my supervisor is.

Q: Do you feel that there are competencies that are specific to your area of expertise?

A: Yes, I can say that the competencies have come from a clinical foundation but yes I do think they are relevant. All this stuff around ethics and cultural competence and the legal requirements and do no harm and respect for individuals, that's common sense. It applies to any role really and whatever area of psychology you're practicing. I think IO psychology is a really funny area of psychology. It's kind of what I would say is the parasite of psychology. It has no theories or philosophies unique just to IO psychology. It leans on social psychology and applies it to the workplace. So do we really have unique issues?

Okay so the setting is different and that's what makes it different. That's I think where a lot of people struggle to bridge the gap between the clinical setting and the workplace setting. But can't we read between the lines and see that we're speaking the same language, it's just maybe the way the language is framed is very clinical. So it's taking that language and just putting a bit of a workplace frame around it to make it more immediately applicable and okay yeah, I get that that's what I do on a day-to-day basis that's relevant to me, but the foundation of it, no it's fine. Parasite of psychology is not very attractive is it (laugh).

Q: It's a description.

A: We have no theories. We just apply social psychology in the workplace. Everything that I do in leadership development comes from social psychology. There's nothing unique to IO.

Q: I've always thought… not having done any of the papers, I've always considered it quite different.

A: The workplaces yes, the environment.

Q: So situationally it is.

A: Yes. That's just my perspective. I know there are a lot of people out there fighting for a separate scope, fine. But for me it makes no different, it's just the setting that you're applying that scope in.

Q: If we're talking about situational factors, having a high level of competence is necessary for being a good practitioner, what about personal and social and situational factors that might affect competence. When I'm thinking situational you're working for a company that would have tools readily available for you, whereas someone who is working in private practice may not have the same access. You would have feedback, you'd have meetings and then there's the personal thing, motivational, health, all those sorts of things that influence certain social supports. Are they big factors in competence?

A: Probably one of the hardest things I've found in maintaining my competence in a workplace is that I don't have access to academic journals. I can't read the latest and without the strong connection that I have to people like Helena and Brenda at Auckland University and actually the IO6, so the special interest groups and the presenters we have come along, they're typically presenting their PhD research and things like that. Without that connection I would be oblivious to what's going on in the academic world. It's really hard to maintain competence without access to journals.

Q: That's a situational struggle in a way?

A: Yes so once you're out of university and in the workplace and practising how do you maintain knowledge of…

Q: Get access.

A: Yes, how do you know… we're supposed to be bridging the gap between the best research and applying it in the workplace, and yet we can't access the research, we've got to find another way so we've got to get creative.

Q: What about personal factors? Do they influence competence? Health or motivation, family things, that sort of stuff?

A: Yes, I think that's probably normal in any role. You're not on 100 per cent of the time and no one ever is, but having awareness, knowing that I'm not on today.

Q: There's other things going on.

A: There's other things going on exactly, so maybe today's not the best day to do something or give someone a particular line of advice. I think that's a common professional self-awareness thing. Just know how you're you're feeling at that point in time, what advice you're giving and how that's going to impact and how it's going to go down, I don't think that's unique to psychology. So knowing that is one thing, but then thinking about the impact and the damage that you can cause if you do.

Q: Do you feel the current method of measuring competencies is sufficient?

A: The current method being the self-reflective review that you submit?

Q: Yes, going to workshops and all those sorts of things, the conferences.

A: I think the process can be simplified. My husband's an audiologist and they have a continuing competence requirement as well. They have a really simple point system that I'm somewhat envious of. For him going to a journal club, going to peer supervision, going to conferences, it earns him points. It's a really transparent and easy way to show that he is maintaining his education. I feel like our process requires a lot of justification, so you've got to look at the specific areas that you want to develop and then find opportunities to develop and then prove that you've… and it's very qualitative. There must be a way of streamlining this and making it a little more simple.

Q: Because that's the way the medical fraternity do it and the legal fraternity, it's a point system and it's simple.

A: Yes, maybe we could take a leaf out of their book. There is a bit of a challenge in that people will do the bare minimum and that they will do the things that are easy.

Q: Yes, interest based rather than needs based and that is an issue, when you're attending things for interest rather than things that you need to be…

A: Yes, so how do you get that balance of encouraging people to educate themselves in areas that…

Q: I guess a self-reflective review should be showing and then the things you attend should be showing that you've attended…

A: That marries out.

Q: Yes.

A: Yes sometimes the things that you need are not available.

Q: That's true too. Not accessible, yes for sure, and particularly I think New Zealand's small and if you want to go and attend things often they're overseas, it's expensive, it's time, it's not easy.

A: Sometimes some of the things that I've identified as my need in the past, so certain things around cultural competence, has been reaching out to people like Belinda Borell at Massey university at the Waiariki Institute and just having a coffee with her to just increase my knowledge and my awareness in a particular area. I don't know how you would capture or document those points.

Q: Yes, the fact that you've done that. That's vital.

A: Yes it's in alignment with an area of need, but not something you can easily track by a points system.

Q: Do you feel that the characteristics of competence take into consideration the professional lifespan? So do they cover from new graduate through to someone retiring after 20 years or 30 years, or should there be different requirements around each stage?

A: I've never thought about that. I've been a registered psych for probably almost ten years and I don't think over that period of time my requirement has changed in terms of competence. I think they're generic enough to suit the different spans of the professional life cycle. However I am good friends with an older psych who is approaching retirement and the feedback that he had when he was audited for the CPP process, his feedback was that he needs a more experienced supervisor than him. It was like umm - is anyone really more experienced than him? Yes he needs a supervisor, I completely agree with that, because you've got to sound out your thinking with somebody else, but there is nobody more experienced.

Q: Do you think that's where peer supervision is really of more importance because that exact scenario was just brought up to me last week by a psych who said I'm coming to the end of my time, but there's no supervisor that's more experienced or older that I can go to at this point for the area that I work in. What am I supposed to do now for a supervisor? They felt much like you, that peer supervision had been invaluable, so maybe…

A: Yes and sometimes those peers are 20 years younger (laugh).

Q: They may be, yes.

A: And there's so much value from them because the research stuff they're exposed to is up to date.

Q: And there's not quite the same issues around being part of a group peer supervision with younger supervisors as there might be if you're an older experienced one and…

A: Yes, I can see that becoming an issue. Do the competencies still remain relevant across the professional lifespan? Yes I think they probably do. I don't think it changes; it's just the supervision process that changes.

Q: That needs to be tweaked a little bit, specifically when you talk about that person you know. Gosh it can be tricky.

Do you think there's room for it to be more narrative thing rather than, personal review, what do you think?

A: More narrative?

Q: As in your own words, a narrative from you, self-narrative rather than a requirement of this sort of structure with these kinds of words.

A: I think the structure simplifies the process. I think the structure is helpful. I don't know what people would [32.26] without structure.

Q: No, and I guess it makes it harder maybe for people looking through it to then evaluate it.

A: Yes. Having not, or it's been a while, really looked at a lot of detail about things like the Code of Ethics and the competencies and so on, I haven't pulled them apart, I haven't read the Code of Ethics, I haven't read the cultural competence stuff for a long time and every year it's something that you pull out and you skim and am I really giving it the time and thought that I should? I'm not sure. I do feel pretty rusty.

Q: I guess it's part and parcel, if you feel you're being a competent practitioner, the things you've told me would make you a competent practitioner, you're covering those things anyway just as a natural course. Finding the time to go through and to make sure you're practicing and all of that on top of everything else…

A: I think it probably has become a natural part of the way that I operate but I can see how for some people what do you do to maintain your knowledge and keep it fresh, there's no annual workshops to go on.

Q: Something like that, an update, then after so many years require to attend a workshop so that you can… That's not a bad idea is it?

A: Yes, bit of a refresh.

Q: Yes, because other professions do that.

A: Yes, take a look at the Code of Ethics, take a look at cultural competence.

Q: Yes and what's changed and discussions.

A: And making it really applicable to your work is important. So bringing scenarios or looking at how to apply it in your work makes it more real, rather than just talking about the concept and the theory.

Q: Was there anything else you want to add?

A: No, it's not something I've thought of for a long time.

[End of recording 35.07]

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Q: One of the risks we take with the western model and the indigenous people is it does not fit, whereas that's much more holistic.

A: Yes, I see a huge amount of western psychology flying under the flag of Maori focus psychology, New Zealand Maori, actually being the last of the colonisers. We're teaching them theory of mind and all this sort of nonsense and it comes from western cognitivism and that western cognitivism is based upon is now being put into a lot of stuff that's being passed off as Maori psychology. It's criminal, but I think people are unaware they're doing that.

Q: No, oblivious to it.

A: Yes.

Q: That's another situation where it's going to take major change.

A: Yes, I was fortunate, I worked in a Maori mental health unit for a while and we had two groups of people. We had urban Maori whose first language was English and during the renaissance of the late 80's and what have you started learning Maori and returned to Maori ways and what have you. But they are primarily Pakeha, the horrible American terms, the [01.52] Negros that [01.54]. Then you had these other people who had grown up in rural areas whose first language was Maori and didn't have any qualifications but had been brought in, but they were the ones to go and learn from.

If you wanted to kind of get a sense of Maori conceptions of mental health and how they traditionally went about dealing with it. Lower down the pecking order went into the cooking pot, but people higher up, there were methods of actually dealing with it, which more fit with some of the more successful kind of ways that we have, was just containing them but staying warm and close and what happens is the psychosis will disappear. Now that's exactly what's being done with [02.48], this model in Northern Finland if you know the open dialogue?

Q: Yes.

A: Basically they just embrace them. They're not removing them from the social network, they're embracing them and just staying in dialogue, keeping the dialogue going and eventually he starts joining back in with the dialogue and all that's happened is some sort of breakdown has occurred in the social network, not in the individual, not internalised. To remove them is dangerous, which is exactly what we've been doing for

hundreds of years and then wondering why we've got this huge population of people.

Q: Yes and then trying to put them back out.

A: The social member closes ranks and says no you keep them. You've got them, you keep them.

Q: And traditionally the Maori culture is they're a community.

A: Yes they've got whakawhanaungatanga way which embraces that.

Q: Do you mind if I just ask you some more specific questions?

A: Yes, go for it.

Q: What I'm doing is it's not about the specific competencies; it's more about competence in general around practice. So if I was to ask you what does competence mean to you in a general sense?

A: In one of the papers which I've sent to you you'll see that I've said that competence probably can be defined as some sort of position on a ladder from novice to expert and it's somewhere along that scale, how far along it is. But by and large it's not a good term, it's not a good word because if you actually ask the public what they want, they don't care whether you're competent, they want to know if you're any good. They want to know whether you're effective and effective should be more important and when you look at the act of protecting the public, the best way to protect the public is to let them know whether they're seeing somebody who is effective or not.

One of the things that's popping up all around the world in various forms is various public feedback systems and where somebody is effective. Now with tradesmen here in Auckland and Wellington we've got a site called No More Cowboys. If you go to No More Cowboys - do you know the site?

Q: Yes I do.

A: Now we've got the Uber Taxi phenomena which has sprung up globally and we're using feedback and the taxi driver can rate you as well as a passenger.

Q: Yes and in medical and teaching, many yes.

A: Yes because that's what the public are wanting to know. They're wanting to know whether they're seeing somebody who is going to be effective.

Q: They check reviews.

A: Yes. Now what's happened is there's a whole heap of research, you'll see in one of my papers, by a guy called Maurice Cliner. Have you come across Maurice Cliner?

Q: I don't think so.

A: Maurice Cliner looked at all sorts of attempts to protect various professions or to protect the public from various professions, licensing of professions and he's got a lifelong bit of research and work on it. Basically the client thing is it's actually more to protect the guild. It's guild protection rackets and there's no evidence or the evidence is extremely poor that the public is better protected by having these boards and licensing [06.31]. One of the arguments that Cliner puts and it applies here in New Zealand, that if you were to go to an insurance company for indemnity insurance and you were a counsellor, which isn't licensed, and they also did psychologists which are, you would pay the same fee.

So Cliner's argument is that it would seem that the insurance companies are not seeing that there's more risk involved in being licensed or being unlicensed and adjusted their fees accordingly. It's a very difficult argument because once you've got a license they could say that that's due to the licensing, but that argument doesn't apply either because another one that Cliner's got is they decided in the noughties, 2003 or 2002 or something to start licensing mortgage brokers in the States because of the number of scams and various kinds of atrocities had gone on.

When the 2008 crash occurred they found it was riddled with… that licensing hadn't done a thing, there was still all sorts of scams and rip-offs and God knows what. The licensing hadn't reduced that at all. So it's not they're doing what it's planning to do, so what you'll see me arguing is I'm arguing for outcome feedback systems, Duncan and Miller sort of stuff where the client… you know the Duncan and Miller stuff?

Q: Yes.

A: So there you're getting a measure of your effectiveness, which is far more…

Q: To the clients.

A: Yes to the clients.

Q: That's what competence is. It's about protecting the public.

A: Yes and you're going to do it more through effectiveness I think than through competence. I think competence… what happens is that there's usually a public outcry over something, say the Lake Alice scandal here in New Zealand or the cervical cancer thing. We've had various public outcries, which seems to drive the call for greater public protection but

actually the people who drive it into existence are actually the people teaching it, the people teaching midwifery or the people teaching psychotherapy or whatever.

Now we would have probably a quite different set of core standards or core competencies had the teaching of psychology in this country been more [09.14] relations focussed, so analytically focussed and they hadn't been cognitively focussed, we would have had a whole heap of different standards. So what it is the people are teaching who are actually driving the core competencies that we end up being measured against.

Q: So rather than being knowledge based, the competency being based around knowledge base, it's around practice. It's around as you say effectiveness of treatment.

A: That effectiveness hasn't come in. It's been ignored. If you get taken to the board you're getting measured against the core competencies.

Q: How do you measure it then, competence?

A: I don't think you can, especially in… like we've got at least 500 schools of psychotherapy, each with completely different things. Some of them are really far out, do you know provocative therapy?

Q: No.

A: *Christ it's the third time this week you've said about cutting your wrists. You are useless. You can't even get that right.* It's brilliant eh? It uses humour. There's obviously only some people who can do it. We had a hospital chaplain once and he did it brilliantly, he was a real [10.32].

We're solution focussed, which I'm quite… now that doesn't do any assessment. We don't need to know the problem. The solution focussed person, you could come in, and it's particularly good, I was saying to a psychologist the other day, it's particularly good if you're dealing with somebody who has got a very embarrassing problem. Say you've got a very prudish woman, there's a famous Milton Ericson case where this woman came to see him and she was a very prudish woman who was a schoolteacher and she'd farted loudly in class and been too embarrassed to go back and asked Ericson to help her through that.

But in a case like that the kindest thing you can do is actually protect her from having people talk about the problem, so the solution focused therapist, I mean their first question, when they get the opportunity to say it, is can you imagine what might be going on when this problem has resolved? I don't need to know that, but can you imagine what that might look like? How much of that is occurring now and on a scale of 1 to 10, you're a 10, that's happening full-time, and 1 is only a little bit of it happening, where are you now? So then we can start to… we've never

even assessed the problem or dealt with the problem, but we can get a solution occurring and into place without knowing the problem.

Now that would go against the core competencies. The core competencies require me to make some sort of assessment and then make some sort of formulation. Even if I'm doing that on-goingly, revertively, I'm still required to take that kind of thinking, that kind of thinking that's driving it. But in practice I don't need to do that, I need to help them get into a place where they can…

Q: Where they have control of it themselves.

A: Yes, Wittgenstein has got a phrase called 'now I can go on' and that's where we try and get people to. So I think the whole idea of competence is a questionable word in itself.

Q: Not appropriate do you feel in this situation?

A: Yes, it's got too much space to allow all sorts of people to get in there and create their own definition and meaning of it.

Q: That's exactly right. Competence has different meanings for everybody, even if you look up dictionaries, how it's defined is very loose.

A: Whereas effectiveness is easier and defined more tightly.

Q: il's clear, effective practice or effective outcome?

A: Yes.

Q: We talked a little bit before about self-reflection. How important do you think self-reflection is for competent practice?

A: Again I think [14.07] has put a whole new slant on the whole idea of self-reflection by making it more about your perceptual knowledge than your conceptual knowledge. Self-reflection as occurring in western culture is more of a conceptual knowledge where you're looking at yourself through various lenses and deciding whether you're too tall, too short, whether you're complying with core competencies or not. You're looking at sort of… it's a conceptual thing.

That shift in perceptual knowledge is like a shift in a [14.47] from seeing if it's a duck to seeing if it's a rabbit, or seeing it from two faces to a vase. What's happened is your perceptual knowledge has changed. So self-reflection for me should be around a shift in perceptual knowledge and this is what I'm getting from the [15.06] is that a shift in perceptual knowledge occurs. So I start to see myself in a different light and as I do, if I stop seeing myself as Joe Brown looking at the world and I start to see myself as the universe looking at itself, a whole different… which is what every major religion is taught in its more mystical form, then I start

to sort of shift in the sense of how I look after myself and how I look after others.

That invites me to a form of self-discipline [15.43], which is not a difficult self-discipline, but a self-discipline where my needs aren't getting in the way of my ability to stay here with the client, the patient, and sense where their needs and what have you is and to allow that conversation, that therapeutic conversation, to develop a life of its own, which is what I wanted to have, a really good therapeutic conversation will just take on a life of its own, it will take off somewhere and go where it needs to go.

Q: Not structured.

A: No, it doesn't need to be planned.

Q: So it captures a lot more.

A: Yes, and at the moment what's happening is that self-reflection [16.31] it creates an anxiety and you'll see it amongst clinical psychologists or any psychologist around the country. It generates an anxiety about whether I am or not and that anxiety is actually debilitating them from being able to just let go, so it's actually harmful. The board is actually creating harm to the public through the [16.57] mechanism that is put into place to try and protect the public.

Q: Because you can't be present particularly, you've always got something in reserve.

A: Yes and you're always worried about God, did I put that in the right words or I've had too many shifts in the conversation… So you're doing this monitoring sort of thing, which keeps you in a state of anxiety and you're not present. So will the board take any responsibility for the harm it's doing? I suggested… you'll have a little laugh at the end of one of the papers at what I'm… Voltaire makes the comment that the English Navy are particularly fond of hanging an admiral every now and again because it keeps all the others on their toes.

That guy Saul, I can't think of his first name, he's written a book called Voltaire's Bastards, points out that at the beginning of the 20th century the Navy moved to a different tactic where they pinned a medal on them and put them out to retirement, far more civilised behaviour (laugh) and there's a comment with regard to the board (laughter).

Q: So has this been accepted and published?

A: Well at the moment it's sitting with the journal editor.

Q: In New Zealand?

A: Yeah, New Zealand journal first of all because of New Zealand and the way we're doing it here. It's sitting there and I know that John will be struggling because he doesn't really like me to write stuff…

Q: That rocks the boat.

A: Yes, that identifies personally some of the people making stupid mistakes. I did a paper a while back and it was very much focussed on Justice Wild who had struck a nurse off the nursing council, struck a nurse off, and he took it through to the high court and Justice Wild put an acceptor's argument and stuck with the nursing council's decision. It was a really fascinating case.

This guy was working for this telephone health line who was the mental health component, he was a psych nurse in Wellington and it was in the early 2000's when the government were trying to give out a lot of these health contracts to private companies as they were. This company [19.46] came in, which is a large multinational, and set up this health line where people could phone in and ask health questions and this guy was working on a shift there as the mental health component.

One night he's working and this call comes in and it's this guy out in the Hutt Valley saying I've got a gun and I'm going to start shooting people. So he immediately patched the police in and carried on talking with this guy and it turned out this guy was under the Mental Health Act, had had multiple armed defender squad in the past call-outs and he was under the Act and he was meant to be monitored by Lower Hutt DHB. They were meant to visit him daily obviously for medication, which was their main kind of thing, but they hadn't been.

It was right on Christmastime and so he was trying to get hold of them and the police said don't bother if you're trying to get hold of the Lower Hutt DHB crisis team, we haven't been able to get them all night. It turned out they were out at a Christmas party and hadn't even been to visit this guy all day. They were actually out with the manager, the duty manager of [21.08] as well, which is also meant to be called in should he get any crisis stuff like this come up and he thinks he's meant to be available online. So they couldn't contact him either, the nurse couldn't.

So they kept talking and talking and they surrounded the place, armed defend squad had the place surrounded, phone call went on an hour, the armed defender squad said lure him into the kitchen, we can get a clear shot there. The guy, he'd been abusing the nurse and everything as well - I'm gonna do you and your family as well. So finally he said I'm gonna hang up now and start shooting. The police said don't let him hang up. So this nurse says to him, look here mate, you make one more threat against me and my family I'm gonna come out there and I'm gonna get that gun and I'm gonna stick it so far up your arse you won't know whether to wind your watch or fart. The guy cracked up laughing (laugh) as you would - sorry mate, I just wanted my meds eh?

So the whole tension went out of it and he negotiated a surrender and the porch light goes out and he lies on the ground and gets shifted off… the police come in and thank the nurse and tell him great job, well done, dah, dah, dah. On the following Monday they sacked him and a complaint came from Lower Hutt Crisis Team to the nursing council that he had made a threat to a psychiatric patient. The nursing council struck him off.

Q: So they weren't even available…

A: Yes they were at the Christmas party and when it got… the nursing council consisted of three senior nurses, none of whom had mental health experience whatsoever, their expert witnesses were the crisis team from Lower Hutt. They said we would never do that. You can't make a threat like that to a patient, that is really bad practice.

Q: Look at the outcome.

A: So they struck him off. So he… everyone said to him this is just bloody nonsense, you've got appeal, so he took it to the high court. In the high court Justice Wild said I haven't had time to read all this bloody thing, he hadn't read all the defence documents, and said the nurse's council know what they're doing in cases like that. They called again the same expert witnesses and the same people who said this is not what nurses do. He had the police negotiator and the patient's actual psychologist all in his defence team, standing up and saying what a marvellous job, dah, dah, dah, even the psychiatrist saying this is good.

The judge got into this argument with him, with the psychiatrist, about whether he had made threats which happened all the time, he said I threaten I'll section them under Mental Health Act. You don't threaten to go and stick guns up people's bottoms. Everyone was looking at the credibility of that. Would this nurse need to put on gloves? How would you actually go about sticking… (laughter). It's ludicrous eh in terms of that sort of level. The judge said you don't want to be judged on your outcomes, you want to be judged on following due process.

That was the defence used in Nuremberg. I was just following the orders and following due process. The Nuremberg trails declared that wasn't a defence, but Judge Wild decided that it was and we shouldn't be judged on outcomes if we're following due process.

I wrote a paper about that saying this is so wrong because it's not protecting the public. The public want to know that they've got somebody effective who they're seeing, not somebody who is following the bloody book, and they've got the right to know that.

Q: This nurse got the best outcome, simply because he reacted in a way… he wasn't thinking.

A: A very experienced nurse too. He ended up bankrupt, health compromised. There are crimes occurring here in the name of due process.

Q: Yes, keeping in line with the core competencies, competencies…

A: That's why in our own core competencies we've got all this danger built into it. Did you watch… I've tried to get hold of [26.38] Joseph but haven't been able to do so but have you watched his… he went through the health practitioner's tribunal a couple of years ago and I was trying to work out what actually happened. It was a very interesting case to look at.

A mother had made a complaint against him, he was a Maori psychologist in New Plymouth, and he had a 15-year-old girl and the mother's complaint was he had taken her off her ADHD medication and as a result of that she deteriorated. Now the girl herself ended up giving a thing saying that no he hadn't, it was a decision that I made. She had a falling out with her mother and she was sick of taking these bloody pills and just decided to stop taking them.

Reading between the lines he'd given her some advice on how she might manage herself should she take that course, but it was quite clear that he hadn't told her to do that and they dropped that charge. But then they [27.44] you're not having proper supervisory relationship and all this core competency stuff. They went for him on that.

Q: Do you think it becomes a witch-hunt?

A: Yes exactly.

Q: So we didn't get you on that, but we don't want you practising.

A: Yes, I tried to find him and catch up with him because this guy… I don't know, there was a film or documentary that was on TV that this guy made and it was [28.13] Parihaka. Parihaka was that place where that Maori peaceful protest had taken place in about 1860 around New Plymouth and they'd taken them all out and killed them and dumped them at sea and done all sorts of things and the whole lot got sent to a jail in Otago. It was kind of like the whole [28.33] thing basically with this Maori tribe.

So he made this document of taking a whole lot of kids from that area on a bus trip, a road trip, down to Dunedin to see the jail that their ancestors got sent to and tell the story and get their reflections, which was quite a nice little documentary and he'd done that, so he was sort of also listed as a filmmaker. But he got the [28.56] psychologist after that, after that experience…and we haven't got… clearly [29.04] reasonably well steeped in Maori and sense of justice and blah, blah, blah, but again

probably felt that [29.11] system because done another Maori system over eh on basically some sort of nonsense. I want them to catch up and get this side of the story a bit clearer because I was trying to read between the lines of what had happened.

Q: I can see where it could clearly cause trouble, having the competencies the way they are defined competence.

A: That's what the client finds too. Basically what you've got is the people teaching it, they get in charge and it becomes a bit of an old boys network around that group and so if you're in with that group or that hierarchy you're fairly safe. If you're challenging that then you're in a dangerous position.

Q: You're really not covered if you're outside of the very specific ways of practising psychology or what they define as competence. It's kind of risky isn't it to step outside if you want to continue practising?

A: Yes and yet you might be extremely effective.

Q: What do you see as priorities in competence?

A: Getting rid of the word competency out of the system. I think that's the first priority.

Q: So you'd change it to effectiveness?

A: Yes.

Q: Is this happening anywhere else? When I look at the Australian competencies, the United States, the UK, they're not dissimilar.

A: No, we are doing that. One of the disturbing this is that Steve Osborne has now found some status on a panel of international people drawing up international standards. What it's going to do is it's going to kill the 500 schools of therapy, 500 plus schools of therapy, and get it down to one similar little core thing but one of the things that's happening that we're seeing is the rising up of coaching because there's more and more people who are getting outside that system. So I think that's what will happen, coaching will take over.

Q: Coaching will take over those other schools of psychologies?

A: I think so. They may well do. That's just unfortunate eh that psychology is going to lose touch with that. I think [32.04] but being a psychologist doesn't make you any more effective. It doesn't matter what your background is or isn't, the training isn't tied to effectiveness, first thing… There's a paper way back in '79 which found humanity professors outshone trained therapists [32.40] and since then there has been lots more showing that this is not… your training doesn't… and one of the

things that, I mean one you'll find in my paper is that it goes all the way back to Adam Smith. Adam Smith saw this guild dominance where the guild suddenly gets some charge and one of the first things the guild does when it gets in charge is it starts banking up the amount of training that you need, so they capture you for longer.

If you were getting outcome measurements coming out and say you find out you don't do well with marriage and stuff, then that's going to trigger you to go and explore that area, go and do a Hendrix workshop or Goffman workshop or whatever or you talk to friends, dah, dah, dah whatever. So [33.46] will enhance your thing, this way here, it's kind of like they're trying to put the cart before the horse and say that you need to know a certain level of this. Whereas what I would have is like the outcome measurement tells you more directly what you need to go and study because you do an analysis on that.

Q: So more interest based or more where you feel that you have, not deficiencies but maybe weaknesses?

A: Yes, I was using a programme called Assist, which is a Duncan and Miller system and I could break my year down, I could break down the stats, and look whether I'm doing better in the first quarter of the year, the second quarter or the third quarter or the fourth quarter. I found I tended to do better in spring than I did in autumn. That led to self-reflectiveness as to what is going on with that or I could look at cases and decide that I deal better with women than men or with children than adults or families to singles or whatever.

I could break it down and then go and explore that as to how I could lift that because if I want my overall effectiveness to go up and then become more effective, which is what I'm wanting to do, I'm wanting to look at where the weak spots are. I either don't practice with those people and cut them out or I go and develop that. Research is coming in on expertise. There's a guy called Magnus Carlsen, have you heard of him?

Q: No.

A: He was a prodigy in chess, a young Scandinavian guy, early twenties, so he was a great grand master. Now what's happening with Carlsen is that he's coming out with whole new patterns, whole new ways, new strategies and ways of doing it that nobody has seen before and so that's what we're wanting. If the 500 schools of various Carlsens have come up and found a new pattern and put into place then that's great and we want to encourage more of that because when I go to find out about how I can improve my marital counselling and there's some new [36.20] have found a new way of doing it, I can look at that too and look for those patterns. That's useful. Now that's not going to get into the core competencies.

Q: No, it's going to be very defined about where and what you can learn. So really what you're saying is it's really less knowledge based, it's less about the training, and more about the personal attributes of a person.

A: Yes.

Q: So simply because you've got A's all the way through does not make you a competent practitioner.

A: No, oh no. Although I did (laughter) but that was just because I read so much. So if I got stuck on a case I would be straight into a library to find every… like way back in the 80's I had all of Erikson's books and what have you. Is there a case in Erikson's lot that did something like that or Hayes or whatever. I'm looking at the CBT literature because they didn't have examples of how to do it but Hayes or Erikson would have these really far out ways of looking at it.

Q: Yes, how can I use that?

A: Yes exactly.

Q: As a practitioner there's a lifespan from early graduate through to retirement. Do you think competence is captured or is it (interruption).

[End of recording 38.27]

Q: Do you think characteristics of competence capture the lifespan, so from early novice through to getting close to retirement because surely competence is different for different phases of the lifespan? I know we're talking about competence, which is not a word you like, but it's what it is at the moment?

A: Probably everyone has a different perception of you at different ages, so they would have different expectations of you. If you were a young person who just left school both the clients and your employer would have more allowance for you to have… be a bit more slower or clumsy or lets you even support that.

Q: Would they have more support around them?

A: Yes they might have more support around them. Yes there probably would be less support.

Q: Increased supervision.

A: Yes.

Q: As you're going through the lifespan of your career supervision must become a different…

A: It does but I'm sort of thinking… I know some really incompetent old psychologists and I wouldn't send my cat to them.

Q: What is it that makes them incompetent?

A: I haven't seen successful outcomes. Again it's that thing straightaway, they just are not getting… high drop out rates and what they tend to do is they tend to move into more managerial positions. There's two or three - in the DHB there's clinical advisors, which is like the top position, I've been in that role. But I remember a psychologist telling me about a clinical advisor in her DHB and she was a very prim woman, the psychologist, whose advice was even more prim but this woman was quite prim, and she shocked me by saying that if that woman was on fire I wouldn't walk across the road and piss on her, which was a real shock. She was not the sort of woman who would make a statement like that or use that metaphor, that phrase.

She occupies quite a powerful political position now in the world, the one she was referring to, and certainly I've seen people, a number over the years, I mean I was in [03.13] in the '70's so I've seen a lot in time and certainly we've got a few out there that it's probably just as well they've moved into a management position and not into actually seeing people, but they're still having incredible effect.

Q: So they've got influence?

A: Because they start having an influence. It's not as bad as incompetent nurses in mental health because they actually occupy management roles far more. What they tend to do is then put their incompetent ways of going about it into law as practises that everyone else has to do and that's dangerous. So I suppose as time goes on… if I put my focus on effectiveness you'll find out whether you can improve and lift your effectiveness to get up above average. Most psychologists on the bell curve place themselves above average, which would make a lop-sided bell curve or not the bell curve - it defies the bell curve. You'll actually never find a psychologist who actually rates himself below average, well all counsellors and therapists and God knows what eh? They don't want to put themselves down there.

I think if there's effectiveness and you're using feedback you would see whether you are improving and getting up into the above average [04.41]. I think with the competence thing you're blind to that because self-deception potential is so high you can't really know, and the board's new step to use supervisors more, that does help because you can have a folie à deux, eh? Two people can be equally blind.

Q: Yes and not honest.

A: Yes. As a supervisor it would be nice if [05.14] I'm aware that what's happening is that we're becoming increasingly defensive.

Q: I was about to say the supervisor may not want to report the supervisee because it may reflect on them.

A: Yes. I find what I'm doing is I'm recording more and notes and what have you to make sure the supervisee has done everything, rather than staying focussed on their development as I originally did, I wasn't really focussed on the harmful side so much as kind of like where they needed to grow, I am now far more focussed on making sure they've got all their paperwork in order, that they've got… we're just all moving to this defensive forms of practise. Defensive forms of practise affects effectiveness.

Q: So just covering yourself?

A: Yes that's what's going on. So back to the original question of whether… I suppose there should be some shifts over the career in what competence is if you're going to use that word. It's a hard question - I get stuck around that world competence and just what the hell it means. I mean if they were say average and they stayed average all their life then I guess that's what the government wants or what the board wants. They want at least that, they're not really interested in factors.

What I see is… you see a lot of it, especially in DHBs, you see a whole raft of psychologists who get really good at doing assessments and they can assess this patient down to the nth degree. They've run every measurement tool that's available out there and written these 10, 15 page descriptions of them, but they haven't got a therapeutic bone in their body. They're a bit Aspergery, they can't actually develop a relationship or a rapport. They don't get it with them.

Q: So they have to have that very focussed structure just to do this, but then dealing with whatever…

A: Yes and I see this is where the bloody [07.57], this is where you buggers have bloody gone and done with regards to ACC; they've positioned themselves as the experts on assessment and telling people what they ought to do. So basically psychologists are writing out these treatment plans and then passing them down to lower order counsellors and others further down - from the $150 people and pass it down to the $80 counsellors, to actually deliver this fancy treatment plan.

Now what happens is that the counsellors just do their own thing as they always have and pay whatever lip service they need to pay. It's just nonsense but the psychologists want to be more important and the clinical psychologists want to be more important too and position themselves over there in the hierarchy.

Q: Do you think competence covers all of the different focuses of psychology? Do you think there should be different requirements?

A: Well there is isn't there because you've got the psychologist, clinical psychologist, counselling psychologist…

Q: Industrial…

A: …educational psychologist. No, we haven't got an industrial practice yet.

Q: Not health either do we?

A: No. So we've only got the educational, clinical, counselling and the psychologist is meant to be a basic one and then these others are meant to be a slightly higher order, but it probably doesn't cover teaching psychologists. I know some really good researchers who can't call themselves psychologists because they're not practising within those scopes and they're a bit bitter about having the word psychologist stolen from their amenity.

Q: Because there is a place for them.

A: Yes exactly.

Q: As a psychologist.

A: Yes.

Q: Thank goodness for them.

A: Yes exactly. I wouldn't have all this inactive psychology going on if it wasn't for those guys, they're the ones who did the research and started to make that bridge from the philosophers who had figured it out to actually figure it out as applies and practise in the field of psychology. With regard to perception and cognition, I am now, you know, we have got the job of making that bridge in practise as clinical. I have a lot of my papers on a website called academia.edu, which is a place where you can share academic papers kind of thing.

The other day I got into the top 4% for a week there. It's a global thing so it means there were a lot of people downloading papers of mine that week, which is great.

Q: It is great. Were they specific papers? Can you have a look and see?

A: Actually yes, I can see what it was. The ones that were mainly getting hit were actually my Maori papers. I've got a Maori outcome paper, tool, kopapa outcome [11.40].

Q: It's exam time.

A: Well no it's been taught in politics and I've also got the [11.47]. I mean I just stumbled up on it. The [11.51] idea has been out for a long time, but nobody had written it up. So I just took - a great opportunist, I just wrote it up. So now it becomes the reference point. It's one of the major schools of counselling therapy. I had all the Duncan and Miller stuff translated into Maori.

I'm still puzzling about as you age should competency shift - it goes, but thinking about it outside of it, as I get older… has my competency in driving changed? No I don't think it would be any worse than it used to.

Q: Is that born from previous experience or is that just part of getting older?

A: Yes it is isn't it? I'm becoming a better cook but again it's… like life, your competencies do shift as you get older, so why should this be any different? Presumably people would feel safer driving with me now or would they if I had a bunch of 20 year old mates who I took my kid's 20 year old friends out, they'd say God your dad drives like an old fuddy. He's so boring in the car; we're having no fun.

Q: I won't drive with my father (laugh).

A: Is his competence going downhill is it?

Q: I think so (laugh). What if you saw someone that you felt was incompetent, wasn't a competent practitioner?

A: Well you do.

Q: What do you do?

A: It's very hard. I have reported a couple of people to the board but the first step is usually to approach them and talk to them because you want to move that, help me…

Q: And it does not always go well.

A: No, for example I got into trouble once for approaching a social worker and said it appears to me, and I don't see this as personal to you, but there are requirements you have to with CYFS that actually shift you into the potential for actually child abuse. Sometimes you remove kids from homes when, with a bit more work, something could have been done to change that home environment and we know that moving a kid into some foster thing can be extremely damaging and some extremely abusive situations follow so you don't have a good record as parents CYFS and you're doing that. So it seems to me that all CYFS social workers are potentially child abusers because of requirement.

Q: So they're following due process.

A: Yes, what they're required to do and I appreciate that you're an underfunded and overworked government department that is becoming increasingly risk aversive because of the risk management culture that we're now all under and it's meaning you're having to do more and more paperwork and risk averse sort of stuff and not take chances. Sometimes therapeutic outcomes come from a certain degree of risk taking by the social worker, therapist, whatever and I see this happen.

She reported that to her boss who reported it to another psychologist and the other psychologist went and complained to the board about me saying that CYFS social workers are child abusers - taken out of context.

Q: Okay just focussed on that.

A: Yes, a statement that was removed from its context. So that's our bloody risk averse culture, how do things get bloody escalated to complaints.

Q: So it's very difficult to actually… if you see someone incompetently practising to actually do something.

A: I didn't meant that social worker herself was…

Q: No, you were talking about general…

A: Yes, we were actually at the time dealing with what I call million-dollar mama. She had cost the state well over a million bucks. She was a junkie working as a prostitute who had had a child and because of her circumstances CYFS had moved in and taken the child and done no work with her. She had filled that emptiness with another child. She had now just given birth to her fifth child with this repeating pattern and it was obvious, it should have been obvious to everyone after the second at least, that the work actually needs to be done with this woman.

Talking to the woman it was clear she had quite an obviously abusive background. Her mother actually ran a brothel so really sad circumstances. She'd keep swooping in on any one of these children's lives from time to time. It was an Australian social worker who called her a million dollar mama, [18.27] best way to phrase them [18.30]. Probably for a lot less you could have got for her…

Q: Yes a successful outcome with the children for the children.

A: Yes by just doing some good work with the mum and getting her somewhere in life. So that's how that conversation came about, but it ended with me being charged with telling, acting in an unbecoming manner, as a psychologist by telling a CYFS social worker that they were child abusers. I mean it's just…

Q: Out of context (laugh).

A: That sort of thing happens so the correct thing is to have those conversations, it is morally the correct thing to do, but in today's world that's extremely difficult. I mean the risk management, I've got a couple of papers I did on risk management and they wouldn't publish them because they were criticizing the judge, Justice Wild. I saw a kid the other day, you're not allowed to name your kid Justice, but I saw somebody - there's things that you can't call your kids eh? But I saw a kid the other day and it was on the news or something and I saw they'd spelt Justice - Justyce.

Q: I know one who is Justize with a z, so they're still Justice.

A: Yes they've got round it eh? I mean people have tried Prince and King haven't they?

So what's happened is that risk management culture has taken over [20.31] has become massively risk adverse.

Q: So we're at risk then of having incompetent therapists because people are frighted of reporting it?

A: Yes or confronting it.

Q: Or confronting it or just doing anything about it. It's better just to ignore it.

A: Yes I think that's happening.

Q: Yes because of the risk to yourself.

A: Yes and not finding out for sure because what could happen then is that somebody says somebody and nobody is actually going to go and find out.

Q: No one has spoken to the person.

A: No one talks to them; everyone just avoids them. So you might have somebody who is highly effective and they're just being avoided because somebody has given them a bad name, that they're incompetent. I mean like the case with that Maori psychologist, he's been labelled now in a negative way by the board. He may have been a highly effective therapist and they've done harm if that's occurred, not just to him but to the…

Q: The community that he's in.

A: Yes, so there's real problems around that and that's all part of my anti-competence as a word in use. It's effective; it cuts all that crap out.

Q: So you're not anti the board?

A: No, I think that they can be useful.

Q: [22.10] the board?

A: Well I think there are some individuals there who have lost the plot, they're part of my admirals so perhaps give them a medal and put them out to retire kind of thing eh? Say we switch to an outcome thing, somebody raised this one with me, and we had a Brian Tamaki spring up in our midst and everyone who went to him was reporting great outcomes but they were all getting caught up and becoming members of his church community. Now we've got to be careful now because how we project our moral values onto that situation, should that be a no go or not? If we were in India we'd have no problem whatsoever, some guru, somebody sprung up with a new following, so there might be an okay allowance on that.

I guess people going would know that there is a high risk that they're going to end up being a member of that church, so that would be reasonably transparent. My argument was that if we had effectiveness, if the board's job was to show currently your effectiveness rating as a 6 out of 10 or whatever, and they could see that there were other therapists around who also had a 6 out of 10 they may not want to go to Brian Tamaki, because you'd have to become a member of the church [23.50] you're some sort of more quiet humble person sitting in the back room, getting 6 or 7s out of him.

Another one that comes up is sometimes that using the Duncan and Miller system somebody can be getting good outcomes but they might be relapsing within two years or three years and so what [24.20] is doing in Finland is they've got two and five year follow-ups. So I think one of the things the board could do is sort of keep an eye out for that sort of stuff, that we need to be implementing a two year or a five year follow up, even if it's a random one, because that would give us a deeper look at effectiveness.

Q: Yes.

A: So if we switch to effectiveness we could still have the board but the function would be around a whole lot of different values to where it is now. Getting away from that [24.58] kind of thinking which is keeping everyone in a state of anxiety to saying look, you're doing well but you are getting a little low on your five year follow up, is that something you need to look at or do you want to move up? You're getting good scores on your immediate, your five year chart is showing a low average, your call what you do about that. We're letting the public know, when they look it up they'll see it and they're get an immediate quite quick hit off you. That would solve that problem but it's a whole different function for them.

Q: It's interesting.

A: It's more direct accountability to the… I mean at the moment you're accountable to the board, not to the public, not to your clients. This way is putting more direct accountability to your client, which is where it should be.

Q: That's what it's all about; it's about protecting the public or providing the public with the best service possible.

A: Yes exactly.

Q: Even when they say competence, that's what they're saying they're doing, but it's the way that it's done and whether that is actually providing the best service.

A: I'll tell you one of the threats it brings up and I had this discussion with some educationalists, it does threaten the educationalists that they may not be needed. If you went straight to a [26.50] from the very outset instead of doing a bachelor's degree then what happens is if you want to become a psychologist you had to find a voluntary organisation like Life Line, go there and use outcome. Once you consistently for a year have your outcomes up over 60% you are now allowed to call yourself a psychologist okay. Then once your outcomes got up over the 70% mark for two years you can then call yourself a master psychologist. If you manage to get a five-year spell with over 80% you're then a grand master.

Now people would still go and study but the path has now been…

Q: That's back up.

A: Yes that's been put behind the horse. The horse in our profession has been really good at being able to get with people, have some good people skills and help them get back on track if they fall off track.

Q: It would weed people out too.

A: Yes.

Q: Much quicker for those that could sustain it.

A: What's happened now is that… this is what Adam Smith back in the 17th century was saying, that the [28.15] just start ranking up, your requirements to actually practise, and then you have to charge more to get it back. Now one of the things that Klein's research, [28.26] on this was was that in about 1950 when wealth disparity was as its lowest, union membership was high. What the unions were doing was they were demanding, they had force to demand that the managers share the wealth that was coming out. But as we moved from the 1950's we went more and more into service industries and away from manufacturing and

as we did we started to licence professionals. As licensing has increased wealth disparity is growing because what happens is that a firm now actually adds on the cost of a licenced professional to do your job, adds it onto the bill.

So it's not the wealth being shared so if you call in a licenced plumber the firm, which may have a number of unlicensed plumbers, have a set charge for fixing, but the fact that they used a licenced plumber that's an extra charge to cover the cost of a licenced one. So this makes for the wealth disparity and as wealth disparity grows we all know that that's what's growing our social problems and the problems we're dealing with. So we become part of the problem at that stage, we're contributing to the very problems we're being asked to address.

Then we have to provide ourselves with an ethic of why it's okay to charge a whole lot more to people who can't actually afford it.

Q: It puts psychologists out of the… people that really need it, out of reach.

A: What Klein says is that people start turning to self-help methods and he cites a case of a guy in Canada giving himself a root canal (laugh).

Q: That takes a very special kind of person (laugh) and the internet, people just Google and they are able to diagnose and sort themselves out, not always well. There are number of online depression sites where you can go on and do certain things and keep a diary and that becomes a cheaper alternative.

A: I used to share an office with a guy, we were both doing our intern year, at [31.48] Hospital, two interns in the same year, and we'd stuck up on the door of our office, psycho the rapist, and the boss made us take it down but I hadn't seen him for years. I ran into him on the top of, of all places, Te Mata Peak in Hawkes Bay. Just walked up there one day and he was sitting up top with his wife and I hadn't seen him for 30 something years. He was in Brisbane and what he was doing was developing computer programmes, computer therapy programmes. So you go in and you type in I'm depressed, how long have you felt that way? And it has all this response stuff.

Q: It's still keeping the person isolated.

A: Yes exactly.

Q: Which is part of the problem.

A: It may have some good short-term outcomes, those things, but probably their two and five year follow up which would show them up. That's the sort of thing that the board could be doing.

Q: Yes, if you were doing it at the same time as having some human, personal intervention as well or whatever was required, because for people who might be isolated, physically isolated or for the elderly who can't get out maybe, I can see there is a place for it, but there has to also be a personal…

A: Yes I supervise a rural psychologist who is in an extremely isolated part of New Zealand and travels around in a fortnight all these towns. She's got all sorts of self-help type things where she's directing people to and she's quite good at just going in and finding out what they've done and telling them how brilliant they were to get onto that. It seems to be working reasonably well, she doesn't appear to be getting much coming back in the two and five year period that I'm hearing about anyway. There's been no formal measure of that but I'm not hearing of any. Occasionally I'll hear of a come back but they seem to be quite rare. So there is probably a place for those, but that's what that psychologist was doing, putting us all out of business (laugh).

Q: Including himself.

A: Yes, [34.37] carry on programming there'll be [34.40] programmes.

Q: That's right.

I think we've covered everything that I needed to cover.

A: I'll send you those papers.

Q: I would really appreciate that. That would be great.

A: There's two. They're both at the moment waiting to see where John will take them with New Zealand Journal of Psychology. One is on competency and the other is on cultivating a therapeutic self.

Q: Which is related.

A: Yes. How do you get yourself to this place where you're just reflective without having to give a lot of thought.

Q: Yes it comes naturally.

A: Yes, [35.38] How do you cultivate or [35.45] that because that's where everyone wants to get to. They want to get to a place where, like all that stuff on [35.53] on expertise is all focussed around that. It's all focussed around how do we develop our expertise.

[End of recording 36.09]

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Q: In a general sense what does competence mean to you, just your maybe definition of competence?

A: That's a tricky question isn't it? I guess doing things in a way that is useful and productive.

Q: Is it easier if I ask you, as a practitioner, what do you think of when you're thinking competence as a psychologist? So a competent practitioner.

A: A competent practitioner. You can get kind of hung up on what that word competence kind of means.

Q: That is the big issue - competent, competencies, competency.

A: I'm not sure what the definition of competent is.

Q: When you're thinking of a competent psychologist, practicing psychologist, what do they need? What are some of the characteristics of it?

A: Well I guess as a profession you have a sense of what is defined as your role and what you're doing. I guess being competent means that you are meeting the basic requirements of what that profession decides is the requirements I suppose.

Q: For the particular field you're working in, or as a basic level of being a psychologist, your particular area or scope?

A: I guess I'm thinking about it more in general terms. If you're thinking about it in terms of a psychologist then I guess, you know, that we across our science over the years have kind of developed theories and models and research I guess around psychological principles. I guess those get distilled around people working in clinical areas and the leaders are important and then to be competent means that I guess you have a basic understanding of the nature of that, and more specifically the ones that are relevant to being in that field.

I guess it's kind of understanding those principles, and then how those principles are applied to your profession and what's the relevant ones.

Q: What do you see as priorities in being a competent psychologist?

A: Clinical?

Q: No, let's just say across… for any psychologist, what are priorities to being called a competent psychologist?

A: A competent psychologist.

Q: What do they need? So clearly knowledge is…

A: Yeah, I guess it is knowing the science and the literature of the field and the principles and theories. What was the question again?

Q: What do you see as priorities?

A: Okay, the priorities of what?

Q: Of being considered competent.

A: Of a psychologist?

Q: Yes.

A: Staying relevant I guess, staying on top of what people are currently thinking about and researching I suppose or developing. Is that a priority or is it more a priority to understand what the principles are that people are working on? It's probably, if somebody's coming into the area, more a priority is what is most relevant. I mean after that I suppose it's kind of understanding what's current. I must admit I'm finding it quite hard to think of things as a psychologist rather than as a clinician.

Q: If you're thinking as a clinician does that make it easier?

A: I guess it changes the focus a little bit in that obviously we have a body that we have some registration responsibilities to and I guess within our profession we have responsibilities to remain current, to remain reflective in our practicing, to remain accountable. Whereas I think in general in psychology I don't really know what people working in universities and certainly when I see the numbers of psychologists around there's a lot more people that are working in more general areas. I mean I don't really know what their priorities are.

Q: So thinking about that then, there's three current scopes, education, counselling and clinical in psychology.

A: And general.

Q: Yes and general. So you're talking about as a clinician and you're saying that others might have different priorities in practice. Do you think there's a place then for different competencies for different practices, different scopes?

A: Different competencies for different scopes? Well there must be. I mean I guess there's basic principles around understanding what the nature of psychology is and what's important to that.

Q: For everybody?

A: Yes, but when I look at people that are studying basic principles of behaviour change or mental rotation or cognitive processes, they're quite different in clinical requirements. They may not even involve interaction with people, so their priorities and competencies would be quite different. Whereas clinically there's the whole… your responsibility to be working with people and to be ethically, working in an ethical way, that's quite different than people that are not.

Q: If we're talking about someone that you might consider not competent, what are the signs of someone who is not competent and how do you manage that?

A: I guess again… look I'm not sure about it outside the clinical area, but I guess in the clinical area I guess the experience would be people that are not… that are using models that don't appear consistent with what most people are using or they may seem unclear in how they are structuring their work and unclear in terms of their outcomes and probably diagnostically unclear.

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Q: Lacking in competence?

A: I mean I'm not sure these are signs of everything, but I guess that would be the main things that I would imagine that you would see. So appearing kind of inconsistent and the models that they're using don't seem to be what most people are using and…

Q: Their outcomes…

A: …outcomes are unclear and I think diagnostically probably they are maybe missing obvious things. I guess that would be loosely what I would see.

Q: How would they measure someone who is lacking in competence? Do the competencies currently pick that up?

A: Would the competencies pick that up?

Q: How can it be measured?

A: Theoretically you're relying on self-reflection and you're relying on supervision, but in clinical settings where there is a number of people working I guess you're also relying on the structure of the service as well to be able to pick things up. Within a service like this you've got senior clinicians, plus you've got a psychological structure that is assessing quality and monitoring quality, so it's picked up through that. So there's a lot of different ways.

Q: Is it measuring outcomes? Is that what you mean when you say measuring quality or picking…

A: Is it measuring outcomes? There are a lot of outcome measures, do they measure quality here? They measure some things that I guess would give you an indication of quality, but they're not an accurate measure of quality. So whether somebody is completing their paperwork, I mean I guess it's a rough estimation of quality, but it's not necessarily like a real measure of quality.

Q: So outcome isn't a true indication of competence necessarily.

A: No, not necessarily. I mean I suppose there are a few other measures in terms of where the clients are improving, which I suppose is a closer measure of it, but it's nowhere near accurate enough to be able to really say that somebody's…

Q: I guess that works if you're in a DHB kind of setting, but if you're in private practice you're not having outcomes measured in the same way. So that doesn't work in that sense anyway.

A: Yes, unless they have like a rating system or Google or something (laugh).

Q: Yes exactly, or they have something that clients have to fill in. You can't force clients to fill in things anyway regardless and in general people who are unhappy with the service will fill things in before people who are happy, so I guess it's not an appropriate way.

A: Yes and I imagine in an enlarged DHB where there's a lot of psychologists and a lot of structure around then it's much easier I guess but in a smaller team or one where you're pretty much in sole charge, then yes it's going to be quite different.

Q: You touched on supervision, what part does that play in being a competent practitioner?

A: I guess it is a major part of it within our particular field in that it's kind of a main place that you're doing your reflective part of your practice and I guess having somebody also reflecting back to you and having some sense of benchmark I suppose or a sense of comparison.

Q: So you find that is quite high in the list of things that, to you, competent practice, supervision is an important one.

A: Yes.

Q: Reflection in your daily practice, what part does that play and is it important?

A: Reflection of your daily practice…

Q: When you're thinking about a competent clinician.

A: It's obviously a very important part of it. It's part of how you shape your formulation and whether you are happy with the intervention strategies that you're choosing to use. So partly that's personal reflection and it's also what you take along to your supervision as well. So yes that's a really important part of being competent.

Q: I guess there's times when there's clinicians who, regardless of how much self-reflection, they may not see what they're missing, you can do self-reflection and not see it. How do you measure the gaps or the parts in your knowledge or skill that are missing? Is that what self-reflection does for you?

A: You're saying can you see the things that you can't see in a sense?

Q: Yes, is that what self-reflection provides?

A: It provides… hopefully it provides a good indication of that, but obviously you can't necessarily know what you don't know. With any luck you can identify a gap or a need to know more about what you don't know. I guess in that sense that opens up that area, but whether it necessarily provides the answer I guess that's what you need to be finding in other places. I guess supervision kind of adds to that as well in that it's an outside perspective of what you don't know.

Q: The people that I've interviewed, a lot of them have said that the priorities for them are knowledge and skills when it comes to being a competent practitioner, but there are also the characteristics of attitudes, belief, your self-awareness, all of those things, that have to play a big part in your practice. Would you say that they are equally as important for being a competent clinician?

A: I'm not sure how useful it is to try and quantify whether things are equals or priorities. I guess they're all important.

Q: I guess what I'm trying to say is say the competencies, they will measure your knowledge and skills, but they can't really capture those more elusive things of your experience or your attitudes, your beliefs, your self-awareness and yet they clearly have to have some sort of impact on your practicing. Is there some way of measuring those do you feel?

A: I guess they become more apparent when you're working in groups in organisations to other people, but then they can be difficult things to talk about and to bring forward.

Q: I guess you could have someone that has all the knowledge but if they don't bring with them an attitude or they carry certain beliefs and things then it's going to impact on their ability to practice competently. You can have the knowledge, but may not have the… you have to have the knowledge as a basic, as a basis regardless of everything else, to be competent and the other things you hope.

A: Yes. I guess I have seen here over time people that come in, not necessarily in our profession but in other professions, that lack a lot of those skills and they are difficult to challenge and to work from an organisations point of view I think, because they're not necessarily doing anything wrong in terms of their knowledge and skill base. Perhaps skill base is not quite correct but their knowledge…

So I guess difficult for organisations to work those particular issues I think.

Q: It is much easier to measure knowledge and skills and I guess that's what the competencies capture and to be a competent clinician you need to be using the competencies, but then they don't capture the full picture.

A: Yes.

Q: The idea of developmental competence, so you have someone who is newly out of university and through the professional lifespan, do you feel that there are room for different competencies or are there different competencies or competence around each of those stages?

A: So what you're asking is is the competency different at different levels?

Q: Yes and is it sufficient just to be covered by the competencies? Should there be more scaffolding around a new clinician, someone who has been out for five years, or someone who has been out for 20 or someone who is at the end. When there's someone that's towards the end of their career, who supervises them?

A: That's an interesting question. I guess there's the assumption… it's obvious that people get more competent as they get more experienced, but I guess the flipside of that is that there's a basic level of competency that you would expect and if people fell below that then…

Q: That's the thing; how do you judge that - the line of competence and how is it judged?

A: I guess when somebody is new out then I guess there's an expectation that they may not be able to do certain things, but that they would seek an appropriate level of support to do those things and that they would have the insight to do that. So I guess there's the expectation that they would be doing that and then you would expect that people after that are

more competent to be doing the work alone. So I guess if you had somebody that was more senior and then you thought no actually they're not competent to do things, they need to go back and be making sure they have the level of scaffolding. So I guess there is a shifting perception and I guess an agreement and that's about awareness, self-awareness and the limits of others.

So back to your question, what was your question again?

Q: I think in a roundabout way you've probably answered it. It was about the lifelong professional lifespan and do the characteristics of competence take into phases from new graduate to retirement. So supervision must play a big part in that. I'm thinking that when you come to the end of your career finding a supervision for an older practicing person gets a little bit more difficult because I'm sure a lot of them don't want to be supervised by someone younger with less experience.

So we were taking about supervision. What makes a competent supervisor and who supervises the supervisors? Is it just a natural progression - you become a supervisor because you've done so many years of experience? I don't know if that's an appropriate way.

A: I don't know that it quite works quite… I think there's probably a point where, I don't know, five or ten years out, where you start looking for different things and it might be more specific skills. In some ways, some people that are coming straight out or a few years out, have much more, a much tighter understanding of certain models or skill groups or things like that that you might seek out. I think there comes a point where it doesn't matter so much, so I'm not sure that when you're 30 years out you're looking for somebody that's 35 years out. It reaches a point where it doesn't matter in that sense.

A part of your question seemed to be about supervisors supervising supervisors. I think that is partially true, that it is a system that your supervisor gets supervision and supervising so it does become a pyramid scheme of some description (laugh).

Q: I guess it has to because you have to have… you want them to be competent so it needs to be someone keeping an eye on things.

A: Yes.

Q: One of the things, when we're talking about the competent clinician, is knowing the field that you work in. So you're working with youth, young people and there are people who work with young people through to adults, which is a very wide range with very different things. I guess part of being competent is knowing enough to stay within your field and passing people on. Just having spoken to a few people some people find that difficult.

A: They find the passing on difficult?

Q: They find…

A: Or in their field?

Q: …probably staying within their field, and taking on situations or clients that maybe aren't their specific speciality, which means they're probably not as competent as someone that's been working in that particular field for some time. So say we have someone that's worked with adults for a long period of time, but they're doing some work with youth, or they've had some youth coming in and they're working with them, completely different specialties. How can that be remedied because clearly part of competence is knowing, being aware of what your abilities are?

Do you see it or have you seen it?

A: Have I seen it? I guess I work in an environment where the organisation imposes a degree of structure on that, but even within that there's obviously people that work here with pre-schoolers, whereas I don't, and if I did it would mean up-skilling in the interventions and the models that they use in that area. So I guess that even within these lose fields with adults, are you competent to work with borderline personalities, if you haven't had experience in that kind of area or personality disorders. I think there's obviously an enormous number of ways of dividing up a certain area and saying whether you're competent in that area, so it is a matter of working out what it is in that particular client that you're working with and knowing the material and being competent with the material in the area and I guess you make decisions around that.

People that work across… I think there's always a process of people learning and so they will be pushing themselves into areas that they may not be initially competent at, but they need to get support. Are people doing it without having competence in the area? I don't know, probably. Should they be? Probably not. I mean I imagine that if you're in a small team or working by yourself you may be getting clients that are pushing outside your area of competence and I guess you need to be aware of that and to be getting the appropriate support for that.

Q: That kind of feeds into cultural competence for people working with cultures and sub-cultures outside of our own. You I guess must see a variety of cultures. Do you seek supervision with specific cultures or when we think of New Zealand as a bicultural society, you may be fairly proficient in Maori and customs and things… are you culturally competent or is it a big thing for a psychologist to be? Is it important?

A: I think it's important and I think that we're lucky in that our organisation provides quite a lot of support around it, so we have Maori Pacific staff that we would not begin working a case with without having them as part of that case. I imagine that that's a pretty rare luxury that we have and of

course I've certainly worked with Sri Lankans and Middle Eastern people that I didn't have cultural support for. That culture has an enormous impact on their psychological processes they're presenting and their families. So yes it is a really big area.

Q: How do you overcome, say if there was a lack of knowledge in some particular culture, how do you deal with that?

A: I guess try and get a bit of information is obviously helpful and we work exclusively with families so you've got that resource to use in terms of I guess asking questions about how this works in a cultural sense. I guess those are the main resources we have and then it's just being open and aware that that's a limitation in your understanding of what's happening and trying to I guess reflect that within your understanding of the process and the intention that you're using.

Q: You must see such a variety of cultures here, which I think being in private practice or small practices, it's not necessarily the same.

A: No and I guess in those practices you've probably got the option of laying out to a potential client that that's your limitation as well and they can make a decision around that. Coming somewhere like here they don't have that option but then we do have more resources I suppose.

Q: That's an important thing in being a competent practitioner is resources. Resources, so admin, because a big part of being competent is administration and things. So admin, the fact that you have everything you need to practice. Outside of that I guess to be competent there's your own personal things, keeping healthy, your own mental wellbeing and social issues too. They almost play a part in being a competent practitioner. Have you worked in private practice yourself?

A: Only in a very, very small degree.

Q: So when it comes to things such as working in an environment like this, the support is quite different?

A: Yes.

Q: Admin wise and personal wise.

(Interruption)

Q: Your views on the personal social situation or factors, we were just talking about those, which might influence competence.

A: That's an interesting area isn't it? I guess it's a field in which they're probably quite important, you know, your own functioning and own state and what's going on in your world is probably… I suppose it does in most fields but because you're relying on that personal interaction with

people, I imagine a big part of how competent we are and again something that's not going to be captured by a competency kind of test.

Q: So it's a matter of managing it yourself and being aware that the road rage you had on your way in, in that traffic, I'm still boiling about isn't going to…

A: Yes. I guess this comes back to your own self-reflection and your own insight and your own ability to raise it in supervision and your own skills at separating that out from what you're doing. Again much easier in a large team where there's a lot of people that you're involved with. It's a bit difficult when you're in private practice I would think.

Q: We've covered everything.

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A: I'm not sure that there's anything in particular that I want to add. It's been interesting thinking about it and I think it could have been useful to think about it a bit more before talking about it. I guess it's something that because it's become a part of the way that we work and you have all these structures that are built in around it, you probably don't…

Q: Think about it.

A: You don't necessarily think about it as a concept.

Q: It's almost taken care of for you in a way.

A: Yes, particularly when you're training, I guess there's a huge amount of observation and focus on it and then it's all very much focussed on passing and doing what you need to do to do that and having a degree of support around you through that period. So you don't really need to think about all those concepts so much.

Q: Just out of curiosity, do you feel that there is room for… this is just something I've been thinking about… do you think that competence should start with the selection of students? I don't mean getting to the post-grad programmes, but at an earlier stage. Say in a similar way they might do for medicine or something like that.

A: I think they do… so you mean prior to getting into a… again I guess we're talking about clinical psychology rather than just psychology in general.

Q: Yes, so there is getting into clinical, you have to apply and interview and have good marks, but prior to that, say even for an undergraduate, do you think that there's room for assessing students earlier or is it that they drop out anyway along the way or they don't go on to be registered?

A: I think it would be tricky because of the numbers. You get so many that get to undergraduate level, to be able to know and then given there are so few that are going through at that to the diplomas, well doctorates now aren't they? I assume that there is a fairly thoughtful process in terms of letting people through and getting a sense of whether they are going to be able to meet a lot of those non-specific areas of competence and what their interaction and self-reflection. I imagine that's the biggest part of what people are thinking about, maybe not in an explicit way. So I think it would be hard to do that stuff at a level before then.

Q: Yes and it does happen, as you say, in some form post-grad.

A: Yes.

[End of transcript]

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Q: In a general sense, what does competence mean to you?

A: It means having, demonstrating and having the skills and proficiency in practising in a way that meets the client's needs, but also is safe and goes according to the ethical and other guidelines of our profession. Actually a lot of competency has to do with not just knowing it but demonstrating it. I think actually that's a really big thing. Acting in a way that a psychologist, as understood by the board, should act.

Q: Do you think the board captures all of the requirements to be a competent practitioner? Things such as attitudes and personal characteristics.

A: Actually I don't know that any board could, so I don't think so, but I don't think any board could.

Q: So it's not something that could be measured.

A: It can't be measured by a pen and paper exercise that you fill in once a year, and it's a very… but could be measured by feedback from service users or something like that, so there could be other ways of measuring it. Whether the board has the resources to do that is a different question. It would be really resource intensive and also you would have to have agreement about what those things were.

I think it takes a particular personality style, a particular type of person and also that varies within each area that you're working. The stuff that it takes to be administering neuropsych tests or to be in private practice or to be in the forensic system or do be in an in-patient unit or to be working with kids is quite different.

Q: The ideas that you just told me about competency in practise, so safety, meeting client needs, not just knowledge, demonstrating the ethics of it, how do you demonstrate that in practice?

A: Formally, there's informal and formal ways of demonstrating it. Formally by meeting the requirements of the board. Formally by maintaining my practising certificate and everything that that entails. Formally, by checking things out in supervision and using supervision. Formally by actually demonstrating that I do things in terms of my job description and modelling what I think a competent psychologist should do for the other psychologists since I'm the leader. So that also includes all the requirements of my actual employer as well, like performance review, because I have to have 360 feedback and all of that stuff.

Informally by accepting feedback, of which psychologists are not backward in coming forward (laugh) if they don't agree with something that you do. By trying to be non-defensive, by listening, by not thinking

I'm an expert in everything, by being curious and maintaining learning, by encouraging others to do that and by actually that way that you present yourself either to service users or do colleagues or to anybody that you're working with.

You represent a professional psychologist point of view. It's just even the non-verbal way, how you hold yourself, how you talk about things, how you use a scientist practitioner model and use evidence-based practice and are willing to stand up for maybe an alternative point of view, especially as psychologists quite often have an alternative point of view, a more holistic point of view. All of the stuff that makes the core of what we're trained in.

Q: What do you see as priorities a competent psychologist should have? I guess in a way you've covered this. Safety, ethical, knowledge, demonstration of it, is there a priority?

A: I think it depends on actually where you're working, although actually working in an ethical way and doing no harm and all that stuff would be priorities anywhere that you work. I think those things, working in an ethical way and sticking within what you know actually, within your scope and within what you actually know about rather than making stuff up (laugh).

Q: That is something I come to a bit further on. How do you know if someone is lacking in competence?

A: Informally you know, actually teams pick that up really easily.

Q: So you're talking about if you're working in a DHB?

A: In a DHB, or even actually outside of a DHB in private practice. Service users give you feedback, people complain. Within a DHB team members give feedback, you can actually pick up when someone's not performing. Maybe not all of the time, but there are certain points where you can pick that up. When they're transferring their caseload, in times of change you can pick things up. But also formally we're putting in a framework for that so we're putting in an audit framework and a supportive collaborative framework for exactly that reason.

Up to now we've picked up when somebody is not competent too late when actually a disaster has happened and we've done the investigations and you look back in the notes and I pick up when somebody's not competent. For example when a service user is referred to me that has seen say a psychologist out in the community, and I can pick up that they haven't done things. Or I read the psychologist report and I think it's not succinct and it doesn't cover… it doesn't have a formulation and it doesn't cover the things that I would expect a psychologist to be covering.

So there's ways of picking that up, but I don't think we're formal enough. The board picks it up when they have a complaint as well and then it needs to be investigated, so there are lots of ways but I guess people still kind of slip through. I think with experience also, when you're employing people you can… I've been on lots of interview panels and I'm quite often on interview panels and you can see the way people present themselves. Us being smarter about how we interview people, asking for cases, asking people to talk through formulations and things, actually we're getting better at picking up non-competent people.

Q: If you come across a non-competent person what do you do?

A: It depends.

Q: So sometimes dealt within…?

A: If it's someone who say is presenting at an interview situation for employment they don't go any further. If it's one of our staff here then actually we try and… it depends on how incompetent they are, but actually we try and be collaborative and mentor people. We have a whole system of doing that, so we have practice supervisors whose job it is to sit alongside. We might contact somebody's supervisor and say what areas we think, we might audit their files, we might do a whole lot of things depending. If it's gross incompetence, like someone has done something really dangerous, then we might actually… I mean I'm bound to inform the board.

If it's someone for example that's outside our service that for instance has done something I think that is grossly problematic, say I've received a referral for someone and I can see that that psychologist has really worked incompetently, then I might refer that to the board as well.

Q: Do you think there's room for feedback from the patients or clients and then a follow-up? Would that show competence?

A: We should always be getting feedback from our service users.

Q: Is that a standard thing? Do they because I could imagine a lot don't and particularly the ones that have had a good experience often don't?

A: We're getting actually smarter at doing that. I actually ask at the end of all my sessions, and it's not particularly scientific, but I do ask was it worthwhile coming today? Did you get what you needed? There are measures, like for instance Scott Miller has a whole lot of measures around whether people are actually getting what they came for. I think we're more and more focussed on having consumer feedback and being responsive to feedback, although in saying that sometimes what people want us to do and what we need to do if someone is very unwell might be two different things, so I guess we need to be thoughtful about that.

I'm not there to be my client's friend, quite often I do a lot of exposure and behavioural kind of stuff for people who, for instance, are really, really anxious. If I'm their friend then I'm helping them avoid that, but if I'm a competent psychologist then I actually am encouraging them to deal with it and actually to feel discomfort. So we're not there actually to be people's friend, I think we need to be really clear about that.

Q: I looked at your article in dealing with distress. It was great.

A: I do a lot of that sort of thing. That is not always that people love it, in fact quite often they don't.

Q: They'd be facing demons and things I guess at times.

A: Exactly. I think we need to be thoughtful about that and not just take our competence from the feedback of our clients. That informs it, but it's not the whole question.

Q: It could just be disparity between what they thought they needed or wanted and what's required.

A: Exactly, so that should be part of the information that informs us but not the whole information.

Q: Outside of a high level of competence what would you say are important personal, social and situational factors that may impact or influence competence? So when I'm talking about personal I'm talking about things like your motivation, vitality, energetic state. Situational would be availability of tools, information and supplies and social is leadership, management, social support.

A: Personal factors would be your own state of mind and your own mental health and your own level of burn-out and your own motivation to do the job and your own sense of compassion for other people and your own…

Q: These all require quite a level of self-awareness.

A: Absolutely and your own insight into… I hate that word, insight. Your own understanding of where you're at. You have to be an okay person in order to be able to take on and not be overly affected by other people's trauma. So you have to actually have a sense of your own boundaries and you have to have actually an ability to tolerate distress and good skills in terms of doing that. You have to have really good people skills to get people to tell you what, you know, so there's actually quite a few personal qualities.

What was the second one?

Q: Social, so that's leadership management, social support.

A: You have to have the structure to be able to work, especially in public health services. When you're in private practice I guess you provide your own structure, although you need the room to practise in, you need parking spaces for people to be able to come to you, you need good relationships with people and GPs for example to refer you. You need basic kind of computer skills and all of that stuff so you do need that infrastructure as well.

In a public health service, which is where I work, you also need leadership support, management support, a good space to do your work in, systems that help you in terms of just recording your information. You need a supportive team because actually psychologists probably deal with the most complex, high risk, people. You need the system to support you in working a different way and the length of time that that takes because we don't just give people pills.

You also need enough psychological mindedness through the whole system and our system is very medical model. If there is no psychological mindedness then you're stumped at every point and you actually can't do what you need to do.

Q: What do you mean by that?

A: If for instance you were in a team which will not listen to you where you are actually unable to practice, then it's very hard to demonstrate competency, it's very hard to maintain competency, its very hard not to be affected by that. There are some teams where there is a large influence of taking pills.

Q: The medical model is really…

A: …strong and in our services it is too, but you also need a collegial context. What was the last bit?

Q: The situational, so the availability of tools, information, supplies…

A: Yes you need tests for testing; you need just the same sort of things as every other profession needs. You need the right forms to fill out at the right time and you need your employer to pay for them.

Q: Do you think within that would fit the opportunity to continue learning?

A: Absolutely, so you need continuing development and continuing support.

Q: So support by your team, or whoever you work for.

A: And money.

Q: Yes exactly.

A: You need financing to go to conferences and the really important thing that psychologists need, which actually I cannot get people to understand, is time. You need time to sit and formulate. You need time to look up the literature. You need time to develop treatment plans. You need time to score neuropsych tests. You need time.

Q: Yes, because when else does it happen?

A: Exactly. Actually one of the other things you need is curiosity and openness and a sense of what's right and wrong. It's not just ethics, it's moral, social justice perspective because we could very easily misuse our tools, so you have to have that ethical moral backbone behind it all.

Q: And you have to stick to it I guess, which can be hard as you say with teams that are opposing… because you're the advocate for the patient, although other professionals consider that they are sure…

A: But actually I think we are the best trained, in our services we're the best trained and we're the ones who see the biggest picture.

Q: Yes, so not just focussed on give them medication.

A: Well we're not just focussed on these are the symptoms, it's because we're formulation based and we look at it in a big picture kind of way. We also have skills in not just dealing with service users, we deal with systems, so we actually have skills in that area so we can potentially change whole systems if they're used right. Quite often they're not used right.

Q: No, I can imagine. It is difficult to define competence in a manner that applies to all specialties. This could make assessing competence difficult to achieve. What do you feel are competencies specific to your area of expertise? Do you work with a specific age group?

A: I work in adult mental health, so that's 18 to 65. Not all of my work, but most of my work is with a particular diagnosis, so borderline personality disorder. So the particular competencies that I need are knowledge and training in that particular area, but I think generally psychologists in whatever area need knowledge and training number one in assessment. We are quite often called on for second opinions and we need to be able to distinguish between when something's biological and something isn't. We need to be able to do really good assessment and formulation.

Quite often we're the ones that look at that bigger picture and can do that and we're actually quite often used for that and that includes using psychometrics or whatever other tools we have. What was the question again?

Q: What do you feel are competencies specific to your area of expertise?

A: Okay, so to be able to assess and formulate is really important and to be able to deliver an inherent treatment inherent to the evidence base, not going off on a complete tangent. But have it tailor made for that particular service user, that's one thing that psychologists do that's different from having somebody, a nurse, whatever, who is trained in just standard CBT for example. We are trained in a number of different models and we dance with them, you know? We do pick and mix.

Q: So really tailor-made.

A: Tailor made. Because I'm in a leadership role I also need a very thick hide (laugh) and backbone and courage I think. Any psychologist in a leadership role needs courage to stand up. I think that's really important, courage to question the status quo. I think all psychologists actually need that. To stand up and to allow themselves to be the tall poppy because that's our job in the team.

If we don't do that, if we sit behind and actually… because most of the psychologists… in fact pretty much all the psychologists in mental health for example are clinical psychologists, so they've all had six to seven years of training and all that that brings and we have to be actually okay with that.

Q: Yes, take pride in it.

A: Absolutely but we don't. Not everyone does. We kind of shrink behind and kind of be self-effacing and don't speak up too much because you do get hammered if you do, but we have to be past that.

Q: Yes you do and I think even the psychologists do that to clinical psychologists.

A: Absolutely. Actually we have to just hold our space.

Q: Yes, you've done the work, you've got the knowledge and…

A: You hold the space, exactly, rather than giving in to everybody and actually allowing people who are less competent but end up being on the same pay scale as us and kind of…

Q: They have a bigger voice or whatever.

A: Exactly. That does not do us any good. We've given away far too much.

Q: [27.09] action.

A: Well yes.

Q: It is something that needs to be…

A: Well there's a whole movement in psychology which I'm very much involved in.

Q: For clinical psychologists?

A: No, it's a movement around the future of psychology.

Q: Future initiative?

A: Yes. Have you hear of that?

Q: I have yes.

A: Really? That's interesting. That started from a conversation that I've had with Fiona Howard at Auckland University.

Q: And it's still moving, it's growing?

A: Absolutely, I'm not sure if it's growing but it's moving and it's there but the problem is that people, that psychologists just want to do their work. We're not very political. We need to be political because we will be lost if we're not political because everybody else is claiming our space and they don't do it as well as us and we need to be just proud of that and say well actually, I've got more training in doing this. Sorry, but that's how it is, there you go.

Q: Do the current competencies capture all the characteristics of competence?

A: No.

Q: What do you think they don't capture? What don't they capture?

A: I'd have to actually have them in front of me so I can't really tell you, but I think the personal qualities of leadership and demonstration of… the personal qualities of leadership because actually psychologists should be leading. We've got that much skill and training but we are crap at organising ourselves, total crap.

Q: Why do you think that is? Is it just not cohesive or as you say everybody is just working and they don't want to…

A: It might be also part of the New Zealand psyche frankly. If you look at the APA in the States, that has huge power. It stands up to psychiatry, it has all these different divisions and it has a really strong voice. Look at how the whole world has adopted the APA referencing and look how strong that organisation is and how they have political influence. If you look at the British psych society it's the same thing, they come up against the DSM5 and write articles that are actually picked up and listened to.

Look at New Zealand - we have the Psych Society. We have the clinical college. We're fighting amongst ourselves. We don't want to stand up too much. We're not going to get anywhere until we have some strength somehow, courage, pride. One of the things that we have done is be blancmanged into Allied Health. I don't think that's been helpful. It's not been helpful in terms of competence as well because in terms of the politics of say DHBs which have the majority of the money in terms of health, being under Allied Health tends to make us smaller and because we're peers with other less qualified…

Q: So you have to adopt their…

A: Yes so it kind of turns into a common denominator and that does us no good, no favours at all, and within the hierarchy of the DHBs the leadership and the decision-makers are generally not psychologists.

Q: So really there needs to be a psychologist up there at that point.

A: There are some psychologists coming up in the clinical direction, but usually not in the operational direction and the reason is because of pay. In order for a nurse, social worker in OT to go up into management where you're influential on the way that the service develops you take a pay rise to do that. A psychologist takes a pay drop.

Q: So it's not very encouraging.

A: The system is against us rising up operationally and operationally is where the power is because that's where the money is. So we are rising up in the clinical area, there are lead clinicians who are psychologists, there's an Allied Health director in our DHB that's a psychologist, but they don't have the money. The money is held through the other… and that's… When I sit in meetings with the people that are organising the strategic direction of things there are no other psychologists because it's the managers that do that. I don't know whether that's relevant.

Q: It's all interesting.

A: But it also relates to competence because the expectation is lowered. We've turned into blancmange and so therefore we have to set our standards and hold our standards, rather than other people who set lower standards because we're Allied Health and therefore we can fill in just the same as a social worker can fill in and that's actually not how it works, but that's actually a fight I'm having right now. Those sorts of things make a really big difference and having the people who are in power to decide that not be psychologists makes a difference too in terms of their competencies that they expect, job descriptions that they write, all of that.

Q: What part should the board play then?

A: I think the board actually walks a tightrope. They walk a tightrope between the political system and all of the stuff that I've been talking about because that exists up there and being a strong voice and advocate because their role is not to be an advocate for psychology, their role is protection, so the health and whatever competency act. That's their role, which actually makes it difficult. I'm not sure that the board has a role, but I think if we were all united into one voice society or one voice clinical…

Q: Numbers.

A: Absolutely or some political organisation that has strength, that would be helpful.

Q: Do you think though that maybe people who are part of something like that might be ostracised?

A: Part of?

Q: A group like that. Sort of trying to give a bigger voice to psychologists. It's like a movement.

A: With the future of psychology that hasn't actually happened that I'm aware of, except that there's a general tendency and I think that this is more rather than being psychologists I think this is a New Zealand culture and I think we're lost until that changes.

Q: You could be right and that could be quite a bit further down the track.

How do you define cultural competence?

A: Actually probably having an understanding that not everyone thinks the way that you do and that other cultures have different norms, ways of thinking, expectations etc. My definition is probably wider than… probably quite a wide definition.

Having a cultural competence also involves having a knowledge of a broad knowledge of the main other cultures that you're dealing with, number one, but number two who to call if you don't. Knowing when you don't know.

Q: That's the important thing - knowing when you don't know and what to do about it.

A: Yes. I think that actually goes through all the competence. It's not bluffing, it's knowing when you don't know about something and either going to look it up, asking for help, getting supervision, doing what you need to do to get that knowledge or to have an expert advise you.

Whether that's culture, a particular diagnosis, anything else, it's the same thing.

Q: That's a competent practitioner.

A: Yes.

Q: What part does supervision play in ensuring competent practise?

A: It could play no part or it could play the whole part. It depends on how the practitioner uses it because supervision does not require, the kind of supervision that psychologists understand, does not require that you present everything to the supervisor so you can cherry pick and you could hide your competence in front of a supervisor really easily. So I'm not sure that it does, it only gives you competence if you use it in a way…

Q: That it was meant to be used.

A: Exactly but there's no measure of that. With the board's competency framework you could do all of that…

Q: And never have the difficult ones come to light.

A: No, you could be doing crap, but we've put in another layer of that so we don't just rely on people's clinical supervisor, we have professional supervisors for our services. I have eight professional supervisors who don't do the kind of traditional supervision, but they do the auditing and they do the mentoring and they do the sitting in the same service and hearing what the psychologist says and all of that bit.

Q: So there would be someone coming in and observe at times?

A: We could do that but usually it's a designated position of someone who usually is in the same team or in the same service. We know very well who works well and who doesn't.

Q: So it's covered fairly well then within the DHB.

A: It's covered within our DHB. Not every DHB, but within our DHB we try and cover that, but that's just relatively recently. I don't think the board structure covers it, which is why we needed that. I'm not quite sure how the board could do that either because it doesn't have enough resources to be able to do that in any case. They would have to send auditors out and know how to audit everything, they would have to develop tools for every different area, it just would actually be quite… or you have such lose categories that it's kind of not meaningful.

Q: It wouldn't be caught.

A: So I don't know how they'd do that.

Q: I must have a look at see in other countries what they do.

Do the characteristics of competence take into account all the phases of the professional lifespan from the new graduate to retirement?

A: No. Well yes and no. One would expect growing… well there's evidence to show that when people are new grads and they know the latest evidence that are actually within the first two to five years, you're actually the most competent that you are through your whole career. People who have been around for 30 years like me who haven't had training for years and years and are completely outside the evidence base and haven't maintained things can be far less competent than an intern who is just out of university, so it's quite a variable thing.

Q: Is there anything that could be done to ensure better competence throughout the lifespan?

A: I think the idea of having continuous learning that actually the board already has is actually I think pretty much one of the few things you can do.

Q: Is that sufficient?

A: You've got to think whether you want a police state as well.

Q: So told you have to do so many…

A: No, being so watched that there's no room for innovation, that there's no room for trialling things out, that there's no room for difference of opinion. Psychology is full of different models. I practice within the evidence base that I use and someone who has a psychoanalytic training might be totally different. How would you marry all of that up? I can't see how you would do it.

Q: So really it's on yourself to be a continuous learner and being up to date with the latest and that's again time.

A: Yes, that's again time, opportunity. We have people who have huge caseloads and are just kind of trying to…

Q: Just keep on top of that.

A: And then all the other things that the board requires; and then all the other things that the DHB requires. You also don't want burnt-out people. If it's such a policed workforce then we will lose because psychology is a science but it's also an art. We'll lose the art of it. You need some flexibility in that so I'm not quite sure how you'd solve that problem. I don't have to come up with all the answers (laugh).

Q: No you don't (laugh). What part does self-reflection play in being a competent psychologist?

A: Actually I think we're crap at self-reflection. I think we really are. We're really good at reflecting in our clients and formulating and figuring stuff out, but training and self-reflection is very variable and crap.

Q: So the training itself isn't sufficient…

A: Doesn't prepare you to be doing self-reflection. The board puts in their competency thing that whole thing on self-reflection. What? How do you do that? How do you do that when you're kind of scientifically trained and we have no skill in self-reflection I don't think (laugh). Well, some people do depending also on their tradition, but people like for instance who are trained in a CBT, self-reflection, nah (laugh). We don't know about that. That is the biggest stumbling block in doing that stupid document. People hate self-reflection. I hate doing the self-reflection bit. I don't think I have it right and I don't think that anybody knows how to do that. It's a complete waste of time.

Q: Do you think there should be a formula around it?

A: I think it has to start with the training. We have to be trained in how to do self-reflection. Is that a thing that the psychologists should do or have we just adopted that from social workers? Although I think you do need to have the capacities to reflect on yourself but I don't think we're trained in doing that.

Q: Would it be enough to do self-reflection with your supervisor?

A: That's what we're supposed to do, but I think that hugely varies. I am sure the board, actually their idea of what self-reflection, my idea and anybody else's idea would be totally different because actually none of us… it's not part of our training. I never did a paper on self-reflection. I had to look at evidence based scientist practitioner, all that kind of stuff, you have to be good academically and do paper A, B and C, and I guess you have to reflect on yourself enough to be able to do those things, enough to be able to not burn out, enough to be able to bring things to supervision and reflect on your case.

We're good at reflecting on our case, that's what we're trained to do, we're good at formulating what are the factors, being the Sherlock Holmes of the mental health world, actually even in physical health we're the Sherlock Holmes. But reflecting on yourself? Who taught you to do that? No idea about that. That's the thing that I'm sure, in all your interviews, that's the thing that people hate the most of the CCP. The people I supervise, myself, hate it. Complete waste of time because you just write stuff down in order to pass and get the bit of paper in.

Q: In one hit - got to get this done. That's been the common thread.

A: Yes what is self-reflection? It's bollocks. Sorry (laugh).

[End of recording 48.00]

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Q: To begin with, tell me what does competency mean to you in a general sense?

A: In a general sense basically the ability to demonstrate a set of skills, knowledge, attitudes in one's professional practice and establish them.

Q: When you are using these in a professional practice, what do you think of then when you're considering competence, as opposed to a general idea or more specific with you in practice?

A: In practice we look specifically at the prescribed set of competencies that the board has prescribed, and look for evidence that in fact those are being translated into day-to-day activities of psychologists.

Q: If you suspected that someone wasn't practicing competently, are there a standard of steps to ensure competency, that that would be picked up?

A: I would discuss any grave concern or something like that. [01.43] the legislative considerations and the [01.49] considerations. Fortunately the current legislation [01.54] in terms of competence leaves it to the discretion of a practitioner as to whether they do or don't report competence issues. A health practitioner may or [02.08] report competence issues with another practitioner [02.12] where you're obliged to do so.

Ethically the first approach should always be to the other practitioner if they're a colleague. There must be some good reason why not, if there's some history or circumstance that means it's going to go badly, then ethically what you do and what I would ask you to do, if I'm that close that I can see the history [02.40] maybe through the client or something, I [02.47]. It may be through discussion [02.59] or maybe through discussion [03.01] oh you're right, I didn't see it that way, you're right, I'm wrong. If we can't get anywhere with [03.05] would you be willing to have a conversation with your supervisor about this or your line manager or somebody so that I can just be reassured that you have somebody else who has had some input.

Very occasionally it can go so far as sit down with your supervisor and your advice provider so we can have a conversation. If I just get a flat no, there's nothing wrong and I'm still concerned, then I have the back up and consider [03.34]. One of my options, and without knowing the circumstances of how it came to my attention [03.42] but again starting with the least obtrusive, least aversive sort of approach building up to the most serious thing which would be reporting to the [03.55].

Q: What do you see as priorities in competence. We're not talking specifically about the core competencies, but competency in practice for a practitioner in practice.

A: I guess you can't avoid [04.23] because it's got to be very basic things, getting the relationship right, getting the opening right, getting the closing right, getting things like informed consent right, those very basic things that establish a safe place for the relationship to happen. [04.44] my background in clinical psychology I work with clients, but I'm aware in those role now that there's other kinds of psychologists so what I'm saying may not fit for an IO psychologist [04.58] but the very basics are probably still largely, but the main thing and we see this all the time with the complaints we get, with the competence applications we get.

It's not the complicated stuff that goes wrong, the higher level, professionally testing for something or whatever, it's the basic stuff. They didn't get it right at the beginning, they didn't explain the limits of confidentiality, they didn't explain why they had chosen this therapy over that therapy. They haven't properly outlined some aspect of the process and the client was caught off guard and surprised and disappointed and doesn't know what else to do. Get those basics right and 99 per cent of the time things are going to go well.

The second layer then is make sure you know your stuff, which is know how to properly assess the situation, make sure you know what the range of [05.56] are. It makes me bonkers when a psychologist only has one tool in their toolkit. It doesn't matter what the client [06.04] ready, you need to have that. Also knowing the limit of your own abilities, you know what? This problem actually fits better [06.16] and I don't know how to do that so I'm going to refer you on to somebody else.

Q: You were talking about the basics fitting the different scopes of psychology; do you feel that there are specific competencies for the different scopes?

A: There are and in fact we've prescribed some.

Q: For the clinical and the educational.

A: Clinical, educational and counselling so far. We're on the cusp of…

Q: Neuropsych?

A: …looking at neuropsych and that will be an interesting one. [06.50] counselling has some [06.52] educational.

Q: They fit in all of them.

A: Yes, [06.57] we believe that those, that the psychologist competencies, competences, as I've been trained by my international project colleagues to use, fit with every kind of psychologist, but a clinical psychologist will have some additional [07.16]. They'll have some in common but there are some that are unique and the same goes on for [07.22]. We haven't

created scopes for those, we haven't prescribed those additional competences, because we've taken the approach as we are going to do the core areas of practice, if other branches thought that they have an argument why their scope should also be prescribed and that means they've got to show that their branch poses some unique risk to the public not properly controlled, then we're just going to leave it and we're going to leave it all within the [07.59].

Q: Neuropsychs are now moving forward with that.

A: Yes they're going to push forward and there's some interesting ripples happening there but on the face of it and we're largely seeing the first round of consultation and on the face of it everybody agrees that they do pose a particular risk to the population [08.20] can be done poorly, can be misused, a diagnosis [08.25] impact people their entire lives [08.28] particularly a lot of it is done under [08.29]. If you get it wrong [08.33] it's particularly risky.

So the answer to your question is I think there are certainly competencies that are unique to the profession.

Q: Do you feel it's enough to just demonstrate the basics of competence to be considered competent?

A: If you can, and again this comes from my [09.11] role, if you can show that you are demonstrating the core competencies as we have prescribed them, then yes you are competent. If however you are going beyond that, so if you've set up as some sort of a specialist doing the specialist part incompetently then you're incompetent. You may be a competent psychologist, but you are not a competent whatever, neuropsychologist or whatever it might be. It's important to make those distinctions because again where a psychologist can get in trouble a lot of the time, is when they push past that boundary into new areas sometimes because of just general interest, sometimes it's a monetary thing, sometimes… like I used to practice in Canada in a very rural area and I was the only psychologist for hundreds of miles around.

People said couldn't you do this and I had to learn to say no I can't. I know some psychologists can do that, but I can't. That's where you get into trouble when you say I could try that, and you may not have the proper education or supervision or whatever.

[10.22] competence in the culture generally because you're not paying attention to your [10.27].

Q: If in a scenario like that where you're branching out into another area, is it enough for them to attend a conference or a workshop and would that be enough to make them competent in specific areas?

A: It entirely depends on what it is. If it's a very simple technique… say it's a new test, you could go to a conference, you could go to a one day workshop and come away with enough that you could competently get started. You probably should still have some ongoing specialist supervision around it for the next little while, but some stuff you can pick up quite quickly. Other things not probably like neuropsychology. There's lots of clinical psychologist who have maybe a half course or something in some neuropsyh stuff, should they be practicing as neuropsychologist? No. You're going to do basic training, yes, but if they want to take that next step up and actually be doing specialist assessments [11.26] they're not going to get away with a single workshop or a conference. They're going to go and do university papers and be working on that kind of [11.35].

Q: Presumably ACC would require that.

A: It's going to be interesting to see what ACC does around if we…

Q: Yes.

A: It will depend on the nuances of the scope being prescribed.

Q: Right, it will too. It might change things a bit. What part does self-reflective review play in competence?

A: Huge. You're familiar with our continuing competence programme?

Q: Yes.

A: It's the foundation stone of our programme. All of the research that we've looked at shows that just going to courses, earning points, reading books basically makes no difference to peoples competence. What will make the difference is if they do an actual bit of self-reflection with some external input and guidance, because we can't buy in to our own gaps and that sort of thing and then more deliberately go about saying okay so I've identified these areas of weakness, these areas of growth, then address those. This is how I'm going to deal with it and then do a bit more reflection at the end and see what difference it has made.

So self-reflection, proper self-reflection, is just not going to happen so it's got to be [12.53] and not just self-reflection but self-reflection with some sort of knowledgeable other in the process at some stage.

Q: So a little bit more than self-reflection, that's involving somebody else?

A: Yes.

Q: That is a core part of the continuing [13.10] programme.

A: My colleague, he's my psychology advisor down the hall here, and he did a lot of the research being setting up the CCP and one of the interesting bits he found, and I'm not going to get the names right but it will be in our CCP online, shows that those who are objectively the most competent are the harshest on themselves in terms of self-reflection and actually see more gaps and so on than there probably are. The opposite is true, those who are productively the least competent can be the ones that most rate their competence and say they're the most competent. Hence the need for that external set of eyes to help people balance.

Q: Do you think it's a lack of insight or do you think it's a form of covering up?

A: A combination of things, right down to ego and training and saying I know this stuff [14.12].

Q: And personality because some people are much more critical on themselves and others just…

A: They do things a bit lightly and [14.18] whereas the people who always think oh I don't know if I've got this [14.24]. It's a really interesting point I think.

Q: Do you think that self-reflection should be an ongoing thing, as in from the beginning of the year you're doing it at set periods of time, rather than sort of [14.44] or just send it off or whatever?

A: Absolutely and we unfortunately see that when we do our audit at the end of year. It's sometimes quite apparent that they dip a little bit at the beginning maybe and at the end they're gone, oh crap I'm being audited, so I'd better show this stuff… which doesn't mean they necessarily…

Q: No.

A: It's just they haven't written it down or they haven't documented it and they haven't properly followed that process. But for some it also means [15.14]. We've had one guy who was audited the first or second year I think and his entire response was, "Yeah, I've done my review, I'm fine, I'm strong in all areas. I don't need to do anything." One of the things I love about in the psychology profession is its culture of supervision and part of that is having another person, but a big part of that is about force yourself to sit down in a couple of weeks and self-reflect in the presence of another.

Hopefully even that's not all people are doing. Hopefully, as I did in my practice, at the end of each session with a client I have a sit and I have a bit of a think and I read the notes and I say what does this mean about where they were, where they are, where are we going, and you document all that and how did I do in there and how am I doing today? That sort of thing should always be part of that.

Q: Outside of a high level of competence is going to be a lot of factors that influence your competence on a daily basis or weekly basis. What sort of situational or personal factors may impact that?

A: You mean how's the driving today? What's happening with my daughter? Is my wife mad at me? Is the dog okay?

Q: Yes, on a personal level and then…

A: Do I like this client or does this client piss me off? [16.54] do it alone personal factors.

Q: And administration I guess and all of the things that go with that.

A: [17.05] thinking about [17.07] your mood, my mood, all [17.11] on effort and…

Q: Yes, that's going to impact on your competence to…

A: It's not going to change [17.20], it's not going to change your skill, you're still as you were, but…

Q: [17.25]

A: Yes and that third part of it, that's why the very first question you asked around where there's competence, the ability to demonstrate skills and knowledge and so on. It's not just about holding them, it's about being able to demonstrate them and that's every time out of the gate, you've got to be able to do that.

Q: I guess that the way we're taught psychology at university, it's just knowledge and skills in here basically…

A: Until you get to…

Q: Until you go to clinical and not many get into clinical, so get that far.

A: When you say clinical, I would hope to see an example in an IO programme or a health psychology programme.

Q: Once they've finished their undergraduate degree and maybe got their masters it's just they've not done any…

A: Some will do some [18.20], not all.

Q: Not all so then you're out…

A: But you're not a psychologist.

Q: No, not a psychologist, but for 12 months you're under supervision for a number of hours.

A: Is your background in Australia? So the first thing [18.36] it's different here. Unless you do the university-based programme, a postgraduate diploma or a d.clin.psych or get into one of our two accredited agencies, you don't ever get to be a psychologist. You can't just do your supervised practice in Australia. It's one of our…

Q: There was a letter from you recently that was to the Australian… well not recent, but it was a letter that you wrote to the Australian Board regarding that, the differences because they were looking I think at reviewing…

A: Yes, I was actually over there in December at a meeting with their HODs and association and everybody came into [19.16].

Q: It would be good if it lined up with New Zealand.

A: Well we're heading in that direction. Everybody is heading to [19.25] international [19.27].

Q: Is the current method of measuring competence sufficient?

A: It's a broad question because you do it at different times. The first time a psychologist's confidence is well and truly tested is at that final stage of training, written exam, oral exam, all that kind of stuff. I think they do a pretty good job, certainly the programmes we accredit here in New Zealand I think do a very thorough job around that process. So is that proficient? Yes.

If you then hit a spot at some point in your career thereafter where your competence is brought into question and the board has to do a competence review, I'm pretty confident we've got that right as well. It's not ideal because strangers show up and they'll start asking questions and looking at your files and so on, but we try and make sure it's not a rushed process, that it's a collaborative process. They're here to learn together and collaborate with the practice [20.46] self-identify with [20.47]. Is that a sufficient process? I think it is. Could it be better? I think it could be.

The other thing that's already being talked about at the international project is stage 2. Stage 2 is okay, we've identified these poor competencies for professional practice but how are we going to assess them and that's going to be the next big project I think. I'm very, very interested in where that's headed. Assessing competence isn't my area of expertise, I'm not even sure who it is in academia and so on in this area is, but I'm really looking forward to talking to someone and finding out what is the cutting edge now in terms of assessing competence.

Americans are already talking about another multiple-choice exam to determine competence. I have initial serious doubts of the ability of a multiple-choice exam to assess competence. Some domains of competence okay, but for all…

Q: No.

A: …competence, I just don't know. Other professions, I think nurses now in Alberta have developed interactive scenarios on computers and you go in and there's your client and you start talking to him and all that kind of stuff.

Q: That's a step up.

A: Exactly, [22.20] go through and do all that. Yellow Quays in California have similar, huge money on these simulations, online simulations and of course doctors for years have been doing, having actors. I think those things make a lot more sense to me. They still have some weakness and some studies show that they're inconsistent depending on who the players are on the day and all that kind of stuff.

So I'm very interested to see how the next part of this project goes and see what can we do better because if we're going to start re-examining the qualification system we have because the problem right now is United States you've got to have PhD [23.01], Australia [23.06] and Mexico is something different and now you've got the Euro side, Euro and so forth. The [23.16] and no one is actually looking, no one is looking beneath the surface to see what… what core competencies have actually been imparted. No matter what the [23.30] of the course is what have they covered?

Q: Yes and that's something everybody should have.

A: [23.36] of competencies and then ideally people will start to move to saying well our training, we can certify that it provides [23.54] and that will start to become the benchmark. So it won't matter whether it's about whether you're a doctor, a nurse or…

Q: Or what university you're at.

A: Yes, it will probably still have to be some sort of an accreditation system or a training that says yes in fact they have [24.10] but the title won't matter any more. That's a huge change. The Americans are scared to death of losing their PhD, but they're open to it and it will be interesting to see where it goes. I think countries like New Zealand are well placed because we do sort of have that [24.31]. I don't think we're doing more than we need to do.

Q: Is what you're saying accepted in New Zealand?

A: I think most of the people I deal with regularly in New Zealand think we've got it great. There are increasingly vocal protests from particularly Maoridom saying this model doesn't fit us. In fact your core competencies don't fit us. We want to come up with our own kaupapa Maori [25.17]. Well train our own people. We will train our own people, we'll [25.20] people and they'll be Maori psychologists. I've been working and gradually [25.27] for some years when I was a member of the board in early 2000 that was already growing quickly. It's gone quiet again now but just recently one of my colleagues on the working group national project is [25.42] and he works with the kaupapa Maori research unit there and I hear it's starting now to [25.53] some of the stuff. So it will be interesting to see people who have a different ideas as to whether what we're doing is adequate and right or not.

Q: Presumably the core competencies would be the same regardless of… like culturally they would be the same across the board.

A: I think the cultural competencies will probably be the same, but it's the skills and the knowledge that will be different. They are quite clear, in fact some of the stuff in the early 2000's were saying we'll toss the western model entirely and start over again. It's not about clients, it's not about [26.36], it's about [26.40]. Those of us seeped in the western tradition will have a hard time letting go of that stuff [26.49] and that's what makes us different, but psychotherapists [26.54].

Q: Then we come to cultural competence with specific regard towards Maori and you see the potential for harm with the current form of competence.

A: Around a client?

Q: Yes.

A: Again I am not expert in that. When I first came to New Zealand I worked about 80 per cent of my caseload was Maori. One of the things I learned is a Maori is not a Maori and I was working with youth in a clinic from 14 to 21 and they were vastly different from one another in terms of their connection with the culture, in terms of whether or not they were well connected, in terms of how they interpreted it in their own life and how they wanted it dealt with. So if some right up front came in with somebody else and I'll be involved, I'll be speaking, I'll be doing this and doing that, great. We had cultural support come in and join us and [28.27] and so on. But others, and I think you could say the majority, were coming in and say I don't care what the cultural model is, I'm a teenager and I want this private and I want you to ensure me that this is going to be private, which of course I would happily do [28.46] confidentiality. Was that culturally unsafe for them? I don't think so.

I think they were given a clear choice and options and freedom to make that choice. To me [29.03] even when we start to talk in these more

modern terms about people's culture, it quickly breaks down because Evil Knievel, what's my culture? Is it Canadian, is it Kiwi, is it white, is it something else because I've got some other background, is it rich, is it poor, is it gay, is it straight, is it how many different things? So how can you go up to a person in the street and say you must be from this country. [29.37].

Cultural safety for me is about dealing with the individual and being open to what they bring and who they are and not imposing all your own crap on them. So is our approach to psychology dangerous for them? Not if it's done right because if it's done right you do give them that freedom and you do have those conversations and you would hopefully recognise very promptly the first thing, this western model that you're bringing and the CBT that you're thinking you're doing with me or whatever it might be doesn't fit for me. I actually want to have a more spiritual aspect, I want to have more of this, and I again confidentially say well okay we can either carry on with this and bring somebody else to help with those parts, or I can refer you on to my colleague who does that kind of [30.30].

I think done right [30.38] unsafe. What I would worry about is that new system coming in, if it comes in, kaupapa Maori, any new system tends to be a bit rigid [30.54] done this way and this is the way we see it. You've got to be careful with that [30.59] if it's more about processes and so on.

Q: People can be caught between the two cultures. The young people get identified more with western, but have been…

A: Yes, I was fortunate to work with a lot of Maori psychologists over the years who have often times been exactly that, been caught between the two, their training and their university and their old friends from university tend to be Pakeha. Now they're in Rotorua and they're working with their own people again and they're realising some of the stuff doesn't fit and it doesn't work. How am I going to balance that? How can I be in tune to this [31.40] but also to my people? If it's a struggle that means you're thinking about it [31.50] and you're probably going to be thinking about it so you [31.53].

Q: Yes, if it will work today it will work tomorrow.

The characteristics of competence. Do you feel that they take into account all the professional lifespan, say from new graduate to a practitioner of 30 years to someone close to retirement? I'm looking at it say from the view of someone close to retirement who supervises, might have already retired, they're at the end of their [32.31] but they still require supervision and then you have the new graduates down here. Do the competencies or does competence fit all of the lifespan?

A: I think it does, the core competencies. If you have got the core [32.44] that is lifelong. Again that's where in my [32.53] is about core competencies or basic competence. Do I want psychologists to go beyond that? Absolutely. I hope they will and I think they should [33.03] leadership roles or more specialised roles they need to go [33.07] but my job is just to make sure they've got that core and that they're safe. It's interesting, every profession in the world seems to recognise that a new skill is coming out needs additional support and needs that additional supervision for a while to get themselves settled and sorted and bed down all the skills they've actually learned and that's great. We get very few complaints against brand new practice.

As we move into mid-career people the complaint numbers start to rise. The people that are most commonly complained about, we've still got a lot of work to do around our numbers and our research, but the one that's most commonly complained against are those who have started to slip away from the profession. They've gotten themselves isolated, either geographically or just in terms of not having supervision, not going to conferences or not being connected to other psychologists.

By late career it's a bit of what you've described, people are thinking I've been there, I've done it all, I don't really need supervision and they become isolated through that mechanism or they've lost the interest or the energy for staying up to date with the latest stuff, so they're still applying things that [34.24] or some years ago [34.27]. So we start getting more and complaints about them [34.33].

If they all maintained the core competencies throughout their career, which means staying in touch with the profession, staying in supervision and so on, I think they probably wouldn't get into trouble.

Q: So you've said you feel self-reflection was the underpinning. What would be next?

A: Well the self-reflection is not a [35.03], a desire, a willingness, a motivation to do something with what you've learned through your self-reflection. It's one thing to identify an issue but if you think that's interesting and carry on it's not going to do you much… so that's drive to continue to be competent, to continue to be professional. I think [35.33] and that starts getting into the ethics and so on. I think generally the profession is a highly ethical profession. There's bad apples in every profession.

So core competencies. I see the code of ethics standing right alongside that and you can't really have one without the other and you've got to not just see the code of ethics as a real good old read sometimes [36.03] a part of everyday practice. Again it might be [36.11] a bit of both of those but staying connected is proving to be more and more important in one way or another, despite what your circumstances might be. You might have taken a job on the west coast of the South Island you're the only

psychologist around for miles, but that means you've got to put in a little extra effort to maintain those connections and do that extra work.

It is I guess the life long learning kind of thing, which ties back into the drive. It's an ever-changing process, there's some things that don't change, but there's a lot that does. I think that's one of the things that for me, I've practiced for 20 years and for me it's one of the things that made it such a rewarding career was learning something. If I wasn't going to a conference or reading a book or a journal article I was learning something from my clients. Every day [37.05] and never fail to keep me interested, but you've got to have that interest in that sort of learning. If you're not open to it then you're probably [37.16] into the profession.

Q: So you're not practicing at the moment? This is full-time for you on the board?

A: Yes. I started practicing in 2006 and it for ten years.

Q: I think that's pretty much all. We've covered along the way most of what I've needed to ask. Is there anything you would like to add?

A: I don't think so. If you think of something you should or would have asked feel free, you've got my number.

[End of transcript]

170319_0037

Q: In a general sense what does competence mean to you?

A: The ability to do a job well, have the skills, knowledge and capability to do the job well.

Q: As a psychologist what things do you think of when considering competent practise? So that definition of competence, but how do you use that when you're acting as a psychologist?

A: Well the core competencies of a psychologist are having adequate knowledge and doing research to make sure that you've got up-to-date knowledge about skills. Sorry what was the question again?

Q: As a psychologist what things do you think of when considering competent practise? Is it like using the competencies as a guideline to be competent?

A: Yes, using them as a guideline so that you can practise professionally and ethically and keeping within the boundaries of the law and being competent to communicate.

Q: So it's building that relationship.

A: Yes building a relationship and communicating what you're wanting to do and communicating the knowledge that you have in an effective way. Also I guess too you have to have adequate supervision to make sure that you are acting ethically and professionally and are keeping up to date with your own development, personal development, continuing competence.

Q: So that's maintaining your knowledge?

A: Yes, maintaining and continually building on it.

Q: How do you do that?

A: I generally will look at doing some sort of short course most years. This year I've done one on developing mindfulness in a strength-based coaching way. Attending conferences, conferences are always a really good way to keep up with the most recent research and what people are finding is working or isn't working. Also peer supervision as well as regular supervision with professional supervision. Peer supervision is always good.

Q: So that's getting feedback?

A: Discussing relevant issues with your peers in the industry yes.

Q: Is there anything that you see as a priority that a competent psychologist should have?

A: A priority? Well I think all the core competencies are important. I don't think that they operate independently; you can't have one and not the others. You have to be professional, ethical, have to be operating within the boundaries of the law. You need to be getting regular supervision; you need to be keeping your knowledge up to date. You need to be communicating well, all of those things. They don't operate in isolation.

Q: How do you know if someone is lacking in competence? What could you tell by their practise or what are signs or red flags that may make you think that there's incompetent practise happening?

A: I guess it's situation-specific. There might be like, boundaries is a big issue around keeping confidentiality around clients. If somebody was talking about their client or who they were seeing then they shouldn't be identifying people, that would be a cause for concern. What other sort of things do you mean?

Q: What about people that might work outside their area of expertise?

A: That's always a concern. That's an area of competence isn't it? That's one of the things, that's one of the Code of Ethics, you don't operate outside of your area of knowledge and expertise. I think there are people that would do that. You wouldn't want an IO psych providing clinical psych help. It's okay to identify and then refer, but to take on that yourself would be very unethical. It would be very dangerous for the client.

Q: Can competence be measured?

A: I don't know. To some degree it's subjective. There's certainly standards that you have to measure up to, so to some degree it can be.

Q: So the board's guidelines would be…

A: And the continuing confidence programmes to make sure that people are developing themselves and doing what they say they're going to do to develop themselves and meeting the standards, the ethical standards.

Q: What about outcome based measurements?

A: For competence?

Q: Yes.

A: I guess for an IO psych you've got the framing measuring and planning, so if you're framing up a situation and planning it you need to measure whether it's working or not and if you continue to do things that aren't

working then that wouldn't be very competent. There's always a bit of trial and error and people are different and so not everybody is going to respond the same way, but it would be incompetent to just have a set way of doing things regardless of whether you were getting any results.

Q: Outside of a high level of competence, what would you say are important to personal, social, situational factors that may impact or influence competence? I'm thinking personal factors; motivational things that might be going on in your life or that might affect competence. Situational, people that work for the DHBs may have ready access to tests and measurements and those sorts of things that someone in private practise might not. Does that mean there's different levels of competence - and social support?

A: That's not necessarily competence if they've got access, they might be more developed but not necessarily… as long as the person that doesn't have access isn't trying to use them without…

Q: Experience or knowing…

A: Yes. Sorry can you repeat the question?

Q: It's to do with personal, social and situational factors that might affect being a competent practitioner.

A: Yes if you get overloaded at home or at work, things like good record keeping can slide and you might not be doing the job to the standard professionally… that would be a danger. Discipline is another competency so that's an area that could slide. Is that the sort of thing you're meaning, situational pressures?

Q: Yes absolutely.

A: There's also pressures… I don't know if this is relevant but if you go into a workplace and they've hired you to see somebody and if you don't make it clear at the beginning what the boundaries are around who owns the information, I mean you need to be really competent around setting boundaries, otherwise you find yourself in some quite sticky situations where the employer might be wanting information that you've told the client that you won't give the employer. Is that the sort of thing you mean?

Q: Yes.

A: That sort of thing can put pressure on both relationships and that's where it's really important to have good supervision so that you make sure that you deal with that sort of situation well.

Q: Talking about supervision, what part does that play in competence?

A: Your supervisor should be somebody that's competent… well I prefer to have somebody who is confident in my particular area of practise. Different people have supervisors for different things. I have a couple of supervisors for different areas that I'm working in so that I'm making sure I'm getting the knowledge, the expert knowledge, in specific areas.

Supervisors generally have a lot more experience but they can hold you accountable or point things out that you hadn't considered might need to be done differently, or just act as a sounding board so that you can talk it through yourself to make sure that you… It builds your competence because it builds your confidence I think if you've got somebody that you respect that you can talk about professional issues with.

Q: Is it difficult to define competence in a manner that applies to all specialities and do you think there are competencies specific to your area of expertise as opposed to say a clinical psychologist or an educational psychologist?

A: They're very different areas. Clinical psychs tend to want to move into area of IO psychs more than IO psychs can more into clinical psych. Educational psych is different again. I think we've all got a broad knowledge of everybody's speciality.

Q: Are there specific competencies that are relevant to each speciality?

A: I don't know. The knowledge skills and research is very different for each scope isn't it but that's a competency, so that's not a different competency, it's just the content of that competency is different.

Q: So the general idea of competence applies to everything but do you feel they are all under one umbrella, or are there specific competencies for each scope?

A: I don't know because then you think about you'd behave differently, you have to relate to different people in the competencies, but that still just comes under the umbrella of professional practise. So the competency is professional, it's just the actual area is different, but the competency is the same. I don't know - it's not something I've given much thought to. I mean the privacy issues are the same; the legal aspects are the same. Not that I can think of, I think it's just the content of the competencies.

Q: So overarching it's the same for all of them.

How do you define cultural competence?

[End of recording 12.29]

170319_0038

A: I define cultural competence as having awareness of cultural diversity but at the same time recognising my own culture and what I bring to the situation. So having an ability to adapt the way I work and being culturally sensitive at the same time, so always checking the perceptions and the attitudes, so making sure that I can bring the skills needed to achieve.

It's having the awareness of the cultural diversity and just being able to function effectively within that diversity.

Q: Yes and acknowledging your own…

A: While acknowledging my own culture and recognising the impact that has on the situation.

Q: If you were in a situation where you felt that culturally you needed some support, what would you do?

A: If I had already identified that I needed the support I would approach cultural advisors to tell them about the situation and get their insight as to how to best proceed.

Q: We talked about supervision and what part it played in ensuring competent practise. What about self-reflection, what part does that play in competence?

A: It's really important because you need to be reflective. You're not going to develop if you don't take time to stop and look at situations and think about what happened and what you could have done differently and then make plans… it's part of the research and knowledge part I guess. You need to be looking at what you're doing all the time and just check in on what's going on so that you can improve and provide the best support.

Q: With the self-reflection, do you practise that daily, frequently, after each situation?

A: It's part of who I am. I regularly, every day, will think through situations, what went well and what didn't go well, what could have been done differently but yes I also write it down and use Ross model of reflection and try and… if it's something that's quite a big thing I'll try and find a chapter or some research around that issue and read up on it.

Q: And supervision would play a part in self-reflection?

A: Yes.

Q: A self-reflection review, a requirement of the board, does that play a part in self-reflection?

A: Yes it keeps it at the forefront of your mind that it's important to do it.

Q: Do the characteristics of competence take into account all the phases of the professional lifespan from the new graduate to those close to retirement?

Here I'm thinking about the support around a new graduate and someone who is coming close to retirement, they may not have any supervisors that are older than them or more experienced so where do they have a pool of supervision from or where do they get supervision? Do you feel it's fairly even all across the board or are there different times where the requirements of competence are different? Should it be tighter around a new graduate than someone that's been practising for 30 years?

A: I think that… I was just thinking about when I said supervision is somebody that's usually more experienced, I'm thinking of people that I know. I think just as long as they're experienced, they don't have to be more experienced. I think they still need supervision even if it's peer supervision and the new graduate should be competent just to practise under those guidelines as well having had a lot of supervision during their registration.

[End of recording 05.26]

170319_0039

Q: Do you think that competence is the same throughout the lifespan and what part does supervision play through that?

A: I think that supervision is important all the way through because you don't want people going off being lone cowboys. If they want to continue to be registered then they need to continue to be meeting the core competencies. I think that if you're going to continue to practise you need to be meeting those core competencies.

Q: We were talking before about recognising someone that's incompetent, practising incompetently, what steps would you take if you recognised that in someone?

A: If I was sure that they were definitely being unethical then I would approach the board with a complaint.

[End of recording 01.12]

170319_0040

Q: If you're aware that someone is practising incompetently what are the steps you would take?

A: I would need to make sure that there was proof and not just hearsay. You don't want to waste the board's time by making a complaint and it's just hearsay, so possibly talk to their superiors or their supervisor and make sure that there was something and then make a complaint to the board. But I think it's just as dangerous to not have it investigated because otherwise rumours can fly around and people's reputations can be damaged unnecessarily.

[End of recording 00.38]