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Service User Views of Clinical Psychologist Competence

A thesis submitted in partial fulfilment of requirements for the degree of

Doctor of Clinical Psychology

At Massey University

Albany, Aotearoa New Zealand

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2023

Abstract

People who engage with mental health services are often not included when developing professional practice guidelines, including clinical psychology core competencies. There is a lack of research regarding how service users view psychologist competence, and service users have never been explicitly involved in generating related competencies. This leads to a limited understanding of whether existing conceptualisations of competence and competencies align with service user views. I aimed to inform current theoretical and practical understandings of competence and competencies by asking what service users identify as competent practice for clinical psychologists (CPs) and how service user views of clinical psychology (CP) competence aligned or contrasted with existing aspects of the New Zealand Psychologist's Board (NZPB) core competencies. I adopted a social constructionist, user-led orientation based on co-production principles. This informed a mixed methods survey ($n = 73$) and individual interviews ($n = 12$) that asked A-NZ adults who had seen CPs for mental health support how they viewed CP competence. Analyses included descriptive statistics for quantitative data, content analysis for the qualitative survey data, and thematic analysis for the qualitative interview data. The analyses were then compared with the existing core competencies. The findings included five main areas that participants highlighted as important for CP competence: Interpersonal Skills and Relational Presence; Responsive Contact; Cultural Responsivity; Mental Health-Related Stigma, Discrimination, Exclusion, and Power (MHSDEP); and Safe Processes and Profession. A major aspect of service user views that contrasted with the NZPB competencies was the area of MHSDEP, especially in reference to power. Service user views of competence inform contemporary conceptualisations of competence and provide information about what is needed to make the current competencies more responsive and fit for purpose. I recommend that service user views be incorporated into the current competencies. It is clear from this study that the views of people with lived experience of mental distress are crucial for informing professional practice processes and guidelines for psychologists and mental health services more widely.

Acknowledgements

Thank you to my amazing supervision team, who provided guidance passionately, critically, and empathically. Thanks to Dr Clifford Van Ommen for being primary supervisor from 2021. For being intuitive and caring, and for the many edits always managed super-fast. Thanks to Associate Professor Joanne Taylor for the long-standing support, identifying my blind spots and eliciting how to get to my best, and the dedication to include people with lived experience in psychology training. Thanks to Dr Miriam Larsen-Barr for being generously available as an external supervisor, providing countless hours of input that I greatly needed, and ensuring service user perspectives are front and centre.

Thanks to Dr John Fitzgerald for being primary supervisor for the first 2.5 years, persevering through challenges with the confidence I could make this work. Thanks to Associate Professor Paul Merrick for being primary supervisor in 2020 with a nurturing approach. Thanks to Robyn Vertongen for the writing support and my cohort for our shared experiences.

Thanks to Dr Pikihuia Pomare, Tatiana, Borni, Marion Maw, James Hita, Mary O'Hagan and others who prefer anonymity for the consultations and valuable feedback. Thanks to Anne Goodman (NZPB) and Claire Jackson (BPS) for the open correspondence and information.

Thanks to World of Difference, Building Bridges Trust Tangata Whai Ora scholarship, Graduate Women NZ North Shore, the NZCCP President's Award, Changing Minds and fellow Rākau Roroa for the tautoko (support) that means so much.

Thanks to the many clinical psychologists who offered generous support and shaped my early lens of clinical psychology practice, especially consultant clinical psychologist Holly Coombes. Thanks to the Massey Centre for Psychology, Louise and Helen, for the interview space and support.

Thanks to the many who helped advertise and recruit and continued to check-in, including and not limited to: FIXATE, Marian Maw; Peerzone, Mary O'Hagan, Lisa Archibald; Emerge; ATLEN; Engage Aotearoa; Changing Minds, Tatiana Hotere, Taimi Allen, Ally, Cate Hennessey; the Rākau Roroa network; University of Otago World of Difference, Tracey Gardiner; The Mind Tribe; Mental Wellness

Matters; BINZ; NZ Mental Health Consumer/Whai Ora Information Sharing, Denise Caltaux; Ember, Dick Downing; Oasis Network Inc; Anxiety NZ; Equip; Werry Workforce Whāraurau; Peer Support network; Mental Health NZ; Voices of Hope; Silverline Otago; The Nutters Club NZ; Hearing Voices Network A-NZ, Adrienne Giacon; Balance Aotearoa, Frank Bristol; ISPS NZ, Aidan and Helen; Mental Health Foundation NZ, Kim Higginson; Mind and Body, Saskia Hawke; Drive Counties Manukau; and “Take it from us”, Planet FM mental health radio, Sheldon Brown.

Thanks to family and friends for the persistent encouragement, including mum, dad, Emily, Amelia, Arlo, Merls, Henri, Jay, Chloe, Aroha, Vanessa, and Cole- let’s go fishing soon. Thanks to the therapists I have seen in the other chair.

A heartfelt thank you to all who have shared their experiences of mental distress with me. You truly shaped this; I hope I listened well enough.

A most important, enduring, grateful, and poignant thank you to all participants and those who shared feedback. I appreciate your generosity, sincerity, and faith in me. I hope you can be proud of this work.

Memoriam

In memory of Shane, never forgotten, and those who passed during my training, Renae, Poppa, Nana, and dear colleague Aimee.

Dedication

This is dedicated to those who move through distress and those who endeavour to walk alongside.

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Abbreviations and Terminology

Abbreviations

A-NZ: Aotearoa, New Zealand. Aotearoa is the Te Reo Māori term for New Zealand, which can be used interchangeably or with New Zealand.

APA: American Psychological Association

BPS: British Psychological Society

CA: Content Analysis

CBT: Cognitive Behaviour Therapy

CCP: Continuing Competence Programme, New Zealand Psychologists Board

CP: Clinical Psychologist

DBT: Dialectical Behaviour Therapy

DPC: Division of Clinical Psychology, British Psychological Society

DSM: Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association

GP: General Practitioner medical doctor

MHSDE: Mental Health-Related Stigma, Discrimination, and Exclusion

MHSDEP: Mental Health-Related Stigma, Discrimination, Exclusion, and Power

MoH: Ministry of Health

NZCCP: New Zealand College of Clinical Psychologists

NZPB: New Zealand Psychologists Board

SDE: Stigma, Discrimination, and Exclusion

SDEP: Stigma, Discrimination, Exclusion, and Power

TA: Thematic Analysis

HPCA Act; The Act: Health Practitioner's Competence Assurance Act

UK: United Kingdom

US; United States: The United States of America

Terminology

This list aims to set out my preferred terms used in this study. Historically, labels have been imposed on people with lived experience of mental distress and their experiences that are stigmatising, demeaning, and disempowering. Given that language influences how

meaning is made, I have strived to use terms that do not perpetuate stigmatisation or disempowerment.

Client: A person who attends or will attend psychology services. I prefer this term to “patient” or “consumer”, as discussed below under “service user”.

Expert by Experience: A person who has experienced mental health challenges and/or mental health services and has valuable expertise due to these experiences.

Intervention: The range of psychological techniques and services applied in partnership with service users. I prefer intervention to “treatment”. This is due to the negative connotations associated with biomedical terminology that can transmit disempowering constructions of mental well-being.

Kaupapa: A Te Reo Māori term that refers to a collective vision, aspiration, and purpose.

Lived experience of mental distress/lived experience: Lived experience of mental health-related challenges. “Person with lived experience” describes a person or people with direct experience of mental distress rather than people with indirect experience, such as family members. Other terms used in A-NZ to describe people with lived experience referenced in this thesis include “tangata whai ora”. When I refer to service users, I mean people with lived experience who have also accessed services for mental well-being.

Mana Whenua: Refers to Māori as the indigenous peoples who hold authority and territorial rights over the land in A-NZ (Moorfield, 2011).

Māoritanga: Māori culture, practices, beliefs, and way of life.

Mātauranga Māori: Māori knowledge and learnings that include traditional Māori concepts of knowledge passed down from Māori ancestors that predate European settlement in A-NZ.

Mental distress: Experience(s) of mental health challenges and associated outcomes. Mental distress is my preferred term instead of “mental illness”, “mentally ill”, and “mental disorder”, as these terms emphasise a biomedical orientation that contrasts with the biopsychosocial lens of psychology. I do not use the term “disorder” in this thesis. For example, when describing diagnoses participants have received, I offer alternative terms to convey the clusters of distress a person has identified experiencing. I endeavour to avoid transmitting stigma by labelling a person or people as “disordered”.

Pākehā: A Te Reo Māori term for A-NZ people of European descent.

Pepeha: An introduction in Te Reo Māori that shares people’s connections with people and places important to them.

Service user: A person with lived experience who has accessed services for mental health-related challenges/mental distress/mental well-being. Service user refers to people who have accessed any mental health services and also refers to people who have accessed psychology services specifically. Service user is recommended by the BPS (2019) and is used in the A-NZ Disability Commissioner Act 1994 and the subsequent Code of Health and Disability Services Consumers’ Rights (Health and Disability Commissioner, 1994). This is a preferred term to provide an alternative to stigmatising, biomedical and outdated terms such as “patient”. I preferred service user to “consumer” as consumer can imply passive receipt of services. The term service user reflects that this study aims for people to comment

on psychology service provision to enhance the services psychologists provide. I use service user interchangeably with client and tangata whai ora.

Tangata whai ora: Te Reo Māori term for a person seeking health, which is preferred to “consumer” (e.g., He Ara Oranga, 2018).

Tau Iwi: A Te Reo Māori term for non-Māori people in A-NZ.

Te Ao Māori: Māori worldview that acknowledges the interconnectedness of all things living and non-living.

Te Reo Māori: Aotearoa New Zealand’s officially recognised indigenous language.

Te Tiriti o Waitangi/Treaty of Waitangi/Te Tiriti: The founding document of A-NZ signed by the British Crown and some Māori Rangatira (chiefs) in 1840 granting British sovereignty. Te Reo Māori and English versions and understandings of Te Tiriti held discrepancies that contribute to inequity and disparities for Māori that continue today. Within healthcare, the principles of Te Tiriti are commonly acknowledged as partnership, participation, and protection.

Te Whare Tapa Whā: A model for understanding Māori Hauora (wellbeing) that includes four cornerstones, taha hinengaro (mind and emotions), taha wairua (spirituality), taha tinana (physical) and taha whānau (family and social connections).

Whakawhanaungatanga/Whanaungatanga: Te Ao Māori processes to establish relationships that prioritise reciprocity and mutual respect.

Whānau: Te Reo Māori term that encompasses family, extended family, and other key people deemed important to a person.

Introduction

In psychology, competence is commonly understood as the knowledge, skills, and attitudes required for adequate practice (BPS, 2017; NZPB, 2017). In Aotearoa New Zealand (A-NZ), the Health Practitioners Competence Assurance Act 2003 (HPCA Act; Ministry of Health, 2019) exists to ensure registered health professionals, including psychologists, practice in a way that protects the public from harm. The HPCA Act requires registered psychologists to be competent as prescribed by the New Zealand Psychologists Board (NZPB) core competencies, which set out minimum requirements for a registered clinical psychologist (NZPB, 2017; 2018a).

Currently, no existing research explores or considers service user views of psychologist competence. Internationally, and in A-NZ, core competencies for psychologists have been developed within the psychology profession without explicit service user consultation. This is despite service users being in a unique position to comment on psychologist competence and how psychology services can meet their needs and aspirations. Collecting service user feedback about what is important for competence and exploring how these views relate to the existing NZPB competencies can generate better understandings of what makes a clinical psychologist (CP) competent.

This study explores service user views of CP competence and how these views align and contrast with the existing NZPB CP competencies. I aim to enhance current understandings of competence and to contribute to strengthening professional practice and the effectiveness of CPs in A-NZ and more widely.

My experiences of using mental health services for mental distress and my CP training have influenced my interest in this topic. People with dual perspectives like me in the psychology workforce have started to be recognised in recent studies. For example, in the UK over 60% of psychologists have previous or current experiences of mental well-being challenges (Tay et al., 2018). Many of these psychologists would have accessed psychology services. My dual experiences motivate my belief that the field of psychology can and should continually improve and evolve in response to

feedback from the people we aim to support. In seeking feedback from service users, I hope to contribute to more effective mental health care.

Outline of Thesis

Chapters One and Two discuss the relevant background and literature regarding why it is important to explore service user views of CP competence. In Chapter One, I set out how competence has been defined and functions in psychological practice. Theoretical understandings that include therapist effectiveness and perceptions of competence are discussed. I then outline competence-based practice in psychology and the competence acquisition models that developed from this notion. Competence as a regulatory function outlines how the competencies were developed internationally. I then draw on the service user movement, highlighting key arguments for involving service users in competence development. I conclude the chapter by identifying key gaps in current understandings of competence.

Chapter Two focuses on the A-NZ context, outlining competence and competencies in A-NZ. I discuss the obligations of A-NZ psychologists and how these relate to competencies and service users. I then highlight some factors that have created barriers to service user involvement in research, competency development, service provision, and professional practice. I outline examples of national service user-informed competency development in other A-NZ mental health professions. To conclude, I outline my aims and research questions.

In Chapter Three, I set out the methodology, describing the social constructionist and user-led underpinnings that guide the methodological choices for this project. I set out the quantitative and qualitative frameworks and participants. I discuss the procedures and data collection methods, which were a survey and individual interviews. I then describe the analytic processes for the quantitative and qualitative data.

In Chapter Four, I present the analysis of the Service User views of CP Competence survey and discuss how participant views align and contrast with the NZPB core competencies. In Chapter

Five, I present the interview analysis, and discuss how participant views align and contrast with the NZPB core competencies.

In Chapter Six, I summarise the main areas of service user views of CP competence across the survey and interviews, in the key areas of interpersonal skills and relational presence, responsive contact, cultural responsiveness, mental health-related stigma, discrimination, exclusion, and power, and safe processes and profession. This section explains the findings, drawing on relevant theory and research to provide a wider context and literature base for each section. I also discuss how the findings align and contrast with the NZPB competencies and identify some strengths and limitations of this study. I then discuss the resultant implications and recommendations, specifically for current understandings of competence and the current competencies, more generally for the field of psychology, and briefly, other services that work with people with lived experience of mental distress.

Chapter One: Competence in Professional Psychology

In this chapter, I set out current understandings of competence in professional psychology, firstly outlining how competence is defined and by whom, and the relationship of competencies to the broader notion of competence. Key theoretical underpinnings for understanding competence are discussed concerning overseas developments, before summarising the main gaps and critiques with how competence has been conceptualised and how psychology competencies have been developed in general.

A major issue highlighted in competence research is the research-practice gap between how competence is defined and what it actually means to practice CP competently (e.g., Fletcher, 1997; Mansfield, 1996; Spencer & Spencer, 1993). In psychological practice generally, attempts to define the term competence have been made without reference to or involvement with mental health service users, and competencies have been agreed upon within the profession of psychology, where professionals are positioned as experts (e.g., Bartram & Roe, 2005; Roe, 2002).

Understandings of Competence and Competencies

Defining Competence and Competencies

Common understandings of competence in professional psychology include the adequate performance of a task and role (Roe, 2002), though competence is also understood as developing and maintaining high standards in practice (BPS, 2017, 2018). Competence also refers to safe practice and monitoring and working within limits of knowledge, skill, training, education, and experience (BPS, 2017, 2018). Competence is underpinned by benefitting the people and communities a psychologist serves (Epstein & Hundert, 2002). Competence is considered developmental, where it is developed throughout a psychologist's career, and context-dependent, where required competence depends on specific tasks expected of a psychologist (Rubin et al., 2007; Zuckerman, 2012). Despite the widespread use of the terms competence and competencies, psychology as a profession has

struggled to identify, define, and operationalise the competencies required for adequate and safe practice (Nash & Larkin, 2012; Von Treuer & Reynolds, 2017).

Competencies are set-out units of competence that specify the minimum standards psychologists should meet in carrying out their professional responsibilities (Kaslow, 2004; Shippmann et al., 2000). This includes knowledge, skills, and abilities (Campion et al., 2011). While knowledge encompasses integrating and understanding a range of information (NZPB, 2017), it can also include attitudes, beliefs, values, dispositions, self-perceptions, and motivations (Mentkowski, 2000). Skill and ability components refer to communication skills, professional behaviours, clinical reasoning, technical skills, and strategies (Epstein & Hundert, 2002; Rubin et al., 2007). Competencies depend on self-awareness, including of emotions and values, engaging in self-reflection, and understanding one's presence (Epstein & Hundert, 2002; Rubin et al., 2007).

While individual competencies set out by professions are usually displayed and discussed as discrete, with distinctive categories, in practice competencies are also dynamic and flexible, often overlap, and can be transferrable across settings (Kaslow et al., 2004; Rubin et al., 2007; Von Treuer & Reynolds, 2017). Competencies are also considered observable and measurable, thus open to continuous evaluation and refinement (Rubin et al., 2007; Stratford, 1994).

Competence and Therapist Effectiveness

Some studies refer to psychologist competence in terms of effectiveness, where therapist effectiveness (or the helpfulness of a psychologist) is related to competence. This literature base is dated, not specific to CP, and generally does not differentiate psychologists from other therapists. However, it illustrates attempts to explore therapist factors contributing to effective client outcomes. For example, international outcome-focused competence research has explored ethical behaviour (e.g., Collins & Arthur, 2007; Schwartz-Mette & Shen-Miller, 2018), cultural competence (e.g., Cabral & Smith, 2011; Rogers-Sirin et al., 2015), and therapist effectiveness (e.g., Beutler, 1997; Kingdon et al., 1996; Luborsky et al., 1997; Trepka et al., 2004).

Therapist effectiveness literature is important to consider, as competence impacts client outcomes and the usefulness of mental health interventions; thus, competence is crucial for the delivery of psychological therapies (Barber et al., 2007; Schaffer, 1982; 1983; Jacobson & Hollon, 1996; Kingdon et al., 1996; Roth & Pilling, 2007; Strunk et al., 2010). This means more effective outcomes for clients are achieved by psychologists who are more competent (Shaw et al., 1999; Yeaton & Sechrest, 1981). Therapist competence has been highlighted as relevant to understanding treatment efficacy- whether “better” or more helpful intervention is carried out by therapists who are more competent (Shaw et al., 1999; Yeaton & Sechrest, 1981). Further, measuring the “adequate” delivery of interventions is highlighted as crucial for both clinician training and measurement of intervention outcomes (Strunk et al., 2010).

In therapist effectiveness research, outcome-related factors include a strong therapeutic alliance, adherence to appropriate competency guidelines (Beck et al., 1979), and having skills specific to the mode of therapy (e.g., Cognitive Behaviour Therapy). Therapist competence was also reported to encompass factors beyond adherence to protocol (e.g., Hill et al., 1992; Strunk et al., 2010) and therapeutic alliance measures (e.g., Horvath, 2006; Raue & Goldfried, 1994). The literature also specifies the dispositions, knowledge, and skills therapists should have (e.g., Francis & Cameron, 1991; Peterson et al., 1992; Hesketh, 2000).

Most studies investigating the relationship between clinician competence and client outcomes have mainly focused on Cognitive Behaviour Therapy (CBT) using the Cognitive Therapy Rating Scale (CTRS; Young & Beck, 1980; Vallis et al., 1986). Shaw et al. (1999) found a mixed effect, where therapist competence was unrelated to symptom change. However, when therapist adherence to CBT strategies and facilitative conditions (nonspecific aspects of treatment such as warmth and rapport) were added as covariates, competence predicted change on the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960), accounting for an additional 15% of the variance (Shaw et al., 1999). Other studies have indicated significant positive relationships between CTRS ratings of therapist competence and outcome. For example, Trepka et al. (2004) and Kuyken and Tsivirkos

(2009) found a positive association between therapist competence and Beck Depression Inventory-II (BDI; Beck et al., 1996) scores post-intervention. Strunk et al. (2010) also found an association between variability in practitioner competence and subsequent variability in symptom change for mild-moderate depression (measured by the BDI-II and HRSD). Therapist competence ratings also predicted session-to-session symptom change early in treatment when patients improve most rapidly, and early competence ratings also predicted end-of-treatment symptom severity (Strunk et al., 2010). These studies infer that therapist competence is important as competence impacts client outcomes in various ways.

An issue with these competence-outcome studies is a lack of reliability in how competence is measured, where the reliability of competence ratings has often been surprisingly low (Shaw et al., 1999; Strunk et al., 2010). For example, one study yielded intraclass correlation coefficients of less than 0.1, indicating poor reliability across ratings of therapist competence (Jacobson & Gortner, 2000). Strunk et al. (2010) highlighted that the predictive value of their CTRS competence ratings was more useful for capturing variability in competence across sessions conducted by the same therapist rather than capturing variability in competence across different therapists. Further, therapist competence may predict longer-term symptom change due to differences in client characteristics or dimensions of therapist competence not captured by the CTRS (Strunk et al., 2010). Thus, there are issues with reliability and validity in these investigations of how to ascertain therapist competence, highlighting the need to look beyond the measures of previous studies to expand the profession's understanding of how to measure and evaluate competence (Strunk et al., 2010).

Another issue for professional psychologist competence focuses on self-assessment of competence, where direct estimates of reliability/accuracy with which practitioners make judgments about their own competence are generally absent (Dobson et al., 1985). A small amount of dated research considering the reliability of self-rated competence highlighted that the reliability of these ratings is generally poor (Shaw et al., 1999; Strunk et al., 2010; Jacobson & Gortner, 2000). The common reliability issues across studies that have measured competence mean a lack of validity and

practical usefulness with the existing studies' conceptualisation and measurement of competence. Some non-psychology cultural competence studies also highlight issues with clinician self-assessment of competence. Gushue et al. (2008) discuss that while clinicians' self-reports about their own cultural competence can indicate how knowledgeable they are about cultural issues or cultural sensitivity (centred around ethnicity), self-assessment cannot reveal whether clients experience therapists as culturally sensitive (Gushue et al., 2008). As clinician self-report surveys capture limited understandings of service users' experiences, limited understandings of cultural competence are also generated (Tummala-Narra et al., 2012). Given the above issues, considering alternative methodological designs that do not rely on quantitative measurement and clinician self-report will likely enhance current understandings of competence.

Client Perceptions of Competence

Few studies have considered that clients' perceptions of competence can contribute to existing understandings. In psychology, no further studies are identified beyond some cultural competence studies. Some dated psychotherapy studies focusing on the therapeutic alliance consider clients' perceptions of therapists. The most recently known study is by Wright and Davis (1994), who asked what service users want in a therapeutic relationship in CBT. Relevant findings include that clients' perceptions of therapist characteristics (such as warmth and friendliness), not therapist behaviours, predicted therapeutic outcomes (Wright & Davis, 1994). Also, clients want to view their therapists as competent (Wright & Davis, 1994). The Wright and Davis study emphasises that client views of competence can contribute to new understandings. Of note, though service user views were considered important, the Wright and Davis (1994) study followed a case-study approach that heavily relied on the researchers' (who were also clinicians) interpretation of what service users reported.

Cultural competence is one particular area of research that has, in part, considered service users' views. These studies are not specific to psychology and frame cultural competence in terms of multicultural competence and cultural diversity based on ethnicity, thus pertaining to ethnic minority

clients rather than service users as a cultural grouping more widely. Cultural competence studies discuss that when clients have provided ratings of their therapist's multicultural competence (focused on ethnic differences), competence relates to perceptions of therapist empathy, the quality of the working alliance, and satisfaction with therapy (Fuertes et al., 2006). Further, if a client perceives their therapist as culturally competent, this leads to relief and greater confidence in the therapist's ability to help despite cultural differences (Gushue et al., 2008). When asked about cultural incompetence, service users most disliked a lack of clarity about what therapy entails, discrimination, and microaggressions through direct or indirect messages of discomfort or disapproval (e.g., Gushue et al., 2008; Sue, 2010). Further, negative experiences of a therapist based on cultural incompetence can lead to negative attitudes toward therapy in general (Diala et al., 2000; Lee et al., 2006).

While cultural competence research highlights the need for professionals to raise their awareness of (and response to) clients from differing cultures, cultural competence focuses on ethnic differences, and the research is not specific to psychologists. Major critiques include that competencies and how a therapist embodies them have not been explored in the "intersecting and interconnected way that clients experience them" (Kelly & Greene, 2010; p. 196). Thus, future research needs to explore therapeutic dyads that focus on service users' views of cultural competence and "address the multiple intersections of the identity of clients and clinicians and how these intersections may influence the therapeutic process" (Tummala-Narra et al., 2012; p. 173). Although cultural competence research is one area that has considered the usefulness of service user views, no studies could be found about people who experience mental distress as a cultural group, no studies that consider service user views as important to areas of competence outside of ethnic diversity, and no studies specific to psychologists.

Competency-Based Practice

In professional psychology over the last 30 years, theories about competence and approaches for identifying what the competencies should be were developed based on the notion of

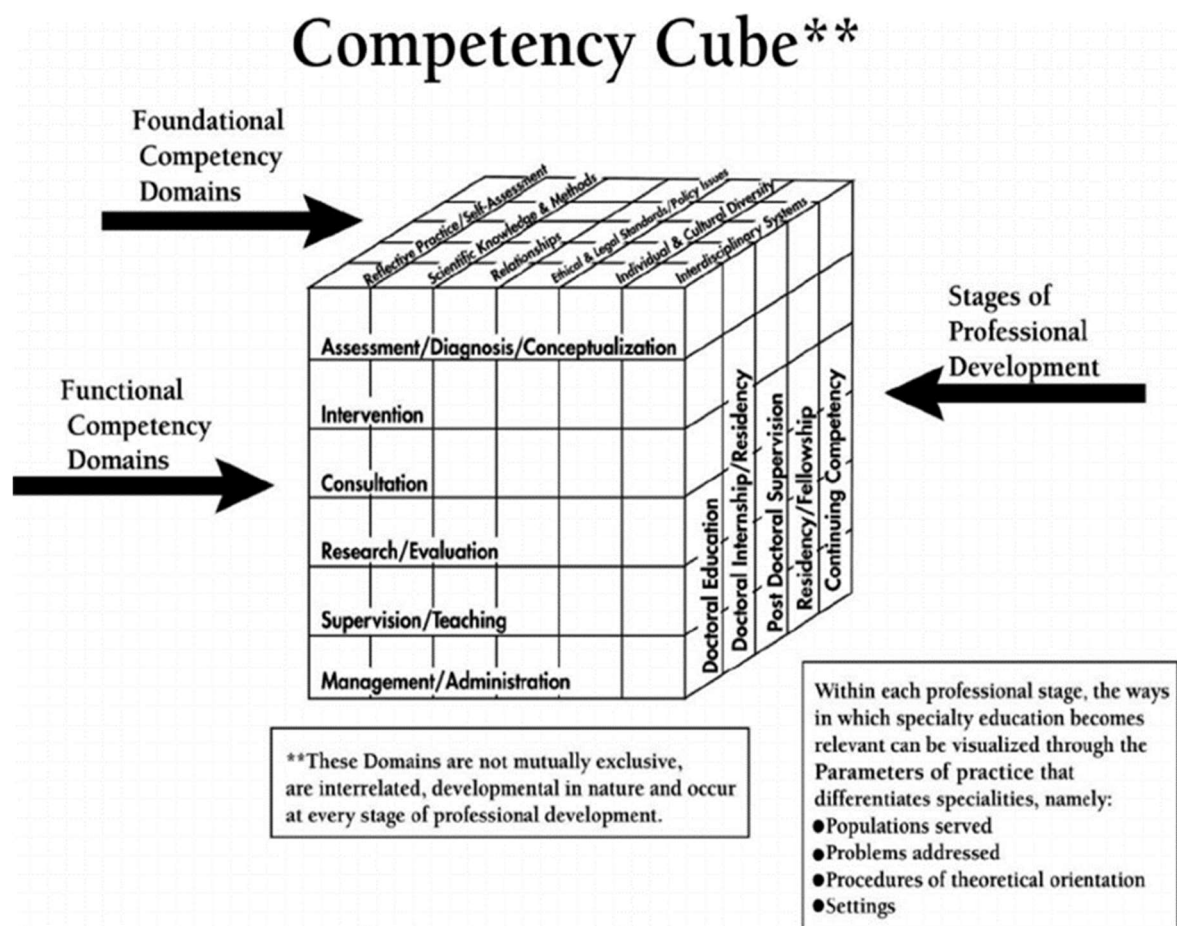
competency-based practice. This is commonly called “the culture of competence” and means attending to competency-based education, training, and credentialing (Kaslow, 2004; Kaslow et al., 2004; Sumerall et al., 2000; Peterson, 2004). The international research on psychologist competence is focused on the competency-based practice area (Fouad et al., 2009; Roberts et al., 2005), contributed to by work groups, conferences, organisational projects, and commissions (Rubin et al., 2007). Further contributions to psychologist competence have included published books about the definition and selection of core competencies (e.g., Rychen & Salganik, 2001), the development of competency models (e.g., Lucia & Lepsinger, 1999), competency-based approaches for education and assessment (e.g., Andrews & Burruss, 2004; Palomba & Banta, 2001), and implementing competency-based education and training in psychology (Sumerall et al., 2000).

The development of competence acquisition models informed the early core competencies in North America and Canada, which were later drawn upon by other countries, including A-NZ. Competence acquisition modes include the Cube model (Rodolfa et al., 2005), the Interlocking Rings model, and the Pyramid model (Nash & Larkin, 2012). The Cube model (Rodolfa et al., 2005; see Figure 1) was the first to emphasise the acquisition and development of benchmark competencies through “foundational competencies” (professionalism, reflective practice/self-assessment/self-care, scientific knowledge and methods, relationships, individual and cultural diversity, ethical legal standards and policy, and interdisciplinary systems) and “functional competencies” (assessment, intervention, consultation, research/evaluation, supervision, teaching, and management-administration). The Cube model also encompassed professional development stages, from doctoral education to continued competence. The Interlocking Rings model (Nash & Larkin, 2012; see Figure 2) focuses on competence acquisition at the internship level and the acquisition of additional competence during a psychologist’s career. The Pyramid model (Nash & Larkin, 2012; see Figure 3) focuses on competence acquisition in specialty areas (e.g., clinical child psychology) by integrating the foundational and functional competencies from the Cube model with the training processes from the Interlocking Rings model. The Pyramid model contains “specialty functional competencies” as well as

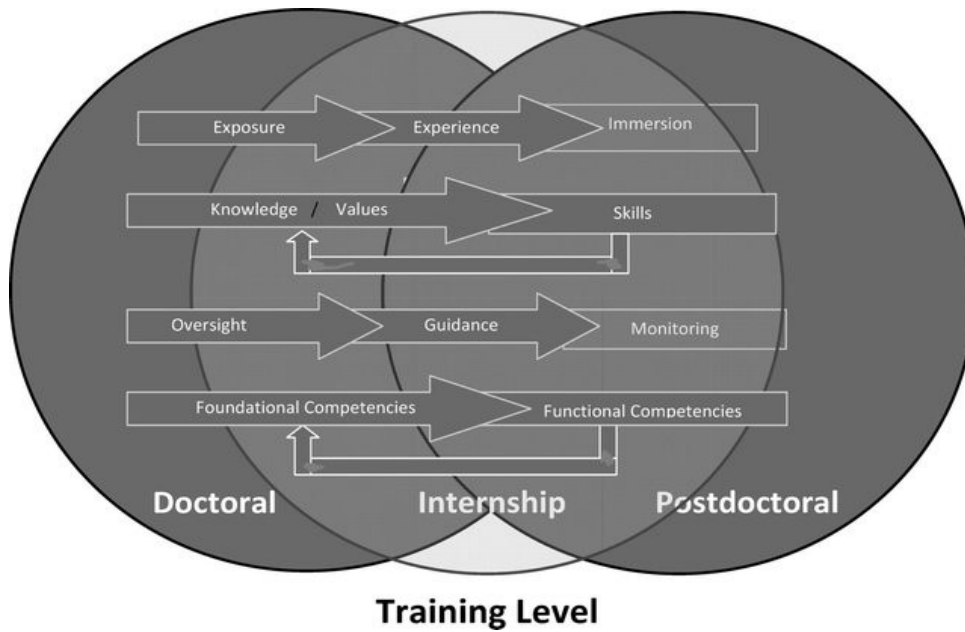
“core functional competencies” and “core foundational competencies”. These models reflect a focus on the attainment and development of competence as well as the underlying structure of the core competencies used in A-NZ today- such as the “General Scope” competencies and the “Vocational Scope” competencies (discussed in Chapter Two).

Figure 1

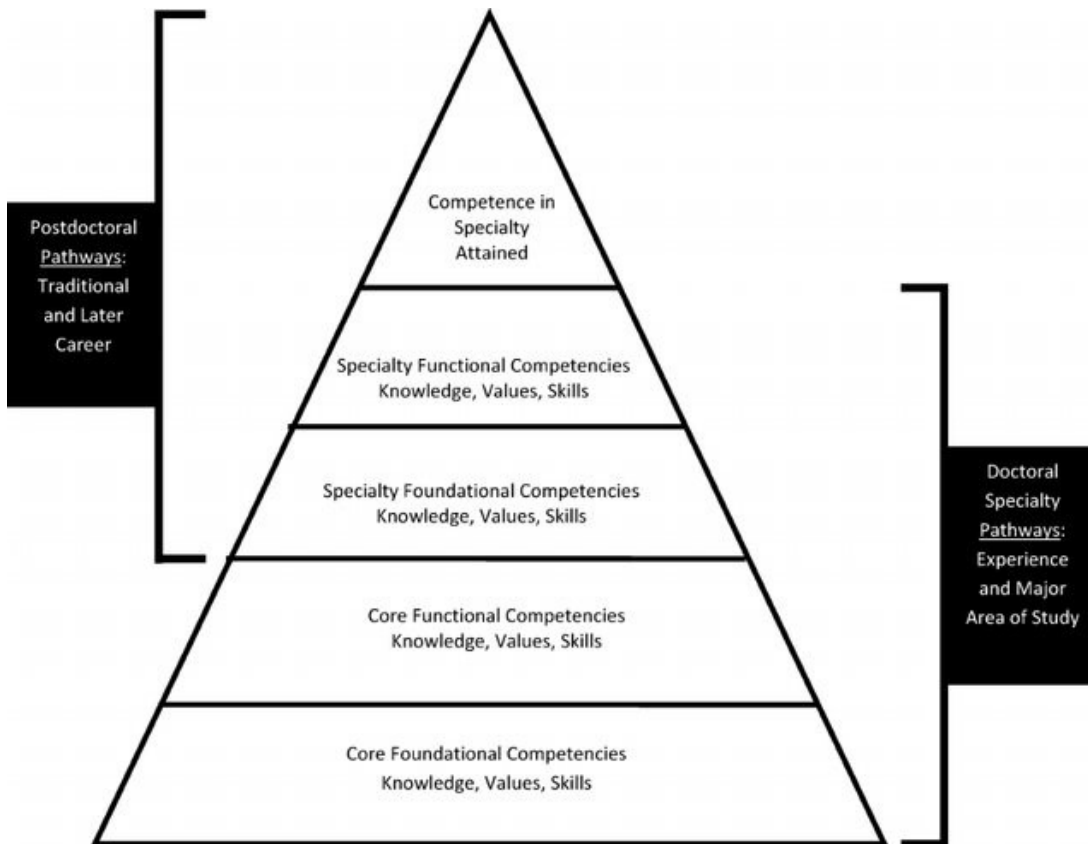
The Cube Model of Benchmark Competencies



Note. From “A Cube Model for Competency Development: Implications for Psychology Educators and Regulators,” by E. Rodolfa, R. Bent, E. Eisman, P. Nelson, L. Rehm, & P. Ritchie, 2005, *Professional Psychology: Research and Practice*, 36, p. 350. Copyright 2005 by the American Psychological Association. Reprinted with permission.

Figure 2*The Interlocking Rings Model*

Note. The Interlocking rings model shows progressions in training processes. From "Geometric Models of Competency Development in Specialty Areas of Professional Psychology," by J. M. Nash and K. T. Larkin, 2012, *Training and Education in Professional Psychology*, 6(1), p. 39. Copyright 2012 by the American Psychological Association. Reprinted with permission.

Figure 3*The Pyramid Model of Specialty Training*

Note. The brackets indicate the training level when the development of specialty area competencies occurs. From “Geometric Models of Competency Development in Specialty Areas of Professional Psychology,” by J. M. Nash and K. T. Larkin, 2012, *Training and Education in Professional Psychology*, 6(1), p. 42. Copyright 2012 by the American Psychological Association. Reprinted with permission.

These models focus on competence development rather than directly examining how competence is defined. As these models are general and non-specific to different areas of psychology, one critique was that organisations relevant to a specific field of psychology need to be involved in identifying competencies fit for a specific area of practice (e.g., clinical psychology; Nash & Larkin, 2012). Further, dialogue at national and international levels to define and agree upon the competencies required at each stage of training and practice was recommended (Nash & Larkin, 2012). Competence model research centred around whether to concentrate on what must be taught

for individuals to become competent (input) or on competencies psychologists should demonstrate to qualify for accreditation (output). “Input” refers to a set of learning requirements that define what knowledge and skills are needed to meet required standards and, therefore, the educational curricula to become a psychologist. “Output” refers to a set of standards that set clear performance criteria and define work contexts where relevant demonstration of performance takes place, in other words, the roles and functions that should be performed (Bartram & Roe, 2005). While Input and Output relate somewhat to how competence is understood and defined, evaluating competence within the profession based on teaching or demonstration standards (input) and role and function (output) was critiqued as not offering a sufficient base to set satisfactory professional standards (Roe, 2002). This is because the Input model (focused on training and education) emphasises factors for gaining a basic level of competence, which arguably could lead to less emphasis on requirements for higher levels of competence. A disadvantage to the Output model is that assessing individual competencies is time-consuming and costly. Further, the standards in the Input and Output models were considered not contextualised for professional practice. This meant that how competence and competencies were defined and theorised carried little practical value as they were not grounded in the real world and, therefore, not ecologically valid (Bartram & Roe, 2005).

As an alternative to Input and Output models, Roe (2002) presented a model of occupational psychologist competence that incorporated input, output, and other factors into a “Competence Profile”. This includes competencies, sub-competencies, knowledge, skills, attitudes, abilities, personality traits and other characteristics essential for carrying out an occupation. Competence Profiles were also acknowledged as limited, as each profession of psychology then needs to develop context-specific competence profiles relevant to the work context of a particular psychologist (Roe, 2002). The lack of sufficient research regarding the tasks psychologists perform and the demands placed on them was highlighted as a key limitation that led to complications with implementing competence profiles (Roe, 2002).

Each model developed to conceptualise competence contains domains of knowledge, skills, attitudes, and values required of all psychologists through different stages of professional development. Each of these models was appraised to have limited usefulness beyond theory, limited applicability to real-life professional practice, and limited applicability to a specific role and context of psychology work (Bartram & Roe, 2005; Nash & Larkin, 2012; Rodlfa et al., 2005; Roe, 2002).

Recommendations for competence research at the time were to stop building upon existing models and move beyond the acquisition/developmental focus to the practical application and development of specific competencies relevant and fit for purpose within professional psychology contexts (Roe, 2002). Despite the issues outlined, these models pervade the current theoretical base of competency-based practice. Thus, generating alternative theories and approaches to understanding competence in specific areas such as CP appears valuable to inform contemporary professional practice.

Competence As a Regulatory Function

Developments within the paradigm shift to competency-based training and licensing for psychologists focused on defining specific competencies, considering how to attain these competencies, developing measurements for competence, and offering remediation when competence is not consistent with expected levels (Carraccio et al., 2002; Harden, 2002). In psychology currently, the evaluation of meeting competencies is a major component of accreditation processes (Strunk et al., 2010). Therefore, competencies are integrated into professional training programmes so that psychology trainees are aware of their obligations and can practice safely when training is complete. Much international literature about competence focuses on training models for competence (e.g., Kaslow et al., 2009; Kenkel & Peterson, 2010) and competency-based training (e.g., Donovan & Ponce, 2009).

Using competence as the benchmark for which psychologists are deemed fit to practise originated in response to the influx of soldiers returning from World War II with significant

psychological impacts. Psychology was not a regulated profession until 1945 when the US Department of Veterans Affairs asked the American Psychological Association (APA) for information about programmes that train psychologists to ensure that professional psychology could provide responsive and effective - thus competent - care (APA, 2006). During the next year, training programmes were identified, and accreditation processes in the US were developed for psychologists corresponding with developing competencies for training and regulating psychology practice. At this time, individual states began implementing laws regulating psychology practice (Rodolfa et al., 2014). All US psychology Boards and training programmes were given the directive to license competent psychologists. The main criteria to ascertain readiness to practice for most US and Canadian jurisdictions was meeting training and education requirements and accrual of supervised professional experience hours (Rodolfa et al., 2014). The demonstration of specific skills in psychological practice was less of a focus. This changed in the 1980s when competency-based approaches became more of a focal point (Rodolfa et al., 2014).

In the US, the American Board of Professional Psychology provides board certification for CPs by verifying that they are competent to deliver high-quality services to meet public needs (<http://www.abpp.org>; Finch et al., 2006; Rubin et al., 2007). In the US, CPs must meet general and speciality area (e.g., CP) competencies outlined by the speciality area board. General competencies for all specialities are professional knowledge, assessment, intervention, interpersonal functioning, ethical and legal standards and behaviour, commitment to the speciality and awareness of current issues, and supervision and consultation (Finch et al., 2006). Additional competencies for a speciality area, assessed by the corresponding speciality board, are thought to ensure more robust processes to assess competence. Speciality-specific area competencies are considered to tap into competence in a manner more reflective of actual practice (Rubin et al., 2007). This is similar to specialist “scopes” of practice in A-NZ, such as “Clinical Psychology”, which have additional competence requirements to the expected competencies of any (or all) practising psychologists. Like A-NZ, competence is an ongoing concept included in Ethical Codes and Codes of Conduct in North America (APA, 2002) and in

the Guidelines and Principles for the Accreditation of Programs in Professional Psychology (APA, 2001, 2006).

The British Psychological Society (BPS) is the professional body for psychology accreditation in the United Kingdom (UK). Accredited (Doctoral) programmes aim to prepare trainees for professional practice as CPs and meet the requirements for Chartered membership of the BPS and full membership of the Division of Clinical Psychology (DCP). The Health and Care Professions Council (HCPC) regulates practising psychologists in the UK. Like A-NZ, anyone who wishes to practise using a title protected by the Health Professions Order 2001 is legally required to be registered by the HCPC and meet the HCPC Standards of Proficiency. These are threshold standards and expectations of knowledge and abilities deemed necessary for a health practitioner to practice safely (unique to a healthcare profession) (BPS, 2019). Thus, competence is used to ensure psychologists can practice adequately and safely within relevant legislation, as competencies are considered to ensure psychologists meet the prescribed standards of the associated regulatory body.

Competencies Development

Key contributions to how competencies have been developed in the Western world were profession and licensure-driven. The 1949 Boulder Conference for Clinical Psychology was the first conference to focus on competence. This led to the Boulder and Vail models of training, which are the main philosophical frameworks for developing psychologist competencies today (Rodolfa et al., 2014). In Canada, a scientist-practitioner model of doctoral clinical training was endorsed at the Couchiching Conference in 1965 (Conway, 1984; Rodolfa et al., 2014). At this time, regional and programme differences in training models and degree types in Canada were considered problematic (Rodolfa et al., 2014). The Canadian Psychological Association adopted accreditation criteria based on competence and competencies in 1984 to provide more standardisation to training curriculums (Rodolfa et al., 2014). In 1986, the National Council for Schools and Programs of Professional Psychology (NCSPP) framework specified training to be competency-based, and six core competency

areas were defined (Callan et al., 1986; Peterson et al., 2010). Refining these initial core competencies has continued, though the core areas remain similar (e.g., Kenkel & Peterson, 2010; Peterson et al., 1992; Peterson et al., 2006; Peterson et al., 2010). In 2002, Diversity as a core competence area was added, emphasising understanding and appreciating human differences and alluding to issues of power, privilege, and oppression (Kenkel & Peterson, 2010). Although influential, the NCSPP framework and subsequent revisions were considered largely theoretical and lacking practical utility (APA, 2006; Rodolfa et al., 2014). What also stands out is a noticeable dilution of attention to collaboration and power when responding to clients (Rodolfa et al., 2014).

Advocacy as an area of competence expected to be developed throughout a psychologist's career was identified at the 2001 Education Leadership Conference in Washington (Belar et al., 2003). A literature base for specific core competencies was established at the 2002 Future Directions in Education and Credentialing in Professional Psychology conference (Association of Psychology Postdoctoral and Internship Centers, 2004; e.g., Arredondo et al., 2004; Bieschke et al., 2004; Daniel et al., 2004; De la Fuentes et al., 2005; Elman et al., 2005; Falender et al., 2004; Krishnamurthy et al., 2004; Spruill et al., 2004). Competence assessment workgroups then arose, as continuing to develop existing ways of assessing competence was deemed insufficient to ensure competent psychologists (Roberts et al., 2005). Around the same time (2001-2004), the US and Canada Mutual Recognition Act established competencies similar to the NCSPP competencies (Rodolfa et al., 2014), providing the basis for the core competencies currently used in A-NZ.

The US-based Competency Benchmarks Workgroup (Fouad et al., 2009), Competency Assessment Toolkit (Kaslow et al., 2009), and Benchmarks system (Hatcher et al., 2013) focused largely on expanding the Rodolfa et al. (2005) Cube model. The expanded model was then identified as overly complicated for psychologist trainers and considerably more complex than models and systems used by other professions (Fouad et al., 2009; Hatcher et al., 2013; Rodolfa et al., 2014). As a result of complexity and useability issues- paralleled in the critiques of the competence acquisition/developmental models- the Benchmarks application was considered limited and

insufficient for continuing to understand how to define and assess competencies (Rodolfa et al., 2014). Despite enduring critiques, the Health Service Psychology Education Collaborative (2013) adopted the Benchmark model core competencies (Rodolfa et al., 2014). Processes such as the development of the Benchmarks, the Competency Assessment Taskforce, and the Toolkit reflect a large amount of convergence regarding the types of competencies considered essential for psychological practice through each stage of competency development. This may be partly due to the similarities of the within-profession task forces and groups that contributed to competency development. The supervision, teaching, and training competencies were not supported for inclusion due to various opinions about when these competencies should be accrued. For example, many regulators thought these competencies could be acquired after licensure rather than before licensure (Rodolfa et al., 2014).

In 1974, the British Psychological Society (BPS) Division of Clinical Psychology (DCP) published the first guidelines for CP professional practice. These were reviewed and rewritten in 1983, 1990, and 1995 to reflect developments in professional practice and legislation (DCP, 1995). The 1995 guidelines emphasised respect for service users and providing services that value clients and treat them with respect and dignity. Members of the BPS developed the 1995 guidelines in consultation with the Health and Care Professions Council (the statutory regulator for practising psychologists). Contrasting with the US and Canadian developments, the practice guidelines consultation process also included the distribution of the draft guidelines to Experts by Experience (EBEs). The EBEs were psychology service user representatives who were working with the BPS in various contexts (BPS, 2017). The BPS is the only known organisation within psychology that explicitly invited feedback on practice guidelines from service users. The BPS pointed out that developing the guidelines relied on a mainly consultative process within the profession while giving EBEs already associated with the BPS some opportunity to provide comments.

The BPS current core competencies for CP include the therapeutic alliance as central within competency areas of Psychological Assessment and Psychological Intervention. The ability to work

with clients from diverse backgrounds and awareness of social and cultural factors is highlighted under Personal and Professional Skills. The competency area of Service Delivery Skills includes working with service users and carers to facilitate their involvement in service planning and delivery, working with issues and processes to enable organisational change, and developing and sustaining effective partnerships with a range of commissioners and delivery systems (BPS, 2017).

International Approach to Competence Development. An international approach to the development of competencies began in 1995 with a series of conferences attended by psychologists from around the world. The purpose of the Fifth Congress was to provide a “common consensus” for competence globally (International Project on Core Competences in Professional Psychology, 2013, p. 3). This was to enhance professional identity and international recognition due to concerns about variability in regulatory, educational, and training systems (APA, 2013). The attendees were to ascertain “What are the competencies that any psychologist should have?” (APA, 2013., pg. 1) to develop globally agreed upon benchmark competencies. The “International Project on Competence in Psychology” (IPCP) was assembled as an outcome. The IPCP aims to seek continued input across countries with work groups from Canada, China, Colombia, A-NZ, Norway, South Africa, the UK, and the US, with the intention to evolve international understandings of competence and competencies in the future (APA, 2013; Rodolfa et al., 2014). The international conferences reflect the need for the profession of psychology to better understand competence and continue to refine competencies that are relevant to contemporary practice.

Monitoring Competence

Current mechanisms that monitor competence are part of how competence and competencies are used to regulate professional psychology. In contrast to training and initial registration as a professional psychologist, across and within boards internationally, there is no general standard external assessment of competence when registration is renewed and throughout a psychologist’s career (Rubin et al., 2007). Regulatory bodies rely on complaints processes and self-

monitoring, which hinge on the awareness and commitment of psychologists to limit their practice to areas they are competent in (Rubin et al., 2007). In the US and Canada, ongoing training and education is the single licensing action which addresses the maintenance and development of competence by licensees. A reason provided is that affordable and acceptable ways to maintain clinical skills and judgment over time have not been developed (Rubin et al., 2007). However, research in this area is dated. Another way to indicate competent practitioners are registers identifying psychologists whose education, training and experience qualify them as health service providers. Examples include the A-NZ Psychologists Board register (<http://www.psychologistsboard.org.nz/search-the-register>), the US National Register of Health Service Providers in Psychology (<http://www.nationalregister.org>), and the Canadian Register of Health Service Providers in Psychology (<http://www.crhsp.ca>).

As the need for comprehensive assessment of competencies was recognised (Fouad et al., 2009; Kaslow et al., 2009), processes to effectively evaluate psychologist competency were considered (Jonason et al., 2003). For professional regulation, psychologist competence is usually assessed based on training and outcome competencies endorsed by psychologists (e.g., Fouad et al., 2009; Hadjistavropoulos et al., 2010; HDC, 2018; Okiishi et al., 2003; Pitama et al., 2017; Slade et al., 2014; Wing et al., 1998). Issues with psychology as a profession evaluating professional practice competence are similar to the competence definitions and effectiveness research. For example, it is a natural human phenomenon to both overestimate one's own competence and find it difficult to recognise one's own incompetence, which can lead to inflated self-assessment (Kruger & Dunning, 1999). Psychologists can also overestimate their competence and may not become more competent over time with practice, training, and supervision (Ericsson et al., 2006; Miller et al., 2015).

The Service User Movement

Service user, psychiatric survivor, and civil rights movements illustrate that calls for service user involvement in mental health services have been present historically and remain today. They

have influenced the development of advocacy and reasons for the need for service user input in mental health services. However, it is not documented whether these movements influenced competence developments in psychology. The service user/survivor movement is:

A term used to describe the existence of numerous individuals who speak out for their own rights and those of others, and local groups and national organisations set up to provide mutual support or to promote the rights of current and former mental health service users to have a voice. (Wallcraft et al., 2003, p. 3)

The Mental Health Research Fund (MHRF) was implemented in the UK in 1949 to address the lack of mental health research funding and to investigate how the environment shaped mental health when shell-shocked soldiers returned from the war. This was also when the competency movement in psychology began. In 1952, the MHRF focused on tackling stigma and deficit-based approaches and started influencing government health and social policies in 1960 (Mental Health Foundation UK, 2022). In the UK, mental health service user efforts were initiated in the 1970s when anti-psychiatry groups developed due to concerns about human rights and treatments for people who experience mental distress (Turner et al., 2015). In 1971 the first known service user union was formed, the Scottish Union of Mental Patients (Turner et al., 2015; Wallcraft et al., 2003). The Mental Patients Union (MPU), a permanent union for mental health service users, was then established after a group of service users and staff protested the proposed closure of the Paddington Day Hospital (PDH). The protest group were concerned that closing that therapeutic community would lead to receiving services in traditional psychiatric settings where physical interventions would be prioritised and psychotherapies would not be offered (Crossley, 1999). After the protest was successful, the MPU (which later became CAPO – Campaign Against Psychiatric Oppression) published *The Need for A Mental Patients Union: Some Proposals*, known as “The Fish Manifesto” (Crossley, 1999). The MPU acknowledged psychiatry as a form of social control, stated that service users should be able to participate in services which affect them, and highlighted the need to uphold the dignity and human

rights of service users (Crossley, 1999; Wallcraft et al., 2003). Further developments led to groups such as MIND beginning to advocate for legislative changes. In 1973, the Mental Health Foundation (MHF) was established in the UK, partly due to the MHRF. The MHF was established in A-NZ in 1974, which later led to national A-NZ initiatives to end discrimination and exclusion based on lived experience of mental distress. One example is the Like Minds Like Mine campaign, which started in 1997 due to the third Mason Inquiry (Mason et al., 1996). This campaign draws on the social model of disability (e.g., Abberley, 1987) and the power of contact, which encourages equal contact between people of excluded groups and people of groups that exclude (Ministry of Health and Health Promotion Agency, 2014). Influences of the service user movement, specifically in A-NZ, are discussed further in Chapter Two (see p. 37).

During the 1970s, psychological approaches and the corresponding evidence base were increasing, resources for community mental services were acknowledged as scarce, and rhetoric that services should acknowledge and mitigate the devaluation and marginalisation of service users grew (Wallcraft et al., 2003). In the 1980s, local service user forums were established, and in 1985, UK, Dutch, and US service user groups met at the MIND/World Federation for Mental Health conference. From 1986 onwards national networks of service users were established with the explicit goal to address stigma and misunderstanding, such as the Survivors Speak Out network (Wallcraft et al., 2003). Further developments included patient councils and user-led advocacy projects such as the Nottingham Advocacy Group, Mindlink (a service user network within MIND), and the Hearing Voices network, which started holding national events in 1990 (Wallcraft et al., 2003). In 1989, the MHF upheld people with lived experience of mental distress as central and equal partners and membership organisations developed further. The UK National Health Service and Community Care Act 1990 established a requirement for service user participation in community services planning, and subsequently, user-run services were formed. Advocacy efforts in the 1990s included the UK Advocacy Network and the Mental Health Task Force Service User Group, which produced guidelines for service user charters and advocacy and held service user conferences and training events

(Wallcraft et al., 2003). In 1994, in a context dominated by lab-based research, the MHF conducted the first major piece of social research to address mental health challenges in the community rather than hospitals (Mental Health Foundation UK, 2022). MHF initiatives that followed include Mental Health Awareness Week (established in 2001) and other mental health events.

In 2002, the National Institute for Mental Health employed an ‘Experts by Experience’ consultative group in the UK (Wallcraft et al., 2003). Since then, attention to service user rights has led to developments in social policy and more focus on “person-centred care, well-being, recovery, the involvement of service users and increased access to psychological therapies” in mental health service design and delivery (Turner et al., 2015, p. 600). However, inclusion and equality of service users often contrast and compete with service delivery objectives based on cost and medical management/symptom reduction (Turner et al., 2015).

Models developed by the service user movement, such as the recovery model, were responses to critiques about mental health care being paternalistic, symptom-focused, pathology-focused and located in deficit models of an individual that, accordingly, needed to be treated with medication (Jacob, 2015). The service user movement also drew on international human rights agreements, such as the International Bill on Human Rights, which outlines that no one should experience cruel or degrading treatment and that everyone has the right to freedom of thought, opinion, and expression (O’Hagan, 2004a). The social model of disability then arose, situating the cause of disability within society rather than an impaired individual (O’Hagan, 2004b).

The Service User Gap in Psychology Competency Development

Service user input in psychology has not been considered a way to aid understanding of competencies, despite competency development being a collaborative endeavour within the profession. A rare exception is the DCP initiating consultation from Experts by Experience (see p.16). In the literature reviewing the process and development of competencies, there is no mention of the relevance of the US and Canadian models and competencies for people engaging with psychology

services. As developments in competence for professional practice continued, one trend remained- a lack of consideration for service user input. The implicit understanding appears that professional workgroups and surveys provided sufficient knowledge and experience to conceptualise competence and define competencies. Throughout competency development, there was some acknowledgement and focus on service user-relevant ideas, such as relationships, collaboration, human rights, respect for diversity, attention to power and privilege, and advocacy, though to different degrees at different times. The US and Canadian early core competencies included responsiveness, reflectiveness, and cultural sensitivity. They acknowledged the importance of attending to privilege, power, oppression, and goals of understanding and facilitating clients' well-being. However, competency development remained solely in the profession and service users were not considered in the ongoing developments about what core competencies should be and how they should be assessed. This was despite developments in mental health policy and service user involvement.

While there is a trend of not involving service users in competencies development, there are psychologists who have dual perspectives, of their own lived experiences of mental distress and as psychologists. In the UK, over 60% of psychologists have previous or current experiences of mental well-being challenges (Tay et al., 2018). Among graduate students and faculty in accredited psychology training programmes in the US and Canada, 80% reported a lifetime history of mental health challenges (Victor et al., 2022). Many psychologists with dual perspectives will have accessed psychology and mental health services. However, few disclose this in work settings. Consequently, the insights drawn from their lived experience may be lost. The BPS DCP published a recent statement about CPs with lived experience. This statement recognises that lived experience is an advantage and a strength for practising and trainee CPs and helps to "enrich practice" and "improve service provision" (BPS, 2020. p. 1). Given the prevalence of CPs with lived experience, it is likely there was some input from service user perspectives when conceptualising competence and developing competencies. However, the degree of this influence is unknown, and the value of these perspectives was not considered at the time. Further, psychologists with lived experience may have views that

differ from non-psychologist service users without a CP background. Thus, overtly exploring service user views of competence is important.

Summary

Continued research about what constitutes competence and further developing competencies for psychology remains useful for ensuring the quality of licensure, education, and training throughout a psychologist's career. Specifying competencies is important so the profession can structure training programmes and regulatory boards. Defined competencies can be verified to gauge whether they are externally valid, that is, whether the existing competencies and understandings of competence are relevant and fit for purpose from the point of view of those experiencing professional psychology services.

The culture of competence in psychology instigated a focus on ascertaining competence through competencies agreed upon within the profession (Roberts et al., 2005). Key contributions include acquisition/developmental models and competency frameworks developed by educators (Hatcher et al., 2013) and regulators (Rodolfa et al., 2013). Though these models and developments were different structurally, they were comparatively equivalent in content, and the competencies themselves in the Western world stayed relatively the same over the years despite the acknowledgement of the need to evolve competencies in line with legislative and professional practice changes. Over time, the profession itself continued to develop the standards by which they were regulated, and service users were not explicitly involved in competence development or review processes (Rodolfa et al., 2014). This was despite broader legislative developments that emphasised responsibility to service users.

As competence is an ethical and legal requirement, as are requirements to ensure collaboration and advocacy, and minimise exclusion and inequities, integrating service user input would respond to these obligations. Further, little has been reported historically on whether the recipients of psychology services agree or disagree with the current views of competencies needed

for a psychologist to be deemed competent. The service user movement, increased acknowledgement of service user rights, and the need for lived experience involvement in mental health services and research occurred parallel to the competence movement in psychology. Despite emerging initiatives and the influence of the service user movement across different mental health sectors internationally, the lack of service user views in psychology competence development has not been identified, acknowledged, or studied as a significant gap. As the core purpose of competencies is to ensure psychology services benefit the person receiving the services, and competencies can be measured and evaluated, service users can assist with redefining and gauging competence and competencies.

Today, developing competence and competencies means psychology can better protect and serve people who receive psychology services (Rodolfa et al., 2014). Thus, increased emphasis on service user involvement in the competence space is crucial. Drawing on the contributions of the service user movement, without service user involvement competencies in psychology are at risk of tokenism and paternalism, in contrast to partnership and collaboration. Competence critiques enhance rationale for this study by emphasising that: 1) exploring views of psychologist competence from those that have experienced practising psychologists moves us beyond theoretical understandings of competence that have remained relatively alike since their early development and assume that they continue to meet the needs of the public; 2) service user views of competence specific to CP and the area of mental health allows for a context-specific lens for competence and competencies; 3) service user views can provide information about the practical applicability of the existing theoretical understandings of competence, as those experiencing psychology can comment on, from their position, what is useful for them to see from psychologists within that role and context; 4) asking service users about their views of competence attends to the primary purpose of the competencies, the protection and safety of the public through responsive and safe psychology practice; and 5) asking service users about competence can establish a research base to enhance understanding of what competence consists of and what competencies should be, adhering to the

scientist-practitioner approach for psychology. Moving beyond within-profession competence understandings is salient for a more responsive profession. The A-NZ context specifically is also important to provide further rationale for this study and is discussed next.

Chapter Two: The A-NZ Context of Competence and Service User Inclusion

This chapter focuses on competence and competencies, their purpose, and how they are used in the A-NZ context. I discuss current conceptualisations of competence, outlining the NZPB core competencies and the general and CP scopes. I outline competence as an ethical obligation and how this relates to stigma and discrimination. I then highlight issues with the lack of service user involvement in A-NZ psychology and discuss examples of competencies developed with differing levels of service user involvement in other A-NZ mental health workforces.

Competence and Competencies for A-NZ Clinical Psychologists

The New Zealand Psychologists Board (NZPB) defines competence as the interaction of knowledge, skills, judgment, and diligence (NZPB, 2017, p. 4). Knowledge involves integrating and understanding a range of information well enough to attend to different professional issues that may be encountered. While considered an essential foundation for competence, knowledge alone does not ensure competence. Skill is the effective application of knowledge in actual practice. Judgement is knowing when and under what circumstances to apply certain skills. Judgement encompasses self-reflection and awareness of personal values, experiences, attitudes, and social context and how these can influence actions and understandings. Diligence refers to the consistent application of knowledge, skills, and judgement in professional actions, and prioritising client needs. Each component, knowledge, skill, judgement, and diligence is regarded as building upon each other. Further, each contributes to ensuring that a psychologist performs at an expected level to provide the best possible service to each client (NZPB, 2017). Competencies are components of skills, knowledge, judgement, and diligence, and competence involves the integration of different professional abilities measured by competencies (NZPB, 2017). Psychologist competence is considered a process of continual refinement throughout a psychologist's career, where competencies will vary depending on experience and context of practice (NZPB, 2017). For the NZPB, competence is an ongoing career-long process that a psychologist must maintain and build upon.

The NZPB Core Competencies and Competence Regulation Processes

The NZPB core competencies (NZPB, 2018a) were developed in 2006 as a requirement of the Health Practitioners Competence Assurance Act 2003 (HPCA Act [The Act]; MoH, 2022a). The HPCA Act exists to “protect the health and safety of members of the public by providing mechanisms to ensure that health practitioners are competent and fit to practise their professions” (MoH, 2022a, p. 12). The HPCA Act replaced the previous 1981 Psychologists Act and mandates the NZPB to assure the public that psychologists are fit to practice and provide high-quality and safe services. Section 118(i) of the Act requires the NZPB to “set standards of clinical competence, cultural competence (including competencies that will enable effective and respectful interaction with Māori), and ethical conduct to be observed by health practitioners of the profession” (MoH, 2022a, p. 90). Thus, competencies are certain standards deemed to ensure competent practice. The Act also requires a health practitioner to work within a defined scope of practice. Any A-NZ psychologist needs to meet the core competencies defined for their scope(s) of practice and register with the NZPB to practice.

As shown in Table 1, the A-NZ core competencies (NZPB 2018a) have six parts. These include the core competencies required of any registered psychologist (general scope; Part One), Cultural Competencies (Part Two), and additional competencies required for a particular vocational scope—clinical, counselling, educational, and neuropsychologist (Parts Three-Six). Each part has a description of the area of competence and lists the Knowledge and Skills required for that area. There are nine areas under the “Psychology” (General) scope, and the “Clinical” scope has additional core competencies across four areas. The general and vocational scope core competencies are the minimum necessary to protect the public and may not convey all the possible competencies a psychologist holds. Unlike the general and scope-specific competencies, the Cultural Competencies are proposed standards for working with diverse groups, and a psychologist is not expected to meet all of these competencies (NZPB 2018a). The NPZB does not specify why Cultural Competencies are not the minimum standards required of a psychologist, though they note that cultural competence is a cumulative process (NZPB 2018a).

Table 1*NZPB Competency Areas for General Scope, Cultural Competence, and Clinical Scope*

Part	Area
Psychologist (General) Scope	Discipline, Knowledge, Scholarship, and Research Diversity, Culture, and the Treaty of Waitangi/Te Tiriti o Waitangi Professional, Legal, and Ethical Practice Framing, Measuring, and Planning Intervention and Service Implementation Communication Professional and Community Relations, Consultation, Collaboration Reflective Practice Collaboration
Cultural Competencies	Recognition of commitment to the Treaty of Waitangi/Te Tiriti o Waitangi and principles of partnership, participation, and protection as ethical and competence requirements Cultural Safety Cultural Competence Specific Awareness, Knowledge, and Skills
Clinical Scope	Discipline, Knowledge: Scientific Foundations and Research Diversity, Culture, and the Treaty of Waitangi/Te Tiriti o Waitangi Framing, Measuring, and Planning: Assessment and Formulation Intervention

In 2003 a working group of psychologists drafted a set of proposed competencies to produce the NZPB core competencies. The proposed competencies were then modified after distribution to selected registered psychologist groups for feedback. At that time, different scopes were established to attend to the range of actions undertaken by psychologists. The scopes resulted from NZPB consultation with the New Zealand Psychological Society (NZPsS) and the New Zealand College of Clinical Psychologists (NZCCP; NZPB, 2003), A-NZ's two professional psychology bodies. In reference to the Act, the "General" and "Vocational" scopes acknowledge that there are different degrees of risk to the public across three contexts: 1) practice directed at maintaining and enhancing health, well-being, and development; 2) groups, organisations, and communities; and 3) advancing and communicating the knowledge base of the science of psychology (NZPB, 2003). All A-NZ psychologists are required to register within the General scope, which offers or delivers any psychology service that applies "psychological knowledge, principles, methods and procedures of understanding, predicting, ameliorating, or influencing behaviour, affect or cognition" (NZPB, 2018c, p. 1). Psychologists working

in defined branches of psychology can also hold a relevant vocational scope of practice, such as the Clinical scope if deemed adequately educated, experienced, and competent. The purpose of vocational scopes is for the public to identify which psychologists are most suitably qualified in different areas of practice that carry differing risks and hold the necessary knowledge and skills in that area (NZPB, 2018c). Thus, registering in the Clinical scope enables safer practice through regulation by defining specific qualifications, experience, and competencies required to register under that scope.

Maintaining Competence. Under the HPCA Act, the NZPB is also responsible for ensuring a psychologist has maintained competence to be issued an Annual Practising Certificate. The Continuing Competence Programme (CCP; NZPB, 2017) was introduced by the NZPB in 2009 to meet these obligations. The CCP assists psychologists in monitoring and maintaining competence and provides a way to check that psychologists continuously meet competence standards throughout their careers. Initially, the NZPB drew on the College of Alberta Psychologists' CCP and consultation and feedback within the profession, such as with the NZCCP and the NZPsS. The NZPB states that the CCP content and processes will continue to evolve based on ongoing feedback from the psychology community (NZPB, 2017). The CCP involves a psychologist's self-reflection to identify learning requirements and opportunities for competence growth (NZPB, 2017). Self-reflection was deemed to include self-awareness of knowledge, assumptions, and past experiences in relation to the core competencies. Self-reflection also involves critical evaluation of one's own knowledge, skills, judgement, and diligence, which relies on internal honesty and integrity. Reflection is considered central to intentional learning, problem-solving, and validity testing (NZPB, 2017). In addition, self-reflection also involves considering feedback from others. The self-reflection process in the CCP was developed to "maintain the vitality and safe practice of individuals and to promote psychology's high professional standing" (NZPB, 2017, p. 4). Key to the CCP is the reliance on self-reflection and self-reporting, which relies on awareness of shortcomings and accepting and responding to feedback. Like

the core competencies, the CCP was developed within the profession without other stakeholder involvement.

In accordance with the HPCA Act, the NZPB is also responsible for addressing when a psychologist may not be competent. Processes to assess and address gaps in meeting minimum levels of competence required to practice psychology include Competence Reviews and Competence Programmes overseen by the Competence Review Panel and the NZPB Conduct, Competence and Fitness Committee (see: <http://www.psychologistsboard.org.nz/competence-matters/competence-reviews>). Inquiries into a psychologist's competence can be instigated by a Section 34 Notice from a colleague, employer, Professional Conduct Committee, or the Health and Disability Commissioner- on behalf of the public. The Health Practitioners Disciplinary Tribunal, which operates independently from the NZPB, is another avenue for psychologist complaints. The tribunal was established by the HPCA Act to consider charges against any health practitioner registered under the Act and usually involves the most serious complaints (see: www.hpdt.org.nz). Therefore, a psychologist who does not meet the required competencies can face many reviews, processes, and consequences within the profession and from other agencies. While concerns about psychologist competence can be raised within the profession, they can also be raised by a service user, where a body independent from the NZPB can review concerns to determine a course of action.

The Clinical Psychologist Scope

The Clinical Psychologist (CP) scope is a protected title in A-NZ. Consistent with international definitions (e.g., BPS, 2019), A-NZ CPs are defined as specialists in the “assessment, formulation, diagnosis and treatment of emotional, mental or behavioural problems affecting adults, children or families” (NZPB, 2003, p. 1). Clinical psychologists are deemed experts in understanding how to assist people to make changes in their lives, by applying “psychological knowledge and theory derived from research to the area of mental health and development” (NZPB, 2018b, p. 1; NZCCP, 2020). They are

expected to practice “with due regard to ethical, legal, and Board-prescribed standards”, to which competence is central (NZPB, 2018b, p. 1).

The activities of psychology assessment and intervention involve partnerships between clients (service users) and CPs in a two-way process that works better with improved outcomes when there is open communication, mutual collaboration, and mutual understanding (NZCCP, 2020). This includes encouraging clients to share their expectations of a psychologist and raise concerns if they arise. The NZCCP (2020) seeks to assure clients they will be treated with dignity and respect. Choice is also emphasised in that a service user can change their psychologist and provide feedback if any aspect of their care is unhelpful (NZCCP, 2020). In A-NZ mental health care CPs can also be responsible clinicians under the Compulsory Assessment and Treatment Act 1992 (MoH, 2001). Being legally responsible for a service user’s compulsory care makes it more paramount that psychologists understand the rights, needs, and preferences of service users. Given the number of roles and duties a CP undertakes with clients, the professional expectations of a CP and what clients should reasonably expect hinges on 1) assurance that CPs have entered robust training and licensing processes, 2) understanding that the client is one-half of a collaborative and responsive working alliance and process, and 3) that client autonomy and well-being is upheld and advocated for.

Beyond practice with an individual client, CP roles also often involve training, supervision, mentoring, and role modelling of evidence-based practice (Stewart et al., 2014). In this way, CP practice can inform and influence other professionals within mental health care. The NZCCP attests that the government must work with CPs to mitigate the large and unacceptable inequity and poor outcomes for service users in current mental health services (NZCCP, 2021). They acknowledge the recommendations of the Simpson report, which called for better collaboration between stakeholders such as professionals and service users (e.g., Came et al., 2021b; NZCCP, 2021).

Of relevance to investigating competence, a CP operates within a scientist-practitioner orientation, which relies on practice-based evidence and critical evaluation of professional practices (BPS, 2019; NZPB, 2018b). Central is using psychological science to address human issues, being

critical of and contributing to research and emerging knowledge bases, and developing, evaluating, and refining services to be useful to service users, psychology, and other professions. Recognising gaps in current research, critically examining current professional practice, and responding to these issues are thus responsibilities of CP. This is why it is important to add to existing understandings of what competent practice should entail.

Competence and Ethics

Competence is an important ethical responsibility for CPs, and, though competencies and ethical requirements are differentiated, they are interdependent and can overlap. The Code of Ethics for Psychologists Working in A-NZ (the Code; NZPB, 2012) and the core competencies provide the minimum standards registered psychologists must uphold. The NZPB also developed the Code in response to the Act. As psychologists who do not meet ethical or competence standards negatively affect clients, colleagues, employers, and the reputation of psychology, psychologists have a legal, moral, and professional obligation to address and resolve competence concerns (NZPB, 2011).

The Code also sets out CPs ethical responsibilities to service users that relate to including service users in developing professional practice guidelines. Within Principle 2 of the code: Responsible Caring, the domains of “Competence”, “Active Participation”, and “Vulnerability” are essential to ensure the ethical obligations of Responsible Caring are met. Principle 4 of the Code, Social Justice and Responsibility to Society holds psychologists accountable in their practice for the welfare, respect of, and benefit to society. This means that psychologists must consider issues that relate to the wider well-being of society in their practice, for example, competence issues. Valuing, advocating for, and respecting individuals and groups outside the profession, for example, service users, is also in the Code. Thus, in addition to the ethical obligations associated with work involving individuals and groups, psychologists also have an ethical obligation to attend to the wider social implications of their work and the activities of psychology as a profession. This includes ensuring that

practice standards and competencies are consistent with the wider needs of the communities they serve.

Within-Profession Regulation in A-NZ Psychology Practice

As there is limited research and information about service user involvement in A-NZ psychology services and no existing guidelines or frameworks to include service users in professional psychology practice, it is reasonable to conclude that there is little actual involvement of mental health service users within psychology. For example, it is not a stated requirement to have service users on the NZPB, though it is specified that the Board should include two laypeople (Designated Audit Agency Group, 2021). The Ministry of Health (MoH) are responsible for recruiting and electing prospective laypeople, and the Board has little input into who the laypeople will be (NZPB, personal communication, August 15, 2022). The MoH typically elects lay people for regulatory boards based on governance/regulatory experience, community service, Te ao Māori/Tikanga Māori competency, and the ability to represent underrepresented community groups. At times, the MoH also consider legal, financial and management skills, if deemed necessary, on a Board (MoH, personal communication, August 16, 2022).

There is no consideration of explicitly involving people with lived experience, despite the expectation that statutory boards should represent the diversity of people in A-NZ and include candidates with the required skills, experience, and competencies for the role (MoH, 2022b). Incidentally, the last NZPB performance review comprised the self-reflection of four of the five Board members. Self-assessment was evaluated at a high standard, and the core performance standards were deemed fully achieved (Designated Audit Agency Group, 2021). This is another example of within-profession self-regulation that relies heavily on self-report and self-assessment, even when externally reviewed. Limited participation of service users and not seeking comment from service users puts the profession at risk of not meeting needs and expected performance standards. This

appears to be a “blind spot” where 1) service user input is not considered, so it cannot be implemented, and 2) it cannot be ascertained what service users might contribute.

The Need for Service User Views of Psychologist Competence

The lack of provision for service user participation in psychology directly contrasts with recommendations for A-NZ mental health professions to seek out service user views proactively, establish ways to attain service user input and implement service user participation in service development (e.g., MoH, 2021; Patterson et al., 2018). Psychology is falling behind other mental health professional spaces where service user participation is increasing, for example, the World of Difference psychiatry training programme at Otago University (Newton-Howes et al., 2020).

Calls for Service User Inclusion in A-NZ Mental Health Services

Greater emphasis on the rights of service users in A-NZ’s mental health system arose from legislation requiring service user preferences to be considered in the provision of services (e.g., Code of Consumer Rights: Health and Disability Commissioner, 1994). These also apply to CP services. The earliest Mason Inquiry (Mason et al., 1988) was the first A-NZ report investigating mental health service provision. The report identified a lack of consultation with service users, especially Māori. It proposed a model of community care where service users would be asked about and involved in shaping mental health services, including participation in policymaking and service management. The third Mason Inquiry (Mason et al., 1996) identified mental health-related stigma and discrimination as ongoing issues in A-NZ mental health services. This landmark document led to the Blueprint report (Mental Health Commission, 1998b), highlighting recovery-focused approaches and identifying discrimination as a major barrier to recovery. The Blueprint emphasised that the rights of service users in A-NZ must be upheld, that service users should have more participation and control in the services they receive, and that the needs of service users should drive service improvement. The Blueprint also stated that individual mental health professionals must innovate service delivery and continuously explore new and better service methods (Mental Health Commission, 1998b).

Increasing service user participation across all levels of mental health services was identified as a priority in *Rising to the Challenge*, the Mental Health and Addiction Service Development Plan 2012–2017 (MoH, 2012) and the Mental Health and Addiction Workforce Action Plan 2017–2021 (MoH, 2018). He Ara Oranga, the most recent Government Inquiry into Mental Health and Addiction, acknowledged that “too many people are treated with a lack of dignity, respect and empathy” in A-NZ mental health services (Patterson et al., 2018, p. 11). A key priority and recommendation was to position people with lived experience and people accessing mental health services at “the centre of the system” (Patterson et al., 2018, p. 14). *Kia Kaha, Kia Maia, Kia Ora Aotearoa*, the response to He Ara Oranga, reported that “[a] well-trained and motivated workforce with the right skills, knowledge, competencies and attitudes is required to ensure that people with mental health and addiction issues receive high-quality care and support,” (MoH, 2020, p. 10). In these reports, psychologists are not mentioned specifically, except in the Mental Health Foundation (2004) report, which found that most service user interactions with psychologists were positive and rewarding.

One response to the identified human rights and inclusion issues was the adoption of service user advisory and representative roles in some services, such as consumer representatives in District Health Boards. However, these initiatives have not been implemented in psychology. Further critiques include the lack of service user advisors within training programmes and ethics committees and ad hoc use of service user consultation in community services (Patterson et al., 2018).

Conceptualising Service User Exclusion

The advantages of including service user perspectives in research and practice include being able to explore mental health services differently, enhancing the relevance of studies to clinical practice, and generating new and more comprehensive knowledge (Allam et al., 2004; Faulkner, 2009; Goodare & Lockwood, 1999; Hanley et al., 2004; Ramon & Lifecraft, 2000; Rose, 2003; Trivedi & Wykes, 2002). Despite the acknowledgement that service users, like all members of the public, should be able to influence research about public services (Faulkner, 2009), some common issues have been

noted. Key factors contributing to barriers to service user involvement include that certain types of knowledge that exclude service users have been prioritised (e.g., Dirth & Adams, 2019; Jones & Shattell, 2016), the existence of biases and assumptions about people with lived experience (e.g., Happell, 2010; Roper & Happell, 2007), and the presence of professional power imbalances (e.g., Faulkner, 2009; Warne & McAndrew, 2008). Further, stigma and discrimination have long been identified in mental health service provision, which reinforces the exclusion of people with lived experience and may impact CP competence.

Devaluing Service User Knowledge. While professional expertise is essential to inform service planning, delivery and evaluation, service users have specific knowledge, including their experiences of distress, their care, and what helps them (e.g., Allam et al., 2004; Faulkner, 2009; Goodare & Lockwood, 1999). This differs from professional knowledge (Happell, 2010). Within academia and research, professional knowledge can be highly privileged and considered scientific and objective compared to service user knowledge, which is regarded as individual and subjective (Gee et al., 2016; Scholz et al., 2018; Veseth et al., 2017). Regarding psychological theory, Dirth and Adams (2019) draw on Disability Studies to comment on the colonisation of knowledge. They hold that individualist models of self and society that inform hegemonic psychological science are dominant based on the influence of the medical model and positive psychology. In this way, lived experience tends to be viewed as an individual phenomenon. Individualist models may hide the “structural or ecological affordances that enable or disable action and agency” (Dirth & Adams, 2019, p. 266). This serves to reproduce understandings of disability that are marked by devaluation and hopelessness, which can contribute to a broader view that service users are helpless “sufferers”. This “lens” may lead to questioning the reliability and usefulness of including service users in research and additional expectations imposed on this group to ensure their participation is “valid”. One result is that service users are not asked to contribute to research or comment on services they experience.

Some UK and Australian literature highlights the status quo as a reason why service users are often not involved sufficiently in mental health research and policies. These identify stigma, systemic

discrimination, and gatekeeping as factors (Jones & Shattell, 2016; McKeown et al., 2011; Russo, 2012; Sweeney et al., 2009). For example, some researchers feel that involving service users may negatively impact the quality of the research based on the perception that service users may not be able to understand professional concepts (Faulkner, 2009). While many service users are motivated to improve services, common views identified are that service users who participate in studies about services have negative views to “vent” and that this is undesirable. This denounces the right of service users to comment on their experiences, having a silencing effect (Faulkner, 2009). Other issues include beliefs that service users are unreliable and vulnerable because of mental health challenges (Happell et al., 2015) and that service user feedback is negatively influenced by a variety of factors, such as motivation, goal reprioritisation (Christensen et al., 2017), cognitive biases (Andersen & Hjortskov, 2015; Olsen, 2013, 2015) and politically motivated biases (Baekgaard et al., 2017; Baekgaard & Serritzlew, 2016; Christensen et al., 2017; Marvel 2015, 2016). This literature emphasises that service user views are inconsistent and unreliable, which justifies excluding people with lived experience and leads to implicit assumptions that service user input is not worthwhile. A biased focus is reflected, as it is reasonable to expect any person receiving any service to be influenced in their evaluation by the abovementioned factors. It is also reasonable to expect that these factors are influenced by the services a person has received.

Service User Participation Issues. There are also different arguments about whether individual service users can speak for the service user group in a broader sense. Examples include common understandings that service user participants should represent the views of “ordinary” service users (Happell, 2010) and that service users with negative experiences are unrepresentative of the larger group and, therefore, not able to speak on the group’s behalf (Crawford & Rutter, 2004; Tobin et al., 2002). Roper and Happell (2007) note:

To suggest that the voice of consumer activists or advocates should be less influential unless it can be demonstrated to be representative is tantamount to discriminating against a group

that is already marginalised and subject to the stigmatising attitudes of mental health professionals. (p. 6)

Regarding the idea that individual service user views are biased and not representative, Crawford and Rutter (2004) found the views of a mental health service user group to be similar to a random sample of mental health service users when asked to rate the importance of specific priorities for service developments. The main difference between responses was the higher weighting assigned to each priority by the organised group. The point that both groups identified the same priorities provides a basis to challenge the assumption that individual service users who choose to participate do not reflect the views and opinions of those who do not (Crawford & Rutter, 2004).

In contrast to the view of a consumer not being representative enough is the concept of the 'homogenous' service user (Happell, 2010). This assumes that any nominated service user within a profession is sufficient to represent the service user population, leading to tokenistic participation (Happell, 2010). There is, however, no single service user view. There are many areas of disagreement, contention, and diverse views and preferences within the service user movement. In a practical sense, service users may not only bring a singular view but also tap into the experiences of others.

Another issue is the questioning of which service users are most appropriate to participate and, therefore, have their views heard based on the severity categorisation of mental distress. Given that a particular challenge for service users with complex presentations of mental health challenges is engagement and retainment in services, it seems sensible to explore the views of individuals considered to experience more severe mental health presentations (Bowersox et al., 2013; Fischer et al., 2008; Katz et al., 2019; Kreyenbuhl et al., 2009; O'Brien et al., 2009; Oliver et al., 2010; Roe et al., 2016). A research approach that acknowledges the importance of collecting views from service users who have experienced a range of mental distress and accounting for possible barriers to participation in the design navigates this issue (Hack et al., 2019). Another identified barrier to service user

participation in research is stricter expectations for participants with lived experience of mental distress, such as more stringent participant criteria and more checks to ensure criteria are met to be able to participate (Tobin et al., 2002; Happell & Roper, 2006). These create additional barriers for researchers when designing and getting projects approved and can deter participants who may need to expend considerable effort to participate in a study. Examples include answering criteria checks multiple times to justify meeting participant criteria and providing more personal and mental health-related information to be considered a “valid enough” participant.

Power imbalances between Professionals and Service Users. One barrier to service user views being considered in professional development realms is potential difficulties for professionals who hold historical and traditional power (Browne et al., 2008; Davis et al., 2001; Goodwin & Happell, 2006; Happell, 2008; Wellard, 2003, 2007). One example is the reluctance to work with service users due to fear of losing power or status (Faulkner, 2009). Acknowledging the rights of service users to participate can sometimes challenge professionals, which requires overcoming professional defensiveness and fear of criticism to receive and consider service users' views (Roper & Happell, 2007; Warne & McAndrew, 2008).

Understandably, accepting criticism of services can be difficult for healthcare professionals. For example, mental health professionals may feel drawn to defend negatively viewed actions, even when not directly related to an individual (Roger & Happell, 2007; Happell, 2010). To illustrate, some literature highlights that nurses believe service users should be more understanding of professionals and surrender their right to be critical to ease the potential distress and unrest it may cause to the profession (Happell, 2010; Happell et al., 2019; Lilja & Hellzen, 2008; McCullough, 2008; Warne & McAndrew, 2008). While this research is not specific to psychology, it is worth considering whether the factors mentioned are also relevant in psychology services and training organisations. Specifically, CPs may need to move through individual and professional discomfort to hear and accept service user views.

Stigma, Discrimination, and Competence

Stigma and discrimination are also relevant, as conceptualising competence without service user input contrasts with CPs' ethical responsibilities to service users, and the area of stigma and discrimination may be an area of competence to which service users can add new understandings. In the Code of Ethics, Non-Discrimination is a sub-category which requires psychologists to "recognise that all persons and peoples are entitled to equal benefits from the contributions of psychology" (NZPB, 2012, p. 5). Within this, psychologists are required to correct, prevent, and avoid practices that are disrespectful or discriminatory of the cultural, legal, civil, or moral rights of others. However, stigma and discrimination specifically related to mental distress are not mentioned specifically in the core competencies or the Code. Mental health-related stigma and discrimination (MHSD) is a broad term that includes stigma or prejudice (negative beliefs about people with lived experience), discrimination (denial of the fair or legal rights of people with lived experience), and internalised stigma (negative stereotypes about people with lived experience of mental distress which individuals apply to themselves) (Corrigan et al., 2014).

Mental health-related stigma and discrimination are worth considering as the widespread prevalence of MHSD in A-NZ has been acknowledged and is thus likely to impinge on psychologist competence. For example, *Respect Costs Nothing* (Mental Health Foundation, 2004), the first A-NZ survey that asked service users about mental health-related discrimination experiences (n = 785), found that 84% of participants experienced mental health-related discrimination across all life domains. This survey reported the negative consequences of discrimination, including that fear of discrimination (often based on past experiences) is as debilitating as direct experience (Mental Health Foundation, 2004). Due to fear of MHSD, almost half of the sample had stopped participating in important life areas, including mental health services. Other studies outline outcomes of stigma and discrimination as prejudice, loss of dignity, loss of basic human rights, loss of participation in community, work, and education settings, loss of self-esteem, loss of belief in recovery, reduced help-seeking, more difficulties maintaining wellness, and less support from others (Mental Health

Commission 1998b; Mental Health Foundation, 2004; Ministry of Health, 2005; 2007; O'Hagan, 2001; Peterson et al., 2008).

Of relevance to CP, it is well established that mental health professionals hold discriminatory and stigmatising beliefs about mental distress and that many service users experience MHSD from mental health services (Mental Health Foundation, 2004; Peterson et al., 2008). External and internalised stigma and discrimination negatively impact service user engagement and intervention outcomes and create barriers to service user inclusion in professional regulation and evaluation of services (Hack et al., 2019). Reported outcomes for service users include disrespect, not being taken seriously, being talked about rather than talked to, being degraded, ridiculed and discouraged, and being treated as incompetent (Mental Health Foundation, 2004). Mental health professionals have been advised to reduce mental health-related discrimination by being aware of personal stigmatising and discriminating attitudes, engaging in education to replace myths and assumptions about mental distress and service users, and taking action to challenge discriminatory attitudes and behaviours (Mental Health Foundation 2004; Case Consulting, 2005).

Although the presence and effects of MHSD are understudied within mental health research (Clement, Schauman, et al., 2015; Hack et al., 2019), some psychology literature also highlights the consequences of MHSD. These include negative impacts on help-seeking behaviours, access to mental health support, and therapeutic engagement, increased mistrust in services and professionals, and an increased likelihood that psychological recommendations will not be followed (Clement, Schauman, et al., 2015; Clement, Williams et al., 2015; Hack et al., 2019; Rüsçh et al., 2009; Tsang et al., 2010). The small samples, varied settings, and limited findings of this small set of studies are noted. Therefore, further investigation of how MHSD impacts CP service engagement and delivery is needed.

There is some focus on stigma and discrimination in professional standards in the Code and the core competencies. In the General scope competencies, stigma and discrimination are referred to in terms of alleviating distress “associated with stigma, discrimination and social exclusion (based

upon ethnicity, gender, sexual orientation, disability, or religious beliefs)” (NZPB 2018a, p. 5). In the CP scope, the Diversity, Culture and Treaty of Waitangi area refers to an adequate “understanding of the concepts of stigma, discrimination and social exclusion as applied to diverse client groups, including the consequences of these factors in the practice of psychology” and “integration of the concepts of stigma, discrimination and social exclusion into assessment and treatment processes” (NZPB, 2018a, p. 20). The cultural competencies include knowledge of socio-political influences (e.g., stigmatisation and marginalisation) and knowledge of “the history and manifestation of oppression, prejudice, and discrimination in home country, and that of the client and their psychological sequelae” (NZPB, 2018a, p. 16).

Though there is some attention to stigma and discrimination in psychology professional practice guidelines, these understandings rely on clinician self-reflection and peer review and do not include MHSD specifically. While useful, this may limit current understandings, as MHSD cannot be comprehensively evaluated by those not experiencing it. When psychologists have lived experience of mental distress and service use, internalised stigma may affect the identification of biases and implicit prejudice. Psychologists as professionals also hold different positions to service users as clients, and with this comes different positions of power. Mental health-related stigma and discrimination are likely to be an area of competence where service users can contribute to better understandings within psychology practice.

A-NZ Service User-Informed Competencies Development

The development of competency-based practice in psychology overseas has drawn on other professions across health and education (Kaslow et al., 2006; Marrelli et al., 2005; Naquin & Holton, 2006; Ricciardi, 2005). Thus, it is relevant to consider A-NZ mental health services that have included service users in competency development. Generally, A-NZ’s mental health services have become increasingly focused on service users’ views about services. This began with deinstitutionalisation across the 1970s-1990s and the development of a recovery-oriented system response (Collings et al.,

2010; HDC, 2018). Mental health inquiries (see p. 37) and the adoption of service user advisory and representative roles also provided an impetus for service user preferences to be considered in the provision of services (including psychology, e.g., code of rights: HDC, 1994). Following legislation, service user-informed workforce development strategies have been implemented by some services with differing degrees of service user involvement.

One example is the Nursing Council Addiction Specialty Nursing Competency Framework (Drug and Alcohol Nurses of Australasia, 2018). Although the Nursing Council did not directly consult with service users, they sought feedback from representatives of the A-NZ Alcohol and Other Drug Consumer Network (Drug and Alcohol Nurses of Australasia, 2018). Integrating service user perspectives further, the Peer Workforce Core Competencies (Te Pou o te Whakkaaro Nui [Te Pou], 2014) were developed through consultation with peer support workers, peer leaders, and service user forums held regularly for anyone to voice competency considerations. One of the Peer Workforce Core Competencies is Lived Experience and Peer Values (Te Pou, 2014). A strength of these competencies is that they are translatable for both workers and service users - and those in the space of both - providing a shared language within and across services.

The Werry Workforce Whāraurau (2019) Real Skills Plus ICAMHS/AOD competency framework (Real Skills) is another example of a service user-informed approach to competency development. Real Skills focuses on the knowledge, skills and attitudes needed to work with young people with mental health and/or addiction difficulties, whānau, and community. Real Skills was developed with Matua Raki, Te Rau Matatini/Te Rau Ora, and Te Pou, all of which actively prioritise service user involvement and learning from service user experience in their services. Real Skills also draws on Youth Consumer Advisors and Family/Whānau advisors, valuing the lived experience of mental health services upfront. They have an E-Skill Plus Tool, which identifies areas for workforce development and plans service delivery according to feedback. This survey is available to everyone, including CPs, and individuals can assess their own competence through a performance indicator-based system. In this way, service users can input feedback about performance indicators that then

inform the Real Skills competencies. The Werry Workforce Whāraurau (2019) encourages all mental health workers (including psychologists) to adhere to the Real Skills Plus competencies as an adjunct to profession-specific competencies. This recommendation is not mandatory, as A-NZ psychologists are accountable solely to the NZPB competencies as legislated by the HPCA Act. The main points of difference between the peer worker, nursing, and Real Skills competencies and the NZPB psychology competencies are (1) explicit acknowledgement of the value of lived experience and inclusion of service user views as an advantage to improving services, and (2) the degree of consultation and involvement of service users when developing and evaluating these frameworks.

A further example of service user-informed competency development in A-NZ is the Mental Health Commission Recovery Competencies for Mental Health Workers, which are competencies for mental health workers using a recovery approach (O'Hagan, 2001). The Recovery Competencies are based on recovery principles from the Blueprint for Mental Health Services in NZ, a report created by the lived experience community (Mental Health Commission, 1998b). When the Blueprint was published, the Government acknowledged the need for a recovery approach and instructed that the Blueprint was to be fully implemented by mental health workers (O'Hagan, 2001). This attempt for mental health professions to acknowledge a recovery approach arose from the acknowledgement of insufficient attention in mental health disciplines to the service user movement and service user participation. This encouraged different understandings of mental health, supporting the personal resourcefulness of service users, supporting individuals to develop relationships and support networks, and assisting individuals to effectively use services and resources (Mental Health Commission, 1998a; O'Hagan, 2001). The recovery-based competencies were seen by some as signalling a fundamental change to the education of mental health workers (Mental Health Commission, 1998b, 2012), requiring new ways of practising in the mental health sector. Their benefits include applicability to clinicians working with service users of all ages and cultures in all services and sectors, including mainstream, kaupapa Māori and service user-run services. The Real Skills competencies also have explicit values and attitudes to guide a practitioner. Both the Real Skills

and Recovery Competencies (see Table 2) highlight responsiveness to service users and whānau and draw on service user-informed approaches. Enabling the participation of service users and whānau is central. These competencies overtly recognise stigma, discrimination, social exclusion, and the rights of people with lived experience as discrete areas of competence, contrasting with the NZPB core competencies.

Table 2

NZ Competencies with Service User Input

Recovery Competencies “A competent mental health worker”:	Real Skills “Every person working in a mental health and addiction service”:
<ol style="list-style-type: none"> 1. Understands recovery principles and experiences in the A-NZ and international contexts 2. Recognises and supports the personal resourcefulness of people with mental distress 3. Understands and accommodates the diverse views on mental distress, interventions, services, and recovery 4. Has self-awareness and skills to communicate respectfully and develop good relationships with service users 5. Understands and actively protects service user’s rights 6. Understands discrimination and social exclusion, its impact on service users and how to reduce it 7. Acknowledges the different cultures of A-NZ; knows how to provide a service in partnership with them 8. Knowledge of community services and resources; actively supports service users to use them 9. Knowledge of the service user movement; able to support their participation in services 10. Knowledge of family/whānau perspectives; able to support their participation in services 	<ol style="list-style-type: none"> 1. Utilises strategies to engage meaningfully and work in partnership with service users; focuses on service users’ strengths to support recovery 2. Contributes to whānau ora for Māori 3. Encourages and supports whānau to participate in the recovery of service users; ensures that whānau have access to information, education and support 4. Recognises that service users and their whānau are part of a wider community 5. Uses strategies to challenge stigma and discrimination; provides and promotes a valued place for service users 6. Implements legislation, regulations, standards, codes and policies relevant to their role in a way that supports service users and their whānau 7. Actively reflects on their work and practice; works in ways that enhance the team to support the recovery of service users <p>Values</p> <ul style="list-style-type: none"> • Respect; Human Rights; Service; Recovery • Communities; Relationships <p>Attitudes</p> <ul style="list-style-type: none"> • Compassionate and caring; genuine; honest; non-judgemental; open-minded; optimistic; patient; professional; resilient; supportive; understanding

Drawing on competencies developed with people with lived experience illustrates the different ways other professions, such as nursing and the peer workforce, have considered the input

of service users valuable to understanding competence. Acknowledging other professions' developments leads to asking whether service users should have been consulted in psychology. Service user involvement may have mediated the conceptual complexity that was developing within psychology's understandings of competence at the time. Also, it may have generated understandings of assessing competence by drawing on the lived experience of people who had experienced the services of a psychologist. However, concerns about complexity and limited translation of competence to practice remained solely within the psychology profession.

Issues with the Lack of Service User Views of Psychologist Competence

Clinical psychology practice hinges on professional standards (competencies and the Code of Ethics) and collaborative and inclusive approaches that place service users at the forefront of psychologist activities. Given that the competencies exist to ensure the protection and safety of the public- including service users- the profession must consider that service user views of competence can strengthen professional practice for CPs. Inviting and collecting service user views about CP practice aligns with CP's responsibilities to 1) uphold the principles of inclusion, collaboration, and advocacy in CP work, 2) address gaps in current research and contribute new knowledge, and 3) influence and inform wider mental health services.

There is limited specific and current research to inform understandings of professional competence for psychologists in A-NZ. Although there are NZPB practice guidelines and other texts for guidance on the professional practice of psychology (e.g., Waitoki et al., 2016), there is no current research in A-NZ to help define specifically what the competent provision of psychology services entails. While core competencies are scheduled for review occasionally, the last NZPB review was in 2012. Despite competencies requiring continuous development, future competencies required for a psychologist have been discussed as remaining basically the same (NZPB, 2017). This assumes that competencies today are currently fit for purpose and will also be so in the future. This contrasts with views that professional practice should evolve continually to meet the needs of the profession and

people receiving psychology services. As competence is the profession's benchmark to ensure appropriate and responsive care for service users, it is relevant to be interested in the input of service users when defining competence and determining competencies. Without service user views, it cannot be confirmed that the competencies that psychologists are trained, regulated, and monitored by meet the requirements of service users.

The current A-NZ core competencies represent a consensus view of the profession, determined in 2006, of what constituted competent practice. This appears to be an approach that the profession deemed to be an acceptable representation of current practice at that time. Service users are not noted as being involved in competency development (NZPB, personal communication, January 17, 2019). While psychologists with lived experience of mental distress may have been covertly involved in competence development as stakeholders, stigma-related factors may have prevented these psychologists from openly advocating for views arising from lived experience. This appears reasonable as disclosing lived experience of mental distress and, therefore, representing a service user perspective may carry repercussions. There are NZPB guidelines that state that "personality issues" and "mental illness, especially depression, bipolar disorder, or substance abuse" are factors that can cause unprofessional behaviour (NZPB 2020; p. 4). Further, suppose a psychologist thinks another psychologist's mental health impairs their professional function. In that case, they must discuss this with a Board Psychology Advisor, who will ascertain whether to make a formal notification (NZPB, 2011). This implies that lived experience of mental distress can be used as a reason to question a psychologist's competence. The reluctance of CPs with lived experience to share their experiences and views in professional settings constrains opportunities to advocate for or contribute to service user views, especially if views are not specifically invited or explicitly valued by the profession.

The lack of explicit inclusion of service user views for competence development has prevented their contributions from being documented or differentiated from views of competence of those without lived experience of mental distress or experiences of using psychological services. The

scientist-practitioner basis of CP must identify gaps in current research and practice and add to the literature base of professional practice. As it is a professional responsibility to enhance the autonomy, well-being and inclusion of people experiencing mental distress on systemic as well as individual levels, innovating the way service users are integrated into professional practice within psychology carries the potential to influence within-profession and also wider systems (other professionals and professions) to improve health care and responses to mental distress. There is currently no information about whether service user views of competence differ from professional understandings of competence and what service user views of CP competence will contribute to current understandings.

Summary

As discussed in Chapter One (e.g., p. 25), psychology competency frameworks and models have been critiqued for a lack of practical utility and development (e.g., Commission on Accreditation, 2006; Rodolfa et al., 2014). Across the development of competencies, there has been a systemic lack of attention to whether service users could contribute. As Rubin et al. (2007) suggest, input from “multiple constituency groups” is needed to identify competencies and thresholds for competency attainment and identify and use meaningful approaches for assessing competence. I argue that service users are a constituency group that can provide input to better understand competence.

Asking service users what they deem competent practice to be is one way to gather understandings representing service user preferences, ensuring the core competencies are suitable to guide psychology practice. Exploring service user views enables validity-testing of current understandings of competence outside of the profession. Lags in psychology between the start of the competency-based movement and the widespread adoption of a culture of competence and its assessment have been attributed to a lack of appropriate evaluation strategies (Carraccio et al., 2002). Considering the perspectives of service users for understanding competence can provide additional information to address this gap.

However, numerous barriers to service user involvement in research and practice development make participation and inclusion difficult (see p. 37). Examples include assumptions and biased expectations about service users as participants. Not inviting and integrating service user perspectives implies that professionals hold and interpret the type of knowledge “worth knowing”. This is in direct contrast to national policies and inquiries that have consistently acknowledged the need to hear and respond to people who access A-NZ mental health services (e.g., Code of Consumer Rights (HDC, 1994); Blueprint report (Mental Health Commission, 1998b); Rising to the Challenge, the Mental Health and Addiction Service Development Plan 2012–2017 (MoH, 2012); the Mental Health and Addiction Workforce Action Plan 2017–2021 (MoH, 2018); He Ara Oranga (Patterson et al., 2018); Kia Kaha, Kia Maia, Kia Ora Aotearoa (MoH, 2020) . I highlight the need for multiple forms of inclusion and consultation with multiple parties (including service users) when planning, developing, and implementing professional practice guidelines that inform service delivery. Further, barriers to service user involvement confirm that care is required to develop an appropriate research design for any project that seeks to better understand the views and experiences of people with lived experience of mental distress.

While insufficient involvement of people with lived experience in the development and evaluation of professional mental health services has been acknowledged in A-NZ (see p. 37), these acknowledgements are not explicitly aimed at psychologists. Exploration of how and where service users may be involved in developing psychology’s competencies and the utility of this may inform psychology-specific understandings of competence. In a wider sense, consultation with service users provides an opportunity to understand more about changes in public need and demand and expand the knowledge and skills of psychological practice for service user engagement and accessibility. A comprehensive approach to understanding what makes a psychologist competent, therefore, is one that also includes people who have experienced psychology services.

Investigating service user views of CP competence provides the opportunity to move forward from previous understandings of competence. Of note is the need for a thorough and systematic

approach to collecting views of competence to inform a knowledge base sensitive to the likely diversity of service users' views, experiences, and preferences. An approach that values different forms of knowledge and multiple realities and does not seek to confirm one true reality (e.g., social constructionism) is relevant here. Given the barriers that led to service users not being considered as having useful views to share regarding professional practice and the impacts of stigma and discrimination on service users being able to provide feedback, an approach to explore service user views must hold human rights at the centre. It is important to adopt an approach that does not assume mental health challenges are individual failings, does not allow pathology and diagnoses to overshadow the profession's responsibilities, and values service user experiences and views as meaningful.

Aim and Research Questions

This study aims to explore service user views of CP competence and consider how they may relate to the existing core competencies for the practice of psychology in A-NZ.

The research questions are:

1. What do service users identify as competent practice for CPs?
2. How do service user views of CP competence align or contrast with existing aspects of the NZPB core competencies?

Chapter Three: Methodology

In this study, I sought to collect service user views of what makes CPs competent and identify how participant views align and contrast with the existing NZPB core competencies (research questions one and two). I required a new research design approach to address gaps in current understandings of competence and encourage participation from people who had seen CPs for mental health support. Consequently, I adopted a user-led social constructionist orientation that incorporated principles of co-production for the methodological underpinnings.

I chose a primarily qualitative mixed methods design to gather a range of views. I collected data using a survey and interviews to attend to the issues with current competence research and service user involvement in research and academia (identified in Chapter Two, p. 37; e.g., Christensen, 2018; Glasby & Lester, 2004; Lawn, 2015; Mockford, 2012). The survey data collection method meant I could ask about competence in various ways across different areas, and participants could consider and form their answers over time rather than in the moment.

Interviews offered an alternative for participants who could not participate in the survey and/or preferred to comment on competence verbally. Interviews meant I could check my understandings and interpretations of what the interviewees said during the interviews and ask for further examples, elaboration, and clarification in specific areas or regarding specific aspects of competence.

Participants were self-selected adults who had seen at least one CP for mental health support in A-NZ, and I used descriptive statistics to summarise the demographic and contact with CP information. Qualitative survey responses were analysed using content analysis, and ratings of different competence areas were analysed using descriptive statistics. Interview transcripts were analysed using thematic analysis.

Theoretical Underpinnings

Social Constructionism

This study draws on Burr's (2015, 2019) description of social constructionism, that knowledge is provisional, formed in context, and located socially, historically, and contextually. In this thesis, competence is seen as socially constructed. Specific social processes shaped how competence is currently understood and influenced how the core competencies were selected and deemed appropriate. Epistemologically, what counts as competent practice has not been objectively determined but created and shaped through human social interaction and the constructive force of discourses (Burr, 2015, 2019). Professional views have been prioritised in understanding competence and what the competencies should be. Therefore, current understandings of competence function as "assumed knowledge" controlled by disciplinary power (Foucault, 1973a, 1973b, 1979). Professional power means that service user perspectives have not been considered, so their views do not contribute to assumed knowledge. Service user views are separated from professionals through this exclusion, relating to the notion of the "mad" separated from the "sane" (Foucault, 1973a).

Social constructionism holds the epistemological possibilities that multiple views of reality are possible and that dominant understandings of reality can shift (Burr, 2015). As it is possible that service users will have different understandings of competence than psychologists, service user views need to be compared with current dominant (professional) understandings to enhance existing knowledge and provide a more inclusive understanding of competent practice. The service user perspectives explored in this study are two-fold, as I explore a) views based on previous experiences with CPs and b) preferences for competent practice.

Qualitative tools are necessary to investigate competence as social constructionism assigns importance to the meaning of accounts/texts (Burr, 2019). Any approach to better understand competence depends on the discursive resources available. Opening up opportunities to interpret what service users view as competence to provide "evidence" for knowledge generation is therefore

important. Understandings of competence have been shaped through language, and language is crucial to understanding social phenomena (Burr, 2019). Thus, I needed to collect constructions of competence from typically excluded participants and a way to compare these constructions to dominant understandings of competence. I considered that service user views of competence could draw from similar discourses and make similar claims to the current understandings, and I also wanted to be able to gather and include contrasting discourses. Rather than generating “truthfulness” I aimed to attain “usefulness” to ideally strengthen professional practice.

Regarding participants, social constructionism holds that any person’s point of view is valid, allowing diverse perspectives shared by diverse participants to be explored. This negates common barriers to service users participating in research, discussed in earlier chapters. For example, assumptions about the representativeness and validity of service user views based on the categorisation of symptoms, severity, or any other within-group difference did not impede participation in this study. Any individual who met the selection criteria was eligible to participate and provide legitimate data, and data saturation was not required or relevant. In a practical sense, any person who has seen a CP in A-NZ has seen a CP who is required to adhere to the same core competencies.

Co-production and User-led Underpinnings

I drew on co-production and user-led research principles to guide an alternative approach to how competence has previously been researched and understood. These principles guided the underlying assumptions of this study and informed my methodological choices. Co-production shifts away from traditional research assumptions of service users as “subjects” to genuinely value service user expertise and build collaborative relationships with people with lived experience of mental distress (Happell et al., 2018; Happell & Scholz, 2018; Roper et al., 2018; Slay & Stephens, 2018). Through partnership and collaboration, co-production addresses power differentials between service users and professionals, often perpetuated by traditional academic research approaches (Gordon &

O'Brien, 2018; Roper et al., 2018; Slay & Stephens, 2013). This is important as power differentials affect service users' autonomy, self-determination, choice, and dignity (Slay & Stephens, 2013). Co-production also aligns with Trauma-Informed and Recovery-Oriented approaches that emphasise holistic well-being, hope, and personal strengths to support people towards a self-determined, meaningful, and satisfying life (Davidson, 2008; Roper et al., 2018; Shepherd et al., 2008).

User research (also known as survivor research) emerged from the mental health service user/survivor movement (Faulkner et al., 2021). A user-researcher is a person with lived experience of mental distress who uses that lived experience to inform their research, carried out in partnership with peers (The Lived Experience Research Network, 2014; Te Pou, 2020). User-led research values experiential knowledge (Russo, 2012), challenging assumptions that researchers are more reliable and credible when they are distanced from the experience(s) being explored. Being closer to the direct experience of a phenomenon being explored leaves less chance for distortion, inaccuracy, and damage in the resultant knowledge generated (Beresford & Russo, 2016). Thus, my own lived experiences of mental distress and times of service use can be considered strengths that have informed my research processes.

The central user-led principles in this study are empowerment, equality, and change. For example, I committed to empowering mental health service users, to support them to have a greater say in services that affect them. My purpose was to enable silenced voices to speak and to be given the space to be heard. I acknowledged that mental health service users have traditionally been excluded from contributing to the knowledge bases used to support them (psychology and competencies). I hold that service users are "credible knowers" (Radden, 2012) and that experiential knowledge is valuable for mental health research where the basic premises of professional knowledge are critiqued (Faulkner et al., 2021).

The co-production principles I drew on were the inclusion of service users as equal and valued partners and assets from the outset; acknowledgement, exploration and addressing of power differentials; reciprocal relationships between researchers/professionals and service users; and

engaging with lived experience networks as an optimal way of sharing knowledge (Happell et al., 2018; Happell & Scholz, 2018; Roper et al., 2018; Slay & Stephens, 2018). Co-production principles guided the decision to recruit a supervisor with lived experience of mental distress. Several other co-production-based decisions included consultation with service user groups when developing research questions and aims, developing measures, procedures, and participant criteria, and seeking and responding to feedback during data collection. I discuss consultation processes further in Ethical Considerations (see p. 71). I attempted to value transparency, being clear from the outset about my goals and making it explicit that, while I endeavoured to consider and adhere to co-production values where possible, I ultimately controlled the project. I was also open about my lived experience and motivation to ensure that psychology services are responsive to those who receive them.

While user-led and informed by co-production principles, areas of this study diverged from co-production. I control this thesis, and one of my purposes is to meet the university requirements for a Doctor of Clinical Psychology qualification. The findings and conclusions are based on my organisation and interpretation of the data collected. This differs from co-production, which emphasises participation throughout each research process. This means that for true co-production, service users would have been involved in interpreting the findings and reviewing and contributing to the discussion and conclusions (Roper et al., 2018).

Consultation

A cornerstone of this study was the degree of consultation undertaken in the planning, designing, and data collection stages. After recruiting a CP with lived experience as an external supervisor, I researched and sought out A-NZ service user groups and organisations. I contacted some, introduced myself and shared ideas for this study, which led to consultation meetings. We got to know each other at each meeting, which meant sharing some of my experiences and why I believed in this project. Being authentic and vulnerable enabled a sense of connectedness and mutual trust between myself and service user organisations. Their trust was demonstrated by sharing

honest feedback, which shaped the research questions, the survey, and the interviews. They also provided contacts and vouched for this study with wider service user networks during recruitment.

An example of mutual trust and reciprocity was being given Changing Minds Rākau Roroa (Tall Tree) training during the early phases of this study. Rākau Roroa enriched my understanding of how to conceptualise and discuss mental distress, assisted me in better describing my values and motivation for the study, and provided guidance on how to share parts of myself in ways that helped other service users and organisations feel safe. A valuable part of service user consultation included discussions about language, such as how to talk and ask about distress and experiences in ways that allow people to feel valued and respected. How the survey was worded and explained to participants was the result of these discussions with service user stakeholders. Consultation processes ultimately led to people feeling comfortable participating and providing rich, honest, and open responses.

Participants

Eligibility

The inclusion criteria for the survey and interviews were people aged 18 and over who had seen at least one CP for mental health support in A-NZ and could remember their experiences with the CPs well enough to comment on them. Interview participants were required to not have completed the survey. They initially needed to be able to travel to an Auckland venue, which was omitted when the ethics committee approved video interviews. Exclusion criteria for all participants included people not being certain that they had seen a CP and people who saw CPs for something other than mental health support. All participants were required to indicate how they knew they had seen a CP (see Table 3).

Table 3*How Participants Knew They Saw a Clinical Psychologist*

Sample	Count	%
Survey Participants		
Informed by professional or service	35	38.46%
Checked Myself	26	28.57%
Informed By Title	18	19.78%
Indicated by Correspondence	9	9.89%
Checked with Others	3	3.30%
Interview Participants		
Informed by Professional or Service	9	60%
Informed by Title	2	13.33%
Checked Myself	2	13.33%
Checked with Others	2	13.33%

Recruitment

Survey and interview participants were recruited through A-NZ mental health and service user organisations (see Appendix A). I selected recruitment organisations due to their well-known online presence and connection with other service user networks, meaning they could quickly reach a range of service users. I emailed the recruitment organisations, introducing myself and the study's aims and proposed design, and they indicated their support by email and at in-person meetings. When the survey was live, recruitment organisations advertised it with a link to the survey on their websites, social media, mailing lists, and newsletters. Interview expressions of interest were distributed similarly, with potential interviewees instructed to contact me. Adverts (see Appendix B) were re-shared after two weeks. The study was also publicised at the Service User in Academia Symposium in Wellington (December 2019) and on the Planet FM Mental Health Radio show "Take it from Us" (January 2020). Survey participants could enter a draw to win one of 20 \$40 grocery vouchers, and each interviewee received a \$40 grocery voucher.

The survey was available online for eight weeks and was checked in Qualtrics weekly to gauge the volume of responses, track incomplete surveys, and check practical issues. Interview recruitment took place over six weeks, starting two weeks after the survey was live. Interviews took place

alongside the survey data collection, finishing about two weeks after the survey closed. This allowed me to consider live feedback about the survey provided by the service user networks, which I could then include in my interview questions. I could also offer participation to those who could not complete the survey and preferred an interview. Online video interviews were implemented due to feedback to organisations and me from people in other regions of A-NZ who were eager to participate.

Participant Selection

All participants were self-selected. For survey participants, the advertised link led to the survey information sheet (see Appendix C), followed by the survey itself (see Appendix D). The information sheet stated the criteria, and then the start of the survey required participants to indicate that they met the selection criteria. After the demographic information in the survey, there was a further survey item to check again that a participant was certain they had seen a CP. Participants who were unsure were directed out of the survey with a message that thanked them for their time, stated that they needed to be completely sure they had seen a CP, and provided researcher details for any queries.

When prospective interview participants contacted the researcher, they were emailed the participant information sheet, which specified the criteria (see Appendix C). I also checked whether potential participants were certain they had seen a CP for mental health support in A-NZ and how they knew. I checked the criteria again at the start of each interview.

Final Samples

As I was unaware of any similar studies that had been carried out, it was difficult to estimate how many people would take part. People with different lived experiences and who may identify within different groups regarding psychological well-being can have different needs and preferences at different times across different contexts. As it is not possible to hear from every single service user with every single range of human experience of mental health challenges, data saturation was not an

expectation. This does not mean that capturing the views of service users is any less important, and I do not claim this research is exhaustive in that sense.

There were 73 fully completed surveys. An additional 102 surveys were started but not completed and were omitted. Most incomplete surveys involved drop-out during the introduction. Without knowing, reasons for drop-out may have been due to the length of time required and not meeting the inclusion criteria.

I aimed for a purposive sample of up to 10 interviewees for the interviews, though there were many more expressions of interest than expected, particularly after I offered video interviews. I stopped interviews after 12 were completed. This was mainly due to time constraints, and I had collected a large amount of data by that point. Thirteen additional people were eager to take part in the interviews during recruitment.

Participant Demographics

Survey. As shown in Table 4, the survey sample ($n = 73$) predominately identified as women (83.56%). Almost half (49.31%) were between 30-49 years of age, with just under a quarter (24.65%) between 20-29 years of age (range = 18-72 years, $M = 39.4$, $SD = 13.05$). Survey participants were mostly Pākehā/NZ European (74.42%), and 13.95% indicated Māori. Over half of the survey sample were tertiary graduates (57.53%), and almost one quarter (24.65%) were tertiary undergraduates. For occupation, 15.07% worked in mental health support, and 9.59% were allied health professionals. One-fifth of the sample (20.55%) were not formally employed (including $n = 2$ due to mental health), and 12.33% were students.

Table 4*Survey Participant Demographics*

Category	Count	%
Gender		
Women	61	83.56%
Men	8	10.96%
Gender Diverse	4	5.48%
Age (Years)		
18-19	2	2.73%
20-29	18	24.65%
30-39	20	27.39%
40-49	16	21.92%
50-59	11	15.07%
60-69	5	6.85%
70-72	1	1.37%
Ethnicity		
Pākehā/NZ European	64	74.42%
Māori	12	13.95%
Other/ Other European	7	8.14%
Asian	2	2.33%
Pasifika	1	1.16%
Education		
No High School	4	5.48%
High School	8	10.96%
Tertiary Undergraduate	18	24.65%
Tertiary Graduate	42	57.53%
Prefer Not to Say	1	1.37%

^a Age is collapsed into categories.

Interviews. As shown in Table 5, over half of the interviewees identified as women ($n = 8$) and Pākehā ($n = 7$). One-third identified as Māori, including Māori/Other European and Māori/Jewish. This was important as Māori are often underrepresented in mental health studies. The mean age of interviewees was 40 years ($SD = 13$, range = 24-57 years), and all participants had high school level or higher education. Participants were mostly in paid employment ($n = 8$) or studying ($n = 3$). One was a beneficiary in supported living. Participants held a range of occupations including speech and language therapist, social worker, business owner, accounts manager, mother, teacher, child education advocate, lived experience educator, and consumer advisor.

Table 5*Interview Participant Demographics*

Category	Count	%
Gender		
Men	4	33.33%
Women	8	66.67%
Age (Years) ^a		
20-29	4	33.33%
30-39	3	25%
40-49	1	8.33%
50-59	4	33.33%
Ethnicity		
NZ Pākehā	7	58.33%
Māori	4	33.33%
Canadian	1	8.33%
Education		
High School	3	25%
Tertiary Undergraduate	3	25%
Tertiary Graduate	6	50%

^a Age is collapsed into categories.

Measures and Procedure**Survey**

Survey Items. I built the survey (see Appendix D) myself using Qualtrics Software. The survey items were:

1) *Selection Criteria and Consent* (see p. 253)

2) *Demographic Information* included age, gender identity, ethnicity, level of education, and occupation.

3) *Contact with Clinical Psychologists* (see p. 254) asked about the range of experiences with CPs, reasons for seeing CPs, and other support received for mental health. Response options included tick boxes participants could select from, as well as “Prefer not to say” and “Other” options to which participants could provide open-box responses.

4) *Overall Clinical Psychologist(s) Experiences* (see p. 257) asked about general views of competence before “competence” was described. Participants indicated the helpfulness of CPs using

a five-point rating scale (ranging from “extremely helpful” to “extremely unhelpful”) and then provided information in an open-box format about what the CPs did that helped and what was unhelpful.

5) *Your Views of Clinical Psychologist Competence* included a description of competence: “*In clinical psychology, a competent clinical psychologist is one that has adequate knowledge, skills and attitudes to practice psychology safely*” (see p. 257). Participants were informed that CPs in A-NZ adhere to the NZPB Core Competencies and were then asked what they thought made a CP competent and what a competent CP would do or say. Responses were provided in an open-box format.

6) *Areas of Clinical Psychologist Competence* asked respondents about nine specific areas of competence: Knowledge; Diversity, Culture and Te Tiriti o Waitangi; Professional, Legal and Ethical Practice; Understanding Your Situation (Framing Measuring and Planning); Services (Intervention and Service Implementation); Communication; Professional and Community Relations, Consultation, Collaboration; Reflective Practice; and Stigma, Discrimination, and Social Exclusion.

Each *Competence Area* item contained three parts:

- a) The area description.
- b) A five-point rating scale for indicating how important that area of competence was, ranging from “very important” to “very unimportant”.
- c) An optional comment box that invited respondents to share why they gave their rating and provide examples.

After the competence area items, respondents were asked whether it was important to know whether a CP had lived experience of mental distress/times of service use by selecting yes or no. They were then asked to provide open-box answers for why or why not.

7) *Additional Items* were open-box questions that asked whether there was anything else to add about what makes a CP competent and hopes for CPs in terms of competence. Participants were asked whether it was important to be asked their views about competence (yes or no), and they

could provide an open-box response as to why or why not. A final open-box question invited feedback about participating in the survey.

A list of resources was provided after completion, and then survey participants could follow a link to provide their details for the voucher draw and/or later be provided a copy of the research summary.

Survey Development. The Demographic items were designed to collect information about the sample. The Contact and Experiences with CPs sections were intended to facilitate recall of experiences with CPs and to gather specific information about CP experiences to be able to describe the variety of experiences participants had. The competence items were designed to collect information about views of competence in various ways. The Helpfulness items encouraged sharing general ideas about competence before definitions of competence were provided, for example, “in your experience, what did your clinical psychologist(s) do that helped?” The Views of Competence items sought feedback about competence without priming, descriptors, or specific examples of how the profession has conceptualised competence. The Anything Else and Hopes for Competence items were intended to elicit further information about what is important for CP competence after considering the Areas of Competence. The Lived Experience item sought to explore the potential relationship between psychologists’ lived experience of mental distress/times of service use and views of competence.

The Areas of Competence items were designed to gather views about specific areas of competence. The Area items were partially based on the NZPB Core Competencies (NZPB, 2018a). The process included reviewing Part One: General Scope, Part Two: Cultural Competencies, and Part 3: Clinical Scope (NZPB, 2018a). For each area within the three parts (e.g., Discipline, Knowledge, Scholarship, and Research), I examined the definition, knowledge, and skill descriptions. I then created the survey Area Descriptors based on skills, attitudes, and knowledge thought to be observable and possible to be commented on by people who had seen a CP. I used layperson language so participants could comment on specific professional concepts (and areas of competence)

without requiring professional knowledge or language. I assumed that most people cannot be realistically expected to have detailed CP knowledge and related language, such as legislative requirements, existing training processes, disciplinary boundaries, and academic underpinnings. The survey did not ask about aspects and areas of the core competencies that were thought to require specialised knowledge, such as supervision.

Each section of the survey signposted what the following section was about, why that section was important, and what respondents were required to do. These were designed so participants knew what to expect and what was required, as well as to provide encouragement and express appreciation for the time and effort put into answering questions that required considerable thought and writing.

Once drafted, I showed and discussed the survey with five service user organisations, who provided feedback on the structure, the items, what should be included or omitted, and the language and instructions. The survey was then pre-piloted by a supervisor- a CP with lived experience of service use. Pre-piloting checked usability, the usefulness/relevance of the items, and whether the area descriptions made sense. At that point, I had compiled competence area descriptions for nine areas: Knowledge; Diversity, Culture and Te Tiriti o Waitangi; Professional, Legal and Ethical Practice; Understanding Your Situation; Services; Communication; Professional and Community Relations, Consultation, Collaboration; Reflective Practice; and Stigma, Discrimination and Social Exclusion.

In contrast to the eight other areas, the Stigma, Discrimination, and Social Exclusion area is not a specific area in the core competencies. The area description for Stigma, Discrimination, and Social Exclusion was created based on Te Pou's (2018) Let's Get Real: Challenging Stigma and Discrimination: Essential Learning Module. Te Pou is the national mental health and addictions workforce development centre, and their challenging stigma learning module is recommended by the Ministry of Health for any mental health worker in A-NZ. I included this area to explore views regarding stigma and discrimination in relation to competence as there are references to stigma, discrimination, and social exclusion in different parts of the competencies. Literature also highlights

the presence of stigma and discrimination in mental health services (Hack et al., 2019; Mental Health Foundation, 2004; Peterson et al., 2008), which impacts 1) clients' views of clinicians, 2) service user participation in planning, provision, and evaluation of mental health services, and 3) how service users are responded to in care systems (as discussed in Chapter Two).

The Areas of Competence ratings (ranging from very important to very unimportant) intended to identify whether there was alignment or divergence about the perceived importance of each area of competence that could be contrasted with the core competencies. Asking about the perceived importance of a competence area and why, in the context of each area descriptor, was intended to move participants away from evaluating their CPs and encourage views of what ideally would make a competent CP, consistent with the research questions. To further emphasise that I was not collecting evaluations of psychologists, I provided these instructions in the survey introduction: "I am interested in your views on what makes a competent clinical psychologist based on your general views of using their services. If you saw more than one clinical psychologist, consider all your experiences. I don't want you to feel like I'm asking you to judge your psychologist(s) individually and there is no way for anyone to know which clinical psychologist(s) you saw. The hope is that this survey can generate some new understandings about your hopes for clinical psychologists based on your views of what may make them competent. For this reason, if you can think of your experiences overall that would be helpful." (See Appendix D, p. 253). The instructions were also written to attempt to navigate potential social desirability effects when service users may want to rate clinicians highly as they like them and may not feel comfortable being asked to judge their psychologists.

Survey Revision. I revised the survey in consultation with three volunteers who gave feedback about useability, face validity, the usefulness of the items, length, how the survey could be reduced, and language. Volunteers met the selection criteria and were interested in providing feedback after hearing about the study from the recruitment organisations or being approached by me. Collectively they held positions in academia, peer support work, consumer advisory roles, and roles in recovery competency development. They all had worked with CPs extensively as clients and

professionals, and one represented a whānau perspective. They received a \$40 grocery voucher in appreciation of their input. The volunteer's feedback was recorded, and the survey was adjusted accordingly. The survey underwent three major revisions following feedback from the research team, service user groups, cultural advisors, academic staff members on the confirmation panel, and volunteers. For example, layperson area descriptions of competence and instructions throughout the survey were edited multiple times. Also, more open questions about competence were provided initially before the areas of competence items.

Survey Completion. The survey was estimated to take around 30 minutes to complete, and I considered there may be a high amount of incomplete surveys. To help ensure survey completion, I stated how long it might take to complete the survey at the start. Consultation processes helped identify where survey items could be reduced. As some survey items were optional, I predicted that there would be unavoidable missing responses and varying response rates across qualitative survey items.

Interviews

Four of the semi-structured interviews were in-person at the Centre for Psychology in Auckland, and eight were video interviews via Zoom. The interviews were voice-recorded and transcribed. The transcribed portions of the interview recordings ranged in duration from 32 minutes to 67 minutes (mean = 47.51). The interview processes (see Appendix E) included:

1) Pre-Interview. Pre-interview material consisted of the Participant Information Sheet (PIS) and consent form (see Appendix C), a questionnaire to collect information about demographics and the nature of contact with CPs (see Appendix E), background information about the study with a link to the NZPB competencies, a list of discussion points, and an agenda. I emailed the pre-interview material to participants at least two days before each interview. Participant queries, questions and comments were invited and answered by email, though options to discuss on the phone or in person

were offered. Some questionnaires were returned by email, and some were returned at the beginning of the interview.

2) Interview Induction. The interview started with whakawhanaungatanga (relationship building). This included mihi (greetings), introductions, and karakia (incantation for spiritual protection and guidance), followed by refreshments for those in person.

3) Follow Up. Criteria checks, consent and information forms, and assistance with demographic information and experiences with CPs questionnaires then took place as needed.

4) Exploration of Views of Competence. The voice-recorded portion of each interview included:

Overall views of what makes a CP competent (based on survey items 22, 23, 24, 25, 37, 38).

Views of CP competence in the nine Areas of Competence (based on survey items 26-34).

Views about CP lived experience of mental distress/times of mental health service use and whether/how this relates to competence (based on survey items 35 and 36).

Views of being asked about competence (based on survey items 39-41).

I used a semi-structured Interview Schedule to guide the interviews (see Appendix E). At times, this involved discussing how competence and the areas of competence were framed in the survey (the layperson descriptions). The interviews generally flowed conversationally with participants touching on the interview questions and guide points naturally. When certain areas were not raised by the participants, I asked about them specifically.

5) Completion of Interview. After the voice recording stopped, the closing portion of the interviews included debriefing and well-being checks, opportunities for questions and feedback, acknowledgements and thanks to the interviewee, karakia (Māori prayer to close the interview) and refreshments (for those in person).

6) Post-Completion. After the interviews finished, the participants were given or sent their vouchers and a thank you card. The voice recordings were transcribed and then deleted. Participants had a five-day period where they could choose to view their transcripts and have parts of the

interview omitted if they wished, which no participant opted for. The transcriptions and pre-interview questionnaires provided the data for analysis.

Ethical Considerations

This project was approved by the Massey University Human Ethics Committee, SOA 19/63, with a minor protocol amendment during recruitment to allow for online video interviews.

Commitment to Te Tiriti and Mana Whenua. I sought to uphold Te Tiriti o Waitangi and integrate Te Ao Māori (Māori worldview) and Tikanga processes (customs and traditional values) to ensure the inclusion and safety of Māori participants throughout. I undertook several cultural and informal consultations, with multiple tangata whenua and tangata whai ora. For example, I consulted with a Kaitohutohu Ahurea (cultural advisor) from a service user organisation and a Kaupapa Māori senior lecturer and CP when developing this study. Research processes involved consideration of appropriate Tikanga such as whakawhanaungatanga (relationship building), karakia (incantations and prayer), and manaakitanga (hospitality and care) to ensure appropriate tautoko (support and advocacy) for tangata whai ora.

Ensuring Safety. I considered that participation may bring up difficult memories and experiences. Though participants were not asked to report on their health or experiences of adverse health, they were required to remember times with CPs, which may also mean times of distress. In the PIS, the survey itself, and at the beginning of the interviews, I explained that taking part may evoke strong reactions. I encouraged participants to contact me, support networks, and suggested national resources if needed. As it can be challenging to think about vulnerable times, I suggested that participants choose a time when they felt able to cope with any difficult emotions that might arise safely. While it can be distressing to recall times when experiences with services were not helpful, I acknowledged that some might find it healing to be given a place to voice these experiences and a way to use them to make a difference for others. Potential participants were also invited to contact me if they had any questions or concerns about participating, which a few people did. A

debrief page and resource list of relevant national support services were provided upon survey and interview completion. Participants could discontinue survey participation by closing their internet browser at any time before the submission button was pushed, and these surveys were excluded from the study. One participant chose to discuss their survey and concerns with me after it was submitted, and this survey was deleted.

Planned actions to take if an interview participant became distressed were discussed before each interview, including checking in, taking a break, and/or stopping participation. A member of the supervision team was available by phone at the time of each interview to provide guidance if needed. No interview participants opted to stop or terminate their interviews. Each interview involved a thorough debriefing after the recording stopped to check well-being and signpost potential support options and the resource list, and each interviewee signalled when they felt safe and ready to continue with their day. No participants were known to the researcher on a personal level.

Transparency With Psychology Organisations. I considered the chance that some individuals or groups may view this study as a criticism of professional psychology. I endeavoured to ensure a positive and aspirational orientation. I informed interested organisations and the NZPB through transparent dialogue about the purpose and aims of this project. I sought supervision when necessary for guidance.

Analysis

Survey data were analysed using descriptive statistics and content analysis (CA), and interview data were analysed using thematic analysis (TA). My qualitative analysis approach followed method triangulation, as I used CA and TA to analyse data about the same phenomenon of interest (competence) to generate broader understandings (Carter et al., 2014; Polit & Beck, 2012). I considered the survey data more “static” as participants responded to survey items away from the researcher. The survey CA allowed me to compile and sort representations of answers to a range of prompts (survey items) about competence after collecting data with a wide range of content and

many participants. The interviews TA allowed me to explore in depth the underlying ideas, assumptions, and conceptualisations of elements that participants identified as important for competence (semantic). The interviews meant I asked fewer participants about in-depth aspects of competence and explored their answers in the moment. Through the CA and TA, I sought to answer the research questions of what service users identify as competent practice and how these views align and contrast with aspects of the NZPB core competencies.

Qualitative Survey Data: Content Analysis

Content Analysis (CA) is an approach that organises and interprets qualitative data, allowing individual units of meaning to be identified (Berg, 2007). I chose CA as the survey collects discrete pieces of text (the survey responses), which I could then sort and describe. I interpreted the data at two points: the derivation of categories (meaning units) and what content units constitute these, and the final interpretation of the CA (Crowe et al., 2015). As CA can be expanded across multiple descriptions of experiences and views to develop broader understandings of a concept (Crowe et al., 2015), diverse service user views within and across survey items could be analysed.

Representativeness is not prioritised in CA, sample size can vary, and sampling can be purposive or open (such as recruiting through service user networks), though the diversity of participants can assist in understanding a concept of interest (Crowe et al., 2015). Examples of CA for mental health contexts include descriptions of discrimination experiences (Hamilton et al., 2014), mental health help-seeking in rural communities (Boyd et al., 2011), parental perspectives of their child's presentation (Crowe et al., 2011), and loneliness among mental health service users (Lindgren et al., 2014).

The CA for the survey item responses was based on Berg's Model of Stages of the Content Analysis Process (2007; Berg & Lune, 2017) with coding guidelines (steps 1-3) adapted from Strauss (1987; 1990). The process included:

1) Sorting Content Units. Initially, I compiled the responses for each survey item and read through them several times to gain familiarity with the data and how it referred to the research questions. The written answers were broken down into text chunks and then continuously refined into content units. Content units were blocks of text that contained one main idea or concept. During coding, I identified descriptive terms to start sorting the content units. I then made categories from the codes based on how each content unit referred to the research questions and corresponding survey items. I numbered each content unit with the corresponding participant to track how many participants commented on a category.

Though I selected CA to provide inductive identification and wanted to focus on manifest content (the survey responses), top-down imposition to a degree was unavoidable (Abrahamson, 1983; Berg & Lune, 2017). For example, when coding and developing categories, I would likely have considered potential categories based on areas and descriptions in the core competencies, competence literature, and the survey items themselves. I attempted to manage the tension between top-down imposition and inductive identification by coding the survey responses with no pre-existing framework. When content units seemed large and descriptive, they were separated into one main idea or type of content for each. This made it harder to piece together inferences not grounded in the data. Every content unit for every survey item was coded and categorised. I was consistently looking for understandings that resisted/escaped professional frameworks. I hoped this active searching balanced my implicit top-down identification processes that would have been subconsciously explaining the data and how to categorise it.

2) Developing Analytic Categories. In this stage, I continued to develop grounded categories by sorting content units within each survey item into similar groups. I also developed subcategories based on content units that provided a particular direction or element of information within a category. I recorded categories/subcategories, their definitions, and criteria for coding content units into the categories/subcategories in a code book. I labelled categories/subcategories using

participants' words or ones I created based on my impression of each emerging category/subcategory.

3) Refining Categories/Subcategories. The categories/subcategories underwent several reviews, checking and reworking category labels, criteria, and content unit fit within a particular category/subcategory. Some categories/subcategories were merged or split and grouped according to commonality across content units for a particular concept. I recorded the number of content units within each category/subcategory and the number of participants that provided content units sorted into a category/subcategory.

4) Checking Consistency Across the Data Set. In this stage, the categories/subcategories across all survey items were continuously cross-checked to see whether content units fit better under a different category/subcategory and whether category/subcategory labels, definitions, and criteria remained consistent or needed more specificity.

5) Comparison with the NZPB Core Competencies. To address research question two, I then compared the CA with Part One (general scope), Two (Cultural Competencies), and Three (clinical scope) of the NZPB core competency subsections. Aspects of the core competencies (descriptors, skills, and knowledge sections) that corresponded with each category/subcategory were recorded in the code book to track points of similarity and contrast. This involved a somewhat deductive or top-down process, as the core competencies provided a framework against which to compare the CA findings. I could then identify where CA findings were similar or different to aspects of the core competencies.

6) Collapsing Individual Survey Items.

In this stage, I collapsed the CA for all the survey items that pertained to research question one, what makes a CP competent (items 22-34, 36-38, see Appendix D), into one final analysis. The content units for these survey items were collapsed due to the large similarity of content units and categories/subcategories across survey items. I continued to refine category/subcategory labels, definitions, and criteria. I checked each content unit to ensure they met the corresponding

category/subcategory criteria. I recorded the final totals for the content units and the number of participants that provided responses sorted into each category/subcategory. I chose not to report the content unit counts in these findings for ease of understanding and to focus on the number of participants that commented within a category/subcategory. As some survey items were forced response and some were optional, there were different amounts of both content units and the number of participants who responded to different survey items (Appendix F).

Qualitative Interview Data: Thematic Analysis

I used Thematic Analysis (TA; Braun & Clarke, 2006, 2012) for the interview transcripts. This project's epistemological and ontological assumptions informed my choice for TA (Braun & Clarke, 2021). These are that there are existing understandings of competence (e.g., the core competencies), and analysis needs to draw out new understandings about competence that may align or contrast with existing understandings. Gaps in what is currently known about psychologist competence provided, to some degree, pre-existing coding frames. TA offered a theoretically flexible approach for qualitative data compatible with social constructionism within psychology research (Braun & Clarke, 2006). It provides a rich description that can be used to answer complex questions (Braun & Clarke, 2006). This was relevant as little is known about what service users view as competent practice of CPs. TA allowed me to conceptualise and interpret themes abstracted from transcripts - moving from specific expressions to more general statements about competence.

Interpreting themes and subthemes allowed exploration of what service users identify as competent practice (research question one) and compare service user views with the NZPB competencies (existing understandings of competence, research question two). TA assisted the research aims, to capture a range of views reported by a diverse sample of participants. These included experiences that shaped participants' understandings of competence, what it means for a CP to practise competently, and broader comments on, ideally, what a participant would like and expect from a competent CP. I could also explore how participants made sense of their experiences

and views and how the broader social context (e.g., barriers to competent practice) influenced their meaning-making. I could capture themes mentioned by many participants and identify important themes mentioned rarely, as there is no rule for how much data needs to relate to a theme or pattern to be considered a valid finding (Braun & Clarke, 2006). This was important to generate findings that differ from what is currently understood about competence.

The TA was analyst-driven, shaped by my theoretical and analytic interest in the area of competence (Braun & Clarke, 2006). I undoubtedly drew on my own life experiences when I organised and interpreted the interview data (Alvesson & Kärreman, 2011; Brinkmann, 2012). This involved questioning what was taken for granted, such as my own assumptions about what the data means and how it should be organised.

The TA process based on Braun and Clarke (2006;2012) included:

1) Familiarisation. During transcription, I cleaned the data, removing words commonly used in informal speech that did not contribute to what was being spoken about. I noted potential surface themes- ideas and concepts that appeared to stand out and relate to the research questions. These were tabulated with potential themes and ideas noted during the interviews. I then read the twelve transcripts several times. I noted initial points of interest, perceived patterns, areas that stood out in relation to the research questions, and my thought processes.

2) Coding. For each transcript, I coded blocks of text according to my interpretation of the main "message" blocks of the text seemed to convey. I labelled codes and grouped them into general areas based on their similarities. The codes and their location (participant number) were tabulated with my ideas for potential themes. I recorded labels for potential themes and criteria for codes to be grouped together in a code book.

After all the interviews were coded, I refined the codes across the data set according to commonalities across blocks of text that seemed to group together or interrelate. I checked codes to ensure the research questions were captured. When participants commented on " incompetence " examples, these text blocks were grouped with the corresponding codes for competent practice. For

example, a block of text discussing a CP not listening was grouped with codes about competent listening. This meant I could identify what would constitute competence from examples of incompetence.

3) Theme Search. I identified themes at semantic/explicit and latent/interpretive levels (Braun & Clarke, 2021). Identifying themes at latent levels adheres to the constructionist paradigm (e.g., Braun & Clarke, 1996; Burr, 2003), where participants' meanings about what is considered competent practice are socially produced and reproduced as an interaction between CP and client, and interviewer and interviewee.

I considered relationships and meanings within and between different coding clusters to identify themes that appeared to be semantic/explicit. Then, I considered interpretations of the broader meanings embedded in the coding clusters to identify latent/interpretive levels. To count as a pattern or a theme, I looked for commonalities across the data set and also for less prevalent codes, which could still constitute a theme. A theme was considered legitimate if it captured anything related to the research questions. I organised code clusters into provisional themes and subthemes according to the central messages of the clusters, noting my rationale for these selections and potential alternative themes/subthemes. I ended up with six provisional themes. I defined these with central organising concepts- criteria of how codes fit into each theme/subtheme. I collapsed or expanded themes/subthemes as needed and noted relationships between the provisional themes. This led to themes/subthemes being collapsed, split, or modified.

4) Theme Review. Themes were checked across all the interviews to ensure the themes captured all of the codes in the data set. Codes were cross-checked across other themes/subthemes to test whether they fit better under a different theme/subtheme. I continued to refine criteria for codes to fit into a theme/subtheme. Though not commonly required or reported, the prevalence of a theme has been used in TA (e.g., Braun et al., 2003; Meehan et al., 2000). I recorded the number/proportion of participants that provided responses sorted into a theme and subtheme and,

at times, refer to these. Due to my intention to inform professional practice, information about how many people think a certain aspect of competence is important may be useful.

5) Theme Defining and Naming. I generated more specific rules about why a code fell under a certain theme/subtheme rather than another one to end up with clearly differentiated themes/subthemes. I then refined definitions and labels for each theme/subtheme. Despite data saturation not being necessary for the TA, on reflection, the first three participants captured the six final themes. The nine remaining participants continued providing comments that met these six themes' criteria.

6) Core Competencies Comparison. To answer research question two, how views align and contrast with the core competencies, I reviewed the NZPB competencies in relation to the TA. This involved reviewing the general scope, clinical scope, and cultural competencies. I recorded aspects that aligned with participant findings, their location in the core competencies, and how this fitted with the generated themes/subthemes. I then reviewed the general scope, clinical scope, and cultural competencies again to identify where TA findings were not mentioned in the competencies, considering both the generated themes/subthemes and the coding clusters within these. Aspects of the competencies that aligned and contrasted with The TA were tabulated and set alongside the relevant TA theme/subtheme.

Quantitative Data: Descriptive Statistics

I used SPSS Statistics 25 (IBM, 2017) to summarise quantitative data from the survey and interviews, primarily with measures of central tendency. For the survey, I used descriptive statistics to summarise how important different areas of competence were deemed to be and to summarise yes or no forced-choice items. These included the importance of knowing CPs have lived experience (item 35) and the importance of being asked about competence (item 39). Qualitative data collected with these items provided more detail about why participants selected their responses.

Reflexivity Processes and Researcher Positioning

Researcher reflexivity occurred throughout this study, as recommended for qualitative approaches (Braun et al., 2015). I used reflexivity processes (discussed below) to clarify and allow transparency about how I influenced and shaped the project, including my assumptions and potential biases. I considered reflexivity crucial to monitor and explore my own positionings given my lived experiences of mental distress, times of service use, training in a CP programme, working with clients as a CP trainee and intern psychologist, and navigating academia as a user-led researcher.

My reflexive processes included writing continual self-reflections, starting from my initial ideas for this study. I often discussed my self-reflection material in supervision. I included some of my reflexive material in this thesis, which I selected as examples of how I influenced and impacted parts of the study (e.g., initial positioning and motivation for the study, impact of my positioning on data analysis processes). I also kept a process journal and a data analysis journal. The process journal outlined my ideas, pieces of literature, decision-making processes, challenges, and process considerations. The data analysis journal was considered feedback to craft action and information to understand a situation or resolve a problem. This corresponds with the interpretive approach of CA, to organise or reduce data to uncover patterns of human activity, action and meaning (Berg, 2007).

Managing my orientation in this study required identifying what beliefs I hold, what experiences led me to hold them, and how they may impact this study- as strengths and potential complications. I was motivated to carry out this study due to my own experiences with therapy services and conversations with people who have experienced mental distress. While my encounters with CPs, psychotherapists, and counsellors have been largely positive, I also recalled my own and others' times when we felt the services we received were not what was hoped for. For myself, negative experiences were limited to non-psychologist professionals. However, the impact of those experiences made me consider that others may have had detrimental experiences with psychologists. In a wider sense, over time, I had paid attention to narratives that continued to emerge about ideas

and hopes to improve interactions with therapists, which were often not listened to. Service user articles, mental health enquiries, service user organisations, clients, and whānau inform this.

Clinical psychology training solidified my interest in conducting this study, where stigmatising and unhelpful negative views of service users were sometimes implicitly and explicitly demonstrated by fellow trainees, academics, lecturers and trainers, myself, colleagues, clients, and those close to and around me outside of psychology. I paid attention to navigating these, sometimes identifying them overtly and sometimes observing my own internal thoughts and feelings in reaction. I held onto experiences where trainees, trainers, supervisors, and many others transmitted positive regard for clients, emphasised non-judgmental approaches, collaboration, and many more demonstrations of a desire to advocate and walk alongside people experiencing distress.

Initially, my main motivation for this study was to explore whether professional guidelines (competencies) guide psychologists to be truly responsive to service users. As my idea arose from considering that some service users may have had negative experiences with psychologists, I was aware that I might overlook positive experiences. I made a concerted effort to recognise and address this potential bias. One example was reflecting on my own times in therapy, and how they enriched and assisted me in my life to provide balance to the negative and highly distressing times I have also experienced. I also considered others' narratives of difficult and negative times in terms of what they had hoped for. Thus, attention to negative experiences became opportunities for growth and change to inform the profession.

Researcher Influence on Data Analysis

While reflection on researcher positionality can be neglected and dismissed in psychological science (Nzinga et al., 2018), acknowledging my influence is critical for rigorous research. Psychology deals with human experiences, and all researchers are human beings who carry life experiences that interact with and influence their work (Bourke, 2014). Naming and engaging with my positionalities- including lived experience of mental distress and times of service use, and absence of some

experiences (e.g., I have never experienced community mental health services) allows me to better contextualise my analysis and highlight the viewpoints of the participants in my findings (Victor, Devendorf et al., 2022; Victor, Schleider et al., 2022). One example I provide here describes navigating my reporting of the analyses.

Generating reports for the qualitative analyses carried challenges. I was drawn to report participants' narratives and arguments rather than moving to interpret them from my lens. I diverted to this tendency time and again. I was also drawn to include all of the excerpts and all of the examples every participant shared, meaning the reported findings initially were lengthy, unwieldy, and thus lacking in structure making overall meanings less clear. Initially, I found it hard to describe the data in a broader way others could understand, as I considered every piece of data important and was immersed in fine detail. These challenges were partly influenced by already working in psychology roles, where I accept what clients say and their interpretation and meaning-making. Before I worked directly with clients and perhaps without my own lived experience, it is likely I would have interpreted qualitative data from a different space where I felt more comfortable shaping my own interpretation of what clients say.

I cycled across several personal processes during the analyses. Initially subconscious, I gradually became more aware of several elements of influence for working understandings of the data. One was acknowledging that I wanted participant views to be front and centre and to somehow "speak for themselves". I linked this to my personal values and to the values of the project, feeling uncomfortable about interpreting the data from my own lens. I could then acknowledge my frustration about why I had so much control and experienced a grieving process where I was aware that my voice as the researcher may be more valued than the participants. I started accepting that from the start of collecting the data, I was already interpreting, as simply understanding a word a participant uses is already marked by personal experience. It was then a constant challenge to question how and why I was interpreting and organising the data.

I noticed that I was applying excerpts to my own experiences as a person with lived experience and client, and to my own experiences and values as a developing clinician. I was also drawing on direct experiences with clients and colleagues. I consolidated these unavoidable processes by focusing on the research questions, grounding myself back to considering competence. I used supervision and my journals as places to unpack how I was bringing myself into the analysis processes, often reflecting on my positionings and internal tensions. For example, at one stage comparison to the core competencies felt like an ethical dilemma, where I experienced fear about how I may be perceived or portrayed by the profession. At times, when I did not understand my own influencing factors, I learned to tune into my body, emotions, and thoughts to identify that I was undergoing some internal working out of the data I was absorbed in. This often meant noticing and naming anger, sadness, frustration, relief, fears, worries, hopes, happiness, positivity, and promises (to myself, participants, and future clients). I sought out literature about the use of emotion and affect in qualitative research (e.g., Loughran & Mannay, 2018; Rau, 2020), finding concepts I could resonate with, such as embodied meaning-making (Wetherell, 2012), and mindfulness-based pedagogy (Wong, 2013). I drew on Mannay (2018), who offers commentary on researcher emotions when working with topics that are hard to speak of and hard to bear (p. 103), which helped me to understand my varying reactions to the data. I considered being both an “insider” and an “outsider”, noticing my “judging mind” and the use of spirit, mind, and body to navigate these processes (Nobe-Ghelani, 2018). These processes allowed me to identify and consider my positioning, approaches, and reactions (my humanness), as strengths rather than a threat to my own implicit assumptions about needing to remain impartial to produce a robust analysis. In identifying my influencing factors, they became less subconscious and more purposeful. This assisted consolidation and reporting of the data into respective categories/subcategories and themes/subthemes, with clearer explanations of my interpretations.

Chapter Four: Survey Analysis

This chapter sets out the survey analysis, with descriptive statistics for the quantitative items and content analysis for the qualitative items. In Part One, I describe the sample. Part Two refers to research question one, what service users identify as competent practice for CPs. In Part Three, I focus on research question two, how service user views align and contrast with the NZPB core competencies. I focused on the data for this chapter, so research and literature from sources outside the participants are not included. This is an ethical decision based on the values and premises of this study, where service user voices are prioritised and valued as “sufficient” data. In this instance, referring to other literature would imply that participant views need to be “validated” by outside sources.

Part One: Survey Participant Experiences with Clinical Psychologists

Survey participants drew on a wide range of experiences with CPs. As shown in Table 6, half the sample had seen at least two CPs across various settings. All of the survey participants last saw a CP in adulthood, and most saw the CP(s) recently or within the last five years. Some participants had seen the CP(s) over six years ago. These participants were not excluded from the study as they indicated they remembered their experiences with CPs well enough to comment on them, and the CP(s) they saw were required to adhere to the same core competencies that inform practice today. Further, these views of CP competence are important to capture as they may influence whether a service user will engage with a CP in the future. In general, the participants saw CPs relatively regularly over some time.

Table 6*Survey Participant Contact with Clinical Psychologists*

	Category	Count	%
Number Seen			
	1	36	49.32%
	2	14	19.18%
	3	12	16.44%
	4	3	4.11%
	5	5	6.85%
	6+	1	1.37%
	DR	2	2.74%
Setting			
	Community MH/In-Patient	56	50%
	Private practice	37	33.04%
	ACC	9	8.04%
	EAP	5	4.46%
	Other	3	2.68%
	Oranga Tamariki	2	1.79%
Age First Seen (Years)			
	05-09	2	2.74%
	10-19	17	23.29%
	20-29	26	35.62%
	30-39	6	8.22%
	40-49	11	15.07%
	50-59	4	5.48%
	60-69	2	2.74%
	DR	5	6.85%
Age Last Seen (Years)			
	18-19	3	4.11%
	20-29	25	34.25%
	30-39	15	20.55%
	40-49	17	23.29%
	50-59	5	6.85%
	60-69	3	4.11%
	DR	5	6.85%
How Long Ago			
	Current	31	42.47%
	1-5 Years	21	28.77%
	6-10 Years	8	10.96%
	11-16 Years	6	8.22%
	40-46 Years	2	2.74%
	DR	5	6.85%
Duration			
	1 Hour	17	14.17%
	2- 10 Weeks	24	20%
	3- 9 Months	31	25.83%
	1-5 Years	42	35%
	9-13 Years	2	1.67%
	DR	4	3.33%
Regularity			
	Twice a week	2	2.74%
	Weekly	38	52.05%
	Fortnightly	21	28.77%
	Monthly	6	8.22%

Category	Count	%
Not regularly	6	8.22%

Note. DR= Don't Remember; MH= Mental Health; ACC= Sensitive Claims; EAP= Employee Assistance

Programme; Oranga Tamariki= Ministry for Children. As more than one option could be selected for Settings and Duration, percentages are expressed as a proportion of the total responses. Number Seen; Age; How Long Ago; Duration; and Regularity responses are collapsed into categories.

As shown in Table 7, survey participants saw CPs for a range of difficulties and for multiple reasons ($M = 3.62$ reasons). Most of the sample indicated that their daily life was affected by the difficulties for which they saw a CP. Participants indicated they drew on helpful and unhelpful experiences with CPs, and some did not have a choice to see a CP. Ten participants offered reasons for why it was not a choice to see a CP, including being mandated or required by mental health services or other services, the choice being made by a doctor, living in a rural region, and not being asked. There were various reasons for stopping sessions, which indicates a variety of views about the CP contact overall. Survey participants indicated using a wide range of other professional supports for mental health, with most seeing at least three different types of professionals. It is unknown whether they saw other professionals alongside CPs, at different times, or a mixture of both, and it is possible that participants drew on these experiences to inform their views of CP competence.

Table 7*Survey Participant Experiences with Clinical Psychologists*

Category	Count	%
Reason		
Low Mood	48	65.75%
Anxiety	48	65.75%
Trauma	40	54.79%
Sleep Issues	26	35.62%
Relationship Issues	20	27.40%
Work Stress	16	21.92%
Personality Issues	12	16.44%
Physical/Medical	10	13.70%
Mania/Hypomania	9	12.33%
Behaviour Issues	9	12.33%
Learning Difficulties	6	8.22%
Alcohol/Other Drug	5	6.85%
Eating Issues	4	5.48%
Suicidality	3	4.11%
Hallucinations/Delusions	3	4.11%
Self-Harm	2	2.74%
Obsessions/Compulsions	1	1.37%
Grief	1	1.37%
Diagnostic Category		
Depression	40	66.67%
Anxiety ^a	32	53.33%
Post-Traumatic Stress ^b	25	41.66%
Bipolar	12	20%
Obsessive-Compulsive	7	11.67%
Alcohol/Drug Use	4	6.66%
Borderline Personality	4	6.66%
Anorexia Nervosa	3	5%
Psychosis	2	3.33%
Autism-Spectrum	2	3.33%
Dysthymia	2	3.33%
Prefer Not to Say	2	3.33%
Acute Stress	1	1.67%
Attention-Deficit	1	1.67%
Histrionic Personality	1	1.67%
Mild Traumatic Brain Injury	1	1.67%
Daily Life Affected		
Most/ A Lot	65	89.04%
Some	6	8.22%
A Little	2	2.74%
Overall Helpfulness		
Extremely helpful	24	32.87%
Mostly helpful	24	32.87%
Neither helpful nor unhelpful	13	17.81%
Mostly unhelpful	11	15.07%
Extremely unhelpful	1	1.37%
Choice		
Yes	55	75.34%
No	15	20.55%
Mandated/Required	6	8.22%
Not asked	3	4.11%

	Category	Count	%
	Doctor Chose	2	2.74%
	Location	1	1.37%
	Don't know	3	4.11%
Reason for Stopping			
	No Longer Needed	29	30.85%
	Systemic/Service Related	15	15.96%
	Financial/Restricted Contact	14	14.89%
	Location/Circumstantial	12	12.77%
	Therapeutic Relationship	11	11.70%
	Perceived Usefulness	8	8.51%
	Stopped by Psychologist	3	3.19%
	Stopped by Parent	2	2.13%
Other Supports			
	Medication	63	86.30%
	General Practitioner	57	78.08%
	Counsellor/Psychotherapist	53	72.60%
	Psychiatrist	50	68.49%
	Peer Support	42	57.53%
	Nurse	27	36.99%
	Social Worker	23	31.51%
	Occupational Therapist	11	15.07%
	Community Support Worker	3	4.11%
	Dietitian/Nutritionist	2	2.74%
	Psychologist (General Scope)	1	1.37%
	Herbalist	1	1.37%
	Endocrinologist	1	1.37%
	Financial Mentor	1	1.37%
	Outpatient Group Therapy	1	1.37%

Note. As more than one option could be selected for Reason, Diagnostic Category, Choice-No, Reason for Stopping, and Other Supports, percentages are expressed as a proportion of the total participants. For Reason for Stopping, percentages are expressed as a proportion of the total responses ($n = 94$).

^a Anxiety includes Panic and Agoraphobia.

^b Post-Traumatic Stress includes Complex Post-Traumatic Stress.

Part Two: Content Analysis of What Makes a Clinical Psychologist Competent

Table 8 summarises the content analysis of the qualitative answers for the various survey items that asked about competence. I sorted the content units into eight categories, with 22 subcategories. The categories and subcategories are ordered by the number of participants that provided content units sorted into each category/subcategory, from the highest number of participants to the lowest. I follow this order when discussing the findings, except for *Appropriate Assessment*, which I discuss before *Responsive Intervention and Support*, as, in practice, assessment

takes place before intervention. As the participants reported, the categories and subcategories that make up views of competence are interrelated and connected, and often do not exist independently. For example, *Responsive Intervention and Support* relies on *Appropriate Assessment*, and *Therapeutic Approach* relies on *Relational Presence*.

Categories for the CA include *Therapeutic Assessment and Intervention*, referring to assessment and intervention approaches tailored to clients' unique needs. Participants reported that tailored support requires understanding a client's journey and what may be helpful (*Appropriate Assessment*), and then providing tools and facilitating services that target these needs (*Responsive Intervention and Support*). Competence includes a CP recognising when interventions are not assisting and acting to facilitate a more helpful service, relating to advocacy (*Reliable and Ethical Practice*) and *Competent Systems*. *Positive Impact* and *A Wider View* underpin competence for assessment and Intervention processes, as participants discussed that a competent CP is helpful in the long term and adopts holistic approaches as well as specific assessment processes and therapeutic models. Many participants discussed competence as CP effectiveness and CP helpfulness, suggesting that underlying competence in all areas means that CPs are ultimately helpful for SUs.

Relational Presence refers to competent CPs acting in the client CP dyad to create and maintain a *Safe Space*, where partnership is shared through *Collaboration*. Being *Authentically Human* and implementing effective *Reflective Practice* were discussed as crucial for the therapeutic relationship. Participants reported that competence in the *Relational Presence* category is fundamental for competence in all other areas.

The *Lived Experience and Competence* category identifies the ways that lived experience can positively influence competence (*Lived Experience as an Advantage*), and how CPs manage and utilise lived experience as a key aspect of competence (*Managing Lived Experience*).

For *Effective Communication*, participants highlighted that *Active Listening* and the ability to assist understanding (*Facilitate Understanding*) makes a CP competent. *Non-Verbal* indicators of competent communication were also highlighted.

The *Professionalism* category encompasses *Reliable and Ethical Practice, Discipline Knowledge, Professional Requirements, and Maintaining and Growing Competence*. Participants reported that professional, ethical, and legal practice is an essential and paramount area of competence, fundamental to competence in every other area.

In the *Culturally Responsive* category, participants highlighted that responsiveness to Māori, in particular, is essential for CP competence. Cultural responsiveness also includes understanding and *Navigating Diversity and Privilege* and *Attending to Cultural Needs* with Māori, diverse genders, and diverse sexualities throughout CP contact and processes.

For *Competent Systems*, participants discussed CP competence more widely than competence in terms of an individual CP. Participants shared their views of competent systems and systemic competence, imparting that services, systems, and workforces need to be competent for individual CPs to be competent.

For the *Stigma, Discrimination, Exclusion (SDE)* category, participants highlighted that this area is crucial for competence (*An Important Area*). CP competence was discussed as being able to acknowledge and identify SDE and its effects (*Noticing and Naming*) and effectively navigate, counter, and mitigate SDE in practice (*Responding Adequately*).

Table 8*Summary of the Content Analysis of Views of Clinical Psychologist Competence*

Category/Subcategory	Count	%
Therapeutic Assessment and Intervention	73	100%
Responsive Intervention and Support	65	89.04%
Appropriate Assessment	46	63.01%
Positive Impact	46	63.01%
A Wider View	9	10.96%
Relational Presence	71	97.26%
Safe Space	69	94.52%
Collaboration	38	52.05%
Authentically Human	35	47.95%
Reflective Practice	22	30.13%
Lived Experience and Competence	66	90.41%
Lived Experience as an Advantage	41	56.16%
Managing Lived Experience	35	47.95%
Effective Communication	64	87.67%
Active Listening	50	68.49%
Facilitate Understanding	36	49.32%
Non-Verbal Communication	12	16.44%
Professionalism	59	80.82%
Reliable and Ethical Practice	43	58.90%
Discipline Knowledge	29	39.73%
Professional Requirements	29	39.73%
Maintain and Grow Competence	20	27.40%
Culturally Responsive	34	46.58%
Navigating Diversity and Privilege	25	34.25%
Attending to Cultural Needs	18	24.66%
Competent Systems	32	43.84%
Stigma, Discrimination, Exclusion	28	38.36%
Responding Adequately	14	19.18%
Noticing and Naming	10	13.70%
An Important Area	10	13.70%

Therapeutic Assessment and Intervention

The *Therapeutic Assessment and Intervention* category refers to how competent CPs approach and conduct assessment and intervention activities that support clients in ways that assist them. These responses were sorted into four subcategories, *Appropriate Assessment*, *Responsive Intervention and Support*, *Positive Impact*, and *A Wider View*. When participants referred to CPs approach more generally, rather than specifically linked to assessment and intervention activities they

were sorted into other categories, for example, *Collaboration* in the *Relational Presence* category. When the responses delineated assessment or intervention specifically they were sorted into those categories, and when they referred to both they were sorted into other subcategories within the *Therapeutic Assessment and Intervention Approach* category.

1) Appropriate Assessment

Appropriate Assessment refers to participants indicating that competent CPs conduct assessments in ways that enable suitable, relevant, and helpful understanding of a client and their difficulties. Participants reported that accurate formulations and collaborative assessment processes lead to effective support recommendations and follow-up post-assessment. Participants highlighted that competent assessments include CPs gathering relevant information, drawing out details, and extrapolating key ideas. Assessments that include precipitating factors, predisposing factors, and relevant psychological concepts and explanations were described as crucial. Specific examples included identifying thought processes and patterns, identifying maintaining factors, considering reasons for behaviour, and together generating ideas of things that may help.

Applying my issues to psychological impacts/reasons. (#53)

Participants commonly highlighted that competent CPs do not make assumptions prior to assessment and remain open-minded throughout assessment processes (relating to *Reflective Practice* and *Professionalism*).

He was sceptical at first and quite antagonistic... He thought it was a waste of time, didn't think I was autistic. But once we were underway, he realised he was wrong. (#71)

Participants reported the importance of differential diagnosis and formulation, for example, knowing the difference between mild anxiety and OCD diagnoses. Some participants highlighted that competence means understanding and not holding damaging assumptions about self-harm. Participants reported that the consequences of a lack of knowledge about mental distress and

differential diagnosis include client frustration, increased distress, and inaccurate and non-specific formulations that negatively impact intervention processes and outcomes.

Explaining why you don't "self-mutilate", you self-harm (because mutilation means to severely disfigure, which is not what I do). Having to explain that the "acting out" is not being manipulative, it is caused by extreme distress and pain. If you were in extreme pain you would do the same thing. That actions don't necessarily match emotions (that you can be feeling intense emotions even if your cut isn't that deep etc). (#69)

Participants reported that specific and accurate diagnoses (thus, differential diagnoses) and formulations are expected and should be shared transparently with clients. Competent diagnosis includes getting to know a client and their lives and exploring underlying issues, life events, relationships, and backgrounds. Not "jumping to conclusions" too soon and not forcing clients to "fit into a box" were commonly reported. Robotic, biomedical, and pathology-based assessments were considered indicative of incompetence.

I wanted to talk to a person who could gather the information they needed without sounding like they were checking information from the DSM-V. (#42)

Formulations not coherent with clients' understandings of themselves and their distress were reported as unhelpful, confusing, and damaging for the resultant intervention.

She tried to convince me that the sexual abuse I experienced wasn't sexual abuse when I knew that it was, a previous clinical psychologist had confirmed that it was. This was not helpful and was an insult to my intelligence. I wondered whether this psychologist couldn't be bothered with the paperwork. (#18)

As reported, competent CPs check formulations and differential diagnoses with clients and revise them when a CPs conceptualisation does not match the clients (relating to *Collaboration*).

The psychologist had a theory about why I experience depression which I did not share... This was confusing to me as this wasn't my experience and didn't fit with my own memories and understandings. The psychologist did not revise her theory and continued to insist on apparent poor attachment being the core issue. This was challenging and upsetting as it made me question myself and my own family. (#29)

Participants reported that competent assessment also includes support recommendations and follow-up post-assessment. Enabling access to intervention beyond assessment, diagnosis, and medication was reported as essential, as was follow-up evaluation of whether services had assisted, and connection with other services.

Didn't give me more advice on what to do now I have a diagnosis other than take meds. Aka no further care or treatment plan. (#66)

2) Responsive Intervention and Support

The *Responsive Intervention and Support* subcategory refers to participants describing that competent CPs provide intervention in a flexible tailored way that corresponds with client needs. Participants discussed competent intervention as adapting and tailoring a range of modalities, providing feedback and affirming progress, and reviewing intervention processes and tapering sessions appropriately. Many participants identified that competence means providing helpful ideas, tools, and techniques for specific and relevant challenges. Building trust before suggesting skills and tools was emphasised, as was ensuring that specific techniques are implemented at the right time. Competence was reported as appropriately responding to what a client is saying and asking for. This requires moving beyond assessment and diagnosis to what individual issues mean for a client, which supports them to put their distress into context.

It wasn't all about diagnosis, we were solving individual issues that made sense for the various trauma that occurred. (#32)

Participants discussed that a competent CP provides a range of modalities and is open to different approaches. “Strengths-based” and “trauma-informed” interventions were emphasised, which included identifying positive elements of a person’s life that can be enhanced.

That they remain fully open to all possibilities regarding the development of distress and healing from it. (#64)

Participants highlighted that competence includes flexibility and a tailored approach. This includes adapting specific therapeutic paradigms such as DBT, CBT, Acceptance and Commitment Therapy (ACT), Mindfulness, and Eye Movement Desensitisation and Reprocessing (EMDR) according to client’s needs.

Ability to use a variety of different psychological modalities to understand, help and support without sticking blindly to a “pet theory” that does not fit with a client's own understanding of their experiences. (#29)

Participants commonly reported that competence includes focusing on what a client needs to unpack or address. Participants provided examples of CPs focusing on their own preferred areas, which led to clients feeling dismissed and unassisted.

I sometimes felt like I wanted to spend more time talking about the times when I felt like I couldn't go on in life.. I sometimes felt like she didn't want to hear about it (she denied that was the case). It is hugely difficult to sit with that level of despair. (#63)

Participants reported that competent CPs provide psychoeducation, including information about mental distress, psychological theories, and general well-being to aid clients’ understanding of their difficulties. Many participants emphasised that providing a range of skills and tools to assist with specific challenges is essential for competent intervention. They highlighted that a competent CP builds trust first, before offering skills and tools in a collaborative way.

Form trust with me first, then give me tools to help myself. (#16)

Participants commonly reported that demonstrating competence means skills and tools utilised are practical, relevant, useful, and provide real solutions for individual challenges. Teaching tools and skills to address specific issues such as mood, anxiety, emotions, decision-making, and managing conflict were reported as essential for indicating competence. Examples of specific tools included grounding, mindfulness, timelines of high and low periods to identify cycles and patterns, techniques to cope and deal with feelings, ways to track and improve sleep, and creating a “toolkit” for times of intense distress. Helpful tools and skills in the context of suicidal thoughts and self-harm included creating safety plans and dealing with suicidal thoughts.

In terms of crisis when I was really unwell, my psychologist was really helpful and gave me good skills and tools to help with my distress. (#72)

Participants highlighted out-of-session tasks, which included setting and checking homework and things to think about between sessions. Participants also reported that competent support includes providing and encouraging use of resources as supplements to interventions. Examples included books to read, recommendations for financial assistance, support groups, group interventions, and expressing feelings through art.

Options that can be slightly alternative to look in that direction to find what best works for the person i.e., for me that's knitting. (#10)

Participants also indicated that competent intervention includes regular feedback and affirmation of progress. Regular reviews of intervention processes, changing approaches when needed, and referring clients to other services or CPs when interventions are not helpful were highlighted as crucial to indicate competence. This also relates to advocacy (*Reliable and Ethical Practice*) and *Competent Systems*.

A great psych will recognise when the service they provide is not adequate for you and can refer on if they do not have the speciality or the system is not responding to the client's needs.

This takes the form of advocacy. (#57)

Participants highlighted session tapering and discontinuation in a way that feels safe for a client.

We gradually cut our sessions down from fortnightly to monthly which helped me to wean off the sessions. Once I did finish I realised I was ready, and I could cope. (#39)

Participants explained that being competent means being flexible with how support is provided. One participant found it helpful that a CP became their case manager to “hold” them until they were accepted by a community service, another described not being discharged where they met discharge criteria but felt they would not be able to cope. Another participant found it helpful to have regular hospital visits after an overdose, and others described text and email support outside of sessions.

3) Positive Impact

For the *Positive Impact* subcategory, participants emphasised that CP effectiveness is integral to competent practice, and that competent CPs ensure they positively impact client well-being. Participants frequently indicated that competence means CP contact leads to improvements after each session and in the long-term after sessions have ended. Examples of *Positive Impact* included feeling better after sessions, coming to terms with difficult experiences, instilling hope, and achieving long-term well-being.

Being able to do therapy in a safe way without making things worse long-term. (#27)

Participants reported that positive impact includes assisting clients to make sense of what they are going through, such as facing and coming to terms with traumatic experiences.

Helped me come to terms with my children being sexually abused, helped me to face the situation, helped me to accept it was not my fault, helped me build the strength to face their abuser and see justice for my children. (#39)

A competent CP was reported to be “mana-enhancing”, empowering, and instilling hope and autonomy. Competence also meant life-changing and life-saving experiences.

Saved my life, as in helped me move forward in my recovery hugely. Helped me build trust in myself and others safely. Incredibly positive and helpful experience. Life changing. (#62)

Participants reported that skills and understandings that last post-intervention and allow a person to manage their well-being autonomously are crucial for competence.

I have always felt that the psychologist's end goal is to have me not come anymore. Not pressure, but that we are working towards a sustainable, long-term mental health goal. (#5)

Participants reported that competent CPs seek feedback post-intervention to ensure a positive impact.

Evaluating the success of my recovery didn't happen (to my knowledge) and I wish it had so I could provide feedback. (#52)

4) A Wider View

The *Wider View* subcategory refers to a competent CP approaching assessment and intervention with the understanding and ability to integrate a range of contributors to well-being. Participants commonly reported that non-medicalised, holistic approaches and “views of recovery” are crucial aspects of competence. Participants reported that competent intervention means being able to target not only the cause of challenges but also wider structures external to a person.

A non-medicalised approach. One of the most important factors is having a holistic approach.

(#64)

Participants commonly reported that hierarchical positioning and biomedical approaches contribute to ineffective practices and incompetence.

The clinical psychology profession I think tries to situate near the top of the hierarchy in health practice. In practice, I have found their competence lacking in many areas towards me.

They seem to be above in the bio-medical model. Just below psychiatrists who overall seem to be bloody useless. But people can be nice people in spite of their profession. (#34)

Participants reported that competence includes acknowledging the wider social and political contexts both CPs and clients operate within.

Understanding the current climate, both politically and socially, that their client exists in. (#2)

Relational Presence

The *Relational Presence* category refers to how competent CPs interact within the CP/client dyad and build and harness the therapeutic relationship to facilitate intervention and outcomes. This includes what a CP brings to the therapeutic alliance and how they work to build relationships. Responses pertaining to *Relational Presence* were sorted into four subcategories, *Safe Space*, *Collaboration*, *Authentically Human*, and *Reflective Practice*.

1) Safe Space

The *Safe Space* subcategory refers to competent CPs providing protection and fostering trust, which enables clients to express themselves without fear. Content units were sorted into *Safe Space* when participants referred to the sense that there is space to feel safe with a CP throughout various processes, which closely relates to *Reliable and Ethical Practice*. Participants reported that validation

and acceptance, as well as attunement and connection, are essential for CPs to create a safe space that underpins all other CP activities.

Participants described that competent CPs create an environment where clients can express emotions such as sadness and anger and speak freely, which was deemed essential for fostering trust and security. Demonstrating patience and maintaining a calm pace was viewed as signalling an environment where clients can share their experiences and challenges.

She creates a safe space for me, where I am beginning to trust her and feel comfortable talking about the things that are interfering in my life. (#27)

Participants highlighted that feeling safe included being comfortable and welcomed.

Someone who can put you at ease and make you feel comfortable regardless of why you are visiting. (#39)

Many participants emphasised that validation and acceptance are essential for competence. Validation involves accepting client experiences, behaviours, and what they share, and believing that these make sense contextually. This includes CPs being non-judgemental, reassuring, and treating clients with positive regard. Treating clients as precious and human means not talking down to clients and noticing their strengths and potential.

They view people as precious and full of promise and strength, rather than sick victims who need help. (#64)

Suspending judgement about what a client discusses was highlighted as allowing true listening and understanding (related to *Effective Communication*), which facilitates acceptance of a client's point of view and what they are experiencing.

Mainly show no judgement about anything that is brought up by the client. Make the client feel safe and heard. (#24)

Validation was also described as supporting clients to feel valued and deserving.

She treated me kindly and made me feel I was important and deserving of help. (#20)

Reassuring clients and acknowledging their experiences were reported as important skills for CPs to utilise. Not dismissing clients was highlighted, for example, when experiencing suicidal thoughts.

It is very invalidating for someone to respond with "OK" when you are feeling suicidal. I'm sure they've seen it all before... but how can you be so calm when I'm about to die? (#69)

Related to *Stigma, Discrimination, Exclusion*, avoiding bias and prejudice was reported as important for feeling accepted, seeing clients as unique people beyond any "disorder" or diagnostic category.

Not looking at a person as a disorder or a bag full of deficits, but rather, an individual person with individual circumstances, systems and histories (their own and intergenerationally) which have led to their current distress. When we approach distress like this we can see that almost always the distress makes sense, lies within a context, and we avoid pathologising people unnecessarily, which in my view, is a form of violence. (#64)

Participants regarded incompetence as responding to clients in a dismissive way and minimising experiences, resulting in clients feeling like a burden, or not in need of or deserving of support. Paternalism was also described as signifying incompetence, for example, being treated as a subordinate child. Further examples of invalidation, which indicate a lack of competence, include telling clients their reactions are "not normal" and responding to distress, grief, and suicidality in a nonchalant way. Participants reported that invalidation means CPs are not able to provide the coping strategies clients need, a point related to *Responsive Intervention and Support*.

My experience with all health professionals is that my knowledge of what is happening to me was dismissed, minimised, re-storied, or I was blamed as an uncompliant client and treatment and consequences became detrimental to me in some way. (#34)

Participants also specified that incompetent practice includes being dismissive, patronising, accusing a client of attention seeking, and conveying annoyance, disapproval, and contempt.

The psychologist I saw in hospital treated me with annoyance and contempt. I really felt that he hated me and thought I was a no-hoper. (#51)

Many participants reported that central to competence is using attunement and connection to enable a sense of shared humanity, where the client and CP work together in an authentic way (relating to *Authentically Human*). This means identifying and responding appropriately to clients' emotional states, demonstrating care and empathy, and building rapport and trust.

I hope that we start acknowledging the role that empathy, honesty and openness play in competence. I think that pressure to be "professional" can create distance between people being supported and psychologists, rather than acknowledging the shared humanity which unites us and ultimately allows healing and recovery. (#51)

Respect and honesty were considered integral for a trusting connection. Participants described the "Power of connection" (#44), illustrated by examples of CPs putting clients at ease and building relationships.

I think psychologists need to be assessed as being competent in their relationship-building skills. I had a psychologist in the past that was great in knowledge, skills, and attitudes, but had very little relational skills. Despite being competent in other areas, I struggled to engage with the process because it felt so intellectual and inorganic much of the time. (#72)

Empathy was reported as essential to competence. This involves being able to hold the emotional experience of clients, such as recognising pain and empathising with it. Participants commonly reported that competent CPs put in the effort to truly feel a client's experience and demonstrate they care by displaying patience, kindness, compassion, and warmth.

Was friendly, not distant or aloof, and treated me with dignity and warmth while I struggled to understand my symptoms. (#52)

Participants discussed that incompetent practice includes a lack of connection which leads to feeling inferior and intimidated. Examples included temperaments clashing and not "gelling", leading to feeling on guard, frustrated, and unable to provide feedback.

Empathy is also very important and treating people as human beings. Most times I have seen clinical psychologists I felt as if I were on trial or trying to pass a test. It was traumatic for me to feel as if I am trying to prove that I am one of the "good patients" or being assessed for a purpose other than my own well-being. Competent clinical psychologists acknowledge that I am an adult with strengths and abilities who has experienced trauma. (#51)

2) Collaboration

The *Collaboration* subcategory refers to competence as taking a partnership approach that allows clients more presence and power in relational and therapeutic processes. Participants reported that competent CPs emphasise clients' perspectives and aim for better power sharing regarding intervention choices and therapeutic decisions. Collaboration was identified as respecting and learning from a client, walking alongside them, making processes transparent, and working toward client-led aspirations. Participants reported that collaboration means CPs take on feedback and plan strategies with clients, such as inviting open discussions around suggested approaches. Valuing client knowledge, not imposing decisions about interventions, and adapting therapeutic care in a flexible way were highlighted. Competence was also signified by working with others, such as

bringing Whānau and support people into the therapeutic space and drawing on colleagues' knowledge. While similar to the *Therapeutic Assessment and Intervention* category, *Collaboration* was sorted into *Relational Presence*, as collaboration was discussed as a relational process that enables responsive assessment and intervention.

A competent clinical psychologist would know from day one with a client, that their job is to empower and walk alongside them in their recovery. An attitude of walking alongside means that the client is truly the expert of their experience more so than any book, research or study. (#72)

Participants reported that respect is integral to collaboration, for example, respecting clients' wishes and asking clients what would be most helpful for them. Competent CPs prioritise client knowledge, which was reported as leading to true partnership and more effective assistance.

I need to feel that I could say, we should go here, or not there, and that feedback be seriously considered. (#5)

Participants referred to collaboration as involving transparent processes. This means openness and honesty, such as about structure, having a clear plan together, and giving constructive feedback.

The client and the psychologist would then work together to co-create a plan for what the client wishes to get out of the sessions with regular reviews. (#29)

Participants reported that competent CPs assist clients in making decisions about interventions that correspond with their needs and discuss the parameters of different aspects of interventions. Participants reported that competent CPs discuss how they work and let clients know why it is important to share their personal information.

When I first started seeking mental health support I was extremely suspicious about why anybody wanted to know about my life (which made it really hard to get help!). I think it can be helpful to tell clients some of the ways that psychologists work so that clients can understand why you want to know everything. (#69)

Collaboration also means prioritising clients' views in intervention plans and emergency processes, checking intervention targets with clients, and gathering feedback. As reported, this enables clients to have more control in interventions and more agency in deciding what is helpful.

It's important to me they ask if their method is helping me. I am all for meaningful and sustainable change. They need to check if it's helping towards that goal or something the person actually wants to change first. (#61)

Participants reported that competent CPs create opportunities for working with whānau and friends.

Very helpful to have family and friends involved in my care and have my psychologist help me explain things to others and work through particular situations and provide DBT skills with both parties. (#69)

Participants highlighted that competence includes drawing on other professionals and people with lived experience of mental distress. This means competent CPs work well with others such as a multi-disciplinary team and various services.

My current psychologist remains linked in with my community key worker and psychiatrist, and I find this quite helpful as she will contact them on my behalf when needed and this saves me from having to repeat myself various times. (#12)

3) Authentically Human

Authentically Human refers to CP competence as displaying humanity, such as coming across as “themselves”, “down to earth”, grounded, and relatable. Participants reported that competent CPs show their uniqueness and come across as real people so they can relate to clients on a genuine level. Showing humanness and personality was reported to strengthen relationship building, partnership, and safety. Participants also referred to a genuine commitment to and interest in healing. They reported that authenticity requires finding a good balance between clinical knowledge and authentic human relationships.

Being a human being, not just a clinician who has learned from books. (#42)

Being authentically human was reported as countering the silencing and intimidating effects of CPs holding the “expert” role, so clients can feel validated and therefore equally human.

Often when I have been unwell I have felt like I was the only person who thought like I did or reacted like I did. I hated myself. Hearing another person (especially a professional) saying they can sometimes think like I do is very validating. It may not have always been the case but it's good when they can say that too. (#61)

Coming across as an authentic human was reported as a strength that enables trust and a sense of connection. Examples of CP authenticity include appropriate use of humour, sharing some things about themselves, and integrating personal experiences and learnings into practice.

It is ok to present as a human being with failings, in fact, those "failings" can be seen as tremendous strengths by clients and make them appear personable and trustworthy. (#29)

Pressure to be professional and “Ego” were considered barriers to authentic human relationships. “Ego” was described as CPs conveying that they are “better than” their clients. Some participants shared that communicating a sense of superiority is an indication of incompetence, and

that pressure to be seen as professional can mitigate humanness (related to *Professionalism*). Being real and remaining humble was reported to demonstrate that CPs care about and can relate to others.

Pressure to be professional prevents psychologists from acknowledging their own limitations and mistakes, whilst empathising with those of the person receiving support. (#51)

Participants reported that competent CPs are dedicated and loyal, and display integrity by taking a deep interest in clients and having an overarching commitment to positive outcomes. Competence means CPs taking their role seriously and being focused and interested in their work. A genuine passion for psychology and assisting people through distress was also discussed.

Authentic commitment to healing and caring. (#57)

Participants reported incompetence as conveying disinterest, such as yawning, falling asleep, frequently checking watches, glancing at phones, and answering phone calls during sessions. These were discussed as communicating that a CP does not care about their job and therefore would not care about clients.

Genuine passion for the job seems important... because, without this, they really won't be in a position to care properly for their clients. (#52)

4) Reflective Practice

Reflective Practice refers to competent CPs demonstrating self-awareness and the ability to reflect on practice, mitigate biases, and engage in self-care. Participants also reported competence as including an awareness of relational dynamics and attending to personal power and privilege.

Reflective Practice relates to the *Maintain and Grow Competence* subcategory (under *Professionalism*), as a competent CP is able to use reflective practice to then build supports to maintain and grow competence.

Participants indicated that incompetence includes a lack of self-awareness. Examples provided include taking a dictatorial approach, not noticing the negative effects of actions and words for a client, defensiveness, and inconsistent behaviour, such as being “hot and cold”. Relating to *Collaboration and Stigma, Discrimination, and Exclusion*, participants shared that competent CPs reflect on their personal presence and reactions, and how these may impact clients. This includes self-awareness and transparency about personal limits and motivations.

I find it helpful when psychologists are reflective on their own limitations and motivations.

When I first started doing EMDR, my psychologist said that he was interested in this field and wanted to gain more experience in it. I appreciated the openness of this statement and that while he clearly wanted to help me, he was also honest about his own goals and needs. This made it feel like more of an equal partnership and less of the dynamic where a competent helper takes pity on a helpless sick person. (#51)

Participants also reported that a competent CP can identify and actively work on individual biases.

The ability to keep their own personal strong emotions and biases out of consultations and not impose them onto patients. i.e., diet, religion or strong personal opinions about a situation. (#32)

Participants highlighted that competent reflective practice includes identifying and responding to personal and professional limits and engaging in self-care. It was reported as crucial that CPs know when and where to get support for themselves.

Work through their own difficulties so they are available for their clients. (#63)

Lived Experience and Competence

Lived Experience and Competence refers to participants discussing CP lived experience of mental distress explicitly in terms of competence, such as how lived experience impacts on practice and service provision. This was mostly commented on in survey items 35 and 36. Two-thirds of the survey sample ($n = 47$) thought it was important to know whether a CP has lived experience and one-third ($n = 26$) deemed it not important to know. Content units for *Lived Experience and Competence* were sorted into subcategories *Lived Experience as an Advantage* and *Managing Lived Experience*.

1) Lived Experience as An Advantage

Lived Experience as an Advantage refers to CP lived experience as a positive factor that enhances competence. Relating to *Relational Presence*, participants reported that CP lived experience increases CPs empathy and acceptance toward clients. Lived experience was described as “a leveller” that strengthens connection and aids rapport. This provides a safe space where clients can open up, which decreases power imbalances within the therapeutic relationship. Relating to *Therapeutic Assessment and Intervention*, participants reported that CP lived experience increases the positive impact of CP-client interactions. Relating to *Professionalism*, participants highlighted that lived experience enhances competence and credibility, as having personal experiences of mental distress positively supplements theoretical textbook learning and knowledge.

Competency is when the clinical psychologist can truly understand what a person is going through. Often that only comes because they have lived experience. (#73)

Participants discussed that CPs with lived experience will be more understanding towards clients, due to experiencing their own challenges. Knowing a CP has lived experience was reported to help clients to feel more accepted, more validated, and less judged. Participants highlighted that this makes it easier to open up, be honest, and be heard.

Because I wouldn't feel judged or like I'm crazy when I talk about certain things or how I feel.

(#55)

Relating to *Relational Presence*, knowing that CPs are human with their own challenges was considered an advantage that assists the therapeutic relationship. Participants reported that CP lived experience contributes to CPs coming across as more “real”, relatable, and authentic.

If I know a person has had their own experiences with mental distress it immediately personalises them to me (which helps with a therapeutic relationship). (#29)

Participants reported that CP lived experience is a “big bonus” and contributes to positive experiences with CPs, such as feeling less alone in struggles, having confidence in the CP and intervention, and fostering hope and inspiration. These positive impacts were attributed to CPs knowing what it is like to be on the other side of the client-psychologist relationship, knowing that they had also faced struggles, and the evening out of power differentials.

Their mental distress may be different to mine, yet it would show that they are not afraid to open up about their own struggles. In fact, it will give me hope that they have managed to overcome and still be able to function well. (#73)

Participants reported that CP lived experience enhances competence because theoretical knowledge and learning about mental distress is not equivalent to direct experience. Some participants highlighted that when CPs know how mental distress really feels they will be more likely to “get it”, which is more valuable than qualifications.

Learning about something and living through something is really different. (#58)

No qualifications can beat lived experience. (#59)

2) Managing Lived Experience

For *Managing Lived Experience*, participants reported that competent CPs use their lived experiences in a helpful and discerning way that has therapeutic utility which benefits clients. This includes appropriate sharing and knowing that not all CP experiences may be relevant for clients. Some participants highlighted that CP lived experience does not automatically mean competent practice, and that sometimes clinicians with lived experience can cause harm. Participants reported that disclosure needs to be negotiated between the client and CP, and that disclosure is not a “right” clients should expect from a CP.

This is transgressing a boundary of confidentiality - it is not only important for the client's privacy to be kept but also the clinicians. (#38)

Participants discussed that sharing lived experiences can be important, but sharing needed to be done in an appropriate way that maintains firm boundaries. Keeping safe regarding what to share included keeping examples brief, relevant, and of benefit to clients.

I have always appreciated it when psychologists disclose their experiences of mental distress. In my case this was done in a respectful way which was clearly thought out and intended to support me. (#51)

Participants reported that competence means acknowledging that CPs own experiences of, and reactions, to mental distress, and what assisted them, will not be the same as another person's. It may suit some CPs and not others to disclose, and it may suit some clients and not others to know about CP lived experience.

I have friends who have depression themselves but don't understand why I still struggle with mine, and I have friends/medical people who haven't, but they understand it. For some people being told that might make them feel more at ease. This would have been my answer

when I was mid-20s, but now I don't mind as much as long as the person understands about how it affects people. Everyone feels it differently, so I don't think it matters. (#10)

Some participants reported that competence includes CPs being in a “well enough frame of mind” to work with others and not have their work affected by mental distress. A few participants discussed that CP lived experience is irrelevant to competence, as reliable training, self-reflection, and the ability to do the job are more important. Disclosure of lived experience was considered unprofessional by one respondent.

I believe someone trained in a clinical setting has the training and empathy to understand mental illness without having lived it. (#3)

Some participants highlighted that competent CPs are aware of the potential for harm that can arise from disclosing lived experience. Examples included judging the CP, feeling in competition with them- such as who is the “sickest”, feeling a sense of responsibility for the CPs well-being, and feeling bad for the CP. Participants highlighted that concern for a CP may detract from clients' needs being prioritised in the therapeutic relationship and intervention. One participant highlighted that lived experience when not managed appropriately can contribute to abuse.

I think it would be a distraction. Sometimes I think it is entirely inappropriate too. The sessions are there for the client and not the psychologist. It's about their expertise in that rather than their own experience. I have been taken advantage of by people with lived experience of addictions who were working as clinicians. They were able to gain my trust far quicker than any other professional. That led to sexual, psychological and emotional abuse, and that has created a severe barrier for me when it comes to getting help when I am struggling. (#61)

Effective Communication

The *Effective Communication* category refers to a competent CP using communication styles and skills effectively to listen and respond to clients and adequately exchange information. Content units for *Effective Communication* were sorted into three subcategories, *Active Listening*, *Facilitate Understanding*, and *Non-Verbal Communication*.

1) Active Listening

The *Active Listening* subcategory refers to competence as effective listening and using communication techniques that indicate to clients that they are truly being heard. Participants commonly reported that active listening needs to come before anything else a CP does, as active listening provides validation and a sense of joint purpose. Competent listening includes taking clients seriously, listening in a non-judgemental manner, listening to understand, paying attention, accurately reflecting, and allowing a client to talk.

They listened to me. They didn't try to tell me how to think or that my thinking was wrong.

(#28)

Participants shared that competent CPs are easy to talk to and act as a “sounding board”. *Active Listening* is related to *Safe Space*, as participants identified the importance of taking time to listen, pause, reflect back on what a client has said, and appropriately manage pace. These were identified as crucial to allow clients to feel seen as people and not as diagnoses, in turn strengthening the therapeutic alliance.

Listen. The last one was so great because she really listened. She would pause and reflect and then share her own insights. When unpacking trauma, slow listening is very helpful. (#48)

Participants reported that competent CPs also listen to what is unsaid. Also related to *Safe Space and Responsive Intervention*, participants shared incompetence as CPs “talking down” to them and not listening, which leads to a lack of trust, perceived rejection, and withdrawal.

One psychologist I dealt with barely listened to what I had to say and instead had her head down reading my notes. She interrupted and asked questions that had nothing to do with what I had been talking about. I felt disrespected and ignored. (#19)

2) Facilitate Understanding

Facilitate Understanding refers to how a competent CP uses communication to enable understanding for clients. While related to *Collaboration* and *Therapeutic Assessment and Intervention*, *Facilitate Understanding* focuses on communication techniques rather than relationship building and specific assessment and intervention techniques.

Participants reported that facilitating understanding means making information and concepts understandable using straightforward language and taking the time to provide clear explanations, for example, when discussing ways to manage distress related to varying presentations. Explaining in ways that are understandable includes using plenty of examples, providing clear calm instructions, repetition and reframing, and breaking down discussions into manageable chunks. Regularly explaining processes and effectively communicating with others were also identified as important.

Takes the time to explain every aspect so that people understand the situation better. (#65)

Participants highlighted competence includes concise explanations that are able to be remembered, such as for ethical matters. Participants also reported that competent CPs use straightforward language to discuss how they work and what to expect.

It would be great if psychologists could take some time to learn how to explain to people how they work and the tools they use, in plain English. I think acronyms and explaining something as "great" before the person has tried it, may lead to the person feeling like they have failed if it doesn't help. (#61)

Speaking openly with warmth, choosing words that convey reassurance, and using language in ways that empower clients was deemed essential for competence.

My clinical psychologist appears to be very competent at saying a lot of things in such a way that they steer me towards appropriate and beneficial change. (#32)

Reported examples of incompetence included using labels, complicated language, biomedical language, and jargon. Competence was also discussed as facilitating understanding within wider teams.

My inpatient psychologist did not seem to communicate effectively with the rest of my treating team which caused some difficulties and confusion for me in terms of conceptualising my problems. (#49)

3) Non-Verbal Communication

For *Non-Verbal Communication*, participants reported that a competent CP comes across as relaxed, calm, and composed, with open body language. A friendly demeanour, smiling, and eye contact were identified as signalling comfort and safety. Consistent body language and congruence across different aspects of communication were reported to assist clients to feel at ease.

Have congruence between the body language, facial expression and words. e.g., body language of all crossed limbs, and then say I am relaxed. This wouldn't be good, as something would be off. (#5)

Professionalism

The *Professionalism* category refers to operational and procedural aspects of professional practice, and activities that encompass CP as a profession more widely than individual relational and therapeutic approaches. Participants identified professionalism as CPs conducting themselves appropriately for their role and what is expected of a CP. This includes following legal and ethical obligations, having relevant knowledge, meeting professional requirements, and maintaining competence. Content units sorted into *Professionalism* were placed into four subcategories, *Reliable and Ethical Practice*, *Discipline Knowledge*, *Professional Requirements*, and *Maintain and Grow Competence*.

1) *Reliable and Ethical Practice*

Participants reported that reliable and ethical practice is an essential aspect of competence. Reliable practice refers to transparent and consistent professional behaviour. This includes establishing and maintaining appropriate boundaries and roles and providing information and clarification about CP and client duties and expectations, initially and throughout contact. Participants highlighted that competent CPs uphold privacy and confidentiality and adhere to ethical standards and the code of conduct. This includes knowing clients' rights and standing up for them when needed. Participants discussed competence as understanding "true advocacy", noting that often responsibility is placed solely on clients to know their rights and articulate their needs.

I have had a clinical psychologist stand up for my needs (within guidelines) which was very important to me and empowering. This helped build my trust within the therapeutic relationship. (#57)

Participants highlighted that competent CPs are professional by being respectful, thorough, and prepared. Examples of incompetence included recording incorrect dates and personal information, not reviewing notes before sessions, and giving incomplete handouts and homework.

Participants commonly reported that establishing and maintaining professional, emotional, and physical boundaries are crucial for competence. This includes providing clear roles for CPs and clients which are clearly explained and navigating challenges to roles and relationships. Competent CPs were deemed as assisting clients to understand boundaries and helping clients set, clarify, and adhere to their own boundaries.

Understanding boundaries also helped with reassuring me and feeling safe. It laid further groundwork for more meaningful work. (#52)

Participants reported that competent CPs are clear about availability and contact. This includes specifying the type of contact outside of sessions, such as text messages or email, and the nature of the contact, such as during times of intensified distress or to reinforce intervention concepts after sessions. Participants reported that competence includes being consistent with agreed-upon availability, which fosters respect and trust.

She respected me, was never late and very rarely unwell. When she was away or unwell she stayed in contact or provided a "cover" person to contact. (#63)

Participants described incompetence as a lack of reliability. This included not being on time, rescheduling and cancelling appointments last minute, and not accepting client feedback about scheduling issues. Participants also reported that CPs leaving before interventions are complete affects reliability and thus, competence.

Left me mid-sessions so I had to start again with a new clinical psychologist. This activated attachment traumas. (#34)

Participants reported that competent CPs are clear about rights, benefits, and risks. This includes maintaining privacy and confidentiality and handing private information appropriately. Being

transparent about confidentiality limits, such as what information will be shared and what processes will occur in crisis situations was also reported.

One clinical psychologist told my employer that I had attempted suicide which resulted in me losing my job. She was concerned that I was not able to do my work to an adequate standard but didn't talk to me about this first or ask me enough questions to gauge whether this was true or not. (#51)

Participants highlighted that unreliable professional behaviour such as boundary issues leads to a lack of trust and safe practice. Boundary transgressions were highlighted as overstepping the CP role, for example, several participants commented on CPs insisting on driving clients home after medical procedures. Boundary breaches, such as using restraint, were deemed incompetent.

Unfortunately, I have mainly found psychology hasn't worked for me and I have struggled to feel comfortable with any of the psychologists who have worked with me. Last year I reflected on whether that was because the first time I saw a psychologist, she restrained me in a chair and got my partner at the time to hold me in it too. She thought I was having a repressed memory. I was having a panic attack and just wanted to leave (also my partner was violent at home, and I didn't disclose that at the time). (#61)

Participants highlighted that therapeutic processes cannot take place without CPs adhering to professional, ethical, and legal practice, which offers protection against abuse.

As I have experienced abuse by professionals, it means a lot to me to know that they absolutely will follow the expectations of their professions. Anything less would be a deal breaker. (#61)

Participants also commonly reported that unethical and incompetent practice includes not referring clients to appropriate services in a timely way.

Psychologists should have an ethical responsibility to refer clients to further services if they think they would benefit the client e.g., referrals to eating disorder services, Segar House, occupational therapists etc. It took too long for me to gain access to [other] additional services. There is no reason why I was in the system for 3+ years before some of these referrals took place. (#69)

2) Discipline Knowledge

Discipline Knowledge refers to the professional knowledge required to practice competently. Participants reported that competent CPs draw on a range of clinical and lived experience knowledge. This includes knowledge about their role, best practices, intervention techniques, and how service user research applies to practice. Participants highlighted the importance of knowledge about “holistic healing”, trauma-informed care, mental health, brain and behaviour relationships, and a wide range of presentations and diagnoses. Having knowledge about other relevant services, resources, and practical supports was highlighted. Knowledge about how to interact with a range of individuals across a range of situations, and keeping knowledge up to date was also reported.

I think they should also make sure they are keeping up to date with resources and skills and other therapies available. (#47)

Participants commonly reported that knowledge of service user-led research and lived experience perspectives is essential for competent knowledge of mental distress.

Competent in relevant knowledge of mental distress based on clinical and peer-led research. (#72)

Participants reported that competence means having adequate knowledge in areas CPs are expected to work in, such as trauma, addictions, physical health, and holistic healing. Accountability for claiming knowledge in a certain area was also reported.

It's very important that if a CP lists that they are competent in a problem area they have in-depth knowledge. In particular, OCD has so many subsets and in order to receive proper treatment, the CP needs to understand. (#54)

Relating to *Stigma, Discrimination and Exclusion*, prioritising knowledge based on biomedical and illness-based (pathologically focused) understandings was reported to be a sign of incompetence.

If it is adequate knowledge of a largely medical-based model of mental illness, then I would find that incompetent. (#72)

Participants also reported that competent CPs have adequate knowledge to appropriately respond to a range of situations and individuals, such as whānau members.

Be prepared for any situation. E.g., I brought along my brother who has severe dyslexia and Erlin syndrome and yet she kept giving him things to read. A competent one would know that this is not appropriate. (#8)

3) Professional Requirements

The *Professional Requirements* subcategory refers to participants describing that thorough training, education, and experience is important to ensure CP competence. This includes having a sound education and relevant qualifications. Participants emphasised the importance of life experience as well as professional experience. Participants highlighted that selection processes for CP training programmes should be rigorous and based on more than academic performance.

Participants shared that selection criteria should include lived experience, volunteering, and community work, as experience in these areas demonstrates competence, authentic genuine care, and passion to work in the field.

That selection is based on their lived experience as well as good academic performance.

Volunteering and community work should be another aspect of the criteria to show that they genuinely want to make a difference. (#73)

Participants identified that competence requires CP training that is good-quality, science-based, and professional. Training in a range of therapeutic approaches was highlighted, in particular, moving beyond CBT to other approaches such as DBT and EMDR.

More to be trained in things like EMDR, not just things like CBT. (#56)

Participants reported that training needs to encompass more than theories and diagnosis, such as “openness to client experiences”. Training about mental health-related stigma was deemed crucial for competence, as this will increase CPs receptiveness to client experiences.

More educated on the stigma around certain difficulties that clients may present with. (#46)

Participants highlighted that competent CPs maintain registration and a practising certificate. Some participants discussed that the titles and qualifications of CPs do not ensure competence, and that authenticity and how a CP relates to others is more important.

I do not believe someone's qualification makes them who they are or how competent they are, it is dependent on how they conduct themselves in the complexity of diverse social relationships. (#34)

Participants highlighted that sound clinical experience contributes to competence and includes reputation, length of time practising, and work experience in various settings. Commonly reported was that competent CPs have life experience, the skills to work with people experiencing mental distress, and experience regarding what other people with lived experience have found helpful.

They have the skills and experience to help identify issues and experience of what other people have found helpful. (#51)

4) Maintain and Grow Competence

The *Maintain and Grow Competence* subcategory refers to CPs being committed to preserving competence, developing competence continually, and being professionally supported to be competent. Participants highlighted that competence includes ongoing professional development throughout a CPs career and continuously striving to develop competence further. This relates to *Reflective Practice*, as self-awareness as discussed by participants is needed for CPs to then put in place supports to maintain and grow competence. *Maintain and Grow Competence* also relates to *Discipline Knowledge*, such as keeping up to date with new studies and research, learning new therapeutic modes, and attending current seminars.

Once trained they always endeavour to learn of new practices and research in their area of work and new therapies available. (#47)

Participants acknowledged that some CPs lack competence across several areas. Relating to *Culturally Responsive*, improving cultural competence was frequently reported as important. Relating to *Competent Systems*, participants highlighted that competence can be compromised by service or systemic issues, such as workforce pressure. Participants reported that personal and professional support for CPs is essential for competence. Examples include regular and “sound” supervision and “thorough oversight” by the Psychologist’s Board. Peer support, peer supervision, and regularly interacting with other psychologists were also reported as relevant supports for maintaining and enhancing CP competence.

Monthly hub where they meet with other psychologists for discussion and learning. (#19)

Participants reported that they hope CPs are better supported in their roles and their own well-being to prevent cynicism and burnout, thus, a decrease in competence. Participants also hoped CPs would be better supported by the registration board, which meant advocating for CPs and the profession.

This is where registration boards have become more like lobbyists for the few, not advocates for the profession or the wider health community. This criticism may seem harsh, but how will your registration board help you if you are being bullied at work I wonder, for example. (#34)

Culturally Responsive

For the *Culturally Responsive* category, participants reported that competent CPs work effectively and safely with culturally diverse people, such as Māori and people with diverse genders and sexualities. Participants highlighted the importance of identifying differences and privilege and being able to attend to the different needs of Māori during all CP activities. Content units in the *Culturally Responsive* category were sorted into *Navigating Diversity and Privilege* and *Attending to Cultural Needs*.

1) Navigating Diversity and Privilege

Navigating Diversity and Privilege means that competent CPs are aware of their cultural identity, positioning, and views about cultural differences. Awareness about diverse cultures and cultural practices and understanding how they may apply in practice was also highlighted, specifically in the context of Māoritanga and colonisation, sexuality, gender, and spirituality. Regarding *Reflective Practice*, participants reported that competent CPs can identify and navigate their cultural biases and are aware of and transparent about their resulting limitations. Not having to be an expert on another culture while being culturally understanding was described as important, as was ongoing learning about working with different cultures.

Participants highlighted that competent CPs consider and helpfully harness similarities and differences regarding outlook, life experience, and personal characteristics. Competence was reported to be demonstrated when a CP openly acknowledges and accepts that difference exists, which fosters connection between CPs and clients.

Participants frequently commented that competent CPs recognise and harness their privilege. This includes acknowledging the disparities between Māori and non-Māori, understanding colonisation effects, upholding Te Tiriti, and identifying a CP's own cultural biases.

If they aren't aware of their own cultural biases they may not be very good as a psychologist!
(#25)

Participants reported that competent CPs understand generational differences, gender identity, and sexuality. When these are misunderstood, frustration and a lack of confidence in the care received from a CP results. Participants highlighted that competence means being open to and non-judgemental of clients' cultures, values and beliefs.

Very obvious mine had no experience with alternative relationship dynamics or sexuality. When I was talking, she was visibly confused, and I had to explain basic concepts of my type of lifestyle to her (polyamory and bdsm). (#66)

Acknowledging and valuing spirituality in relation to healing was deemed very important for competence. Participants reported that if CPs are not accepting of clients' spiritual views, they cannot share fundamental parts of who they are, and fear being misdiagnosed or encountering other negative repercussions.

I did not feel it was appropriate to divulge my spiritual beliefs to her in case she thought I may be delusional! (#41)

Participants reported that competent CPs are interested in working with cultural minorities and can respond to and learn from the varying cultural and community norms of clients and whānau. Relating to *Competent Systems*, participants highlighted that it is important for CPs to represent the communities their clients are from. A range of cultures, ages, backgrounds, and lived experiences in the CP workforce was reported as crucial. Participants reported that incompetence includes CPs incorrectly assuming that they are being culturally appropriate.

I think a lot of clinicians also don't know how to work with ethnic people. They think they are culturally appropriate in their practice, but some of them don't even know the difference between Hindi and Hindu. (#6)

2) Attending to Cultural Needs

Attending to Cultural Needs refers to competent CPs being able to demonstrate cultural competence and cultural safety. This means responding adequately to varying cultural and community norms of clients and whānau, throughout assessment, intervention, and wider activities. Participants reported that competent CPs adapt interventions to align with a person's beliefs, morality, and cultural identity, and can identify and work through culture-related stereotypes with clients. Adapting interventions and processes to incorporate Te Ao Māori and other cultural needs was emphasised. Participants discussed that when CPs rely on theory rather than a holistic approach that incorporates culture, a lack of understanding of culture and associated values results, which causes harm and demonstrates incompetence.

The main issue was not addressing my culture or family, I am a biracial Māori woman from a divorced family and because they didn't recognise this they caused more harm and pain as a result. (#57)

Participants reported that attending to cultural needs includes a commitment to integrating Te Ao Māori into practice. This includes Tikanga processes, such as building relationships through

whakawhanaungatanga, Pepeha, karakia, and using Te Reo Māori (Māori language) correctly.

Participants also reported that competent CPs integrate Māori models into CP processes. Examples include using pūrakau (Māori creation myths) and the Te Whare Tapa Whā model, which incorporates hinengaro (mind), tinana (body), wairua (spirit), and whānau (family).

If not heard I feel on all Whare Tapa Whā levels that I do not exist, which brings up my defences. (#34)

Participants reported that competent CPs understand the need to prioritise Mātauranga Māori (Māori knowledge) and Te Ao Māori (customary processes) for effective mental health care. This includes understanding the effects of colonisation on mental health service provision.

Māori culture especially has had its own way of dealing with mental distress effectively before mainstream public health, so understanding cultural effects and colonisation should be of utmost importance. (#43)

Participants highlighted that competent CPs prioritise responsiveness to Māori and Te Tiriti to counter disparities in Māori mental well-being that include mental distress, suicide, addiction, and intergenerational trauma. Participants also discussed that competent CPs attend to socio-demographic factors such as poverty, that also contribute to disparities. Participants highlighted that culturally safe intervention is extremely important due to the historical disempowerment of Māori within mental health care, which contributes to distrust of systems.

With high rates of Māori suicide rates, addiction, poverty.. etc, and the awful legacy of poor treatment within the mental health sector for Māori, any psychologist without knowledge of Te Tiriti o Waitangi and Māori kaupapa shouldn't even be allowed to work, including those that have been psychologists already for a number of years. (#72)

Participants reported that not knowing how to work with transgender people and not allowing deeper discussion about sexual issues indicates incompetence. Participants highlighted that competent CPs facilitate a “sacred space” that recognises culturally diverse people as whole beings. Participants discussed that competent CPs honour cultural needs as an integral part of a person and weave these into intervention processes. This means adapting approaches to an individual’s cultural diversity, which includes value systems (e.g., Western and Eastern), spirituality, gender, and sexuality.

Being a woman, a lesbian, an atheist, intelligent and autistic are important elements of who I am, but they are rarely considered part of my cultural make up. I find my cultural needs are disregarded pretty much. (#71)

Competent Systems

In the *Competent Systems* category, participants discussed that competence includes the systems that CPs work within, as incompetent systems negatively impact the competence of CPs. The notion of competence was thus expanded beyond individual CPs to include the workforce as a whole. Competence was reported to also include the mental health system, through recognising and addressing CP availability and accessibility issues. Participants reported that competent systems understand the need for CPs, prioritise CPs in the mental health workforce, and regard CP interventions as the typical, standard approach for people experiencing mental distress.

In a perfect world, seeing a psychologist would be affordable and a normal experience and we might not all be so screwed up! (#39)

Participants often posited that competence means that more CPs are available, accessible, and are offered to more people. Participants described a competent CP workforce as growing, with more people wishing to be CPs, and more being trained.

I hope they become more available and numerous than psychiatrists. Especially for young people. I think medications are extremely dangerous and suppress people. (#62)

A siloed medical focus in the mental health system was reported as a barrier which makes accessing CP services difficult, leading to incompetent care. Relating to *Therapeutic Assessment and Intervention*, participants reported that the advantages of more CPs include providing “much-needed” alternatives to biomedical approaches, better support for mental distress, and people spending less time in the mental health system.

Talk-based therapies actually work toward a cure. Meds simply dummy down the symptoms. I would like to see clinical psychologists given way, way more profile in the solution set available to mental distress clients. (#45)

Participants commonly reported that a competent CP workforce creates easier access to CP input, including in low socio-economic areas, General Practitioner (GP) settings, and corrections. Participants also discussed that a competent workforce tackles systemic issues involving being able to access CPs at the right time, such as early intervention, in-patient entry, initial assessment with psychiatrists, and before discharge.

I hope there are more competent clinical psychologists, so people don't have to be put on a waiting list for a year when they need help now. (#28)

Participants identified that competent systems include adequate resourcing for CPs, for example, in publicly funded community mental health services.

I wish that they are given more funding and less pushed for resources for the work they do. (#32)

Participants also frequently reported that competent systems would mean CPs are more publicly accessible and affordable.

I could not afford follow-up appointments. I would have loved to do that - this guy was really, really good. But, sadly, talk-based therapies aren't easily funded here in NZ, and it's pretty darn expensive to fund them out of your own back pocket... So, one consultation was what I could afford, and that's all I got. (#45)

Participants identified systemic obstacles related to *Therapeutic Assessment and Intervention*. Short-term relationships when CPs can only offer limited sessions were reported to undermine the therapeutic relationship and long-term well-being, contributing to views of incompetence.

Others I've seen only offered 3-4 sessions. How can you ever deliver therapeutic care in so few sessions?! (#48)

Stigma, Discrimination, Exclusion

The category *Stigma, Discrimination, Exclusion* refers to competent CPs being aware of and attending to stigma, discrimination, and exclusion (SDE). This means identifying and understanding the impact of SDE on mental health care, being able to mitigate these impacts during assessment and intervention and acknowledging and recognising their influence and impact on clients, clinicians, and services. Participants reported that competent CPs recognise SDE, and address power and privilege to mitigate their effects. Participants commonly reported that CPs need to be competent in this area to be competent in all of the other reported areas (categories) of CP competence. Participant responses for *Stigma, Discrimination, Exclusion* were sorted into *An Important Area*, *Noticing and Naming*, and *Responding Adequately*.

1) An Important Area

An Important Area refers to participant responses that identified SDE as a crucial area for competence, CPs, and psychology. Participants reported that SDE is “the most important area”, a “big concern”, and “absolutely key”.

If I could rank all these concepts, this one would be number one. (#72)

Participants reported that SDE as an area of competence is important as stigma and discrimination should never be reflected by a health professional, and that self-awareness regarding stigma and discriminatory practices is essential (relating to *Reflective Practice*). Respondents commented that the SDE area description in the survey (outlined previously) was what should be expected from any competent CP. Respondents highlighted that if CPs do not attend to SDE effectively they then contribute to and perpetuate their effects. Thereby, doing nothing to address this area indicates incompetence.

Self-awareness around stigma and discriminatory practices is essential if psychologists want to do their job well. (#51)

Participants reported that competence includes being aware of and countering the effects of internalised mental health-related stigma.

A lot of this [attention to SDE] needs to come from acceptance within yourself, but the psychologist is part of you learning to do so. (#39)

Relating to *Competent Systems*, participants reported that constrained systems contribute to SDE. For example, under-resourced systems lead to CP fatigue, which means CPs do not have enough capacity to acknowledge and respond to SDE, resulting in less competent care for clients.

This [SDE] is exacerbated by the emotional exhaustion that I think the clinicians experience from existing in a stretched service. They are constantly picking up pieces and there isn't any room left to give out "care". (#69)

2) Noticing and Naming

Noticing and Naming refers to CP competence including being able to identify mental health-related SDE (MHSDE) and acknowledging their existence. Participants described stigma as making

assumptions about, labelling, using negative terms to describe, and taking a negative approach to people who experience mental distress. Participants highlighted that MHSDE exists, and that psychologists are not immune to their influence. For example, some CPs can hold an “othering” attitude towards people with lived experience. Participants shared that CPs may assume that they do not hold mental health-related biases due to having knowledge of mental distress and can hide mental health-related prejudice. This however creates a blind spot that does not allow for the identification and acknowledgement of MHSDE, resulting in incompetence.

I have found that often psychologists hold a lot of stigma towards people experiencing mental health challenges. They assume that because they have a lot of specific knowledge in this field that they are not prejudiced. (#51)

Participants considered it essential that CPs are open and aware of the existence of MHSDE in order to address its effects.

I do think it's important they be open and truthful about the reality that there is a lot of stigma and discrimination out there. It does happen a lot in families. Believing it's not is not helpful. Sometimes people don't want to raise it. (#61)

3) Responding Adequately

Responding Adequately means that competent CPs respond to MHSDE throughout assessment and intervention processes (relating to *Therapeutic Assessment and Intervention*). Participants reported that competence includes demonstrating “attitudes void of stigma and discrimination” (#72), learning about MHSDE together during intervention, and supporting clients with experiences of MHSDE. Participants reported that competent CPs prepare clients and their whānau to navigate mental health and diagnosis-related SDE.

Borderline Personality Disorder has a huge stigma. Need to prepare for the client to experience discrimination. (#33)

Participants acknowledged that CPs can perpetuate MHSDE, which was reported as indicative of incompetence. Incompetence was also indicated when CPs' personal beliefs and worldview stop them from being objective and understanding (relating to *Reflective Practice*).

One of my vices is porn. My psychologist is very affirming that my struggles don't devalue me as a person, and that they are common in males. So, there is no shame in talking about this issue. (#5)

Participants reported examples of competent CPs mitigating mental health and diagnosis-related SDE. These included "being able to break through those [mental health-related] stereotypes" (#46) and navigating the negative effects of diagnostic labelling during assessment.

Does not enter into the relationship with pre-conceived ideas and prejudices based on my diagnoses or what my medical notes say. (#51)

Participants reported that they and many others who have accessed mental health services have been harmed as a result of MHSDE, and competent CPs understand this and do not perpetuate such harm. Participants highlighted that competent CPs understand that MHSDE is "unhealthy" and "toxic", and that not attending to these amplifies distress and disempowerment for clients. Participants provided examples of perpetuating harm which indicates incompetence, such as looking down on clients, making assumptions, and negatively labelling clients due to physical appearance. Outcomes of stigmatising experiences were reported as feeling devastated, shamed, and judged.

I have in the past felt like some professionals have looked down on me. That has been quite devastating. Especially when they make assumptions about me or my thinking. (#61)

Participants reported that incompetence includes a CP conveying disrespect due to a client experiencing mental distress, which leads to silencing, devaluation, and dehumanisation. Therefore, when SDE exists in the therapeutic relationship there cannot be an effective therapeutic alliance (relating to *Relational Presence*). Participants reported that mental health professionals that transmit mental health-related stigma and belittling views of people who experience mental distress are unable to competently assist or care for clients.

If I am told I am weird or crazy there is no way we can have a good relationship. (#37).

Several participants reported life-threatening consequences because of harm due to MHSDE. Examples included shutting down, elevated distress, loss of service access, silencing of abuse, increased self-harm, and suicide attempts.

As a 12- to 14-year-old I was experiencing very severe trauma symptoms as well as depression and anxiety. My first two psychologists brushed it off as attention-seeking and that I was trying to use it as a method of gaining status. This led to me bottling up all my feelings and experiences. As a result I did not disclose my childhood sexual abuse until 21 years of age after a suicide attempt which left me in a coma for four weeks. (#12)

Summary of the Survey Analysis of What Service Users Identify as Competent Practice for Clinical Psychologists

After conducting a CA of the qualitative survey answers to items that asked participants about their views of CP competence, I generated eight main categories of competence. The categories reflected assessment and intervention processes, relational aspects, lived experience, communication, professional expectations, cultural responsiveness, systemic competence, and stigma, discrimination, and exclusion. These responses provide an answer to what service users identify as competent practice for a CP (research question one). In the next section, I will address research

question two, identifying how service user views align or contrast with the existing aspects of competence as described in the NZPB core competencies.

Part Three: How Survey Findings Align and Contrast with the NZPB Core Competencies

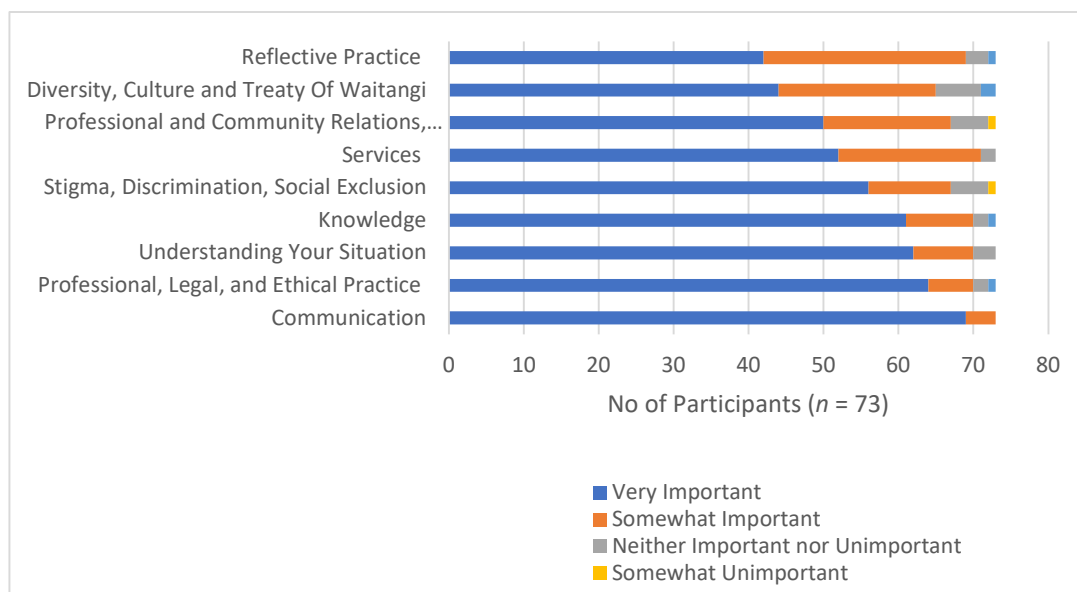
In this section, I discuss how survey participants rated competence areas and then compare how service user views of competence (Part Two) align and contrast with existing aspects of the NZPB Core Competencies (research question two).

Importance Ratings for Areas of Competence

Figure 4 shows that survey participants predominately rated each area of competence as Very Important (VI) or Somewhat Important (SI). This indicates that the existing areas in the NZPB competencies (as described in the survey) are important areas for service users. *Communication* was an area rated slightly more important by participants than other areas. However, differences between area ratings were marginal when VI and SI ratings were grouped together. As reported by some participants, *Diversity, Culture and Treaty of Waitangi* may have been rated less important as most respondents were non-Māori and thus considered this area less relevant to them. As *Reflective Practice* involves CPs internal processes, it may have been more difficult to comment on this aspect, lowering its importance rating.

Figure 4

Areas of Competence Ratings



Summary of How Service User Views of Competence Align and Contrast with Existing Competencies

This section refers to research question two: how do service user views of competence align or contrast with existing aspects of the NZPB core competencies? I summarise the main aspects of alignment and contrast of service user views when compared to the NZPB core competencies. For clarity, “NZPB competencies”, “core competencies” and “Board competencies” refer to the NZPB core competencies. “Service user views” or “participant views” refer to the participant findings. While I have attempted to delineate aspects of competence within and across categories/subcategories, as discussed in Part Two, categories/subcategories are often interrelated and overlap. This will be discussed further in Chapter Six. As outlined in Chapter Three, the competencies comparison focuses on the NZPB competencies pertaining to CPs, which are the general scope, clinical scope, and cultural competencies. The survey analysis identified that service user views of competence shared some similarities with the NZPB core competencies and also revealed some key differences. See Appendix G1 for a table that sets out in more detail aspects of alignment and contrast of participants’ views with the Board competencies.

For *Therapeutic Assessment and Intervention*, participants specified checking and mitigating assumptions and inviting and incorporating client feedback about assessment and formulation.

Competent approaches to assessment, formulation and intervention were reported as holistic, recovery-focused, and tailored to an individual, which are not Board-specified competencies. Participants reported intervention targets and change in a wider sense, moving beyond an individual, such as addressing external factors influencing distress and facilitating wraparound support both within and across services. They emphasised that considering client's needs and preferences are essential for effective intervention, as was implementing a range of helpful skills and tools, and ultimately being helpful, which are less of a focus in the core competencies.

For *Relational Presence*, participants heavily emphasised providing a safe space and coming across as authentic in a more detailed way than indicated in the core competencies. Participants particularly emphasised relational trust, rapport, and collaboration. Regarding reflective practice, the NZPB competencies include self-awareness, self-reflection, and self-assessment. Service users further specify responding to what has been recognised or reflected upon. The Board competencies focus on within-profession reflexivity (from the psychologist or supervisor), whereas participants reported that reflexivity also involves considering feedback from clients. As participants reported, prioritising within-profession feedback over service user feedback is likely to impede a psychologist's ability to critically self-reflect and consider relevant feedback (e.g., from clients) that strengthens self-reflection and professional practice. This also relates to other areas such as *Culturally Responsive and Stigma, Discrimination, Exclusion*.

Service user views of competence in the *Lived Experience and Competence* category were a major area where participant views of competence were not in the Board competencies. The core competencies do not include CP lived experience as an advantage or managing lived experience as a specific competency.

For *Effective Communication*, communication skills that create and maintain rapport and collect relevant information are consistent with the Board competencies. Communication as a two-way process, truly hearing clients, and communication as aiding the achievement of shared

understandings and establishing a joint purpose are not in the Board competencies. Continual checking of understanding is also not noted amongst the Board competencies.

For *Professionalism*, core competencies that emphasise ethical and safe processes and knowledge of interests and the rights of others align with participant views, though service users are not mentioned explicitly. The importance of relations, consultation, and communication with people with lived experience as a cultural group is not explicit in the Board competencies. Regarding discipline-based knowledge, service users were specific about valuing and harnessing service user knowledge and research, contrasting with the core competencies. Participants provided examples of the consequences of a lack of adequate and relevant knowledge, such as incorrect assumptions that undermine CPs' ability to care for and assist clients, which is not mentioned in the Board competencies. While advocacy is in the Board competencies, participants specified that advocacy includes responding systemically to clients' needs. The core competencies emphasise theoretical and empirical knowledge, and does not state that service user views and preferences contribute as relevant evidence. Participants also highlighted that supports in addition to supervision, such as peer support, professional support, and service (systemic) support, enhances CP competence, as does life experience and being transparent about credentials.

For the *Culturally Responsive* category, participants emphasised the recognition of and response to power and privilege, including disparities for Māori and cultures that are not Pākehā. This is not specified to the same degree in the core competencies. Both the NZPB competencies and participants highlighted the importance of Te Tiriti principles of partnership and equity, however, participants emphasised understanding the effects of colonisation on partnership and equity and how psychology work is carried out. Responsiveness to the intergenerational effects of disempowerment of people from non-majority cultures and mitigating stereotypes based on culture were also more prominent in participants' responses.

Participants identifying *Competent Systems* as an aspect of competence contrasts with the core competencies which mainly focus on individual CP factors. Participants reported that

understanding, identifying, and working to ameliorate organisational and systemic barriers to effective mental health care are crucial aspects of CP competence. These are not indicated in the core competencies.

For *Stigma, Discrimination and Exclusion*, mental health-related and diagnosis-related SDE are not in the Board competencies. Further, in the Board competencies, the effects of MHSDE are not considered culturally, socially, and politically bound embedded factors or contextual variables that impact assessment and intervention. Participants highlighted that competence includes mitigating systemic factors that perpetuate the transmission of SDE. Related to *Reflective Practice*, “cultural safety” and “cultural competence” in the cultural competencies include accurate self-assessment of how personal biases, lack of relevant knowledge, and socio-political influences impact psychology activities. However, self-assessment, or assessment with supervision, is unlikely to uncover implicit MHSDE biases without external feedback from those in a position to identify them. The core competencies emphasise “knowledge” of SDE, whereas participants emphasise “skill” where competent CPs act to mitigate SDE. SDE are predominately in the Cultural Competencies, however, these competencies are not minimum requirements for competence. Participants reported that countering SDE, and particularly MHSDE, is fundamental to CP competence.

Chapter Five: Interview Analysis

This chapter outlines the analysis of interview participants' views of CP competence. In Part One, I describe participants' experiences with CPs. I then discuss the thematic analysis (TA) of the interview transcripts, structured by research question one, what service users identify as competent practice for CPs (Part Two). In Part Three, I address research question two, how service user views of competence align and contrast with aspects of the NZPB core competencies. Like the survey analysis, I focus on presenting the data and do not include research and literature from non-participant sources.

Part One: Interview Participant Experiences with Clinical Psychologists

As shown in Table 9, interviewees drew on a wide range of experiences with CPs. Most had seen more than one CP for mental health ($M = 3$) in a variety of settings. Most interviewees had seen CPs regularly and had last seen a CP recently. Some participants ($n = 3$) had seen the CP(s) over six years ago. These participants remained in the study due to the reasons discussed on p. 84.

Table 9

Interview Participant Contact with Clinical Psychologists

Category	Count	%
Number Seen		
1	2	16.67%
2	4	33.33%
3	1	8.33%
4	2	16.67%
5	2	16.67%
6-7	-	-
8-10	1	8.33%
Setting		
Community/In-Patient Mental Health	15	60%
Sensitive Claims	4	16%
Primary Care	3	12%
Private Practice	2	8%
University	1	4%
Age First Seen (Years)		
8-10	2	16.67%

Category	Count	%
20-30	7	58.33%
30-40	1	8.33%
40-48	2	16.67%
Age Last Seen (Years)		
23-20	4	33.33%
30-40	3	25%
40-50	3	25%
50-57	2	16.67%
How Long Ago		
Current	7	58.33%
1-5 Years	2	16.67%
6-10 Years	2	16.67%
15 Years	1	8.33%
Timespan		
2 Hours-6 Months	3	25%
7-12 Months	-	-
1-10 Years	3	25%
11-18 Years	2	16.67%
22-26 Years	4	33.33%
Duration		
1-6 Hours	6	27.27%
6-10 Months	6	27.27%
1-2 Years	6	27.27%
3-5 Years	2	9.09%
10 Years	1	4.55%
26 Years	1	4.55%
Regularity		
Once/ Occasionally	4	25%
Weekly	7	43.75%
Fortnightly	3	18.75%
3 Weekly/Monthly	2	12.50%

Note. As more than one option could be selected for Settings, Duration, and Regularity percentages are expressed as a proportion of the total responses for each item. Number Seen; Age; How Long Ago; Timespan; Duration; and Regularity responses are collapsed into categories.

As shown in Table 10, interviewees saw CPs for a range of reasons. Some did not have a choice to see them (e.g., they were legally required to), and all of the participants' daily lives were affected by the difficulties they saw the CPs for. There was a range of reasons for stopping CP contact, and each interviewee received three or more other types of support for mental well-being, which likely informed their views of what constitutes competence.

Table 10*Interview Participant Experiences with Clinical Psychologists*

Category	Count	%
Reason		
Anxiety	12	100%
Low Mood	11	91.67%
Trauma	11	91.67%
Sleep Issues	7	58.33%
Relationship Issues	6	50%
Personality Issues	6	50%
Work Stress	5	41.67%
Behaviour Issues	5	41.67%
Learning Difficulties	4	33.33%
Physical/Medical	4	33.33%
Alcohol/Other Drug	3	25%
Hallucinations/Delusions	3	25%
Eating Issues	2	16.67%
Mania	1	8.33%
University Stress	1	8.33%
Self-Harm	1	8.33%
Prefer Not to Say	1	8.33%
Diagnostic Category		
Post-Traumatic Stress ^a	8	66.67%
Depression	7	58.33%
Anxiety	7	58.33%
Bipolar	3	25%
Obsessive-Compulsive	2	16.67%
Psychosis	2	16.67%
Anorexia Nervosa	2	16.67%
Borderline Personality	2	16.67%
Dissociative Identity	2	16.67%
Oppositional Defiant	2	16.67%
Alcohol/Drug Use	1	8.33%
Autism-Spectrum	1	8.33%
Attention-Deficit	1	8.33%
Dyspraxia	1	8.33%
Other Personality	1	8.33%
Choice		
No	9	37.50%
Yes	15	62.50%
Daily Life Affected		
Most/A lot	12	100%
Overall Helpfulness		
Helpful	5	41.67%
Mixed	5	41.67%
Not Helpful	2	16.67%

Category	Count	%
Reason for Stopping		
Dissatisfaction	5	29.41%
Ran Out/ Terminated	3	17.65%
Discharge	2	11.76%
Referred to Another Service	2	11.76%
Requirements Complete	2	11.76%
Psychologist Left/Moved	2	11.76%
Participant Moved	1	5.88%
Other Support		
Medication	11	91.67%
Counsellor/Psychotherapist	11	91.67%
General Practitioner	11	91.67%
Psychiatrist	9	75%
Nurse	8	66.67%
Peer Support	6	50%
Social Worker	5	41.67%
Support Worker	2	16.67%
Occupational Therapist	1	8.33%
Dietitian	1	8.33%
Consumer Advisor	1	8.33%
Other	1	8.33%

Note. As more than one option could be selected for Reason, Diagnostic Category, Choice, Reason for Stopping, and Other Supports, percentages are expressed as a proportion of the total participants. Choice and Reason for Stopping percentages are expressed as a proportion of total responses for that item.

^a Post-Traumatic Stress includes Complex Post-Traumatic Stress.

Part Two: Interview Analysis of What Makes a Clinical Psychologist Competent

Table 11 summarises the TA of the interview transcripts where interviewees were asked about CP competence. I sorted the coded blocks of text into six themes, with 15 subthemes. For ease of reporting, I ordered the themes and subthemes from highest to lowest number of participants that provided blocks of text sorted into a particular theme/subtheme, and I discuss the TA in this order. Similar to the CA, the interviewees reported that the themes and subthemes that make up their views of CP competence are connected and often related. For example, *Responsive Framing and Intervention* relies on *Relationship Building*, and *Attention to Stigma, Discrimination, Social Exclusion, and Power* underpins competence for all the other themes.

Themes for the TA include *Responsive Framing and Intervention*, referring to assessment and intervention approaches that are specific and relevant to clients' particular needs and preferences (*Flexible, Tailored, and Focused Intervention*). Interviewees discussed competence as placing clients at the centre of assessment and intervention activities (*Prioritising the Person*) and *Understanding Context and How to Assist* as essential for assessment and intervention.

The *Ensuring Safe Practices* theme refers to professional guidelines and behaviour expected of competent CPs, such as having *Adequate Training, Knowledge, and Experience*. Participants discussed that competence means consistently *Seeking Feedback and Updating Practice* based on service user input, and *Quality Assurance and Professional Conduct* specify the professionalism expected of CPs that builds trust in the profession.

Participants commonly highlighted that *Relationship Building* is fundamental to all other activities of competent CPs, which includes being human and relatable (*Authentic Connection*), self-aware (*Self-Awareness*), and paying attention (*Attentiveness and Perceptiveness*).

Participants discussed that attention to mental health-related *Stigma, Discrimination, Social Exclusion, and Power* (MHSDEP) is essential for CP competence. This means acknowledging that MHSDEP exists, learning about and identifying resultant inequities, and responding adequately to mitigate negative effects and impacts for clients, professionals, and services. MHSDEP as an area of competence impacts every other theme identified. For example, CPs cannot ensure safe spaces as a profession if MHSDEP is not attended to, and understanding how MHSDEP affects assessment, intervention, relationship building, and cultural safety is essential to carry out competent activities in those areas.

Relating to *Responsive Intervention*, interviewees highlighted that competent CPs support clients and communities more widely than within an individual client (*Responsive Care Beyond the Individual*). This means demonstrating *Advocacy* and working to implement *Wider Supports*, such as assisting with other services and resources to supplement well-being.

Participants considered *Cultural Responsivity* important for competent CPs. This includes responsiveness to Māori people and ways of being (Māoritanga). Participants also highlighted that acknowledging and responding to different cultures, genders, sexuality, and spirituality is essential for effective relationship building, safe practice, and competent assessment and intervention.

Table 11

Summary of The Thematic Analysis of Views of Clinical Psychologist Competence

Theme	Subordinate Theme	Count
1. Responsive Framing and Intervention		12
	1.1 Flexible, Tailored, and Focused Intervention	12
	1.2 Prioritising the Person	10
	1.3 Understanding Context and How to Assist	9
2. Ensuring Safe Practices		12
	2.1 Seeking Feedback and Updating Practice	12
	2.2 Adequate Training, Knowledge, and Experience	12
	2.3 Quality Assurance and Professional Conduct	10
3. Relationship Building		12
	3.1 Authentic Connection	11
	3.2 Self-Awareness	7
	3.3 Attentiveness and Perceptiveness	5
4. Attention to Stigma, Discrimination, Exclusion, and Power		9
	4.1 Mental Health-Related Stigma and Discrimination	7
	4.2 Power Differentials and Inequality	7
5. Responsive Care Beyond the Individual		8
	5.1 Advocacy	5
	5.2 Wider Supports	5
6. Cultural Responsivity		7
	6.1 Māoritanga	7
	6.2 Gender, Sexuality, Spirituality	5

1. Responsive Care: Framing and Intervention

The *Responsive Care: Framing and Intervention* theme refers to interviewee descriptions of competence as delivering appropriate, relevant, and effective intervention. This includes supportive assessment and intervention processes that respond to client needs and preferences. Responses were sorted into three subthemes, *Flexible, Tailored, and Focused Intervention*, *Prioritise the Person*, and *Understanding Context and How to Assist*.

1.1 Flexible, Tailored, and Focused Intervention

The *Flexible, Tailored, and Focused Intervention* subtheme refers to competent CPs providing interventions that are adapted to an individual's preference, situation, and needs, being flexible when crafting and delivering intervention, and focusing on improving well-being throughout intervention. Interviewees highlighted CP competence as taking a broad view of what has happened to a client, to provide a range of therapeutic options which are whole-person focused. Holistic approaches that provide alternatives to medication were commonly discussed as important. Participants reported that competent CPs stay focused in session, keep clients on track, hold and instill hope in clients, and provide things to work on between sessions. Sessions that make progress and provide ways for clients to navigate feeling stuck were also considered indicators of competence.

Participants reported that competent intervention includes CPs increasing clients' understandings of distress by identifying the characteristics of an individual's distress and offering explanations that make sense. This includes CPs reframing and co-constructing helpful understandings of how to navigate distress, such as "shining a light" on aspects clients are unaware of. Competent CPs were reported to teach clients how to engage in their own reframing, leading to increased clarity, awareness, and autonomy.

It did give me a whole new perspective. At first, I was shocked, to hear your own story told back to you and framed in a completely different way which you hadn't even seen. It's like somebody knows you better than you know yourself. I was like, wow, that's really impressive that somebody can do that. It made me reframe a lot of my previous experiences. (6)

Participants commonly reported that competent CPs are flexible in their approach to intervention, and tailor interventions by providing a range of options to fit client's needs. CP competence was viewed as adapting approaches such as EMDR, CBT, DBT, and mindfulness. Participants highlighted that competence means deviating from intervention approaches when appropriate and understanding that not all approaches are helpful for everyone.

To not be afraid to deviate from a treatment manual. It's very easy to go "it's evidence based so this will work". And, if it's not working, it's the client's fault for not trying hard enough. At that stage, even if they're [clients] not trying hard enough for you [CPs], they may be trying in the capacity that they have left. It may be that the standardised treatment that is evidence-based may not work for them, and that there are other things you may need to try. So being able to work with that and have that conversation. (3)

Participants reported that competent CPs adopt holistic approaches to provide much-needed alternatives to biomedical paradigms and medication,

Clinical psychology does something quite different because the medication doesn't help you unpack any of it and doesn't actually do anything useful to help you. Psychiatry dumbs you down. Whereas unpacking and being able to find tools to help you through it, is actually pretty darned important. (4)

Competence was also discussed as consolidating divisive understandings between mental and physical health into a whole person understanding.

Clinical psychologists play a really important role in moving mental health further away from being really, really medical and back towards health care as a whole, because the arbitrary split between mental health and general health is ridiculous. (1)

Relating to *Prioritise the Person*, participants reported that competence in being flexible means adapting interventions to client's ideas and views. Responding to client feedback was reported to enhance a tailored and responsive approach that responds to client needs as they emerge and change.

Be willing to listen and learn and change or challenge what you already thought was the right way of doing things. Be willing to change the way that you do things if it's not meeting the needs of the people it's for. (6)

Interviewees reported that competent CPs suggest supplements to intervention, such as breathing applications on phones, reading materials, and other things to work on between sessions.

He gave me that tutoring almost, as well as the therapy. It was quite good. He was like, "read this book, read that book". I was like, "ok, ok, I'll do that". (5)

Participants reported incompetence as adopting inflexible approaches, not tailoring interventions to individuals, and not focusing on what was needed. These factors were reported to increase pressure on clients to be "fixed" and "wear a mask" to indicate the intervention helped when it had not.

I felt [the CPs] had tried hard, and I wanted them to think that I was fixed. I was scared that they would say oh no, she's a hopeless case because it was ineffective. So, I was always covering myself, I wore a mask. I hid a lot of my traumas. (12)

Other reported consequences when interventions are not appropriately tailored and focused included clients feeling blamed and stigmatised, assuming responsibility for intervention ineffectiveness, withdrawal of support, and increased distress (*relating to Stigma, Discrimination, Exclusion, Power*).

It didn't help me outside the door. Then they said, "we can't help you, you've been doing it for so long and it's not working, so we have to withdraw our services". I had no one and you felt like a failure. You don't feel good enough because you aren't fixed. Then you're left out in the world on your own and you go blacker and blacker. Each time that happens it gets harder and harder. (7)

Interviewees highlighted that competent CPs encourage and celebrate progress, provide “positive takeaways” at the end of each session, and hold hope for clients throughout intervention.

It wasn't until I got the psychologist who changed things around and actually made me want to fight for recovery, and actually engage me in treatment, and made me see that actually, I could get better. (3)

1.2 Prioritising the Person

The subtheme *Prioritising the Person* refers to competent CPs seeing a client as a person first and foremost and conveying that the client is the most important person throughout the assessment and intervention processes. Participants reported that competence includes collaboration, inclusion, transparency, and moderating assumptions. Examples of prioritising clients included upholding dignity and respect, informed choice and consent, and believing clients. Participants reported that competent framing means CPs do not reduce clients to a diagnostic label. Seeing clients as people first was deemed crucial for competent and effective intervention.

See people as people first and then whatever their presenting illnesses, second. That often doesn't happen. They go and you get your clinical information, they have all your notes, but I don't think they could tell you anything about me... my hobbies, what my interests were before. But they could tell you my weight and all the medical issues that were going to be wrong with me. So, I think that needs to be some sort of competency. A lot of negative experiences have been around that. (3)

Interviewees highlighted that competent CPs use collaboration and inclusion to see clients as people first. This means discussing anticipated approaches that may be taken and ensuring they correspond with what a client wants.

To actually have collaborative treatment where it's discussed with the person beforehand.

What do they want? A safe space before putting them in a place with so many health professionals where they are silenced. That would be a big one. (3)

Interviewees reported that competent CPs are transparent with clients. This includes providing information about rationale and approach and offering to share notes and reports. These were deemed important for clients to be more autonomous regarding their care.

Transparency is so important. I was like, "I want to see what you're writing about me, I want to read it, why are you going to multidisciplinary team meetings without me?" And they'd be like, "it's just for the clinicians". It's like, why are you more important than I am? I don't actually want to read all my notes, but I want to be allowed to read them, and I don't want to have to argue for it. It is really important to be involved in all the processes. (6)

Participants reported that competent CPs are willing to listen and see clients as knowledgeable, which helps to moderate assumptions.

It's good the one I've got now is actually willing to listen to me if she thinks I do actually know something. She'll not try and tell me she knows more than I do. (6)

Interviewees discussed incompetence as CPs making assumptions, such as labelling clients based on previous clinicians' impressions. Participants highlighted that a barrier to not seeing clients as people first is when CPs conceptualise clients in a certain way due to biased and stereotyped assumptions of how a person with a particular set of presenting issues or diagnosis "should" behave. These assumptions can be passed onto other clinicians, which reinforces and maintains unhelpful assumptions (relating to *Stigma, Discrimination, Exclusion, Power*).

The psychologist who did an initial assessment totally went with what their colleague had written. I don't think they were starting by seeing me as who I am because I've got these

labels written down... The psychiatrist said you must have borderline personality disorder because what I'm hearing is all manipulation... you're manipulating the system to get what you need. The psychologist I think had read all of that and didn't see me afresh. And that was difficult. But I also understand that faced with a colleague that you have to work with and faced with a patient, it must be sometimes hard to distance yourself from what your colleagues have said. (1)

Participants reported negative outcomes for clients when CPs do not prioritise their views and see them as people. These include silencing effects, misdiagnoses, the provision of distressing, incompetent and unhelpful interventions, and distrust of mental health professionals.

Baggage followed me from the first counsellor. She was really convinced that things had happened that hadn't really happened and that loomed over me. She was trying to make me fit into the box of who becomes anorexic, I suppose. That information she passed on to the eating disorder service who ran with it as well. That then got passed on to the psychologist. I was like "but that's not true, can we move off that?". [The CP] wouldn't. She wouldn't listen to what I thought or what I felt. She had an agenda on how you treat someone how I was presenting. She wouldn't listen because I was the eating disorder person that lied and manipulated so why would you listen to me. If I kept speaking, more lies or twisted truth was added to my file. I'm not even saying that and yet it's being written. I just cut and run from there basically. (6)

1.3 Understanding Context and How to Assist

The *Understanding Context and How to Assist* subtheme refers to competent CP approaches to assessment, and formulation, which assists with intervention. Participants identified that competence includes adequate knowledge of clients' presenting challenges and specific and accurate formulations and diagnoses. Further, competent CPs attend to contextual variables to identify what

will assist clients. This includes gaining accurate understandings and interpretations of clients' challenges through thorough investigation of client's histories, impacts of disempowering experiences, and social and relational aspects. These all inform the selection and implementation of appropriate intervention modalities. Participants reported that competent CPs implement assessment and intervention processes that are clear and make sense for clients, and direct clients to others when CPs do not have the knowledge or understanding required to assist.

I'd been through a lot of people who said they were going to help me, for counselling or psychology, who had no idea, and they played around. I was distressed and confused, and it mucked up my brain. (12)

Accordingly, participants described incompetence as CPs not knowing how to assist, with this resulting in confusion and distress. Examples included labelling and changing diagnoses due to inaccurate understandings of context. Interviewees reported that competent CPs seek wider understandings of a person's challenges, which leads to formulations and diagnoses that are more specific and relevant.

I got labelled with trauma and adverse experiences. Then [a few years later] an educational psychologist said, "have you considered that you may have ADHD?" People jump on bandwagons, if they're not really aware of what's happening in society and they're not really good at looking at the information. (12)

Participants reported that trauma-informed practice and finding out what has happened to a person are crucial aspects of competent practice. These were deemed essential for CPs to then generate solutions to assist.

That's what trauma-informed practice is all about, find out what happened in the past, what happened to this person, and they will be better able to provide them with a solution. (12)

Interviewees described that competent CPs explore with clients the impact of trauma and previous experiences with mental health services. They highlighted that adequate understanding involves careful history taking and understandings that normalise what clients are experiencing. These factors provide emotional space where clients can talk about and deal with distress and traumatic experiences.

I finally realised "I trust you and can actually speak about what's been happening underneath everything". That took 18 months of her being like, "right, let's talk about your negative experiences in therapy. And let's talk about why you can't trust me". I'd never been asked "what were your negative experiences? How has your treatment impacted your current mental health state?". Part of it is my inpatient treatment, there was a lot of trauma. I was 18 and would see people who had just slit their throats. (3)

Participants discussed that competent CPs understand client challenges by drawing on frameworks sensitive to developmental, relational, and social aspects.

She understood that there must have been something that happened that captured me at this pre-teenage [stage]... She allowed me to grow up and go through the developmental stages I was not allowed to do at home, which isn't something I'd ever experienced. No one had looked at me from an attachment perspective, or been like, "I will reparent you." (3)

Participants reported that competent CPs investigate and understand trauma stemming from complex social situations, such as intimate partner violence, financial constraints, and employment factors. Participants reported that outcomes of CPs not understanding contextual factors include decontextualising challenges and pathologising distress. Thus, competence includes developing formulations that include and respond to aetiological dimensions.

While seeing the psychologist for nine years [during an abusive relationship] I had to be someone I wasn't for a long time, I didn't have any choice. My psychologist didn't understand

why I didn't just leave. So, it became easier just to study psychology, it kept me going for another week. (7)

Interviewees described competent CPs as confident in finding solutions for clients based on accurate formulations that arise from understanding different presentations of distress.

I've got dissociative identity disorder, and it's very hard to find someone that understands that... They didn't really understand how to treat me or how to help me, then I got stressed and then the alters came out. I've been through [multiple community mental health services] and even they don't really understand how to help me. To learn more about the diagnosis, give something to people to understand what it is. I've even been through the prison system because of my alters and the prison system didn't even understand it, they just thought I was having them on. I feel like an alien, like I don't belong. It puts me backwards. (9)

2. Ensuring Safe Practices

The *Ensuring Safe Practices* theme refers to more general participant descriptions of competent CPs establishing and protecting the safety of clients, whānau, the community, and CPs themselves. Safe practices include seeking feedback and engaging in other processes to ensure and enhance competence. They also include protection from emotional and physical harm due to inappropriate intervention and boundary transgressions. Responses were divided into three subthemes, *Seeking Feedback and Updating Practice*, *Adequate Training, Experience, and Knowledge*, and *Quality Assurance and Professional Conduct*.

2.1 Seeking Feedback and Updating Practice

The *Seeking Feedback and Updating Practice* subtheme refers to interviewees discussing that it is essential that CPs have robust ways to monitor and ensure that current practice aligns with shifting social norms and perspectives. Participants highlighted the limitations of within-profession monitoring of competence. They discussed that regular, consistently invited feedback from service

users can ensure and strengthen competence. Participants reported that competent CPs monitor their competence by seeking feedback directly from clients and do not rely solely on supervisors and other psychologists. This includes working with service user agencies, treating service user views and research as acceptable forms of knowledge, and acknowledging the perpetual risk of professional psychology imposing an “us and them” divide in relation to service users. Participants indicated that competent CPs keep up with advances in practice and society to better relate to people with lived experience of mental distress.

The ones I struggle with are those who don't relate. It's the old school of mental health thinking. I would find them more competent if they kept up with society's times. Not just study once 20-30 years ago and they're still competent. (7)

Participants identified that regularly and consistently inviting feedback from service users is an essential way to determine and maintain competence. Follow-up after feedback is provided was also identified as crucial. Participants identified that while supervision is one place competence can be monitored and enhanced, limits include service users having different experiences and occupying a different position relative to supervisors.

Supervisors are also trained in that field, and probably overwhelmingly more mentally well than the people who are seeking the services. So, you're looking at it from a well point of view, rather than an unwell point of view... Maybe your supervisor thinks you're competent, but they're supposedly well and also have lots of experience in a clinical setting. Whereas someone who's unwell and doesn't understand what DBT and CBT and ACT are might just feel completely lost and drowning in the language that the therapist is using. (2)

Participants discussed that within-profession monitoring of competence could be potentially irrelevant due to assessment processes that do not translate to practice.

A lot of it can be paperwork for the sake of ticking boxes and getting your practicing certificate or license or whatever. But we're not actually measuring the skill, the practical skill at the end of the day. (2)

Involving services that are inclusive of service user perspectives was reported as a way to make psychology understandings of competence more relevant.

I hope that they close the disconnect between what's happening at grassroots and what's happening with those setting these competencies so they're more in line. Get feedback from people with the lived experience and NGO's [Non-government organisations], because they have the eyes and ears where it's needed, and they know what a good psychologist and bad psychologist looks like. (12)

Participants identified an “us and them” tension between service users and the profession, where the profession of psychology assumes accurate understanding of competence and competencies, and thus holds the power to define professional guidelines. Participants shared that incorporating service user views means acknowledging that these perspectives are an acceptable form of knowledge.

Getting a questionnaire like you did and getting ideas about how to do things and the core competencies. Like, what do people actually want from the psychologist and the support that they need rather than just psychologists assuming. (5)

Participants identified the importance of research that incorporates service user views of competence to inform professional practice for the future.

Yes [research with service users about professional practice is important]. Because otherwise they'll just base it on research and stuff that the high-top people think. Not voices of those

going through their journeys. If they don't ask service users, they usually just make things up.

(9)

2.2 Adequate Training, Experience, and Knowledge

The *Adequate Training, Experience, and Knowledge* subcategory refers to participants reporting that competence includes vigorous psychology training and knowledge of systemic issues that can impact responsive care. Participants highlighted that competent CPs draw on clinical and life experience, and that CP lived experience of mental distress enhances relatability and improved outcomes for clients. Interviewees reported that competent CPs have undergone robust and credible training from reputable institutions, which instils confidence and safety assurance.

Participants identified that work experience, including experience across several different fields, such as trauma and chronic pain, contributes to competence. They highlighted that CP training and experience should accentuate observing and listening to real people. Participants spoke of “theory vs experience”, where not being able to relate to people experiencing mental distress can create unhelpful professional practices that defer to textbook and theoretical knowledge. Such routine deference to theory was deemed as indicative of incompetence.

All these new psychologists need to learn more about mental health because if they don't, they're just going to go by what their tutor or lecturer says. Have interactions with people with mental health challenges, go to mental health facilities. Places where they can actually interact with clients, even organisations that help people. Because I don't think half the psychologists out there have lived experience, they're just wanting that as a job, as a career... They go by the book. (10)

Participants reported that competent CPs draw on life experiences that help them relate to others.

There are two different types of people, there's one that's had no life experiences that have just studied it and enjoyed it and have a competent mind. And there's people that have come through life experiences that have studied it have a completely different way of dealing with people. (7)

Interviewee's reported that CP lived experience of mental distress can bolster competence, including normalising distress and role modelling that mental distress does not exclude people from being CPs. Further such advantages for CPs include having lived experience of using mental health and support services.

If they've had experience of services it is also helpful. And how they might be treated by the services. I suppose you guys probably all have to go through therapy yourselves, don't you? (6)

Participants considered that CP lived experience can enhance competence by contributing to more effective interventions and formulations, empathy, and service user confidence and trust in a CP's ability to help. Some participants felt that they would be more understood and less judged with a CP with lived experience, and therefore would open up more in sessions.

It would help me open up about myself knowing that someone else has been through the same thing that I'm talking to... They'd be a bit more friendly, wouldn't seem like it's all professional. If they're being all professional and not as friendly, I think they might think that they're a bit high up or something compared to people who have mental health challenges. (9)

Other participants reported that shared humanity and a sense of connection are paramount for competence, irrespective of whether a CP has lived experience.

I've connected with some people on a really deep level that have not had personal experience of mental illness and yet really have the ability to empathise and understand. (2)

2.3 Quality Assurance and Professional Conduct

For the *Quality Assurance and Professional Conduct* subcategory, interviewees identified that professionalism and processes that ensure high value service provision are important for CP competence. They shared that competent practice offers protection, for example, through maintaining clear boundaries. Although participants highlighted that when seeing CPs they expect them to be competent, they also acknowledged that CP competence could differ across services and types of distress. They considered it important for service users to know about the core competencies, and that the competencies act as a way to help them determine adequate service provision.

Participants considered professional conduct to include being accurate with notes and reports, and producing useful, understandable reports and recommendations.

Incompetent people show up late, don't take notes. The report that they produce is incomprehensible, makes no sense, makes no recommendations, and you can't actually do anything with it. Then you've got to pay the bill. (4)

Participants highlighted that professional conduct includes CPs being clear with clients about what to expect from a CP and what is expected of clients. Competent CPs were deemed to consistently clarify and meet the expectations that they explicitly outline.

I had a contract straight away, and it was what she expected of me and what I could expect from her, and that we will be doing this journey together. She made it clear in the contract that I'm in charge of my journey, she is not going to do it for me, but will be alongside me. And that she expects me to turn up every week, even when I don't feel like it it's important to come. (8)

Participants highlighted that competent CPs are transparent and honest regarding information about registration, training, and experience.

Quite often when you're looking for psychologists, they're like, I'm a clinical psychologist on their website, but they'll then list 50 disorders. It's like, I don't trust you because you can't be competent in all of this.... It's not always accurate, some of them will list numerous different things and I don't see how these can connect up. And they won't list what their other training has been in therapies and things. (3)

Participants indicated the core competencies are important as they offer protection, assurance, and are helpful for knowing what to expect.

It would help right at the start [knowing core competencies exist]. if I had known, I would have known what to speak up to say, hey, this is not working for me, or I don't understand what's happening, why are you doing this. (12)

Interviewees highlighted that competent CPs consistently maintain and model boundaries and assist clients to embed helpful boundaries in their lives. Boundaries were reported to contribute to safe processes and self-agency for service users, both within interventions and in their lives more generally.

Boundaries. Because when you grow up in a dysfunctional family, you're not given and allowed boundaries, so you don't even understand the concept... If you rescue me, you're more or less telling me that you believe I can't do it on my own. (8)

Participants reported that boundaries include upholding confidentiality and privacy, such as specifying what information would be shared in what instance, and not engaging in discussions with whānau members without a client's permission. For example, one participant discussed a time their daughter contacted their CP attempting to get the participant committed. The CP notified the

participant and let them know that information would not be shared without the participant's permission. The participant described feeling safe and confident that the CP was professional and thus would be trustworthy and not take extraneous information into account that may not be relevant.

Participants reported that competent CPs are specific about what types of support will not be offered (e.g., crisis support). They discussed that competence includes reliability and consistency about contact, such as CPs being available when they say they will be and making limits about contact out-of-hours clear.

She made it so there were boundaries, I could contact her outside of therapy sessions, but I could only contact her during her work hours. And I love that because it was like, I can contact you, but there are boundaries, and this makes me feel safe. (3)

Several participants reported that incompetence is indicated by irregular contact and sessions, such as repeatedly cancelling sessions. These participants described that when they expressed dissatisfaction with unreliable contact, their concerns were dismissed and framed as attributed to their mental distress. This was reported to result in increased distress, confusion, self-blame, and feeling unable to provide the CP with feedback.

One minute he was fine with me contacting him out of hours, or if I emailed, he would send me a really big helpful reply... He'd be really responsive and then I'd get these really short sharp replies about contacting him out of hours, and he'd just not respond and then get passive aggressive. Then he just kept cancelling appointments... He would say, I've got these health problems. It made me feel like I was expecting too much, to want him to keep his appointments... He would text or email me needing information on a weekend. But if I did the same, I got a really hostile response... He made me feel like I was being unreasonable. He'd be like oh, you grew up with a sick mum, so I understand how this is triggering for you, but you've got to understand that people do have illnesses, it's not my fault... Then he'd be like

“it’s hard when you email me if I’m having problems with my health”. He was basically saying I was making him sicker; I was making things harder. (6)

Participants reported that competent CPs are aware of the importance of boundaries, and the impact of boundary breaches. Examples of boundary breaches were unhelpful understandings, harmful comments, and inappropriate responses to a client’s challenges. One participant discussed a CP asking for weight loss tips, sharing their own binge eating behaviours, and making damaging comments about the clients eating behaviours during an intervention to address eating challenges. Participants reported that boundary breaches occur from a lack of CP self-awareness and not keeping focused on clients’ needs.

Several participants identified indicators of CP incompetence, including feeling constrained in the therapeutic environment and there being a lack of clarity about what is expected from them in this space. Some examples include being chastised for wiping feet on an inside decorative doormat, not being allowed to put feet up on a couch, not being able to take their shoes off, and inappropriate use of pets in session, such as a CP talking to their dog for a significant amount of time in session.

Participants reported that knowing what to expect enables feeling physically safe and consequently being able to trust and engage with CPs.

It feels safe, it feels predictable. I know that the moment I get into her room, I can sit on the couches and make myself feel comfortable and safe, and for the next hour, I don't need to worry about anyone else. I don't need to worry about her. And you just feel safe and contained and I can let my emotions happen. I can be honest with her. (6)

Although interviewees expected CPs to be competent and fit to practice at a high standard, they realised that competence could differ across services due to a lack of supports for CPs.

Seeing the difference... You can see that those in the mental health sector, they deserve the same training as ones that go into private practice, and they're not getting it. How can they help service users when they're not given the resources? (8)

3. Relationship Building

The Relationship Building theme refers to how competent CPs are able to use personal and relational factors to build effective relationships. This includes drawing on self-awareness to relate to clients authentically and attentively. Participant comments sorted into this theme were divided into three subthemes, *Authentic Connection*, *Self-Awareness*, and *Attentiveness and Perceptiveness*.

3.1 Authentic Connection

The *Authentic Connection* subtheme refers to competent CPs being able to connect with clients authentically within the therapeutic alliance. This was described as CPs being real, showing their humanness, providing empathy, and accepting clients. Participants reported that competent CPs treat clients as real people, build rapport, establish working alliances, maintain genuine, trusting relationships, and acknowledge and repair ruptures. Participants reported that such CPs relate to clients in a reciprocal way, by displaying genuine respect for and interest in working with people experiencing mental distress.

That they'd be happy being with people with lived experience... I think they should be just happy to be working alongside people who are less fortunate than themselves, and I hope that's the way they see it, too. (11)

Participants reported that competent CPs are friendly, able to smile, and display openness and honesty, which contributes to an authentic relationship.

Participants highlighted that competence includes CPs understanding barriers to authentic connection such as the imposition of hierarchies and enactment of power. The "power of contact" was discussed as a way to navigate these barriers.

Break down the hierarchy, make it so you're not sitting opposite the person, you're not writing secretly, you're not using big words. Sit down next to them and just be a human, and they'll tell you whatever you want to know... It's that contact, the power of contact. It's all about that. (6)

Participants reported that competent CPs are comfortable being human with their clients and showing they are real people. Showing individuality in a balance with being professional was commonly reported.

They make it ok to have differences and be different, that it's our differences that make us special. They're not a profession to just roll out robots. (8)

Authenticity was reported to include demonstrating some openness about who CPs are as people and letting clients get to know them more. This was regarded as mitigating stress and distress, and as mediating the divide between CPs and clients. Helpful disclosure was identified as respectful of boundaries, brief, non-specific, and relevant. Participants provided examples of appropriate openness, such as CPs sharing that they experienced fertility challenges, found parenting challenging, and experienced anxiety as a young person.

Maybe if they open up a bit more about who they are. Explain who they are, how long they've worked for, what their passions are, stuff like that. It would help because I'm supposed to open up, but I don't know who the other person is. I get panicky, my PTSD symptoms start, I get stressed. (9)

Participants reported that competent CPs are open about making mistakes, appropriately address ruptures, and undertake repair processes. This was regarded as making the CP seem more human, and thus, as positively addressing the power differential in the therapeutic relationship.

To have her actually be like, "I'm sorry" brings her down off the pedestal, it makes her human and show they do make mistakes and making mistakes is ok, it is going to happen. (3)

Participants reported that competent CPs build authentic connections by using empathy and normalising, validating, and accepting clients and their expressions of distress. These were discussed as fostering trust and providing relief from clients' feeling like a burden.

She allows me to get angry, to be angry about something because she knows in my past if I told someone that I didn't like something they'd reject me. It's so important that she allows me that freedom because I'm learning to be safe telling people I don't like that particular thing, and the way that she doesn't react to it, it's good. She accepts it. (8)

Participants provided a number of examples of CPs demonstrating a lack of empathy, such as being judgemental, saying happiness is a choice to a client in an inpatient setting, and referring to people killed by trains as idiots who deserved to die. Such inappropriate comments were regarded as signalling incompetence. An effect of this was a loss of trust that generalised to all mental health services.

I've had some psychologists say things to me which I found extremely unhelpful... come across as judgmental or lacking awareness and empathy. To me that comes across as being not competent... Not being able to emphasise with why people might be acting or behaving the way they are or experiencing what they are experiencing...It creates and feeds into the massive distance that you feel between service users and service providers, a lack of trust in service providers. A lot of things had happened on my journey where I had lost faith in people being able to empathise or care or provide adequate service. I feel a lot more comfortable now. It's probably since I've seen this last psychologist, he's normalised a lot of stuff for me and normalised a lot of my experiences, which has been very helpful. (2)

3.2 Self-Awareness

For *Self-Awareness* participants reported that competence includes CPs openly and honestly reflecting on their practice and subsequently harnessing this information. This includes appropriate use of self and personal experiences and open and honest reflection about one's limitations and self-care needs. Appropriate awareness includes CPs being aware of their potential effect on clients. For example, participants highlighted not making assumptions about clients that are based on CPs personal experiences and being aware of the potential for burdening clients who may feel responsible for CPs difficulties or challenges (relating to *Professional Conduct*). Interviewees highlighted that competent CPs are honest and transparent about personal limits.

If [CPs] don't know something, they will tell you that. They don't try and think that they have to give you an answer... The best way to help is being honest about your own limitations. (8)

Participants identified that self-care is crucial to maintain self-awareness and competence (relating to *Ensuring Safe Practices*). They indicated that competent CPs take care of themselves and are aware of their own experiences and recognise when these need to be attended to.

I would say deal with your own shit first. (12)

Regular self-check-ins, checking values, and examining motivation for engaging in psychology work were described as examples of appropriate actions to maintain competence.

Maybe if at the end of every day they assess their own feelings and emotional well-being about what happened that day because it can be really heavy for you all as much as it is for the client. Assess your values and your why and why you want to do it. (5)

3.3 Attentiveness and Perceptiveness

Attentiveness and Perceptiveness refer to competent CPs being able to empathically attend to a client's experience and appropriately use communication skills.

[Incompetence] would feel to me like, I see that they're not listening, they're not paying much attention, or if they keep asking me to repeat what I say. (9)

Listening skills and awareness of appropriate ways to communicate were identified as crucial for attending to and understanding clients.

She didn't understand about communication with me. I have problems with communication if I'm around someone else who has communication problems as well. So, when I'm around someone like you, I don't have a problem with communication because I'm listening to someone who's competent in that area. But with others, we become a nuisance to each other because we both have communication problems, and I can't understand where they're coming from. (11)

Interviewees reported that competence includes CPs being able to effectively orient to clients and perceive what is going on for them during sessions, such as identifying instances of dissociation. Perceiving client's experiences in the moment allows the CP to tailor approaches to client needs. This provides opportunities for clients to learn more about themselves and develop useful skills (relating to *Responsive Framing and Intervention*).

She's the first person ever that's managed to be able to tell I get quite dissociated. She's obviously more skilled, because I find it useful to dissociate myself or switch off a bit. To begin with it was quite weird because she'd be like, no, were stopping we're not talking about that anymore because I can see you're not really here. And it's like, how do you know that before I even know that? But over time I've become more aware. It's good to be able to learn how to use it rather than how it can ruin things for you. That's been really useful. (6)

4. Attention to Stigma, Discrimination, Exclusion, Power

The *Attention to Stigma, Discrimination, Exclusion, Power* (SDEP) subtheme refers to participants identifying competence as CPs being able to identify and respond to stigma, discrimination, exclusion, and power differentials related to lived experience of mental distress (MHSDEP). Responses for this theme were sorted into *Mental Health-Related Stigma and Discrimination* and *Power Differentials and Inequality*. When interviewee responses referred to SDEP that was not specific to mental distress and clearly met the criteria for another theme, they were sorted into that theme. For example, participants reported “wearing a mask” due to worry about professionals’ stigmatising assumptions. When participants specifically linked “wearing a mask” to impacts for assessment and intervention, they were sorted into *Responsive Framing and Intervention*. Discussed further in Chapter Six, SDEP and MHSDEP pervade all areas of what was reported to contribute to competence.

4.1 Mental Health-Related Stigma and Discrimination

The *Mental Health-Related Stigma and Discrimination* subtheme refers to labels, assumptions, and stereotyping due to lived experience of mental distress, and the effects of these. Participants commonly reported that competent CPs understand, respect, and support people with lived experiences of mental distress, rather than seeing clients as manipulative, attention-seeking, and annoying. Noticing, acknowledging, and mitigating mental health-related stigma and discrimination was reported as crucial to competent practice. Participants identified that hierarchies and power imbalances amongst professionals can make acknowledging and mitigating mental health-related stigma and discrimination difficult. They reported that competent CPs are able to navigate these challenges to counter the effects of mental health-related SDEP.

Participants described competent CPs as being aware that mental health-related stigma and discrimination exist in the mental health system and that they act as a major barrier to establishing trust and support. Competent CPs are able to identify and challenge mental health-related stigma

and discrimination when enacted by CPs and other professionals. They highlighted that some professionals view clients as “sloppy mental patients” which contributes to an “aura of superiority” where service users feel disempowered.

Invalidating clients’ distress due to mental health-related stigma and discrimination was reported as incompetent practice. Examples included CPs engaging in eye-rolling, and not providing interventions for suicidality based on an assumption that a client is attention-seeking. Participants shared that some professionals demonstrated fear about working with people experiencing mental distress. This was regarded as incompetent, and as one outcome of mental health-related stigma and discrimination.

I could see it was like, oh, we can't cope with this... You could see it in his face. I'm thinking, you're here to help find a solution. That's why I never told people, because they start treating you differently... Psychiatrists, psychologists, they're in that world. So, they should be sitting there, just like you and I, and saying, yes, I can deal with that, yes, I understand. (12)

Participants discussed that competent CPs demonstrate an understanding of the effects of mental health-related stigma and discrimination for clients. Such effects include feeling that no one cares, experiencing a loss of self-esteem, an increase in stress and distress, and, more broadly, perceiving a lack of adequate support and service access.

Feeling that I was constantly in the way when I was in the services, the blow to my self-esteem and confidence, I still have that now. I don't have the confidence that I used to have before I was unwell. And that's all because of all the stigma that's been associated with mental distress basically, like, you're still the crazy one. (2)

Participants commonly reported that competent CPs know about and mitigate diagnosis-related stigma and discrimination. Several participants commented specifically about borderline

personality diagnoses. For example, a CP saying, “oh no, I can’t take another borderline”, and then responding “you don’t like rejection do you” when the client broke down in tears.

I was diagnosed with borderline personality disorder, which is very stigmatised within mental health services. I overheard clinicians saying we’re the hardest clients to work with. I already had formulated in my head this impression of what other people must think of me, and then to hear something like that, which is confirming that we may very well be the hardest clients to deal with. It’s very easy to interpret that negatively. (2)

Interviewees acknowledged that power imbalances between professionals facilitate the transmission of mental health-related SDEP. Participants reported that competent CPs are able to effectively navigate SDEP in work settings, such as by embodying counter examples for colleagues. Ongoing anti-stigma training was considered vital for achieving CP competence.

The immediate answer is to say, when you see it happening, call it out. “Hey, that’s not quite right”. But those are your colleagues, and you will be junior. So, it’s not going to be that easy for you to call them out... You’d get branded as a troublemaker, and then any good that you might have been able to achieve would be countered by “Oh yea, that Alice she’s a troublemaker. She’s a mental patient who is now a clinical psychologist we don’t need to listen to her we actually know better”. So how do you counter that? Setting a good example might be a good way to do it. They can’t gripe about a good example. If there is training on anti-stigmatisation, that’s a brilliant thing to have. (4)

4.2 Power Differentials and Inequality

Power Differentials and Inequality refers to power differences between clients and CPs where clients are not treated as equal and are not valued as autonomous persons due to their lived experience of mental distress. Interviewees described competence as a CP being able to

acknowledge, identify, and work to mitigate power differentials between clients and CPs, as well as clients and wider mental health services.

Participants described that competent CPs are able to identify and navigate the undermining of service users when it occurs. This was discussed as through the positioning of CPs as “experts” who know better than clients who are “less than”.

We did clash at times because I'm a social worker. When she wanted to she would pull rank, make me feel like “I'm a clinical psychologist, and you're just a social worker”. I was all about transparency, I want to know what's being said, give me a copy of everything. She was like “oh no this is just for the clinicians”. She knew how much I hated that kind of thing. It would only come out when I'd challenged her on something, so I think it was just definitely a defence-type thing. (6)

Participants reported that CP competence includes being able to value clients and their contributions as equal to those of CPs and other professionals.

When I saw my psychologist, it was noticeable to me that the whole time it was two adults having a conversation and it was an equal playing field. I didn't leave thinking that I'm a little girl, I wasn't being talked down to. I could've been someone that was at a workshop with her, she treated me like an adult. That's the main thing. (8)

Participants discussed that competent CPs identify and counter the effects of paternalistic encounters on clients. Such effects include clients feeling demeaned and humiliated, and uncertainty about a CPs agenda and competence to carry out their work. Interviewees also discussed that it is important for CPs to mitigate the resultant self-blame, self-hate, traumatisation, and confusion clients experience when clinicians transmit damaging assumptions that are harnessed by other professionals.

The first psychologist, that was really bad. That was part of a bigger thing, where everyone believed all this stuff about me that wasn't true. Then I started believing, that I was suicidal, I was anorexic, all of it. I thought those things were real and so I was traumatised by them. I was like, I'm this horrible person... It was really bad for ages. That made me sicker for a long time. It took a long time to be able to figure out what was real and stop blaming myself and hating myself for it. (6)

Participants reported that CP competence includes understanding and attending to the consequences for clients when power differentials and inequality lead to exclusion from appropriate support. Reported examples included denying access to crisis care when clients are suicidal based on assumptions a client is an “alcoholic”, discharge from services due to incorrectly assuming a client is using alcohol and drugs to cope, and ignoring suicidality after a client had previously been sectioned. Participants frequently highlighted that being excluded from appropriate services causes significant harm, such as increased distress, suicidality and suicide attempts.

Two months after the section I saw [a clinical psychologist] and said I'm feeling suicidal. She looks at me and goes, “can you remember what happened when you told me that last time?” I said “yes”. And she goes, “so you know what's going to happen this time? Let's forget that you've said anything, and we'll just start off as if you've just entered the room. Now how are you today?” And I said I'm ok because I thought she's going to keep saying this until I say I'm not suicidal. She didn't want the paperwork. I went home and I was in the hospital that night with a suicide attempt, with two young children. (8)

Participants identified that within-profession hierarchical power differentials make it difficult for newer psychologists to identify and mitigate inequalities. Thus, competent CPs work to notice and dismantle power differentials that disempower their colleagues.

It's so hard for them to challenge their superiors because they're in such a competitive environment that it really does impact on their future if they do challenge. (6)

Participants reported that competent CPs are aware of how biomedical paradigms perpetuate power imbalances. One interviewee referred to the existence of power differentials and inequality in how the core competencies are written.

They are very much thinking about it [the core competencies] from a medico-legal perspective. Even though the terminology might be different it's still coming up with very much an us and them approach of "we are the professionals, they are the patients". I don't think it's ever designed for service users and clients to read; it would be phrased very differently if it was... I think a lot of professionals don't like their professional documents to be open to clients. (1)

5. Responsive Care Beyond the Individual

Responsive Care Beyond the Individual refers to CPs providing supportive services that are responsive to service users and the wider public's needs more broadly, rather than focusing on individual CPs processes and skills. Responses for this theme were sorted into two subthemes, *Advocacy* and *Wider Supports*.

5.1 Advocacy

For *Advocacy*, participants described competent CPs as supporting clients to attain services and resources to navigate mental distress outside of therapy sessions. This means assisting clients to navigate services and facilitating information provision and access to helpful resources outside of mental health services. Participants reported that competent CPs assist decision-making about client needs within services, and speaking up and responding effectively when client needs are not being met.

It's really easy to get lost in the system. It's really easy to not understand the system. How do you know that the one clinician that you have the most contact with is making the right calls for your health? It should fall within your consumer rights that you know what options are available and you get to pick them. I first got unwell when I was 19. I didn't end up in the public services until I was 25. I don't think I got referred to the eating disorder services until I was about 28. I didn't end up in Segar house until I was 30... Where were the people that were advocating for me or saying, this is what's wrong, we need to do something about this... I relied primarily on [the CP] to make adequate calls for me. And I don't think they did. (2)

Participants described advocacy as including follow-up after psychology work, such as ensuring report recommendations are implemented.

I think if they hear back from the client that the recommendations are being ignored there is room there to be proactive and actually go back and say, what's going on? Why are you ignoring these? (1)

Interviewees discussed that competent advocacy includes CPs assisting to connect service users with other services and networks that may be beneficial, such as mental health initiatives and service user organisations. The benefits of this involvement were reported as supplementing well-being gains acquired during intervention, longer term support after service use, an increased sense of purpose, and the provision of opportunities to contribute to positive change in mental health systems.

Encourage people to become involved with user groups or mental health initiatives or that sort of thing... The involvement actually does give you a sense of purpose. And it does give you an avenue to get support, probably advocacy as well. (4)

Participants identified incompetence as a lack of advocacy that contributes to increased stress and distress for service users, such as self-harm, disempowerment, and isolation. Thus, competent CPs are there for clients to support their autonomy and well-being.

Be in a position of being able to advocate for me because I didn't have any support. Going into some of those meetings, it's just horrendous. You feel so victimised and so ostracised. If it's possible for a clinical psychologist to be a support person to be an advocate in those situations, it would potentially be incredibly helpful. (1)

5.2 Wider Supports

Related to *Advocacy*, *Wider Supports* refers to participants reporting that competent CPs are knowledgeable about and provide options to enhance well-being and intervention progress outside of mental health services. Participants also described competent CPs as working to address barriers that exist when trying to access CP services and undertaking prevention work. Participants highlighted that people often do not know what CPs do, and what services and resources are available to support wellbeing. Thus, competent CPs provide this information.

They never tell you what resources are available to you. When I first went to mental health they said, what do you want from us. And I'm thinking, I don't know, I've never been to mental health before. They wanted me to say what I wanted, but I don't know what support they offer... Through [one service] I've only had counsellors. Now, having a clinical psychologist, I didn't know there was a difference. (8)

Participants described competent CPs as facilitating access to supplemental supports, for example, peer supports, wellbeing organisations, and alternative approaches such as Trauma Sensitive Yoga and journaling.

Maternal mental health was great because they said, look, here's these other lovely pregnant ladies who are all having a really hard time. Why don't you talk to each other? And then here are these lovely ladies who all have very tiny babies, why don't you talk to each other? And that was so so good... I didn't know that there was such a thing as peer support 15 years ago. To have met another 25-year-old who was having a sucky time, that would have been really helpful. Or to have been referred to Anxiety New Zealand and some of the groups, to know they existed. (1)

Interviewees discussed that competent CPs are aware of and work to reduce availability and access issues, such as long wait times to see CPs, high CP turnover, and CPs often changing when clients are seeing them in a service. Participants highlighted that these workforce issues negatively affect views of how competent CPs are collectively as profession.

A lot of the ones I've contacted asking for appointments are like, no, we're not taking any more claims or we're not doing this or we're not doing that. Even my psychologist said that he's been turning people away and I was lucky to get in with him. (5)

Participants also discussed CPs working to address access specifically for men and people who have been subjected to sexual violence, and for people for whom other services, such as counselling, have not been beneficial. Not being able to access CPs was reported to affect clients' lives, jobs, families, and "everything". Participants reported being aware of access and continuity issues contributes to guilt that others "need" CP input more than they do.

Competent CPs were also described as working with the general public to enhance well-being and assist communities to better understand mental distress and support. Reported areas for preventative work included working with young people and adolescents around, for example, sexual predation and violence, and education in schools and communities about how to identify and approach mental health challenges.

Making people in the general public aware of signs of problems that could be going on, like children and abuse. Looking out for those tell-tale signs and making people aware that kids can cover things up because they've been groomed or whatever. Because later on these kids have all these problems. (5)

Benefits of working with wider communities were reported as increased awareness of mental wellbeing, more knowledge about CPs, and less uncertainty about accessing CPs in the future.

They're learning resources that they wouldn't otherwise know. If I was a teenager, it wouldn't be as scary to me if in a few years' time I was told "you're going to see a clinical psychologist". I'd remember you coming in, having a talk, and it would be "oh, it's not that scary". You know what you're getting into. (1)

6. Cultural Responsivity

Cultural Responsivity refers to CPs being able to competently attend to elements of culture and diversity that differ from the dominant cultural and social groups in A-NZ. Participant responses for this theme were sorted into *Māoritanga* and *Gender, Sexuality, Spirituality*.

6.1 Māoritanga

The *Māoritanga* subtheme refers to Māori culture, traditions, and ways of life. Participants highlighted that competent CPs integrate Tikanga and Te Ao Māori aspects and practices into CP activities in an ongoing way. Competence was also reported as CPs learning about and understanding racism, acculturation, and Te Tiriti o Waitangi and how these apply to Māori in A-NZ.

It's important that psychologists learn more about the treaty and know how to understand the Māori side of what us Māori go through... Racism is truly important to learn about especially if you're going to be a psychologist. (10)

Participants discussed that competence means being aware of different cultural norms and the impacts of unfair treatment in mental health care due to culture.

I was going through special programmes because they diagnosed me with ADHD... Later down the track, I haven't got ADHD... I was only little, but I was looking at their faces and thinking to myself they must do it to every single Māori child, by thinking we're all hyperactive. Yet you see the white kids, they're not. I think we get treated unfairly. (11)

Participants described competent CPs as learning about and honouring Te Reo Māori language and Tikanga (processes) such as Pepeha and Marae roles that have been eroded and diminished by colonisation effects. A competent CP understands that not all Māori are the same. They are able to reconnect clients with culture in a way that fits with a client's experience of and identification with culture at a specific time.

There's diversity within cultures. Just because I'm Māori doesn't mean that I can speak Māori or do anything Māori. (12)

Competent CPs are aware of stereotyping, where one Māori person is assumed to represent all Māori, and tokenism, where Māori are expected to demonstrate Māori processes in Tau Iwi (non-Māori) settings.

I get really annoyed when people say, "who wants to do karakia", then they look to me. Or they say "we don't understand this word" so they look to me. You need to be understanding of that and understand diversity. (12)

Related to colonisation effects, interviewees commonly indicated that competence is demonstrated by being able to use alternatives to western paradigms. This includes Te Ao Māori conceptualisations and intervention approaches such as Te Whare Tapa Whā.

When I got introduced to Te Whare Tapa Whā suddenly it was like, ok, I make sense. I've never come across a Western model of healthcare that makes as much sense as a Māori model of healthcare. (1)

Relating to SDEP, participants described that the prioritising of medical and western models are based on an assumption that these models are superior. This was viewed as indicative of arrogance and a lack of reflection by Pākehā.

Cultural sensitivity is really, really important here. There are different ways of doing things. It's an arrogance, people from my culture, white males particularly, do fall into it. We assume that everybody does things our way. But our way is one of many dozens of different ways... For example, the Māori model, Te Whare Tapa Whā... we don't do that. They actually say there's four different pillars that need to be supported, mental health is one of them, but also family health, spiritual health and physical health. It's a darn good idea, but it's not implemented. We have the medical model and that's pretty much it, you get medicine, and the rest is something separate. I can see how that wouldn't work for Māori because it doesn't work for us. (4)

Commonly reported was that the medical model “one size fits all approach” does not work for both Māori and non-Māori. Interviewees discussed that competent CPs integrate more Te Ao Māori approaches into mental health service provision. Te Ao Māori approaches were reported as advantageous compared to Western models which were viewed as individualistic and pathologising.

Western healthcare has gotten so individualistic. You see the problem in front of you and your job is to “fix” or manage at least, if it can't be fixed. If your job is to manage, you don't look at what can be healed and what can be changed. If your job is to fix, you don't necessarily look at what life is like if it can't be fixed. You just see the people who can't be fixed as your failures. (1)

Participants also indicated that Te Ao Māori approaches offer a more supportive, cohesive, and coordinated approach.

If you go to a Māori health thing they pull people in and it's a team effort, and you're given the resources and you're told about them. And that's what I like. Also, they meet together. I have my GP and [community] mental health, and [other organisation]. They all know they can meet together. Because if one person, like my GP, was doing one method, and my psychologist was doing the opposite, I'd end up with spaghetti brain. (8)

Some participants viewed Māori CPs as more respectful and enabling of connection through culture. Non-Māori clinicians were described as less likely to listen and adopt a relevant approach (related to *Responsive Intervention*).

I'm Māori as well, so it's a cultural experience. Having the same culture, she understands what I was going through. I research the psychologist before I see them... are they Māori, do they respect the culture, do they do the Māori side... I've seen other white people. They just don't know how you are and how you how you feel. They go by their book, how they were taught in their lectures, but they're not listening to the client. When I get their writing, I can tell that they've gone by the book, they've just gone from what past people have written, they've not actually listened to what I have to say... That's why now I request a Māori psychologist, because they're culture and Whānau based. (10)

6.2 Gender, Sexuality, Spirituality

Gender, Sexuality, and Spirituality refers to competent CPs responding appropriately to diversity in terms of gender, sexuality, and spirituality. This means learning about diversity, being open to the different cultural needs of clients, integrating these aspects into assessment and intervention, and working with clients on challenges they experience due to gender, sexuality and spirituality.

Participants described competent CPs as acknowledging same-sex partnerships and including partners in therapeutic processes without “shutting them out” (relating to *Wider Supports*).

I didn't feel like my partner was welcome, part of the conversation. [The CPs] weren't asking them any questions or really including them. I like someone that as well as helps me helps me with whānau. If I don't have someone that's going to consider my partner, then they're not worth seeing. (9)

Participants described gender equality as valuing genders and sexualities that may be different to those of the CP, and thus facilitating openness to processes suggested by clients (relating to *SDEP*).

They told him I couldn't join [a psychology session]. It just puts me down, being a gay person and supporting him. I think every psychologist needs to learn about gender equality. It would make me feel more inclined to see them, because if they've learned more then they'll be more approachable. (10)

Regarding gender, one participant described being labelled as a “male chauvinist”. This response portrayed an outdated and less than competent approach by the CP.

I did have a few problems with discrimination, being accused of being a male chauvinist. That's all old stuff, male chauvinist. (11)

Participants highlighted that sexuality, sex, and religion should be paramount, yet are missing from competence specifications and mental health service provision.

Of all those core competencies, they've missed sexuality and sex, and religion, which is what they're avoiding down here [community mental health service]. I keep trying to bring it up but they're ignoring it completely because it's a taboo subject, sex and religion. (11)

Participants considered that ignoring sexuality and sex is problematic, as issues related to these are then not addressed when they are impacting a person's well-being.

Persistent sexual arousal, I have a problem with that... I did bring it up and [the CP] just bypassed the whole thing completely. I thought, that's why I'm here, I'm here to talk to you about my problems. I didn't feel like she dealt with it properly, and I didn't feel that she knew everything that she should. (11)

Relating to *Responsive Assessment and Intervention*, participants reported that competent CPs learn about different religions and religious groups, are able to understand religious experiences, and can assist clients to process how their religious experiences may have impacted them. For example, one respondent reported addressing spiritual abuse in the context of intimate partner violence in CP sessions was crucial.

I told her that I wanted to go back to therapy because there'd been a lot of spiritual abuse too, because of the churches. I said to her thank God I never became a Christian when I was married or I'd still be married to him, because they don't believe in divorce. (8)

Summary of the Interview Analysis of What Service Users Identify as Competent Practice for Clinical Psychologists

I generated six main themes regarding competence from the TA of interview transcripts to answer research question one: What do service users identify as competent practice for CPs? The themes identified assessment and intervention processes, professional conduct and procedures, building relationships with clients, attending to MHSDEP, and cultural responsiveness. In Part Three I will address research question two, identifying how service user views align or contrast with the existing aspects of competence as described in the NZPB core competencies.

Part Three: How Interview Findings Align and Contrast with the NZPB Core Competencies

In this section, I provide a comparison of how service user views of competence (Part Two) align and contrast with existing aspects of the NZPB Core Competencies (research question two). I summarise the main aspects of alignment and contrast of service user views when compared to the NZPB core competencies. Though I have attempted to group different aspects of competence into different themes/subthemes, these are often interrelated and interdependent, discussed further in Chapter Six. The interview TA showed that service user views of competence share some similarities with the NZPB competencies, and also revealed some differences. See Appendix G2 for more a more detailed example of aspects of alignment and contrast of participants' views with the Board competencies.

For the *Responsive Framing and Intervention* theme, participants emphasised collaborative and inclusive processes between client and CP throughout assessment and intervention. The Board competencies also do not emphasise seeing clients as people first and foremost, which includes listening and moderating assumptions and conveying that the client is the most important person in the intervention processes. Participants emphasised integrating clients' experiences, preferences, and feedback in assessment and intervention processes. They also highlighted competent intervention as providing tools and skills for clients to progress in their lives, holding hope for clients, and normalising responses to traumatic events and contextual variables. Participants emphasised relevant formulations and differential diagnoses that correspond with client's perspectives. A partnership approach to assessment and intervention processes is not mentioned specifically in the Board competencies, and trauma-informed approaches are not explicit competencies. Another area of contrast is an approach to assessment and intervention that is holistic and takes a whole-person approach, offering a range of alternatives to biomedical approaches. Seeking feedback specifically from service users was not indicated in the Board competencies.

Regarding the *Ensuring Safe Practices* theme, the Board competencies aligned with participant views in general regarding the importance of safe, legal, and ethical practice, and scope-

specific knowledge. Contrasting with participant views, the Board competencies do not emphasise the importance of seeking and incorporating service user views to inform understanding and monitoring of competence. Limits of measuring and monitoring competence within the profession are not acknowledged in the Board competencies. In contrast to the Board competencies, participants considered life experience, lived experience, and the ability to balance “theory vs experience” as aspects of competent practice. Participants specified anti-stigma training and transparency about training, experience, and registration as necessary, which is not indicated in the Board competencies. One area of contrast is that the Board competencies tend to situate factors that can impact service provision within clients, particularly, within client deficits (e.g., cognitive ability and personality factors, NZPB, 2018b, p. 22). Participants acknowledged different CP factors that can impact service provision (e.g., assumptions based upon MHSDEP), providing further rationale for the value of seeking professional practice feedback from outside the profession.

Regarding the *Relationship Building* theme, the Board competencies acknowledge respect underpinning all intervention activities, which is also highlighted by participants. Participants placed more emphasis on the power of genuine connection. Establishing rapport is indicated in the cultural competencies though participants position rapport as a fundamental foundation for all areas of competence. Overall, there is less emphasis on the importance of the therapeutic alliance and processes such as rupture and repair in the Board competencies. Shared humanity, “being real”, and getting to know a client as a person first rather than focusing on pathology or problems are absent in the Board competencies. The self-awareness indicated in the Board competencies align with participant views, though participant views further highlight using reflective practice openly and honestly within the CP-client dyad. Awareness of the appropriate use of the CPs own experiences and the potential negative effects on clients, such as burdening and making assumptions about clients, is not explicit in the Board competencies. The self-care core competency is “effective self-care”, which participants elaborated on, including self-check-ins, reflecting on values and motivation, and regular supervision. Seeking external review of practice is in the core competencies, however, they do not

specify external review of self-awareness and use of self from clients, as participants did. The Board competencies contain elements that align to a degree with validating and accepting clients' points of view and needs. Empathy is a cultural competency, though participants highlight that conveying empathy, validation, and acceptance is crucial for all client and CP interactions. The Board competencies include interventions being based on well-developed formulations, psychological theory, and models of change (Intervention, clinical scope). The participants specified that paying attention and attuning to clients are the basis for all CP interactions.

The Board's cultural competencies (Part 2) are the most similar to participant views regarding *Attention to Stigma, Discrimination, Exclusion, and Power*. However, unlike the general and clinical scope competencies, cultural competencies are not minimum requirements for a psychologist to be considered competent. While the cultural competencies align with participant views in this area, they do not specifically refer to the relevance of attending to SDEP for people experiencing mental distress as a cultural group. The Board competencies do not acknowledge mental health-related stigma or diagnosis related-SDEP. The Board competencies include knowledge of "psychopathology", "mental disorders", "serious mental illness" and "psychological problems" (lived experiences of mental distress), which includes knowledge of theoretical and empirical literature, and knowledge of theories and diagnostic classification systems. These competencies do not directly highlight knowledge of SDEP regarding the lived experience of mental distress. The Board competencies do not acknowledge the importance of knowledge and awareness of the role of mental health labels and how to navigate their effects, ongoing anti-stigma training, the responsibility of CPs to challenge MHSDEP, and how this may be achieved. A further gap is knowledge and awareness of power differentials between professionals and the positioning of CPs amongst hierarchies within services and how this impacts client care. The core competencies include CPs treating clients with dignity and respect, identifying and mitigating biases, and recognising their own unique positions. However, these are not directly related to people experiencing mental distress.

Navigating systemic SDE in mental health services is not in the core competencies. A further gap is identifying and mitigating unfair treatment and discriminatory processes, and identifying and mitigating labels, assumptions, and stereotyping (internal and external). Recognition of a CPs own diagnosis-related stigma and personal biases related to these, and acknowledgement of unequal positionings of those with mental distress is a further gap in the Board competencies. Recognition that CPs hold the responsibility to notice, name, and work to challenge stigma, discrimination, exclusion, and power is not in the competencies. In contrast, participants highlighted that responsibility should shift from clients (traditionally vulnerable and silenced) to the profession, which holds more power and capacity to navigate and change the effects of SDEP. Not present in the competencies are understanding and exploring the effects of power differentials and inequality and how these impact person's lived experiences (e.g., being humiliated, demeaned, and blamed).

Main aspects of contrast for *Responsive Care Beyond the Individual* include knowledge and facilitation of services, options, and resources outside of psychology to supplement psychological work and provide support post-service use. Participants identified knowledge of mental health and service user-led models, theories, and paradigms, such as peer support and lived experience literature, which is not in the Board competencies. Assistance to navigate systems and accountability to service provision, for example, follow-up of recommendations after assessment or psychology contact and responding when recommendations are not followed, are not in the core competencies. Addressing systemic barriers to continuity and reliability of psychological services and wider mental health services, and knowledge of and mitigation of the impact of systemic barriers to effective mental health care, are also not Board competencies. Participants reported that CP competence should include working to improve mental health services, such as access issues, which is not in the core competencies. Participants report that without these acknowledgements, CPs are unable to mitigate ineffective care and adverse outcomes as a result of systemic failure and psychologist scarcity. Prevention work is not included in the Board competencies. In the Board competencies, risk is alluded to as pertaining to an individual, with risk factors such as systems failures not made explicit.

Regarding *Cultural Responsivity*, aspects of the NZPB competencies that most closely align with findings are the cultural competencies (Part 2). The cultural competencies are not considered minimum requirements of competence by the Board. In contrast, participants reported cultural competence and cultural safety as essential for competence. Consistent with findings are the cultural competencies' emphasis on Te Tiriti and attention to diversity. Participants specified the integration of Te Ao Māori processes, protocols, and therapeutic approaches. They further highlighted attention to colonisation, racism, and acculturation specific to Māori in mental health service provision. Participants explicitly specified limitations and issues with biomedical and Western paradigms, which the Board competencies in part acknowledge. Cultural connectedness and integration of spirituality were emphasised heavily by participants. Knowledge of cultural issues and diversity are in the competencies, though participant findings state that competent CPs move from knowledge to acting and providing intervention for cultural and diversity issues, such as recognising intergenerational loss. Participants also expand on concepts of SDEP for people that do not belong to dominant cultures in A-NZ, including increased power differentials between CPs and clients through assumptions of superiority, racism, and tokenism. The core competencies do not refer to responding to the loss of cultural norms and customs that can be regained through intervention and understanding that connection through culture assists healing.

Aligning with participant views, the cultural competencies include knowledge of family structures, gender roles, values, and worldviews that differ among groups. Participants further highlight that competence also includes knowledge of gender, sexuality, sex, spirituality, and religion. The Board competencies do not specifically acknowledge competent CPs being able to support the needs of people with different sexualities, sexual behaviours, gender identities, and religions without being uncomfortable, lacking in confidence, or conveying these subjects as "taboo", pathological, or in need of correction. Relating to *Self-Awareness*, while self-assessment and external review (including supervision) are in the Board competencies, participants specify that external review should include client and Whānau feedback about whether cultural needs have been understood and

met. Further, participants regarded competence as including CPs taking action to remedy unmet cultural needs.

Chapter Six: Discussion and Conclusions

The aim of this study was to inform professional practice by exploring what service users view as competent practice for CPs and identifying how these views align and contrast with the existing NZPB core competencies. I followed a social constructionist and user-led design with co-production underpinnings. Through a survey and individual interviews, I collected views about CP competence from adults who had seen at least one CP for mental health support in A-NZ. I sorted participant views of competence using CA for the survey responses and TA for the interview transcripts. The survey and interview analyses were compared with the NZPB core competencies to identify aspects that align and contrast with participant views. The total data set included 73 surveys and 12 interviews.

This chapter starts with discussing the findings compiled across the survey and interviews. I summarise each of the five main areas identified for CP competence. For each area, I draw on relevant literature that supports the findings to build on the current theoretical base about aspects of competence and what the competencies should be. Each area discussion ends with a recap of how the findings compared with the existing competencies. After the discussion, I highlight key limitations, strengths, implications, and future research and practice recommendations. The chapter ends with some concluding statements.

Discussion

What participants identified as competent practice for CPs across the survey and interviews can be conceptualised into five areas: *Interpersonal Skills and Relational Presence, Responsive Contact, Cultural Responsivity, Mental Health-Related Stigma, Discrimination, Exclusion, and Power, and Safe Processes and Profession* (see Table 12).

Table 12*Summary of Findings*

Main Areas of Competence Service Users Identified
1. Interpersonal Skills and Relational Presence
2. Responsive Contact
3. Cultural Responsivity
4. Mental Health-Related Stigma, Discrimination, Exclusion, Power
5. Safe Processes and Profession

While participants commented that some areas were crucial for competence in other areas, all areas were discussed as interlinked. For example, *Interpersonal Skills and Relational Presence* was an area that most participants discussed as necessary and foundational for competence in all other areas. For *Responsive Contact*, participants discussed what competent assessment, formulation, and intervention should consist of while also acknowledging that competence in this area relies on competence in the other main areas. Participants reported that competence is indicated by interventions and outcomes being helpful, empowering, mana-enhancing, and enduring well after contact with a CP ends.

For *Cultural Responsivity*, participants discussed the importance of CPs being able to identify and acknowledge differences and diversity, meet Te Tiriti obligations, and enhance responsiveness to Māori. Cultural responsivity also meant appropriately working with diverse genders, sexualities, and religious experiences.

For the *Mental Health-Related Stigma, Discrimination, Exclusion, and Power (MHSDEP)* area, participants indicated that CPs should be able to acknowledge and identify MHSDEP and its effects and should also work to mitigate these aspects. Competence was indicated in attending to MHSDEP within interventions and across the profession and mental health services.

Safe Processes and Profession refers to aspects that should underpin all activities of a CP and the profession in general. This includes how competence pertains to systemic issues highlighted by the participants.

Participants also drew on the concept of CP “helpfulness” as a way to conceptualise competence, emphasising that competent CPs are helpful and effective and that helpful CPs are competent. Further, participants identified the same aspects of helpfulness that were also discussed as aspects of competence. Thus, the notion of helpfulness appears to be relevant to understanding the notion of competence for these participants. For example, if a CP is considered helpful, they are likely also to be perceived as competent, and if a CP is perceived as unhelpful, they are likely to be perceived as lacking competence.

A further finding was of service user views about CPs with lived experience of mental distress and how appropriately managed, such experiences can contribute to the CP’s competence. I discuss each of these key points in the following sections.

1) *Interpersonal Skills and Relational Presence*

How CPs interact and build relationships with clients stood out as an essential area for competence. Interpersonal and relational aspects were reported as important for all CP activities and foundational for all competent practices, such as *Responsive Contact, Safe Processes, Cultural Responsivity, and MHSDEP*. The importance of the therapeutic relationship has been widely acknowledged in literature. For example, many studies identify that the most helpful aspect of therapy is the therapeutic relationship and that service users attribute unhelpful or harmful therapy to therapists not engaging in a caring, authentic, and collaborative way (e.g., Flückiger et al., 2018; Lavik et al., 2022; Norcross & Lambert, 2019). Participants also considered being non-judgemental and authentically human as key to a CP being viewed as competent.

Participants commonly reported that a sense of connection is vital to enable trust. This means demonstrating acceptance, providing empathic interpretations of what clients are experiencing, and communicating an understanding of the client’s needs. The therapeutic alliance is commonly understood as consisting of the humanistic attitudes of congruence, empathy and unconditional positive regard (Geller & Greenberg, 2002; Malet et al., 2022; Rogers, 1957).

Corresponding with the findings, Lavik et al. (2022) found that a strong therapeutic relationship is a successful consolidation of the real relationship and the working alliance in CP and client dyads. The real relationship encompasses relational processes where two human beings come to appreciate and enjoy each other, in which connection on a person-to-person level and genuineness are essential (Lavik et al., 2022). The working alliance includes relational processes that occur when the dyad takes on a therapeutic purpose and a working bond. This involves the client believing that the CP will help, that the CP accurately understands a client's distress, and that the intervention is going well. Others have described the emotional bond (e.g., Gelso & Kline, 2019) as consisting of the working bond (part of the working alliance) and the person-to-person bond (which pertains to the real relationship). As the notion of emotional bond has been critiqued as vague and non-specific (Horvath, 2018), the subsequent conceptualisation of the real relationship includes holding a realistic perception of another, experiencing another as they truly are, and expressing genuineness by relating to another in an authentic way (Gelso & Kline, 2019). Some research has noted that the real relationship is important for positive intervention outcomes (e.g., Constantino et al., 2021) and that such a relationship is what allows therapists and clients to connect with their inner worlds and start a process of joint emotional elaboration (Negri et al., 2019). Lavik et al. (2022) hold that the real relationship is an essential basis for therapeutic work to take place.

Mirroring participants' descriptions, Lavik et al. (2022) discuss the need for an optimal level of tension between the real relationship and the working alliance. This includes identifying and repairing ruptures as a successful therapeutic relationship involves relational growth between the client and CP. In Lavik et al.'s (2022) study, the CPs found it demanding to move from building a personal relationship to a more work-based instrumental alliance. However, the main process that destabilised the therapeutic relationship was CPs prioritising intervention processes at the expense of relational processes. For example, moving too quickly to impart skills and tools. Pace, patience, not becoming distracted by the therapist's need to be productive and, at times, suspending theoretical knowledge were all identified as crucial for success (Geller et al., 2010). Establishing a collaborative

working alliance relied on a strong real relationship. Otherwise, intervention processes tended to threaten or destabilise the relationship. Thus, the real relationship (being authentically human) has to come first and the alliance second.

Further, presence also involves preparing to be with a client before the session, reflecting on presence in the session, and reflecting on the processes and positioning of both therapist and client (Geller et al., 2010). Therapist awareness of their own experience corresponds with the concept of emotional awareness. This is where communication and attentional receptivity enhance the connection between the client and therapist (Malet et al., 2022). Participants in the current study identified that power differentials are reduced when genuine caring and relational aspects are attended to. This positively impacts their sense of self, the therapeutic alliance, and intervention choices and outcomes. Participants also identified that a CP would be perceived as less competent when relational aspects were absent. Effects included feeling invalidated, dismissed, stigmatised and excluded from their own care and therapeutic journey. This relates, in particular, to *Safe Processes* and *MHSDEP*.

In this study, every participant commented on the importance of interpersonal skills and relational presence. Notably, CP presence is emphasised less in current CP-specific understandings of competence and the NZPB competencies for the general and clinical scopes. However, the NZPB Counselling scope has more competencies based on the therapeutic relationship and the working alliance. The relatively small attention to relational competence and competencies may be because therapist presence has been reported as difficult to define, conceptualise, and measure (Malet et al., 2022). However, in this study, service users were explicit about what CP presence and relational aspects consist of, such as authenticity and humanness, and provided examples of what these aspects of competence would look like. This is likely an area that it is important to ask service users about. Though widely studied and conceptualised by researchers, the therapeutic relationship has been less studied or understood from the point of view of clients (Krause et al., 2011; Lavik et al., 2022). This

may be why relational competencies are not emphasised more in the general and clinical scope competencies.

2) Responsive Contact

Participants identified CP competence in terms of assessment, formulation, differential diagnosis, intervention, outcome measurement, and support outside of the therapy room. Imparting effective tools and skills was reported to demonstrate CP competence. Skills and tools need to be relevant, applicable, and helpful for a client. Regarding approach, participants identified that knowledge and skill in a range of approaches, models, methods, and paradigms are crucial. Lavik et al. (2022) also discuss that the appropriate application of techniques involves adapting these to a client's needs, this being essential for interventions to be useful to service users. They discuss enabling positive intervention outcomes with future-focused plans that instil hope. This is consistent with the participant accounts. Lavik et al. (2022) highlight collaboration and the appropriate timing of different aspects of intervention. For example, rupture occurs when clients feel pushed into utilising tools and skills. Further, a therapist feeling pressure to be "effective" can result in them attempting to implement tools and skills that are either irrelevant to the client or at an inopportune time or pace.

For responsive contact, participants emphasised true collaboration between clients and CPs, where the client's view is incorporated at every stage of contact. For example, participants value the provision of a differential diagnosis that is specific and valid for them and formulations that are tailored to their experiences. Participants also emphasised tailored and flexible assessment and intervention approaches and support per client wishes and needs. Gordon et al. (2022) discuss autonomy as "privileging will and preferences in mental health care" (p. 1), highlighting the importance of supported decision-making for service users throughout assessment and intervention. This includes enabling service user options and choices, education, and facilitating decision-making support. Regular reviews and reflection are also acknowledged (Gordon et al., 2022). Participants also highlighted that inviting, enabling, allowing, and responding to client feedback throughout

assessment, intervention, and post-intervention are crucial aspects of competent practice. As an example of how this can be done in clinical practice, Miller et al.'s (2015) Feedback Informed Treatment (FIT) approach uses Routine Outcome Monitoring (ROM). FIT is a structured way for therapists to measure service-user-oriented outcomes and goals. It also measures an individual therapist's contribution at each intervention stage and at each psychology session. ROM can also be used after intervention to ascertain the overall impact and identify where therapist factors may have hindered the client's progress. Miller et al. (2015) indicate that outcome measures will be ineffective unless ROM fosters information and targets for each unique therapist. This is because FIT allows measures of therapists' baseline ability and ongoing, critical feedback, thus allowing opportunities to tailor practice more effectively to client needs. This approach is one way to better ensure that interventions are helpful, empowering, and long-lasting, this being reported as essential by participants.

For participants, competence involves CPs knowing about and facilitating support beyond the client-CP interaction in the therapy room. Relevant to this is the notion of "social prescribing", recommended by the World Health Organisation for mental health clinicians (2022). Social prescribing refers to connecting clients with various non-clinical services that support and improve health and well-being. It is considered holistic, client-centred, and a way to "de-medicalise health service provision", empowering clients to enhance their well-being (WHO, 2022, p. 2). Like participants' reports, social prescribing should be tailored to individuals with a unique and personalised approach. This can include a variety of supports co-designed with the client to improve well-being and where progress is monitored. This attends to socioeconomic, cultural, and environmental conditions that affect well-being, drawing on wider social and community networks and individual lifestyle factors.

Discussed further in *Cultural Responsivity*, participants specified that assessment and intervention approaches should include Te Ao Māori aspects. This includes the Te Tiriti o Waitangi principles of partnership, protection, and participation and Te Whare Tapa Whā. Participants also

reported that CP competence includes adopting holistic and trauma-informed approaches. Holistic and trauma-informed approaches were considered advantageous as they move beyond situating problems in a deficit-based framework located within an individual. Participants identified that when holistic and trauma-informed approaches are not implemented, assumptions, biases, and overly narrow perspectives result. One consequence reported was of CPs relying on a biomedical focus, which undermines the opportunity for positive effects throughout assessment and intervention.

The He Ara Oranga enquiry identified that, currently, mental health care in A-NZ is not delivering positive outcomes for tangata whai ora, and that responses to people in mental distress are through “too narrow a lens” (Patterson et al., 2018, p. 11). Commented on further in the *MHSDEP* section, many participants discussed that when CPs adopt a biomedical focus this can impact competence. Specifically referring to assessment and intervention, Crowe (2022) comments that psychiatric discourse maintains power and authority across how mental distress is conceptualised and how services are provided. One issue identified is that the hierarchical nature of psychiatric dominance can oppose recovery-focused models and trauma-informed practice, which creates barriers to effective care (Crowe, 2022).

To a degree, the NZPB core competencies for assessment and intervention align with participant views. For example, the NZPB competencies include collecting relevant information, systematic evaluation, applying assessment-supported interventions, identifying and managing process issues, and considering contextual valuables that impact service provision. Participants, however, emphasised flexible, adaptable, and tailored approaches, useful skills and tools, specificity through differential diagnosis, and feedback from service users. The working alliance was highlighted as a key element for assessment and intervention by participants. In contrast, the Intervention areas of the general and clinical scope core competencies do not include the therapeutic relationship or working alliance. The core competencies also do not emphasise that a CP needs to know about and facilitate support beyond CP contact.

Participants specified the importance of holistic approaches and alternatives to biomedical approaches, such as trauma-informed approaches. Adopting holistic and trauma-informed approaches are not NZPB competencies. The NZPB competencies also do not recognise that competence includes recognition and mitigation of the limitations of biomedical paradigms and approaches. This is a major contrast with participant views of CP competence.

3) Cultural Responsivity

Participants identified that cultural responsivity, particularly to Māori, is a key aspect of competence. This is an important finding given that the literature discusses that current mental health services and approaches do not serve Māori well, as evidenced by poorer mental well-being outcomes (Cunningham et al., 2018; Kopua et al., 2021). For example, compared to non-Māori, more Māori enter mental health facilities, are readmitted after discharge, experience seclusion, and are subject to compulsory treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Patterson et al., 2018). Mirroring participant reports, over-reliance on Western knowledge, and a lack of acknowledgement and integration of Te Ao Māori, Mātauranga Māori, and Māori models of well-being are current issues (Kopua et al., 2021).

Participants identified that competent CPs adhere to Te Tiriti o Waitangi principles and acknowledge and reflect on how indigenous perspectives and ways of being differ from majority cultures. The NZPB Code of Ethics acknowledges obligations to Te Tiriti and psychologists' positions of power and influence (NZPB, 2012a). However, A-NZ psychologists were part of the BPS until 1968, and there are likely influences from this that have influenced current A-NZ practice (Escott & Abraham, 2021). Escott and Abraham (2021) and Levy (2018) call for ongoing challenges to scientific racism, flow-on effects of colonial practice, and outcomes from being taught specific (and narrow) forms of psychology (Wright, 2020). This also relates to *Safe Spaces and Profession*.

Participants discussed that competent CPs know about and attend to colonisation impacts in their practice. Colonisation, which included the theft of land, led to the demise of Māori customs,

language, knowledge systems, worldviews, values, beliefs and ideas about well-being (Escott & Abraham, 2021). In 1840, the British Crown signed Te Tiriti, acknowledging Tino Rangatira (sovereignty) for Māori, where customary rights and beliefs were to be upheld (Came et al., 2021; Network Waitangi, 2018). Despite Te Tiriti, the recent He Ara Oranga and the Health Services and Outcomes Kaupapa Inquiry (WAI 2571) have acknowledged the continued need for culturally appropriate and responsive approaches and services (Russel et al., 2018; Waitangi Tribunal, 2019).

Participants highlighted that competence includes knowledge of diversity between and within cultures and openness to follow and integrate Tikanga and Te Ao Māori processes. Aligning with participant accounts are critiques that psychology systems of assessment and intervention are culturally bound and based on Western models that can conflict with Māori views and ways of being (Durie, 1985; Escott & Abraham, 2021). Further, privileging the biomedical model and monocultural and deficit-oriented approaches have contributed to current mental health inequities for Māori (Russell et al., 2018; Mental Health and Wellbeing Commission, 2021). This also relates to participant responses in the *MHSDEP* area. In contrast to such approaches, components of Māori pathways to well-being have been identified as 1) Te Reo Māori: Māori language; 2) Taiao: connection with the environment; 3) Wairua: Māori spiritual beliefs and practices; 4) Mahi-a-toi: Māori expressive art forms; 4) Take pū whānau: Māori relational values; and 6) Whakapapa: intergenerational relationships (McLachlan et al., 2021).

Aligning with participant responses, existing literature conceptualises Māori well-being as holistic, where spirit, body, society and natural environment are interconnected (Wirihana & Smith, 2019). Further, roles and relational processes are deemed crucial, including sharing practices and knowledge between generations and extended whānau environments (Wirihana & Smith, 2019). Māori-centred approaches to mental well-being have been developed, such as Paiheretia, which aims to enhance identity, connect with cultural heritage, and balance relationships (Wirihana & Smith, 2019). Whakapapa kōrero is the intergenerational transmission of bodies of Māori knowledge that are integral to Māori relationships, processes, and ways of being (Wirihana & Smith, 2019). Te Whare

Tapa Whā (Durie, 1985) is a Māori model of wellbeing explicitly reported by participants. This model acknowledges the interconnectedness and importance of taha tinana (physical body), taha wairua (spiritual/connectedness), taha whānau (relational), and taha hinengaro (mind).

In the Meihana model (Pitama et al., 2017), the image of the Waka Hourua (double-hulled canoe) is used to include Te Whare Tapa Whā as well as the clinician-client-Whānau relationship and Taiao (physical environments). Ngā Hau e Whā (the four winds of Tawhirimātea) attends to historical and current influences on Māori: colonisation, racism, migration, and marginalisation. Ngā Roma Moana (the four ocean currents) refer to Te Ao Māori aspects that may influence clients/whānau in differing contexts: Āhua (personalised indicators), Tikanga (Māori cultural principles), Whānau (relationships, roles and responsibilities), and Whenua (genealogical or spiritual connection to the land). Finally, Whakatere (navigation) integrates information from the Waka Hourua, Ngā Hau e Whā and Ngā Roma Moana into formulation, differential diagnosis, and intervention (Pitama et al., 2017). The aim of the Meihana model is to provide a structured model for clinicians and services to explore, acknowledge, and mitigate personal and organisational biases within mental health care and delivery (Pitama et al., 2017).

Alternative structures for psychology sessions have also been suggested, such as The Hui Process (Lacey et al., 2011). Based on Te Ao Māori engagement practices, the Hui Process includes: “mihimihi (initial greeting engagement), whakawhanaungatanga (making a connection/building relationships), kaupapa (attending to the purpose of the encounter) and poroaki/whakamutunga (closing the session)” (Pitama et al., 2017, p. 8). He Puna Whakaata (McLachlan et al., 2019) is another example of a therapeutic approach that draws on Mātauranga Māori to achieve positive outcomes for Māori. He Puna Whakaata consists of five types of interventions: Whai Tikanga Cards, Te Whare Tapa Whā, Whai Tikanga Pleasant Event Scheduling, Decisional Balance, and Korurangi (see McLachlan et al., 2019).

Participants discussed that competent CPs acknowledge social and political contexts and combat associated challenges resulting from these wider contexts. Included is the ability to

responsively work with diverse sexualities, genders, and religions. This means providing interventions that support clients with challenges related to sexuality, gender, and religion. Sex, sexuality, and religion are not specified in the NZPB competencies.

The NZPB Cultural Competencies and the Diversity, Culture, and Te Tiriti o Waitangi areas of the General and Clinical scope core competencies generally align with participant accounts. However, colonisation, acculturation, and magnification of MHSDEP for people belonging to non-dominant cultures are not emphasised. Attention to Māoritanga is in the NZPB competencies, though the dominance of Western paradigms being counter to Māoritanga is not attended to. The interview participants highlighted that the medical model does not work for the dominant culture (Pākehā) and thus is very unlikely to work for those from other cultures. There is a lack of specificity around culturally safe models in the NZPB competencies, while participants provided suggestions of specific models such as Te Whare Tapa Whā. The NZPB do not emphasise seeking feedback specifically about being culturally competent from service users.

4) Mental Health-Related Stigma, Discrimination, Exclusion, and Power

Participants reported that MHSDEP is an area of competence that is fundamental to all other aspects of CP competence and pervades all areas of CP practice. Participants discussed that competent CPs are aware of the effects of MHSDEP, such as “othering” and implicit biases that can negatively affect the provision of care. Participants identified that MHSDEP needs to be considered and understood as contextual and risk factors that can cause harm if not attended to. Competent CPs learn about, understand, and address the myriad of negative consequences of MHSDEP for service users, whānau, CPs, other professionals, the profession of psychology, and wider mental health services. Participants also specified that competence includes ongoing anti-stigma education and training to maintain CP competence. Participants identified that when CPs do not attend to the impacts of MHSDEP on clients, they are viewed as incompetent. This finding will likely apply to any

psychologist and other mental health professionals. Further, participants discussed that competence includes also actively mitigating SDEP at systemic levels.

Relating to the findings that MHSDEP both negatively impacts and overlaps with interpersonal skills and relational presence is a recent study of traumatic experiences for mental health service users within therapeutic relationships (Bacha et al., 2020). Their participants reported experiencing disempowering and dehumanising approaches. Outcomes of these approaches were reported as a diminished sense of self-worth, an increased sense of vulnerability, increased self-harm, and increased distress. Further reported was a sense of lack of control over services, problematic relationships with services, harmful interventions, and compliance with harmful interventions (Bacha et al., 2020). Similar to the current study, helpful (competent) relationships for participants included psychologists treating people with lived experience of mental distress as unique individuals and as “living breathing human beings’ and not just as patients” (Bacha et al., 2020, p. 11). They identified the depersonification of service users and professional power as central issues. Thus, professionals (and professions) must be sensitive to power when responding to service users, influencing how clients perceive the quality of care provided (Bacha et al., 2020).

The literature discussed in Chapter Two (e.g., p. 40), pertaining to service user exclusion and stigma, discrimination, and competence, is relevant to service user findings about MHSDEP. Participants also highlighted limitations of medicalised frameworks for understanding and supporting mental distress and that MHSDEP is likely to reinforce and maintain unhelpful biomedical approaches. Kopua et al. (2020) also acknowledge that psychiatry and psychology are predominantly based on diagnostic-based mental disorder models. Mental well-being challenges are subsequently positioned as individually located pathologies resulting from biological or cognitive deficits. Consequently, such challenges are considered independent of the broader context (Beresford, 2002). Further, mental health care relies on dominant diagnostic systems such as the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM reliance encourages mental health care that is medically managed

and controlled (Kopua et al., 2020; Rangihuna et al., 2018; Russell et al., 2018). Some alternatives to biomedical approaches are discussed later in this section and in *Safe Processes and Profession*.

As discussed by participants, the medicalisation of mental distress in psychology prioritises the “expert” or “professional” clinician on both individual and systemic levels (Bacha et al., 2020; Kopua et al., 2020). For example, final formulations ultimately rest with the CP, not the client, which can result in imposing diagnoses and interventions. As a result, clients may feel they need to hide their true needs and cannot discuss their experiences, thus continuing to receive interventions that are not effective for them. Systemically, clinicians positioned as “experts” results in service users not having the opportunity to express their views about mental health care (Bacha et al., 2020). This prevents people with lived experience of mental distress from 1) receiving effective and responsive care and 2) providing input into how mental health care (including psychology) is delivered.

Participants highlighted an “us and them” divide that impacts CP competence. This includes labelling clients as problematic and making assumptions about clients’ lived experiences. This leads to professionals assuming they know best and making decisions for clients. A key aspect of competence would be identifying these assumptions and managing the power imbalances that preclude and maintain them. This divide is also important in terms of service users being included in what the competencies are, as assuming only CPs can deem what the competencies should be likely exacerbates CP and client divides where power, and thus, decision-making, is retained by professionals. “Substituted decision-making” refers to clinicians making decisions for clients based on what they believe to be in the best interests of a client (Gordon et al., 2022). This denies clients the right to make decisions about themselves or be supported to do so following their will and preferences. As such, substituted decision-making does not align with the Convention on the Rights of Persons with Disabilities (CRPD) (Gordon et al., 2022), an international human rights instrument that clarifies the application of existing human rights to persons with lived experience of mental distress (UN, 2006, p. 4).

Participants reported that MHSDEP produces inequities for service users that include exclusion from services and exclusion from effective mental health care. They highlighted that MHSDEP impacts CP practice by excluding clients from competent assessment, formulation, and intervention. Service user views of competence include CPs responding to mitigate SDEP by integrating the impacts of MHSDEP into assessment, formulation, and interventions with clients.

The Power Threat Meaning Framework (PTMF; Johnstone & Boyle, 2018) relates to the present study's findings and provides a relevant framework for how issues around MHSDEP can be framed and navigated in CP. The PTMF, published by the BPS DCP, highlights the importance of power, responses to threats, and identity in understanding lived experience of mental distress. The PTMF can be used as an assessment, formulation, and intervention framework. Furthermore, it can be used as a framework to investigate and then mitigate the transmission of MHSDEP by professionals and services. The PTMF can also be considered a meta-framework (Johnstone & Boyle, 2018), where other bodies of evidence can be accommodated to make this approach relevant to practice. Thus, the PTMF can be used in conjunction with service user perspectives to mitigate how MHSDEP operates and impinges on CP competence, specific to the A-NZ context.

Results from the present study correspond with the PTMF. For example, issues with biomedical approaches, such as diagnoses that situate pathology within an individual, and a lack of attention to the effects of cultural, social, and relational environments which undermine appropriate intervention. Aligning with participant reports, the PTMF highlights limitations of the colonised psychology knowledge base that impact current practice. Echoing the "us and them" findings, the PTMF identifies assumptions of objectivity where professionals hold power and service user input is not valued. Participants and the PTMF identify a lack of appreciation of the centrality of meaning, agency, and subjective experience in psychological approaches. This includes judgements about who is "mad" based on implicit biases about acceptable ways of thinking and being that pervade society. For professional practice, one example is a focus on gathering evidence so as to fit clients into

diagnostic “boxes”. The PTMF also highlights that power includes possible re-traumatisation by the mental health services themselves, relating to iatrogenic harm discussed later in this section.

The PTMF is useful in terms of the current study as it delineates different types of power: coercive, legal, economic and material, biological/embodied, interpersonal, and ideological. There is an emphasis on ideological power being fundamental to how people (including CPs) identify, make sense of, and experience mental distress, both individually and collectively. This is important as ideological power is usually invisible and difficult to identify (Johnstone & Boyle, 2018). The present study’s findings highlight the relevance of iatrogenic power, of which there is little recent literature specific to CP in A-NZ. Boisvert and Faust (2002) discuss iatrogenic power in terms of how labels and language influence service users’ self-perceptions. Further, iatrogenic power includes pathology-oriented belief systems that impact how clinicians discuss, conceptualise and categorise the experiences of clients, which contributes to negative therapeutic effects. They discuss that iatrogenic harm can result from clinicians’ over-reliance on belief systems where therapists interpret service user experiences of mental distress as pathological (Boisvert & Faust, 2002). When this is communicated to clients using pejorative language, clients are inducted into this belief system, which can be reinforced by secondary gains for therapists (e.g., fitting distress into a system that makes sense for the CP syntonically with the dominant culture, feeling needed, and feeling able to understand a client).

SDEP is a major area of contrast between the service user findings and the core competencies. Specifically, MHSDEP, which is SDEP related to the presentation of mental distress and mental health diagnosis. SDEP is present in the core competencies in relation to culture but not in relation to experiences or expressions of mental distress or belonging to the “service user” group. Hierarchical structures and power differentials are major areas of concern also not indicated in the competencies. Participant findings in the MHSDEP area most closely align with the NZPB cultural competencies and core competencies in the area of Diversity, Culture, and Te Tiriti o Waitangi. However, as discussed previously, cultural competencies are not the minimum standard required for a

general registration or clinical psychologist. The Diversity, Culture and Te Tiriti sections for the general and clinical scopes also do not refer to the “Skill” to 1) identify and 2) alleviate distress due to the effects of SDEP, specifically throughout intervention. The participants stated that a competent CP would actively counter and create healing spaces from the impacts of SDEP at all process points, including assessment, formulation and intervention.

The Board competencies also do not explicitly specify the impacts of MHSDEP for service users as a clinician-instigated contextual variable that can impact assessment, formulation, and intervention. MHSDEP is not acknowledged in the Professional and Reflective sections. In contrast, participants linked SDEP and MHSDEP directly with CP self-awareness and reflexive practice. This reflects a bias or blind spot in the Board’s competencies. The NZPB core competencies do not mention CP’s lived experience at all, and in general, there is a lack of reference to people with lived experience of mental distress. These areas of contrast mean that aspects of competence relating to SDEP identified as important by participants are missing. This has implications for training and monitoring competence in this area and, ultimately, has consequences for client care.

5) Safe Processes and Profession

Regarding findings across both analyses, participants indicated that competent discipline knowledge includes understanding and valuing research and perspectives pertaining to lived experiences of mental distress. Berg (2021) commented that evidence-based psychology practice currently consists of two quality parameters- efficacy and efficiency. Efficacy was discussed based on a scientocentric ideal originating from evidence-based medicine, which was used as a template for evidence-based psychology practice (Levant, 2005). For example, medical randomised controlled trials were assumed to be “bias-free” and thus superior to other ways of generating knowledge or carrying out research, with psychology adopting these assumptions and methods (Berg, 2021; Cochrane, 1999).

Berg posits that proper understanding and use of scientific findings requires leaving the scientocentric focus on efficacy behind, as efficiency is the only relevant parameter for determining quality in clinical care. For example, for Berg (2021), efficiency includes considering client values and allowing evidence-based practice to be related to ethical standards that underpin psychology practice (discussed in Chapter Two). Like the findings, Berg (2021) also discusses “clinical utility” as combining different sources of knowledge, such as participant knowledge, to find optimal interventions in real-life settings. The main question, then, is whether a clinician has the knowledge, skills, and resources to assist a client. Theoretically, knowledge and skill pertain to the existing competencies, where competence is seen as made up of an individual CP’s knowledge and skills. The concept of resources pertains to participant comments about competence including systemic awareness and action for a competent workforce collectively.

The Indicative Trauma Impact Manual (ITIM; Taylor & Shrive, 2023) offers an alternative to dominant ways of understanding mental distress, such as that found in the DSM. Taylor and Shrive (2023) highlight that current psychology approaches can be biased and support the medicalisation and pathologising of human distress. They offer Anti-Pathologising Trauma-Informed Services (APTIS) as an alternative approach. The ITIM was developed in response to people speaking about their need for validation of trauma and distress experiences. Taylor and Shrive (2023) hold that dissatisfaction with mental health care is often due to not being validated, listened to, heard, or accepted. Much of the ITIM and underlying APTIS principles mirror the present study’s findings.

The ITIM’s underpinning approach is captured in the acronym VALIDATE:

- Victim Focused: focusing on rights, experiences, needs and well-being, advocacy and protection.
- Anti-pathology: does not support pathologisation, medicalisation, restraint or forced treatment of responses to trauma.
- Logical: logical and explainable approaches to traumatised people which is in their best interests.

- Informed: well-informed and educated service provision of evidence-based approaches to abuse, harm, and oppression; commitment to teaching clients and the wider community about trauma, distress, harm and oppression.
- Dynamic: flexible response, understanding that unique and tailored approaches are necessary for everyone.
- Anti-Opressive: commitment to anti-oppressive practice and theory and rejects any resource, theory, policy or practice that oppresses, harms, silences, ignores or stereotypes marginalised groups of people.
- Trauma-informed: understands how trauma and distress impact humans.
- Ethical: strives to do no harm and follow ethical guidelines to avoid harm and discrimination (Taylor & Shrive, 2023, p. 30).

Aligning with service user views of CP competence, APTI holds that people require different services at different times, tailored to their needs. Service users should receive services without being labelled as mentally ill or disordered, and distress should not be blamed on individual “deficits”. Further, professionals must advocate for clients and provide support to remove incorrect or inaccurate, misleading, harmful and biased information (including diagnoses) from records. The ITIM acknowledges that professionals assisting service users are likely to have significant experiences of trauma and distress themselves, as well as vicarious trauma as a result of their work context and environments. Thus, clinicians need to acknowledge and understand their own trauma and ways of coping.

The Ecological Model of Trauma and Distress- adapted from Bronfenbrenner’s Ecological Systems Model and Taylor’s Ecological Model of Victim Blaming Experiences (Taylor & Shrive, 2023, p. 358), also relates to the *Safe Profession* findings. This model is a tool to explore the influences of trauma, distress, power, control, and oppression. The different Ecological Levels include social narratives, stereotypes, beliefs, politics, faith, media, norms and bias; institutions of power, law,

health, and authority; communities and groups; interpersonal relationships, family, and support networks; and the individual.

I propose that psychologists can use this model as 1) a reflexive tool for individual CPs and 2) a tool for the profession to consider how, collectively, psychology may be operating as both a harmful and helpful system for people with lived experience. For example, the model can help identify where harm and narratives about people experiencing mental distress come from (including about self), systems that may be distressing, oppressing, or controlling, and how these systems may be related or influence each other. The model can also be used to identify places of safety, forms of support, and systems that are already working.

Participants discussed collaboration as central to competent processes and that truly listening to clients is paramount to any CP contact. They indicated that reflective practice means the pursuit of self-awareness, especially awareness of the CP's own limitations. Service users emphasised that self-awareness being ascertained by the individual CP or supervisor can be limited and may result in oversights. These oversights may include failing to recognise biases regarding lived experience, which requires specific education (such as SDEP training) to identify. Regularly inviting, accepting, and incorporating service user feedback into practice was identified by participants as a way to mitigate some of these issues, which would require a degree of vulnerability from the profession.

The current findings highlight the relevance of CP vulnerability in establishing safe processes. I argue that the notion of vulnerability can also be applied as a collective and systemic concept of profession-wide vulnerability. In other words, how CP as a profession protects/defends vulnerability collectively. This may be a barrier that has prevented the integration of service user views into professional practice. Based on relational theory, reciprocal vulnerability recognises ways therapists' unique subjectivity influences clients and therapeutic relationships (Aron & Lechich, 2012). Mutual vulnerability recognises the ways therapists influence and are influenced by the therapeutic relationship (Powers, 2017). For example, exploring personal motivations and histories is crucial, as

they affect the ability to be empathic and attuned to clients' experiences (Powers, 2017). This relates to self-awareness and self-reflection as routes for monitoring and maintaining competence.

Relating to the archetype of the wounded healer (e.g., Martin, 2011; Zerubavel & Wright, 2012), Powers (2017) found that therapists described a process of restriction and resistance to being vulnerable. This was in response to inner experiences, which led to engaging in defensive processes to protect from emotional responses. Outcomes of clinicians restricting/defending vulnerability were discussed as creating distance from clients' experiences, blocks in the therapeutic relationship, and a lack of openness, acceptance, and understanding in the client-CP dyad (Powers, 2017). Echoing the present study's findings, clients can then feel misheard, misunderstood, rejected, and not seen. Thus, accurate self-awareness and being open to feedback from clients can be seen as forms of vulnerability needed for CPs to engage in a therapeutic relationship positively. Barriers to clinician vulnerability were discussed as fears about disclosure, abandonment, rejection, and feeling helpless, bad, or ashamed (Powers, 2017). Interestingly, clients share these fears, highlighting mutual fears associated with vulnerability (Powers, 2017). Powers also discussed developmental capacity, where therapists' capacity to be vulnerable increased as they became more experienced. In contrast, in the present study, newer CPs were viewed by some participants as more competent. This was based on the understanding that newer CPs are more likely to incorporate relevant concepts and current literature and research into practice.

Though relational vulnerability corresponds with the *Relational Presence* findings, vulnerability is also relevant for monitoring and maintaining competence. Systemic vulnerability may be foundational to ensure safe and competent practices upon which other competence areas can be built. I also consider that a lack of vulnerability (both collective and individual) may stem from fear of incompetence, which then perpetuates existing mechanisms to keep framing and conceptualising competence in the same way. For example, one reason for not seeking service user feedback, both as individual CPs and profession-wide, may be based on fear of identifying blind spots and gaps in understanding. It is possible that identifying gaps may be implicitly seen as a threat due to pressure

on the profession to be competent. This may create barriers to maintaining and evolving competence for individual CPs and the profession.

For the present study, participants highlighted the importance of monitoring and addressing competence to ensure a competent CP workforce. This meant that competence was regarded as broader than pertaining only to the individual CP, instead referring to a competent profession and competent systems. Workforce issues have been acknowledged by the NZCCP (2023). This includes that there need to be more CPs in the workforce and that more CPs need to be funded and trained. Participants in the current study highlighted that competent CPs and a competent CP workforce acknowledge and work towards this goal, both as individual clinicians and as a workforce.

Some literature further pertains to the present study's findings about systemic competence, including workforce diversity, training, and experience. For example, and also relating to *Cultural Responsivity*, the 2016 Waitangi Tribunal claim (WAI, 2725) found the Crown breached Te Tiriti by failing to ensure that academic and professional psychology meet the needs and requirements of Māori (Levy, 2018). The basis of this claim was that A-NZ has preserved monocultural psychology without meaningful change. The claim calls for a substantial improvement in cultural competence training and support to develop the Māori psychology profession and workforce (Levy, 2018). Despite guidance on supporting Māori psychology students and trainees that has existed for over ten years (Escott & Abraham, 2021), reports indicate that support for Māori undertaking psychology training is either minimal or inadequate (Levy, 2018).

Escott and Abraham (2021) observe that Māori are perceived as 'others' rather than partners, given the Pākehā operated environment, where there is no expectation for clinicians or educators to immerse in Māori culture. This leads to selecting when to "dip" into Māoritanga and Tikanga, which maintains biases and clinician confusion around how to work effectively with Māori. I contend that these concepts can also apply to people with lived experience in CP more broadly, as part of a non-dominant or unseen and unacknowledged cultural group at training and education levels. The Code of Ethics implores psychologists to address and challenge unjust norms and behaviour that

“disempower people at all levels of interaction” (NZPB, 2012b, p. 25). I argue that mechanisms that disempower Māori and other non-dominant cultural groups may also pertain to service users in general. This is because service users experience a system colonised by biomedical hierarchies and a lack of acknowledgement of the value of lived experience.

Considering how the participants’ views of CP competence aligned with the Board competencies across the survey and interviews, there were many that aligned with the competencies in the Professional, Legal and Ethical Practice section (Part 1). Participants commonly discussed the ethical, legal and professional obligations of CPs and considered these obligations as part of competent practice. They provided many examples and illustrations of how CPs would be considered competent in this area. Examples of similar aspects include knowing clients’ rights and interests, identifying boundaries of competence, and making ethical decisions. Additionally, participants often discussed building trustworthy, safe, and transparent processes as essential to underpinning competence in ethical and legal areas. Participant findings about professional, ethical, and legal practice were linked to interpersonal aspects of competence, such as connection, trust, and being authentically human. Thus, how service users define professionalism appears to be subtly yet importantly different from the kind of ‘expert human’/‘objective distance’ positions that CPs may be trained in or encouraged to hold.

The NZPB competencies emphasise and prioritise a scientist-practitioner approach, for example, when gathering information from a client. However, a scientist-practitioner approach likely values certain types of theoretical knowledge coming from a particular origin that is not bias-free (as discussed in Chapters One-Three). For example, service users report that valuing biomedical and Western approaches without valuing knowledge and theory of other current service user-valued approaches indicates incompetent practice. Compared to service user views, the Board competencies do not emphasise CPs seeking external feedback (e.g., from service users) specifically about self-awareness and reflective practice. This is of note as implicit and unconscious biases by nature are hidden from the person (or people) that hold them.

The Board competencies include advocacy in terms of effectively advocating for client needs and, at times, taking on advocacy roles. Giving the impression that they view advocacy as pertinent to competence, the participants were more specific about what competent advocacy involves. For example, CPs engaging in prevention work in communities and systems. Advocacy was also discussed as ongoing after CP contact ends and beyond individual client input. For example, CPs working to improve accessibility and system navigation as an aspect of competence. Participants highlighted that competent practice is systemically bound within wider systems and acknowledged that systems can provide barriers to competence.

Participants discussed that support beyond self-assessment and supervision is needed for CPs to be competent. Such support enables CPs to be more aware and responsive to the views they hold that negatively impact their competence. Participants viewed competent reflective practice as including actively seeking, responding to, and integrating client feedback. The NZPB competencies prioritise within-profession feedback that involves self-reflection by an individual CP and/or supervisor feedback. With less emphasis on client feedback, important comments that can enhance a CPs competence and indicate incompetent practices are lost.

Regarding maintaining and evolving competence, evaluating competence based on service user feedback is not in the Board competencies. It is reasonably expected that during a CPs career competence and meeting core competencies will vary, as will how CPs apply and interpret competencies. It is also worth recognising that the application and interpretation of competencies depend on factors such as personal experience (life, lived, and clinical), training programmes, supervision, workplaces, and professional development. As service user views of CP competence provide rich and specific input and feedback about competence in real-life contexts, more emphasis on valuing and integrating processes where service users can better inform competent practice in CP is important.

Summary of Findings and the Existing Core Competencies

Broadly, key aspects of the findings across the survey and interviews that align with the existing NZPB competencies include reference to professional ethical and legal practice, responsive interventions, and, to a degree, cultural responsiveness. However, there were many key differences, of which the nuances are discussed in Chapters Four and Five. As an overview, service users commonly highlighted the essential competencies of how a CP interacts with clients (*Interpersonal Skills and Relational Presence*). Service users specified that competent interventions are holistic, trauma-informed, long-lasting, and encompass wider supports than those provided in the therapy room. Service users provided details specifically on responsiveness to Māori. For example, competence means knowing about colonisation and integrating Te Ao Māori into approaches. Gender, sexuality and religion were identified as important aspects for crafting competent processes and interventions. A further gap was attention to SDEP, and specificity about MHSDEP, which is not in the Board competencies. In particular, there is limited mention and consideration of power in the NZPB competencies. This contrasts with the significant number of participants who discussed competence as CPs noticing and attending to power in their interactions with clients and wider work.

Strengths and Limitations

A major strength of this study was the degree of consultation and input from service user groups and people with lived experience of mental distress. As discussed in Chapter Three (see p. 56), the principles of co-production provided a framework to invite and integrate views and concerns of different service user groups into the research design and the measures themselves. The collaborative approach also aided recruitment, where I had networks of services advertising and vouching for this study. This meant participants were willing to contribute to the study and provide lengthy, honest, and detailed data.

Another strength of this study was being user-led. My lived experience and training as a CP provided both insider and outsider perspectives, and my awareness of this instigated the consultation

and reflexivity processes outlined in Chapter Three (see p. 80). For example, participants discussed that knowing I had lived experience contributed to them feeling safe and trusting me with their views. I believe that knowing personally what it is like to face a professional in a vulnerable space contributed to sensitivity, gratitude, and respect for the participants. My insider lens allowed me to consider aspects of competence that may have been missed, overlooked, or not considered had I never experienced mental distress or seen a professional for mental distress. My dual experiences meant I could often relate to what the participants discussed from a client perspective and, drawing from experience working as a clinician, could also see how CPs can practically demonstrate the competence articulated by the participants.

The participation criteria enabled people with a variety of lived and CP experiences to participate, which was advantageous in capturing a range of views from a diverse group. The criteria also meant that no views were deemed exempt or irrelevant to the study due to arbitrary assumptions such as mental distress being “too severe” or “not severe enough”- as discussed as a barrier for participatory research in Chapter Two (see p. 40). Across the survey and interviews, A-NZ Pākehā and women were over-represented, with fewer Māori and men participants, and very few gender-diverse participants. There were no Asian or Pasifika participants. People with lower education levels, for example, not having finished high school, and people not currently employed, were underrepresented. Other underrepresented groups include people who saw the CP(s) for alcohol and drug issues, obsessions and compulsions, brain injuries, cognitive difficulties, and people in corrections. Considering how to recruit underrepresented groups and make the measures more accessible will be helpful in the future to better understand the views of a greater variety of people who see CPs, including people who see CPs for something other than mental health. It is also important to state that the findings were the views of the 85 participants who took part, and that obviously does not mean that the findings represent the views of all service users. More people wanted to take part in the interviews than could be managed. In future studies, focus groups are one way to facilitate more face-to-face participation. Whānau views of CP competence were not collected

in this study and is an area worthy of future investigation to gather more information about how competent CPs support clients and whānau.

The participants shared a range of helpful and unhelpful experiences they had had with CPs, and those who shared negative experiences also included positive aspects and experiences they would hope to have in the future. This is important as, irrespective of actual experiences, service users can still constructively comment on what comprises competent practice. Asking about what competence ideally would look like and their hopes for CP competence, rather than requiring participants to evaluate their CP's competence, was useful, as participants could thus provide both retrospective and prospective views about competence.

Two different data collection methods were useful, as the survey and interviews provided different ways of understanding views of competence. However, both required a significant amount of time and verbal or written communication capabilities, which may have meant that people unable to write, use a computer, or carry out a conversation for a period of time could not participate in the study. As I mainly recruited through service user networks online, people not engaged with these organisations and those without internet access likely did not participate. Additionally, the survey was lengthy, which may have deterred some potential participants. The survey could have been simplified with fewer items. However, this would have resulted in less comprehensive data.

Regarding how the two data collection methods contributed to the findings, the survey canvassed a large overview of what constitutes competence, and participants could take time to form answers. The interviews enabled free-flow views of competence, where I could provide in-the-moment support and flexibility and check my own understandings. While the findings were quite consistent across the survey and interviews, there were subtle differences in how the different measures answered the research questions. For example, in the interviews, there was more discussion about sexuality, sex, and Māoritanga, and more discussion about the negative experiences with CPs and other professionals that informed participant views of CP competence. Thus, it will be

useful for future studies to supplement surveys with other data collection methods that gather views more directly in an open structure.

One important limitation is that the Te Ao Māori findings were interpreted through my Pākehā lens and likely reflect the worldview and privilege that accompanies my cultural grouping. Given that Māori were underrepresented and Te Ao Māori findings were interpreted by a Pākehā, in the future, Kaupapa Māori approaches would be useful for professional practice research. Another major limitation was no service user participation in the analysis stages, including checking the results and conclusions, as required for co-production. This likely would have led to a more robust and comprehensive understanding of the results. I will invite participant feedback about the results summary once this is distributed.

Another strength was collecting participant feedback about the survey and interviews, which provided information about the data collection measures. Based on survey items 39 – 41 (see Appendix D pp. 261-243), most survey and interview participants want to be included in conversations about professional competence and think their views of competence should be acknowledged. Some participants reported that their views may not be heard and that participating may not lead to improvement or change. Most participants found the survey and interviews positive or “fine” to participate in, noting that these were useful ways to collect their views. Some survey participants considered the survey too long and, at times, challenging to respond to.

Implications and Recommendations

The results from this study show that service users have important perspectives about CP competence that add to current understandings. The findings also indicate existing aspects of the competencies that align with participant views. However, additional focus is needed regarding incorporating service user views into how competence is conceptualised and competencies are generated. This has implications for the processes under which competencies are generated, what

they consist of, how CPs acquire and maintain competence, and how the profession informs professional practice guidelines.

Understandings of Competence and Competencies

Service user views of CP competence contribute to the knowledge base of how competence is conceptualised and provide specificity of what the core competencies should be to be truly responsive to service users and fit for purpose in a practical sense. Service user views highlight what competence means to them and indicate aspects of the core competencies that correspond with service user views and aspects that may need attention. Regarding conceptualising competence in a broader sense and attending to the current NZPB definition of competence discussed in Chapter Two (see p. 28), service user perspectives add information about the knowledge, skill, judgement, and diligence needed to view a CP as competent as shown in Table 13.

Table 13

Competence Understandings Service Users Address

Competency Element	Definition from Profession	What Service User Views Add
Knowledge	Integrating relevant information to inform practice and identify issues with professional practice	Understanding the types of knowledge expected from clients Understanding how knowledge gaps impact client care
Skill	Knowledge applied effectively	Understanding which skills help a person and if there are skills that do not help
Judgement	Helpful decision-making and applying skills that are contextually relevant	Information about how clients know a psychologist is making effective decisions and following robust processes
Diligence	Consistent application of knowledge, skills and judgement to prioritise the needs of clients	Information about how diligence is demonstrated and portrayed to clients

Recommendations For the Current Competencies. Service user views of competence inform recommendations for the current NZPB core competencies, based on alignment and contrast with existing aspects of the core competencies, as set out in Chapters Four and Five and Appendix G. Compared with the findings, the main areas where there are gaps in the existing competencies

include interpersonal skills and relational presence, responsive assessment and intervention, cultural responsiveness, and MHSDEP. I recommend that service user views in these areas be given careful attention to inform the current core competencies. It is also worth reviewing the competencies in the general scope and other scopes, as well as the clinical scope, and considering how service user views from this study pertain to the competencies across these scopes.

Further, given how crucial cultural responsiveness was reported, I recommend that the cultural competencies be reframed as compulsory rather than optional. It is also crucial to attend to MHSDEP as an area of competence, and generate core competencies to provide guidance that better ensures CPs can learn, notice, and mitigate the effects of MHSDEP. To truly respond to the findings, I recommend revising and replacing the current biomedical and deficit-based language in the current competencies, with a commitment to revise other professional documents and guidelines in the same way. Examples include revising problem-focused, individualised, and pathologising language such as “psychopathology”, “serious mental illness”, “treatment”, “problems”, and “disabilities/disability”, which is prevalent throughout the current competencies. Changing such language adheres to the study’s findings and values and prioritises service user views. This is an important step in attending to the harm current paradigms reinforce, aligning with historical and contemporary mental health enquiries and service user-focused literature (see Chapter Two, e.g., p. 37).

Research Implications

The need to continually check assumptions and understandings of what the public needs from CPs to ensure safe practice is important as CP practice evolves. Thus, research that continues to explore and develop understandings of competence needs to continue into the future. Service user views highlight considerations of SDEP and MHSDEP as crucial to competence. This finding, coupled with the lack of research about MHSDEP and power in general in CP, calls for more research about MHSDEP and SDEP and how these biases and practices hinder or facilitate competence. Additionally,

given findings about cultural responsiveness, future research that explores Māori service users' views of competence would be useful.

I highlight the need to continue research that values and supports service user inclusion and highlights what service users contribute to current understandings of professional practice, both within psychology and other sectors that have contact with people with lived experience of mental distress. More research will likely enhance understanding and build on existing literature bases to better inform current policies, procedures, and professional guidelines. More research that prioritises, values, and supports user-led and co-produced approaches is crucial to be able to conduct robust studies that generate effective findings and implications. This is a joint responsibility shared between the profession, academia, mental health workplaces and other research sites.

Professional Practice Implications

Regarding clinical practice, the findings inform how CPs can practice competently, seek and integrate feedback, navigate systems and barriers in a wider sense, and how CPs can locate distress beyond individual pathology. Participants emphasised interventions that are accurate, targeted, tailored, flexible, and responsive to feedback. They highlight that competence includes considering how interventions impact clients' lives long-term and how clients can be better involved in their care. Further, the findings inform how competence includes CPs navigating systemic issues and working collaboratively with clients, whānau, colleagues, other services, and wider systems.

Service users emphasised competence in the area of interpersonal skills and relational presence. Given the lack of focus in the current competencies, it is worth considering how CPs can be supported to be more human, authentic, relatable, and approachable in their work. Further, with the upsurge of e-therapies, telehealth, and mental health applications heightened by the COVID-19 pandemic, I consider that caution must be exercised when assuming that interpersonal and relational aspects of competence during remote or electronically-based delivery of CP services is equivalent to face-to-face contacts. This might miss some important aspects of relational competence described by

service users. Further, any digital interventions must be evaluated by service users in a robust and truly collaborative way.

Additionally, given the findings about CPs with lived experience and competence, I recommend that the profession supports and values CPs with lived experience. Specifically, lived experience should be viewed as a strength rather than a deficit to be hidden. This would mean CPs can be given adequate support to harness and use their experiences in their work. I recommend that the profession reflects on how the current education and training of CPs both assist or hinder competence development and how stigma reduction measures can be built into CP training programmes. For example, training CPs could include an emphasis on incorporating contemporary forms of knowledge important to service users (such as literature about the service user movement). This includes reflecting on which paradigms have been integrated into current practice, identifying blind spots in the profession, identifying how service user views are diminished or devalued, and adopting processes that navigate these issues. I invite the profession to examine psychologist selection and training processes in light of the findings. This could include reviewing what is focused on and prioritised as selection criteria and how service users are included in selection processes. For example, what is the role of lived experience and life experience in selecting trainees? Additionally, I recommend that people with lived experience be included on selection panels and in examination processes for psychologist training programmes. Ideally, people with lived experience would be involved in teaching and training CPs, including CPs with lived experience (e.g., Hogg & Kemp, 2020).

Though I focused on views of competence for CPs specifically, it is likely that the participants drew on experiences with other types of psychologists and professionals. Thus, the findings may inform professional practice across various professions that both work with and have workers with lived experience of mental distress.

Implications for Professional Guidelines

As well as contributing to setting benchmarks for what is needed to practice competently, the findings can inform how competence is maintained and monitored. This can include the NZPB continuing competence programme, guidelines for approaching competence concerns, and supervision guidelines. The findings confirm that ongoing and purposeful service user input should be sought in evaluating the processes that are used to gauge whether CPs are competent. Such input is crucial to the facilitation of power sharing.

In a wider sense, asking service users their views allows the profession to prioritise clients' needs consistently and facilitates effective responses to clients, aligning with the human rights and ethical responsibilities discussed in Chapter Two (e.g., p. 37). The findings and the implications from this study are an opportunity for professional psychology to reflect on and revise professional guidelines. Such reflection can facilitate a challenge to wider mechanisms of dominance in both other mental health sectors and wider socio-political contexts that impact people with lived experience of mental distress. Inviting and integrating service user views into developing other professional guidelines enables the profession to respond more effectively, provide optimal care, and identify other aspects not derived from the profession that may make professional guidelines more fit for purpose. Thus, a recommendation is to include service users to inform other professional documents, such as the Code of Ethics and Code of Conduct.

Though this study focuses on CP, the findings can be considered in relation to the competencies specified for psychologists in other scopes and sector-specific competencies pertaining to psychologists. For example, the competencies pertaining to public sector psychologists. The findings also likely inform other professions that work with people with lived experience of mental distress. For example, the findings and study processes can inform their professional guidelines (such as competencies), processes, and policies. Further, the study has socio-political implications, such as considering the wider structures that create and maintain barriers to service user inclusion and, more specifically, maintain or mitigate MHSDEP. For example, this can include government policies, service

fundings, advisory groups, statutory bodies that regulate mental health services (e.g., the Ministry of Health), and other stakeholders such as community organisations. Though I focused on CPs in A-NZ, and while I recognise that service user views of competence are contextually located, some of these implications and recommendations likely also pertain to overseas contexts.

Conclusions

This study contributes to the current evidence base of how competence is conceptualised and delineates what the core competencies should be. Collecting and analysing service user views of CP competence provided crucial information about what constitutes competence and which aspects of competence align and contrast with existing competencies for CPs in A-NZ. Involving service users offers an alternative approach to what has historically been undertaken to generate competencies. This is important as involving service users identifies new information and understandings not uncovered by within-profession processes. The findings also mean that psychology as a profession cannot assume to have covered everything relevant to service users (or any other stakeholder group) without asking them.

Critical aspects of competence for service users include interpersonal and relational processes, which are essential for building trust, without which CPs will not be viewed as competent in any other area. The profession must urgently consider ways to support CPs to be human, authentic, and relatable. Participants identified key aspects of service provision, such as responsive assessments and formulations, tools and skills that truly assist, services coordination and wrap-around, and interventions that last beyond the therapeutic contact. They highlighted that competence includes advocacy, where service users can be confident that CPs will support them according to their needs.

Attending more effectively to culture, particularly Te Ao Māori, indicates that cultural competencies must be compulsory rather than optional and that holistic and flexible tailored approaches to intervention are important. Furthermore, service user views highlight that attending SDEP, particularly MHSDEP, is crucial for CP competence. This requires more attention and

consideration as both specific competencies as they pertain to an individual CP and in relation to the psychology profession more broadly. Limited consideration of power in the competencies, CP research, and training is a significant barrier to understanding and examining how power differentials impact CPs, the profession, and service user experiences of service delivery and outcomes. Reflecting on the current prioritisation of certain types of knowledge and how these have affected CP practice warrants attention. For example, how the biomedical model influences psychology practice and impacts client care.

Another aspect of competence that requires attention is systemic competence, where individual CPs work with systems to generate change and more responsive care. Within this, competence is conceptualised as broader than the consideration of individual CPs to include delineating what constitutes a competent workforce. Though service users emphasised systemic competence, this concept is largely missing from the core competencies.

I also consider how service-user knowledge has not been valued or integrated into professional guidelines, which can be traced back to the type of research that is carried out, how CPs are educated and trained, and how competence is ascertained and monitored. I conclude that service users are valuable and crucial informants for how competence is conceptualised and what the competencies should be. It is important for the profession to prioritise developing processes where service users can truly participate and be included in developing professional guidelines, and I encourage the profession to better embed lived experience expertise in all current processes.

Consideration and care must be taken when developing ways to better include people with lived experience. This study contributes examples of what worked to encourage participation and collect rich responses. In particular, collaboration and co-production principles were essential. Valuing relational processes between professionals and service users is paramount to any endeavour that seeks service user input.

Regarding the user-led approach, my 'insider' and 'outsider' roles added richness, heart, and understandings, which I believe strengthened this study. I recognise my privilege and my

responsibility for being entrusted with participants' views. I strive to treat these views with respect and care and to attend to their implications moving forward. I continue to cherish the vulnerability participants demonstrated in this study. As well as greatly appreciating what these views contribute to the profession, I acknowledge and cannot understate how greatly they have enhanced my own personal learning and development as a clinician and fellow human. I will carry these views with me throughout my professional career and continue to value and advocate for the perspectives shared. I surmise that user-led research should be valued and seen as a strength to draw upon to better inform professional practice.

Further, supporting psychologists with lived experience is important for the profession, including harnessing these experiences and views and better understanding how lived experience informs competent practice. I acknowledge the complexity of holding dual perspectives and encourage the profession to better support and value psychologists with lived experience. Attending to MHSDEP within psychology is essential to make it safe for psychologists to reveal, share, and draw on their experiences of mental distress to inform professional practice. This requires embedding processes that mitigate MHSDEP, such as creating dedicated roles with specific remits. Further, CPs with lived experience do not represent all people with lived experience and cannot be assumed to negate or replace the need for consultation and inclusion of non-psychologist people with lived experience.

In summary, for the profession to attend to the goal of attaining and maintaining competence and specifying competencies, it is paramount to truly seek out, hear, and respond to service user views. This promises to provide competencies that are fit for purpose and produce a CP workforce better equipped to provide effective and supportive care for people with lived experience. Though I focused on CPs, aspirationally, this study can inform psychology more generally, as well as other services, organisations and statutory bodies involved with people with lived experience of mental distress.

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Appendix A

Recruitment Organisations

Anxiety NZ Trust

Aotearoa Therapists with Lived Experience Network

Balance Aotearoa

BINZ

Changing Minds and Rākau Roroa

Drive

Emerge

Engage Aotearoa

Equip

FIXATE

Hearing Voices Network Aotearoa NZ

International Society for Psychological and Social approaches to psychosis New Zealand

Kites Trust

Mental Health Foundation

Mental Health NZ Aotearoa

Mind and Body

Mind Tribe

Mothers Matter

NZ Mental Health Consumer/ Whai Ora Information Sharing

Oasis Network

Peer Support NZ

Peerzone

Planet FM Mental Health Radio

Samaritans

Shared Vision Hearts and Minds

Silverline Otago

The Nutters Club

Voices of Hope

Workwise

World of Difference

Appendix B

Advert Examples

Views of Clinical Psychologist Competence Study

Have YOU seen a Clinical Psychologist in New Zealand?

If you are 18 and over and have been to at least one clinical psychologist in NZ for mental health **your views are needed**.

I am a Massey University clinical psychology student and Rākau Roroa seeking service user views of clinical psychologist competence.

If you would like to share your views and contribute to the mental health sector's understandings and valuing of lived experience, you can choose to participate by:

1) Completing a 30 minute survey

https://massey.au1.qualtrics.com/jfe/form/SV_3aY4RUEChRSvy97



Every completed survey will have a chance to win a \$40 Voucher

2) Alternatively, you can express interest to take part in a one-hour interview in Auckland

Each interview participant will receive a \$40 voucher

Please get in touch to express interest or if you have any questions.

Alice Stevenson

alice.stevenson.1@uni.massey.ac.nz

All queries about this project are strictly confidential.

Seen a clinical psychologist in NZ?

SHARE YOUR VIEWS

of

what makes a **competent** clinical psychologist

Survey: https://massey.au1.qualtrics.com/jfe/form/SV_3aY4RUEChRSvy97 (Win a \$40 voucher)

Interview: VIDEO INTERVIEWS NOW AVAILABLE! Email: alice.stevenson.1@uni.massey.ac.nz (\$40 Voucher for each interview)


Thank you



Alice; Psychology student and Rākau Roroa

All queries about this project are strictly confidential

**Tune in! To Take it From Us
This week
In discussion with Alice Stevenson**

<p>Take It From Us Mental Health Radio Planet FM 104.6</p>		<p>This Tuesday 14th January 12.30 pm</p>
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If you've used the services of a psychologist, Tomorrow's show on mental health radio Take It From Us is for you.
Academic researcher Alice Stevenson
 Is exploring the services of psychologists to find out what's good, and what's perhaps not so good about the support we get from them. Hear about her research on
Take It From Us
This Tuesday 14th January on PlanetFM1104.6 @ 12.30pm.

Appendix C

Participant Information Sheets and Consent Forms

Survey Information Sheet

Service User Views of Clinical Psychologist Competence

If you are 18 years and over and have seen at least one clinical psychologist for mental health services in New Zealand, you are invited to share your valuable views.

Tēnā koe, I'm Alice, a Doctor of Clinical Psychology student in the School of Psychology at Massey University in Albany.

I am interested in strengthening mental health services. A desire for more voice and choice for those using mental health services has led me to design a research project that explores service user/tangata whaiora views of what makes a helpful or 'competent' clinical psychologist.

My aim is for this research to inform psychology as a profession, leading to more responsive psychological services. Your participation means the chance to have your voice heard. You will be contributing to a project that has not been done before, in Aotearoa or overseas. Your contribution will inform my doctoral thesis. It is my hope that my report will lead to long-term change, giving service users/tangata whaiora more input into how competence is considered in clinical psychology. Aspects of this report will be submitted for consideration to be published in journal articles and results may be shared at conferences. This is so the voices of participants can reach professionals working around the world and support further research in this area.

Taking part in this study involves filling out an anonymous, online survey based on your views of clinical psychologist competence. The survey will take around 30 minutes to complete, depending on how long you spend on each question. You will be asked to provide some demographic information and to answer some questions based on your experiences. You have the option to fill the survey out yourself, ask someone to read the survey and input your answers for you, or contact the researcher to request a paper copy of the survey. The chance to win a \$40 grocery voucher will be offered for your time.

If you are not sure about whether you saw a clinical psychologist, please clarify this before taking part and only take part if you are sure you saw a clinical psychologist. You can contact the researcher if you need help with this. If you have seen more than one clinical psychologist, you can choose to take part in one survey based on your overall experiences.

Privacy and Confidentiality

Survey participation is **confidential**. Some of your experiences and words may be used in my reports. Anything that could make it possible to identify you, or other people involved in your experiences, will **NOT** be included. You will be provided with a summary of the research findings if you would like one. Your email address provided for the research summary and the draw will be securely stored, kept separate to your survey responses, and destroyed in accordance with the Massey University Human Ethics guidelines. Only the research team will have access to these details.

Participation is voluntary. You are NOT obliged to take part in this study.

If you choose to take part, you have the right to:

- Withdraw from the survey at any time without your responses being used, provided you do not click the submit button at the end of the survey. Please be aware that, once you have submitted your survey, it will not be possible to withdraw your responses.

- Ask any questions about the study at any time, and have them answered fully
- Participate with the understanding that any information that could identify you will not be shared.
- Share openly about your experiences in a non-judgmental, confidential environment. Your responses will be treated with respect during data analysis and in the presentation of results.

Benefits and Risks

There are **no foreseen risks** associated with this project. The questions in the survey are about your views of clinical psychologist competence. While you will not be asked in detail about your experiences of mental distress, the survey does call on you to remember these times and your experiences with clinical psychologists. As this can bring up difficult emotions, you may find it useful to contact the researcher, your support networks or the 1737 phone line. Additional resources are listed at the end of the survey. To prevent distraction and additional distress, it is helpful to choose a time of low stress to participate. As it can be challenging to think about times you were vulnerable, choose a time when you feel you are able to safely cope with any difficult emotions that might arise as you reflect. While it can be distressing to recall times when your experiences were not helpful, some may find it healing to be given a place to voice these experiences and a way to use them to make a difference for others.

You are the best person to decide if this is a suitable time to take part in this survey. You can contact the researcher if you have any concerns or questions about this study.

All inquiries regarding this project will be confidential.

If you are 18 and over and would like to take part, follow the questions below. You can stop participating by closing your browser at any time. Your answers will be discarded if you do not press submit.

Researcher: Alice Stevenson

██████████ Txt or Call (Please leave a message if I am unavailable)
██████████@uni.massey.ac.nz

Supervisor: John Fitzgerald (Senior Lecturer, Massey University)

0800 MASSEY (0800 627 739) extn ██████████
██████████@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 19/63. If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63363, email humanethicsoutha@massey.ac.nz.

Interview Information Sheet

Service User Views of Clinical Psychologist Competence

If you are 18 years and over and have seen at least one clinical psychologist for mental health services in New Zealand, you are invited to share your valuable views.

Tēnā koe, I'm Alice, a Doctor of Clinical Psychology student in the School of Psychology at Massey University in Albany.

I am interested in strengthening mental health services. A desire for more voice and choice for those using mental health services has led me to design a research project that explores service user/tangata whaiora views of what makes a helpful or 'competent' clinical psychologist.

My aim is for this research to inform psychology as a profession, leading to more responsive psychological services. Your participation means the chance to have your voice heard. You will be contributing to a project that has not been done before, in Aotearoa or overseas. Your contribution will inform my doctoral thesis. It is my hope that my report will lead to long-term change, giving service users/tangata whai ora more input into how competence is considered in clinical psychology. Aspects of this report will be submitted for consideration to be published in journal articles and results may be shared at conferences. This is so the voices of participants can reach professionals working around the world and support further research in this area.

If you are not sure about whether you saw a clinical psychologist, please clarify this before taking part and only take part if you are sure you saw a clinical psychologist. You can contact me (Alice, the researcher) if you need help with this.

Participation in this part of the study involves taking part in a one-hour face-to face interview with myself (Alice, the researcher). In this interview you will be asked to provide some demographic information and to answer some questions based on your experiences. You will then be asked about your views of clinical psychologist competence in a guided discussion. You can respond to this discussion however you choose.

The interview will be voice recorded and transcribed. After transcription the voice recordings will be erased. You will receive a \$40 grocery voucher for your time.

Transcriptions will be securely stored and used to write my research report. This may be submitted for consideration to be published. Some of your experiences and words may be used in these reports. Anything that could make it possible to identify you will **NOT** be included. You will be provided with a summary of the research findings if desired.

Participation is voluntary. You are NOT obliged to take part in this study.

If you choose to take part, you have the right to:

- Not answer any question without having to explain why
- Withdraw from the study, or choose to omit any part of the interview up until 5 days after the date of the interview, without having to explain why
- Ask any questions about the study at any time, and have them answered fully
- Provide information on the understanding that your name and any other identifying information will not be used in the final report
- Ask for the audio recorder to be turned off at any time during the interview
- Share openly about your experiences in a non-judgmental, confidential environment. Your responses will be treated with respect during data analysis and in the presentation of results.

A **consent form** will be issued and must be signed before the interview.

Privacy and Confidentiality

Interview participation is **confidential**. Some of your experiences and words may be used in my reports. Anything that could make it possible to identify you, or other people involved in your experiences, will **NOT** be included. You will be provided with a summary of the research findings if you would like one. Your email address provided for the research summary will be securely stored, kept separate to your interview transcripts, and destroyed in accordance with the Massey University Human Ethics guidelines. Only the research team will have access to these details.

Benefits and Risks

This project is estimated to be **low risk**. We will be discussing your views of clinical psychologist competence. While you will not be asked in detail about your experiences of mental distress, the interview may call on you to remember these times and your experiences with clinical psychologists. As this can bring up difficult emotions, you may find it useful to advise the researcher, or contact your support networks or the 1737 phone line. Additional resources are listed at the end of this document. To prevent distraction and additional distress, it is helpful to choose a time of low stress to participate. As it can be challenging to think about times you were vulnerable, choose a time when you feel you are able to safely cope with any difficult emotions that might arise as you reflect. While it can be distressing to recall times when your experiences were not helpful, some may find it healing to be given a place to voice these experiences and a way to use them to make a difference for others.

You are the best person to decide if this is a suitable time to take part in this study. You can contact the researcher if you have any concerns or questions about this study.

All inquiries regarding this project will be confidential.

If you are 18 and over and would like to take part, contact me on the details provided below.

Researcher: Alice Stevenson

██████████ Txt or Call (Please leave a message if I am unavailable)
██████████@uni.massey.ac.nz

Supervisor: John Fitzgerald (Senior Lecturer, Massey University)

0800 MASSEY (0800 627 739) extn ██████████
██████████@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 19/63. If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63363, email humanethicsoutha@massey.ac.nz.

Resource List

If you find the survey or interview brings up distress, you might find it useful to have some support, you can contact the researcher, your support networks, or some suggestions from below.

In an emergency, call 111 or proceed directly to the emergency department of the hospital

1737, need to talk?

Free, 24/7 confidential support.

National mental health and addictions helpline with support from trained counsellors.

Your local **GP**

Lifeline Aotearoa

Free, 24/7 confidential support.

Phone: 0800 LIFELINE (0800 543 354) or free-text HELP (4357).

<https://www.lifeline.org.nz/services/lifeline-helpline>

Depression Helpline

Trained counsellors who can listen and consider possible supports. Maōri and Pasifika pages online.

Phone: 0800 111 757; Text: 4202; Email: through their website: <https://depression.org.nz>

The Lowdown

A website to help New Zealanders understand depression and anxiety from their own perspective.

Get in touch with a trained counsellor by free txt (5626). Website: <https://thelowdown.co.nz/>

Warmline

Free peer support services for people experiencing mental illness or those supporting them.

Phone: 0508 WARMLINE (8-12pm every night).

Samaritans

Confidential and non-judgemental support to anyone in emotional distress.

Phone: 0800 726 666 (24/7).

Suicide Crisis Helpline

Support, information and resources to people at risk of or affected by suicide.

Phone: 0508 828 865 (0508 TAUTOKO) (24/7).

Healthline

Free advice from trained registered nurses. Open 24/7.

Phone: 0800 611 116

Health and Disability Commissioner

For concerns about mental health services you have received. <https://www.hdc.org.nz/>

Clinical Psychologist Competence

PARTICIPANT INTERVIEW CONSENT FORM

I have read the Information Sheet and have had the details of my involvement in the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to the interview being voice recorded.

I understand that I can withdraw myself from this study at any time up to five days after the interview.

I agree to participate in this study under the conditions set out in the Information Sheet.

Tick box if you would like a copy of the research study summary report sent to you when it is available (you will need to provide an email address).

Full Name: _____

Signature: _____

Date: _____

Email address (if required): _____

Appendix D

Survey

Service User Views of Clinical Psychologists Competence Survey

Welcome to the Service User Views of Clinical Psychologists Competence Survey. This survey is for people 18 years and over who have seen at least one clinical psychologist for mental health in New Zealand.

I am interested in your views on what makes a competent clinical psychologist based on your general views of using their services. If you saw more than one clinical psychologist, consider all your experiences. I don't want you to feel like I'm asking you to judge your psychologist(s) individually and there is no way for anyone to know which clinical psychologist(s) you saw. The hope is that this survey can generate some new understandings about your hopes for clinical psychologists based on your views of what may make them competent. For this reason, if you can think of your experiences overall that would be helpful.

For this study, it is important that you know the professional(s) you saw was a clinical psychologist and not another kind of mental health professional trained to deliver talking therapy. If you are not sure, please contact me (Alice, the researcher) to see if there is a way to clarify this before you complete the survey.

Please read the following participant information.

Note: You can withdraw from the study at any time, even after you consent. To do this, just close your browser. Your responses will not be saved.

Participant Information Sheet

To confirm your participation in this survey please complete the following:

- I am at least 18 years of age
- I have seen at least one clinical psychologist for my mental health
- The clinical psychologist I saw was in New Zealand
- I know that the professional I saw was a clinical psychologist (not a counsellor, psychotherapist, or other mental health professional trained in talking therapy). Note: If you are not sure, contact the researcher.
- I remember my experiences with a clinical psychologist well enough to comment on them

I consent to participate in this study

Yes

No

Getting to Know You

The following questions aim to find out more about you. The details you provide will help us to better understand the people who have shared their views in this study.

1. What is your age (in years)?

2. What is your gender identity?

- Female
- Male
- Gender Diverse
- Other (Open box)
- Prefer not to say

3. What is your ethnicity?

- Māori
- Pākehā/NZ European
- Pasifika
- Asian
- Middle Eastern
- Latin American
- African
- Other European
- Other (Open box)
- Prefer not to say

4. What is the highest level of education you have received?

- No high school
- High school graduate or equivalent;
- Tertiary undergraduate (university, trade school, college)
- Tertiary Graduate
- Prefer not to say

5. What is your occupation? (Open box)

6. How much total income did you personally earn in 2018?

- \$0 – \$14,000
- \$14,001- \$48,000
- \$48,001-\$70,000
- \$70,001-\$100,000
- Over \$100,000
- Prefer not to say

Your Contact with Clinical Psychologists

Following are some statements and questions that explore your experiences with clinical psychologist(s). Your answers will help me learn more about your journey, in terms of the services you used. Some of these questions may feel intrusive. I have included them in the survey so I can describe the range of experiences of the people who have taken part in this survey. I will not be drawing conclusions in my study based on how you respond in this section. If you feel uncomfortable answering any of the questions in this section, you can choose to not respond. Thank you for your understanding.

7. How sure are you that you saw a clinical psychologist?

- Completely sure
- Mostly sure
- Neither sure nor unsure
- Mostly unsure
- Completely unsure

8. How did you find out that you saw a clinical psychologist? (Open box)

9. How many clinical psychologists have you seen for mental health in New Zealand? (forced number)

- I don't know

10. What setting did you see the clinical psychologist(s) in? (Please choose as many as relevant to you from the following)

- Private practice
- Community mental health
- Inpatient services
- Corrections
- ACC,
- Oranga Tamariki
- EAP
- Other: (please describe)

11. How old were you when you first saw a clinical psychologist? (Number response)

- I don't remember

12. How old were you when you last saw a clinical psychologist? (Number response)

- I don't remember

13. Approximately, how long did you receive services from a clinical psychologist(s) for? (Open box: If you have seen more than one psychologist please note how long you saw each one for, if possible.)

14. How regularly did you see your psychologist(s)?

- Weekly
- Fortnightly
- Monthly
- Not Regularly
- Other (Open box: please describe)

15. Was it your choice to see a clinical psychologist?

- Yes
- No: If comfortable, please describe why not:
- Prefer not to say

16. What other professional supports for mental health have you used? (Checklist; please choose as many as relevant)

- Medications
- Counsellor or psychotherapist
- Occupational therapist
- Social worker
- Nurse
- GP
- Psychiatrist
- Peer support
- Other (open box)
- Prefer not to say

17. What brought you to a clinical psychologist? (Please select as many as relevant)

- Low mood
- Anxiety
- Sleep issues
- Alcohol/other drug issues
- Hallucinations and/or delusions
- Mania
- Trauma
- Work stress
- Relationship issues
- Learning difficulties
- Physical/medical injuries/conditions
- Behavioural issues
- Personality issues
- Other (open box)
- Prefer not to say

18. Did you receive a diagnosis?

- No
- Yes: What was it?
 - Depression
 - Bipolar
 - Anxiety
 - Alcohol/Drug Use
 - Schizophrenia
 - Post-Traumatic Stress
 - Obsessive-Compulsive
 - Other (Open Box: Please Describe)
 - Prefer not to say

19. What was the reason you stopped seeing the clinical psychologist(s)? (Open Box)

20. How affected were you by your difficulties at the time/s you saw a clinical psychologist?

- Most of my daily life was affected
- A lot of my daily life was affected

- Some of my daily life was affected
- A little of my daily life was affected
- Very little of my daily life was affected

Thank you for letting me get to know a bit about your experiences, I really appreciate how much you have shared so far.

Your Overall Clinical Psychologist(s) Experiences

The following three questions ask you to comment on your overall experiences with a clinical psychologist. I am interested in getting a general picture of how you feel about your experiences when you saw a clinical psychologist for mental health. You will notice that for the following questions, you will be asked to provide a rating, and then there will be two open-ended questions. Your words and ideas are important to this study, so it would be helpful if you could write as much as possible in the open-ended question boxes.

21. Overall, did seeing the clinical psychologist(s) help you to improve the difficulties you went to them for?

Please rate how helpful your sessions were overall:

- Extremely helpful
- Mostly helpful
- Neither helpful nor unhelpful
- Mostly unhelpful
- Extremely unhelpful

22. In your experience, what did your clinical psychologist do that helped? (Open)

23. In your experience, what did your clinical psychologist do that was unhelpful? (Open)

Thank you for sharing your experiences with me, I appreciate the time you have taken so far.

Your Views of Clinical Psychologist Competence

The following section is about your views of what makes a clinical psychologist competent.

In clinical psychology, a competent clinical psychologist is one that has adequate knowledge, skills and attitudes to practice psychology safely.

You will notice that these questions have open-ended boxes that require written answers. Your voice and words are crucial and important. Your written views are what will inform this study and work. I acknowledge the time, effort and thought that goes into responding to questions in this way. Thank you.

In New Zealand, clinical psychologists must follow Core Competencies that are set out by the New Zealand Psychologists Board. I am interested in your views of what makes a competent clinical psychologist.

24. What do you think makes a clinical psychologist competent?

25. What would a competent clinical psychologist do or say?

Thank you for your responses so far.

Areas of Clinical Psychologist Competence

*Following are descriptions of nine areas that relate to clinical psychologist competence. I am interested in **how important** each of the areas are to you, in terms of the services a person would wish to receive from a clinical psychologist. You can also provide comment on why each of these areas may or may not be important if you wish.*

Please read the following statements about what clinical psychologists do and consider your own experiences of this area.

Knowledge

Competent clinical psychologists have knowledge about the area they are working with you in. They talk about what methods they use and why they would help. They describe this in a way you can understand. Competent clinical psychologists are open to new ideas and your perspectives. They discuss with you how new ideas or approaches could be helpful or unhelpful.

26. How important is this area of clinical psychologist competence to you?

- Very important
- Somewhat important
- Neither important nor unimportant
- Somewhat unimportant
- Very unimportant

Comment box: You may provide additional comment if you wish. Why did you give this rating? Can you share any examples?

Diversity, Culture and Te Tiriti o Waitangi

Competent clinical psychologists are culturally safe. They work helpfully with people of different cultural backgrounds. They are aware of cultural diversity.

Note: Culture can include ethnicity, gender, spiritual beliefs, sexual orientation, abilities, lifestyle, beliefs, age, and social status.

27. How important is this area of clinical psychologist competence to you?

- Very important
- Somewhat important
- Neither important nor unimportant
- Somewhat unimportant
- Very unimportant

Comment box: You may provide additional comment if you wish. Why did you give this rating? Can you share any examples?

Professional, Legal and Ethical Practice

Competent clinical psychologists openly acknowledge ethical and legal issues. This includes explaining confidentiality, privacy, rights, benefits and risks. Competent clinical psychologists advocate for you. They make you feel safe, supported and like you are being helped.

28. How important is this area of clinical psychologist competence to you?

- Very important
- Somewhat important
- Neither important nor unimportant
- Somewhat unimportant
- Very unimportant

Comment box: *You may provide additional comment if you wish. Why did you give this rating? Can you share any examples?*

Understanding Your Situation

Competent clinical psychologists gather information relevant to your issues. They ask about your life history, current situation and what your issues mean to you. Competent clinical psychologists consider supportive aspects in your life. They look for opportunities for change in your environment and situation. They explore solutions that are relevant to you. They regularly check your progress.

29. How important is this area of clinical psychologist competence to you?

- Very important
- Somewhat important
- Neither important nor unimportant
- Somewhat unimportant
- Very unimportant

Comment box: *You may provide additional comment if you wish. Why did you give this rating? Can you share any examples?*

Services

Competent clinical psychologists carry out sessions based on the information you provide. The sessions are relevant to your needs and situation. Competent clinical psychologist(s) work to build new solutions. They support meaningful and sustainable change. They give you information about different mental health services when needed. They evaluate how their services affect you.

30. How important is this area of clinical psychologist competence to you?

- Very important
- Somewhat important
- Neither important nor unimportant
- Somewhat unimportant
- Very unimportant

Comment box: *You may provide additional comment if you wish. Why did you give this rating? Can you share any examples?*

Communication

Competent clinical psychologists clearly convey ideas. They respond to your feedback and information. Competent clinical psychologists are personable and ask relevant questions. They help you to feel at ease, listened to and heard. They tell you what is going to happen in a way you can understand.

31. How important is this area of clinical psychologist competence to you?

- Very important
- Somewhat important
- Neither important nor unimportant
- Somewhat unimportant
- Very unimportant

Comment box: *You may provide additional comment if you wish. Why did you give this rating? Can you share any examples?*

Professional and Community Relations, Consultation, Collaboration

Competent clinical psychologists create and maintain a helpful relationship with you. They explain and help you to understand their roles and responsibilities to you. They explain and help you to understand your roles and responsibilities in your sessions together.

32. How important is this area of clinical psychologist competence to you?

- Very important
- Somewhat important
- Neither important nor unimportant
- Somewhat unimportant
- Very unimportant

Comment box: *You may provide additional comment if you wish. Why did you give this rating? Can you share any examples?*

Reflective Practice

Competent clinical psychologists act within the limits of their competence. Their personal characteristics help you in your sessions. They seem able to reflect on their own points of view and how this may affect you and their relationship with you.

33. How important is this area of clinical psychologist competence to you?

- Very important
- Somewhat important
- Neither important nor unimportant
- Somewhat unimportant

- Very unimportant

Comment box: *You may provide additional comment if you wish. Why did you give this rating? Can you share any examples?*

Stigma, Discrimination and Social Exclusion

Stigma exists when people are recognised as different, and then labelled as such. This can lead to negative stereotyping, prejudices, isolation, ridicule, loss of status, loss of dignity and loss of basic human rights. "Discrimination" is a term that describes these acts.

Competent clinical psychologists should understand stigma, discrimination and social inclusion. They seem to identify and correct their own thoughts, beliefs or behaviours that contribute to stigma and discrimination. They challenge stigmatising attitudes and behaviours. Competent clinical psychologists help you to understand stigma, discrimination and social inclusion. Competent clinical psychologists help you with the impact of stigma, discrimination and social inclusion.

34. How important is this area of clinical psychologist competence to you?

- Very important
 Somewhat important
 Neither important nor unimportant
 Somewhat unimportant
 Very unimportant

Comment box: *You may provide additional comment if you wish. Why did you give this rating? Can you share any examples?*

35. Would it be important for you to know if your clinical psychologist had lived experience of mental distress/times of service use?

- Yes
 No

36. Why/Why not? (Open)

Survey

Thank you for your input so far, this is the final section. These last few questions consider what is important to you regarding areas of clinical psychologist competence and how you found the survey.

37. Considering all the areas mentioned, is there anything else you would like to say about what makes a clinical psychologist competent? (Open)

38. Considering competence, what are your hopes for psychologists?

39. Is it important for you to be asked your ideas about clinical psychologist competence?

- Yes
 No

40. Why/why not? (Open)

41. How have you found completing this survey? (Open)

Thank you for sharing your valuable views.

To submit your answers, press Submit

Submit

Thank you for submitting your responses. I appreciate the time and effort you have taken to inform this study.

Please enter your email address if you would like to enter the draw for a \$40 grocery voucher (Open Box)

Please enter your email address if you would like a copy of this study's summary (Open Box).

Keep reading if you would like to see a list of national resources and some other suggestions, should this survey bring up any strong emotions for you.

Appendix E

Interview Questionnaire and Communication

Pre-Interview Questionnaire

Service User Views of Clinical Psychologist Competence Interview

Welcome to the Service User Views of Clinical Psychologist Competence Interview. Before we get started, it would be wonderful if you could answer the following questions.

These questions ask about demographics and some aspects of your contact with clinical psychologists. This is so I can describe the range of people that took part. I will not be linking your answers here with your interview, and I will not be making inferences about the information you provide here and my findings. These pages will be destroyed once I have inputted your answers into my database.

The nature of these questions can feel intrusive, and I thank you for your openness and understanding. You can choose to answer don't remember or prefer not to say if you wish.

Getting to know you

1. What is your age (in years)?
2. What is your gender identity?
3. What is your ethnicity?
4. What is the highest level of education you have received?
 - No high school
 - High school graduate or equivalent
 - Tertiary undergraduate (university, trade school, college)
 - Tertiary Graduate
 - Prefer not to say
5. What is your occupation?

Your Contact with Clinical Psychologists

6. How did you find out that you saw a clinical psychologist?
7. How many clinical psychologists have you seen for mental health in NZ?
8. What setting/s did you see the clinical psychologist(s) in?
9. How old were you when you first saw a clinical psychologist?
10. How old were you when you last saw a clinical psychologist?
11. Approximately, how long did you receive services from a clinical psychologist(s) for?
12. How regularly did you see your psychologist(s)?
13. Was it your choice to see a clinical psychologist?

14. What other professional supports for mental health have you used? (Please choose as many as relevant)

- Medications
- Counsellor or psychotherapist
- Occupational therapist
- Social worker
- Nurse
- GP
- Psychiatrist
- Peer support
- Other (open box)
- Prefer not to say

15. Given that there can be a range of reasons that lead to seeing a clinical psychologist, what brought you to a clinical psychologist? (Please select as many as relevant)

- Low mood
- Anxiety
- Sleep issues
- Alcohol/other drug issues
- Hallucinations and/or delusions
- Mania
- Trauma
- Work stress
- Relationship issues
- Learning difficulties
- Physical/medical injuries/conditions
- Behavioural issues
- Personality issues
- Other (open box)
- Prefer not to say

16. Did you receive a diagnosis?

- No or: Yes: What was it?
- Depression
 - Bipolar
 - Anxiety
 - Alcohol/Drug Use
 - Psychosis
 - Post-Traumatic Stress
 - Obsessive-Compulsive
 - Other (Open Box: Please Describe)
 - Prefer not to say
 - Don't know

17. What was the reason you stopped seeing the clinical psychologist(s)?

18. How affected were you by your difficulties at the time/s you saw a clinical psychologist?

- Most of my daily life was affected
- A lot of my daily life was affected

- Some of my daily life was affected
- A little of my daily life was affected
- Very little of my daily life was affected

Thank you for letting me get to know a bit about your experiences, I really appreciate how much you have shared so far.

Interview Schedule

- **Criteria Check**
- **Pre-Interview Questionnaire**
- **Views of Clinical Psychologist Competence Discussion points:**

1. What do you understand about clinical psychologist competence?
2. How do you know a clinical psychologist is competent?
3. Which examples come to mind when you think about clinical psychologist competence?
4. Based on your experiences, what is important for you in terms of a competent clinical psychologist?
5. Did you know there were different areas of clinical psychologist competence? What would be the important areas for you?
6. What else would you like to say about competence?
7. Considering competence, what are your hopes for psychologists?

Guide Points

- The concept of competence- describe and enquire
- Areas of competence- describe and enquire
 - Discipline knowledge
 - Diversity, culture and te Tiriti o Waitangi
 - Professional, legal and ethical practice
 - Framing, measuring and planning
 - Intervention and services
 - Communication
 - Professional and community relations, consultation, collaboration
 - Stigma discrimination and social exclusion
- Would it be important for you to know if your clinical psychologist(s) had lived experience of mental distress/times of service use? Why/why not? Would it make them more or less competent?

The Interview Process

Is it important for you to be asked your ideas about clinical psychologist competence?

Why/why not?

How have you found participating in this interview?

Interview Instructions- Via email at least two days prior to the scheduled interview

Subject line: Interviews for Psychologist Competence Project

Tēnā koe (name),

Thank you for so generously offering your time to take part in my study.

The date and time of your interview is..... at You will be joined by myself (Alice). I look forward to meeting you and am very appreciative of your willingness to share your valuable knowledge and views with me.

Please read through the attached participant information sheet. I have also attached a consent form you may like to read through in advance.

Below is some additional information:

Background

Currently clinical psychologists in New Zealand must adhere to a set of Core Competencies mandated by the New Zealand Psychologists Board. In case you are interested, you can view these [here](#). I am interested in views of competence from those that have experiences with clinical psychologists. This is to explore whether existing competencies reflect the views and needs of service users. It is my hope that my findings can be used to help inform education, training and professional development of clinical psychologists.

Following is a suggested format for the interview. Between now and then, I encourage you to reflect on what psychologist competence means and looks like to you. You can consider the characteristics, knowledge, skills, and abilities a psychologist could have that would make you think they are competent.

You can also consider the discussion points at the end of the email. We may discuss some of these.

Agenda

1. Welcome, information, consent forms.
2. Whakawhanaungatanga including introductions/mihi and karakia.
3. Demographic questions, questions about nature of experiences with clinical psychologist(s).
4. Discussion of psychologist competence, with discussion points to guide.
5. Questions about how you find commenting on competence.
6. Closing: Questions, acknowledgements, karakia, koha and refreshments.

Thank you for contributing to this project. In participating it is essential that you are as comfortable as possible, so if you have any queries, questions or comments, do not hesitate to get in touch by reply email.

Any correspondence about this project will be treated with the strictest confidentiality.

I look forward to meeting you in person/via video on

Ngā mihi,
Alice Stevenson (Researcher).

Discussion points

1. What do you understand about clinical psychologist competence?
2. How do you know a clinical psychologist is competent?
3. Which examples come to mind when you think about clinical psychologist competence?
4. Based on your experiences, what is important for you in terms of a competent clinical psychologist?
5. Did you know there were different areas of clinical psychologist competence? What would be the important areas for you?
6. What else would you like to say about competence?
7. Considering competence, what are your hopes for psychologists?

Appendix F

Survey Item Participant Responses and Content Units

Table F1

Respondents (n) and Content Units (CU) for Each Survey Item

Survey Item	Core Competence Area	n	CU
22 What Was Helpful		73	190
23 What Was Unhelpful		73	114
24 What Makes a Clinical Psychologist Competent		73	277
25 What Would a Competent Clinical Psychologist Do or Say		73	205
26 Knowledge	Discipline, Knowledge, Scholarship & Research	38	62
27 Diversity, Culture and Te Tiriti o Waitangi	Diversity, Culture and Te Tiriti o Waitangi	34	58
28 Professional, Legal and Ethical Practice	Professional, Legal and Ethical Practice	34	58
29 Understanding Your Situation	Framing, Measuring and Planning: Assessment and Formulation	35	47
30 Services	Intervention and Service Implementation	25	32
31 Communication	Communication	29	50
32 Professional and Community Relations, Consultation, Collaboration	Professional and Community Relations, Consultation...	19	32
33 Reflective Practice	Reflective Practice	19	29
34 Stigma, Discrimination and Social Exclusion	Stigma, Discrimination and Exclusion	27	56
36 Important to Know About Lived Experience		66	118
37 Anything Else to Add		37	89
38 Hopes for Clinical Psychologists		57	123
39/40 Important to Be Asked About Competence		68	75
41 Completing the Survey		68	116

Note. Final counts for *n* and CU may vary slightly as when the CA was collapsed during analysis stages four and five some content units

were further split.

Appendix G

Content Analysis and Thematic Analysis Comparison with the NZPB Core Competencies

Tables G1 and G2 show how participant views of CP competence aligned and contrasted with aspects of the NZPB core competencies (research question two). These tables also provide examples of how the TA and CA findings can translate into competencies (units of competence) in the format the core competencies are set out in currently.

Table G1

Comparison of the CA Findings with the Core Competencies

CA Category/Subcategory	Aspects of Participant Views that Align with the NZPB Competencies	Aspects of Participant Views that Contrast with the NZPB Competencies
Therapeutic Assessment and Intervention		
Responsive Intervention and Support	Awareness of the need to adapt theoretical direction for more effective intervention (Cultural Competencies) Knowledge of a range of psychological theories and models of change Apply at least one therapy model Create safe supportive and effective environments Specific needs of a client are the basis for intervention Apply interventions supported by assessment and the “best evidence available” Include evaluation of how services have impacted clients	Provide helpful and relevant skills and tools Encourage supplemental resources to reinforce therapeutic work Awareness of different types of client feedback- verbal and non-verbal, implicit and explicit- that provide information about a psychologist’s practice Ability to coordinate wraparound with other services and professionals
Appropriate Assessment	A high standard of interviewing Collect relevant information Systematic assessment, evaluation, and problem-solving (Framing, Measuring, and Planning; general scope) Consider and include clients interpretations of situations	Knowledge of biases and misassumptions that can affect responsive assessment, formulation, and planning. Allow clients to provide feedback when assessment and formulation do not fit with their views or expectations Competent assessment includes holistic understandings of a client

	<p>Interpretation of data collected can be subjective</p> <p>The purpose of assessment is to understand a client and all aspects of their presentation (clinical scope)</p> <p>Selection of strategies based on information and “best possible evidence”</p> <p>Include groups, organisations and community</p> <p>Understanding clients is “ideally” an ongoing collaborative process</p>	<p>Relevant evidence consists of service user’s views, needs, and preferences</p> <p>Collaboration throughout assessment and formulation is essential to devise interventions that garner a positive impact</p> <p>Competent assessment includes reinforcement of progress and strengths</p> <p>Navigate organisational barriers to appropriate assessment</p>
Positive Impact	<p>Develop client capability; promote shared understandings; identify and manage process issues (clinical scope)</p>	<p>Provide positive results that last after therapeutic contact</p> <p>Instil autonomy and hope</p>
A Wider View	<p>Consider contextual variables that affect service provision</p> <p>Provide information about alternative services where required</p> <p>Attitudes of respect, flexibility, broadmindedness, and willingness to share knowledge (Intervention, clinical scope)</p>	<p>Lack of specificity of “best evidence” in the Board competencies can imply that psychological knowledge that provides the basis of interventions, held by a psychologist, may be superior to clients</p> <p>The competencies focus on alternative psychological services, whereas participants report other service options beyond psychology</p> <p>Co-ordinate care and wraparound with other services</p>
Relational/Presence		
Safe Space	<p>Emphasis on effective relationships with clients</p> <p>Create and maintain rapport</p>	<p>Ability to provide a safe space</p> <p>Connection, trust and rapport are essential for competent service provision</p> <p>Navigate barriers to effective relationships collaboratively</p>
Collaboration	<p>The central role of a psychologist is to work with people</p> <p>Respect, flexibility, broad-minded approaches, and willingness to learn and share knowledge are fundamental to all intervention activities</p> <p>Some mention of therapeutic alliance factors (clinical scope)</p> <p>Seek external review of practice</p> <p>Effective relationships with other professional and non-professional groups</p>	<p>No mention of service users explicitly in the core competencies</p> <p>An ongoing collaborative process is essential to understand clients</p> <p>True collaboration means checking understandings, mitigating assumptions, and responding when misassumptions have been made</p> <p>Actively seek and incorporate service user feedback throughout activities</p> <p>External review includes ongoing seeking and responding to service user feedback</p>
Authentically Human	<p>Understand the role of self-awareness and potential consequences of a lack of self-awareness (e.g., negative impacts on the therapeutic alliance, intervention processes, client outcomes)</p>	<p>Awareness of psychologist-client differences, similarities, and different points of view</p> <p>Understand how differences require incorporation in a collaborative way</p> <p>Awareness that self-reflection and reflection on therapeutic practice enables connection through human authenticity and validation</p>
Reflective Practice	<p>Self-knowledge</p> <p>Ability to reflect on and recognise personal factors</p> <p>Critical, constructive, and accurate self-reflection</p>	<p>Stigma, prejudice, and bias are unlikely to be able to be accurately assessed by those not experiencing it (overlap with SDE category)</p>

	The competencies highlight “accurate” self-assessment and supervision, which implies a psychologist and supervisor are sufficient to ascertain whether self-assessment is accurate Ability to self-reflect about assumptions and prejudice. Thus, effective acknowledgement of internal biases and prejudice is based on the ability to accurately self-assess.	The NZPB cultural responsiveness emphasis is on self-reflection, self-assessment and intervention design, which differs from collaborative approaches reported by participants Identify personal and professional limits Identify personal motivations Share relevant limitations and motivations Respond effectively to personal and professional limits (e.g., ongoing learning, onward referrals) Check-in with clients about self-awareness and reflective practice
Lived Experience and Competence		
Lived Experience as an Advantage Managing Lived Experience		Harness lived experience of mental distress as an advantage to practice Awareness of appropriate use of own lived experiences Support and value CPs with lived experience of mental distress
Effective Communication		
Active Listening	Acknowledgement of active listening and adapting communication and service approaches in response to “audience”, limited references to truly hearing clients	Communication is a reciprocal, two-way process Active listening ensures CP and client are on the same kaupapa (collective vision and purpose) Check own understanding throughout contact Do not assume understanding
Facilitate Understanding		Effectively explain what CPs do and how they work Communication is fundamental to competence, processing, and healing Enable clients to communicate with others (e.g., whānau) Check client understanding throughout contact Ensure information is presented in a way that can be understood Use jargon-free and non-medically based language in a non-pathologising way
Non-Verbal Communication		Relational aspects of communication are essential for competence
Professionalism		
Reliable and Ethical Practice	Knowledge of the interests and rights of others Knowledge of legal issues and how to navigate these Clarify roles and responsibilities Take on advocacy roles at times Advocate for clients’ needs while balancing safety issues and the wider community’s needs	Inform about and adhere to boundaries Confidentiality is crucial for trust, safety, and therapeutic alliance Safety, for clients and CPs, is essential for any CP activities Value and act in accordance with the interests and rights of service users Acknowledge and identify the potential for harm and abuse

		<p>Explain ethical and legal processes in ways that can be understood and retained</p> <p>Advocacy is part of a CPs role</p> <p>Acknowledge that assumptions and judgements provide barriers to advocacy</p>
Discipline Knowledge	<p>Being open to new ideas and innovation (Discipline, Knowledge; general scope)</p> <p>Knowledge of the main groups a psychologist will work with (Cultural Competencies)</p>	<p>Emphasis on valuing service user views and research as knowledge</p> <p>Includes knowledge about positive change, which should draw on clients and service user literature</p> <p>Discipline knowledge has a positive impact on clients and intervention</p> <p>Knowledge needs to be understandable and relevant</p> <p>Competent knowledge accepts service user research and literature and client perspectives as adequate and equal knowledge to psychology literature and research</p> <p>Awareness of incorrect assumptions due to a lack of knowledge, and their effects on clients</p>
Professional Requirements		<p>Relevant experience includes lived experience and life experience</p> <p>Being clear about credentials</p>
Maintain and Grow Competence	Competence is maintained and enhanced through supervision	<p>Competence can also be maintained and grown through collaboration with clients and Whānau, peer supervision, support from registration boards, and paying attention to client's needs throughout therapeutic processes</p> <p>Psychologists need to be supported to be competent</p>
Culturally Responsive		
Navigating Diversity and Privilege	<p>Recognise the impact of culture (Diversity, Cultural Competencies)</p> <p>Te Tiriti principles: partnership, participation and protection</p> <p>Understand Māori models of health (general scope)</p> <p>Understand the limitations and impacts of the western world on psychology models and techniques</p>	<p>Awareness and attention to power and privilege</p> <p>Awareness and attention to client's membership within communities</p> <p>Awareness of disparities due to power and privilege</p> <p>Learn about and act to counter the ongoing effects of colonisation</p>
Attending to Cultural Needs	<p>Work respectfully and collaboratively with a wide range of people</p> <p>Flexibly incorporate Māori models, practices and protocols (clinical scope)</p>	<p>Recognise that a person is made up of cultural, spiritual and whānau elements</p> <p>Seek ongoing feedback from clients of different cultures to ensure Te Tiriti principles and responsive intervention processes</p> <p>Respond to intergenerational effects of disempowerment of people from non-majority cultures</p> <p>Mitigate stereotypes based on culture to enhance wellbeing</p> <p>While adaptation and incorporation of models is a competency, the Board competencies emphasise intervention design rather than implementation</p>

		Adapt intervention to views and beliefs of other cultures (e.g., sexuality and gender) See a person on all Te Whare Tapa Whā levels, Taha Hinengaro (mind), Taha Tinana (body), Taha Wairua (spirit), and Taha Whānau (relational)
Competent Systems		
		Identify organisational and systemic barriers to competent services Acknowledge that competence encompasses systems as well as individuals Navigate and mitigate systemic barriers, e.g., limited access to sessions, limited follow-up, referrals to other services in a timely manner Work actively with other services and systems to enable access for clients
Stigma, Discrimination, Exclusion		
Responding Adequately	Understand biases, beliefs and values and how these can impact client and professional functioning (Reflective Practice) Understand the consequences of stigma, discrimination and social exclusion in psychology (Diversity, clinical scope) Knowledge of how wider context can impact assessment processes Consider relevant factors for the assessment of risk Knowledge of history and expression of oppression, prejudice and discrimination (Cultural Competencies) Knowledge of socio-political influences, stereotyping, marginalisation and stigmatisation effects on the lives of certain groups, in relation to identity formation, developmental outcomes, and manifestations of mental “illness” (Cultural Competencies)	Value and consult with people with lived experience Include service users and people with lived experience as a cultural group Understand that stigmatising views impact accurate assessment including the understanding of, planning for, and providing support for risk Accurate risk assessment includes the risk of loss to follow-up due to stigma and discrimination Risk is unable to be ascertained if the effects of stigma, discrimination and social exclusion for a client are not assessed Understand potential harms caused by related stigma, discrimination, and social exclusion such as ineffective or absent support, declined service provision and increased mental distress Understand and mitigate mental health-related SDE consequences such as silencing and therapeutic alliance impacts
Noticing and Naming	Affirming and non-prejudiced working stance (Diversity) Integrate stigma, discrimination and social exclusion into assessment and intervention processes (Diversity, clinical scope) Recognise cultural factors which influence health and response to treatment Complete culturally safe clinical assessments Alleviate distress associated with stigma, discrimination and social exclusion, based upon ethnicity, gender, sexuality, religious beliefs or disability (Diversity, general scope) Knowledge of contextual variables that impact intervention	Understand that mental health-related stigma exists and creates vulnerability and harm for people with lived experience of mental distress Understand that mental health-related stigma can be held and transmitted by professionals Knowledge of the detrimental consequences of mental health-related stigma Ability to reflect on personal biases about people with lived experience Knowledge about stigma, discrimination, and social exclusion based on lived experience of mental distress, diagnostic classification, and other assumptions based on service users as a group Stigma, discrimination, and social exclusion are factors and contexts that can impact assessment, formulation, and service provision

	<p>Knowledge of the interests of clients</p> <p>Knowledge of “normative values” about illness and help-seeking behaviour (Cultural Competencies)</p> <p>Accurate self-assessment of how personal biases, lack of relevant knowledge, and socio-political influences impact psychology activities; respond accordingly</p>	<p>Integrate stigma, discrimination, and exclusion into assessment, formulation, and intervention</p> <p>Recognise that stigma, discrimination, and social exclusion are factors and contexts that can impact outcomes and accurate evaluation of services</p> <p>Recognise that self-assessment is unlikely to uncover implicit biases without external feedback from those in a position to identify them</p> <p>Identify “normative values” of a clinician (e.g., that a client experiencing suicidality is “attention seeking”)</p>
An Important Area	<p>Awareness of disempowerment and implicit assumptions based on the culture of a psychologist</p> <p>Cultural Safety: provides clients with the power to feedback and be involved to change negatively viewed or experienced processes to contribute to positive outcomes and experiences with psychologists</p> <p>Understand and recognise cultural origins, assumptions and limitations of psychological practice within cultures</p> <p>Unsafe cultural practice: any action that diminishes, demeans or disempowers the wellbeing and identity of an individual, family or group</p> <p>Cultural Competence: recognises diversity in worldviews and practices for a psychologist</p> <p>Understanding of a psychologist as a culture bearer</p> <p>Understanding of historical, social, and political influences on wellbeing</p> <p>Create trust and respect when developing relationships</p> <p>Knowledge of the cultural basis of psychological theories and commitment to adjust practice as needed</p> <p>Awareness of psychologist’s and client’s cultural lens, and how these shape personal values, assumptions, judgements, and biases</p> <p>Knowledge of how psychology practices are historically and culturally embedded and how practices (theory, methods, paradigms) change over time due to societal values and political priorities</p>	<p>Though awareness and integration of concepts regarding stigma, discrimination, and social exclusion are in the Board competencies, skills to target the effects of stigma, discrimination, and social exclusion in practice are not explicit</p> <p>Stigma, discrimination, and social exclusion are identified as a paramount area of competence</p> <p>Stigma, discrimination, and social exclusion are identified as an area that traverses all of the other areas of competence</p> <p>Stigma, discrimination and social exclusion are predominantly mentioned in the Diversity and Cultural Competencies sections of the Board competencies, whereas service users mention stigma, discrimination, and social exclusion within and across each area of competence</p> <p>Ability to navigate and mitigate stigma, discrimination, and social exclusion in wider services and systems (e.g., workplace, organisation)</p> <p>Understand that strained systems increase the transmission and perpetuation of stigma, discrimination and social exclusion</p> <p>Clinical psychologists have a duty to notice and counter systemic and organisational stigma, discrimination, and social exclusion</p> <p>Recognise the socio-political context a clinical psychologist is operating within and work to intervene and mitigate stigma within this context</p>

Table G2

Comparison of the TA Findings with the Core Competencies

TA Theme/Subtheme	Aspects of Participant Views that Align with the NZPB Competencies	Aspects of Participant Views that Contrast with the NZPB Competencies
1. Responsive Framing and Intervention		
1.1 Flexible, Tailored, and Focused Intervention	<p>Effectively apply at least one therapy model, awareness of other models</p> <p>Knowledge of factors that can influence framing and intervention and integrating such factors into intervention planning. Factors in the core competencies include cognitive ability, personality, and social, political, and cultural factors</p> <p>Integrate relevant contextual issues into the assessment and intervention plan, modify formulations and intervention plans as new information arises and changes occur (clinical scope)</p> <p>Incorporation of trauma into intervention planning, as one of several possible “presenting variables” in the core competencies (alongside cognitive deficit, personality, and substance abuse)</p> <p>Develop solutions from the context</p> <p>Identify factors that offer opportunities for positive change</p> <p>Ongoing evaluation, revising formulations, and modification of intervention</p> <p>“Do no harm” (Discipline)</p> <p>Effective intervention plans (clinical scope)</p> <p>Develop client capability to support meaningful and sustainable change</p> <p>Be responsive to “new knowledge” (Discipline)</p> <p>Openness to ideas and innovation</p> <p>Openness to considering other perspectives</p> <p>Nonbiased and effective plans and interventions</p> <p>Understand cultural foundations and the “possible limitations of CP models and techniques from the Western world tradition” (Diversity, clinical scope) (NZPB, 2018, p. 21)</p>	<p>Be able to apply a range of models (more than one)</p> <p>Tailor models to an individual’s needs and preferences</p> <p>Factors that influence intervention include an unhelpful focus, inaccurate differential diagnosis (and formulation), and focusing on issues a CP may deem important, but a client may not</p> <p>Make changes based on service user feedback and well-being improvements, or lack of improvements</p> <p>Include trauma-informed approaches throughout assessment, formulation, and intervention</p> <p>Hold hope for clients and interventions</p> <p>Ongoing evaluation involves regularly seeking client feedback and adapting interventions in real time based on feedback</p> <p>Evaluations need to be grounded in clients’ perception of effectiveness, including perceived gains in wellbeing</p> <p>Enable client autonomy and progress that can be maintained long-term</p> <p>Flexibility in crafting interventions</p> <p>Openness to adapt approaches and tools as relevant to clients</p> <p>Take a wider view of mental distress that encompasses the whole person</p> <p>Provide a range of therapeutic options that are whole-person focused</p> <p>Processes to critically evaluate Western paradigms’ limitations and impact on practice</p> <p>Offer alternatives to biomedical models and approaches</p> <p>Act to mitigate limitations of diagnostic systems</p> <p>Offer an array of approaches and options to supplement interventions</p>

	Interventions responding to the needs of the client Limitations of diagnostic systems (Diversity, general scope)	
1.2 Prioritising the Person	Assessment and intervention planning are collaborative Application of Te Tiriti principles of partnership, participation, and protection Non-prejudicial and affirming stance Understand process and manage process issues (Intervention; clinical scope) Strive for best practice through “confirmation or challenge”	See clients as people first and foremost rather than focusing on pathology or problems Convey the client is the most important person throughout assessment and intervention processes Transparency is essential throughout assessment and intervention processes Seek ongoing feedback from service users to identify process issues Confirmation or challenge by service users specifically
1.3 Understanding Context and How to Assist	Knowledge of contextual variables that influence framing and intervention Collect relevant data including clients’ interpretations of situations Listen actively to understand different perspectives Adapt approaches and communication in response to “audience and circumstances” Consultation delivered in a way others can understand Interpretation within a relevant conceptual framework Recognise the subjective nature of interpretation of data and subjective realities Understand information from other professionals that impact assessment Exploration of assumptions regarding cultural differences, such as differences in beliefs, practices, and behaviours (Diversity) “Knowledge of psychopathology, serious mental illness and the relationships with diagnostic classification systems” (Discipline, clinical scope) and “effective use of psychiatric nosologies”	Better integration of clients’ experiences and perspectives into assessment and formulation to better respond to their needs Normalise responses to traumatic events and other contextual variables Service users are the key audience for adapted approaches Conceptual frameworks are relevant to clients Identify limits of collateral data such as other clinicians’ impressions, how notes have been written, and how clients are conceptualised by others Acknowledge the divide and associated discrepancies between “well and unwell” when conceptualising a client’s distress Knowledge of the negative effects of framing and labelling experiences based on biomedical models Provide differential diagnoses that are specific, informative, and helpful for clients Explore previous diagnostic and therapeutic experiences and the impact these have had - including how they may affect intervention

2. Ensuring Safe Practices

2.1 Seeking Feedback and Updating Practice	<p>Practice that is responsive to new knowledge Working to “best practice” that can be ascertained by confirmation or challenge (Discipline, clinical scope) Undertaking professional development Ability to evaluate services Acknowledge the need for professional development Ability to identify areas for development (Reflective Practice) Seek external review of practice. The core competencies specify supervision Communication of outcomes Understand therapeutic relationship “process” and effects on intervention, identify strengths and limitations during intervention (Intervention, clinical scope) Supervision is a space where competence can be monitored and enhanced Implement and evaluate professional development plans based on critical self-reflection and critical feedback</p>	<p>Incorporate service user views as acceptable “knowledge” and evidence in psychological practice Contribute to ongoing development to how competence is understood and conceptualised Acknowledge the power of psychology as a profession to hold an “us and them” divide between service providers and service users Anti-stigma training is necessary for professional development Competence extends to the consistent provision of services Evaluate competence by seeking and integrating service user feedback Evaluation should include the effects of a lack of competence for a client, for example, with process and boundary issues Seek external review of practice via client feedback Recognise limits of supervision and profession-guided evaluations of competence Critical feedback can come from clients Collect client feedback regarding competence regularly and consistently Acknowledge that reliance on self-reflection and supervision for monitoring and developing competence comes from a “well” perspective that does not completely capture how a client may evaluate competence. This leads to gaps in understanding how competent a psychologist may be, further amplifying an “us and them” trajectory that may provide barriers to the monitoring and development of competence</p>
2.2 Adequate Training, Knowledge, and Experience	<p>Demonstrating knowledge of best practice for the CPs area of practice Being aware of the range of clients a particular psychologist is likely to see (Professional, Legal and Ethical Practice)</p>	<p>Experience in a range of areas Value listening and observing real people Ability to usefully apply life experiences to balance theory with experience Acknowledge that theory overriding experience can create unhelpful professional practices Life experience and lived experience of mental distress are strengths that enhance authentic connection and shared humanity Honest and accessible information about registration, training, and experience</p>
2.3 Quality Assurance and Professional Conduct	<p>Collaboration in planning and decision-making at the systems level, strategies to promote development and change in systems, effective seeking of consultation (Professional and Community Relations) Demonstrate competence in terms of knowledge and application of Te Tiriti o Waitangi, relevant legislation, and ethical codes.</p>	<p>Accurate notes and reports that make sense and provide helpful suggestions Consistent competence across services and across different presentations of mental distress Make clients aware of the core competencies Maintain negotiated CP roles consistently A CPs wellbeing is a potential occupational risk factor</p>

	<p>Ability to evaluate the efficacy and safety of approaches and practice in accordance with scope-specific knowledge</p> <p>Demonstrate knowledge of the rights and interests of clients, including the application of Te Tiriti principles of partnership, participation and protection</p> <p>Clarify roles and responsibilities, outline the nature of services, discuss input in certain situations, and negotiate and clarify psychologist involvement</p> <p>Maintain safe and supportive environments,</p> <p>Recognise ethical features and conflicts</p> <p>Apply ethical decision making</p> <p>Understand boundaries and the limits of competence</p> <p>Ability to identify biases</p> <p>Identify potential occupational risk factors</p> <p>Effective self-care</p> <p>Maintain safe and supportive environments</p>	<p>Awareness of more than personal characteristics, such as life circumstances, physical illness, times it may not be suitable to see a particular client, and triggers, and how these impact professional activities</p> <p>Identify CP and relational factors that influence intervention and thus need to be incorporated into intervention planning and implementation. Psychologist and relational factors include quality and consistency of the therapeutic alliance, management of ruptures and repairs, boundary breaches and transgressions, inappropriate understanding, damaging comments, and a focus outside the client's needs</p> <p>Appropriate communication about cancellations, out-of-session contact, and termination of services</p> <p>Potential factors influencing safe practices in the Board competencies focus on the deficit of clients rather than CP and therapeutic alliance factors, such as boundary transgressions</p>
3. Relationship Building		
3.1 Authentic Connection	<p>Work respectfully (Diversity, clinical and general scopes)</p> <p>Attitudes of respect underpin all intervention activities (Intervention, clinical scope)</p> <p>Willingness to learn and share knowledge (Intervention, clinical scope)</p> <p>Identify positive aspects of the environment during assessment (Framing, general scope)</p> <p>Knowledge of methods for effective working relationships (Professional and Community Relations)</p> <p>Ability to establish rapport (Cultural Competencies)</p> <p>Understanding "process" in the therapeutic relationship and effect on intervention (Intervention, clinical scope)</p> <p>Knowledge of and exploring issues of diversity and individual differences and incorporating difference as "issues" into treatment (intervention) planning (cultural competencies, Diversity general scope)</p> <p>Affirming and non-prejudicial stance, actively include others' understandings (Diversity, general scope) and knowledge of</p>	<p>Prioritise identifying positive aspects of a person</p> <p>Acknowledge the importance of shared humanity</p> <p>Appropriate opening up of personal experiences in a boundaried, brief, non-specific, and relevant way</p> <p>Emphasise the importance of the therapeutic alliance and processes such as rupture and repair</p> <p>Move from knowledge to the ability to establish helpful working relationships and genuine connection</p> <p>Friendliness, openness and honesty are important for authentic connection</p> <p>Move from understanding to ability to work with therapeutic processes to strengthen the alliance and navigate power differentials</p> <p>Display human and authentic aspects of self and confidence to show a CP is a real, unique person</p> <p>Managing personal characteristics to the degree where a psychologist may not come across as an authentic person may create barriers to authenticity and humanness</p> <p>Differences between client and CP are strengths in the therapeutic relationship and intervention processes. For example, modelling that it is acceptable to be different lowers stress and intimidation</p>

	<p>the interests of clients (Professional, Legal and Ethical Practice)</p> <p>Convey empathy in culturally sensitive ways (cultural competencies)</p>	<p>CP presence that is kind, with ‘being yourself’ balanced with professionalism helps establish rapport across cultures</p> <p>Being non-judgemental and conveying compassion for clients leads to validation, which is the foundation for safe and supportive environments</p> <p>Understanding that empathy bridges gaps between CPs experiences, opinions, and world views and those of clients, enabling validation and a better understanding of clients’ needs</p> <p>Conveying empathy is crucial for all client and CP interactions</p> <p>Identify client burden as a factor that impacts positive change</p>
3.2 Self-Awareness	<p>Continuous critical self-reflection</p> <p>Manage how personal characteristics impact professional activities</p> <p>Understand subjective realities and how these affect practice, (Diversity, general and clinical scopes)</p> <p>Accurate self-assessment</p> <p>Understanding and evaluating strengths, weaknesses, and limitations</p> <p>Understanding patterns of behaviour, emotional and cognitive biases, motivation, beliefs and values and how these impact clients and professional practice</p> <p>Managing the impact of personal characteristics (Reflective Practice)</p> <p>Accurate reflection and evaluation of practice including bias (Reflective practice)</p>	<p>Open and honest reflection of limits within the therapeutic relationship</p> <p>Awareness of appropriate use of own experiences and effects on clients- such as placing burden and making assumptions</p> <p>Using reflective practice openly and honestly within the CP-client dyad- such as being open about motivation, values and limitations, and how these may affect clients</p> <p>Utilise self-check-ins, reflect on values and motivation, regular supervision</p> <p>Ability to reflect openly and honestly about limitations and self-care needs</p> <p>External review of self-awareness can be sought from service users</p> <p>Reflection and evaluation of therapeutic presence</p> <p>Enable trust, attune to clients’ needs, accept clients’ perspectives and preferences</p> <p>Validate client’s experiences</p> <p>Identify and mitigate client burden</p>
3.3 Attentiveness and Perceptiveness	<p>Consider and include client’s interpretations of situations (Framing, general scope)</p> <p>Knowledge of communication skills, a high standard of interviewing, and effective communication (communication)</p>	<p>Astuteness and perceptiveness contribute to ability to notice client’s experiences, processes within the therapeutic relationship, and how to respond</p> <p>Accurately perceiving and paying attention to what is going on for a client is the foundation for supporting change</p> <p>Participants emphasise understanding and tuning into clients rather than using psychological theory as the basis for all CP activities</p> <p>Non-verbal communication includes attunement and paying attention</p>
4. Attention to Stigma, Discrimination, Exclusion, and Power		
4.1 Mental Health-Related	<p>Recognising, understanding, and managing stigma and discrimination includes recognising cultural factors that</p>	<p>The effect of SDE specifically related to mental health presentations includes diagnosis-related stigma</p>

<p>Stigma and Discrimination</p>	<p>influence health and presentation of mental distress and response to intervention, and understanding and responding to issues regarding stigma, discrimination and social exclusion in practice</p> <p>Work from a non-prejudicial and affirming stance, explore assumptions of self and others' cultural differences</p> <p>Alleviate distress associated with SDE (Diversity)</p> <p>Understand the consequences of SDE in psychological practice (Diversity, clinical scope)</p> <p>Preserve the dignity of people. Unsafe cultural practice: any which disempowers, diminishes or demeans the well-being and "cultural identity" of any individual, family or group (cultural competencies)</p> <p>In the Board competencies power is discussed in terms of cultural safety: provide SUs service with the power to comment on practices and contribute to change negatively experienced services (Cultural Competencies)</p> <p>Cultural competencies refer to "disability" as an element of culture</p> <p>Cultural competence refers to a psychologist as a "culture bearer" and recognition of historical, political, and social influences on well-being to foster relationships and commitment to modify practice in response</p> <p>Knowledge of oppression and discrimination of an individual and their psychological sequelae</p> <p>Knowledge of socio-political influences includes stigma and stereotyping (cultural competencies), and acknowledgement that these mechanisms affect manifestations of mental distress</p> <p>Integrate SDE concepts in assessment and treatment (Intervention, clinical scope)</p> <p>Recognition of factors that influence health, impact intervention planning, impact response to intervention, and culturally safe assessments, though the Board competencies specify these factors as cognitive ability and personality factors</p>	<p>Recognise mental health-related stigma as a cultural factor that influences health and response to intervention</p> <p>Explore implicit assumptions about mental distress</p> <p>Participants specified that mitigation of SDEP pertains to all areas of competence, whereas, in the Board competencies, reference to SDE are predominately in the Diversity and cultural competencies areas</p> <p>Counteract effects of SDEP within wider care systems and services, not just within psychologist-client interactions</p> <p>Not diminishing, demeaning and disempowering individuals or groups due to mental distress</p> <p>The Board competencies imply that the onus is on clients to comment on practices</p> <p>The Board competencies do not highlight the responsibility of CPs to identify and re-balance power differentials</p> <p>Unclear whether experiences of mental distress are considered a "disability" or an element of culture in the Board competencies</p> <p>Knowledge of the impacts of stigma and stereotyping on service provision and care is not a competency in the core competencies</p> <p>Attending to and acting to mitigate stigma and discrimination is not made explicit in the assessment, formulation and intervention core competencies</p> <p>Knowledge of service user theories, such as regarding mental health-related stigma</p> <p>Findings are more explicit about not labelling, making assumptions, and stereotyping due to sorting a person into a diagnostic classification</p> <p>Acknowledge potential transmission of assumptions due to mental health-related stigma and diagnosis-related stigma</p> <p>Impacting factors across assessment and intervention activities include SDEP</p> <p>SDEP variables influence the therapeutic relationship and thus should be included in intervention strategies</p>
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	<p>Knowledge and identification of contextual variables that influence a therapeutic relationship and inclusion of these in intervention strategies</p> <p>Understanding therapeutic relationship “processes” and identifying and managing process issues</p>	
4.2 Power Differentials and Inequality	<p>Awareness and knowledge of own cultural identity, practices and values (Diversity, general and clinical scopes)</p> <p>Awareness and understanding the cultural identity of clients</p> <p>Understand limitations of CP models, cultural foundations and techniques from Western traditions, and knowledge of cultural influences for clients (clinical scope)</p> <p>Identify Te Tiriti principles of partnership, protection and participation, and how these impact practice (Cultural Competencies, Diversity, general scope)</p> <p>Understand the role of a psychologist in relation to other stakeholders, consulting effectively, and promoting psychological perspectives in team settings (Professional and Community Relations)</p> <p>Knowledge of the rights of clients and advocacy for client’s needs, knowledge of boundaries of personal competence, and recognition of ethical features and conflicts (Professional, Legal and Ethical)</p> <p>Create and maintaining effective, supportive and safe environments</p> <p>Consult with culturally knowledgeable people</p> <p>Identify biases, beliefs and values and how these impact clients, identify areas of professional development, accurate reflection of own practice- including bias, and knowledge of the need for professional development (Reflective Practice)</p>	<p>Power is considered a process issue which needs to be identified and mitigated for a CP to be considered competent</p> <p>Recognise and mitigate power imbalances between professionals and clients, by recognising a psychologist’s position as a “professional”, an “expert” or a “well” person.</p> <p>Understand the effects of the positions of both CP and client regarding power and implications for all aspects of service provision and use</p> <p>Equality and autonomy are not made explicit in the Board competencies</p> <p>An “egalitarian relationship” is referenced (Professional and Community Relations) in terms of consultant (CP) and consultee, rather than an egalitarian relationship between client and CP</p> <p>CPs are ideally situated to mitigate SDEP between clients and professionals</p> <p>Advocacy involves working to minimise the impacts of SDEP</p> <p>Acknowledgement of CP power is not present in the competencies, and attention to, and mitigation of inequality is seldomly mentioned</p> <p>See and value clients as equals, uphold their contributions as equivalent to those of CPs</p> <p>Understand how SDEP impact clients’ positions in service interactions, thereby affecting current and future mental health care</p> <p>Understand internalised stigma as a result of a lack of power and equality</p> <p>Acknowledge that psychologists can reinforce stigmatising assumptions and attitudes of other professionals</p> <p>Consultation specifically with SUs</p> <p>Training to support lived experience perspectives and better understand and mitigate SDEP</p> <p>Ongoing attention to implicit bias and SDEP education to increase the ability to self-reflect in this area</p> <p>Attend to systemic consequences for clients when SDEP influence their care</p>
5. Responsive Care Beyond the Individual		
5.1 Advocacy	Effectively advocate for clients’ needs	The Professional and Legal core competencies state advocacy is balanced with considering safety issues and wider community needs. This implies that advocacy

	<p>Understand the role of the psychologist in relation to other stakeholders Knowledge of systems being worked with and how to work with them</p>	<p>for a client competes with the needs of communities and safety, while findings highlight that advocacy for clients improves wider mental health systems (and therefore communities) through improved access to services, more effective care, less suicidality (and therefore risk), and supports that last beyond service use Advocate for and address access and continuity issues as well as wider supports for clients Advocate for clients when navigating systemic barriers Maintaining safe, supportive and effective systems (as well as environments)</p>
5.2 Wider Supports	<p>Maintain supportive, safe and effective environments Identify management and process issues Practice in adherence to ethical codes Identify ethical features, values and conflicts Apply ethical decision-making to ethically complex situations Do no harm Develop solutions based on context (Framing, general scope), build on environmental supports Promote capability to support meaningful and sustainable change (Intervention, general scope) “Broadminded approach” with the willingness to learn and share knowledge Intervention strategies can be system-based (Intervention, clinical scope) Communicate information about psychological services to clients Convey contributions of psychology to the community at large (Professional and Community Relations)</p>	<p>Facilitate access to services, reliable and continuous access to psychologists Initiation of wider supports Systemic barriers such as inadequate service provision affect intervention, though systemic factors are not identified in the Board competencies as framing, intervention, or evaluation targets Advocate for clients and navigate ineffective service provision providing accountability to services Responsibility to respond and follow-up when service user needs are not met Knowledge that inconsistent access and continuity of services create ethical issues a CP is situated within Systemic issues identified by participants contrast with “doing no harm” Awareness and mitigation of issues related to termination, cancellation, and discontinuation of psychological services Contribute to better mental health systems Facilitate growth of the psychology profession Facilitate access to psychologists Follow-up of psychologist recommendations and advocacy to navigate system failures Consider systemic barriers and systems that create barriers, and implement ways to navigate these Identify systemic failure, for example, lack of access to psychology and/or mental health services, as contributing to significant risk including death by suicide In the Board competencies, risk is alluded to as pertaining to an individual, with risk factors such as systems failures not made explicit Facilitate systemic capability to support people experiencing mental distress, for example, enhance connection, develop systems and environments that provide opportunities for continued alleviation of mental distress after psychology input (e.g., peer support, service user organisations)</p>

		<p>Knowledge and provision of options of other supports and resources that may be of assistance to a client</p> <p>Knowledge and facilitation of potential long-term wider supports for clients beyond psychological intervention</p> <p>Knowledge of paradigms for long-term support after intervention, e.g., peer support and trauma-informed approaches</p> <p>Knowledge of the strengths of wraparound services for Sus</p> <p>Prevention work in community settings is not referred to in the Board competencies pertaining to CPs</p>
6. Cultural Responsivity		
6.1 Māoritanga	<p>Unsafe cultural practice is any action that diminishes, demeans or disempowers cultural identity and well-being (cultural competencies)</p> <p>Awareness of own cultural identity and values (Diversity, clinical scope)</p> <p>Awareness of how own culture, gender, class, ethnic identity, sexual orientation, organisational affiliation, practice orientation, and “disability” (ability) shapes values, assumptions, judgements and biases (cultural competencies)</p> <p>Psychology practice in Aotearoa involves dual paradigms and worldviews that reflect Māori and non-Māori as partners to Te Tiriti, recognition of the centrality of Te Tiriti, and preserving the dignity of people</p> <p>Treaty relationships between ethnically and culturally diverse people are recognised as central to competent and ethical practice</p> <p>Knowledge of the principles of Te Tiriti: partnership, protection, and participation, and inclusion of these in professional practice</p> <p>Te Tiriti Principles include recognising and providing for Māori interests, responding to the needs of Māori and ensuring equal opportunities for Māori (cultural competencies)</p> <p>Awareness of applicability of other therapy models (Discipline Knowledge, clinical scope), and incorporation of</p>	<p>Attend to cultural differences and context</p> <p>Work flexibly and transparently with clients that are culturally diverse</p> <p>In the core competencies the cultural competencies are not required as a minimum for competence, whereas participants reported that cultural competence and cultural safety are crucial for all CP activities</p> <p>Learn about and seek to understand colonisation, acculturation, and racism and how these apply to Māori in Aotearoa</p> <p>Awareness of racism specifically in the context of mental health</p> <p>Understand that not all Māori are the same due to the intergenerational effects of acculturation</p> <p>Identify and mitigate tokenism, e.g., assuming one Māori person represents all Māori and expecting Māori to lead Māori processes in non-Māori settings</p> <p>Non-Māori psychologists seek to learn about and incorporate Te Ao Māori in professional practices</p> <p>Implement alternatives to Western paradigms and approaches</p> <p>Implement alternatives to biomedical approaches</p> <p>Honour Māori processes and protocols</p> <p>Integrate cultural and spiritual connectedness (The four examples above also pertain to assessment and intervention)</p> <p>Understand that biomedical, individualistic frameworks are ineffective and assume a “one size fits all” approach to mental health care</p> <p>Psychology can enable connection through cultures which mitigate oppression, prejudice and discrimination</p> <p>Participant views highlight action and intervention (rather than knowledge) to assist with disempowering factors and disconnection</p>

	<p>Māori models, protocols and practices (Diversity, clinical scope)</p> <p>Understand the cultural foundation of psychology, limitations of techniques from Western world traditions, and limitations of CP models (Diversity, clinical scope)</p> <p>Knowledge of how psychological approaches, methods and practices are historically and culturally embedded (cultural competencies)</p> <p>Recognise and actively support Kaupapa Māori (cultural competencies) aligned in part with participant views that support retention of Māori customs, processes, and wellbeing paradigms such as Te Whare Tapa Whā.</p> <p>Knowledge of the history and manifestation of oppression, prejudice and discrimination in Aotearoa, on lives of clients and relating to psychological sequelae (Cultural Competencies)</p> <p>Socio-political influences are noted in the core competencies as stereotyping, stigmatisation, land and language loss and marginalisation, aligning with participant views</p> <p>Understand how SDE applies to different client groups and consequences of these in psychology practice (Diversity)</p> <p>Awareness of the needs and health status of Māori</p>	<p>Participant views expand on SDEP, noting power through assumptions of superiority, racism, tokenism, and intergenerational loss</p> <p>Acknowledge and respond to the loss of cultural norms and customs that can be regained through intervention</p> <p>Understanding and valuing that connection through culture assists in healing</p> <p>External review should include seeking client and Whānau feedback about whether cultural needs have been understood and incorporated helpfully</p> <p>Knowledge that silencing of clients and ineffective interventions can be due to cultural needs not being met</p> <p>Accurate reflection and evaluation of one’s practice is unlikely as a psychologist holds different positioning and power to clients and clients of diverse cultures - therefore service user feedback should be actively sought, including in the area of cultural responsiveness</p>
6.2 Gender, Sexuality, Spirituality	<p>Ethical obligation to meet diverse needs of client populations</p> <p>Adapt approaches to respond to audience and context</p> <p>Willingness to learn (Intervention, clinical scope)</p> <p>Knowledge of family structures, gender roles, values, and worldviews that differ among groups (cultural competencies)</p> <p>Integrate relevant presenting and contextual variables in intervention, including variables that may influence intervention (Intervention, clinical scope)</p> <p>Critical and constructive self-reflection, understanding personal weaknesses, biases, beliefs, and values, and their impact on professional functioning and client care (Reflective Practice)</p> <p>Accurate assessment of one’s own cultural competence, know when circumstances negatively influence professional</p>	<p>Ability to identify and correct assumptions, biases, unfair treatment, and discriminatory practices when working with diverse people</p> <p>Appropriate inclusion of other individuals, such as when working with diverse sexualities</p> <p>Learn different ways of working with different cultures</p> <p>Appropriate inclusion of and respect for same-sex partners</p> <p>Intervention is ineffective when cultural diversity, including gender, religion, sexuality, and spirituality, is not integrated into assessment, formulation, and intervention</p> <p>Identify and be open with a client when not comfortable working with a particular culture</p> <p>Competence means being able to target relevant key areas such as sexuality, sex, religion, and gender without being uncomfortable, lacking in confidence, or conveying these subjects as “taboo”</p>

<p>activities and adapt as needed. Circumstances noted include biases, lack of required knowledge and skills, and socio-political influences (cultural competencies)</p> <p>Accurate reflection and evaluation of professional practice, seek external review of practice</p> <p>Though supervision is mentioned for external review, the NZPB competencies do not make explicit that external review about cultural responsiveness can (and should) include client feedback.</p>	<p>Cultural competence is expected and fundamental in areas that include, gender, sexual orientation, and religion. The Board cultural competencies are not expected as a minimum requirement of a psychologist</p> <p>Recognise that it can be challenging for clients to articulate their expectations of cultural competence, thus a psychologist needs to advocate for cultural responsiveness</p> <p>Professional development in areas involving different cultures</p> <p>Identification of cultural competence gaps from service user feedback</p> <p>Integration of service user feedback about whether cultural needs have been met adequately and, if not, how to meet these needs</p> <p>Acknowledge that lack of cultural competence on a systemic-service level is a major risk factor for increased mental distress including suicide, self-harm, disempowerment, lack of access to services and ineffective care</p> <p>Cultural responsiveness should be included when estimating the impact of services</p>
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Appendix H

Research Case Study

Service User Views of Clinical Psychologist Competence: Internship Learnings

Submitted 27.11.2020 to meet internship completion requirements for the Doctor of Clinical Psychology.

Abstract

This report outlines some lessons linked to my doctoral research, Service User Views of Clinical Psychologist Competence, resulting from my internship at Manaaki Kakano (Maternal Infant Mental Health) and He Tupua Waiora (Pregnancy and Parental Services) at Northland District Health Board in Te Tai Tokerau (Whangārei and the Mid North), 2020. Specifically, this case study focuses on one element of my research, stigma and discrimination. A summary of the research project with key informing literature is discussed. Some elements of the project will then be outlined. Reflections of how this related to the mahi (work), whai ora (clients), and my personal and professional development will be shared. Learnings include noticing my own “stigma radar” and when it was activated, navigating stigma and discrimination in the workplace in a way that enabled new understandings, and noticing and moving through my own stigmatising views and assumptions.

Service User Views of Clinical Psychologist Competence

Overview

Both overseas and in New Zealand there is growing acknowledgement of the importance of service user/tangata whai ora voice regarding policy, planning, and implementation of mental health services. Despite this acknowledgement, service users are often not included in the development, provision and evaluation of most mental health services, including psychological services. One example of this is within the development of clinical psychologist core competencies, one of two main governing standards for professional psychologists. The competencies were developed by the New Zealand Psychologists Board (NZPB) without the purposeful involvement of service users/tangata whai ora. Examining service user views of what psychologist competence is made of is a way to both explore service user inclusion in psychological services and consider how service user views may inform professional practice.

In general, there is a lack of research regarding service user evaluations and perceptions of clinical psychologist competence, leading to unclear understandings of whether existing competencies align with the needs and perspectives of those who have used psychological services. It has been considered that barriers to service user engagement in understandings of professional practice may be enhanced by the absence of research that acknowledges service user views. In this study, a social constructionist orientation informs a mixed methods online survey and individual interviews to explore service user views of what their views and preferences for clinical psychologist competence may consist of. The unique positions of tangata whai ora/service users allow their contributions to inform and strengthen psychological practice. This study aims to enhance understandings of clinical psychologist competence with an aspiration to strengthen professional practice and training through regulation for clinical psychology in Aotearoa.

A Focus on Stigma and Discrimination in Terms of Clinical Psychologist Competence

Most research regarding service user views of competence focuses on cultural competence specifically, which means there is a gap in research and understandings of professional competence in

a wider sense. Limited and dated studies focusing on cultural competence have considered tangata whai ora/service user perceptions of competence. Wright and Davis (1994) found that service user perceptions of therapist characteristics, not therapist behaviours themselves, predicted outcomes. Among perceptions of therapist characteristics, they found that clients wanted to perceive their therapists as 'competent'. Horvath (2006) suggested the client's evaluation of the outcome of therapy, and not the therapist's, may be more important in evaluating the success of therapy. Also, a client's negative experience with a therapist can lead to negative attitudes toward therapy (Lee et al., 2006). Clients' ratings of their therapist's multicultural competence were found to relate to perceptions of the therapist's empathy, the quality of the working alliance, and satisfaction with therapy (Fuertes et al., 2006). Further, if a client perceived their therapist as culturally competent, this led to a feeling of relief and greater confidence in the therapist's ability to help (Gushue et al., 2008). When Gushe et al. (2008) summarised service user perspectives of incompetence they found that service users most disliked: lack of clarity about what therapy entails, discrimination, and microaggressions through direct or indirect messages of discomfort or approval.

Stigma and discrimination, therefore, are important to consider as elements of clinical psychologist competence. Mental health-related stigma is a broad term that includes stigma (negative beliefs about those with lived experience), discrimination (denial of the fair or legal rights of people with lived experience), and internalised stigma (negative stereotypes about people with lived experience which individuals apply to themselves) (Corrigan et al., 2014). Both external stigma experiences and internalised stigma influence service user engagement and outcomes (Hack et al., 2019). There is some focus on stigma and discrimination in professional standards in both the Code and the Core Competencies for psychology in Aotearoa, however, these understandings rely on clinician self-reflection and peer review. While useful, this may limit current understandings, as mental health related stigma and discrimination is unable to be comprehensively evaluated by those not experiencing it. This is likely to be an area of competence that service users can contribute new understandings to.

In the Code of Ethics for Psychologists Working in Aotearoa, under Principle 1: Respect for the Dignity of Persons and Peoples, 1.2 Discrimination is included as a sub-category. This requires psychologists to “recognise that all persons and peoples are entitled to equal benefits from the contributions of psychology” (NZPB, 2008, p. 5). Regarding practice, these requirements include that psychologists seek to prevent or correct practices that are discriminatory; recognise that decisions based on service allocation and delivery must not be made on capricious or discriminatory grounds; and avoid or refuse to partake in practices that are disrespectful or discriminatory of the cultural, legal, civil, or moral rights of others. There is no mention of stigma specifically within this document.

The NZPB Core Competences highlight stigma and discrimination in Part 1: Psychologist Scope within the skill section. This requires the “alleviation of distress associated with stigma, discrimination and social exclusion (based upon ethnicity, gender, sexual orientation, disability, or religious beliefs)” (NZPB 2018, p. 5). Stigma and discrimination are also in Part 3: Clinical Psychologist scope within the knowledge and skills sections of Diversity, Culture and Treaty of Waitangi. This requires a clinical psychologist to have an adequate “understanding of the concepts of stigma, discrimination and social exclusion as applied to diverse client groups, including the consequences of these factors in the practice of psychology” and “integration of the concepts of stigma, discrimination and social exclusion into assessment and treatment processes” (NZPB, 2018, p. 20). Under Part 2: Cultural Competencies, registered psychologists are required to have knowledge of “socio-political influences (e.g., poverty, stereotyping, stigmatisation, land and language loss, and marginalisation) that impinge on the lives of identified groups (e.g., identity formation, developmental outcomes, and manifestations of mental illness) and knowledge of “the history and manifestation of oppression, prejudice, and discrimination in home country, and that of the client and their psychological sequelae” (NZPB, 2018, p. 16).

The traditional and historical widespread presence of stigma and discrimination for those with lived experience has been acknowledged (e.g., Mental Health Foundation, 2004), as well as the impact on client outcomes, engagement with services, and barriers to service user inclusion in

professional regulation and evaluation of services they experience. For example, direct outcomes of stigma and discrimination include prejudice, loss of dignity, loss of basic human rights, loss of participation in the community, work and education settings, loss of self-esteem, loss of belief in recovery, reduced help-seeking, more difficulties maintaining wellness, and less support from others (Mental Health Commission 1998a, 1998b; Mental Health Foundation, 2004; Ministry of Health, 2007; O'Hagan, 2001; Peterson et al., 2008).

Though not specifically focused on psychology, *Respect Costs Nothing* (Mental Health Foundation, 2004) was the first survey in Aotearoa that asked service users about experiences of mental health-related discrimination. Of the 785 respondents, 84% reported experiences with discrimination across all life domains, including employment, housing, friends, family and community. The report noted that discrimination carried long-term effects and impacts, and fear of discrimination (often based on past experiences) was reported to be as debilitating as direct experience (Mental Health Foundation, 2004). Nearly 50% of respondents reported withdrawing from participation in areas including work, education and training, relationships and families, sports and recreation, and mental health services due to fear of discrimination. The report highlighted that many service users experience stigma and discrimination from mental health services (Mental Health Foundation, 2004), a notion also recognised in other research (e.g., Peterson et al, 2008). This was experienced in ways that included disrespect, not being taken seriously, being talked about rather than talked to, being degraded, being put down, being ridiculed or discouraged, and being treated as incompetent (Mental Health Foundation, 2004). The report also highlighted that mental health professionals can reduce discrimination by being aware of personal stigmatising and discriminating attitudes, engaging in education to replace myths and assumptions about mental distress and service users, challenging discriminatory attitudes and behaviour in interactions with service users, and taking action to challenge discriminatory attitudes and behaviours (Mental Health Foundation 2004; Case Consulting, 2005).

In terms of engagement with psychological services and professionals, other findings report that mental health-related discrimination and stigma negatively impact help-seeking behaviours and initial access to mental health care (Clement, Schauman, et al., 2015). For example, among adults with presentations classed as “severe”, stigma and discrimination were significantly associated with lower treatment initiation, engagement, and attendance (Hack et al., 2019). In community settings in the United Kingdom, mental health discrimination experiences also impacted client’s engagement, through mistrust of services and professionals (Clement, Williams, et al., 2015). Among adults with schizophrenia spectrum and affective presentations in outpatient services in the United States, low perceived discrimination was related to higher attendance of psychotherapy sessions over a 6-month follow-up period (Rüsch et al., 2009). Among a sample of adults with schizophrenia presentations in outpatient settings in Hong Kong, less internalised stigma was associated with higher attendance, and more agreement with professional recommendations (Tsang et al., 2010). These few studies’ small samples, varied settings, and limited findings clarified that further investigation of ways in which stigma and discrimination experiences and internalised stigma impact treatment engagement and therapeutic relationships are needed. The presence and interactions of discrimination and stigma are considered to be understudied within mental health research (Clement, Williams, et al., 2015; Hack, et al., 2019). This is a major argument against relying on direct feedback or evaluation of competence without the input of service user views. Therefore, research that allows service user perceptions of stigma and discrimination to emerge is useful.

Purpose

I sought to explore service user views of clinical psychologist competence and consider how they may relate to the existing Core Competencies for the Practice of Psychology in Aotearoa New Zealand. The research questions are:

1. What do service users identify as competent practice for clinical psychologists?
2. How do service user views of clinical psychologist competence align or contrast with existing aspects of the NZPB Core Competencies?

Method

Methodology

This project holds the epistemological view that the phenomena of the social world and their meanings are not objective but created and shaped through human social interaction (Burr, 2015; 2019). This position considers that there are multiple views of reality, that what one group may view to be “real” may differ from another, and that dominant understandings of ‘reality’ can shift (Burr, 2015). Therefore, ontological questions that seek one “truth” cannot be answered within this paradigm, given that meaning does not exist but is created (Burr, 2019). This suggests that service users are active agents in constructing views of competence with the psychologists they have seen.

Given a social constructionist epistemology, meanings of competence depend on who experiences and perceives it. Competence is a product of the social realm individuals exist in, with common professional understandings traditionally formed and built upon by clinical psychologists. In this way, professional policies and procedures of psychology have omitted a group of “knowers” (service users) who have knowledge of competence through their experiences and perceptions. In this study, competence is seen as a structural issue shaped through changes in social processes that may evolve understandings of competence. This study acknowledges competence as an evolving product of the social realm and aspires to shift the focus to those who have used clinical psychology services. The service user realms explored in this project are two-fold, as this study explores a) views based on experiences that draw on the therapy room sitting opposite a clinical psychologist; and b) preferences of those situated in a position to provide insight into the practice of psychology.

Data Collection Process: Survey

A mixed methods anonymous online survey explored service user views of clinical psychologist competence. The survey items were created based on the Core Competencies for the Practice of Psychology in Aotearoa New Zealand (NZPB, 2018). The survey was piloted with four service users. Content analysis will explore qualitative data and quantitative data will be summarised using IBM SPSS Statistics 25 (IBM, 2017).

Data Collection Process: Interviews

Interviews were of one-hour duration. Four were held face-to-face and four were online. The interviews followed a semi-structured format that was based on the survey items and views of clinical psychologist competence in the nine key competency areas. The data from these interviews is currently undergoing thematic analysis.

Participants and Recruitment

Participants were people aged 18 and over that had seen at least one clinical psychologist for mental health support in New Zealand. Recruitment was through New Zealand mental health and service user organisations. Recruitment organisations advertised the survey and interviews online during a six-week period. The final sample included 73 fully completed surveys and 12 interviews.

Ethics

Ethics approval was granted by the Massey University Human Ethics Committee: Southern A, Application 19/63.

Preliminary Findings

Data analysis has not yet been completed. However, one major emergent finding is that perceived stigma and discrimination affects how competent service users view a clinical psychologist to be. Further, experiences of stigma and discrimination from other mental health professionals makes it more likely a clinical psychologist will then be perceived as less competent. The implications of this will be discussed in the final thesis, though these can be considered within my development as an intern psychologist.

Intern Psychologist Considerations of Stigma and Discrimination

The development of my doctoral thesis and my experiences as a new intern psychologist caused me to reflect on my own understanding of clinical psychologist competence throughout the year. One of my key learnings during the internship was that I had developed a view of what clinical psychologists “should” and “should not” be. This was developed during the course of my doctoral research and long before in my honours project that investigated access to talking therapies for low mood in primary care. Even before that, my views were formed when I became interested in mental health through my own adversities growing up and through the stories shared with me of so many others’ journeys of mental health challenges. Actually practising as an intern psychologist added many more dimensions to these understandings.

One difficulty for me was to re-frame my views and be more compassionate regarding my own expectations of myself as a clinician. Careful, kind and wise guidance from my supervisor helped me remain critical of my practice while also realising that trying to be perfect, accurate and always right was an unattainable goal. I realised that this moved me away from why I was so passionate about being a psychologist, to walk alongside, understand and serve others in pain and disempowered spaces. This also helped me to recognise my own reactions to my team members at times. For example, the frustration and, at times, anger when a client had not received services that were evidence-based, responsive, and ultimately helpful. Underlying my responses of frustration was actually fear- for clients who may not be provided with the best possible services, and the outcomes and costs this would hold for them, for us who work in mental health, and for our communities.

One salient moment was being told a formulation and psychology input was not needed for a client perceived as experiencing first-episode psychosis. This led to disbelief and a sense of confusion. It felt like we were driving the client to somewhere they had never been before, with no knowledge of why we were going there and no road map to get there. The decision of the team to endorse that psychology was not needed felt like the client would become endlessly lost on this unknown road. I continue to wonder whether other clinicians’ own assumptions and perhaps unconscious stigma

about this client and what they were experiencing had created barriers to working as a team to consider best practice. I also became very aware of different scopes of practice for different disciplines. This made me thankful for the responsiveness and hope that psychology holds. It also led me to consider the strengths of other disciplines and how they may be helpful as I work in the mental health system.

Reflecting on competence, working during COVID-19 meant moving to online assessment and intervention. My research experiences helped with this as I had recently conducted video interviews. I had already thought through and learnt awareness of how to protect an individual's safety, dignity and privacy. This was helpful during lockdown when I could apply the same principles to my work with clients. This enabled me to have client contact and continue therapeutic work through a time when we all needed to be responsive and vulnerable to try new things. My considerations of protection and safety for service users extended to video multidisciplinary team meetings when we worked from our homes. For example, while discussing clients, one of my colleagues had family members in close proximity. I wondered about the appropriateness of discussing clients at their most vulnerable times in front of those not part of our team. This led to the setting up of guidelines for video meetings. I wonder whether this may have been another example of unconscious bias. I consider whether we would be as casual to discuss our own deepest difficulties around those not part of a safe, agreed-upon space.

Reflecting upon discrimination, what struck me during the internship was how significantly note writing affects the lens through which clinicians "see" clients and enforce thinking we already know the client before we have met them. My "stigma radar" became activated when I read sentences that described clients as "childlike", "borderline", "manic", or "intellectually disabled", with no further descriptions, evidence, or diagnostic clarification. I also noticed that clients are very aware of how clinicians may view them. For example, I worked with a client who had been in and out of community mental health services for many years. He had a complex history of trauma and disempowerment and several past diagnoses that included Borderline Personality Disorder, Bipolar

Disorder, Alcohol and Other Drug use (methamphetamine). He was described in notes as “resistant” to the services provided. The first thing he said to me was, “you’ve read my notes; you will know how messed up I am”. I felt deep sadness at his resignation that I, a stranger, had already evaluated and confirmed his “pathology” from reading notes written by other people. I sought to get to know him on his own terms, not through the eyes of another clinician. In the nine months we worked together, he rarely missed a session. He was a diligent and hardworking client, and I was fortunate to be alongside him as he resolved some of his past hurt and pain- some of which were rendered by previous treatment with mental health services.

Regarding discrimination, an influential moment during the internship was during a psychologist’s hui, where local statistics for adults who had engaged in Northland DHB mental health services were shared. The disparities confirmed a stark and sad reality. Within Northland DHB, Māori are less likely to be accepted for services, have less clinician time, are less likely to have the option for psychologist input, and, when they did have psychologist input, would have far less psychologist time. Stigma and discrimination are clearly mechanisms of influence here. I wonder whether this is because we begin categorising clients based on ethnicity since receiving that first piece of paper about them- the referral. The assumptions we may make about what will work for different people based on our own lens appear to be costing those most vulnerable in our communities.

As I progressed through my internship, I attempted to identify my own potential for implicit, unconscious stigma. For example, some clients I assumed were “not as unwell” as others actually held significantly ingrained, inflexible and debilitating core beliefs. One father I worked with initially seemed moderately stressed. When I completed the BDI-II, he was 39 on the scale, which indicated Extremely Severe low mood. On the DASS-21 his Stress level fell in the Mild range. Another time I perceived that a client seemed to enjoy the therapeutic relationship as “something to do”. After a few sessions, she shared that she was considering suicide many times a day and regularly thought about driving her car off a cliff. She was also not leaving her home. Continuing to consider times I potentially stigmatise is of ongoing importance. The assumptions I make are a threat to understanding people on

their terms and a barrier to identifying people's most needed intervention targets, with discriminatory services an inevitable consequence.

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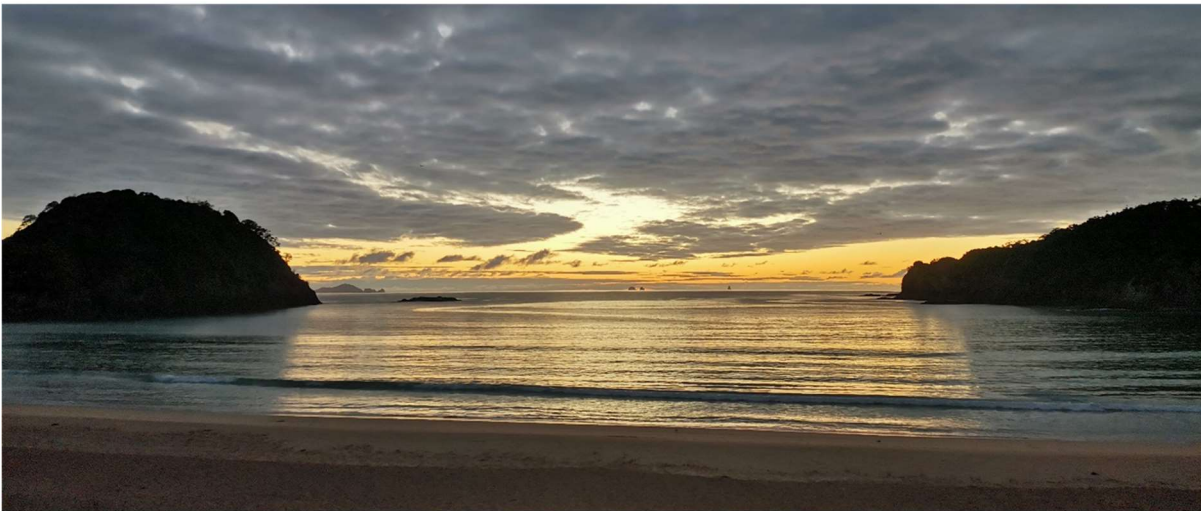
Appendix I

Summary Of Findings

Service User Views of Clinical Psychologist Competence

Summary of Findings

Alice Stevenson, Doctor of Clinical Psychology Thesis; Submitted 2023; Completed 2024



Statement of Purpose

I extend my heartfelt gratitude to all the participants and stakeholders who generously shared their time and knowledge for this study. Thank you very much for participating. Now that the study has been completed, I am getting in touch to provide feedback on the findings.

I also thank the supervision team, Associate Professor Clifford Van Ommen, Associate Professor Joanne Taylor, and Dr Miriam Larsen-Barr, for their guidance and support. This project was approved by the Massey University Human Ethics Committee.

I conducted the Service User Views of Clinical Psychology Competence study as a partial requirement for the Doctor of Clinical Psychology. In offering this summary, I aim to provide a brief overview of some main findings to inform participants, interested service user groups, psychology organisations, and mental health services. This summary is not exhaustive, as it does not cover all aspects of the study, and I encourage any further correspondence.

Background and Methodology

People who engage with mental health services are often not included as stakeholders in the process of developing professional practice guidelines, including clinical psychology core competencies. There is a lack of research about how service users view psychologist competence in Aotearoa and overseas. This leads to a limited understanding of whether existing conceptualisations of competence and competencies align with service user views.

I aimed to inform current theoretical and practical understandings of competence by asking what service users identify as competent practice for clinical psychologists. I then explored how these

views aligned or contrasted with existing aspects of the New Zealand Psychologist's Board (NZPB) core competencies.

I adopted a social constructionist, user-led orientation based on co-production principles. This informed a mixed methods survey ($n = 73$) and individual interviews ($n = 12$). Participants were adults who had seen clinical psychologists in Aotearoa New Zealand for mental health support. Analyses included descriptive statistics for quantitative data, content analysis for the qualitative survey data, and thematic analysis for the qualitative interview data.

Key Findings

I organised the findings into five main areas of competence that participants commented on and provided detailed examples about:

1) Interpersonal Skills and Relational Presence

How clinical psychologists interact and build relationships with clients stood out as an essential area for competence. Interpersonal and relational aspects were reported as important for all clinical psychologist activities and foundational for all competent practices. Relational presence included clinical psychologists being non-judgemental and authentically human. Participants commonly reported that a sense of connection is vital to enable trust. This means demonstrating acceptance, providing empathic interpretations of what clients are experiencing, and communicating an understanding of the client's needs.

2) Responsive Contact

Participants identified clinical psychologist competence in assessment, formulation, differential diagnosis, intervention, outcome measurement, and support outside the therapy room. Imparting relevant and effective tools and skills was reported to demonstrate competence. Participants identified that knowledge and skill in various approaches are crucial. Participants emphasised true collaboration, where the client's view is incorporated at every stage of contact. Participants also highlighted that inviting, enabling, allowing, and responding to client feedback throughout assessment, intervention, and post-intervention are crucial aspects of competent practice. Participants reported that clinical psychologist competence includes adopting holistic and trauma-informed approaches. Competent clinical psychologists were deemed to move beyond situating problems in a deficit-based framework that imposes a biomedical focus.

3) Cultural Responsivity

Participants identified that cultural responsivity, particularly to Māori, is a key aspect of competence. Participants highlighted that competent clinical psychologists are aware of the limitations of an over-reliance on Western knowledge. They reported that competence includes acknowledgement and integration of Te Ao Māori, Mātauranga Māori, and Māori models of well-being. Participants reported that competent clinical psychologists adhere to Te Tiriti o Waitangi principles and attend to the impacts of colonisation in their practice. Participants discussed that competent clinical psychologists acknowledge social and political contexts and combat associated challenges resulting from these broader contexts. Participants reported that competence includes working with diversity in sexuality, gender, and religion. They also emphasised the importance of seeking specific feedback about being culturally competent from service users.

4) Mental Health-Related Stigma, Discrimination, Exclusion, and Power

Participants reported that mental health-related stigma, discrimination, exclusion, and power is an area of competence that is fundamental to all other aspects of clinical psychologist competence. Participants identified that stigma, discrimination, exclusion, and power based on assumptions and biases about mental distress need to be understood as contextual and risk factors that can cause harm if not attended to. Participants highlighted limitations of medicalised frameworks for understanding and supporting mental distress and that mental health-related stigma, discrimination, exclusion, and power are likely to reinforce and maintain unhelpful biomedical approaches. Participants reported that competent clinical psychologists actively counter and create healing spaces from the impacts of stigma, discrimination, exclusion, and power at all process points, including assessment, formulation and intervention. Participants highlighted an “us and them” divide that impacts competence. This divide includes labelling clients as problematic and making assumptions about clients’ lived experiences. This leads to professionals assuming they know best and making decisions for clients that contradict their needs and preferences. Further, participants discussed that competence includes actively mitigating mental health-related stigma, discrimination, exclusion, and power at systemic levels. Participants highlighted the importance of ongoing anti-stigma education and training to maintain competence. The findings in this area likely apply to any psychologist and other mental health professionals.

5) Safe Processes and Profession

Findings about professional, ethical, and legal practice were linked to interpersonal aspects of competence, such as connection, authenticity, and collaboration. Participants reported that valuing biomedical and Western approaches without valuing knowledge and theory of other current service user-valued approaches is problematic. Participants emphasised that competent clinical psychologists seek external feedback (e.g., from service users) about self-awareness. This is of note as implicit and unconscious biases are, by nature, hidden from the person (or people) who hold them. Participants highlighted that competent practice is systemically bound and referred to a competent profession and systems. Participants discussed how clinical psychologist competence can be influenced by personal experience (life, lived, and clinical), training, and professional processes. Participants identified incorporating service user feedback into practice can mitigate some of these issues.

Participant Views and the Current Core Competencies

Aspects of the findings that somewhat align with the existing competencies include reference to professional ethical and legal practice, responsive interventions, and, to a degree, cultural responsiveness. However, the cultural competencies are currently not the minimum requirements expected of any psychologist. Interpersonal and relational aspects were important areas for service users that are not as prevalent in the current competencies. A major finding was attention to mental health-related stigma, discrimination, exclusion, and power. Limited consideration of power is a significant barrier to examining how power differentials impact psychologists, the profession, and service user experiences of service delivery and outcomes. Another aspect requiring attention is systemic competence, which encompasses individual clinical psychologists working with systems to generate change and a competent psychology workforce.

Conclusions and Implications

The findings contribute to contemporary understandings of the current theoretical base about what competence consists of and what the core competencies should be from the perspectives of service users. As service user views of clinical psychologist competence provide rich and specific feedback about

competence in real-life contexts, more emphasis on valuing and integrating processes where service users can inform competent practice is important. This study can assist clinical and other psychologists, and mental health services. For example, it can be developed to inform regulatory and monitoring processes. In the thesis, I provide commentary on each reported aspect of competence, drawing in relevant theory, practical applications, and suggestions for professional practice. A psychology workforce that attends to service user views of competence will be more effective, more supported, and better equipped to understand and respond to people with lived experiences of mental distress.

Future Directions

The full thesis will be available through the Massey University online library or on request. I look forward to writing about and publishing the findings and implications in more depth. I hope for ongoing Korero (conversation) and action to address the implications. The understandings generated in this study have positively impacted my practice, and I wish the same for other clinical psychologists.

Thank you for reading this summary and for participating in the study. Your participation is valued and has contributed to new knowledge. I invite questions, comments, and feedback.

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