

**REPORT OF THE JOINT REVIEW GROUP ON
PSYCHOLOGICAL SERVICES
IN THE HEALTH SERVICES**



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DUBLIN, MARCH 2002

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1 Introduction

In 1995 the Department of Health (now the Department of Health and Children) agreed with IMPACT, the Trade Union which represents the vast majority of psychologists employed in the health services, that there should be a limited review of psychological services in the Irish health service. It was apparent that if service development needs were to be effectively addressed then such a review was essential.

It was agreed that the group carrying out this review would be representative of the Department of Health, Service Employers and IMPACT. In addition, it was agreed that the Psychological Society of Ireland, as the professional body for psychologists, would be asked to appoint an observer.

It was also agreed, following preliminary discussions, that the review would focus on three core issues:

1. The development of a Human Resource plan for psychological services in the health service
2. A review of the career structure for psychologists working in the health service
3. Consideration of the appointment of a Psychology Advisor in the Department of Health and Children.

The review, therefore, has examined in detail the implications for such critical areas as workforce planning, Human Resource management and management structures necessary for the continuing development and expansion of psychological services in line with the needs of the wider health services.

For a number of reasons it was not until the second half of 1999 that the Group commenced detailed work on its agenda. Over the following two and a half years, the full Group has met on a total of thirteen occasions while sub-groups have met on numerous other occasions.

The current membership of the Group is:

Mr. Kevin Callinan, IMPACT

Mr. David Gaskin, Health Service Employers (North Eastern Health Board)

Mr. Brian Glanville, IMPACT

Ms. Caroline Kelly, Department of Health and Children

Ms. Ella Lovett, IMPACT

Ms. Ann McCarthy, IMPACT

Mr. Tom Sheehan, IMPACT

Mr. Michael McGinley, Health Service Employers (North Western Health Board)

Mr. Se O'Connor, Health Service Employers' Agency.

The Psychological Society observers are:

Ms. Isolde Blau and **Ms. Jane Frye**.

The Group is jointly chaired by Mr. Michael McGinley and Mr. Brian Glanville.

Former members of the Group include Ms. Adrienne Harrington, Dept. of Health and Children (1999-2000), Dr. Michael Timms, Health Service Employers, Dr. Deirdre MacIntyre, IMPACT, and Ms. Maeve Kenny, IMPACT.

APPROACH TO TASK

At the outset, given the considerable length of time which had elapsed between agreement in principle to establish the Joint Review Group and the actual commencement of its work, and the evidence of growing pressures on the provision of psychological services, it was decided to adopt the rather unusual approach of both developing policy and actively engaging in promoting the implementation of that policy. The Group decided that actions urgently required to address specific issues falling within its remit should not be delayed by the need to complete all of the Group's work and prepare a final report.

Accordingly, this report sets out

- An account of the approach taken by the Joint Review Group in addressing its task
- Our conclusions and recommendations
- The steps taken to date to implement those recommendations
- A summary of work yet to be completed and recommendations as to how this should be done.

In general, our approach to our task has been to develop and reach preliminary agreement on a draft position paper on each of the topics within our remit. These papers were then circulated to our various constituencies and this was followed by a consultation process with the constituencies. The feedback from this process was brought back to the Joint Review Group which then worked at agreeing a final position. As soon as this had been achieved, individual members (or sub-groups as appropriate) took on the task of promoting the implementation of the Group's decisions. The Group itself has monitored progress in implementation and, as necessary, has given additional support to the process.

While the work of the Review Group has been ongoing for more than two years, the publication of this report comes at a particularly opportune time following the launch of the new Health Strategy in November 2001. The adoption of the recommendations contained in this report will help to ensure that psychological services are appropriately aligned to support the implementation of the Health Strategy's goals and change frameworks.

2 The Role of Psychologists in the Irish Health Services

Psychologists working in the health services play an integral role in the delivery of a wide range of services. This includes the following:

- Assessment and diagnosis of individual, system (family), or service problems
- Treatment using psychologically based techniques
- Evaluation of the outcomes of clinical intervention
- Consultation with other health professionals so as to support them in their client work
- Teaching/training of (1) psychologists and (2) other health professionals
- Research including service evaluation
- Contributing to policy development and service planning
- Participation in the design and implementation of health promotion/prevention strategies
- Management of services both directly and through participation in supervisory boards/committees
- Supervision of both psychologists and other health professionals
- Participation in investigation/enquiry processes
- Provision of expert opinion for the courts and other quasi-judicial bodies.

Currently, psychologists in the Irish health services are filling some or all of these roles in relation to a broad range of care groups. These include

- Infants, children and their families with developmental, emotional, intellectual and physical disabilities or problems
- Adolescents with a wide range of difficulties from adjustment problems to serious mental disorder
- Adults with mental health problems ranging from anxiety, depression and major mental disorder
- Families and couples with significant relationship difficulties
- Adults with learning, physical and sensory disabilities
- Older adults and their Carers
- Victims of sexual and other abuse, both child and adult
- Refugees and Asylum Seekers
- Emergency response to people exposed to traumatic events
- Social groups with identified high health risks, e.g. young single mothers, and substance abusers.

Clinical psychologists deliver their services in a number of ways

- As part of a multidisciplinary team of health professionals
- As part of a network of health professionals
- As the sole health professional providing a service to the client.

They do so in a variety of settings ranging from

- Hospitals
- Community based Health Centres
- Residential Centres
- Nursing Homes
- Schools
- Domiciliary settings.

The then Minister for Health first prescribed qualifications for health service psychologist posts more than thirty years ago. At that time the minimum qualifications for appointment to the Basic Grade was an honours degree in psychology and two years satisfactory post-graduate experience. However, over the years the profession, in collaboration with key health service employers, has promoted progressively rising standards of professional post-graduate training. Post-graduate clinical diploma training programmes were introduced in the late 1970's followed by university based Master's level programmes and, in the 1990's, by Doctoral level training. These training programmes have helped to insure that the training and skills of psychologists have matched the developing requirements of the health services.

During this period also other applied psychological specialisms relevant to the health services have emerged – e.g. counselling psychology, neuropsychology. The numbers employed from these specialisms are relatively small at present with the vast bulk of psychologists employed in the health services being clinical psychologists. This is likely to continue to be the case, at least for the medium term, and accordingly the human resource proposals, which follow in the next chapter, focus on the provision of Clinical Psychologists.

3 Human Resource Plans for Psychological Services

The key to the delivery of high quality psychological services is the sufficient availability of skilled and trained personnel, well led and appropriately resourced. The Group approached the task of developing a Human Resource plan for psychological services by

- Considering the role and likely developmental direction of psychology in the health services and
- Carrying out a review of the current psychological resources in the health services.

The IMPACT members of the Review Group tabled a paper on the role and developmental direction of psychology in the health services (Appendix 1). The Joint Review Group subsequently adopted this paper as a working document.

It is noteworthy that there has never been a systematic plan for the development of psychological services in the Irish health services and accordingly, development has been on an essentially ad hoc basis. However, the recent publication of the new Health Strategy provides a detailed framework within which the future development of psychological services can be planned on a systematic and structured basis.

The new Health Strategy (Section 100) gives the Department of Health and Children the responsibility of leading “the development of an integrated system of workforce planning aimed at anticipating the number and type of staff required to provide a quality health service”. In this task it will work closely with the Health Services Skills Group.

In the United Kingdom the DHSS has sponsored at least two major planning reviews of psychological services in the last twenty-five years. The first of these was published in 1977 and the second in 1990. More recently (2000) the Scottish Health Department has published a review of its services. In the absence of a review of our services in Ireland, the United Kingdom reviews have in some ways, perhaps, had a greater influence on the direction of service planning than might otherwise have been the case.

The 1990 Report of the DHSS’s Manpower Planning Advisory Group (MPAG) noted that the utilisation of psychological expertise and knowledge was not confined to clinical psychologists alone and that the “range of psychological skills possessed across the various disciplines can be located within a skills framework related to three levels of activity:

- Level 1** Basic psychological activity such as establishing, maintaining and supporting relationships with patients and relatives and using some simple, often intuitive, techniques such as counselling and stress management.
- Level 2** Undertaking circumscribed psychological activities (such as Behavioural Modification). These activities can be described by protocol. At this level there should be an awareness of the criteria for referral to the psychologist.
- Level 3** Activities that require specialised psychological intervention, in circumstances where there are deep-rooted underlying influences, or which call for the discretionary capacity to draw on a multiple theoretical base, to advise an individually tailored strategy for a complicated presenting problem. Flexibility to combine and adapt approaches is the key to competence at this level and comes from a broad, thorough and sophisticated understanding of the area of psychological theories.

Clinical psychologists are the only profession which operates at all three levels. It is the skills required for Level 3 Activity, entailing flexibility, generic knowledge and application of psychology, which distinguish clinical psychologists from other disciplines.

This system of categorising levels of psychological expertise is an important one in considering both the role of psychologists in the health services and the numbers which might be required to fulfil that role.

Since the vast majority of psychologists currently employed in the health services are clinical psychologists the Joint Review Group has not considered the position in relation to the roles of other relevant psychological specialisms in detail.

THE PRESENT SERVICE POSITION

At the commencement of our Review relatively little systematically obtained information was available at a national level on the nature of psychological services in the health service. In 1994 the IMPACT Vocational Group carried out a survey, through its members, of the numbers of psychologists employed in the health services, their grades and the level of vacancies. During the second half of the 1990's Carr and his colleagues have published a number of studies of clinical psychologists (Carr, A. (1995), Carr, A. (1996), Doran, A. and Carr, A. (1996), Carr et al (In Press). However, the information, whether formal or informal, which was available to us pointed clearly to the existence of major shortfalls in the provision of psychological services. The principal deficits were

- Inadequate staffing levels in many existing services with frequent reports of long waiting lists
- A significant range of services which were devoid of any psychological input
- Significant difficulties experienced by employers in both the recruitment and retention of trained staff.

It was accepted that the difficulties which employers had experienced in recruiting psychologists had tended to act as a disincentive to the creation of further posts since it was believed that it would not be possible to fill these. Accordingly, a simple census of vacancies would not give an accurate picture of the real requirement level.

THE JOINT REVIEW GROUP'S SURVEY

Because of the limited nature of the information available to it, the Joint Review Group decided to carry out a survey of its own of the psychologist resources available in the health services before developing human resource planning proposals on the basis of that data. A report of this work was presented to the Joint Review Group at its meeting on the 7th March 2000 (See Appendix 2). Key points from the report were

- At the end of 1998 there were 307 psychologists employed in the health services on a whole-time equivalent (WTE) basis
- 96% of psychologists were employed at either the Trainee, Basic or Senior grades with only 4% employed at the Principal or Director grades
- 11% of psychologists were job sharing
- 75% of psychologists employed were aged 45 or under

- The gender breakdown of the psychologist workforce was 74% female/26% male. There was evidence to show that the proportion of women in the psychologist workforce had risen 6% in the 5 years from 1992 to 1997
- 12% of posts were vacant.

The health service census for 2000 indicates that there have been some changes in the position in the period 1998 - 2000:

- The WTE number of psychologists employed in the health services has risen to 370 - an increase of 20%
- Over 60% (38 WTE's) of this increase has been at the Basic Grade level
- There has been virtually no change in the proportion of staff employed at the Principal and Director grades which remains very small - up from 4% to 5%
- About one-third of all psychologists are working in the ERHA region.

LIKELY MEDIUM-TERM DEVELOPMENTS IN THE DEMAND FOR PSYCHOLOGICAL SERVICES

The Review Group also considered the likely pattern of demand for psychological services over the medium term. It concluded that

- Despite the increase of one-fifth in the number of psychologists working in the health service over the past two years noted above, there is no indication that the demand for psychologists to work with the major existing care groups has yet been satisfied. The proposals set out in the new Health Strategy confirm this view
- The increasing recognition of the importance of the psychological dimension(s) of a broad range of health and social problems, is likely to lead to the emergence of distinct new care groups or sub-groups. Recent examples range from chronic pain sufferers through to victims of institutional abuse
- What was an embryonic trend of locating psychology services close to general practice and other primary healthcare providers is likely to expand in line with the plans for the development of the new model of primary health care delivery set out in the Health Strategy
- There is likely to be an expanding need for psychological input into health promotion/prevention programmes
- As health services seek to increase their evidence-based decision making, there will be a greater demand for the research expertise of psychologists
- Greater numbers of psychologists are likely to move into management roles in the health services
- The involvement of health service psychologists in the provision of educational psychology services to schools will decline and eventually be phased out as the National Educational Psychology Service of the Department of Education and Science takes over this function.

RESOURCE PLAN PROPOSALS

Two factors are key to any Human Resource plan

- The supply of an appropriately trained and skilled workforce in sufficient numbers to meet service requirements and
- The retention of staff once recruited.

On the supply side, it was clear to the Joint Review Group that there was a major resource shortage and that the key factor in this was the inadequate number of post-graduate training places in clinical psychology. By late 1999 the position in this regard was that the average annual output from the two university-based post-graduate training programmes in clinical psychology was twelve and that the number of graduates from the Psychology Society of Ireland's Professional Diploma Courses in Clinical Psychology had averaged three per annum over the previous five years.

Reports from the university programmes indicated that the demand from graduates for the small number of available places in post-graduate training was very high and therefore interest in pursuing a career in clinical psychology amongst graduates did not present a supply side problem.

In year 2000, on the basis of,

- The number of vacant posts in the health services as indicated by our survey
- The pattern of growth in the employment of psychologists in the health services over the five year period 1992 – 1997
- The likely pattern of job sharing – particularly given the preponderance of women in the profession
- Likely patterns of natural wastage over the next five years reflecting the demographic structures of the workforce

the Joint Review Group estimated on a preliminary basis that the Irish health services will have a requirement for at least fifty new professionally qualified clinical psychologists per annum for the (i.e. about 35 training places over the existing level of provision] in order to bring about an improved balance between the supply of and the demand for qualified staff. In effect, this meant in excess of a tripling in the output of post-graduate training programmes over that pertaining in 1999.

A sub-committee of the Joint Review Group met with the heads of the various university Departments of Psychology and representatives of the management of the P.S.I. Diploma in May 2000 in order to inform them of health service requirements, explore their interest in responding to them and discuss any requirements which they might have.

The Department of Health and Children responded swiftly to the requirement for the provision of extra training places. In September 2000 the Department invited bids from all health agencies including voluntary bodies to provide additional Trainee clinical psychologist Posts in association with any of the recognised post-graduate training providers. Successful bidders were informed in November 2000 of the availability of funding for a total of 30 additional trainee posts for three years in respect of which training would be provided through participation in the Psychological Society of Ireland's (PSI) training programme commencing Autumn 2001.

The effect of this new funding has been to bring about a rapid increase in the numbers enrolled on the Psychology Society's professional Diploma in Clinical Psychology (currently about 35). Unfortunately, the university sector has been slower to respond but by the commencement of the academic year 2001-2002 it is anticipated that the intake to the programme at TCD will double from six to twelve and that the UCD programme will have increased its intake from an average of six per annum to ten per annum. In addition, at least two other third level institutions, neither of which have previously been involved in the post-graduate training of clinical psychologists, are seriously examining the possibility of doing so and it is expected that at least one, if not both, of these proposals will come to fruition.

The recently completed reviews of psychological services in the Midland and North Eastern Health Board Regions, together with preliminary findings of a review currently under way in the Eastern region, suggest, however, that the Joint Review Group's estimate of likely medium term demand for psychologists is too conservative. The new Health Strategy also recognises the need to recruit and train extra psychologists. The progress in relation to the provision of the additional training places for psychologists represents an important start to this process.

Indeed, one of the main strands of the framework for Human Resources in the Health Strategy is ensuring a qualified, competent workforce. Integration with education, training and professional bodies in order to ensure that numbers of training places match the demand for skills within the health sector is a priority against the backdrop of the introduction of workforce planning for the health service on a national basis.

The Strategy draws attention to the necessity for the expansion of existing educational and training facilities to meet the substantial extra numbers of health professionals required to deliver the objectives set out in the Strategy for the health service and includes an explicit commitment to the provision of resources necessary to enable the education sector to respond to the skills need of the health sector.

The Health Strategy highlights the objective of aligning workforce planning with the service planning process being undertaken in the health board and the key role of the Action Plan for People Management in elaborating on how investment in training and education under the Strategy will be developed and implemented in order to provide the financial and practical supports for training and development of new staff hence ensuring that "... the health service has the right people with the right competencies..... to deliver the goals and objectives of the Health Strategy". The key role of the HR function in the health system in contributing to workforce planning as an integral part of strategic planning is also emphasised.

In the light of the above and the commitments in the new Health Strategy, the Review Group recommends that a comprehensive workforce planning exercise should be carried out over the first half of 2002 in order to establish the medium-term requirement for additional training places to support the continued development of psychological services. **It is, however, vitally important that the immediate short-term measures recommended by the Review Group, and already being implemented should proceed without delay.** The longer-term planning exercise should ensure that the work begun by the Joint Review Group is continued and further developed in a structured and systematic fashion in the years to come and that the medium-term requirement for additional training places is quantified in precise terms.

In order to promote an effective response by both the education sector and health agencies to the requirement for additional training places in psychology and ensure best use of the available resources, the Review Group believe that that the allocation of any additional training places in the future should be guided by certain conditions including:

- There should be accountability and transparency regarding the selection of students for all post-graduate places including the joint establishment of a central selection process for the selection of candidates by the relevant colleges and service providers
- The provision of placements should be co-ordinated across all health boards to maximise the contribution to the overall training requirements. Every effort should be made to ensure that placements are reflective of the diverse settings in which psychologists are employed
- Consideration should be given to the block release of students for lecture purposes. It is felt that the system of weekly releases does not allow students to interface as effectively as is possible in the work environment.

The Joint Review Group therefore recommend that a group be established under the auspices of the Health Skills Group (to be established shortly under the Programme for Prosperity and Fairness) consisting of representatives of all training courses/programmes and employers participating in post-graduate training of clinical psychologists.

Finally, it is important to note that the costs of post-graduate training of clinical psychologists are off set by a number of factors

- Students work on placement an average of 3.5 days/week during the three years of training providing, under supervision, direct services to clients
- The research dissertations which students are required to carry out as part of their training address important research questions of service providers.
- Service providers with strong links to training bodies are in a better position to both recruit and retain staff.
- Placement supervisors employed in the service provider agencies have opportunities for development through the programmes provided for supervisors by the training bodies.

4 Organisation/Management Structure for Psychological Services

A major task of the group has been to examine the organisation and management of psychological services in the health services bearing in mind

- The demand for expansion of the services
- The need for greater accountability
- The need for greater effectiveness/efficiency
- The changes taking place in the wider health services

and to consider how their organisation and management can be enhanced so as to achieve these objectives.

The most up-to-date information (2000) on the psychologist workforce indicated that 95% of the workforce was employed within the three grades, Senior, Basic, and Trainee, with only 5% employed within the grades of Principal and Director. However comparisons of employment patterns between statutory (principally Health Board) employers and those of the voluntary sector indicate there is a significantly greater number of posts at the higher grades in the voluntary sector. We were, therefore, particularly concerned to develop a template model which would, in the first instance, address the greatest area of need in the Health Board Services and which would also be relevant to services in the voluntary sector. In the longer term we were also concerned that it would facilitate the appropriate integration and co-ordination of services and provide strategic leadership and vision.

Early in 2000 the Joint Review Group adopted a working paper setting out a template for the organisation of psychological services in regional health boards. Following consultation with constituents a revised document was adopted at our meeting of the 26th October 2000 (see Appendix 3).

The template is intended to provide an outline for the development of psychological services in health boards which can serve as a guideline framework for the benefit of both service users and providers. However, it is not intended to stifle the development of local initiatives. Key objectives of the template are

- To provide a framework for organising and managing psychological services so that they are fully aligned with the Community Care Area structure of Health Boards
- To ensure that psychological services are effectively led and managed with clear lines of accountability
- To ensure that Health Boards will be in a position to develop and maintain a strategic vision of their psychological service requirements.

The principal components of the template can be summarised as follows:

- Within a Health Board each Community Care Area should develop a team of psychologists with an appropriate level of resources and skills to meet the needs of its care groups
- Each of these teams will be headed by a Principal Psychologist, who will have responsibility for managing the services within agreed objectives and budget and will report to the Area General Manager

- The mix of grades and skills within each team needs to be appropriate to the Area's service requirements, which reflect the following considerations:
 - The career grade (i.e. the grade which a competent practitioner can expect to achieve) for psychologists working in the health services should be that of Senior psychologist and the number of posts designated at this and the higher grades of Principal and Director needs to reflect this consistent with the template document (Appendix 3)
 - Within the area there should be a Senior Psychologist in every major service team
 - In the case of some services a very high level of specialised clinical expertise may be required and in order to obtain this expertise the Board may decide to designate such a post at Principal Psychologist level
- Each Board should create a post of Director of Psychology. This person will carry a range of functional responsibilities including those of advising the Board's senior management in relation to psychological services generally, their strategic planning and other relevant matters. In addition he/she should also have responsibility for the maintenance and promotion of uniformly high standards of professional practice, cost effective training and the continuing professional development of the Board's psychologist staff. Pending review it is intended that the Directors will, additionally, carry responsibilities for the management of psychological services in one of the Community Care areas.
- The working of the template should be subjected to operational review three years after its introduction. In particular, it is likely that as services develop the span of control required at both the Principal psychologist (Service Manager) and the Director may become too great for them to manage effectively and accordingly revised structures may need to be put in place. This will be an important task of the operational review.

The Joint Review Group expects that the application of the template set out above will give rise to the requirement for the creation of a total of 9 additional Director posts and 23 additional Principal posts. However, given that these roles are already being performed in a number of health boards areas on an acting basis, it is estimated that about 25% of these new posts can be filled on a non-replacement basis through upgrading of existing posts.

The Joint Review Group recommends the implementation of these proposals by all Health Boards in order to put in place a psychology services management structure with the capacity to contribute significantly to the achievement of service development plans on a basis that delivers value for money in terms of the very significant commitment of financial and staffing resources involved.

5 Assistant Psychologist Grade

Late in 2000 the Joint Review Group began to consider the introduction of a new grade of Assistant Psychologist. A discussion paper prepared by a member of the Joint Review Group was circulated and a decision taken that members would consult with their constituencies.

Assistant Psychologists have been widely employed in the NHS in Gt. Britain. In Ireland, apart from a pilot scheme in the mid-Western Health Board, Assistants have not been employed in the health services.

It is envisaged that Assistants, working directly under the supervision of a qualified clinical psychologist, could provide a much needed extra psychological resource, and in the process, acquire the practical experience which is often so valued at selection for professional post-graduate training.

IMPACT representatives brought the issue to the 2001 Annual General Meeting of Health Services Psychologists Vocational Group at which a motion was adopted supporting the introduction of the new grade in principle (subject to certain safeguards).

However, at a meeting of the Joint Review Group held on the 10th May 2001 the HSEA representative indicated that, from their perspective, further time would be required to examine the benefits which could be expected to result. Accordingly it was decided that there should be no further consideration of the matter within the framework of the Joint Review. However, we recommend that the HSEA, in consultation with health service agencies, gives further detailed consideration to the matter and, following this, brings forward proposals for discussion with IMPACT.

6 Psychology Advisor in Department of Health and Children

Early in its work the Joint Review Group considered the issue of the appointment of a Psychology Advisor in the Department of Health and Children. The Review Group saw considerable advantages for the co-ordination and development of services at national level in such an appointment. The Review Group unanimously recommended this to the Department of Health and Children. It submitted an outline of the role which, in its opinion, should be undertaken by the Advisor.

In due course the Department made a formal response rejecting the recommendation and making an alternative proposal that it would meet annually with the Directors of Psychology as a group. These documents are contained in Appendix 4.

This response was not acceptable to the IMPACT members of the Review Group. Accordingly, in order to avoid delaying the publication of this report, it has been agreed that further discussions will take place between the Department, **the HSEA** and IMPACT with the aim of reaching a mutually satisfactory outcome in 2002.

7 Implementation of Recommendations

It is recommended that a small group be established consisting of the Joint Chairs of this review group, a representative of the HSEA and a representative of the Department of Health and Children with the task of assisting in and monitoring the implementation of the recommendations of this report.

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Appendix 1

HSEA/IMPACT Review Group on Psychological Services in the Irish Health Service

Paper prepared by IMPACT ON THE Roles and Developmental Directions of Psychology in the health services.

INTRODUCTION

The employment of psychologists in the Irish health service goes back at least to the mid-1950s. Currently, the Irish health services employ a little over 300 psychologists with the potential to employ a great deal more, as indicated by the number of unfilled posts. Traditionally, the vast majority of psychologists employed have been clinical psychologists - i.e. psychologists whose training has been principally in the application of psychological science to the resolution or amelioration of clinical problems, whether in individuals, small or large group contexts. A small number of educational psychologists have also been employed. More recently, other psychological specialisms such as neuropsychology, health psychology and counselling psychology have begun to emerge and small numbers of these have been employed in the Irish health services.

There has never been a systematic plan for the development of psychology in the Irish health services - while individual agencies may have had structured plans of their own, the overall pattern of development has been essentially an ad hoc one. However, in the United Kingdom, the DHSS has sponsored at least two major planning reviews in the last 25 years. The first of these, known as the Trethowen Report, was published in 1977. The second, and much more relevant exercise, was published in 1990 by the Dept. of Health Manpower Planning Advisory Group (MPAG) and was based on preparatory work carried out for it by the Management Advisory Service (MAS) which was published in its report in 1989.

The MPAG report which reviewed clinical psychology services, noted that the utilisation of psychological expertise and knowledge was not confined to clinical psychologists and that the **“range of psychological skills possessed across the various disciplines can be located within a skills framework related to three levels of activity:**

Level One

Basic Psychological activity such as establishing, maintaining and supporting relationships with patients and relatives, and using some simple, often intuitive techniques, such as counselling and stress management.

Level Two

Undertaking circumscribed psychological activities (such as behaviour modification). These activities can be described by protocol. At this level there should be an awareness of the criteria for referral to a psychologist.

Level Three

Activities that require specialised psychological intervention, in circumstances where there are deep-rooted underlying influences, or which call for the discretionary capacity to draw on a multiple theoretical base, to advise an individually tailored strategy for a complicated presenting problem. Flexibility to combine and adapt approaches is the key to competence at this level, which comes from a broad, thorough and sophisticated understanding of the various psychological theories.

....clinical psychologists are the only profession which operate on all three levels. It is the skills required for level three activity, entailing flexible and generic knowledge and application of psychology, which distinguish clinical psychologists from other disciplines". (MAS, 1989).

MPAG (1990) went on to state that clinical psychology's contribution to the NHS was poorly promoted and that the profession's profile was inappropriately low in view of the impact that it could have on the effectiveness of services. It is probably an understatement to say the same is true of Ireland. Bearing "Level Three" skills in mind the role of the psychologists in the health services comes into sharper focus.

THE ROLE OF PSYCHOLOGISTS IN THE HEALTH SERVICES

In the Irish health services psychologists are required to fulfil a wide range of roles which include the following:

- Assessment and Diagnosis of individual or system (family, service) problems
- Treatment using psychologically based techniques
- Evaluation of the outcomes of clinical intervention
- Consultation with other health professionals so as to support them in their client work
- Teaching/training of (1) psychologists and (2) other health professionals
- Research including service evaluation
- Contributing to policy development and service planning
- Participation in the design and implementation of health promotion/prevention
- Management of services both directly and through participation in supervisory board/committees
- Supervision of both psychologists and other health professionals
- Participation in investigation/enquiry processes
- Provision of expert opinion to courts and other quasi-judicial bodies.

SERVICES TO CARE GROUPS

Currently, psychologists in the Irish health services are filling some or all of the roles listed above in relation to a broad range of care groups. These include:

- Infants, children and their families with developmental, emotional, intellectual and physical problems or disabilities
- Adolescents with a wide range of difficulties from adjustment problems to serious mental disorder
- Adults with mental health problems ranging from anxiety/depression to major mental disorder
- Families and couples with significant relationship difficulties
- Adults with learning/physical/sensory disabilities
- Older adults and their carers
- Victims of sexual and other abuse - both child and adult
- Refugees
- Emergency response to people exposed to traumatic events
- Social groups with identified high health risks (e.g. young single mothers, substance abusers).

CONTEXTS IN WHICH CLINICAL PSYCHOLOGISTS DELIVER SERVICES

Clinical psychologists deliver services sometimes as part of a multi-disciplinary team of health professionals, sometimes as part of a network of health professionals, and sometimes as the sole health professional providing a service to the client.

The settings within which the services are delivered include:

- Child and family centres (child guidance clinics)
- Community Care/Health centres
- General Hospitals (in-patient and out-patient) settings
- Psychiatric hospitals (in-patient and out-patient) settings
- Rehabilitation hospitals (in-patient and out-patient) settings
- Residential units for both children and adults
- Schools (mainstream and special)
- Day centres
- Nursing Homes
- Domiciliary settings
- Voluntary/community organisation centres
- Vocational training and employment centres.

SHORTFALLS IN PRESENT SERVICE POSITION.

Shortfalls in the provision of psychological services can be viewed under 3 headings

- Inadequate staffing levels in existing services (e.g. long waiting lists)
- A wide range of services devoid of psychological input
- Difficulties surrounding the recruitment and retention of trained staff (e.g. nos. of unfilled posts) - essentially related to
 - (a) training problems
 - (b) working conditions
 - (c) career promotion opportunities.

It is widely recognised, both by the profession and by health service managers, that there are very substantial shortfalls in the provision of psychological services. This is evident from the difficulties experienced by agencies in recruiting suitably qualified psychologists and the large numbers of unfilled posts. The difficulties which employers have experienced have tended to act as a disincentive to the creation of further posts since there is a belief that it will not be possible to fill these.

It is our impression that the statutory agencies have experienced greater problems in recruiting psychologists than has the voluntary sector. Waiting list figures are one measure of shortfall in service supply. Recently, the Psychologists' Vocational Group in IMPACT carried out a survey of waiting list times for services provided by members. This data has been broken down by category of service provided and health board region and will be presented separately.

LIKELY MEDIUM TERM DEVELOPMENTS

- There is no indication that the demand for psychological expertise from the major existing care groups has yet been satisfied. There are significant waiting lists for many psychological services, especially in the public sector. Demand, therefore, supported by arguments of equity and effectiveness, is likely to continue on behalf of these services.

In addition, the increasing recognition of the importance of the psychological dimension(s) of a very broad range of health problems is likely to lead to the emergence of distinct new care groups. For example, in recent years our health service has begun to recognise the needs of those suffering from chronic pain and there is now a demand for a psychological input into these services. Another example is the recognition of the valuable contribution which psychologists can make in the field of cardiac medicine in bringing about behaviour change.

As the sophistication of our neo-natal and paediatric health services continue to develop it is likely that demand will develop for an increased input from psychologists in this field, especially in relation to neuropsychological assessment.

The ubiquity of the demand for counselling/psychotherapy means that new groups, often supported by powerful political lobbying, are likely to continue to emerge. Recent examples include Hepatitis C sufferers and Adult Victims of Institutional Abuse.

The embryonic trend of locating psychology services close to general practice and other primary health care providers is likely to continue and further develop.

- Health Promotion/Prevention. The capacity to analyse and develop models of human behaviour is central to health promotion and primary prevention of disorder. This kind of task requires the core competencies of psychology. Examples of programmes where psychology has made a major input include the Stay Safe programme, the Substance Abuse Prevention programme and Parenting Skills Training programmes.

Psychology has already made significant contributions to the development of measures of wellness and competency and these are of major significance in the field of health promotion.

- Monitoring and evaluation of services. As evidence based decision making becomes increasingly important in the context of resource allocation within the health services it is likely that the research expertise of psychologists will be increasingly sought after, not simply in relation to the assessment of their own interventions, but also those of other health professionals. In this way psychologists will be contributing to the setting of practice standards.
- The last five years in the Irish health services has seen a major emphasis on health service management development. This emphasis is likely to be with us for the foreseeable future. It will impact on psychology in two ways. Firstly an increasing number of psychologists are likely to find themselves moving into the role of clinical management in one form or another. Secondly, psychology as a science has made a major contribution to the development of what is now referred to as management science. It is likely therefore that psychology will make a significant contribution to the general development of management expertise in the health services.
- The involvement of health service psychologists in the provision of educational psychology services to schools will decline and eventually be phased out as the Department of Education develops its own specialist school psychology service.

The planned significant development of the education psychology services will put major pressure on the health services in an already squeezed labour market.

Paradoxically, the withdrawal of health service psychologists from the provision of education psychology services is unlikely to mean that they will withdraw from schools, as these are increasingly recognised as powerful settings for effective health interventions.

Appendix 2

Human Resources Plan for Psychology Services in the Health Service

INTRODUCTION

This paper is tabled for discussion by the HSEA/IMPACT Psychology Review Group at its meeting on the 7th March 2000. The paper contains an analysis of the current level of psychology service provision in the health services, projections of probable development over the next five years and planning proposals for addressing human resource needs in that period.

In preparing this paper we wish to acknowledge our indebtedness to Ms. Ciara Murphy, Research Officer, HSEA and Mr. Brian Kinch, Principal clinical psychologist E.H.B. for their invaluable contributions.

HEALTH SERVICE HUMAN RESOURCES – THE PRESENT POSITION

The information set out below on psychologist resource disposition is based on data from two sources: -

- The Department of Health and Children’s Personnel Census dated 31/12/98 and
- The HSEA Survey of Psychologist Resource Utilisation in Health Service Agencies carried out in 1999.

We have used these two sources of information because of some incompleteness in the data returns of the HSEA survey which has resulted in the two data bases giving somewhat different figures in respect of total numbers of psychologists in employment – the D.H. and C. figures at the end of 1998 show a total of 307.57 psychologists employed while the HSEA survey gives a total of 268. However, the HSEA survey was specifically designed to yield information which would be of value in human resource planning and it is our view that notwithstanding some missing data in the survey, the information is more than sufficiently robust to allow for generalisation to the health service psychologist population as a whole.

At the end of 1998 (D.H. and C. figures) the total number of psychologists employed in the health services and the grades at which they were employed are as set out in Table 1. below.

TABLE 1

TOTAL NUMBER OF PSYCHOLOGISTS EMPLOYED (DoH&C 1998)						
Grade	Director	Principal	Senior	Basic	Trainee	Total
Number	8.00	4.60	106.87	163.82	4.28	307.57
% of Total	2.6	1.50	34.75	53.26	7.89	

From Table 1 it is apparent that 96% of the psychologist workforce is contained within the three grades, Senior, Basic and Trainee, while only 4% is contained within the two highest grades. Inevitably this must have an impact on staff retention rates.

Table 2 sets out the pattern of employment of psychologists for each of the employers who responded to the HSEA survey. The table shows that the total number employed in those organisations in 1999 was 278. However, if account is taken of the number of staff who are job-sharing (31) then the whole time equivalent number of psychologists employed drops to 263.5 – a reduction of 5.6%.

TABLE 2

PATTERN OF EMPLOYMENT X EMPLOYER (HSEA SURVEY)															
Employer	No. of Staff Employed	Breakdown by Grade						Job-sharing Breakdown by Grade						No. Job Sharing	W.T.E. Employed
		Director	Principal	Senior	Basic Grade	Trainee	Unknown	Director	Principal	Senior	Basic Grade	Trainee	Unknown		
N.W.H.B.	20	-	1	6	13	-	-	-	-	1	1	-	-	2	19
W.H.B.	30	-	1	8	21	-	--	-	-	3	3	-	-	6	27
S.E.H.B.	27	-	-	6	15	6	-	-	-	-	1	-	-	1	265
M.H.B.	13	-	-	3	8	1	1	-	-	-	-	-	-	0	13
M.W.H.B..	17	-	-	8	9	-	-	-	-	-	-	-	-	0	17
S.H.B.	9	-	-	7	2	-	-	-	-	-	-	-	-	0	9
E.H.B.	49	1	1	12	26	9	-	-	-	3	1	-	-	4	47
St.J. of G.	25	-	1	11	10	3	-	-	-	2	2	-	-	4	24
Beaumont Hosp.	3	-	-	2	1	-	-	-	-	1	1	-	-	2	2
St. Vs Fairview	3	-	1	1	1	-	-	-	1	-	1	-	-	2	2
N.E.H.B.	21	-	-	2	19	-	-	-	-	-	2	-	-	2	20
St.Marys Baldoyle	1	-	-	-	1	-	-	-	-	-	-	-	-	0	1
Tallaght	2	-	-	2	-	-	-	-	-	2	-	-	-	2	1
Rotunda	1	-	-	-	-	-	1	-	-	-	-	-	-	0	1
Bros. Of Charity	12	-	1	7	4	-	-	-	-	-	2	-	-	2	11
St. Ms House	16	-	1	9	5	-	1	-	-	-	-	-	-	0	16
Western Care	8	-	-	1	5	2	-	-	-	-	-	-	-	0	8
Sunbeam House	1	-	-	-	-	-	1	-	-	-	-	-	1	1	.5
N.Rehab.Board	3	-	-	3	-	-	-	-	-	2	-	-	-	2	2
Galway Assoc.	4	-	-	1	3	-	-	-	-	-	-	-	-	0	4
Daughters of Char.	9	-	-	4	5	-	-	-	-	-	-	-	-	0	9
Charleville	1	-	-	1	-	-	-	-	-	-	-	-	-	0	1
St. Vincent's E.P.	3	-	-	3	-	-	-	-	-	1	-	-	-	1	2.5
TOTAL	278	1	7	97	148	21	4	-	1	15	14	-	1	31	263.5

Table 3 gives an age x grade profile of the psychologist workforce. 75% of the workforce is aged 45 or less. Only a relatively small percentage of the workforce will reach retirement age in the next five years (4.4% are aged 56 or more years).

TABLE 3

AGE PROFILE x GRADE (HSEA SURVEY)							
Age Group	GRADE						Total in Age Grp
	Trainee	Basic G	Senior	Principal	Director	Grade Unknown	
20 – 25	1	1	-	-	-	-	2 (0.7%)
26 – 30	14	33	1	-	-	-	48 (17.9%)
31 – 35	4	42	11	-	-	-	57 (21.3%)
36 – 40	1	21	18	1	-	-	41 (15.3%)
41 – 45	-	23	29	-	-	2	54 (20.1%)
46 – 50	1	9	17	2	-	-	29 (10.8%)
51 – 55	-	10	12	2	-	1	25 (9.3%)
56 – 60	-	1	3	1	1	-	6 (2.2%)
61 – 65	-	1	4	1	-	-	6 (2.2%)
TOTALS	21	141	95	7	1	3	268 (100%)
AVERAGE	30.24	36.91	44.21	51.57	58	46.33	39.54

Cumulative Percentage	0.7%	18.6%	39.9%	55.2%	75.3%	86.1%	95.4%	97.6%	100%
At or Under Age	25	30	35	40	45	50	55	60	65

Table 4 gives further information on the pattern of job sharing broken down by age. Age data on two of the thirty-one job-sharing staff was missing, but information was available on the remaining twenty-nine. The pattern of results indicate that over 50% of staff job-sharing are in the age range 36 to 45 but only 36% of the total population fall into this age range. More than 75% of the job sharers fall into the age range 36 – 50, although only 45% of the total population falls in this age range (see Table 3). This means that job-sharing is heavily concentrated in these age bands.

TABLE 4

JOB-SHARING X AGE (HSEA SURVEY)			
	No	% Age of Total	Cumulative % Age
20 – 25	0	0	
26 – 30	4	13.78	13.78
31 – 35	2	6.90	20.68
36 – 40	8	27.59	48.27
41 – 45	7	24.14	72.41
46 – 50	7	24.14	96.55
51 – 55	0	0	96.55
56 – 60	1	3.45	100
61 – 65	0	0	100
	29	100	
Missing data (2 posts)			
TOTAL	31		

Table 5 sets out information on the gender breakdown of the psychologist workforce by grade for the years 1992 and 1997. This data is based on the DoH&C survey.

TABLE 5

Percentage Female x Grade (DoH&C)				
Grade	1992		1997	
	Total No. of Females	% Female	Total No. of Females	% Female
Trainee Cl. Psychologist	8	73%	21.8	93%
Clin Psychol. Basic Grade	80.95	76%	130.17	80%
Senior Psychologist	34.6	62%	66.36	65%
Principal	0	0	1.6	44%
Director	1	13%	1	13%
Total	124.55	68%	220.93	74%
Total No. of Psychologists	183.14		300.11	

The results show an overwhelming preponderance of women in the profession. This preponderance is at its greatest in the Trainee grade and falls progressively up the grade structure. A comparison between the figures for 1997 with those for 1992 shows that the proportion of women employed in the profession rose by 6% over the five year period. Over the period, the total no. of psychologists employed increased by 116.97. Of this increase, 96.38 or 82.47% were female. In human resource planning terms this is significant when taken in conjunction with the pattern of job-sharing revealed by the HSEA survey.

The picture in relation to vacancies (based on the HSEA survey data) is set out in Table 6.

TABLE 6

VACANCIES X GRADE X NEW POSTS (HSEA SURVEY)		
		New
Senior	10 (29%)	6
Basic Grade	25 (71%)	9
Total	35 (100%)	15 (43%)
Total in Post in W.T.E.	263.5 (88%)	
Total Vacancies	35 (12%)	
	298.5	

N.B. No Vacancies at Director/Principal.

The data is broken down in terms of the grade of the vacant post and whether it is a new or existing one. The results show that in 1999 12% of posts were vacant. * Of these, 57% were existing posts and 43% were new posts. 71% of the vacancies were at Basic Grade while 29% were at Senior. No vacancies were shown at Director or Principal grades

- The recent HSEA Survey of Nursing Post Vacancies showed just under 5% of these posts vacant.

RESOURCE PLAN PROPOSALS

Two factors are key to any human resource plan:

- The supply of an appropriately trained and skilled workforce in sufficient numbers to meet service requirements and
- The retention of staff once recruited.

The principle focus of this paper is on supply, but issues of retention are obviously also of concern to the group and need to be further examined by it. Information from the two data bases will be of major assistance in this task.

HEALTH SERVICES PSYCHOLOGIST RESOURCE REQUIREMENT TO 2005.

The requirements of the health services for professionally trained psychologists over the next five years can be estimated by taking account of the following factors:

1. Vacant Posts: The HSEA Survey indicates that twelve percent of posts were vacant in 1999. Applying this proportion to the numbers contained in the DoH&C census for 1998 gives a figure of 37 posts vacant.
2. Growth in requirement for psychologists in the health services: Estimating growth in requirement for staff is always difficult, however there are some figures available from previous years which can assist the estimation process. The DoH&C figures for 1992 and 1997 (See Table 5 above) indicate that over the five year period in question, the total number of psychologists employed in the health services increased by 116.97. This is equivalent to an average annual compound rated increase of 12.77%. Applying this rate to the total number employed in the health services at the end of 1998 (307.57) would suggest that the increase in employment during 1999 is likely to have been of the order of 40.

Obviously it would be unrealistic to plan in the medium and long term for an annual growth requirement of this size. However, given the fact that psychology is a relatively young profession in the health services, that the base in absolute terms is small and that the range of services where psychological input is required is expanding, we believe that it is reasonable to assume that growth in requirement by the health services for psychologists over the next five years will continue at between 10 and 12% per annum.

If we assume that the number of posts in the health services at the end of 1999 (including vacancies) was 340 and we project a 10% per annum growth in requirement over the next five years, then the increase in the total number of staff required over the five year period is 207 or an average annual rate of 41.5. w.t.e.

3. Natural Wastage: The age profile of the profession (see Table 3) indicates that provision for natural wastage through retirement over the next five year period will not be a major consideration – over that period we can expect an average annual retirement of two or three people.

However, we have no data which would allow us to estimate wastage through people leaving health services employment prematurely (i.e. before retirement age). Anecdotal evidence suggests that the pattern of emigration of professionally qualified psychologists which was widely recognised in the earlier years of the 1990s, is now much less marked and the balance between emigration and immigration is probably broadly neutral. Recent reports from the U.K. suggest that the demand/supply equation for psychologists in the NHS is beginning to come into balance and this, together with imminent salary adjustments in this country, should ensure that over the next five years there will be no net outflow of psychologists from the country.

4. Gender considerations: Table 5 shows that at the end of 1997 74% of the psychologist workforce was female. Tables 3 and 4 give information on the age distribution and the numbers of people who are job-sharing. For the age group 26 – 50, which encompasses over 85% of the total population, 12% are job-sharing. Given prevailing patterns of child-rearing, it is likely that job sharing over the next five years will increase from its present level and provision needs to be made for this when we come to consider training requirements.

The conclusion to be drawn from the data and assumptions outlined above, is that the short-term requirement of the health services up to the end of 2005 would necessitate an annual output from professional post-graduate training of between 45 and 50 psychologists.

The present average annual output from the two university based post-graduate training programmes in clinical psychology is 12. The output from the Psychological Society of Ireland's professional diploma course in Clinical Psychology is not known but the number of students registered for the diploma currently is 35.

Appendix 3

Revision Tabled by IMPACT 26/10/2000 Following Consultation with Members

A TEMPLATE FOR THE ORGANISATION OF PSYCHOLOGY SERVICES IN REGIONAL HEALTH BOARDS

INTRODUCTION

These proposals are tabled by the Joint Chairmen for consideration by the Joint Review Group at the meeting to be held on the 5th November next.

In drawing up these proposals we have had regard to:

- The new organisational/management structures emerging in health boards and
- The discussion document tabled by IMPACT Career Structure for Psychologists in the health service (April 1996)

These proposals are intended to provide an outline for the development of psychology services in health boards which can serve as a guideline framework for all of the stakeholders involved:

- Health Boards
- Professional Psychologists working in the health services
- Department of Health and Children
- Their trade unions
- Major Service Providers
- Their professional organisations

It is not intended to stifle the development of local initiatives but rather to provide a facilitative framework for development.

PROPOSALS

1. Within a health board, each Community Care area would develop a team of Psychologists with an appropriate level of resource and skills to meet the needs of its Care Groups.
2. Each team would be headed by a Principal Psychologist who would have responsibility for managing the services within agreed objectives and budget and who would report to the Area General Manager.
3. The mix of grades and skills needs to be appropriate to the area's service requirements but it should reflect the following considerations:
 - The career grade for psychologists working in the health services should be that of Senior Psychologist and the numbers of posts designated at this and the higher grades of Principal and Director needs to reflect this.

- Where services are unified within a geographic area under the clinical management of Principal Psychologist, posts at senior level should be established within each significant care group or specialist area, as appropriate, e.g.

Child Care

Adult Mental Health

Disability

Child Psychiatry

Acute Hospitals

Elderly Services

These posts should hold responsibility for the planning and delivery of the psychology service within their respective care groups. The posts should be mainly clinical, but hold a management and supervisory role in respect of basic grade psychologists, who would report to this senior grade.

In the absence of a unified structure, all single handed posts should be graded at senior level.

- In the case of some services a very high level of specialised clinical expertise may be required and in order to obtain this expertise the Board may decide to designate such a post at Principal level.

4. Each Board would create a post of Director of Psychology. This person, in addition to managing the services in one of the Community Care areas, would also have responsibility for advising the Board's senior management in relation to psychological services, its strategic planning of psychological services and other relevant matters. He/She would also have responsibility for ensuring the maintenance of uniformly high standards of professional practice and promotion, cost effective training and continuing professional development of the Board's psychologist staff.

In the interim, as services are developing, it may be necessary in some boards for the Director to additionally carry responsibility for the management of psychological services in one of the community care areas. However, as the board-wide responsibilities of the Director expand (mirroring the expansion of the services) a point will be reached where it will not be possible to combine these two sets of responsibilities.

*** Nationally, the public health services are delivered through ten regional health boards. Each board is divided into a number of community care areas - thirty-two in total. In line with the Health Strategy document, it is the policy of the DoH&C and the health boards that, with the exception of general hospitals and some other specialist services, all health services should be delivered through the general management structure of the community care areas. This means that the programmatic care structure that operated previously is being progressively changed and replaced by a more locally focused generic structure based on community care areas. Within each community care area, services are organised around key care groups (e.g. children and families, people with disabilities, the elderly etc.).**

Appendix 4

Psychologist Advisor to Department of Health and Children

At its meeting on 11th November 1999, the Joint Review Group on Psychological Services supported the proposal:

“that the Group believes that there would be significant advantages to the health services if the Department of Health and Children were to appoint a Psychology Advisor to its staff”.

The Group requested the Department of Health and Children representative to convey this recommendation to the appropriate quarters in the department and to report back to the next meeting.

The advantages which would accrue from such an appointment include the following:

1. It is clear to all the members of the Review Group that there is an urgent need to develop psychological services within the health services, and that there are currently serious deficits of service provision. These deficits include a shortfall in supply of suitably trained psychologists which is reflected in the widespread difficulties which have been experienced by service provider organisations (both statutory and voluntary) in filling vacancies. The Review Group is in course of drawing up recommendations for a short term human resource plan for psychological services nationally. Driving the implementation of these recommendations, assuming they are accepted, will be an important task for the advisor.
2. The health services are currently undergoing a period of rapid expansion with new care group needs emerging, e.g. children with autistic spectrum disorders, child and adult victims of sexual abuse, trauma victims including refugees. These are in addition to the long standing care groups where service enhancement and best practice requirements mean that psychological expertise is required as part of a comprehensive multi-disciplinary approach to care. To-date, in the planning of services, the provision of psychological resources has often been overlooked. The cost effective provision of modern health services requires an appropriate multi-disciplinary skill mix. In many of the developing services professional psychological expertise is absolutely essential.
3. As the Department of Health and Children further develops its strategic planning role for the health services, the importance of communication and information exchange between the profession and the planning process will become more marked. In this respect the advisor can make an important contribution by ensuring that the Department has available to it the best psychological expertise/advice and by helping the profession to focus its inputs appropriately. In addition, he/she will be able to make a valuable contribution by promoting effective liaison between the Department, the Health Boards and other agencies.
4. There are a number of state agencies, including the HSEA itself, who, from time to time, have a requirement for psychological expertise. The advisor could either provide this expertise directly or refer the agency to an appropriate source.
5. As psychology services develop in both health boards and other agencies there will be a need to set standards for quality, effectiveness and efficiency. The importance of coordinating these standards across the agencies is obvious. The advisor can play a key role in this process.

We envisage that the advisor would be appointed for a three-year term on a part-time basis. The extent of the commitment would be determined by the size of the task(s) in hand and would be reviewed at appropriate intervals. The costs involved would be small and the potential gain for the Department and for the health services as a whole would be substantial.

Response from the Department of Health

Appointment of a Psychology Advisor to the Department of Health and Children

The Department of Health and Children has considered the proposal put forward by the Joint Review Group on the appointment of a Psychologist Advisor to the Department.

Having examined in detail the arguments made for such an appointment, the Department makes the following response:

1. It is accepted that the issue of workforce planning for the psychology profession is one that requires urgent attention. However it is not felt that an advisor would necessarily be in a position to progress this issue in a more efficient manner than is currently the case.

The Joint Review Group has made major strides in securing funding for the employment of additional trainee psychologists and in securing agreement from the universities in relation to additional training places. This work is not yet complete and it is understood that there are at least two further colleges interested in providing postgraduate training for clinical psychologists.

The Department is aware that a short-term workforce planning study has been undertaken by the Group and that it is proposed that a medium-to-long term study be undertaken by the Health Skills Group to be established under the Programme for Prosperity and Fairness. This study will continue the work of the Review Group and ensure a sufficient supply of psychologists into the future. It is already the responsibility of Departmental officials to progress this issue, and it is not believed that an advisor would be any better placed to ensure its advancement.

2. The Department acknowledges the developments in relation to the rapid expansion of services. The Review Group's proposals in relation to an enhanced career structure in the Health Boards acknowledges the developments that have been made in the area of psychology and anticipates further such developments. With the creation of additional Principal and Director posts, the Department believes that any perceived overlooking of the provision of psychological services can be addressed.

The service planning process within the Health Boards takes on board the varying needs of specific care groups and the contribution of Directors to this process will ensure that this input is made. Health service employers are particularly conscious of the contribution that psychologists have and can make and are anxious to increase the number of clinical psychologists in their employment if a sufficient supply can be guaranteed.

The Department of Health and Children has an increasingly limited input into the employment control process in Health Boards and Boards are now in a position to employ any mix of professional staff that they deem to be appropriate if the issue has been flagged in their annual service plan. It is no longer necessary for Boards to seek approval from this Department to employ staff if this criterion is fulfilled. For this reason, it is envisaged that the Directors at local level will have greater influence in securing an increase in the number of clinical psychology posts than an advisor at national level.

3 + 4. The Department is conscious of the increasing importance of communication between itself and the profession. It has always been open to meeting with the professional body and has an excellent working relationship with the Psychological Society of Ireland (PSI). It is envisaged that this form of communication will continue.

Additionally, the Department would welcome an input from the profession to the Health Strategy which is being drafted at the moment.

It is envisaged that the Directors of Clinical Psychology will be a key group to advise the Department and any other relevant agencies. The Department proposes that there be an annual meeting between this group and officials within the Department to discuss issues of mutual interest. If at any other time, it is felt that input is required, the Department could call on the group for such advice. It is also envisaged that the Directors would establish links with other relevant agencies.

5. The Department accepts that there is a need to set standards in relation to quality, effectiveness and efficiency. However, it again feels that the Directors as a group are best placed to ensure that this standard is achieved and maintained.

