Report of the National Psychology Project Team:

Establishment of a National Psychology Placement Office and Workforce Planning

15 January 2021

Human Resources
Leaders in People Services

Foreword

Following a review of Eligibility Criteria for staff and senior grade psychologists in 2016, an Implementation Group was established to implement the revised standards. The Implementation Group recommended the establishment of a National Psychology Placement Office. Inter alia an action from the Department of Health, to prepare a workforce plan for psychological services in the HSE, including an examination of the framework for training psychologists for the health service and the type and skill-mix required for the future, was required,

HSE Community Operations convened a Project Team to progress the recommendation of the Implementation Group and to make a contribution to a workforce plan for psychological services provided for, and funded by, the HSE.

The Project Team that developed this Report included representation from Clinical, Counselling and Educational Psychology; Social Care, Disability, and Mental Health services; Community and Acute services, Operational and Strategic HR, and the Health and Social Care Professions office. The work of the Project Team was also informed by a stakeholder consultation process.

Cross-sectoral and stakeholder involvement reflects the intent to ensure all relevant stakeholders continue to feed into the management of student placements and workforce planning into the future. It is anticipated that the governance and oversight structures to be established under the placement office will embody stakeholder collaboration and engagement.

The National Psychology Placement Office will be established under the auspices of the Chief Clinical Officer's office with a focus on formalising placement management; working with multiple regional stakeholders building on the existing networks and relationships; and further strengthening and supporting psychology services and students. Key actions will include:

- establishing governance and oversight structures;
- developing a formal and robust system to manage and coordinate placements;
- building communications and engagement processes with cross-sectoral stakeholders;
- a review of the current funding model to ensure the appropriate supply of the future psychologist workforce.

I would like to take this opportunity to thank the Project Team members for their work and express my appreciation to the many stakeholders who have informed and assisted in the establishment of a National Psychology Placement Office, and contributed to the considerations for a workforce plan for psychological services.

Dr Cathal Morgan
Assistant National Director (Head of Operations – Disability Services)
Chair of the National Psychology Project Team

Executive Summary

1. Background and context

In 2016 a Review Group produced the "Report of the Review Group – Eligibility Criteria for Recruitment of Psychologists to the Health Service Executive". The Report recommended revised eligibility requirements for entry into competitions for Psychology posts, which were applied to staff grade and senior psychology competitions run in 2016 and 2017.

An Implementation Group established to look at implementing the revised eligibility standards, due to come into effect in October 2018, recommended the creation of a National Psychology Placement Office as a matter of urgency.

The National Director for Human Resources committed to establishing a Project Team to implement this recommendation and, inter alia, consider the preparation of a workforce plan for psychological services in the HSE, including an examination of the current framework for training psychologists for the health service and the type and skill-mix required for the future.

In February 2019, HSE Community Operations convened a Project Team comprised of representatives from Clinical, Counselling and Educational Psychology; Social Care, Disability, and Mental Health services; Community and Acute services, Operational and Strategic HR, and the Health and Social Care Professions office. The work of the Project Team was also informed by a stakeholder consultation process.

The Team held 11 meetings between February 2019 and August 2020; and undertook a thorough process of stakeholder engagement to inform their work.

In line with its Terms of Reference, this Report sets out the Team's proposals to establish a national psychology placement function within the HSE, and outlines considerations for a workforce plan for psychological services in the HSE.

2. The Context for Psychology Services in Ireland

In order to plan for psychology services, we need to understand the drivers of demand that will impact on psychology services over the coming years. Chapter 2 identifies existing inter-agency cooperation, key drivers of demand for psychology services, and the future considerations for a psychological services workforce plan.

In the context of strengthening community-based care, the Project Team has identified a number of areas in which inter-agency working is well established e.g. TUSLA and NEPS, while the IPS Model of Care dovetails with that of the HSE and Vision for Change.

Recognising that Sharing the Vision allows for each area to determine what staff should be prioritised based on need and available resources; and noting that Sláintecare's plan for community-based services will require an expansion of infrastructure and workforce capacity; the Project Team is of the

view that new development funding will be required to build capacity into the future and to protect and strengthen services.

The need to consider funding of professional psychology training, to include counselling and education programmes, is also recognised.

3. Psychology education and training in Ireland

As with demand side factors, we need to understand the future labour supply side environment and the role of the various stakeholders in preparing the future supply of psychologists.

Chapter 3 summarises the interfaces identified by the Project Team and sets out the current approach to training placements and funding for clinical, counselling and educational psychology students.

There is no national coordination of the placement process in terms of student / placement management or resource allocation. Likewise, there is no structure to accommodate those psychologists who have qualified in another jurisdiction seeking to make good any gaps in experience, or existing HSE and funded agencies employees seeking appropriate work experience as part of their professional development and to meet new eligibility requirements.

In addition, there is no official list / database of locations / services / settings, and associated criteria that are deemed appropriate healthcare settings in the context of student placements. The Project Team agree that a database would allow for improved oversight and management of placements.

Following consultation with National HR and Community Operations in October 2020, agreement was reached on deferring the effective implementation date of the 2016 Eligibility Criteria requirements to 1st October 2024. It is also agreed that the grand parenting approach included in the 2016 Report be updated, and extended, thereby removing the supervised work experience requirement for existing professionally qualified psychologists currently employed in public psychology services.

Recognising the HSE is the largest organisation offering placements, thought needs to be given, more broadly, as to the needs of the health and social services sector. There are areas where much of the service provision is by voluntary agencies and other statutory bodies; therefore, psychologist workforce planning, the training process, and funding of Clinical, Counselling and Educational psychologists should encompass the need for psychology in both HSE and non-HSE settings, to avoid creating any internal labour market competition, rather than exclusively HSE settings.

4. The current psychology workforce in the Irish public health service

In addition to understanding the factors that have informed its development and influence the demand for psychology services we also need to understand our current workforce. Chapter 4 summarises the current workforce position, based on available data.

HSE psychology services are delivered across a number of sectors. While the HSE has specific responsibilities for training placements, as set out in the Health Act 2004, the link across the sectors to supply the future workforce means it would be beneficial to all sectors to work collaboratively to avoid the unintentional creation of internal labour market competition.

There are significant grounds for a review of the existing Psychology structures to take account of the expansion in psychology numbers and grades; the widening remit of the service across care groups; the changed statutory and regulatory environment in which HSE services currently operate; and the changed and changing organisational structures within the HSE.

Workforce planning approaches, that taking a whole of system approach or whole of organisation approach, as appropriate, would support current and future sustainability of the psychology workforce supply. In addition, demographics will have significant implications for supply-side decisions. Factors such as age and gender, which impact on replacement demands, need to be considered when determining supply.

To support decision-making, accurate data including psychologists being correctly graded on HR systems, and improved data collection and information regarding entry and exit patterns, and attrition rates would be beneficial.

Finally, the Project Team recognises the role of multi-disciplinary teams within the delivery of psychological services, which will have an impact on the workforce requirements for psychological services into the future.

5. Psychology services into the future

The requirement for psychological services is likely to increase and those with responsibility for planning services must address needs as well as demand. Chapter 5 identifies a number of the key drivers that are likely to produce significant changes to the way in, and extent to, which psychological services are delivered, and notes the implications this will have on workforce planning and the future psychological workforce.

The projected global shortfall of 15m healthcare workers by 2030 means consideration should be given to alternative and flexible approaches to how health services are delivered.

The changing role of professions, and greater fluidity in skill-mix, will require a greater alignment of skill sets to work tasks. This is critical in the context of community-based working, through different modalities.

While new technology is unlikely to impact on the demand for mental health professional, its effects on service provision could be transformational.

The psychological workforce will, increasingly, be working in tiered arrangements and the workforce will require robust governance and supervision structures. Memoranda of Agreement and Programme Boards in HEIs will need to align with innovations and change within the healthcare landscape.

6. Workforce planning for psychology services

A workforce plan needs to take account of the wider spectrum of psychological services and disciplines that are (current and future) to be regulated under CORU and have regard to other sectors where psychological services are provided, i.e. Tusla, Justice and Education Sectors. Chapter 6 identifies the necessary actions for the development of a workforce plan for psychological services.

Methods used to determine whether or not a workforce shortage exists, range from calculating ratios of practitioners to populations, to comparison between historical and existing practitioner numbers and extrapolations of the numbers of disciplines required on the basis of changing demographics.

These methods assume that the fundamental structure of the workforce is set, and ignore the potential for substitution between roles, the potential for new roles, and the impact of developing technologies and practices. However, whatever the method of shortage assessment, the workplace environment offered, and the time required to train them, all affect the workforce supply.

As health needs, and our population continues to grow, there is a requirement to maintain, develop and consolidate safe and effective governance structures for psychologists within the HSE.

With the integration of services under Sláintecare, and the reconfiguring of services into six regional areas, there will be a need to have robust structures to effectively manage and optimise use of resources. Although a hierarchical structure is in place, there is significant variation nationally

The Project Team concludes that in order to identify the future requirement for psychologists in the public health system, there are a number of considerations including the following that will need to be considered and addressed in advance of, and to inform a wider workforce plan for psychological services.

- Funding with regard to retaining qualifying trainees and sponsorship of psychology training programmes.
- The number, mix and relationship between the professions delivering psychological services.
- Service requirements; Models of care, care group designation and service delivery methods and the employment of a multi- disciplinary approach to delivery of care.
- Impact of Covid-19 and the associated increase in demand for psychology services.
- Potential changes by Psychologist Registration Board at CORU to the educational or experience pathway leading to registration as a professionally qualified psychologist.
- Workforce diversification to allow for greater capacity and flexibility in response to service needs i.e. both generic and specialist skills are required.

7. National Psychology Placement Office

Chapter 7 sets out a proposed National Psychology Placement Office (NPPO) function to fall under the auspices of the National HSCP Office within the Chief Clinical Officers office. Noting, the additional workload and responsibility, and requirement for appropriate resourcing; the following sections include proposed governance arrangements and staffing to facilitate the establishment and operation of same.

Governance and arrangements

Informed by the work of the Project Team and stakeholder consultation, and taking account of the outcomes sought, the proposed governance and arrangements are set out below:

- Convene a national steering group of relevant stakeholders including HEIs, statutory agencies, key voluntary agencies, and relevant HSE Divisions E.g. Quality Improvement Division to:
- Develop a formal memorandum of understanding (MOU) between the HEIs and HSE, Tusla, NEPS and the Irish Prison Service.
- Develop a formal MOU between HEIs and relevant Section 38 voluntary organisations and Section 39 organisations in receipt of funding.
- Convene a national placement coordinators group based on regional health care areas and HEIs.
- Develop a common set of placement documentation across HEIs, including for assessment of student practice.
- Consider the impact of the student experience on recruitment.

Management and coordination of placements

The NPPO will have responsibility for creating a formal, robust system for coordination of placements of current HSE and HSE funded Section 38 and Section 39 staff that will need to complete additional placements(s) to meet the identified eligibility criteria for employment in the HSE.

The table below sets out the suggested staffing and role requirements based on student numbers of 286 in 2018/19; and costs based on the mid-point of the HSE salary scales as at 1st January 2020.

Proposed Staffing for National Psychology Placement Office

STAFFING	COST
1 x national head of psychology placements (director / principal psychologist level: Clinical, Counselling or Educational) **OR** Administrative equivalent	€98,876
1 x Business Manager (Grade VIII)	€71,519
6 x placement coordinator posts (senior psychologist grade) assigned regional responsibility aligned with HSE regions with an equal mix of counselling, educational and clinical psychologists from different training backgrounds.(€86,951)	€521,706
2 x Grade IV administrative officers (€36,215)	€74, 430
Align HEIs with regional assignment of placement coordinators to support harmonisation	Administrative costs
Placement coordinators in HEIs	Already in place
Develop a national database of placements including HSE, Tusla, the IPS, NEPS and voluntary organisations.	Administrative costs under the auspices of the National Psychology Placement Office
Consider a software system such as ARC to manage the planning, organisation and administration of students on placement.	€50,000
Make provision for internationally qualified psychologists who may not meet all PSI standards, and existing employees requiring additional placements, to undertake placements and access HEI supports through the coordinated system	Administrative costs under the auspices of the National Psychology Placement Office
Commence development of a mechanism to ensure consistency and standardisation of placement quality and recognition, including database of appropriate health care settings	Administrative costs under the auspices of the National Psychology Placement Office
Develop and implement a single placement record for each trainee	Administrative costs under the auspices of the National Psychology Placement Office

The establishment of the NPPO within the National Health and Social Care Professions Office is dependent on the appropriate funding and WTE resources being put in place.

Memoranda of Understanding/Agreement should be developed for all domains of psychology to bridge gaps in information and establish procedural guidelines.

A placement office will provide the opportunity to formalise placement identification and availability and enable cross-agency collaboration with regard to placements between the HSE, Tusla, IPS, NEPS and voluntary agencies. Noting that there are already strong networks and relationships at local level with HEIs, the NPPO can build on what already works well to further strengthen and support psychology services and students. The proposed Hub and Spoke model, involving multiple regional stakeholders, would assist in maintaining flexibility.

Finally, a central placement office will facilitate improved and strengthened communication between the health and social care system and HEIs to better enable psychology training programmes to respond to, and contribute to, identifying the needs of the system.

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List of acronyms

CAMHS: Child and Adolescent Mental Health Services

GA: General Adult

POLL: Psychiatry of Later Life

CBT: Cognitive Behavioural Therapy

ASD: Autism Spectrum Disorder

ID: Intellectual Disability

DBT: Dialectical Behaviour Therapy

1. Introduction

1.1. Background and context

A 2016 Review Group produced Report of the Review Group - Eligibility Criteria for Recruitment of Psychologists to the Health Service Executive. This review was commissioned by the National Director of Human Resources in the context of significant organisational change and re-alignment in the Health Service Executive (HSE); and the Commission for Public Service Appointments Report (CPSA, 2013) on recruitment of psychologists. This Report recommended revised eligibility requirements for entry into competitions for Psychology posts. Specific requirements were set out for eligibility to enter competitions up to October 2018. These criteria have been implemented and applied to staff grade and senior psychology competitions run in 2016 and 2017. Eligibility requirements for competitions after October 2018 were also outlined (Appendix 1).

The 2016 Review Group recommended the establishment of a group (the Implementation Group) to look at the practical steps necessary to implement the revised eligibility standards, due to come into effect in October 2018, for staff grade and senior psychology posts. Report of the Psychology Review Implementation Group.

1. The Report stated:

Recommendation 5.1

It is the view of the Implementation Group that the original implementation date of the revised criteria, October 2018, be deferred, given the challenges identified and delays to date, is not achievable. We recommend that HSE HR changes that date to **1 October 2019** and plans a review of progress within 12 months.

Recommendation 5.2 Create as a matter of urgency a National Psychology Placement Office which could assist with:

• Placement identification

• Placement allocation

• Maintaining a single education and placement record for all trainees

• Garda Vetting

• Deeper examination of any potential implications stemming from cited EU Directives and Implementation Regulations etc.

The National Director for Human Resources, noting that the creation of a National Psychology Placement Office, as set out above, has organisational and resource implications, committed to establishing a Project Team to implement this recommendation. In addition, the Project Team were to also consider, inter alia, an action from the Department of Health, the preparation of a workforce plan for psychological services in the HSE to include an examination of the current framework for training psychologists for the health service and the type and skill-mix required for the future in line with A Vision for Change.

1.2.Establishment of the Psychology Project Team

In February 2019, HSE Community Operations convened a Project Team to progress the recommendation of the Implementation Group with special emphasis on the recommendation to establish the National Placement Office.

In April 2019, recognising the potential negative impact of maintaining the October 2019 date for implementation of the revised Eligibility Criteria; and noting, the impact that Covid-19 has had on the work of the Project Team, the Psychology Project Team recommended the date be deferred to 1st October 2024 implementation in the context of future graduating psychologists accessing the required placements.

1.2.1. Terms of Reference

Establishment The Psychology Project Team will be established by National HSE, under the governance of, and sponsored by, the HSE's Leadership Team.

Purpose The purpose of the Psychology Project Team (PPT) will be to implement arrangements that deliver a national psychology placement function within the HSE, and workforce plan for psychological services in the HSE.

Terms of Reference - Key Obejctives:

Objective 1:

Implementation of recommendation 5.2 of the Report of the Psychology Review Implementation Group that provides for an Operating Model with the following key functions.

1. Eligibility Criteria.
2. Ongoing Placement identification, co-ordination with defined process and procedures to be applied, giving due regard, and consideration, to the existing process for clinical psychology.
3. Placement allocation (and ongoing)
    - Including the identiciation of appropriate placement types and service areas
    - Roles and responsibilities, including operating environment
4. Maintaining a single education and placement record for all trainees
5. Ensures Garda vetting completion
6. Scopes any potential implications stemming from cited EU Directives and Relevant Regulation ([ncluding Statutory Instrument No. 8 of 2017: European Union (Recognition of Professional Qualifications)].

Objective 2:

To design and recommend to the HSE Leadership Team a workforce plan for psychological services provided for, and funded by, the HSE inclusive of the following key deliverables.

Priorirty tasks:

1. Carry out an examination of the current framework for training psychologists (inclusive of clincial, educational and counselling) and set out key findings
2. Based on the above referred to examination, consider and propose future requirements for clinical, counselling and educational psychologists within the health sector
3. Make recommendations in respect of MOUs, SLAs and governance arrangements with relevant third level educators and service units and between services, and supported trainee psychologists.

Development of a Workforce Plan for the wider Psychological Services:

The HSE is required to develop a workforce plan to address the future type and skill mix required for delivery of psychological services in line with A Vision for Change, and Slaintecare Implementation Strategy Goal 2 Strategic Action 4 Expand Community-based Care, and informed by the models of care. This plan is required to take account of the wider spectrum of psychological services and disciplines that are/ intended (current and future) to be regulated under CORU and have regard to other sectors where psychological services are provided, i.e. Tusla, Justice and Education Sectors.

Following completion of the above referred to tasks, the working group will consider and provide observations to the HSE in respect of the method/ framework to enable the HSE to deliver the referred to workforce plan.

Approach to Implementation:

1. The PPT will establish two seperate “sub-groups” tasked with leading the development of the above referred to Objectives 1 and 2.
2. The subgroups will be chaired by a member of the PPT and will report /be accountable to the PPT for the duration of the Project Team term.
3. The subgroups will comprise key representatives of both the PPT as well as key experts necessary to fulfill the mandate given.
4. The PPT will set and agree the objectives and timeframe for the subgroups utilising an agreed project mangement tool (gantt chart)
5. A key emphasis of the subgroups will be to ensure a robust consultation process with the following key stakeholders as part of the deliberative process.
    - Consult with CHOs, Hospital Groups, funded agencies, HSE Operations, and Strategy and Planning, HEIs, as required, to determine the capacity of the system to provide; a) appropriate accredited placements and; b) the necessary supervisory arrangements to meet future service demands.
    - Consult with the Psychological Society of Ireland on the Society’s accreditation rules for supervision of clinical, counselling and trainee psychologists;
    - Consult with the Heads of Psychology Services Ireland on the identification and allocation of placements and supervision for clinical, counselling and educational

trainee psychologists;

- Consult with other relevant stakeholders as appropriate to the Terms of Reference of the Project Team, including IR representative bodies;
- In consultation with the relevant HEIs establish the placement availed of for the academic year 2017/2018 and projected requirements for the years 2018/2019 and 2019/2020;

1.2.2. Membership

The Project Team held 11 meetings during the period February 2019 – August 2020. As at 6th August 2020 the membership of the Team was as follows:

- Cathal Morgan, HSE Corporate, Assistant National Director, Chair
- Niamh Clarke, Principal Psychology Manager, CHO 8 *
- Aidan Corr, Senior Psychologist, St Paul's Service
- Mary Davis, Principal Psychology Manager, Disability Services, CHO 2
- Mary Doran, HBS Recruit
- Paddy Duggan, HSE Strategic Workforce Planning and Intelligence
- Janette Dwyer, Head of Social Care, CHO 5
- Daniel Flynn, Principal Psychology Manager, Mental Health Services, CHO 4
- Theresa Heller, HR Lead, Mental Health Community Operations
- Natalie Hession, Principal Psychologist, Psycho-oncology St. Luke's Hospital
- Declan Hynes, Head of HR CHO 6
- Diane Lynch, HSE Strategic Workforce Planning and Intelligence
- Mac MacLachlan, HSE Clinical Lead for Disability and Professor of Psychology, Maynooth University
- Marian Meaney, Disability Strategy, Community Strategy & Planning *
- Jackie Nix, Assistant National Director, HR Community Operations
- Tess O'Donovan, Assistant National Director HR Acute Services
- Meena O'Neill, Principal Psychology Manager, CHO 2
- Ed O'Dea, Principal Psychology Manager
- Eileen Walsh, Health & Social Care Professions Office

* Left the Project Team due to reassignment or other factors

To progress the work of the Project Team, two sub-groups, were established to progress Objective 1 and Objective 2 respectively. Each Sub-group was chaired by a member of the Project Team and additional members were invited to join each sub-group to inform, and contribute, to the work. Membership of the two Sub-groups is available in Appendix 2.

1.3.Stakeholder engagement

The Project Team has endeavoured to ensure that a thorough process of stakeholder consultation has been conducted to inform their work.

In line with proposals for stakeholder consultation and engagement agreed by the Project Team, the purpose of stakeholder engagement has been three-fold:

- To communicate and inform stakeholders of the establishment of a National Psychology Placement Office (IAP2 Spectrum – engagement level 1);
- To seek feedback to inform the establishment of a National Psychology Placement Office and an operational remit in the areas of trainee psychologist placements including identification, requirements and preparation (IAP2 Spectrum – engagement level 2);
- To seek feedback on identifying key drivers that are likely to produce significant changes in the ways in which, and the extent to which, psychological help can be made available to those who may benefit from it; and the implications for the psychological workforce (IAP2 Spectrum – engagement level 2).

A high-level stakeholder mapping exercise was undertaken by the Project Team to identify stakeholders who were likely to have an interest in the establishment of a placement office. This exercise informed the approach to consultation.

Communication and engagement commenced in October 2019, with an introductory briefing session for all stakeholders.

A half day workshop was hosted on 28th February 2020. A week in advance a high-level synthesis paper was issued to all attendees. The purpose of the paper was to support discussions on the day, and to seek views, in particular, to assist with the finalisation of the establishment of the placement office and associated remit. Feedback was also sought in relation to the key drivers of change in the provision of psychological services, and the implications for the psychological workforce. Stakeholder feedback was requested on the following questions:

1. Are there any other considerations with regard to the availability of, or demand for, placements that should be taken into account?
2. Are there any other key interfaces between the placement provider organisations and HEIs that should be taken account of?
3. What gaps in information flows exist – either within placement provider organisations or across the health and education sectors?
4. Is there a specific requirement to scope out the current local governance arrangements in place between the HSE/Section 38s and the HEIs, in respect of placement management for Clinical Psychology Trainees?
5. Is there a further specific requirement to scope out the current arrangements with regard to placement management for Counselling and Education Psychology Trainees?
6. What service developments should be a priority of psychologists?

7. How should psychologists respond to the increasing range of assessment, support and intervention options?
8. How should the training of psychologists evolve in order to adapt to innovations in technology, skill mix, and service user empowerment?

The workshop involved an introduction outlining the context and purpose of the day by the Chair of the Project Team. Stakeholders were divided into pre-determined groups to ensure an even representation of all stakeholder cohorts. During the first session the groups discussed and noted their feedback on Questions 1 – 5; following which key messages were shared by each group. The second session adopted the same approach and considered Questions 6 – 8.

The workshop discussions identified a number of benefits that would arise from a centralised approach to placement planning and management:

- Longer term planning of, and for, placements.
- Development of national agreed standard placement criteria.
- Development of common placement learning agreements.
- Development of national agreed supervisor accreditation.
- Improve and strengthen communication between the HSE system and HEIs to better enable education to respond to, and contribute to, identifying the needs of the system.

With regard to the key drivers of significant change for the future delivery of psychological services, the key implications for the psychological workforce identified were:

- Workforce diversification.
- Generic vs. specialist skills.
- Equitable funding for training across clinical, counselling and educational psychology.
- Quality support and assurance.
- Competency framework.
- Leadership in Multi-Disciplinary Teams and community healthcare.
- Staff tasks should align with their competency, level of employment and remuneration.

An overview of the themes emerging from the consultation workshop is included in Appendix 3 including a number of core objectives for the proposed National Psychology Placement Office. In addition to the briefing and workshop, bilateral engagements took place with the Department of Health, Psychological Society of Ireland, Heads of Psychology Services Ireland (HPSI), Forsa, HSE Operations, and the Office of the Chief Clinical Officer.

1.4.Acknowledgement

The Chair and Project Team members would like to express their sincere thanks to all those who have contributed to the consultations, engagements, and sub-groups for their interest and commitment to working collaboratively together to strengthen psychology services into the future.

2. The Context for Psychology Services in Ireland

2.1.Introduction

In the context of strengthening community-based care, and the importance of developing policies to optimise the supply of professionally trained psychologists, Working Together for Health: A National Strategic Framework for Health and Social Care Workforce Planning highlighted the need to understand the drivers informing labour market dynamics, and considering both workforce supply and demand in informing workforce planning policies and practices.

The chapter conclusions seek to identify existing inter-agency collaboration and / or cooperation; the key drivers of demand for psychology services, and identify future considerations for a psychological services workforce plan.

2.2.Provision of publically funded Psychology services in Ireland

2.2.1. Psychology in the Health Service Executive

Psychologists aim to reduce psychological distress and to enhance and promote psychological wellbeing in our communities by the systematic application of knowledge derived from psychological theory and research.

Psychologists typically spend about 10 years studying, researching, and gaining clinical experience and completing a 3-year doctoral level professional training. Qualified psychologists are trained to be competent in assessment, formulation, multi modal interventions, evaluation, research, consultation and ethical awareness. They are competent to work with service users, with a wide range of clinical presentations across different organisational environments – health; education; justice and prison services; and social inclusion;, and have the skills to teach, supervise, and support others' learning in the application of psychological skills, knowledge, practices and procedures.

Clinical, counselling and educational psychologists are currently employed either directly through the Health Services Executive (HSE), or by voluntary service providers funded by the HSE. Psychologists within the health service work in both community and hospital based settings, and in all tiers of service provision (primary, secondary and tertiary care). Psychologists work collaboratively with staff and service users in the full range of care environments – acute hospitals, mental health services, disability services, older persons' services, child, adolescent and adult primary care services; as well as contributing to health promotion and population-based initiatives within health and well-being.

Growing numbers of psychology staff (see Table 4.2), and levels of more specialised services, has led to an increased requirement for Principal Specialist posts in a number of CHO areas. These posts provide support to the Principal Psychology Manager, or Director of Psychology, in providing effective clinical governance of staff working in specific care areas. Principal Psychologist Specialists typically carry a significant clinical practice caseload. Principal Specialists are directly line managed and report to the Principal Psychology Manager, or Director of Psychology. In areas without Principal

Psychologist Specialists, Senior Psychologists are line managed and clinically supervised directly by the Principal Psychologist Manager.

Senior Psychologists typically engage in substantial direct clinical work and have supervisory roles over more junior psychology staff including Staff Grade Psychologists, Psychologists in Training and Assistant Psychologists. Staff Grade Psychologists, where appropriate, will support Senior Psychologists with supervision of Psychologists in Training or Assistant Psychologists.

The early history of professional psychology within the health system in Ireland was influenced by prevailing medical models of working such as the Child Guidance clinics, and was characterised by one to one assessment and treatment in a clinical setting. However, as far back as the late 1970s and early 1980s, and influenced by the Community Psychology movement in the UK, there has been a gradual shift towards broadening the remit of psychology towards delivering psychological knowledge and interventions at community and population level, with the aim of promoting population health and well-being, and community resilience in both physical and mental health spheres. Wider health policy such as Healthy Ireland – A Framework for Improved Health and Well-being 2013-2025 has supported a move away from illness, or disease management, to promoting community health and well-being, with initiatives drawing extensively on psychological models of behaviour change.

The following provides an overview of psychology services across the different areas of the public health service.

Community Healthcare Organisations

i. Primary Care Psychology Services

Primary Care by definition is a universal service operating to a life span model of service delivery. This model envisages that "all but the most complex and acute health care needs of individuals, families and groups may be effectively met within the primary care setting" (Primary Care – A New Direction, DoH&C, 2001). Psychology services delivered at this level incorporate a range of assessments, interventions and consultations, whether as dedicated members of a primary care team or as part of the wider primary care network.

Vision for Change (2006) recommended that "all individuals should have access to a comprehensive range of interventions in primary care that do not require specialist mental health provision" and which include access to "specialist psychological interventions". Locating psychology services at Level 1 of the HSE Service Delivery Model (Appendix 4), has been shown to be cost effective in addressing a range of psychological difficulties and disorders at an earlier stage, thereby reducing inappropriate referrals to costlier Level 2 services e.g. Child and Adolescent Mental Health Services.

Sharing The Vision – A Mental Health Policy for Everyone (2020) is a policy that builds upon the good work achieved over the past decade, and provides a framework for investing in a modern, responsive mental health service fit for the next ten years. In relation to Psychology services the above policy states:

- The cornerstone of service delivery in secondary care will continue to be the multi-disciplinary Community Mental Health Teams (CMHTs). The multi-disciplinary nature of the CMHTs enables a variety of professional perspectives to be combined in case formulation, care planning and service delivery.
- Access to a range of counselling supports and talk therapies in the community/primary care should be available on the basis of identified need so that all individuals, across the lifespan, with a mild to-moderate mental health difficulty can receive prompt access to accessible care through their GP/ Primary Care Centre. Counselling supports and talk therapies must be delivered by appropriately qualified and accredited professionals.

ii. Specialist Psychology Services

Access to psychology services at these levels is in the context of multi-disciplinary teams catering for clients with more complex and enduring presentations both in community and acute hospital settings. This level also includes services to children and families at risk, encompassing child welfare and protection, children in care and family support services. Psychologists are core members of all multi-disciplinary teams providing services to individuals with complex developmental, social, emotional and psychological needs.

The Progressing Disability Services for Children and Young People programme objective is to achieve a national unified approach to delivering health services so that there is a clear pathway to services for all children regardless of where they live, what school they go to, or the nature of their developmental delay or disability. The programme's objectives are based on recommendations from the 2009 Report of the Reference Group on Multidisciplinary Services for Children aged 5 to 18 Years which was adopted by the HSE in 2010 as the framework for development of disability services for children. This report states clearly that all multidisciplinary teams must have a psychologist as a member of the team.

Within many areas of the HSE a specialist Psychologist service is provided to TUSLA under a service level agreement. These services are centred round dealing effectively with the negative effects and long term consequences of childhood adversity. The level of complexity of the needs of these children requires timely access to appropriate assessment and treatment options in order to minimise the negative effects on social, emotional and psychological functioning, personality development and quality of life.

iii. Specialist National and Regional Services

These are highly specialised national and regional services generally delivered by multi-disciplinary teams to address complex and challenging conditions. They include Special Care/High Support Services, Forensic Services, Autistic Spectrum Disorder (ASD), and Acquired Brain Injury Services.

The National Forensic Mental Health Service (NFMHS) aims to offer care and treatment to individuals with a severe mental disorder who have exceeded the capacity of secondary mental health services and criminal justice/youth justice services.

The NFMHS, in Portrane, is a 170-bed facility consisting of the Central Mental Hospital (CMH), inclusive of Forensic Mental Health Intellectual and Developmental Disability Teams, Forensic Child and Adolescent Mental Health Service (FCAMHS), and a Forensic Intensive Care Rehabilitation Unit (F-ICRU). The NFMHS service also provides a prison in-reach service. The current clinical model of service in the Central Mental Hospital is based around 7 Pillars of care. The needs of the above patient groups are met through the provision of specialist forensic mental health teams (MDT) in addition to therapeutic programmes focusing on Physical Health (Pillar I), Mental Health (Pillar 2), Substance Misuse (Pillar 3), Harmful Behaviours (Pillar IV), Self-care activities and daily living (Pillar V), Education Occupation and Creativity (Pillar VI), Family and Social Networks (Pillar VII).

The NFMHS has a strong academic track record within the fields of forensic psychiatry and forensic clinical psychology. As a national tier three and tier four highly specialised service, the NFMHS has an essential role in teaching and training of professional psychologists.

Acute Hospital Services

Hospital psychologists provide psychological interventions to a wide range of physical conditions and medical areas including oncology, cardiac, diabetes etc.; to both adults and children in hospitals across the country. These psychologists, with specialist skills, aim to improve psychological wellbeing by facilitating both adjustment and adaptation to the challenges of illness and/or treatment regime.

Through the delivery of psychological assessment and therapeutic services, that are evidenced-based and recovery-focused, they work on the prevention of the development of more significant psychological issues, thereby having a positive impact on the health outcomes of patients and their families. In addition to the provision of treatments, hospital psychologists provide unique input to other professions and multi-disciplinary teams. They teach, supervise, and support others' learning in the application of psychological skills, knowledge, practices and procedures in patient care. Medical cost offset is gained through the provision of psychological access within the health service. Hospital psychologists design and conduct evaluations to ensure acute care services are evidence-based, have high throughput, are accessible and demonstrate value for money.

2.2.2. Irish Prison Service

A Vision for Change (VfC) enshrined the position that responding to mental health and promoting wellness requires 'whole of Government' responses and that VfC's successful implementation, whilst led by the Department of Health, is a cross-departmental task. The Irish Prison Service (IPS) has been involved in the consultation process for the next iteration of VfC. The IPS's Psychology Service philosophy on the provision of psychological services to people in custody explicitly enshrines the principle of equivalence of care as its cornerstone. Consequently, the IPS's Psychology Service

model of care (Appendix 5) dovetails with that of VfC, and the HSE, in being bio-psycho-social, strengths-based, and organising services in a layered care model.

2.2.3. Psychology in Tusla

Tusla – Child and Family Agency was set up in 2014 following the enactment of the Child and Family Agency Act (2013), which sets out among the statutory functions of the agency the provision of psychology services for children and families with significant needs. This includes children living within highly vulnerable family settings and children who are living in alternative care services, as well as young adults in receipt of aftercare services. This statutory requirement establishes Tusla as a major commissioner of psychological services for children and families in Ireland, both from non-statutory providers and via MOUs with the HSE. Tusla directly employs psychologists within multidisciplinary care teams, who provide services at a level analogous to HSE secondary care services.

Tusla also operates highly specialist services for young people who are placed in secure settings (special care or detention), or who are at significant risk of being placed in such settings. Psychologists within Tusla provide holistic broad-focused services that address concerns related to disability, psychopathology at all levels of complexity, family functioning, alternative care, broad- and focused systems-level support, and population-level support. Services are delivered to parents and carers, and to young people of all ages.

Tusla services are part of an all-encompassing health care provision and smooth transition into aftercare/adulthood. Close co-operation with other health care providers in primary care, mental health and disability is of paramount importance. The TUSLA psychology service is an essential secondary service provider in the care pyramid, with referral protocols up and down to specialised services of mental health/disability and generic services of primary care

Since its inception, Tusla has been, after the HSE, a primary funder of psychology training in Ireland.

2.2.4. National Educational Psychological Service

NEPS is a constituent section of the Department of Education and Skills. NEPS provides a psychology service to all schools nationally to support the wellbeing, social, emotional and academic development of all learners with special consideration to those with special educational needs and those at risk of marginalisation.

NEPS provides a consultative approach to schools delivered through a multi-tiered model of service; i.e. provide a continuum of service to schools, in line with the Department of Education's continuum of support for learners that is embedded in the school system.

2.3.Demand for Psychologists in the HSE

In light of the growing awareness of the role of developmental and psychological contributors to physical and mental well-being across the life-span, and acknowledging the impact of Covid-19 in recent times, demand for psychologists and psychological services is growing in all areas of health and social care provision, including in Acute settings where psychology services are available. Other

factors that have contributed to increased demand include both economic and policy changes. At a time of increased focus on 'value for money' within health services, the cost effectiveness of psychological interventions for a broad range of developmental and mental disorders has been clearly demonstrated. At a policy level for example, the move towards a Recovery model in mental health has prompted increased demand from service users for greater access to a more holistic, collaborative and person-centred psychological and social understanding of mental health difficulties, and a consequent demand for greater access to psychological interventions as an alternative, or adjunct, to medical and biologically based treatments.

Widespread access to internet-based information, and the success of public health campaigns, has led to a democratisation of knowledge around positive physical and mental well-being, and as a result there is increased demand from the wider public for access to psychological information and support.

While it is not possible to provide a full and comprehensive outline of the demand pressures for psychologists within the HSE, the following section outlines key drivers of demand and the impact of Covid-19.

2.3.1. Impact of Covid-19

At the beginning of the Covid-19 crisis and knowing its potential impact on our wellbeing, the HSE enacted a comprehensive psychosocial response at a national level and across the Acute Hospitals and local Community Healthcare Organisations (CHOs). At a national level current services and new innovations were aligned and scaled up to provide supportive interventions that incorporated emotional care and practical help e.g. Tele-Health, Occupational Health, Employee Assistance Programme (EAP), Health and Safety, and National HR.

At the CHO level, local Psychosocial Response teams were activated. The CHO psychosocial response was required to meet the varying psychological and social needs of the general public from child to older adults impacted directly and indirectly by Covid-19. HSE priorities at the CHO level in the early phase of Covid-19 included psychosocial supports for HSE staff, nursing home management, and staff in HSE residential units for older persons and private nursing homes.

Across the Acute Hospitals, psychosocial responses were mobilised to support staff and members of the public. For staff, some of these initial psychosocial initiatives focused on peer to peer; team and adverse event supports; and for the public providing bereavement services for patients and families, communication care to promote connection and virtual communication between isolated patients and families; psychosocial support around distress caused by isolation; and visiting restrictions.

2.3.2. Mental Health Services

Critical to meeting the need for increased access to, and effective deployment of psychological interventions and therapies within mental health, is availability of professionally qualified psychologists to provide and consult on psychological assessment and formulation on which decisions on the appropriate type and degree of psychological intervention and therapy required can be based. Psychologists are well placed to provide up-skilling and training to mental health staff and to provide

consultation, supervision and support to multidisciplinary colleagues so as to improve psychological understanding of individual service user presentation and indicated intervention needs.

Sharing the Vision sets out key challenges and objectives for which the provision of psychological services will be required. Examples include the following:

- In order to relieve pressure on acute inpatient beds, there will be a need for specialist psychological interventions that have demonstrated effectiveness in reducing and preventing repeat hospital admissions for some of the most vulnerable mental health service users.
- A move towards increased access to intensive therapeutic support in day hospitals, intensive care rehabilitation and psychiatric intensive care units will require psychological input as part of the therapeutic packages available.
- In recognition of demographic changes towards an increase in numbers of older people who have greater risk of mental health difficulties, and higher levels of neurological disease such as dementia, psychologists will be required for differential diagnosis, intervention and care planning.

International research speaks to the growing need for specialist mental health provision for those with often very complex needs arising from dual diagnoses of addiction/substance misuse, disabilities such as Autism Spectrum Disorder, or Intellectual Disabilities.

In the absence of a broader model of care for psychological services, Mental Health Services is the only area to have undertaken formal workforce planning, the details from that exercise are set out below.

The Mental Health Workforce Plan Report (2018) provides an overview of the current supply gap, and the expected future demand for psychologists within the services provided by specialist Mental Health Services i.e. Child and Adolescent, General Adult and Psychiatry of Later Life. The current staffing compliment in Psychology equates to 53% against Vision for Change, 2006. It should be noted that this plan focussed only on the contribution of Clinical Psychologists. Future requirements, as delineated below should be updated to include the contribution of psychologists of other designations.

Future requirements for staff within Mental Health Services (see Table 2.1) was also a consideration of the above Report, the data for which was derived from the Service Improvement and Clinical Programme initiatives currently in progress. The Report also highlights that mapping of mental health posts within Primary Care, Social Care and Acute Services was out of scope of the project. In that regard, it further recognises that this is a known risk to the accuracy of the mental health data, and it recommends that further work take place to address this issue.

Table 2.1. Future requirements for Mental Health Staff

	CAMHS	GA	POLL	Total
Psychologists Vision for Change recommendation	190.5	190.5	47.6	428.6
Psychologists in Post	72.5	132.2	22.1	226.8
Unmet need	118	58.3	25.5	201.8
Future Requirements (Clinical and Service Improvement Programmes)				120
Total # of Psychologists required				**321.8**

This table includes the Vision for Change Psychology staffing requirements for the main areas of service managed by Mental Health Services, however it did not look at the recommendations and current staffing of Mental Health of Intellectual Disability (Adult & Child); Recover and Rehabilitation services, and specialist services such as Perinatal Mental Health and ADHD specialist services.

Of note, is that the WTEs outlined in VfC 2006, will continue to remain the staffing ratio Community Mental Health Teams (CMHT) should aspire to, albeit they are not contained in the new Sharing the Vision policy. It is also recognised that each CMHT has its own unique need depending on various factors (deprivation, demographics etc.) and the new policy allows for each area to determine what staff should be prioritised based on need and available resources. This will require the establishment of a baseline with respect to existing level of services and a prioritisation of resource allocation to protect and strengthen services. In this context, the Project Team acknowledges that new development funding will need to be secured through Strategy and Planning in order to build capacity into the future.

2.3.3. Disability Services

Among key drivers of increased demand for psychologists within the statutory and voluntary disability sectors are the following:

- Increased rates of mental health difficulties in children and adults with additional needs;
- International evidence of the high prevalence of ASD and ID in prison services which will require the development of awareness, expertise and services within the criminal justice and prison system;
- The roll-out of the Progressing Disabilities policy framework and resulting re-organisation of services into Network teams will expose gaps in existing levels of Psychology service for children with disabilities and their families.

The continuing international upward trend in the prevalence of life-long developmental disorders such as ASD, now considered a common disorder, are resulting in increased demand for diagnostic and intervention services to support individuals and their families, and to which psychological input is core.

Related to this, is the consensus that early, intensive intervention, based on sound psychological theory and research findings (behavioural and developmental), leads to positive clinical and health economic outcomes. While currently there is no statutory right to appropriate intervention, pressure

from individuals, families, lobby groups and the growing economic long-term costs of failure to provide comprehensive and systematic intervention, is likely to lead to significant pressure to increase resource allocation, including psychology services to this population.

2.3.4. Primary Care Services and Health and Well-Being

The policy direction towards the provision of improved community based health services for physical and mental health set out in Sláintecare and Sharing the Vision, will require greater investment in Psychology services at Primary Care level, and further integration of psychological models of behaviour change in public health campaigns within Health and Well-Being. Psychological assessment, as part of broader multidisciplinary team-working, will be central to accurate diagnosis of presenting difficulties across the life-span, and the development of early intervention supports to meet a broad range of needs that are currently inadequately resourced at this level.

The roll out of Progressing Disabilities, and its emphasis on moving service provision for individuals with disability whose needs are considered 'non-complex', to Primary Care will challenge Primary Care services to resource and develop disability sensitive services and models of service provision that have not traditionally been part of service provision at this level. An increase in the number of psychologists currently employed in Primary Care will be required to meet the expanded assessment and intervention needs of this new care group within Primary Care; train and up-skill staff; and to contribute to service development in this area.

2.3.5. Acute Hospitals

The experience of illness and hospitalisation is inherently stressful and is associated with increased psychological difficulties across patient groups. This can adversely impact quality of life, overall well-being, adherence to medical treatment and subsequent patient recovery. Hospital psychologists ameliorate these difficulties through the delivery of psychological assessment and therapeutic services that are evidenced-based, recovery-focused, and tailored to the specific needs of patients and their caregivers.

Psychological services in hospital settings can be augmented to achieve optimal clinical care in a way that reduces cost. Factors that are central to this include purposeful workforce planning; re-configuration of psychology governance; ordered succession planning; a stepped-care approach to psychological care; psychological training and support for multidisciplinary teams; robust supervision arrangements of psychologists to quality assure services; seamless transition of patients from paediatric to adult services; reduced inpatient admissions; and increased emphasis on patient experience feedback. Unfortunately, there is a disparity of access to psychology across hospitals nationwide.

2.4.The Policy Context

2.4.1. Sláintecare

Sláintecare Strategic Action 4, Expanding community and primary care, is at the heart of the Sláintecare vision. It acknowledges that creating a shift of care from the acute setting to the

community will be particularly challenging, and will require a new plan for the organisation and operation of community care services. This will build on work already underway to develop Community Healthcare Networks and primary care teams.

Sláintecare is seeking to strengthen community-based care to provide a comprehensive service ranging from prevention to diagnostic services, disease management, disability care, mental health care, rehabilitation and palliative care. Expanding workforce and infrastructure capacity in the community to deliver the plan for community-based services has been identified as critical for achieving this vision. Increased workforce capacity, in relation to both employed staff and contracted professionals, will be required in the community. This will include a range of specialist and non-specialist staff including psychology among other professions and talk therapies.

2.4.2. Sharing the Vision

The successor policy to A Vision for Change – Sharing the Vision mirrors Sláintecare in that the focus of mental health care will be to provide access to care when and where it is needed. The policy focus is on action-oriented outcomes that will seek to bring about tangible changes in the lives of people experiencing mental health difficulties across the population, with primary and secondary care interventions as required. An outcome based policy, it aims to support significant changes in how mental health services are delivered, striving to ensure that individuals can achieve better measureable results as far as possible.

Supporting the mental health of the population must encompass actions that range from building resilience, through prevention, early intervention and treatment of mental health issues, to treatment and on-going support for those with complex conditions. Therefore, the policy seeks to build capacity for mental health treatment and support in primary care and to support the valuable role of community and voluntary sector organisations. This is designed to improve early access to support for people with mental health difficulties and will help avoid an over-reliance on specialist mental health services. Recommendations have also been made about improving the resources and working practices of community mental health teams and other parts of the specialist mental health services, to maximise the outcomes by the most effective use of these resources and skill mix in the teams.

The role of multi-disciplinary teams was highlighted in the previous Vision for Change and the current policy will continue to support this way of working. This includes a focus on the role of primary care psychological interventions that can address a majority of mental health conditions. Consequently, psychology will continue to play an important role in assessment, care planning and treatment interventions.

The revised policy is underpinned by a wide-ranging public stakeholder consultation process that also incorporated relevant themes arising from submissions to the Joint Oireachtas Committee on the Future of Mental Healthcare in Ireland.

2.5.Conclusion

Inter-agency working amongst psychologists is in place across a number of areas. TUSLA psychology services work in close co-operation with other health care providers in primary care, mental health and disability. The National Educational Psychological Service engages in regular consultation with health and disability sectors working with families of children with disabilities. Within the HSE and HSE-funded organisations, psychologists work across all aspects of our health and social care systems and are firmly embedded in primary care, acute care, mental health, social care, and disabilities service provision. While the Irish Prison Service's model of care dovetails with Vision for Change and the approach of the HSE.

Sharing the Vision: A Mental Health Policy for Everyone; continues to support the role of multi-disciplinary teams as highlighted in the previous version; including a focus on the role of primary care interventions that can address a majority of mental health conditions. Psychology will continue to play an important role in assessment, care planning and treatment interventions.

Critical to Sláintecare's plan for community-based services are the expansion of infrastructure and the workforce capacity of specialist and non-specialist staff including psychologists. The demand for psychological services, including the current and any future public health emergency, will need to be determined in order to accurately understand the workforce demand. A psychological services workforce plan would need to take account of any models of care and skill mix requirements, to ensure that planning encompasses the psychological services in their totality, and not just that of the HSE.

In this context, and in line with Sharing the Vision, in which each area is to determine what staff should be prioritised based on need and available resources, new development funding will need to be secured through Strategy and Planning in order to build capacity into the future, to protect and strengthen services.

Finally, an investment in Professional Psychology training would help begin to manage the current shortfall of psychologists across the services; and involve the HSE (with other partners) investing in psychology to include, the currently unfunded counselling and education programmes.

3. Psychology education and training Ireland

3.1.Introduction

As with demand side factors this chapter summarises the future labour supply side environment to provide an understanding of the role of the various stakeholders in preparing the future supply of psychologists.

The chapter summarises the interfaces identified by the Project Team and sets out the current approach to training placements and funding for clinical, counselling and educational psychology students i.e. the future psychology workforce.

3.2.Education

The education of psychologists in Ireland is currently accredited by the Psychological Society of Ireland (PSI). In the near future, this will fall under the remit of the professional regulator for psychologists in Ireland, CORU. The planning for registration is at an advanced stage.

Students who successfully complete one of the eight post-graduate courses, that take place at six institutions in Ireland, are eligible for registration with the PSI and employment in Irish public service.

Figure 3.1 Education pathway for psychologists employed in the HSE

Achieving the status of a professionally qualified psychologist differs from the pathway and professional qualifications required of other health care professionals in that an undergraduate qualification in psychology does not qualify the graduate to practice the profession, unlike dietitians, physiotherapists, social workers, nurses, midwives and others. Table 3.1 overleaf provides a high-level overview of the education and experience journey of those entering a doctorate in psychology.

Table 3.1 Education and experience of psychologists undertaking a Doctorate in Psychology Programme

***1 Entrants to Doctorate in Clinical Psychology (based on O'Shea and Byrne, 2011)**	***2 Entrants to Doctorate in Educational and Child Psychology (UL) and Doctorate in Educational Psychology (UCD)**	***3 Entrants to Doctorate in Counselling Psychology**
● The mean age for entry to DClinPsych programmes was reported to be 27.67 years. ● 89% (n = 116) of applicants had completed full-time postgraduate study in a clinically related field. ● Shortlisting criteria included academic qualifications, research experience, clinical experience and personal skills. ● 71% (n = 92) worked in Assistant Psychology posts prior to entering clinical training. ● 45% (n = 59) had worked as a Research Assistant. ● Exclusive of Research Assistant and Assistant Psychologist positions, 77% of applicants (n =100) also worked in other clinically relevant positions (prior to entering training) including counsellor, special needs assistant, ABA tutor, care assistant, social care worker, support worker and support group and/or call facilitator. ● Many applicants may have spent a minimum of three years completing their undergraduate qualification, one to two years completing their postgraduate qualification(s), a minimum of one year engaged in clinical research and/or work, and then entered a programme during their first year of application (45%).	● Suitable candidates for these doctorate courses typically have a psychology qualification at Masters level (e.g. MSc or MA) and sometimes PhD level. ●A minimum of two years full time relevant work experience including work as an Assistant Psychologist, Behaviour Analyst, Support Worker or Research Assistant in addition to experience of working with children in specialist preschool and school settings, healthcare, social care and other early years settings, and adults in University settings, ID services and those engaged in Adult Literacy or Rehabilitative programmes or services. ● Research related to educational and child psychology (as demonstrated by involvement in research activities) and publications in peer reviewed journals, book chapters, significant role in work related research projects, presentation at peer reviewed conference national/international, non-student related poster presentations	In order to be shortlisted for interview, candidates must demonstrate experience in the following domains: ● Academic (typically an extra MSc or MA, but also 1st class honours are recognized or other related BSc, Bas and/or PhD by research – provided they are related to counselling psychology) ● Research (papers, conference presentations, research assistant positions – again in the area relevant to counselling psychology) ● Work experience (including voluntary – again in the area relevant for counselling psychology, normally this should be at least two years full-time equivalent – assistant psychologist posts are typical, but as we have also international applicants, e.g., various EU countries (virtually majority of EU countries) and non-EU countries, e.g., Australia, Singapore, China, Canada, USA, India – their work experience may vary according to the country of origin) ● Personal Development (people may get a qualitative recognition if they have any personal development experience – e.g., therapy, etc. – this is normally not assigned points, unless part of a formal education, e.g., counselling or psychotherapy training)

Figure 3.2 Psychological Society of Ireland Accreditation

Approved post-graduate courses	
NUI Galway	D. Psych. Sc. in Clinical Psychology
University of Limerick	D. Clin. Psychology
University College Dublin	D. Psych. Sc. in Clinical Psychology Doctorate in Educational Psychology
University College Cork	D. Clin Psychology
Trinity College Dublin	D. Clin. Psychology Doctorate in Counselling Psychology
Mary Immaculate College, University of Limerick	Doctorate in Educational and Child Psychology

Accreditation Guideline requirements

There are requirements for the design, organisation, management and resourcing of programmes to ensure they prepare graduates for autonomous professional practice, characterised by high standards, competence, and collaborative working with high levels of professional skill and knowledge. The accreditation guidelines focus on:

- Professional principles and values
- Academic programme content
- Administration and governance
- Admission requirements
- Assessment
- Quality and assurance

Placement requirements

Counselling Psychology

- 450 hours supervised client contact
- Placement experience over a minimum of 30 months based on at least two placement days per week
- Client experience, including diversity, in at least three settings
- Placement should vary across problems, conditions and disorders
- Placement should cover clients of all life span developmental stages
- Placement under the supervision of a qualified counselling psychologist (at least one placement) or another appropriately qualified psychologist with extra training in psychotherapy.

Educational + child Psychology

- 300 full days practical experience in applied settings across health and educational settings, including minimum 60 days supervised work experience in Child Disability care area and minimum 60 days Child Psychology (HSE Primary Care or CAMHS)
- 120-day placement in National Educational Psychology Service
- Opportunities for core skills acquired on placements include experience with assessment, formulation, intervention, systemic change, team working, ethical practice, supervision and research
- Placements focused on developmental needs of children and young people 0-18+ including disability, learning, mental health across health, education and social care setting
- Placement supervised by an educational and child, clinical or counselling psychologist

Clinical

- Placement should provide opportunity to acquire skills in assessment, formulation, intervention, evaluation and reporting.
- There are two placements categories “Core” and “Advanced”, a minimum of one Advanced placement is required.
- Core Placements are in the areas of:
  - Child and Adolescent services
  - Psychological services for adults
  - Services for people with intellectual disability
- A case load of a minimum of ten clients per placement where a trainee is the main psychologist is required.
- Placement under the supervision of a Senior Clinical Psychologist.

3.2.1. Psychologist who have qualified in other jurisdictions

Professional psychology qualifications awarded outside Ireland are assessed for equivalence, or gaps in clinical experience, against the Psychological Society of Ireland's criteria by the competent authority, the Department of Health (with the assistance of the Psychological Society of Ireland). Where gaps in experience are identified by the Department, the applicant can, as per the EU Qualifications Directive, apply for compensation measures (where the individual must undertake a supervised placement or placements period of academic learning to acquire and evidence additional clinical experience. There is no structure in place to accommodate these placements, facilitate access to such placements, or any periods of academic inputs that might be required to support same. Individuals are required to source such placements independently.

3.3.Training and Placements

Placements for professional training are provided by a number of agencies in line with accreditation criteria for each course of study. Placements are limited by a number of factors which include the placement physical environment, and the availability of supervisors who meet the criteria set down by the professional body.

Historically and currently, the contracted arrangements in place for Clinical psychology trainees means a larger number of the available placements, are given to these trainees as they are HSE employees and placements must be provided as part of their contract of employment. There are a limited number of available supervisors at any one time, which can limit the health system's ability to provide placement opportunities to other trainees in both Counselling and Educational professional training programmes. The Project Team recognise the need for national co-ordination of the placement process in terms of student / placement management, or resource allocation; and the need for enhanced and sustainable collaboration between health service providers and educators in preparing and developing the future psychology workforce.

Psychology managers work with course teams to try to optimise the availability of placements, subject to meeting professional body accreditation guidelines. Placements vary in duration from 4 to 10 months approximately, depending on the course of training and stage of development.

3.3.1. Demand for placements

Doctoral programmes are available in the three streams of professional psychology and offer approximately 90 places between them on an annual basis; educational (10-20), counselling (14) or clinical psychology (60).

3.3.2. Identification and Availability of placements and supervisors

Currently the educators liaise directly with Psychology Managers/Directors/Principal psychology managers in individual services to secure placements. Each Clinical psychology programme is aligned to either one or more HSE CHO area from where their trainee funding has originated, and where the Memorandum of Agreement is held. Trainees are required to take up training places as required within the sponsoring area and this often involves significant levels of travel or relocation. For

Educational and Counselling programmes, there is no consistent approach, and each training institute needs to approach individual managers to request placements in geographical areas that suit the needs of their trainees as far as is possible. Those seeking additional training days as part of gaining validation from the Department of Health will link directly with relevant service mangers to secure such experience in their preferred location.

The HSE List of Supervisors prepared by Psychology Managers for the Higher Education Institutes provides details of approximately 420 available supervisors across the four placement areas. This will however, vary from year to year given gaps with vacant posts; lengthy recruitment timelines; statutory and other leave entitlements; and access to appropriate clinical space in service areas.

3.3.3. Examples of other placement settings

Irish Prison Service

Irish Prison Service (IPS) Psychology Service Psychologists provide training inputs to Psychologists on doctoral training across the majority of counselling and clinical training programmes in Ireland. The Irish Prison Service has provided numerous placements over the years, and currently has one active placement.

Tusla

Tulsa, psychology services are provided to meet the needs of children and young people in care whose needs do not meet the criteria for the existing HSE Psychology services, or are delivered alongside HSE Psychology services. The senior psychologist is the supervising grade for the lower staff grades including trainees. Currently there are 14 Clinical Psychology trainees in Tusla.

National Educational Psychological Service

The National Educational Psychological Service (NEPS) supports University College Dublin (UCD), Mary Immaculate College of Education, Limerick (MIC) and, from time to time U.K. institutions, in providing training placements for Trainee Educational Psychologists (TEPs). This support is offered in the interests of the educational psychology profession, NEPS and individual TEPs.

NEPS psychologists contribute to the training of Educational Psychologists on both the UCD and MIC course through lectures and the provision of workshops across all three years of training.

NEPS's commitment to the training and provision of placements for TEPS is fundamental to ensuring a steady supply of suitably qualified and experienced practitioners for schools, and a training placement in NEPS is a requirement for both UCD and MIC professional training programmes.

3.4.Practice placements, placement requirements and supervision

The Eligibility Review Group defined **Appropriate Health Setting** to be "a setting which facilitates placement/clinical experience to be gained where the trainees / students have the opportunity to be supervised by an appropriate supervisor who is working within the health setting. The placement should include opportunities to acquire skills in assessment, formulation, intervention, evaluation and

reporting with a range of clinical problems in terms of complexity and severity seen within a care group population e.g. Child (0-18) Adult, Disability (lifespan)".

During the Implementation Group's stakeholder consultations, the educators reported that clarity was required on "appropriate health setting" to allow them identify appropriate placements for their students. This lack of clarity contributes to uncertainty for graduates at job application stage, and educators, in the context of availability and location of placements. It also created a situation in which existing employees no longer knew whether their employer considered them to have eligibility for promotion/transfer.

The Implementation Group recommended descriptions of the requirements of "appropriate healthcare settings" on foot of the revision of the care group areas by the Eligibility Criteria Review Group Report, as set out in Table 3.3 below. Applicants for Clinical and Counselling Psychologist posts are required to have experience in all four health care settings to be deemed eligible.

Table 3.2 Care Group Delineations for Staff and Senior Grade Psychology Posts in the HSE effective 01.03.2016

	Panel 1 – Care Group Area	Panel 2 - Care Group Area	Panel 3 - Care Group Area	Panel 4 - Care Group Area	Panel 5- Care Group Area
Clinical	Disability – Child Disability	Disability – Adult Disability	Adult Psychology Services	Child Psychology Services	Lifespan Primary Care
Counselling	Disability – Child Disability	Disability – Adult Disability	Adult Psychology Services	Child Psychology Services	Lifespan Primary Care
Educational	Disability – Child Disability			Child Psychology Services	

The Report of the 2016 Review Group recommends that existing employees, who do not have the relevant placement/clinical experience, are facilitated to undertake supervised work placements in the care groups required, to facilitate them being eligible to apply for future competitions. From a service perspective some of the challenges arising from this recommendation include the HSE's ability to maintain continuity and standard of services, and backfilling of posts etc., while the employees move to complete work experience in other care group settings. Other challenges relate to the need to ensure standardisation and formalisation of competencies required, a formal evaluation process, and the organisation's capacity to provide appropriate supervision.

One of the challenges which may arise for individual clinicians is the need to complete work experience in a care group area that they have no desire or intention of working in. Further, HSE, and HSE-funded employees, may not be able to avail of transfer or promotion opportunities within their current care group area if they do not complete the required work experience in a different care group area/s, following the implementation of the proposed revised eligibility criteria.

Recognising the impact of the current system, consultation with National HR and Community Operations was scheduled for early September 2020, to identify an agreed resolution to the challenges outlined above.

It is important to note that conditions within a given placement can fluctuate. Placements at one point in time may meet the eligibility criteria and then due to service restructuring, change of staff, amount of placements on site, maternity/sick leave of supervisors etc. may not meet the criteria. However, it should be noted that any such changes to placement will not deem those trainees who have previously completed that particular placement ineligible. Equally, a placement site which has previously been deemed ineligible may be eligible in the future if placement criteria are met. The assessment of placement suitability involves on-going monitoring and communication with current, and possible new placement sites, and may involve carrying out site visits to new potential placement sites in order to expand and meet the demand for appropriate placements for trainees and existing HSE psychologists.

The HSE relies on PSI accreditation standards to identify appropriately qualified and experienced supervisors. The PSI requires that supervision is provided broadly at a 2:1 ratio, with supervision being provided by suitably qualified personnel.

Currently within the HSE, a limited number of supervisors can offer a placement at this ratio due to a lack of the appropriate physical environment and IT requirements, and many of the qualified workforce who provide supervision for the programmes working part time. There is a requirement for engagement with HSE Operations and Estates to resolve the challenges outlined with respect to the physical environment and IT requirements. Supervision capacity is further reduced with the current on-going Covid-19 environment and the social distancing requirements being put in place in each HSE physical space.

Acknowledging the challenges that Covid-19 presents to the capacity for supervision the PSI have issued guidance for the temporary derogation to supervisor requirements for professional training programmes during COVID-19 as follows:

- For trainees currently on Clinical Psychology training programmes, the requirement for the supervisor on either a core or specialist placement to be a Senior Clinical Psychologist will be temporarily changed to Senior Psychologist.

- For trainees currently on Counselling Psychology training programmes, the requirement for the supervising psychologist to have counselling or psychotherapy training/experience will be suspended temporarily.

- The accreditation criteria for Educational Psychology training are suitably flexible to not have caused identifiable difficulties.

In this context, and based on the number of existing psychologists (Senior or staff grade as appropriate to each professional course); and the educators' projected training intake to 2023 (Appendix 6), it is not possible to project the exact number of supervisory placements that will be required.

Irish Prison Service

The IPS Psychology Service provides placements for Trainee Psychologists and regular teaching input to various Doctoral Trainee Psychologist University programmes. Placements are delivered in consultation with training programmes, whereby placement experience is delivered to address client needs, but also to fulfil the accreditation standards and course requirements. At present there are twelve senior psychologists available to supervise placements. The ratio of psychologists in training to placement supervisors can be 1:1 and not more than 2:1. Placements are identified by the Senior Psychologist, the Principal Psychologist Manager and/or the Head of Service.

Tusla

Placements are delivered in consultation with training programmes, whereby placement experience is delivered to address client needs, but also to fulfil the accreditation standards and course requirements.

Placements within TUSLA are primarily specialist placements and cover the wide range of trauma, attachment and neurodevelopment as well as specific practice teaching on working with children in different care scenarios and with specific profiles, e.g. victims as well as perpetrators of sexual harmful and/or abusive behaviour. A substantial sub-cohort of children and young people also access wider health care services.

National Educational Psychologist Service

Since the commencement of the doctorate programme in UCD and MIC, NEPS accommodates all year 2nd and 3rd year trainees from MIC and UCD for a total of 120 days placement (January to December). Part time trainees from UCD also complete a NEPS placement. All applications for training placements in NEPS are routed centrally through the Regional Director (RD) with overall responsibility for placement by the College Course Coordinator or Placement Tutor from the relevant training body.

NEPS accepts Trainee Educational Psychologists (TEP) on training placements who have completed at least one full year of professional training and at least one previous training placement. This is based on the assumption that NEPS will continue to provide placements for psychologists in the more advanced stages of their professional training courses, only. In this regard, it is expected that each TEP will have reached a level of competency in basic applied psychological practice before their NEPS placement.

Trainees placed with NEPS are each assigned to a NEPS team and to a Lead Supervisor within that team.

3.5.Funding for Training

Health Service Executive

Currently, Clinical Psychology Trainees, on the doctoral programme, are HSE employees and are in receipt of partial funding (60%) of HEI fees each year. In return, they commit to continuing as HSE employees for a fixed period of three years on qualifying. The HSE does not employ or contribute to HEI fees for Counselling and Educational Psychologists during their doctoral training, although the majority of their placements are within the HSE.

Key benefits to services of funding for all psychology training include:

- Direct individual work with service users.
- Contribute to multidisciplinary team work through staff consultation, research and training.
- Improved recruitment and retention of psychologists.
- Partnership between university programmes and Psychology Services to ensure a future supply of psychologists

Irish Prison Service

The Irish Prison Service (IPS) has sponsored four Trainee Clinical Psychologists in the past. This has not been possible for 2020 due to financial constraints and this will continue to be reviewed annually and IPS senior management are positively disposed to this possibility in the future.

Tusla

Tusla has a very small number of directly employed clinical psychologists and has funded a limited number of students on programmes: eight currently in Year 2 and five in Year 3, who will be funded through to completion.

Regarding new intake, having assessed their position, it is Tusla's intension to focus on building a base of in-house capacity in the immediate term with funding currently associated with training being redirected to direct employment.

This means that Tusla will no longer have the resources available to invest in any new cohorts. The situation will be monitored over time and consideration given to the possibility of sponsorship in the future.

National Educational Psychology Service

NEPS does not provide funding for trainee psychologists; however trainees are remunerated for travel expenses incurred for school visits.

3.6.Garda vetting.

The National Vetting Bureau (Children and Vulnerable Persons) Acts 2012 to 2016 provides a statutory basis for the vetting of persons carrying out "relevant work with children or vulnerable persons".

The National Vetting Bureau Act imposes a legal requirement on health service employers to ensure that all candidates for employment (whether permanent or fixed-term / temporary, fulltime or part-time) in positions which constitute "relevant work" must undergo Garda vetting as a condition of their employment, including students. There is also a requirement for non-employees such as those on work experience to be vetted. The onus is on the management of the service to determine if a vetting disclosure will be required, prior to initiating arrangements for the filling of the post or making an offer of engagement.

Currently there is no formal national system for exchanging vetting outcomes between the educators and placement providers. This means that a trainee could potentially be subject to multiple vetting if placements are in different organisations or service areas. For example, in service areas that are regulated, Nursing Homes, Mental Health etc., where the regulating authorities require site specific Garda Vetting.

Clinical Psychology Trainees are all vetted by the HSE during the processing of their employment once they have been selected by one of the programmes. Section 38 agencies are registered organisations with the Bureau and are responsible for the Garda vetting and assessment of persons who are deemed to come within the scope of Section 12 of the Act, prior to employment or engagement by the organisation.

However, this does not apply to Section 39 organisations, where a full Garda vetting report is required, as set out by HIQA. Resource constraints have meant that the HSE's national recruitment office are not able to undertake this on behalf of trainees, nor is it possible for the programmes or the placement sites to seek these directly from the HSE as it would be a breach of confidentiality as per current regulations. To avoid trainees having to make multiple applications for Garda vetting over the course of their training, programmes obtain Garda vetting for their trainees at University level, and trainees are able to source their full Garda vetting report from their University admission's office.

3.7.Conclusion

There is no national co-ordination of the placement process in terms of student / placement management or resource allocation. There is a need for enhanced and sustainable collaboration between health service providers and educators in preparing and developing the health workforce with emphasis on the broader health and social care system's requirements in relation to learning content, outcomes and placement experience.

Of particular note, is that within the current system Memoranda of Agreement and funding is in place for clinical psychology only. The current funding model does not provide for funding of Counselling and Educational psychology. The appropriateness of this model needs to be reviewed in the context of ensuring the appropriate supply of the future psychologist workforce; and providing equity across the three streams of psychology (Clinical, Counselling and Educational).

Relevant EU Directives on the recognition of professional qualifications Regulation (S.I. No. 8 of 2017) place obligations on Host and Home Member States in respect of the recognition of professional qualifications. There is no structure in place to accommodate placements for those

psychologists who have qualified in other jurisdictions and are seeking compensation measures to make good any gaps in experience identified by the Department of Health.

There is also no agreed process for current employees who are required to undergo supervised work experience in order to meet the proposed revised Eligibility Criteria.

With regard to appropriate healthcare settings, there is no official list / database of locations / services / settings, and associated criteria, which are deemed appropriate healthcare settings in the context of student placements. A national database of locations / services / settings, including criteria, should be developed to provide clarity for students and educators alike. Given that this will vary dependent on resources at any point in time, it will need regular monitoring and review to ensure it is accurate.

Noting that placements can, at a given point in time, meet the eligibility criteria and for a range of reasons not meet the criteria at a later date; and vice versa, establishing a centrally based assessment of placement site suitability would support and improve the identification, allocation and coordination of placements. Further, it will facilitate increasing the number of suitable sites to meet demand as required.

Ultimately, the database would allow for improved oversight and management of placements and contribute to positive placement experience and the strengthening of broader planning of psychology services.

Recognising the impact of the current system, and the additional Covid-19 driven demand for psychological services; and following consultation with National HR and Community Operations in October 2020, agreement was reached on deferring the effective implementation date of the 2016 Eligibility Criteria requirements to 1st October 2024.

In addition, it is also agreed that the grand parenting approach included in the 2016 Report be updated, and extended, thereby removing the supervised work experience requirement for existing professionally qualified psychologists currently employed in public psychology services. Of note is that this extension does not remove the requirement for these applicants to demonstrate, if called for interview, the competence required for the Care Group for which they are applying. The full revised criteria are set out in Appendix 7.

Further, the HSE is by far the largest organisation offering the most placements and thought needs to be given more broadly as to the needs of health and social services sector. There are areas (e.g. paediatrics, maternity, disability services, etc.) where much of the service provision is by voluntary agencies and other statutory bodies (e.g. Irish Prison Service, Tusla and National Educational Psychological Service); therefore, psychologist workforce planning, the training process, and funding of Clinical, Counselling and Educational psychologists should encompass the need for psychology in both HSE and non-HSE settings, to avoid creating any internal labour market competition, rather than exclusively HSE settings.

4. The current psychology workforce in the Irish public health service

In addition to understanding the factors that have informed its development and influence the demand for psychology services we also need to understand our current workforce. This chapter summarises the current workforce position, based on available workforce data.

4.1.Demographic profile of HSE psychologists

The HSE Census reveals as at the end of May 2020, there were 1,152 (1,015 Whole Time Equivalents, a steady increase on the May 2012, 663 WTE as shown in Table 4.2). Of these 169 WTEs are Trainee Psychologists, 104 WTEs are employed in Acute Services and 910 in Community, of which 158 WTEs are employed by Section 38 agencies.

Table 4.1: Health Service Psychologist Staffing by Staff Group (Excluding Trainees) - May 2020

Psychologists	**846 WTE**
Psychology, Director of	3
Psychologist, Principal	84
Psychologist, Senior	455
Psychologist	304

Note: While the total WTE figure is accurate, a validation exercise is required by Operations to enable the HR data to accurately reflect the mix of clinical, counselling and educational psychologists employed.

Table 4.2: Psychologist WTE (excluding Trainees) May 2012 – May 2020

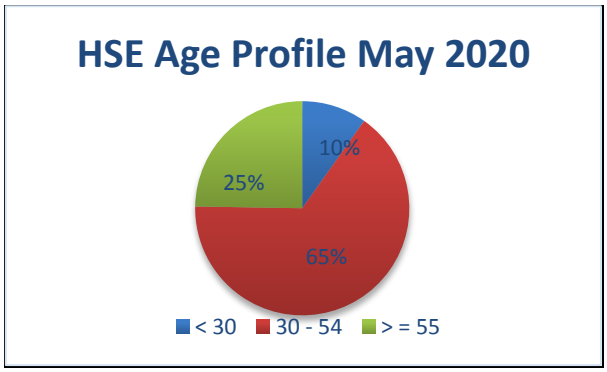
Psychologists WTE	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
	544	600	682	744	764	795	814	827	**846**

4.1.1. Age profile

The HSE Workforce is ageing, with approximately 68% of all HSE staff aged over 40 years with 20% aged under 35 years. In contrast, 32.6% of those employed in the general population are aged under 35 years (SOLAS, 2019). Figure 4.1. shows the age profile of staff currently employed in the HSE.

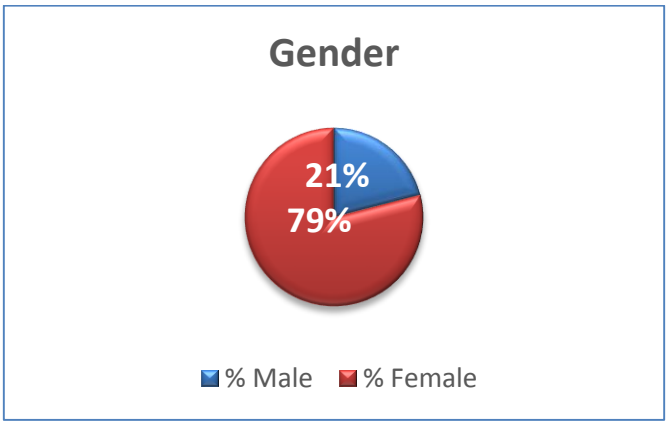
The age profile of the HSE Psychologist workforce reveals 10% are under 30 years and 25% are over 55 years. This is a reflection of the long training period of professional psychology.

Figure 4.1: Age profile of HSE staff at May, 2020



HSE data shows 72.8% of psychologists working on a full-time basis and 27.2% part-time; with 79% of the total psychology workforce being female (Figure 4.2.). The size of the female psychologist workforce, and percentage of those working part time, along with the younger generation being more interested in, and influenced by, lifestyle factors (McAleese, 2013); means workforce planners will need to incorporate the demand for flexible working practices into their forecasting to ensure that there are sufficient WTEs of psychologists in the health system to maintain service provision.

Figure 4.2 Gender breakdown of psychology workforce (May, 2020)



4.1.2. Workforce Planning Capacity and Capability

The National Health and Social Care Professions (HSCP) Office, previously within National HR Division, and now reporting to the HSE's Chief Clinical Officer, was established in February 2017. Its primary focus is to strategically lead and support health and social care professions to maximise their potential and achieve the greatest impact for the design, planning, management and delivery of people-centred, integrated care for the benefit of the population they serve.

Some of the core functions of the new expanded HSCP Office are as follows:

- Enable HSCP leadership and influence
- Coordinate HSCP input to design, planning, implementation and evaluation of services
- Focal point for HSCP and linkage between stakeholders
- Professional advice and coordinated engagement with HSCP
- Influence HSCP to work to the highest levels of their competence
- Model and support inter-professional learning and collaborative practice
- Strengthen culture of work-based research
- Strategic planning and input into national strategies
- Collect and analyse data and evidence to support decisions on HSCP roles and development
- Identify, evaluate and further develop best practice and innovation
- Organisational leadership on HSCP education and development
- Influence the development of mechanisms for CPD
- Support CPD and learning culture with a strong focus on enhancing impact and outcomes
- Provide HSCP input to strategic workforce planning

There are approximately 26 different professions, including psychologists, in the HSCP grouping, totalling approximately 16,000 people (HSE and Section 38s); the majority of whom provide direct patient/service user care with others, such as medical scientists and clinical biochemists, providing vital diagnostic services.

Student Practice Placements

Under Section 7 of the Health Act 2004 specific accountability and responsibility is assigned to the HSE in relation to the education and training of 'students training to be registered medical practitioners, nurses or other health professionals'. Student placements are now a core part of most professional and healthcare training programmes. These placements take a variety of forms depending on the discipline and range from weekly to block placements in many professions to longer periods and sometimes trainee positions in others.

4.2.Irish Prison Service Psychology Workforce

Figures (Table 4.3) provided by the Irish Prison Service (June, 2020) reveal a total of 32 psychologists employed

Table 4.3: Number of Psychologists employed (June 2020)

Current staffing (Jan 2020)	
Total number of psychologists	**32**
Head of Service	1
Principal Psychologist Manager	1
Senior psychologists (Grade I).	9
Staff grade psychologists (grade II) posts.	22

4.3.Tusla Psychology Workforce

Data (Table 4.4) from June 2020 reveals the very small number of directly employed psychologists in Tusla.

Table 4.4: Tusla Psychology Workforce (January 2020)

Total number of psychologists	**28**
Principal Psychologists	2
Senior Grade Psychologists	10
Staff grade Psychologists	2
Trainee Clinical Psychologists	14

As noted earlier, after the HSE, Tusla has been a primary funder of psychology training in Ireland. Currently there are eight students in Year 2, and five students in Year 3 who will be funded through to completion. However, having reviewed their position Tusla has confirmed that they do not have the resource availability to invest in a new cohort at this time.

4.4.National Educational Psychologist Service

As of August 2020, the National Educational Psychological Service (NEPS) has sanction for 221 psychologist posts (Table 4.5), employed in 24 offices across eight organisational regions, providing support to local schools within their catchment area.

Table 4.5: National Educational Psychologist Service Workforce (August 2020)

Total number of psychologists	**221**
Director	1
Regional Director	8
Senior Educational Psychologists	40
Main Grade Educational Psychologists	172

4.5.Psychology workforce developments in the Irish public health service

The Principal Manager grade was introduced to manage structures at Local Health Office (LHO) level. The structures of the HSE have evolved considerably, and so too has the level of responsibility and the number of staff that report to them. In many cases Principal Managers work across divisions, which is out of step with national structures in the HSE.

Principal Manager Grades are on the same scale as Principal Specialists; the role is very different and involves working at policy and strategy level. For example, Principal Managers sit on the mental health management team and represent psychology at a national level. Principal Specialist management duties, on the other hand, are closely aligned to the operational services within their care group and up to 75% of their work is clinical.

Assistant Psychologist posts were created to support services and enhance the service provision and research capacity of qualified psychologists. Assistant Psychologists are psychology graduates who work under the direct supervision of a suitably qualified psychologist. Following induction and training, they can be deployed to perform prescribed tasks commensurate with their level of competence. This includes assisting qualified Psychologists with triage assessment, intervention, service delivery and research.

In 2018, the HSE recruited 114 ‘assistant psychologists’ as well as 20 psychologists in a dedicated funding allocation of €5 million. The individuals recruited have a primary degree in psychology, many of whom intend to compete for a place on a doctorate in psychology programme. Part of the selection of suitable candidates for the doctoral training requires individuals to have experience of working with relevant client groups, and this requirement often results in interested individuals working in a voluntary capacity with organisations.

4.6.Conclusion

HSE psychology services are delivered across a number of care areas including in adult mental health, primary care, acute hospitals, child and adult disability and other services. While the HSE has specific responsibilities for training placements, as set out in the Health Act 2004, the link across the sectors to supply the future workforce means it would be beneficial to all sectors to work collaboratively to avoid the unintentional creation of internal labour market competition.

Both staff and senior grade posts are well established in the health service with clear job descriptions and contributions to service provision across all care areas. With regard to Principal Specialist posts, consideration needs to be given to clarifying the roles and duties to better reflect the nature of the work in different care group areas.

There are grounds for a review of the existing Psychology structures and career pathway to take account of the expansion in psychology numbers and grades, and the changed and changing organisational structures within the HSE.

A combination of short-, medium- and longer-term workforce planning approaches, taking a whole of system approach or whole of organisation approach, as appropriate, would support current and future sustainability of the psychology workforce supply. In addition, demographics will have significant implications for supply-side decisions. Factors such as age and gender, which impact on replacement demands, need to be considered when determining supply.

To support decision-making, accurate data including psychologists being correctly graded on HR systems, and improved data collection and information regarding entry and exit patterns and attrition rates would be beneficial.

Finally, the Project Team recognises the role of multi-disciplinary teams within the delivery of psychological services, which will have an impact on the workforce requirements for psychological services into the future.

5. Psychology services into the future

5.1.Introduction

This chapter identifies a number of key drivers that are likely to produce significant changes in the ways in which, and the extent to which, psychological help can be made available to those who may benefit from it. These changes will have implications for workforce planning and the future psychological workforce. This workforce will include both doctoral-level professional psychologists and other cadre who use psychological interventions. This is not intended to be a comprehensive review of such factors, but rather highlighting some of the most salient.

5.2.Services and supports

Reflecting the wider remit of psychology, models for the delivery of psychology services within our health system, are set out in a number of Briefing Papers produced by the Heads of Psychology in Ireland (Primary Care, November 2015; Mental Health, November 2014, Health and Well-Being, June 2016). Taking an integrated view of psychological services across primary, secondary and tertiary care, a central concept of Stepped or Layered Care is at the core of these documents. Stepped/Layered care promotes the delivery of psychological and wider mental health care in the manner that best meets the needs of individuals and the communities in which they are embedded. This runs from population level interventions aimed at resilience building (e.g. fully accessible on-line or 'town hall' interventions), to high volume –low intensity group or individual interventions (guided self-help; group psycho-education, brief consultation for those with mild to moderate presentations) to low volume –high intensity interventions for the smaller minority with moderate to severe or complex presentations (e.g. DBT or Psychodynamic Psychotherapy). Essential to the effectiveness of such a model is the provision of integrated and seamless access to the appropriate level of service at secondary or tertiary level. The layered/stepped care approach suggests increased emphasis on Psychologists role in training and supervision of multidisciplinary colleagues in the delivery of psychological therapies, and in providing consultation support to team colleagues in psychological formulation. Across the country, there are many examples of the success and effectiveness of delivery of psychological services at all levels of the Layered Care model.

Psychology services have demonstrated the value of the Layered Care model and the capacity of psychology services to deliver preventative and early intervention at times of national crisis. Psychologists have led in the development and delivery of Psychosocial supports in the current COVID crisis context, in partnership with colleagues at all levels within the health system and with partner agencies in the community. Population based resilience building initiatives include print, radio and on-line media campaigns, community based initiatives aimed at vulnerable groups include targeted nursing home supports, perinatal supports, support to those living in direct provision, and supports to front-line staff within the HSE, private and voluntary sectors. Psychosocial interventions have been delivered in tandem with more traditional group and individual interventions to those with greater needs who have continued to access services at primary, secondary and tertiary level.

The requirement for psychological services and supports is likely to increase. Distinguishing between needs, wants and demand is useful: needs may be considered as basic to human survival; wants as desires arising from a person's awareness of something they feel they would benefit them; and demand from their ability to access or advocate for it. Someone who is suicidal may need psychological intervention, but be unaware of how it could benefit them, or that such services exist. Alternatively, they may be aware of, find acceptable and want such help, but lack the means – financial, geographical, time – to demand it from psychological service providers. The provision of psychological services in Ireland, as elsewhere, has primarily reflected demand but should also address need, and how people can fairly access help to address their needs.

The World Bank predicts that by 2030 there will be a global shortfall of 15m health workers: "Growth in the demand for health workers will be highest among upper- middle-income countries, driven by economic growth and population growth and aging, resulting in the largest predicted shortages…" (Lie, et al, 2016, p. ii). These shortages of conventional health workers, working in conventional ways, have led to recognition of the need to rethink access to and provision of heath. In the Irish context, Minister Jim Daly argued at an e-Mental Health Conference in 2018, that there is a moral responsibility to try additional and alternative approaches: "It's time for new thinking and a new direction". Access to psychological services is currently uneven and unfair. Alan Kazdin, Professor of Clinical Child Psychology at Yale University, argues that worldwide - including in the United States - the vast majority of children and adolescents who could benefit from psychological services receive no treatment at all. He states that one of the key barriers responsible for this is the prevailing model of psychosocial interventions; characterised by one-to-one, in-person treatment, provided by a mental health professional with a long period of training, in some sort of clinical institutional setting (e.g., clinic, private practice office, health-care facility). Kazdin stresses that such a "model greatly limits the scale and reach of psychosocial interventions" (2019, p. 455). Kazdin (2019) suggests that the key characteristics for a model of service provision that can provide greater access to services are: affordability, reach beyond traditional service models to be more inclusive of marginalized individuals and groups, acceptability (to the user) of the model of delivery, scalability to a large population, feasibility (model can be implemented and adapted to varied local conditions to reach diverse groups in need), flexibility (options and choices because no one model of delivery is likely to have the reach needed) expansion of the non-professional workforce and expansion in the setting where interventions are provided. Such aspirations for greater access to services have important implications for the psychological workforce. The left three circles of Figure 5.1 present Kazdin's

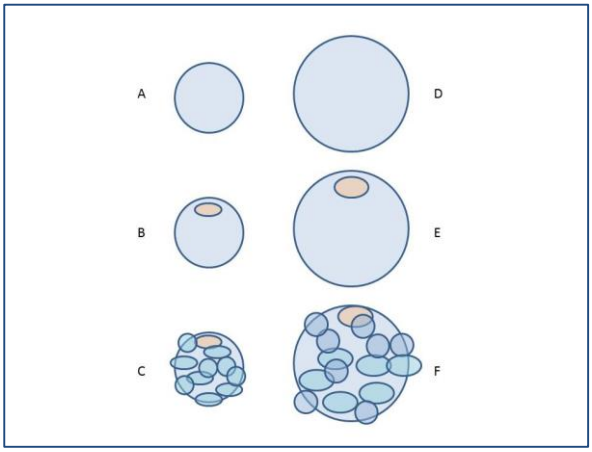


Figure 5.1 Kazdin's conceptual illustration

conceptual illustration of the need for services (A), the extent to which current models of psychological service provision address this need (B) and the idea that multiple models of provision - some of which overlap - could address much more of the need (C). Kazdin argues that "The reality may be that even with multiple models, some individuals in need of care will be missed. This means only that the goals to develop the models cannot be static and new options will invariably be welcome and necessary" (p. 465). In fact, the way in which Figure Y interprets Kazdin's original diagram is slightly different. A – C represents the need that people are aware of; and it anticipates that as services provision increases, awareness of need increases (D-F); it also places some models of provision 'outside' or only overlapping the overall scope of psychological services, recognising that some models of intervention may have relevant psychological components, but also may have some irrelevant psychological components. As Kazdin notes, models of service provision will and should develop and reorganise over time. We recognise that the need/want/demand for psychological interventions is dynamic and requires some degree of oversight and governance. It is important to note that while the facilitators and barriers to access will differ across countries and regions, the experience of access being uneven is a common one and also applies to the Irish health system.

5.3.Changing role of professions

The role of professions is changing. Susskind and Susskind (2016) in The Future of Professions, anticipate an incremental transformation' in how expertise is produced and distributed in society, which "will lead eventually to the dismantling of the traditional professions [and] increasingly capable systems will bring transformations to professional work that will resemble the impact of industrialisation on traditional craftsmanship" (p2). There are now more unique visits each month to the WebMD network of sites, than to all the doctors in the USA. Greater access to health information through technological innovation is one reason for this, but the Susskind's also argue that "While professions have knowledge, experience, skills and know-how that those they help do not…we cannot afford them, they are often antiquated, the expertise of the best is only enjoyed by the few, and their workings are not transparent" (p 3). Of relevance to the context of the psychological workforce, they suggest many professions "have become increasingly introspective, driven into greater specialization" (p. 4). While this may not apply to all psychology services in Ireland, it is relevant to some of them, at least to some extent, and it is certainly an important consideration regarding how services may develop.

5.4.Services user voice

The greater empowerment of patients/clients/service users will become a core value and practice for psychological services as well as all other disciplines in mental health. Greater access to knowledge, greater appreciation of the salience and value of their own personal knowledge and experience, and greater awareness of their basic human right to make choices regarding health, welfare and life; will mean that service users will have a much stronger voice and role in determining their psychological assessments, interventions and monitoring. The co-production of services and provision of

interventions and supports by non-psychologists and non-professionals, in a blended way, will be a feature of future access to services. Durcan et al (2017) note the growth in the number of people working in peer support roles in mental health services; and the development of a growing number of voluntary and community sector organisations in the UK mental health field. In response to this and in order to value and encourage it, Durcan et al (2017) suggest that service providers "develop career pathways that reflect their changing needs. This may mean creating opportunities for careers that go across professional and agency silos" (p. 42, italics added); that there should be more postgraduate training for mental health service competencies that are open to a wide range of disciplines (p. 42, italics added). The call for much more training for collaborative approaches to service provision recognizing that "Coproduction with service users and carers requires preparation and training" (p. 42).

5.5.Workforce skill mix

There will be greater fluidity in workforce skill mix. Within the healthcare professions skill sets sometimes overlap and at other times work tasks are aligned with a particular profession without the relevant skill set necessarily being a central part of that cadre's training. There is need to align skill sets to work tasks, through relevant competency frameworks within the training of health workers. But there is also a need to recognize that shorter and specifically focused training can confer effective skill sets on other cadre (Johns et al, 2018); these are the principle of task shifting and/or task sharing, with the Increasing Access to Psychological Therapies (IAPT) programme in the UK being a good example of such an approach.

An EU Expert Group exploring the future skills and competences of the health workforce in Europe suggested that: "The language of skills and competences is useful when considering multiple health workforces, and their potential activity in the future, because it allows a consideration of what will need to be done rather than trying to work forward from the existing division of roles and responsibilities." (Slide 4, italics added, Edwards and Fellows, 2015). This emphasis on staff skills, rather than on staff types, is seen as critical, especially when operating in complex environments such as community-based rehabilitation (MacLachlan, et al, 2011).

The Global Health Workforce Competency Framework that WHO is currently developing (see https://ezcollab.who.int/educationhub) focuses on skills and competencies, rather than the traditional cohorts of established health professions. It considers what skills are needed to effectively perform a particular task; rather than the power or position of different health worker cadre. Thus people with shorter and more focused training can produce equally efficacious outcomes to more traditional career paths; carers, family and the person themselves should be recognized as potentially being part of the health and welfare workforce.

5.6.Technology

The Effects of technology on service provision can be transformational. The term the "Fourth

Industrial Revolution" refers to how new technologies, such as artificial intelligence and the internet of things, will and already are dramatically changing our capabilities and expectations. In health, education and social services, technology changes the capability of individuals (service providers and users) and of the systems that they operate within. While the above drivers of change are strong in their own right, technology will be a major facilitator and catalyst for them. From a European perspective, the European Public Health Association has called for "Digital health systems to foster new innovative ways to reach and engage people" (see Sharp, 2019, p. 9), while the World Economic Forum counsels us to "think systems, not technologies", to developing such systems "by design, not by default" and to think of "empowering, not determining" service users (Aikman, 2017). Aikman also stresses "there is no single future [but] multiple future options …" (Slide 9). To embrace the potential benefits of such futures there will inevitably be disruption of current systems and professional roles and practices.

An example of how Artificial Intelligence (AI) may present both opportunities to service improvement and challenges to health workers, is a study on the use of AI in breast cancer screening, which found that AI was more effective than extensively training individual consultant radiologists; and as effective in identifying cancers as two such doctors working in combination (McKinney et al, 2020). If the AI algorithm for effective detection further improves it may have significant implications for how humans work in this area.

Cullen's (2018) review of e-Mental Health envisages different types of interventions with varying levels of therapist involvement. These include a blended mix of (therapist-provided + technology-delivered/self-administered), guided/supported (not necessarily by a therapist) and technology-delivered / self-administered (unsupported). Internationally there are a plethora of such initiatives and so too are there are in Ireland. In Ireland, these include MyMind (psychological support with therapists, face-to-face, on-line and at work), Turn2Me (a thought catcher for sharing ideas with an on-line community, on-line support groups, and –on-line counselling and therapeutic e-mail), Connect (telephone counselling and support), SilverCloud (offering over 30 health programmes, from wellness to severe mental health conditions) and Pesky gNats (both an online game and mobile app supported by a therapist) led by Prof Gary O'Reilly, Director of the UCD Clinical Psychology Programme. These approaches are often integrated with other interventions. The use of an array of different tiered interventions, in a stepped approach, is illustrated by the Student Counselling Service at TCD (McLoughlin, 2018).

5.6.1. Early progress

The need for change to increase access to services was already being acknowledged and welcomed in many areas, but COVID19 has provided an urgent and unexpected imperative to change how services are delivered more immediately. For instance, psychologists are now offering traditional individual and group sessions remotely using tele-health platforms such as phone, Attend Anywhere, Webex and Zoom to name but a few. Psychologists in disability services are using new, streamlined and more accessible remote assessment procedures to assist in the diagnosis of Autism Spectrum Disorders.

'Non-traditional' but now established low-intensity/open-access models such as stress control lectures for the general public are now available online, and drop-in advice clinics have moved into the virtual space allowing the general public rapid access a short phone/video consultation with a psychologist from their home. Online/electronic CBT based programmes such as Silvercloud are in use with adults in primary care and mental health settings, while programmes such as Pesky gNats are in use with children and adolescents. A current pilot project exploring the development of an assistant psychologist role in primary care is utilising e-therapy through programmes such as Pesky gNats, Silvercloud and a new Cognitive Behavioural programme for adolescents which is being finalised. This pilot is also looking at delivering a model which has the ability to reach a much greater population, through groups and workshops. Initial results suggest that satisfaction levels with these newer services tend to be good and may actually lead to a greater demand as the services become more accessible and streamlined. A range of further, large-scale developments would likely continue this trend.

Example: Figure 5.4 provides a summary of the experience of Brothers of Charity Services Ireland, Galway Services on the use of technology to provide rapid and effective supports during the Covid-19 pandemic.

Figure 5.4: Experience of Brothers of Charity Services Ireland, Galway Services on the use of technology for adult services for people with mild ID during Covid-19:

In April 2020, BOCSI, Galway Services began use of Wellola (similar to Attend Anywhere) as a platform to continue psychotherapy (CBT, DBT, and addiction related supports) via the smart phones of people with mild Intellectual Disability (ID) who had been in receipt of 1:1 or group CBT, DBT, and/or addiction focused psychological supports. The Wellola software is very simple and permits face to face sessions using a text link sent by the psychologist which the person can then open to begin the session.

BOCSI, Galway Services provide services and supports to people with ID, including those with mild ID, including those with children; others with forensic and antisocial challenges; some have transferred from the foster care system; some experience addition to alcohol, illicit drugs and occasionally addictions to certain websites.

Some of the adults have had very adverse experiences as children and adults. When Covid-related government directives began around March 12, 2020, BOCSI Galway psychologists were able to continue supports via residential care staff which is the model mainly in use in such settings. However, in the case of people with mild ID, psychologists normally work directly with the person supported in a 1:1 or group format (family supports provided also).

Members of the BOCSI, Galway Services team have provided summaries of their experiences during Covid-19 to date.

Senior Psychologist 1

The use of tele-health, using regular or smart phone (Wellola (face to face) or via phone calls), has resulted in the majority of my clients increasing their attendance levels by at least 40%. One client who found it difficult to travel to appointments now attends all tele-therapy appointments. About 35% have about the same as usual attendance which is positive.

I took on a new client during the pandemic whom I have not yet met face to face as we work through the phone but that has gone very well for her. She was struggling with anxiety about the

pandemic, distress at not being able to see her ill mother in hospital, and the loss of her job and routine. Her mother is now home; my client has a well-established routine and self-care plan and ready for discharge soon.

One of the DBT clients has required a doubling of the number of sessions and I have found myself providing up to four hours per week support to her family and support team. She is a woman who has struggled with very serious issues, and staff around her have had significant burnout. While she has struggled greatly over the last months she is currently doing well.

Senior Psychologist 2

The use of tele-health during pandemic has been a means to screen for those who will require face to face therapy on an on-going basis when ease of restrictions permit. It has also informed us of the people who are coping well at the moment and possibly will continue to do so using technology instead of office based face to face sessions.

'No shows' have reduced as many find tele-health 'handier' and less time consuming. The feedback that I have received is that this is due to no travel, less hassle, easier for them to attend in that they are not relying on family members to bring them to an office. In addition, they feel that they have more independence and value the private phone-call, and in some instances reduction in cost of travel to appointment is a factor so they make themselves available for the phone based session.

For a couple of clients, it has enhanced their communication skills as tele-health has identified that some clients can be more focused when using a phone. A couple of individuals that I would have had weekly appointments with, now after a period of tele-health are coping well with fortnightly or less check ins. So I believe it will be a way forward for some clients which will prove effective.

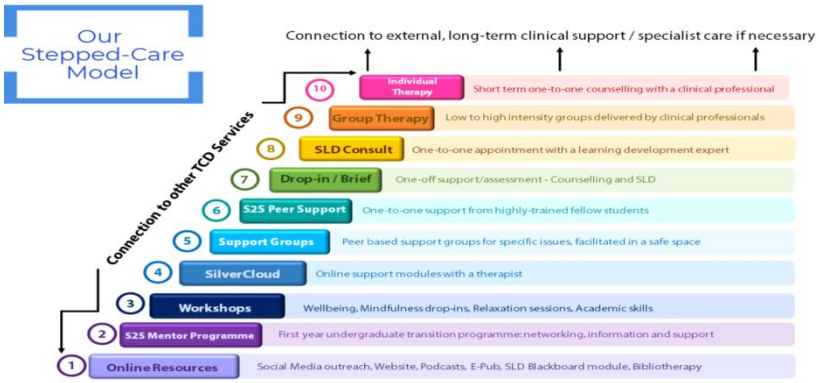
Dialectical Behaviour Therapy Psychotherapist

The BOCSI Psychology Department partnered with the HSE's National DBT project office about 6 years ago and we became the national pilot site for Dialectical Behaviour Therapy for persons with ID. This month (August 2020) the group element of DBT is resuming using Microsoft TEAMS. Below is a recent summary from the BOCSI psychotherapist to the front line community link workers who support some of the persons:

"The DBT Skills Group will be conducted via Microsoft Teams. Each person is now used to video sessions for individual therapy and hopefully will find the shift to doing video sessions for skill group as stress free as possible. Each person will be trialling Microsoft Teams with their individual therapist before the first skills group, just to get used to the format. If any support staff are meeting individuals in person and could install Microsoft teams onto their phone or tablet that would be a great help. Also, if one person from each team would be able to support an individual at each group that would be very important. I will contact each designated support person for the group directly to set up teams and to also give you a bit more info"

The brief feedback above is specific to our experiences to date and relates to the significant cohort of people with mild ID whom we support. We also provide services to children with ID as well as adults with moderate to high support needs. We had no difficulty continuing services via staff and while we initially used teleconferences, we have reverted to using Microsoft TEAMS for client reviews and frontline staff meetings. While the learning curve was steep and headsets became a must, a lot of the glitches have settled. The service is working towards all frontline staff having an email address as this is a must for access to webinars and training provided via HSELand which is a work in progress.

Figure 5.2 The Stepped Care model used by the TCD Student Counselling Service; combining online self-help, internet-supported and in-person interventions and onward referral.



While there are other models of care that embrace pathways with multiple options, the broader systematic organisation of service in Ireland is yet to embrace the opportunities that such an approach offers for greater access to and customisation of interventions. The nature of the Fourth Industrial Revolution is that it is boundary-spanning – across traditional professions, across sectors and across direct therapeutic intervention, targeted psychosocial education and training, and general psychological literacy. These and other more conventional types of psychological and behavioural interventions; used by occupational therapists, social workers, psychiatrists, nurses and others, including other types of psychotherapists; offer an ever increasing panoply and potentially blended delivery of intervention types and modes.

Foley and Woollard (2018) argue that "it is unlikely that technology will reduce demand for mental health professionals in the foreseeable future [however the impact] it will have on investigations, interventions and settings of care will, however, alter the skills required along with the roles and functions of staff" (p. 24). Foley and Woollard (2018) conclude that "Over the next 5 to 10 years, as pathways of care and entire organisations are reorganised, work will be reimagined around new technological capabilities. This will involve significant disruption to the roles and functions of staff and the skills required will evolve" (p. 32; italics added).

5.7.Health intervention approaches

A new approach to classifying health interventions can accommodate new approaches. The array of intervention types and the greater fluidity of options can be construed within the recently developed World Health Organisation's International Classification of Health of Interventions (ICHI) (WHO, 2017, "Beta Version"), illustrated in Figure 5.3.

Figure 5.3 World Health Organisation's International Classification of Health of Interventions (ICHI)

According to the ICHI a health intervention is 'an act performed for, with or on behalf of a person or a population whose purpose is to assess, improve, maintain, promote or modify health, functioning or health conditions'. The three axes of classification referring to the "Target" (the entity on which the Action is carried out;), the "Action" (the deed done by an actor to the Target) and the "Means" (the processes and methods by which the Action is carried out), is seen as addressing all types of health and related interventions. The approach may also be applied to the broader range of interventions offered by psychology; for instance, across education, justice or employment. The intervention axis recognizes different levels of action in the "social-ecological system": The "Individual" themselves, "Close interpersonal", "Extended interpersonal", "Organisation", "Community" and the "Political system". This array presents significant opportunities for psychologists to operate in new ways and at new levels in their role as change agents.

We require new systems developed with appropriate oversight. In reviewing how technology will affect mental health services in the UK, Durcan et al (2017) argue that "all mental health practitioners [should] receive significant training in psychological intervention, for instance doing psychological formulations. The mental health service model of the future should be one that gives a greater role to psychological thinking and being psychologically informed. This needs to be reflected in the training of all professionals and in the development of mental health practitioner competencies" (p 4).

A greater 'psychologising' of the work force, more and different types of interventions, coming from different sources and using different types of technology, will require new systems and oversight for them to be used effectively and efficiently; oversight and direction concerning the best options, combinations and contraindications for interventions; which should be based on individual needs, personal circumstances, interests, aptitudes and personality. In this regard we envisage a new role for psychologists, not as gatekeepers, but as curators of such options, while of course continuing, where appropriate to provide face-to-face services. The consulting role that psychologists often provide to other professions may therefore need to be considerably developed within a new architecture of services and access, which will necessarily involve some disruption of current approaches.

Commissioned by the World Economic Forum to look at neuro-technologies, Doraiswamy, London and Candeias (2019) argue that "We must also combat the natural tendency to focus only on the ethics of "doing something new" and pay more attention to the ethics of "not doing something new". The tacit implication is that the status quo is both proper and ethical, although this is not always the case. In fact, given the scale of the diagnosis and treatment gaps that exist within mental health – and

the problems people and society as a whole face as a result – there are strong ethical arguments for taking bold action in this space." (p. 18).

5.8.Health system approaches

A Rights-based approach to services

The Special Rapporteur for Health (2019) states that "health systems can improve equity, efficiency, effectiveness and responsiveness by strengthening primary care while decreasing the unnecessary use of specialists and hospital care (see A/HRC/35/21/Add.2, para. 36)" (p.8). He also argues that "Where there is greater equality and power shared between primary and secondary care and workers, it becomes easier to attract, train, fund and retain primary health-care workers, if they are adequately supported" (p. 8). The Special Rapporteur for Health calls for a "more participatory, less hierarchical approach to the workforce so that the experience and views of all workers in health-care are valued. The current system values health-care workers differently, depending mainly on the length of their training. Most health-care systems give physicians decision-making power at all levels … because the hierarchical system prioritizes clinical knowledge based predominantly on biomedical evidence. …" (p 6, 2019). The Special Rapporteur argues that a human rights - based health system that reduces power imbalances and hierarchies between different cadres of health-care workers will contribute to a more resilient and sustainable workforce. Thus it is important that in attempting to challenge and disrupt existing structures and dominance within the health system, there is not simply a changing of the guard, with the dominant role of one profession being replaced by another hierarchical structure; but rather democratisation of health provision, much greater empowerment of service users, greater blending of delivery across different health professions and service users themselves.

5.9.Conclusion

For economy of exposition in this chapter we have focused more on the delivery of psychological interventions than on other important aspects of psychological work, such as assessment, formulation, or health service organisational strengthening with other service providers and service users. We recognise that provision also differs across the population, for example, for people with disabilities, in the prison service or in direct provision. It is also important to acknowledge that within Ireland not only are many psychologists already creatively and enthusiastically responding the issues highlighted above, but are also internationally recognised as doing so.

The requirement for psychological services is likely to increase and those with responsibility for planning services must address needs as well as demand.

The projected global shortfall of 15m healthcare workers by 2030 means consideration should to be given to alternative and flexible approaches to how health services are delivered.

The changing role of professions, and greater fluidity in skill mix, will require a greater alignment of skill sets to work tasks. This is seen as critical in the context of community-based working, through different modalities.

Technology and e-mental health offerings will influence service delivery, likely leading to a more blended approach of therapist-provided and technology-delivered/self-administered interventions.

While new technology is unlikely to impact on the demand for mental health professionals, its effects on service provision could be transformational. This will impact on roles and functions, and the skills required which needs to be reflected in professional training. Therefore, technology innovations within the HSE should take account of existing infrastructure limitations, service needs and the resources – including training – necessary to use them.

The psychology workforce will increasingly be working in tiered arrangements tied in with levels of complexity of presenting problems. Workforce arrangements will require robust governance structures and effective supervision arrangements. Memoranda of Agreement and Programme Boards in the HEIs will need to align with innovations and change within the healthcare landscape.

6. Workforce planning for psychologists

6.1.Introduction

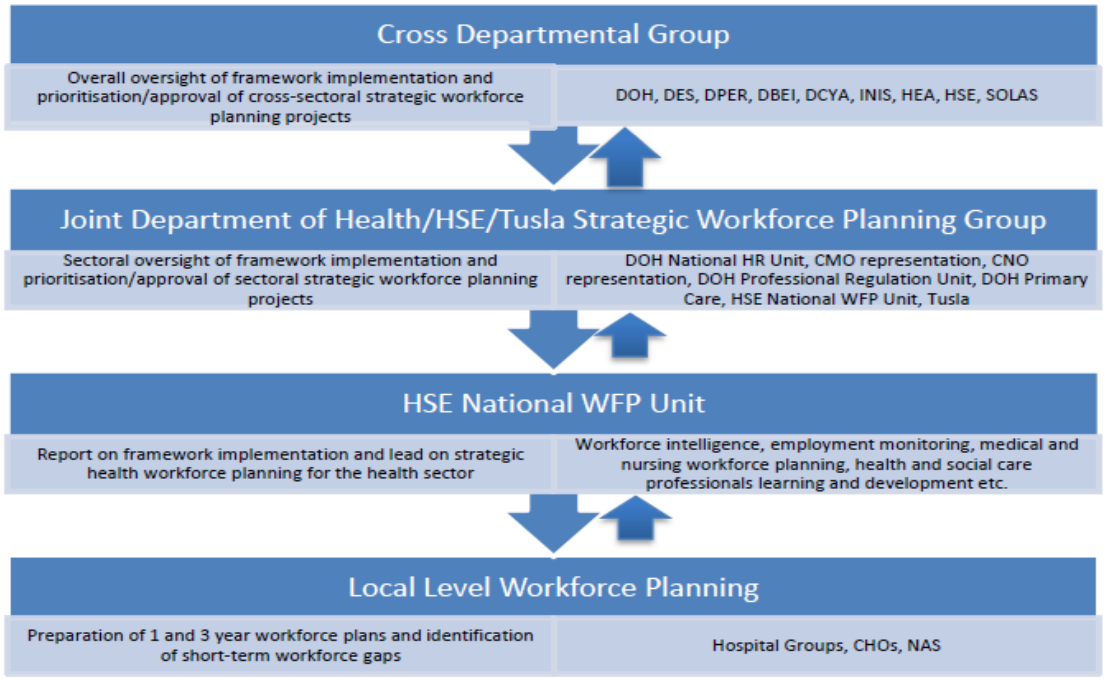
A workforce plan needs to take account of the wider spectrum of psychological services and disciplines that are (current and future) to be regulated under CORU and have regard to other sectors where psychological services are provided, i.e. Tusla, Justice and Education Sectors. The chapter conclusions summarise the necessary actions for the development of a workforce plan for psychological services.

6.2.The context for workforce planning

The Project Team's observations on a workforce plan for psychological services are in the context of the Sláintecare Implementation Strategy's Goal 4 Strategic Action 9 "to build a sustainable, resilient workforce that is supported and enabled to deliver the Sláintecare vision", in addition to Goal 2 Strategic Action 4 of expanding community-based care.

These observations are grounded in the Five Step Approach to workforce planning and governance structures set out in Working together for Health: A Strategic Framework for Health and Social Care Workforce Planning in Ireland. Figure 6.1 and 6.2 below.

Figure 6.1 Structures and governance arrangements



The National Strategic Framework is underpinned by principles which require workforce planning;

- to be focused on identified current and future needs of the service;
- be a dynamic process which includes; a multi-disciplinary and team based approach, changing skill mix, new roles, development of new competencies and behaviours;
- to use multiple time lines;

- to be sustainable, cost effective and offer value for money;
- To conform to the WHO Global Code of Practice on International Recruitment of Health Personnel and as far as possible plan on the basis of self-sufficiency;
- To take account of the workforce needs of the public, voluntary and private health and social care systems when planning for a future supply, 10 years plus;
- To consider how current and future demand for services is measured and assessed;
- To ensure all relevant stakeholders can feed into the process of health workforce planning.

The governance structure acknowledges that some solutions reside at the policy level, either at cross-departmental level (health, education, finance, etc.), or the broader health sector (DoH, HSE and TUSLA) with others resting at national and local levels in the HSE.

A workforce plan for psychological services requires appropriate organisational engagement and collaboration so that profession specific knowledge and service requirements combine in the formulation of workforce planning priorities. The HSE's workforce planning approach also requires engagement with the HSE's Commissioning Oversight Group who set organisational priorities which will inform and guide the focus of strategic workforce planning; and a Cross-Divisional WFP Group, including acutes and community, which informs, supports and directs the implementation of the framework. The Strategic Workforce Planning and Intelligence unit is responsible for identifying possible priority areas for sectoral and cross-sectoral strategic workforce planning projects for consideration and approval by the Joint DoH /HSE / Tusla Group and/or Cross-Departmental Group, as appropriate.

Five Step Approach to workforce planning

The Framework is intended support short, medium and long-term health and social care workforce planning. The Framework is solution focused with emphasis on the identification of solutions at appropriate levels of the service. The model provides a structured approach to workforce planning through analysis, solution generation, implementation and review. Step 2 clearly situates employment planning/monitoring and workforce intelligence, planning and modelling, and forecasting activities as necessary enablers for identification and implementation of appropriate local and national HR solutions, and sectoral and cross-sectoral policy solutions (Steps 3 and 4).

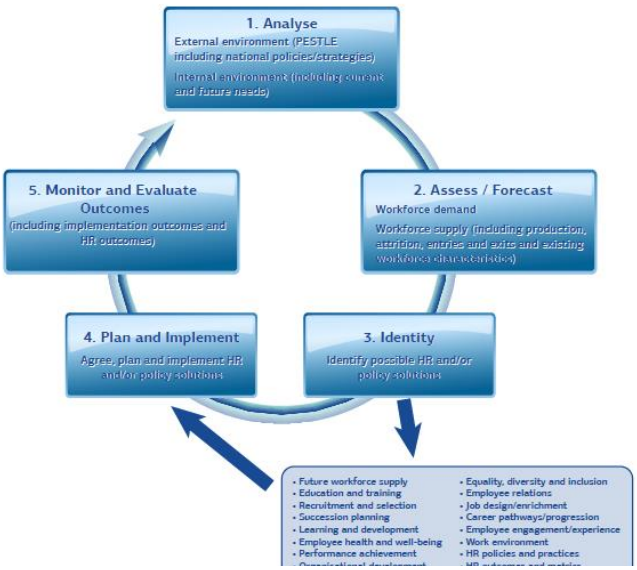


Figure 6.2 Five-Step Approach for workforce planning

6.3.Workforce planning for the wider psychological services

Workforce planning for the wider psychological services must adopt a strategic and long-term approach incorporating the elements of the Five Step Approach and adopting the Labour Market Framework, (Appendix 8); which presents a framework for considering the health labour market and the policy levers that influence it. Workforce planning for the wider psychological services should therefore consider the following:

- The number, mix and relationship between the professions delivering psychological services in community and acute services; psychologists, psychotherapists, counsellors, behavioural therapists, family therapist and addiction counsellors etc.
- Service requirements; models of care, care group designation, service delivery methods and the employment of a multi- disciplinary approach to delivery of care.
- The composition of the planned Health Care Areas (HCA). This new structure will demand integration of services, better communication and information exchange, and movement of talking therapies between services in each HCA.
- The current and potential future role of psychotherapists, counsellors, behavioural therapists and family therapists in delivering psychological services in conjunction with psychologists.
- Robust and needs-based planning and modelling capacity, building on and learning from current initiatives, notably the work of NDTP and ONMSD.
- An understanding of the interdisciplinary role played by professionally qualified professional psychologists and other therapists, including 'talking therapists' across the care groups including mental health and social inclusion services.
- Increased multi-disciplinary and inter-professional training, learning and practice.
- The training pathways and professional threshold qualifications for psychologists, counsellors and psychotherapists against the implications of potential changes by the Psychologist, Counsellors and Psychotherapists Registration Boards at CORU to the educational or experience pathway leading to registration as a professionally qualified psychologist, counsellor and psychotherapist.

Of note, is that the National Counselling Service (victims of abuse, CIPC and SHIP) require appointees to meet the European professional qualification standard; a primary qualification in health or social science and a post grad in psychotherapy; a 6-year training pathway. This is in contrast to the Psychological Society of Ireland's requirement that clinical, counselling and educational psychologists require a Doctorate which typically means 11 years of study and work experience to a become a professionally qualified psychologist, (undergraduate 4 years, Masters 2 years, and 2 years work experience and 3 years' doctorate). This is a longer pathway than required for all other health and social care professions.

- Funding available in the Department of Health approved annual HSE Pay and Numbers Strategy for supporting psychology trainees and employment of the various professions in the psychological services; psychologists, psychotherapists, counsellors, behavioural therapists, family therapist and addiction counsellors.

- The aptness of the current funding model which does not provide for funding of Counselling and Educational psychology in the context of ensuring the appropriate supply of the future psychologist workforce.

The Mental Health Workforce Plan Report provides predicted supply levels of each discipline over the next 10-year period. The supply levels are based on a number of initiatives which are currently underway to drive an increase in supply such as the Assistant Psychologist Pilot Program in Primary Care. Table 6.1 below shows the throughput from training for the period 2019 – 2021.

The 2002 Review of Psychology Services suggested the immediate need for 50 trainees per annum to sustain services. Since this time there has been an increase in population, and an increased level of interest from the public in accessing evidence-based psychological interventions, across all aspects of the health service, to assist them in managing their mental health. Almost twenty years on we have reached the level recommended in 2002 (see Table 6.1) therefore consideration must be given to reviewing the trainee numbers required and associated placements, alongside having a well-co-ordinated national training scheme, including counselling and educational psychologists, governed and managed by the HSE.

In addition, there is a requirement to build on the 2018 Mental Health Workforce Plan, establish a psychology workforce baseline with respect to existing level of services, and a prioritisation of resource allocation to protect and strengthen services. This will require new development funding to be secured through Strategy and Planning in order to build capacity into the future.

Table 6.1: Number of HSE funded psychologists in clinical training and year of graduation.

	NUIG	TCD	UCC	UCD	UL	Total
Sept. 2019	10	14	-	7[2]	10	41
Sept. 2020	9	16	-	11	10	46
Sept. 2021	14	16	8[3]	16	12	66
Total	33	46	8	34	32	

There are five clinical psychology training programmes in Ireland: Trinity College Dublin (TCD); University College Dublin (UCD); National University of Ireland Galway (NUIG); University of Limerick (UL) and University College Cork (UCC) established in 2016.Five trainee posts in UCD funded by one-off Assessment of Need-related funding means there will be at most 2 roll-over posts (reliant on local area funding) for Sept. 2017 intake.
No roll-over posts for Sept. 2017 intake in UCC programme.

6.4.Conclusion

Methods used to determine whether or not a workforce shortage exists, range from calculating ratios of practitioners to populations, to comparison between historical and existing practitioner numbers and extrapolations of the numbers of disciplines required on the basis of changing demographics.

These methods assume that the fundamental structure of the workforce is set, and ignore the potential for substitution between roles, the potential for new roles, and the impact of developing technologies and practices. However, whatever the method of shortage assessment, the workplace environment offered, and the time required to train them, all affect the workforce supply.

There are significant grounds for a review of the existing Psychology structures to take account of the expansion in psychology numbers and grades; the widening remit of the service across care groups; the changed statutory and regulatory environment in which HSE services currently operate; and the changed and changing organisational structures within the HSE.

As health needs, and our population continues to grow, there is a requirement to maintain, develop and consolidate safe and effective governance structures for psychologists within the HSE.

With the integration of services under Sláintecare, and the reconfiguring of services into six regional areas, there will be a need to have robust structures to effectively manage and optimise use of resources. Although a hierarchical structure is in place, there is significant variation nationally

The Project Team concludes that in order to identify the future requirement for psychologists in the public health system, the following will need to be considered and addressed in advance of, and to inform a wider workforce plan for psychological services.

- Funding to retain qualifying trainees.
- On-going funding / sponsorship of psychology training programmes, including counselling and educational psychology.
- Funding for supporting all psychology trainees and the employment of the various professions in the psychological services.
- Greater consistency in structures nationally to provide for stability.
- Clear lines of clinical and line management reporting.
- The number, mix and relationship between the professions delivering psychological services; psychologists, psychotherapists, counsellors, behavioural therapists, family therapist, addiction counsellors, and assistant psychologists.
- Service requirements; Models of care, care group designation and service delivery methods and the employment of a multi- disciplinary approach to delivery of care.
- Impact of Covid-19 and the associated increase in demand for psychology services.
- Potential changes by Psychologist Registration Board at CORU to the educational or experience pathway leading to registration as a professionally qualified psychologist.
- Workforce diversification – allow for greater capacity and flexibility in response to service needs i.e. both generic and specialist skills are required, but not necessarily to the same level, or across the same scope of practice, in the evolving psychological workforce.

In addition to the workforce planning specific conclusions above, the Project Team recommends the following, which while not directly related to workforce planning, have a direct impact on the future supply of psychologists:

- A review of current recruitment and selection process and the appropriateness of national, regional and specialised recruitment campaigns.
- Establishment of a national Eligibility Criteria for recruitment to the roles of counsellors and psychotherapists in mental health, disabilities and social inclusion services.

7. National Psychology Placement Office

7.1.Introduction

The chapter sets out a proposed National Psychology Placement Office (NPPO) function to fall under the auspices of the National Health & Social Care Professions (HSCP) Office within the Chief Clinical Officers office. Noting, the additional workload and responsibility, and requirement for appropriate resourcing; the following sections include proposed governance arrangements and staffing to facilitate the establishment of, and operation of same.

The proposed governance and remit of the Office as set out below has been informed by the work of the Project Team, the conclusions of the preceding chapters, and the consultation workshop held in February 2020 (see Appendix 3).

7.2.Governance and arrangements

Convene a national steering group of relevant stakeholders including HEIs, statutory agencies, key voluntary agencies, and relevant HSE Divisions E.g. Quality Improvement Division to:

- Develop a formal memorandum of understanding (MOU) between the HEIs and HSE, Tusla, NEPS and the Irish Prison Service.
- Develop a formal MOU between HEIs and relevant Section 38 voluntary organisations in and Section 39 organisations in receipt of funding.
- Convene a national placement coordinators group based on regional health care areas and HEIs.
- Develop a common set of placement documentation across HEIs, including for assessment of student practice.
- Consider the impact of the student experience on recruitment.

7.3.Management and coordination of placements

The NPPO will have responsibility for creating a formal, robust system for coordination of placements of psychology students at a national level within the HSE and HSE funded agencies. The NPPO will have responsibility for creating a formal, robust system for coordination of placements of current HSE and HSE funded Section 38 staff that wish to complete additional placements(s) either as part of professional development and / or to meet the identified eligibility criteria for employment in the HSE.

The Implementation Group Report noted that “Currently the educators liaise with managers in individual services directly to secure placements. This means that Psychology Managers may be approached individually by educators seeking placements for trainees. There is no national co-ordination of the placement process in terms of student/placement management or resource allocation. The need for co-ordination will become more critical due to the challenges previously identified.”

Table 7.1 sets out suggested staffing and role requirements based on student numbers of 286 in 2018/19; and costs based on the mid-point of the HSE salary scales as at 1st January 2020.

Table 7.1: Proposed Staffing for National Psychology Placement Office

STAFFING	COST
1 x national head of psychology placements (director / principal psychologist level: Clinical, Counselling or Educational) **OR** Administrative equivalent	€98,876
1 x Business Manager (Grade VIII)	€71,519
6 x placement coordinator posts (senior psychologist grade) assigned regional responsibility aligned with HSE regions with an equal mix of counselling, educational and clinical psychologists from different training backgrounds.(€86,951)	€521,706
2 x Grade IV administrative officers (€36,215)	€74, 430
Align HEIs with regional assignment of placement coordinators to support harmonisation	Administrative costs
Placement coordinators in HEIs	Already in place
Develop a national database of placements including HSE, Tusla, the IPS, NEPS and voluntary organisations.	Administrative costs under the auspices of the National Psychology Placement Office
Consider a software system such as ARC to manage the planning, organisation and administration of students on placement.	€50,000
Make provision for internationally qualified psychologists who may not meet all PSI standards, and existing employees requiring additional placements, to undertake placements and access HEI supports through the coordinated system	Administrative costs under the auspices of the National Psychology Placement Office
Commence development of a mechanism to ensure consistency and standardisation of placement quality and recognition, including database of appropriate health care settings	Administrative costs under the auspices of the National Psychology Placement Office
Develop and implement a single placement record for each trainee	Administrative costs under the auspices of the National Psychology Placement Office

7.4.High-level operational remit for the Placement Office

- Working within, and under, the governance of the Chief Clinical Officer's Office and National HSCP Office with regard to all lifelong learning and continuous professional development.
- Contribute to and support strategic workforce planning with regard to the supply of psychologists.
- Relationship building and management with Higher Education Institutes, Regulator, Psychological Society of Ireland (PSI), CORU, and other key stakeholders to ensure the required supply of appropriate of graduates with the necessary knowledge, skills and competences are delivered.
- Budget and contract management.
- Student supports and funding.
- Link with local area Principal psychology managers to ensure placement availability and governance of the trainee psychologists on placement
- Strategic planning for intake of psychology students working with other stakeholders i.e. Tusla, NEPS and IPS, to ensure a positive student experience.

- Working in consultation with the PSI and CORU
- Quality and assurance of placement experience, assessment, and supervision.
- In the context of the Strategic Framework governance structures contribute to the Education Forum to ensure the supply and development of an appropriate and sustainable health and social care workforce to meet population health and social care needs.
- Processes for Trainee Psychologists to provide feedback about their placement experiences and for this information to be evaluated and used for future NPPO planning.

7.5.Conclusion

The establishment of the NPPO within the National Health and Social Care Professions Office is dependent on the appropriate funding and WTE resources being put in place.

Memoranda of Understanding/Agreement should be developed for all domains of psychology to bridge gaps in information and establish procedural guidelines. Current local governance arrangements should be scoped out and built upon with respect to placements for clinical, educational and counselling trainees, to develop a single overarching governance framework for placement management; to include placement provider organisations, HEIs, and the Psychological Society of Ireland. Governance arrangements should give consideration to learning outcomes, CORU developments and risk assessment.

A placement office will provide the opportunity to formalise placement identification and availability and enable cross-agency collaboration with regard to placements between the HSE, Tusla, IPS, NEPS and voluntary agencies. Noting that there are already strong networks and relationships at local level with HEIs, the NPPO can build on what already works well to further strengthen and support psychology services and students. The proposed Hub and Spoke model, involving multiple regional stakeholders, would assist in maintaining flexibility.

A centralised placement office would facilitate planning across all areas of placement management. Including:

- an appropriate funding model across clinical, counselling and educational trainee psychology programmes,
- the development of a placement database to track placement types and number of placements,
- the development of a supervisor register to include a quality assurance mechanism,
- the development of placement criteria,
- the development of common placement learning agreements, including feedback loops and opportunity for remediation,
- the development of national agreed supervisor accreditation;
- educators maintaining their ability to input to placement design and match placements to the individual learning needs of trainees, including facilitating research opportunities,

- facilitating work experience for current employees of HSE and HSE-funded organisations to up-skill and gain eligibility for relevant care group areas,
- facilitating the introduction of service user advocacy in informing psychology training and education.

There is a national working group looking at the implications of impending Garda Vetting Policy Changes and NPPO representation on this group would be beneficial not only to psychology students but those of all other health and social care disciplines.

Finally, a central placement office will facilitate improved and strengthened communication between the health and social care system and HEIs to better enable psychology training programmes to respond to, and contribute to, identifying the needs of the system.

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Appendices

Appendix 1 – Eligibility criteria from October 2018

Staff Grade Posts:

1. **Health**

   Candidates for and any person holding the office must be fully competent and capable of undertaking the duties attached to the office and be in a state of health such as would indicate a reasonable prospect of ability to render regular and efficient service.

2. **Character**

   Candidates for and any person holding the office must be of good character.

Possess a recognised Irish university degree or diploma (QQ1 level 8 equivalent) obtained with 1st or 2nd class honours in which Psychology was taken as a major subject and honours obtained in that subject.

AND

An Irish professional post-graduate qualification accredited by the Psychological Society of Ireland in clinical, counselling or educational psychology. See explanatory Note 1and Note 2 below.

OR

Possess an equivalent qualification from another jurisdiction validated by the Department of Health (An Roinn Sláinte).

Note:1 The above eligibility criteria apply without prejudice to applicants employed in a post of Psychologist or above in the Irish public health service at October 2002.

Note 2 Irish trained applicants who qualified on or before 30/09/2022

Applicants with Clinical or Counselling Psychology qualifications awarded on or before 30/09/2022.

Applicants with a clinical or counselling psychology qualification must demonstrate that they have acquired, in appropriate health settings in each of the areas of Disability (Child and Adult), Child Psychology, Adult Psychology, at least 60 days or equivalent supervised clinical placements** as part of the professional qualification

OR

at least 60 days or equivalent post qualification supervised work experience as a psychologist;

OR

a combination of both.

Applicants with Educational Psychology qualifications awarded on or before 30/09/2022.

Applicants with an educational psychology qualification must demonstrate that they have acquired in appropriate health settings in each of the areas of Child Disability and Child Psychology at least 60 days or equivalent in supervised clinical placements** as part of the professional qualification or at least 60 days.

OR

Equivalent post qualification supervised work experience as a psychologist or a combination of both.

****** Combinations of supervised clinical placement experience as part of the qualification and post qualification supervised work experience within a single care group area to give a total of 60 days are not acceptable.

AND

All candidates must possess the requisite knowledge and ability, including a high standard of suitability), for the proper discharge of the duties of the office.

Senior Grade Posts:

Eligibility Requirements for Senior Grade Posts from 01.10.2022

Possess a recognised Irish university degree or diploma (QQI level 8 equivalent) obtained with 1st or 2nd class honours in which Psychology was taken as a major subject and honours obtained in that subject

AND

An Irish professional post-graduate qualification accredited by the Psychological Society of Ireland in clinical, counselling or educational psychology. (See explanatory Note 1, Note 2 and Note 3 below).

OR

Possess an equivalent qualification from another jurisdiction validated by the Department of Health. (An Roinn Sláinte).

Note 1: The above eligibility criteria apply without prejudice to applicants employed in a post of Psychologist or above in the Irish public health service at October 2002.

Note 2: Irish trained applicants who qualified on or before 30/09/2022

Applicants with Clinical or Counselling Psychology qualifications awarded on or before 30/09/2022.

Applicants with a clinical or counselling psychology qualification must demonstrate that they have acquired in appropriate health settings in each of the areas of Disability (Child and Adult), Child Psychology, Adult Psychology at least 60 days or equivalent supervised clinical placements** as part of the professional qualification

OR

at least 60 days or equivalent post qualification supervised work experience as a psychologist.

OR combination of both.

**** Note**: Combinations of supervised clinical placement experience as part of the qualification and post qualification supervised work experience within a single care group area to give a total of 60 days are not acceptable.

Applicants with Educational Psychology qualifications awarded on or before 30/09/2022.

Applicants with an educational psychology qualification must demonstrate that they have acquired in appropriate health settings in each of the areas of Child Disability and Child Psychology at least 60 days or equivalent in supervised clinical placements** as part of the professional qualification or at least 60 days.

OR

Equivalent post qualification supervised work experience as a psychologist or a combination of both.

** Note: Combinations of supervised clinical placement experience as part of the qualification and post qualification supervised work experience within a single care group area to give a total of 60 days are not acceptable.

Note 3: Applicants with Clinical or Counselling Psychology qualifications awarded on or after 01.10.2022.

Applicants with a clinical or counselling psychology qualification must demonstrate that they have acquired in appropriate health settings in each of the areas of Disability (Child and Adult), Child Psychology, Adult Psychology at least 60 days or equivalent supervised clinical placement as part of the professional qualification

Applicants with Educational Psychology qualifications awarded on or after 01.10.2022.

Applicants with an educational psychology qualification must demonstrate that they have acquired in appropriate health settings in each of the areas of Child Disability and Child Psychology at least 60 days or equivalent in supervised clinical placements as part of the professional qualification or at least 60 days.

All candidates must possess the requisite knowledge and ability, including a high standard of suitability for the proper discharge of the duties of the office.

Appendix 2 - Membership of Sub-Group

Membership of Sub-Group 1

- Declan Hynes, Chair. Head of HR CHO 6
- Niamh Clarke, Principal Psychology Manager, CHO 8 *
- Aidan Corr, Senior Psychologist, St Paul's Service
- Mary Davis, Principal Psychology Manager, Disability Services, CHO 2
- Mary Doran, HBS Recruit
- Janette Dwyer, Head of Social Care, CHO 5
- Jackie Nix, Assistant National Director, HR Community Services
- Ed O'Dea, Principal Psychology Manager
- Ladislav Timulak, Course Director, Doctorate in Counselling Psychology, Trinity College Dublin
- Eileen Walsh, Health & Social Care Professions Office

* Left the Project Team due to reassignment or other factors

Membership of Sub-Group 2

- Mac MacLachlan, Chair. HSE Clinical Lead for Disability and Professor of Psychology, Maynooth University.
- Daniel Flynn, Principal Psychology Manager, Mental Health Services, CHO 4
- Meena O'Neill, Principal Psychology Manager, CHO 2
- Paddy Duggan, HSE Strategic Workforce Planning & Intelligence
- Diane Lynch, HSE Strategic Workforce Planning & Intelligence
- Theresa Heller, HR Lead, Mental Health Community Operations
- Cormac O'Connor, Senior Counselling Psychologist, Muiriosa Foundation (S38)
- Natalie Hession, Principal Psychologist, Psycho-oncology St. Luke's Hospital
- Moira Kennedy, Senior Educational and Child Psychologist, CHO 6

Appendix 3– Overview of stakeholder consultation and engagement

Introduction

The Project Team has endeavoured to ensure that a thorough process of stakeholder consultation has been conducted to inform their work.

In line with proposals for stakeholder consultation and engagement agreed by the Project Team, the purpose of stakeholder engagement has been three-fold:

- To communicate and inform stakeholders of the establishment of a National Psychology Placement Office (IAP2 Spectrum – engagement level 1);
- To seek feedback to inform the establishment of a National Psychology Placement Office and an operational remit in the areas of trainee psychologist placements including identification, requirements and preparation (IAP2 Spectrum – engagement level 2);
- To seek feedback on identifying key drivers that are likely to produce significant changes in the ways in which, and the extent to which, psychological help can be made available to those who may benefit from it; and the implications for the psychological workforce (IAP2 Spectrum – engagement level 2).

A high-level stakeholder mapping exercise was undertaken by the Project Team to identify stakeholders who were likely to have an interest in the establishment of a placement office. This exercise informed the approach to consultation.

About the Consultation and engagement Process

Communication and engagement commenced in October 2019, with an introductory briefing session for all stakeholders.

A half day workshop was hosted on 28th February 2020. A week in advance a high-level synthesis paper was issued to all attendees. The purpose of the paper was to support discussions on the day, and to seek views, in particular, to assist with the finalisation of the establishment of the placement office and associated remit. Feedback was also sought in relation to the key drivers of change in the provision of psychological services, and the implications for the psychological workforce. Stakeholder feedback was requested on the following questions:

9. Are there any other considerations with regard to the availability of, or demand for, placements that should be taken into account?
10. Are there any other key interfaces between the placement provider organisations and HEIs that should be taken account of?
11. What gaps in information flows exist – either within placement provider organisations or across the health and education sectors?
12. Is there a specific requirement to scope out the current local governance arrangements in place between the HSE/Section 38s and the HEIs, in respect of placement management for Clinical Psychology Trainees?
13. Is there a further specific requirement to scope out the current arrangements with regard to placement management for Counselling and Education Psychology Trainees?
14. What service developments should be a priority of psychologists?
15. How should psychologists respond to the increasing range of assessment, support and intervention options?
16. How should the training of psychologists evolve in order to adapt to innovations in technology, skill mix, and service user empowerment?

The workshop involved an introduction outlining the context and purpose of the day by the Chair of the Project Team. Stakeholders were divided into pre-determined groups to ensure an even representation of all stakeholder cohorts. During the first session the groups discussed and noted their feedback on Questions 1 – 5; following which key messages where shared by each group. The second session adopted the same approach and considered Questions 6 – 8.

The workshop discussions identified a number of benefits that would arise from a centralised approach to placement planning and management:

- Longer term planning of, and for, placements.
- Development of national agreed standard placement criteria.
- Development of common placement learning agreements.
- Development of national agreed supervisor accreditation.
- Improve and strengthen communication between the HSE system and HEIs to better enable education to respond to and contribute to identifying the needs of the system.

With regard to the key drivers of significant changes for the future delivery of psychological services, the key implications for the psychological workforce identified were:

- Workforce diversification.
- Generic vs. specialist skills.
- Parity of esteem and equitable funding for training across clinical, counselling and educational psychology.
- Quality support and assurance.
- Competency framework.
- Leadership in MDTs and community healthcare.
- Staff tasks should align with their competency, level of employment and remuneration.

A thematic analysis of the feedback derived from the two sessions is set out below for information and consideration by the Project Team: These themes will be reflected in the final report, as appropriate.

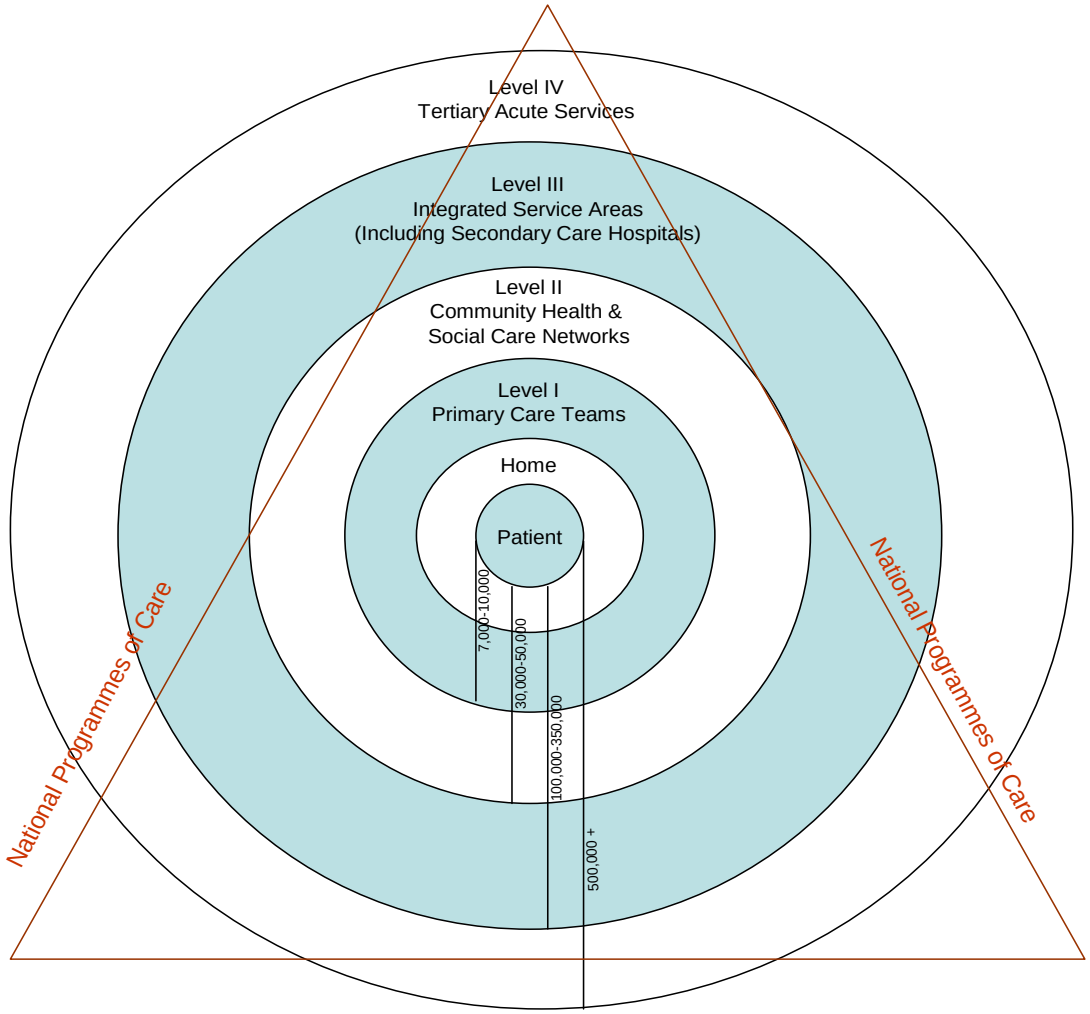
Theme	Consultation Feedback
Governance	• There were strong views that the placement office should build on what already works well i.e. networks and relationships at local level; and where they are in place the MOUs/MOAs. A Hub and Spoke model involving multiple regional stakeholders would assist in maintaining flexibility. • A placement office would provide the opportunity to formalise placement identification and availability – not just based on goodwill. • Placements should be cross-agency to include HSE, Tusla, IPS, Education and voluntary agencies. This will assist in areas of high demand e.g. Progressing Disability has placed considerable pressure on placement availability. • Current local governance arrangements should be scoped out and built upon with respect to placements for clinical, educational and counselling trainees, to develop a single overarching governance framework for placement management; to include placement provider organisations, HEIs, and the professional body. • A centralised placement office would facilitate medium – to longer-term planning of placements and funding. • Governance arrangements should give consideration to learning outcomes, CORU developments and risk assessment. • Placement funding should be managed and allocated on the basis of equity for all. • The status of employee or non-employee is a very important factor which impacts upon the interface between placement provider organisation and the HEI. • Address clinical indemnity cover for non-employees in placement provider organisations. • Development of MOAs / MOUs for all domains of psychology to bridge gaps in information and establish procedural guidelines. • Facilitate the introduction of service user advocacy in informing psychology training, education and service user empowerment into the future. • A national lead for psychology should be considered to work with the Integrated Care Lead and other National Clinical Advisors and Group Leads e.g. Primary Care and Mental Health to: – Provide direction / strategy – to feed into shaping future developments. – System planning. – Health economics. – Recruitment & Retention strategies. – Governance in respect of CPD and trainee placements – Identify needs and opportunities for services to work across sectors. – Provide the opportunity for targeted and budgeted CPD.
Quality Assurance	• Mechanism developed to ensure that there is one standard and a consistent approach to managing placements including monitoring, a feedback loop, and opportunity for remediation. • Develop criteria for appropriate settings for placements - uncouple healthcare from appropriate settings – which are cross-agency. • Develop a database of physical placement settings – placement definitions and requirements in terms of supportive infrastructure. • Develop supervisor accreditation – setting out minimum requirements, skills and training.

	• Database of type, level and number of placements.
	• Develop a supervisor register to include a quality assurance mechanism.
	• Develop placement criteria, working with HEIs to ensure placements
	  – Meet student needs.
	  – Educators maintain ability to input to placement design and match placements to the individual learning needs of trainees.
	  – Consideration is given to the need for research opportunities including the time to carry out research.
	• Work with HEIs / PSI to incorporate the mixed experience competency model into placement, competency is evaluated at care group level.
	• Develop placement / care group level learning agreements to include outcomes, logistics, risk management.
	• There is a need to develop psychological implementation science to investigate inputs, outcomes and impacts for alternative intervention cohorts, types and modalities.
	• Focus on self-care – avoid burnout and support practitioners.
	• Develop a balance between service demands and demands for placements and supervisors.

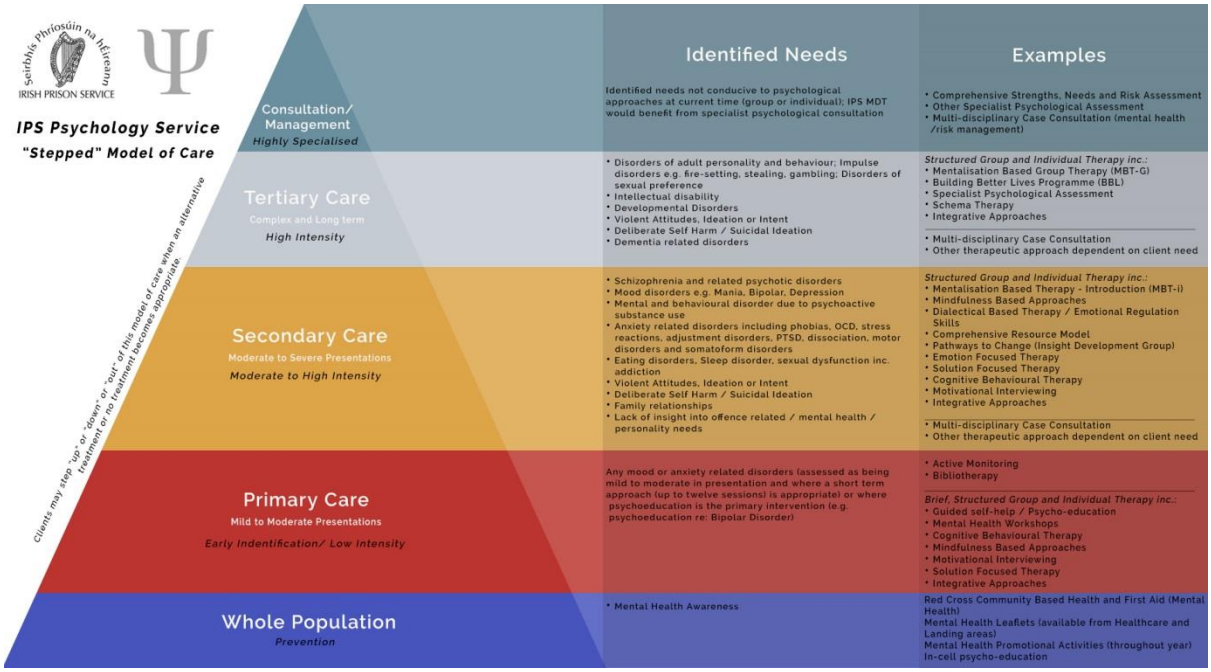
Infrastructure	• Cognisance must be given to the quality of the placement experience with regard to accommodation, ICT facilities and other organisational supports and its impact of attracting and recruiting future psychologists to the system. • Centralised I.T. system to manage placements e.g. DIME for NCHDs would be beneficial and would contribute to longer term planning of placements.
Workforce Planning	• Workforce planning – a tiered model that allows for layered care. e.g. Assistant Psychologist; psychologist at senior organisational management level. • A more complex, flexible and open approach to tiered and layered psychological interventions – which incorporates a plethora of training, methods and modalities – will require professional oversight form professional psychologists to ensure quality standards and safety. • Increased system-focused training: leadership, consultancy, trans-disciplinary work to ensure competency to take on leadership roles in MDTs • Mobility – a transfer scheme across locations at the same level of employment should be facilitated where vacancies exist. • Workforce diversification – allow for greater capacity and flexibility in response to service needs. • Review grading structure with possible revision of terms used. • Both generic and specialist skills are required, but not necessarily to the same level, or across the same scope of practice, in the evolving psychological workforce. • Staff tasks should align with their competency and level of employment and remuneration (in particular regarding the supervision of trainees). • Where contracts of employment with the HSE are not in place, but service providers are providing services on behalf of the HSE, a clinical indemnity scheme should be in place.

Future delivery of psychological services	• Evidence-based with an emphasis on practice-based evidence. • Strong governance with respect to staffing structures. • Aligned with Sláintecare. • Appropriate allocation of services to address both mild-moderate and moderate-severe e.g. mental health – prevention / early intervention. • Change in service provision should be a constant and so services should have the capacity to adopt to and incorporate service innovations. • Constant review and evolution/adaptation of training re above. • Intervention and ongoing psychological formulation, not diagnosis, should be prioritised. • Service user involvement in evaluation, feedback, planning and prioritisation is important. • Balance in managing demands e.g. legislative requirement Assessment of Need can lead to psychologists not being involved in intervention which can create tension. • Staff training – a concern that psychologists are only dealing with complex caseloads leading to a lack of diversity in caseloads. • Need medium term (not yearly) budgeting to support medium- to long-term planning • All psychology disciplines should be involved in planning service developments. • More focus on leadership and consulting roles for psychologists is needed. • Technology innovations within the HSE should take account of existing infrastructure limitations, service needs and the resources – including training – necessary to use them. • The psychology workforce will increasingly be working in tiered arrangements tied in with levels of complexity of presenting problems. • Tiered workforce arrangement will require robust governance structures and effective supervision arrangements • Ensuring that the Programme Boards in the HEIs align with innovations and change within the healthcare landscape e.g. Progressing Disabilities has been reflected in modifications to placement requirements on Clinical psychology programmes. • Through MOU and MOAs, HEIs can be required to show capacity to adapt to changes where necessary.

Appendix 4 – HSE Service Delivery Model



Appendix 5-Irish Prison Service Psychology Model of Care



Appendix 6 – Educators' projected training intake to 2023

Projected intake of Clinical, counselling and educational psychology trainees

Years	**2020/2021**	**2021/2022**	**2022/2023**	**2023/2024**
Clinical	191	188	187	186 / 188
Counselling	42	42	42	42
Educational	70	67	71	67
Total	**303**	**297**	**300**	**295 / 297**

Current and projected psychology trainee numbers 2020 - 2024

Counselling Psychology				
TCD	**2020/2021**	**2021/2022**	**2022/2023**	**2023/2024**
1st year	14	14	14	14
2nd year	14	14	14	14
3rd year	14	14	14	14
Total Counselling by year	**42**	**42**	**42**	**42**
Educational				
MIC	**2020/2021**	**2021/2022**	**2022/2023**	**2023/2024**
1st year	12	12	12	12
2nd year	12	12	12	12
3rd year	12	12	12	12
Total	**36**	**36**	**36**	**36**
UCD	**2020/2021**	**2021/2022**	**2022/2023**	**2023/2024**
1st year	10	10**	10**	10**
2nd year	13	11	11	11
3rd year	11	10	14	11
Total	**34**	**31****	**35****	**31****
Total Educational by year	**70**	**67**	**71**	**67**

**Based on 2020 intake as intake for 2021-2024 unknown. Capacity exists to take in more Trainees but numbers are limited by the availability of placements

Clinical				
NUIG	**2020/2021**	**2021/2022**	**2022/2023**	**2023/2024**
1st year	14	12	12	12 / 14
2nd year	12	14	12	12
3rd year	15	12	14	12
Total	**41**	**38**	**38**	**36 / 38**
TCD	**2020/2021**	**2021/2022**	**2022/2023**	**2023/2024**
1st year	16	13	15	17
2nd year	14	16	13	15
3rd year	16* / **	16	17	13
Total	**46***	**45**	**45**	**45**
*1 funded place St. Pats – not renewed ** Maternity leave				
UCD	**2020/2021**	**2021/2022**	**2022/2023**	**2023/2024**
1st year	11	15	17	11
2nd year	17	11	15	17
3rd year	14	17	11	15
Total	**42**	**43**	**43**	**43**
UCC	**2020/2021**	**2021/2022**	**2022/2023**	**2023/2024**
1st year	8	8	9	9
2nd year	9	8	8	9
3rd year	9	10	8	8
Total	**26**	**26**	**25**	**26**
UL	**2020/2021**	**2021/2022**	**2022/2023**	**2023/2024**
1st year	12	12	12	12
2nd year	12	12	12	12
3rd year	12	12	12	12
Total	**26**	**26**	**25**	**26**
Total Clinical by Year	**26**	**26**	**25**	**26**
Clinical, Counselling and Education Total by Year				
	2020/2021	**2021/2022**	**2022/2023**	**2023/2024**
Clinical	191	188	187	186/188
Counselling	42	42	42	42
Educational	70	67	71	67

Appendix 7 - Revised eligibility criteria January 2021

Below are the professional qualifications and experience required for the appointment and continuing as an entry grade psychologist. The criteria cover the following cohorts of employees and external applicants.

Category A. Employed pre October 2002

Category B. Employed between October 2002 to 31st January 2021

Category C. Employed 31st January 2021 to the 30th September 2024.

Category A/2024 Qualified pre 01.10 2024 and employed post 01.10.2024

Category B/2024 Qualified post 01.10.2024

Criteria effective to 30 September 2024

Psychologist, Clinical	**Grade Code 3689**
Psychologist, Counselling	**Grade Code 3691**
Psychologist, Educational	**Grade Code 3690**

In exercise of the powers conferred on me by Section 22 of the Health Act 2004, I hereby approve the qualifications, as set out hereunder, for the appointment and continuing as **Psychologist – Clinical/Counselling/Educational** in the HSE **up to 30th September 2024.**

Category A (Employed pre October 2002)

1. Professional Qualifications, Experience, etc.

Eligible applicants must

i. Have been employed before 25th October 2002 and be currently in employment as a psychologist in the public health system; the HSE and agencies funded under Section 38 and Section 39 of the Health Act 2004

And

ii. Demonstrate competence in the Care Group/s applied for

And

iii. Possess the requisite knowledge and ability, including a high standard of suitability and ability, for the proper discharge of the office

Category B (Employed between October 2002 and 31st January 2021)

1. Professional Qualifications, Experience, etc.

Eligible applicants must

i. Be currently employed in a named publically funded psychological service, Note 1.

And

ii. Have a university degree or diploma (QQ1 level 8 equivalent) obtained with 1st or 2nd class honours in which Psychology was taken as a major subject and honours obtained in that subject

And

iii. Have an Irish post-graduate professional psychology qualification accredited by the Psychological Society of Ireland in Clinical, Counselling or Educational Psychology

Or

An equivalent qualification from another jurisdiction validated by the Department of Health.

And

iv. Demonstrate competence in the Care Group/s applied for.

And

v. Possess the requisite knowledge and ability, including a high standard of suitability and ability, for the proper discharge of the office

Note 1. Psychological services delivered or funded by the Department of Health, Department of Justice, Department of Education and the Department of Children, Disability, Equality and Integration aimed at improving the mental, physical or social health or wellbeing of the clients they serve.

Category C (Employed 31st January 2021 to the 30th September 2024.)

1. Professional Qualifications, Experience, etc.

Eligible applicants must

i. Have a university degree or diploma (QQ1 level 8 equivalent) obtained with 1st or 2nd class honours in which Psychology was taken as a major subject and honours obtained in that subject

And

ii. Have an Irish post-graduate professional psychology qualification accredited by the Psychological Society of Ireland in Clinical, Counselling or Educational Psychology

Or

An equivalent qualification from another jurisdiction validated by the Department of Health.

And

iii. Demonstrate competence in the Care Group/s applied for

And

iv. Applicants with a clinical or counselling psychology qualification must demonstrate that they have acquired in appropriate health settings, **for the area / areas for which they wish to apply** - Disability (Child and Adult), Child Psychology, Adult Psychology - either at least 60 days or equivalent supervised clinical placements as part of the professional qualification; or

at least 60 days or equivalent post-qualification supervised work experience as a psychologist. Note 2.

Or

Applicants with an educational psychology qualification must demonstrate that they have acquired in appropriate health settings **for the area / areas for which they wish to apply** - Child Disability, Child Psychology - either at least 60 days or equivalent supervised clinical placements as part of the professional qualification; or at least 60 days or equivalent post-qualification supervised work experience as a psychologist. Note 2.

Note 2: Combinations of supervised clinical placement experience as part of the qualification and post qualification supervised work experience within a single care group area to give a total of 60 days are not acceptable.

Criteria effective on or after 1st October 2024.

Psychologist, Clinical	**Grade Code 3689**
Psychologist, Counselling	**Grade Code 3691**
Psychologist, Educational	**Grade Code 3690**

In exercise of the powers conferred on me by Section 22 of the Health Act 2004, I hereby approve the qualifications, as set out hereunder, for the appointment and continuing as **Psychologist – Clinical/Counselling/Educational** in the HSE **on or after 1st October 2024.**

These criteria apply without prejudice to applicants employed up to the 30th September 2024 in a post of Psychologist, or above, in an Irish publically funded health service; the HSE and agencies funded under Section 38 and Section 39 of the Health Act 2004.

Category A/2024

Applicants who qualified as psychologist, before 1st October 2024 who are not employed as a psychologist in a named publically funded psychological service, Note 1.

1. Professional Qualifications, Experience, etc.*

Eligible applicants will be those who on the closing date for the competition:

i. Have a recognised university degree or diploma (QQI level 8 equivalent) obtained with 1st or 2nd class honours in which Psychology was taken as a major subject and honours obtained in that subject

And

ii. Have an Irish post-graduate qualification accredited by the Psychological Society of Ireland in clinical, counselling or educational psychology

Or

An equivalent qualification from another jurisdiction validated by the Department of Health.

And

iii. Applicants with a clinical or counselling psychology qualification must demonstrate that they have acquired at least 60 days or equivalent supervised clinical placements in appropriate health settings **in each of the three areas**; Disability (Child and Adult), Child Psychology and Adult Psychology, as part of the post-graduate professional qualification, **or equivalent post-qualification supervised work experience as a psychologist.**

Or

Applicants with an educational psychology qualification must demonstrate that they have acquired at least 60 days or equivalent supervised clinical placements in appropriate health settings **in both areas** of Child disability and Child Psychology as part of the post-graduate

professional qualification, **or equivalent post-qualification supervised work experience as a psychologist.**

Note 1. Psychological services delivered or funded by the Department of Health, Department of Justice, Department of Education and the Department of Children, Disability, Equality and Integration aimed at improving the mental, physical or social health or wellbeing of the clients they serve.

Category B/2024

Applicants who qualified as psychologist after the 1st October 2024

1. Professional Qualifications, Experience, etc.*

Eligible applicants will be those who on the closing date for the competition:

i. Have a recognised university degree or diploma (QQI level 8 equivalent) obtained with 1st or 2nd class honours in which Psychology was taken as a major subject and honours obtained in that subject

And

ii. Have an Irish post-graduate qualification accredited by the Psychological Society of Ireland in clinical, counselling or educational psychology

Or

An equivalent qualification from another jurisdiction validated by the Department of Health.

And

iii. Applicants with a clinical or counselling psychology qualification must demonstrate that they have acquired at least 60 days or equivalent supervised clinical placements in appropriate health settings **in each of the three areas**; Disability (Child and Adult), Child Psychology and Adult Psychology, as part of the post-graduate professional qualification.

Or

Applicants with an educational psychology qualification must demonstrate that they have acquired at least 60 days or equivalent supervised clinical placements in appropriate health settings **in both areas** of Child disability and Child Psychology as part of the post-graduate professional qualification.

Frequently asked questions

Q 1 What is Eligibility Criteria?

A 1. Eligibility criteria are the specific threshold requirements for entry into a recruitment competition for employment in the specified profession and grade. Satisfying the eligibility criterion does not give automatic progression to interview stage as shortlisting on role specific requirements may be applicable. The outcome of the competency-based interview and subsequent clearances, including references, are the final stages leading to a decision on suitability and appointment. There is no onus on an interview board to qualify all or any candidate who is called for interview.

Q 2 Why does the criteria effective to 30 September 2024 list three categories of potential applicants?

A 2. The requirement to classify applicants into 3 categories is because of the revisions that have taken place over the years in professional education standards and Care Group designation.

Category A facilitates applications from psychologists employed pre-2002, and currently employed, in the publically funded health service; the HSE and agencies funded under Section 38 and Section 39 of the Health Act 2004, to participate in recruitment campaigns without further proof of qualifications. Such applicants must prove that they have the competence to practice safely in the Care Group for which they apply.

Category B facilitates applications from psychologists who hold a professional qualification in Clinical, Counselling or Educational Psychology and who are currently employed in the designated publically funded psychological services.

Category C. applies to all applicants who do not qualify under Category A or Category B. The requirements in the criteria at Category C **1** (iii) specify the placements or work practice that must be evidenced by Clinical, Counselling or Educational Psychologist to be eligible to apply for post in designated Care Groups. The table below illustrates the Care Groups and associated required qualifications.

Care Group Areas	**Professional Psychology Qualifications required**
Disability – Child Disability	Clinical, Counselling, Educational
Disability – Adult Disability	Clinical, Counselling
Adult Psychology Services	Clinical, Counselling
Child Psychology Services	Clinical, Counselling, Educational
Lifespan Primary Care	Encompasses Care Groups of Adult Psychology Services and Child Psychology Services

Q 3 What impacts will the criteria effective on or after 1st October 2024 have?

A 3. The criteria entitled A/2024 applies to psychologist who qualified before 1st October 2024 who are not employed as a psychologist in a named publically funded psychological service at the time of application. The criteria facilitate eligibility through a combination of placements and supervised work experience in each of the three care group areas. The National Psychology Placement Office will assist in this pathway.

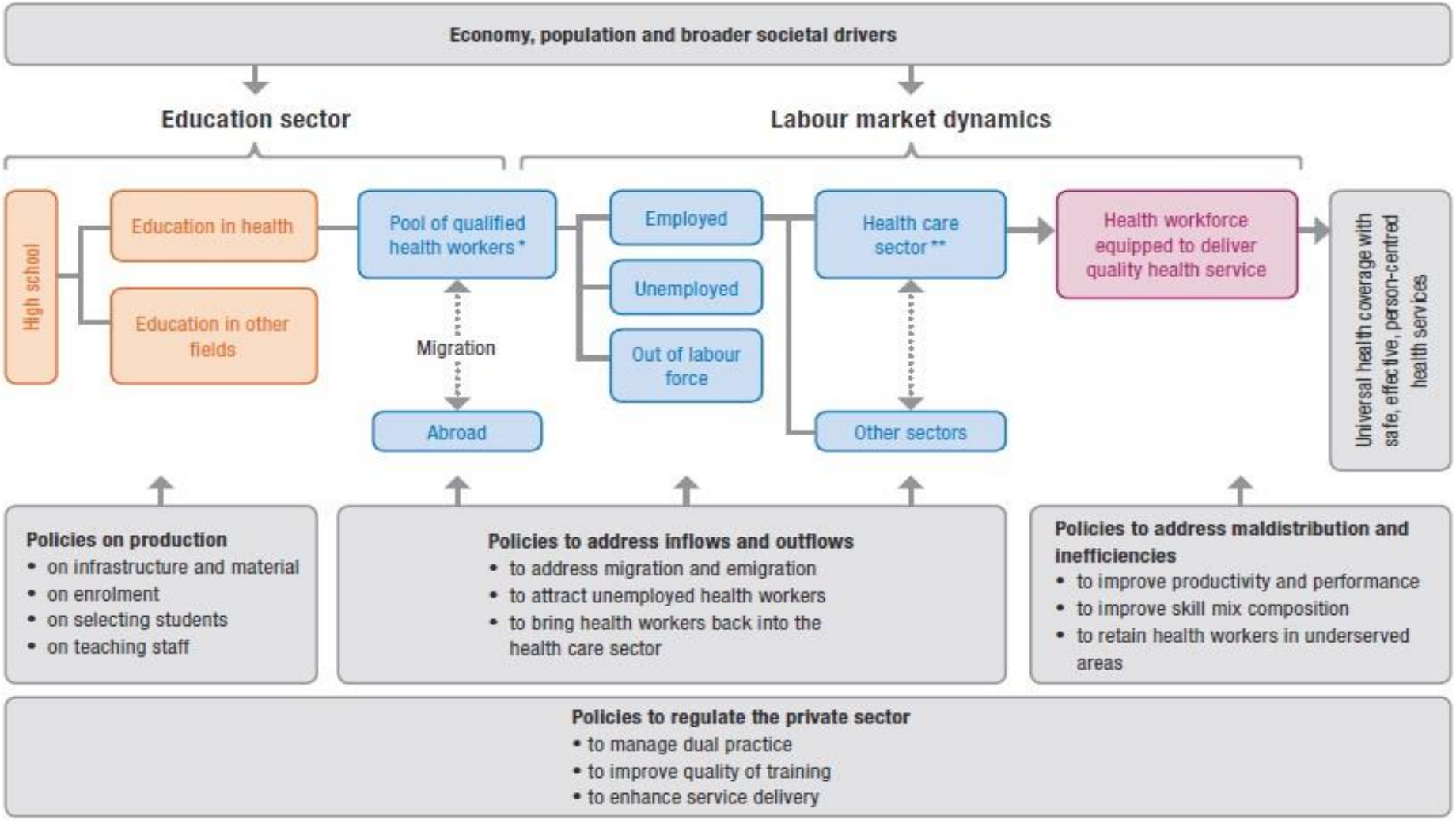
The criteria entitled B/2024 apply to all who qualify as psychologists after the 1st October 2024. These psychologists will have to have completed the prescribed placements as a combination of placements and supervised work experience will no longer be acceptable

Q 4. What are the criteria for senior Psychology posts?

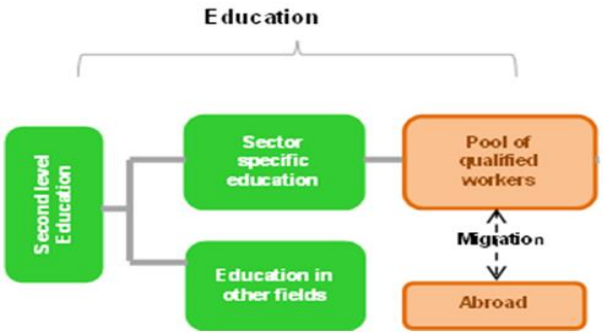
A 4. These criteria also apply to applicants for senior posts with the inclusion of the established requirement that:

Applicants must have at least five years satisfactory post-graduate experience in the area of professional psychology, no more than three years of which was spent in gaining the post-graduate professional qualification and no less than two years full-time spent in post-qualification experience as a professional psychologist. Years in excess of the permitted three years for completion of the post-graduate training or time not worked will not be taken into consideration when assessing the five years' experience requirement.

Appendix 8: Comprehensive health labour market framework (Sousa et al, 2013)



The Future Workforce



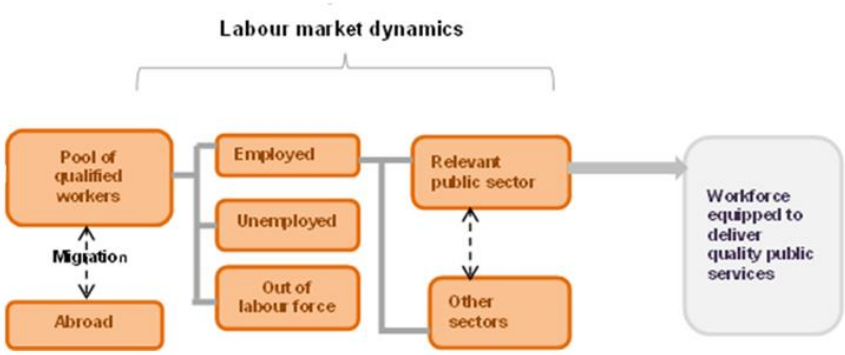
Policies relating to production of the future workforce:

- Infrastructure and materials
- Enrolment of students
- Selection of students
- Teaching staff

Some of the factors to be considered:

- Attraction of second level students to third level programmes
- Attrition rates at undergraduate and postgraduate levels
- Attraction, recruitment and retention to teaching roles and posts
- Management of placements, where these are necessary

The Current Workforce



Policies relating to the current workforce:

- Inflows and outflows
- Migration and emigration
- Attracting back unemployed workers and bringing them back into their sector(s)
- Measures to address mal-distribution and inefficiencies
- Measures to improve productivity and performance
- Skill mix composition
- Retaining key workers in underserved areas

Some of the factors to be considered:

- Attraction, recruitment and retention strategies
- Continuous professional development
- Working environment
- Career pathways