

A profile of psychologists' workload in Ireland

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A survey of psychologists in three Local Health Office Areas in Ireland profiled their caseloads, work complexity and their use of professional time. Results suggest lower caseloads than in previous research.

PSYCHOLOGISTS' CASELOADS are of growing concern for service users, clinicians and service managers (Division of Clinical Psychology, 2007). Caseloads impact on the quality of service provision including access and effectiveness (Shield et al., 2003). Excessive caseloads can impact on the well-being of clinicians and have been linked to stress derived from role ambiguity, ethical dilemmas and a sense of inequity within the system (Hannigan et al., 2004). There are also clear implications for funding agencies who may be concerned with high throughput (i.e. value for money), manpower planning and the day-to-day management of psychology services.

In addition to profiling professional activities (i.e. how professional time is spent), using data from 1993, Carr (2000) found a median caseload of 51 cases among clinical psychologists ($N = 111$) working across a broad spectrum of Irish services. Research in the UK indicated a median caseload size of 33 and a mean caseload of 39 among psychologists ($N = 355$) that included mean figures of 48, 29 and 39 for those working in child, learning disability and adult services respectively (Skinner & Baul, 1997). Related to the latter, clinical psychologists ($N = 6$) on UK community mental health teams also had a mean caseload size of 39 (range 19–46), but these figures may have been inflated by the inclusion of cases seen by psychologists in clinical training or assistant psychologists (Greenwood et al., 2000). Inclusion of such supervised cases may also have inflated the

average of 62 'active' cases among clinical psychologists in a Northern Ireland adult mental health psychology service (Forsythe & Gallagher, 2003). A more recent Irish study ($N = 73$) found a median caseload size of 50 (O'Dowd, 2008).

Caseload variability may be attributable to a number of factors including the need to see some service users more frequently or to spend more time in direct assessment or treatment work. However, the cases of those with numerically smaller caseloads may be complex and require higher levels of skill that translate into heavier workloads (Manpower Advisory Service, 1989). In addition to variable caseload mixes, non-clinical pressures (e.g. administrative duties) may also impact on how caseloads are managed.

This current study profiles psychologists' caseloads in terms of caseload size, number of cases seen, and waiting lists. It also examines other factors that may influence caseload variability including time allocated to manage a typical case, how professional time is spent, and complexity of work.

Method

An 18-item questionnaire was designed, with item generation informed by an earlier study of clinical psychologists in Ireland (Carr, 2000), data from the Psychology Workforce Steering Group (NHS Education for Scotland, 2008), and the three-tier model of skills from the Clinical Psychology Project (Manpower Planning Advisory Group, 1990). Based on the measure suggested by Bhaskara (1999) the definition of 'caseload' provided on the questionnaire was 'the number of files or cases open (active) at one time, even if no activity took place during that month'.

Subsequent to piloting, the 18-item questionnaire was mailed to 65 Health Service

Executive (HSE) and voluntary organisation psychologists in three HSE local health office areas. Thirty-five returned completed questionnaires (a response rate of 54 per cent). Data from three principal manager grade respondents were excluded as a review of the responses showed them to be atypical and their inclusion could skew the findings. Thirteen were working in HSE child and adolescent psychology, defined as including those in both community care, and (secondary care) child and adolescent mental health services, five in HSE secondary care adult mental health psychology, and three in HSE primary care psychology. Those assigned to the latter category were assumed to work with clients across the life-span (i.e. all age groups). The fourth category was Voluntary organisation psychologists ($N = 11$). Of these, 10 were working in 'intellectual disability' psychology and one in 'physical disability' psychology. Caseloads were compared across these four categories of psychologists, and between HSE and Voluntary psychologists. Of the 32 respondents, 21 worked full-time while 11 worked reduced hours (e.g. job share). Sixteen were staff grade psychologists and another 16 worked at senior grade.

Definitions of level of skill required, based on previous Manpower Advisory Service (1989) research, were provided in the questionnaire. Tier 1 level skills were defined as skills required to establish and maintain supportive relationships and the use of basic

behavioural techniques. Tier 2 skills were defined as conducting structured assessments or manualised interventions, and Tier 3 level skills as those required to manage complex psychological problems (e.g. drawing on multiple theoretical models to inform assessment-driven hypotheses testing, complex formulations and interventions).

Results

Caseload, waiting lists and average number of sessions per case

When data were pro-rated to reflect a standard 35 hour week, the mean caseload per psychologist was 30 cases (range = 10–64) or a median caseload of 25 (modal range 20–29; see Table 1). The data were analysed using Mann Whitney U test. The median caseload size of 22 for HSE psychologists ($N = 21$) was significantly lower than the 32 of voluntary psychologists ($N = 11$; $z = 2.33$, $p = .02$, $r = .412$). Likewise, the median caseload size of 20 for HSE child and adolescent psychologists ($N = 13$) was significantly lower than that of voluntary psychologists ($z = 2.70$, $p = .006$, $r = .551$). No other differences across categories were statistically significant for caseload sizes.

The mean number of cases seen during the previous calendar month was 21 cases. HSE adult psychologists saw more cases (34) than those in child and adolescent psychology (19), primary care (13) and those in voluntary services (21). The mean number of cases opened for the entire sample was seven

Table 1: Caseload, waiting lists and average number of sessions per case across services.

	Full sample ($N = 32$)	HSE child & adolescent ($N = 13$)	HSE adult ($N = 5$)	HSE adult ($N = 32$)	Voluntary ($N = 32$)
Caseload (median)	25	20	45	20	32
Cases seen	21	19	34	13	21
Cases opened	7	5	9	5	8
Cases closed	4	4	6	5	3
Waiting list – Clients	14	17	13	16	10
Waiting list – Months	7	7	3	4	12
Average number of sessions per case	12	12	14	14	12

Table 2: How professional time is spent across services (%)

	Full sample (N = 32)	HSE child & adolescent (N = 13)	HSE adult (N = 5)	HSE adult (N = 32)	Voluntary (N = 32)
Caseload (median)	36	44	53	36	23
Cases seen	21	17	14	21	29
Cases opened	4	4	4	7	4
Cases closed	6	7	7	4	6

while the mean number of cases closed was four. The mean number of waiting list cases was 14 that translated into a waiting-time of seven months (range 0–36). The average number of sessions per case for the entire sample was 12 (range 6–30).

How professional time was spent

The amount of time allocated to particular tasks were analysed by converting the number of hours per week to a percentage of total hours worked. This percentage was used to generate the number of hours on a particular task if each psychologist worked a standard 35-hour week. Combined data across all categories indicate that psychologists spent 36 per cent of their time (12 hours per week) on direct client work (assessment, formulation and treatment). Indirect client work accounted for 21.4 per cent of their time (7.5 hours per week). This comprised of preparing reports (8.8 per cent) and liaising with client’s relatives (7.7 per cent) and other professionals (4.9 per cent). Additionally, participants spent 13.3 per cent of their week (4.7 hours) on administration, 8 per cent (2.8 hours) on attending meetings, 6 per cent (2.1 hours) on preparing reports, 6 per cent (2 hours) on providing supervision, education and training, 4 per cent (1.5 hours) on personal development (e.g. CPD, receiving supervision) and 2 per cent (0.7 hours) on research.

When examined by service area (see Table 2), voluntary psychologists spent 23 per cent of their time (8 hours) working directly with clients, HSE primary care psychologists 36 per cent (12.5 hours), HSE child and adolescent psychologists 44 per cent (15 hours),

and HSE adult psychologists 53 per cent (19 hours). The treatment component of direct work accounted for 29 per cent (10 hours) of HSE adult psychologists’ workload, and 26 per cent (9 hours), 20 per cent (7 hours) and 10 per cent (3.5 hours) respectively of HSE child and adolescent, HSE primary care, and Voluntary psychologists’ workload.

Voluntary psychologists spent 29 per cent of their time (10 hours) in indirect work, while those in HSE adult, child and adolescent, and primary care respectively spent 14 per cent (5 hours), 17 per cent (6 hours) and 21 per cent (7 hours) in indirect work. Corresponding figures for time working indirectly with client relatives were 14 per cent (or 5 hours), 4 per cent (1.5 hours), 3 per cent (1 hour), and 6 per cent (2 hours) respectively.

Complexity of work

Voluntary psychologists indicated that they engaged in Level 1 complexity work 35 per cent of the time, Level 2 complexity work 34 per cent of the time and Level 3 complexity work 30 per cent of the time. Corresponding figures for (HSE) child and adolescent psychologists were 35, 29 and 37 per cent of the time. While figures for primary care psychologists were comparable (e.g. 27 per cent, 35 per cent, 38 per cent), those for adult psychologists were different (e.g. 19 per cent, 23 per cent, 58 per cent).

Discussion

Notwithstanding study limitations (e.g. small number of respondents), the indicated median caseload size of 25 is only half that of previous studies (e.g. Carr, 2000; O’Dowd, 2008). Despite no obvious explanation for

this finding, some hypotheses can be put forward.

While participant psychologists spent 13.3 per cent of their time on administration, they also spent 6 per cent of their time on preparing reports and 8 per cent on attending meetings. This totals 27.3 per cent. Yet figures for 'routine administration' in Carr (2000) and O'Dowd (2008) were only 11 and 11.9 per cent respectively, with no figures reported for preparing reports or attending meetings. These differences may reflect increased teamworking or administrative responsibilities (e.g. having to produce longer reports), or inefficiencies in report writing among this study's participant psychologists. Future research needs to ensure that the category 'administration' is sufficiently defined.

The Carr sample worked a mean of 37 hours per week or two hours more than this study's participants. However, the latter also spent considerably less time on research (1.8 per cent) relative to those in Carr (6 per cent), O'Dowd (3.1 per cent) and in Scotland (5.1 per cent; NES, 2008). While they spent a similar amount of time training others (6 per cent) as those in O'Dowd (5.3 per cent), it was less than in Carr (8 per cent). They also spent less time on continuous professional development (2.4 per cent) than in Scotland (5.7 per cent; NES, 2008).

The lower caseload sizes found may also reflect any one of a range of other factors. For example, only taking on cases that one can manage out of fear of litigation, the need to undertake excessive travel in some geographical areas or perhaps a poor value-for-money ethos among the psychologists in this sample. Whatever the explanation, any change is particularly pronounced for HSE psychologists whose median caseload (22) was significantly lower than that of Voluntary psychologists (32). However, the relatively low HSE median caseload may partially reflect a decreased emphasis on direct work with clients and a small but welcome shift towards a shared care or consultant role model (Manpower Advisory Service, 1989). The figure of 57 per cent of psychologists' time being spent on direct or indirect work was similar to the results of 57 per cent for Irish

psychologists (Carr, 2000) and 62 per cent for Scottish psychologists (NES, 2008). Yet, whereas psychologists in Carr's (2000) study spent 47 per cent of their time in direct work, this figure was only 36 per cent in this study. However, it may be more beneficial to consider the indicated caseload size figures of specific services.

Surprisingly, primary care psychologists had a median of only 20 cases, provided 14 sessions per case and saw only 13 cases (during the previous calendar month) suggesting that they were not using the brief therapeutic and/or consultation models demanded by this high throughput environment for mild-to-moderate presentations (as described by White, 2008). However, with the ongoing confusion regarding reconfiguration of community care services to primary care, some child cases seen may have been more secondary in nature (e.g. investigative interviews, child protection).

In contrast, a caseload size of 45 among the secondary care adult mental health psychologists is higher than in previous studies (Greenwood et al., 2000; Forsythe & Gallagher, 2003). Despite an average of 14 sessions per case, in the context of 34 cases seen and only 14 per cent of time devoted to indirect client work, this caseload figure suggests a high throughput model, albeit requiring Level 3 skills 58 per cent of the time. Such a model contrasts with the continuity of care and recovery models needed for severe and enduring mental health presentations. It may be that the practice in adult secondary care services is more appropriate to primary care settings and vice versa.

The median caseload size of 20 of child and adolescent psychologists possibly reflects the safe practice of working intensively with a limited number of complex cases. Indeed, referred children often live within families with long-standing and multiple problems that require time-intensive intervention and ongoing liaison with multiple stakeholders. However, lengthy psychologist waiting lists suggest the need for more efficient processing of cases (e.g. use of best-practice guidelines, administrative support, information technology, waiting list initiatives and of more productive

meetings). Ultimately, all stakeholders need to realise equivalency of effect for both lower and higher doses of best-practice intervention.

The tentative findings of this small-scale study could inform future research; for example, a larger scale study that includes independent monitoring of psychologists' caseloads (and associated caseload complexity; Curtis & Byrne, 2009) and how they spend their time. However, as quality of performance can lose out to quantification (e.g. the more readily available currency that is caseload size), rather than merely evaluating input variables (e.g. number of intervention hours), future research also needs to evaluate outcome measures such as whether service users achieve acceptable levels of psychological, social and occupational functioning.

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