



## **Psychological Society of Ireland Review of the Assessment of Need Standard Operating Procedure**

The Psychological Society of Ireland (PSI) is the learned and professional body for psychology in the Republic of Ireland. Established in 1970 the Society currently has almost 3000 members.

The PSI is committed to maintaining high standards of practice in psychology and also to exploring new and innovative ways of furthering psychology as a real and applied science.

This document was prepared in response to concerns raised by members of PSI in relation to the proposed implementation of a Standard Operating Procedure (SOP) for Assessment of Need (AON) within the HSE on 1<sup>st</sup> of April 2018.

**While PSI is supportive of an AON SOP in principle, we have significant concerns regarding the document in its current iteration. It is our considered opinion that the changes to clinical practice described within the SOP will in many cases prove detrimental to children and their families. As a result we are hereby requesting that the implementation date be postponed to allow for engagement and consultation with PSI and other relevant Health & Social Care Professional representative bodies.**

**Furthermore, we would advise any psychologist electing to comply with the SOP to satisfy themselves that they are not in so doing potentially in breach of the PSI Code of Professional Ethics (2011) and / or CORU Framework for a Common Code of Professional Conduct and Ethics (2010).**

A summary of our concerns follows. We would emphasise that the present document is by no means an exhaustive list of all of the concerns raised to date by our members, nor are each of the points below dealt with as comprehensively as will be required for satisfactory consultation.

1. We wish to observe that, despite the fact that it will clearly impact the work of a large number of psychologists, the SOP was drafted without any prior consultation with or agreement from PSI.

2. It is the opinion of PSI that the Preliminary Team Assessment (PTA) model is contrary to the spirit of the *Disability Act (2005)*, which was developed as rights-based legislation. The PTA is a brief screening assessment only. Its introduction will significantly reduce the level of assessment provided to a child under the statutory framework of Assessment of Need. Currently, the child's needs determine the level and type of assessment provided under their AON. These assessments vary because children's needs vary. The SOP replaces this arrangement with a uniform screening assessment (the PTA model) to be completed in a maximum of 90 minutes, regardless of the child's needs.

The 2005 Act confers not only an entitlement to an Assessment of Need but also imposes an obligation on the HSE to provide such an assessment within defined time periods (see section 9 [5] of the Act) and to ensure that the Assessment is carried out in accordance with 'prescribed standards' (section 10).

These prescribed standards are the 2007 iHIQA *Standards for the Assessment of Need* (2007; available at <https://www.hse.ie/eng/services/list/4/disability/disability-assessment/standards-for-need-assessment.pdf>). The iHIQA Standard 1, 'Person Centred Approach' states, 'The Assessment of Need is person centred at all stages. The person is enabled to express what is important to him/her as a person. *The Assessment of Need is built around the person, appreciates the person as an individual, and focuses on outcomes important to him/her*' (italics added).

The SOP fundamentally changes the HSE's operational understanding and provision under the Disability Act. On the proposed implementation date, the HSE will move from the current system of person-centred assessment to a system which provides for a minimal screening assessment in all cases.

3. It is inappropriate and inaccurate for diagnostic assessments to be uniformly classified as '*health needs*'. This reduces the statutory component of the assessment

of a child's needs to a screening process, and pushes the core assessment provision carried out by psychologists outside of the statutory framework in all cases, regardless of the child's person-centred needs. It is relevant that the independent Disability Appeals Officer has found against the HSE on several occasions for failing to provide a comprehensive Assessment of Need, including failures to address the specific concerns of the applicant (parents and guardians) relating to diagnostic assessment.

4. The iHIQA *Standards* also stipulate that '*...those who carry out the assessment will be statutorily independent and the assessment itself will be undertaken without regard to existing service levels or related cost considerations*'. It is our view that the proposed SOP fails to satisfy these requirements. The proposed move toward a screening assessment approach will markedly reduce the clinical autonomy of assessors. Furthermore, as the model does not appear to be driven by clinical standards or the spirit of the Disability Act (2005), we are concerned that financial considerations may indeed be a significant factor here.

5. The *Disability Act (2005)*, Section 8 (7), states that '*...an assessment report shall set out...determinations in relation to the following -*

*(a) Whether the applicant has a disability,*

*(b) In case the determination is that the applicant has a disability -*

*(i) A statement of the nature and extent of the disability,*

*(ii) A statement of the health and education needs (if any) occasioned to the person by the disability,*

*(iii) A statement of the services considered appropriate...to meet the needs of the applicant and the period of time ideally required...for the provision of those services and the order of such provision'.*

The stipulated duration of a PTA (90 minutes) is insufficient for this purpose. Within such a short timeframe it is unlikely that a psychologist would be able to give an

accurate indication of the nature or extent of the disability. In many cases, it would not necessarily be clear whether or not the child has a disability.

A psychological assessment requires the review of detailed information regarding multiple factors such as birth and developmental history, medical history, social and behavioural functioning, and family history and current functioning. Adequate time with parents or guardians is required for this purpose, along with adequate time with the child for the purposes of direct assessment. We contend that the constraints of the PTA do not permit an assessment to be *'built around the person'* in a person centred manner, as is stipulated by the iHIQA standards.

It is essential to explore parent's or guardian's concerns for their child and at the conclusion of an assessment to provide time for the family to process their reactions to any diagnosis and / or other feedback (see *Informing Families of Their Child's Disability: National Best Practice Guidelines*). It is a profoundly significant experience for an individual and his/her family to be informed of a disability, and in some cases to be informed that legally she/he does not appear to have a disability.

The SOP states that *'no family should leave the clinic without some strategies to support the child / young person'*. Such strategies need to be offered on the basis of a comprehensive clinical assessment.

It is the view of the PSI that in the majority of cases it would not be possible for a psychologist to complete a comprehensive assessment, formulate problems, generate strategies, and feed these back to parents within the maximum timeframe of the PTA. Due to time constraints on the assessment process, psychologists completing a final Summary Report Form may often find themselves unable to offer an opinion regarding a determination of disability and a summary statement on *'the nature and extent of the disability'*.

6. In the view of the PSI introduction of the SOP will give rise to the following risks:
  - a) A child may incorrectly be deemed not to have a disability, as the disability is not evident or fully reported by parents / carers at the screening assessment. The

absence of evidence in a single screening session is insufficient evidence to provide a definitive determination of the absence of a disability. A determination that a disability is 'absent' cannot be reliably or safely made under a PTA model. This may result in some children receiving an incorrect determination of no disability, consequently being denied more comprehensive assessment, and receiving either no or inappropriate intervention.

b) A child may be incorrectly diagnosed, as a comprehensive assessment is not provided for within the PTA model. Many children will be placed on inappropriate waiting lists, resulting in further delays for the child in accessing appropriate services.

c) A child may be deemed likely to have a disability, but to require further comprehensive assessment to determine the nature and extent of the disability. They will then be placed on a further waiting list, potentially for a number of years in some areas, in order to receive comprehensive assessment.

Under the SOP the HSE will move from the current AON system of person-centred assessment to a system which provides for a minimal screening assessment. Consequently the HSE is at risk of exacerbating delays for many children and their families in accessing / applying for a wide range of appropriate and needs-based financial supports, educational provision and supports, health services and other supports provided to children with disabilities.

7. The proposed SOP will impact most negatively in those geographical areas where there are gaps in services and extremely long waiting periods to receive comprehensive assessment outside of AON. Conversely it will have less impact in areas where the waiting times for services are shorter. It is acknowledged that, depending on geographical location, the implications of the SOP for the professional practice of psychologists will vary.

8. Diverting existing clinical resources to provide PTA assessments, which will not provide meaningful information to guide intervention, will present risks to the continuity of existing levels of service provision. PSI would welcome clarity on whether a risk assessment has been completed as to the projected impact of the SOP on waiting

lists for services (e.g. EIT, SADT, Primary Care, CAMHS), especially given the existing long waiting lists for such services in many areas.

9. The parallel operation of the new SOP and the iHIQA Standards is likely to give rise to conflicting requirements for psychologists. Of particular relevance for psychologists is a published Determination by the Disability Appeals Officer, which included the following deliberation; *'the contents of HSE guidance cannot be relied upon to excuse or justify any failure of (the psychologist) to comply with the HIQA standards.'* This Determination also noted that *'a finding that aspects of the HIQA standards have not been complied with in a particular case is not a judgement on a particular individual's professional performance but rather is a Determination that an Applicant is entitled to a further assessment of his/her needs.'*

10. Members of the PSI are also required to practice in compliance with their Code of Professional Ethics (2011), potentially relevant sections of which are reproduced at Appendix 1. The PSI encourages Members who will be required to work according to the proposed AON protocol to carefully review the Code and to satisfy themselves that should they elect and/or be required to follow the SOP they are not in so doing potentially acting in breach of the ethical guidelines for their profession.

## **Appendix 1**

The following sections of the Psychological Society of Ireland Code of Professional Ethics (2011) & CORU Framework for a Common Code of Professional Conduct and Ethics (2010) may be of importance for psychologists to consider in light of the proposed implementation of the SOP.

### **PSI Code of Professional Ethics**

- Avoid or refuse to participate in practices which are disrespectful of the legal, civil, or moral rights of others.

- Avoid entering into agreements or contracts which might oblige them to contravene provisions of this Code of Professional Ethics.
- Carry out pilot studies to determine the effects of all new procedures and techniques which might carry some risks, before considering their use on a broader scale.
- Not carry out any scientific or professional activity unless the probable benefit is proportionately greater than the risk involved.
- Speak out if the policies, practices or regulations of the organisation within which they work seriously ignore or oppose any of the principles of this Code of Professional Ethics.
- Uphold the discipline's responsibility to society by promoting and maintaining the highest standards of the discipline.
- Protect the reputation of the profession and discipline by ensuring that all professional activities carried out conform to the provisions of this Code of Professional Ethics.
- Assess the individuals, families, groups, and communities involved in their professional activities adequately enough to discern what will benefit and not harm those persons.
- Refuse to help individuals, families, groups, or communities to carry out or submit to activities which, according to current knowledge and/or legal and professional guidelines, would cause serious physical or psychological harm to themselves or others.

### **RECOMMENDED PROCEDURE FOR ETHICAL DECISION-MAKING**

Section 3.6 of the Code of Professional Ethics deals with the resolution of ethical dilemmas, and all the clauses in that section are relevant to the making of ethical decisions.

Clause 3.6.1 states that members shall adopt a systematic approach to both the investigation of ethical issues and the resolution of dilemmas, and recommends use

of the formal decision-making procedure presented here. The procedure is designed for both routine issues and immediate problems.

1. Define carefully the issues and parties involved.
2. Scan the Code of Professional Ethics and identify all relevant clauses. Also check other applicable professional guidelines (for example, those of government departments or health boards) and any pertinent legislation. Consulting with colleagues is also often appropriate.
3. Evaluate the rights, responsibilities and welfare of all affected parties.
4. Generate as many alternative decisions as possible - the more the better.
5. Evaluate carefully the likely outcome of each decision.
6. Choose what, in your professional judgment, is the best decision, implement it, and inform relevant parties.
7. Finally, take responsibility for the consequences of the decision.

The complexity of ethical issues makes it likely that different principles and subclauses will occasionally clash; in addition, the provisions of the Code may also be at odds with legal provisions and/or other relevant guidelines. Unfortunately, the resolution of ethical dilemmas is not guaranteed to be simple. However, professional bodies and the law accept that practitioners may make errors of judgment, and that such errors are distinct from malpractice. The formal decision-making procedure is intended to reduce the incidence of decisions which are mistakes because they are taken in the heat of the moment, without consideration of all the relevant factors. What is required, in all cases, is a considered professional judgment taken in a systematic way.

**Framework for a Common Code of Professional Conduct and Ethics – CORU - Health and Social Care Professionals Council (2010)**



- Each registrant must avoid entering into agreements or contracts which might oblige them to contravene provisions of the Code of Professional Conduct and Ethics.
- Each registrant must carry out duties and responsibilities in a professional and ethical way. Service users are entitled to receive good and safe standards of practice and care. The Health and Social Care Professionals Council's aim is to protect the public from unprofessional and unethical behaviour. Registrants must be familiar with the standards they are expected to meet. The purpose of these standards is to protect the public.
- Each registrant is personally responsible for making sure that the registrant protects the best interests of the service user.
- Not do anything, or allow anything to be done, that the registrant has good reason to believe will put the health or safety of a service user at risk.