



**Guidelines on Best Practice for Psychologists
working with Children aged less than 5 years
under the Disability Act 2005 Assessment of
Need Process**

June 2010 Ver. 1

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Rationale

The Disability Act 2005 came into operation on the first of June 2007 for children aged less than 5 years and was welcomed on a broad basis as it finally acknowledged the rights model of disability, which had been advocated by professionals in the field of disability for some time. However, at a meeting of the Division of Clinical Psychology of the Psychological Society of Ireland on Friday 1st February 2008, attended by over one hundred psychologists, a number of concerns were raised with regard to the implementation of the act and implications for parameters of best practice for psychologists. Due to the significance of concerns raised, PSI Council approved a working group to establish a set of guidelines for the profession to ensure that psychologists could continue to comply fully with the Disability Act 2005, when working with children aged less than 5 years and their families, without compromising their standards of best practice. Similarly, it is hoped that these guidelines will assist psychologists working as part of multi-disciplinary teams to fully comply with the Disability Act 2005 without disrupting effective team-based practice.

Terms of Reference

To develop a set of guidelines for psychologists working with children aged less than 5 years and their families within the context of the Disability Act 2005, with respect to the following:

1. Defining disability (including intellectual disability, developmental delay, and mental health impairment)
2. Consent (including confidentiality)
3. Psychological assessment
4. Working in teams

This document relates primarily to intellectual disability and mental health. However, it may also be applicable to psychologists working with children aged less than 5 years who have physical and sensory disabilities, and other disabilities, such as those secondary to a medical illness.

The Disability Act 2005 poses new challenges for professional practice. Psychologists are urged towards resolving conflicts between their professional code of ethics, their own conscience and legal demands. The purpose of this document is to make recommendations about professional practice within this legal framework. This document is intended to be used in conjunction with the Code of Professional Ethics of the Psychological Society of Ireland (PSI, 2008), the Disability Act 2005 and related statutory instruments (e.g. S.I. No. 263 of 2007, Government of Ireland, 2007), and the Standards for the Assessment of Need (Board of the Interim Health Information Quality Authority (iHIQA, 2007)).

1. Defining Disability

A new legal definition of disability was introduced in Ireland in the Disability Act 2005. This definition has commonalities and differences with the established clinical taxonomy as it relates to intellectual disability and mental health.

Disability has been legally defined in the Disability Act 2005 as follows:

...“disability”, in relation to a person, means a substantial restriction in the capacity of the person to carry on a profession, business or occupation in the State or to participate in social or cultural life in the State by reason of an enduring physical, sensory, mental health or intellectual impairment...

where the substantial restriction:

...(a) is permanent or likely to be permanent, results in a significant difficulty in communication, learning or mobility or in significantly disordered cognitive processes,

and...

(b) gives rise to the need for services to be provided continually to the person whether or not a child or, if the person is a child, to the need for services to be provided early in life to ameliorate the disability.

In summary, the legal definition of disability requires a substantial restriction (which is permanent or likely to be permanent and requires early and/or ongoing service provision) in occupational, social, or cultural life by reason of an enduring physical, sensory, mental health, or intellectual impairment. It is the assessment officer, rather than the clinician, who makes the determination as to whether or not a child meets the definition of disability contained in the Disability Act 2005 (See section 4.1.3 of *Assessment Officer Process and Practice Guidelines*; Health Service Executive [HSE], 2009).

1.1 Intellectual Impairment: Intellectual Disability

Intellectual Disability is well-defined in international research and clinical practice. Standards for identification and classification are available from accepted sources, such as the World Health Organisation's (WHO) International Classification of Diseases (ICD)/International Classification of Functioning, Disability, and Health (ICF); the American Psychiatric Association's (APA) Diagnostic and Statistical Manual (DSM); and the American Association of Intellectual and Developmental Disabilities' Definition Manual on Disability. These standards are shared by many disciplines, including psychology.

- 1.1.1 The specialist role of the psychologist is in the assessment of the child's intellectual ability, adaptive behaviour and other associated needs, diagnosis of intellectual disability where appropriate, and in the provision of a package of recommendations for intervention/supports to meet such needs. The assessment process (including formulation and differential diagnoses) and the reporting of findings (including package of recommendations) should be in line with international standards of best practice and informed by specialist knowledge of developmental psychology, syndrome profiles, and childhood disorders.
- 1.1.2 The clinical definition of disability does not automatically meet the legal criteria for disability. Clinical definitions of intellectual disability do not stipulate the need for specialist clinical services to be provided continually by a public body; therefore they may not meet the legal definition of disability. For example, some individuals with mild intellectual disability may function adequately in mainstream environments without specialist services.
- 1.1.3 The precise legal definition of disability (as it relates to intellectual disability) is a complex and perhaps tautologous relationship between underlying impairments, substantial restrictions, enduring difficulties in communication, learning, mobility, and cognition, and the need for the provision of services by or on behalf of a public body. In relation to intellectual disability, in the absence of sufficient clinical evidence, the psychologist

should not exceed the limitations of best practice by making a legal determination of disability. In such cases, the competent psychologist presents the clinical findings to the assessment officer, highlights ambiguities or gaps in the knowledge/evidence base where they exist, and allows the assessment officer to consider this information in making a legal determination of disability.

1.2. Intellectual Impairment: Developmental Delay

Global developmental delay is a subset of developmental disabilities defined as significant delay in two or more key developmental domains, where delays are evident in comparison to same-age peers and are evidenced by performance that is two standard deviations or more below the mean on age-appropriate, standardised norm-referenced tests (Shevell et al., 2003).

- 1.2.1 The role of the psychologist is in the assessment of key domains in child development and their associated needs, diagnosis of developmental delay where appropriate, and in the provision of a package of recommendations for intervention/supports to meet such needs. In respect of the intellectual or developmental impairments with which children aged less than 5 years present, international standards of best practice should be followed in the differential diagnosis of intellectual disability and delay.
- 1.2.2 The capacity of the parents/guardians to address their young child's difficulties is a key factor that the psychologist takes into account in their assessment. This is a complex area that often requires a highly specialist and skilled approach.
- 1.2.3 Children aged less than 5 years are known to have substantial variability in their rate of development and clinical presentations over time and it is often difficult to predict the course of their needs over a 12 month period. In many cases, it will be against best practice to give a clinical opinion on predicted development over a 12 month period. It is sometimes more appropriate to defer clinical opinion until the child has received some interventions and/or a review has been conducted. Prognoses and long term predictions of level of need should always be reported conservatively and with due respect to the evidence base with regard to child development and the limits of predictive validity of assessment tools for children aged less than 5 years.
- 1.2.4 The psychologist will be aware that many delays do not require the provision of specialist services for their amelioration, as they are part of a normal developmental trajectory. In the absence of sufficient clinical evidence, the psychologist should not exceed the limitations of best practice by making a legal determination of disability based on developmental delay.

1.3. Mental Health Impairment: Mental Health Disorders

The two dominant classification systems for mental health impairments are the ICD (currently in its 10th edition; WHO, 1996) and the DSM (currently in its fourth edition; APA, 2000). The majority of interdisciplinary research findings and clinical guidelines are organised around these two systems. Diagnosis of mental health impairments should follow the standards set in such classification systems and should only be made by professionals who are competent to do so by virtue of their qualifications, training and expertise.

- 1.3.1 The role of the psychologist is in the assessment and diagnosis (where appropriate) of a mental health impairment and the identification of specific areas of need. The diagnosis of a mental health disorder does not automatically meet the legal criteria for disability. Recommendations for assessment, formulation, intervention and service provision are made with respect to the up to date knowledge base and skill set of the clinician.
- 1.3.2 In reporting the clinical findings of an assessment, psychologists should be mindful of the substantial variability in such factors as: aetiology, the course of various disorders, individual differences (within-disorder variability), family and cultural influences, the changing need and symptom profile over time/development, the variability of individual responses to different interventions, and unpredictable systems changes. Predicting level of need and prognosis is sometimes clear but in many cases it is unclear in relation to underlying mental health impairment.
- 1.3.3 In the absence of sufficient clinical evidence, the psychologist should not exceed the limitations of best practice by making a legal determination of disability based on a mental health condition. In such cases, the competent psychologist presents the clinical findings to the assessment officer, highlights ambiguities or gaps in the knowledge/evidence base where they exist, and allows the assessment officer to consider this information in making a legal determination of disability.

2. Consent & Confidentiality

2.1 Consent

Psychologists work within a legal context in terms of informed consent whether or not the child is referred via the Assessment of Need process. There are a number of core principles within the legislative stipulations and standards (the Disability Act 2005 and the iHIQA 2007 Standards) and professionally within the PSI Code of professional ethics that are shared in relation to informed consent, such as agreeing to work collaboratively, respecting and including children and their guardians in decisions affecting them, providing information in ways that can be understood, and sharing information on a need/entitled to know basis.

- 2.1.1 Psychological assessment shall only be carried out after the psychologist has obtained the explicit consent of the child's legal guardian(s).
- 2.1.2 Psychologists should ensure that the child's guardians understand the nature, purpose and anticipated consequences of psychological assessment under the Disability Act 2005, so that they may give informed consent. For example, where the timing of a psychological assessment is inappropriate, it is the duty of the psychologist to make explicit any harmful effects that an untimely assessment may have before informed consent can be deemed to have been obtained.
- 2.1.3 Psychologists should view informed consent not just as the signing of a consent form, but as the outcome of a process of agreeing to work collaboratively. Informed consent is an ongoing process that is part of every session (National Federation of Voluntary Bodies, 2007).
- 2.1.4 Families should be informed that they can withdraw consent at any time, with the consequences of same clearly explained so that an informed choice can be made.
- 2.1.5 Psychologists should be responsive to non-verbal indications of a desire to discontinue if individuals have difficulty in verbally communicating such a desire.

2.2 Confidentiality

Issues of confidentiality and consent are closely related (Hersen & Rosquist, 2007). Confidentiality in psychological services is kept to the extent allowed by law and best practice. Legally nothing has changed for psychologists with the introduction of the Disability Act 2005. The iHIQA 2007 Standards outline that information is processed in line with the Data Protection Acts of 1988 and 2003. Also included in governing practice are the Child Care Act, 1991 and Freedom of Information Act, 1997.

- 2.2.1 The psychologist shall clearly define for consenting guardians the limits of confidentiality with regard to assessment. This should include clearly outlining who will have access to assessment results and how such information will be used.
- 2.2.2 The iHIQA 2007 Standards outline that professional reports can be accessed according to the policies of the health/education sectors; however, under HIQA Standard 4 Professional standards (such as *Policy on the use of psychometric tests in Ireland*; PSI, 2006) for confidentiality should also be respected. Therefore, the child and family's rights to confidentiality must be respected by psychologists on a case by case and need-to-know basis.
- 2.2.3 Psychologists will endeavour to limit access to those with a right to know, who have been named to the child's guardian(s), and for whom the guardian(s) have provided consent.

- 2.2.4 Families need to be informed about where records will be kept and for how long. Each service will have its own security procedures for storage of paper and computer records. In terms of record keeping, records should be kept in line with legislation and local/national guidelines. Psychologists will protect data kept on file so that only those who have a right of access can obtain them.

3. Psychological Assessment

A psychological assessment is a complex process, which may or may not involve the use of standardised norm-referenced tests.

- 3.1.1 Psychological assessment of children aged less than 5 years should only be carried out by psychologists who have the recognised training and experience required to meet the competencies of this specialist role. In order to comply with the specifications of the Disability Act 2005 and the iHIQA 2007 Standards, the psychologist should not exceed the limits of clinical competence in conducting an assessment.
- 3.1.2 In carrying out psychological assessments, the psychologist should follow international best practice guidelines.
- 3.1.3 Psychological assessment should only be carried out when it is judged by the psychologist to be in the best interests of the child and family.
- 3.1.4 When psychometric and other standardised tests and procedures are carried out as part of a psychological assessment the psychologist will abide by the PSI Policy on the use of psychometric tests in Ireland (PSI, 2006) and other key standards for best practise, such as Standards for Educational and Psychological Testing (APA, 1999).
- 3.1.5 The psychologist is responsible for designing and carrying out their psychological assessment in accordance with the needs of the child and family. This may or may not include the use of standardised tests, interviews, observations, play-based or other non-standardised assessments, and collateral sources of information (*e.g.* information acquired in liaison with other team members). The psychologist is responsible for making recommendations arising from their own assessment.
- 3.1.6 The psychologist shall be cognisant of language and cultural influences on test performance in the design and execution of their assessment.
- 3.1.7 The Informing Families: National Best Practice Guidelines (National Federation of Voluntary Bodies, 2007) reflects the need to give feedback to parents/guardians throughout the process of their child's psychological

assessment. The psychologist should ensure that parents/guardians are kept up to date at all times with honest information, which includes acknowledging any uncertainty that exists about their child's diagnosis, and explaining any suspected diagnoses that are being investigated.

- 3.1.8 The psychologist shall endeavour to build a good relationship with children and their families throughout the assessment process. Building a healthy alliance with parents/guardians is a priority, particularly since the initial diagnosis may be the beginning of a long term parent-psychologist relationship.
- 3.1.9 The psychologist shall offer feedback to parents/guardians on their assessment findings. Parents/guardians have a right to both verbal and written feedback, with clear opportunities provided to further discuss the assessment findings and recommendations if required. Feedback should be provided in line with best practice guidelines (e.g. National Federation of Voluntary Bodies, 2007)
- 3.1.10 The psychological report is part of the psychological assessment and it is the psychologist's duty of care to furnish parents/guardians with a written report of their child's assessment, unless the psychologist feels it is not in the child/family's best interests.
- 3.1.11 Recommendations following from an assessment should be in the best interests of the child and family, and are not necessarily limited to recommendations for service provision. Recommendations may include a plan for further assessment.
- 3.1.12 While there can be a legal mandate for review assessments within a 12 month period of initial assessment, it is for the psychologist to determine the form, extent, and specific procedures they will carry out with respect to ethics, the needs of the child, and the stipulations of the law.



4. Working in Teams

There is a large scientific literature on the effectiveness of team work within the health and social care service areas. It is now recognised that team working is an effective method of delivering health and social care services and psychologists can have a positive impact on service users' psychological well-being by being integrated and embedded within teams. However, integration does not mean genericism; teamwork does not mean that disciplines within teams become homogenised (British Psychological Society, 2007). Although some aspects of team members' roles will overlap, psychologists will retain their unique identity and contribution within the team. The key components of effective and efficient team working have been outlined elsewhere, and include: team composition, boundaries, role clarity, cohesion, mutual respect, communication, policy development, information systems/record keeping, reporting structures, leadership, and clear goals/objectives.

- 4.1.1 It is incumbent on the psychologist to work effectively as part of teams.
- 4.1.2 In order to work effectively as part of teams, the psychologist will understand key competencies of their own profession as well as the key competencies of the other disciplines with which they work. The psychologist will understand and promote the key role of the psychologist on the team, in the best interests of the child and their family.
- 4.1.3 In order to work effectively, the psychologist should promote models of best practice within the team. This may include highlighting gaps in evidence and limits of professional competencies.
- 4.1.4 Professionals working in teams are (in the eyes of the law) likely to be held responsible for their own mistakes. Therefore, when working within team-based models of assessment and intervention, the psychologist will ensure that they are working within parameters of evidence based practise.
- 4.1.5 The psychologist will endeavour to form close and effective working relationships with other team members, with assessment officers, and with other professionals involved in service delivery.

Conclusion

It is envisioned that this document will serve as the acting best practice guidelines for psychologists who are required to assist in the Disability Act 2005 Assessment of Need process. The guidelines synthesise the current requirements of the law with minimum standards of practice as they relate to psychological assessments and reporting. As such, they represent an acting code of conduct for psychologists' work in this area.

It was noted during the drafting of this document that psychologists have outstanding concerns not addressed herein but which will be of considerable practical significance to their work and clients. In general, these concerns related to operational challenges arising from the implementation of the act within the context of their local and/or national employing organisations. These kinds of issues are outside the terms of reference of the current document; however it is hoped that individuals, unions, and professional bodies engaged in negotiating with employers around implementation will be able to use these guidelines as a summary of the challenges and obligations of psychologists working in this field.

Given that the Disability Act 2005 is not yet fully implemented, and that the interpretation of the act is being refined as new issues are identified and explored (e.g. determinations of the Office of the Disability Appeals Officer), it is recommended that these guidelines be reviewed within 18 months time.

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PSI, 15 February 2010.

References

American Association on Intellectual and Developmental Disabilities. (2010). *Intellectual disability: Definition, classification, and systems of supports* (11th ed.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

American Psychological Association. (1999). *Standards for educational and psychological testing*. Washington, DC: Author.

Board of the Interim Health Information Quality Authority. (2007). *Standards for the assessment of need*. Dublin: HIQA

British Psychological Society (2007). *New ways of working for applied psychologists in health and social care: Working psychologically in teams*. Leicester, UK: Author.

Government of Ireland (1988). *Data Protection Act, 25/1988*. Dublin: House of the Oireachtas.

Government of Ireland (1991). *Child Care Act, 17/1991*. Dublin: House of the Oireachtas.

Government of Ireland (1997). *Freedom of Information Act, 13/1997*. Dublin: House of the Oireachtas.

Government of Ireland (2003). *Data Protection Act, 6/2003*. Dublin: House of the Oireachtas.

Government of Ireland (2005). *Disability Act, 14/2005*. Dublin: House of the Oireachtas.

Government of Ireland (2007). *Statutory Instruments. S.I. No. 263 of 2007. Disability (Assessment of needs, service statements and redress) regulations 2007*. Dublin: House of the Oireachtas.

Health Service Executive (2009). *Assessment officer process and practice guidelines, June 2009*. Dublin: Author.

Hersen, M., & Rosquist, J. (2007). *Handbook of psychological assessment, case conceptualization, and treatment*. Hoboken, NJ: John Wiley & Sons.

National Federation of Voluntary Bodies. (2007). *Informing families of their child's disability: National best practice guidelines*. Dublin: Author.

Psychological Society of Ireland (2006). *Policy on the use of psychometric tests in Ireland*. Dublin: Author

Psychological Society of Ireland (2008). *Code of professional ethics of the Psychological Society of Ireland*. Dublin: Author.

Shevell, M., Ashwal, S., Donley, D., Flint, J., Gingold, M., Hirtz, D., Majnemer, A., Noetzel, M., & Sheth, R.D. (2003). Practice parameter: Evaluation of the child with global developmental delay: Report of the Quality Standards Subcommittee of the American Academy of Neurology and the Practice Committee of the Child Neurology Society. *Neurology*, 60 (3), 367-380.

World Health Organisation (1996). *Multiaxial Classification of Child and Adolescent Psychiatric Disorders: The ICD 10 Classification of Mental and Behavioural Disorders in Children and Adolescents*. Cambridge: Cambridge University Press.

World Health Organisation (2001). *The International Classification of Functioning, Disability and Health (ICF)*. Geneva: Author.

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