Psychological Society of Ireland

Review of the Child and Adolescent Mental Health Services (CAMHS)

Standard Operating Procedure

Response to the call from the HSE Mental Health Division for submissions to inform the review of the CAMHS Standard Operating Procedure (SOP)

The 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.

The Psychological Society of Ireland (PSI) welcomes the opportunity to contribute to the review of the CAMHS SOP.

We are content for our response to be made public. We are also content to be contacted by the HSE Mental Health Division in relation to this response.

Signed on behalf of the Psychological Society of Ireland Council

Brendan O Connell
President
1 February 2018

Whilst, overall, we feel that the existence of a CAMHS SOP is very helpful, we have a range of concerns regarding the document in its current iteration. Briefly, these are as follows:

1. We note that (13.7) if '*the child / young person is assessed as having no moderate or severe mental health disorder*', CAMHS will not remain involved. By '*disorder*' we understand the SOP to mean that the client meets the criteria for a psychiatric diagnosis utilising either DSM 5.0 or ICD-11.

   However, many researchers have pointed out that psychiatric diagnoses are plagued by major problems regarding reliability and validity. So-called 'symptoms' do not cluster together in the manner predicted, research suggests a continuum rather than the proposed distinct difference between everyday (normal) experiences and unusual (abnormal) experiences, and where the diagnostic system predicts a clear difference between categories, there is extensive overlap. Overall, research suggests that diagnostic categories do not reflect any meaningful patterns. Furthermore, psychiatric diagnoses do not reliably predict response to medication or other interventions. Therefore, whilst diagnostic systems such as these may identify troubling or troubled people, they do not meet the rigorous criteria demanded for a field of science.

   We propose that the requirement for a child / young person to meet the criteria for a psychiatric diagnosis in order to avail of a CAMHS service be replaced by a requirement that they be presenting with psychological distress and moderate to severe functional impairment in at least one area of daily living.

2. We also note use of the terms '*treatment', 'comorbid', 'very unwell', 'symptoms', 'discharge'*, and '*illness*' in the 2015 SOP. We contend that such terms are not appropriate. Use of these and similar terms encourages the medicalisation of natural and normal responses to distressing life experiences; responses which undoubtedly have distressing consequences, but which do not reflect underlying illnesses. Research has consistently failed to demonstrate that mental health difficulties arise from biological abnormalities; consequently, it is unhelpful to suggest that children / young people in distress may be understood as presenting with 'an illness like any other'. Furthermore, it has been demonstrated that biogenetic causal beliefs within the general population are related to negative attitudes regarding mental health difficulties (e.g. Read et al. 2006). We accordingly request that such terminology is removed from the revised SOP.

3. The rationale for psychiatry automatically assuming the role of 'clinical lead' is highly questionable. The notion that this role should be based on privilege of profession without due regard for competencies required is concerning. We recommend instead the drawing up of a Job Specification for the Team Clinical Lead role followed by the selection (via an open and transparent process) of a suitable individual on each team.

4. The current SOP states that '*each child and adolescent attending CAMHS must have a named consultant who is responsible for overall care and treatment*'. We contest the assertion that the consultant psychiatrist holds overall clinical responsibility and are not aware of any legal basis for this belief.

   As psychologists, we have our own legal, professional, and ethical responsibilities. Psychologists are accountable for those tasks for which they are recognised as competent as a result of their training. We further understand that no one professional can be held accountable for another professional's actions except in part by negligent delegation or inappropriate referral.

   The Mental Health Commission's Teamwork resource paper (2010) comments (4.4.1): *'Not in keeping with current models of practice, it is inappropriate to interpret that consultant psychiatrists carry overall responsibility if they are involved, however peripherally, in the care of service users, or for all referrals received…'* A 'distributed' model of responsibility is described, whereby clinical '*responsibility is distributed among the involved team members according to their role and contribution…With this model the consultant psychiatrist remains responsible for their own direct clinical involvement, including the quality of advice and assessment given. They also retain 'clinical primacy' in selected and specified cases, and work in a consultative fashion with other team members…*'

   Within this model each professional is clinically responsible for the service that they provide, whether this is discipline specific or cross disciplinary. In addition, each clinician has a responsibility to consult with the clinical lead and multi-disciplinary team members as appropriate and is accountable to the team via the core team structures such as the team meeting and periodic case review meetings.

   In addition, while systems in operation in other countries are not directly relevant to professionals working in Ireland, we should refer to such systems in order to assist in the further development of best practice. The English courts have rejected the approach

known as the ‘Captain of the ship’ doctrine, which suggests that professionals in charge of teams are responsible for the negligence of their team members, even though they are personally blameless (British Psychological Society, 2001). The UK Royal College of Psychiatry state (2005) that:

‘Many psychiatrists work in systems that are not based on referral of patients to a specific consultant. Instead, the multidisciplinary teams of which they are a member may provide health and social care services to a substantial number of patients. Referrals are made directly to such teams and decisions about allocation to an appropriate professional are made according to the teams’ policies. In these teams, the responsibility for the care of the patients is distributed among the clinical members of the team. Consultants retain oversight of a group of patients who are allocated to their care and are responsible for providing advice and support to the team. They are not accountable for the actions of other clinicians in the team’.

Here in Ireland referrals are also typically made to CAMHS teams and not specifically to named consultant psychiatrists. Therefore, it is our understanding that as the child / young person was not referred to the consultant, it follows that the consultant cannot delegate care to another member of the team and thus potentially retain a degree of clinical responsibility.

We recommend that any reference to clinical responsibility be omitted from the SOP, and that a multi-stakeholder group including several legal experts produces a guidance paper on clinical responsibility in mental health teams.

References

British Psychological Society (2001). *Working in Teams*

Mental Health Commission (2007). *Quality Framework for Mental Health Services in Ireland*

Mental Health Commission (2010). *Teamwork within mental health services in Ireland*

Read, J., Haslam, N., Sayce, L., Davies, E. (2006). Prejudice and schizophrenia: a review of the 'mental illness is an illness like any other' approach. *Acta Psychiatrica Scandinavica*, 114(5): 303-18

Royal College of Psychiatry (2006). *New ways of working for psychiatrists: Enhancing effective, person-centred services through new ways of working in multidisciplinary and multi-agency contexts*