

Submission Responding to

The Health Professions Regulatory Advisory Council's Discussion Guide on
Interprofessional Collaboration

Submitted by

The Ontario Association of Consultants, Counsellors,
Psychometrists and Psychotherapists

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1. About OACCPP

The Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists is an incorporated professional association created in 1978 to represent the professional interests of providers of mental health services in the areas of consulting, counselling, psychoeducational assessment and psychotherapy.

OACCPP members work in a variety of settings including clinics, hospitals, colleges, school boards, counselling and psychotherapy centres, employee assistance programs, business and industry. Some work in the social work field. About 60 per cent are in private practice.

Current membership is approximately 1900. The majority of OACCPP members have Masters degrees; some hold PhDs. Many have undertaken additional training in counselling, psychotherapy and related disciplines. A small number are Psychological Associates, registered with the College of Psychologists of Ontario.

OACCPP has four categories of membership. General members must meet academic, training and practicum requirements; certified members must, in addition, pass written and oral exams among other requirements. Both groups are required to hold professional liability insurance. The other two categories are associate (student) membership and affiliate membership. All members must adhere to OACCPP's Code of Ethics.

OACCPP's mandate is to:

- i) ensure the availability of competent mental health services, and accessibility to these services, by all segments of the general public;
- ii) represent the interests of OACCPP members individually and collectively; and
- iii) promote professional standards.

2. Background (Regulation of Psychotherapy)

In 2007 the Government of Ontario passed *The Psychotherapy Act*, under which a new College of Psychotherapists and Registered Mental Health Therapists of Ontario will be created (when relevant clauses of the Act are proclaimed). Currently, a process is underway to select members of a Transitional Council and Transitional Registrar.

As HPRAC is aware, OACCPP was an active participant in the consultation process leading to HPRAC's recommendation that psychotherapists be regulated and a new regulatory College established. OACCPP continues to support the regulation of psychotherapists and remains actively engaged in the process to establish the new College.

3. The Minister's Referral

In June 2007, Hon. George Smitherman, Ontario Minister of Health and Long-Term Care, asked HPRAC for advice and recommendations on issues associated with interprofessional collaboration. Specifically, he requested that HPRAC:

recommend mechanisms to facilitate and support interprofessional collaboration between health Colleges... beginning with the development of standards of practice and professional practice guidelines where regulated health professions share the same or similar controlled acts, acknowledging that individual health Colleges independently govern their professions and establish the competencies for their profession [and that HPRAC] take into account, when controlled acts are shared, public expectations for high quality services no matter which health profession is responsible for delivering care or treatment.

3(a) HPRAC's interpretation

HPRAC has interpreted the wording of the Minister's request to mean that any initiatives [resulting from deliberations on this issue] should assist health regulatory colleges to work collaboratively rather than competitively, and to learn from and about each other through a process of mutual respect and shared knowledge to:

1. improve patient care and facilitate better results for patients;
2. protect the public interest; and ensure the highest standards of professional conduct and patient safety;
3. regulate the health professions in a manner that maximizes collective resources effectively and efficiently, while protecting the public interest;
4. optimize the skills and competencies of diverse health care professionals to enhance access to high quality and safe services;
5. ensure access to high quality and safe services no matter which health profession is responsible for delivering care or treatment; and
6. enhance scopes of practice to ensure that all regulated health professionals work to their maximum competence and capability.

4. Definition of Interprofessional Collaboration

HPRAC has adopted the definition developed by HealthForceOntario:

Interprofessional care is the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings.

5. Rationale for Interprofessional Collaboration

Upon reviewing HPRAC's Consultation Discussion Guide and its literature and jurisdictional reviews, OACCPP notes a preponderance of expert opinion suggesting that interprofessional collaboration at the clinical and/or regulatory levels may deliver some or all of the following benefits:

- health care professionals able to practice to the full extent of their training and qualifications (important in light of predicted shortages of health care personnel); greater job satisfaction;
- most appropriate practitioner enabled to provide services, thereby maximizing scarce health care resources;
- seamless patient/client care, resulting in positive patient/client experience within the health care system;
- sharing of best practices between/among professions, and possible collaboration in developing standards of practice and practice guidelines, particularly when professions share overlapping scopes of practice and access to the same or similar controlled acts;
- possible integrated complaints and reports systems among health regulatory colleges to facilitate resolution of cases arising in a multi-disciplinary health care settings; integrated Quality Assurance programs to support common standards for competencies and restricted acts;
- shared learning experiences/education modules for students in related disciplines, leading to greater understanding and appreciation of the skills and contribution of other health professionals; and
- economies of scale resulting from possible sharing of administrative and other functions among regulatory colleges, including possible amalgamation of certain colleges (those providing closely related services);

OACCPP also notes HPRAC's statements (quoted below) regarding the limited evidence to support improved patient outcomes and the value of interprofessional education:

Although there is a general sense that teamwork produces better results for patients, there are difficulties in demonstrating the relationship through research...

Literature supporting the value of interprofessional education is thin. This is especially the case for published reports of pre-licensure professional education.¹

¹ *Consultation Discussion Guide on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals*, February 2008, p. 21

6. Challenges and Opportunities

HPRAC's Discussion Guide and accompanying literature and jurisdictional reviews suggest that the prospect of enhanced interprofessional collaboration at the clinical and/or regulatory levels presents the following challenges and opportunities:

6(a) Challenges/Barriers

- Lack of common understanding of terminology
- Structural challenges in legislation, regulations and regulatory processes, including:
 - overlapping scopes of practice
 - shared Controlled Acts giving rise to: different interpretations and standards of practice, issues re delegation, lack of conflict resolution mechanisms
 - barriers to information sharing
 - inflexibility of the RHPA
 - delayed regulation approval, and duplication in developing regulations that could be shared among Colleges
- Profession-specific education, lack of awareness/understanding of other professionals' skills and training
- Differences in philosophical approach, cultural differences
- Competition/turf protection
- Funding models

6(b) Opportunities

- Trend toward increased interprofessional education
- Emerging professions and new regulatory Colleges
- New Objects in RHPA's Procedural Code
- Potential for sharing resources and functions among Colleges
- Adoption of collaboration as a core competency by some Colleges
- Cross appointments on professional committees
- Shared electronic health record (EHR)
- Government policies to promote interprofessional collaboration, leadership by key Colleges and government ministries

7. Overview and Discussion

7(a) OACCPP's interpretation

In considering the Minister's Referral and HPRAC's interpretation of the Minister's wording, the main thrust of the referral appears to be aimed at:

- optimizing the skills and competencies of health care professionals in order to maximize health human resources in light of pending shortages of health professionals;
- encouraging and facilitating multi-disciplinary team-building to enable diverse health professionals make full use of their training and competencies;
- enhancing scopes of practice where appropriate to support these goals; and
- exploring possible regulatory changes to facilitate interprofessional collaboration by regulatory Colleges. With regard to the former, the Minister appears to place particular emphasis on Colleges that share the same Controlled Act(s) working together to develop common standards of practice and practice guidelines.

The overall framework for initiatives resulting from this process is protection of the public interest to ensure the highest standards of professional conduct and patient safety.

7(b) OACCPP's response

OACCPP has opted to respond to some but not all of HPRAC's Discussion Guide questions (see Section 8 for responses to specific questions).

As a professional association representing professionals soon to be regulated under the new College of Psychotherapists and Registered Mental Health Therapists of Ontario, OACCPP lacks the depth of experience with regulatory issues that many of the currently regulated professions possess.

Nevertheless, we work in multi-disciplinary teams and in workplace settings where interprofessional collaboration may or may not be supported and encouraged. Many of our members have encountered professional cultural barriers that stand in the way of greater professional collaboration and better outcomes for clients.

As a profession about to be regulated, we view the Minister's Referral and HPRAC's consultations on Interprofessional Collaboration as an opportunity to take a leadership role in developing attitudes and mechanisms that support such collaboration.

Psychotherapists, consultants, counsellors and psychometrists have diverse backgrounds and academic training. As we work together to build a new College, we have an opportunity to embrace foundational principles that support interprofessional collaboration at the regulatory and clinical levels.

OACCPP further recognizes the potential for collaboration between and among Colleges that share overlapping or similar scopes of practice and/or Controlled Acts – particularly with respect to the development of common standards of practice and practice guidelines, parallel quality assurance programs and consistent complaints and discipline processes. Again, as we move toward regulation, OACCPP foresees an opportunity to incorporate principles and processes that support interprofessional collaboration at the College level.

7(c) Summary of OACCPP's views on interprofessional collaboration

In general, OACCPP supports the move toward greater interprofessional collaboration, and we expect to endorse principles and practices that strengthen such collaboration as the new College of Psychotherapists and Registered Mental Health Professionals takes shape.

In particular, OACCPP supports interprofessional education. One can only imagine that over time students in various health disciplines will develop a better understanding and appreciation of their respective competencies through participation in collaborative learning experiences.

OACCPP is of the view that Colleges sharing the same Controlled Acts should collaborate in the development of standards of practice and practice guidelines, and further, that quality assurance programs with respect to such Controlled Acts should include similar or parallel elements. Such an approach, we suggest, would support consistent complaints and discipline processes and facilitate fair handling of cases in which professionals from different disciplines are implicated.

OACCPP is less convinced that a joint reporting and complaints/discipline structure would prove efficacious. On this point, our association requires further insight regarding the rationale for such a move, and evidence to support a claim for greater efficiency. Our concern is that we may lose control over complaints and discipline processes for our members before we've had an opportunity to develop our own baseline of experience. Only with such experience can we hope to provide meaningful input to the creation of a joint complaint and discipline structure that will be functional and fair to all.

With regard to the creation of a new umbrella regulatory body to oversee the Colleges and promote interprofessional collaboration, OACCPP is concerned that adding another layer of bureaucracy may serve to slow regulatory processes. On the other hand, we recognize that such a body could be instrumental in forging collaboration among Colleges in the development of common practice standards and consistent complaints/discipline processes. OACCPP will follow this debate with interest and may wish to provide further input as its thinking on this issue evolves.

8. OACCPP's Responses to HPRAC's Questions

As mentioned above, OACCPP will answer some but not all of HPRAC's Discussion Guide questions. As we are not yet members of a regulatory College (but soon expect to be), we lack direct experience with many of the regulatory issues raised by HPRAC. Hence, we have answered those questions on which we believe we can provide meaningful input, based on our experience as mental health service providers working as independent practitioners or in multi-disciplinary settings.

HPRAC preamble to Question no. 1

HPRAC has developed the following statement to convey its interpretation of what the Minister's question portends.

[HPRAC's] view is that any initiatives should be directed to finding ways to assist health regulatory colleges and their members to work collaboratively rather than competitively, and to learn from and about each other through a process of mutual respect and shared knowledge to:

- Improve patient care and facilitate better results for patients;
- Protect the public interest; and ensure the highest standards of professional conduct and patient safety;
- Regulate the health professions in a manner that maximizes collective resources effectively and efficiently, while protecting the public interest;
- Optimize the skills and competencies of diverse health care professionals to enhance access to high quality and safe services;
- Ensure access to high quality and safe services no matter which health profession is responsible for delivering care or treatment; and
- Enhance scopes of practice to ensure that all regulated health professionals work to their maximum competence and capability.

1. Please comment on the statement above, which HPRAC has used to define collaboration among the Colleges. Are there elements that should be added or removed? If so, what are they?

It would be difficult to argue against any of the principles included in HPRAC's interpretation of the Minister's question. The first two points are self-evident; the third on maximizing resources is equally incontestable.

The fourth, which deals with "optimizing the skills and competencies of diverse professionals to enhance access...to services" makes eminent good sense in theory. However, whether this approach has the potential to produce desired results is open to question (only time and well-designed research will answer this question).

The fifth point above also appears self-evident. However, it is pregnant with unstated implications that are likely to be controversial, such as the need for consistent practice standards, quality assurance programs and complaints/discipline processes across Colleges, to ensure consistency in service quality and patient safety, no matter which professional is providing the service.

The final point, which deals with enhanced scopes of practice, appears to be 'last but not least.' It introduces the prospect of amending profession-specific Acts to enhance scopes of practice for some or all of Ontario's health professions. This is potentially a larger exercise that could serve purposes well beyond the stated objectives of facilitating professional collaboration and

optimizing health human resources. Further elaboration by HPRAC would be helpful.

With regard to psychotherapy, soon to be a Controlled Act shared by five regulated health professions, the implications of possible changes to the scopes of practice are not immediately apparent. However, OACCPP would like to reserve the right to comment further as this debate unfolds and we become aware of potential implications. (Appendix 1 lists scopes of practice of professions granted access to the Controlled Act of psychotherapy).

5. Are there professional cultural issues that act as barriers to collaboration among the Colleges? What steps should be taken to minimize these barriers? Who should provide the leadership to eliminate them? What role can health care associations, including associations whose members are regulated professionals, play in this process?

Yes, professional cultural barriers act as barriers. Most OACCPP members, if not in private practice, work in multi-disciplinary settings in which the MD is invariably at the top of the professional hierarchy. This results in an approach to treatment based on the medical model (disease/treatment approach), which is antithetical to some psychotherapists and counsellors.

Within the hospital setting, all professionals have access to patient charts, as required. This is not always the case in other settings. Often physicians are willing to discuss a mutual patient or client only with other regulated health professionals. Unregulated professionals such as counsellors and psychotherapists may be denied this opportunity. In some settings, for example, registered nurses have greater access to physician consultants than do employee assistant program (EAP) counsellors performing similar jobs.

Professional language (medical jargon, for example) may serve as a barrier to meaningful communication between professionals. Sometimes it appears to be used as a deliberate tactic to establish rank and cut off communication. Sometimes it is the result of habit and training. In either case, jargon may serve as a barrier to communication and interprofessional collaboration.

6. Do you have evidence from your experience that liability issues are a barrier to inter-professional care?

It is reasonable to assume that concerns about potential liability may act as a barrier to interprofessional collaboration in situations such as that described above, i.e. where a registered nurse has more ready access to physician consultation than does an unregulated professional. Such concerns may also arise in settings where some regulated professionals hold professional liability insurance and others do not.

7. Should all regulated health professionals be required to hold minimum professional liability insurance coverage?

Yes.

8. If so, what would be the minimum expected terms and conditions for that insurance coverage?

Required coverage should be \$1-2 million.

22. Would a joint quality assurance program among relevant Colleges enable the Colleges to develop common standards of practice or professional practice guidelines where the same or similar Controlled Acts are shared?

It is reasonable to assume that a system requiring consistent or parallel quality assurance programs would facilitate development of common standards of practice and professional practice guidelines. However, OACCPP does not support a joint program structure.

23. Would a joint quality assurance program among Colleges whose members have similar scopes of practice, share the same or similar Controlled Acts, or provide closely related services often involving the same areas of the body, provide opportunities for enhanced continuing competence and exposure to best practices? If yes, how should program standards be jointly set and measured?

It is reasonable to assume that a joint QA program could facilitate sharing of best practices among Colleges, and opportunities for shared professional development offerings (seminars, courses, workshops, print and electronic media). OACCPP does not believe, however, that a joint QA structure is a necessary precursor to the cooperative development of QA offerings.

32. Should minimum guidelines, standards and policies concerning matters such as conflict of interest, advertising, record keeping and the consent process be consistent across all Colleges? If yes, what guidelines, standards and policies could effectively be applied to all regulated health professions? If not, why not?

Yes guidelines, standards and policies governing items such as conflict-of-interest, advertising, record keeping and consent should be consistent. However, Colleges must have the ability to elaborate such policies, standards and guidelines, as necessary, to protect the public interest.

33. What kinds of structures and processes could facilitate collaboration among Colleges to address issues related to standards of practice and professional practice guidelines for those professions that deal with closely related activities (e.g. dental hygiene, dental technology, dentistry and denturism; or opticianry, optometry and

ophthalmology)? (For example, joint colleges, collaborative Councils or independent bodies such as the Council for Healthcare Regulatory Excellence in the UK.)

Interprofessional committees or boards would serve the purpose.

36. Should the standards of practice and professional practice guidelines that the Colleges adopt be legally enforceable? Why or why not?

This is a complex legal question that is beyond our experience as a profession still on the brink of regulation. We will be interested to hear the views of other professions on this important question.

40. How will greater collaboration among the Colleges serve to enhance interprofessional care at the clinical level?

It would be easy to assume that greater collaboration among Colleges would lead to enhanced interprofessional care at the clinical level, especially if such collaboration produces consistent standards of practice, shared professional development experiences, and greater appreciation of the skills of other professionals. Such an assumption would be pure conjecture, however, and cannot be supported. The question requires empirical research.

41. Are any changes to the RHPA, the health profession Acts or their regulations needed to encourage, require, facilitate and enable interprofessional care at the clinical level? If so, what are they? Should Ontario law have a requirement similar to the one in New Zealand?

A directive, such as New Zealand's guarantee that every health care consumer has a right to expect cooperation among providers to ensure quality and continuity of services, would strengthen growing awareness of the importance of interprofessional collaboration.

42. If so, what should the requirement look like and should there be consequences for a failure to meet the requirement?

Perhaps the requirement to collaborate (and cooperate) with other health professionals could be incorporated into professional codes of conduct. Failure to meet this requirement could result in a reprimand or more serious consequences, depending on the seriousness of the incident.

9. Conclusions

OACCPP is pleased to have this opportunity to provide input to HPRAC's consultation on interprofessional collaboration. A summary of the association's views is found in section 7(c).

In general, OACCPP supports the move toward greater interprofessional collaboration, especially interprofessional education. The association also supports collaboration in the development of practice standards and professional practice guidelines, consistency in complaints and discipline processes and common elements for quality assurance programs across Colleges that share similar Controlled Acts and overlapping or similar scopes of practice.

We are less inclined to support structural changes such as joint Colleges or joint programs. We are also lukewarm to the idea of an umbrella regulatory authority for health professions, fearing this will add another layer of bureaucracy, increase costs and possibly slow regulatory processes.

Scopes of Practice

Appendix A

For professions granted access to the Controlled Act of Psychotherapy

1. Medicine

Scope of practice

3. The practice of medicine is the assessment of the physical or mental condition of an individual and the diagnosis, treatment and prevention of any disease, disorder or dysfunction. 1991, c. 30, s. 3.

2. Nursing

Scope of practice

3. The practice of nursing is the promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function. 1991, c. 32, s. 3.

3. Occupational Therapy

Scope of practice

3. The practice of occupational therapy is the assessment of function and adaptive behaviour and the treatment and prevention of disorders which affect function or adaptive behaviour to develop, maintain, rehabilitate or augment function or adaptive behaviour in the areas of self-care, productivity and leisure. 1991, c. 33, s. 3.

4. Psychology

Scope of practice

3. The practice of psychology is the assessment of behavioural and mental conditions, the diagnosis of neuropsychological disorders and dysfunctions and psychotic, neurotic and personality disorders and dysfunctions and the prevention and treatment of behavioural and mental disorders and dysfunctions and the maintenance and enhancement of physical, intellectual, emotional, social and interpersonal functioning. 1991, c. 38, s. 3.

5. Psychotherapy

Scope of practice

3. The practice of psychotherapy is the assessment and treatment of cognitive, emotional or behavioural disturbances by psychotherapeutic means, delivered through a therapeutic relationship based primarily on verbal or non-verbal communication. 2007, c. 10, Sched. R, s. 3.

6. Social Work

The Social Work and Social Service Work Act, 1998 does not include a scope of practice.