



**Ontario Association of Psychological Associates**  
**Association des Associés(es) en Psychologie de l'Ontario**  
16-1375 Ch. Southdown Road, Suite 303, Mississauga, Ontario, L5J 2Z1

May 29, 2008

Barbara Sullivan, Chair  
Health Professions Regulatory Advisory Council  
Suite 806 Box 18  
55 St. Clair Avenue West  
Toronto, ON M4V 2Y7

Dear Barbara:

OAPA has been pleased to be part of HPRAC's consultation on interprofessional collaboration. We fully support the government's objective of ensuring that any obstacles (formal or informal), that make it difficult for health professionals to collaborate, be minimized as much as possible. OAPA appreciates the opportunity to have its voice heard on this important issue and hopes that its members will continue to be consulted as this process unfolds.

OAPA would also like to take this opportunity to highlight the experience of their members regarding interprofessional collaboration. One of the key issues for us has been the lack of knowledge regarding the one scope of practice for psychology in the province of Ontario. The title 'psychological associate' is not well understood by members of the public, by Psychologist members of the College of Psychology or by other health professions. This has been a real obstacle to optimizing the skills and competencies of our membership and to ensuring access to high quality and safe services for the public. It is our fervent hope that this process that the government has initiated will allow for some resolution to this longstanding issue.

OAPA is also including the results of a survey we conducted with our membership. We asked them to share their experiences in settings in which they work with a variety of regulated health providers, either in a formalized team approach or a less structured system. I trust you will find their comments helpful.

With best regards,

Caroline Koekkoek, M.A., C. Psych. Assoc.  
President, OAPA



# Interprofessional Collaboration Among Health Colleges and Professionals

## Background

*Health Systems Improvements Act 2007* (June 2007) gave the Colleges the following new objectives:

- to promote and enhance relations between the College and its members, other health profession colleges, key stakeholders and the public;
- to promote interprofessional collaboration with other health profession colleges;
- to develop, establish, and maintain standards and programs to promote the ability of members to respond to changes in the practice environment, advances in technology, and other emerging issues.

A central issue is to increase interprofessional collaboration between health professions that share the same or similar controlled acts.

## What is Interprofessional Collaboration?

There were many definitions of “interprofessional care” (i.e. interprofessional collaboration at the clinical level) but none found in the Literature Review for collaboration at the regulatory (i.e. College) level. HPRAC proposes 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;
- 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 ensure 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.

### OAPA and Interprofessional Collaboration

OAPA fully supports the government's objective of interprofessional collaboration among regulated health care providers and the way in which it has articulated these objectives. The members of OAPA find the following issues to be important in facilitating interprofessional collaboration:

- 1. An improved understanding of the scope of practice of Psychological Associates for other health care providers, psychologists, and the public;**
- 2. Strategies to address the shortage of service providers in the field of children's mental health as this leads to long waiting lists and difficulties collaborating with other health care providers;**
- 3. Strategies to address systemic issues that affect interprofessional collaboration for Psychological Associates who do not work in a primary health care setting such as, referral policies, policies around sharing information;**
- 4. The development of regulations to expressly state that interprofessional collaboration is a goal or expected practice and a body to share strategies that are working successfully to achieve this goal.**

We hope that the Ministry of Health and Long Term Care takes these recommendations into consideration along with our following thoughts on its discussion questions.

1. Please comment on the above statement that HPRAC has used to focus this discussion and initiatives. Are there elements that should be added or removed? If so, what are they?

**OAPA supports the overall goal of promoting health regulatory colleges and their members to work collaboratively. OAPA also believes that intraprofessional collaboration and interprofessional collaboration are equally important. Within the College of Psychologists, OAPA believes increased awareness of the scope of practice of Psychological Associates by the public and by Psychologist members would improve access to patient care, maximize collective resources, and ensure all regulated health care professionals work to their maximum competency and capability.**

2. Are there barriers in the RHPA, the health profession acts or their regulations that restrict or prevent collaboration among the Colleges? If so, what are they? Should they be eliminated? If so, how? (For example, do existing scopes of practice restrict or prevent collaboration among health professionals?)

**A lack of communication to members of the public and other health professionals about scope of practice issues for members from the College of Psychologists is a barrier to collaboration. Public education about scope of practice is essential and is not as well done as it could be.**

3. Are there barriers in other Acts or regulations that restrict or prevent collaboration among Colleges? If so, what are they? Should they be eliminated? If so, how?

**PHIPA has regulations about confidentiality of patient information that can affect interprofessional collaboration between health care providers. PHIPA is cumbersome when health care providers do not work in a primary health care setting (for example, school boards). PHIPA should not be eliminated, but some improvement in the exchange of information would be helpful. Because psychological services aren't billable to OHIP, full interprofessional collaborated is impeded. There are parameters impacting on our ability to collaborate due to regulations (e.g. some services are only to be provided by certain health care providers).**

4. Are there other policy and/or systems issues that act as barriers to collaboration among Colleges? If so, what are they? Should they be eliminated? If so, how?

**OHIP billing procedures can be a barrier around interprofessional collaboration. In the mental health field, the need for referrals for some services to be signed by a physician hinders access for patients (psychiatrists, admission to hospital). Concern about safety risk for the client and the public, when a patient who is judged to be a concern (e.g. suicidal or homicidal) is not admitted to hospital. A lack of understanding of scope of practice can interfere with interprofessional collaboration.**

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?

---

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

**No**

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?

**Each profession should set a minimum requirement for their members.**

9. What changes to RHPA, the health profession acts or their regulations are needed to encourage, require, facilitate, and enable collaboration among Colleges?

**Updating of the RHPA regulations to expressly state that interprofessional collaboration is a goal or expected practice and developing a body that would create standards for best practice, cooperation and consistency.**

10. What changes to other Acts or regulations are needed to encourage, require, facilities and enable collaboration among the Colleges?

--

11. What Collaborative policy or program initiatives are needed to ensure support is provided to new Colleges as they are being established?

**OAPA supports the idea of providing support to new Colleges, such as the College of Psychotherapists. Consultation from Colleges that share a similar scope of practice to develop mechanisms around interprofessional collaboration would be desirable.**

**Existing colleges should be actively encouraged to lend consultative support to new Colleges as they are being established.**

12. Are there administrative responsibilities within Colleges that could be shared with related Colleges? What barriers exist to shared administrative services?

**There are undoubtedly some administrative responsibilities that could be shared with related Colleges, but the individual Colleges have systems**

**established that appear to work well for dealing with administrative responsibilities (e.g. complaints, discipline).**

13. Should Ontario introduce a common framework, consisting of common structures and processes for all regulated health professions to address complaints, investigations, or disciplinary matters arising in an interprofessional care setting?

**A common framework across Colleges would be helpful; however, complaints and discipline issues against members should continue to be handled by their respective Colleges. Many of our interprofessional teams include professions not regulated under the RHPA, which is a concern.**

14. Is so, what should and should not be included in the common framework?

**A common framework should include all processes currently in use by the College of Psychology to address complaints, investigations and discipline.**

15. If not, should the RHPA, nonetheless, be amended to give individual Colleges greater flexibility to deal with complaints, investigations, and discipline arising in an interprofessional care setting within their own already-established structures?

**Not at the present time.**

16. If so, what should and should not be addressed in an amendment to the statute? For example, should the RHPA be amended to enable Colleges to establish joint committees to deal with complaints, investigations, and discipline in respect of issues arising in an interprofessional care setting?

**No. Complaints should be made to the College of which the alleged offender is a member.**

17. Considering reforms in other jurisdictions, what would be the merits of a single complaints model in Ontario? How should such a model be funded?

---

18. Would the authority to conduct joint investigations following complaints or reports relating to professionals who work in a multidisciplinary setting or practice provide more efficient investigations of such cases?

**It is possible that a joint process may be more efficient if there are complaints against more than one team member (it might help reduce**

**duplication of work). However, it is important to respect the individual rights of each health care professional and to allow decisions to be made by the member's respective colleges.**

19. Should Colleges have further authority to collaborate in the disposition of complaints and reports relating to professionals in multidisciplinary setting or practice?

**In some circumstances, it may be helpful; however, there are concerns that the rights of the individual health practitioner be respected.**

20. Could such authority contribute to patient safety in interprofessional care?

**Not directly.**

21. Is legislative change required to accomplish these goals?

---

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

**Ideally yes, but it would a challenging process in the field of mental health as there is a difference of opinion around what the guidelines should be (for example, psychotherapy).**

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?

**See 22. Ideally yes, but it would a challenging process in the field of mental health as there is a difference of opinion around what the guidelines should be (for example, psychotherapy).**

24. Is legislative change required to accomplish these goals?

---

25. Should an independent arm's length organization facilitate and support collaboration among the Colleges, particularly with a view to the development of common standards of practice and professional practice guidelines?

**This would appear to be helpful to encourage interprofessional collaboration is given priority and to organize the development of common practices. Yet it may not have the desired effect as it could be construed as overly mandated. A separate department in the Ministry to act as a body to share information about interprofessional collaboration rather than as a watchdog would be seen as helpful. This body could share information about initiatives and practices that are working well and share information between Colleges about practices, scope of practice, and controlled acts.**

26. If so, what should its specific mandate include or not include?

- Educate the Colleges, professions and the public on the regulatory model, the health professions and everyone's role within the regulatory system;
- Create common resource repositories (e.g. a data warehouse to tract regulatory indicators, such as the level and nature of quality assurance activities, complaints and disciplinary actions and the cost of regulation);
- Research and develop standards of practice and professional practice guidelines, and disseminate best practices;
- Resolve disagreements among professionals that share overlapping scopes of practice and the same or similar Controlled Acts
- Address issues arising from conflicting legislation and
- Have an oversight function over regulatory bodies, as in the United Kingdom

**The individual Colleges do provide education to the public and other professionals about members' roles and the health regulation system in general so this need not be duplicated. This arms length organization should focus on disseminating best practices for interprofessional collaboration, developing family health teams, and resolving disagreements /issues arising from conflicting legislation. No additional oversight body is needed beyond the Ministry of Health.**

27. Are there existing bodies that could take on responsibilities in this area? If so, what are they?

---

28. If not should a new and independent oversight body be formed? If so, how should it be funded?

**No.**

29. Should the Minister direct the Colleges, using his existing powers under the RHPA, to engage in specific collaborative initiatives (e.g. to develop instruments to support interprofessional care)? Why or why not?

**Yes, it may be positive, but there may be issues related to staffing and financial resources in Colleges that will be needed to address this. It appears that there also need to be changes in the training and education of health professionals that would encourage more collaboration.**

30. If so should the Minister provide financial or other incentives to the Colleges to undertake these activities?

**Yes, financial assistance to deal with additional expenses incurred would be beneficial. Not necessarily an incentive, but remuneration for expenses, particularly for the smaller colleges, so that members will not have to bear the cost through increased fees. Financial assistance to set up a separate department to facilitate sharing of information between Colleges on interprofessional collaboration would also be helpful.**

31. Should the Colleges be required to report to the Minister and/or the public on their collaborative activities on a regular basis? Why or why not?

**During the development of these initiatives, some reporting on progress and development of best practice mechanisms would likely be helpful. Once these are established, they should be self-sustaining and ongoing reporting may not be required.**

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?

**Consistent guidelines across all Colleges would be best.**

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 (eg. 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)

**Joint colleges and an independent body to oversee colleges are not seen as a good idea.**

34. Would the development of a *Collaborative Toolkit*, containing some of all of the elements suggested above, serve to facilitate and support collaboration among the Colleges?

**Yes.**

35. If so, what should be included in a *Collaborative Toolkit* and who should be responsible for developing it?

**A general tool kit with a framework, specific collaborative initiatives, samples of common language that would be used between Colleges around principles, purpose, goals and targets and ground rules would be beneficial. The Ministry of Health should be responsible for developing it with collaboration from Colleges.**

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

**No. These are regulations of self-regulating professions to serve as guidelines for best practice and protection for the public.**

37. If so should the Colleges be given statutory rule-making powers (as in New Brunswick) allowing them to enforce the standards of practice and professional practice guidelines that they adopt? Why and why not?

**No, see above.**

38. What kinds of enforceable rules should the Colleges be able to make without needing Ministerial or legislative approval?

**The current enforceable rules of the College of Psychologists of Ontario are sufficient.**

39. What accountability must accompany any rule-making authority?

**A demonstration that procedures are in place to address complaints from the public.**

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

**Greater collaboration between the Colleges will reinforce efforts already underway and provide a mechanism to address any difficulties or complaints that arise. There appears to be many clinical settings using or developing this model already, so the collaboration between Colleges will support this trend.**

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?

**The scope of practice of Psychological Associates is not well understood by other regulated health care providers, including Psychologists, and this is a barrier to interprofessional care.**

42. Should Ontario law have a requirement similar to the one in New Zealand?

**No.**

43. Is so, what should the requirement look like and should there be consequences for a failure to meet this requirement?

---

## APPENDIX

Summary of the responses obtained from members to OAPA questionnaire about interprofessional collaboration:

**Question – In your experience/setting when does interprofessional collaboration work well for your clients/patients?**

- For multidisciplinary assessments if there is a case manager providing recognized leadership
- When there is good communication, regular team conferences with all members present
- Staff are secure (no turf wars)
- There is a consensus of opinion
- Managers are familiar with work of all team members and don't favour their own profession
- When people are flexible in thinking how to support people with complex needs (e.g. a complex differential diagnosis)
- Open and respectful –“level playing field”
- Generally it always works well
- Focus is on the well-being of the client
- Compatibility with styles – so can see clients over a shorter time frame
- Meeting regularly to brainstorm
- When members respect others & recognize limits of own competence
- When referrals can be made in a timely manner (less than three months wait)
- When a wide range of needs are addressed (family, financial, parenting etc)
- When there are venues for effective communication- perhaps a third party who acts a conduit for relaying info
- Particularly helpful for clients with complex issues
- When team members have several perspectives and sets of expertise
- When patient is made aware of what's available to them
- When each professional does not try to dictate to another, especially outside their scope of practice
- When scope of practice is well understood- this is often not the case for Psychological Associates who often find must explain scope of practice
- When doing collaborative assessments, planning interventions for students, coordinated feedback between home and school
- When professionals agree about the nature of client's difficulties and the methods needed to increase well-being

**Question: Describe any barriers to patient care arising from a lack of collaboration among regulated health providers.**

- Psychiatrists teaching counselors how to consider diagnoses rather than referring for a psych assessment
- Long wait lists, lack of openings for services (psychiatric counseling, special class placements, clinical care)
- Poor communication and lack of face to face contact
- Lack of knowledge about expertise
- Disagreements or lack of clarity about model of care
- Lack of respect of professional boundaries
- Turf war, fear of downsizing which makes people want to protect their own
- Patients can receive conflicting messages if team not communicating on a regular basis
- Developmentally disabled clients have some difficulty receiving care from generic services in northern Ontario
- Shortage of services/beds – poor communication about wait times
- Takes much longer to get accurate picture of client's issues if they have to wait weeks between appointments with various professionals
- Complete lack of feedback once client is referred
- Poor assessment of mental health needs and therefore ineffective treatment
- Misinformation and lack of communication results in parents feeling they are not getting enough for their child
- Disruption in continuity of care (inpatient to outpatient)
- Extremely difficult to get in touch with physicians and almost impossible to have physicians and psychiatrists as part of community services
- Hard to get information from physicians about physical conditions that may be related to mental health issues (e.g. sleep apnea)
- Lack of respect and recognition particularly in psychology where practitioners with different qualifications tend to undermine one another causing anxiety for clients
- Clinicians who are practicing outside scope of practice (doing psychotherapy)
- Professions argue over diagnostic labels –wasting patient's time (Semantic Pragmatic Disorder vs PDD)
- Diagnosing erroneously without data available from other professionals
- Making recommendations for services without consulting on availability or appropriateness
- Conflicting messages
- Lack of practitioners in Northern Ontario (clinical psychology, psychiatry)
- Psychiatrist has a very different take of patient's problems

**Question: Are there barriers that hinder health care providers' collaborative work?**

- Agencies have services that have age limits about the children they will see and then these children go on another waitlist causing interruption in services
- Government funded Resource Teachers and Infant Child Development Services do similar work with preschoolers creating competition and making it difficult for psychological service providers
- Financial restrictions within an agency can prevent collaboration- this is magnified across institutions
- Payment of physicians on a fee for service basis can result in an unwillingness to participate in interdisciplinary meetings (that they can't bill for)
- Need for formal referrals to go through physicians is a hindrance to collaborative efforts of other professionals
- Attitudes of professionals making them not open to working with other professionals
- Ministries make collaboration difficult between service providers in different Ministries
- Professionals wedded to traditional treatment options (long term psychodynamic therapy) versus learning or providing shorter term therapy or CBT – people not trained in these methods
- Shortage of staff in schools to work collaboratively as much as desired as there is pressure to get to waitlist
- The cases that we may want to collaborate on may not be our school's priority
- Consent procedures vary from agency to agency
- Only get paid for open files in some agencies –Ministry issues make it hard to collaborate more informally
- Not enough services so staff are so rushed– psychiatrists, children's mental health services
- Need to ensure client consent to exchange information – need to extend "circle of care" idea beyond hospital
- Wrap around care for delinquent youth
- No structures to assure proper communication
- Lack of understanding of roles and abilities of various disciplines- hierarchies that place doctors as leaders or coordinators
- PHIPPA makes people overly cautious, OHIP failing to cover psychological services relegates these services to second class or unaffordable so clients may not be referred
- Psychological Associate title seems to be a barrier as it is not well understood
- In rehabilitation, insistence that clients' care be provided to insurers by physicians
- Staff vacancies not filled

- Turf wars
- Clinicians who think they know how to do something they don't – psychotherapy
- Although we are very collaborative (in hospital setting) we have been reprimanded for not being efficient and cost effective if multiple professionals attend a meeting with one patient
- Title Psychological Associate hinders the work of psych. associates and collaboration because we must constantly explain our scope of practice
- Workload and number of locations we work in
- Children's mental health is relegated to the Ministry of Child and Youth Services so psychological associates are only accessible through government agencies or third party insurance
- Hard to collaborate with medical professions as their services are not under the same umbrella (i.e. only physicians can refer to a local psychiatrist, if not they can't bill OHIP)
- Psychology services providers can't hospitalize patients when we evaluate risk –have to depend on ER physicians to agree or disagree

**Question: What would remove these barriers?**

- Creating more than a single point of intake in agencies so child can get services
- Permitting professionals to request services from one another without signature of physician will allow professionals to work more collaboratively
- Increased collaboration among Ministries with established protocols and policies for this
- Increased education and encouragement and policy development to have professionals from all sectors of mental health work together in the best interest of the clients
- A guide to working together collaboratively
- Not necessarily requiring a diagnosis to obtain service
- Open dialogue, greater ministry support for different levels of professionals, more awareness of territorialism- re professional self-interest, money for training, and supervision of evidence-based therapy and researching effectiveness
- More money for staff, more training for professionals regarding what collaboration is and how to make it work
- Institutional support for collaboration (although we have it in principal we don't have time to make it work to maximum potential)
- Regular communication structures in place for funding mechanisms that did not provide competition in a geographical area (if one group gets money another does not)
- Fewer strings attached to funding as they hinder flexibility

- Rethinking rules on privacy and confidentiality- especially for people aged 12 through 20 as it is hard for doctors, schools, and community agencies to work cooperatively
- Case manage for individual client with power to access timely help from different agencies
- Regular ground rounds style of local mental health agencies
- Commitment on part of management to patient's best interests
- Clarification of some of the day to day movement of information under PHIPA, specifically the circle of care concept
- Clarification by HPRAC regarding role and abilities of psych associates
- OHIP coverage for psychological services
- Internally, individual efforts within one's team usually pays off
- At the institutional/regulatory level- unsure ? more education efforts, lobbying changes to title?
- Given stress on health care system, insurers should be prepared to allow other health professionals to provide information regarding need for services
- Funding, education, disciplinary action through management or regulatory body
- Clearly inform medical practitioners of the harm that comes from not working in consultation with those professionals who are skilled at gathering appropriate data (e.g. Doctors who do psychotherapy and provide worrisome diagnoses)
- Remove barriers in communication and services to clients that occurs as a result of confusion over title
- Creating school teams that have more realistic case loads
- Have a clear responsibility enshrined in health care legislation to address children's mental health needs
- Expand scope of practice for psych practitioners (i.e. giving psych associates and psychologists the authority to refer to a psychiatrist or neurologist – it would free up money spent on consultation fees)
- Give psychology practitioners greater participation in hospitalization procedures for suicidal or homicidal patients