OPA Submission Regarding the CTI Guideline

September 11, 2015

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Introduction

Thank you for the time you took to meet with us in the consultation session to engage in discussion about the Expert Final Report and the draft Common Traffic Impairment Guideline (CTI Guideline). We appreciated the open dialogue and thoughtful consideration of our questions. During the session we identified several areas of particular concern regarding access to services outside of the CTI for patients with psychological and mental disorders (including brain injuries). We will limit our comments to these areas and provide alternatives where appropriate.

In our submission, we address the following:

- clarification of language in the draft guideline
- potential confusion regarding appropriate classification of accident victims with mental and psychological disorders
- barriers created by the physician/NP gatekeeper referral processes for psychological diagnostic evaluation and treatment services.
- improved process for approval of psychological assessments.

We look forward to further opportunities to work with you toward increasing the effectiveness and efficiency of the delivery of services for accident victims without creating barriers for patients with mental and psychological disorders. We believe our proposals are consistent with our understanding of the policy goals of the Guideline, but do not create barriers. We are happy to provide further information regarding the concerns we identify in the Draft Guideline and the solutions we propose.

Key Recommendations

Recommendations regarding clarification of language in the draft guideline

- Replace the term “anxiety” with “worry and nervousness” and the term “depressed mood” with “unhappiness, sadness”, to differentiate early psychological signs and symptoms from psychological disorders.
- Modify the Common Traffic Impairment (CTI) definition as follows, “A Common Traffic Impairment" (CTI) means any one or more of the following ~~impairments~~ *(remove)* that result from a motor vehicle accident”.
- Replace the headings Psychological Impairments and Mental Impairments with a single heading: “Symptoms and Signs Involving Cognition, Perception, Emotional State and Behaviour”
- Restrict the use of the term “Psychological interventions/services” to “services of a psychological nature” that are provided by or under the direction of a member of the College of Psychologists of Ontario as per the Psychology Act.

- Describe the interventions provided within the CTI to address early psychological signs and symptoms as "supportive" and "educational" not "psychological".
- Consider replacing the label Common Traffic Impairments (CTI) with Common Soft Tissue Injuries (CSTI)
- Modify the certification statement as follows, "An insured person's impairment does not come within this Guideline if a health practitioner (as identified depending on the circumstances described below), acting [*remove*: ~~impartially~~] [*insert:* responsibly in the best interest of their patient's health care] and within the scope of his or her expertise, confirms in writing and provides [*remove*: ~~compelling evidence~~] [*insert:* clinically relevant information]."

Recommendations regarding potential confusion about appropriate classification of accident victims with mental and psychological disorders

- Include the descriptions and the examples of Type I and Type II injuries from the Cote Report within the CTI Guideline to provide the framework for inclusion and exclusion
- Confirm that the CTI Care Pathways address initial signs and symptoms of emotional upset and distress *but not* mental and psychological disorders
- Do not include persistent symptoms of mTBI/Concussion as CTI impairments.
- Do not include a Mental Impairment or mTBI/Concussion Care Pathway within the CTI Guideline framework.
- Build screening into the Physical Impairment CTI Guideline Care Pathways to identify symptoms of mTBI/concussion that persist and/or interfere with function for referral for specialized evaluation and treatment.
- Facilitate timely referral for individualized symptom based treatment outside of the CTI when required due to mTBI/concussion.

Recommendations regarding barriers created by the physician/NP gate-keeper referral processes for psychological diagnostic evaluation and treatment services

- Do not require a physician gate-keeper for access to a psychologist; allow direct access to self-refer as well as referral by other health professionals.
- Include psychologists, with physicians and nurse practitioners, as listed health professions who are able to provide the confirmation and compelling evidence and allowed to sign the OCF 24 when there is a psychological disorder.
- Modify the language proposed for the OCF 24 to require "clinically relevant information" rather than "compelling evidence."
- If the government incorporates a physician gate-keeper model requiring a physician's signature on an OCF 24 prior to treatment, confirm that the insurer must consider on its merits an OCF 18 for assessment to determine if there is an impairment that is not a CTI, without requirement of the OCF 24.

Recommendations regarding improved process for approval of psychological assessments

Applications for psychological services (diagnostic evaluation and treatment) should be routinely approved if:

- An appropriate screening instrument has been completed and scores provided that indicate a need for referral for psychological diagnostic evaluation and treatment.
- Administration of appropriate screening instrument and referral by the health professional providing the physical treatment has been completed;

OR

- For patients who self-refer (or when it has not been completed by the physical treatment provider), the psychologist or psychiatrist or physician completes an appropriate screening instrument;

AND

- An appropriate intake screening interview is completed.
- The psychologist, psychiatrist, or physician with appropriate expertise diagnosing and treating mental/psychological disorders has completed an intake screening interview to confirm indications of psychological and mental disorders and obtained informed consent for the application and communication;

AND

- An appropriate application is submitted by the psychologist certifying that the proposed services are reasonable and necessary.
- This certification requires that the psychologist has spoken directly with the patient and determined the patient is reporting symptoms that are likely accident-related and that are likely to be interfering with the patient's functioning and for which treatment is likely required.

Clarifying Language

During the consultation we addressed specific terms used in the Draft Guideline that have multiple meanings. Some terms have different meanings when used colloquially, by healthcare providers, or in regulations. This is why it is easy to confuse the terms symptom, injury, impairment and disorder, as their meanings depend on the context and who is using them. For example, in everyday usage, people commonly describe themselves as depressed, anxious, stressed or in pain. Healthcare providers may use these same terms as a label for a diagnosed disorder or simply to note the presence of a symptom that may not flag a disorder. This type of confusion is also seen when specific meanings of terms like injury and impairment are defined differently in regulations such as the SABS and CTI Guideline from how they might be used by healthcare providers. As discussed during the consultation, we review here some of the more problematic terms and offer alternatives that are less likely to be misconstrued.

Language used to illustrate early psychological signs and symptoms of psychological impairments

As described above, some terms may create confusion because they are used both to convey a complaint or symptom as well as to convey a diagnosed disorder. The CTI Guideline uses the terms "depressed mood" and "anxiety" as examples of early psychological signs and symptoms along with "fear, anger, frustration and poor expectation of recovery". The terms "fear, anger, frustration and poor expectation of recovery" are not likely to cause confusion. However, the terms "depressed mood" and "anxiety" create confusion, as they connote both symptoms and diagnoses. We suggest alternative terms such as unhappiness, sadness, worry and nervousness to illustrate these early signs and symptoms without confusing the signs and symptoms with diagnosed disorders.

Our suggestion to replace terms anxiety and depression is consistent with The International Statistical Classification of Diseases and Related Health Problems (ICD), which is the system of diagnostic nomenclature required for identification of disorders under auto insurance. The ICD Chapter V – "Mental and behavioural disorders" (F00-F99) provides diagnostic terms, codes, criteria and explanations for diagnosed disorders. Chapter XVIII, "Symptoms and signs involving cognition, perception, emotional state and behaviour" (R40-R46) provides terms, codes, and some criteria, which are kept separate from diagnosed disorders.

OPA Recommendation

- **Replace the term "anxiety" with "worry and nervousness" and the term "depressed mood" with "unhappiness, sadness", to differentiate early psychological signs and symptoms from psychological disorders.**

Impairment

The difference between SABS and clinical use of the term *impairment*, particularly when coupled with the qualifiers mental or psychological in the proposed CTI Guideline, may lead to confusion. Consistency with the SABS may require the use of the term impairment in some sections of the CTI definition to link to other sections of the SABS. However, it appears that the term *impairment* is also used in the CTI Guideline when what is actually being referred to are *injuries and symptoms*, not impairments or disorders. It is important to replace these references with alternative language that more accurately conveys the more limited inclusion of initial injuries and symptoms in the CTI.

The CTI Guideline states,

> *Part B - Definition of Common Traffic Impairment*
> *Impairments resulting from motor vehicle accidents often present as clusters of physical, mental and psychological signs, symptoms, injuries or conditions.*
>
> *A "Common Traffic Impairment" (CTI) means any one or more of the*

following impairments that result from a motor vehicle accident:

To reduce potential confusion from the use of impairment we suggest removing the second use of the word impairment from the definition as follows, "*A Common Traffic Impairment" (CTI) means any one or more of the following ~~impairments~~ that result from a motor vehicle accident".*

OPA Recommendation

- **Modify the CTI definition as follows, "A Common Traffic Impairment" (CTI) means any one or more of the following ~~impairments~~ *(remove)* that result from a motor vehicle accident".**

Mental and psychological impairments

The CTI Guideline further states:

> ***Physical impairments:*** *grades I, II and III (cervical radiculopathy) neck pain and its associated disorders (NAD); headaches associated with neck pain; thoracic and lumbar spine pain; thoracic radiculopathy and lumbar radiculopathy (nerve root injury); grades I and II girdle and limb sprains and strains and related soft tissue injuries; grades I and II sprains and strains of the temporomandibular joint and related soft tissue injuries; skin and muscle contusions; abrasions and skin lacerations which do not extend beneath the dermis; and pain associated with any of the above listed impairments.*
>
> ***Mental impairments:*** *mild traumatic brain injury (MTBI) (manifested as a loss of consciousness lasting less than 30 minutes after the accident, altered consciousness < 24 hours after the accident, post-traumatic amnesia < 24 hours after the accident, and an initial Glasgow Coma Scale of 13 to 15), with normal structural imaging, and with signs and symptoms resulting from the MTBI lasting no more than 3 months.*
>
> ***Psychological impairments:*** *early psychological signs and symptoms that include poor expectations of recovery, post-collision depressive symptomatology, fear, anger and frustration.*

We recommend changing the language in the headings *Psychological Impairments* and *Mental Impairments* . These headings should not include the term impairment. It would be clinically and scientifically more consistent with the intent of the Guideline to use headings that describe symptoms. The following language from ICD is recommended, "*Symptoms and Signs Involving Cognition, Perception, Emotional State and Behaviour" (we do not comment on Physical Impairments).*

OPA Recommendation

- **Replace the headings Psychological Impairments and Mental Impairments with a single heading: "Symptoms and Signs Involving Cognition, Perception, Emotional**

State and Behaviour"

The Terms "Psychological" and "Mental"

We agree with the CTI Guideline model that indicates early signs and symptoms such as "fear, anger, frustration and poor expectation of recovery" should be addressed within the CTI Guideline. Diagnosed psychological disorders are not included as they require more specific expert diagnostic evaluation and treatment. However we note that the use of the heading *Psychological Impairments,* as included in the definition of Type I impairments included in the CTI Guideline is too easily misconstrued. It may inaccurately imply classification of diagnosed psychological disorders as Type I disorders falling within the CTI Guideline, although it was confirmed this is not the intent.

We note that the SABS has traditionally relied upon ICD nomenclature. There is also parallel concern regarding the use of the heading *Mental Impairments* as implying inclusion of cognitive impairments and Post Concussive Disorders resulting from Brain Injuries within the CTI definition. Therefore we recommend the headings *Psychological Impairments* and *Mental Impairments* be replaced with a heading focusing on symptoms from the ICD, "*Symptoms and Signs Involving Cognition, Perception, Emotional State and Behaviour".*

OPA Recommendation

- **Replace the headings Psychological Impairments and Mental Impairments with a single heading: "Symptoms and Signs Involving Cognition, Perception, Emotional State and Behaviour"**

"Psychological" Interventions/Services

The term "psychological" is often used colloquially to refer to various interventions and services, often including all treatments that are not of a physical nature.

However, by Ontario law, psychological services/interventions have a very specific meaning and can only be provided by members of the College of Psychologists. The Standards of Professional Conduct of the College of Psychologists of Ontario, September 1, 2005 (Revised March 27, 2009) states,

> *Psychological Services refer to services of a psychological nature that are provided by or under the direction of a member. Psychological services include, but are not limited to, one or more of the following:*
> *a. Evaluation, diagnosis and assessment of individuals and groups*
> *b. Interventions with individuals and groups*
> *c. Consultation*
> *d. Program development and evaluation*
> *e. Supervision*
> *f. Research.*

The Psychology Act, Section 8 states,

> *(2) No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as a psychologist or psychological associate or in a specialty of psychology.*
>
> *(3) A person who is not a member contravenes subsection (2) if he or she uses the word "psychology" or "psychological", an abbreviation or an equivalent in another language in any title or designation or in any description of services offered or provided.*

We agree that supportive and educational interventions/services to address initial emotional upset, concerns, and etc. should be provided within the CTI. These services are most often provided by the health professional providing the physical treatment. These services/interventions are appropriately described as supportive and educational interventions rather than as psychological.

OPA Recommendation

- **Restrict the use of the term "Psychological interventions/services" to "services of a psychological nature" that are provided by or under the direction of a member of the College of Psychologists of Ontario as per the Psychology Act.**
- **Describe the interventions provided within the CTI as supportive and educational**

Impartial

We were concerned that the term *impartial* might convey a health professional who did not have a treating relationship with the patient. We thought it might imply that the patient would be required to attend an Insurer Examination. During the consultation session on August 17, 2015 it was clarified that this is not the intention. Rather that there should not be a "conflict of interest" on the part of the health professional. We agree that the certifying health professional should be acting responsibly in the best interest of their patient's health care. However, facilitating appropriate care and making referrals is a critical role for every health professional and the term "impartial" is out of context in clinical assessment and treatment, referral or recommendation for other care and certifying the need for referral and other care. We are also concerned that the term "compelling evidence" implies a legal process, whereas the term "clinically relevant information" is neutral and more generally used in clinical contexts.

OPA recommendation

- **Modify the certification statement as follows, "An insured person's impairment does not come within this Guideline if a health practitioner (as identified depending on the circumstances described below), acting [*remove*: ~~impartially~~] [*insert:* responsibly in the best interest of their patient's health care] and within the scope of his or her expertise, confirms in writing and provides [*remove*: ~~compelling evidence~~] [*insert:* clinically relevant information]."**

CTI Inclusion and Exclusion

An explicit goal of the proposed CTI Guideline is to broaden the *impairments* addressed by the Guideline, as was indicated in the presentation during the consultation, "*More impairments able to access treatment protocols"*. We are concerned that in attempting to broaden the scope of the CTI Guideline and make it more inclusive, there is a risk of harm to individuals with psychological disorders (including brain injuries). The CTI Guideline correctly asserts the need to provide educational and supportive interventions for accident victims who are experiencing initial symptoms such as upset, distress and worry along with their CTI physical injuries. However, this must not be misconstrued as including individuals with psychological disorders. It is essential that the CTI Guideline clearly distinguish the inclusion of initial symptoms such as distress and upset from psychological and mental impairments/disorders which are excluded.

Injury Typology: Type I vs Type II as per the Cote report

Dr. Cote's research group described a three-level typology for classification of motor vehicle accident injuries. We find this approach useful. They also correctly described that initial post-traumatic psychological signs and symptoms, such as nervousness, worry or sadness, are included as a component of Type I injuries and addressed in the Care Pathways. In contrast, the Cote report states that examples of Type II injuries include fractures of the femur and hip, shoulder dislocation/fracture, facial fractures, depression or post-traumatic stress disorder. The report also confirms "The management of Type II injuries is not within the scope of our report".

The three-level typology provides the rationale and criteria for inclusion in the CTI Guideline. (Type III refers to the subset of Type II injuries which fall within the conceptual framework of catastrophic impairment within the Ontario Statutory Accident Benefits Schedule (SABS).) The first two levels will be briefly reviewed here as the relevant background for discussion of inclusion of emotional and cognitive symptoms and the exclusion of psychological and mental disorders from the CTI. The Cote Report provides the following descriptions regarding classification of initial emotional/cognitive symptoms as type I and psychological/mental disorders as type II:

> *Type I Injuries:*
> *Type I injuries are those traffic injuries which have been shown in epidemiological studies to have a favourable natural history (recovery times ranging from days to a few months). These injuries include musculoskeletal injuries (such as Neck Pain and Associated Disorders Grades I-III, Grades I and II sprains and strains of the spine and limbs); traumatic radiculopathies; mild traumatic brain injuries" and post-traumatic psychological symptoms such as anxiety and stress. The proposed* Care Pathways *outlined in our report pertain to Type I injuries.*

Common features are not confined to physical injuries alone. It is important for health care professionals and injured persons alike to understand that the experience of psychological symptoms such as anxiety, distress and anger is natural and not-atypical after a traffic collision; most psychological symptoms are temporary…

General Approach to the Management of Type I Injuries:
… The management should include education, advice, encouragement to stay active (including return to work), and reassurance that Type I injuries and their associated distress and discomfort are usually of a time-limited nature…

Type II Injuries
Type II injuries typically involve a substantial loss of anatomical alignment, structural integrity, psychological, cognitive, and/or physiological functioning. The majority of patients with such injuries will require (in addition to natural healing) a significant amount of medical, surgical, rehabilitation, and/or psychiatric/psychological intervention to ensure an optimal recovery. There is an evidentiary basis for major concern about both the extent of recovery and about the likelihood of complications developing and/or persisting in the absence of such expert care; significant impairment and disability are primary concerns.

Examples of traffic collision-induced Type II injuries include fractures of the femur and hip, shoulder dislocation/fracture, facial fractures, depression, or post-traumatic stress disorder.

The rationale and examples for classification as Type I and Type II provide the foundation for appropriate inclusion in the CTI Guideline. We recommend that the descriptions and the examples of Type I and Type II injuries be included in the explanatory notes in the CTI Guideline to provide this context.

OPA Recommendation

- **Include the descriptions and the examples of Type I and Type II injuries in the Cote report within the CTI Guideline to provide the framework for inclusion and exclusion**

Initial symptoms of emotional upset and distress vs psychological and mental disorders

It is our understanding that initial signs and symptoms of distress and upset are appropriately addressed within the CTI Guideline with basic supportive and educational interventions by the health professional providing the CTI treatment. It is correct that upset and distress are not uncommon after an auto accident. In most people, initial distress generally does not interfere with function and tends to resolve rapidly without requiring psychological interventions. Further, it was confirmed in the consultation meeting on August 17, 2015 that psychological and mental disorders are not included in the CTI Guideline as they are not Type I injuries.

Unlike Type I injuries, psychological and mental disorders are Type II injuries that do not have favourable outcome without treatment. Also, psychological and mental disorders often cause functional impairment and/or disability. Further, psychological and mental disorders require and benefit from specialized treatment. In addition, this treatment is highly individualized and variable both in type and duration/intensity, requiring specific tailoring of a treatment plan on a case by case basis, and so does not fit a standardized protocol. We agree that the distinction between providing monitoring, education and support for emotional symptoms within the CTI Guideline vs treatment of mental and psychological disorders outside of the CTI Guideline is necessary.

We agree with the basic model that initial emotional distress can be handled by the CTI treatment providers who are able screen, provide educational and supportive interventions, and monitor their patients within the CTI. When symptoms persist beyond expected recovery, interfere with function, or worsen; the treating health professional should refer for more specialized diagnostic evaluation. The recommendation to use standardized screening instruments may facilitate identification for referral. This initial education, support and timely referral should contribute to improved outcomes for patients who are found to have psychological disorders.

OPA Recommendation

- **Confirm that the CTI Care Pathways address initial signs and symptoms of emotional upset and distress *but not* mental and psychological disorders**

mTBI/Concussion

We agree with the conclusion of the Cote group that the Ontario Neurotrauma Foundation Guidelines for Concussion/ Mild Traumatic Brain Injury & Persistent Symptoms (Second Edition) (ONF Guideline) is an up-to-date and sound Guideline regarding management and treatment of individuals with mTBI/concussion as well as Post-Concussive Syndrome/Disorder. However, the characterization of mTBI/concussion and the Post-Concussion Disorder and the management/treatment recommended in the ONF Guideline do not fit within the CTI paradigm. This reinforces our conclusion that brain injuries are not Type I injuries. Therefore there should not be a Mental Impairment or mTBI/Concussion Care Pathway within the CTI Guideline framework.

After initial evaluation to rule out significant medical emergencies, the ONF Guideline recommends early supportive and educational interventions and monitoring. Individuals with symptoms that interfere with function and/or persist (for some symptoms this means days) require referral for interventions (diagnostic evaluation and treatment) that are outside of the scope of the CTI to foster better outcome. There are screening instruments recommended in the ONF Guideline that may be of use. The ONF Guideline recommends referral to *initiate specific symptom based multi-disciplinary treatment (pharmacotherapy, psychotherapy, physiotherapy, occupational therapy) if symptoms are not sufficiently resolved within days*. This recommendation differs significantly from the recommendations in the CTI Care Pathways.

Further, the individualized nature of the response to brain injury and the resultant impairments is highlighted in the ONF Guideline. Thus, the ONF Guideline emphasizes the need to take an individualized approach to treatment, incorporating the research evidence along with the treating clinician's experience and judgement and the patient's preferences. There is not a standardized, *prescribed* approach to treatment across patients in the ONF Guideline as is found in the Care Pathways. In addition, according to the ONF Guideline, treatment should continue to be provided as long as it is reducing impairment and restoring function. Individuals with persistent impairments may require highly individualized, intensive, multi-disciplinary ongoing care.

OPA Recommendation

- **Do not include persistent symptoms of mTBI/Concussion as CTI impairments.**
- **Do not include a Mental Impairment or mTBI/Concussion Care Pathway within the CTI Guideline framework.**
- **Build screening into the Physical Impairment CTI Guideline Care Pathways to identify symptoms of MTBI/concussion that persist and/or interfere with function for referral for specialized evaluation and treatment.**
- **Facilitate timely referral for individualized symptom based treatment outside of the CTI when required due to concussion/mTBI.**

Gate-Keeper

We have consulted with the Ontario Medical Association (OMA) and other healthcare professional associations and the consensus is that returning to the physician gate-keeper role is not consistent with current practice. It is our understanding that there is also consensus that a gate keeper model would cause delays in care for patients, increased costs to the system, confusion amongst caregivers and would not be in keeping with the collaborative inter-professional approaches that the government and its Ministry of Health and Longterm Care is working hard to promote.

We understand from the presentation during the August 17, 2015 consultation that there is an intention to have "an increased physician role" in the CTI Guideline. This increased role is intended to provide "clear coordination of care". It is believed that "physician or NP determination of impairments not covered if received Guideline treatment" will provide better health outcomes. However we have concerns that while intended to improve the quality of patient care, the requirement of a physician/Nurse Practitioner (NP) will create delays in accessing necessary services for accident victims with psychological and mental disorders.

In the case of patients with mental and psychological disorders, we are aware that some may believe that only physicians/NPs are able to respond to referrals for further evaluation and management of these patients. This belief reflects an outdated notion of the role of psychologists in modern health care systems. We will address several common beliefs (some of which were expressed in the August 17, 2015 consultation session) that seem to reflect an incomplete understanding of the scope of practice of psychologists, their training and

expertise, and their usual role in modern, evolving health care systems. Further, imposition of a gate-keeper requirement will create an additional barrier to necessary and timely services for those patients with mental and psychological disorders for a variety of reasons, which we explore below. We offer alternative recommendations.

Triage and the Role of Psychologists

We understand from the presentation by Dr. Cote and the consultations on Aug 17, 2015 that the intention of "refer to physician" was to direct the CTI treatment provider to send the patient to a health professional with a higher level of diagnostic ability who can order/perform appropriate tests, rule out serious pathology, and triage/direct for further assessment and/or treatment. We understand the need to triage patients who are not responding as expected to treatment. Although referral to the physician/NP is one option, another option is referral to a psychologist when patients are presenting with new or worsening mental or psychological symptoms. Psychologists are highly experienced in coordinating with medicine and allied health providers to triage and provide appropriate answers to diagnostic questions when mental and psychological disorders are suspected (but not yet confirmed).

Psychologists' competence to conduct patient triage and render the right diagnosis to plan the right treatment at the right time is now more recognized in all areas of health care. Direct referral to a psychologist would lead to a timely diagnosis, while requiring a physician to assess the patient first might result in delays for the patient.

It was asserted during the consultation session that prior to receiving treatment from a psychologist, the patient must be screened for medical causes by a physician/NP. However, psychologists are educated and trained to look for and have ample experience in recognizing red flags for medical disorders, and know to refer appropriately to physicians when indicated.

<u>It would be an efficient process for a psychologist to receive referrals from the treating CTI provider when psychological or mental symptoms persist or increase.</u> Psychologists' relevant expertise and legislated scope of practice to fulfill the tasks required is established in the Psychology Act, 1991, S.O. 1991. The Psychology Act states,

> *Scope of practice*
> *3. The practice of psychology is the assessment of behavioral and mental conditions, the diagnosis of neuropsychological disorders and dysfunctions and psychotic, neurotic and personality disorders and dysfunctions and the prevention and treatment of behavioral and mental disorders and dysfunctions and the maintenance and enhancement of physical, intellectual, emotional, social and interpersonal functioning.*
> *Authorized acts*
> *4. In the course of engaging in the practice of psychology, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, <u>to communicate a diagnosis identifying, as the cause of a person's symptoms, a neuropsychological disorder or a psychologically based psychotic, neurotic or personality disorder</u>.*

As indicated in the Psychology Act above, psychologists are able to provide a "diagnosis identifying, as the cause of a person's symptoms, a neuropsychological disorder or a psychologically based psychotic, neurotic or personality disorder". This includes identifying the need for further evaluation of any physical basis of the presenting symptoms. This requirement of all psychologists is also stated in the College of Psychologists of Ontario's Registration Guidelines, Appendix C – Definition of Practice Areas:

> *In the practice of psychology, in order to formulate and communicate a diagnosis, a member must have the following knowledge, skills and training directly relevant to the area(s) of practice and client groups indicated on the Declaration of Competence in order to treat the client and evaluate the effectiveness of the treatment. Therefore, the ability to communicate a differential diagnosis must apply to every psychologist or psychological associate, with the exception of those practising exclusively within the area of industrial/organizational psychology.*

When mental or psychological symptoms are persisting/worsening and more expert/specialized diagnostic evaluation and treatment is required, referral to a psychologist, whose scope of practice is appropriate, would be an efficient/effective process for timely access to necessary services.

Need for Access to Diagnostic Testing for Appropriate Triage

Psychologists utilize psychological tests as a component of diagnostic evaluations. These types of testing are understood to have strong validity and reliability with respect to aiding in the diagnostic process for mental and psychological disorders. Research has shown psychological test validity to be comparable to medical test validity.

Psychological diagnostic evaluation

Psychologists have particular expertise in diagnostic evaluation, including test administration and interpretation. Psychologists are trained in a robust assessment methodology to provide differential diagnoses. In addition to patient report of symptoms, psychologists employ a variety of data collection methods including: clinical observation; clinical interview with patient (often extensive) and relevant collateral sources of information such as family members; consultations with other health care providers; and review of the medical file and health care record. In addition, administration and interpretation of psychological tests provides a rich source of standardized, objective and reliable information that is utilized in the assessment. Many of these tests have validity measures to help to screen for any tendencies to exaggerate difficulties that would not be captured in a diagnostic interview alone. As a result of the assessment, psychologists are able to determine the need to involve other healthcare practitioners (such as physicians when potential medical disorders are flagged) and the most appropriate treatment to reduce the impairments and restore function. If after assessment psychological treatment is indicated, the psychologist is able to provide the treatment to the patient ensuring continuity of care.

Psychologists have expertise covering the full range of mental and psychological disorders
An incorrect assumption sometimes held is that psychologists do not have the expertise to address more severe disorders or subtle presentations. In fact, psychologists' education, training and experience encompass the full range of mental and psychological disorders including assessment, diagnosis and treatment of patients with the most severe disorders. Psychologists' assessment methodology also is ideally suited to diagnostic evaluation of patients with subtle or complex presentations. Psychological assessment methodology relies on multiple sources of information as described above. This multi-method approach allows an accurate assessment.

Importance of knowledge of patient history
We agree that it is essential to be aware of a patient's history. Obtaining the history always is a component of a psychological assessment. The history is obtained from a variety of sources that may include: the patient's report; collateral information; consultation with other health professionals including the family physician; and review of the health record.

Ethnic/cultural sensitivity
The issue of ethnic/cultural matching and sensitivity was raised in the consultation session. There is also the issue of providing treatment in the patient's native language when the patient is not comfortable or capable of adequately communicating personal information in English. A panel member suggested that, as there are an increasing number of family physicians from various ethnic groups, patients are likely to be more comfortable with physicians of the same ethnicity and more likely to be open to telling them about their mental and psychological symptoms.

We agree that ethnic/cultural/linguistic matching is an issue that can be very relevant to the disclosure or non-disclosure of mental or psychological problems. There are some patients for whom an ethnic/cultural/linguistic match is essential to their comfort addressing these issues. Some of these patients may not have a physician within their ethnic/cultural/linguistic group but may be able to access a psychologist available who meets these requirements. Other patients may be more comfortable with a health professional who is not part of their ethnic community.

Patient choice is critical in this area and must be respected.

Physician/NP gate-keeper model creates a barrier for patients with psychological and mental disorders

While a physician/NP gate-keeper is a reasonable approach to provide integrated care in some instances, this model creates a delay for the subgroup of patients with psychological and mental disorders. Patients with mental and psychological disorders are often very reluctant to discuss their problems with any health professionals due to a variety of factors including stigma and avoidance of traumatic memories which is often a hallmark feature of individuals with certain diagnoses such as Posttraumatic Stress Disorder. Therefore, it is important to minimize the number of health professionals the patient must disclose their story to in order to gain access to treatment as this is potentially re-traumatizing.

For a significant proportion of patients with mental and psychological disorders, a requirement to first have a physician review and confirm their psychological condition prior to being able to be seen by a treating psychologist, who will also review/assess and confirm/diagnose their psychological condition in order to determine treatment, might create a delay. This may result in delay or avoidance in seeking treatment, resulting in increased and more entrenched impairment and disability. Direct referral to a psychologist would most often lead to an earlier correct diagnosis, while requiring a physician to assess the patient first would most often result in delays for the patient.

Integrated care

Allowing direct access to psychological assessment does not mean that care would not be integrated. Psychologists work in concert with the patient's physician, following a variety of routes that are responsive to the patient's needs and situation. Some patients are referred to psychologists by their physician for assessment and treatment. Others may self-refer, reflecting increased knowledge of the value of psychological treatment. Others are referred by other health care professionals.

Regardless of the referral direction, ongoing communication between the treating psychologist and the physician (with patient consent) is part of sound practice. Psychologists also frequently refer their patients to the patient's physician or medical specialist for follow up and investigation of medical conditions when indicated.

Additional administrative responsibility and paperwork expectations placed on physicians

While integrated care is in the patient's interest, the additional administrative requirement of the physician to provide "confirmation and compelling evidence…" on an OCF 24 does not address a clinical care need. This requirement appears more like a medical-legal requirement addressing insurer adjudication issues for the insured person's ability to access funding for services.

The requirement to provide "compelling evidence" is inconsistent with the way in which treating health professionals communicate about patients. Often the referral by the family physician to a specialist, including to a psychologist, is because they have a question regarding diagnosis or treatment. Referrals are often made when the patient has complaints or the physician notes symptoms and determines that it is in the patient's interest to have a further diagnostic evaluation conducted. Therefore, there may be no compelling evidence at that point, only diagnostic questions to address. In general clinical practice, referral for diagnostic evaluation and treatment does not require the physician to complete a separate report or form.

Psychological assessment may be required prior to completion of the OCF 24

The diagnostic expertise of psychologists is evident in the bi-directional nature of referrals between physicians and psychologists. Physicians often refer to psychologists to provide an assessment and diagnosis of their patients. The physician may have identified that there were signs and symptoms that warranted further investigation.

Psychological assessment methodology is designed to provide a context to support disclosure regarding mental and psychological disorders using several methods of data collection including interview, observation and psychological tests. To address issues of engagement in the diagnostic process and accurate appraisal of symptoms, psychological assessment protocols provide extensive time for clinical interviews. Psychological assessment results in a differential diagnosis of psychological disorders, including neuropsychological consequences of brain injuries. In many instances, a psychological assessment provides the information required for the "confirmation and compelling evidence" of the psychological condition for OCF 24.

It is our understanding from a review of PART I b of the Draft Guideline that even if the model of physician gate-keeper is adopted and the physician is required to certify the OCF 24 prior to application for treatment, it is possible to apply for assessment on an OCF 18 prior to completion of the OCF 24. It states,

> Part I - Delivery of OCF-18 Permitted in Certain Circumstances
> *Despite subsection 38 (5) of the SABS, an OCF-18 must be accepted and considered on its merits by an insurer if delivered:*
> (a) *for the purpose described in Part D above in respect of an insured person who*
> *has not received any treatment under this Guideline*
> OR
> (b) *for the purpose of proposing an assessment or examination to determine whether an insured person who has already received any treatment under this Guideline has an impairment that comes within this Guideline.*

It is essential to confirm the insurer's obligation to consider an application for approval of an assessment on behalf of the patient without the requirement of the OCF 24. The assessment may be required to determine if there is "compelling evidence" for the certification on the OCF 24. We note that although the insurer is obligated to consider the application for approval of assessment, they are not obligated to approve it. If they do not agree that the assessment is reasonable and necessary, they may obtain an Insurer Examination if they wish another opinion on the proposed services.

Conclusion and recommendations regarding the "gate-keeper" model

As described above, the CTI introduces a new requirement of a "gate-keeper" model into access to health professional diagnostic assessment and treatment under the SABS. It requires patients to be reviewed and confirmed by a physician/NP in order to access other treatment during or further treatment after the completion of the CTI. There is direction to the CTI treatment provider to refer to the physician/NP if there are "new or worsening physical, mental or psychological symptoms" or if there is "incomplete recovery" at the end of the Care Pathway. The role of the physician/NP is further confirmed by the requirements in PART D, Impairments That Do Not Come Within this Guideline, "confirmation and compelling evidence…must be provided only by a physician or nurse practitioner in a completed and signed OCF-24". As discussed above, this model may create delays for patients with mental and psychological disorders. These patients would benefit from the option of direct referral to psychologists to provide timely access to necessary diagnostic evaluation and specific treatment.

We have provided information above that substantiates the competence, legal authority and responsibility of psychologists to function as autonomous health professionals to conduct diagnostic evaluations, make and communicate a diagnosis, and prescribe and provide treatment for patients with mental and psychological disorders. We also have discussed a number of reasons why the requirement of a physician/NP review and confirmation prior to being seen by a psychologist can create delays in timely access to needed psychological services. We propose the following recommendations to address these concerns:

OPA Recommendation

- **Do not require a physician gate-keeper for access to a psychologist; allow direct access to self-refer as well as referral by other health professionals.**
- **Include psychologists, with physicians and nurse practitioners, as listed health professions who are able to provide the confirmation and compelling evidence and allowed to sign the OCF 24 when there is a psychological disorder.**
- **Modify the language proposed for the OCF 24 to require "clinically relevant information" rather than "compelling evidence."**
- **If the government incorporates a physician gate-keeper model requiring a physician's signature on an OCF 24 prior to treatment, confirm that the insurer must consider on its merits an OCF 18 for assessment to determine if there is an impairment that is not a CTI, without requirement of the OCF 24.**

Improved Process for Approval of Psychological Assessments

We are aware of the need for a clear process to support adjusters in providing sound adjudication of applications from psychologists for diagnostic evaluation of patients regarding psychological and mental conditions. We propose a new model to assist in the process for approval of appropriate applications without routine insurer denial and requirement of Insurer Examinations. While we are concerned about inappropriate barriers to services for patients

with legitimate needs; we also are aware of the need to eliminate frivolous applications for psychological services. Therefore it is incumbent on the proposing psychologist to ensure that their practice procedures are in accordance with The Guidelines for Assessment and Treatment in Auto Insurance Claims published by the Ontario Psychological Association, 2010 (OPA Guidelines), relevant requirements from the College of Psychologists, and the FSCO licensing process. Psychologists should understand that failure to comply with these requirements could result in complaints to and censure by the College of Psychologists, as well as loss of license and penalties through the FSCO process. The model we are proposing would curtail inappropriate applications and at the same time remove barriers to reasonable and necessary psychological services.

We support the recommendation in the Report to use appropriate screening instruments with norms/threshold scores for identification of patients who require referral for psychological diagnostic evaluation and treatment (we note that screening instruments may not be appropriate/available for some patients due to language or other concerns. Exceptions will need to be made in these situations.). These screening instruments should be completed either by the health professional providing the physical treatment or by the psychologist proposing the diagnostic evaluation if the patient self-refers or, it has not been completed by the physical treatment provider. Following the referral from the treating health professional or the patient's self referral, the psychologist will review the information provided by the screening instrument. The psychologist should also complete an appropriate intake screening interview to confirm the indications of a mental or psychological condition resulting from the accident requiring diagnostic evaluation and treatment and obtain informed consent for the application. Insurers should be able to routinely approve applications for psychological services when these processes are followed.

OPA Recommendation

Applications for psychological services (diagnostic evaluation and treatment) should be routinely approved if:

- **An appropriate screening instrument has been completed and scores provided that indicate a need for referral for psychological diagnostic evaluation and treatment.**
- **Administration of appropriate screening instrument and referral by the health professional providing the physical treatment has been completed; *OR***
- **For patients who self refer, (or when it has not been completed by the physical treatment provider) the psychologist or psychiatrist or physician completes an appropriate screening instrument;**

AND

- **An appropriate intake screening interview is completed:**
- **the psychologist, psychiatrist, or physician with appropriate expertise diagnosing and treating mental/psychological disorders has completed an intake screening interview to confirm indications of psychological and mental disorder and obtained informed consent for the application and communication;**

AND

- **An appropriate application is submitted by the psychologist certifying that the proposed services are reasonable and necessary.**
- **This certification requires that the psychologist has spoken directly with the patient and determined the patient is reporting symptoms that are likely accident related and that are likely to be interfering with the patient's functioning and for which treatment is likely required.**

Guideline Development and Dissemination of the Research

We are aware that the Cote group conducted an extensive review of the available research on treatment for a number of injuries resulting from automobile accidents. In our previous submission regarding the research report we raised some of our concerns regarding the assumptions that guided the determination of which interventions were supported by the "evidence" and included in the Care Pathways. We anticipate that the treatment professionals who are directly involved in the provision of treatment for individuals with the injuries included in the CTI will have more specific comments.

We believe that there are additional issues to be addressed in the translation of the research findings into practical treatment Guidelines. Creation of treatment Guidelines requires incorporating professional consensus on recommended treatment. This is especially true where there is a paucity of high quality research evidence, as stated by Cote. For many conditions there is not sufficient research to support highly directive, prescriptive and restrictive treatment protocols such as the ones in the Care Pathways. In addition, the responsibility and authority of the treating health professional to rely on their own expertise to determine the most appropriate treatment for the individual patient must be incorporated into the CTI Guideline. This is a requirement of all health professionals. Patient choice and preferences need to be acknowledged and need to be given greater weight in determination of treatments to be provided. This consideration has been shown to be an important determiner of health outcomes.

Creation of Guidelines that will meet policy objectives to provide timely and cost effective care will also require a number of further considerations. There is a need to determine: likely number of treatments; time per treatment; and professional personnel required to deliver the treatment. This information is necessary to determine likely typical costs and range of costs to treat each of the impairments and provide the services according to the applicable Care Pathway. The model of how the treatment will be provided and the funding model for patients with multiple impairments with multiple applicable Care Pathways also need to be addressed.

We suggest that it would be very useful to provide the extensive Cote Research Report on the evidence of effectiveness of various treatments to the health professional treatment community. We are aware that many of the components are being published as articles in various journals. However, it would be more helpful if it were accessible to the health professional community as a single integrated document.

Conclusion

Thank you again for meeting with us in the consultation session on August 17, 2015. Based on our understanding of our discussion, we have addressed the following and provided our recommendations:

- clarification of language in the draft guideline
- potential confusion regarding appropriate classification of accident victims with mental and psychological disorders; and
- barriers created by the physician/NP gate-keeper referral processes for psychological diagnostic evaluation and treatment services.
- improved process for approval of psychological assessments

We would welcome an opportunity to meet to discuss our recommendations and assist with any questions you might have. We look forward to participate in the further development process.