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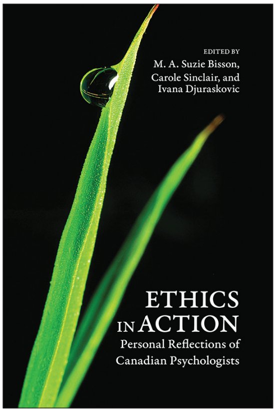

ETHICS IN ACTION: PERSONAL REFLECTIONS OF CANADIAN PSYCHOLOGISTS

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ISBN 978-1-77385-570-7

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Intrusions: Third-Party Requests for Psychotherapy Information

Brian Chartier, Linda M. McMullen, Annik Mossière

Locating Ourselves

Each of us has come to be interested in the topic of ethical issues in working with third parties in our own ways.

Brian: My interest in this area arose over a decade ago when I was seeing a client in my private practice for a company that carried the disability insurance for the client. The client was off work due to severe depression. After a period of time, the insurance company requested a progress report, which I supplied noting that the client remained depressed and listing a series of cognitive and behavioural symptoms. I also noted that the client had "improved" and was displaying only a moderate level of depression. About a month later, the client came in and reported that his benefits were being terminated because I had reported that he was "improved." I had felt quite proud that the client had shown progress and was stunned by the consequences of mentioning this improvement in the progress report. Such an experience might be exceptional, but it raised questions for me about my contribution to the problem that arose, and about what should be done to address such experiences with third-party payers.

Linda: Unlike Brian, my interest in the topic of ethical decision making arose from my qualitative research work examining how healthcare professionals (mainly family physicians and pharmacists) construct their decision-making processes with regard to prescribing and dispensing antidepressants; and how service users/clients construct their decision-making processes regarding taking or rejecting antidepressants. Having been trained as a clinical psychologist and having developed expertise in qualitative inquiry, I have had a particular interest in the ways people talk about depression and antidepressants when asked about their decision-making processes. In my conversations with healthcare professionals and service users, I have been struck by the ethical dilemmas that are explicitly raised or implicitly alluded to. Examples include instances in which a client presents to a family physician with a request for an antidepressant and the family physician understands the patient's experience of depression as situationally-based and unlikely to be alleviated with an antidepressant, or whether (and how) prescribers raise the question of the significant placebo response to antidepressants with their clients.

Annik: I have long been interested in ethical decision making. As a clinical graduate student in clinical psychology, this interest was amplified by my first practicum working with clients who had been in a motor vehicle accident (MVA). I found myself questioning some of the insurer's policies, particularly with respect to what personal issues could be treated. For example, a young woman reported symptoms of trauma after an MVA. The symptoms were related to the accident but also embedded in, and exacerbated by, a past sexual assault. I had asked about the possibility of the insurer covering the treatment of this complex trauma; however, it was denied since aspects of the person's reaction were not a direct result of the accident (i.e., more historical). Since then, my work in forensic psychology allowed me to further develop awareness about other types of ethical challenges in third-party situations such as the ethical intricacies of power imbalances, issues of confidentiality, and the impact of diagnoses.

Overview

The primary focus of this chapter is on how Principle III of the *Canadian Code of Ethics for Psychologists* (Integrity in Relationships) applies to dealing with third parties. Although psychologists are expected to demonstrate the highest integrity in all their relationships (e.g., Canadian Psychological Association [CPA], 2017, Principle III, Values Statement), the principle of Integrity in Relationships generally should be given the third highest weight (CPA, 2017, Preamble) among the *Code's* four principles. That is, some aspects of Principle III might need to be subordinated to the values contained in principles related to respecting the dignity of persons and peoples (e.g., respecting their moral rights), and responsible caring (e.g., protection from harm). From our perspective, a psychologist's responsibility to the person being assessed or receiving a service is greater than the responsibility to those indirectly involved (e.g., third-party payer). The goal of this chapter is to consider when, and under what conditions, a psychologist should or should not release psychotherapy information to a third-party insurer and the role of Principle III in making such decisions.

Concerns in Working with Third Parties

Although there are ethical codes and practice standards that guide our work as psychologists, the application of these codes and standards can be complicated when third parties are involved. For this chapter, the term *third party* includes such entities as insurance companies, employee assistance programs, workers' compensation boards (WCB), and government agencies (auto insurance in some provinces). Barnett and Johnson (2008) highlighted the fact that the best interests of a client can sometimes be in conflict with the interests of third-party organizations. The "best interests" of a client, by definition in the *Code*, are those interests that support the dignity and well-being of individuals and groups and are morally justifiable. When third parties are involved, we have a responsibility as psychologists to balance the requirement for truthful and accurate reporting to the third parties with maintaining the moral rights of our clients to privacy and informed consent. Moral rights are defined in the *Code* as "the fundamental and inalienable rights of persons and peoples," are "grounded in moral reasoning," and may be "protected by international, regional, and national declarations, constitutions, laws, and statutes." As such, several ethical considerations arise when dealing with third parties. These considerations include the psychologists' specific roles and responsibilities to the parties involved, the psychotherapy client's moral rights and best interests, the legitimate interests and "need-to-know" of the third party, and how best to balance what is owed by the psychologist to each of the parties involved (e.g., the injured worker and the insurance company).

In looking at third-party payers, the *Canadian Code of Ethics for Psychologists* (CPA, 2017) makes distinctions among a "primary client," a "contract examinee," and a "retaining party,"[1] as well as distinguishing whether individuals or groups are "independent, partially dependent, or fully dependent" in their decision making. Individuals receiving psychotherapy are deemed to be "primary clients" (i.e., "receiving services that are intended to help with the individual's . . . own issues, responsibilities, questions, or problems" [CPA, 2017, Definition of Terms]). In situations in which third parties are involved, a primary client may be independent, partially dependent, or fully dependent, depending on the level of choice they have about whether to receive psychotherapy, and under what conditions or limitations. We have found that, in the third-party context, most psychotherapy clients are either partially or fully dependent on the third party, particularly with regard to the funding of treatment. We also have found that the distinctions between types of clients and the level of dependence/independence are helpful in defining roles for all parties involved in a psychological service to a primary client, as well as in demarcating the parameters of informed consent. In our (Annik and Brian) experience, most clients are not aware of these distinctions. It is, however, our role, as treating psychologists, to be aware of these distinctions in the context of consent and integrity in relationships. For example, consent must be handled differently for an independent, partially dependent, or fully dependent client in terms of such matters as information sharing, treatment planning, and payment of services.

A second important related issue noted in the *Code* is vulnerability. Vulnerability arises whenever the dignity, well-being, and best interests of any individuals or groups are more easily violated. The *Code* notes four circumstances in which there is such heightened vulnerability: (a) when particular characteristics such as a low level of cognitive and emotional functioning or a history of oppression are present; (b) when there is a reduced capacity to consent voluntarily; (c) when an individual such as a claimant has to contend with a more powerful individual or group such as an insurance company; and (d) when there is a high risk of harm (CPA, 2017, p. 9). These instances of heightened vulnerability readily apply in the context of third-party involvement in psychotherapy.

In sum, the *Canadian Code of Ethics for Psychologists* (CPA, 2017) addresses some important aspects of the ethical issues and processes in working with third parties. However, we have found that balancing the legitimate interests and requests of third parties with the moral rights and best interests of clients is not easy. Thus, in the following three scenarios, we show how such ethical balancing might proceed. Although this analysis is primarily done through the lens of Principle III (Integrity in Relationships), the other principles in the *Code* also are considered.

Scenario #1

> **Client A:** You receive a request from an insurance company for psychotherapy information about a client whose psychotherapy is being paid for by the company. The client was physically injured in a serious fall at work and remains off work due to the physical injury. The insurer includes a generic release of information that is dated over 12 months ago. The client conveys to you that, at the time he signed the release, he was told that he either signed it or his benefits would be terminated. Some of the current issues being addressed in psychotherapy revolve around his experiences of having been abused as a child.

The following discussion of this case will explain the problems and issues related to (a) signing a generic or omnibus release of information, (b) signing an enduring release of information, when changing conditions may require revision to the form and the extent of consent, and (c) when a client referred for one condition may reasonably result in treatment of other conditions.

The Moral Right to Confidentiality and its Relationship to Integrity in Relationships

This scenario highlights the conflicts that can arise among the ethical principles in the *Code*. The psychological services are being provided to a primary client who at best is partially dependent upon the insurance company that is paying for the psychological services. In addition, the therapy client is vulnerable. And further, when seeking help from a mental health professional, individuals are often, and rightly so, concerned about confidentiality. The expectation of confidentiality has long been an important component in maintaining a positive therapeutic relationship between client and psychologist (Jagim et al., 1978). As such, protecting confidentiality has always been an important obligation of psychologists (e.g., American Psychological Association, 2017; CPA, 2017). Typically, ethical standards require information disclosed to a psychologist to be held in confidence and not released without the client's consent except under certain specific conditions (e.g., when there is the potential for harm to the client or someone else, or when a child or other vulnerable person is being abused or neglected). Although these limits are standard in the discipline, additional limits concerning confidentiality become imposed on the client-psychologist relationship when a third party is involved.

A key position of the *Code* is that a psychologist's greatest responsibility for protection of moral rights, well-being and best interests is to those clients who are most vulnerable in a situation (typically the psychologist's primary client or contract examinee). Although the responsibilities of psychologists to third parties need to be honoured, our responsibility as a psychologist to third-party payers is normally secondary to the responsibilities regarding the moral rights (e.g., privacy and confidentiality) of vulnerable clients. While this ordering seems straightforward, some legal statutes and organizational policies involving third parties may require the release of information with or without the clients' fully informed or fully voluntary consent (Truscott et al., 2013). For example, we have found that if a client initially seeks services from a psychologist and then submits a claim for benefits/coverage to an insurance company, the client may have to agree to the insurance company having access to information from the psychologist[2] (e.g., access to diagnosis and services/treatments provided). Hence, in spite of the existence of a previously signed consent form, and even a client's subsequent statement that they would like the information disclosed to the insurance company, it is a matter of integrity for the psychologist to inform a client, whose psychotherapy information is being requested, of the possible consequences of the disclosure and of any reservations the psychologist may have. (cf. Ethical Standard III.13 which instructs psychologists to inform clients of any limitations "imposed by third-party payers"). Moreover, Ethical Standard I.26, under Principle I (Respect for the Dignity of Persons and Peoples), of the *Code* indicates that psychologists should clarify the nature of multiple relationships to all concerned parties when obtaining consent. In addition, Ethical Standard III.13 also reminds psychologists that they need to be "clear and straightforward" about their explanations, especially those related to consent. (For example, Brian found it quite helpful to explain to clients what information a third party may and can request and to note the precautions that should be considered such as when a retaining party requests a copy of all the therapy notes.) This kind of explanation is consistent with Ethical Standard III.14. Even after such explanations, dependent or partially dependent primary clients might not understand the comprehensive implications of consenting to disclose particular information and might not fully realize that they could be permitting third parties to use and share their information in any way that the third party sees fit (Koocher et al., 2008, p. 212). This issue is further exacerbated when consent forms are signed far before treatment issues arise. As such, we find that a significant responsibility falls on the psychologist (Ethical Standard III.14) to ensure all reasonable steps are taken to communicate as clearly as possible in protecting clients' moral rights to privacy, confidentiality, and informed consent.

We have found it helpful to follow several steps of action recommended in the literature (e.g., Fisher, 2008; Smith, 2003; Vanderpool, 2013) that are consistent with Principle III. These include preparation, transparency, open and straightforward discussion with the client, adequate documentation, and discretion. First, we need to be prepared as psychologists. Clients need to understand their moral rights and psychologists need to own their ethical responsibilities and be familiar with relevant local and federal laws, ethical obligations, clinical guidelines related to third-party treatment, and the legitimate interests and need-to-know of the third party. Second, we have a duty to be transparent and tell clients the truth about the limits to confidentiality up front and at the outset. Doing so requires time, honesty, clarity, and repetition on the part of the psychologist. We need to inform clients of any roles or potential conflicts of interest that might affect confidentiality. Psychologists need to discuss with clients the rights they might forgo when receiving services paid by a third party (e.g., discuss that WCBs legislatively have the right to access personal and health information regarding a client, and that the client needs to decide about the acceptability of these limits). As informed consent is an ongoing process, we also need to reopen the conversation if/when the client's circumstances (or the psychologist's intentions) change. Third, although not strictly required under Principle I, a practice that can enhance the openness and transparency expected under Principle III is having the client sign, prior to beginning services and when circumstances change, a written consent form that outlines many of the points presented above. Ongoing documentation (e.g., dates of service and fees; diagnostic impressions, treatment plans, client contact) also helps to ensure transparency and openness. Finally, we should exercise discretion in responding ethically to requests for personal health information. With respect to Scenario #1, for example, when being seen by a psychologist for pain related to an insurance-covered injury, a client might disclose a history of sexual abuse that is affecting her/his current well-being. Although this disclosure is relevant to treatment, it is unrelated to the insurance injury. Should the client choose to retain confidentiality regarding such history, this decision needs to be respected. Specifically, psychologists have a responsibility to release only the minimum amount of information necessary. They should disclose information only agreed upon in the written authorization signed by the client, and release only the information that is relevant to the purpose of the service and to the purpose of the request for information (Fisher, 2008; Smith, 2003; Vanderpool, 2013).

The practice of releasing only the relevant information needed for a specific purpose is reinforced by various practice guidelines and jurisdictional advisories. For example, the Saskatchewan College of Psychologists' *Practice advisory on release of psychology records* (2013) states that psychologists dealing with third parties "must limit access to client records to preserve confidentiality" (p. 3). Further their *Practice advisory on final checklist for consent* (2013) states, "When a request for release of information is received . . . [t]hat request is for specific information for a specific purpose. . . . [a] letter from an insurance company with an omnibus general release for all information does not meet practice expectations or legislative requirements for protecting private information" (p. 4).

Overall, then, the issues we have discussed above highlight the importance of the moral right to be *informed* about confidentiality and its limits, and the risk to this moral right not being respected when third parties are involved. Further, it also falls to the psychologist to inform third parties or "retaining parties" of restrictions on disclosure due to the right to confidentiality, even in a third-party scenario.

The Moral Right of Informed Consent to Services, and its Relationship to Integrity in Relationships

Another highly relevant issue with respect to this first scenario is the issue of informed consent to services. If communication with third parties is involved, the primary client has the right to be informed in the consent process about the purpose(s) of the service and the involvement of third parties, as well as a right to be given the opportunity to ask questions (Barnett et al., 2008). It also involves the right and ability of the informed client to then decide to *provide or refuse consent* to the services offered within these limits.

The potential for refusal highlights that the process of informed consent is viewed as voluntary. Truscott and Crook (2021) stated that "The ethical foundation for consent is derived from the principle of autonomy whereby each person's right to be free from controlling influence by others is respected" (p. 84). It could be argued, however, that clients who participate in treatment through third parties cannot provide fully informed consent because such services inherently lack the element of full voluntariness and remove some of the clients' autonomy and freedom (Bemister et al., 2011; Melton et al., 2007; Vanderpool, 2013). In terms of the *Code*, such individuals are considered partially dependent. Specifically, if treatment is mandated by employers in order to get compensation, the client is not able to refuse without serious consequence. Even if clients are fully involved in the informed consent procedure, and it is done with full disclosure, the client is constrained by needing to abide by the terms and conditions of the services if s/he wants to receive treatment. In this type of scenario, we have found that clients often perceive that they are required to undergo an examination or treatment to access monetary benefits or as a condition of their employment, and if they do not abide by the terms of the service providers, they will not receive the services (Vanderpool, 2013). For example, in a WCB insurance setting, the client who does not agree to the terms of mandated treatment might not get the rehabilitation needed or obtain salary compensation. In addition, psychologists need to recognize that clients often trust and depend on them to guide client decisions. These features of the client-psychologist relationship can lead unaware therapists to influence decision making in ways that violate Ethical Standard III.28, which encourages therapists to not take advantage of the trust and dependency of clients. Thus, in the context of obtaining informed consent, we have found that possible decisions regarding the acceptance of terms of service need to be discussed with the client to determine what consequences are and are not acceptable to the client.

In addition, clients often blindly sign consent forms and related documents because they view their signature more as a requirement to obtain the desired coverage or required services than a personal choice (Bemister et al., 2011). However, while clients can experience the pressure to sign as involuntary, they do in fact have a choice as to whether to undergo a treatment plan. It is up to the psychologist to explore clients' expectations about what signing a consent form means. Specifically, psychologists need to be certain that clients understand that they do indeed have a choice, albeit between less-than-ideal options, such as forgoing a disability claim or voluntarily relinquishing employment (Vanderpool, 2013).

Because of the serious consequences described above, we believe it is the psychologist's responsibility to explore what is in the best interests of the client, while managing the multiple relationships inherent to third-party work. In particular, the psychologist might want to consider involving the retaining party in a consent process at the time of agreeing to a contract (See Ethical Standard III.31).

This involvement might lead to a better understanding by a third-party payer of the importance of privacy to the treatment process, as well as an understanding of the problem of "blank-check" consent forms. It also might lead to agreement from the third-party payer that they will accept limits on the type of confidential information they seek (cf. Ethical Standard IV.14).

Summary

In Scenario #1, the client is informed that he must sign or face serious consequences. The client might feel coerced into treatment and coerced into agreeing that unlimited confidential information will be disclosed. The issues being addressed at the time of the request of the third party for psychotherapy information include significant past traumatic experiences, which, from clinical experience, are known to affect a client's capacity to deal with pain and develop greater resilience (Mancini et al., 2006). Protecting the client's privacy about such matters while assisting the third party to make its own legitimate decisions is complicated by problems in the consent process, particularly given that the consent was obtained over 12 months ago and was not framed as a request for specific information for a specific purpose.[3] In Brian's experience, many of the clients who are seen in a rehabilitation setting are dealing with residual effects of previous trauma, which complicates and may prolong the treatment process. The dilemma is his desire to communicate to the insurer the severity of the issues the client is dealing with, but without disclosing the details that are protected via confidentiality. In cases of this nature, Brian often spoke directly with the insurer to indicate that the client had disclosed other psychosocial issues that are affecting the treatment plan. When pressed by the insurer to disclose the details, he indicated that he had not been given permission to do so. He found this approach to be generally effective.

In conclusion, we believe that such a dilemma requires effective and detailed communication between the psychologist and the third party about limits to disclosure. Such an approach, while requiring more time and effort, is consistent with Ethical Standard III.32, which requires the psychologist to inform all parties "of the need to resolve the situation in a manner that is consistent with Respect for the Dignity of Persons and Peoples (Principle I) and Responsible Caring (Principle II), and take all reasonable steps to resolve the issue" consistent with the best interests of the partially dependent and vulnerable client.

Scenario #2

> **Client B:** You receive a request from a third-party insurer asking you to provide your therapy notes and a DSM-5 diagnosis regarding

an individual involved in an MVA. You have provided a report, but not your notes or a diagnosis. Shortly thereafter, you receive a phone call from an employee of the insurer questioning your report. In the discussion, you become suspicious that the third-party insurer is using unqualified personnel to review psychological reports and provide disposition recommendations. When you contact a manager at the insurance company, the manager refuses to disclose how or by whom files are reviewed.

Privacy Protections

When providing therapy for individuals who have been in a work accident (WCB) or a motor vehicle collision (MVC), information is shared with insurance companies, who use this information to assess the amount of money they are willing to put toward the rehabilitation needed for the individual involved. This practice can impact psychologists' work and clients' healing process, possibly undermining the therapeutic work and the therapeutic relationship, among other consequences (Borkosky & Smith, 2015, Cohen et al., 2006). There can be two types of problems that arise when sharing information: selective editing by third parties and over-disclosure by the psychologist.

The Problem of Selective Editing

Schatman and Thoman (2014) highlight that third-party involvement can become problematic when claims managers engage in "cherry picking" (p. 191) or "selective editing" of records and reports. They provide the example of an individual who was physically injured on the job, resulting in psychological sequelae (specifically, he experienced neck pain and headache as well as problems with concentration, memory, and anxiety), and who had participated in an assessment about this by a psychiatrist. When this individual was sent for an independent medical exam (IME) to assess the claimant's physical and psychological status, the psychiatric assessment from the individual's psychiatrist was not forwarded to the psychiatrist doing the IME, consequently not informing the IME psychiatrist about the connection between the physical injury and the psychological sequelae. Although Schatman and Thoman discuss this issue in the context of what records insurance claims managers selectively provide to psychologists who perform independent examinations of psychological status, the practice also applies to psychotherapists whose records are the ones being selectively held back. When such cherry picking or selective editing occurs, only some of the information is known or focused on. Consequently, third-party decisions are based on incomplete information and can result in unwarranted and harmful termination of appropriate treatment (Schatman et al., 2014).

Adversarial perspectives suggest that third parties cherry pick facts that support the interests of the insurance company (i.e., saving them money by rejecting a claim), and fail to include other notes/facts that would refute their decision (Gholizadeh et al., 2016; Schatman et al., 2014). This type of selective editing reflects a misinterpretation, and importantly a misrepresentation, of what the psychologist reported. In addition, this practice puts a client at risk for harmful psychological and physical repercussions. Given the occurrence of the practice, Schatman and Thoman advocated that psychologists be aware of the potential for selective editing of their reports (e.g., by claims managers). To offset this, Schatman and Thoman advise psychologists to ensure to the best of their ability the reporting of concise and accurate information that is unlikely to be misunderstood or misused. In other words, consistent with Ethical Standard III.1, we need to be prepared to confront any "dishonesty, fraud, misappropriation, or misrepresentation" of client information by a third party.

Based on interviews with psychologists, Cohen and colleagues (2006) found that psychologists find themselves in a position whereby they try to describe a client's condition with sufficient urgency and severity that coverage for treatment will be approved; all the while, being concerned about privacy and being reluctant to put damaging information into a record for fear of misuse. The question is whether this kind of presentation is itself intentionally misleading (e.g., selective editing, as discussed above). On the other hand, this kind of presentation could be viewed as necessary because many third-party assessors/adjudicators who review the client's claims do not have a background in psychology and might therefore be unfamiliar with the context/topics discussed in such reports. Indeed, Ethical Standard II.32 of the *Code* states that psychologists should "be acutely aware of the need for discretion in the recording and communication of information, in order that the information not be misinterpreted or misused to the detriment of others." Whatever the case, report writing and sharing of information is something that needs to be handled with care by psychologists working with third parties (Cohen et al., 2006).

Psychologists can struggle to find ways to protect clients' privacy while meeting the third-party demands for detailed information in progress notes (Cohen et al., 2006). Examination of this issue includes consideration of the *Code,* but Brian and Annik have found that it also can be helped by a review of Canada's federal law (the *Personal Information Protection and Electronic Documents Act*—PIPEDA), the *Health Information Portability and Accountability Act* (HIPAA—see examples in the following section) in the United States, as well as professional practice guidelines and local jurisdiction advisories.

The Problem of Requests for Session Notes

The sharing of unedited notes can be fraught with problems. PIPEDA is the Canadian law relating to privacy, which governs how organizations collect, use, and disclose personal information. The Act requires organizations to obtain consent when they collect, use, or disclose their personal information and to have personal information policies that are clear, understandable, and readily available. It appears that "Quebec, British Columbia and Alberta have adopted private sector legislation deemed substantially similar to the federal law. As well, Ontario, New Brunswick, Nova Scotia, and Newfoundland and Labrador have adopted substantially similar legislation with respect to personal health information" (Office of the Privacy Commissioner of Canada, 2018).

PIPEDA is comparable in many ways to the HIPAA in the United States, except that PIPEDA does not address the specific issue of session notes. However, the Ontario *Personal Health Information Protection Act*, 2004, Section 37 (1) states, "A health information custodian may use personal health information about an individual, . . . (i) for the purpose of obtaining payment or processing, monitoring, verifying or reimbursing claims for payment for the provision of health care or related goods and service." However, as noted previously, many national and local psychology bodies have issued guidelines and advisories that recommend caution in releasing entire records, indicating that any release of information should be limited to *specific content* that meets *specific purposes*.

In US jurisdictions where progress notes are accessible by third parties with appropriate consent forms, the privacy rule compliance specified under HIPAA allows for some flexibility when needing to challenge or comply with third-party requests for this information (Holloway, 2003). Under HIPAA, disclosure of psychotherapy notes requires more than just general consent; it requires specific permission by the client to release this sensitive information (cf. example below regarding guidelines in Saskatchewan). It is worth highlighting that HIPAA's definition of psychotherapy notes explicitly states that these notes are kept separate from the rest of a client's file. Although this practice might differ from the way some psychologists are instructed by their employing organizations to store client information, it does offer greater protections for client notes. For instance, the US Department of Health and Human Services suggests that these notes be kept separate from clients' official records, in order to prevent this information being available to third parties (Holloway, 2003).

In Canada, the release of therapy notes is often guided by provincial professional practice guidelines. For example, the College of Alberta Psychologists states in its practice guidelines *Disclosure of Personal or Confidential Information*, "To the best of their ability, in any circumstance where disclosure is contemplated, psychologists should endeavour to clarify to all stakeholders (i.e., clients, funding agencies, third-party participants, third-party collaterals, etc.) the risks and benefits associated with disclosure." The Saskatchewan *Professional Practice Guidelines (3rd Version)* goes further and states, "Members will inform all clients of the standard limits to confidentiality at the outset of their professional contact as part of an informed consent for treatment process. This will include informing clients that information about them will not be released to any outside source without their permission, except in situations in which there is: (a) potential, imminent harm to the client or others; or (b) suspected neglect or harm to a child, including the witnessing of violence; or (c) a court order to release client information; or (d) where required by legislation." Thus, psychologists are being guided to limit access to client records to preserve confidentiality. These guidelines, as well as many other provincial guidelines, imply that when a request for release of information is received, such requests should be for specific information for a specific purpose. Thus, a letter from an insurance company with an omnibus general release for all information likely does not meet practice expectations or legislative requirements for protecting private information. However, it is important to review local guidelines on an ongoing basis, as such advisories are updated rather regularly in most jurisdictions. Similarly, each province has Acts regarding the protection of health information, as well as professional practice guidelines and advisories/policies. Each provincial legislation/Act specifies the responsibilities of health information custodians. These provincial Acts, guidelines, and policies generally specify that explicit consent must be obtained to release any information, but also may specify when implied consent is present and when information could possibly be shared without explicit consent (See, for example, Steinecke, 2020).[4] It is our belief that being ethical regarding third-party requests for psychotherapy information includes psychologists being familiar with their jurisdiction's relevant Acts, professional guidelines, and policies regarding release of private information.

In Brian's practice, he on occasion sent a letter to the insurer explicitly stating that he would not share his therapy notes, citing the relevant legislation and practice guidelines. If an insurer pressed him further on this disclosure, he followed up with a telephone call to seek their understanding. He usually found this strategy to result in collaborative and co-operative communication. In his experience, third-party assessors/adjudicators with more knowledge about mental health allowed more collaborative interaction regarding the information needed to make their decisions regarding a claim.

However, if an assessor/adjudicator's approach or decision seems to clash with that of the psychologist, the psychologist can consider going above that assessor, and discussing the matter of coverage flexibility with a supervisor or manager. If a third-party assessor/adjudicator misused information obtained from a psychologist, Brian sometimes decided to no longer share information, or to encourage the client to go through the insurers' appeal process to challenge the request for information and its possible (mis)use. While he has found this strategy to be effective in about half of the cases, it is a great deal of work (e.g., assisting the client in writing documentation for the appeal). These considerations speak to the need for psychologists to take on an advocacy role, which is the focus of the next section.

Advocacy

Although the issues of consent, confidentiality, and privacy are not unique to third-party mental health care, it can be argued that disclosure of mental health information is more significant than disclosure of general health information because of the greater risk of stigmatization (Boyle et al., 1995). As a result, higher levels of care and advocacy might be required on the part of psychologists to ensure the promotion and protection of their clients' well-being. This view is consistent with the position stated in the Preamble to the *Code* that its use is intended to be both proactive and reactive. It also is consistent with the values of Principle IV (Responsibility to Society) regarding psychologists advocating for change when societal structures or social policies ignore or oppose the principles in the *Code*.

WCB and MVA insurance cases are prime examples of the types of structure and policy complexities psychologists face in collaborating with third parties. For occupational injury or MVC insurers, the primary purpose and key objective of providing coverage for intervention is based on promoting the client's return to healthy functioning and resumption of occupational or everyday lifestyle activities (Sullivan et al., 2007). Many clients of workers' compensation or motor vehicle insurers present with symptoms of pain and disability; however, sometimes there may be no objectively identifiable disorder or disease (Sullivan et al.). In these cases, the authenticity of the client's condition might be questioned, and a lack of a diagnosis might be deemed insufficient by third-party payers to provide coverage for psychotherapy. As such, a psychologist might find him/herself in an advocacy role working to protect the client in conflict with an insurer (righting the "unfairness" of clients' situations). For example, on one occasion, Annik found herself unsuccessfully advocating with an insurer for extended coverage for a woman who was not only in an MVA but had a history of sexual assault that complicated coping with her accident. She ended up centring sessions on the client's current coping and how the MVC contributed. Annik touched on the client's sexual assault in terms of enhancing her insight regarding its impact on her overall difficulty coping but did not make it the focus of treatment. Instead, she provided the client with information for other resources/services if she was interested in seeking additional psychological support. Through her experience working with this client and the insurer, Annik learned that third parties may limit the scope of our treatment as clinicians. While this may be frustrating, we can at the very least do our due diligence by making an appropriate referral.

We have found that advocating can come in many different forms—whether it be encouraging a client to appeal a decision, or challenging, or not complying with a third-party request. In these cases, a psychologist needs both to ensure that the client is informed and in agreement with the action and to have weighed the potential harms/benefits of her/his behaviour on the client. Adversarial approaches can increase the likelihood of a third party refusing the client's coverage and could even result in cancellation of all future coverage for the client. Appeals or challenges also can result in legal ramifications and increase stress for the client. Although well intentioned, challenging or appealing the decisions of third parties does not always lead to positive outcomes and paradoxically can result in deterioration of the client's health and well-being.

Given the potential negative side-effects that can come with advocacy, how then should a psychologist proceed? Cohen et al. (2006) found the following strategies useful in helping us to live up to our professional and ethical responsibilities in third-party payer situations. First, psychologists can emphasize the negative aspects of the client's condition, not in the sense of making up fraudulent information, but rather in terms of sharing accurate information in a timely or strategic manner that works to help the client (e.g., summarizing only the relevant information in the form of letter to the insurer). Another strategy is for psychologists to adopt the language of the third party and to learn to reframe clients' problems and progress using this language; in other words, "[give] them what they want to hear the way they want to hear it . . . know what the buzzwords are" (Cohen et al., p. 257)—for example, using the precise medical term for a form of cancer rather than the generic word "cancer." Another strategy that Brian has used is to see clients pro bono on a short-term basis when third-party payers have denied urgent care.

Summary

In Scenario #2, where the third party is requesting information that will be assessed by unqualified personnel, the dilemma is whether or not to provide the requested information, given the potential of inappropriate review and decision-making by the third party. The first part of the dilemma can be addressed by informing the client of the request, discussing possible consequences and, if the client agrees, then obtaining consent. The latter part of the dilemma likely requires advocacy by the psychologist, such as requesting to speak to a supervisor or manager within the third-party organization, but only with the client's consent. Advocacy also might be needed when the client chooses to share only a portion of the information requested.

Scenario #3

> **Client C**: You have been seeing a man following the death of his spouse six months previously. There was no prior history of depression, but your client continues to actively grieve the death of his spouse. The costs for psychotherapy have been covered by private insurance. However, the insurer is questioning the ongoing therapy and states that unless a DSM diagnosis is provided, the client will receive no further coverage for therapy.

Diagnoses

The policies of many third-party funders limit the number of mental health care services (i.e., therapy sessions) they will cover, or apply a total fixed dollar amount for such services. Often, the number of sessions covered/reimbursed will vary depending on the perceived severity of the presenting problem (e.g., ten sessions for addiction, six sessions for depression, three sessions for interpersonal problems). There are some serious ethical considerations to keep in mind when working with third parties who require a diagnosis of mental illness and base their coverage of services on the diagnosis (Pope et al., 2016). In particular, we strongly believe that psychologists working with third parties have a responsibility to consider the risks and benefits of providing a diagnosis (See Ethical Standards II.13 and II.14).

Support for our concern about psychiatric diagnoses is found in the research literature. Danzinger and Welfel (2001) conducted a study surveying 108 mental health professionals about their experience and the perceived impact of working for managed-care companies and found that when client diagnoses do not fall within the reimbursement guidelines of insurance companies or managed-care organizations, psychologists can feel pressure to choose between an accurate diagnosis (which may result in denial of third-party coverage) and an alternative and possibly inaccurate diagnosis in order to gain reimbursement (Braun et al., 2005; Danzinger et al., 2001; Murphy et al., 1998). If a client's needs exceed the fixed allotment for a specific diagnosis, then those services are not covered by the insurance companies. Further, clients can be motivated to exaggerate their symptoms (Mittenberg et al., 2002), and psychologists can find themselves endorsing this exaggeration or providing a questionable diagnosis to extend coverage. In Danzinger and Welfel's study, a total of 60% of mental health professionals said they would change treatment plans based on third-party limitations, and 44% admitted that they would change a client's diagnosis to receive additional reimbursement/coverage from the third party. Although we see altering diagnoses and changing treatment plans as likely discreditable and unethical, its reported frequency reflects a common conflict between the responsibility not to provide fraudulent information (or less-than-accurate information), and the responsibility to do no harm and to act in the best interests of the most vulnerable person (i.e., usually the primary client or contract examinee) (CPA, 2017).

Although a benefit to providing a diagnosis might lead to coverage for services, providing a diagnosis also can put the client at risk for harmful consequences (e.g., the stigma of mental illness, Boyle et al., 1995). Moreover, a diagnosis of a mental disorder might endanger a client's chances of gaining future insurance coverage or exclude her/him from certain services (Cohen, et al., 2006, Murphy et al., 1998). In a workers' compensation context, clients with diagnoses might be discriminated against for employment, work promotions, and salary increases (Braun et al., 2005). As such, reflections on balancing the risks, benefits and role of advocacy need to be considered (CPA, 2017).

Summary

In Scenario #3, it should be noted that DSM-5 has dropped the bereavement exclusion that existed in the previous edition. That is, DSM-5 allows for a diagnosis of major depression in the context of bereavement. There is, however, a very instructive discussion in the DSM-5 manual on this issue (American Psychiatric Association, 2013, p. 161). Thus, in this scenario, a diagnosis might be quite legitimate. The question arises, however, as to whether supplying this diagnosis to the insurance company is in the client's best interests, and whether it is stretching diagnostic criteria to meet an insurer's need. The former question revolves around informed consent (See Ethical Standard I.26) and being clear about the needs of the insuring party (see Ethical Standard III.13—clarifying relationships and boundaries among affected parties—which in this case are the client, the insurer, and the therapist—as well as any limitations imposed by the third party); the latter question revolves around confidently providing a clinically accurate diagnosis as required by Ethical Standard III.1. Finally, as Ethical Standard III.35 advises, seeking consultation regarding these issues is advisable.

Conclusion

We have found that maintaining integrity in relationships with third parties and clients is a complicated area, influenced by several client factors and third-party contexts. The scenario discussions above might make psychologists wonder if they can make sensible decisions about participating in services through third parties. For us, one of the most important conclusions is that psychologists should not feel constrained or controlled by their third-party involvement. Yes, we have a duty to make ourselves aware of existing laws and regulations; however, we are ultimately bound by our professional ethics to do no harm and to protect the moral rights of dependent or partially dependent primary clients and contract examinees as much as possible. As such, we strongly encourage psychologists to be proactive in their approaches, both in terms of their communication with clients and with third parties, and to challenge the power of third parties when necessary/appropriate.

We present a set of recommendations in Table 1, some of which we have found helpful when working with third-party insurers (see Recommendations 1 to 3), and some of which are aspirational (see Recommendations 4 and 5).[5] We believe that psychologists should be informing their clients of these recommendations and how they address potential problems that can arise in working with third-party payers. We believe that the recommendations are consistent with the *Code*, particularly Ethical Standard IV.14, and with the privacy legislation that has emerged in Canada, both federally and provincially. The principles in such privacy legislation include accountability; identifying purposes; informed consent; limiting the use, disclosure, and retention of information to the purposes for which the information was collected; and safeguarding the information (LeGault, 2003). However, we recognize that there are problems with the proposed recommendations insofar as they are likely to challenge the business practices of some third-party insurers in Canada. For example, some third-party insurers have reacted negatively to such practices, citing prior consents having been given when clients signed up for insured services. Indeed, provincial legislation governing workers' compensation often broadly permits access to private information.[6] Regardless, these recommendations attempt to balance the privacy rights of individuals with the need for information by third-party insurers who are required to plan and adjudicate.

As psychologists, we have several choices with regard to engagement with third parties: (a) work with them; and/or (b) challenge them; or (c) avoid them. In this chapter, we have touched on a few questions and dilemmas that we (and others) have encountered in working with and challenging third parties. However, it is important to acknowledge that, even when a psychologist decides to avoid working with specific third parties (e.g., WCB or auto insurance), several issues need to be considered. For example, organizations' need of psychological expertise to make the decisions they need to make. Also, it could be doing a disservice to clients not to have access to mental health care arranged and paid for by these organizations (Harris & Zehr, 2014). Even considering the inherent constraints of these third-party arrangements, clients can derive some degree of therapeutic benefit (Haas et al., 1991; Harris & Zehr 2014) and, therefore, perhaps more harm is done by not providing even constrained services. These are the types of risk/benefit analyses (see Ethical Standard II.13) that psychologists need to consider at a systems level. Psychologists have a responsibility to give careful consideration to the features of the insurance plans they join (see Ethical Standard IV.14), the potential impact of the third-party limitations on the therapist-client relationship (such as requirements for disclosure or providing a psychiatric diagnosis), and the appropriateness of various client conditions for time-limited treatment (Haas et al., 1991). The ideal would be to find a way to work collaboratively with all parties.

Questions for Reflection

1. How do you think you would feel if a client withdrew consent for disclosure of an assessment report when payment to you depends on the report being shared with a third party? What do you think you should do? What do you think you would do?
2. In such a situation, do you think there is an inherent conflict of interest that needs to be managed? If so, how would you manage it?
3. In responding to the above situation, how do you think you might honour the Principle III (Integrity in Relationships) value of *Openness and straightforwardness*, while also honouring the Principle I (Respect for the Dignity of Persons and Peoples) value of *Informed consent*, and the Principle II (Responsible Caring) values of *General caring* and *Minimizing harm*?
4. Do you think there might be ways of avoiding this type of dilemma in future? If so, how?

Table 9.1: Recommendations Regarding the Disclosure of Psychotherapy Information to a Third Party

1. Notify third-party insurers with which you work or plan to work (e.g., WCBs, insurance companies) that general requests for information, such as the release of complete files, will not be responded to, as such requests reflect an intrusion into the moral right to privacy. Rather, ask the third party to pose specific questions relevant to the third party's interests regarding progress, prognosis, or any other relevant matter.
2. When a third-party insurer requests a copy of a complete therapy file, decline to do so. If the insurer is persistent, consider using an independent qualified psychologist to mediate the transfer of only specific information from the client file to the third party. The mediating psychologist's role would be to review contents of the file, under trust conditions not to release the file, extracting only the information that addresses specific questions posed by the third-party insurer.
3. When psychologists have had prior therapeutic relationships with a client who is now receiving services from the psychologist paid for by a third-party insurer, notify the third-party insurer that the insurer cannot have access to prior client information as that information is private and was obtained for a different purpose.
4. When psychotherapy information is being used by a third-party insurer to adjudicate eligibility for or continuation of coverage, psychologists should decline to release the information unless the professional qualifications of reviewers (and/or experts used by the third party) are disclosed to the psychologist, and their qualifications are commensurate with their level of duties.
5. Consider working only with third-party insurers that subscribe to an institutional code of ethics and employ professionals with qualifications that are commensurate with their level of duties.

NOTES

1 "Retaining Party" means the *individual* or *group* that has retained a *psychologist* to assess a *contract examinee* for the purpose of helping an external decision-maker (e.g., court, insurance company, or employer) to make a decision (CPA, 2017).

2 Such agreements are often contained in third-party consent forms. However, clients in our experience often do not read consent forms carefully.

3 It is important to understand that we believe that consent is a *process*, not simply the signing of a form. That is, consent should evolve as circumstances change. Although there are no specific practice or ethical guidelines on time limits for consent forms, practically speaking, a 12-month period is a time frame in which circumstances could reasonably change. Therefore, best practice might be that a consent form could be reasonably considered still in effect for 12 months if the client can recall the process of informed consent, the risks and benefits have not changed, and the client has not rescinded that consent at any time in the 12 months. However, we believe this needs to be decided on a case-by-case basis, and that the voluntariness and client's understanding of what they signed always needs to be considered.

4 It is important to note that this discussion is in the context of dealing with individuals who are deemed to have the capacity to provide consent. The issues regarding individuals who are deemed not to have this capacity is a separate topic.

5 These recommendations can be seen as a potential outline or template for a contract with a third-party insurer.

6 For example, the *Manitoba Workers Compensation Act* (2016) states, “Health-care providers must also provide reports to the WCB of injuries that are covered by the WCA (section 20). Reports are for the WCB’s use and purposes, and the worker’s consent is not necessary (p. 34).”

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