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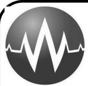


WOODSTOCK HOSPITAL
Woodstock, ON

REVIEWED BY PATIENT & FAMILY ADVISORY COUNCIL

MENTAL HEALTH

TREATMENT AGREEMENT FORM
OUTPATIENT MENTAL HEALTH SERVICES

PRIVACY AND CONFIDENTIALITY

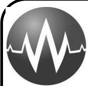
1. The Outpatient Mental Health Department offers a wide variety of programs and services to members of Oxford County, or those rostered with an Oxford County Primary Care Provider. This means we follow the privacy policies of Woodstock Hospital. Details of Woodstock Hospital´s privacy policy are described online at www.wgh.on.ca.
2. The information you share with your mental health worker and/or treatment team will remain confidential except under the following circumstances:
   a) If requested by court order or subpoena
   b) Where there is a disclosure made regarding a child being abused, neglected, and/or is at risk of harm or neglect according to the Child, Youth and Family Services Act (2017). Such information must be reported to the Children´s Aid Society
   c) A client reveals a desire or intent to harm themselves or others
   d) The request is received by the administrator of another hospital
   e) You have been/are being abused by a regulated health professional. Such information must be reported to the College of which the professional is a member
3. The parents/guardians with legal custody of a child less than 12 years old must consent to the counselling process. If there is a joint custody agreement, both custodial parents/guardians must consent to treatment.
4. At times, professionals within any program might share information for the purpose of consultation and/or supervision within the department.
5. You should also be aware that hospital files are not "privileged" documents. A court of law could subpoena the records. In such cases, every effort will be made to satisfy the subpoena with a letter that could be discussed with you before sending it to the judge.
6. Information about your assessment and/or treatment may be shared with your primary care provider (family physician/nurse practitioner), as part of "Circle of Care". To maintain privacy and confidentiality within and outside of the circle of care, the professional will seek consent to access or disclose personal health information when necessary. Please inform us if you do not wish information to be sent to your primary care provider.

Mental Health Stigma

Regardless of which outpatient program you are involved with, we want you to know that your care is a priority and safety is paramount. To ensure continuity, our safety measures will apply to ALL patients involved in our programs, with no exceptions. Your care is managed by the policies and procedures governed by the Mental Health Act.

Fear and misunderstanding can lead to stigma for people suffering with mental health issues. This can lead to feelings of hopelessness, helplessness and shame in those struggling to cope with their symptoms, which can create barriers for treatment. Woodstock Hospital is challenging stigma associated with mental health by understanding, educating and taking a closer look at perceptions toward mental health.

There are many reasons why people develop mental illness. Some are genetic or biological. Some are a result of trauma or overwhelming stress at school, work or home. Some stem from environmental injustice or violence. Sometimes, we simply don’t know.



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Our goal is to reduce stigma by utilizing a person−centered approach to provide a safe environment for recovery.

We actively wish to receive your feedback about your involvement with our programs. Please reach out with thoughts, ideas and ways to improve your treatment with us.

Risks of Using Virtual Services

Woodstock Hospital Mental Health Services may provide services virtually, if required. This may include using virtual platforms such as the telephone, Ontario Telemedicine Network (OTN), webex or others Services provided via these platforms are compliant with privacy legislation regarding personal health information and do not store any of your personal health information. By agreeing to access a virtual service you (the user) are consenting to engage in the virtual platform. The user also consents to using their own internet and/or phone service and technological device, and any associated costs will be paid for by the user.

All patients will be required to provide two patient identifiers at the beginning of their appointment (ie full name and date of birth) and may be asked the reason for their appointment. It is the patient's responsibility to not misrepresent their identity in any way.

There is a risk that services could be disrupted or distorted by unforeseen technical problems. Please provide the clinician with feedback, should you find the quality of sessions insufficient for your needs. There is also a risk of being overheard by anyone near you if you do not place yourself in a private room. You, the patient, are responsible for creating a comfortable and safe environment for the duration of your appointment. It is the responsibility of your clinician to do the same. They will complete all virtual services in a secure and protected space. By agreeing to virtual services you are also agreeing to maintain the privacy of the appointment by not recording or taping the appointment. You are required to be physically located in the province of Ontario at the time of each respective appointment. This is to comply with professional college standards such as the Ontario College of Social Workers and Social Service Workers (OCSWSSW), College of Physicians and Surgeons of Ontario (CPSO), and College of Nurses of Ontario (CNO). By not being in the Province of Ontario, your appointment may be cancelled and/or rescheduled to a later date.

RESPONSIBILITY OF THE MENTAL HEALTH PROFESSIONAL

1. To ensure departmental service components and specific program criteria are delivered in a way that aligns with mandated essential services guided under the Mental Health Act, while following best practices.

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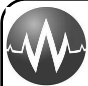
2. To facilitate time–limited patient services that includes: assessment, treatment, and transitional discharge including referral(s) for persons who are experiencing moderate to severe mental health issues/concerns:
    a. Assessment – Once service has been initiated, a thorough assessment of client strengths and needs along with the completion of any necessary assessment tools will be used to complete an intake/assessment and formulate a person centered treatment plan. Recommendations and/or referrals to specific programs will be made based on the client assessment and treatment plan.
    b. Treatment – Pending the outcome of the assessment, the client may be referred to outpatient mental health program(s). The program(s) the client is referred to will facilitate time orientated treatment to help the client achieve their identified treatment goals. The frequency and duration of treatment will be determined based on the program. Session limits will be confirmed with clinicians.
    c. Discharge/Referral(s) – Pending the assessment/treatment outcomes, transitional care will be facilitated in the form of discharge recommendations and/or referrals to other suitable and appropriate community resources.

3. To ensure continuity of care during assessment, treatment or discharge, mental health professionals may require communication with other professionals. As such, in accordance with the Ontario Privacy Legislation, it is our policy to share clients' personal health information as needed with physicians, health care providers at other hospitals or health care agencies who are part of a client´s "circle of care." To maintain privacy and confidentiality within and outside of the circle of care, the professional may seek consent to access or disclose personal health information when necessary

RESPONSIBILITY OF THE CLIENT

1. It is your responsibility to attend all scheduled appointments and to provide 48 hours notice if cancelling. If two appointments are missed without adequate notice, we reserve the right to close the file and a new referral may be required. NOTE: Psychiatric Services (i.e. psychiatrist consultation or follow–up) may have alternative Cancellation/No Show policies that may involve a fee. Please refer to the respective psychiatrist´s policy for further details. Any extenuative circumstances should be discussed in advance. It is the client´s responsibility to contact the respective person for another appointment.
2. We reserve the right to close your file after 60 days of inactivity.
3. If you or members of your household are experiencing symptoms of a potential virus or a contagious condition, please call and rebook your appointment to help limit and prevent the spread of viruses or other potentially contagious conditions.
4. Clients are not to attend appointments while under the influence of substances. Any client who presents to an appointment under the influence will be asked to leave and reschedule. We reserve the right to close the file if substance use becomes a safety concern for hospital staff and patients.



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5. We have no child–care facilities and, therefore, children may not wait unsupervised in the waiting room. It is the responsibility of each parent/guardian to wait while young children are in session and to pick up the child/adolescent promptly afterward.

6. The cost of mental health services at Woodstock Hospital is covered by the Ontario Health Insurance Plan (OHIP). However, you may be expected to pay a fee for some services (i.e. reports, documents, parking). You will be informed in advance of any such charges.

7. If you are in crisis and think that you are at risk of harm to self or others, please contact Reach Out 24/7 at 1–866–933–2023, attend a Talk–In Counselling location, or attend your nearest hospital emergency department for assistance.

Having read, understood, and addressed any concerns with the above information, as well as, discussed the risks and benefits of treatment, I agree to these terms of assessment and treatment. This agreement remains in effect for the period of time that the file is active.

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If Substitute Decision Maker, printed name and relationship

____ ____________________

Signature of Client/Substitute Decision Maker Date (MMM,DD,YYYY)

____ ____________________

Signature of Witness Date (MMM,DD,YYYY)