Informed Consent for Telecare Services

THRIVE CHILD AND YOUTH TRAUMA SERVICES (THRIVE)

COVID-19 is placing stress on Canada's public health system. Based on the advice of the Chief Medical Officer of Health, the Ministry of Health (ministry), in partnership with Ontario Health, *is* recommending increased use of telecare in an effort to limit person to person contact in community mental health care, where it is appropriate.

Thrive Child and Youth Trauma Services is starting to offer some telecare options to make sure that we can continue to care for our clients safely and effectively. Telecare can refer to client/agency communication via texting, email, video chat platforms, social media platforms, websites and other types of online communication. This means that we will be using electronic communications for specific requirements, when face to face appointments are not available. Some of these technologies are provided by the Province. Others have been provided by vendors such as Microsoft or Apple to help make discussions with your clinician, as easy as possible during these difficult times.

It's important to note that client's have the right to withdraw or withhold consent of virtual care options, or to terminate treatment at anytime.

In preparation for the Telecare appointment, please review this information **together with your child/adolescent** and complete the recommended preparation described below. By signing below, you agree to the following statements:

1. I understand that "telecare" can include secure videoconferencing, emails, telephone conversations, texts, and education using interactive audio, video, or data communications.

2. Unless I explicitly provide agreement otherwise, telecare exchanges are strictly confidential. Any information I choose to share with my therapist will be held in the strictest confidence. My private information will not be released unless I am required to do so by law. Therapists in Ontario are required to notify authorities if they become convinced a client is about to physically harm someone, harm themselves, or if they are abusing or about to abuse children, the elderly, or the disabled.

3. I understand that I have the right to withdraw or withhold consent from telecare services at any time. I also have the right to terminate treatment at any time.

4. While telecare will be conducted primarily through secure and private telephone, text messaging or by video conferencing, I understand that there are always some risks with telecare services including, but not limited to, the possibility that: the transmission of your information could be disrupted or distorted by technical failures; the transmission of your

information could be intercepted by unauthorized persons, and/or the electronic storage of your information could be accessed by unauthorized persons.

5. I will work with my therapist to identify an alternative communication method (most often phone) should we be using videoconferencing tools and they fail.

6. I understand that I may benefit from telecare but that results cannot be guaranteed or assured.

7. Telecare is being offered as a supportive intervention during the current COVID 19 crisis. As your therapist, I may determine that due to certain circumstances, telecare is no longer appropriate and that we should resume our sessions in-person when able, as directed by the Public Health Agency of Canada and the Government of Ontario.

8. I understand and accept that telecare through THRIVE does not provide emergency services. If I am experiencing an emergency, I understand that the protocol would be to call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, or if my child is in this situation, I may also call COAST Hamilton at (905) 972-8338.

9. **Parent/Guardian:** please provide the clinician with alternate emergency contact information in case safety concerns for your child/adolescent arise that need immediate attention. If something comes up regarding the safety of your child/adolescent, you may be required to bring your child/adolescent to the nearest emergency department for assessment. Alternately, you as the parent/caregiver may need to call emergency services to bring your child/adolescent to the nearest hospital for further assessment.

10. I will be responsible for the following: (1) providing the computer and/or necessary telecare equipment and internet access, or telephone, etc. for my telecare sessions, (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my telecare/electronic communication sessions.

11. I agree not to record telecare sessions.

12. I agree to be dressed as if I were attending an in-person face to face session.

13. For the safety of myself and others around me, I agree to not be driving at the time of telecare sessions.

14. I have the right to access my medical information and copies of my medical records in accordance with the Personal Health Information Protection Act, 2004 as well as other applicable laws.

15. If we are concerned about you or we lose contact with you, or if you fail to show for a scheduled session, we will contact you by phone to check on your well-being. In addition, if you are showing signs of being in real trouble, we require that we have permission to contact someone to ensure your safety. We require three levels of contacts:

Close personal contact such as a parent or spouse

Name: _____

Relationship: _____

Phone: _____

Professional contact such as a personal physician or other health care professional

Name: _____

Relationship: _____

Phone: _____

Office or Agency that does crisis well-being checks in your community (typically a 24-hour crisis service or the police department).

Crisis response: COAST Hamilton at (905) 972-8338.

I have read this Informed Consent before signing it and I fully understand it. I have been given the opportunity to ask any questions I might have about it and sign it in consideration of the benefits described above.

Client Name (please print): _____

Client Signature: _____

Parent/Guardian Signature: _____

Date: _____

Client Cellphone Number if applicable: _____

Client Email if applicable: _____

Client Home Address: _____

Clinical Therapist: _____