



Community Care Programs, Inc.

Outpatient Mental Health Clinic

—PRIVACY NOTICE—

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses & Disclosures

Community Care Resources, Inc. (hereafter referred to as The Agency) will use and disclose the individual's protected health information in day-to-day operations such as:

- ◆ ***Treatment*** planning and provision whereby The Agency will create treatment plans and gather information to provide effective treatment services. This information may be provided to other service providers, schools and social service agencies.
- ◆ ***Payment*** billing whereby The Agency requests payment from third party insurers including Medical Assistance and from County or State payees.
- ◆ ***Health care operations*** whereby The Agency shares information internally to provide transcription, file maintenance and other necessary information handling functions. The Agency may also disseminate private information with business associates who are directly involved in the essential functions of the organization such as County and State referral sources and contract psychiatric, psychological and social work practitioners who are under contract to The Agency.

Other than the exception in the paragraph above, all disclosures and use of protected health information will be made only with the individual's written authorization and the individual may revoke such authorization.

Special Uses or Disclosures

The Agency may contact the individual to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to the individual.

Individual Rights

The individual has the right to request restrictions on certain uses and disclosures of protected health information and the individual is not required to agree to requested restrictions by The Agency.

The individual has the right to receive confidential communications of protected health information.

The individual has the right to inspect and copy protected health information.

The individual has the right to amend protected health information.

The individual has the right to receive an accounting of disclosures of protected health information.

The individual has the right to a paper copy of this privacy notice upon request.

The Agency's Duties

The Agency is required by law to maintain the privacy of protected health information and is hereby notifying the individual that the agency has a legal duty to implement privacy practices with respect to protected health information.

The Agency is required to abide by the terms of the notice currently in effect; and The Agency reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Complaints

The individuals may complain to The Agency and to the Secretary of State Health & Human Services if they believe their privacy rights have been violated. The individual may submit a written complaint to the privacy officer of The Agency. The individual will not be retaliated against for filing a complaint.

Contact

The Agency privacy officer to whom a complaint must be filed is Daniel J. Simon, Director, c/o *Community Care Programs, Inc.* 6716 Stone Glen Drive, Middleton, WI 53562 Telephone—608 827-7100.

Effective Date

This privacy notice is effective immediately and as of the individual's signature and date on the receipt of notice verification.

Acknowledgement of Receipt of Privacy Notice

Community Care Programs, Inc. has provided the undersigned individual with a HIPAA compliant ***Privacy Notice***. The individual, by signing this form, acknowledges that they have received the ***Privacy Notice***, have read the ***Privacy Notice***, and substantially understand the document and the right to privacy of protected health information that is communicated by the ***Privacy Notice***.

Client Name

Client signature

Date

Parent/Guardian of Individual signature (*when necessary*)

Date



Community Care Programs, Inc.

Outpatient Mental Health Clinic

DHS 94.03 Informed Consent Policy For Psychotherapy Services

It is the policy of *Community Care Programs, Inc.* to provide every client with information concerning their treatment, defined as "informed consent," and incorporated in an informed consent document as contained herein and delineated as follows.

Definition of Psychotherapy Services: Psychotherapy Services are the informed and intentional application of clinical methods, based on established psychological principles, for the purpose of helping consumers change their behaviors, thoughts, emotions, and/or other personal characteristics in ways that the participants see as desirable or healthy.

Psychotherapy Services offered by *Community Care Programs, Inc.* may include, but are not limited to, Sexual Abuse Treatment and Offender Program (STOP), Trauma Focused Cognitive Behavior Therapy (TF-CBT), Dialectical Behavior Therapy (DBT), Trauma Informed Child Parent Psychotherapy (TI-CPP) and other evidence-based treatments. These services provide psychoeducation, instruction and practice to consumers wishing to change a particular behavior, thought, emotion or personal characteristic.

Benefits of Treatment: The desired benefit of Psychotherapy Services is to help the consumer name, monitor and change their behaviors, thoughts and emotions in order to better manage distress and promote well-being.

Example: *If you attend appointments and practice coping strategies, it is likely that you will feel better. You will know when you are distressed, understand the triggers to your distress and be able to apply an evidence-based strategy to your problems.*

Administration of Treatment: The consumer and their support person(s) may be asked to:

- Attend weekly or bi-weekly meetings with the Psychotherapy Services provider
- Practice new strategies at home, school, in the community and at work in order to strengthen their coping skills
- Consult with a primary care physician or psychiatrist for an evaluation of medication needs
- Participate in psychological testing to help them and their treatment team better understand ways to help the consumer

Treatment will be administered following consultation with the consumer and various multidisciplinary service providers on the consumer's team. The team may include supervisors, county and school staff, biologic family and advocates for the consumer.

Example: *Treatment might include meeting with your psychotherapist, doctor or psychologist, talking about difficulties and practicing ways to better manage distress. Medications to reduce anxiety or irritability may be recommended by a doctor but you always have the right to accept or refuse treatment.*

Side Effects: *Any* form of Psychotherapy Services can have side effects such as an increase in problem behaviors, thoughts and emotions. By consenting to engage in Psychotherapy Services, the consumer acknowledges the possibility of side effects or increased symptoms and holds harmless the treating agent (service provider).

Due to the imprecise nature of mental health disorders it is impossible to predict the course of treatment. Although we strive to minimize adverse side effects by applying evidence-based treatments, increased suffering or diminished well-being can, from time to time, occur. The consumer understands that he/she is entering into treatment voluntarily and accepts any and all associated risks.

Example: *As you identify the triggers to and treatments for your distressing behaviors, thoughts and emotions, you may feel worse for a while. This sometimes happens during the treatment process until new behaviors become fluent and comfortable. With practice, you will get better at using healthy coping strategies to make yourself feel better.*

Alternatives to Treatment Modes: The consumer will be informed of all treatment options and the associated benefits and drawbacks including risks and side effects. The consumer will be provided with the least restrictive, least intrusive, least risk prone and most efficacious treatment modality consistent with treatment goals.

Example: Together, you and your Psychotherapy Services provider will review the treatment strategies that are considered 'best practice' for your particular difficulty and desired outcome. You and your Psychotherapy Services provider will choose the best treatment course for your strengths and needs. Other clinics may offer similar services and you are always free to consider them instead of Community Care Providers, Inc.

Consequences of Not Receiving Proposed Treatment: Community Care Programs, Inc. and its agents, assignees, clinicians, administrators and other practitioners not otherwise stated herein are not responsible or liable for any consumer who does not engage in the recommended treatment(s) as defined in the treatment plan. The consumer assumes full responsibility for continued individual and social impairment and for continued mental health deterioration and impairment. Consequences of not seeking appropriate treatment can include, continued emotional suffering, unhealthy behaviors, impaired social functioning, law enforcement involvement, physical deterioration and possibly death.

Should a patient refuse to participate in the recommended treatment(s), Community Care Programs, Inc. reserves the right to unilaterally discontinue the consumer-agency relationship and attendant Psychotherapy Services.

Example: If you do not attend appointments, complete homework assignments and practice new strategies, your problems may get worse. Although we will be your guide, you must do the work. If you choose not to work on your difficulties, you may be asked to stop coming to the clinic.

Effective Time Period of Informed Consent: By signing this form, you acknowledge that you have been duly informed about the Psychotherapy Services in which you are about to participate.

This Informed Consent is active upon the signing of this form by the consumer/parent/guardian and is in effect until _____ (15 months from date signed), the consumer is discharged from care or the consumer unilaterally withdraws from care through written notice of termination, non-compliance with Psychotherapy Services or non-contact with agency for a 30 day period.

Right to Withdraw Informed Consent: The consumer or legal guardian (if consumer is a minor) may at any time, with written notice, withdraw his/her Informed Consent to treatment. Upon written notice received by the Psychotherapy Service provider, all treatment to the consumer will cease and the case will assume "Discharged" status. All further responsibilities for treatment will be discontinued by Community Care Programs, Inc.

- The undersigned patient has read the above document and substantially understands the words, intent, and responsibilities, and is in agreement with the conditions set forth. The undersigned consumer is competent/or is under the guardianship of a competent adult who has read the above document and substantially understands the words, intent and responsibilities set forth and signs below.
- The consumer has received a copy of *Patient Bill of Rights* per Wisconsin Statute, Section 51.61.
- The consumer has been given a copy of the *Grievance Procedure* in the event that a complaint needs formal resolve beyond the Supervisor level.

Example: We recommend that you read the *Patient Bill of Rights* pamphlet and keep a copy of the *Grievance Procedure* form, should you want to pursue a formal grievance. If you wish to stop treatment you can submit a written request or talk to your Psychotherapy Services provider.

I agree to participate and/or allow my child to participate in Psychotherapy Services through Community Care Programs, Inc.

Client Name

Client Signature

Date

Parent/Guardian Signature

Date



Community Care Programs, Inc.

Outpatient Mental Health Clinic

Telehealth Informed Consent

Introduction of Telehealth:

As a client receiving mental health services through telehealth technologies, I understand the following:

- Telehealth is the delivery of mental health services using interactive technologies (*audio, video or other electronic communication*) between a clinician and client who are not in the same physical location.
- The interactive technologies used in telehealth incorporate network and software security protocols to protect the confidentiality of client information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Security Protocols:

- Electronic systems used will incorporate network software security protocols to protect the privacy and security of health information and data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption by adhering to HIPAA guidelines, best policies and practices.

Technology Benefits/Limitations, Requirements & Risks:

- This service is provided by technology (*including but not limited to video, phone, text, apps and email*) and may not involve direct face to face communication.
- These services rely on technology, which allow for convenience in service. There are risks in transmitting information over technology that include, but are not limited, to breaches of confidentiality, theft of personal information and disruption of service due to technical difficulties.
- Clinician and client need access to and familiarity with the appropriate technology in order to participate in the service provided.
- Clinician and client will regularly reassess the appropriateness of continuing services using technologies we have agreed upon and modify our plan as needed.

Exchange of Information:

- The exchange of information will not be direct, and any paperwork exchanged will likely be provided through electronic means or through mail.
- During my telehealth consultation, details of my medical history and personal health information may be discussed with myself or other mental health care professionals through the use of interactive video, audio or other telecommunications technology.

Emergencies & Disruption of Service:

- In an emergency or in the event of disruption of service, or administrative reasons, it may be necessary to communicate by other means.
- In emergency situations or disruption of service the clinician will contact the client by phone.

Telehealth Informed Consent continued

Communication:

By Clinician:

- My clinician will respond to communication during business hours Monday through Friday, 8 am – 5 pm.
- My clinician may use other means of communication in the following circumstances:

By Client:

- It is my responsibility to maintain privacy on the client end of communication.
- I will find a private, confidential space to ensure that my communication is directed only to my clinician during my telehealth consultation.
- I may decline any telehealth services at any time without jeopardizing my access to future services.

Records & Standards:

- My records related to my telehealth sessions with my clinician will be stored in an electronic file and subject to all HIPAA guidelines, best policies and practices.
- State laws and the professional standards that apply to in-person mental health services also apply to telehealth services. This document does not replace the informed consent for services.

By signing this agreement, I agree to the terms of this informed consent and agree to use Telehealth services.

Client Name

Client Signature

Date

Parent/Guardian Signature

Date

Clinician Signature

Date



Community Care Programs, Inc.

Outpatient Mental Health Clinic

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(This document is HIPAA compliant)

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF *PROTECTED HEALTH INFORMATION* ABOUT ME OR THE PERSON LISTED BELOW:

Subject/Individual _____ DOB: _____
(Maiden)

Address _____

Relationship to subject _____

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF *PROTECTED HEALTH INFORMATION* TO BE RELEASED **FROM/TO**:

Individual/Agency _____

Address _____

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF *PROTECTED HEALTH INFORMATION* TO BE RELEASED **TO/FROM**:

Individual/Agency Community Care Programs, Inc.

Address 6716 Stone Glen Drive, Middleton, WI 53562

I UNDERSTAND THAT THE SPECIFIC INFORMATION THAT IS USED OR DISCLOSED IS:

- | | | |
|--|---|---|
| <input type="checkbox"/> Client Information | <input type="checkbox"/> Recommendation | <input type="checkbox"/> Intake Assessment |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Legal Information |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> School Attendance | <input type="checkbox"/> History and Physical |
| <input type="checkbox"/> School Grades | <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Social History |
| <input type="checkbox"/> Drinking/Drug History | <input type="checkbox"/> Treatment History | <input type="checkbox"/> Medication History |
| <input type="checkbox"/> Work Record | <input type="checkbox"/> Progress Reports | <input type="checkbox"/> Lab Results (<i>Specify</i>) _____ |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Behavioral Information | <input type="checkbox"/> Other (<i>Specify</i>) _____ |
| <input type="checkbox"/> Photo Release in Agency Publication (<i>for example</i> : Educational Journal) | | |

I UNDERSTAND THAT THE SPECIFIC USE AND DISCLOSURE OF THE *PROTECTED HEALTH INFORMATION* IS FOR SERVICES RELATING TO:

Treatment Foster Home Care Outpatient Services Other: _____

**** THIS AUTHORIZATION EXPIRES ONE YEAR FROM DATE SIGNED OR _____ ****

- I understand that the information used or disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.
- I understand that I may revoke this authorization by notifying *Community Care Programs, Inc. (C.C.P.)* at 6716 Stone Glen Drive, Middleton, WI 53562 in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by *C.C.P., Inc.* in reliance on this authorization.
- I understand that *C.C.P., Inc.* may not condition treatment of me on whether or not I sign this authorization.

Signature of Subject Individual _____ Date _____

Signature of Person Legally Authorized to Consent for Above Individual _____ Relationship _____ Date _____

Witness

6716 Stone Glen Drive, Suite A • Middleton, WI 53562 • (608) 203-1313 • FAX (608) 827-7101

www.CommunityCarePrograms.com

- If you and the program manager agree with the CRS's report and recommendations, the recommendations shall be put into effect within an agreed upon time frame.
- You may file as many grievances as you want. However, the CRS will usually only work on one at a time. The CRS may ask you to rank them in order of importance.

Program Manager's Decision

If the grievance is not resolved by the CRS's report, the program manager or designee shall prepare a written decision within 10 days of receipt of the CRS's report. You will be given a copy of the decision.

County Level Review

- If you are receiving services from a county agency, or a private agency and a county agency is paying for your services, you may appeal the program manager's decision to the County Agency Director. You must make this appeal within 14 days of the day you receive the program manager's decision. You may ask the program manager to forward your grievance or you may send it yourself.
- The County Agency Director must issue his or her written decision within 30 days after you request this appeal.

State Grievance Examiner

- If your grievance went through the county level of review and you are dissatisfied with the decision, you may

appeal it to the State Grievance Examiner.

- If you are paying for your services from a private agency, you may appeal the program manager's decision directly to the State Grievance Examiner.
- You must appeal to the State Grievance Examiner within 14 days of receiving the decision from the previous appeal level. You may ask the program manager to forward your grievance to the State Grievance Examiner or you may send it yourself. The address is: State Grievance Examiner, Division of Care and Treatment Services (DCTS), PO Box 7851, Madison, WI 53707-7851.

Final State Review

Any party has 14 days of receipt of the written decision of the State Grievance Examiner to request a final state review by the Administrator of the Division of Care and Treatment Services or designee. Send your request to the DCTS Administrator, P.O. Box 7851, Madison, WI 53707-7851.

You may talk with staff or contact your Client Rights Specialist, whose name is shown below, if you would like to file a grievance or learn more about the grievance procedure used by the program from which you are receiving services.

Your Client Rights Specialist is:

Mary Simon or Patty Morter

608-827-7100

NOTE: There are additional rights within sec. 51.61(1) and DHS 94, Wisconsin Administrative Code. They are not mentioned here because they are more applicable to in-patient and residential treatment facilities. A copy of sec. 51.61, Wis. Stats. and/or DHS 94, Wisconsin Administrative Code is available upon request.



STATE OF WISCONSIN
 DEPARTMENT OF HEALTH SERVICES
 Division of Care and Treatment Services
 www.dhs.wisconsin.gov
 P-23112 (09/2016)

**Client Rights
 and the
 Grievance
 Procedure for
 Community
 Services***

**for Clients Receiving
 Services in
 Wisconsin for Mental
 Illness, Alcohol or
 Other Drug Abuse, or
 Developmental
 Disabilities**

*The term Community Services refers to all services provided in non-inpatient and non-residential settings.

CLIENT RIGHTS

When you receive any type of service for mental illness, alcoholism, drug abuse, or a developmental disability, you have the following rights under Wisconsin Statute sec. 51.61 (1) and DHS 94, Wisconsin Administrative Code:

PERSONAL RIGHTS

- You must be treated with dignity and respect, free from any verbal, physical, emotional, or sexual abuse.
- You have the right to have staff make fair and reasonable decisions about your treatment and care.
- You may not be treated unfairly because of your race, national origin, sex, age, religion, disability, or sexual orientation.
- You may not be made to work except for personal housekeeping chores. If you agree to do other work, you must be paid.
- You may make your own decisions about things like getting married, voting, and writing a will, if you are over the age of 18, and have not been found legally incompetent.
- You may use your own money as you choose.
- You may not be filmed, taped, or photographed unless you agree to it.

TREATMENT AND RELATED RIGHTS

- You must be provided prompt and adequate treatment, rehabilitation, and educational services appropriate for you.

- You must be allowed to participate in the planning of your treatment and care.
- You must be informed of your treatment and care, including alternatives to and possible side effects of treatment, including medications.
- No treatment or medication may be given to you without your written, informed consent, **unless** it is needed **in an emergency** to prevent serious physical harm to you or others, or a **court orders it**. [If you have a guardian, however, your guardian may consent to treatment and medications on your behalf.]
- You may not be given unnecessary or excessive medication.
- You may not be subject to electro-convulsive therapy or any drastic treatment measures such as psychosurgery or experimental research without your written informed consent.
- You must be informed in writing of any costs of your care and treatment for which you or your relatives may have to pay.
- You must be treated in the least restrictive manner and setting necessary to achieve the purposes of admission to the program, within the limits of available funding.

RECORD PRIVACY AND ACCESS

Under Wisconsin Statute sec. 51.30 and DHS 92, Wisconsin Administrative Code:

- Your treatment information must be kept private (confidential), unless the law permits disclosure.
- Your records may not be released without your consent, unless the law specifically allows for it.
- You may ask to see your records. You must be shown any records about your physical health or medications. Staff may limit how much you may see of the rest of your treatment records while you are receiving services. You must be informed of the reasons for any such limits. You may challenge those reasons through the grievance process.
- After discharge, you may see your entire treatment record if you ask to do so.
- If you believe something in your records is wrong, you may challenge its accuracy. If staff will not change the part of your record you have challenged, you may file a grievance and/or put your own version in your record.
- A copy of sec. 51.30, Wis. Stats., and/or DHS 92, Wisconsin Administrative Code, is available upon request.

GRIEVANCE PROCEDURE AND RIGHT OF ACCESS TO COURTS

- Before treatment is begun, the service provider must inform you of your rights and how to use the grievance process. A copy of the Program's Grievance Procedure is available upon request.

- If you feel your rights have been violated, you may file a grievance.
- You may not be threatened or penalized in any way for presenting your concerns informally by talking with staff, or formally by filing a grievance.
- You may, instead of filing a grievance or at the end of the grievance process, or any time during it, choose to take the matter to court to sue for damages or other court relief if you believe your rights have been violated.

GRIEVANCE RESOLUTION STAGES

Informal Discussion (Optional)

You are encouraged to first talk with staff about any concerns you have. However, you do not have to do this before filing a formal grievance with your service provider.

Grievance Investigation—Formal Inquiry

- If you want to file a grievance, you should do so within 45 days of the time you become aware of the problem. The program manager for good cause may grant an extension beyond the 45-day time limit.
- The program's Client Rights Specialist (CRS) will investigate your grievance and attempt to resolve it.
- Unless the grievance is resolved informally, the CRS will write a report within 30 days from the date you filed the formal grievance. You will get a copy of the report.

Treatment Rights

You must be provided prompt and adequate treatment.

If you are **14 years or older**, you can refuse mental health treatment until a court orders it.

You must be told about your treatment and care.

You have the right to and are encouraged to participate in the planning of your treatment and care.

You and your relatives must be informed of any costs they may have to pay for your treatment.

Record Access and Privacy Rights

Staff must keep your treatment information private (confidential). However, it is possible that your parents may see your records.

If you want to see your records, ask a staff member.

If you are **younger than 14-years-old**, you must view your records in the presence of a parent/guardian, attorney, judge, or staff member. You may always see your records on any medications you take.

Regardless of your age, staff may limit how much you may see of your records. They must give you reasons for any limits.

If you are **at least 14-years-old**, you can consent to releasing your own mental health treatment records to others.

If you are **at least 12-years-old**, you can consent to releasing your substance use treatment records to others.

Personal Rights

You must be informed of your rights.

Reasonable decisions must be made about your treatment and care.

You cannot be treated unfairly because of your race, national origin, sex, gender expression, religion, disability or sexual orientation.

Patient Rights Help

If you want to know more about your rights or feel your rights have been violated, you may do any of the following:

- **Contact patient rights staff.** Their contact information should be provided to you by your treatment provider. Treatment providers should also list this information on a poster.
- **File a complaint.** Patient rights staff will look into your complaints. They will keep your complaints private (confidential); however, they may need to ask staff about the situation.
- **Contact Disability Rights Wisconsin.** They are the protection and advocacy organization for Wisconsin. Their advocates and attorneys can help you with patient rights questions. Call **608-267-0214** or **800-928-8778**.

For more information, visit:
www.dhs.wisconsin.gov/clientrights/minors

Wisconsin Department of Health Services
Division of Care and Treatment Services
P-20470B (06/2021)



WISCONSIN DEPARTMENT
of HEALTH SERVICES

Rights Of Minors



Outpatient Behavioral Health Treatment

**Information about the
legal rights of children and
adolescents in outpatient
mental health and substance use
treatment**

Consent for Mental Health Treatment

If you are younger than 14-years-old, a parent or guardian must agree, in writing, to you receiving outpatient mental health treatment.

If you are 14 years or older, you and your parent or guardian must agree to you receiving outpatient mental health treatment.

If you want treatment but your parent or guardian is unable to agree to it or won't agree to it, you (or someone on your behalf) can petition the county mental health review officer for a review.

If you do not want treatment but your parent/guardian does, the treatment director for the clinic where you are receiving services must petition the mental health review officer for a review.

Regardless of your age, in an emergency, the treatment director for the clinic may allow you to receive outpatient mental health treatment, but no medication, for up to 30 days.

During the 30 days, the treatment director must get informed written consent of your parent or guardian, or file a petition for review for admission with the Mental Health Review Officer.

Review by Mental Health Review Officer and/or Court

Each juvenile court appoints a mental health review officer for their county. Find the mental health review officer for your county at:

www.dhs.wisconsin.gov/clientrights/mhros

The juvenile court must ensure that you are provided any necessary assistance in the petition for review.

If you request it and the mental health review officer believes it is in your best interests, review by the mental health review officer can be skipped and the review will be done by the court (judicial review).

If the **mental health review officer** does the review, a hearing must be held within 21 days of the filing of the petition for review, and everyone must get at least 96 hours (4 days) notice of the hearing.

To approve your treatment (against your will or despite the refusal of your parent/guardian) the mental health review officer must find that all these are true:

- The refusal of consent is unreasonable.
- You are in need of treatment.
- The treatment is appropriate and least restrictive for you.
- The treatment is in your best interests.

If you disagree with the decision of the mental health review officer, you and your parent/guardian will be informed of the right to a judicial review.

If the **court** does the review, within 21 days of the mental health review officer's ruling, you (or someone acting on your behalf) can petition the juvenile court for a judicial review.

A court hearing must be held within 21 days of the petition, and everyone must get at least 96 hours (4 days) notice of the hearing.

If you do not want the treatment, the court must appoint you an attorney at least 7 days prior to the hearing.

If it is your parent/guardian who does not want the treatment and you do not already

have a lawyer, the court must appoint you one.

To approve your treatment (against your will or despite the refusal of your parent/guardian), the judge must find that all these are true:

- The refusal of consent is unreasonable.
- You are in need of treatment.
- The treatment is appropriate and least restrictive for you.
- The treatment is in your best interests.

A court ruling does not mean that you have a mental illness.

The court's ruling can be appealed to the Wisconsin Court of Appeals.

Consent for Substance Use Treatment

Any minor can consent to substance use treatment at a public facility as long as it is for prevention, intervention, or follow up.

If you are **younger than 12-years-old**, you may only get limited substance use treatment (such as detox) without a parent or guardian's consent.

If you are **12-years-old or older**, you can be provided some limited treatment (assessment, counseling, and detox less than 72 hours) without your parent or guardian's consent or knowledge.

If your parent or guardian agrees to it, you can be required to participate in substance use treatment, including assessment and testing.