SUMMIT COUNTY JUVENILE COURT

CONSENT FOR THERAPEUTIC TREATMENT

Summit County Juvenile Court Detention has clinical services available for youth who are in the detention center. Services include:

Assessment
Crisis Intervention
Brief Counseling
Group Counseling
Psychiatric Services

Clinical Staff will assess youth for mental health or emotional needs as well as lethality risk. They will be available to youth who are in need of crisis intervention and support as needed.

Confidentiality will be maintained by the clinical staff at all times with the exception of these situations:

- A youth shares a plan to cause serious harm or death to themselves, and it is believed the youth has the intent and ability to carry out this threat in the very near future.
- A youth shares a plan to cause serious harm or death to someone else who can be identified, and it is believed this youth has the intent and ability to carry out this threat in the very near future.
- A youth is doing things that could cause serious harm to themselves or someone else, even if they do not *intend* to harm themselves or another person.
- A youth reports current abuse –physical, sexual, or emotional – or that they have been abused in the past. In this situation, Clinical Staff is required by law to report the abuse to Summit County Children Services.
- The youth is involved in a court case and a request is made for information about their mental health and/or services provided while in detention. If this happens, Clinical Staff will not disclose information without the youth's agreement *unless* the court requires them to. If Clinical Staff is required to disclose information to the court, the youth will be informed that this is happening.

Continuity of Care and Referral:

Continuity of care simply means that providers may share information about demographics, history, treatment, medication, diagnosis and utilization in order to work together to coordinate a youth's care. Clinical Staff may be asked to exchange information about youth's mental health to their court worker and other service providers in order to arrange counseling and other services for the youth upon their release from the detention center.

Print Youth's Name:

Consent to Treatment

Signing below indicates that you are agreeing to allow your youth to participate in the above therapeutic services while s/he is in detention.

Parent/Guardian Signature: ______________________________ Date:

Confidentiality

I will respect the nature of the therapeutic relationship and the need for confidentiality within that relationship. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in mental health services as needed.

I understand that I will be informed about situations that could endanger my child. I know the decision to breach the confidential nature of the therapeutic relationship is up to the clinical staff's professional judgment and may sometimes be made in consultation with his/her supervisor.

Parent/Guardian Signature: ______________________________ Date:

Consent to Exchange of Information for Continuity of Care

Signing below indicates that you agree to allow Clinical Staff to share information with your youth's court worker and other service providers in order to facilitate continuity of care both during your youth's stay at the detention center and upon his/her release.

Parent/Guardian Signature:______________________________ Date:

Clinical Staff Signature: ______________________________ Date: ____________

This consent expires six months from the date of execution, unless revoked by the consenting party prior to the date of expiration.