

Client

Department of Health Services
Division of Mental Health & Substance Abuse Services

Rights

<http://dhs.wisconsin.gov/clientrights/index.htm>

Office

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INTRODUCTION TO CLIENT RIGHTS

Applies to: Anyone who is **receiving services for mental illness, a developmental disability, or substance abuse** in the state of Wisconsin.

Brief History of Client Rights in Wisconsin: A 1972 Wisconsin Supreme Court decision entitled, Lessard v. Schmidt, set forth the rights of mental health clients. These rights were then adopted into state law with the creation of subsections 51.61 and 51.30, Wisconsin Statutes in 1976. The law required the Department of Health and Social Services (now the Department of Health Services) to create rules for a grievance procedure to ensure client rights.

The department created the Client Advocacy Program (CAP -- now the Client Rights Office - CRO) to oversee the development of those rules and the grievance process. CAP staff drafted administrative rules to implement client rights and confidentiality and these were adopted as HFS 94 and HFS 92 (now DHS 94 and DHS 92), Wisconsin Administrative Code.

SUMMARY OF CLIENT RIGHTS

TREATMENT RIGHTS: Every client has the right to:

- Receive **prompt** and **adequate** treatment
- **Participate** in their treatment **planning**
- Be **informed** of their **treatment** and **care**
- **Refuse** treatment and medications (unless court-ordered)
- Be free from **unnecessary** or **excessive** medications
- **Refuse electro-convulsive therapy (ECT)**
- **Refuse drastic treatment** measures

RECORD PRIVACY AND ACCESS: (See also, Confidentiality)

- Staff must keep client information **confidential**
- Records cannot be **released** without client consent (with some exceptions)
- Clients may **see** their records **except** that, **during treatment**, client access to records **may be limited** if the **risks outweigh benefits** of access.

- They can **always** see records of their **medications** and **health** treatment.
- Clients **may challenge** the **accuracy, completeness, timeliness or relevance** of entries in their records.

COMMUNICATION RIGHTS: Every **(in)patient** has the right to:

- Have reasonable access to a **telephone** daily*
- See (or refuse to see) **visitors** daily *
- Send or receive private **mail**
- Contact **public officials, lawyers** or client **advocates**

PERSONAL RIGHTS: Every **(in)patient** has the right to:

- Be in the **least restrictive** environment (except for forensic clients)
- Not be **secluded** or **restrained** except in an **emergency** when necessary to **prevent harm** to self or others
- Have a **humane psychological** and **physical environment**
- Be in surroundings that are kept **safe, clean** and **comfortable**
- Wear their own **clothing** and use their own possessions *
- Be provided with access to **laundry** services
- Have regular and frequent **exercise** opportunities
- Have regular and frequent access to the **outdoors**
- Have a reasonable amount of secure **storage space** for their possession *

FINANCIAL RIGHTS

- Be **informed of the costs of their care** and treatment
- Use their **own funds** as they see fit (within some limits)
- Get an **accounting of their funds** if held by the provider
- **Refuse to work** – except for personal housekeeping tasks
- Be **paid for work** they agree to do that is of financial benefit to the facility

PRIVACY RIGHTS: Every **(in)patient** has the right to:

- Not be **filmed** or **taped** without their consent (with some exceptions)
- Have **privacy** in **toileting** and **bathing** *

MISCELLANEOUS RIGHTS: Every client has the right to:

- Be informed of their rights
- Be treated with dignity and respect
- Have staff make reasonable (non-arbitrary) decisions about them
- Make their own decisions about civil rights such as marrying, making a will
- To make their own decisions about participation in religious worship
- Be free from discrimination because of their race, national origin, sex, age, religion, disability or sexual orientation

RIGHT TO FILE GRIEVANCES: Every client has the right to:

- To **file complaints** about violations of their rights
- To have access to the DHS 94 **grievance process**
- To be **free** from any **retribution** for filing complaints

* The rights with an asterisk (*) behind them **may be limited or denied** for certain reasons. See **Client Rights Limitation or Denial** for further information.

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THE GUARDIAN'S ROLE IN TREATMENT DECISIONS

Treatment Rights:

Clients [and thus their guardians] have a **right to participate in the planning** of the individual's **treatment and care.** [§ 51.61(1)(fm), Wis. Stats., emphasis added]

Clients have a **right to receive prompt and adequate treatment, habilitation or rehabilitation, and educational services appropriate for their condition.**
[§ 51.61(1)(f), Stats. and DHS 94.08, Wis. Admin. Code, emphasis added]

Clients have a **right to a humane psychological and physical environment,** which includes specified rights to **social, recreational and leisure time activities.**
[DHS 94.24(3), Wis. Admin. Code, emphasis added]

Clients in ICFs/MR have the **right to receive "a continuous active treatment program,** which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services... that is directed toward

(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and

(ii) The prevention or deceleration of regression or loss of current optimal functional status.

[42 Code of Federal Regulation § 483.440(a)(1), emphasis added]

Chapter 55 [Protective Service System] - Declaration of Policy:

"The legislature recognizes that many citizens of the state, because of serious and persistent mental illness, degenerative brain disorder[s], developmental disabilities or like incapacities, are in need of protective services or protective placement. ...the protective services or protective placement should, to the maximum degree of feasibility ... **allow the individual the same rights as other citizens,** and at the same time **protect the individual** from financial exploitation, abuse, neglect, and self-neglect. This chapter is designed to establish those protective services and protective placements and assure their availability to all persons when in need of them, and to place **the least possible restriction on personal liberty and the exercise of constitutional rights** consistent with due process and protection from abuse, financial exploitation, neglect and self-neglect."

[§55.001, Wis. Stats., emphasis added]

The guardian's duties:

A guardian needs to **endeavor to secure** any **necessary care or services** that are in the ward's best interests, and be involved as required pursuant to § 54.25(1)(b), Stats.

A guardian needs to be aware of and, when applicable, **advocate** for the **client's rights** under § 50.09 and § 51.61, Wis. Stats., and should **advocate for the least possible restrictions** on the ward's **liberty** and exercise of Constitutional and statutory rights, pursuant to § 54.18(2) and § 54.25(2)(d)3, Wis. Stats.

If the guardianship is individualized, with a number of the client's "capacities" identified by the court, then the guardian will have **limited power** over those areas, and will need to carefully review the court findings and determinations in the order appointing the guardian, and ensure that any rights retained by the individual are reviewed with the ward, and exercised by the ward. [§ 54.25(2)(d), Wis. Stats., emphasis added.]

Questions for the guardian to consider in advocating for a client's care and treatment:

- ◆ What is prompt and adequate treatment or services for the individual's condition and needs?
- ◆ How are the individual's treatment needs assessed? Are they prioritized? Are they re-assessed at appropriate intervals?
- ◆ What kind of "functional assessments" may have been completed? Are they timely and relevant?
- ◆ For a less verbal person, are the person's communication needs and styles being assessed, documented and facilitated as necessary?
- ◆ What goals are identified as part of the "Individualized Service / Care Plan"?
- ◆ Are there proper supports or approaches identified and put into place in order to help the person to meet their treatment goals?
- ◆ Has an "Essential Lifestyle Plan" or "Person-Centered Plan" been completed?
- ◆ Are there regular team meetings where the plans/goals are reviewed?

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HOUSE RULES or EXPECTATIONS in RESIDENTIAL SETTINGS CLIENT RIGHTS IMPLICATIONS

The right to a “humane psychological and physical environment” impacts on day-to-day living conditions, opportunities, and expectations for clients and providers. DHS 94.24(3)(a) to (i) guarantee clients’ access to various types of possessions and social, recreational, and leisure time activities, unless there are documented security or safety reasons to deny such access. Sometimes, however, house rules are in place that make clients’ exercising of these basic Constitutional and civil rights contingent upon behavior or compliance with expectations that do not at all relate to safety or security reasons.

When reviewing a facility’s house rules, the following analysis may be helpful:

- 1) **Which rules relate to basic health and safety needs** of clients or providers, and are **imperative** for the **safe management** of a facility or home? These rules must be **justifiable** on a **safety** or **security** basis.
- 2) **Which rules relate to group living expectations** that are necessary to promote a **reasonable degree of peace** and harmony between the clients? An individual’s rights must be **balanced** against the rights of peers. This justifies rules relating to use of common space and time and place limits on noise or use of possessions that may be disruptive to others. In this context it is important to review whether rules as written are the **least restrictive means** of accomplishing the objective.
- 3) **Which rules make access to basic rights** (e.g., community access, leisure or recreational opportunities) **contingent upon client’s compliance?** If the objectives or expectations do not relate to safety or security, these rules are likely to violate a client’s right to be free from arbitrary decisions. In general, it is **not justifiable** to use house rules to hold individuals to a higher standard than the law establishes, or to force compliance with expectations as a pre-condition for exercising of their rights. In some cases, with proper documentation in an ISP / behavioral treatment plan, an **individualized** behavioral approach with certain contingencies may be justified for a client. Such a plan must be consented to by the client and/or guardian. Additionally, clients’ individualized treatment goals and objectives should take priority over more general house rules that could be counter-therapeutic, as applied to the client.

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CLIENT RIGHTS APPLICABILITY

What rights are applicable to whom? When? Where?

Review of **definition of “patient”** (a/k/a client, consumer, resident, member, etc.)

§ 51.61(1) **Bill of Rights** & DHS 94 rights apply to people **receiving services** for mental health, AODA, developmental disabilities or under Ch. 55 PP order.

DHS 10.51 **Family Care rights** apply to people eligible for services, or receiving Family Care services through a care management organization.

Client rights pursuant to sec. 51.61 / DHS 94 and DHS 10 are **portable** and **apply across all care and treatment settings** (following a person through the system).

Other DHS rules [rights] apply to the specific care and treatment settings, e.g.:

- DHS 34 Emergency mental health service programs
- DHS 35 Outpatient mental health clinics
- DHS 63 Community support programs for chronically mentally ill persons
- DHS 83 Community-based residential facilities
- DHS 88 Licensed adult family homes
- DHS 89 Residential care apartment complexes [assisted living]
- DHS 132 Nursing homes

Court orders (e.g., per Chs. 48, 51, 54, 55, 938, or restraining orders) or rules of probation or parole **may override otherwise applicable client rights**. Providers and case managers need to ensure that “up to date” paperwork is on file.

Providers / case managers need to always be aware of their client's **legal status**. A review of legal status should include consideration of **who, in addition to the client, can consent** to services or treatment, release records, and the exercise of rights applicable to the client:

- Activated Powers of Attorney for Health Care or Finances / Property
- Guardians of Person or Estate (a full or limited guardianship)
- Conservators for client funds, or Rep Payees for client disability benefits
- Parents of minors under 14 y/o, versus minors aged 14-17 y/o
- Legal Custodians of minors, or court appointed Guardians of minors

Be aware of **possible limits on the scope or role** of substitute decision makers, and legal standards applicable for their decision-making. The decision at hand, or nature of the consent needed, may also bear on the relative roles of the client *vis a vis* their substitute decision maker(s).

Other **advocates, friends, or relatives** of the client can also provide input.

Some questions to ask regarding **court orders** include:

- Is there a Ch. 51 commitment and/or order for medications and treatment?
- Is there a Ch. 55 Protective Services or Protective placement order?
- Is there a Ch. 971 forensic commitment order?
- Is a Ch. 54 guardianship limited, with the client retaining specific rights?

For **minors**:

- Is there a Ch. 48 or Ch. 938 Dispositional Order?
- Is there a Divorce Decree regarding custody and decision-making?

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RIGHT TO TREATMENT

All patients have the right to receive **prompt and adequate treatment** that is **appropriate for their condition**. (§ 51.61(1)(f), Wis. Stats.)

During the assessment and planning phase of treatment, the treatment provider should consider, as appropriate, whether to:

- Conduct a multidisciplinary functional assessment.
- Assess the frequency and intensity of the target behaviors.
- In complex cases, prioritizing the client's treatment needs
- Develop a person-centered plan to address the client's goals and needs.
- Include the patient and/or the patient's representative in developing the plan.
- Exercise professional judgment in developing the plan.
- Use positive approaches and positive reinforcement wherever feasible.
- Use the least intrusive measures to control behaviors.
- Develop measurable criteria to assess treatment progress.
- Document the specific risks and benefits of the proposed treatment plan.
- For clients with challenging or dangerous behavior, develop an individualized safety plan with specific de-escalation and crisis intervention strategies
- Obtain written, informed consent for the services and treatment plan.

Once the plan has been developed, the provider should:

- Consistently implement the plan across all settings.
- Document the frequency and intensity of the target behaviors over time.
- Monitor the services and program implementation.
- Re-assess the plan periodically, with client input, to ensure its efficacy.
- Amend the plan if significant changes in conditions occur.
- Obtain new consents whenever plan changes (or at least annually).

Special considerations when psychotropic medications are part of a plan:

- There must be a separate informed consent for each medication.
- The medication should be appropriate to the condition(s) the client has.
- They should be within the normal dosage range and must not be excessive.

- If they are outside of the normal range, the reasons must be documented.
- Medication compliance issues should be addressed in the plan.

If the client complains about the treatment plan, the CRS can:

- Review the informed consent documents.
- Review the exercise of professional judgment for any deviations.
- Interview the treatment professionals involved.
- Review the client's participation in the treatment planning process.
- Suggest a second opinion (for free within the provider agency).
- Review documentation to ensure ongoing monitoring and re-assessments.

In general, the CRS must “defer to professional judgment” unless there is evidence that the professionals deviated from professional standards.

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RESTITUTION from CLIENTS in RESIDENTIAL SETTINGS CLIENT RIGHTS IMPLICATIONS

House “rules” can generally include the expectation that clients **respect property** of peers or the facility. However, it is very problematic for house rules or a placement agreement to require restitution, in an across-the-board manner (one size fits all), for damages to items by clients who live in that setting.

In reviewing when or in what circumstances use of **restitution** may be appropriate, it is imperative that the following factors be comprehensively addressed:

- 1) Is there a **history** of the client acting out in ways that cause damage to property? If so, then there should be an **individualized** “treatment plan” (or behavior support plan) in place that spells out how staff are to proactively work with the client to promote and reinforce **positive behavior**, and how staff will respond or intervene in situations where there is a potential for damage. The plan should note potentially successful or effective approaches and interaction styles. It is of great importance to ensure **staff consistency** and that all staff “work off the same page”.
- 2) Is the client able to make a **meaningful connection** between the behavior and/or damage caused, and the potential consequence of restitution? Or, are there indications the client was not in control of the behaviors when they were being displayed or made no connection to possible consequences? This involves the issue of **competency** or **capacity** of the individual. **Individualized assessment** is needed to document that restitution is warranted and meaningful and will be effective in conditioning behaviors and deterring damage. If a client is psychotic or otherwise does not have the capacity to make the connection, then requiring restitution may be arbitrary or unwarranted.
- 3) Has the service provider taken **reasonable measures** to protect the property against any known or **foreseeable risks**? If a client has a history of targeting items such as radios or TVs, then those appliances need to be secured in ways that would prevent them from being toppled, thrown, or damaged. When it is quite foreseeable that a certain harm might occur, and the provider does not effectively guard against it (e.g., by providing sufficient staffing or other environmental safeguards), then it may be the **provider’s responsibility** and **not the client’s**.

- 4) If there is **damage**, there needs to be an assessment after the incident to review whether it is fair and reasonable to require restitution from the client in that circumstance. Is it **more probable than not** that the client in fact did the damage? What is the client's version of events, and his/her credibility? Was the client solely culpable or, e.g., provoked by a peer who should perhaps be held partially responsible due to the provocative behavior? Are there other **mitigating factors** that should be taken into account, e.g., mental instability due to medication changes? Did staff recognize the precursors to the behavior and intervene proactively (and reactively), in accordance with the client's treatment plan? Depending upon the answers to these questions, it may be an arbitrary decision and/or inappropriate to impose restitution in some instances, even when damage occurred. In other words, it may not be reasonable to make the client pay if staff did not properly fulfill their roles and treatment responsibilities to the client. **Documentation** regarding consideration of the above factors is necessary to show there was not a potentially arbitrary decision and that prompt treatment efforts were attempted or occurred. This process should, as much as possible, be a **team assessment** and decision.
- 5) The **amount of restitution** imposed needs to be determined on a **case-by-case** basis, both in terms of amount and a reasonable payment plan. Requiring full replacement cost is not usually valid, due to the depreciated value of the property. Depreciation formulas (taking into account the age/ condition of the item damaged) should be utilized. A maximum amount (or percentage) of a client's funds that could be applied to restitution should be established [because the legitimate treatment goal of a restitution plan is to facilitate learning, not to "make another person whole", or for the provider to act as a "Small Claims Court"]. In no circumstances can all, or nearly all, of a client's earnings or monthly personal allowance be used for restitution. Nor should the payment of restitution be prioritized in a way that precludes access to community, recreational, and leisure activities.

The primary client rights [per § 51.61(1), Stats. and DHS 94, Wis. Admin. Rules] that are applicable when restitution is involved are:

- right to **prompt and adequate treatment** appropriate for one's condition
- right (of client/guardian) to **participate in the planning of treatment & care**
- right to be **free from arbitrary decisions**
- right to the **least restrictive conditions**
- right to access / use one's **personal funds** (and to not have funds taken without due process).
- **federal regulations** and guidelines applicable to clients served via **CIP funds**

[NOTE: This summary **does not address voluntary restitution** which may occur in some instances, guardian-initiated or guardian-paid restitution, or the option of going to "Small Claims Court" where action could be initiated by an aggrieved person.]

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THE RIGHT TO TREATMENT (In the context of crisis intervention services)

Patients have a right to receive **prompt and adequate treatment**, ... appropriate for [their] condition ... [subject to the “shield law”]

Sec. 51.61(1)(f), Stats.

Patients have a right to be informed of treatment and care, and to **participate in the planning** of [their] treatment and care.

Sec. 51.61(1)(fm), Stats.

51.42 Community mental health, developmental disabilities, alcoholism and drug abuse services ... The county ... has the primary responsibility for the well-being, treatment and care of the mentally ill, developmentally disabled, alcoholic and other drug dependent citizens residing within its county, **and for ensuring that those individuals in need of such emergency services found within its county receive immediate emergency services.**

Sec. 51.42(1)(b), Stats.

See definition of “**crisis**” + “**crisis plan**” in DHS 34.01(5) & (6), Wis. Admin. Code

Additional aspects of patients’ right to prompt and adequate treatment:

- discussion of state level DHS 94 Grievance Decision precedents
- right to assessment or re-assessment by county of need for services
- for a person on a waiting list, prioritizing of services may be warranted
- right to continuity of care and treatment (e.g., for county CSP clients)
- awareness of effective proactive / reactive interventions (as applicable)
- access to relevant treatment or medications information (as needed)
- consideration of PRN medications as part of one’s right to treatment

Miscellaneous issues:

How may the person’s expectation of privacy / confidentiality be addressed?
Will crisis intervention staff be trained to do “credibility assessments” as needed?
Review and discussion of Confidentiality document on **exchange of information**

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RESPECTING CLIENT CHOICES

How do we **promote, support, or tolerate** individuals' lifestyle choices?

Choices may be related to individuals' perceptions of the **five basic senses**:

Hearing



Sight



Smell



Taste



Touch



Choices can be influenced by **family, cultural, spiritual or regional values**. Is there any **assessment or documentation** of how a client **expresses** his/her choices?

When / how might staff try to **promote** (or influence) an **individual's choices**?

- **Assessment of choices**, and their **function** and **value** to the person
- Consider use of the "**Essential Lifestyle Planning**" process
- **Proactive efforts** to "open doors" to **new experiences / activities**

What might be needed to **ensure support for individuals' lifestyle choices**?

- **Resources** from within the system such as staffing, transportation, etc.
- Reasonable **access to funds**, and **items necessary** for the **activities**
- Some degree of **compatibility** on the part of **persons living together**

What does it mean to tolerate individuals' lifestyle choices?

- **Acknowledge** the **client's right** to make a choice / engage in an activity
- **Review sources / scope** of **individual rights** (§ 51.61 & DHS 94)
[review Chapter 55 "Declaration of Policy" and DHS 94.24(3)]
- **Avoid**, as much as possible, the societal **double standard** tendency
- Document and address **impediments / obstacles** to clients' choices
- Treatment plans: Address **choices** and reminders of **consequences**
- Develop an **individualized risk management approach** for the issue
- Document criteria for, and parameters of, **time and place limitations**
- Document any "bottom line" **health and safety risks**, and **limits**

Other related issues:

- Tolerance and parameters related to "**age appropriateness**" issues
- Assess if / when a "**choice**" **may be a cue** to other issues or emotions
- **Guardian** should have **involvement / input**, not unilateral authority
- Goal of **team consensus** - with county and provider accountability

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CONFIDENTIALITY AT-A-GLANCE

What's the big deal?

Check out "**Penalties for Confidentiality & Records Violations**"

The Confidentiality Rule

Under sec. 51.30, Stats., treatment information and records are **confidential**. In general, they can **only be released** to others with the **written, informed consent** of the individual, if competent, or the guardian, if not. The rule covers both verbal information and physical treatment records.

The Exceptions

These are the exceptions to the rule above, where certain, specific people or entities may access certain information and/or records for certain purposes **without** the individual's or guardian's written **consent**. There are **27** specific exceptions are listed in the Confidentiality document on our website.

The "**Need to Know**" Standard

The principle of preserving confidentiality requires that disclosures between staff members are limited to the extent of the "need to know" of the person(s) the information is disclosed to. This means that you may disclose **only that information** which the receiver **needs to know** in order to perform their duties in relation to the individual. The only exceptions to the "need to know" are where the statute specifies the information someone is entitled to or when the individual consents.

Patient Access to Treatment Information / Records During Treatment

The individual must have access at any time to their records of all medications and health related treatment. However, **during treatment**, the facility director may restrict access to any other treatment records. To deny access to there must be reason to believe that the **benefits** of allowing access to the individual are **outweighed** by the **disadvantages** of allowing access. Reasons for any such denial must be **documented** into the individual's treatment record.

Written Informed Consent for release of information

Informed consent must be **in writing** and must be voluntarily given by an individual who is "substantially able to understand all information specified on the consent form". The **form must contain certain data**.

Right to copies of disclosed information

The informed consent document must also include a statement of the individual's **right to copies** of disclosed information under DHS 92.05 and DHS 92.06.

Refusing or Withdrawing Consent

The individual **may refuse to consent** or **may withdraw consent** at any time. If this occurs, an agency can no longer access the information (unless covered by one of the exceptions).

AODA Records / HIV/Aids Issues

These areas of treatment have special features and particularly **stringent standards**. Please ask for qualified assistance when applying state /federal law to this area.

When In Doubt -- Ask

The confidentiality rule is considered exceptional in its importance. **Don't guess!** Read the "Confidentiality Explained" document on the CRO Internet site and ask others when a question arises. Check out the how **HIPAA** applies through the HIPAA COW site that can be accessed from the CRO Internet site. A few moments on the telephone or by e-mail could save you a great deal of time and possible trouble, later.

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LIMITATIONS OR DENIALS OF CLIENT RIGHTS

The client rights law allows for certain rights of clients in **residential settings** to be limited or denied for **treatment, management** or **security reasons**. [§ 51.61(2), Wis. Stats.] The rights which may be limited or denied are:

- access to the **telephone**
- wearing one's **own clothing** / using one's own **possessions**
- **storage space**
- **privacy** in **toileting** and **bathing**
- seeing **visitors**

Important points to remember:

- These are the **ONLY** rights that may be limited or denied through this process.
- The limitation must be the **least restrictive alternative**. A right **cannot be denied** if a **limitation** would accomplish the intended goal.
- Rights limits can only be impose **only as long as necessary** to protect the treatment, management or security interest involved. [Some limitations can be long-term, however, if a danger continues to exist.]
- Any limit or denial of rights must be **documented**. (Recommend using F-26100.)
- Rights limitations must be **reviewed periodically** to see if they are still necessary.

[At **hospitals**, federal law requires that limits on phone calls and visitors be reviewed **weekly**. There is space on the form for documenting reviews. If a limitation is long-term, there is a form (DHS-62A) which can be used to document additional reviews.]

- For **county department clients**, a copy of the CRLD must be sent to the **County's CRS** within **2 days**.
- If not a county client, a copy must be sent to the **service provider's** Client Rights Specialists for review.
