Teen Dialectical Behavior Therapy (DBT) Group with Oneida County Human Services

This group is 12 weeks long, consisting of 1-hour sessions every Thursday at 3 pm. It is being held at the Oneida County Human Services building, located at 705 E. Timber Dr., Rhinelander.

Prior to the start of the group on January 29, all interested parties will meet with a group facilitator to complete an assessment to determine if this group is a good fit for you. Some of the things asked cover your basic demographics (name, DOB, phone number), how you were referred, some background questions regarding any counseling experiences before this group, your goals and motivations, and who your supporters are.

Other forms we will review include informed consents, clients' rights, grievance procedures, privacy, and financial responsibilities. Finally, a DBT Commitment Contract will be signed. This outlines the client's responsibilities, as well as those of the treatment team, regarding group sessions. For example, the client will attend group sessions, participate actively, be honest, and practice DBT skills they have learned. The treatment team's responsibilities include, but are not limited to, providing a safe space, respecting client confidentiality and working with the clients.

Please note that if you are not currently enrolled in services (therapy/psychiatry/case management) through Oneida County Human Services, a more in-depth mental health assessment will be required. This would include getting more detailed information regarding any previous trauma and mental health symptoms.

To refer a potential participant, please complete the Oneida County Human Services Timber Drive-Referral Form with the participant's information and include the reason for referral as "Teen DBT Group," along with additional relevant referral information.

For more information regarding our upcoming teen DBT group or if you need any assistance completing a referral, please contact Leahan at 715-493-3656. Thank you

Oneida County Human Services Timber Drive: Universal Referral Form

1. Referral Source Information

Referring Agency/Organization:

_____

Referring Staff Name & Title:

_____

Phone: _____

Email: _____

Date of Referral: ____ / ____ / _____

2. Client Information

Client Name:

_____

Date of Birth: ____ / ____ / _____

Parent/Guardian (if applicable/required if client is a minor or has guardian):

_____

Primary Phone: _____

Secondary Phone (optional): _____

Address:

_____

3. Requested Service(s)

Check all that apply:

- ☐ **Birth to 3**
- ☐ **CLTS (Children's Long-Term Support)**

Mental Health Case Management Services:

- ☐ **CCS (Comprehensive Community Services)**
- ☐ **CSP (Community Support Program)**

Outpatient Services:

- ☐ **Psychiatry (Medication Management)**
- ☐ **Therapy (Mental Health) (do not select this option if selecting CCS)**
- ☐ **Substance Use Disorder Counseling or Peer Support (AODA)**

4. Reason for Referral

Brief description (1–2 sentences):

5. Additional Notes (Optional)

Thank you for your referral. A staff member will contact the client or parent/guardian to complete the full intake process.

Please send referral to referrals@thehumanservicecenter.org