
**ORANGE COUNTY SOCIAL SERVICES AGENCY
CFS OPERATIONS MANUAL**

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Revised: October 6, 2026

Policy No.: I-0303

Mental Health Services

Purpose To provide guidelines for referring children/Nonminor Dependents (NMDs) who have an open case with Children and Family Services (CFS) to mental health services.

Approved This policy was approved by Loan English, Director of CFS.
Signature on file.

Most Recent Revision This revision of the Policy and Procedure (P&P), previously titled Mental Health Screening and Treatment, includes:

- Implementation of the Integrated Practice (IP) - Child and Adolescent Needs and Strengths (CANS) Assessment Tool used in conjunction with the Child and Family Team (CFT)
- Requirement to refer all children/NMDs to the Health Care Agency (HCA) within three (3) business days of case opening, replacing the Mental Health Screening requirement
- Information on Non-Minor Dependent (NMD) rights and authority to consent to mental health services
- Presumptive Transfer requirements previously detailed in the Presumptive Transfer Desk Guide
- Guidance for disclosing mental health information previously detailed in the Disclosure of Mental Health Information Recommendation Desk Guide
- Revision and renumbering of previous Attachment — 3 to Attachment 2 — Mental Health Referral Submission
- Inclusion of new attachments:
 - Attachment 1— Workflow to Complete Child and Adolescent Needs and Strengths (CANS) as a Mental Health Referral

- Attachment 3 — Ex-Parte Template for Court Authorization to Release Mental Health Information
 - Attachment 4 — Out-of-County Placement/Presumptive Transfer Initial Notification Flowchart
 - Attachment 5 — Presumptive Transfer Waiver Request Processing and Notification Flowchart
 - Attachment 6 — Presumptive Transfer Decision Flowchart
 - The following attachments are rendered obsolete:
 - Attachment 1 — Mental Health Behavioral Indicators
 - Attachment 2 — Mental Health Screening Checklist Outcomes
 - Attachment 4 — Authorized Mental Health Providers and Resources
 - Attachments 5 — Determination of Katie A. Subclass Equivalent Guide
 - Attachment 6 — Child and Family Team Model
 - Attachment 7 — Child and Family Team (CFT) Meeting Guide
 - Attachment 8 — Screening to Assessment Flow Chart
 - Inclusion of *The Child and Adolescent Needs and Strengths (CANS) Assessment Tool Coversheet/ Mental Health Assessment Referral (F063-25-837)*
 - *The Mental Health Screening Checklist (F063-25-731)* is rendered obsolete
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Background

In 2002, a California class action lawsuit, *Katie A., et al. v. Diana Bonta et al.*, sought to improve mental health and other supportive services available to children and youth at imminent risk of placement into foster care and those in out-of-home care. A settlement agreement, approved in 2011, transformed the way children receive and access mental health services.

In 2013, the California Department of Social Services (CDSS) and the California Department of Health Care Services (DHCS) developed the Pathways to Mental Health Services Core Practice Model (CPM) in response to the settlement, State initiatives, and federal legislation. The CPM requires partnering with families and collaboration among providers, including the Social Services

Agency (SSA), Health Care Agency (HCA), and other service providers.

Pathways to Well-Being (PWB), formerly Katie A., is a partnership between child welfare and mental health providers to coordinate and deliver comprehensive mental health services.

In 2017, AB 1299 implemented the Presumptive Transfer process for the timely provision of Specialty Mental Health Services (SMHS) when children/NMDs are placed out-of-county. The responsibility for authorization, provision, and payment of mental health services, is the Mental Health Plan (MHP) in the child's/NMD's county of residence. In Orange County, the MHP is the Health Care Agency (HCA) which includes HCA/ Children and Youth Behavioral Health Services (CYBH), Clinical Evaluation Guidance Unit (CEGU), Continuing Care Placement Unit (CCPU), HCA/CYBH Regional Clinics and HCA-contracted providers.

In 2018, CDSS and DHCS released the Integrated Core Practice Model (ICPM) guide that is derived from a compilation of PWB Services. The ICPM moves from working in an individual system/agency to working in a cross-system team environment.

All County Letter (ACL) 18-81 provides the requirements and guidelines for implementing the California Integrated Practice Child and Adolescent Needs and Strengths (IP-CANS) assessment. Refer to CFS P&P Child and Adolescent Needs and Strengths Assessment (CANS) (D-0315) for additional information on the CANS Assessment Tool.

ACL 24-35 provides that all children/NMDs involved in an open child welfare case are categorically eligible to access SMHS and eliminates the mental health screening requirement. Child Welfare Agencies are required to submit referrals to the appropriate MHPs for all children/NMDs within three (3) business days of opening a child welfare case. The California Advancing and Innovating Medi-Cal (CalAIM) initiative updated beneficiary access criteria to SMHS.

ACL 24-43 revised the presumptive transfer requirements to provide that generally when a child/NMD is placed in out-of-county short term facilities, the responsibility for authorization, provision and payment of mental health services is the MHP in the child's/NMD's county of jurisdiction (HCA).

Definitions

For the purposes of this P&P, the following apply:

Intensive Care Coordination (ICC): A type of targeted case management service (Medi-Cal only) that facilitates assessment of, care planning for and coordination of services, including urgent services for children/youth who meet PWB criteria. The ICC coordinator is an identified HCA and/or HCA-contracted clinic therapist.

Intensive Home-Based Services (IHBS): (Medi-Cal only) Mental health rehabilitation services provided to PWB eligible members. IHBS are services designed to improve mental health conditions that interfere with a child's functioning in the home and their community. The services are designed to build skills necessary to improve the family's ability to help the child and the child's ability to function successfully in his/her home and community.

Mental Health Provider: Pursuant to Family Code (FAM) § 6924(a)(2) and Health and Safety Code (HSC) § 124260(a)(2), a professional person, such as any of the following:

- Marriage and Family Therapist
- Licensed Educational Psychologist
- Credentialed School Psychologist
- Clinical Psychologist
- Licensed Clinical Social Worker
- Licensed Professional Clinical Counselor
- Registered Marriage and Family Therapist intern and/or Registered Clinical Counselor intern under the supervision of a licensed professional

Mental Health Treatment: Pursuant to the American Psychiatric Association, an individualized plan developed collaboratively with a mental health clinician and an individual (and family members if the individual desires). It may include psychotherapy (talk therapy), medication or other treatments.

Open Child Welfare Case: Types of cases include Family Maintenance (court and voluntary), Family Reunification, Another Planned Permanent Living Arrangement, Adoption, Guardianship and Extended Foster Care (EFC).

Excludes - finalized adoptions (AAP cases), probate, ICPC Courtesy Supervision, Kin-GAP (funding only).

Note: Emergency Response referrals that are closed without further action are not considered open child welfare cases.

Pathways to Well-Being (PWB) class (formerly known as **Katie A. Subclass Members/Eligibility**): consistent with Orange County Health Care Agency Behavioral Health Services Policy, a child who:

- Is eligible for full scope Medi-Cal (Title XIX)
- Meets Medical Necessity criteria for SMHS
- Has an open child welfare services case
- Meets one or both of the following criteria:
 - Currently in or being considered for: Wraparound, therapeutic foster care, specialized care due to behavioral health needs or other intensive Early Periodic Screening and Diagnostic Treatment (EPSDT) services (i.e. therapeutic behavioral services, crisis stabilization/intervention).
 - Currently in or being considered for a Short Term Residential Therapeutic Program (STRTP), a psychiatric hospital or 24-hour mental health treatment, or has experienced three or more placements within 24 months due to behavioral health needs

Note: HCA/Children and Youth Behavioral Health (CYBH), Clinical Evaluation Guidance Unit (CEGU), Continuing Care Placement Unit (CCPU), HCA/CYBH Regional Clinics and HCA-contracted providers are trained to determine PWB eligibility.

Presumptive Transfer: Pursuant to Welfare and Institutions Code (WIC) § 14717.1, the prompt transfer of the responsibility for providing, arranging for the provision of, and payment for SMHS from the county of original jurisdiction to the county in which the foster child/NMD resides.

Specialty Mental Health Services (SMHS): Pursuant to Welfare and Institutions Code (WIC) § 14184.402, a child/NMD is eligible to receive SMHS when they are at high risk for a mental health disorder due to experiencing trauma as evidenced by any of the following:

- High risk trauma score
- Child welfare/juvenile justice involvement
- Experiencing homelessness

Medi-Cal SMHS services include:

- Crisis intervention services
 - Rehabilitative mental health services
 - Psychiatric inpatient hospital services
 - Targeted case management
 - Psychiatric services
 - Psychological services
 - EPSDT supplemental specialty mental health services
 - Psychiatric nursing facility services
 - Intensive Care Coordination (ICC)
 - Intensive Home-Based Services (IHBS)
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POLICY

General Guidelines

Per CFS P&P Dependency Intake (A-0502) and P&P Jurisdictional/Dispositional Hearing Report (G-0310), upon promotion of an open child welfare case, the Assigned Senior Social Worker (ASW) will provide children/NMDs with timely and appropriate:

- Information regarding their right to consent to treatment
- Referrals and treatment services (e.g., mental health assessment, Child and Family Team, Wraparound, substance abuse counseling)

The ASW will collaborate with the child/NMD, family, and mental health provider on an on-going basis and as often as necessary to appropriately address the child's/NMD's mental health needs.

Refer to the "Court Report Documentation/ Notification" Policy section below for further guidelines on documentation of mental health referrals, assessments and treatment in court reports.

Advisements

The ASW will provide advisements regarding mental health services to children, NMDs, caregivers and parents/legal guardians.

A. Children, Caregivers and NMDs

The ASW will inform children/NMDs in need of mental health services who are 12 years of age or older of their rights to consent to treatment.

Per ACL 21-69, social workers are required to inform caregivers, Child and Family Team (CFT), and children/NMDs in out-of-home placement of the Mental Health Rights as detailed in the Foster Youth Bill of Rights (FYBOR) at the following specified times:

- Once every six months
- At time of placement
- Each placement change

For further guidance regarding the FYBOR refer to CFS Dispatch Foster Youth Rights (D-0316-D).

B. Parents/Guardians

The ASW will inform parents/legal guardians of the following:

1. Their child's right to consent to outpatient mental health services, counseling, and residential shelter services (if they are 12 years of age or older).
2. A mental health provider who knows that a child/NMD has been removed from the physical custody of their parent/legal guardian will not release/disclose the child/NMD's mental health information without Juvenile Court authorization.

Document advisements given to children, caregivers and their parents/legal guardians in a Child Welfare Services/Case Management System (CWS/CMS) case contact.

**Consent for
Mental Health
Services**

Refer to CFS P&P Consent for Medical Care and Physical Examination (I-0206) for detailed guidance on consent for mental health treatment of children. Mental health treatment is included in the basic medical care for children.

A. Parental Consent

Pursuant to WIC§ 369(g), parents or legal guardians have the legal authority to consent to medical care, including mental health, unless otherwise restricted by Court. If efforts to obtain parental consent are unsuccessful, the ASW may seek Court authorization.

Per Family Code (FAM) § 6929(f), a parent or legal guardian may consent to counseling for a child's drug or alcohol related problem, when the child does not consent to the care.

Note: The Juvenile Court may also provide authorization for a representative of the Social Services Agency (SSA) to sign consent on behalf of the child; however, the ASW will first seek to obtain parental consent.

B. Child's Consent

1. Child Under 12 Years of Age

Consent laws do not provide for children younger than 12 years to voluntarily consent to their own mental health treatment, including drug and/or alcohol treatment services.

2. Child 12 Years of Age and Older

Pursuant to FAM § 6924(b) and Health and Safety Code (HSC) §124260 (b), a child 12 years of age or older may consent to mental health services, if the child, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services and unless prohibited by court order.

3. Child 16 Years of Age and Older

Pursuant to WIC 369 (f) a dependent child 16 years of age or older may consent to receive medications for opioid use disorder from a licensed narcotic treatment program as replacement narcotic therapy without the consent of the child's parent, guardian, or social worker, and without a Court order to the extent expressly permitted by federal law. A dependent child 16 years of age or older may consent to opioid use disorder treatment that uses buprenorphine at a physician's office, clinic, or health facility, by a licensed physician and surgeon or other health care provider, whether or not they have the consent of their parent, guardian, social work and without a court order.

C. NMD Consent

Pursuant to WIC § 303, NMDs retain all legal decision-making authority as an adult. Per ACL—17-22E, this decision-making authority includes the right to privacy

regarding medical conditions, and the right to consent to medical and mental health treatment.

D. **Court Consent**

The assigned SSW will seek court authorization for mental health treatment when parental consent is not obtained, parents refuse/decline consent, or there is parental disagreement on consent.

**Mental Health
Assessment
Referral**

Pursuant to WIC § 14184.402, children/NMDs involved in an open child welfare case are categorically eligible to access SMHS.

A. **Initial Mental Health Referral**

An initial mental health referral will be submitted on behalf of all children/NMD within three (3) business days of case opening.

1. **Emergency Response**

Following the decision to promote a referral to a case (Family Preservation Services [FPS] or Court), the ASW will:

- Make a reasonable effort to obtain parental consent for mental health services by requesting the parent/legal guardian sign the *Health Care Agency Behavioral Health Services Informed Consent for Services and Telehealth Consent*
- Request that the parent/legal guardian provide prior mental health/psychological reports and/or evaluations regarding the child (if available)

Refer to the “Consent for Mental Health Services” section below for guidance on parents’ unavailability or refusal to consent.

The ASW or designee will upload the following consent forms to child’s case in CWS/CMS:

- a. Signed *Health Care Agency Behavioral Health Services Informed Consent for Services and Telehealth Consent*.
- b. Signed *Authorization for Release of Information form (F063-25-228)*.

Refer to CWS/CMS Data Entry Standards—Import a Document into CWS/CMS for further guidance.

2. **Intake / FPS**

Within three (3) business days of case opening in CWS/CMS the ASW will submit a “Mental Health Referral Packet,” to Health Care Agency (HCA) via secure webmail encrypted email to: PWBMHReferral@ochca.com

For confidentiality purposes, Personal Identifying Information (PII) (e.g., client name) will not be included on the ‘Subject’ line of the email.

The packet consists of:

- a. Most recently completed CANS Tool (if available).
- b. *CANS Coversheet/Mental Health Assessment Referral (F063-25-837).*
- c. Signed *Health Care Agency Behavioral Health Services Informed Consent for Services and Telehealth Consent* to enable child/NMD to receive or participate in mental health services.
- d. *Signed Authorization for Release of Information form (F063-25-228).*
- e. Current case plan (if available).
- f. Needs and services plans from current placement provider (if available).

For information on obtaining a written release of information, and guidelines on CFS client confidentiality, refer below to “Release of Mental Health Information/Records” Policy section.

Refer to Attachment 1— Workflow to Complete Child and Adolescent Needs and Strengths (CANS) as a Mental Health Referral for further guidelines, as applicable.

For further instruction on how to submit a Mental Health Referral Packet, refer to Attachment 2 — Mental Health Referral Submission.

Note: When indicated by the IP-CANS assessment, consider referrals to Wraparound and/or Multi-Dimensional Treatment Foster Care, which use family-focused and team-oriented interventions. For placement criteria and referral process, see CFS P&P Wraparound Referral and Services (D-0511).

B. Subsequent Mental Health Referrals

Children/NMD initially referred but not receiving Mental Health Services will be re-referred by the ASW:

1. As informed by the IP-CANS, in collaboration with the CFT.
2. Per best practice, when there are concerns about a child/NMD's mental health, such as following a significant life change or traumatic event or upon observation of significant mental health changes.

Note: Completion of CANS occurs a minimum of every 6 months unless circumstances indicate an earlier reassessment is needed. Refer to CFS P&P Child and Adolescent Needs and Strengths (CANS) Assessment (D-0315) for additional guidance on CANS and CWS/CMS Data Entry Standard (DES) Developmental & Mental Health Screenings and Services (J0202) for documenting referrals.

Notification of Completed Mental Health Assessment

A. Assessment Results

Per CFS policy, upon notification of a completed mental health assessment by HCA/CYBH or CEGU, the ASW will consult with the mental health provider regarding the findings and recommendations.

HCA/CYBH or CEGU will determine whether the child/NMD is PWB eligible and inform the CFS PWB liaison.

The ASW will be notified of PWB eligibility by the PWB liaison from the CFSPathways2WellBeing@ssa.ocgov.com inbox.

1. Non-PWB Eligible

The ASW will:

- Confirm with HCA if the child/NMD was referred to their Managed Care Plan (MCP) for lower level of care services.
- Maintain on-going collaboration with the mental health clinician, if needed.
- Complete subsequent CANS assessment a minimum of every 6 months

2. **PWB Eligible**

PWB eligible children/NMDs may receive SMHS. The ASW will schedule a Pathways CFT:

- Within 30 days of receiving notification/determination of PWB eligibility.
- At least every 90 days thereafter to support the child/NMD's mental health needs until the child/NMD is no longer PWB eligible.

A Pathways CFT may be conducted by a CFT Facilitator, Wraparound or STRTP provider. The ASW will receive documentation of the meeting from the facilitator and document in a CWS/CMS case contact narrative.

Refer to CFS P&P Children and Family Team (CFT) (D-0314) for additional details for child and family teams.

Refer to the "Court Report Documentation/ Court Notification" section below for guidance on documenting mental health services in court reports.

Exceptions to Child's Right to Consent

Pursuant to FAM § 6924(f) and FAM § 6929(e), children, regardless of age, may not consent to the following without the concurrence of a parent or legal guardian:

- Psychosurgery as defined in WIC 5325 (g) (**Note:** Psychosurgery cannot be performed on a child under any circumstances)
- Psychotropic drugs
 - See CFS P&P Psychotropic Medication: Dependent Child (I-0306)
- Convulsive Treatment (**Note:** Convulsive treatment cannot be performed on a child younger than 12 years under any circumstances)

- Pursuant to WIC 5326.8, children ages 12 to 15 years old may be provided with convulsive treatment only in a life-threatening emergency if the child is considered mature enough to give informed consent and the parent and child consent to convulsive treatment (this applies to both voluntary and involuntary admissions to a psychiatric facility)
- Children younger than 16 years may not receive replacement narcotic abuse treatment (e.g., methadone treatment) without the consent of the parent or legal guardian.
 - Refer to CFS P&P Substance Abuse Services for Children (D-0510) for further guidance.

Release of Mental Health Information/Records

A. Guidelines on Exchanging Information

The ASW may require a child's/NMD's mental health records in order to coordinate and oversee the mental health needs of the child and to fulfill the responsibility of reporting the health and safety of the child to the Juvenile Court.

Per Civil Code (CIV) § 56.103, for children in out-of-home care, a mental health provider may disclose mental health information to a county social worker, or any other person who is legally authorized to have custody or care of a child, for the purpose of coordinating mental health services and treatment provided to the child.

Note: The child's mental health information obtained pursuant to CIV § 56.103 will not be further disclosed unless it is for the purpose of coordinating mental health services and treatment; the information may not be admitted into evidence in any criminal or delinquency proceeding against the child.

Pursuant to CIV § 56.10, mental health records can also be released when requested by Court pursuant to a court order. The assigned SSW will submit:

- An Ex Parte Application and Order to the Juvenile Court to request the child's mental health records pursuant to CIV § 56.10.

-And-

- *Authorization to Use and Disclose Protected Health Information (PHI) (F063-28-343)*

Per HSC § 123115(a)(2), a child's representative (e.g., a parent or legal guardian) is not entitled to inspect a child's patient records if the child consented to treatment, or if the mental health provider determines that allowing access to the child's records would have a detrimental effect on the provider's professional relationship with the child, the child's physical safety, or the child's psychological well-being.

For dependent children residing with a parent or legal guardian, the assigned SSW will attempt to obtain the parent or legal guardian's authorization for release of information. If the parent or legal guardian is unable or unwilling to provide the release, the assigned SSW will document the request for the child's mental health records and the reason for the request (e.g., to manage and report on the mental health care needs of the child) in the appropriate court report.

B. Obtaining Court Authorization to Exchange Information

Pursuant to WIC § 5328.03(a)–(e), when a child's physical custody has been removed from the parent/legal guardian, a therapist will not allow a parent or legal guardian to inspect or make copies of a child's mental health record/information, unless a Juvenile Court or other Court issues an order authorizing the parent or legal guardian to inspect or obtain copies of the child's mental health information, after finding that such information would not be detrimental to the child.

Court authorization may be sought to release a child's mental health records/information to a parent/legal guardian when each of the following applies:

- If the parent/legal guardian will be involved in the child's mental health services, including, but not limited to:
 - Child's Individual Therapy
 - Conjoint therapy
 - Family therapeutic services (e.g., Child and Family Team [CFT], Wraparound, Treatment Foster Care Oregon – Orange County)

Home, Therapeutic Behavioral Services, etc.)

- The parent/legal guardian's limited access to the child's mental health information would not be a detriment to the child

Refer to Attachment 3 — Ex-Parte Template for Court Authorization to Release Mental Health Information.

Refer to section titled, "Disclosure of Mental Health Information" in the Court Recommendations Master List for Autotext codes available to include in the summary and long recommendations of a court report.

Note: A NMD's mental health information/records will not be released without the consent of the NMD.

For additional information on obtaining a written release of information and guidelines on CFS client confidentiality, refer to CFS P&P Confidentiality—CFS Client Records (F-0105).

For additional information on obtaining and releasing protected health information, refer to CFS P&P Acquisition of Health Care Information (I-0404).

For additional information on the sharing of confidential mental health information, including substance abuse treatment, with the Child and Family Team (CFT), refer to "Confidentiality/Release of Information" Policy section of CFS P&P Child and Family Teams (D-0314).

Out-of-County Mental Health Services / Presumptive Transfer

The ASW will initiate mental health services for children and NMDs placed in out-of-home care outside Orange County through the process known as Presumptive Transfer.

Children/NMDs who receive assistance under the Kinship Guardianship Assistance Payment Program (Kin-GAP) and who receive assistance under the Adoption Assistance Program (AAP) are no longer dependents of the court, nor subject to court supervision, and are therefore not subject to presumptive transfer provisions.

Prior to placing a child/NMD in an out-of-county placement, the ASW shall notify HCA via Placement Information Change (PIC) form or Foster Care Application (FCAPP) form. If notification before placement is not possible, the ASW will notify HCA no later

than three (3) business days from the date the child or NMD arrives at placement.

For guidelines on providing notification for out-of-county placements refer to Notice for Placement Changes and Out-of-County Placement Desk Guide.

When a child/NMD is removed from an out-of-county placement and placed back in Orange County, the ASW will notify the following parties that the responsibility for providing, arranging for the provision of, and payment for SMHS returns to Orange County:

- Former county of residence's mental health provider
- Orange County Health Care Agency at OCPresumptiveTransfer@ochca.com
- Presumptive transfer coordinator at clericalpresumptivetransfer@ssa.ocgov.com

The ASW will document a child/NMD's eligibility for and determinations made regarding Presumptive Transfer in Court reports and CWS/CMS. Refer to the "Court Report Documentation/Notification" and "CWS/CMS Documentation" Policy section below for further guidelines on documentation.

A. **General Responsibilities**

When children/NMDs are placed outside Orange County, the presumptive transfer process will be initiated immediately.

SSA maintains responsibility to:

1. Determine child/NMD eligibility for Presumptive Transfer, as follows:
 - a. Consult with the CFT and consider the team's input when making determinations regarding Presumptive Transfer.
 - b. Identify existing exceptions to Presumptive Transfer. Refer to section D (2) below for exceptions.
 - c. Make decisions on waiver requests.

2. Notice specified parties (child/NMD, person/agency responsible for mental health decisions on behalf of the foster child, child's attorney) and County Mental Health Plans (MHPs) of:
 - a. Presumptive transfer requirements.
 - b. Exceptions
 - c. Options to request a waiver.
 - d. The right to a judicial review, when applicable.
 - e. Decisions regarding presumptive transfer.
3. Provide information regarding the Presumptive Transfer of SMHS to the Juvenile Court for judicial review, when applicable.

B. Child and Family Team Meeting

Per ACL 17-77 and ACL 18-60, an effective CFT process allows the child/NMDs and families to actively participate in case planning and may over time lead to an increase in positive outcomes, including improvements in placement stability. The CFT process represents an opportunity to mitigate the negative impacts a change in placement can have on a foster child/NMD and their family.

The CFT strives for permanency with the foster child or NMD's own family or other resource families. As such, the CFT should develop a plan for the foster child/NMD to return to his or her community with clear milestones, goals, and timelines, when appropriate. Presumptive transfer will be discussed by the CFT to:

- Provide:
 - Recommendations concerning placement
 - Services and supports
- Determine whether:
 - Presumptive transfer of SMHS would benefit the child/NMD and support family reunification efforts
 - An exception to presumptive transfer exists
 - The child/NMD would be negatively impacted if the responsibility for providing or arranging

SMHS remains with Orange County (for placements in Short-term Facilities)

For further guidance on the role of the CFT when providing input on placement decisions and CFT meetings (i.e., frequency, time, location, facilitation, and scheduling) refer to CFS P&P Child and Family Team (D-0314).

C. **When Presumptive Transfer Does Not Apply**

Pursuant to WIC § 14717.2 (b), if the child/NMD is placed out of county in a community treatment facility (CTF), group home (GH), short-term residential therapeutic program (STRTP), or is admitted to a children's crisis residential program (CCRP), Orange County HCA is responsible for arranging and providing SMHS, unless either of the following circumstances exist:

1. The child/NMD's case plan specifies that the child/NMD will transition to a less restrictive placement in the same county as the facility where they are placed.

-or-

2. As informed by the CFT, the ASW determines the child/NMD will be negatively impacted if responsibility for providing or arranging SMHS is not transferred to the new county of residence where the facility is located. The ASW shall document the basis for making this determination in the case record.

If either circumstance described above exists at any time during a child's/NMD's placement in an out-of-county short-term facility, presumptive transfer still applies.

D. **When Presumptive Transfer Applies**

Children and NMDs who are in out-of-home placement **and** placed outside Orange County with relatives, including non-related extended family member (NREFM), resource families in Therapeutic Foster Care homes or any other non-congregate setting **and** who require medically necessary SMHS are eligible for Presumptive Transfer.

The responsibility for authorization, provision, and payment of SMHS is to be transferred to the MHP in the child's/NMD's county of residence unless:

- An exception to Presumptive Transfer applies (see list below) **and**;
- A waiver is requested by a party, as specified per WIC §14717.1 (d) **and**;
- The waiver is approved by the Social Services Agency (SSA)

Refer to the “Exceptions” policy section below for further guidelines when presumptive transfer may be waived.

1. **Initial Notification**

a. The Resource Family Approval (RFA)/ Placement Senior Social Worker (SSW) will:

- Identify and approve the out-of-county placement.
- Complete Part A of *Out-of-County Placement/Presumptive Transfer Notice Worksheet (F063-25-829)*. Email worksheet to the ASW.

Note: If the child/NMD has already been placed out-of-county or will be placed in 48 hours or less and is in imminent danger to self or others, or experiencing an emergency psychiatric condition, it is considered expedited, and notification needs to be sent as soon as possible.

b. The ASW will:

- Complete remaining section (Part B) of *Out-of-County Placement/Presumptive Transfer Notice Worksheet (F063-25-829)*.
- Email completed Notice Worksheet to Clerical Presumptive Transfer inbox at: clericalpresumptivetransfer@ssa.ocgov.com.

Refer to Attachment 4 — Out-of-County Placement/Presumptive Transfer Initial Notification Flowchart for further procedural guidelines regarding processing forms.

2. **Exceptions**

Pursuant to WIC 14717.1 (d)(5), presumptive transfer may be waived (SMHS remains in Orange County) when any of the following circumstances exist:

- a. Transfer would disrupt continuity of care or delay access to services provided to the foster child/NMD.
- b. Transfer would interfere with family reunification efforts documented in the individual case plan.
- c. Child/NMD's out of county placement is expected to last less than six months.
- d. Child/NMD's new county of residence is within 30 minutes of travel time to their currently established SMHS provider.

3. **Waiver**

A waiver of Presumptive Transfer may only be requested if one of the above exceptions exists.

A waiver request can be made by the following parties:

- a. Child/NMD
- b. Person responsible for making Mental Health decisions on behalf of the child (parent/guardian)
- c. Child's Attorney
- d. SSA
- e. Any other interested party who owes a legal duty to the child involving the child's health or welfare

A waiver is to be submitted within seven (7) calendar days of the issuance of initial notice of presumptive transfer.

If the waiver is approved, responsibility for authorization, provision, and payment of SMHS remains in county of original jurisdiction.

If a waiver is denied, responsibility for authorization, provision, and payment of SMHS transfers to the county of residence.

Refer to Attachment 5—Presumptive Transfer Waiver Request Processing and Notification Flowchart for procedural guidance.

4. **Judicial Review**

For specified parties (child/NMD, person responsible for making mental health decisions on behalf of the child (parent/guardian), child's attorney, SSA) who disagree with the waiver determination, judicial review may be requested.

The ASW will provide the following forms to any party requesting judicial review:

- a. *JV 214- Request for Hearing on Waiver of Presumptive Transfer*
- b. *JV 214A- Notice of and Order on Request for Hearing on Waiver of Presumptive Transfer*
- c. *JV 215- Order After Hearing on Waiver of Presumptive Transfer*

Per California Rules of Court (CRC), Rule 5.647 the Court must receive the request for judicial review no later than seven (7) court days after the notification of waiver determination.

For additional guidance to determine if Presumptive Transfer is required, refer to Attachment 6 — Presumptive Transfer Decision Flowchart.

**Court Report
Documentation/
Notification**

The ASW will report to the Court any concerns or (anticipated) special needs regarding a child/NMD's mental health, including emotional and/or behavioral issues. Additional information to be documented includes:

- Child/NMD referrals for mental health assessment services (including dates)
- Child's progress in mental health treatment
- Information about CFT meetings held

- Child/NMD's eligibility for and determinations made regarding Presumptive Transfer

If recommending conjoint therapy or other specific mental health service for a child where the therapist needs to share limited information orally for purposes of meeting therapeutic goals with a parent/legal guardian, and/or the child's planning and support team (e.g., participants in CFT, Wraparound, etc.), document the facts that support the following:

- Why it would be in the child's best interest to involve the parent/legal guardian in a child's specific mental health service (e.g., child is receiving intensive mental health services and parent/legal guardian involvement is crucial, case plan requires conjoint counseling; or therapist recommends involving parent/legal guardian, etc.).
- Why an order authorizing the therapist to share limited information about the child's mental health with the parent/legal guardian would not be detrimental to the child.

Specify any proposed safeguard in place for the child's privacy and well-being (e.g., therapist will not disclose information contrary to the child's safety, emotional or physical well-being, or detrimental to therapeutic relationship, etc.).

This information will be documented under the Child/NMD Evaluation "Mental & Emotional Status" section, prepared for the following court reports:

- Jurisdictional/Dispositional hearing
- WIC 366.26 Selection and Implementation hearing
- Each subsequent Status Review hearing

For additional guidance to document the child's/NMD's mental/emotional health needs, refer to the CFS P&P applicable to the hearing for which the court report is being prepared.

CWS/CMS Documentation

Information regarding the child's/NMD's mental health referrals and treatment will be documented in CWS/CMS. This information will be updated as needs and services change.

In accordance with Division 31-320.52, topics related to mental health should be clearly documented in case contact notes and regularly addressed throughout the life of the case.

A. Health Notebook

The ASW or designee will enter and update the following information in the CWS/CMS Health Notebook, as applicable:

- Completion of the child/NMD's mental health referral using the CANS assessment, if available
- Referral for mental health assessment /services
- PWB eligibility

Refer to CWS/CMS Data Entry Standard (DES) Developmental & Mental Health Screenings and Services (J0202) for further instructions and information.

B. Case Contact Narrative

The following mental health information will be documented in a CWS/CMS case contact narrative, as applicable:

- Initial and subsequent mental health screenings (including dates)
- Referrals for mental health and developmental assessments (including dates)
- PWB eligibility by mental health services provider
- Results of a mental health assessment referral from HCA
- Mental health services provided or referred
- Ongoing follow-up/communication regarding mental health services, activities, and linkages (e.g., CFT, Wraparound, and other collaborative family team meetings, consultations/conferences via email, telephone, or in person, etc.)
- Family/NMD refused/declined services
- Child/NMD's eligibility for and determinations made regarding Presumptive Transfer
- Current psychotropic medications and prescribing psychiatrist/pediatrician
- Counseling/therapy updates
- Emotional and behavioral status/needs

Refer to CFS P&P Case Compliance Contacts and Documentation (E-0105) for further information on case narratives for case contacts and service providers.

Refer to Attachment 2 — Mental Health Referral Submission for detailed guidelines on completing mental health referrals.

REFERENCES

Attachments and CWS/CMS Data Entry Standards

Hyperlinks are provided below to access attachments to this P&P and any CWS/CMS Data Entry Standards that are referenced.

- [Attachment 1 — Workflow to Complete Child and Adolescent Needs and Strengths \(CANS\) as a Mental Health Referral](#)
- [Attachment 2 — Mental Health Referral Submission](#)
- [Attachment 3 — Ex-Parte Template for Court Authorization to Release Mental Health Information](#)
- [Attachment 4 — Out-of-County Placement/Presumptive Transfer Initial Notification Flowchart](#)
- [Attachment 5 — Presumptive Transfer Waiver Request Processing and Notification Flowchart](#)
- [Attachment 6 — Presumptive Transfer Decision Flowchart](#)
- [CWS/CMS Data Entry Standards—Developmental and Mental Health Screening and Services \(J0202\)](#)
- [CWS/CMS Data Entry Standards—Health and Education Passport \(J0203\)](#)

Hyperlinks

Users accessing this document by computer may create a direct connection to the following references by clicking on the link provided.

- CFS P&P [Acquisition of Health Care Information \(I-0404\)](#)
- CFS P&P [Referral and Case Filing \(E-0102\)](#)
- CFS P&P [Case Compliance Contacts and Documentation \(E-0105\)](#)
- CFS P&P [Confidentiality—CFS Client Records \(F-0105\)](#)
- CFS P&P [Court Medical Consent for Non-Dependent Children \(I-0201\)](#)
- CFS P&P Consent for [Medical Care and Physical Examination \(I-0206\)](#)
- CFS P&P [Psychotropic Medication: Dependent Child \(I-0306\)](#)

- CFS P&P [Substance Abuse Services for Children \(D-0510\)](#)
- CFS P&P [Child and Family Teams \(D-0314\)](#)
- CFS P&P [Wraparound Referral and Services \(D-0511\)](#)
- CFS P&P [Extended Foster Care \(EFC\) \(J-0101\)](#)
- [American Psychiatric Association](#)
- [Continuing Care Placement Unit](#)
- [Court Recommendations Master List](#)
- [Integrated Core Practice Model \(ICPM\)](#)
- [Notice for Placement Changes and Out-of-County Placement Desk Guide](#)
- [Presumptive Transfer County Points of Contact](#)
- [Statewide MHP Contact List for Children/Youth Placed Out-of-County](#)

Other Sources

Other printed references include the following:

None.

FORMS

Online Forms

Forms listed below may be printed out and completed, or completed online, and may be accessed by clicking on the link provided.

Form Name	Form Number
Out-of-County Placement/Presumptive Transfer Notice Worksheet	F063-25-829
Notice of Presumptive Transfer of Specialty Mental Health Services (SMHS)	F063-25-822
Notice of Proposed Out-of-County Placement Waiver of Presumptive Transfer of Specialty Mental Health Services (SMHS)	F063-28-236
Objection to Out-of-County Placement and Notice of Hearing	F063-25-823
Presumptive Transfer Notification for County Mental Health Plan (MHP)	JV-556
Proof of Notice of Out-of-County Placement	F063-25-825
Presumptive Transfer Waiver Notice Worksheet	F063-25-849
Notice of Waiver Request Presumptive Transfer of Specialty Mental Health Services (SMHS)	F063-25-835
	F063-25-824

Hard Copy Forms

Forms that may be completed in hard copy (including multi-copy NCR forms) are listed below. ***For reference purposes only***, links are provided to view these hard copy forms, where available.

Form Name	Form Number
Authorization to Use and Disclose Protected Health Information (PHI)	F063-28-343
Health Care Agency Behavioral Health Services Informed Consent for Services and Telehealth Consent (English)	F346-301
Health Care Agency Behavioral Health Services Informed Consent for Services and Telehealth Consent (Spanish)	F346-301Sp
Health Care Agency Behavioral Health Services Informed Consent for Services and Telehealth Consent (Vietnamese)	F346-301Vn
Authorization for Release of Information (English)	F063-25-228
Authorization for Release of Information (Spanish)	F063-25-228Sp
Consent for Medical Care and Physical Examination	F063-28-13

CWS/CMS Forms

Forms that may **only** be obtained in CWS/CMS are listed below. ***For reference purposes only***, links are provided to view these CWS/CMS forms, where available.

Form Name	Form Number
CANS Coversheet/Mental Health Assessment Referral	F063-25-837

LEGAL MANDATES

[Welfare and Institutions Code \(WIC\) Section \(§\) 300\(b\)\(3\)](#) specifies the criteria which allows a parent or legal guardian to provide a child spiritual treatment through prayer alone and specifies that the Juvenile Court will not assume jurisdiction unless necessary to protect the child from suffering serious physical harm or illness.

[WIC § 303\(d\)](#) a NMD retains all legal decision-making authority as an adult.

[WIC § 369\(f\)](#) provides that a dependent child aged 16 or older may independently consent to receive medications for opioid use disorder from a licensed narcotic treatment program, such as replacement narcotic therapy, without needing parental, guardian, social worker, or person in loco parentis consent

[WIC § 369\(g\)](#) recognizes a parent's or legal guardian's right, in the absence of any court restriction, to consent on behalf of their child, to medical, surgical, dental, mental health, or other remedial treatment

[WIC § 370](#) authorizes the Juvenile Court to order that the social worker obtain the services of psychiatrists, psychologists, or other clinical experts to assist in determining the appropriate treatment of a child, and as may be required in the conduct or implementation of that treatment.

[WIC § 5325\(g\)](#) grants patients the right to refuse psychosurgery. Psychosurgery is defined as operations such as lobotomy, psychiatric surgery, and behavioral surgery.

[WIC § 5326.8](#) establishes the right of patients involuntarily detained in a state hospital to have their rights respected and protected.

[WIC § 5585.50](#) authorizes 72-hour treatment and evaluation of children, when as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled and consent for voluntary treatment is not available.

[WIC § 5328.03](#) states that when a psychotherapist knows that a child has been removed from the physical custody of his or her parent or legal guardian, he/she shall not allow the parent or guardian to inspect or obtain copies of mental health records of the minor patient unless the Juvenile Court has issued an order authorizing the parent or guardian to inspect or obtain copies of the mental health records of the minor patient after finding that such an order would not be detrimental to the minor patient.

[WIC § 14716](#) mandates local mental health plans to establish a procedure to ensure access to outpatient mental health services, as required by the Early Periodic Screening and Diagnostic Treatment program standards, for any child in foster care who has been placed outside his or her county of origin.

[WIC § 6552](#) authorizes a child within the jurisdiction of the Juvenile Court to request inpatient or outpatient mental health services.

[WIC § 11376](#) mandates local mental health plans to provide mental health services to foster children who have been placed under legal guardianship, who are receiving assistance under the Kin-GAP Program, whose foster care court supervision has been terminated, and who are residing outside their county of origin.

[WIC § 16125](#) mandates local mental health plans to provide mental health services to foster children whose adoption has become final, who are receiving or are eligible to receive assistance under the Adoption Assistance Program, including Medi-Cal, whose foster care court supervision has been terminated, and who are residing outside their county of origin.

[WIC §14717.1](#) requires foster children to gain timely access to specialty mental health services when placed outside their county of jurisdiction, known as the presumptive transfer process.

[WIC § 14184.402](#) specifies the criteria for medical necessity and specialty mental health services.

[California Rules of Court \(CRC\) Rule 5.647](#) authorizes the presumptive transfer of specialty mental health services to the child/NMDs county of residence.

[California Code of Regulations \(CCR\) Title 9, § 1810.247](#) provides definitions for “Specialty Mental Health Services.”

[Civil Code \(CIV\) § 56.10](#) provides criteria for the release of medical information to a third party, including release of medical information to a court pursuant to a court order.

[CIV § 56.103](#) affirms mental health provider/professional may disclose mental health information, to a county social worker or any other person who is legally authorized to have custody or care of a child, for the purpose of coordinating mental health services and treatment provided to the child.

[Family Code \(FAM\) § 6920](#) affirms the capacity of a child to consent to medical, dental, or mental health services under certain circumstances.

[FAM § 6924\(a\)](#) and [§ 6929\(a\)](#) defines mental health professional/provider and authorized providers for consenting children of 12 years of age and older.

[FAM § 6924\(b\)](#) provides criteria for allowing children 12 years and older to consent to outpatient mental health treatment or counseling, and residential shelter services.

[FAM § 6924\(d\)](#) states that the parent or legal guardian will be involved in the child’s treatment, unless the provider in consult with the child determines that the involvement of the parent or legal guardian would be inappropriate.

[FAM § 6924\(f\)](#) states that children may not receive convulsive therapy or psychosurgery, or psychotropic medication without the consent of a parent or legal guardian.

[FAM § 6929\(b\)](#) mandates that children 12 years of age or older may consent to medical care and counseling related to the diagnosis and treatment of a drug or alcohol related problem.

[FAM § 6929\(c\)](#) outlines when involvement of a parent or legal guardian in a child's drug or alcohol treatment plan is appropriate.

[FAM § 6929\(e\)](#) states that children may not receive replacement narcotic abuse treatment (e.g., methadone treatment) without the consent of a parent or legal guardian, except a child 16 years of age or older that may consent to receive medications for opioid use disorder from a licensed narcotic treatment program as replacement narcotic therapy without the consent of the minor's parent or guardian only if, and to the extent, expressly permitted by federal law.

[FAM § 6929\(f\)](#) affirms the right of a parent or legal guardian to seek medical care and counseling for a drug or alcohol related problem of a child, even if the child does not provide consent.

[Health and Safety Code \(HSC\) § 123110](#) provides criteria for a child's right to inspection of his or her patient records pertaining to health care services for which he or she is lawfully authorized to consent.

[HSC § 123115\(a\)\(2\)](#) states that a child's representative (e.g., a parent or legal guardian) is not entitled to inspect a child's patient records if the child has the right to inspection under HSC Section 123110, or if the health care provider determines that allowing access to the child's records would have a detrimental effect on the provider's professional relationship with the child, the child's physical safety, or the child's psychological well-being.

[HSC § 124260\(b\)](#) provides criteria for allowing children 12 years and older to consent to outpatient mental health treatment or counseling.

[HSC § 124260\(d\)](#) provides that the child's parent or legal guardian is not liable for payment for mental health treatment or counseling services unless the parent or legal guardian participates in the mental health treatment or counseling, and only for services rendered with the participation of the parent or guardian.

[Penal Code \(PEN\) § 11165.7](#) defines mandated reporters under the Child Abuse and Neglect Reporting Act (CANRA).

[PEN § 11166](#) specifies reporting responsibilities for mandated reporters under CANRA.

Katie A., et al. v. Diana Bonta, et al. (2011), a class action lawsuit, resulting in settlement, which implemented changes to the mental health and other supportive services available to children and youth who are in foster care or who are at imminent risk of placement in foster care.

[Integrated Core Practice Model Resource Guide](#), the CPM Guide describes how the county child welfare and mental health systems and service providers can work together to address the mental health needs of children and families in the child welfare system.

[California Department of Social Services \(CDSS\) All County Letter \(ACL\) 17-22E](#) NMDs retain legal rights as an adult to consent to medical and dental care, as well as to the frequency at which that care is received.

[CDSS ACL 17-77](#) outlines the implementation plan for the Presumptive Transfer process as a multi-agency collaboration.

[CDSS ACL 18-09](#), [CDSS ACL 18-81](#) and [CDSS ACL 18-81E](#) provide requirements for administering and implementing the IP-CANS assessment tool within a CFT, including completion of CANS, confidentiality, use of the IP-CANS as a mental health referral tool, data submission, training and automation.

[CDSS ACL 18-60](#) provides for the Presumptive Transfer policy guidance including forms and flowcharts.

[CDSS ACL 18-85](#) provides clarification regarding sharing of CANS assessments between county placing agencies (i.e., child welfare departments) and mental health programs.

[CDSS ACL 21-27](#) provides information about IP-CANS training and certification, mandatory entry of CANS data, and introduces the CFT/CANS Implementation Support Toolkit.

[CDSS ACL 21-69](#) clarifies the authority and responsibilities of the Office of the State Foster Care Ombudsperson, and expand, clarify, and revise the rights of foster youth under the Foster Youth Bill of Rights.

[CDSS ACL 24-35](#) and [Errata](#) provides that in lieu of the required mental health screening, child welfare agencies must submit referrals to the appropriate mental health plans for all children and youth within three (3) business days of opening a child welfare case and on an ongoing basis, as determined necessary by the child and family team (CFT) and as informed by the IP-Child Adolescent Needs and Strengths (CANS) tool.

[CDSS ACL 24-43](#) provides an update on presumptive transfer requirements for children/youth placed in out-of-county short-term facilities.

[California Department of Social Services \(CDSS\) All County Information Notice \(ACIN\) I-21-18](#) provides the California Integrated Core Practice Model (ICPM) which outlines the most current best practices for the delivery of timely, effective, and collaborative services to children/NMDs and families, which includes a framework for Child and Family Teams (CFT).

REVISION HISTORY

Since the effective Date of this P&P, and prior to the Current Revision Date, the following revisions of this P&P were published:

September 16, 2011

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