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

**Effective Date:** November 1, 1992  
**Revised:** September 16, 2011  
**Revised:** April 9, 2015

**Policy No.:** I-0303

## **Mental Health Screening and Treatment**

**Purpose** To provide guidelines for mental health screening and treatment for children who have an open case with Children and Family Services (CFS).

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**Approved** This policy was approved by Gary Taylor, Director of CFS, on April 9, 2015. *Signature on file.*

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**Most Recent Revision** This Policy and Procedure (P&P), previously named “Mental Health Treatment and Psychiatric Hospitalization for Children,” has been substantially revised to incorporate implementation of the Core Practice Model (CPM) principles, including but not limited to mental health screening and teaming responsibilities mandated by *Katie A., et al. v. Diana Bonta et al*, settlement, State initiatives, and federal legislation.

Mental Health Screenings will be conducted for children who are:

- Taken into protective custody
- The subject of a non-custody petition
- Dependents of the Orange County Juvenile Court
- Referred for Voluntary Family Services (VFS)
- Referred for Informal Supervision pursuant to WIC § 301 or WIC § 360(b)
- Referred for Voluntary Placement
- Non-dependents under Legal Guardianship

The information related to psychiatric hospitalizations has been removed from this P&P and will be included in an upcoming policy addressing psychiatric hospitalizations (new CFS P&P [Psychiatric Hospitalization \[I-0308\]](#)).

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## Background

Research indicates that 30 to 85 percent of foster children and youth have a diagnosable mental health disorder. In contrast, the rate for non-foster care children and youth is significantly lower, at 10 to 20 percent. Further, foster children exhibit behaviors that require a mental health assessment and/or intervention at a rate five times that of their non-foster care counterparts.

The consequences of unmet mental health needs for foster children can lead to placement instability, school failure, delinquency, and institutional care. As young adults, former foster youth are more than twice as likely as their peers to experience continued mental health problems and higher rates of drug dependency, housing instability, and homelessness.

In 2002, a California class action lawsuit, *Katie A., et al. v. Diana Bonta et al.*, filed in federal district court, 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 these children receive and access mental health services.

In 2013, the CPM was developed in response to the Settlement Agreement, 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. The CPM process is initiated by screening children for potential mental health needs that may result in a referral for further assessment and/or teaming with mental health service providers to successfully address the mental and behavioral needs of children and their families.

The CPM is a way of relating to and working with children and families based on shared values and principles. These include, but are not limited to:

- Working within a team environment to build a culturally relevant, trauma-informed system of supports
- Providing services that are responsive to the strengths and

- underlying needs of families being served
  - Acknowledgement that families are the best experts about their own lives and preferences
  - Natural supports that have valuable information and resources to share
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## Definitions

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

**Consent:** Permission to receive mental health services. For children, this involves their ability to understand the information provided by a health care professional and to make informed decisions regarding the treatment alternatives presented.

**Katie A. Class Member:** Pursuant to *Katie A., et al. v. Diana Bonta, et al.* (2011), children in foster care or who are at imminent risk of foster care placement **and** for whom each of the following apply:

- Have a mental illness or condition that has been documented, or if an assessment has already been conducted, would have been documented, **–And–**
- Need individualized mental health services

**Katie A. Subclass Members/Eligibility:** Pursuant to *Katie A., et al. v. Diana Bonta, et al.* (2011), a child who:

- Is eligible for full scope Medi-Cal
- Meets Medical Necessity criteria for Specialty Mental Health Services (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 or other intensive services, therapeutic behavioral services, specialized care rate due to behavioral mental health needs or crisis stabilization/intervention
  - Currently in or being considered for a group home (RCL 10 or above), 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), Court Evaluation Guidance Unit (CEGU), Continuing Care Placement Unit (CCPU), HCA/CYBH Regional Clinics and

HCA-contracted providers are trained to determine Katie A. Subclass eligibility of a child.

**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 Clinical Counselor
- Registered Marriage and Family Therapist intern and/or Registered Clinical Counselor intern under the supervision of a licensed professional

**Mental Health Treatment:** Any service directed toward early intervention in, or alleviation or prevention of, mental disorder(s), including, but not limited to, diagnosis, evaluation, treatment, respite care, special living arrangements, socialization, case management, transportation, information, referral, consultation, and community services.

Pursuant to the CPM Guide, (2013), the following definitions also apply:

- **Child/Children/Youth:** Individuals involved with, at risk of involvement with, or eligible to receive services from CFS. The terms “children” and “youth” may be used interchangeably.
- **Child and Family Team (CFT):** A team comprised of the child and family and ancillary individuals who are working with the child and family toward achieving their mental health goals and successful transition out of the child welfare system. Essential participants are the child and the child’s primary caregiver, mental health provider, and assigned social worker
- **Family:** Blood and adoptive parents and relatives, step-families, legal guardians, foster parents and unrelated persons that have emotionally significant relationships with the child/family

- **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 the Katie A. subclass 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 Katie A. Subclass 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

**Note:** The State added ICC and IHBS to the existing Medi-Cal (Specialty Mental Health Services) billing codes to service Katie A. Subclass members.

- **Mental Health Assessment:** A comprehensive assessment that is tied to the mental health care plan and completed by a mental health professional, which provides:
  - An in-depth strength based evaluation of underlying needs and mental health concerns
  - A broad assessment of psychological risk factors related to a child's environment (including a trauma assessment)
  - A clinical assessment of current functioning
- **Mental Health Screening:** A brief assessment to identify the possible need for a more in-depth Mental Health Assessment and mental health services. A screening, by itself, does not determine either the actual need for mental health services or the kinds of services that may be needed
- **Open Child Welfare Case:** A case in which a child who:
  - a) is in foster care or
  - b) has a voluntary family maintenance case (at imminent risk of foster care), including both court ordered and by voluntary agreement

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

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## POLICY

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### General Guideline

Per CFS Policy, CFS staff will make efforts to ensure that upon assignment of an open child welfare case, children receive timely and appropriate:

- Mental health screenings
- 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)

CFS staff will collaborate with the child, family, and mental health provider on an on-going basis to appropriately address the child's mental health needs.

In general, parents or legal guardians who are available, capable, and willing to consent to medical care, including mental health care, and whose rights to do so have not been restricted by Court, have the legal authority to consent to in-patient and out-patient mental health treatment for a child.

### Mental Health Screening

Pursuant to class action lawsuit, *Katie A., et al. v. Diana Bonta, et al.* (2011), all children with an open child welfare case will have a *Mental Health Screening Checklist (F063-25-731)* completed on their behalf.

A. **Initial Mental Health Screening:**

The initial screening will be completed during the Investigations stage or when the case first promotes to a VFS case.

When receiving assignment of a case, the assigned social worker will review the child's Permanent Record for any mental health history available. Upon first contact with a child, the assigned social worker will complete the initial *Mental Health Screening Checklist (F063-25-731)* and provide follow up as deemed necessary; refer to section "Screening Results" below.

The *Mental Health Screening Checklist (F063-25-731)* will be completed regardless of whether the child was screened by a HCA CEGU provider or another mental health service provider.

Refer to Policy section on “CWS/CMS Documentation” below for information on documentation and tracking.

**B. Screening Results:**

The child may be referred for a mental health assessment based on the results of the *Mental Health Screening Checklist (F063-25-731)*. Refer to [Attachment 2—Mental Health Screening Checklist Outcome](#) to determine if a referral for a mental health assessment is necessary.

**C. Subsequent Mental Health Screenings:**

Children initially screened but not referred for a Mental Health Assessment will be re-screened as follows by the assigned social worker:

- At the time of each Case Plan Update (approximately every six months)
- Per best practice, when there are concerns about a child’s mental health, such as following a significant life change or traumatic event or upon observation of significant mental health changes (All County Letter [ACL] 14-79)

**Note:** A child subject to rescreening is one who has not been identified as meeting Katie A. Subclass criteria, even if the child previously had a mental health assessment completed and is receiving mental health services.

Refer to [Attachment 1—Mental Health Behavioral Indicators](#) for a list of behavioral indicators, which may necessitate a subsequent Mental Health Screening.

**Mental Health Assessment/ Services**

**A. Assessment Referral:**

If the *Mental Health Screening Checklist (F063-25-731)* completed on behalf of a child indicates a mental health assessment is necessary **AND** the child is eligible for full scope Medi-Cal, refer the child to one of the following for a mental health assessment:

- CEGU (for children temporarily residing at Orangewood Children and Family Center)

- Health Care Agency/Children and Youth Behavioral Health (HCA/CYBH) clinic
- HCA-contracted clinic

When referring to HCA/CYBH clinics for a mental health assessment, the assigned social worker will submit a “Mental Health Referral Packet,” which consists of:

1. *Mental Health Screening Checklist (F063-25-731)*.
2. Signed provider’s consent form to enable child/youth to receive or participate in mental health services.
3. Prior mental health/psychological reports or evaluations (if available).

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

For further instruction on how to submit a Mental Health Referral Packet, refer to [Attachment 3—Mental Health Referral Submission](#).

Referrals to other approved providers may be considered if the child is not eligible for full scope Medi-Cal and/or the child’s mental health needs would be served best by another provider.

Refer to [Attachment 4—Authorized Mental Health Providers and Resources](#) for a listing of available and approved providers/resources.

**B. Assessment Results:**

Per CFS policy, upon notification of a completed mental health assessment, the assigned social worker will consult with the mental health provider regarding the findings and recommendations in order to coordinate a timely linkage to mental health services.

**Determination of Subclass Eligibility:**

- **Medi-Cal Provider:**  
A HCA/CYBH or HCA-contracted provider completing a mental health assessment is

responsible for determining Katie A. Subclass eligibility and notifying the assigned social worker of Katie A. Subclass eligibility

- **Non-Medi-Cal Provider (Medi-Cal eligible):**  
A non-Medi-Cal (e.g., SSA-contracted, Individual Provider Program [IPP], private insurance, etc.) provider completing a mental health assessment is not responsible for determining Katie A. Subclass eligibility. The assigned social worker will submit a referral to CCPU to determine Katie A. Subclass eligibility and need for intensive mental health services. Refer to the CCPU intranet site under CFS Resources for information on the referral process
- **Non-Medi-Cal Provider (non-Medi-Cal eligible):**  
A child that is non-eligible for full scope Medi-Cal benefits would not be entitled to receive Katie A. Subclass member services, such as ICC and IHBS. However, in an effort to ascertain whether a child's mental health needs are being addressed to the best degree possible, the assigned social worker may utilize [Attachment 5—Determination of Katie A. Subclass Equivalent Guide](#) to determine if the child is considered a Katie A. Subclass equivalent (non-Medi-Cal eligible for full scope benefits)

Refer to the “Child and Family Team (CFT)” Policy section below for further guidelines when a child meets Katie A. Subclass eligibility or its equivalent.

### **Child and Family Team (CFT)**

Pursuant to the Core Practice Model (CPM) Guide (2013), children identified as members of the Katie A. Class and Subclass are entitled to receive the following services:

- Establishment of the CFT
- Development/implementation of an Individualized Plan of Care
- Ongoing communication between CFT members
- Child and family centered meetings (CFT meetings)

**Note:** For Katie A. Subclass Members, 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 \(D-0511\)](#).

A. **CFT Development:**

Per CPM, the CFT will minimally include:

- Child (as developmentally appropriate)
- Child's family (primary caregivers)
- Assigned social worker
- Mental health provider/representative

Upon determination that a child is a member of Katie A. Class or Subclass, the assigned social worker will engage the child and family in a discussion of the values and principles of CPM.

Through this discussion, the assigned social worker will ask the family to identify supportive team members, which may include:

- Formal/paid supports (e.g., parent partners, health professionals, teachers, etc.)
- Informal/natural supports (e.g., extended family members, neighbors, friends, faith-based, clergy, tribal members and other individuals willing to support the child and family)

Team members may join and/or leave the CFT process at any time.

See [Attachment 6—Child and Family Team Model](#) and *The Child & Family Team* brochure (F063-25-755) for additional information regarding CFTs.

B. **Individualized Plan of Care (IPC):**

CFT members will participate in the development and implementation of the IPC in an effort to:

- Identify child and family strengths
- Identify causes for the child's behaviors necessitating intervention and/or services
- Incorporate Transition Planning steps towards lower level of care and/or exit from CWS
- Match services and supports to identified needs
- Build consensus towards resolution of differences or conflicts

CFT members will consider the following when identifying services for the child and family:

- Services are to be provided in a timely manner and consistent with the IPC
- Services are to be individualized and responsive to the changing needs of the child and family
- Services are to be accessible and deliverable in the community in which the child and family reside

IPC monitoring and follow-up by CFT members will involve:

- Continually monitoring, adapting, and evaluating the effectiveness of the IPC, taking into consideration current circumstances and resources
- Routinely reassessing the child and family's situation:
  - Intervention process
  - Progress
  - Barriers and challenges
  - Change results

**Note:** Pursuant to the CPM Guide, for Katie A. Subclass Members, the IPC will be reviewed within 90 days or sooner.

C. **Ongoing Communication Between CFT members:**

Per CPM, the assigned social worker will maintain regular/ongoing communication and sharing of information, including but not limited to face-to-face discussions, with the mental health provider and other CFT members in an effort to keep these parties informed of information needed to make decisions regarding the IPC.

Team members may communicate in various ways, such as:

- Telephone (person-to-person or conference)
- Email (following confidentiality of protected health and personal information mandates)
- Meeting/Staffing

D. **CFT Meeting Framework:**

CFT meetings will occur as often as the child, family, assigned social worker and/or the mental health provider deem necessary.

The assigned social worker will maintain appropriate documentation of the CFT meetings to aid the continuous improvement planning process. The *Child and Family Team Meeting Summary (F063-25-751)* may be used to summarize the meeting discussion. Refer to “CWS/CMS Documentation” Policy section below for additional information on documentation.

When scheduling CFT meetings, the composition, meeting frequency/location, and/or use of a specially trained facilitator will be based on the child and family’s needs. For example, Katie A. Subclass Members who display more intensive needs and challenges may benefit from a more structured, formal, facilitated team meeting; whereas less complex needs may benefit from a more informal team meeting.

See [Attachment 7—Child and Family Team \(CFT\) Meeting Guide](#) for guidelines to facilitate a CFT meeting.

## CFT Meetings

- A. **Initial CFT Meeting for Katie A. Subclass Members:**  
Per CFS policy, once the mental health provider has identified a child as a Katie A. Subclass Member, the assigned social worker will contact the Team Decision Making (TDM) scheduler within 30 days of notification to schedule the family’s initial CFT meeting, which is referenced as a CFT TDM. For further direction on scheduling a CFT TDM meeting, refer to CFS P&P [Team Decision Making \(D-0308\)](#).

During the initial CFT meeting, the TDM Facilitator’s primary role is to lead members in the development of:

1. A Safety Plan (as deemed necessary).
2. Ground rules for the meeting and decision making process.
3. Identification of CFT members.
4. Goals of the IPC.
5. A Family Vision statement.

The TDM Facilitator will complete the *Child and Family Team Meeting Summary (F063-25-751)*.

**Note:** For Katie A. Subclass members, the assigned social worker will invite CFT members to future TDM meetings related to placement needs. The TDM Facilitator will review the implementation of the IPC with the CFT during the TDM. When scheduling a TDM meeting for a Katie A. Subclass Member, the assigned social worker will inform the TDM scheduler that the meeting will be a “placement CFT TDM” meeting.

B. **Initial/Subsequent CFT meetings for Katie A. Class and Subsequent CFT meetings for Katie A. Subclass Members:**

The assigned social worker will facilitate CFT meetings, unless it is determined that a specially trained facilitator is required based on the child and family needs. CFT meetings will occur as often as deemed necessary by the child, family, assigned social worker, and/or the mental health provider.

For Katie A. Subclass members, only the initial CFT meeting is required to be facilitated by a TDM Facilitator unless the purpose of the subsequent meeting is to address placement changes/concerns.

Refer to “Child and Family Team” Policy section above for further guidelines.

**Consent for  
Mental Health  
Services**

A. **Parental Consent:**

Pursuant to Welfare and Institutions Code (WIC) Section (§) 369(f), parents or legal guardians who are available, capable, and willing to consent to medical care, including mental health care, and whose rights to do so have not been restricted by Court, have the legal authority to consent to in-patient and out-patient mental health treatment for a child.

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 Social Services to sign consent on behalf of the child; however, the assigned Senior Social Worker (SSW) 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.

**Note:** Per Best Practice, a child’s attorney may be advised of a child’s mental health needs for information only; however, if the parent’s or legal guardian’s rights have been restricted, then the child’s attorney/Guardian Ad Litem (GAL) consent to a child’s treatment and/or release of mental health information/records is necessary.

See “Parental Consent” section above for additional information.

2. Child 12 Years of Age and Older:

Pursuant to FAM § 6924(b) and Health and Safety Code (HSC) §124260, a child 12 years of age or older may provide consent for mental health services, unless prohibited by court order. Based on the legal statute applied by the mental health provider, there may be funding restrictions to Medi-Cal benefits.

<b>Medi-Cal Benefits Apply</b>	<b>Medi-Cal Benefits Do Not Apply</b> *Pursuant to HSC § 14029.8
<p>Pursuant to FAM §6924(b), child consents to mental health treatment or counseling on an outpatient basis, or to <i>residential shelter services</i>, and <u>both</u>:</p> <p>(1) The child, in the opinion of the attending Mental Health Provider, is mature enough to participate intelligently in the treatment.</p> <p>(2) The child would present a danger of serious physical or mental harm to self or to others</p>	<p>Pursuant to HSC §124260, child consents to mental health treatment or counseling on an outpatient basis, and the Mental Health Provider believes the child is mature enough to participate intelligently in the treatment.</p>

without treatment <u>or</u> is the alleged victim of incest or child abuse.	
<b>Note:</b> Pursuant to FAM § 6929(b), children 12 years and older may consent to counseling related to the diagnosis and treatment of a drug or alcohol related problem. Medi-Cal benefits may or may not apply; further Medi-Cal eligibility assessment would be necessary.	

See [Attachment 4—Authorized Mental Health Providers and Resources](#), for a listing of authorized providers.

**Medi-Cal Benefits Eligibility**

Per best practice, the assigned social worker will partner with the Medi-Cal eligibility worker to determine if the child is eligible for full scope Medi-Cal benefits and/or to resolve problems that interfere with the child’s ability to access benefits/services.

Per to HSC § 124260(d), the parent or legal guardian is not liable for payment for mental health treatment services, counseling, or residential shelter services provided to a consenting child if the parent or legal guardian did not participate in or consent to the services provided.

**Note:** In accordance with FAM §§ 6924(d) and 6929(c), when a child 12 years of age or older consents to outpatient mental health services or drug/alcohol treatment services, the parent/legal guardian will be involved in the child’s treatment unless the provider, in consult with the child, determines that involvement of the parent/legal guardian would be inappropriate. The decision to notify or not notify the parent/legal guardian is the provider’s responsibility.

C. **Advisements:**

The assigned social worker will complete the following:

- Inform children who are in need of mental health services and who are 12 years of age or older of their rights to consent to their own treatment
- Advise parents or legal guardians of their children’s rights to consent to outpatient mental health services, counseling, and residential shelter services
- Document advisements given to children and their parents or legal guardians in a Child Welfare Services/Case Management System (CWS/CMS) case contact

## 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 (**Note:** Psychosurgery cannot be performed on a child under any circumstances)
- Psychotropic drugs
  - See CFS P&P [Psychotropic Medication: Dependent Child \(I-0306\)](#)
- Electro-Convulsive Treatment (ECT) (**Note:** ECT cannot be performed on a child younger than 12 years under any circumstances)
  - Children ages 12 to 15 years old may be provided with ECT only in a life-threatening emergency if the child is considered mature enough to give informed consent and the parent and child consent to ECT (this applies to both voluntary and involuntary admissions to a psychiatric facility)
- Children 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 \(D-0510\)](#)

**Note:** For children in out-of-home care, the assigned SSW will seek court authorization for mental health treatments mentioned above as deemed necessary. See CFS P&P [Medical Care Authorization \(I-0206\)](#).

## Refusal to Consent to Treatment—Religious Beliefs

Pursuant to WIC § 300(b), the Juvenile Court may intervene to protect the life and health of a child over the religious objections of the child's parent or legal guardian. This may occur when the parent or legal guardian of the child has unreasonably refused to consent to medical treatment including treatment for mental or emotional illness.

In the event that a parent or legal guardian refuses to consent to mental health treatment for a child based on religious beliefs, and the treating medical professional reports that mental health treatment is necessary to prevent the child from suffering serious physical harm or illness, CFS staff will refer to CFS P&P [Court Medical Consent for Non-Dependent Children \(I-0201\)](#) or [Medical Care Authorization \(I-0206\)](#) for guidelines and procedures.

## Confidentiality of Mental Health Information/ Records

The assigned SSW may require a child'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.

In accordance with HSC § 123110 (a), when a child age 12 years and over consents to mental health treatment or counseling services, the provider can share the related mental health records with the parent or legal guardian only with written authorization from the child. If a child, 12 years of age or older, is unable or unwilling to provide a written authorization to release the records, 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.

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 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. Refer to [Disclosure of Mental Health Records Recommendation Desk Guide](#) when seeking authorization to allow a therapist to share a child's mental health/therapeutic service information with the parent/legal guardian and/or the child's planning and support team.

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.

**Exception:** Pursuant to Penal Code (PEN) §§ 11165.7 and 11166, information concerning a child's mental health may be provided by a mandated reporter for the purpose of assisting in a child abuse or neglect investigation being conducted by the investigating child welfare department and/or law enforcement.

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 \(I-0404\)](#).

### **Out-of-County Mental Health Services**

CFS staff will initiate mental health services for Medi-Cal eligible foster children placed outside their county of jurisdiction by contacting the County mental health plans (MHPs) for the child's county of placement (i.e., host county).

Pursuant to WIC § 5777.6, MHPs are required to establish a procedure to ensure access to specialty mental health services for children in foster care placements (relatives/NREFMs/Foster Family Homes, Foster Family Agencies) and who are placed outside their county of jurisdiction (i.e., county of origin).

Also, per WIC §§ 11376 and 16125, MHPs are required to provide specialty mental health services for children in legal

guardianship (with termination of court dependency), who are receiving Kin-GAP assistance, and for children with a finalized adoption receiving or eligible to receive Aid to Adoptive Parents (AAP) assistance who reside outside their county of origin.

Specialty mental health services include:

- Rehabilitative mental health services
- Psychiatric inpatient hospital services
- Targeted case management
- Psychiatric services
- Psychological services
- Early Periodic Screening and Diagnostic Treatment (EPSDT) supplemental specialty mental health services
- Psychiatric nursing facility services
- Intensive Care Coordination (ICC)
- Intensive Home-Based Services (IHBS)

The California Department of Health Care Services (DHCS) created the Statewide MHP Contact List for Children/Youth Placed Out-of-County, a directory of MHP contact information to facilitate communication between counties, providers, and MHPs regarding mental health services for children who are placed or residing outside their county of jurisdiction or origin. To locate the name and contact information for the Out-of-County Placement Coordinator, refer to the [Statewide MHP Contact List for Children/Youth Placed Out-of-County](#) website.

CFS staff will advise relative guardians (without court supervision) receiving Kin-GAP assistance, and adoptive parents (finalized adoptions) receiving or eligible to receive AAP funds, to contact the MHP Out-of-County Placement Coordinator in their county of residence to request mental health services. CFS staff will provide the appropriate name and contact information as contained in the [Statewide MHP Contact List for Children/Youth Placed Out-of-County](#).

If the MHP in the child's county of placement is unable to provide the requested mental health services, CFS staff will contact the secondary service provider, Orange County Mental Health Plan/CalOptima Beacon, at (800) 723-8641.

CFS staff requiring consultation or assistance with obtaining out-of-county mental health services for children on their caseload will contact the [Continuing Care Placement Unit](#) (CCPU).

**Court Report  
Documentation/  
Court Notification**

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

- Child screened for a mental health assessment
- Referrals for mental health services
- Child’s progress in mental health treatment
- Information about CFT meetings held

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

- Jurisdictional/Dispositional hearing
- And–**
- Each subsequent Status Review hearing

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

Per WIC § 370, the Court may order the assigned SSW to obtain the services of psychiatrists, psychologists, or other clinical experts as needed to determine or provide appropriate treatment.

**Note:** Any conflicts in court orders should be promptly reported to the Court, as this may require a submission of a *Request to Change Court Order (JV-180)* to request a change in court order.

**CWS/CMS  
Documentation**

Information regarding a child’s mental health screening and treatment will be documented in the child’s Health Notebook in CWS/CMS. This information will be updated as needs and services change. Refer to CFS P&P [Case Compliance Contacts and Documentation \(E-0105\)](#) for further information.

Further, the following mental health information will be documented in a case contact, as applicable:

- Initial and subsequent mental health screenings
- Referrals for mental health and developmental assessments
- Katie A. Subclass eligibility by mental health services provider
- Mental health services provided or referred
- Ongoing follow-up/communication regarding mental health

services, activities, and linkages (e.g., CFT, Wraparound, TDM, and other collaborative family team meetings, consultations/conferences via email, telephone, or in person, etc.)

- Family/youth refused/declined services

**Note:** For CFTs, Wraparound, TDM, and other collaborative family team meetings, CFS staff will select “FEE-Family Mtg/TDM/Family Case Conferencing” under the Case Management Service/Referral in the CWS/CMS Contact.

The assigned social worker will enter and update the Health Notebook, per the data entry standards on mental health services, refer to [CWS/CMS Data Entry Standards—Developmental & Mental Health Screening and Services](#) and [CWS/CMS Data Entry Standards—Health and Education Passport](#).

## Filing

Per CFS P&P [Referral and Case Filing \(E-0102\)](#), completed forms will be filed as follows:

- *Authorization to Use and Disclose Protected Health Information (PHI) (F063-28-343) on the Medical Acco (F063-25-1115)*
- *Mental Health Screening Checklist (F063-25-731) on the Mental Health/Development Acco (F063-25-1150)*

## Resources

For a list of authorized providers and resources, refer to [Attachment 4—Authorized Mental Health Providers and Resources](#).

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## REFERENCES

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### 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—Mental Health Behavioral Indicators](#)
- [Attachment 2—Mental Health Screening Checklist Outcome](#)
- [Attachment 3—Mental Health Referral Submission](#)
- [Attachment 4—Authorized Mental Health Providers and Resources](#)
- [Attachment 5—Determination of Katie A. Subclass Equivalent Guide](#)

- [Attachment 6—Child and Family Team Model](#)
  - [Attachment 7—Child and Family Team \(CFT\) Meeting Guide](#)
  - [CWS/CMS Data Entry Standards—Developmental and Mental Health Screening and Services](#)
  - [CWS/CMS Data Entry Standards—Health and Education Passport](#)
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## 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 [Medical Care Authorization \(I-0206\)](#)
  - CFS P&P [Psychotropic Medication: Dependent Child \(I-0306\)](#)
  - CFS P&P [Substance Abuse Services for Children \(D-0510\)](#)
  - CFS P&P [Team Decision Making \(D-0308\)](#)
  - CFS P&P [Wraparound Referral and Services \(D-0511\)](#)
  - [Statewide MHP Contact List for Children/Youth Placed Out-of-County](#)
  - [Continuing Care Placement Unit](#)
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## Other Sources

Other printed references include the following:

None

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## FORMS

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**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
<a href="#">Child and Family Team Meeting Summary</a>	F063-25-751

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**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
<a href="#">Authorization to Use and Disclose Protected Health Information (PHI)</a>	F063-28-343
Medical Acco	F063-25-1115
Mental Health/Development Acco	F063-25-1150

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**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
<a href="#">Mental Health Screening Checklist</a>	F063-25-731

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**Brochures** Brochures to distribute in conjunction with this policy may include:

Brochure Name	Brochure Number
<a href="#">The Child &amp; Family Team</a>	F063-25-755

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## LEGAL MANDATES

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[Welfare and Institutions Code \(WIC\) Section \(§\) 300\(b\)](#) 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 § 369\(f\)](#) 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 § 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 § 5777.6](#) 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.

[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.

[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](#) 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.

[Pathways to Mental Health Services—Core Practice Model Guide \(2013\)](#), 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.