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SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

The Children's Transition Services (CTS) Referral Process

The Children's Transition Services (CTS) is a weekly county wide meeting designed to coordinate referrals for different levels of care, adding needed adjunctive services, as well as referrals to FSP services. The meeting consists of and is facilitated by Behavioral Wellness Team Supervisors and Regional Managers in collaboration with contracted Community Based Organizations (CBO) and/or other BWELL program team members. CTS participants review and evaluate the presented referrals to determine the appropriate level-of-care needed for each client being referred / transferred. Referrals include new clients, as well as existing clients transitioning to a different level-of-care. The client is then assigned to the program that best addresses their needs. All treatment services are customized and tailored to meet the individualized needs of each client and/or their caregiver(s) to ensure continuity of care**.**

CTS Referral Process:

- An initial, updated or comprehensive assessment needs to be completed prior to referring to CTS when possible, unless a child/youth is referred from a hospital or higher level of care.
- The BWELL CTS referral form (Children Transition Services) needs to be completed and submitted via email to the pertaining Team Supervisor and Regional Manager in advance of the next CTS meeting for review unless there is an urgent situation. FSP must be selected if the referral is for FSP services.
- The referring party attends the CTS meeting (in person, via video conferencing or by phone) to present the case for clinical consultation.
- Cases are referred and assigned to the appropriate level-of-care.
- The assigned care coordinator will be assigned and documented.
- when referring a child/youth for FSP services the assigned care coordinator will be tasked with outreaching the client to review and complete the FSP partnership agreement.
- The assigned clinic/program will meet with the client and/or caregiver(s) and open the client to services within three (3) to five(5) business days after the CTS meeting date.
- Established clients will require an updated Assessment and updated treatment plan to reflect the need for a higher or lower level-of-care, in order to be transitioned or referred.
- Once the receiving program has scheduled the intake and opened the client (client attended first appointment and is linked), notify the referring party of the linkage/engagement so that program can close the fac/prog and ensure continuity of care.