DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
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DATE: XXX

ALL COUNTY INFORMATION NOTICE (ACIN) NO. 25-XXX
BEHAVIORAL HEALTH INFORMATION NOTICE (BHIN) NO. 25-XXX

TO: ALL CHIEF PROBATION OFFICERS
ALL COUNTY WELFARE DIRECTORS
ALL TRIBES WITH A CALIFORNIA TITLE IV-E AGREEMENT
COUNTY BEHAVIORAL HEALTH PROGRAM DIRECTORS
COUNTY DRUG AND ALCOHOL ADMINISTRATORS'
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION OF CALIFORNIA
COUNTY WELFARE DIRECTORS' ASSOCIATION OF CALIFORNIA
CHIEF PROBATION OFFICERS OF CALIFORNIA
CALIFORNIA STATE ASSOCIATION OF COUNTIES
CALIFORNIA REGIONAL CENTERS
ASSOCIATION OF REGIONAL CENTER AGENCIES
DOR REGIONAL DIRECTORS
COUNTY OFFICES OF EDUCATION SPECIAL EDUCATION LOCAL PLAN AREAS

SUBJECT: POLICY CHANGES TO SUPPORT ALIGNED USE OF THE CHILD AND ADOLESCENT NEEDS AND STRENGTHS TOOL BY COUNTY BEHAVIORAL HEALTH PLANS, COUNTY CHILD WELFARE AGENCIES, AND JUVENILE PROBATION AGENCIES

REFERENCE: Assembly Bill (AB) 403, Mental Health and Substance Use Disorder Services Information Notice (MHSUDS IN) NO. 17-052, All County Letter (ACL) NO. 18-09/MHSUDS IN 18-007, ACIN No. I-21-18/MHSUDS IN No. 18-022, ACL NO. 18-81, ACL NO. 18-85/MHSUDS IN NO. 18-029, MHSUDS IN NO. 18-048, ACL NO. 21-27, COUNTY FISCAL LETTER (CFL) NO. 21/22-69, WELFARE AND INSTITUTIONS CODE SECTION 832

BACKGROUND:
As part of the California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 Demonstration, the California Department of Health Care Services (DHCS) and California Department of Social Services (CDSS) are pursuing alignment of the protocols for and items included in the Child and Adolescent Needs and Strengths (CANS) tool. A recommendation to align the CANS across both departments came from the California Advancing and Innovating Medi-Cal Foster Care Model of Care Workgroup, which was regularly convened between June 2020 and April 2021,[1] and the Child and Family Team (CFT) Implementation Team, which convened regularly between 2019 and 2024 and was then re-launched as the CFT CANS Statewide Forum and Steering Committee in 2025.[2] DHCS and CDSS will align their CANS processes to ensure that county child welfare agencies, county juvenile probation agencies, behavioral health plans (BHPs), and specialty mental health services (SMHS) providers administer the same CANS tool in the same manner so that results are comparable, outcomes can be tracked over time, and to further promote collaboration of the CANS between partners. This will ensure that CANS results can be more easily shared between entities, which supports streamlined care for children and youth served in both systems. It will also help to ensure that a single CANS is administered to children involved in both systems to avoid redundancy.

Both DHCS and CDSS have previously released guidance on the use of their respective CANS tools, including joint guidance for county partners, staff, Tribes, and providers. To date, there have been differences in policy and requirements guiding the use of the CANS between the two departments. CDSS and DHCS are working collaboratively to inform alignment of the CANS and necessary corresponding policy changes for both departments.

The policy changes to support aligned use of the CANS between the two departments, as well as new updates required by AB 161, which impact alignment, and previous guidance, which will be maintained without changes, are detailed in this BHIN/ACL. **This joint BHIN/ACL supersedes some elements included in previous guidance from both departments on the CANS as detailed in Tables 2 and 3 below.**

The policy changes detailed in this joint BHIN/ACL are an initial phase of policy changes, specific to administrative alignment, to support aligned use of the CANS between the two departments. The changes in this joint BHIN/ACL are effective within 90 days of release of this joint BHIN/ACL. The Departments anticipate a subsequent phase of policy changes, which will focus on

[1] For more information see the Medi-Cal's Foster Care Strategies Memorandum.
[2] For more information see the Medi-Cal's Foster Care Strategies Memorandum.

programmatic alignment, necessary automation changes, and use of the CANS tool.

Ongoing alignment work will be informed by parallel efforts involving alignment of data reporting and sharing systems between the two departments, use of the CANS to support the CDSS new foster care rate structure, and ongoing work by the CDSS to refine how the trauma module is used.

Previous CDSS and DHCS guidance on the use of the CANS include:

- MHSUDS IN NO. 17-052: *Early and Periodic Screening, Diagnostic and Treatment (EPSDT) – Specialty Mental Health Services Performance Outcomes System Functional Assessment Tools for Children and Youth* (11/14/2017)
- ACL NO. 18-09/MHSUDS IN 18-007: *Requirements for Implementing the Child and Adolescent Needs and Strengths Assessment Tool within a Child and Family Team* (1/25/2018)
- ACL NO. 18-81: *Requirements and Guidelines for Implementing the Child and Adolescent Needs and Strengths Tool Within a Child and Family Team (CFT) Process* (7/2/2018)
- ACL NO. 18-85/MHSUDS IN NO. 18-29: *Clarification Regarding Sharing of CANS Assessments by County Placing Agencies and Mental Health Programs* (7/9/2018)
- ACL NO. 25-10: *Updated Requirements for Administration of the Integrated Practice-Child and Adolescent Needs and Strengths Tool and Child and Family Teams (2/18/2025)*
- MHSUDS IN NO. 18-048: *Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)- Specialty Mental Health Services Performance Outcomes System Functional Assessment Tools for Children and Youth* (10/17/2018)
- ACL NO. 21-27: *Child Welfare Requirements for Child and Adolescent Needs and Strengths (CANS) Training, Certification, and Entry of CANS Data into the CARES-Live System* (3/12/2021)
- ACIN I-35-24: *New Resources Available to Enhance Fidelity and Support of Child and Family Team (CFT) Meetings and the Child and Adolescent Needs and Strengths (CANS)* (7/19/2024)
- COUNTY FISCAL LETTER (CFL) NO. 16/17-22: *Child and Family Team Claiming Instructions* (10/11/2016)
- CFL NO. 19/20-37: *Fiscal Year 2019-2020 Child and Family Teams and Child and Adolescent Needs and Strengths General Fund Allocation* (10/31/2019)
- CFL NO. 21/22-69: *Fiscal Year 2021-2022 Child and Family Teams and Child and Adolescent Needs and Strengths General Fund Allocation* (2/2/2022)

- CFL 21/22-72: *Updated Claiming Instructions for the Child and Family Teams (CFT) Process and the Child and Family Needs and Strengths (CANS) Assessment Activities* (2/3/2022)
- CFL NO. 22/23-23: *Fiscal Year 2022-2023 Child and Family Teams and Child and Adolescent Needs and Strengths General Fund Allocation* (10/31/2022)
- CFL NO. 23/24-36: *Fiscal Year 2023-2024 Child and Family Teams and Child and Adolescent Needs and Strengths General Fund Allocation* (1/16/2024)
- CFL NO. 24/25-18: *Fiscal Year 2024-2025 Child and Family Teams and Child and Adolescent Needs and Strengths General Fund Allocation* (10/4/2024)
- ACIN I-21-24/BHIN 24-021: *The California Children, Youth, and Families Integrated Core Practice Model and the California Integrated Training Guide* (5/29/2024)

The CANS Tool:
CANS is an open domain tool for use in multiple youth-serving systems that address the needs and strengths of youth, adolescents, and their families. It is a flexible and evolving tool that supports open discussion and collaborative decision-making regarding care coordination and planning, levels of care, services, and placement (if applicable). It provides a framework for developing and communicating a shared vision and uses youth and family information to inform planning, support decisions, and monitor outcomes. The CANS is used to assess well-being, identify a range of social and behavioral health care needs, and support care coordination and collaborative decision making.

In addition to the CANS being used to inform case planning and service support delivery, CDSS is utilizing the CANS to inform the Tiered Rate Structure beginning in 2027 and will be exploring how the CANS data can best be used to inform and identify population-level needs and development service arrays to meet those needs. CDSS offers the use of CANS reports within Evident Change's SafeMeasures system, available to county child welfare staff, juvenile probation staff, and CDSS.

The CANS is designed based on communication theory, making it a "communimetric" tool. There are six key principles of a communimetric measure that apply to understanding the CANS:

1. Items were selected because they are each relevant to case/treatment planning.
2. Each item uses a 4-level rating system that translates into action.
3. Ratings should describe the child/youth, not the child/youth in services. In practice, this means that the completer should consider whether that need would still exist if the intervention or service was removed. An intervention may mask a need.

4. Culture and development should be considered prior to establishing the action levels.
5. The ratings focus on the current needs and strengths of the child/youth, without considering the cause of their conditions or behaviors.
6. A 30-day window is used for ratings to make sure assessments stay relevant to the child/youth's present circumstances. In practice, this means that the reviewer is not supposed to consider how the youth was a year ago or three months ago, but at present.

When completing CANS, each of the items is rated on a scale from 0 to 3.[3] A rating of "2" or "3" on a CANS need item suggests that this area must be addressed or is "actionable." A rating of a "0" or "1" on a CANS strength identifies an area that can be used for strength-based planning and a rating of "2" or "3" indicates a strength that should be the focus on strength-building activities. The six modules that comprise "CANS Core 50" represent the minimum common items required to be used by DHCS and CDSS. BHPs and county child welfare agencies may opt to add questions specific to their local needs, if desired.

[3] The "CANS Core 50" includes the 50 items which comprise the core CANS tool. There are additional modules which can be utilized in addition to these 50 core items.

Table 1: The CANS Basic Structure[4]

Behavioral/Emotional Needs Domain 1. Psychosis (Thought Disorder) 2. Impulsivity/Hyperactivity 3. Depression 4. Anxiety 5. Oppositional 6. Conduct 7. Anger Control 8. Substance Use 9. Adjustment to Trauma **Life Functioning Domain** 10. Family Functioning 11. Living Situation 12. Social Functioning 13. Developmental/Intellectual 14. Decision Making 15. School Behavior 16. School Achievement 17. School Attendance 18. Medical/Physical 19. Sexual Development 20. Sleep **Risk Behaviors** 21. Suicide Risk 22. Non-Suicidal Self-Injurious Behavior 23. Other Self-Harm (Recklessness) 24. Danger to Others 25. Runaway 26. Sexual Aggression 27. Delinquent Behavior 28. Intentional Misbehavior	**Cultural Factors Domain** 29. Language 30. Tradition and Rituals 31. Cultural Stress **Strengths Domain** 32. Family Strengths 33. Interpersonal 34. Educational Setting 35. Talents and Interests 36. Spiritual/Religious 37. Cultural Identity 38. Community Life 39. Natural Supports 40. Resiliency **Caregiver Resources and Needs Domain** 41. Supervision 42. Involvement with Care 43. Knowledge 44. Social Resources 45. Residential Stability 46. Medical/Physical 47. Mental Health 48. Substance Use 49. Developmental 50. Safety

History of the CANS for DHCS and CDSS:

[4] For more detail on the CDSS CA IP-CANS tool and its usage, please see ACL NO. 18-81.

In 2017, CDSS and DHCS each engaged in an extensive effort to review assessment tools to select a tool that best fit each department's particular needs. Both departments decided to adopt the CANS assessment tool.

As noted in prior guidance (e.g., MHSUDS IN NO. 17-052, ACN No. I-21-24/BHIN No. 24-021), DHCS adopted the core 50 items of the CANS[5] as a tool to measure child and youth functioning.[6]

Additionally noted in prior guidance (e.g., ACL NO. 18-09/MHSUDS IN 18-007, ACN No.I-21-18/MHSUDS IN No. 18-022) and pursuant to AB 403 and the Continuum of Care Reform (i.e., the intent of the legislature to improve California's child welfare system and its outcomes by using comprehensive initial child assessments and working with a child, youth, and family as part of a team), CDSS adopted the "California Integrated Practice CANS" (CA IP-CANS). The CA IP-CANS was selected as the functional assessment tool to be used within CFT processes to guide case planning and placement decisions.

As outlined in previous guidance (e.g., ACL NO. 18-81), CDSS' CA IP-CANS includes the core 50 items of the CANS, the ability to assess up to four caregivers, and the 12-item "CANS Potentially Traumatic/Adverse Childhood Experiences" module. The 12 items in the trauma module are static, "yes or no" indicators (unlike the core 50 items, which are rated on a scale of 0-3), which indicate whether or not a child/youth has experienced a particular trauma. If the child/youth has ever had one of these experiences, it would always be rated in this module, even if the experience was not currently causing problems or distress in the child/youth's life. Thus, these items are not expected to change except in the case that the child/youth experiences a new trauma, or a historical trauma is identified that was not previously known.[7] [8] Additionally, the CA

[5] California CANS-50 is available here.
[6] DHCS contracted with the University of California Los Angeles (UCLA) to recommend evidence-based tool(s) to measure children and youth functional outcomes in California. Using several criteria, UCLA made a recommendation to DHCS for a statewide outcomes measurement, which was the PSC-35 tool (parent/caregiver version). In addition, DHCS determined it would also be beneficial to adopt a tool representing the clinician's perspective of child/youth functioning formed through a collaborative assessment process including the youth, caregivers, and other individuals identified by the youth and family, which resulted in the selection of the CANS-50. For more detail on DHCS' process for selecting the CANS, see MHSUDS IN NO. 17-052.
[7] At this time DHCS will not be adopting the CANS Potentially Traumatic/ Adverse Childhood Experiences module to align with CDSS.
[8] CA IP-CANS Manual is available here and the CA IP-CANS Rating Sheet is available here (CA IP-CANS Rating Sheet in Spanish).

IP-CANS includes an Early Childhood Module to be used with children from birth to five years old.

While both DHCS and CDSS selected the core 50-item CANS tool, there are clear differences in terms of how the CANS has been administered by the two departments. The complexity, scope, and impact of these differences has become clear over time, which has contributed to a call from stakeholders for alignment of the use of the CANS between the two departments.

DHCS Use of the CANS
As noted in previous DHCS guidance (e.g., MHSUDS IN NO. 17-052, MHSUDS IN NO. 18-048), the CANS-50 is used as a structured assessment for identifying youth and family actionable needs and useful strengths, as well as to measure youth functioning. It provides a framework for developing and communicating about a shared vision and uses youth and family information to inform planning, support decisions, and monitor outcomes. The CANS-50 is to be completed for all children/youth (ages 6 to 20) who receive BHP SMHS services. BHP SMHS providers complete the CANS-50 through a collaborative process which includes children and youth, and their caregivers (at a minimum).

CDSS Use of the CANS
Previous CDSS guidance (e.g., ACL NO. 18-81) states that for CDSS, the CFT, CA IP-CANS, and case plan are interconnected and inextricably linked. CFTs serve as the primary vehicle for collaboration and information-gathering to inform the CA IP-CANS assessment and case planning for a child or youth. For this process, the CA IP-CANS should be completed collaboratively with the child/youth (ages 5 to 21), family, and other stakeholders, including members of the CFT. For children from birth to five years old, CDSS uses the CA IP-CANS Early Childhood Module.[9]

As a communimetric tool, the CA IP-CANS tool helps the CFT prioritize actions regarding identified needs and strengths using team-based decision making and care planning. Through the use of open communication, engagement, and consensus building, the use of the tool results in a collaborative, family-centered assessment process with the family and CFT members. These functions are further emphasized by AB 161.

[9] At this time DHCS will continue to use the PSC-35 and will not be adopting the Early Childhood-CANS to align with CDSS. For more detail on the Early Childhood CANS, see ACL NO. 18-81. Available here.

POLICY:
The policy changes detailed in this joint BHIN/ACL include:

- Administration of the CANS at case closure and/or end of treatment;
- Requirement of training through the Regional Training Academies (RTAs) and certification through Innovation Population Health (IPH) for all individuals administering the CANS on behalf of placing agencies (ACL 25-10);
- Requirement for IPH certification for all BHP SMHS practitioners who administer the CANS; and
- Eliminate the requirement of specific professional licensure/certification for individuals administering the CANS if the individuals have received training through the RTAs and IPH certification.

These policy amendments to support the aligned use of the CANS between BHPs, county child welfare, and juvenile probation agencies, as well as previous areas of guidance which will be maintained without policy changes, are summarized in the tables below.

Table 2: DHCS Policy Changes

Area of Guidance	Previous DHCS Policy	Updated DHCS Policy
Training and Certification Requirements: Center for IPH Training and Certification	• MHSUDS IN 17-052 • MHSUDS IN 18-007	DHCS amends previous policy (i.e., MHSUDS IN No. 17-052) to align with CDSS policy by requiring that all BHP SMHS providers administering the CANS complete certification via the Center for IPH (formerly the Praed Foundation). Additionally, as described above, all individuals administering the CANS on behalf of placing agencies, including BHP SMHS practitioners when applicable, must participate in required training through RTAs and certification by IPH).
Professional Requirements for Providers: Licensure requirements	• MHSUDS IN 17-052 • MHSUDS IN 18-007	DHCS supersedes previous policy (i.e., MHSUDS IN No. 17-052) to remove the requirement that individuals administering and being reimbursed for costs associated with the CANS be clinically licensed providers ("clinicians"), as long as they meet the certification requirement of possession of a bachelor's degree and have complied with the new requirement to obtain and maintain CANS certification through IPH. CDSS policy (i.e., ACL 21-27) which specifies BHP "clinicians" as the individuals administering the CANS must also be amended.

Table 3: CDSS Policy Changes

Area of Guidance	Previous CDSS Policy	Updated CDSS Policy
Cadence of Administration: Triggering Events	• ACL 18-81 • ACL 25-10	CDSS amends previous policy (i.e., ACL 18-81) to align with DHCS policy by requiring that a CANS be completed at the closure of a child welfare case. CDSS further amends previous policy to increase CANS updates specific to placing agencies.

DHCS Policy Change: CANS Training and Certification Requirements
Previous CDSS guidance (e.g., ACL NO. 21-27, ACL NO. 18-81) requires that the CANS must be completed by an individual who is currently certified by the IPH to administer the CANS, and that recertification take place on an annual basis. Additionally, guidance strongly recommends that child welfare supervisors who oversee case planning should be CANS-certified in order to reinforce and coach staff on the appropriate use of the CANS.

Requirements for BHPs Completing CANS on Behalf of a Placing Agency
Previous joint guidance (i.e., ACL NO. 18-09/MHSUDS IN 18-007) states that the CDSS will provide training opportunities for skilled facilitators and staff who will administer or utilize CANS results. Counties are also encouraged to reach out to their local or neighboring counties, providers, or other system partners who have been trained and certified in the CANS tool to provide coaching and training opportunities. Previous guidance (i.e., ACL No. 21-27) provides information on the required CA IP-CANS training and certification requirements and explains that there are CDSS-approved CANS trainings that provide competency and readiness for the use of the CANS. These trainings are intended for an array of professionals and partners who are part of the CFT process. The guidance specifies that for participants (e.g., child welfare social workers, BHP providers, and CFT facilitators) the CDSS trainings on CANS are not intended to be a sequence; participants take only one, depending on need for preparation for certification and/or understanding the use of the CANS. Please note, the CANS trainings have been updated since the release of ACL 21-27, with Module D no longer being regularly offered unless requested through RTAs. CANS training and technical assistance is provided by CDSS via the IPH and the RTAs. The CDSS approved CANS training offerings are available via the California Child Welfare Training website and by reaching out to each RTA for their region. **BHPs and additional system partners seeking to access CANS training and certification for individuals administering the CANS under the terms of a formal agreement with placing agencies shall utilize the CDSS approved CANS trainings.** Additional guidance from CDSS if forthcoming regarding CDSS CANS training requirements and access to CDSS-approved trainings.

Requirements for BHPs Not Completing CANS on Behalf of a Placing Agency
DHCS guidance encourages, but does not require, training and certification through IPH. Previous CDSS guidance (i.e., ACL No. 21-27) echoes this, noting that while completion of the CDSS approved CANS training is not a requirement for county BHPs, all partners are encouraged to attend the CDSS approved CANS training(s) that apply to their role. As noted in previous guidance (i.e., MHSUDS IN NO. 17-052), DHCS expects BHPs to provide or arrange for training to all BHP providers who will be administering the CANS. Additionally, it is stated that it is important that BHPs ensure

that CANS training is provided to their staff by a trainer who holds a current CANS training certificate. This prior guidance states that the IPH provides training and certification and is an optimal resource, as IPH is current on the advances in the CANS training curriculum. The guidance links to the IPH website as a source of more information.

Requirements for all SMHS practitioners administering the CANS
All BHP SMHS practitioners administering the CANS are required to be certified by IPH. Additionally, more specific training requirements to achieve IPH certification may be included in subsequent phases of guidance. No previous guidance verbiage will need to be superseded in DHCS guidance. However, ACL NO. 21-27 explicitly notes "completion of the CDSS approved CANS training is not a requirement for county BHPs," and this language will be amended in future iterations of CDSS guidance. This requirement is herein introduced and supersedes all prior DHCS guidance on the CANS, as well as the use of the verbiage in ACL NO. 21-27 which conflicts with the new requirement.

The requirement that all SMHS providers administering the CANS be certified by IPH will ensure that individuals administering the CANS on behalf of both departments will do so with consistency and a common understanding of the tool's use and philosophy.

This guidance noted that BHPs will incur costs to train providers to administer and complete the CANS, and that DHCS will reimburse BHPs for the costs of CANS training for providers and the time that providers spend in training for CANS. BHPs will be reimbursed based on their training costs, including costs for CANS training for CANS-certified BHP providers and the time providers spend in training. DHCS considers training and certification for individuals administering the CANS to be a Utilization Review/Quality Assurance cost, which is currently claimed on the MC 1982 form. BHPs will still be reimbursed for the costs, which they incur for both training costs and time which providers spend in training.

DHCS Policy Change: Professional Requirements for Providers Who Administer the CANS
CDSS guidance does not require professional licensure or credentialing for individuals who administer the CANS, as long as they are actively CANS certified. Previous guidance (e.g., ACL NO. 21-27, ACL NO. 18-81) simply states that the CANS must be completed by an individual who is currently certified by the IPH and recertified on an annual basis. Additionally, this guidance notes that counties may choose different ways to administer the CANS within the CFT based on local needs and practice, including these options:

- The CFT facilitator is a CANS-certified individual and must collaborate with the Case Carrying Social Worker (CCSW).
- The Behavioral Health Clinician is a CANS-certified individual and must collaborate with the CFT facilitator and the CCSW.
- The CCSW is the CANS-certified individual and must collaborate with the CFT Facilitator.

Previous DHCS policy (MHSUDS IN NO. 17-052) specifically uses the language "clinicians" to refer to individual SMHS providers who administer the CANS and are reimbursed for associated costs. The guidance specifically notes that BHPs will be reimbursed for the time which clinicians spend completing the CANS. The use of "clinicians" to refer to BHP providers administering the CANS is echoed in CDSS guidance (i.e., ACL NO. 18-81, ACL NO. 21-27).

Previous policy will remove reference to, and specification of, "clinicians" as the individuals who may administer the CANS in county BHP and SMHS contexts and be reimbursed for costs. New policy will not specify a licensure or credentialing requirement for individuals who administer the CANS or receive reimbursement for costs associated with implementation, so long as they meet the certification requirement of possession of a bachelor's degree, are actively CANS certified, and will use the term "CANS-certified BHP provider" instead. The use of "CANS-certified BHP provider" will supersede "BHP clinician" in all previous CDSS and DHCS guidance.

Removing clinical licensure requirements in tandem with the introduction of the requirement of certification via IPH will ensure that individuals administering the CANS on behalf of both departments will do so consistently. This alignment policy allows for a broader range of BHP providers, including those who might have more familiarity with a given child or youth, to administer the CANS.

CDSS Policy Change: Cadence of CANS Administration
As noted in prior joint CDSS and DHCS guidance (e.g., ACL 18-09/MHSUDS IN 18-007) children, youth, and non-minor dependents (NMDs) receiving SMHS are assessed by using the CANS every six months.

Per previous DHCS guidance (e.g., MHSUDS IN NO. 17052, MHSUDS IN NO. 18-048), the CANS must be completed at the beginning of SMHS treatment, every six months following the first administration, and at the end of treatment (i.e., case closure).
As noted in prior CDSS CANS guidance (e.g., ACL NO. 18-81), a CANS assessment shall be completed prior to the development of a case plan during an initial CFT meeting (to take place as soon as possible and no later than 60 days following involvement with

the child welfare system) and is required every six months thereafter, unless there have been significant changes in the child's, youth's, or NMD's functioning or circumstances occur which require updating the CANS and case plan to reflect the current need(s).

CDSS issued updated requirements for placing agencies' completion of the CA IP-CANS in early 2025 through ACL 25-10. Effective July 1, 2025, all county placing agencies are required to complete a CA IP-CANS for children and youth with an open child welfare case or probation placement case for youth in foster care within specified timeframes. Placing agencies are further required to ensure that completed CA IP-CANS are entered into CDSS's CARES database promptly following completion in order for California's new foster care rates system to function properly. ACL 25-10 also updates requirements related to the cadence of CA IP-CANS that are required, CFT required timelines, and training requirements.

DHCS currently requires that a CANS be administered at the end of treatment. CDSS does not currently require that a CANS be administered at child welfare case closure, but this is understood to be best practice. Pursuant to ACL 25-10, **CDSS revised previous policy to explicitly state that the CANS must be administered at child welfare case closure to align with DHCS' requirement that a CANS be administered at end of SMHS treatment (i.e., case closure).**

Administration of the CANS at case closure will ensure that a CANS is completed for children and youth involved in child welfare on the same cadence as for children and youth receiving SMHS, and that CANS results will be available to any subsequent providers of care.

Unchanged Policy: Confidentiality
As noted in previous joint guidance (i.e., ACL NO. 18-09/MHSUDS IN 18-007), appropriate and effective confidentiality and information sharing practices are key components of the CFT process. Welfare and Institutions Code Section 832 authorizes information sharing between CFT members relevant to case planning and necessary for providing services and supports to the child, youth, or NMD, and family and requires the execution of appropriate authorizations to share such information. Information and records communicated or provided to the CFT by all providers, programs, and agencies, as well as information and records created by the team in the course of serving its children, youth, and their families, shall be deemed private and confidential and shall be protected from discovery and disclosure by all applicable statutory and common law. All discussions during team meetings are confidential unless disclosure is required by law. Previous CDSS policy states that a person designated as a member of a CFT may receive and disclose relevant information and records within the CFT, subject to the child, youth, or NMD and/or their parent or guardian signing an authorization to release

information, as required depending on the type of information. CDSS and DHCS have developed a universal release of information (ROI) form to be used by the CFT.

As noted in previous CDSS guidance (e.g., ACL NO. 21-27, ACL NO. 18-81), an ROI for each individual assessed must be obtained prior to sharing the CANS results with individuals or entities other than the county placing agency or BHP during the CFT meeting. Additionally, guidance notes that in order to ensure compliance with Part 2 of Title 42 of the Code of Federal Regulations, while sharing the CANS as expeditiously as possible, county BHPs or child welfare and juvenile probation agencies must redact items (i.e., items 8 and 48 in the CANS Core 50, and item 41 in the Early Childhood CANS) which discuss or evaluate the family's (i.e., the youth and/or caregivers) substance use and these items may not be included and discussed at the CFT meeting unless an ROI is obtained to specifically release this information.

Unchanged Policy: CANS Claiming and Reimbursement
Per previous CDSS guidance (e.g., CFL NO. 23/24-36), county child welfare and juvenile probation agencies can continue to claim administrative CFTs costs, inclusive of CANS administration, through the CEC/CECRIS using the following CFTs PCs:

- PC 944/0944 (CFT – Federal)
- PC 945/0945 (CCFT – Non-Federal)

Per previous DHCS guidance, providers may use the following codes to bill for the administration of CANS under Short-Doyle/Medi-Cal:

- **H0031**: Mental Health Assessment by Non-Physician; or
- **H2000**: Comprehensive Multidisciplinary Assessment.

Per prior DHCS guidance (MHSUDS IN NO. 17-052) BHPs will be reimbursed for the costs associated with administration of the CANS. These costs include:

- Costs for CANS training for CANS-certified BHP providers;
- Time CANS certified BHP providers spend in training for and completing CANS; and
- Time staff spend entering Pediatric Symptom Checklist (PSC-35) and CANS data into a data system (documented).

Unchanged Policy: CANS Data Reporting
Previous joint guidance (i.e., ACL No. 18-09 & MHSUDS IN 18-007) states that while county placing agencies and county BHPs are to complete and share CANS assessments, each respective entity is expected to submit the CANS data to their respective lead state agency. County BHPs must submit to DHCS the CANS data for all children and youth in Medi-Cal, including children, youth, and NMDs in the child welfare system, in accordance with DHCS' data submission specifications described in previous

guidance (i.e., MHSUDS IN NO. 17-052). County placing agencies and county BHPs are required to share previous CANS assessments for children, youth, and NMDs assessed and/or served by either system with one another as early as possible. Completion of a universal information release form shall not be required for this purpose.

CDSS has software capable of automating the CANS within a platform which allows for individual raters such as CANS-certified providers and certified county staff to complete the CANS, and systematically transfer and integrate the completed CANS data within the new CWS system, known as the Child Welfare Services-California Automated Response and Engagement System (CWS-CARES).[10] The CWS-CARES is under further development as of the writing of this BHIN/ACIN and will be available in late 2026.

Per ACL 21-27, all county child welfare and juvenile probation agencies are required to enter CANS data into the CARES-Live system for all children with an open child welfare case, regardless of which agency completes the CANS.[11] [12] This creates a need for BHPs and SMHS providers that complete CA IP-CANS under the terms of a formal agreement to provide the placing agency with the completed CA IP-CANS upon completion.

As previously noted in DHCS (MHSUDS IN NO. 17-052) guidance, BHPs will incur costs for data entry and for necessary technical changes to county data systems to collect and report CANS data to DHCS. DHCS will reimburse BHPs for costs associated with documented time spent entering CANS data into a data system and time spent preparing/submitting CANS data to DHCS (based upon BHPs costs). DHCS will use a portion of the funding to build a data system to capture PSC-35 and CANS data submitted by BHPs. BHPs will be required to submit data according to DHCS specifications once the new system is ready. BHPs are expected to collect and report to DHCS the data obtained from CANS. Accordingly, counties will need to develop a process to capture, store, and submit this information to DHCS, as specified in CANS data dictionary.

[10] Placing agencies are currently required to enter CA IP-CANS data into CARES-Live. After CARES-Live is decommissioned in 2026, placing agencies will continue to be required to enter CA IP-CANS data into the CWS-CARES.
[11] In prior guidance (ACL NO. 18-81) a critical error occurred wherein two items in the CA IP-CANS were reversed. That ordering error has been corrected in this joint guidance document, **but confirmation is required to ensure that CANS Data Question#7 = Anger Control and Question#8 = Substance Use in all county data systems**.

Per previous guidance (MHSUDS IN 18-048), BHPs must submit data collected using the CANS to DHCS on a monthly basis, with data collected in a given month reported by the last day of the following month. Data will be submitted in batch files to the Behavioral Health Information Systems.

Unchanged Policy: CANS Data Sharing Between BHP and County Placing Agency
As noted in prior joint CDSS and DHCS guidance (e.g., ACL 18-09/MHSUDS IN 18-007), county child welfare agencies, juvenile probation agencies, and county BHPs are jointly responsible for ensuring that a single CANS tool is completed for each child, youth, and NMD for whom they share responsibility. As such, county placing agencies and BHPs must share with each other completed CANS assessments and their resulting identified outcomes for children assessed and/or served by both agencies to avoid unnecessary duplication and over-assessment of children, youth, and NMDs.

Per previous joint guidance (ACL NO. 18-85/MHSUDS IN NO. 18-29), if a child, youth, or NMD has a previous CANS assessment completed by a county BHP, and if the child is referred to a county placing agency, the BHP is required to share the previous CANS assessment with the county placing agency as early as possible. If a current CANS assessment has been completed by a county BHP or their contracted provider, the CFT must use it. The placing agency is not required to complete a new CANS but should consider whether any updates to the CANS rating are appropriate.

Additionally, previous joint-DHCS and CDSS guidance (e.g., ACL NO. 18-09/MHSUDS IN 18-007), states that for children, youth, and NMDs who are already in foster care and are not currently receiving SMHS, the CANS tool functions as the required mental health screening. If the screening indicates that there may be a mental health need for SMHS, the placing agency shall make a referral to the county BHP. The county BHP must accept the completed CANS assessment and not complete a new CANS assessment but may consider whether any updates to the CANS ratings are appropriate. Recent CDSS guidance (ACL 24-035) removes the requirement of a screening and introduces the requirement for a referral to an BHP to be made within three days of case opening by the county placing agency.
When sharing CANS, counties must be cognizant of the fact that questions, responses, and ratings on the CANS assessment rating a child/youth/NMD's or caregiver's problems with substance abuse (i.e., substance use disorder (SUD)-specific questions) cannot be released without a completed and signed ROI/ authorization. If an authorization or release is not in place for the SUD-specific questions, BHPs are still required to share the remaining portions of the CANS assessment, as allowed under state and federal privacy laws. However, county BHPs must redact the portions of the CANS assessment that discuss or evaluate the child/youth/NMD's or caregiver's problems with substance use until an authorization or release is obtained.

Effective Date and Compliance Monitoring
This joint BHIN/ACL constitutes an initial phase of guidance to support CANS alignment and will be effective within 90 days of release of this joint BHIN/ACL. A subsequent phase of policy changes focused on programmatic alignment, necessary automation changes, and use of the CANS tool will be forthcoming.

BHPs are responsible for ensuring accountability and compliance with program requirements applicable to the BHP. DHCS will carry out its responsibility to monitor and oversee Medi-Cal behavioral health delivery systems and their operations as required by state and federal law. DHCS will monitor Medi-Cal behavioral health delivery systems for compliance with the requirements outlined above, and deviations from the requirements may require corrective action plans or other applicable remedies.

Placing agencies are responsible for ensuring accountability and compliance with program requirements applicable to placing agencies. CDSS will carry out its responsibility to monitor and oversee placing agency responsibilities and their operations as required by state and federal law. CDSS will monitor placing agencies for compliance with the requirements outlined above, and deviations from the requirements may require corrective action or other applicable remedies. Further guidance from CDSS is forthcoming regarding CFT and CANS fidelity requirements for placing agencies.

Please direct any questions to cwscoordination@dss.ca.gov and BH-CONNECT@dhcs.ca.gov.

Sincerely,

Original signed by

Paula Wilhelm, Deputy Director
DHCS, Behavioral Health

Angie Schwartz, Deputy Director
CDSS, Children and Family Services

Original signed by