MENDOCINO COUNTY FAMILY AND CHILDREN'S SERVICES ORGANIZATIONAL ASSESSMENT

Conducted for:
Mendocino County Family and Children's Services

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Executive Summary

This report presents the results from the organizational assessment of Mendocino County's Family and Children's Services (FCS) conducted by the Northern California Training Academy at the UC Davis Extension Center for Human Services. This organizational assessment did not review policies or practices related to ICWA as part of its scope of work. The organizational assessment was conducted to evaluate the overall effectiveness of Mendocino's FCS and to highlight areas working well and provide recommendations for organizational improvements.

Key Recommendations and Findings

Mendocino County's Family and Children's Services is in a state of crisis, and has been for several years. Despite this prolonged crisis state, there is still no unified vision among leadership, staff, the Board of Supervisors, and community partners about how to address the factors that perpetuate the crisis. Suggestions from one segment of the organization are frequently met with resistance by the others, and key decision-makers are consistently in conflict about where to begin addressing the agency's challenges.

The review team would like to acknowledge the enduring passion and commitment of the staff who remain dedicated to serving Mendocino County's most vulnerable children and families. The staff who work at FCS deserve recognition for the tenacity and resilience they have demonstrated.

In our attempt to diagnose the organization and provide recommendations on how to address the presenting issues, the team unanimously came to the following conclusions:

1) In spite of many challenges, FCS has a number of existing strengths to build upon. As a child welfare organization, it does have the potential to become a leader in child welfare policy and practice over time.

2) Most of the organizational challenges FCS is experiencing are common among child welfare agencies and can be addressed through additional support, training, technical assistance and leadership.
3) There are a number of distinct, overarching stressors facing FCS that must be addressed immediately to bring this organization out of its crisis. Until these internal stressors are addressed, no meaningful change can occur.

The review team analyzed surveys, focus groups and conversations and found stakeholders were able to identify the same issues as being problematic. As solutions were discussed, however, it was common to hear blame placed on other groups of stakeholders for being unwilling to implement these solutions. This report will detail several areas in need of improvement, but before any meaningful change can occur, this team recommends Mendocino County, prior to addressing what we have been identified as Priority Recommendations, address the key "Implementation Recommendations.

Implementation Recommendations (Abridged*)

Implementation Recommendation One: Create and communicate a strategic and transparent plan for improvement, including recommendations in this report. Mendocino County FCS should develop an Implementation Team to discuss programmatic and policy changes in the organization, troubleshoot challenges and assess positive growth.

Implementation Recommendation Two: Provide all staff with training on the SCARF model. An overview of the SCARF model is available in the Introduction section of this report. When implemented, the SCARF model can be used *in the moment* by all staff as a vehicle for understanding their responses to organizational changes; this can then positively impact future acceptance of behavior.

Implementation Recommendation Three: Align Mendocino's FCS leadership (including supervisors) style and organizational culture and climate with the SCARF model such that staff feel adequately rewarded and less threatened by the lack of status, certainty,

* Please note that the Discussion section of this report contains additional information regarding the implementation/priority recommendations summarized here.

autonomy, relatedness, and/or fairness: The Discussion and Conclusions section of this report contains more detailed recommendations for applying the various aspects of the SCARF model toward organizational improvement.

Priority Recommendations (Abridged)

Priority Recommendation One: Adopt a "retention focused organization" approach. Currently Mendocino FCS leadership and staff are focused on turnover rates and subsequent recruitment of staff. The focal point for staff and leaders must shift to what is being done to retain current staff. This can be accomplished by focusing on providing more supportive and consistent supervision, conducting a caseload size/workload and job task survey, and offering a pay differential for staff in the Fort Bragg office.

Priority Recommendation Two: Reinstitute Monday through Friday office hours. Currently, Mendocino County FCS is open from Monday through Thursday and closed Friday through Sunday, leaving gaps in services, communication and morale. The Friday closure was commonly noted amongst community organizations and foster parents as a barrier to communication and collaboration. Moving to a five-day work week will enable FCS to facilitate more visitation between children and families and enhance their collaboration with community partners who work five-day work weeks.

Priority Recommendation Three: Strengthen investigation and assessment processes with increased transparency and collaboration. This includes an improved use of safety and risk assessments, safety planning processes and critical decision making skills.

Priority Recommendation Four: Enhance permanency practices, with an increased emphasis on behaviorally based case plans and engagement of children and youth. In addition, the implementation of an evidence-based visitation program and permanency roundtables will work to improve permanency outcomes for youth. Using Family Team Meetings and robust safety planning will also help children achieve permanency faster, and maintain permanency with their families of origin safely.

Priority Recommendation Five: Increase collaboration with stakeholders. Collaboration with both county counsel and resource families be achieved by expanding on current practices. Access to legal counsel for social workers not just immediately before court hearings, but also to assist with writing petitions and making recommendations, is important to improving the quality and timeliness of court reports. Supervisors have an important role in showing social workers how to utilize county counsel as a resource for understanding the legal foundation of their court reports. Mendocino FCS is beginning implementation of Residentially Based Services and Resource Family Approval, two key components of legislation supporting improved outcomes for children and families served by child welfare. Both of these strategies should improve the quality of communication FCS has with resource families.

Priority Recommendation Six: Integrate a systematic Continuous Quality Improvement (CQI) Cycle. Mendocino County FCS should adopt a variety of mechanisms to monitor and promote effective practice. As noted in the July 2016 Policy Brief issued by the Child Information Gateway, Children's Bureau, CQI is a particularly effective mechanism for child welfare agencies to: conduct a variety of case reviews; track and report on performance measures; and implement statewide, regional, or local improvement plans. Mendocino County can successfully implement monthly reviews of Structured Decision Making and Family Team Meetings, including the CFSR reviews. Leadership should meet with the team assigned to CQI monthly to monitor progress.

Priority Recommendation Seven: Tell your story. Overcoming the long-standing perceptions of child welfare practice both past and current requires consistent, clear and transparent communication. Tell the story from the beginning; provide accurate information about budget cuts, reduction in worktime and salary, restoration of the work week, and Mendocino's outcomes. Create dashboards so all staff and community partners know how the current data reflects the outcomes of children and families being served by the agency. Clarify strategies, practices and expectations on how both the agency and the community can partner to improve the lives of children and families being served. Align

data outcomes with contract deliverables with community providers. Develop review points within the organization to examine practice and impact on data. An example could be a quarterly review of the decisions from RED teams, the outcome of the SDM assessments conducted, and entry rate into care. Identify trends of substantiations, demographics, reason for removal and identify any areas for improvement including training, coaching, and consistency in policies and practices.

Introduction

In February 2016, Mendocino County's Health and Human Services Agency (HSSA) contracted with the Northern California Training Academy (NCTA) at the UC Davis Extension Center for Human Services to conduct a comprehensive organizational review of the Mendocino County Family and Children's Services (FCS). Mendocino County FCS is a division of Social Services, a branch of the consolidated Mendocino County Health and Human Services Agency (HHSA). Family and Children's Services is responsible for the safety, permanency and well-being of children and families served by public child welfare. The NCTA was tasked with examining the systems and processes used by FCS to determine whether they were aligned with their intended goals and outcomes. To this end, the NCTA conducted a thorough examination of all aspects of FCS's child welfare practice, organizational culture, and staff training, including both a quantitative review of child welfare outcome data and a qualitative review of perceptions and insights into the agency.

To conduct the qualitative review, the NCTA team relied on the time and expertise of the hardworking staff of Mendocino County Family and Children's Services; we thank them for their time spent with researchers answering questions and providing their thoughtful reflections on local child welfare practice.

CONTEXT

In conducting the organizational review, it is important to understand the historical context of the agency. An arguably important event that has had lasting impacts on Mendocino's HHSA was the California State budget crisis which began in 2008 and lasted until 2012. The shortfall of the state budget undermined the ability of counties to fund programs and staff positions to meet the needs of the community, specifically the child welfare client population. In 2010, Mendocino HHSA furloughed all staff by ten percent, or eight hours during each pay period (reducing from a 40 to a 36-hour work week). When the temporary furloughs were imposed, all staff were required to work a "4-9's" schedule Monday to Thursday, such that they worked four days per week, nine hours per day. Prior to the furlough, most staff

worked four ten-hour shifts (4-10's), some working Monday through Thursday and others working Tuesday through Friday, and the agency was open Monday through Friday. Furloughs were discontinued in February 2012; however, a ten percent permanent wage reduction was imposed. While fiscal years 2015-2016 and 2016-2017 saw staff receive increases of three and two percent, respectively, Mendocino County child welfare staff wages still remain lower than they were in 2009.

In 2014, The Sunset Commission estimated that the Texas Department of Family and Protective Services spent $54,000 for each caseworker who left the agency, due in part to costs associated with recruiting and training new workers. Per the Mendocino County Child Welfare County Self-Assessment (2015), from July 2013 through July 2015 approximately 44 (of 115) staff left their position voluntarily or were let go (this includes staff in classifications including office assistants, program specialists, social worker assistants, social workers, social worker supervisors, legal clerks, a program administrator and a foster care eligibility supervisor). Seventeen of the 44 staff members were social workers. Reasons for staff leaving were many, including retirement, termination, transfers or promotions to other departments, relocation out of Mendocino County, and higher paying jobs in the county or in neighboring counties. As of August 30, 2016, Mendocino County had 12-18 vacant social worker positions.

These two primary organizational stressors (budget cuts and staff retention) culminated in 2015 when a Grand Jury report, "Children at Risk," was released. The report issued strong recommendations for immediate change in the agency and outlined many challenges facing Mendocino County, including those of "noncompetitive compensation, work overload, poor management, and low morale."

FRAMEWORK FOR ORGANIZATIONAL ASSESSMENT

The NCTA conducted the review using a lens of organizational diagnosis and social neuroscience. Knowing that the agency encountered many stressors and organizational changes, the review team decided that it was not only important to understand how different

parts of the organization are managed and working, but also to understand how chronic organizational stress impacts the functioning of the various parts of the organization.

GUIDING FRAMEWORK FOR THE ORGANIZATIONAL ASSESSMENT

The NCTA review team examined the organizational culture (proficiency, rigidity, and resistance) and the organizational climate (engagement, stress, and functionality)[1] of Mendocino's FCS using two models to examine how various parts of the organization functioned: the Marvin R. Weisbord's Six-Box Model[2] of organizational diagnosis (see Figure 1); and the SCARF social neuroscience model[3]. In addition, the review team consulted with the National Child Welfare Workforce Institute (NCWWI) to ensure recommendations were in alignment with national standards for workforce issues. NCWWI is funded by the Children's Bureau to integrate and apply multiple interventions designed to sustain comprehensive improvements in child welfare workforce practices.

WEISBORD'S SIX-BOX MODEL

Weisbord's model is an established method of reviewing an organization and has been utilized by hundreds of organizations throughout the past 30 years (see Appendix A for a more detailed overview of the model). It provides a systemic approach for analyzing the relationships among factors that influence how an organization is managed based on its: 1) purpose, 2) structure, 3) relationships, 4) rewards, 5) leadership and 6) helpful mechanisms.

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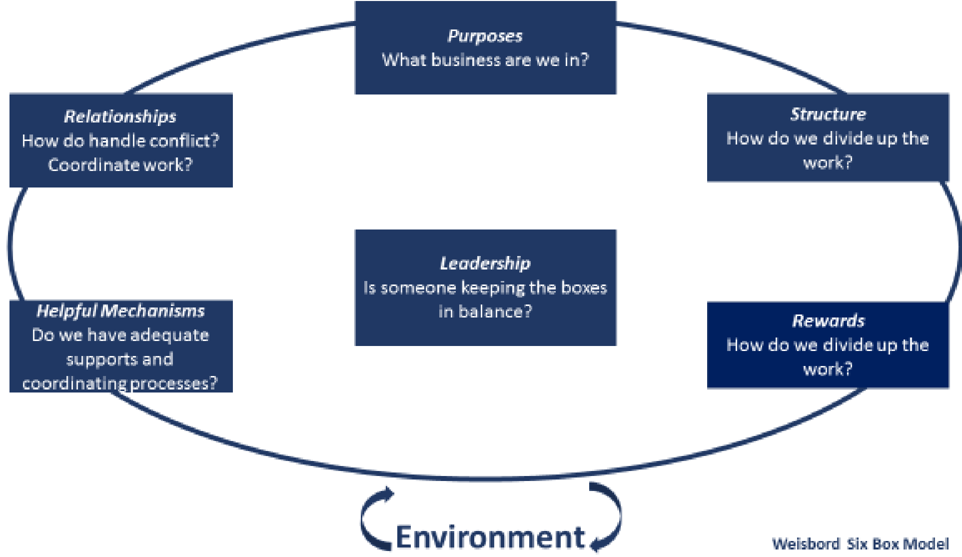
[1] Glisson C, Green P, Williams NJ. (2012) Assessing the organizational social context (OSC) of child welfare systems: Implications for research and practice. Child Abuse & Neglect;36:621–632.

[2] Weisbord, M. (1978). Organizational diagnosis, six places to look for trouble with or without a theory. *The Journal of Group and Organizational Management, 1,* 4, 430-447.

[3] Rock, D. (2008). SCARF: a brain based model for collaborating with and influencing others. *NeuroLeadership Journal, 1*, 44-52.

Figure 1.



The Weisbord model gives attention to issues such as: planning, incentives and rewards, the role of support functions, internal competitions among organizational units, standards for remuneration, partnerships, hierarchies and the delegation of authority' organizational control, accountability and performance assessment. The model also follows the basic 'systems' approach to organizational functioning including the well-known 'inputs' and 'outputs' categories.

SCARF Social Neuroscience Model[4]

Research has found that when people feel threatened, their ability to think critically or deal with complex situations plummets, depending upon the severity of the threat. Threat can create avoidant responses such as fear, sadness, anxiety, lack of safety, depression, and lack of focused attention, all of which can contribute to disengagement at work. The SCARF model may be an especially useful way for examining the current organizational culture and climate of Mendocino due to the many stressors FCS is experiencing. Since the California budget crisis in 2008, Mendocino FCS has been an organization in stress. This stress may have been originally

[4] Rock, D. (2008). Scarf: a brain based model for collaborating with and influencing others. *NeuroLeadership Journal, 1*, 44-52.

caused by financial reasons, but they have become stressors to the workforce, and these stressors have led to changes that can be viewed as social threats.

Rock (2008)[5] suggests the use of the SCARF model as an important way to foster organizational resilience when major changes occur (see Figures 2 & 3). The SCARF model describes the interplay between brain networks and threat-and-response. SCARF stands for Status, Certainty, Autonomy, Relatedness and Fairness. Employees who experience high levels of rewards in all areas of the SCARF model are more likely to be engaged in their work as compared to employees who experience high levels of threats[6]. The model is built on three central ideas:[7]

1. The brain treats many social threats and rewards with the same intensity as physical threats and rewards (Lieberman, & Eisenberger, 2009).
2. The capacity to make decisions, solve problems and collaborate with others is generally reduced by a threat response and increased under a reward response (Elliot, 2008).
3. The threat response is more intense and more common and often needs to be carefully minimized in social interactions (Baumeister et al, 2001).

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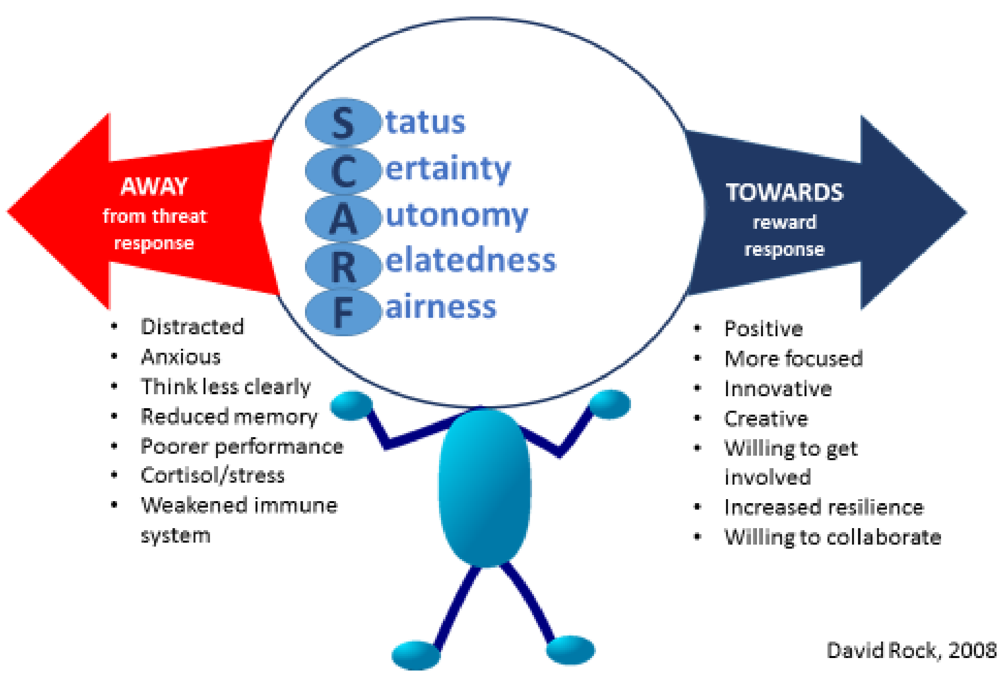
[5] Rock, D. (2008). SCARF: a brain based model for collaborating with and influencing others. *NeuroLeadership Journal, 1*, 44-52.

[6] Rock, D. & Yiyuan, T. (2009). Neuroscience of engagement. NeuroLeadership Journal, 2, 1-10.

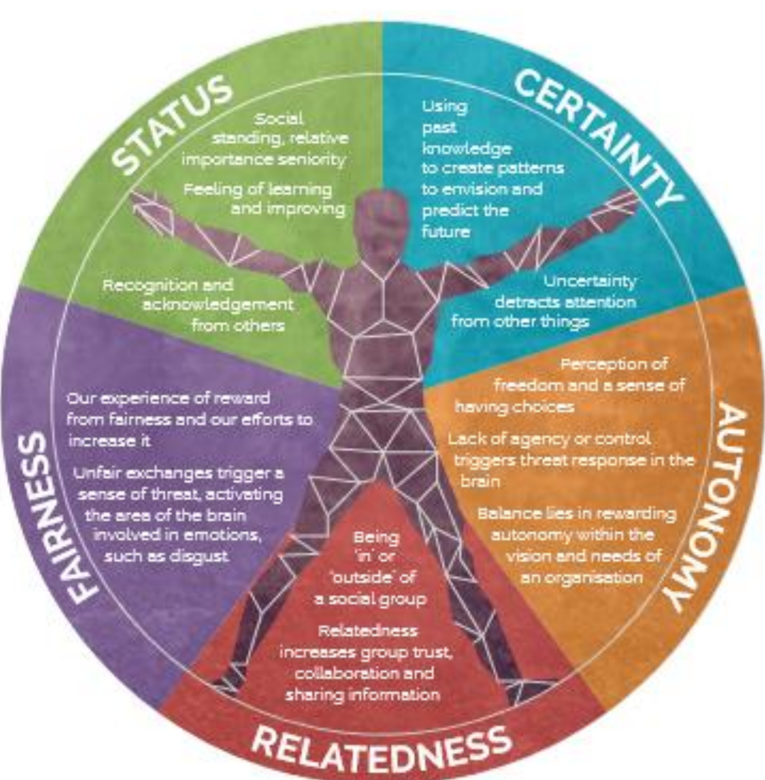
[7] Retrieved from: http://www.neuroleadership.co.in/scarfsolutions/about/index.html

Figure 2. SCARF Model[8]



[8] Rock, D. (2008). SCARF: a brain based model for collaborating with and influencing others. *NeuroLeadership Journal, 1*, 44-52.

Figure 3. Diagram in Ward, V. & Hiscocks, F. 2016



Status refers to how important people feel in relation to others. Within in an organization, it is how people perceive of a potential or real reduction in status that can generate a strong threat response. Things that imply ineffectiveness or "less than" can initiate a threat response; and those that are more direct criticisms send people into a position to defend and react[9]. People who feel their professional role is threatened in this way can adversely impact aspects of the organization. In relation to Weisbord's model, the purpose, relationships, and rewards may be aspects of the organization with the greatest impacts.

Certainty refers to the ability to predict the future. The brain is constantly trying to predict the near future. As Rock (2008)[10] notes, the brain "craves certainty;" without the ability

[9] Rock, D. (2008). SCARF: a brain based model for collaborating with and influencing others. *NeuroLeadership Journal, 1*, 44-52.
[10] Rock, D. (2008). Scarf: a brain based model for collaborating with and influencing others. *NeuroLeadership Journal, 1*, 44-52.

to predict, the brain engages in a threat response that can be debilitating, depending on the level of uncertainty. Rock classifies things like not knowing your supervisor's expectations or job security as large uncertainties. In fact, reward responses are generated when people believe they meet expectations. (Schultz, 1999, as cited in Rock, 2008).

Autonomy refers to how much control people perceive they can exert in their work environment. “Allowing people to set up their own desks, organize their workflow, even manage their working hours, can all be beneficial if done within agreed parameters. Sound policy establishes the boundaries within which individuals can exercise their creativity and autonomy. Sound policy should enable individual point-of-need decision-making without consultation with, or intervention by, leaders. In this regard, sound policy hard-wires autonomy into the processes of an organization.” (Rock, 2008, p. 48). Feeling micromanaged is one of the greatest threats to creating a positive work culture. Autonomy is related to all aspects of Weisbord’s model of organizational functioning, especially leadership, purpose, and rewards.

Relatedness refers to having a sense of safety with others, of being with friend rather than foe. Relatedness is a driver of behavior in many types of teams, from sports teams to organizational silos. "People naturally like to form ‘tribes’ where they experience a sense of belonging.” (Rock, 2008, p. 48) Relatedness is important for building organizational trust, supporting collaborations, and producing good work morale.

Fairness is the transparency in the organization for clear expectations and rewards for fairness. Unfair exchanges, lack of ground rules and expectations create a strong threat response while transparency, communication, and participation generate positive work outcomes. Leadership is important for inspiring fairness in the workplace by demonstrating equality and fairness and setting the tone for how the relationships and systems should function in the organization. Fairness is not only about how individuals themselves want to be treated in the organization, but also about how other people in the organization are treated fairly.

SUMMARY OF THE INTEGRATED ORGANIZATIONAL ASSESSMENT FRAMEWORK

Examining child welfare systems through the integrated lens of the Weisbord and SCARF models provides a comprehensive approach to examining the organizational culture and climate of Mendocino County FCS. The Weisbord Six-Box Model provides a framework for examining “what is” and “what should be” within the organization’s purpose, structure, vision, leadership, relationships, rewards, and helpful mechanisms throughout the culture of the organization. The SCARF model provides more information about the ways that these various factors of the organization contribute to perceived threats and rewards, or the psychological health of the work environment.

Methodology

Consultation Team

The team was comprised of nine NCTA staff and instructors with experience and expertise in child welfare services, policy, practice, and training.

Procedure

To conduct this business review, the NCTA used three main sources of data:

1. Questionnaires, interviews and focus groups of stakeholders to elicit quantitative and qualitative data related to the Weisbord Six-Box Model and the social neuroscience SCARF model;
2. Existing reports on Mendocino County FCS;
3. Mendocino County child welfare data statistics. Specifically:
   - Weisbord Organizational Diagnosis Questionnaire;
   - Qualitative case reviews (Safety Organized Practice focus) of 14 cases, including eight referrals from 2014-2015;
   - Qualitative case review (Structured Decision Making focus) of eight cases, including six referrals from 2014-15;
   - Focus groups and interviews conducted using questions tailored for several key stakeholders, including: social workers, program managers, leadership, supervisors, foster parents, clerical staff, and members of the legal community, and court representatives (see Appendix A);
   - Data analysis (UC Berkeley's California Child Welfare Indicators Project and SafeMeasures);
   - Culling of reports; specifically, the 2015 Mendocino County Self-Assessment; and
   - Business process mapping.

Wiesbord Organizational Diagnosis Questionnaire

Child welfare staff working for Mendocino County's Family and Children's Services were asked to complete the Organizational Diagnosis Questionnaire[11] (ODQ) online using Qualtrics during February and March of 2016. The ODQ consists of 35 items and asks respondents to indicate their current views of their organization, from "strongly disagree" to "strongly agree"[12] with the midpoint indicating a neutral viewpoint. All items were reverse scored so that higher scores indicated a higher level of agreement (e.g., 1= "strongly disagree" and 5= "strongly agree").

A total of 56 respondents (47 females, 9 males) completed the survey, with 44.6% indicating they had completed some college and about a third indicating they had a BS/BA degree. Most respondents identified as Caucasian (n=49, 87.5%), three or five percent identified as Hispanic/Latino, three or five percent identified as African-American and one person indicated they did not have a primary race/ethnicity. The average age of respondents was 47.27 years (range of 23 to 66 years[13]). On average, respondents indicated they had worked in the field of child welfare for 6.74 years (range of .16 to 26.42 years) and an average of 3.36 years (range of .08 to 21.08 years) working in their current position.

Safety Organized Practice Case Review

A Safety Organized Practice (SOP) case review process was completed from May 18 – 20, 2016. Safety organized practices are child welfare approaches focused on the safety of the child within the family system. The SOP methodology is informed by a variety of best- and evidence-informed practices, including group supervision, Signs of Safety, Motivational Interviewing, and solution-focused treatment. Safety organized practice brings a common language and framework for enhanced critical thinking and judgment on the part of all involved with a family in the pursuit of a balanced, complete picture of child welfare issues, and the

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[11] Preziosi, R. (1980), ``Organizational Diagnosis Questionnaire''. The 1980 Annual Handbook for Group Facilitators, University Associates, New Jersey

[12] Note. The original ODQ responses options range from 1-7, we modified the response options to five categories as fewer response options are recommended when administering surveys online as to assist with ease and use of completing the survey.

[13] Note. Three people declined to answer this question.

implementation of SOP is one vehicle by which counties in California are in alignment with the California Core Practice Model. The purpose of the case reviews was to assess the depth and consistency of SOP practice behaviors within its child welfare department. A total of eight referrals (four from 2014 and four from 2015) and six cases (three from 2014 and three from 2015) were completed for a total of 14 case file reviews.

Table 1: Case file review breakdown:

Year	# Reviewed	Case/Referral	Service Component
2014	4	Referrals	Emergency Response
2014	1	Case	Family Reunification
2014	1	Case	Family Maintenance
2014	1	Case	Permanency Planning
2015	4	Referrals	Emergency Response
2015	1	Case	Family Reunification
2015	1	Case	Family Maintenance
2015	1	Case	Permanency Planning
TOTAL	14	Referrals & Cases	

Structured Decision Making Case Review

A Structured Decision Making (SDM) case review process was completed on May 19 – 20, 2016. Structured Decision Making (SDM) is a validated tool that uses clearly defined and consistently applied decision-making criteria for screening for investigation, determining response priority, identifying immediate threatened harm, and estimating the risk of future abuse and neglect. Child and family needs and strengths are identified and considered in developing and monitoring progress toward a case plan. SDM is used by every county in California, other jurisdictions throughout the United States, and in several other countries. The sampling contained opened and closed referrals and cases from 2014 and 2015. There were six cases that were reviewed and eight referrals. Among these cases, there were two family maintenance (FM) cases, two family reunification (FR) cases and two permanent placement (PP) cases reviewed. Each of these cases remained open as of the review date. Of the referrals that were reviewed, there were four 10-day referrals and four immediate response referrals. All of the referrals were closed.

Results

To present the findings we first offer a description of the outcomes of children in foster care in Mendocino County as compared to the state of California and national standards. We then describe findings through the integrated lens of the Weisbord Six-Box model and the SCARF social neuroscience model.

CHILD WELFARE OUTCOME DATA

The 1994 Amendments to the Social Security Act authorize the U.S. Department of Health and Human Services to review state child and family service programs to ensure conformity with the requirements in titles IV-B and IV-E of the Social Security Act. The Children's Bureau, part of the Department of Health and Human Services, administers the review system, known as the Child and Family Services Reviews. Ultimately, the goal of the reviews is to help states improve child welfare services and achieve the following seven outcomes for families and children who receive services:

Safety

- Children are, first and foremost, protected from abuse and neglect.
- Children are safely maintained in their homes whenever possible and appropriate.

Permanency

- Children have permanency and stability in their living situations.
- The continuity of family relationships and connections is preserved for families.

Family and Child Well-Being

- Families have enhanced capacity to provide for their children's needs.
- Children receive appropriate services to meet their educational needs.
- Children receive adequate services to meet their physical and mental health needs.

California child welfare data is available publically by the California Child Welfare Indicators Project (CCWIP), a collaborative venture between the University of California at Berkeley and the California Department of Social Services (CDSS). The following table shows the federal outcome measures and the respective indicators, to which all counties and states must

present data. Mendocino data is also displayed, both in this table and in subsequent graphs. National standards are presented for each indicator.

Table 2. Comparison of National Standards, Mendocino County and California for CFSR Statewide Data Indicators, April 2015 through March 2016

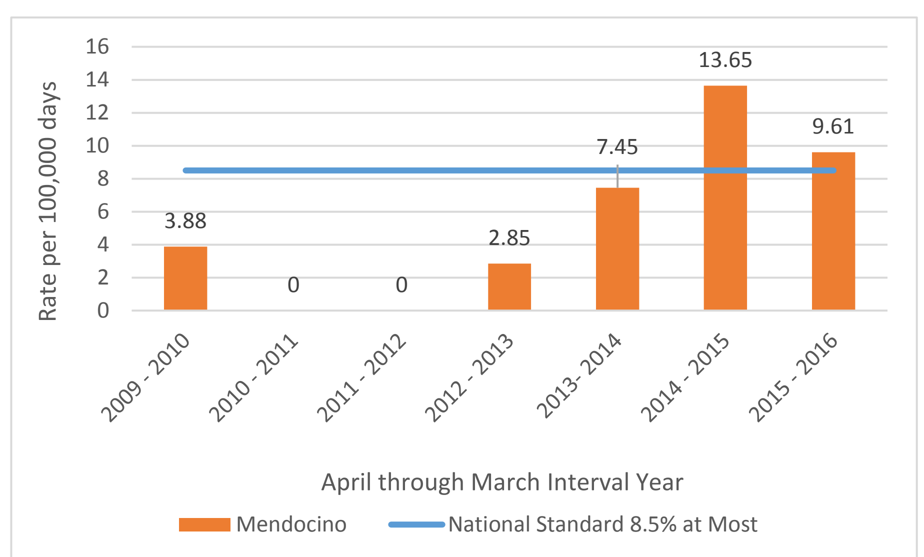
Statewide Data Outcomes and Indicators	National Standard	Mendocino County	Ranking in the state (out of 58 counties)
Indicators for Safety Outcome 1			
Maltreatment in Foster Care	No more than 8.50 victimizations per 100,000 days in care	9.61 victimizations per 100,000 days in care	49th
Recurrence of Maltreatment	No more than 9.1%	15.4%	51st
Statewide Data Indicators for Permanency Outcome 1			
Permanency in 12 Months for Children Entering Foster Care	No higher than 40.5%	38.6%	23rd
Permanency in 12 Months for Children in Foster Care 12 to 23 Months	No higher than 43.6%	45.5%	30th
Permanency in 12 Months for Children in Foster Care 24 Months or More	No higher than 30.3%	18.1%	44th
Re-Entry to Foster Care in 12 Months	No higher than 8.3%	18.9%	53rd
Placement Stability	No more than 4.12 moves per 1,000 days in foster care	7.11 moves per 1,000 days in foster care	53rd
Entries to Care	California state average (no national standard): 3.4 entries per 1,000 total child population	162	162 entries or 8.7 per 1,000. Mendocino County has the 9th highest entry rate in the state (per 1,000).

As shown in Table 2, Mendocino County FCS is performing below national standards, and below the California state average, on six of the seven outcomes, and above national standards for one of the seven outcomes (permanency in 12 months for children in foster care for 24 months or more).

CFSR3: Safety Performance Area 1: Maltreatment in foster care

Measure: Of all children in foster care during a 12-month period, what is the rate of victimization per day of foster care? This indicator assesses whether CWS is making sure children in foster care are not abused nor neglected by child welfare approved placements.

Figure 3: Mendocino County Annual Rate of Maltreatment in Foster Care per 100,000 days, April through March[6][14]



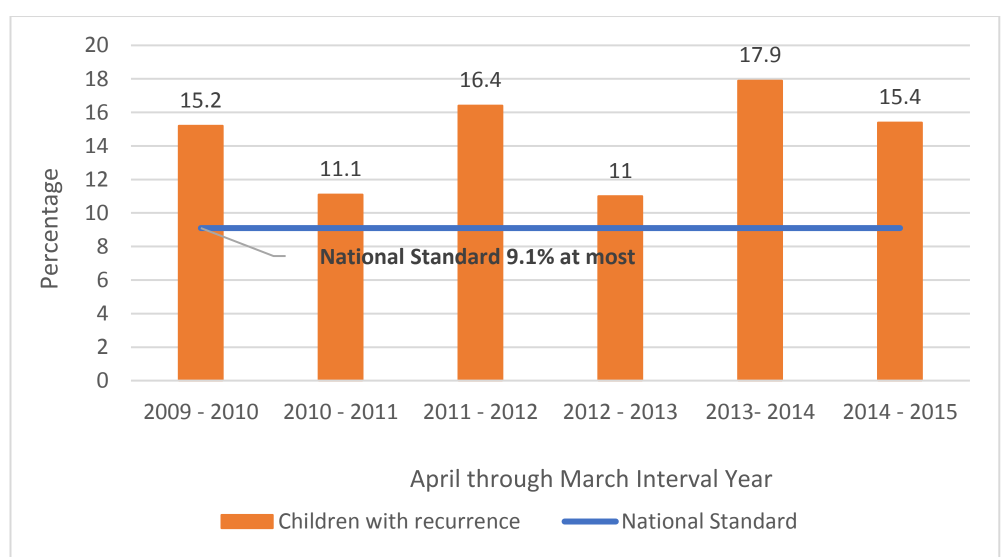
The national goal is to rank below 8.50 (rate per 100,000 days in care). The most recent data shows that Mendocino County has performed lower than the national standard for the past two years (April through March). In the period from April 2014 through March 2015, there was a total of 11 cases of maltreatment in foster care, and from April 2015 through March 2016 there was a total of eight. Prior to 2014, however, Mendocino County had consistently achieved the national standard (however, this may be due to an issue in in the manner in which this information collected by the California Department of Social Services).

[14] Note: For the 2010-2011 and 2011-2012 years there were not any reports of maltreatment while in foster care for Mendocino County.

CFSR3: Safety Performance Area 2; Recurrence of maltreatment

Measure: Of all children who were victims of a substantiated maltreatment allegation during a 12-month reporting period, what percent were victims of another substantiated maltreatment allegation within 12 months of their initial report? This indicator assesses whether necessary actions were taken by CWS to address the immediate safety threats and prevent future abuse and neglect that resulted in a subsequent report.

Figure 4: Mendocino County Percentage of Recurrence of Maltreatment (April through March)



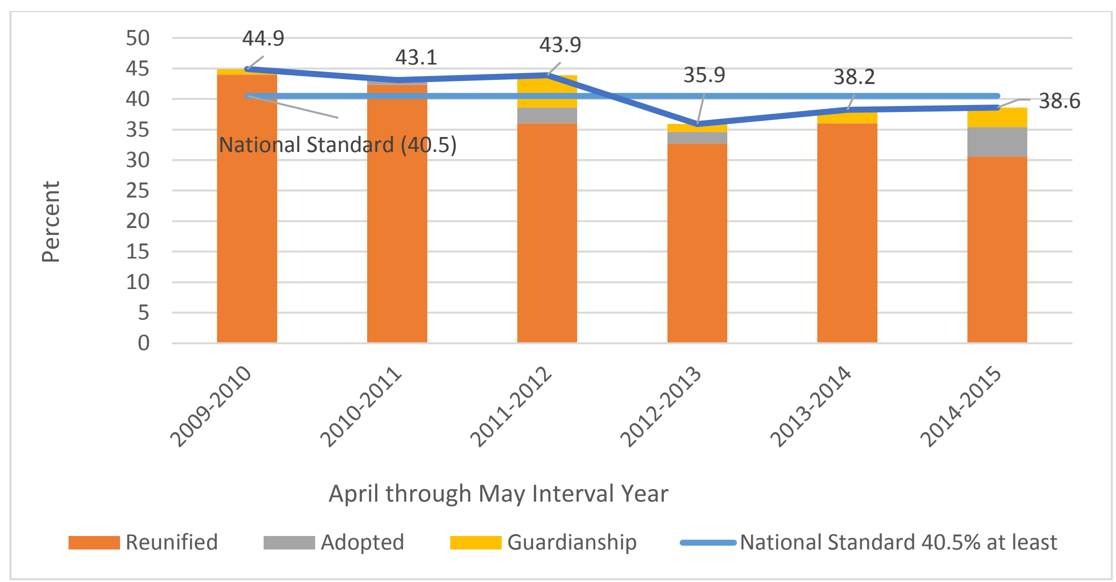
The data reflects that Mendocino County is currently out of compliance. The most recent annual rate of recurrence for April 2014 through March 2015 was 15.4% (meaning 15.4% of children had another referral within the subsequent 12 months). The national standard is to be 9.1% or below.

This area of practice is particularly challenging for Mendocino, as they have not met the national standard in the last eight years.

Permanency Performance Area 1: Permanency in 12 months for children entering foster care

Measure: Of all children who enter foster care in a 12-month period, what percent discharged to permanency within 12 months of entering foster care? Permanency is described as a child living in a safe and permanent home, outside of foster care. This indicator emphasizes the need for CWS to reunify or place children in other permanent homes as soon as possible after removal.

Figure 5. Percentage of permanent placements within 12 months for children entering foster care in Mendocino County.



The national goal is to be above 40.5%. The most recent data shows Mendocino County at 38.6%, just below the national standard. This means 38.6% of children who entered care within a 12-month period achieved permanency within the next 12 months, conversely, 61.4% remained in care or emancipated from the foster care system (turned 18 years of age).

Permanency Performance Area 2, Permanency in 12 months for children in foster care 12-23 months

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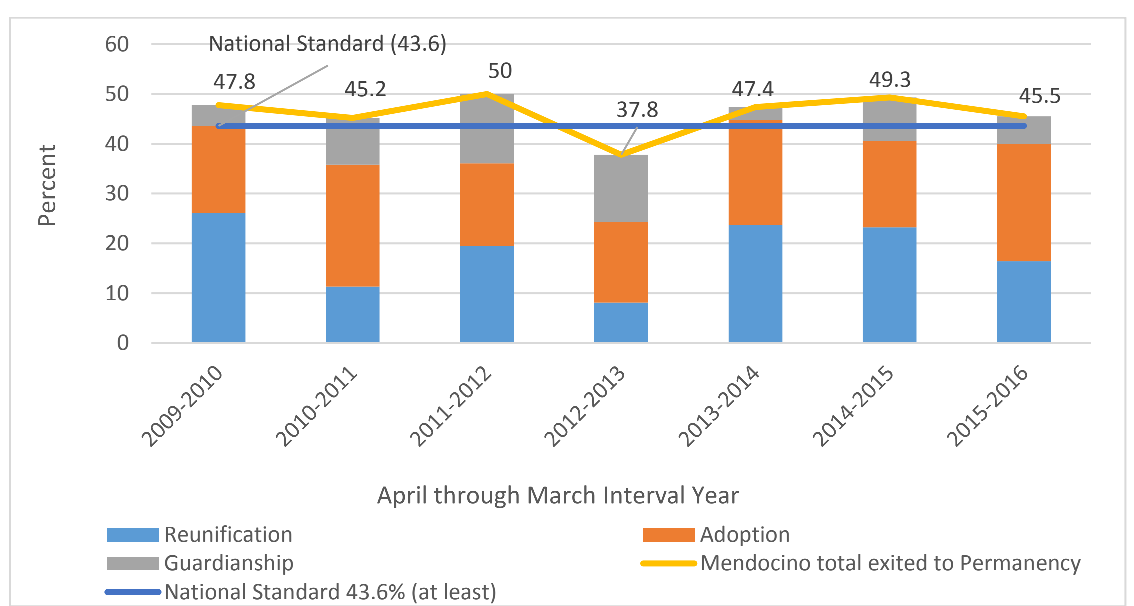
Measure: Of all children in foster care on the first day of the 12-month period who had been in foster care (in that episode) between 12 and 23 months, what percent discharged from foster care to permanency within 12 months of the first day of the 12-month period? This indicator emphasizes the need for CWS to reunify or place children in other permanent homes as soon as possible after removal.

Figure 6. Percentage of permanent placements within 12 months for children in foster care between 12 and 23 months.



The national goal is to be above 43.6%. The most recent data shows Mendocino County at 45.4%, just above the national standard. For the past 5 years, Mendocino County has been inconsistent, sometimes significantly exceeding the national standard (with a high of 58.5%) and at other times falling far below the standard (with a low of 27.5%).

Permanency Performance Area 3; Permanency in 12 months for children in foster care 24 months or more

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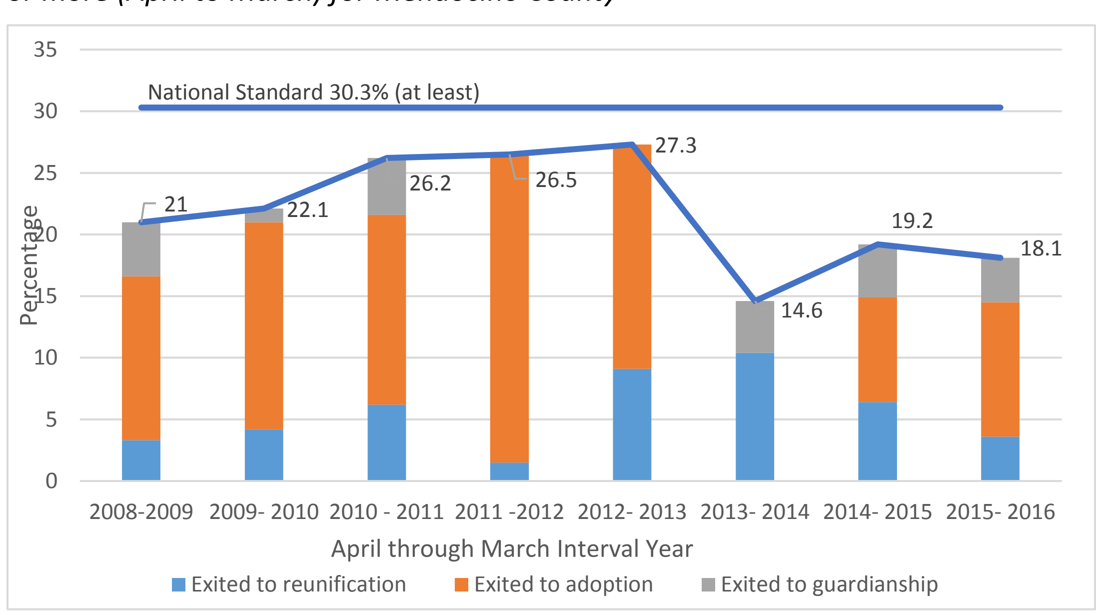
Measure: Of all children in foster care on the first day of the 12-month period (April 1) who had been in foster care (in that episode) more than 24 months, what percent discharged from foster care to permanency within 12 months (by March of the following year) of the first day of the 12-month period? This indicator emphasizes the need for CWS to continue striving to achieve permanency for children who have been in foster care for 2 or more years.

Figure 7. Percentages by types of permanency in 12 months for children in foster care 24 months or more (April to March) for Mendocino County

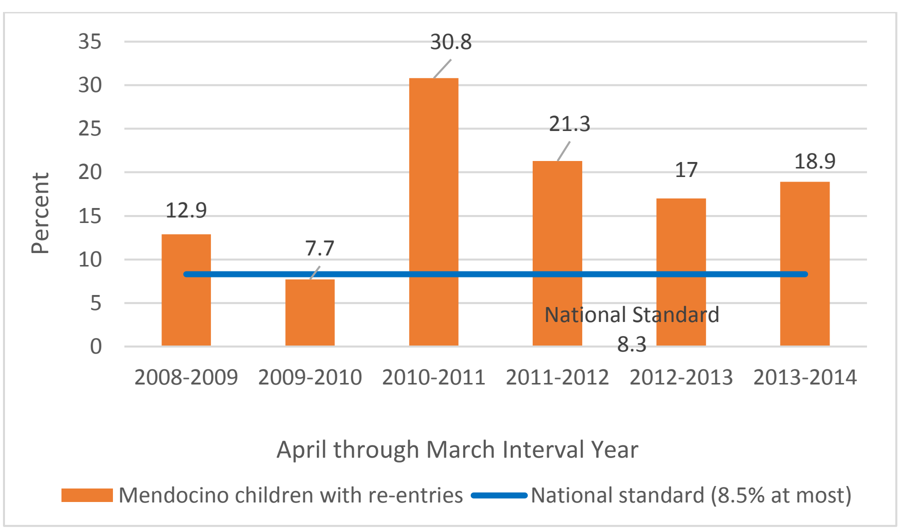


Mendocino County is currently out of compliance with this measure. The national goal is to be above 30.3%, which means that at least 30.3% of children in foster should find a permanent placement within this 12 month period. For the time period 2015 – 2016, 88% of children and youth who had already been placed in foster care for more than 24 months either have remained in care or exited to non-permanency (which means they turned 18 years of age and are no longer considered part of the federal child welfare system). California has extended foster care for youth ages 18 – 21 years that gives youth the option of continuing with the case management and support of a child welfare social worker and the court system, which may include living independently or remaining in care for an additional three years.

Permanency Performance Area 4: Re-entry to foster care

Measure: Of all children who enter foster care in a 12-month period who discharged within 12 months to reunification, living with a relative(s), or guardianship, what percent re-enter foster care within 12 months of their discharge? This indicator emphasizes that although it is important to reunify children with their families as quickly as possible, children also should be reunified when it is safe and appropriate and with sufficient supports to prevent subsequent maltreatment that would necessitate another removal.

Figure 8. Percentage of children in Mendocino County who re-entered foster care within 12 months of their discharge

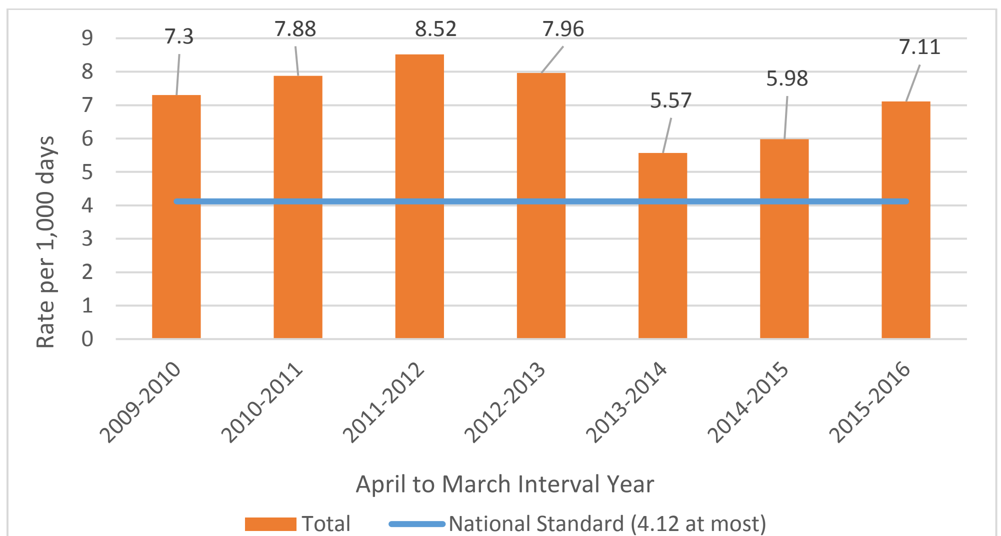


The data indicates that Mendocino County is currently out of compliance with this measure (national standard is to rank below 8.3%), and has not achieved compliance on this measure since 2010. The most recent year extract shows Mendocino County at 18.9%, well above the national standard. Previously, their reentry rate had been as high as 30.8% (2011).

Permanency Performance Area 5: Placement Stability (moves per 1,000 days)

Measure: Of all children who enter foster care in a 12-month period, what is the rate of placement moves per day of foster care? This indicator addresses placement stability as a critical component of permanency and well-being of children in foster care.

Figure 9. Mendocino County rate of placement moves per day of foster care



As noted in the above table, Mendocino County is not in compliance with the national standard, to be below 4.12 (rate per 1,000 days in care). The most recent data shows Mendocino County at a rate of 7.11. Mendocino County has not achieved the national standard since 2007, at one point reaching a high of 9.54 (2010).

Entry Rates in Mendocino County

Mendocino County's removal rates were also analyzed. Mendocino County is currently ranked as having the 21st smallest total child population in the state of California, with 18,718 children under the age of 18. There are 37 counties with larger child populations. Counties most similar in size are Yuba and Nevada; however, Mendocino has a significantly larger population than many of the 20 small, or frontier counties, who maintain child populations, with 16 of them having less than 10,000 children.

Mendocino County ranks as having the 9th highest entry rate per 1,000 children statewide. As shown in Table 4, Mendocino County removes the same amount of children as significantly more populous counties such as Yolo, Santa Barbara and San Mateo. The California state average rate of removal is 3.4 per 1,000. Mendocino removes 8.7 children per 1,000. As noted in Table 3, Mendocino has a dramatically larger number of entries than counties within a range of 5,000 to 10,000 (counties with less than 10,000 total child population are not included as their very small numbers of total children skew results; large sibling sets can dramatically increase the rate per 1,000 children). As demonstrated in Table 4, counties with similar numbers of entries have up to nine times the amount of total child population as does Mendocino. With the exception of Tehama County, the counties listed in Table 3 have a significantly lower rate of entry per 1,000 children. There are certainly multiple reasons for these statistics, and as noted in the recommendations in the Discussion and Conclusions section, further work is needed in order to fully understand this concerning rate.

Table 3. Comparison of entry rates with county population sizes that are similar to Mendocino County

County	Total child population	Entries January 2015 – December 2015	Rate per 1,000
Lake	13,229	53	4
Tehama	15,281	157	10.3
San Benito	15,472	44	2.8
Nevada	16,783	39	2.3
Mendocino	18,718	162	8.7
Yuba	21,461	110	5.1
Sutter	25,137	88	3.5
Humboldt	26,770	210	7.8

Table 4. Comparison of county population with entry rates that are currently similar to Mendocino County

COUNTY	TOTAL CHILD POPULATION	ENTRIES JANUARY 2015 – DECEMBER 2015	RATE PER 1,000
EL DORADO	36,657	131	3.6
SANTA CRUZ	56,397	139	2.5
TEHAMA	15,281	157	10.3
YOLO	44,407	158	3.6
MENDOCINO	18,718	162	8.7
PLACER	82,728	167	2
SAN MATEO	162,299	174	1.1
SANTA BARBARA	98,512	187	1.9
MONTEREY	109,013	191	1.8

MENDOCINO'S FCS ORGANIZATIONAL STRUCTURE

Mendocino Family and Children's Services is led by a Deputy Director who reports to the COO. Five senior program managers (PM) report to the deputy director. Each PM has had experience in the field of child welfare; three of the five have spent more than 25 years in the field. One PM in Ukiah is responsible for the emergency response and court units, and family services (30 FTEs). Administrative functions are assigned to another PM, including quality assurance, the Ukiah administrative staff, foster care eligibility, and the independent living program. The third PM is responsible for integrated services, the Ukiah family center, Katie A. services/ Wraparound, Residential Based Services, and the foster care nursing unit. The fourth manager is responsible for the Willits office. The fifth manager is responsible for the Fort Bragg office.

Units

FCS is divided into three offices and service areas: Fort Bragg, Willits and Ukiah. Of the 45 allocated social worker positions, Fort Bragg has six social worker FTEs, Willits has nine social worker FTEs and the rest (30) are located in the Ukiah office.

Maintaining the Fort Bragg office has become a persistent challenge for management. Staff retention has been a significant barrier which further adds to the feeling that the staff which stay are “isolated and disconnected” from the rest of the county. Of the six social worker FTEs allocated to Fort Bragg, there were five vacancies as of August 2016. The one supervisor in Fort Bragg is currently carrying more than 15 cases.

Referrals for the three offices were analyzed based on data from October 4, 2016. On this date Mendocino County had a total of 636 open referrals; however, only 136 were made within 30 days of October 4. Many of the 500 cases that have been open for more than 30 days have been open for longer than 100 days.

Mendocino County maintains two non-case carrying units for placement and safety organized practice. Both units serve all three locations. The placement unit primarily focuses on placement changes with children already in foster care, and the SOP unit focuses on facilitating family team meetings during investigations in emergency response and ongoing cases as requested.

Staffing Characteristics

A survey of staffing positions was conducted in September 2016 and is presented in the following table.

Table 5. Mendocino County FCS Staffing Characteristics

Position	Number
Deputy Director	1
Sr. Program Manager	5
Program Administrators	4
Staff Services Administrator	1
Social Work Supervisor I & II	9
Social Worker I – V	31
Social Work Assistant II	26
Sr. Program Specialist	3
Program Specialist I/II	6
Nurse Case Manager Supervisor	0
Nurse Case Manager	1
Nurse Case Assistant	0
Secretary	1
Office Assistant Supervisor II	2
Office Assistant II and III	11
Legal Clerk II & III	5
Eligibility Supervisor (Foster Care)	1
Eligibility Worker (Foster Care)	3
Vocational Assistant	2
Mental Health Rehab Specialists	3

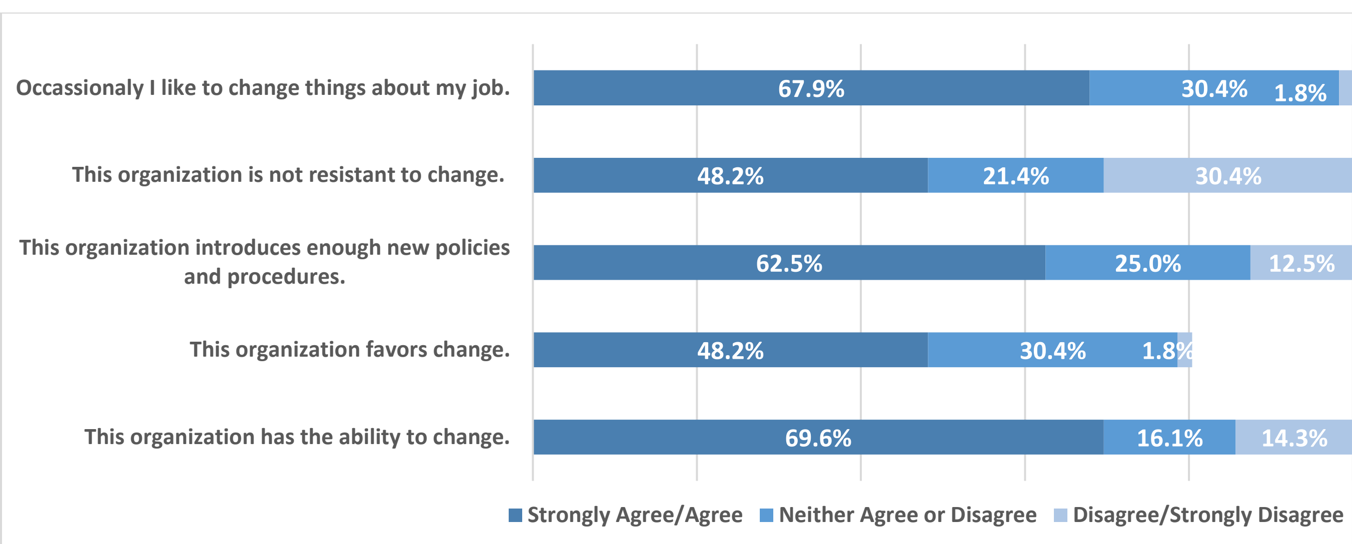
Judicial System

The Mendocino County Superior Court has a single judge assigned to Juvenile Court. The current judge, although experienced on the bench, has been presiding in the Juvenile Court for less than one year. The judge schedules regular monthly meetings that include agency, CASA, county counsel and attorneys.

PERCEPTIONS OF MENDOCINO'S FCS ORGANIZATION: OVERALL SURVEY RESULTS

A total of 56 people working for Mendocino's FCS completed an online survey about the organizational climate of the agency. Results from this online survey (see Figure 10) revealed that the majority of workers felt that the organization had the ability to change (69.6%) and that the organization introduced enough new policies and procedures (62.5%). However, fewer workers strongly agreed or agreed that the organization favored change (48.2%).

Figure 10. Mendocino County CWS Perceptions of Organizational Change

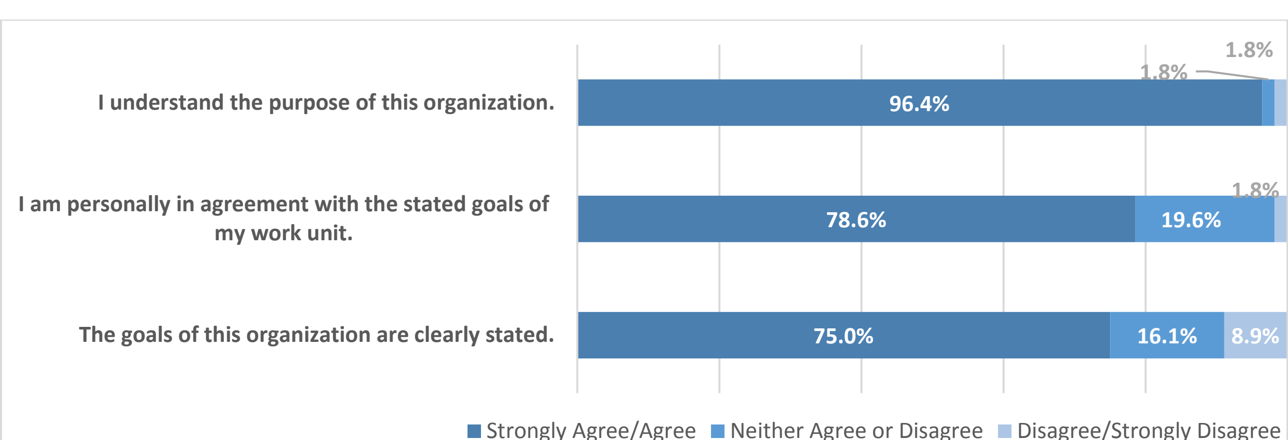


Next, each of the results from the six boxes in Wesibord Model are presented.

Perceptions of Purposes of the Organization

Questions were also asked about the perceived purposes of the organization. As shown in Figure 11, while most (96.4%) strongly agreed or agreed that they understood the purpose of the organization, less were in agreement that the stated goals of the organization were clearly stated (75%). While most (78.6%) strongly agreed or agreed that they personally agreed with the stated goals of their unit, 19.6% neither agreed nor disagreed.

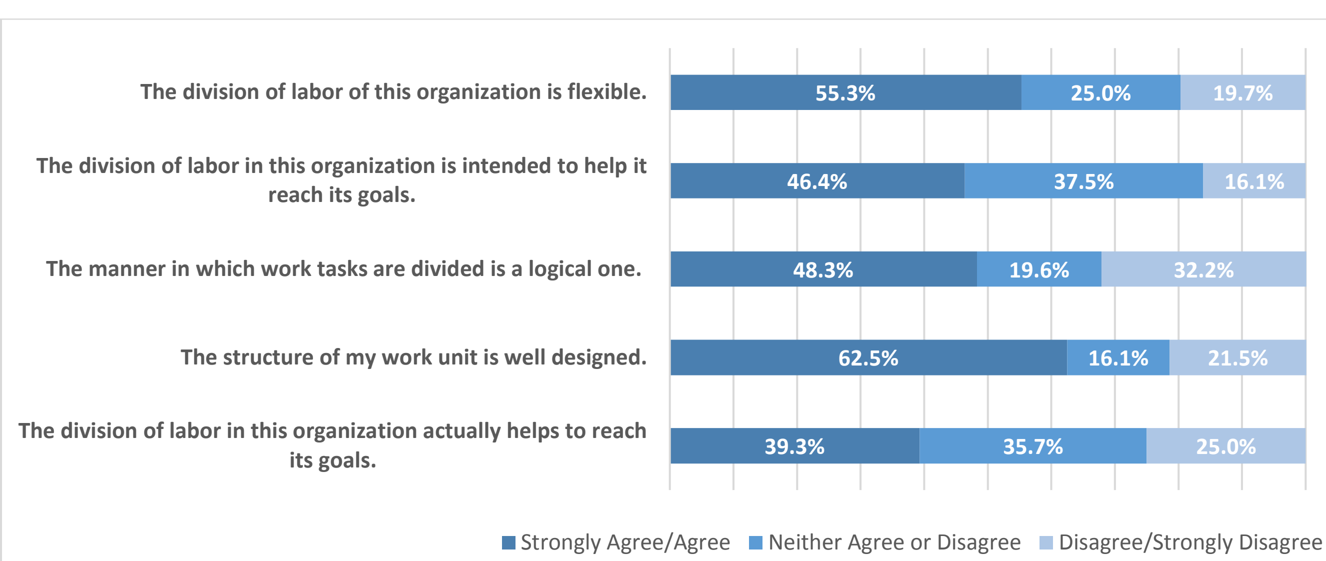
Figure 11. Mendocino County CWS Perceptions of the Purposes of the Organization



Perceptions of the Organization’s Structure

Results revealed that staff felt that the structure of the organization was an area with needed improvements. As shown in Figure 12, only 39.3% strongly agreed or agreed that the division of labor in the organization actually helped to reach its goal and 35.7% neither agreed nor disagreed. Additionally, 32.2% disagreed that the manner in which work tasks were divided was a logical one, and 21.5% disagreed that the structure of their work unit was well designed.

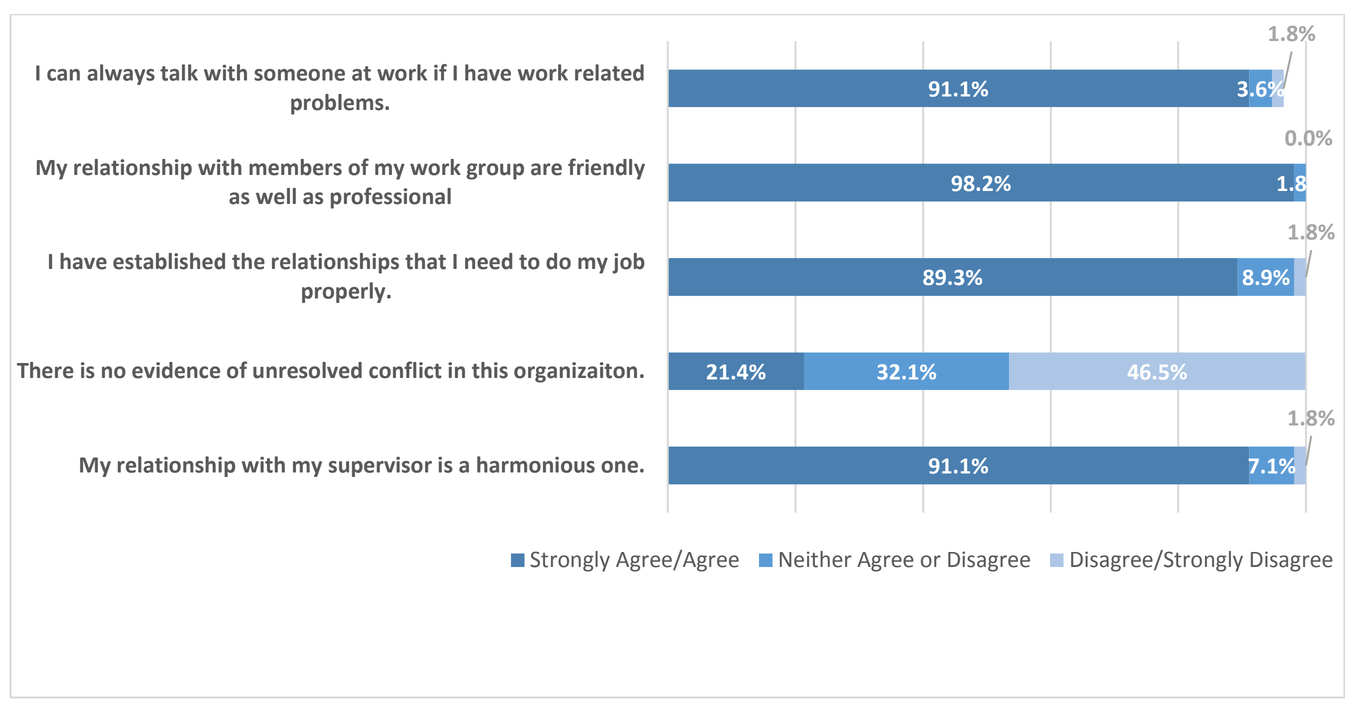
Figure 12. Mendocino County FCS Perceptions of the Organization’s Structure



Perceptions of the Relationships in the Organization

With most of the questions that asked about relationships, there was a high level of agreement (89% and above) that working relationships within the organization were supportive, harmonious, friendly, and productive (see Figure 13). The one area that evidenced improvement was 46.4% of workers feeling that unresolved conflicts existed in the organization.

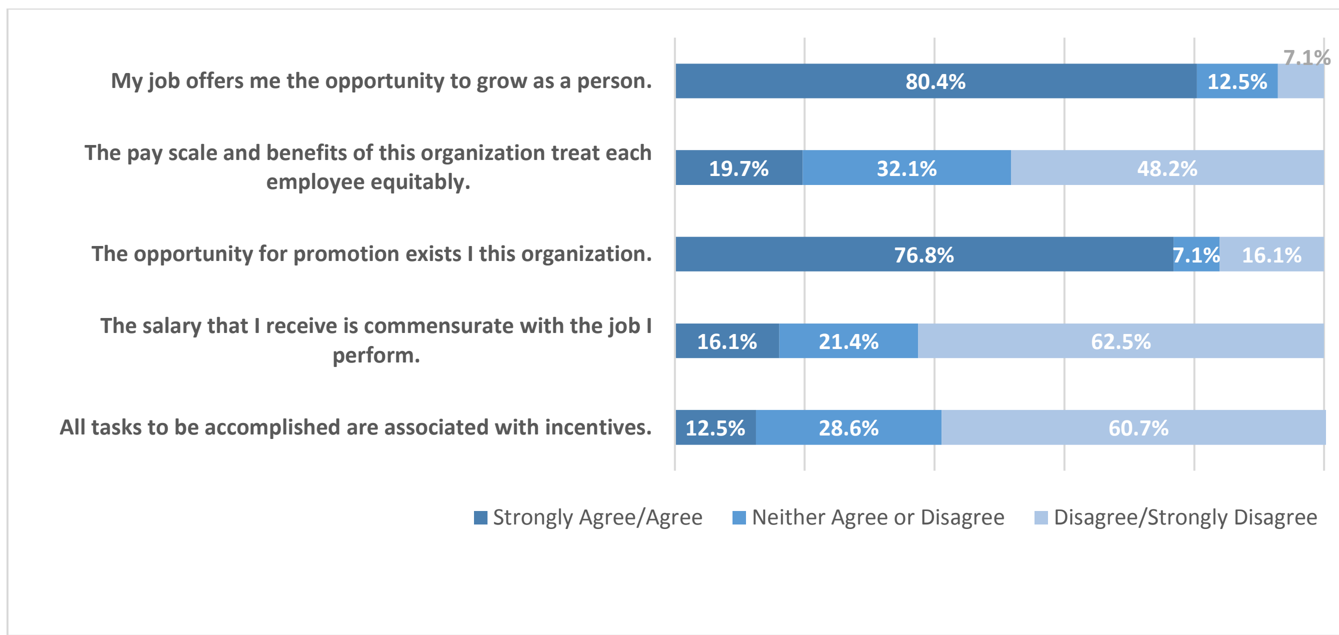
Figure 13. Mendocino County FCS Perceptions of the Relationships in the Organization



Perceptions of Organizational Rewards

While most (80.4%) felt that their job offered them the opportunity to grow as a person and 76.8% felt there was opportunity for promotion, the majority viewed unfairness in the pay scale, salaries and benefits of the organization's employees (see Figure 14).

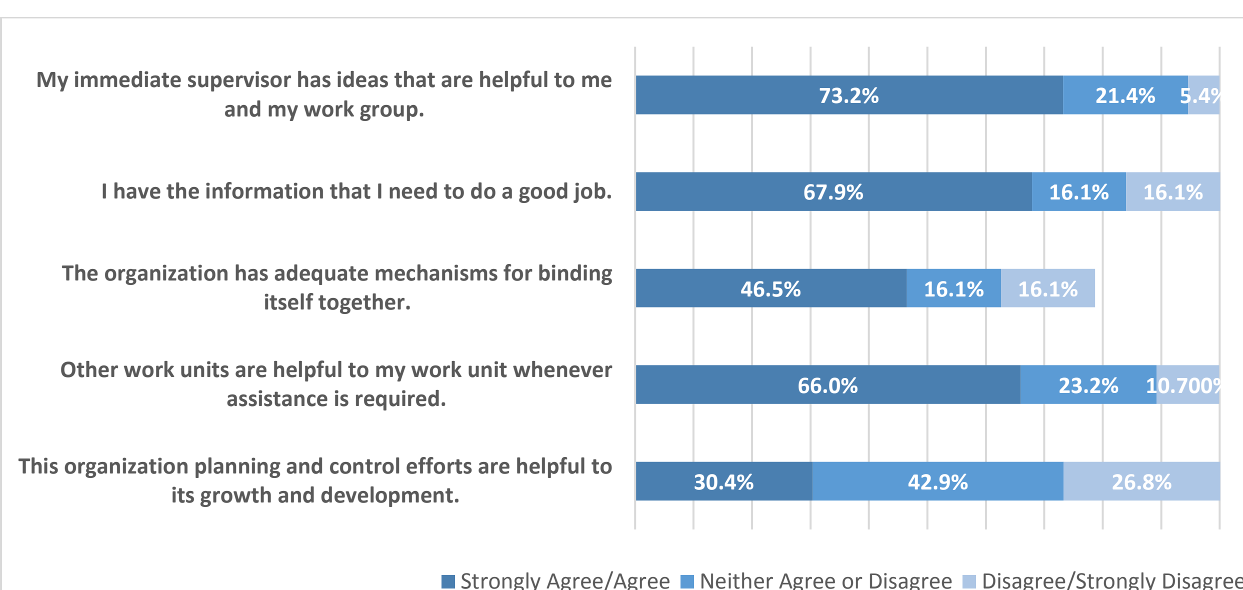
Figure 14. Mendocino County FCS Perceptions of Organizational Rewards



Perceptions of Helpful Mechanisms in the Organization

Most (73.2%) strongly agreed or agreed that their immediate supervisor had ideas that were helpful to them and their work group; that they had the information they needed to do a good job (67.9%); and that other work units were helpful to their work unit whenever assistance was required (66.0%). There was less agreement with the organization having adequate mechanisms to support the work and that the planning and control efforts helpful to the organization's growth and development.

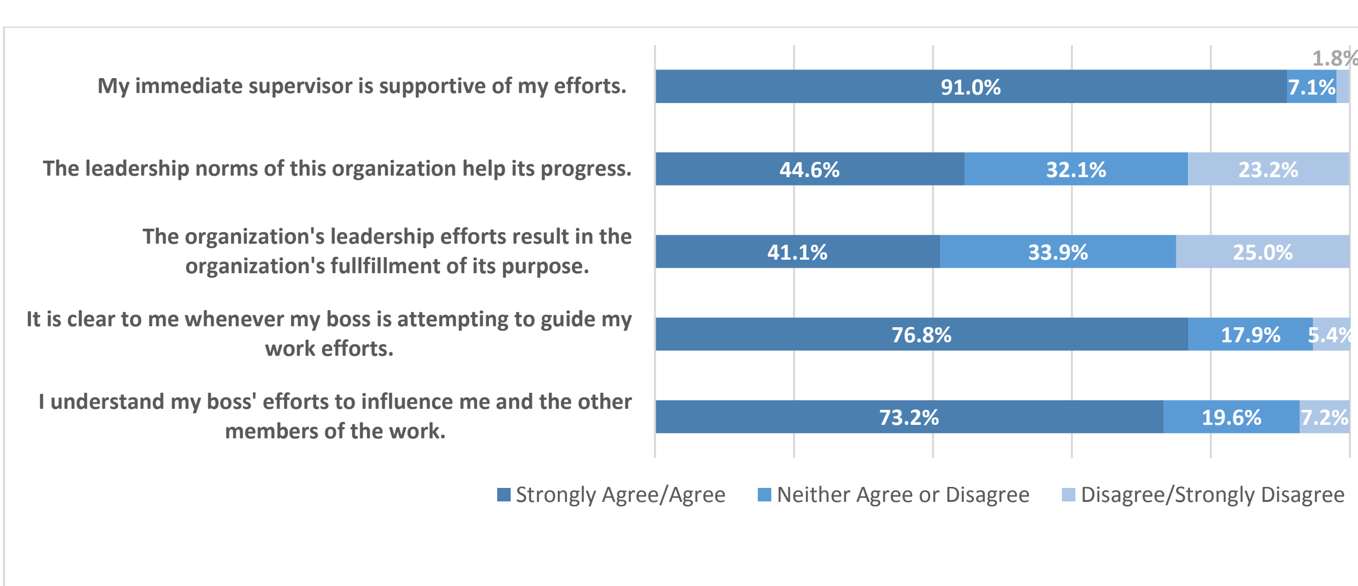
Figure 15. Mendocino County FCS Perceptions of Helpful Mechanisms in the Organization



Perceptions of Organizational Leadership

The majority (91%) strongly agreed or agreed that their immediate supervisor was supportive of their work efforts. Most also agreed that efforts for their boss to guide their work and the work of others was clear. There was much lower agreement with the leadership norms of the organization helping its progress and that the organization's leadership efforts resulting in the fulfillment of the organization's purpose.

Figure 16. Mendocino County FCS Perceptions of Organizational Leadership



Overall Results: Perceived Organizational Threats and Rewards

In almost every focus group, the topic that generated the most conversation and engagement was that of the level of stress the agency and its staff faced. In most focus groups, the word “crisis” was used to describe the working environment; that they are in “crisis mode”. There were two primary causes of stress discussed amongst focus group participants: 1) belief that caseloads/workloads are extraordinarily high, and 2) belief that staff are not fairly compensated. Focus group participants also discussed the workplace climate that has evolved in light of these stressors.

FOCUS GROUP RESULTS

Below, results from focus groups are presented according to the SCARF model and by perceived threat or reward. Strengths of the organization will fall under the “perceived reward” categories and challenges under the “perceived threats”.

Perceptions of Status in the Organization

Perceived Status Rewards

Some commented that their positions and work offered them the opportunity to grow as a person and that there were opportunities for promotion. The majority felt that their supervisor was supportive of their efforts and fostered creative thinking. If the high levels of stress were addressed at all levels of Mendocino’s FCS, then these rewards can foster resilience and productive work.

Perceived Status Threats

A common theme revealed in the focus groups with all levels of staff was the perception that leadership make decisions using a top-down approach (without the input of staff) and that staff have a strong desire to collaborate and be involved in more organizational decisions. This perception was presented during focus groups and individual interviews, and while few specific examples were provided the perception is worth noting. In moving forward and developing strategies for organizational improvements, providing opportunities for inclusion through

participation and feedback will be critical to support the change in culture already underway by leadership. Some participants raised the notion that staff are afraid of punishment and/or retribution, but because of confidentiality we cannot provide specifics.

While it is impossible for the review team to draw conclusive answers regarding these perceptions, the perception of threat does exist and may adversely impact the relationships, rewards and alignment of purpose within the organization. Additionally, there have been changes to the leadership of the organization, with staff having new direct supervisors, which can create perceived threats about the viability of their positions and create uncertainty around work roles and responsibilities. These types of uncertainties can impact professional growth and trust in the work environment. Whenever an organization undergoes significant leadership changes as Mendocino has this past year, and the context of the changes have been as a result of concern about the practices in the child welfare agency, one can expect staff to be fragile. The need for and importance of inclusion, transparency and communication cannot be understated.

Another theme that emerged from the focus group and interviews was the miscommunication that occurred because of the demands of the job. For example, some social worker aides believe social workers don't provide adequate information regarding clients or expectations, and believe this happens because social workers are too busy with unmanageable caseload sizes. These perceptions of miscommunication may also impact the organization's ability to make people feel supported, rewarded, and capable of professional progress and growth.

While initial training and ongoing training was recognized in the focus groups as an essential part of child welfare practice in Mendocino County FCS, maintaining a consistent level of practice has been very difficult due in large part to the continuous turnover in staff and thus the continuous need for staff training. For example, new social workers arrive without Core training, and in some cases without a background in child welfare or social services. This places a challenge on management to have social workers away from the offices and away from the families they serve to participate in the training they need, even though they recognize that

training not only supports their success and effectiveness as practitioners but also improves satisfaction and promotes retention. Stakeholders recognized that many children have specialized needs that requires social workers to build skills through training for both assessment and case planning. Completion of Core training, coaching in the correct and consistent application of the training, and regular monitoring are essential to integrate training into practice. However, due to challenges in work schedules and perceptions that the structure or the organization is challenging can impede staff to grow professionally and threatens organizational progress and improvements.

Perceptions of Certainty in the Organization

Perceived Certainty Rewards

Social workers participating in the focus groups agreed and conveyed certainty in the organization's mission to keep children safe, empowering families to keep their children safe, returning children to families and working with parents. In addition, direct, open, and honest communication was described as a shared value; however, none of the focus group participants could affirm that this value was included in the mission statement of the organization.

Participants in focus groups expressed generalized support for the new leadership within HSSA. The newly appointed County Chief Operations Officer (COO) has direct responsibility for HSSA. The COO is known from her work with the Mendocino County Zero to Five program but is new to child welfare. Staff are hopeful that new leadership will improve communication with the Board of Supervisors and other county agencies.

Social workers, supervisors and program managers commended the FCS Deputy Director for her hard work and intelligence. They also expressed that they would like to have more direct contact with her and stated the importance of leaders in FCS being accessible and visible. Participants felt that increased interactions and exposure with the FCS Deputy Director would offer some needed and essential supports in the current environment in which social workers have been publicly criticized and had their integrity questioned while also being asked to accept increased responsibilities.

Mendocino is working to establish a training program for all new social workers to complete prior to receiving cases/clients. This is just starting but will serve – and already is serving – to help new social workers have a greater understanding of what the job entails prior to working with children and families.

Perceived Certainty Threats

In all of the focus groups, participants discussed feelings of uncertainty pertaining to the budget, leadership changes, public perception and staff turnover. Participants talked about the changes in the past several years and how "crazy" and "wild" the times have been. This dominant theme of uncertainty in the purposes, structure, relationships and leadership of the organization highlights various aspects of the organization that are viewed as being managed ineffectively. Some of this uncertainty was attributed to changes in the court unit, significant changes in work schedules, and reductions in pay. Additionally, issues associated with organizational transparency, visibility of leadership, and challenges communicating with leadership were discussed during these focus groups as impediments to the overall mission. Regarding implementing new programs, utilizing data, and providing training, one PM summarized the feelings of the group by stating that, "It is hard to be proactive when we are always responding to emergency reactionary situations."

Perceptions of Autonomy in in the Organization

Perceived Threats

In most focus groups, participants expressed views that they felt too overwhelmed to affect change in their organization and shift roles and responsibilities. There is a pervasive belief amongst workers that there is simply too much work to be able to have a sense of control over their work and work days. Participants talked about the "crisis mode" with which they operate, but also celebrated their compassion for each other in how they all try to manage with the workload. This sense of not having control and time to exert choices in their work can be problematic for the relationships, sense of reward, and structure of the organization. Though not mentioned in the focus groups, it is possible that working in this overwhelmed crisis state

can contribute to organizational factors falling through the cracks and contribute to poor client satisfaction and outcomes.

In September 2016, a survey of caseload sizes showed that the ten FM/FR/PP workers in the Ukiah office carried a caseload that ranged from 1 - 26, with most having more than 12 but less than 20. Sixteen workers, not including those who are only Emergency Response workers, averaged 15 cases. The Fort Bragg and Willits offices are more difficult to assess given the turnover in staff, but caseload sizes are much higher in both of those offices. Also noted is that supervisors are carrying caseloads. Table 6 presents the Child Welfare League of America recommended caseload/workload size.

Table 6. Child Welfare League of America Recommended Caseload/Workload

Service/Caseload Type	CWLA Recommended Caseload/ Workload
Initial Assessment/ Investigation	12 active cases per month, per 1 social worker
Ongoing Cases	17 active families per 1 social worker and no more than 1 new case assigned for every six open cases
Combined Assessment/ Investigation and Ongoing Cases	10 active on-going cases and 4 active investigations per 1 social worker
Supervision	1 supervisor per 5 social workers

Perceived Relatedness in the Organization

Some important pieces of the organization supported relatedness is terms of building organizational trust, supporting collaborations, and producing good work morale while the community factors served as significant threats. Social workers expressed that coworkers cared about each other and generally tried to encourage one another to do good work.

Perceived Relatedness Rewards

Mendocino County child welfare is the direct responsibility of the Deputy Director for FCS. She describes her role as advocating for and supporting staff, providing staff with resources that will help them do the best job serving families, and keeping informed about issues impacting child welfare within Mendocino County and across the state. The Deputy Director works to set clear expectations and reports that her expectations are clearly understood by her managers, although she acknowledges that she follows her managers' work closely. She describes herself as passionate about the work and improving services for children and families. Additionally, relationships within the agency are considered by staff to be "well managed." The foundation for this culture rests on many years of stability at the PM and supervisory level. Program managers feel a close connection to staff and feel appreciated by staff. "I am a buffer between social workers, supervisors and management…I am very [engaged] with my supervisors. I feel like I have their respect. I have the hardest working staff that I have ever seen in child welfare."

The strong culture of close relationships and working together as a team was consistently reported by social workers, supervisors, and management as making the work more rewarding. This culture was reflected in the focus groups and individual interviews.

In January 2016, Mendocino FCS implemented the FCS Deputy Director Award, which is awarded each month to staff who are nominated by peers, supervisors and managers. Nominations are reviewed at the monthly FCS Leadership meeting and award recipients are selected. Award certificates are presented at the monthly FCS all-staff meeting and copies are e-mailed to all staff with the monthly FCS newsletter. During focus groups with staff, this was not identified as a system in place to recognize staff. This is an important step to recognizing staff on a regular basis, but, as in any organization, the impact of these important changes can be slow to make a difference in staff perceptions of the organization.

Social workers were lauded for using SOP and family team meetings in working with families, being committed to engaging parents and open minded about how to make things better, and truly caring about the children and families they work with day to day. Expertise in ICWA and good relations with local tribes were identified as particular strengths among FCS social workers.

Perceived Relatedness Threats

Staff feel the impacts of the grand jury report and scrutiny from the community. Retention of social workers was identified as the most significant and persistent challenge for the agency. Both the court and counsel acknowledged that stable workforce relates directly to what happens in the courtroom, including late court reports (20%), continuances, and contested hearings. Mendocino has implemented a new practice that all petitions are reviewed by county counsel prior to being filed with the court; however, this is not consistently happening. Attorneys for parents and children vary in experience and often have other court appointments that impact the court calendar. Attorneys recommended expediting discovery requests as a means of reducing continuances (e.g., using electronic filing over secure connections). One deputy county counsel recently arranged office hours on Mondays at the

Ukiah offices to be more accessible to answer questions and discuss cases. It was agreed that it would be beneficial for the new HSSA leadership to reach out to the county administration and Board of Supervisors regularly to discuss the needs of children and families in the county and the vital service provided by social workers in working with families at risk.

Another challenge discussed across several focus groups is the belief that social work practice and decisions is not consistent among social workers. That is, family's experiences with child welfare may change depending upon who is their assigned case worker. This notion was discussed by foster parents, social worker aides and social workers. The majority of focus group participants attributed this inconsistency across practice to a lack of time caused by retention issues. In addition, issues such as changing social workers, lack of communication, and untimely communication were discussed. Foster parents would like more information about health and dental care.

Perceived Fairness in the Organization

Perceived Threats

Per focus groups conducted as part of this review, focus groups conducted as part of the CFSR County Self-Assessment (2015) and findings from the Grand Jury report, there is a pervasive belief that Mendocino County FCS social workers "train and trot", which is to say new social workers start their career at Mendocino County and then, once trained in the field, they move to higher paying positions at neighboring counties. Focus group participants expressed disappointment, frustration and anger over what they perceive to be unfairly low wages compared to colleagues in neighboring counties. As noted in Table 7, Lake County, Humboldt, Sonoma and Yolo Counties pay higher wages than Mendocino. Lake and Sonoma Counties are both within commuting distance to Mendocino County.

Program managers report feeling increasing pressure from staff turnover and workload increase over recent years. Due to the high vacancy rate, standard procedures for case assignments have to be adjusted and caseloads are not balanced. The number and types of case

assigned to workers are consequently based on the worker's estimated knowledge base rather than maintaining a preferred caseload distribution.

These threats of fairness contribute to people in the organization feeling less rewarded and valued and can contribute to people leaving the organization and finding jobs elsewhere. It can also negatively impact efforts to contribute to the growth of the organization.

Another perceived threat to fairness is the possibility of retaliation; in various focus groups, at least one participant discussed the belief that some in leadership positions may retaliate against staff who do things such as apply for different jobs. The agency's position is to encourage staff to pursue opportunities for career advancement, better job fit, and opportunities to gain new skills. While this comment was voiced by a small portion of staff, it is important to acknowledge this perception and address in a proactive manner. Often in an organization negative perceptions can grow and hinder the great work to create a positive work environment. This sense of feeling threatened to convey disagreements with decisions can create an organizational culture of mistrust.

Table 7. Annual Salary Comparison of Mendocino, Lake Sonoma, Humboldt and Yolo Counties

Position	Mendocino Annual Range	Lake Annual Range	Sonoma Annual Range	Humboldt	Yolo
Social Worker Assistant			41,137 – 50,028		
Social Worker I	37,460.80 – 4,531.20	41,220 – 50,112			
Social Worker II	41,329.60 – 50,232.00	45,444 – 55,248			
Social Worker III	43,409.60 – 52,769.60	50,112 – 60,924			
Social Worker IV	45,572.80 – 55,411.20	55,248 – 67,164	63,761.52 – 77,494.80	41,560 – 73,753 (several different classifications with steps included)	62,718 – 76,231
Social Work Supervisor I	50,252.80 – 61,089.60	58,008 – 70,512			
Social Work Supervisor II	52,748.80 – 64,126.40	63,960 – 77,748	71,275 – 86,636	60,414 – 82,718 See above note	68,985 – 83,856

Findings from Case Reviews

Key Findings: Safety Organized Practice Case Review

The overall impression from the case file review conducted May 18-20, 2016, was that Mendocino County has an established history with using Safety Organized Practice (SOP). The county has implemented several strategies aimed to increase the depth of SOP practice including 1) creating a dedicated SOP unit which is responsible for facilitating family team meetings and safety mappings during the investigation phase, and 2) implementing RED (Review, Evaluate, Direct) Teams, and adopting corresponding tools and forms. Individual social workers in Mendocino County also champion the philosophy of Safety Organized Practice and use different pieces of the SOP model throughout their practice. It is important to note that in focus groups some participants discussed a desire for the RED teams to be more consistently implemented; they believe that the RED team is sometimes not well attended and overall participation is low.

While it appears that SOP is being implemented and in some situations implemented with greater degrees of depth, the documentation of SOP within the case plans reviewed was inconsistent. For example, while the case plans were well written with clear objectives and specific action steps, case plans were also primarily service and compliance-oriented rather than focused on behavior change. Even for many of the cases that had some documentation of SOP (such as the creation of family safety/support networks), there was little to no documentation of ongoing collaboration throughout the life of the case or evidence of aftercare safety planning, both key components of a fully integrated safety organize practice.

The following list provides more specific points of strengths and challenges found from conducting the SOP case file reviews.

Strengths

- Mendocino County staffs a dedicated SOP unit which facilitates Family Team Meetings (FTMs) for the Ukiah, Willits and Fort Bragg offices. These meetings are facilitated to

ensure that child welfare develops agreements and joint understanding between families, the department and other team members regarding the cause and level of intervention. The process was well documented in the SOP case files, which also contained well written harm and danger statements, safety goals and safety network partnering (which are outcomes of the FTM).

- Documentation exists in the files which indicates social workers utilize safety organized practice elements and tools such as: the three question model and solutions focused interview tools.
- There were several helpful forms and tools used by social workers to document safety plans and SOP with families, including documents entitled “Safety Plan", "Risk Reduction Plan", “Family Trajectory Form” and “Family Empowerment Plan.”

Areas for Improvement

- Of the cases that had documented FTMs using the SOP format, an initial FTM was held at the beginning of the case. Subsequent meetings to ensure ongoing collaboration with the support network were not held, with the exception of one case. Some social workers documented harm and danger statements and safety goals in case pans and some case plans had behaviorally specific objectives that aligned with the safety mappings and included the parent’s voice; however, most of the service objectives were focused on completion of services rather than desired behavioral changes.
- Visitation practice and policy varied among social workers, leading to inconsistent notes and documentation. For example, the review team found the documentation neatly filed within the case files, but there appeared to be no consistent standard or consistent monitoring of the standard for organizing the information with the exception of placement paperwork. Visitation plans and documentation of progression of visits/family time were inconsistent. Some visit plans were very minimal one visit per week for an infant).

- Parent Empowerment Group notes included the use of SOP language, but its use was inconsistent.

Key Findings: SDM Case Review

The following overall impressions of the utilization of Structured Decision Making (SDM) in Mendocino County are based on actual cases/referrals from 2014 and 2015.

A total of six cases and eight referrals were reviewed. The six cases were evenly divided between FM, FR, and PP service components. Each of the cases remained open as of the review dates (May 19-20, 2016). All of the referrals had been closed.

Based upon the review, it is recommended social workers and supervisors receive refresher SDM trainings to increase accurate use and completion of the SDM tools. The findings revealed that 1) Hotline tools are not completed immediately, 2) completion of the Safety and Risk tools needs to improve with narratives and tools matching, and 3) accurate completion of Family Strengths and Needs Assessment needs to improve and be used in informing decisions made in the case. Specific findings are provided in the bullets below.

Reviewed Referrals

- The Hotline Tool was completed for every referral; however, one-half were completed timely. This suggests the tool was completed after a decision had been made.
- All of the eight referrals had a documented SDM Intake Screening tool and a Response Priority tool (again, only four were timely).
- The Safety Assessment Tool was completed 100% of the time; however, documentation errors and technical errors were noted during the review.
- The majority of the Safety Assessments, although created late, recommended actions that were reasonable and the course of action taken by the social worker was congruent with the final tool recommendation.
- The Risk Assessment Tool was completed 100% of the time; however, both of the risk assessments were lacking in information that may have been indicative of the risk factors which were checked.

- Two of the referrals, 25%, had a lack of information in CWS/CMS to make a decision concerning SDM Risk Factors, yet the Risk Factors were scored. Information was missing in the documentation within CWS that would indicate that the risk factor that was checked on the tool was actually present in that referral. For example, if the factor for domestic violence (DV) was checked, there should have been some mention in CWS/CMS that DV was present in the home. In 25% of the referrals reviewed, the information that informed the risk assessment tool was not present in CWS.
- The majority of the time in this review, the risk assessments were not created according to the SDM policy and procedures; instead, they were created late. The risk assessment P&P indicates the assessment tool shall be created after the safety assessment and before the close of the referral; however, risk assessments matched the outcome of the case or referral the majority of the time.

Reviewed Cases

- The Initial Family Strengths and Needs Assessment (FSNA) was only completed in one of the six reunification cases. None were completed for the in-home cases.
- The Reunification Reassessment was completed in four of the six reunification cases. Of those 50% (three) were completed timely and one was completed late. In two of the cases (33%), the FSNA was not completed at all.
- Three, or 50%, of the Reunification Reassessments matched the information in CWS/CMS.
- For the two in-home cases, both had Risk Reassessment tools; however, they were completed late.
- The Safety Assessment was not completed for the Involuntary In-Home cases.

Discussion and Conclusions

“I am not here for a paycheck. We are here because we care and want to help. My supervisor understands and supports me…we have stuck it out for the right reasons.”

– Mendocino County Social Worker

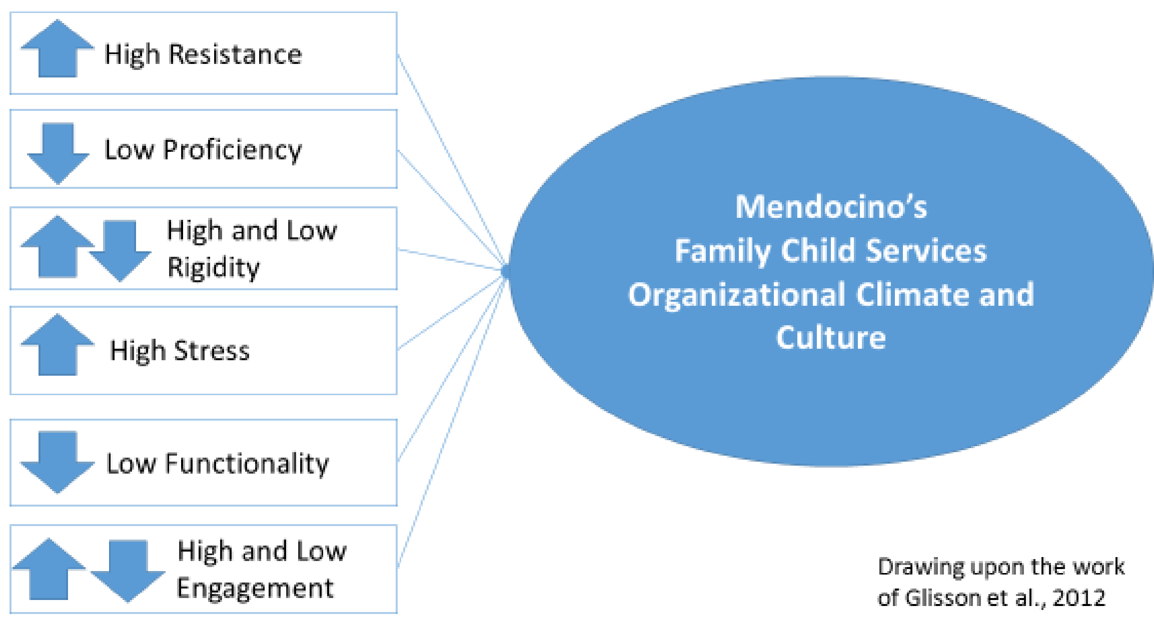
When all of the findings from the focus groups, interviews, case reviews, organizational survey questions and child welfare outcome data are integrated, the results reveal that Mendocino’s FCS is approaching a state of crisis in terms of staff cohesion and critical decision making abilities due to overwhelming social threat responses. There was also, however, a sense that change was possible if the stressors of the work are addressed. It is worth noting that the findings from this report may in themselves heighten the anxiety and perception of social threats within Mendocino County FCS; however, if the findings are viewed with a constructive lens (as a presentation of FCS's challenges, with recommendations to make lasting improvements to the organization from the infrastructure on out), successful and positive changes can be made.

Due to the many perceived threats in status, fairness, autonomy, and relatedness, there is a sense of despondence among workers which makes for a highly resistant culture toward implementing new policies and practices and adopting innovative changes. Additionally, the perceived threats to status, fairness, and autonomy creates challenges in being responsive to clients and being able to place the well-being of their clients first.

Workers at all levels reported that they are able to accomplish meaningful things in their work and that they strive to treat their clients in a personalized way; however, the low functionality of the organization creates an environment where workers lack role clarity and do not feel they are supported with the resources they need to successfully perform their job duties. The greatest challenge revealed through this analysis was the immense amount of stress workers perceive. Workers feel that they have many conflicting demands, are emotionally

exhausted, and do not feel that they are being fairly rewarded. All of these factors can create a less engaged work environment, which negatively impacts creativity and decision making. Figure 17 shows the various areas impacting Mendocino's FCS's organizational climate and culture. It appears that the organization is high in resistance and stress, low in proficiency and functionality, and has both high and low characteristics of rigidity and engagement.

Figure 17.



Mendocino County FCS has certainly had a difficult past eight years. The impacts of the budget crisis were profound; staff morale plummeted after a salary cut in 2011 that has yet to be fully restored, which was followed by community scrutiny and the Grand Jury report in 2015. In spite of this crisis state, the Mendocino FCS staff clearly remain passionately dedicated to serving children and families. They inherently understand the overall mission and vision of child welfare, and, as many participants shared, they "aren't in this line of business for the money." They are dedicated to clients and children and work tirelessly for the benefit of those they

serve. Staff are engaged in their work, but conveyed many times that they are also emotionally exhausted and overloaded in their work.

For Mendocino County FCS to successfully move out of this period of crisis, it is imperative that leadership (supervisors, program managers and above) have a solid and firm understanding of the history of the Mendocino budget challenges. It was discovered during this review that myths abounded regarding this history, which may feed into the creation of more myths about unfair case load sizes and the like. In this instance, the lack of common understanding about the budget crisis has led to a much heightened fairness threat response, which may then feed into a belief that other things are unfair as well. It would be beneficial to review the budget history with all staff and then set an agenda for the future.

While the broader mission and vision of child welfare is clear to staff, those asked were not able to identify division and/or program goals (beyond that of child welfare regulations to close cases). Staff discussed a desire for more open communication with leadership, which could include that of the vision and goals. In addition, some staff discussed the community perception of child welfare and the unfair expectations they may have of the agency.

This report has detailed several areas in need of improvement, but before any meaningful change can occur, this team recommends that all levels of leadership understand the importance of decreasing SCARF threat response amongst staff when discussing changes that are to occur in Mendocino County FCS in order to improve child safety, permanency and well-being. Leadership should capitalize on the strengths of Mendocino FCS and set forth an agenda for improvement, one that does not highlight the challenges facing Mendocino, and one that has a solution focused approached to the current state of the organization. If staff feel they are the cause of the poor outcomes, they may go further into status threat response. The good news, however, is that, as cited in Rock, 2008, “people feel a status increase when they feel they are learning and improving and when attention is paid to

“In most people, the question ‘can I offer you some feedback’ generates a similar response to hearing fast footsteps behind you at night.” (Rock, 2008, p. 47)

this improvement. This probably occurs because individuals think about themselves using the same brain networks they use for thinking about others" (Mitchell, 2006). [15]

The following section provides key recommendations for Mendocino's FCS. Please note that the first four recommendations should be considered "Implementation Recommendations" and implemented before the others. These recommendations are designed to lay the groundwork for successful implementation of the "Priority Recommendations"; they provide a framework for addressing the readiness of the organization to make positive changes. See Table 8 following the priority recommendations for a detailed proposed timeline of implementations.

Implementation Recommendation One: Create and communicate a strategic and transparent plan for improvement, including recommendations in this report. Mendocino County FCS should develop an Implementation Team whose responsibility will be to oversee implementation of new programs and practices, which may include the creation of ad hoc work groups. The implementation team should be a cross-section of the organization with representation from all levels and units. The implementation team should meet regularly and often, to discuss programmatic and policy changes in the organization, troubleshoot challenges and assess positive growth. This team will have an important role in the cycle of Continuous Quality Improvement (see Priority Recommendation Six).

Implementation Recommendation Two: Provide all staff with training on the SCARF model. The SCARF model can be used *in the moment* by all staff as a vehicle for understanding their responses to organizational changes; this can then positively impact future acceptance of behavior. As cited by Rock and Cox, 2012, knowing the SCARF model "provides people with an easy-to-recall framework to label and reappraise their response."[16] Understanding the SCARF model also allows people the ability to predict when they may feel a threat response, and then as a way to explain why they responded to an event that already occurred. Ideally, staff will be

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[15] Rock, D. (2008). SCARF: a brain based model for collaborating with and influencing others. *NeuroLeadership Journal, 1*, 44-52.
[16] Rock, D., and Cox, C. (2012). SCARF in 2012: updating the social neuroscience of collaborating with others. *NeuroLeadershipJournal, 4*. p. 2

able to use all three avenues (predicting their response; reappraising their response; and understanding their response) as a way to reduce their actual threat response.

Implementation Recommendation Three: Align Mendocino's FCS' leadership (including supervisors) style and organizational culture and climate with the SCARF model such that increasing the reward response and decreasing the threat response is prioritized.

- **Status:** Mendocino FCS workers need and deserve positive feedback. Given the harsh public criticism they have faced, they are very vulnerable to status threats. Leaders must find ways to acknowledge, even publically, the hard work of those workers who remain at FCS. It is imperative for leadership to create, articulate and model a positive, strength-based culture at Mendocino FCS. Currently, the narrative of FCS is that of crisis and stress, and it is one they are constantly forced to respond to rather than direct; leaders can take control of the FCS narrative by laying out a clear plan for recovery focused on what is working well in Mendocino County instead of what isn't. For example, instead of talking about staff vacancies, leadership can discuss success stories that are happening on a daily basis.
- **Certainty:** Change generates uncertainty, yet change must occur. Provided in the following pages are sample timelines for implementing the recommendations provided in this report. This kind of transparency is needed to give staff clarity about where the organization is headed; staff need to feel like they know what kinds of changes are coming and when they might be implemented. A strategic plan will provide both internal and external stakeholders with more trust that things are going to change for the better. "Much of the field of change management is devoted to increasing a sense of certainty where little certainty exists."[17]
- **Autonomy:** Attempts must be made to allow staff some amount of decision-making about changes that are to occur. This can come in the form of choices

[17] Rock, D. (2008). SCARF: a brain based model for collaborating with and influencing others. *NeuroLeadership Journal, 1*, p. 48.

(i.e., “Would you prefer choice A or choice B?”) or even some discretion on when that change may occur (for example, "This change can happen in October or November; which would be better for you?”). Staff should also be encouraged to participate in the Implementation Team and other ad hoc teams that will be created.

- **Relatedness:** Given the turnover rates at FCS, focus needs to be given to providing positive social interactions amongst all staff such that positive working relationships can be forged with new workers. Creating safe connections between and amongst FCS staff will increase relatedness/reward response. This may include hosting employee events or other opportunities for staff to build relationships or perhaps even include looking at pairing new workers with a “mentor” or “buddy” who can help bring them on to the team in a positive way. Additionally, extra support needs to be given to the staff in the Willits and especially Fort Bragg office such that they feel part of the organization and not so isolated. Leaders must provide visible support for workers by regularly walking around work areas, having one-on-one conversations, sitting in on case conferences and by engaging staff directly and individually.
- **Fairness:** This is dealt with similarly to the certainty response in that increased transparency and communication can go a long way. FCS staff will function better with clear expectations in all situations and an understanding of what the future holds for Mendocino child welfare.

Priority Recommendations

Priority Recommendation One: Adopt a “retention focused organization” approach: Currently Mendocino FCS leadership and staff are focused on turnover rates and subsequent recruitment of staff. The focal point for staff and leaders must shift to what is being done to retain current staff, primarily by providing supportive and consistent supervision.

- **Conduct a Caseload Size/Workload Study.** Importantly, staff at all levels (including leadership) have made caseload sizes and turnover the focal point of the very low staff morale. Staff recite the amounts of open positions regularly and the issue has become a rallying cry of sorts for the amount of stress staff have been under the past six years. Conducting a caseload size/workload study in combination with a job task survey will provide the agency a firm understanding of what the present status is, and what it should be. There are two key issues: 1) case load sizes and 2) staffing structure (see discussion of case load sizes on page 43 and staffing characteristics in Table 5).
    - In this review, it appears that caseload sizes for the ongoing units in the Ukiah office may not be as high as staff believe, and even considerably lower than many jurisdictions. Yet participants in focus groups believed caseload sizes to be incredibly high. While the Willits and Fort Bragg office are in fact suffering from significant turnover and understaffing, in reviewing the staffing positions assigned to each of those offices, it is difficult to assess whether the amount of positions at each location are indeed required. It is possible that the workload size of the three offices may not require the amount of current staffing positions assigned to each one, but because of the open staffing positions and constant messaging about staff vacancies, staff have drawn the conclusion that they are overburdened by caseload sizes.
    - Additionally, a great strength of Mendocino FCS is the amount of support staff for social workers. The SWAs, legal aides, placement unit, SOP unit, PHN's all strive to help social workers provide comprehensive assistance to families. As noted in the Children's Bureau Information Gateway's July 2016 Issue Brief, "workload varies by a number of case characteristics, such as where the child resides (e.g., in his/her home, relative home, foster home, or congregate care), the number of children involved, the phase of the case process (e.g., intake, assessment, investigation, permanency), court involvement, permanency goals, task types (e.g., face-to-face contact, service planning, team meetings, and/or documentation), and the complexity of the case. It also is affected by the

worker's caseload. Workload also varies by agency characteristics such as location (i.e., urban, rural, remote), number of staff, and number of support staff." This comprehensive analysis is beyond the scope of this organizational review, but some examples of potential reorganization are presented throughout this section.

- **Offer pay differential to staff in the Fort Bragg office.** Retention rates at the Fort Bragg office are unsustainable, and additional resources should be invested to counter the turnover. Considering pay differential, or regular use of county car for computing to Fort Bragg, a rotation shift until positions can be filled permanently are among suggestions for consideration. The urgency for which staff retention at this office needs to be addressed cannot be overstated.
- **Hotline:** Having two full-time screeners may be more than needed for the population of Mendocino County. Screeners should enter data directly into CWS/CMS, which will reduce errors in data entry. Management should consider eliminating having referral information go to a data entry person, which could impact the integrity of the information. Screeners should also have access to past referral information when screening a new referral.
- **Court reports:** Many counties have adopted a largely paperless process for filing and serving court reports by utilizing technology that maintains confidentiality. This would both expedite delivery of reports to the court and counsel, reduce time allocated for personal service and mail delivery and reduce the number of continuances due to late reports. Memorandums of Understandings (MOUs) can be put in place if required by the courts or third party agencies, limiting access and protecting client confidentiality.
- **Mendocino currently provides clinical supervision for staff who are pursing licensure (LCSW or MFT).** Encouraging staff to take advantage of this important resource that has been available since November 2014 will help build capacity in the workforce and can be an excellent recruitment incentive. FCS has contracted with two LCSWs to provide weekly group supervision to FCS staff who are pursuing LCSW, MFT or LPCC licensure. Since April 2016, FCS has partnered with a community based organization, Mendocino

County Youth Project, to provide opportunities for FCS staff pursuing clinical licensure to gain clinical experience on Fridays as part of their 40-hour work week. This is an underused resource available to staff that can increase recruitment, retention and the clinical skills of staff.

- **Enhance coaching based supervision.** Coaching is a leadership and supervisory strategy that can lead to improvements in practice, quality of work, and the agency's success in working with children and families by 1) improving systemic implementation of a practice; 2) creating positive changes in behavior; and 3) embedding professional development in day to day practice. Implementation science researchers claim that "human services are far more complex than any other industry" (Fixsen, Blasé, Naoom, & Wallace, 2009, p. 531). When making a program or practice change in the field of child welfare, all practitioners must adopt that change, which means the practitioner is the focus of the change itself (Fixsen, et al., 2009). Child welfare staff need advanced critical decision-making skills that cannot be taught in a one-time training, but relies on continuous coaching. Mendocino County leadership and supervisors should both be coached and receive training to develop a coaching-based supervision style.
- **Wellness of the Workforce.** Secondary traumatic stress is the emotional duress that results when an individual hears about the firsthand trauma experiences of another. Its symptoms mimic those of post-traumatic stress disorder (PTSD). Accordingly, individuals affected by secondary stress may find themselves re-experiencing personal trauma or notice an increase in arousal and avoidance reactions related to the indirect trauma exposure. They may also experience changes in memory and perception; alterations in their sense of self-efficacy; a depletion of personal resources; and disruption in their perceptions of safety, trust, and independence. Secondary trauma can have a significant impact on retention of child welfare social work staff and supervisors.
    - Recommend training for all supervisors on secondary trauma, and strategies for addressing their own trauma.
    - Recommend training all supervisors on strategies for addressing trauma through case consultation process.

- Recommend providing training on secondary trauma to all staff.
- Develop process groups or resources for social workers to address issues of secondary trauma, and seek guidance for working with families whose lives have been impacted by trauma.

Priority Recommendation Two: Reinstitute Monday through Friday office hours. Currently, Mendocino County FCS is open from Monday through Thursday and closed Friday through Sunday, leaving gaps in services, communication and morale. A key mission of Mendocino County Division of Social Services is to "strengthen and empower individuals and families, to maximize personal and financial self-sufficiency." This is reflected in the availability of services; the Friday closure was commonly noted amongst community organizations and foster parents as a barrier to communication and collaboration. Simply, the FCS organization can better serve child welfare clients if the office is open five days per week (allowing for more visitation between children and families and enhanced collaboration with community partners who work five-day work weeks). As such, work schedules should allow for the ability of FCS to be open for business at least five days each week. There are a variety of alternative work schedules that allow for staff to work on Fridays, including a standard five-day work week, compressed schedules including a four-day week; and a four-day week alternating with a five-day week. Considerations for implementation of a five-day schedule may be: 1) asking for volunteers to move to either a Tuesday through Friday or a Monday through Friday schedule, and 2) assigning all new staff to work a five-day schedule.

Priority Recommendation Three: Strengthen investigation and assessment processes with increased transparency and collaboration.

- **Improve use of safety and risk assessments (SDM), safety planning processes and critical thinking skills for social workers.** Provide enhanced coaching and supervision for the consistent and effective use of risk and safety assessment tools (SDM), as well as Safety Organized Practices (SOP). An ad hoc committee should be convened to monitor SDM consistency and fidelity via case reviews on a monthly basis, the results of which should be shared with the CQI and implementation teams.

- **Assess/review all entries into child welfare.** The entry rates for children and youth in placement are among the highest in the state. While the RED teams review 10-day investigations, it is recommended that immediate response referrals are also reviewed by a team to assess for SDM alignment, and to ensure consistency across social workers and supervisors. It is recommended that additional oversight is provided to the assessment process to ensure safety and risk are appropriately assessed. Even though entry rates are high, it is not clear that removal decision are made systematically, ensuring that all children have access to the safety foster care can provide. RED teams have been noted as a strength of the organization, but because this is a fairly new practice we would recommend that the RED team process be observed for fidelity to the model by a subject matter expert. In addition, current referrals that have been open for longer than 30 days must be immediately assessed. The large number of cases that have been open for referral longer than 30 days present a risk to children and a liability for the agency.

Priority Recommendation Four: Enhance permanency practices.

- **Permanency planning:** Permanency planning can be strengthened and outcomes improved by developing templates for behaviorally based case plan language for use in case plans, and by encouraging staff to attend case planning training and expand the use of SOP practice in contact notes, court reports and case plans. There are many resources available to shift practice toward behavior change and away from a mere service compliance focus. This may include development of templates with SOP language and inclusion of safety goals that are behaviorally based, and the integration of SDM into SOP processes to assist with decision making and the articulation of safety goals and case plan objectives. Stress should be placed on ensuring that the voice of the child is heard, especially in safety mapping. Staff would benefit from SDM refresher training to help them achieve these other practice changes.
- **Implement an evidence-based visitation program.** A strength of Mendocino County FCS is the robust visitation center and support staff dedicated to coordinating and

supervising visits. However, this program can be significantly strengthened by the inclusion of key promising practices such as visits coaching. Two potential programs include the visits coaching model as proposed by Marty Beyer, PhD, University of Oregon and the STRIVE model from the University of Washington. Visitation is a key strategy for improving permanency for children by promoting healthy attachment and reduces the negative effects of separation for the child and parents, establishing and strengthening the parent-child relationship, keeping hope alive for the parent(s) and enhances parents' motivation to change, helping parents gain confidence in their ability to care for their child and allows parents to learn and practice new skills, providing a setting for the caseworker or parenting coach to suggest how to improve parent-child interactions and helping with the transition to reunification.

- **Convene Permanency Roundtables.** The goal of the Permanency Roundtable is to expedite legal permanency for the child, stimulate thinking and learning about new ways to accelerate permanency and identify and address systemic barriers to timely permanency. A Permanency Roundtable will be a professional consultation team (comprised of FCS staff) for a youth who has been in out of home placement for over a year or who has been assigned a permanency goal of Other Planned Permanency Living Arrangement. Permanency Roundtables are a structured, in-depth meeting process developed to meet the goals of 1) increasing the number of a youth's permanent connections, 2) expediting permanency for children and youth, 3) stimulating thinking and learning about new ways to accelerate permanency, and 4) identifying and addressing systematic barriers to timely permanency.
    - Permanency Roundtables are defined by their relentless pursuit of permanency and are held every 90 days on a case until permanency is achieved. Each meeting follows an agenda that promotes forward thinking and creativity. Meetings focus on creating action plans designed to bust down barriers to permanency and develop permanent connections. This includes working to improve a youth's permanency outlook and to reduce the level of restrictiveness in their living situation.

- Related to Permanency Roundtables are Family Finding practices. Review the current structure and practice for Family Finding, and start Family Finding at ER to support building family networks of support, and relative placements if needed.

Priority Recommendation Five: Increase collaboration with stakeholders. Collaboration with both county counsel and resource families be achieved by expanding on current practices. Access to legal counsel for social workers not just immediately before court hearings, but also to assist with writing petitions and making recommendations, is important to improving the quality and timeliness of court reports. County counsel have established Monday office hours at FCS in Ukiah and report that social workers seem to be unaware of their availability. Supervisors have an important role in showing social workers how to use this resource and in helping them understand the legal foundation of their court reports. Mendocino FCS is beginning implementation of Residentially Based Services and Resource Family Approval, two key components of legislation supporting improved outcomes for children and families served by child welfare. Both of these strategies should improve the quality of communication FCS has with stakeholders.

Priority Recommendation Six: Integrate a systematic Continuous Quality Improvement (CQI) Cycle. Mendocino County FCS should adopt a variety of mechanisms to monitor and promote effective practice. As noted in the July 2016 Policy Brief issued by the Child Information Gateway, Children's Bureau, CQI is a particularly effective mechanism for child welfare agencies to conduct a variety of case reviews, track and report on performance measures, and implement statewide, regional, or local improvement plans. Mendocino County can successfully implement monthly reviews of Structured Decision Making and Family Team Meetings, including the CFSR reviews. Leadership should meet with the team assigned to CQI monthly to monitor progress. These include the design of specific data dashboards on a variety of topics which can be reviewed monthly by leadership and the Implementation Team.

The inclusion of reviewing SDM tools as part of supervision with social work staff needs to be a consistent practice to maintain fidelity and consistency of SDM as part of assessments and decision making.

Priority Recommendation Seven: Tell your story. Overcoming the long-standing perceptions of child welfare practice both past and current requires consistent, clear and transparent communication. Tell the story from the beginning; provide accurate information about budget cuts, reduction in worktime and salary, restoration of the work week, and Mendocino's outcomes.

- **Create data dashboards** so that all staff and community partners know how the current data reflects the outcomes of children and families being served by the agency.
- **Clarify strategies, practices and expectations** on how both the agency and the community can partner to improve the lives of children and families being served.
- **Align data outcomes** with contract deliverables with community providers.
- **Develop review points within the organization** to examine practice and impact on data. An example could be a quarterly review of the decisions from RED teams, the outcome of the SDM assessments conducted, and entry rate into care.
- **Identify trends** of substantiations, demographics, reason for removal and identify any areas for improvement including training, coaching, and consistency in policies and practices.

IMPLEMENTATION PLAN

The table on the following pages provides recommended tasks and activities as well as a suggested timeline for engaging in these activities over the next 12 months. These are suggestions and the timeline should be adjusted within what is realistically achievable and desired by Mendocino's FCS.

DRAFT **Proposed Tasks & Activities for the Implementation Plan**	**Start**	**End**	**2016**				**2017**			
			Sep.	Oct.	Nov.	Dec.	Jan./Feb/ Mar	Apr/May/ Jun	Jul/Aug/ Sep	Oct.
Leadership meet with consultant to create strategic plan to communicate the results of the organizational assessment	10/1/16	11/1/16								
Overview of SCARF model to staff	11/1/16	11/1/16								
Leadership present results of organizational assessment with some concrete strategies for how Mendocino's FCS plans to address threats and increase rewards	11/1/16	11/16/16								
Leadership (including supervisors) to receive training on the SCARF model such that supervision begins to adopt a retention focused approach	11/1/16	11/1/16								
Development of overall implementation team	11/1/16	ongoing								
Development of teams to guide: SDM, SOP, Entry Rates, Caseload Study,	12/1/16	ongoing								
Conduct a caseload size/workload study	12/1/16	1/1/17								
Implement RED team procedures for immediate referrals	11/1/16	ongoing								

DRAFT **Proposed Tasks & Activities**	**Start**	**End**	Sep.	Oct.	Nov.	Dec.	Jan./Feb/ Mar	Apr/May/ Jun	Jul/Aug/ Sep	Oct.
Shift to a 5 day week work schedule (discussion to begin in November)	1/6/17	10/1/17								
Mendocino FCS leadership meet with county counsel and staff with expert consultant to develop strategies to improve communication	12/15/16	3/1/16								
Coaching of key Core Practice Behaviors (SOP, SDM)	1/31/17	6/1/17								
SOP Training to Specific to Creating Behaviorally Case Plans	2/1/17	3/1/17								
Refresher trainings of SDM	2/1/17	4/1/17								
Permanency Roundtables										
Establish communications protocol and process for feedback regarding CFSR Case Reviews and other ad hoc teams	1/1/17	6/1/17								

CONCLUSIONS

In our attempt to diagnose the organization and provide recommendations on how to address the presenting issues, the team unanimously came to the same conclusions. As a child welfare organization, there are a number of existing strengths to build upon, and while FCS has the potential to become a leader in child welfare policy and practice, there a number of overarching issues that must be addressed immediately to bring this organization out of its state of crisis, decreasing the many perceived threats and increasing the rewards. It is imperative that Mendocino FCS move to a five-day work week to successfully combat the many stressors, improve child welfare outcomes for children, and improve relationships within the community. Until these issues are addressed, no meaningful change can occur. These issues and challenges can be successfully addressed through additional support, training, technical assistance, and leadership.

The review team would like to acknowledge the enduring passion and commitment of the staff who remain dedicated to serving Mendocino County's most vulnerable children and families. The staff who work at FCS deserve recognition for the tenacity and resilience they have demonstrated. We thank them for their time spent with researchers answering questions and providing their thoughtful reflections on local child welfare practice.

Appendices

Appendix A: Overview of the Weisbord's Six-Box Model

Marvin R. Weisbord's Six-Box Model[17], is commonly used as a way to assess an organization and provides a systematic way to analyze relationships among variables that influence how the an organization is managed and possible areas for improvement. The model consists of seven areas of the organization: purposes, structure, relationships, rewards, leadership, helpful mechanisms, and attitude toward change.

Box One: Purposes

- Are division and program goals clear and agreed upon by all? Are the mission, vision and guiding principles clear and agreed upon?
- Are program goals linked to the whole (division, agency, and community) or do they exist as part of a silo?
- Is the organization being run as if its goals with those stated

Box Two: Structure

- Are role expectations clear and agreed upon?
- Is the way responsibility and authority are delineated helping or hurting goal achievement?
- Are there important organizational tasks falling through the cracks?
- Does the current structure positively impact client satisfaction and outcomes?

Box Three: Relationships

- How much do people need to work together, especially across programs and in collaborative efforts with the community? How well do people actually get along with each other?
- To what extent does conflict hurt performance?
- Are there existing mechanisms to manage conflict between programs or units?
- How do decisions made by one unit impact the work of others?

[17] Weisbord, M. (1978). Organizational diagnosis, six places to look for trouble with or without a theory. *The Journal of Group and Organizational Management, 1,* 4, 430-447.

Box Four: Rewards

- Is the organization rewarding (formal and informal reward system) what it needs to reward to achieve its goals?
- What do people feel rewarded or punished for doing?
- Are people motivated to perform?

Box Five: Leadership

- To what extent does the leadership monitor the six boxes to keep them in balance and address issues as they arise?
- To what extent does the leadership inspire a shared vision, encourage continuous improvement, lead by example, and foster a positive, “can do” workplace?
- How cohesive is the leadership team as it works to lead this division?

Box Six: Helpful Mechanisms

- Are organizational systems aligned with current goals? (e.g., reward system, hiring, orientation, training, performance management, communication, meetings, contracting, etc.)
- Are key processes aligned with stated goals? Are processes linked across programs and divisions when appropriate?
- Is there a feedback system in place to encourage learning from doing? (e.g., after action reviews)
- Is training effectively linked to performance improvement?
- Is there a system for all staff to identify problems and suggest solutions? Are suggestions listened to and acted upon when appropriate?
- Is a system in place to regularly measure customer satisfaction and employee satisfaction; and is that feedback used to make improvements?
- Is there consistent practice among staff in working with families?
- Are there policies and procedures in place to support organizational processes?

Appendix B: Safety Organized Practice (SOP) Case Review Summary

Background

A Safety Organized Practice (SOP) case review process was completed on 5/18/16 – 5/20/16 as part of Mendocino County's Organizational Assessment conducted by UC Davis, Northern California Training Academy. The purpose of the case file reviews were to assess the depth and consistency of SOP and California Core Practice Model practice behaviors within its Child Welfare department.

Practices assessed include the following:

- Safety Organized Practice tools, practices and documentation
- Prevention and investigation practices; safety planning
- Engagement and teaming practices – Inclusion and ongoing collaboration with support networks
- Assessment and use of Structured Decision Making tools
- Case planning and service delivery
- Visitation plans
- Documentation and organization of case files
- Monitoring and adapting
- Transition and aftercare planning
- Concurrent planning/family finding/permanency planning

Methodology

Mendocino County is interested in determining the depth of SOP practice among Supervisors, Social Workers, and support staff. A total of eight (8) referrals (4 from 2014 and 4 from 2015) and six (6) cases (3 from 2014 and 3 from 2015) were completed for a total of 14 case file reviews. Social Worker interviews were not completed as part of the SOP case file

reviews; instead, focus groups were conducted as part of the broader organizational assessment process.

Case file review breakdown:

Year	# Reviewed	Case/Referral	Service Component
2014	4	Referrals	Emergency Response
2014	1	Case	Family Reunification
2014	1	Case	Family Maintenance
2014	1	Case	Permanency Planning
2015	4	Referrals	Emergency Response
2015	1	Case	Family Reunification
2015	1	Case	Family Maintenance
2015	1	Case	Permanency Planning
TOTAL	14	Referrals & Cases	

Interviewer's Impressions

The following overall impressions were made based on the case file reviews conducted May 18 - May 20, 2016.

- Mendocino County has a strong history with SOP practice, which has been hampered by staff retention issues. However, key staff have been to many trainings and have pursued a clinical depth and approach to the work that is engaging, helpful and change oriented to the families that are served. The SOP unit is highly skilled at facilitation, SOP philosophy and structure and championing the practice.
- Social Work staff have varying degrees of SOP training, knowledge and experience. The majority of Social Workers (SWs) have not attended the SOP foundational training. Additionally, newer staff are still learning the practices and staff turnover over the past few years has impacted implementation efforts and consistency of SOP documentation.
- There is a systemic SOP family mapping process in place with all families that have a referral where it is needed and/or the child is at risk of being removed from the home. The process is well documented and contains harm and danger statements, safety goals

and safety network partnering between the agency and the family. This documentation is kept in a separate “SOP Folder” within the case file.

- Of the cases that had documented Family Team Meetings/SOP meetings, they had initial FTMs at the beginning of the case but did not hold subsequent meetings throughout the life of the case to ensure ongoing collaboration with support network (with the exception of one case who held several meetings throughout the life of the case)
- Most of the cases had some documentation of the support network had little to no documentation of ongoing collaboration/engagement of support network and aftercare safety planning.
- There were some case plans that had behaviorally specific objectives that aligned with the safety mappings and included the parent’s and safety networks voice, however most of the service objectives were focused on completion of services versus desired behavioral changes.
- Some SWs documented harm and danger statements/safety goals in case plans.
- SDM Safety and Risk assessment tools were completed on every case/referral, however the SDM Family Strengths and Needs Assessment (FSNA) tool was only completed for one of the cases reviewed.
- SWs exhibited a depth in practice and critical thinking in working with families that included expertise in family engagement, cultural humility, appreciative inquiry, strength-based and trauma informed practices.
- SWs utilize a variety of solution focused interviewing questions and techniques. There was some documentation of use of the three questions and scaling questions with families.
- In 2015, there was documentation of Red Team notes in two referrals.
- At least two workers documented SOP consistently throughout their case, receiving "Accomplished" and "Distinguished" scores for their practice

- SOP blue case files were found in most cases; well documented FTM/SOP meeting notes including the three questions, harm and danger statement, safety goals, support network, strengths, complicating factors, next steps, etc.
- There were several helpful forms and tools used by SWs to document safety plans and SOP with families, including documents entitled "Safety Plan", "Risk Reduction Plan", "Family Trajectory" form and "Family Empowerment Plan"
- There were particular areas of strength noted in case file documentation for 2014 and 2015 referrals and cases combined, namely in gathering input from family and organization of assessment information.
- There were particular areas of strength noted for 2014 referrals and cases combined, namely in gathering input from the child, family and others.
- There were particular areas of strength noted for 2015 referrals and cases combined, namely in gathering input from the family, organization of assessment information and the use of harm and danger statement in case documentation (Family team meeting/safety mapping notes, court reports, case plans, safety plans, case contacts).
- Visitation plans and documentation of progression of visits/family time were inconsistent. Some visit plans were very minimal (one visit per week for an infant).
- There was thorough documentation neatly filed in the case files; however there appeared to be no consistent standard for the organization of information in case files. Placement paperwork was consistently found to be in one specific section, however, the rest of the documentation was all filed together with no particular order (correspondence, health & education information, service referrals, service provider reports, drug tests, safety plans, etc.). It was difficult for reviewer to know where to look for information in case files.
- Expanding consistency of FTMs/safety mapping, safety network building with families, integrating SDM use and ongoing use of SOP practices throughout the child welfare continuum of practice reflected in the documentation of daily child welfare contact notes, court reports and case plans will continue to deepen SOP practice in Mendocino County.

- In future implementation efforts, it will be crucial for leadership at all levels and supervisors to continue to model SOP.

Best Practices/Supports for Social Workers

Mendocino County has implemented several best practice strategies aimed to increase depth of SOP practice to improve outcomes for children and families including but not limited to having a dedicated SOP unit, Facilitated Family Team meetings, Review Evaluate Direct (RED) team meetings, and various forms and tools.

The following tools/forms/practices were found in the case files and identified as examples of supports/best practices by reviewers:

1. RED Team (Daily; using Quad mapping tool)
2. FTMs are held for families utilizing mapping framework document
    a. FTM facilitators are full time staff members (internal staff)
3. Parent Empowerment Group notes included the use of SOP language increasing consistency of language for families and community partners.
4. In 2015, the reviewer noted a new form "Referral Assessment Check List" - summarized all pertinent information on one form
5. SOP blue files were found in most cases and included well documented FTM/SOP meeting notes including the three questions, support network, strengths, harm, complicating factors, next steps, etc.
6. There were several helpful forms and tools used by SWs to document safety plans and SOP with families, including documents entitled “Safety Plan", "Risk Reduction Plan", “Family Trajectory” form and “Family Empowerment Plan”. These forms provided clear, well written harm and danger statements, safety goals, and behaviorally specific action steps for the family.

7. A few case plans included documentation of Harm & Danger statements, Safety goals, and behaviorally specific action steps (mostly focused on service compliance vs. desired behavioral changes).
8. A few cases had documentation of "Treatment team meetings" utilizing SOP three column map (w/Therapist, child, caregiver, parent, service providers)
9. A couple of the screener notes included documentation of the three questions.

Reviewer's Impressions of SOP Practice

What is working well?	What are the worries?	What needs to happen next?
General Knowledge of SOP		
• All SW's demonstrated a knowledge of SOP engagement strategies including the use of cultural humility, strengths based and trauma informed practice, and how to assess a family for harm and danger. • All pertinent information appears to be printed and filed in the case files • SDM Safety and Risk assessment tools were completed on every case/referral • In 2015, saw Red Team notes completed for a couple of referrals • In 2015, saw a new form "Referral Assessment Check List" - summarized all pertinent information on one form • At least two workers documented SOP consistently throughout	• Safety mappings/FTMs appear to be routinely done at the beginning of a case; however only one case reviewed included evidence of ongoing meetings throughout the child welfare continuum of service (with the exception of 1 case who held several meetings throughout the life of the case). • Files appeared to be disorganized and not clearly labeled. There was no consistent filing system and it was difficult to know where to find information. • SDM FSNA tool not completed consistently (only one case) • Case plans had well written and clear objectives and specific action steps but were service oriented (focused on completion of services vs. demonstrating desired behavior changes and	• Develop a consistent documentation and filing procedure; create file tabs to organize files (case plan, referrals, releases, HEP, correspondence, drug testing, etc.) • Develop a visitation procedure to ensure consistent documentation of visits, outline standards/guidelines for progressive visitation and tips for supervision and mentoring of parents during visits, etc. • Develop templates for Behaviorally Based case plan language for staff. Encourage staff to attend case planning training, review of SMART objectives and developing plans using family centered language. Utilize the Case plan field tools developed by Karen Martin/CalSWEC. Provide in-house training and

the case, receiving "Accomplished" and "Distinguished" scores for their practice

- Use of "Safety Plan" documents, "Risk Reduction Plan" documents
- SOP blue files found in most cases; well documented FTM/SOP meeting notes including the three questions, support network, strengths, harm and danger statements, safety goals, complicating factors, next steps, etc.....nice variety of documents and visual tools such as the "Family Trajectory" form and "Family Empowerment Plan"; visuals for the family with harm and danger statements, safety goals, and behaviorally based action steps
- Three cases had well documented SOP/FTM/Safety mapping meetings with the family and support network present (primarily in 2015).
- Safety mapping meetings have depth and focus not just on the surface issues but the underlying drives that families have that put children in danger of experiencing child abuse and neglect.
- There is evidence that the safety mapping that is done helps strategize ways increased safety over time)
- No consistency with visits….some visit plans were very minimal (one visit per week for an infant)…no consistent documentation of visits
- No Red Team notes found in any 2014 referrals/cases. Not sure when the County first implemented Red Teams.
- Most of the cases that had some documentation of the support network had little to no documentation of ongoing collaboration/engagement of support network throughout the life of the case or evidence of aftercare safety planning.
- It appears SWs rely on FTMs to develop Harm, danger statements, safety goals, and case plan objectives rather than developing the skills and expertise to develop these with the family (regardless of whether an FTM occurs).
- Outside of the safety mapping/FTM notes there was little consistent documentation of SOP practice found in case plans, court reports and contact notes.

mentoring around behaviorally based case plans that are focused on desired behavioral changes that demonstrate safety over time vs. successful service completion only.

- Consider using “Parent agrees to” rather than “Parent will” in case plan objectives to indicate a more collaborative practice.
- Expand the use of safety mapping/FTMs with families throughout the life of a case ER, FR, FM, PP, Adoptions) to ensure ongoing development, monitoring and adapting of safety goals, safety network, family strengths and needs; using it on a daily basis as a philosophy and tool rather than an event or task.
- Integrate the use of SDM into the SOP process to assist with focusing, decision making and articulation of safety goals and case plan objectives.
- Expand the use of SOP with permanency planning cases to further develop safety networks and permanency efforts for children in long term foster care. This may include creating/amending some current forms to include use with older youth (i.e. three column mapping document, Safety

to keep a child safe at home where they do not have to come in to foster care.

- Case transfer sheet found in a couple of cases - detailed information about the case to ease transition to new worker
- Use of Case Plan update forms noted in one case reviewed
- Several case plans had very clear, detailed and specific action steps associated with each service objective.
- One case documented the use of case conferences, treatment review meetings, and Risk reduction plans (similar to safety plans). The case documented ongoing collaboration with the family's tribe, the use of family finding and the use of a case transfer summary document. The parent in this case said "the SOP meeting was helpful and eye opening" and wondered when there would be another one scheduled. three questions and scaling questions used/documented. The treatment review meeting notes documented child's spiritual/cultural needs, strengths/goals...very well documented. There were trauma referrals made for children and mother.
- A couple of cases had a lot

circles for youth, etc.)

- Reflect SOP practice in contact notes, court reports and case plans. This may include development of templates with SOP language and inclusion of safety goals/behaviorally based objectives into case plans.
- Continue to build safety networks with families and partner to provide safety and effective behavior change for parents and children that keep children safe. This includes assignment of specific roles for each member of the safety network and ongoing communication with the network throughout the life of the case.
- Continue to model coaching throughout the organization to help build reflective skills of all staff. Consider enrolling supervisors and managers in the UC Davis Coaching Institute.
- Set up a mentoring program for newer workers with SOP "Rock stars" to increase consistency of practice among all staff. Create an in-house coaching/mentoring relationship between FTM facilitator and case managing SWs, (i.e., shared facilitation) to increase competence and

of SOP: documentation of Harm and Danger Statements, Safety Goals, SOP/FTM meeting notes in SOP file.

- A couple of cases had more than one FTM meeting. One meeting had older children in attendance. Support network was documented with specific roles in a few cases.
- One case had several safety plans completed throughout the life of the case (with Danger statements/safety goals included on safety plan form). There was use of a "Family Trajectory form" that included a scale from 0 Danger to 10 Safety and desired behaviors along the scale with associated trajectory of progressive visitation plan through reunification.... (Upgrade: include SDM on trajectory form)
- One case included a document: "Family Empowerment Plan" form (Included picture of a house with family activities listed in attic area, then listed a scale of 0 Danger to 10 Safety, Behaviorally based goals and action steps (steps 1 - 10) the agency would like to see the family complete along the continuum of the case to demonstrate safety over time and lead to Reunification –

ease of SWs doing their own safety mappings when needed.

- Ensure consistent safety planning (could be done in an FTM meeting or home visit) at the back end prior to case closure to engage the safety network to be part of safety plan after CWS involvement ends. This includes safety planning and network development with older youth prior to them aging out of care.
- Incorporate child's voice into Safety Mapping/FTM meetings utilizing three houses/Safety house tool, picture of child, etc.
- Consider creation of clear guidelines for consistent use and documentation of SOP throughout the life of a case.
- Consider a refresher training on SDM and the benefits of using the SDM Family Strengths and Needs assessment tool (FSNA) throughout the life of the case and particularly before each case plan update to ensure consistent and comprehensive to monitor and adapt to the changing needs of the family throughout the life of the case.
- Consider sending all staff to the SOP foundational training, including staff

(Reunification was depicted as the front door of the house)....a wonderful visual tool and very specific/clear for the family! Love it!).

- Family Empowerment group notes included danger statements/safety goals, providing consistency of language among the agency, family and service provider.
- One case had a total of nine safety maps documented in the case…five family team meetings and four case conferences….very well documented FTM/case conference notes with three questions, harm and danger statements, safety goals, safety network, safety network is detailed with specific roles, natural supports and service providers, of engagement and focus on family strengths.. Case plan and Court reports included danger statements/safety goals. Case plan included specific, clear action steps (mostly service oriented).
- One permanency planning case had a case plan that included harm & danger statements, thorough documentation of child's voice/needs/strengths, discussion about treatment services for child's trauma, documentation of child's support network (youth

who may have attended in the past (as a refresher). Following the foundational training, consider sending staff to all SOP Advanced training modules or request that these trainings be brought in-house.

- Consider developing an SOP Corner/focus area with posters, forms and supplies (three questions Mapping Grid, 4 Quad Mapping Tool, three houses, Safety house tool, markers, paper, etc.) to remind and support SWs in regular SOP practice.
- Consider developing templates/examples of SOP language for case plans, court reports, screener narrative, case contacts, etc.

placed with relative who
will maintain connections
to community of origin,
family and friends). TILP
case plan completed and
strength based.

Appendix C: Structured Decision Making (SDM) Case Review Summary

Background

A Structured Decision Making Review case review process was completed on 5/19/16 – 5/20/16 as part of Mendocino County's Organizational Assessment conducted by UC Davis, Northern California Training Academy. The purpose of the case file reviews were to assess the depth and consistency of SDM within its Child Welfare department.

Review Summary

The sampling contained opened and closed referrals and cases from 2014 and 2015. There were six cases that were reviewed and 8 referrals. Of the cases there were two FM cases, two FR cases and two PP cases reviewed. Each of these cases remains open as of review date. Of the referrals that were reviewed there were four 10 day referrals and four Immediate Response referrals. These cases were reviewed for SDM Reunification Reassessment, Family Strengths and Needs, Risk Reassessment and the Safety Assessment. Reunification cases were reviewed only for the Reunification Reassessment and the Family Strengths and Needs assessment. All other cases were reviewed for the Risk Reassessment, Family Strengths and Needs and the Safety Assessment. All the referrals were closed. The reviews were completed in two designated days which consisted of CWS/CMS, Structured Decision Making, and file reviews for each case and referral.

Overall Impressions

The following overall impressions of the utilization of Structured Decision Making (SDM) in Mendocino County, Health and Human Services Department were made based on cases/referrals reviewed:

Reviewer's Impressions of SDM Utilization

What is working well?	What are the worries?	What needs to happen next?
General Use of SDM Assessment Tools		
• The Hotline screening tool and Response priority were completed 100% of the time. • The majority of Safety Assessments recommended actions that were accurate. Actions taken matched the final tool recommendation. • The majority of recommended actions for Risk Assessment were accurate. Actions taken matched the final tool recommendation. • The majority of the cases had the Reunification Reassessment completed and the actions met the CWS/CMS documentation.	• 50% of the Hotline tools were completed late. • The majority of the Safety Assessments were created late. • The Risk Assessment tool was created with missing information in CWS/CMS 25% of the time. • Family Strengths and Needs Assessment tool was completed on only one out of 6 cases. • The Reunification Reassessment was completed four out of the six cases reviewed and 50% of the factors checked on the tool did not match the CWS/CMS documentation. • There were Risk Reassessments completed on in-home involuntary cases however both were late. • There were no Safety Assessments completed. • The case files were hard to review due to the organization of the files.	• Accurate completion of the Hotline tool is immediately upon receipt of the call. Review of the policy with the social workers and the supervisors. • Completion of Safety, and Risk, tools on consistent (100%) basis with narratives and tools matching. However 63% of the Safety Assessments were completed late. Refresher training concerning the policy and procedures is recommended. • Accurate completion of Family Strengths and Needs Assessment needs to be addressed and a refresher training on when to complete and why is recommended. • In-home involuntary cases had two late risk reassessments and no safety assessments. Training on the policy and procedures is recommended. • Internal SDM case reviews for all programs are recommended.