CDSS
CALIFORNIA HEALTH & HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • www.cdss.ca.gov
JENNIFER TROIA
DIRECTOR
GAVIN NEWSOM
GOVERNOR

Alameda County Department of Children and Family Services 2026 On-Site Visit Findings and Recommendations

Introduction

As the single state agency responsible for the administration and supervision of the Child Welfare Services (CWS) system, pursuant to Welfare and Institutions Code (WIC) section 10600, the California Department of Social Services (CDSS) is charged with providing oversight to county child welfare agencies that administer direct services to children and families. The CDSS performs various oversight activities to ensure that services protect children, strengthen families, and are focused on safety, permanency, and well-being. In this instance, as described in more detail below, CDSS conducted a review pursuant to subdivision (c) of WIC section 10605 after receiving information suggesting that the Alameda County Department of Children and Family Services (DCFS) may be out of compliance with regulations related to timely response to alleged child abuse and prompt delivery of services to foster youth, and timely and accurate documentation of service delivery.

Background

In October 2023, the Alameda County Board of Supervisors requested that CDSS conduct an assessment of the Alameda County DCFS due to concerns regarding services provided to children, particularly those with complex care needs. On January 18, 2024, the CDSS conducted an on-site visit review, which included a thorough case review analysis of 26 children placed at the Alameda County Assessment Center. This review focused on cases involving extended stays and multiple placements. Following this on-site review, the CDSS issued a Findings and Recommendations Report to DCFS on July 12, 2024, outlining identified strengths in Alameda County DCFS practices, key challenges, and recommended next steps.

In 2024, at the direction of the Joint Legislative Audit Committee, the California State Auditor conducted a comprehensive audit of Alameda County DCFS. In September 2025, the Auditor released its report, titled *2024-108 Alameda County Department of Children and Family Services: Delayed Investigations and Support Services Risk the Health and Safety of Youth*. The report found that Alameda County DCFS failed to meet state guidelines pertaining to required timelines for initiating investigations in approximately 50 percent of cases. The audit also determined that Alameda County DCFS did not consistently ensure timely access to necessary physical and mental health services for youth and failed to properly report serious incidents occurring at the county Transitional Shelter Care Facility, which closed in July 2024. Since the Transitional Shelter Care Facility is closed, the findings specific to that facility that were captured in the auditor's report will not be further addressed in this report. Additionally, the report identified that an ongoing workforce crisis within Alameda County DCFS has significantly impacted the department’s ability to perform effectively in these areas,

contributing to gaps in documentation and service delivery. Due to ongoing and increasing concerns raised by stakeholders regarding the findings of the California State Auditor's report and Alameda County DCFS's response to its recommendations, a request was made for the CDSS to conduct oversight and an assessment of Alameda County DCFS practices through an additional on-site review.

On March 26, 2026, a team from the CDSS conducted an on-site visit to the Alameda County DCFS. The CDSS team was comprised of 19 staff, primarily management and leadership level, who oversee front-end policy, system improvement, child welfare workforce challenges, and family permanency and support services. The purpose of this visit was for the CDSS team to use a child welfare lens to assess the county's front-end practices, access to and timeliness of services, the county's workforce crisis and its impact on service delivery, capacity to implement effective corrective actions, and other areas of child welfare practice needing attention. The on-site visit consisted of an entrance and exit conference with Alameda County DCFS leadership and program managers, individual social worker interviews, and separate focus groups for social workers and social work supervisors. The Alameda County DCFS staff who participated in the interviews and focus groups brought expertise spanning the lifecycle of a case: from the initial investigation of a referral to the various phases such as dependency, independent living, and family reunification. The broad range of their professional backgrounds ensured that multiple perspectives on the work performed by Alameda County DCFS were represented to support the overall findings. Concurrently, CDSS conducted a case review of 67 referrals and 52 foster care cases. The case review process included reviewing documentation captured in both the Child Welfare Services/Case Management System (CWS/CMS) and hard case files to better understand practice across several decision points.

Qualitative Data Analysis Process and Case Review Methodology

The CDSS conducted qualitative data analysis using information gathered during the on-site review. Through the application of qualitative coding methods, the CDSS organized, de-identified and coded the interviews and focus group data into categories that allowed themes, patterns, and additional insights to emerge. These qualitative findings helped identify areas of policy and practice concern which were then explored further and supported through the concurrent case review process.

Case reviews included both structured data elements and qualitative review of referral or case narratives to identify patterns in practice, decision-making, and system-level patterns. A random sample of 52 child welfare foster care cases was reviewed. Cases were selected to ensure sufficient time in care to assess placement stability, family finding, service provision, and relationships with siblings and kin. Inclusion criteria required that the removal date occurred on or before March 13, 2026, and that the episode was either still open or had an episode end date on or after July 1, 2025. To ensure sufficient time to evaluate practice, cases were required to have a start date on or before December 13, 2025, providing at least three months of case activity.

Additionally, cases were required to either still be open or have a case end date on or after October 1, 2025, ensuring they overlapped with the review period.

CDSS also completed a random sample of 50 reviews focused on child abuse hotline intake, emergency response, and investigations (front-end focused reviews). These reviews were limited to referrals received between July 1, 2025, and March 13, 2026. Twenty-five of these reviews focused on referrals that were evaluated out (EO) and included criteria related to screening decisions, use of Structured Decision Making (SDM) tools[1], and timeliness. The other twenty-five reviews focused on investigation practices in the domains of timeliness, quality of assessments, use of SDM tools, and documentation. Following the initial review of the 50 front-end focused reviews, an additional 17 referrals were added to the review to explore emerging themes.

Review Findings

The following themes, presented throughout this report, incorporate qualitative information gathered from the on-site review as well as quantitative and qualitative findings through case review. The following themes are organized to present the data collected, followed by a narrative interpreting the findings and identifying compliance and practice concerns. The findings collectively suggest that while foundational practice requirements are present in many cases, the documentation, agency infrastructure, tool compliance, and continuity of staff work do not consistently reflect the standards necessary to ensure child safety, permanency, and well-being.

Hotline Practices and Investigations

Regarding the Alameda County DCFS child abuse hotline practices, the following themes were identified from the on-site interviews and focus groups:

- When new allegations are reported to the hotline on an open case, the case is often assigned to the current social worker for investigation under an outcome of “evaluate out for case management.” This poses challenges as the current social worker may not be skilled in emergency response and it could negatively impact the established relationship the social worker has with the family, and does not align with the MPP requirements that all referrals shall be evaluated using the emergency response protocol described in the regulations (cited below in the Findings section.)

- 10-day referrals are not always assigned immediately, reducing the number of days a social worker has to respond to the referral.

[1] Structured Decision Making (SDM) tools are evidence-based, standardized assessment frameworks used in child welfare practice. These tools guide social workers through critical case points (such as intake, safety planning, and risk assessment) by relying on objective, research backed criteria to ensure consistent, equitable, and child-focused interventions.

- Intake/hotline workers do not always cross report referrals to another county, resulting in additional tasks for the emergency response (ER) social worker (i.e. having to handle the cross-reporting process themselves or occasionally having to investigate and travel out-of-county).

- Staff reported lengthy wait times when calling the Alameda County DCFS hotline. The CDSS conducted a hotline check, in which they experienced longer than average wait times, occasionally exceeding an hour before calls were answered or abandoned.

Regarding the Alameda County DCFS child abuse hotline practices, the following themes were identified through the case review portion of the review:

Evaluated Out Referrals

- Of the initial 50 referrals reviewed, 25 were EO. Of those 25 EO, 18 referrals (72%) had an associated SDM Hotline Tool with missing or incomplete information, and one was missing the Hotline Tool completely. Counties utilize this assessment tool to determine if a child abuse or neglect report meets the threshold for an in-person investigation or if a community referral for services and/or supports is more appropriate.

- The average number of days between the date of screening (the day the Agency received the referral) and the date of referral closure was 12.83 days, and five referrals were closed more than 10 days after screening.

- There was a pattern of insufficient information documented regarding the reason for the determined EO response. The documented screener narrative response rationale for EO referrals and the response determination rationales for 12 referrals (48%) contain the justification, “No WIC 300 abuse or neglect,” and “does not meet WIC 300 requirements.” Six referrals (24%) use “Allegations are vague” as a response rationale. The rationale in four referrals (16%) document that there are “no current” marks, bruises or injuries for referrals alleging physical abuse.

- In two referrals when a case was already open, the referral was EO to “case management,” raising concerns about adequate assessment, response determinations, and procedures for new allegations reported on youth in an open case, who are placed in out of home care.

Investigated Referrals

The sample included a total of 42 investigated referrals. The original sample included 25 referrals; the supplemental sample included 17 referrals. Findings for the 42 investigated total referrals include:

- Documentation indicated that no safety networking took place in seven investigations (17%). In 14 investigations (34%), there were identified supports documented. Safety networking involves the Agency identifying and collaborating with the family's informal support system (extended family, friends, and community resources) to create a safety plan and ensure the safety of the child.

- There were no collateral contacts in eight investigations (20%), representing a gap in the breadth of information gathered during the investigation.

- There was a failure to meet required timelines (24 hours for immediate responses or a 10-day response) in five investigations and documentation was incomplete in five investigations. This suggests that the pace and the quality of investigation practices require attention.

Supplemental Referral Review

The supplemental referral review includes 17 referrals. Of the 17 referrals in the supplemental review, one did not have a complete Hotline Tool:

- There is an incongruence between the Hotline Tool decision response time and the associated response priority in CWS/CMS.

    - Of the 16 referrals with a completed Hotline Tool, the Hotline Tool and the documented response priority did not match in 11 of the referrals (69%). Of those identified 11 referrals, 10 of them were downgraded, in that the Hotline Tool indicated an immediate response, but the CWS/CMS response priority was listed as a 10-day response without an override in WebSDM.

    - For the 10 referrals that were downgraded in CWS/CMS from an immediate response to a 10-day priority, the average number of days until the first attempted or completed contact was 2.7 days.

    - In six of the 10 referrals that were downgraded from an immediate response to a 10-day priority, the process and response time decisions governing these overrides were not clearly articulated in the documentation. Further, the county policy governing these overrides was not clear. In these referrals, "I-credit per strategic intervention" and "10-day strategic intervention" was noted to justify the decision.

- Referrals appeared to pass through multiple hands before being investigated, which may dilute both accountability and comprehension of the referral circumstances by each additional staff member. With an average of 6.5 staff assignments per referral in the supplemental sample of 17 cases and recurring mismatches between CWS/CMS assignments and SafeMeasures completed

contacts, the data points to a workflow issue that diffuses decision-making capacity and accountability.

Regarding the Alameda County DCFS practices for investigating referrals timely, the following themes were identified from the on-site interviews and focus groups:

- The high volume of Immediate Response (IR) referrals screened in daily, combined with current staffing vacancies, has overwhelmed social workers. As a result, social workers prioritize IRs over existing 10-day referrals, which delays the response time for 10-day referrals beyond the required timeline.

- Swing shift social workers are tasked with completing outstanding IRs from the day shift while simultaneously responding to new IRs that arise during their own shift. This overlap in responsibilities can lead to slower response times and increased workload for swing shift staff.

- New 10-day referrals are assigned on staffs' "flex days" and at the end of a workday before a flex day or a weekend, limiting a timely response. A flex day is when a staff person has a scheduled day off due to working longer shifts during the rest of the 40-hour work week.

- The referral assignment process relies on rotation of staff rather than workload or staff capacity, leading to an uneven distribution of work.

- The staff were not aware of a formal policy guiding how to handle delays in a timely response to a referral. Informally, a supervisor or program manager is informed and the reason for the delay may be, but is not always, documented.

- Social workers in the Emergency Response Unit (ERU) respond more promptly to referrals when they have authorized permission to adjust their schedules to accommodate family needs.

- Staff were often required to travel far distances between referral assignments, which impacted their time management. As a result, travel time was noted as a barrier to timely investigations, assessments, and family engagement.

Regarding the Alameda County DCFS practices that result in referrals being open for greater than 30 days, the following themes were identified when coding the notes from the on-site interviews and focus groups:

- A high referral volume and large caseloads create time management challenges, limiting the ability to close cases within 30 days.

- Specific circumstances sometimes affect the ability to close referrals within 30 days, such as the need to monitor child safety, parent sobriety or mental health

needs, as well as required follow-up with law enforcement or other community-based organizations.

Hotline Practices and Investigations and Findings

Staff identified systemic inefficiencies in the intake, assignment, and workload management processes. These inefficiencies, when combined with high referral volumes and caseloads, have contributed to delays in timely responses to referrals. Based on feedback provided by staff, the county appears to experience challenges with referral routing that impact assignment and case management transfer protocols. Staff feedback suggests that examining patterns of case transfers between social workers or units, evaluating the necessity of these transfers, and assessing how continuity is maintained during transfers may provide additional context regarding these challenges. Lastly, repeated shifts in decision-making and documentation across multiple staff, particularly during the early stages of intake and investigation, can fragment case knowledge, reduce ownership over outcomes, and increase the likelihood that important information will be missed or inadequately acted upon.

During the case review, it was identified that Hotline Tools were not consistently completed. According to the SDM Policy and Procedure Manual, the county is required to ensure a Hotline Tool is completed whenever a referral is or will be created in CWS/CMS. Additionally, there was a lack of documentation on why a referral was EO. Per the child welfare services regulations in the CDSS's Manual of Policies and Procedures (MPP), when a referral is EO, the following must be documented: the rationale for the decision, supervisor approval, and the name of the agency to which the family was referred, if applicable (MPP §§ 31-105.17-.173). Adhering to these policies is essential for ensuring the proper use of EO determinations and for maintaining accurate records.

An identified concern from the on-site interviews and focus group was the practice of assigning new referrals with new allegations on open court cases to the case-carrying social worker. The case-carrying social workers may not always have the required training or background to effectively and accurately investigate a child abuse referral. This practice does not align with the MPP requirements that all referrals shall be evaluated using the emergency response protocol described in the regulations. (MPP, §§ 31-101.1-101.4). It is also inconsistent with the CDSS's guidance in All County Letter (ACL) 17-27, which requires CWS agencies to respond to any new allegation on a child in an open case or referral using the same protocols as any other referral. In addition, the MPP section 31-101.2 specifies that a social worker skilled in emergency response should investigate new allegations. As also discussed in ACL 17-27, having an experienced emergency response social worker investigate a referral on an open case prevents negatively impacting the working relationship between the case-carrying social worker and the family.

The practice of not closing out referrals within 30 days does not conform with the requirements in MPP section 31-101.5. That regulation provides that, within 30 calendar days of the initial in-person investigation or removal, whichever occurs first, the social worker must determine whether child welfare services are necessary. If services are not necessary, the referral must be closed. It also does not align with guidance in ACL 17-28. The guidance outlined in ACL 17-28 states that to safeguard the welfare of vulnerable children while giving CWS staff adequate time to investigate and assess safety, CWS is instructed to begin the 30-day count from the initial removal or in-person investigation, but no later than 10-days following the original report. That ACL also clarified that ER referrals are not intended to remain open beyond 30 days.

Additional concerns included delays in 10-day referral assignments, prolonged hotline wait times, significant travel due to the county's geographical size, and the impact of prioritization of IR referrals over 10-day referrals. Prioritizing IR referrals is appropriate; however, Alameda County's high referral volume and limited workforce capacity affect its ability to respond to all referrals timely. Consequently, prioritizing IR referrals delays 10-day response timelines and contributes to increased stress when social workers receive IR referrals on a daily basis. Staff also identified a lack of formal policies to assist social workers in conducting timely investigations.

Family Finding and Engagement, and Placement with Relatives

Regarding Alameda County DCFS' practice related to family finding and engagement, and subsequent placement with relatives, the following themes were identified from the on-site interviews and focus groups:

- The primary responsibility for family finding rests with the Dependency Investigator Unit and the Placement Unit, supported by a single child welfare social worker dedicated to this role. However, inadequate information-sharing within these units and during case transfers hinders the continuity and effectiveness of family finding efforts.

- High caseloads, understaffing, and limited county resources are barriers to family finding efforts.

- The Resource Family Approval (RFA) process typically takes three to six months for family member approval. However, Alameda County DCFS has experienced a significant backlog in its placement unit, which has caused additional delays in the RFA process for family members. As a result, children are being placed in non-relative homes for longer periods than may be necessary.

- Ongoing family finding and re-engagement efforts are case specific and are regularly influenced by the likelihood of reunification occurring. Staff reported that they were not certain of the county policy for reengaging previously ruled out family members.

- Staff identified Casey Family Programs (CFP) as a family finding resource but noted that the process regularly exceeds 30 days. The process begins with a referral from the county child welfare social worker to CFP for family finding services. CFP then conducts the family finding.
    - When the CDSS participated in an electronic and hard file case review, the CDSS did not note any referrals to Casey Family Programs in the case sample pulled.

Regarding Alameda County DCFS' practice related to family finding and placement with relatives, the following themes were identified from the case review portion of the review:

- Of the 52 cases reviewed, 44% of children were currently placed with relatives or non-related extended family members (NREFMs).

- Of the 52 cases reviewed, 30 involved children with siblings in foster care. Amongst those, 40% were placed with all their siblings, 27% were placed with some siblings, and 33% were not placed with any siblings in foster care.

- Of the 52 cases reviewed, 15 children experienced placement changes during the review period. Of these 15 placement changes, 10 changes (66%) were made to preserve family connections. Specifically, four placement changes were to reassess for sibling placement, and six placement changes were to reassess for relative/NREFM placement.

- Staff generally made identifiable efforts to locate family members. However, once families were identified and services were determined, documentation of subsequent action was often absent or insufficient. Of the 29 children who were not placed with relatives, 48% had sufficient documentation of the reason the child was not placed with relatives/NREFMs, 35% had no reason documented, and the remaining 17% had insufficient documentation, with the last documented update being the initial reasoning for not placing with a relative/NREFM. There were no updates on the continuing efforts to place with a relative/NREFM throughout the child's time in out-of-home care.

- There was limited evidence in the case files that identified family members were systematically assessed for placement, engaged in Child and Family Team Meetings (CFTMs), or provided with the information and support necessary to move forward with becoming a placement resource or maintaining connections with the youth in foster care.

Family Finding and Placement with Relatives Findings

Alameda County's Family Finding efforts lack consistent coordination and sharing of information across programs. There is also a lack of clarity regarding the roles and responsibilities of family finding and placement amongst placement, RFA, and case-carrying social workers. In addition, there is only one child welfare social worker who has a dedicated role to conduct family finding. High caseloads, understaffing, and limited resources for staff impact timely identification of relatives for placement.

The RFA process typically takes approximately 3 - 6 months to receive approval. When this timeline is combined with an existing backlog in the placement unit, it results in children remaining in non-relative homes longer than necessary. In a situation where a relative is ineligible for emergency placement, the county could still explore other options with the family while initiating the RFA process (through the county or Foster Family Agency), such as considering them for a "compelling reason" placement pursuant to WIC section 16519.5. The WIC section 16519.5 and RFA Written Directives Version 8.0, Sections 3-01(a)(21) and 4-09 provide for a more expeditious placement of children with relatives. This approach does require completion of initial health and safety checks and background clearances, with remaining approval steps allowed post-placement. The data reflects that Alameda County may not use these processes on a regular basis to expedite placement with relatives.

As identified in the case reviews, placing all or some siblings together occurred in 66% of relevant cases. According to WIC Section 16002(a)(1), siblings will be placed together, unless it has been determined that placement together is contrary to the safety or well-being of any sibling.

In instances where siblings were not placed together, reasons that were noted included, but were not limited to, the following circumstances:

- The available placement could not accommodate two or more siblings.
- A relative caregiver could only care for one sibling.
- Half- or stepsiblings were placed with their biological family who were not related to the case-focused child.
- The case-focused child did not want to change placements to accommodate having both siblings in one home.
- The sibling required a higher level of care.
- The sibling was a non-minor dependent.

- Placement decisions prioritized the permanency and best outcomes for the case-focused child.

- The behavior and actions of the sibling would jeopardize the safety of the case-focused child if placed together.

Lastly, there is not a clear or consistent policy or guidance for reengaging previously ruled out family members and ongoing family finding efforts vary by case and reunification likelihood. This was evident through the case reviews, in which one of the most substantial patterns identified across the foster care sample was the disconnect between family finding efforts and meaningful follow-through. While the case reviews indicated that staff demonstrated a reasonable ability to identify relatives and family connections, the documented action often ended with identification.

Senate Bill (SB) 354 (Ch. 687, Stats. 2021) amended the law to clarify the juvenile court's ability to authorize placement with a relative who has been previously denied approval as a resource family, if the placement does not jeopardize the health or safety of a child. In 2022, the CDSS issued guidance on implementation of the changes to the law made by SB 354 in ACL No. 22-33. Nevertheless, the case reviews reflects that DCFS has not adopted consistent policy or practices for reevaluation of relatives.

Overall, the findings suggest that Alameda County DCFS would benefit from establishing clearer practice guidance, defined expectations, and sustainable accountability mechanisms that bridge the gap between family identification and active family engagement. This includes documented timelines for follow-up, assignment of responsibility for outreach, and consistent tracking of outcomes to determine whether an identified family member ultimately became a placement or support resource. Additionally, it should be noted that while areas needing improvement were identified, the case review also reflected positive family finding efforts, as placement changes were mostly due to reassessments of sibling placements or a relative/NREFM placements.

Family Visitation

Regarding Alameda County DCFS' family visitation practice, the following themes were identified from the on-site interviews and focus groups:

- There is a lack of adequate visitation space within the county. The county has one primary visitation center, The Gathering Place, and visitations requiring a dedicated facility exceed the capacity which it can accommodate.

- Transportation for children and families to visitation spaces poses a barrier to visitation, exacerbated by the county's large geographic size and the high number of youth placed out of county.

- Case-carrying social workers handle all the administrative tasks related to visitation. The lack of support for administrative tasks adds to the daily workload, with each visit necessary on a social worker's caseload, leading to further delays in documentation and other service deliveries

- There is a lack of collaboration and visitation courtesy protocols between Alameda County DCFS and other counties in which their youth are placed.

- Sibling visits are impacted by limitations in visitation settings, as they are not always accommodated within visitation centers.

Regarding Alameda County DCFS' family visitation practice, the following themes were identified from the case review portion of the review:

- Of the 30 case files in which a child had siblings in foster care with whom they were not placed, sibling visitation occurred consistently for 37% of the children and inconsistently for 63% of the children. Of the 19 children that had inconsistent visits, there were documented reasons for this in 32% of the cases.

- Per case file documentation, family visitation was not applicable to two cases. Of the 50 cases in which family visitation is expected, it took place consistently in 46% of cases.

- Of the 52 case files reviewed, Alameda County DCFS made efforts to maintain children's relationships with family members in 50% of the cases.

Family Visitation and Findings

County staff identify family visitation as one of the most difficult parts of ongoing case management due to the lack of supportive resources, capacity, and coordination challenges. Case carrying social workers are responsible for all visitation-related administrative tasks, which contribute to workload strain and highlight the need for dedicated administrative support. There is limited visitation space to meet demand and sibling visits are not always accommodated which ultimately affects the effectiveness of visitation. As addressed by the CDSS in ACL 15-100, WIC section 16002 requires that county CWS agencies make efforts to place siblings together, and if they are not placed together, to provide frequent visitation.

Additionally, staff identify that the transportation required, particularly for youth placed out of county, further impacts the consistency of visitation. Visitation practices should align with federal guidance that focuses on meaningful family time as a critical step towards reunification. (See ACYF-CB-IM-20-02). Per All County Information Notice (ACIN) I-02-26, clear and practical strategies for addressing challenges when implementing family visitation are key to supporting successful outcomes. It is important that social workers identify these barriers and document how they are addressed within

the case plan as it strengthens accountability for the agency while allowing family progress to be tracked over time. Strategies to proactively address logistical barriers, such as transportation, could include using agency vehicles, coordinated carpools, ride-sharing services, or providing transportation vouchers, as appropriate, to ensure family members participate consistently in family visitation without interruption.

Service Provision

Regarding Alameda County DCFS' service provision delays, the following themes were identified from the on-site interviews and focus groups:

- Agency-related delays include supervisor approval of referrals, inconsistent communication between units, and difficulties identifying providers for youth in out-of-county placements.

- Placement instability delays service provision, particularly for youth with complex care needs, as youth may not remain in one placement long enough to establish services.

- Provider-related delays stem from provider staff shortages, limited availability, waitlists, and constrained community resources.

- Delays in medical services are typically related to Medi-Cal issues, including presumptive transfer of responsibility for specialty mental health services when a child is placed in another county, and timeliness challenges with private insurers.

- Service provision delays are further exacerbated for youth needing specialized services, including those services that can meet language access needs.

- Staff reported an inconsistent utilization of the Child and Adolescent Needs and Strengths (CANS) assessment to inform services. When the CANS is used, staff report delays in receiving results. According to data from the Continuum of Care Reform (CCR) Dashboard, which extracts Integrated Practice (IP)-CANS data from the California Automated Response and Engagement System-Live (CARES-Live) system, Alameda County child welfare's documented timeliness of initial IP-CANS has averaged 0%-1% timeliness since Quarter 4 of 2023. County child welfare agencies have been required to enter IP-CANS data into the CARES-Live system since 2021, per ACL 21-27.

- External Service Providers and service provision delays:

    - There is limited Short-Term Residential Therapeutic Program (STRTP) capacity within Alameda County, which contributes to a reliance on out-of-county placements. According to data from the CCR Data Dashboard, which extracts STRTP data from CWS/CMS,

70.97% of children in DCFS's custody who were placed in an STRTP were in an out-of-county placement in Quarter 4 of 2025.

- STRTPs and Foster Family Agencies schedule medical and dental appointments. However, support with transportation to these services is inconsistent and remains a barrier.

- There are communication gaps between the agency and external service providers in that there is not a formal follow-up procedure on agency referrals or a protocol for joint staffing or engagement with providers.

Regarding documentation challenges in relation to service provision, the following themes were identified from the on-site interviews and focus groups:

- Documentation (i.e. notes, reports, etc.) from external service providers is not provided to the agency across all cases, including youth with complex care needs who typically have multiple service providers.

- There is not a standard process to upload documentation into CWS/CMS; therefore documentation from service providers is filed into the hard file only. However, when the CDSS participated in hard file case reviews at the county office, the CDSS did not find many additional documents in the hard file.

- Staff reported making concerted efforts to obtain documentation from service providers through follow-up communication.

Regarding Alameda County DCFS' case plans and CFTMs, which are intended to identify and address individualized family service needs, the following themes were identified from the case review portion of the review:

- Case plan goals for children were largely generic across the sample and did not reflect individualized planning. The use of placeholder language, generic case plan goals, and boilerplate rationale statements suggest a systemic pattern.

- Of the 52 foster care cases reviewed, case plans were created or updated timely in 81% of the cases.

- Of the 52 foster care cases reviewed, CFTMs occurred timely in 41% of the cases.

Service Provision and Findings

Delays in Alameda County DCFS' service provision were attributed to a combination of agency, service provider, and placement provider factors. Placement instability was noted as further disrupting the continuity of care, especially before services are fully

established. Inconsistent use of the IP-CANS tool also limited the agency's ability to develop timely case plans. Pursuant to ACL 18-81, the IP-CANS tool replaced the child welfare Structured Decision Making (SDM) Family Strengths and Needs Assessment (FSNA)/Child Strengths and Needs Assessment (CSNA), and required child welfare agencies to complete the IP-CANS tool for every open child welfare case. Additionally, ACL 21-27 required the IP-CANS to be documented into CARES-Live beginning July 1, 2021. Further, as of July 1, 2025, ACL 25-10 required all placing agencies to complete the IP-CANS tool for all children and youth in foster care to support the development of the case plan and in preparation for determining the foster care rate under the Tiered Rate Structure. This was a new requirement for juvenile probation, but this requirement for child welfare was previously articulated in ACL 18-81. Additionally, all placing agencies are required to ensure collaborative completion of an IP-CANS tool for all children, youth, and nonminor dependents as described in ACL 25-10 and in accordance with all previously issued requirements that are listed in the same letter. (See ACL 25-10 for all updated requirements). As it pertains to the timeliness of developing case plans, MPP section 31-101.511 states that the social worker shall complete the written case plan within 60 days of the initial removal of the child or the required in person investigation, or by the date of the dispositional hearing, whichever comes first. As such, the inconsistent use of the IP-CANS tool contributes to delays in development of the case plan.

As required by WIC section 16501.1 and MPP sections 31-206 to 235, social workers are required to document and update the case plan goal and any changes in the case plan (e.g., treatment services, providers, or placement changes), at least every six months. While the case reviews revealed that the plans are created and updated timely in 81% of the cases, the case plans appear to use a boilerplate and do not appear to satisfy the statutory or regulatory requirements for individualized updates. These generic case plans in turn can result in offering or providing services that are not tailored for each individual child and youth. Without documentation of the services offered or provided, it is impossible to tell if the case plans reflect the unique needs of each youth in foster care.

External system factors, including limited STRTP capacity and reliance of out-of-county placements, as well as transportation barriers and communication gaps with providers, further impacted service coordination. Documentation challenges also affected service provision including inconsistent receipt of provider documentation, limited guidance and system functionality for uploading records into CWS/CMS, and a reliance on hard files that may not consistently contain complete information.

Documentation

Regarding the Alameda County DCFS' documentation challenges, the following themes were identified from the on-site interviews and focus groups:

- High caseloads require social workers to prioritize investigations and direct case work, often delaying documentation.

- Due to case assignments that are spread across the county and a high population of children and youth placed outside of the county, extensive travel reduces time available for documentation.

- Technology limitations hinder timely documentation, including unreliable VPN access, limited IT support, lack of in-the-field internet/hotspots, ineffective speech-to-text tools, and issues with CWS/CMS.

- To meet documentation requirements and avoid disciplinary action, staff report working through breaks, during lunch, and/or on their days off without pay or using sick leave to complete documentation.

- Recent policy changes and inconsistent communication have caused confusion about whether documentation is considered timely within 72 hours or 30 days.

- Staff reported that there is not a consistent county policy regarding provision and use of protected time or overtime for documentation purposes.

Regarding the Alameda County DCFS documentation challenges, the following theme was identified from the case review portion of the review:

- Across the EO referrals, investigated referrals, and foster care cases reviewed, the documentation frequently captured what happened but not why. Rationales were templated, unsupported, or absent altogether.

Documentation and Findings

Staff identified high caseloads, assignments spread across a large geographic region, and technology limitations as primary barriers to timely documentation. Staff reported a lack of clarity regarding policies on timely documentation, including how and when protected time or overtime may be used to complete documentation. Recent policy changes and inconsistent communication regarding documentation timelines (i.e. 72 hours versus 30 days) have also contributed to confusion and variability in how documentation is meant to be conducted.

With the passage of Assembly Bill 636 (Ch. 678, Stats. 2001), California law required the CDSS to establish, by April 1, 2003, the California Child and Family Service Review (C-CFSR) System to review all county child welfare systems. (WIC § 10601.2). The validity of multiple C-CFSR system outcome measures and other system improvement efforts are reliant on social workers entering documentation correctly and timely in CWS/CMS as mentioned in ACIN No. I-86-06. The lack of proper documentation may result in inaccurate C-CFSR outcome measures which in turn may result in system

improvement plans that do not accurately reflect the strengths and areas for improvement in Alameda County.

Accurate and timely documentation is also essential to informing, developing, and updating case plans which are legally required and crucial for ensuring child safety, well-being, and permanency. As noted above, WIC section 16501.1. and MPP sections 31-206 to 235 require social workers to document and update the case plan goals and any changes in the case plan (e.g., treatment services, providers, or placement changes) at least every six months. Without documentation of services and the results of IP-CANS and CFTMs, there is no evidentiary support for the case plan updates.

Additionally, as described in ACIN No. I-52-14, emergency response investigation contacts should be entered in CWS/CMS within three business days as a best practice for locating families, making in-person contacts, and documenting contacts to respond timely to child abuse and/or neglect referrals. Absent this documentation, there is no evidentiary support for the outcome of the referrals.

When decision-making is not clearly articulated through documentation, supervisors cannot effectively review it, courts cannot adequately evaluate it, and subsequent social workers inheriting a case lack the contextual information needed to provide continuity of care. Strengthening documentation practice will require a culture shift that positions thorough, individualized, and rationale-driven documentation as a core expectation.

Workforce

Regarding the Alameda County DCFS' workforce practices, the following themes were identified from the on-site interviews and focus groups:

- The workforce has faced ongoing challenges in establishing stability due to substantial workforce losses over the past six years. These losses have disrupted onboarding and training processes, as experienced employees have had to absorb additional responsibilities while new staff are being trained, resulting in increased burnout. The agency has been in a continual cycle of recruiting and onboarding to rebuild capacity, further intensifying the strain on existing staff.

- High turnover and low retention coupled with a high volume of referrals yields high caseloads that exceed the staff's capacity, specifically in the ERU and Family Reunification Unit.

- Additional tasks outside of direct case work that contribute to staffs' heavy workloads include travel time related to youth placed out-of-county, supporting interns or peers, and completing administrative tasks including case file management, visitation scheduling, billing, invoicing, reimbursements, record requests, and presumptive transfer documentation for Medi-Cal.

- In 2022, Alameda County DCFS shifted to hiring more staff with bachelor's degrees rather than focusing on those with master's degrees, as filling vacancies had become increasingly difficult. While this has helped fill vacancies, it has also increased the workload of supervisors who have primarily been the most stable workforce in the agency and must now take a more hands on role in training and onboarding.

- There is an unbalanced workload distribution amongst staff, with experience and education as compounding factors. The more experienced staff and staff with advanced, postgraduate degrees have a higher workload.

- To minimize case disruptions and support information transfer, there is a need for a more streamlined and coordinated system to communicate between units, particularly during case transitions.

- Agency leadership expresses a need for more peer-to-peer training or shadowing opportunities. Staff, however, are concerned about the impact on their workload.

- Staff report that supervisors are a primary source of support by having open door policies and being readily available in person or via telephone.

- The county's Case Aid Program utilizes social workers on overtime or scheduled days off, as well as retired staff, to support case carrying social workers to manage their workload more efficiently. These staff provide additional capacity by conducting in-home visits, transporting youth to visitations and medical appointments, and assisting in administrative tasks such as filing or documenting case notes. Staff view the Case Aid Program as a valuable resource that alleviates workload pressures and supports in timely completion of case responsibilities. This program is currently on hold or operating at limited capacity to provide visitation support only.

Regarding the Alameda County DCFS' workforce practices, the following theme was identified from the case review portion of the review:

- Case management was often very strong until the case was transferred to a new social worker and then it declined notably.

Workforce and Findings

The Alameda County DCFS workforce has experienced ongoing instability due to significant staff losses over the last six years, which have disrupted onboarding and training and contributed to increased workload strain and burnout. Staff reported that the agency is experiencing unsustainable workloads, driven by a high volume of referrals, high caseloads, high turnover and insufficient staffing adjustments. Recruitment challenges and low retention further exacerbate caseloads beyond staff

capacity, particularly in the ERU and Family Reunification Unit. Additional workload demands include extensive out of county travel and administrative responsibilities such as case file management, visitation scheduling, billing, invoicing, reimbursements, record requests, and presumptive transfers for Medi-Cal. The shift to primarily hiring staff with bachelor's degrees has helped fill vacancies but has increased supervisory responsibilities for training and onboarding. Workload distribution remains uneven across staff and across units. Staff reported the Case Aid Program as a valuable resource; however, the program is currently on hold or operating at limited capacity to provide visitation support only.

Through the onsite interviews and focus groups, staff identified a need for more streamlined communication across units during case transitions, which was supported by the data in the case review. The decline in case management upon case transfer identifies a process design problem that requires deliberate intervention. Clear assignment protocols, supervisory oversight at transition points, and reduced handoffs where possible would likely strengthen both practice quality and staff accountability.

Staff Retention

Regarding Alameda County DCFS' staff retention challenges, the following themes were identified from the on-site interviews and focus groups:

- Workforce stability varies across units with the Family Maintenance Unit and the Permanent Youth Connection Unit reporting that they currently have a stable workforce while the ERU has high turnover that leads to redistribution of the work amongst staff.

- New social workers, particularly in the ERU, often serve their post-graduation employment obligation for the Title IV-E stipend program and then resign due to secondary trauma and burnout.

- Staff shared knowledge of resignations when staff were transferred to the ERU due to the stressful environment, high workload, and lack of differential pay.

- The transition from a primarily remote environment back to hybrid and in-person work has contributed to retention difficulties, with staff leaving for roles in other sectors.

Regarding Alameda County DCFS' staff morale that was reported to have impacts on county's retention of staff, the following themes were identified from the on-site interviews and focus groups:

- Ongoing policy confusion, particularly where it creates inconsistencies or inequities amongst staff, is a significant source of frustration and contributes to low morale across the agency.

- Differences in support, expectations, and flexibility between the day and swing shifts in the ERU have led to lower morale amongst day shift staff who report less support, unclear expectations, and reduced flexibility in managing their time and tasks.

- The negative public image of the agency and internal messaging contribute to staff feeling undervalued. Staff and leadership both reported that the public attention and pressure have made it harder to recruit and retain social workers to work in the ERU, which exacerbates noncompliance with legal requirements.

- Increased trauma-informed debriefing and support could improve staff morale and retention.

Staff Retention and Findings

Workforce stability varies across units, with the Family Maintenance and Permanent Youth Connection Units reporting more stability, while the ERU experiences high turnover that results in workload redistribution among remaining staff. In the ERU, new social workers often fulfill their Title IV-E stipend obligation and then resign, frequently citing secondary trauma and burnout. Additional turnover is also linked to transfers into the ERU without differential pay, as well as challenges associated with returning from remote to hybrid and in-person work, which has contributed to retention difficulties. Broader factors that have contributed to low staff morale include the negative public image of the agency, internal agency messaging, and ongoing policy confusion, which leads to more inconsistencies in practice. Staff identified a need for increased trauma-informed debriefing and support to improve morale and retention. While the CDSS does not have supervision authority over county personnel matters, the CDSS can work with DCFS to identify supports around trauma informed debriefing and strategies that may increase morale to improve compliance with child welfare laws and policy.

Training and County-Wide Messaging

Regarding Alameda County DCFS' training practices and county-wide messaging, the following themes were identified from the on-site interviews and focus groups:

- Alameda County DCFS leadership and staff identified inadequacies in training to prepare new staff for realistic job expectations, particularly for social workers in the ERU.

- Themes gathered specifically from Alameda County DCFS leadership data:

    - In 2022, when Alameda County DCFS shifted to hiring more staff with bachelor's degrees rather than with master's degrees, it resulted in the need for a more intensive onboarding process with increased training and support from supervisory staff.

  - Alameda County DCFS leadership recognized the need to be intentional in their communication and messaging, particularly in translating recommendations from the State Auditor's report into actionable guidance for supervisors and staff using a supportive and practice-focused approach.

- Themes gathered specifically from Alameda County DCFS individual social worker interviews and social worker and social worker supervisor focus group data included:

  - Training on new procedures was developed in response to the State Auditor's report. Staff described the training as inadequate in that trainers provided a quick preview of the new procedure, followed by a rushed rollout with immediate implementation.

  - Staff described the messaging from leadership in response to the State Auditor's report as focused on corrective action, performance plans, and punitive actions for staff who are out of compliance with specific policies (i.e. timely documentation, number of open referrals, etc.).

  - Following the State Auditor's report, messaging around policies and practices related to the modality of CFTMs has been inconsistent and difficult for staff to navigate.

Training and County-Wide Messaging Findings

Alameda County DCFS leadership and staff identified gaps in training and countywide messaging that are affecting staff preparedness and consistency of practice within the agency. Training, especially for new hires, was described as inadequate and not realistic in preparing new staff to meet job expectations, particularly in ER. This shift has been more noticeable since the agency began hiring more bachelor's level staff in 2022, which indirectly increased onboarding needs.

Alameda County DCFS leadership noted the need for more intentional and supportive communication in translating State Auditor recommendations into clear, practice-focused guidance for supervisors and staff. Staff reported that training related to new procedures was often rushed and implemented quickly, with limited time to understand and prepare for the change prior to the change being implemented. Staff also described state audit-related messaging as primarily focused on compliance, corrective action, and performance management, which contributed to perceptions of a punitive environment. Additionally, inconsistent guidance related to the modality of CFTM practices has created confusion in implementation across the agency.

Recommendations

At this time, intervention and monitoring of Alameda County DCFS by the CDSS is necessary to ensure that state laws and regulations are accurately followed, that Alameda County DCFS is provided with adequate technical assistance, and that support can be provided through a child welfare oversight perspective. This report has outlined key findings that have immediate impacts on child safety, as well as areas that may also be addressed as part of a longer-term strategy for system improvement.

Alameda County DCFS will develop a Corrective Action Plan (CAP), that the CDSS will review and approve, to address all necessary follow-up and monitoring of these immediate action steps. The CAP shall include, but not be limited to, those items listed in the Action Steps section below and should address the findings discussed in this report. The CDSS will provide support and technical assistance to the Alameda County DCFS throughout the development of the CAP, which should be implemented no later than October 1, 2026.

CAP Action Steps:

1. Within 3 months from the beginning of the CAP, Alameda County DCFS must develop a written plan to substantially reduce the number of referrals open longer than 30 days. The plan must include strategies and timeframes by which substantial compliance will be achieved. This plan will be approved by CDSS and monitored throughout the length of the CAP, with ongoing monitoring possible through the System Improvement Plan process beyond the time frame for the CAP, as necessary.

2. Develop and/or strengthen and clarify written county policies and set staff expectations related to reporting and investigating new child abuse and/or neglect allegations when a family has an open referral/case.

3. Develop and/or strengthen and clarify written county policies and set staff expectations around documentation timeliness for all case related documentation, clarification on what documentation must be recorded in the Statewide Child Welfare System of Record and what must be maintained in the hard case file.

4. Develop and/or strengthen and clarify written county policies and set staff expectations that ensure overrides of any safety assessment or referral determination are properly staffed, adequately documented, and approved by a supervisor.

5. Develop a rotation schedule for Hotline staff to ensure that every call that comes into the Hotline is answered in a timely manner. Monthly checks by the

Alameda County DCFS leadership team should be conducted to ensure timely response to Hotline calls, with response time data to be reported to the CDSS.

6. Explore options to monitor fidelity in the use of the SDM Hotline tools. The CDSS can explore this fidelity oversight process with Evident Change to support this recommendation.

7. Develop and/or strengthen and clarify written county policies and set staff expectations on case transfers to ensure stability, consistency, and integrity of child welfare practice for the children and families involved in the cases. These policies and expectations should be developed and implemented to improve the experience of all staff, children, and families during the transition of a case by ensuring consistent and productive processes for sharing information during a transfer.

8. The Alameda County DCFS must implement a plan for how they will complete the IP-CANS tool timely and enter IP-CANS data into the CARES-Live system timely, and in the Statewide Child Welfare System of Record once live in the fall. Clear written policies and procedures must be developed to facilitate this process. This is especially critical to prepare for implementation of the Tiered Rate Structure, under which foster care rates are dependent on IP-CANS data.

9. The Alameda County DCFS should establish a clear, written internal communication plan that outlines strategic outcomes, objectives, and initiatives related to the CAP, while embedding a consistent feedback loop to ensure staff remain informed and engaged in policy and practice changes, as well as understanding the meaning behind the changes in county practices. The plan should be a strengths-based approach, promoting support and encouragement for workers.

10. Develop and/or strengthen and clarify written county policies and set staff expectations related to re-engaging family members for placement and family finding purposes after previously being ruled out.

The CDSS recommends Alameda County DCFS develop longer-term action steps to ensure processes and procedures are created and implemented to elicit lasting systemic changes. These longer-term action steps, including those below, may also be included in the CAP planning so that CDSS can provide additional during the CAP process. The CDSS advises Alameda County DCFS that the CDSS staff will have ongoing site reviews while immediate and long-term action steps are being developed, and thereafter, to provide technical assistance and to ensure proper implementation of the action steps outlined above.

Longer Term Action Steps

1. The CDSS recommends Alameda County DCFS develop a structured rotation pilot that builds on the exploratory strategies they have already tested to strengthen workforce sustainability and reduce burnout. The pilot should include a comprehensive task analysis which will help clarify which tasks can be reassigned to streamline workload expectations. The pilot would further explore a structured rotation model, drawing from approaches the county has tried informally, to provide relief to case carrying staff by using support staff or overtime to complete administrative tasks. To ensure effectiveness, the county should begin with baseline focus groups to assess workload challenges, burnout levels, and supervisory strain, followed by ongoing evaluation throughout the pilot.

2. The Alameda County DCFS should evaluate the effectiveness of administrative task reassignment and identify permanent strategies to maintain workforce stability and support. Similar to other California counties, Alameda County could continue their engagement with Dr. Anita Barbee and her job redesign pilot project for support in this effort.

3. The CDSS recommends Alameda County DCFS explore options around work assignments that take geographic patterns into account due to large numbers of youth placed outside the county, including organizing staff dedicated to a particular region within the county and its neighboring counties. (The CDSS can support in this recommendation with peer-to-peer county connections, such as with San Diego's Centralized Assessment Team System.)

4. The Alameda County DCFS should, with CDSS assistance, explore memoranda of understanding with other counties regarding out of county courtesy visitation and referrals.

5. The Alameda County DCFS should, with CDSS assistance, clarify how participation in the Kin-First Accelerator Program will be used to directly address concerns noted in "Family Finding and Placement with Relatives Findings." This will enable Alameda County DCFS to leverage funding streams and ongoing CDSS support in addressing ongoing work in response to these recommendations.

6. The CDSS recommends that Alameda County explore the establishment of an ombudsperson to serve as a neutral and impartial resource to assist the children and families involved in the child welfare system in clarifying DCFS and state policies and procedures and addressing case-specific and systemic concerns related to child protection and child welfare services programs. The ombudsperson would fill the traditional role of investigating, responding to, and

resolving complaints from children and families in the child welfare system. The CDSS can identify resources to assist in establishing such an ombudsperson.