Juvenile Justice Commission
County of Santa Clara

191 N. First St.
San Jose, California 95113

email: sccjjc@gmail.com

Call to Action

The Juvenile Justice Commission is issuing an urgent call to action regarding the DFCS administered Scattered Sites. Some have called for the closure of the Scattered Sites. While this seems like an obvious solution in the light of the serious problems plaguing them, it overlooks the need to house youth with significant mental health and behavioral issues and offers no alternative solution. This situation is not new to the Dependency system both within this County and throughout the State. Every California county is faced with the same problem, but none have found a successful response, especially in the largest counties. The conundrum of finding an answer to managing high acuity youth (HAY) has been part of this County's history for 30 years. This position paper provides a statement of the problem, some history, a description of the present circumstance of the Scattered Sites, and a proposed course of action to resolve this crisis.

Statement of the problem:

Santa Clara County Juvenile Justice Commission (JJC) has been monitoring facilities which house minors who are coming into care for the first time and those who are already dependents but are without a foster home or treatment facility. The focus of this paper is the housing for a small cohort of high acuity children and youth with complex or high needs who tend to stay longer in shelter care. While this is a relatively small population, they are the most vulnerable and most difficult to place. The JJC has the following concerns about the previously unlicensed facilities, referred to as "Scattered Sites," which are being used for their temporary placement.

- Throughout the State of California there is an absence of appropriate housing for these youth and this was exacerbated by the closure of group homes by the State in 2017 with no alternative plan in place. While the intent of this change was to encourage more family-based homes there continues to be a chronic shortage of appropriate homes for these youth.
- In order to address this issue, the County of Santa Clara has opened and operated a series of Scattered Sites, which it has spent well over a year trying to license.
- These sites have had the following problems which need to be addressed immediately.
  - Inadequate staffing and supervision at the sites.
  - Constant turnover of supervision and staff.
  - Lack of Behavioral Health Service for the youth at the sites
  - Complete lack of programming.
  - Neither the youth nor staff are safe.
- There are no in-county Short Term Residential Treatment Programs (STRTP) that would alleviate or lessen the need for placement for these High Acuity Youth (HAY).

History:

The Juvenile Justice Commission has long expressed concern about housing for high-acuity youth. To put into context the issue of these minors, a history of the County's approach follows:

For more than 20 years, many child advocates around the country, led by the Annie E. Casey Foundation, have promoted closing all congregate care facilities for youth, including shelter care facilities. Following this trend, the County moved to place all children who came into care within a 24-hour timeframe, obviating the need for shelter care. The County was successful for over a year in accomplishing this goal. As a result, the County decided to sell the Shelter facility on Union Avenue and moved the Receiving And Assessment Center (RAIC) functions to Santa Clara Street.

When the Union Avenue facility was closed in 2013, the blueprint articulated by the County stated that moving the RAIC functions to 725 Santa Clara was a temporary solution. To this end, a multi-stakeholder committee was formed to plan a new site for services. The County spent more than 18 months developing service models and operation plans, with a final consensus to use the East Valley Medical Center property in San Jose to house a multi-service center for youth and families either in, or in danger of becoming involved in, the Dependency system. The timeline for opening the new RAIC facility was January 1, 2018.[1] Nothing further was agendized for a year moving on this plan and it was abandoned without further discussion with stakeholders.

When it became clear to the stakeholders that the East Valley site would not move forward as a home for either the RAIC or a new Child Advocacy Center (CAC), a group of stakeholders held a new series of meetings. As requested by members of the Board of Supervisors, a consensus recommendation was presented to the County by stakeholders.[2] This recommendation outlined the programs and services that the stakeholders believed needed to be co-located, with integrated programming, and proposed a site for the medium term. This recommendation was only partially adopted by the County administration; the new CAC has now opened.

While waiting for the County to move forward on the East Valley site, the facility on Santa Clara was flooded, and the RAIC functions were moved temporarily to the Family Resource Center on King Road in San Jose. Hotel rooms were used when necessary to house children until the RAIC moved to a building on Enborg Lane on the Valley Medical Center (VMC) campus on an interim basis. While the building was built on County land, this facility was not owned by the County and so could not be reconfigured to meet the needs of the youth who were staying there, many for over 24 hours. The County responded by attempting to buy the building. Since youth were being held for longer than 24 hours at Enborg, the State required the County to seek a license as a shelter.

While at the Enborg site from 2016 to 2019, the management of both the Department of Family and Children's Services (DFCS) and the RAIC was constantly in a state of upheaval. The RAIC was licensed under a manager who was certified to run a shelter facility, but then that person was promoted away from the RAIC. At this point, management of the facility was rotated every two

---

[1] SCC Board of Supervisors transmittal 78687: R. Menicocci (Nov. 17, 2015) *RAIC Final Strategic Operational Plan and Feasibility Study,* beginning at page 69. Online at http://sccgov.iqm2.com/Citizens/FileOpen.aspx?Type=1&ID=6630&InLine+True

[2] Letter from Ad Hoc Committee on Relocation of the RAIC and Related Services, Supervisor Cindy Chavez (Feb. 13, 2018).

months for at least six months. The lack of continuity in administration of the facility caused inconsistent enforcement of programming. This was exacerbated by the fact that the Enborg facility was not configured to address the needs of children of different ages and varying needs.

During the fall of 2019, several children entered the Shelter with severe emotional and development needs. These youth were served by both the DFCS and the San Andreas Regional Center. Each agency seemed to be expecting the other to come up with placement, resulting in 3 or 4 children spending more than a month in a facility which was not designed to meet their needs. As a result, the most recent on-site RAIC supervisor quit, after approximately six months on the job, while the Social Service Program Manager had responsibility for the Enborg facility was on medical leave. To try and get the chaos at Enborg under control, staff from the Probation Department were brought in to assist the DFCS staff with behavior management. Stakeholders addressed their concerns to the Board of Supervisors (BOS) in December 2019 that there were no new plans by DFCS other than addressing each situation as it arose. Though many stakeholders, including the JJC, asked the Board to instruct DFCS not to close Enborg until a concrete plan was developed, the facility was closed at the end of 2019 without further discussion, nor a plan. DFCS, Behavioral Health, and Probation worked diligently to support the small group of children with higher care needs remaining at the RAIC awaiting suitable placement. As of December 31, 2019, RAIC operations on Enborg Lane were closed and DFCS returned to 725 East Santa Clara and called it the Keiki Center, for RAIC activities.

Commissioners inspected the Keiki Center in November 2019. At that point, the Keiki Center appeared adequate for receiving and stays of less than 24 hours. The Commission visited its replacement, The Welcoming Center, in June, 2021 and May 2022. Its report was published in July 2022. Youth staying over 24 hours, and the use of Scattered Sites were noted in the report. One of these sites the JJC's visited was located in a middle-class neighborhood of single-family homes. While the site was a well-maintained home, it was sparsely furnished, which has proved typical of our visits to other Scattered Sites. The other major characteristic was its staffing, consisting of three rotating shifts of DFCS staff a day. At this point the number of Scattered Sites fluctuated depending on the number of children placed in them at any time. The sites were staffed by DFCS employees, many of whom had years of experience working with high-acuity needs youth.

At the time of that report two to three sites were in use. However, the Commission noted that "even with only one or two youth placed at a site," as was the practice at the time, they were still a group home model in that the staff rotates in and out on an 8 to 10 hour a day work schedule. While DFCS tried to match the staff with the youth in care at the site, this was not always possible due to work schedules. Also, as there was no consistent staffing or youth population in these sites, there was little programing available for the youth. The hope was that the youth will stay in the site for only several days, but some youth have stayed for several months. While this is a very small percentage of the youth who are in care, a better and more permanent solution needs to be found for these high-acuity-needs youth.

To better understand the needs of these High Acuity Youth, (HAY) on two separate occasions, two Commissioners reviewed the court files of a select group of these youth. The level of trauma and multiple traumas inflicted on these youth was extreme. A majority had been in the Dependency system for most of their lives. One was adopted by a relative and then returned to the system. Others had gone from relative placement to another relative placement, to another. Some had serious behavioral issues even as very young children. Almost all have spent time "caring for themself" either as a runaway or within a household where there was no oversight and direction.

Finding appropriate housing and services for these youth has been part of the issues forced upon DFCS. However, the responsibility for addressing the consequences of the plethora of traumas for these youth goes beyond DFCS. It also falls to the county's failure to act on funding or plans made and developed, thereby leaving DFCS to apply a temporary fix instead of an appropriate solution for children under the county's care. In part, this is also a state and federal government issue forced upon the county/DFCS by the closure of group homes without enough of the recommended home-based alternatives.

Since the last published report on The Welcoming Center (TWC) in 2022, the JJC has continued to follow its activities by reviewing the Community Care Licensing (CCL) reports on the state website and reviewing incident reports from the facility. The JJC reviews weekly statistics on the youth placed there and by visiting the facility.

The JJC's visits to TWC on June 28, 2023, and August 23, 2024 showed that TWC is licensed by the California Department of Social Services, Community Care Licensing Division and managed by Seneca, as a transitional shelter facility. Their responsibility is to house and access the behavioral health needs and to assist in placement of children brought into foster care. The license for this facility by the State of California is monitored by the local Community Care Licensing (CCL). Their license provides for only 23 hours and 59-minute care before placing a child into an appropriate relative or other foster care placement. It can facilitate up to 15 children from birth to 18 while an assessment is completed, and potential placement is arranged by the Department of Family and Children's Services (DFCS).

Summary of Visit to TWC

The Welcoming Center property is described as a therapeutic, warm setting that supports young people as they navigate the trauma of a placement change or home removal crisis.[3]It is housed in a two-story building near a popular shopping mall. Once inside it has a home-like feeling recently redecorated with art and new furniture. The facility contains bedrooms and day rooms on the first and second floor. The second floor is decorated for the younger children who spend time there. Their safety is ensured, and their separate needs are recognized and supported by separation from older youth. There is an outside patio with recreational equipment and a sun filtered table. The facility and grounds were well maintained and appropriate for their stated use.

The facility appears to have appropriate leisure time activities for the age groups on each floor and adequate staff is readily apparent. During the onsite visit, there was only one youth in residence.

During the last 18 months, TWC has faced increased challenges due to the number of high acuity youth being taken into care while no additional placement options have been forthcoming. Because of this, the number of youth staying longer at TWC increased and there were, on occasion, older, incompatible youth in the facility. On at least one occasion this resulted in TWC being cited by CCL. To address this situation TWC restricted the youth they would admit to the facility which resulted in the increased use of the Scattered Sites.

Scattered Sites

According to a supervisor at DFCS the Scattered Sites were due to be phased out. However, this

[3] "Information Regarding the Welcoming Center", Seneca Family of agencies. February 19, 2021.

was not achieved due to a lack of appropriate placements for high acuity youth. As a result, DFCS moved to license the remaining two to three homes. This effort was severely hampered by the State of California, which had mandated the closing of group homes years earlier but had provided no replacement licensing regulations for shelters or other temporary placements. This also hampered the JJC's efforts to inspect the homes, as there were no adopted standards with which to inspect them. Despite this, in 2022 and again in the summer of 2024, the JJC visited these facilities. The findings of these visits are outlined below.

Two JJC Commissioners visited two Scattered Sites in October 2022 in south San Jose and Morgan Hill. Though the San Jose site was relatively clean and orderly, the interiors were stark and unwelcoming. At the site in Morgan Hill, JJC attempted to speak with the resident, who declined. This child had turned 13 during the nine months they had been there and had been driven by taxi daily to and from the child's home school in the far northern end of the county.

Two JJC Commissioners visited another Scattered Site on July 30, 2024. This site is a house located in a residential area. The location was unlicensed at the time of the visit but has since been licensed as a Transitional Shelter Care Facility (TRSCF). The Scattered Site is considered only a short-term placement until a more permanent placement is found. However, the majority of youth remain at the site for long periods of time because of the unavailability of appropriate placements or the refusal of the youth to be placed.

Present at the time of the visit was a newly appointed Social Services Program Manager III (SSPM III) who was assigned to manage the Scattered Sites, one Social Worker 1 and a uniformed Public Service Officer (PSO). The facility capacity was three youth, but only two youth resided at the location. One was asleep and the other was not on-site.

At the time of the visit, two staff were assigned to each of the shifts, day, night and graveyard shifts. One staff member worked in the office and the other in the living area. The ratio of staff to minors depends on the number and needs of youth placed in the house. The lowest number of staff is two. There were two youth placed in the house. The JJC asked about the presence of the uniformed Public Safety Officer and were told that one of the youth has a history of volatility.

Staff have either a Bachelor's or Master's degree. One of the staff interviewed during the visit was a newly hired SW I. She reported receiving only trauma-informed training with an expected refresher in six months. They are also offered online training in other areas. None of the staff indicated that they knew how to evacuate the home in an emergency. Staff rotate to Scattered Sites, weekly which just changed from daily. The staff interviewed prefer rotating daily because these youth pose a real challenge to manage.

This house has four-bedrooms, one of which is used as an office. While the home was generally neat and clean, it still had an instructional feel. It was sparsely furnished, with a few pictures. The carpets were dirty, and the kitchen cabinets needed cleaning. The staff is not responsible for cleaning the home. Each of the bedrooms contained a bed, a dresser and a closet. No personal items were present other than clothes. One bedroom was neat but in the other bedroom, the bed was unmade, clothes and a towel on the floor, and empty food containers were next to the bed, all of which is a violation of house rules.

Food for each meal is provided by Valley Health and is delivered twice a day in individual portions, served in paper plates and with plastic utensils. The use of plastic utensils was justified for safety reasons. The youth have access to healthy snacks. Few pots and pans were available. Some of the youth had volunteered to cook, but they must be supervised.

Medications are stored in a locked container in the office. The Youth Bill of Rights is posted as well as the House Rules. When a youth first arrives at the house, the staff explains and gives the youth a copy of the House Rules and Expectations. The Policies and Procedures manual was not provided until after the inspection report was completed. The latest fire inspection report was not produced. Smoke detectors were located throughout the house but had cages around them to prevent tampering, which appeared to be a problem in the past.

The youth are not responsible for the upkeep of the house, unlike the group homes where everyone had chores.

Puzzles and games are available to the youth, but no exercise equipment is provided. A youth may take walks. Youth are generally allowed to leave the home during the day if their primary social worker approves. Some of the youth participate in outside interests. Curfews are set and if the youth does not return the staff will call the youth to find out where they are. If the youth stays out without permission beyond two hours, the police are contacted and the youth is considered a missing person. Unlike TWC, the Scattered Sites do not appear to have established a working relationship with their local police departments.

Each of the youth has an individual program plan which is the responsibility of the primary social worker. Wrap services may be provided, including behavioral health and drug treatment services, however few of these services are provided at the Scattered Sites and some of the youth refuse to participate in these services.

Youth may attend a local school or their own home school. Transportation is provided, if the youth attend their own school. They are able to participate in school-based extra-curricular activities. Some youth refuse to attend school. When this occurs, staff contact the primary social worker. The youth then is denied access to television and is unable to leave the house. Rarely does the staff interact with the school unless the school calls to inform staff that the youth has been sent home.

Staff is trained to use corrective action as a learning experience for the youth. Staff is unable to use corporal punishment, physical restraints, or any intervention that can be construed as disrespectful, demoralizing or degrading. Youth can be sent to their rooms or their privileges might be restricted.

Meeting with DFCS Staff

On two occasions (in September and October) this year, the JJC met with DFCS staff who are working or have worked at the Scattered Sites to discuss the identified issues that make working at the Scattered Site so challenging. These workers included not only line staff but also managers. In the first instance, a few DFCS staff reached out to the JJC to present their concerns. The JJC asked for a second meeting to ask staff to elaborate on the issues raised. More workers attended the second meeting.

The problems identified fall into five general categories - staffing, safety, training, communication with administration and the provision of medications. Their comments are summarized below:

- **Staffing**

  Issues around staffing appear to be the majority of the concerns raised by the DFCS staff. Depending on the youth, the ratio of staff to youth may be one on one or even two on one. Social workers indicated these sites, however, do not have enough ongoing assigned staff to manage the youth. All too often, the agency must ask for volunteers from other areas to cover staffing, but at times the sites may still be understaffed. Since the volunteer staff do not know this population and are often untrained, the regular Scattered Site staff feel the new staff rely too heavily on the expertise of the existing staff which increases their burden of managing the youth.

  Staff turnover was reported as high, resulting in insufficient consistency in building relationships between staff and youth and between staff. Turnover has also occurred with managers, resulting in different management styles and a disruption in continuity. This inconsistency is exacerbated by the short-term staff rotation system used by the agency. Staff do not like this assignment because of the chaos and safety issues that exist. SW's also noted that one Scattered Site facility is too large to effectively monitor youth.

  Also common is the use of entry level or newly hired Social Worker I at the sites. These workers have little or no experience in managing the high acuity youth that live in these houses. Workers indicated that these inexperienced staff lack adequate supervision or oversight by senior staff. They stated that these sites should be staffed with social workers with more experience (SW II and SW III) or a psychiatric SW.

- **Safety**

  Many social workers believe that they are working in unsafe conditions. The staff reported that several workers have been injured at the sites and at least one was hospitalized. Rocks have been thrown at them and cars vandalized. The workers must deal with drug/alcohol use, substance withdrawal, partner violence, gang culture and suicidal ideation; youth sneaking other youth or adults into their rooms; assaultive behavior on staff and other youth in the house; and serious mental health crises. The SWs feel that they are "blind-sided by the youth" and are unprepared to handle the high needs of the youth. They also believe that these events are not appropriately reported. Workers have sought restraining orders to avoid being assigned to a site when a certain youth is present.

  Workers are not generally allowed to use restraints nor to place their hands on the youth. In some instances, approved restraint techniques can be used, but only a limited number of staff are trained in these techniques. Also, a sufficient number of staff are required to do this safely and there are rarely enough staff on site.

- **Training**

  The lack of adequate training appears to be the next most concerning issue presented by these workers. They indicated that the entry level social workers assigned to the Scattered Sites are not given sufficient training prior to their assignment.

  All want more training, in particular on crisis intervention techniques (TCI - Therapeutic Crisis Intervention) and the effects of psychotropic drugs. Not all required components of TCI are being used. The workers do not believe that they have the appropriate tools to

handle these youth, especially when the youth is assaultive. They believe they are acting outside their competence. This situation ultimately impacts the youth as they do not receive the care they need.

- **Communication with Administration**
  The workers reported their fear of retaliation for voicing concerns and seeking support. The retaliation seems to be subtle with workers believing that they are being reassigned. They do not believe the administration is providing enough support for the line-staff.

  They see a disconnect between Administration and line-staff as well as a lack of transparency and planning. Feedback is not solicited, and when given, it is ignored.
  One social worker indicated that they contacted the County's whistleblower hotline and were referred back to DFCS. Consequently, no independent investigations occur into their concerns.

  Three huddles a day occur during the day shift. Managers are required to be on site 20 hours a week, but they report this does not happen. Also, managers are expected to be on call 24/7, but real-time access is limited to phone calls. One social worker reported that they had not received 1:1 supervision for over a year. Staff meetings used to occur weekly, but they rarely occur now.
  Many are unaware whether a policies and procedures manual has been developed for the Scattered Sites. Consequently, they are requesting a written manual and contingency plans. Workers stated that they do not have access to documents and any written expectations. Staff were denied access to the licensing application and supervisors are told by senior staff what information they can share with their staff. The workers want to be kept informed about each youth's history, especially any safety concerns, including access to police reports. Workers also want to be informed and participate in any future changes in program direction.

- **Medications**
  Workers are concerned about the management of medications at the Scattered Sites. The social workers believe that the dispensing of medication is not being tracked. As a result, medications run out, youth miss their medications, are given the wrong medications and the wrong dosage. Errors are not reported as Incident Reports (IRs) Their preference is for a nurse to dispense medications.

First the staff was told that the Scattered Sites were temporary and would be phased out. However, a decision was made to maintain them. Then staff were told that this was a new program, considered to be an innovative pilot project. Staff in these meetings did not call for the dismantling of the program since not enough placement options are available for high acuity youth who do not meet the criteria of STRTPs or hospitalization. They do not belong in the juvenile justice system and the agency has not been able to find placements. They acknowledged that this is a statewide problem that has been amplified since the closure of group homes. Lobbying is needed for alternative options for these youth statewide. In the interim, this County must be creative in its solutions.

Staff offered some changes they would implement to make the Scattered Sites more effective, including:

- Increase the staff to youth ratio, especially in the home with 6-8 youth.

- Add clinically trained staff
- Replace SW I with SW II and III
- Have a supervisor on site
- Introduce 7 Challenges, a comprehensive substance abuse counseling program, since many youth are abusing drugs/alcohol
- Allow the social workers to initiate 5150 (mental health) holds
- Use clinical insights and improve evaluation of youth, to avoid placing youth together with competing needs
- Provide more information to the on-site staff about the youth and their needs
- Improve training - especially on different mental health diagnoses and about psychotropic medications and their side effects
- Allow easier access to a psychiatrist/mental health professionals
- Improve relationship with law enforcement

Conclusion and Call to Action

The crises at the Scattered Sites must be addressed immediately. The Scattered Sites were created as a temporary housing resource while DFCS invested in creating specialized foster homes that would be able to meet the needs of the most challenging youth in their care. At some point the decision was made to keep the Scattered Sites and seek licensure to house youth for a maximum of ten days. However, necessary changes to programming, training and staffing were not made.
The original plan for the Scattered Sites had been for each to accommodate only one youth, or, in rare circumstances, two. Now, as many as eight youth have been housed in a single Scattered Site. In effect, they have been operating as unlicensed group homes for high-acuity youth. Since the State no longer publishes regulations governing group homes, they continued to operate without any guidelines or policies and procedures until June 2024, when two were granted provisional licenses as Transitional Shelter Care Facilities.[4]

Previous regulations for group homes included a tiered system of licensing with strict rules about staff qualifications, training and staff-to-youth ratio. The highest level of care group homes were intended to provide a therapeutic setting for seriously emotionally disturbed youth and required the presence of licensed clinicians. Present State draft regulations for Transitional Shelter Care Facilities allow only for short term, maximum of ten day stays, and are not designed to address youth with complex needs, who are staying longer due to the lack of appropriate long term placements.

Youth have been staying at the Scattered Sites for much longer than ten days. Licensure allows youth to stay up to ten days but without developing long-term housing solutions for these youth needs, they will continue to stay well beyond ten days, making it all the more imperative that the program at the Scattered Sites be staffed with well-trained staff able to meet the complex and varied needs of these youth. These circumstances indicate the urgent need to develop a long-term solution.

While not calling for the closure of the Scattered Sites, the JJC urges the adoption of a two-pronged approach to address the immediate crises.

---

[4] As a part of the application for licensure Policies and Procedures were prepared but staff have stated they were not aware of there being any and had not received any training on them.

- Intensify efforts to develop resources to meet the long-term housing needs of these youth, such as creating an in-county Short Term Residential Treatment Program (STRTP) and specialized foster homes.

- The county should invest in stabilizing the Scattered Sites so that they are able to meet the intense needs of the population that they are serving. The concerns of the social workers for appropriate staffing and training and management oversight must be addressed.

DFCS, the Courts and the Board of Supervisors have responsibility for these dependent youth, but the larger community also has a stake in their care. Any attempt to address their needs should involve a convening of key stakeholders including DFCS staff, Judges, the Behavioral Health Services Department, foster care agencies, community-based organizations, and youth and their attorneys. The Juvenile Justice Commission strongly urges that this recommendation be treated with the highest level of importance.

Approved by the Juvenile Justice Commission, Santa Clara County, on November 5, 2024

Stephen Betts, Chair Juvenile Justice Commission

Penelope Blake, Chair Continuum of Care Committee