Children and Access to Mental Health Treatment in California

Health and Medicine

Inside California Healthcare: The Criminalization of the Mentally Ill (2012–2013)

Amber's Case: The Warehousing of California's Mentally Ill Children (1996–1997)

Strangers in the Night (2000–2001)

Woodland Services: The Changing Face of Child Welfare (2002–2003)

The essays of this collection share a significant topical overlap: access to mental health care in California (primarily for children). The first essay in this collection "Inside California Healthcare: The Criminalization of the Mentally Ill" provides an overview of the mental healthcare system and the issues that plague it. The latter three essays provide more personal accounts within the system, detailing the experiences of children receiving insufficient aid.

The struggles that these children face reveal an important distinction that contrasts with the message

of the other health-related collection, "Growing Pains." While the essays of that collection suggest that the challenges brought by injuries and ailments can result in personal growth, these essays, with little exception, have no happy ending. For the most part, these children were denied a satisfactory resolution to their challenges. Their stories suggest that, without proper access to medical care and sufficient treatment to meet the needs of the patients, the recovery process cannot resolve properly. Injuries and ailments cannot be sources of growth if the patient cannot properly overcome the illness itself. Thus, the essays of this collection emphasize the need for proper support and care.

Inside California Healthcare: The Criminalization of the Mentally Ill

Sari Kosdon

Writer's Comment: The purpose of this UWP-101-assigned essay was to explore a contested ground in California. The article was specifically written to potentially fit Boom: A Journal of California. *In addition, the piece needed to demonstrate something significant about California and to reveal an "invisible" or "hidden" controversial phenomenon. I chose to focus on mental health in California because of the recent media attention to crimes such as the Colorado movie shooting. I was interested to know how the mentally ill received care in our state and if the state is doing what it can to keep people healthy.*

Instructor's Comment: During the fall months, I was simultaneously completing an article for Boom *magazine's "Contested Ground" section and designing new curriculum for UWP 101. The former became the inspiration for the latter.* Boom*'s editors graciously agreed to publish the top submissions from the fifty students in my two sections. A "Contested Ground" essay must cover a lot of ground, establishing the history of every faction of the contest and giving each point of view a fair shake. Sari did a great job at this, tracking down interview subjects and wrangling federal, state, humanitarian, and fiscally conservative concerns into the arena of her essay and showing us their uneasy interplay. In this course, students also served as editors as well as writers, writing rejection or acceptance letters for drafts, ranking final submissions. Sari's essay received the highest score out of all fifty students. It seems fitting that she should appear among the ranks of UCD's best student writers.*

— Laurie Glover, University Writing Program

Image 1: Entrance to Napa State Hospital[1]
"Our mental health hospitals, basically, are an extension of the criminal justice system" (Ken Murch, the chief negotiator for the California Association of Psychiatric Technicians).[2]

It has been two years since Donna Kay Gross, a psychiatric technician employed by Napa State Hospital, was strangled to death in the facility's fenced enclosure. Mentally ill patient Jess Massey, who was sentenced to the hospital by the court, committed the murder. The crime occurred at approximately 5:30 p.m. on Saturday, on a weekend, when security forces are reduced, making such crimes more likely.[3,4] Unfortunately, this type of violence occurs often in forensic hospitals, which cater to mentally disordered offenders. In fact, a Napa State employee admitted to me, "Every time I go into work, I am taking a substantial risk."[5]

Napa State Hospital is a 138-year-old facility located in the midst of hundreds of acres of picturesque wine country. The facility was not originally built to house the criminally insane, many of whom have committed murder, but rather, as Napa State Dr. Patricia Tyler explains,

"depressed grandmas."[6] Today, the hospital's primary patients suffer from schizophrenia and from mood, anxiety, and other personality disorders, illnesses that one of every seventeen Americans endures.[7,8]

The violence exhibited in Napa State Hospital, in many ways, is a result of the changes in the funding of mental healthcare in the United States and in California. What began as noble intentions to efficiently help

the ill have led to poor health care options and dangerous environments in both state hospitals and in the community. In the mid-twentieth century, as society became more tolerant and sensitive towards mental illness, it began implementing healthcare reforms. The consequent changes in mental health laws and the discovery of antipsychotic drugs catalyzed a transition from state-operated mental health systems to a decentralized system of community care. This shift has in turn caused a reallocation of healthcare funds and a change in patient populations in both prisons and state-run hospitals. To better understand the current state of mental health systems and the reason behind Napa State Hospital's unsafe conditions, one must understand the history of the changing mental health policies.

In the mid-1800s, Dorthea Dix took a stand to reform psychiatric history. By 1847, she had visited "300 county jails and 18 state prisons" to chronicle the treatment of mentally ill prisoners.[9] Dix's efforts led to the construction of many new state hospitals.[10] At the time she began her work, there was approximately one public psychiatric bed available per every 5,000 people. By the mid-1900s, there was approximately one psychiatric bed available per every 300 people.[11] Beginning in the 1950s, however, the mental health facilities in California and across the nation experienced humanitarian-based changes. In 1957, the conditions of our mental health systems and the resources allocated to them were reevaluated through the Mental Health Study Act. The 1961 report that the Act commissioned indicated that the hospitals were overcrowded and were being used to quarantine the ill rather than help them. Consequently, in 1963, President Kennedy appealed to Congress to pass a series of acts aimed at moving the mentally ill out of these prolonged confining conditions to voluntary community mental health treatment centers.[12] Concurrent with the legislation that Congress passed, California, a leader in mental health care at the time, passed the Short-Doyle Act to expand community-based mental health facilities even further.[13] Although the changes in legislature were executed with the best intent, the beds available in state hospitals are only a small number more than what existed before 1850.[14]

The Short-Doyle Act, created in response to the new tolerant perspective on mental illness, aimed at treating psychiatric patients close to home instead of in more efficient but distant state hospitals. This change in treatment location to community health centers allowed patients to maintain contact and receive support from close family, friends, and

personal physicians. Community healthcare would also "permit more effective treatment in the early stages of the disorder [and] … allow closer liaison between various medical specialists."[15] To fund the proliferation of community health services, the state matched the funds, dollar-for-dollar, of local governments wishing to establish health services. These services included inpatient and outpatient care and rehabilitative services in general hospitals.

In 1965, two years after the passing of the Short-Doyle Act, Medicaid was adopted into law, shifting the financial coverage of mental illness treatments even more dramatically. The change of money allocation was seen to favor community care over state hospitals like Napa. Medicaid-funded community-based health centers but not State Mental Hospitals. In addition to being funded by Medicaid, community health centers were also funded by the federal Community Mental Health Program. This change in funding encouraged the movement of patients from state hospitals to community health centers where the federal government covered half the cost instead of the state paying the full cost of state hospitals.[16]

These acts, along with the implementation of Medicaid, led to the closing or deinstitutionalization of seven California state hospitals.[17,18] In fact, during this period of closure, the number of available hospital beds decreased 87% from 558,239 in 1955 to 71,619 in 1994.[19] Although state funding increased for community-based services, and despite the initial success of the community mental health centers, the state of California failed to use the money previously allocated to state hospitals to improve these community services.[20]

In addition to the lack of funding and poor money distribution, Ronald Reagan signed the Lanterman-Petris-Short Act into law in 1967. This law purported that the only scenario in which the mentally ill could be contained in a hospital would be through psychological evaluation and criminal sentencing, as was the case with Jess Massey.[21] Through changing hospital commitments, the act led to further deinstitutionalization of state hospitals and the proliferation of the problem. Although community health centers sought to integrate the mentally ill into society, they instead let the ill out on the streets, often with nowhere to go.[22] Therefore, unless the patients were also criminals, the state hospitals had no reason to keep people hospitalized or help them even if necessary. Although this law seems insensitive to the needs of the sick, at the time, it was believed that

the invention of the first antipsychotic drug, chlorpromazine, commonly known as Thorazine, would help the ill become healthy or at least "normal." If people were prescribed these drugs, then the need for these state mental institutions would decrease and so would state spending.[23]

A few problems arose with the Lanterman-Petris-Short Act that have helped create the crisis we see today, including unsafe mental health hospitals and insufficient care of the mentally ill. First, there was no way to ensure that the newly released mentally ill would receive the medication and rehabilitation services necessary for them to live successfully in their communities. Secondly, even if they received medication, there was no guarantee they would take the medication, not only because they are unstable and need to be responsible to take medication consistently and correctly, but also because they do not enjoy the side effects. Lastly, due to the closing and consolidation of mental hospitals, there were not enough beds available for new mentally ill patients. With the rise of these problems and shift from state hospitals to community health centers, many patients wound up in adult homes or homeless in large cities without the care they required."[24]

Funding and healthcare service deficits led California to enact several pieces of legislation in the 1980s. One of these, the Bronzan-Mojonnier Act (1985), aimed to identify the flaws in the health service system, especially the criminalization of the mentally ill. It further aimed to combine treatment and rehabilitation in flexible services.[25] Despite these reforms, many counties still lacked the financial resources to deal with the mentally ill.

In 1991, in response to the fragile state of community mental health, the lack of financial resources and the $15 billion state budget deficit that would result in mental health cuts, California passed the Bronzan-McCorquodale Act, which came to be known as "Realignment." Realignment changed the way in which all community mental health systems, state hospital services for civil commitments, and mental health services for those in "Institutions for Mental Disease" would receive funding.[26] The new "realigned" revenues flow directly to the counties and are no longer allocated to the State General fund and thus are no longer subject to the annual state budget process. The money distributed to counties on a monthly basis comes from two sources: the state sales tax and state vehicle registration fees.[27] Realignment has generally provided counties with the advantages of a stable source of funding, fiscal flexibility

(i.e. ability to roll over funds to enable long-term projects), the ability to serve clients appropriately, and lower restrictive placement costs. Despite these benefits, "Realignment" has proven to be flawed: mental health is still insufficiently funded. It has not kept pace with population or cost of treatment growth, and it is also vulnerable to economic recessions.[28]

The shift in mental health focus from the state to the community level and the deinstitutionalization of state hospitals has packed the prison system with the mentally ill. According to a Los Angeles County jail psychiatrist, "We run the largest mental health facility in the county." Former Sacramento County Sheriff Glenn Craig similarly claims to have operated the "second largest mental health facility in the county" (the first being the county mental health center).[29] The U.S. Department of Justice reported in 2003 that in the preceding decade, forty mental health hospitals closed while four hundred new prisons were established.[30]

An estimated 10-15% of those who enter either the local criminal justice system or state correctional system are mentally ill. Once the mentally ill enter the criminal system, they fall through the cracks, due to a paucity of resources. As Marcus Nieto mentions in his analysis of the criminal system, "Local correctional systems do not engage in long-range strategic planning on how to best identify and serve the mentally ill offender at the local level."[31] In addition to the lack of planning, only state jails are licensed to have correctional treatment beds for mentally ill inmates and not county jails. Also, even if the mentally ill receive help through prescriptive medication, they have the right to refuse the drugs. Once mentally ill offenders are released from either local or state criminal justice systems, there are insufficient aftercare treatments and services for them. A 1991 study conducted in Los Angeles estimated that "90% of the mentally ill offenders receiving mental health services in the county jail were repeat offenders."[32] The help they initially receive does little to change their behavior or prevent them from reentering the criminal system.

Some of these mentally ill end up in forensic state hospitals such as Napa State Hospital. Napa, however, was not always dedicated to a criminally ill population. In fact, their change in patients directly resulted from deinstitutionalization. To avoid closure due to the rapid pace of deinstitutionalization, Napa State converted in the early '90s to primarily serving a population sent to the hospital by the justice system. These people are either incompetent to stand trial, are not guilty by reason of

insanity, or have already been convicted but have failed to comply with their parole terms, resulting in their hospitalization.

Due to the changing structure, Napa State Hospital now serves 80% forensic cases. This change has severely threatened the safety of the state workers and patients. In fact, a Napa State social worker confided in me that she has never seen the safety conditions so bad in her twenty-three years at the hospital. In 1998, to help improve the safety of patients and the overall Napa community, an electric fence was put in place to separate the mentally ill criminals from everyone else. These criminals stay within the fenced area for a maximum of three years, during which they undergo rehabilitative treatment. If they are found to still be ill by the end of the three-year period, they are moved outside the fenced area where they stay until deemed healthy. According to the Murphy Conservatorship, these people cannot be kept indefinitely without their case being reviewed every year.[33]

The fenced-in area does not seem to provide enough security for patients and workers. One of the main issues is that the hospital cannot afford enough guards or police officers to work within the fenced area. As a social worker commented to me, "We need more police in the units." After the death of Donna Kay Gross, a nurse told ABC news that having police in the units "makes a huge difference when they walk through." However, these officers are not permanently stationed inside these units. Interim director Dolly Matteucchi explains, "It has been [this] way ever since Napa State Hospital became a forensics hospital in the early 1990s." She further divulges that at Napa State Hospital, police were not "part of the living environment, twenty-four hours, seven days a week." Since the murder in late 2010, Matteucchi "has asked for twenty more officers who'll be assigned to [forensic] units." Instead of one staff member, two members also now escort patients outside the units. This, however, creates the issue of taking away staff from inside the units. The nurse mentions that when

Image 2: Dr. Richard Frishman, Napa State psychiatrist, photographed after patient-inflicted injury.[34]

several workers left to escort patients, "it resulted in one employee and one psychiatrist on the unit, for at least an hour with twenty patients."[36]

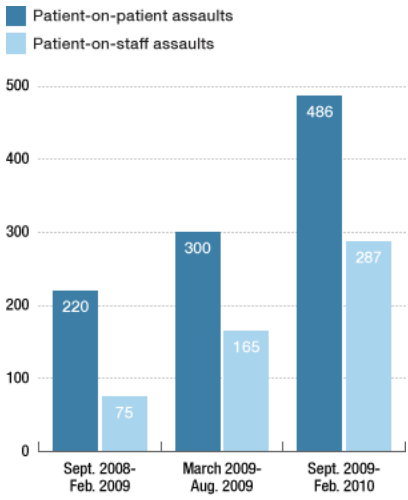

Figure 1: The rise of patient assaults from Sep. 2008 to Feb. 2010.[35]

Since 2010, Napa State has seen some major improvements, such as a new alarm device that state workers wear. These devices, when activated, use a global positioning system to identify the exact location of the employee. In addition to this device, thirteen hospital police officers and twelve new psych technicians have also been hired. While improvements have been made, psych tech Linda Monahan told ABC7 that there are still "way too many assaults" (see Figure 1).[37] Hospital employee unions would like to see officers armed with more than a baton and pepper spray; however, Matteucchi comments that there is no move to equip them. These unions would also like to see specialty units for the violently ill.[38]

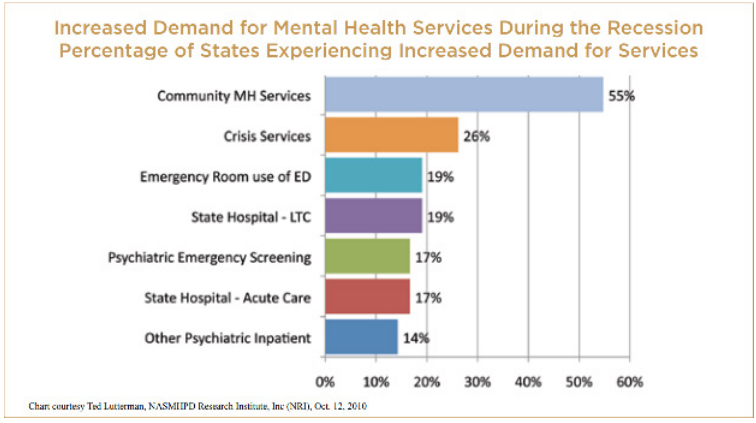

Figure 2: Demand for mental health services has increased while funds have decreased.[39]

Massive cuts to mental health services ($587.4 million in California from 2009 to 2011) have the potential to make our communities unsafe (see Figure 2). While the mentally ill are not necessarily more dangerous than the rest of the population, the risk of them becoming violent increases when appropriate treatment and support are not available. The mentally ill may turn to self-medicating through alcohol or drugs. In fact, a social worker from Napa State Hospital told me that many of her patients worsen as a result of their experimentations with methamphetamine. When the mentally ill do not receive help, they have difficulty staying in school. Lack of needed help among the mentally ill also leads to "suicides, homelessness, arrests, or incarceration."[40] Some violent events, such as the Sandy Hook and the Colorado movie theatre shootings, have been the result of poor aid to the mentally ill.[41] In fact, in a study conducted by the Secret Service's Assessment Center, "93% of assailants exhibited behavior that caused a school official, parent, or law enforcement officer to be concerned before the attack." It was also found that "34% of the assailants had a mental health evaluation prior to the attack."[42]

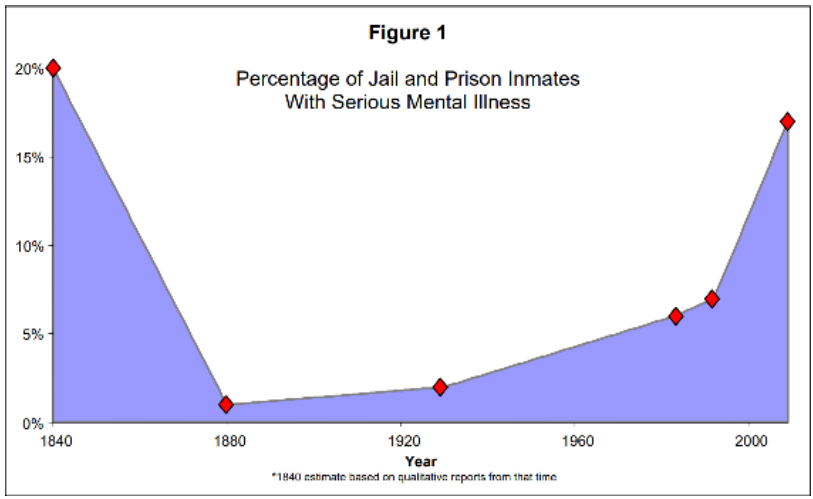

Figure 3: Rate of mentally ill prisoners is nearly the same as the 1840s.[43]

Despite the noble intentions behind the shift from state to community care, mentally ill patients are now worse off under state sponsorship, often having to fend for themselves. Sadly, the mentally ill population currently incarcerated is about the same as when Dorthea

Dix began reforming the treatment of the mentally ill in our country (see Figure 3).[44] Although there was no guarantee that state hospital patients could improve, many patients remained because of the financial support they would not receive elsewhere.[45] Now, we see many mentally ill on our streets because they lack affordable housing. As a Napa State Hospital social worker explained, "Unless the ill person has a case manager who can help him or her complete an SSI application (supplemental security income), many have to wait sometimes 6-7 months before they can even get money."[46] Not only is the form very complicated, but if the person is approved, he or she needs to have an address, which is hard to do when he or she is homeless.

Although there are places where the mentally ill can seek help, such as the community centers, diminished funding from budget cuts has resulted in a lack of staff. This not only can lead to inadequate services, but it also can delay the time it takes to accept a patient into the programs. Although Proposition 63, passed in 2004, increased taxes by 1% for those whose income is in "excess of $1 million," a Napa State Hospital social worker stated that she "sure does not see improvements from increased funds."[47] The mentally ill, with the difficulty of finding affordable housing and of getting in and receiving help from the community centers, become more susceptible to being homeless or ending up in jail.

As the old adage goes, "The more things change, the more things stay the same." Half a century ago, we aimed to integrate the mentally ill into our society; now, we imprison them. Locking the mentally ill in jail is just as problematic as placing them in faulty, overcrowded state hospitals. At least in the hospitals, the mentally ill could receive the help of treatment and the safety and security of a living environment. Imprisoning the mentally ill does not solve their health issues, nor does it help make communities safer. If anything, the perpetual imprisonment can add stress and exacerbate their symptoms. Further, imprisonment defeats the purpose if those imprisoned do not understand why their behavior is problematic. Although we have made improvements to the prison system, for example, getting rid of the three strikes law that permanently incarcerated people after three offenses, additional changes still can be made. Some of the main issues derive from decades of gradual cutbacks, lack of funding, and poor allocation of current resources. If hospitals such as Napa State and community health centers received more money, they could not only become safer, but more effective in

their treatment.

Notes

1 V, Paul. Entrance of Napa State Hospital, 2008, digital image, accessed March 8, 2013. <http://www.flickr.com/photos/pappyv/2463620988/>.

2 Mieszkowski, Katherine. "Napa State Hospital's Grisly Inside Story." The Bay Citizen, December 16, 2010, accessed March 6, 2013. <https://www.baycitizen.org/news/health/napa-state-hospitals-grislyinside-story/>.

3 Interview with Napa State Hospital Social Worker. February 5, 2013.

4 Lee, Vic. "Hospital Director Addresses Safety Concerns." ABC7 News. December 27, 2010, accessed March 4, 2013. <http://abclocal.go.com/kgo/story?section=news/local/north_bay&id=7851113>.

5 Interview with Napa State Hospital Social Worker. February 5, 2013.

6 Mieszkowski, "Napa State." 7 CA Dept of State Hospitals. "Department of State Hospitals -- Napa." Accessed March 6, 2013. <http://www.dsh.ca.gov/Napa/default.asp>.

8 U.S. National Library of Medicine. "National Institute of Mental Health," last modified October 12, 2011, accessed February 18, 2013. <http://www.nimh.nih.gov/health/publications/the-numbers-countmental-disorders-in-america/index.shtml>.

9 Torrey, E. Fuller. Out of the Shadows: Confronting America's Mental Illness Crisis. (New York: John Wiley & Sons, 1997).

10 Torrey, Out of the Shadows.

11 Torrey, Out of the Shadows.

12 National Institute of Health. "Important Events in NIMH History," last modified October 12, 2011, accessed July 20, 2013. <http://www.nih.gov/about/almanac/organization/NIMH.htm>.

13 Sarah Watson and Alison Klurfeld. "California's Mental

Health System." Insure the Uninsured Project, August 2011. Accessed March 8, 2013. <http://itup.org/wp-content/uploads/downloads/2011/08/Mental_Health_Report.pdf>.

14 Treatment Advocacy Center. "New Study Calls for Moratorium on Hospital Closures," last modified fall 2012, accessed March 8, 2013. <http://www.treatmentadvocacycenter.org/home-page/71/81>.

15 Auerback, Alfred. "THE SHORT-DOYLE ACT—California Community Mental Health Services Program: Background and Status After One Year." Western Journal of Medicine 90.5 (1959): 335-38, accessed February 18, 2013.

16 Watson and Klurfeld, "California's Mental Health System."

17 California Healthline. "California Faces Hurdles as More State Mental Institutions Close," last modified March 6, 2008, accessed March 6, 2013. <http://www.californiahealthline.org/articles/2008/3/6/california-faces-hurdles-as-more-state-mental-institutions-close.aspx>.

18 CA Dept of State Hospitals, "Department of State Hospitals."

19 E. Fuller Torrey, Aaron D. Kennard, Don Eslinger, Richard Lamb, and James Pavle. "More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States." Treatment Advocacy Center, May 2010. Accessed March 5, 2013. <http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.>

20 Ryan, Patricia. "California Community Mental Health Funding." California Institute for Mental Health, February 3, 2011. Accessed March 6, 2013. <http://www.cimh.org/LinkClick.aspx?fileticket=mOYILv5wc8w%3D&tabid=242>.

21 California Legislative Analyst's Office. "Major Milestones: 43 Years of Care and Treatment of the Mentally Ill," last modified March 2, 2000, accessed March 3, 2013. <http://www.lao.ca.gov/2000/030200_mental_illness/030200_mental_illness.html>.

22 California Legislative Analyst's Office, "Major Milestones."

23 Torrey, Out of the Shadows.

24 Scanlon, John. "Homelessness: Describing the Symptoms, Prescribing a Cure." The Heritage Foundation, October 2, 1989. Accessed March 6, 2013. <http://www.heritage.org/research/reports/1989/10/homelessness-describing-the-symptoms-prescribing-a-cure>.

25 California Legislative Analyst's Office, "Major Milestones."

26 "History and Funding Sources of California's Public Mental Health System." California Mental Health Directors Association, March 2006. Accessed March 6, 2013. <http://www.mhac.org/pdf/CMHDA_History_Mental_Health_Funding.pdf>

27 Watson and Klurfeld, "California's Mental Health System."

28 Watson and Klurfeld, "California's Mental Health System."

29 Nieto, Marcus. "Mentally Ill Offenders in California's Criminal Justice System." California State Library, February 1999. Accessed February 18, 2013. <http://www.library.ca.gov/crb/99/02/99002.pdf>

30 Sheth, Hitesh, Dr. "Deinstitutionalization or Disowning Responsibility." International Journal of Psychosocial Rehabilitation 13 (2009): 11-20. Accessed Mar 8, 2013. <http://www.psychosocial.com/IJPR_13/Deinstitutionalization_Sheth.html>.

31 Nieto, "Mentally Ill Offenders."

32 Nieto, "Mentally Ill Offenders."

33 Interview with Napa State Hospital Social Worker. February 5, 2013.

34 Potter, Kathryn. Dr. Richard Frishman, Image 2, April 7, 2011, Digital image, accessed March 8, 2013. <http://www.npr.org/2011/04/07/134961467/at-california-mental-hospitals-fear-is-partof-the-job>.

35 National Public Radio, Figure 1, April 7, 2011, Digital image, accessed March 8, 2013. <http://www.npr.org/2011/04/07/134961467/at-california-mental-hospitals-fear-is-part-of-the-job>.

36 Lee, Vic. "Hospital Director Addresses Safety Concerns." ABC7 News. December 27, 2010. Accessed March 4, 2013. <http://abclocal.go.com/kgo/story?section=news/local/north_bay&id=7851113>.

37 Wang, Alan. "State Hospital Workers Remember Death of Colleague." ABC7 News. October 24, 2012. Accessed March 4, 2013. <http://abclocal.go.com/kgo/story?section=news/local/north_bay&id=8857238>.

38 Wang, "State Hospital Workers."

39 Lutterman, Ted. Figure 2, October 12, 2012, Digital image, accessed March 8, 2013. <http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=126233>.

40 Honberg, Ron, Sita Diehl, Angela Kimball, Darcy Gruttadaro, and Mike Fitzpatrick. "State Mental Health Cuts: A National Crisis." National Alliance on Mental Illness, March 2011. Accessed March 8, 2013. <http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=126233>.

41 Gillette, Hope. "Adam Lanza: Complex mental health profile points to premediation." Voxxi. February 19, 2013. Accessed March 6, 2013. <http://www.voxxi.com/adam-lanza-new-evidence-mentalhealth/2/.>

42 Cooper, Donna. "Cuts to Mental Health Services Could Lead to More Spree Killings." Center for American Progress. July 31, 2012. Accessed March 6, 2013. <http://www.americanprogress.org/issues/civilliberties/news/2012/07/31/11871/cuts-to-mental-health-services-couldlead-to-more-spree-killings/>

43 Treatment Advocacy Center, Figure 3, May 2010, Digital image, accessed March 8, 2013. <http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.>

44 Fuller et al, "More Mentally Ill."

45 Aviram, Uri, D.S.W, and Steven Segal, A.C.S.W. "From Hospital to Community Care: The Change in the Mental Health Treatment System in California." Community Mental Health Journal 13.2 (1977): 1-11. Accessed March 8, 2013. <http://socialwelfare.berkeley.edu/Faculty/publications/ssegal/From%20Hospital%20To%20Community%20.PDF>.

46 Interview with Napa State Hospital Social Worker. February 5, 2013.

47 Department of Mental Health. "Mental Health Services Act

(Proposition 63)."Accessed March 4, 2013. <http://www.dmh.ca.gov/prop_63/mhsa/>.

Amber's Case: The Warehousing of California's Mentally Ill Children

Rachel Jacobs

Writer's Comment: Throughout the long ordeal of seeking treatment for my mentally ill daughter, I have actively pursued every possible way to advocate for Amber in her struggle to recover her mental health. Amber is one of the faceless, voiceless children that are shuffled through the juvenile court system in search of appropriate treatment. Amber's story is typical of what happens to mentally ill children, who, because of their resistance to treatment and a tendency to run away, require locked mental health facilities. Although the voice in this article is mine, Amber gave me permission to tell her story, in the hope that her experience will show how urgently we need to provide appropriate care for our mentally ill children.

I wish to thank Jayne Walker for her encouragement and her belief that this article deserves an audience, and for her tireless editorial efforts in my behalf.

Instructor's Comment: In "Amber's Case," Rachel Jacobs's first-person reporting transforms painful experience into powerful advocacy. She tells the story of her daughter's mental illness lucidly and unsentimentally, weaving in contextual details that make the reader see both how and why Amber has been so poorly served by a "system designed to fail her."

Another of Rachel's pieces, "The Invisible Parent," scored equally high in the Prized Writing *competition. She decided, and I agreed, that this is the one that should be published. The issues that "Amber's Case" illuminate have gone virtually unreported in the press. Because she is committed to publicizing the plight of children like Amber,*

Rachel enrolled in my feature article writing class and learned how to apply her talent and training in writing fiction to reporting. I'm delighted to think that this Prized Writing clip will help open doors for her as a freelance writer.

—Jayne L. Walker, English Department

I have few photographs of Amber from the last four years. Those I do have are marred by shadows of twisted barbed wire and a "Take Pictures Here" sign that looms over her head. In all of them, she is backed up against a red brick wall clad in a prison uniform of royal blue t-shirt or sweatshirt, jeans, and white athletic shoes. Amber is an inmate in the California Youth Authority in Ventura. Her crime is being mentally ill, and she is there because, in the final analysis, there was nowhere else for her to go.

Four years ago, on a sweltering August afternoon, I committed my thirteen-year-old daughter Amber to Sunridge, an acute care mental health facility in Marysville, California. That day was the beginning of a long, heartbreaking journey to obtain long-term care for my seriously ill child.

At the time of her initial hospitalization, we were living in a homeless shelter, the consequence of my ex-husband's refusal to pay child support, and my inability, despite my position as head cook at a local senior care facility, to pay our $650-a-month rent in Grass Valley. It was at the shelter that Amber's long-standing but untreated mental illness began to play havoc with her already tightly circumscribed life. Despite the many horrendous experiences I had endured, including rape, Amber's hospitalization and subsequent diagnosis were the most difficult challenges I had ever encountered. And they were only the beginning of my ongoing struggle to obtain proper treatment for her in a system that is designed to fail her.

That summer, Amber's behavior was wildly out of control, swinging from extreme agitation and hyperactivity to lethargy and suicidal depression. She was diagnosed as suffering from bipolar disorder, better known as manic-depressive illness, and borderline personality disorder. While some of her symptoms were caused by the street drugs she sought in an effort to self-medicate, some of them typified my daughter's temperament from birth.

For years I had told friends that something was wrong with Amber. Amber was a difficult baby and an impossible toddler. She was different from other children and seemed always to be struggling to keep herself under rigid control. When she lost control, she raged for hours on end. One afternoon, when she was four, she ran around her bedroom in circles screaming at the top of her lungs for nearly two hours. I never knew what to do when these tantrums occurred. She was beyond soothing, or punishment, or threats, locked into some outrageous cycle of activity promoted by an unseen attacker. But when she was in control, she could be golden—polite, sweet, obliging, and always brilliant.

As a child growing up during the fifties, I was fascinated and horrified by The Bad Seed, the story of a beautiful girl child who charmed everyone but her mother. While Amber was far from the psychotic child murderer of the film, she exhibited what psychiatrists term "inappropriate emotional response." Her smiles looked strained and awkward, as if someone had painted them on. She laughed when other children showed fear or alarm. But for the most part, her emotional response was flat.

Amber rarely slept for more than six or seven hours at a time. By the age of eight, she was staying up half the night reading or cleaning her room. She refused to wear any but the softest clothing and busied herself with mindless activities like rearranging her toys over and over. Amber never felt the carefreeness we associate with childhood. She was always burdened with cares.

I rationalized that her "bad" behavior was caused by colic, or the terrible twos, or hypersensitivity. The truth was, I was afraid. And when she was golden, I could dismiss my intuition that something was very wrong with her. Until the second semester of the fifth grade, when her world shattered because of her parents' divorce, Amber was every teacher's ideal student. Her first grade teacher wrote, "Amber does most things well. Her mature attitude and good study habits result in excellent achievement. She learns quickly, and academically she excels. She is a leader, a help to others, and mostly a positive influence in the classroom." Amber is also a beautiful child. One psychiatrist described her as "tall, slim, and extremely attractive, with long, lustrous, auburn hair."

The social worker and child psychiatrist at Sunridge recommended long-term residential care for Amber. They said that, although lithium had brought her bipolar disorder under control by the end of her thirty-

day maximum stay, her borderline personality disorder required the discipline of a rigidly structured environment. If she did not receive this kind of treatment, her long-term prognosis was extremely poor. She might easily die of a drug overdose or suicide within a year. Or she could commit a violent act that would result in her incarceration. But when personality disorders presented themselves as early as Amber's had, her psychiatrist reassured me, there was a good chance that behavior modification therapy could enable her to lead a productive life. Then the psychiatrist threw the final punch. He said that Amber might suffer from "the bad seed syndrome" caused by a genetic brain malformation.

When I left his office, I almost collapsed in the parking lot. I felt then, and I still feel at times, that my daughter had been given a death sentence. At least, my hopes and dreams for her had died. I've learned since that the grieving process is much the same as when a parent loses a child in death. For almost six months, I cried every day. And I blamed myself for her illness.

Why hadn't I had her treated before? Why hadn't I taken her to a psychiatrist when I first suspected she was ill? The reason is that mental illness, and the denial that sometimes accompanies it, runs rampant in my family. Or as Cary Grant quipped in Arsenic and Old Lace, "It doesn't run, it gallops." On my father's side, one child in every generation suffers from it. His grandmother was mentally ill, and his sister was institutionalized repeatedly until she died of alcoholism at the age of forty-seven. Yet when I asked my father her diagnosis, he said he wasn't sure what it was. My brother made national headlines when he killed his ex-wife's lover in a manic rage a few years ago. But it was my mother's severe mental illness that colored my assessment of my daughter's behavior more than any other factor.

My mother suffers from bipolar disorder and several personality disorders, including histrionic, narcissistic, and borderline. She refuses to admit her illness, despite one hospitalization, and therefore remains untreated. There is an unwritten law in my family that we do not speak of my mother's mental illness. We were taught to accept her abhorrent and irrational behavior as normal when we were growing up. This learned acceptance of wildly abnormal behavior caused me to distrust my feelings and to blame myself for the irrational actions of others. It is also the reason I married a man who mirrored my mother's behavior. Amber's dad was diagnosed with bipolar disorder and borderline disorder after our divorce.

Because of this history, my daughter's diagnosis hit me particularly hard. I had seen too many lives, including my own, ravaged by mental illness. Now, I thought, she at least has a chance. I can find her the help that my mother, brother, and ex-husband didn't receive until much too late. I asked the social worker how I might obtain proper care for Amber. I was informed that MediCal, our only insurance at that time, refused to pay for long-term juvenile residential treatment. Our best hope, she advised, was to involve the juvenile probation department, in the hope that the court would place her in an appropriate facility.

Amber was already on informal probation for pushing down an ex-boyfriend at school. She had thrown rocks at his house and made harassing phone calls to his home. I was advised to call the probation department whenever she disobeyed one of the many stipulations of her probation. For instance, when she refused to attend school, or left the house without permission, or broke curfew, or associated with undesirable peers, I reported these infractions to her probation officer. Poor behavior that other parents might have handled at home, or possibly dismissed, was handled by the probation department, because I was led to believe that sooner or later the court would place her in an appropriate treatment facility.

One evening, approximately three weeks after her release from the hospital, Amber informed me that she was going out to meet her friends, all of whom were addicted to crank, and that there was nothing I could do to stop her. She screamed at me relentlessly for almost an hour as I tried to reason with her. Finally, she headed for the door. I moved to block her escape, and she pushed me aside and bolted. Amber had a history of running away. Once, she was gone for two weeks. I phoned the police and asked them to pick her up. Within ten minutes, she was back home in the company of two officers. I explained the situation to them and asked them to take her into custody. They said their hands were tied unless I filed an assault charge against her for shoving me. I reluctantly filed the charge, and they handcuffed her and took her to Juvenile Hall. This was the beginning of our long, tedious, disappointing journey through the juvenile court system.

Amber spent a month in the Hall; then she was placed on formal probation and rendered a ward of the court. Soon after her release, she was picked up again as a runaway and taken back to the Hall. This time she spent two weeks there before she was released, and the pattern

repeated itself. In December of 1993, four months after her diagnosis, she was placed in Our Family, a group home on the grounds of Napa State Hospital.

According to Ron Sater, a mental health worker in Yolo County, approximately 125,000 emotionally disturbed children in California eventually make their way into the system seeking treatment. Group homes, the most common solution, are numbered according to the restrictiveness of their environment. Children as ill as Amber, who resist treatment and have a history of running away, require locked level-fourteen group homes. What I wasn't told when I began pursuing treatment for her was that California does not currently have licensed, locked level-fourteens. As a result, four hundred Californian children are shipped to Utah, Nevada, Arizona, and other states that offer these facilities.

Our Family was entirely inappropriate for Amber. A popular program for drug-addicted teens, it is staffed by recovering addicts who are not trained to care for the mentally ill. Their policy is that the children are not allowed to leave the grounds, but if they do, they are no longer the legal responsibility of Our Family. Twice, they called to inform me that Amber had walked into Napa and that they were looking for her. The second time she walked, Amber spent the night with a family who found her sitting in front of a 7-11 at midnight, being harassed by a group of boys. The next day she was discharged from Our Family and ridiculed by the staff for failing their program.

Within a month, she stole my checkbook. Her boyfriend forged and cashed $600 worth of bad checks for her and gave her a ride to Reno, where she spent two weeks living with a prostitute. She was found sleeping in a car after trying to drown herself in the Truckee River. The child, who, only two years before, had been selected as "Student of the Year," was hauled into the courtroom shackled and handcuffed. She had not taken her medication in over two months and was again completely out of control. Aware of the seriousness of her illness, the judge placed Amber at Kingsview Mental Health Center in Reedly, California. It was now eight months after her diagnosis.

After her placement at Kingsview, I began attending family support groups sponsored by the California Alliance for the Mentally Ill, or CAMI. At forty, I was the youngest parent in the group and the only one with a child who was not schizophrenic. All of us related experiences of

children who spent time in jail or prison. Most of our children had lived on the streets at one time or another. Too many tears were shed at those meetings by parents who had watched their children fail one inadequate placement after another.

It is safe to say that a large percentage of the 125,000 children in need of mental health care live on the streets. Why? Like my daughter, they resist treatment, develop the dual diagnosis of addiction and mental illness, and slip out of the system as runaways. When Reagan emptied out the mental hospitals with the sanction of the ACLU to give the mentally ill their "liberty," sentimentality as opposed to good sense was the order of the day. As much as some may rail against the idea of locked wards, there will always be those who desperately need the opportunity to be treated within the safety and security they afford.

Of course, the real reason behind deinstitutionalization is economic. State hospitals are expensive. Today, out of the original five, only one is left, Metro in Orange County. Camarillo was recently closed to make room for a junior college, and the children's ward at Napa is being closed while the rest of the hospital is converted to a forensic facility. The new method of standard treatment is not costly institutionalization but "diagnosticate, medicate, and vacate." Those children who are too ill to care for themselves, or to be cared for by family members, fail at one group home after another until finally, only out-of-state placement or the California Youth Authority awaits them. Support services, like respite care, are offered to the families of mentally ill children in only 12 out of 58 counties, and these were developed through the relentless efforts of CAMI. If these children were cancer victims, the public would demand that the appropriate care facilities be made available. Because they are mentally ill, and because many of them have been branded "bad" or juvenile delinquent, they are written off.

At Kingsview, Amber repeated her pattern of running away. She fled with a male resident, and when she was returned, she was arrested for attacking a staff member. By this time, she was institution savvy. She could get herself discharged for two violations: running away or attacking a staff member. Her attacks generally consisted of spitting or tossing glasses of water. She had also started self-mutilating, cutting her arms with whatever was handy, a nail, a razor, a paper clip. After she severed the major artery in her arm, she was confined to the locked psychiatric ward of a local hospital. Upon her release, Kingsview discharged her as

"unsuitable for their program" and recommended a locked level-fourteen home. When I called to find out where to find this kind of facility for Amber, her psychiatrist told me that there weren't any such facilities in California, and that my best hope was to get her into Napa State Hospital. Once again, I brought her home, and soon after, she was taken back to Juvenile Hall for again violating her probation. She had run away and, on a rainy night, had broken into a public school in search of shelter.

It was now December of 1994, sixteen months after her diagnosis. In order to improve my family's financial situation, I had returned to college. I was accepted at the University of California, Davis, and my son and I moved to Yolo County. Amber's probation officer in Nevada County, who had known her since she was in second grade and always liked her, consistently acted in Amber's best interests. We were in for a rude awakening in Yolo County. Although the probation department acknowledged that Amber did not have the criminal record that would ordinarily warrant such a placement, they recommended that she be incarcerated in the California Youth Authority in Ventura, the only girl's CYA facility, for four years or until she turned eighteen.

The California Youth Authority is a child's prison. Most of the teens there are violent gang members, murderers, rapists, armed robbers. Or they are seriously mentally ill, and CYA is an inexpensive place for the counties to dump them. Amber's public defender pleaded that she be sent to the Juvenile Ward of Napa State Hospital, which had not yet been closed. Napa is close enough to Davis that we could have visited her regularly and participated in family therapy. This therapy would have facilitated a smoother transition home when her treatment ended. Instead, a month before her fifteenth birthday, Amber was sentenced to four years in CYA by Judge Arvid Johnson. Judge Johnson refused to address the issue of Amber's mental health. He is on record as saying that "the state of California is not a bottomless money pit" and that Yolo County could not afford to pay for her hospitalization. He said he had heard, although he had no firsthand knowledge, that CYA had many good programs for children with "problems." The public defender contended that CYA is a warehouse for mentally ill children the state does not want to treat.

Amber was in the general population without psychiatric treatment or medication for eight months. The psychiatrist who did her incoming evaluation diagnosed her as suffering from acute amphetamine

withdrawal and not manic-depressive illness. A serious manic episode and my intervention transferred her to the psychiatric ward, where she was re-evaluated, diagnosed as manic-depressive, and treated with lithium. Months later, she was re-diagnosed by their psychiatrists as also suffering from borderline personality disorder and obsessive-compulsive disorder.

In the last two years, CYA has provided Amber with enough care to obtain her high school equivalency degree and complete one semester of junior college. She has been up for parole several times, but she consistently sabotages her release. Amber is now thoroughly institutionalized, afraid of being on the outside. Her most recent parole date of June 1997 was denied for a "sexually acting out episode" (making out with her boyfriend). For this infraction, she was also sentenced to a time-add of nine months and dropped from the work program and from college. As one of her doctors wrote, "Often her acting out in the Ventura School environment does lead to punitive measures which simply drive her defiance in a vicious cycle."

It is now highly unlikely that she will be released before June of 1998, when her maximum sentence is served. Because of the distance and my financial situation, I have visited her only three times in two years. I worry about what will happen when she is finally dumped back on the streets without a community transition program, something the state offers its hardened criminals but denies its minors. During her internment, she has developed a gang mentality and is now at higher risk for later being confined to prison as an adult.

If the residential program that Amber required had been available immediately upon her release from Sunridge, I am convinced that she would not have a criminal record and would now be well enough to live at home. Within two years after Amber first entered the "mental health" system, I learned that MediCal had begun paying for long-term residential care. Ironically, this was too late for Amber because by then, she was a ward of the court and ineligible for MediCal. But I now know that even if money had not been an issue, there still would have been no place in California where she could have received the level of care she needed.

Twelve years after California passed the Community Treatment Facility Bill, the locked level-fourteen group homes that it authorized have yet to open. Since 1985, social workers, mental health workers, and children's advocates have debated the rules and regulations under which

the facilities should operate. While they argue the humanity of using five-point leather restraints on disturbed children, those the facilities were designed to treat are placed out-of-state and hundreds of miles from home by compassionate judges or incarcerated in CYA by the less than compassionate, or they end up living in the streets. And thousands of parents mourn the loss, and the losses, of their mentally ill children.

Strangers in the Night

Michael Ju-Hyun Cho

Writer's Comment: When I started college, I wanted to put theory into practice—to apply what I learned in the classroom to real-world, hands-on situations. Pushing beyond the monotony of textbook education or passive learning, I felt I could make a difference working at a group foster home for boys with severe conduct and emotional disorders. Tangible experiences are genuine and exercising principle into action is what education is all about. Pursuing studies in psychology, I believed the internship would open my eyes to the field. And it did. I wrote "Strangers in the Night" for my English 101 Advanced Composition class under the guidance of Dr. Stephanie Wells, who has a knack for bringing out the best in her students' writings. The essay reveals the tragedy of sexual abuse and provides insight on how counselors work to rehabilitate and cycle the boys back into mainstream society.

Instructor's Comment: Michael wrote this vivid essay in response to my English 101 (Advanced Composition) assignment that he write a reportorial paper, selecting a specific context in which to observe the actions and behaviors of a certain group of his choice and then documenting those observations cohesively. True to his writing style, Michael's essay integrates the factual details of his experience with a narrative fluency that animates his topic and characters as engagingly as fiction, driven by his descriptive prose and his ear for the rhythms of language. I also enjoy his method—which I've noticed in more than one of his essays—of allowing certain phrases, usually spoken expressions, to become leitmotifs that signify a certain recurring state

of mind or character. The combination of truth and pathos that the essay presents manages both to describe and to object to the plight of its subjects, so that even without overtly politicizing its topic, the essay still becomes an implicit demand for attention and action—simply by its reportorial presentation of the only other and all-too-real alternative.

—Stephanie Wells, English Department

Twenty-one years and 109 days is a lo-oo-ng time. But that's what it took. On day number 7,775, I was bitten by an animal with teeth. Not the enamel of any ordinary beast, but one classified under genus *Homo* and species *sapiens*. And 7,775 must have been my lucky day since, by the beginning of day number 7,776, I was the proprietor of three fresh bite marks—angry red imprints blemishing the pinky edge of my right hand, my left ankle, and my right butt cheek. These painful bites came courtesy of three young boys: Andy, David, and Sammy. In brute testimony to their Hannibal Lechter inclinations, I carry these battle scars to this day. I was branded by these human staplers—"welcome to our world"—on the first day of work. Being chomped on like a Kit-Kat bar comes with the territory of working in a group home for boys who suffer from severe behavioral, emotional, and conduct disorders. At times, it can be a pain in the ass—in both a literal and figurative sense.

3:15 am, Monday (November 6)

A set of fingers taps me gently on the shoulder.

"It's your turn. Hey, do you hear me? This interval is all yours."

I raise my tired head from the dog-eared pages of a microeconomics textbook and stare into the bleary eyes of Vivian, my colleague.

"What time is it, Viv?"

Her brows arch with indifference. With a sigh, she glances at her wristwatch. "It's 3:15 and you've got to make your rounds."

Following a world-class yawn, I shake my head side-to-side, in a futile attempt to evict the weariness out of my brain. Morning is still a good three hours from breaking. I stretch slowly, pulling my arms heavenward and curling my hands into two tight fists. A satisfying series of "cracks" and "pops" emanate from my once dormant shoulders and

fingers. I unclench my fists and flex my fingers. Remorsefully, I rise from the comfort of the sofa cushions.

"The flashlight's on the counter," offers Vivian, as she plops down exactly where I had been sitting moments before. She picks up an old issue of Rolling Stone and yanks out a pair of flattened Hershey bars from her hip pocket.

"The Christina Aguilera tramp is a toothpick," Vivian grumbles, as she decapitates the outmatched Hershey.

"She is, she is," I concur, heading toward the hallway. "See you in fifteen minutes."

With nary a glance, she nods and calls out behind me, "Take your freakin' time." She takes another mammoth chunk out of the chocolate. The other bar sits humbly on the table, awaiting execution.

I tiptoe into the darkness, sure of my destination. After a couple seconds, the rods in my retina begin to adjust to the colorless night. The small flashlight extends a faint beam of illumination as I slink—my sneakers squeaking quietly with each step against the cold and hygienic concrete floors—toward the first of three consecutive doorless rooms.

From the vacant doorway, I peer cautiously into the first small room. The space is limited, with beds stacked side-by-side, two per room. With experienced eyes, I scan for detectable signs of movement or feigned sleep—mischief from the room's two occupants. I am greeted by the slight rustles, faint and abbreviated snores, deep inhalations, and soft exhalations.

All quiet on the western front.

"Angelic only during sleep," I say to myself, "And a pack of wolves at sunrise." Without a sound, I tiptoe to the room next door. Two more slumbering figures inhabit the two separate beds—a mirror image of the first. Sleep well, boys. Breathing a sigh of relief, I head toward the final room.

So far, so good . . . all quiet on the central front.

The third room—the eastern front—holds the final two boys. I stand at the entrance and glance at the diminutive and well-covered lumps on each bed. Nothing at all. I could hear only the jaunty drip-drip-drip of the leaky faucet from across the hall. All quiet on the—

Suddenly, I hear a muffled whine, delicate and barely audible. Like a baby's soft whimper. Unable to hear the words clearly, I tiptoe toward the source, reassured by the flashlight's soft glow. Beneath the enormous

Sesame Street comforter is young David—an eleven-year-old who has yet to crack the century mark in weight. He had been the first boy to greet me with his jaws, two months before.

"Hey David buddy, you doing OK?" Under the covers, David flinches at my voice—his tiny body tenses up, and his soft trembling abruptly ends. He lies there, frozen. Dead silence. I hear the drip-drip-drip once again.

Then I hear a tiny peep response. "Who is it? Who's there?"

"It's Mike, your friend. Just making sure you're getting sleep. Making my rounds like always. Hey, you can poke your head out, y'know . . . I know you're awake."

"Where's Viv?"

I kneel at the foot of the bed. With the most reassuring and consoling voice I could muster, I say, "C'mon David, come on out. Vivian's in the front, reading away. C'mon David, you can tell me what's wrong."

After a couple of seconds, a small blond head peeked out. We speak in gentle whispers.

"Hey Mike, what time is it?"

"It's almost 3:30 in the morning."

I hear him shuffling in his bed, moving the blankets back.

"It's really dark right now. Hey, am I going to be in deep trouble for being up this late?"

"Nope."

"How about Viv?"

"What about her, David?"

"She stinks like a cow . . . and chews like one too!"

We giggle softly.

"Mike, can you turn on the lights? I can barely see anything."

He reaches for a pair of thick eyeglasses—glasses that make his pale blue eyes look three times their actual size.

"Afraid not . . . your roomie is sleeping in here too, remember?"

"Uh-huh. And I've got to make the right decision, right?"

"That's right David. Besides, you should be in la-la land, dreaming of Pokemons or something."

"I know. But I'm scared, Mike. Really scared."

David stops, taking a deep, slightly wheezy breath.

"Hey, it's okay. I'm here. Besides, everyone has bad dreams—"

Suddenly, the boy begins to weep—streams of hot tears flowing

freely from his pale blue eyes. This takes me completely by surprise. He is inconsolable with a cry so grief-stricken, so terribly aching, that a lump quickly rises in my own throat. David's face pinches with a pain and anguish I can never imagine. His body quakes with shudders. He angrily yanks the glasses off his head and flings them against the wall.

"Why, why, why?" He repeats this over and over again, choking with sadness. He buries his small, drenched face into my chest. "Why, why, why?"

"Can't you make them go away?"

I realize this was the question David was asking himself when I first heard the sounds of whimpering coming from the eastern front, the third and final room at FIF foster home. His questions do not need any translation.

Why am I here? What am I doing here in this cold room, a prisoner? Why did my damn father beat me? Why didn't my mother stop him? Why did she just stand there and watch him beat me senseless? Why do I have such terrible dreams? Why? Why? Why? What did I ever do to deserve this life?

I could only hug David as he cried for a lost childhood. Nightmares or flashbacks are painful to witness. You look into their cold, hard eyes and confused, terrified little boys peer back. I will never forget those sad, yearning eyes. These kids are in their own private hell.

They remember the pain, the agony, the humiliation we can never understand. We can only promise that everything will be all right when we know it won't ever be. They weep. Why did he hit me so damn hard, huh? What the hell did I do?

Pounded for most of his childhood, David now has trouble seeing straight. He wears glasses. In optometrist parlance, terms like "detached retina" or "occipital lobe damage" spill out. David also has functional and cognitive problems stemming from getting his brain smacked against the back of his skull repeatedly. I read his FF file earlier that fall—minor traumatic brain injury, antidepressants, perceptual disorder, severe child abuse. David carries the look of a deer caught in the headlights. Always flinching. A scared little boy. Ducking down, raising his skinny arms in self-defense to protect his head. Whom can he trust?

For now, he trusts me.

His sobbing is the guttural sound of real, profound physical and emotional anguish. It is like a terrified, involuntary wailing that one would make immediately after hearing about the death of a loved one.

So, David cries for a dead childhood. The sound of the crying is the most terrifying sound I have ever heard.

Why, why, why? What the hell did I do?

I wonder the same exact thing.

FF rules and regulations state that counselors should not stay in the boys' rooms for long periods of time—basically, my job at night is to "check" on the boys and leave them be. In nights like these, those damn rules can go to hell.

I cradle David in my arms, knowing that kind touch—genuine, gentle, sincere, and affectionate contact—is what he is missing. Throughout his life, all he's experienced are hard fists to the side of his head. I spend the rest of the morning with David, watching him sleep and offering a reassuring squeeze whenever he stirs or whimpers.

Vivian understands.

Soon enough, I could hear only the jaunty drip-drip-drip of the leaky faucet from across the hall. All quiet on the eastern front.

10:30 p.m., Sunday (November 26)

Today is one of the nastiest days of the winter season. The torrential rain pelts the earth—huge globules of water saturating humanity. Powerful gusts of howling wind aren't helping matters either. My shift begins in fifteen minutes.

For the boys living at FF, a stigma exists. Your parents beat you. They hate you. You are in custody of the state. You are a screwed-up, hopeless, pile of crap with no future. In the game of life, you are one big loser.

These youngsters are aged seven to twelve, and all are appointed to this home from court rulings as a result of extreme parental neglect or sexual abuse. Name a major emotional or psychological disorder, and I can guarantee at least one of these kids has it. There are twenty-four boys at this level-14 facility, spread across four "campuses" in the city.

The primary reason that these boys are here is their acting out of deviant and sexual behaviors. Some of the older ones have already spent time in juvenile hall facilities—for them, this foster home is their last chance to integrate into society.

What is considered "normal" is dictated by social order. What is "wrong" is an action that deviates from the standards and rules of society. In a nation built on individuality, liberty, and justice, a fair degree of conformity is required to live as productive citizens.

Boys placed at FF are short in these respects. They suffer from fits of aggression that make them highly at-risk. Without proper help and direction, these boys will end up cycling through the judicial and penitentiary system for the rest of their lives.

As a counselor, I guide these children to become more attuned with the norms and proper conducts of society. Though an intern, I am committed to helping these emotionally disturbed boys with their difficult problems and to teaching verbal prompts, decision-making skills, and conflict negotiation. Above all, my most important duty is ensure the child's environment is safe.

Tonight, I am working with the infamous "brat pack"—six boys with the some of the worst behavioral records and hostility in the program. These six are extremely unpredictable, ready to explode without reason. The brat pack is edging toward oblivion—hopelessness. They do not respond well to treatment, medication, or authority. These boys are violent, angry, and frustrated. Mushroom cloud mad.

At 11 p.m., none of the boys wants to sleep—an hour behind schedule. They scream and curse with a vengeance. F-this and F-that! F-you and your mother! A flurry of rock-hard fists, young Andy is restrained and sent to the residential QR (quiet room)—more a padded room than anything else. Upon apology and understanding of his wrongdoing, he swaggers back to his regular room and proceeds to wrestle his sleeping roommate.

He is returned to QR. Now his roommate, Chris, is furious.

By 2 a.m., a collective sigh of relief emanates from the staff as the six boys sleep. The counselors check on them every 15 minutes. This period of reprieve is short-lived.

At 3:30 a.m., I notice a distinct stench wafting from the western room—a blend of urine and excrement. For Tom, the humiliation and shame involved is obvious. He denies all "allegations" and refuses to move. Again, F-this and F-that! F-you and your mother!

For his attentive roommate Greg, this is an episode deserving much ridicule. At 4:00 a.m.—after applying the power of persuasion to its maximum potential—I march an angry, soiled boy to the showers and laundry room.

Tonight, bleach is my best friend.

The counselors hate doing the laundry—sheets stained with blood, tears, vomit, shit, piss, and other unsavory bodily secretions. I drown the

sheets and clothes with the mighty bleach, washing away the shame and guilt, the anger, and the pain.

At precisely 7:00 a.m., little Johnny makes his traditional, albeit unsuccessful, dash for the door. At 7:05 a.m., the chubby boy sulks back to his bed with a stern warning to make the "right" decision. As the new day breaks, the counselors busy themselves in laundry and cooking. These boys must be fed, cleaned, and ready for school (non-traditional, of course) in forty-five minutes.

I try to have a normal conversation with the boys, but it is difficult; they only seem to want to bend the rules, test your authority, eager to scream no's! and how come's. Using verbal prompts and positive feedback, I reinforce their need to make the right decisions.

They look bored.

At 8:15 a.m., the brat pack is on its merry way to school, where they will learn how to multiply and divide or differentiate between an adjective and an adverb.

What's the freakin' point?

Angry and confrontative, these boys have no indiscretions—they will sexually act out, masturbating frequently and publicly. The boys are manipulative, hostile, and impulsive.

They cannot or do not want to differentiate between right and wrong, good or bad. One moment, they will be watching TV; the next instant, they are molesting the boy next to them. What is scary is no one is truly sure what these boys are capable of doing.

Some nights are easy—though restless, the children are obedient and compliant. Some nights are hard—all hell breaks loose as angry boys vent.

It's been a hard day's night.

10:30 p.m., Sunday (December 17)

Winter is the cruelest season of all. What's there to look forward to—non-existent families and friends? To these boys, holiday spirit means absolutely nothing. With the rain and biting cold waiting outside, the boys stay inside the facilities, smack down in front of the TV.

These kids may hate the world, but they sure love the idiot box. Since channels are restricted, the boys ogle the Cartoon Network with near-religious zeal. *Johnny Bravo*, reruns of *Scooby Doo*, and old Warner Bros. classics like *Huckleberry Hound* and *The Jetsons*. Hours and hours of

brainless animation orgy. On day one I learned the obvious. Change the channel, and those kids will eat you alive.

The boys stare at the TV set, usually not laughing at the jokes or physical comedy. They just continue to stare with vacant expressions, snot dribbling down their noses. In their own little worlds.

The internship positions are ending, pending finals week and holiday vacation. The old, disillusioned, and wizened veterans of FF will be gone come January—not surprisingly, lingering nostalgia rarely exists.

But in our place will be yet another anonymous load of wide-eyed, overly enthusiastic, and innocent university interns. We nod at their exuberance as the rookies sign up for the graveyard shifts. Can't be that bad . . . these kids will be sleeping, right? And I get four units of upper division credit, right?

We place bets on the incoming "class"—Who's going to last? Who's going to break down? Who'll be here for more than just a couple days? My poor naive students, prepare to be shocked! The meek may inherit the earth, but they sure won't survive a night at FF.

The Christmas season is the loneliest time of the year—none of the bright wrapping paper, the glowing tree decked with glassy ornaments, or the smell of holiday feast can soothe the kids. There is no sweet surprise. Santa Claus is a lie. There are no hugs and kisses from those who care or should care.

Some of the kids sit by the phone all day, eagerly anticipating a call that will never come. David and Chris always dress up and pack their bags, expecting to be picked up by grandparents or relatives. Sometimes, even they don't show up. With every passing day, the boys become more hostile, more angry, and more bitter.

Tonight, Andy is puking again. He used to spend his early days, vomiting and wailing in the night—for a mommy who will never show up. From what the other counselors tell me, the symptoms return during Christmas.

He has a long, ugly scar that runs from the tip of his right elbow to the back of his hand. It is dark brown against his fair skin—a reminder that what has occurred would always be a part of him, no matter how much he tried to cover it up with long sleeves. His arm functions as well as it ever has, but the scar . . . it will never go away.

The whole FF atmosphere is too sad sometimes. The boys will wake up in the dead of night screaming and shaking from nightmares.

They are traumatized. However, the extent of abuse and molestation are qualitative and invisible.

Unlike the flu or common cold, we cannot simply give them medication, pat them on the head, and tell them they should feel 100 percent by tomorrow morning. Unlike broken bones or cuts, we cannot merely disinfect and bandage the wounds, reassuring them that everything will be all right. We cannot stitch the torn psyche or put their broken spirits into a cast. They have lost their innocence, their childhood, their future, and for the most part, an opportunity to live a healthy and happy life.

Children at the core are only amorphous beings, needing a little push or tug to right themselves. Boys at FF were shoved and yanked. They never had parents who kissed them goodnight.

I wonder if I am merely a glorified jailer locking up delinquents or a true reformer trying to lead the straying back onto the proper path. Sometimes, the kids respond and appear to improve. Nevertheless, just when I think I've made a difference, they'll blow up and revert. Back to square numero uno. The counselors are not heroes—nor pretend to be. We are only doing what ought to be done.

7:45 am, Monday (January 8)

Day number 7,884 is my last day at FF. A new kid, Alex, comes in before breakfast. As I excavate into the cupboard, searching for a full box of Frosted Flakes, I glance over my shoulder to examine the new tenant.

Patches of hair are torn from the roots, and I notice small circular cigarette burns perforating from his dark skin. He also has crooked teeth from the frequent thrashings courtesy of an alcoholic daddy. Someone decided that Alex made a good ashtray or punching bag.

For the child who is physically, emotionally, or sexually abused or brutalized, the pathway from victim to victimizer is crystal clear. I hear that eyes are the windows to the soul. When eyes are cold and hard, it tells me everything I need to know. Alex stares at me with those angry eyes and sneers with utter disdain. I catch a glimpse of his teeth. Yup, we got ourselves another biter.

Woodland Services: The Changing Face of Child Welfare

Luke Muir

Writer's Comment: I must admit that since I was a foreign student, the need to base this piece around a local institution or person had me stuck for some time. Eventually, a friend and previous employee of the Woodland Group Home suggested I might go and take a peek there for inspiration. I was not disappointed. The home has been a refuge for abused children for some fifteen years and has pretty much seen it all. Despite this experience, it was clear the institution was under strain. Child abuse is becoming a staggeringly common problem in the USA, and the cases of abuse are increasingly severe. Add to this the squeezing of local and state budgets prompted by the Republican tax cut strategy, and the outlook for homes like this is not grand. However, I arrived to find a dedicated team at Woodland approaching an often thankless job with enthusiasm and continuing success. Indeed, I found one abused teenager even discussing plans for a career in child welfare himself.

Instructor's Comment: If you didn't read his introduction above, you probably wouldn't guess that Luke Muir was an exchange student from England. He's got such a grasp on the complexity of the problems that he describes in this piece that you might think he was writing a senior thesis on this subject. Not so. As he mentions above, he initially had no idea what he could make the subject of the profile piece that I assign in my journalism course. But when he decided to write about Woodland Youth Services, he devoted himself to finding out everything he could about the program as well as the larger national issues he describes. The resulting article reads like a fine piece of investiga-

tive journalism—memorable characters, great plotlines and important themes.

—Eric James Schroeder, English Department

The statistics are frightening. In the year 2000, 879,000 children in the USA were the victims of child abuse. This means that a child is abused every ten seconds, and of these, half are under eight. Child abuse causes its victims a wide range of problems that can include emotional, behavioral, psychological, and physical disorders. This is only the beginning since these problems will in turn affect the children's ability to complete school, find meaningful employment, and generally succeed in a life hindered from the start. Awfully, insofar as abused children are concerned, those who develop problems due to abuse are the lucky ones, since roughly 1,200 children die as the direct result of abuse each year. The epic proportions of this social problem are perhaps best illustrated by the fact that the annual cost of child abuse imposed on the American economy is greater than the Gross Domestic Product of many African nations, weighing in at just over a staggering $94 billion a year!

Woodland Youth Services (WYS) is a shelter set up to help just such abused children. One of two homes founded by Ms. Brenda Pate in 1984, the shelter handles the grim day-to-day realities of child abuse and its prevention in Woodland and the surrounding Yolo County . For most of these nineteen years, the shelter has provided secure, temporary accommodation for children for a period of up to thirty days whilst they are relocated into foster care.

This role is now changing away from that of a temporary shelter towards that of a more permanent care center—a *group home*, in which children can spend more time. This change is due to what Pate sees as the temporary shelter's increasing inadequacy at genuinely tackling the issues of child abuse: "The challenges we face are becoming more and more complex; group homes are better able to handle the more difficult problems we are seeing these days." The home's shift in emphasis is an indicator of the changing nature of child welfare as well as the increasingly complex and demanding needs of the children that society fails.

Foster care has previously been seen as the best way of dealing with abused children. This is largely due to the belief that abused children

will still be raised in something that approximates a stable family environment, allowing them to prosper. A sound idea in theory, foster care is still the ideal solution for children who have not been seriously disturbed by their experiences. This solution, however, applies to fewer and fewer of the children that Pate comes across. For many years before she founded Woodland Youth Services, Pate was a foster parent herself. She is thus well aware of the trials of foster care: "The children I saw were increasingly disturbed. They had suffered the results of parental drug abuse, and their own physical and sexual abuse. They're behind in school and have serious social, bonding, and emotional problems. They can have an immense amount of anger in them." As such, these children are often too much for even the most committed foster family: "Foster families would have to put up with being called names, [children] punching holes in walls, throwing chairs." Whilst these are things Pate and her colleagues, along with other care workers she terms as "seasoned" professionals, are prepared to deal with at work, she is understandably adamant, "I don't want that kind of violence in my house."

If any corroboration of her view was needed, an afternoon at the Woodland Youth Services shelter certainly provides it. In a two-hour time frame, insults and two chairs are thrown, and there is one fight between two of the older boys, who are quickly restrained by some of the eight staff on call at any one time. "Restraint is for both our safety and theirs," Pate is quick to put in, clearly acutely aware of the fine line that youth services must walk in such matters. Such restraint is not easy, and staff are required to undertake training in order to cope with these demands.

These incidents alone illustrate just how daunting a task the provision of foster care really is. If this were not enough, Pate is quick to emphasize that the bureaucratic regulations that foster parents must abide by do not help matters. Potential foster families are under strict guidelines in their guardianship of these children. Any babysitter, even if related to the foster parents, must go through a series of checks and be adequately trained in areas like first aid. Having given numerous such examples, Pate sighs, saying, "there's always another form to be filled out."

Such bureaucracy combines to give the foster system an inherent inflexibility, of which Pate is clearly all too aware: "Say my husband and I had an anniversary and wanted to go away for the weekend; who do we leave to babysit?" Pate explains that the vast majority of such cases resulted in her own plans making way for the needs of the foster child.

This results in what she terms "foster care burnout." The demands of providing care are overbearing: "Foster families end up simply needing a break."

It is not difficult to see why the children who pass through WYS are in need of so much specialized care. Charlie, one of the boys currently there, has been in and out of the home for the last ten years. He was six when he first arrived. Welfare officers had found him and his sister living in a self-made shack in the back garden. He had simply had enough of the physical and mental abuse he had to put up with at the hands of his parents. On another occasion, Charlie comments he was placed in care "'cause my sister was raped, which wasn't reported, the house was unfit to live in, my mom was being abusive—stuff like that."

At first, one can't help but admire the matter-of-fact manner in which he speaks about such painful experiences. As he goes on, however, it becomes clear that "stuff like that," is pretty much all he knows. It is as normal as a shopping list or brushing his teeth. Since his first stay at WYS, Charlie has been in and out of the home after numerous failed placements with one family after another. This recidivism was a common problem for WYS: "There were not many families willing to look after these kids in the first place," Pate says; "eventually we would run out of placements for a particular child." Lisa Correia, another of the group home staff, agrees: "We were seeing an increasing number of children trapped in the system for long periods of time." This fragmented care did very little to improve the lot of kids. Correia notes, "They've had it up to here; they already have been let down too many times. They begin to feel utterly hopeless." Both women agree that this was one of the most frustrating elements of their job since they saw children who desperately needed stability receiving just the opposite.

Some of these frustrations are a thing of the past for WYS, as from December of last year, their role has officially changed. They now take children in on a more indefinite basis, combining accommodation and treatment for a more consolidated period of time. Both Pate and Correia are enthusiastic about this change. Correia explains, "now we have more scope to work on positive issues that will make a difference. We can work on emancipation issues, teaching these kids how to care for themselves. We can introduce them to some of life's basic normalities, such as a banking account, a job, or obtaining a birth certificate." Foster care is still an ultimate goal, but this is seen as a far longer-term aim once a child has dealt with some of the painful issues that abuse has left them with.

The costs of all this are unsurprisingly very high. WYS's costs for staff alone are almost $50,000 a month, and this is only one element of a total that includes utility bills, food bills, and a huge insurance premium. The costs seem undeniably high, considering that this is a home that only has the capacity for eight children. In this respect, however, WYS is certainly not unique; childcare is expensive, period. These costs are put into perspective when one considers the corresponding costs imposed on society if child abuse is not treated. A study for the Michigan Children's Fund, for instance, concluded that the necessary statewide cost of an effective abuse treatment and prevention program was $43 million per year. In turn, the total cost of child maltreatment in the state was estimated at $823 million! A child welfare think tank, The National Clearinghouse on Child Abuse, is unambiguous in its conclusion that the available evidence shows that "prevention pays."

This message has clearly failed to influence policymakers on Capitol Hill, who have slashed state budgets as part of the Republican tax cut strategy. In turn, state legislators have squeezed welfare budgets to cut their own costs. The effects of such cuts will be acutely felt by abused children. Indeed, the budget for Yolo County's Child Welfare Division has been cut from $5 million in 2002 to just $250,000 for 2003. Although such cuts will not affect WYS heavily (a large percentage of its funds are from federal rather than state sources), for Pate the impact is clear: "Budget cuts are going to severely impact the things that these kids vitally need, and if authorities don't do what needs to be done now, it will have to happen later." Pate is adamant that "if authorities don't pay now, they will pay later." If both Pate and studies like the one above are to be believed, it seems evident that governments will end up paying a substantially greater amount later. In this light, the cuts in welfare spending taking place are not just harmful in the short term to the 900,000 children abused annually, but also represent bad economic management in the long term, for which the American taxpayer will end up paying the bill.

Abused children have an incredibly rough start in life. Their lives would be considerably worse, however, if it were not for the dedication and effort of people like Brenda Pate and Lisa Correia. In a society that often undervalues the type of social work that they provide, these people often give up far more lucrative careers to work in an area that Pate concedes "is far from glamorous." Despite this, her commitment to the children's future is unswerving: "I don't care what they're here for or what they've done; what's important to me is how we can help."

Perhaps the biggest indicator of the credit that both women are due comes from the children themselves, two of whom when asked said that they would eventually like to work with abused children as a career. John, another of the boys who has had repeated stays at WYS says, "If I could get qualified, I'd like to work in a place something like this. I think I could help." Nothing could be further from the usual cycle we hear all too often concerning abused children themselves going on to abuse. A more shining illustration of the things that Pate has achieved is surely impossible to come by.

The names given to both of the children quoted in this article have been changed for legal reasons.