Photograph by
Rachel Styler

sanity maybe madness but the maddest of all is to see life as it is and not as it should be.

–don quixote

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THE ETHICS OF ETHSIX

Inherent Tensions in the Collaboration of Social Workers and Journalists

Benjamin Bourdreaux

The driving goal of Ethsix is to advocate on behalf of social workers and their clients in order to address and improve social ills. This is to comply with the sixth standard of the National Association of Social Workers (NASW) Code of Ethics concerning the social workers' responsibility to fight social injustice.

Journalists likewise have an interest in righting society's wrongs. They serve the public as the fourth estate, providing an additional check on government empowered by the ideals of free investigation and publication. The idea of the magazine is to provide a forum for collaboration between these two groups—a mutually advantageous relationship that, by shedding light on social problems and solutions and giving the voiceless a voice, will foster beneficial social change. However there are acute tensions inherent in the collaboration between social workers and journalists, some of which arose in the preparation of this issue. It became clear, as the two groups worked together to produce these stories, that although social workers and journalists both seek to serve the social good, they have different views about what this requires. This article describes these tensions and examines some of the difficult editorial decisions made for this issue.

The root of the tension is the ambivalent consequences of public exposure. A magazine like Ethsix raises public awareness and may reach those who can help. More immediately, the media provides an outlet for those used to being ignored. But with publication there is also risk of exploitation and political backlash, and, if care is not taken, exposure can harm an already vulnerable population.

An article from the current issue, *Lost in Transition, a foster youth confronts emancipation*, manifested these tensions and left both participating journalists and social workers feeling frustrated and disrespected. At issue was whether the featured subject of the story, a former foster care youth, Brytteni, could read and potentially alter a draft of the article. The journalists claimed a fundamental ethic of their field—journalistic impartiality. This is a commitment to represent the facts free from the bias that comes from a personal relationship with the story. Showing a story to a subject discredits the reporting and misleads readers.

Journalism would be a farce—sheer propaganda perhaps—if subjects could edit or veto their portrayal.

On the other hand, a social worker's commitment is to his or her client; their's is an inherently biased point of view that seeks to protect and serve the client. Acting on Brytteni's behalf, the social workers insisted that Brytteni be able to look at a draft. So a conflict developed between the journalists' impartial concern for the facts and the social workers' biased commitment to their client. What's noteworthy about this conflict is the reasonableness of the respective ethical commitments. It would be easy to caricature the two sides —the vulture swarming to feed on dead meat vs. the overprotective parent too scared to let the child fend for herself. But the journalists and social workers involved cannot be so portrayed. The conflict occurred between level-headed parties and it is precisely the reasonableness of the two sides that make the conflict even more touchy and intractable.

The editors sided with the social workers. The basis of the decision was that the magazine seeks to address the needs of the under-served by providing them an outlet of expression. So better than simply allowing Brytteni to read the draft, the editors decided she would be made a co-writer. Brytteni is now a part of the story rather than simply a source, and this alters the way in which the story is effective and affecting. But the editors' decision does appear to be an acceptable compromise for the two sides: by putting Brytteni on the byline, they ensured that readers would not be misled into thinking that she had no final say on what was printed, and the social workers would be satisfied that she was not

exploited. It is worth noting that in the previous issue of Ethsix the editors made the same decision to show a source the story. Upon reading a draft of the article, the source reneged on her participation and persuaded the editors to remove the article from publication.

Given the collaborative goals of Ethsix, this tension between social workers and journalists will be generally difficult to defuse. How can social workers publicize an issue of social injustice without their bias influencing the representation? Why would readers even trust what's reported in this journal as 'fact'? Why get journalists involved to begin with if their reporting will be second-guessed?

It is important to find acceptable answers to these questions because there is a pressing need for the collaboration Ethsix offers. Journalists are trained to investigate different sides of issues and to present them lucidly to a wide audience. But so many news articles are written on short deadline and are sensationalized for public consumption. This seems especially true of articles regarding victims of social injustice, which are easy for journalists to irresponsibly dash-off. For one thing, social work clients are not able to condemn a sensationalized piece or correct a salacious misrepresentation. Many victims of social injustice have learned that attention is risky, and thus their invisibility to the general public is often intentional. Journalists don't always have the time or the resources to gain the trust of this population and cannot have an adequate understanding of their situation. Social workers, however, are in the trenches full time. They are well-aware of the limitations of the social welfare system long before a hurricane strikes and makes those limitations apparent to all. They have earned the trust of their clients and know how to serve those clients' needs. The difficult trick for Ethsix is to facilitate a collaboration that would allow social workers and journalists to employ their skills without sacrificing the basic ethical commitments essential for their work. This may require the participating social workers to act as experts on social injustice and solutions rather than as advocates for the particular clients or organizations they serve. And it may require the participating journalists to be sensitive to the needs of a vulnerable population and to be guided by these needs, perhaps by adapting some of their investigative ideals. It will be challenging to spell out the respective roles of journalists and social workers in a way acceptable to both parties. But this should be done with an explicit statement of Ethsix' editorial principles. This statement will define, for a start, the rights of social workers to confidentiality, the rights of the person being reported on to speak anonymously, and the rights and responsibilities of the journalist to investigate impartially. These rights can be defined in a variety ways, and it is up to the editors to determine, for instance, whether journalistic impartiality precludes a social worker from working on a story involving their client or workplace. However, a set of guidelines should be in place both to facilitate collaboration and to ensure that readers can understand the unique contribution of the magazine. Social workers tend to be wary of journalists. This resistance may be fully legitimate given the risks of exploitation and sensationalism. But this resistance makes it harder for social workers and their clients to advocate publicly and to conform to the sixth ethic of the NASW standard. Given the distinct and reasonable ethical commitments of journalists and social workers, it's unlikely that Ethsix or any other publication will find an easy resolution to the tension. But the recognition of the conflict, and the formulation of explicit guidelines that respond to it, is an important first step.

Can't stop, won't STOP

A Professional Look at How Harm Reduction Therapy Works

by CHELSEA SIME

For Ann Larie Valentine, it was a client who drank nine beers religiously before bed each night. For Seth Katzman, it was a young woman with a crack habit that would keep her up for three days straight. And for Joy Rucker, it was a 24-year-old man dying from AIDS but unable, and unwilling, to stop using drugs.

These are the cases that solidified their beliefs in the power of harm reduction therapy.

"That was the first time I was ever totally powerless over someone else's decision to use, no matter the policies in place," says Rucker, who at the time was running Rafiki House, a transitional house for individuals with HIV/AIDS. According to Rucker, they admitted the man and then made him leave because he continued to use drugs. "This kid was dying. I couldn't use the clichés that were used in a recovery program – 'Things are going to get better' – because things weren't going to get any better," says Rucker. "His coping mechanism was smoking crack. Who am I to say what it's like to be 24 and dying?"

According to the Harm Reduction Coalition (HRC), harm reduction therapy is a pragmatic approach to reducing the negative consequences of destructive behavior. While it is most often associated with needle exchanges, harm reduction includes everything from handing out condoms to sex workers to getting someone with a risk of heart attack to eat fewer high-cholesterol foods. It's about recognizing that factors like racism, poverty, and trauma history play a role in a person's actions, meeting the client where they are, and treating them only as much or as little as they desire.

Rucker is now the executive director at Casa Segura, an East Bay organization dedicated to stop the spread of disease among injection drug users, Valentine is a social worker at San Francisco General Hospital's emergency room, and Katzman is the director of supportive housing and community service programs at Conard House, a non-profit organization that helps people self-manage mental illness. They are all part of a much larger network of Bay Area social work professionals who are embracing harm reduction as a primary approach to helping clients cope with harmful behavior. While it is still a controversial topic in many parts of the country, harm reduction became the official policy of the San Francisco Department of Public Health (SFDPH) in 2000, before any other city in the country.

Katzman helped draft Conard House's own harm reduction strategy after attending the first national HRC conference in Oakland in 1996. Since the clients' lives and behavior are central to harm reduction, staff members at Conard House meet with their clients regularly to discuss how they can improve a bad situation. "We try to be activists about it, not moralists," says Katzman. "Before, (working in) housing that professed to be clean and sober but knowing full well that they weren't at all clean and sober just felt hypocritical to me," he says. "We want clients to be able to talk about their drug problems, so we need to address that these problems do exist."

In the emergency room, Valentine uses harm reduction because she believes it's the best option. While she says she's unsure whether the hospital has an official policy about it, she knows that by law they are required to treat individuals despite their continuing precarious behaviors. And in many cases, proposing abstinence is out of the question. "Harm reduction to me addresses reality," she says. "The reality is that simply telling someone they are an addict, or telling someone that the behavior they're engaging in is risky, doesn't typically do what it takes to help them reduce or quit that behavior." Instead, Valentine engages clients in a discussion about their addictions. She says that often times, even when people start off saying they don't have a problem, they'll come to the understanding on their own. And that self-realization and desire to change is the key to getting them to alter their habits, not scolding and preaching.

Along the potential road to recovery, harm reduction proponents supply clean syringes, methadone, condoms and a laundry list of other supplies. Opponents argue this only encourages people to continue their destructive behavior. However, the argument is not moderation versus abstinence. Most of those who practice harm reduction admit that abstinence is often the best option, but the difference is that they will never parentally label someone an addict and force them to quit. As Valentine explains, a continuum from moderation to abstinence is often more beneficial in the long-term than encouraging abstinence from the start. "Substance-abusing individuals are not going to have an epiphany just because you've said they should quit and given them good reasons," she says.

And regardless of a mandate by the Department of Health, use of harm reduction doesn't always happen. Rucker has been familiar with the topic for more than ten years and says that while the theory has become less taboo it's not always adhered to. "Like anything else, once you introduce it to mainstream audiences, everyone claims they do harm reduction," says Rucker. "But it's mostly language, not practice." She explains that many agencies have harm reduction policies in place, but if case managers don't approve of the method, it's not embraced or institutionalized. And clients usually aren't informed properly of their options, so no one steps up to complain. Says Rucker, "Unfortunately, this is not really the population that asks a lot of questions."

Harm reduction, by its own principles isn't offering solutions, yet many social workers agree that it's simply the best they've got to work with. "It's a logical approach to a very complicated situation," says Rucker. "When was the last time you successfully controlled someone else's behavior?"

"The reality is that simply telling someone they are an addict, or telling someone that the behavior they're engaging in is risky, doesn't typically do what it takes to help them reduce or quit that behavior."

SWITCHING SEXES SAFELY

San Francisco health clinics address the needs of the transgender population

by eric zassenhaus

Just out of sight from the trimmed green lawns and manicured trees at Civic Center Plaza, runs a small alleyway to the inconspicuous doorway of San Francisco's Tom Waddell Clinic. The clinic is often the last recourse for the city's poor and homeless to get the treatment they need, before ending up in the emergency room. In recent years, it has seen its services scaled back by a cash-strapped city government.

The clinic has an institutional feel: smeary, turquoise tiles shine under fluorescent lights, hallways are lined with chairs, stairways go seemingly nowhere, and print-outs, taped or tacked to the wall, provide nominal directs to the various outposts of the clinic.

In 1993, the Tom Waddell clinic set up their Transgender Clinic, the first of its kind in the United States. The clinic serves the area's primarily male-to-female sex worker community and underclass transgender community. Currently, they are open only four hours a week on Tuesday nights and serve about 400 patients. And though they provide all manner of health care and consultation, hormone treatment is "always a greater part of what [patients] are looking for," says Dr. Linette Martinez, the clinic's director.

The recent proliferation of hormones such as estrogen and testosterone on the black market has many health professionals worried. Martinez says she has seen a substantial increase in the number of her clients who use so-called "street hormones." The growth in their use poses a greater risk to an already vulnerable community, who are exposed to discrimination and violence against them.

Use of both testosterone and estrogen require patients to monitor their blood levels as well as their dosages. The main problem is that the drugs change the capacity of the blood to coagulate. Overuse of either estrogen or testosterone can lead to blood clotting, and Martinez said she often sees patients with spider webs of red clots on their retinal veins and along their legs.

Testosterone in particular can constrict veins and lead to sleep apnea, a condition marked by a lack of oxygen flowing to the brain. This in turn can limit cognition and, if left unchecked, become life threatening.

And though the dangers of injecting hormones such as estrogen and testosterone without oversight are significant, the greater danger-according to Martinez and many others—are the issues surrounding the injection and potential sharing of needles. That, she says, is a matter of economics. Her clients are less likely to have steady jobs and more likely to use other intravenous drugs. For those reasons, they are less likely to be prescribed hormones by a doctor. That means the black market or a prescription from a free-clinic are their only options.

The cost of hormones on the black market is three times what it is for those who can furnish prescriptions, says Nikki Calma, the Transgender Program Supervisor at the Asian and Pacific Islander Wellness Center (A&PI), one of a number of area providers who have started needle exchange programs in an effort to reduce the potential for infection among hormone users. The San Francisco Needle Exchange and HIV Prevention Project, along with the St. James Infirmary, have also incorporated larger 23-25 gauge needles into their needle-exchange programs.

Calma sees estrogen increasingly coming through the Internet, primarily from Germany and Thailand, as opposed to being carried across the Mexican border, where the DEA estimates 90 percent of the testosterone that ends up on the black market comes from, and where there is greater chance of inspection and confiscation. According to Casey McEnry, spokesperson for the San Francisco Drug Enforcement Administration, estrogen is not technically illegal and, though it might be confiscated if found, it wouldn't likely lead to an arrest.

Testosterone, however, is classified as a Schedule 3 substance under the Controlled Substances Act, which means it is illegal to carry without a prescription. And though the trade in testosterone among the transgender community is growing, it is still secondary to the trade among athletes and heterosexual men.

To reduce the risks associated with needle-sharing and unmonitored use of hormones, Tom Waddell Clinic makes the substances available to those who would otherwise get them by other means.

"If we sense that a patient will be responsible, they will get a prescription," says Martinez.

Hormones like testosterone and estrogen are thicker than many other drugs, such as heroin, which makes it more difficult to sterilize used needles. Methods that some programs recommend to prevent the spread of infectious diseases, such as washing syringes in bleach and water, may fail to clean needles used to inject hormones.

The overlap of hormone injectors and intravenous drug users only adds to the problem. In an informal study done in 2000 – one of the few studies done – Dr. Barry Zevin, who works at the clinic, found 32 percent of the clinic's patients had injected drugs in the past. He also found the transgender community are at greater risk for HIV infection and are less likely to seek medical services than the general public.

But along the long, thin hallway at the clinic on Transgender Tuesday night, clients and staff laugh and talk as they wait for appointments or to renew a prescription. The atmosphere is more like a café than a waiting room.

FREE TO BE MAD

The Rights of the Mentally Ill Versus the Responsibilities of Society

by EVE EKMAN

An uncomfortable combination of fear and pity forces my eyes to the ground when I see her. She ambles down the sidewalk in a tight wrinkled halter top and greasy low rise jeans, more appropriate for a fourteen-year-old than this middle-aged, gaunt-faced white woman, her slack skin loose on her boney frame. As she weaves and bobs towards me, I notice a minefield of track marks up and down the lengths of her arms. Her flip flops reveal dirt-caked feet, her sunglassed eyes reveal nothing, but her mouth is moving and she is speaking loudly to herself. There is nothing pleasant about her kind of oblivion.

As a social worker I have had many of these people as clients from outreach with sex workers in cramped hotel rooms along Mission Street to the locked walls inside a psychiatric hospital and the unpredictable emergency room at the county hospital, where I work currently. My role in the ER is with both trauma patients, who have been wheeled in gurney-top from an accident, and those whose troubled lives are a constant state of emergency. My powers and responsibilities for the latter are limited. Protecting the dignity and choice of clients is the linchpin of my role, however I often wish for a greater responsibility in what happens to them beyond our immediate care. The state no longer runs the large institutions that would have held many of these people, keeping them not only from harm, but also from a freedom and choice about their life. There is a fine line between self-determination and societal neglect when applied to those who do not care for themselves in the way we would hope for our families and ourselves.

The deinstitutionalization of state-run mental hospitals did not develop the same romantic allure as other sexy civil liberties movements of the late sixties. There were no love-ins, freedom rides or burning of undergarments for the rights of the mentally ill. Debates on race, gender and war retain headlines, whereas the rights of the severely mentally ill versus the responsibility of society to care for these individuals remain in the dark shadows of public concern. It is a common assumption that deinstutionalization was a social casualty of Reganomics that forced swarms of mentally ill people to become homeless. Newspapers ran photos of ragged and raged mentally ill people crowding and prowling city streets following the widespread closure of mental health facilities in the 1980s. However, deinstitutionalization began far earlier than Regan; his closures were, in fact, a second wave after the movement began in the sixties.

The early swell of humanitarian concern for the mentally ill focused on public criticism of the draconian, and nominally effective, medical practices of electro shock therapy and prefrontal lobotomies, which could be easily perceived as forms of torture or punishment rather than treatment when performed inside locked institutions. The status of a mentally ill patient was much like that of a criminal, except that many were locked up indefinitely. Their 'crime' was being mentally ill and displaying a range of uncontrollable behaviors created by hallucinations, paranoia and suicidal tendencies. These symptoms impaired their everyday functioning and were an immense strain to even the most attentive of families. In nineteenth century England, the creation of state-run mental institutions was considered a progressive and enlightened way to treat the insane and indigent. Opposition arose when people got word of conditions at places such as the infamous Royal Hospital of Bethlem, otherwise know as Bedlam, where patients languished in cramped hectic quarters, often chained to the floors.

The early sixties movement was inspired by psychiatrists, including the prolific Thomas Szas. One of Szas' more popular books, *The Myth of Mental Illness*, declares that schizophrenia, among other mental disorders, does not exist but is a 'perpetuated symbol of psychiatry,' intended to prolong the need and existence of the field. Opposed to inpatient hospital-

ization and locked institutions, Szas likens mental illness to cancer, demanding the patient should have a decision whether or not to receive treatment. Szas considers it immoral to deprive someone of their liberty for what is considered to be in their best interest.

French philosopher and historian Michelle Foucault used a historical study of mental institutions to propose a relativistic construction of mental illness. He wrote that what is considered mental illness simply reflects the cultural and political ideologies of the time, and warned that reality could be tailored to promote a political agenda. In short, those in power could define insanity. This may sound preposterous for the United States, however, dissenting ideologies from artists, writers and academics are often slated as insane. There is a strong ethical and social justice allure of these arguments, to propose 'freedom' for all individuals with mental illness and embrace a relativistic view of reality.

The deinstitutionalization movement of the sixties was well timed with newly engineered psychotropic medication that stabilized formerly out of control patients. These new drugs literally curbed hallucinations, visual and auditory, and calmed the frenetic explosive energy of psychosis and mania; it was like a miracle for many patients. Scaling down institutions was an especially attractive cause for cost cutting politicians, as it is very expensive to run locked 24-hour institutional facilities. Those released to the community had been accustomed to 24-hour care. The new model of care required severely mentally ill people to seek their own mental health services and medication in 'out patient clinics.' Prescribed medications were substituted or piled upon other 'self medication,' in the form of illegal and controlled substances, from alcohol to crack cocaine.

Illustration by Michael Page

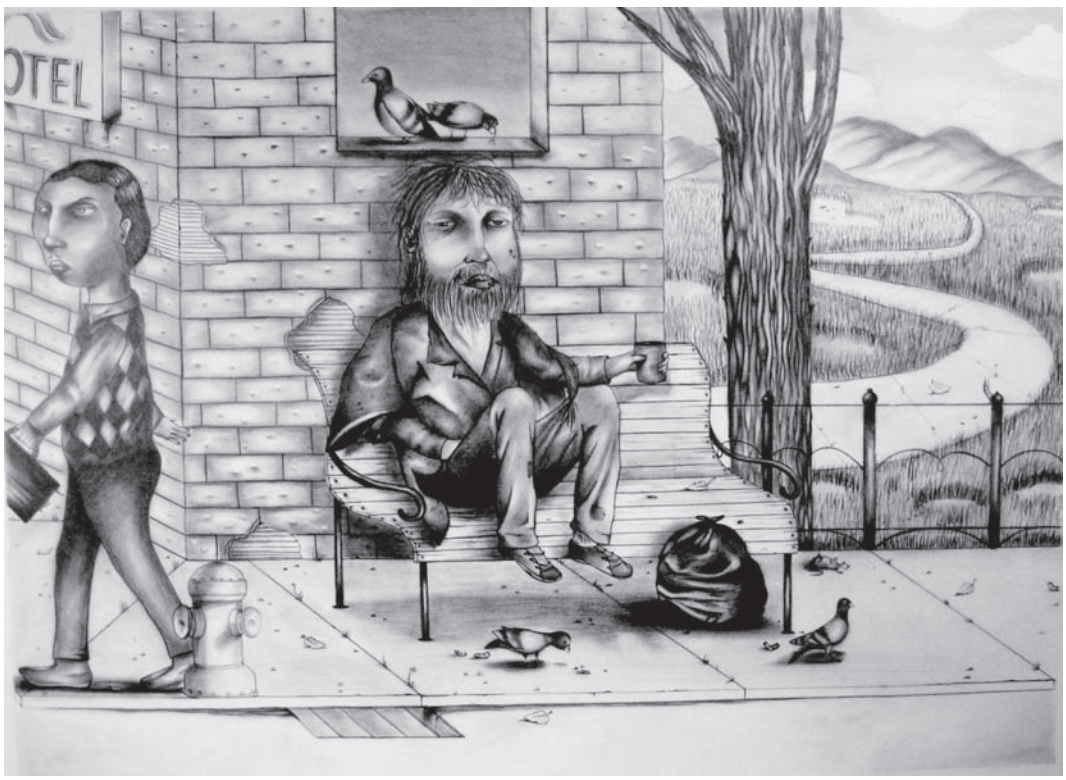


PHOTO BY:
ISAAC MCKAY
RANDOZZI

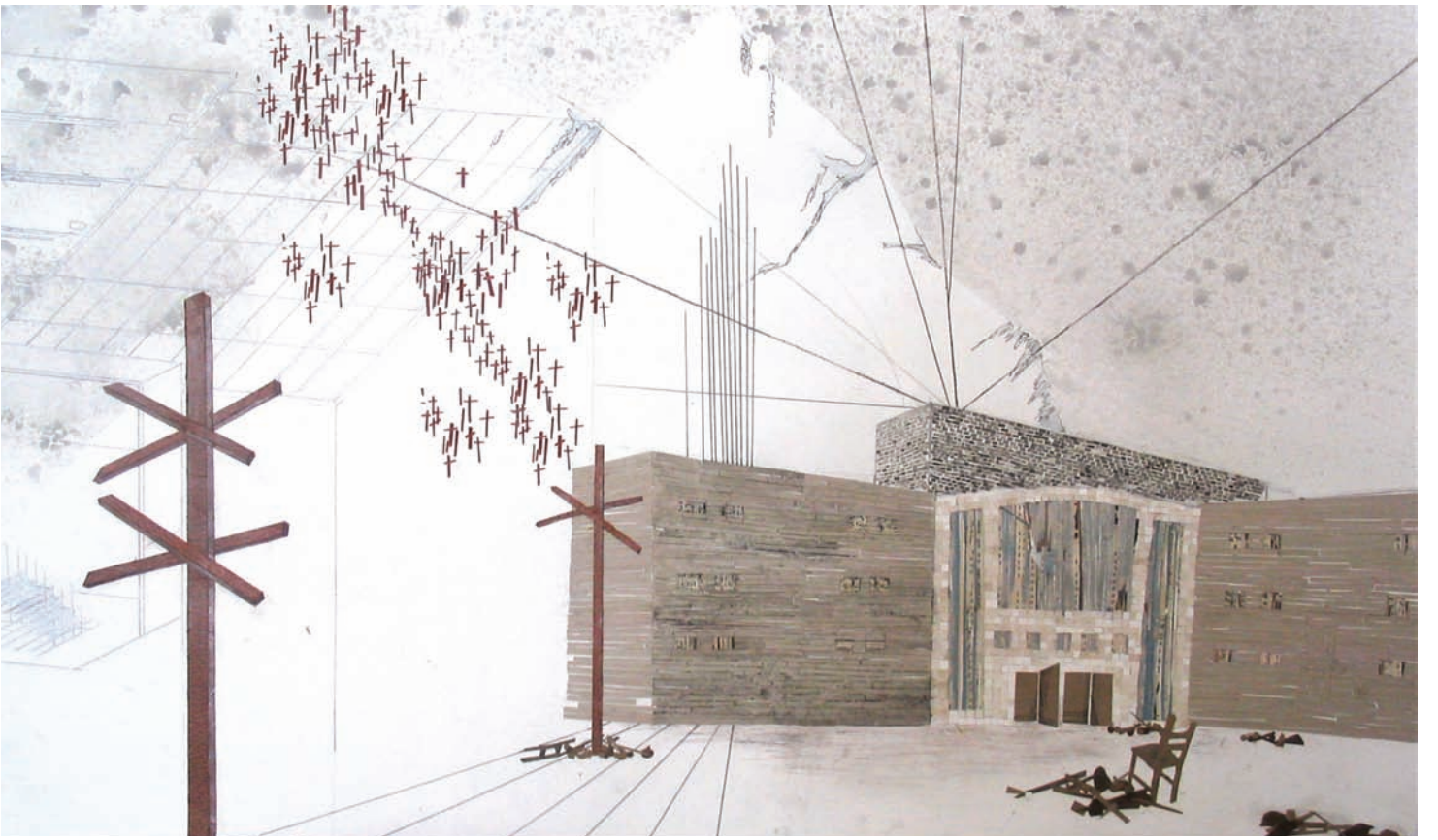
Currently the only way to get inside a locked psychiatric unit in California is to be deemed 'gravely disabled and/or an immediate danger to yourself or others,' and placed on a 5150 legal hold. A 5150 permits a 72-hour detainment under mental health arrest and the individual becomes a temporary ward of the state. This can be extended to a 5250, and eventually a one-year-long conservatorship, after mountains of paperwork and time in court. The conservatorship deems the individual incapable of making their own treatment decisions, and they are required to receive treatment. However, the LPS cannot force someone to take their medications once they have left the hospital, nor prevent them from using drugs or engaging in other dangerous behaviors.

The 5150 is usually done in the streets by cops, they find those walking down a narrow Tenderloin alley naked and covered in feces, or attempting to jump out of their third-floor window. The individual is then taken to the hospital to be evaluated by a psychiatrist for a full assessment and treatment, including diagnosis, medication adjustment, therapy and planning for placement upon discharge (the last being the principal function of the social worker).
I spent a year as a social work intern in a locked psychiatric facility. Many cases remain with me, though I only got to know people for about three days. I had never seen what full-blown mental illness was like; it was initially very intimidating as well as heart wrenching. It often felt rushed to send someone out after only a couple days, and I worried there was no way to ensure their safety after they returned to old habits. One young bearded father, whose methamphetamine abuse had exacerbated his paranoia, had plunged a knife into his own belly. The voices had told him that it was the only way to save his family; he was lucky enough to have insurance from his last construction job and was sent to attend a day treatment mental health facility after discharge. Usually we could place someone in the care of a day mental health program, or back to a supportive family, however there were limitations to what we could require them to do. Once they were taken off the hold, they were free to be mad.
The clinical definitions of mental illness are under constant revision. Unlike cancer or heart disease, there are no scans for the brain or blood tests that precisely show what is happening. For the purposes of medication and treatment, a manual known as the DSM, the Diagnostic and Statistical Manual for Mental Disorders, has categorized the known mental illnesses and is undergoing its fifth revision since 1952. 'Severely mentally ill' is defined by the DSM IV as someone with an "axis one" diagnosis, which includes depression, anxiety disorders, bipolar disorder, and schizophrenia. It is an imperfect and evolving text. Homosexuality was a listed mental illness in the DSM for over thirty years. Illnesses are diagnosed by the symptoms, from the outside in, and research provides new evidence and understanding of illnesses. It is like archeology; new digs provide fragments of

his hallucinations of god and the devil, at war with one another over his soul, and his traumatic flashbacks from prison usually subside once he has sobered up and been given fluid on the gurney

new materials that alter the overall picture of history.
Over the last ten months at the Emergency Room I have seen a handful of patients who cannot seem to break out of a revolving door pattern in our care. The ER is not a place for regulars; it means one is in a perpetual state of medical emergency. This is not a decent existence for anyone. An accurate, yet unkind, label for these people is 'frequent flier', most of who are alcoholics and or drug addicts with mental health issues. Unlike the people I worked with in the locked psych facility, these individuals do not have flagrant hallucinations or demonstrate active suicidality that would land them with a 5150. They may have a DSM diagnosable mental illness or are simply traumatized by years of hard living, but the addiction eclipses everything. These folks are the most slippery "between the cracks", not crazy enough to be taken to the psych ward, not sick enough to be admitted to the hospital. These are the cases that crack social workers, this is when I feel most helpless.

With an alcohol induced puffy face with sheet crease marks that are more likely side walk gap marks, a middle aged Guatemalan man greets me sweetly and shakily in Spanish from his gurney in the hallway of the crowded ER. His tremors from alcohol withdrawl rack his tiny frame like slow motion electrocution. He was the first 'frequent flier' I worked with and I explored every option to keep him from leaving this hospital to return to the streets to drink again. He smiles at me as I come to his bedside, he appreciates the human contact the hospital offers, on the street he would be avoided as though invisible. In the hospital I always talk with him, encourage him to try to stop drinking again and try to talk to his case manager in the community to see if there are any plans left for him. He tells me he wants to stop, sometimes he cries because he feels he cannot stop and he is scared he will die. His hallucinations of God and the Devil, at war with one another over his soul, and his traumatic flashbacks from prison usually subside once he has sobered up and been given fluid on the gurney. Five to ten hours after he arrives in the ER he is sent back out to again with referrals to all sorts of services but he ultimately must chose for himself: to battle the voices and memories or douse them with booze. The city quickly runs out of options to help and protect these individuals, they are not eligible for a 5150, their self destructive drinking and living on the streets is a choice, one they are allowed to make over and over and over and great cost to their physical well being. Alcoholism and or drug use with homelessness is a terminal condition, not simply the corrosive effects on the heart, lungs and liver but the host of accidents and attacks one is vulnerable to all hours on the street and disoriented.



SHELL SHOCK

sam devine

We don't call returning service members "baby killers" anymore, like in the Vietnam era. America remembers Vietnam all too well. Americans have seen homeless vets in wheelchairs. Today's generation grew up with high-school teachers and crazy uncles renowned for having flashbacks.

PAINTING BY
JANA FLYNN
BECOMING FAMILILIAR
WITH AN ILLUSION

We want them cared for, and the Department of Veteran's Affairs, the VA, is rising to the challenge, doing amazing, groundbreaking work, changing policies and expanding facilities, yet vets are still slipping through the cracks. Reports of poor conditions at Walter Reed Army Medical Center, including poor housing, neglect and a hopelessly complicated bureaucratic maze, have drawn attention to broader questions about the treatment of casualties from the wars in Iraq and Afghanistan. At the same time, local communities have been stepping forward and helping care for veterans. But will it be enough?

The signature injuries of both Operation Enduring Freedom (OEF, deployed in Afghanistan) and Operation Iraqi Freedom (OIF) are traumatic brain injury (TBI) and post traumatic stress disorder (PTSD).

TBI is often caused by improvised explosive devices (IEDs), Humvee accidents, mortar blasts, and the ever-popular bullet. TBI means a tremendous range of severity in decreased function and mobility. The VA has bumped up the number of treatment centers at the start of the war from four to seven. Despite advances, doctors never know just how many abilities a patient will regain.

PTSD is an anxiety disorder brought on by a near death and or traumatic event. It is characterized by hyper-vigilance, inability to relax, a short temper, random anger, avoidance, not wanting to deal with the trauma, nightmares, reliving the trauma, withdrawal from family and friends.

All of these symptoms have to do with the fact that OIF and OEF vets are becoming homeless much faster than the veterans of Vietnam and other wars. In 2006, approximately 600 Iraqi veterans had sought homeless health care services from the VA.

According to the VA's national press releases, out of 1.5 million soldiers and Marines deployed to Iraq and Afghanistan, 650,000 have returned and are eligible for care. Of that, 200,000 have been integrated into the VA's health care system. Thirty-six per cent of that number has been diagnosed with PTSD. This means there are still 450,000 vets without health care, including a possible 162,000 with PTSD.

"A lab couldn't create better conditions for causing PTSD," says Amy Fairweather, Director of the Iraq Veterans Project at Swords to Plowshares, a San Francisco non-profit that offers social services and housing to veterans of war.

Deployed troops face 360-degree constant danger, even while on base. The deployed troops are often exposed to the concussive blasts that can cause traumatic brain injury. And the environments in Iraq and Afghanistan are breeding grounds for PTSD. While 3,100 soldiers and Marines have died in Iraq, if a medic reaches them before they die, they have an estimated chance of survival greater than 90 per cent, according Dr. Winkenwerder, head of the Military Health System. This means they have a much higher chance of survival than soldiers of the Gulf War, let alone Vietnam.

When Vietnam vets returned it took them, on average, about 12 years to get integrated into the VA's vast department of Veterans Benefit Affairs, which would in turn give them access to the VA's health program. Today, the VA is giving veterans the benefit of the doubt and allowing two years of care with only the vet's DD214 form, one of a few discharge papers that describe a vet's military service and discharge. This gives vets a chance to get familiar with the bureaucracy and which regulates the amount of VA care they are entitled to.

The VA offers health care to all discharged military service members and marines, so long as they did not receive a

they disregard or resist health care partially because of avoidance and partially because of they blame the government – and therefore the VA – for their injuries and hardships.

dishonorable discharge. Unfortunately, for a number of veterans symptoms of PTSD include: anger, erratic behavior, irritability, and a lack of judgment – the very things that can cause dishonorable discharges.

However, the VA has expanded its facilities. The VA in San Francisco has expanded its social worker staff and so has the VA Palo Alto Health Care System (VAPAHCS). Kerri Childress, spokesperson for the Palo Alto VA says their overall staff has almost doubled. Where they once had one part time social worker, they now have five on staff full time. They're also providing counseling to the families of veterans, another first for the VA.

"At our VA, I think we're doing ok, responding well, making sure folks get a good experience," said Keith Armstrong, director of couple and family therapy at the SFVA. "I'm hiring five social workers. I'm asking for five additional positions and I may get them."

Treatment for PTSD given at the VA consists of therapy, education, and medication. They have a team of social workers, psychologists and psychiatrists. Vets do group therapy with other vets and/or family, as well as couples and one-on-one therapy. A variety of stabilizing medications, like Prozac and Zoloft, can be prescribed for PTSD.

With their premier Poly Trauma Center for Brain and Spinal Injury, the VA Palo Alto seems to be doing well. The nearby Fisher House gives families of patients and recent discharges a free, convenient place to stay. Before the Fisher house, families of service members were struggling to visit their loved ones, spending their savings on hotel rooms. The local community pulled together to fund the Fisher House. The VA received hundreds of thousands of dollars for construction of the house in just a few months. Thanks to community support the place sprang up in a little over a year, showing that we no longer blame the warrior for the war. They're still receiving money regularly – enough to pay for even more families to stay in nearby hotels.

Even though the VA is offering care, many eligible veterans are loath to ask for it. They disregard or resist health care partially because of avoidance and partially because of they blame the government – and therefore the VA – for their injuries and hardships. Unfortunately, the stigma of mental health disorders exacerbates the tendency to ignore treatment options.
I'm not crazy. You're the one who's crazy.

Because of this, the VA is doing outreach. The VA in San Francisco currently has 800 vets enrolled. To get more, SFVA combat veteran case manager Polly Rose has been traveling to veteran centers and National Guard units in Santa Rosa and Petaluma, signing vets up for the VA. "I go to reserve units and talk with families of deployed troops, their wives or

parents – a lot of times it's parents," says Rose. "These guys are so young."

Families are playing a critical role in actively getting vets into healthcare. The parents and spouses of service members have used the Internet to form an impromptu support network, filling in the gaps in veteran care.

"I'm an advocate. I'm part of a group of people that offer services under the wire," says Mary Ellen Salanzo, the proud mother of Corporal Ethan Salzano, United States Marine Corps. She is a troop support activist and a certified professional life coach, offering "classes, coaching, and companioning with a spiritual twist." She offers her services to those that come her way. She believes in serendipity.

She recounts horrific tales of traumatic battlefield situations. In one, a soldier was sent into battle twice with unloaded weapons because his superiors were worried about his mental health. In another, a marine was the lead driver in a convoy of Humvees, traveling on a rocky mountain road. On one side was a river, on the other the mountain. Suddenly, an insurgent threw a child into the roadway. The marine had to choose between the river, an ambush, and driving over a child.
He has a child back home about the same age.
The lives of everyone in the convoy are in his hands.
"What does he say then, when he goes to talk to his god?" asks Salzano.
With all this shame and guilt, what does he do?

"There is no time and space for deliberating in the field. For some there are misgivings and guilt. Survivor guilt is one big area," says VAPAHCS Chaplin Lynn Juckness. "The professionals in health fields assess whether the guilt is tied to PTSD. If they come to you with guilt, often it's in a confessional setting. Then we try to assure them of God's forgiveness."

Chaplain Juckness is one of many spiritual counselors at the VA in Palo Alto. Here they counsel veterans, as well as active servicemen and marines in the TBI and PTSD units. They have chaplains of several denominations and try to connect with soldiers on a spiritual level.

"Gratitude is one spiritual value that multiple people can tap into," says Juckness. "They're grateful that they're still alive, grateful for the VA's care."
A lot of service members wish they could return to battle. "They feel a strong belonging with fellow service members," says Juckness. "They want to be there carrying out the work together. They want to know how their fellow soldiers and marines are doing over there."

A BULLET HAS NO NAME

A Young Man's View of a Gang Life From a Half Way House

by Lisa Elizalde

"I made a list today," Juan said to me in our therapy session. "It's a rest-in-peace list." The notepaper had several names on it: friends, girlfriends and cousins. Many of them were gang members, all of them children killed by gang violence in the last few years. Juan, the owner of this list, is a fifteen year old boy and a therapy client of mine at a school for youth on probation and expelled youth.

When I first met Juan, he was helping me furnish the small empty room that was assigned as my office for my yearlong internship. Together, Juan and I, found a plastic chair and an old blue couch to place in the room. I was grateful to have been given any private space in the school, but the setting was less than ideal. The sterile white walls, sparse furniture and unbearable heat did nothing to encourage the sharing of deep feelings in the little room.

On that first day, Juan took a seat before me on the blue couch dressed in the uniform he was obliged to wear in his group home: a white t-shirt and dark jeans. His hair was short and he carried himself with great self-confidence. I would soon discover a past of intense loss and violence, but sitting before me I only saw the boyishness of a 15-year old in his dimpled smile.

Our initial meeting was obligatory in nature (counseling is a requirement for most youth at the school), but Juan was not resistant; in fact, he was more than willing to sit with a stranger and tell his life story. He was not intimidated by our distinct backgrounds, which would present many challenges for me in learning to understand him. I am a white young female in a masters program for social welfare and he is an adolescent boy placed in a group home to keep him from a his life in a Latino gang. To work with Juan was to learn from scratch since before meeting him I knew little about gangs or the juvenile justice system.

With each session I have grown to know a little more about Juan and it has become more difficult to be detached from the pain he has endured. In a recent session, he spoke of a future helping people and I felt pride. The nature of this work means one week you might walk into school to find one of your students has been arrested and sent to juvenile hall or run away to return to their former lives. With Juan, I hold tight to the times when he seems motivated to look forward because so often our sessions are about his past life in the gang.

He describes the boy he was back then: long hair, facial piercings, showing off tattoos and always wearing blue clothes representing his gang colors. In character, he was a fighter- his gang called him 'little madness', he carried a gun, and sold and used drugs. It is difficult to imagine that the boy who sits before me today and the one he describes are one and the same.

He was born into a family of gang members so it was not surprising that he followed the same path and was initiated at age twelve. Juan needed protection from enemy gangs, who did not care if he was 'officially' a member. He was jumped in by fellow gang members to prove his loyalty. His case follows a growing pattern of increasing numbers of children born into gang families. If you are not born into a gang, you join for protection and to create an identity for yourself.

The stories of the gang are the focus of many sessions and prevent exploration of the other parts in his life that have affected him: the abusive stepfather, the meth addicted mother, the grandmother who called the police on him because she felt threatened, and the girlfriend who died and was pregnant with his baby. Just reading that sentence over makes me tremble. How does anyone make it through this? How does a 15-year-old boy make it through this?

Photograph by
Adam Wier

Often I worry whether I will see him the following week. I'm scared that he will runaway, give up on a system that permits him to make only one call home a week for fear he will contact fellow gang members. He has been a ward of the court and under the care of the justice department for one year. His fate was determined by a social worker that testified against his return home because of his mother's substance abuse. He dislikes the police and social workers. Can anyone blame him? I would also be resentful of the people who took me away from my family and "placed 'shackles' on my wrists." His future in limbo, he has received mixed messages of whether he will be allowed to return home or remain in the group home. I wonder how the system can provide the safest environment for him and whose decision should it be? Would he make the decision to continue to live away from gangs, violence and home?

When Juan speaks of where he's from, he fears he will never be able to escape his life. Juan once said, "God looked into my eyes and did not know what to do with me so he sent me to the back." He meant that God had the power to give him a better life, but chose not to. He attends church and prays every night. His continued faith in God and resilience amaze me. His faith provides a sense of belonging for him that does not involve returning to the gang.

Juan often seems resigned to death. "Even if I try to leave the gang, it's in my blood. The only way I can leave is if I'm killed." He lives in a group home today, but when asked if he feels safe his answer is no. He explains he could be killed by enemy gang member or other violence on the streets. He tells me, "A bullet has no name."

"God looked into my eyes and did not know what to do with me so he sent me to the back."

Often I listen to Juan' story and feel overwhelming sadness, but then I look at him and realize that he is a survivor and will continue to be one. He has moved forward since his initial arrest and continues to take a step closer to a better life every day with the future he sees for himself in helping others. It is the clients like Juan that remind me of why I chose this field.

EVERYDAY I AM HUSTLING. EVERYDAY I AM HUSTLING.

by damon eaves

When my grandmother wanted me to confess to some mischief, she'd look me in the eye and say, "There's nothing in the world worse than a liar." She was born in Tennessee in 1904, the granddaughter of a slave woman and her master. For her generation, getting ahead had as much to do with your level of education as the way in which you carried yourself. Back then, Black folks wanted to prove that they deserved respect as much as they wanted to provide for their families. The lesson she drove home above all others was: without integrity you have nothing.

It's funny how things turn out. Over the past two decades as a mental health worker from the shadiest city corners to the bedside of uninsured patients at the end of their lives, I have come to see that integrity of self, mind and action is an elusive quality each of my clients struggle for. As social workers, we hold on to our own integrity, and use it to create an environment that allows our clients to experience integrity for themselves. The more I develop what that means, the more I have to give.

One of my newest clients at the Alternatives Mental Health Program is Marcus Frazee a 19-year-old who is nearly incapable of relating the "truth". His desire to control reality trumps a straight up relationship with the facts. This is perhaps why he is one of the most successful hustlers I've ever come across. He has been able to turn his perpetual state of desire into a drive that is irresistible. For Marcus and the majority of my mentally ill clients, the object of their momentary desire seems to be the only space for clarity in their lives. Whatever "integrity" they have is eclipsed for the attainment of that object.

Most "hustling" refers to drug sales, illicit sex, scams and stolen goods. The clients I work with form the bottom rung of hustlers who sell anything of any potential value, from empty coffee tins to the watch off their wrist.

According to researcher Lauren Kotloff, from the national non-profit, Public/Policy Ventures, many hustlers begin around age 16. In to her 2005 report, Leaving the Street: Young Father's Move from Hustling to Legitimate Work, the hustlers share key similarities: a history of personal and mental health problems and "a desire to participate in the material wealth of the mainstream."

Within marginalized communities, the persona of the hustler is a hero with many faces. "Getting over" on the system is epitomized in *Robin Hood*, *The Godfather*, and *Hustle and Flow* and throughout the lyrics of popular performers such as Fifty Cent, Ludacris, Snoop Dogg, Ice Cube etc. The hustler achieves success by manipulating and defying the exclusive hierarchies of culture, race and class. The energetic activity, shady exploits, ruthless action and huge windfalls of the hustler/hero make for an intoxicating siren call to the disaffected. There is a lack of adequate options when you are born in the low end of the social and economic hierarchies of this country. A couple years of dependency on meager government hand-outs or working a demeaning and or demanding job for low wages make hustling look even more attractive. The ghosts of Malthusian philosophy resonate in present day San Francisco: the underclass is left to survive with less than they need to do it properly. Examples include the unaddressed hazardous environmental conditions at the defunct Hunter's Point naval base where the majority of the city's Black population live, or the unchecked number of deaths from gang gunplay in the Fillmore. The bottom rung of the social ladder is subject to a jungle of hazards that society has not taken the responsibility to intervene or improve. Marcus Frazee was born on the bottom rung, maybe even off the ladder altogether. Marcus is a twin, when they were born they were immediately placed in foster care because of their mother's drug abuse. They both suffered from seizures as they were weaned off of crack. They were then shuffled

through multiple foster homes until they were placed with an adoptive family at age nine. At 11, the foster family adopted his twin brother, but gave Marcus back to the foster agency and barred him from visiting his brother.

The foster family felt they could not meet Marcus' needs, nor tolerate his explosive temper and problematic behaviors. Marcus was affected by the seizures and neurological damage from in vitro crack exposure. His case in a sense represents societies worst fears about the wave of crack babies produced by the epidemic. Until adolescence, Marcus mimicked autistic behaviors, spending hours flushing the toilet and watching the washing machine, or staring at pictures of bridges.

Traditionally, social services have always flowed from benevolence. From the example first of Jesus, to alms to the poor to settlement houses, the torch of compassion ignited the profession of social work. Social work then professionalized the principles of ethical benevolence. These days however social service decisions are becoming increasingly privatized as for-profit entities make the argument that the management of social services are more cost effective and efficient than non-profit and government agencies.

The encroachment of for-profit corporations into the realm of social services could be an extension of the influence of Adam Smith. The philosophy of "self-interest" and "greed" has infiltrated the essential provision of social services. This headway is most evident in prisons, jails, youth facilities and state hospitals. The staggering budgets of these systems only serve to increase the incentive of for-profit corporations to enter the fray. And as they move in, the notion of "benevolence" is excitedly tossed to the side in place of greed.

In San Francisco, the yearly costs reports of the top several hundred highest users of the mental health system (MHS 140) and community health network medical system (CHN cost reports), reveal that there are a few hundred indigent and Medi-cal eligible patients that cost the system yearly upwards of a half million dollars or more each. The top few hundred clients cost the system millions of dollars.

Photograph of Damon Eaves on the job By Eve Ekman

Medi-cal absorbs most of these costs, but the city must absorb what is left. In 2006 the City of San Francisco set aside $100 million for indigent medical care. Society bemoans these costs, yet, what is forgotten is that the ambulance drivers, hospital staff, and the providers of the essential technology and services are all paid. In this way "indigent" patients with a net earning potential of zero, generate millions of dollars to the local economy over the course of a lifetime.

This same magic of generating billions from the indigent is also seen in the world of incarceration. According to the California Department of Corrections & Rehabilitation Strategic Plan, for 2006 the state of California spent 7 billion dollars on 167,000 inmates at a cost of $42,000 per inmate. By contrast the per student expenditure for California State University system for 2005 was $7,725 per student or roughly 1/6th of what is spent per inmate.

These examples speak volumes to what society values as social "investment" as well as the glaring conflict of interest created by the sheer number of professionals, corporations and vendors who are sustained by the increasing costs within these systems.

Whether you leave the ghetto by ambulance, hearse, paddy wagon, or mobile rubber room, a segment of society is on call to profit from your misfortune. However, while you are alive within these same communities, hustling is many times the mitigating factor between desperation and downright pandemonium.

The fact that those in the inner city must hustle to survive is no surprise, but my client Marcus has the whole thing screwy. When he hustles, he isn't getting ahead, nor is he garnering essential items for survival. He's simply moving from one material lust to another, pawning, trading and hustling each new object for less and less until he has nothing and must dwell in a mental purgatory until the next payday from his weekly allotment of his government disability check. For him, it's a life-sustaining distraction. For those few moments when we have sat together, and he has not been beset by his distraction, he is tearful and in obvious emotional pain as he contemplates an overwhelming future that he simply cannot make sense of. The only way he can speak of it is in dead end sentences and paragraphs sprinkled with references to his own death such as "I should just kill myself now."

Perhaps his state is due to the autism, the neurological damage from the crack, the psychosis or the mania. I'll be honest, I do not know. What I do know is that his hustling distraction serves multiple purposes, all essential to his survival.

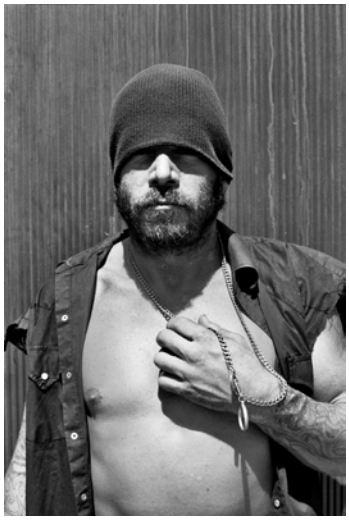
One has to believe within our national consciousness there is an intrinsic value to human life. But maybe it's just some aching part of the social worker in me that wants to believe it is so. My grandmother taught me many other things besides the importance of integrity. I hear her voice in my head when I am at the crossroads and understand that her constant lecturing was her way of giving me a piece of herself. All of the work I do with my clients, including with Marcus, is to imprint some of what my grandmother gave me, a voice within their minds that is hopeful, that makes rational decisions, that is always with them, and when fully integrated, is not mine, but rather theirs.

When someone grows up in a disorganized community and household, or in foster care, or with extensive system contacts, the voice that is heard is not helpful, but batters their self-esteem, spewing loops of negative mantra (and undoubtedly giving encouragement to whatever scheme or opportunity that results in a quick buck).

What we know as social workers is that if there is no hope, then even in the face of opportunity, it cannot be grasped.

With Marcus, I must be hopeful, because my goals are modest and infinite. I ignore his detrimental activities as much as possible, and focus on helping him add positive activities to his repertoire. Hopefully one day he will have the ability to engage in a process that leads to a future that is manageably stable. Perhaps at that point he will be able to abandon the perpetual hustle within a system that has relegated benevolence to the realm of exploitation.

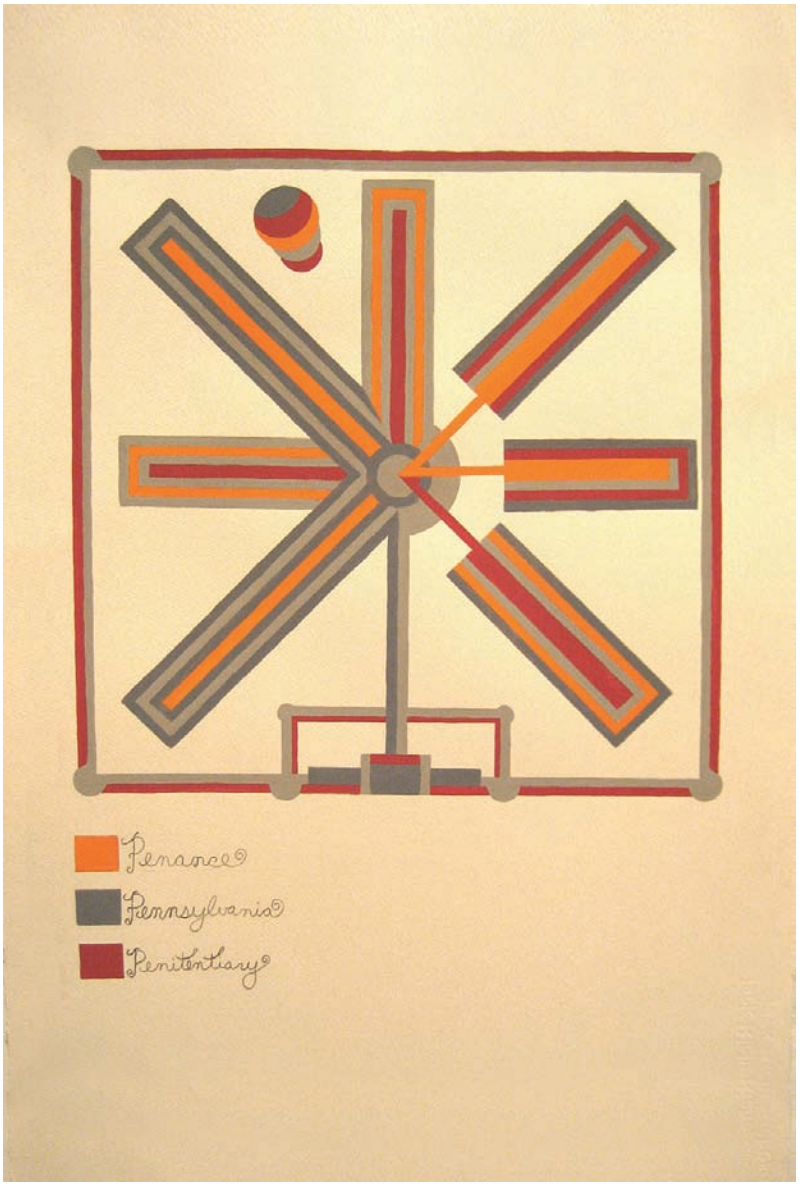
Photographs by
Beryl Fine



"Everything that we see is a shadow cast by that which we do not see."

–Martin Luther King Jr.

Painting by
Sham Saenz



"To emerge from the closed fortresses in which they once functioned and to circulate in a 'free' state. The massive, compact disciplines are broken down in to flexible methods of control. Disciplinary procedures not in the form of enclosed institutions but as centers of observations disseminated throughout society." Michelle Foucault

Foucault employs a description of nineteenth century architect Jeremy Bantam's "panopticon", an architectural solution for order via a polyvalent watching tower. In the panopticon the individual never knows when and where their actions are being tracked and consequently internalizes acting as though being always watched. The physical structure of the Panopticon was intended for any institutional architecture from prison to schoolhouse in which the inmates were individually held in cells and watched from a darkened central tower.

The artist, Sham Saenz, has used architectural blue prints from the first prison based upon the panopticon, The Eastern State Penitentiary. The ESP took the panopticon and employed a new theory of penitence, based on belief that prisoners needed to be isolated and watched in order for them to come to terms with their crimes and repent. This was the first penitentiary was built in Pennsylvania opened in1829; its first inmate was a Black man. Saenz examines this structural form of imprisonment as a contemporary metaphor on race and the philosophy the criminal justice system. The image of the panoptic prison is a potent symbol of societal inequalities exemplified by the disproportional incarceration rates for Black men.

This Pennsylvania Prison, and the panoptic architectural model, was ultimately abandoned however the stigma of imprisonment and the perpetual feeling of being watched is prevalent among all bound to the criminal justice system. Foucault suggests that the power of the panopticon watching invisibly has been disseminated throughout society; this is easily applied to the status of prisoners. Redemption is elusive, even once you have paid your debt with years of your life your name still bears a dark mark in seeking housing, employment and social services, you are watched but not helped, options for subsistence are limited.

"Visibility is a trap. He is seen but he does not see, he is the object of information, never a subject in communication." –Michelle Foucault

HOME AWAY FROM HURT

Families Surviving Violence

——by Edna Adler and Zoneil Maharaj

Angela Smith's husband controlled every aspect of her life, from what she wore and ate to whom she kept as friends. Whenever she defied him, her husband would smack and punch her. His favorite method of keeping her in check: choking her until she passed out. When an ex girlfriend of her husband's helped her realize the abuse would eventually target her children, she left, forced to live in her car with her two boys, aged one and three.

"The kids were scared. I was scared," says Smith, "I was 22 and didn't know about shelters, I didn't even know about welfare."

After receiving her next paycheck, she went to stay at a cheap hotel. The room was moldy and wet, causing one of her sons to catch pneumonia. She took him to the hospital where, she saw a poster that read: "Love is not supposed to hurt." Without hesitation, she called the number for the domestic violence shelter and checked herself in with her children.

According to the National Alliance to End Homelessness, 41 percent of the homeless population in the U.S. are made up of

families, and disproportionately consists of single mothers and their children. A primary reason for this growing population is domestic violence.

In the U.S. alone, there are 5.3 million women who have had violent acts committed against them by an intimate partner (also known as IVP, Intimate Partner Violence), as stated by the National Center for Injury Prevention and Control.

These domestic abuses stem from a host of problems: poverty, lack of employment skills, child abuse, mental illnesses or substance abuse. Bay Area organizations such as La Casa De Las Madres and Building Opportunities for Self-Sufficiency offer support and services to address the various issues connected to domestic violence. But clearly, there is a need for more resources before we can expect substantive change in the current statistics.

Most emergency domestic violence shelters encourage victims to go through a healing process, offering various social services, medical treatment, psychotherapy and assistance with filing restraining orders. Transitional housing programs pick up where shelters leave off.

"For women running away from a desperate situation, safe houses are where they go," says Janny Castillo, Community Organizer for Building Opportunities for Self Sufficiency (BOSS), an organization which offers transitional housing and support services for victims of domestic violence along with those suffering from various issues including disabilities, mental heath problems and HIV. "Once they reach a domestic violence shelter, they are labeled as homeless…but they don't think of themselves as homeless, they think of themselves as women in a desperate situation at point of their lives where they have to make a choice."

When untreated, these abusive situations can be fatal, such as in the unfortunate case of 40-year-old Tanya McCall. She left her high school sweetheart and husband of 13 years, Mathew McCall, in November and filed a restraining order. The abuse, which began when they were teenagers, culminated on March 11 outside of the Acts Full Gospel Church in Oakland at 8 a.m., where she was shot and killed by her estranged husband.

Illustration to the left by Monica Canilao

According to Lisa Polacci, Community Programs Director of La Casa De Las Madres in San Francisco, a multilingual domestic violence shelter that offers various forms of support and services to victims, it usually takes 12 abusive incidents before someone calls 911.

Luckily for Smith, whose name has been changed to protect her identity, she was able to realize the danger she was in before things got too severe. She and her two children now share a room with another single mother with two children inside a home with six other single-mother families through the transitional housing program offered by BOSS.

"If I knew then what I know now about abusive men, I would have left right away. But nobody ever told me anything…I didn't know anything about how to deal with relationships," she says.

Smith has been around domestic violence her whole life, having grown up with her drug-addicted and sexually promiscuous mother and an abusive step father. When she was senior in high school she was raped by a former boss. He ended up serving six years for statutory rape; she discovered she was pregnant and gave birth to her first child.

At 18, she became pregnant yet again. Living with her stepfather became too much to bear and so she took her baby and stayed with friends for a few years. It was then that she met her future (and ex) husband, her former high school basketball coach.

"He was 10 years older than me and very controlling and had a lot of influence on me," she says.

This lack of understanding relationships is a focal point for organizations like BOSS.

Aubrey James is a special needs case manager at the Hale Laulima Family House, a transitional living center in the BOSS network where 80 percent of the residents are victims of domestic violence.

"Before domestic violence comes into these women's lives, a whole bunch of stuff happens first…A lot of women come to us with mental issues from being abused as children, growing up in foster homes and not understanding relationship from an early age," says James. "A lot of these women go from one bad relationship to the next – it may not be domestic violence. It's one poor partner to another. He may not be a batterer, but he may be a drug abuser or alcoholic."

"A high percentage of domestic violence victims have other problems as well," adds Polacci. "Women dealing with domestic violence for any length of time are likely to have issues around depression, either diagnosed or undiagnosed, and Post Traumatic Stress Disorder."

For Smith, substance abuse supplemented the domestic abuse. According to Polacci, the link between substance abuse and domestic violence is a gray area that she hopes will be further examined.

"When people call a crisis line, probably 70 percent of the time around the abuse, somebody was using." Polacci says. "There's a big overlap between substance abuse and domestic violence. But it's also important to state that the violence is not only related to substance abuse. Domestic violence crosses all class and race lines. I know women who have been abused by doctors and lawyers who drive nice cars and live nice lives."

In many cases, leaving behind an abusive relationship also means leaving behind a life that is familiar. When Smith finally chose to escape her abuser, it was hard, even after she admitted herself into an emergency shelter.

"When you separate a family to go into a shelter or housing center, you're asking one person to be responsible for a family," says James. "It's hard working with folks when you break a family up. That's why a lot of folks will go back to their partner because they will have some kind of support, even though it's unhealthy support."

According to James, 50 percent of domestic abuse victims maintain contact with their batterer; half of them get back together with the batterer.

Smith returned to her husband after he told her that he wanted her back and that he would never hurt her again, the day after she entered a shelter for the first time. For eight months, he remained true to his word, refraining from violence. Then she got pregnant, and the violence started again. His abuse led to her having a miscarriage.

She left once more, this time for good. Throughout this ordeal, she feels her children have suffered the most, feeling the brunt of the violent relationship.

"The hardest thing about being homeless, the biggest challenge is having kids and not being stable, not living in one place for more than 6 months since 1999," Smith says.

"Certainly, the effects of children witnessing abuse is long-lasting and gets passed on from generation to generation," says Polacci. "It's not a prescription you'll be an abuser but you're three times as likely as an adult."

Smith and her children are now doing fine, finally having gained a bit of stability. Her children have remained in the same school for the last two years. Her eldest son attends a college prep boarding school on a scholarship he won by writing an essay on human rights.

"Throughout all this, I always felt like a terrible mom, but I must've done something right. I have great kids. They're very smart," she says. "My boys are very gentlemanly. I can't teach them to be men, but I can teach them to treat women well."

Photography by
Ted Pushinsky

LOST IN TRANSITION

A Foster Youth Confronts Her Emancipation

by YOLANDA ANYON and JENNIFER KRASNER,
with special contributions from BRYTTENI

In a photograph Brytteni has of her graduation from McClymonds High School in West Oakland, she is surrounded by friends and an assortment of balloons and flowers. Smiling, with tears in her eyes, Brytteni stood out from the crowd as a beauty in her high-heeled shoes, bright makeup, perfectly pressed hair, colorful acrylic nails and an almost defiant look in her almond-shaped eyes. Reflecting on that day, she remembers somberly, "I was so close to not making it." Then with a youthful bravado, she reveals what she was actually thinking, "I don't have to go to school no more, I'm going to sleep 'till two!"

This carefree vision of life after high school was nothing like the reality of poverty and the possibility of homelessness that Brytteni later confronted. As a young woman in the foster care system, Brytteni's high school graduation marked her independence, both financially and emotionally, from her legal guardian, the State of California. Brytteni acknowledged that this rite of passage was mostly symbolic. "To me, it was different than for some [youth in foster care] who are living in a group home or start foster care when they are nine or 10," she says. "That day [of emancipation], your life changes – you have to move out, you had a social worker. But for me, I had already had my own apartment, I hadn't seen my social worker in three or four months. So as far as I was concerned, I was like, 'I'm already emancipated.'" On that day, Brytteni became one of the 4,000 youth who emancipate from the system every year often unprepared for the growing responsibilities and financial independence that comes with adulthood.

It is true that Brytteni had been surviving on her own for years. Her involvement with the child welfare system began in tenth grade, when she sought the help of a psychiatrist to manage the trauma she was experiencing at home. Without understanding the consequences of her actions, Brytteni told the psychiatrist that her mother was emotionally abusive and neglectful. "My mother would not allow me to be a kid in her house. She had these rules for me especially [compared to my brothers]," she says. Her mother also failed to protect her from sexual and physical harm at the hands of other family members and friends. By law, the psychiatrist had to report this abuse to Child Protective Services, setting in motion a chain of events that led to Brytteni's removal from her mother's home. Over the next three years, she bounced between four different placements, ultimately landing in an apartment on her grandmother's property.

While the purpose of foster care is to protect children from neglect or abuse, the state's child welfare agencies are required to do very little to ensure that those who emancipate from the system are prepared for life on their own. In fact, once a foster care youth turns eighteen or graduates high school, the state is not responsible for keeping track of what happens to them. The only information we have on former foster youth is for those who later receive welfare assistance or get into trouble, which is statistically often the case. According to the California Department of Social Services, approximately 50 percent of young women who were once in foster care end up on welfare within six years of emancipation, compared to only six percent of all females between the ages of 19 and 29. The California Legislature also estimates that over 70 percent of all State Penitentiary inmates have spent some time in the child welfare system. Beyond their involvement with the criminal justice or welfare system, young people who emancipate from foster care experience multiple challenges, including homelessness, mental health problems, and a limited education.

To prevent such problems in early adulthood, national studies say that most biological parents provide their children with emotional and financial support until they turn 26. Starting in the 1980s, researchers, advocates and policy makers argued that states should be expected to do the same for former foster care youth. In response, congress passed the Chafee Foster Care Independence Act in 1999, which provides states with funding

to create Independent Living Skills Programs (ILSP) for "transition age" foster youth between 16 and 21 years old. Federal and state law mandates that ILSP programs provide emancipated youth with access to financial support, housing, counseling, employment, education, and health care services to supplement their own efforts to achieve self-sufficiency. In Brytteni's case, after months of working in a series of dead-end jobs after high school, she was determined to pursue her goal of going to college to become a nurse. From ILSP, she has received $500 to help pay for books and a $500 scholarship for winning an essay contest. The state covers her tuition at community college. All together, this support is worth only $1,250, barely covering two months rent for a studio apartment in the Bay Area. Luckily, her grandmother agreed to continue renting her apartment for $500 a month, which Brytteni splits with her boyfriend. On her own, Brytteni found a part-time job as a cocktail waitress, allowing her to attend classes during the day. Still, at the end of the month, she's never quite sure how she's going to pay all of her bills.

According to Jeff Sloan, Program Manager at Beyond Emancipation, a non-profit organization that serves emancipated youth in the county where Brytteni lives, many youth do not receive the services they need, in part because they never find out about them. "Alameda is consistent with the rest of California in that we are servicing between 20 and 25 percent of youth who are eligible," says Sloan. "We are finding that a lot of these youth in group homes and foster homes aren't getting the information they need, so they emancipate without stable housing, a job lined up, or understand[ing] how to balance a check book. And once youth have emancipated, it is very difficult to track them." Shira Andron, First Foundation Program Manager at First Place for Youth, a provider of transitional housing programs for foster youth, agrees. "Independent Living Skills Programs are preparing youth for transitioning out of care, but we need to make sure that we're talking to kids early and connecting more youth to ILSP to make sure they are on track to meet their goals and connected to related resources," she says. Without these early, strong connections, the vast majority of former foster care youth do not know about these programs and they do not receive services.

In addition to challenges with outreach, state and federal governments do not fund programs for emancipating youth at a level that meets existing demand. In the case of transitional housing, the Children's Advocacy Institute estimates that California only funds enough units to serve two percent of the eligible emancipated youth population. Christy Saxton, the My First Place Program Manager at First Place for Youth, reports that their program for emancipated youth always has "a full waiting list." Sloan says that more funding is warranted because there is evidence that these programs are effective, "Agencies are functioning on a limited budget, even though there is research that demonstrates our youth tend to avoid incarceration at greater rate than those who don't utilize ILSP and our services. Secure housing and training and enrollment in school invariably prevents them from ending up on the streets."

Since Brytteni received only minimal support from ILSP, she attributes her personal success in part to relationships she had with consistent and caring adults while she was in foster care. These individuals did not include social workers or foster parents; they were teachers and youth workers Brytteni met through school. "I had these surrogate mothers, different ones over time. As I've evolved, I've depended on people for different reasons, whatever phase I'm going on. I feel like I have an extended family." Now Brytteni says she has a loving relationship with her boyfriend and his family helps her enjoy life despite her struggles to stay afloat. "Lawrence made a big difference. Now I have someone very similar to me who can understand situations that I'm going through. We are a little family, we talk about that all the time." Professionals and researchers agree that a permanent connection to an adult mentor or family member, in combination with access to concrete services like transitional housing, are the two most significant factors that contribute to transition-age youths' success as an adult.

New legislation presented by California State Senator Carol Midgen could alleviate some of the problems facing emancipated youth if it receives funding by June. Her bill, the "Transition Guardian Plan," would require the state to provide former foster youth with mentoring, support services and a monthly stipend as long as they are following a plan for self-sufficiency that they have developed with the court. The bill is modeled after the very successful Guardian Scholars, which has had a 65-75 percent success rate supporting former foster youth in graduating from college. Although the program would be expensive, and some are concerned about the potential exploitation that could arise from paying mentors, it will save the state hundreds of millions of dollars in the long-term if it keeps former foster youth out of prison and off welfare. Analysis from the Children's Advocacy Institute shows that for every dollar spent on the Transition Guardian Plan, the state could save two dollars in welfare and prison spending. When asked how the foster care system could better support emancipated youth, Brytteni says that youth need mentors, financial assistance, and scholarships for college or a vocational training program. If Congress approves Senator Migden's legislation, Brytteni, and thousands of other youth like her, might get just that.

ETHSIX ARTICLE STATISTICS

Placements: In California 73% of children experience 3-5 foster care placements in their first 3 years of care.

Emancipation: In 2004, 4,255 children emancipated from Foster Care in California (Child Welfare Service Reports for California (2005).

Financial Assistance: The average amount parents pay to assist their children post-18 is $38,340 (2001 dollars, the figure is $42,271 in 2005 dollars and $44,553 in 2007 dollarsBahney, A. (April 20, 2006).

Currently California provides emancipated foster youth with only 5% of this amount in programs and assistance .

College Completion: 1-5% of foster youth enrolled ever graduate college.

Pregnancy Rates: Several studies reveal that girls who emancipate from foster care are far more likely (approximately 3x) than their non-foster youth peers to have a child be 19.

Welfare Use: Approximately 50% of females in the foster care system receive AFDC/TANF Medi CAL within 1-6 years of emancipation.

Justice System: Over 70% of all State Penitentiary inmates have spent some time in the foster care system (May 12 2006 Select Committee Hearing of the California Legislature)

GROWING UP BEYOND THE BORDER

Documenting the struggle of California's undocumented kids.

BY ERIN FEHER AND YAEL MARTINEZ

Jorge* was 14 years old when he left Honduras alone to reconnect with his mother and father, who left for the U.S. nearly ten years ago. He was detained at the US-Mexico border for attempting to cross into the country illegally. Jorge is just one of an estimated 48,000 children who enter the United States from Central America and Mexico each year, illegally and without either of their parents. Approximately two-thirds of them will make it past the U.S. Immigration and Naturalization Service.

In addition to missing his family, Jorge was being sexually abused by a group of men in Honduras. He also faced constant pressure by Honduran gangs to join their violent ranks. He slept many nights on the streets because he had no real home and no immediate family. To him, the life-threatening journey to the US was worth the risk.

In 2005, immigration authorities detained 7,787 unaccompanied minors trying to enter this country, up 26 percent from the previous year. Some head north seeking work, while others are fleeing violence and abuse. Most of the Latin Americans go to reunite with a parent, says Rumeli Snyder, a social worker at Legal Services for Children (LSC) in San Francisco. According to Snyder, these parents leave their young children with hopes of providing a better life for them, and promise to return or send for them when the time is right. With the money they send home the children are often able to move out of debilitating poverty, yet the strain of being away from parents has its own adverse effects. "They spend all their lives wanting to be with their mothers and fantasizing what it will be like," says Snyder.

Reyna Burgos met Jorge shortly after he was caught at the border. She oversees all the kids detained and being held by Immigration and Custom Enforcement (ICE). "They call me whenever they have a new kid at the facility," says Burgos. She says the kids come from all over the world— China, India, Central America— and range in age from five to 17 years old. "And for the most part, these kids are alone," she says.

Burgos visits the detention center every Tuesday. Each time she gives her speech informing them of their rights, and each time she tries to build up a greater trust with each frightened child. "At first they are so scared to talk to me because they think I am going to communicate with immigration," says Burgos.

The children's confusion about who to trust runs deeper than simply a fear of deportation. Many Chinese youth have been brought into the country by smugglers known as "snakeheads," who charge $50—$90 thousand to smuggle them into the U.S. Similarly, parents sacrifice being with their children because they believe a better life and greater opportunity await their children in the U.S. "The Chinese kids are really unlikely to tell you the truth when you first meet them because the snakeheads have said 'Say what I've told you or I'm going to kill you, or I'm going to hurt your family,'" says Lisa Frydman, a staff attorney at LSC.

It can take weeks to get a child just to give his or her name. "If they are coming by plane, they are told to rip up their documents on the plane," says Frydman. Often they land in Canada, the Caribbean or Central America before crossing the final leg into the U.S. ICE reports that in recent months 50 to 100 Chinese each week have been taken into custody trying to cross the Mexican border.

Jorge was able to be released to his parents in Northern California. During their time here, his parents have obtained legal status and can currently live and work in the U.S. without immediate fear of deportation. They have enrolled Jorge in school and Snyder says he is doing well, learning English and happy to be with his family, and away from the abuse and loneliness of the streets of Honduras.

Yet Jorge does not fall into either of the two categories that would qualify him to remain here legally with his family, or what is legally referred to as "relief": Special Immigrant Juvenile Status (SIJS) or asylum. "For him to obtain Special Immigrant Juvenile Status (SIJS) there would have to be a problem now, with the parents – like they were abusing him and we pulled him out of that situation. And asylum is really complicated for children," says Snyder.

"Under asylum law it's not enough that you were beaten on a regular basis and sexually abused, it has to be because of your race, religion or sexual orientation," explains Frydman, "and that's much harder for kids than adults, because they are much less likely to fall into a political opinion category.

For kids that do fall into these categories, legal status can create the opportunity for a new and better life. Rosa* is a transgender teenager who is working toward her GED and is nearing her eighteenth birthday. She suffered physical abuse by her family because she was trangendered, and therefore qualified for SIJS and was placed in the foster care system in a group home. According to Snyder, she has flourished in the U.S. and hopes to become a teacher. On her birthday her dependency case will be closed and she will be moved into an apartment on her own.

For undocumented immigrant youth, there are those that a judge says can stay, and there are those whom are ordered to go back. And then there are those who don't get caught. Undocumented immigrant kids, due to their intense and destabilizing experiences, are often in dire need of medical and social assistance, but are shut out from most services. Frydman explains that the MediCal programs that were created to provide services for all children, regardless of the economic situations of their parents, don't apply to kids who are undocumented.

But since 1998, one thing has been unequivocally guaranteed for undocumented youth throughout the country. It was then that the Supreme Court ruled on Pyler vs. Doe, which ensured undocumented children the right to a free public education, and protected their parents from having to provide their immigration status during any procedure involving the public school system.

"We know some of these kids here are not in this country legally," says Baje Thiara, principal of Newcomer High School in San Francisco, "But we are not immigration, we are a school, and everyone has a right to be here." Newcomer is a transitional public school for non-English speaking students who have recently arrived to the U.S. The school offers general education courses in Spanish, Mandarin, or Sheltered English, an English-based system used to communicate with non-English speakers, as well as three hours of English language development classes per day.

Thiara is all too familiar with the mental health issues that plague many of the newly arrived students, for whom getting to know the U.S. is often coupled with getting to know a family they haven't seen for many years. "So many of these kids were living as adults in their home country. With their families gone, they were the men," says Thiara. "Now here they are children and have to ask to go to the bathroom. There are a lot of discipline issues, and a lot of abandonment issues."

Greg Collins has taught at Newcomer for over 20 years, and says that the challenges facing immigrant kids are immediate and affect them both physically and mentally. "When you are a newcomer, your entire body is under trauma," he says. "It's hard to think about the big picture when you're dealing with the hurdles of everyday."

Lisa Frydman has seen those struggles become too much to bear for some. "The amount of pressure on these kids is unbelievable. Pressure to work and make money to send home to the family, pressure to pay off smuggling debts, the fear that them being here is going to get the whole family caught and deported," says Frydman. She says that these pressures, combined with negotiating the bureaucracy of the immigration system, leads some kids to opt for "voluntary departure," or just giving up and going back.

"under asylum law it's not enough that you were beaten on a regular basis and sexually abused, it has to be because of your race, religion or sexual orientation."

"They are separated from family, they are on their own, and they are dealing with a really tough system, that even with our help is hard to make sense of. And they are looking for these definite answers and we don't always have them," says Frydman.

As is the case with Jorge, locating one's parents is rarely the end to immigration worries. Burgos explains that often times if the parents of a detained child are themselves undocumented, they are reluctant and even refuse to accept guardianship of their child. "There are prerequisites for the child to be released to them, including that they be fingerprinted by immigration, tell them where they live, where they work, and what their legal status is in the United States," says Burgos. "I don't tell them what to do, I just tell them the risks. Often they hold back and say 'Oh my God – as much as I love this child, what do I do?'"

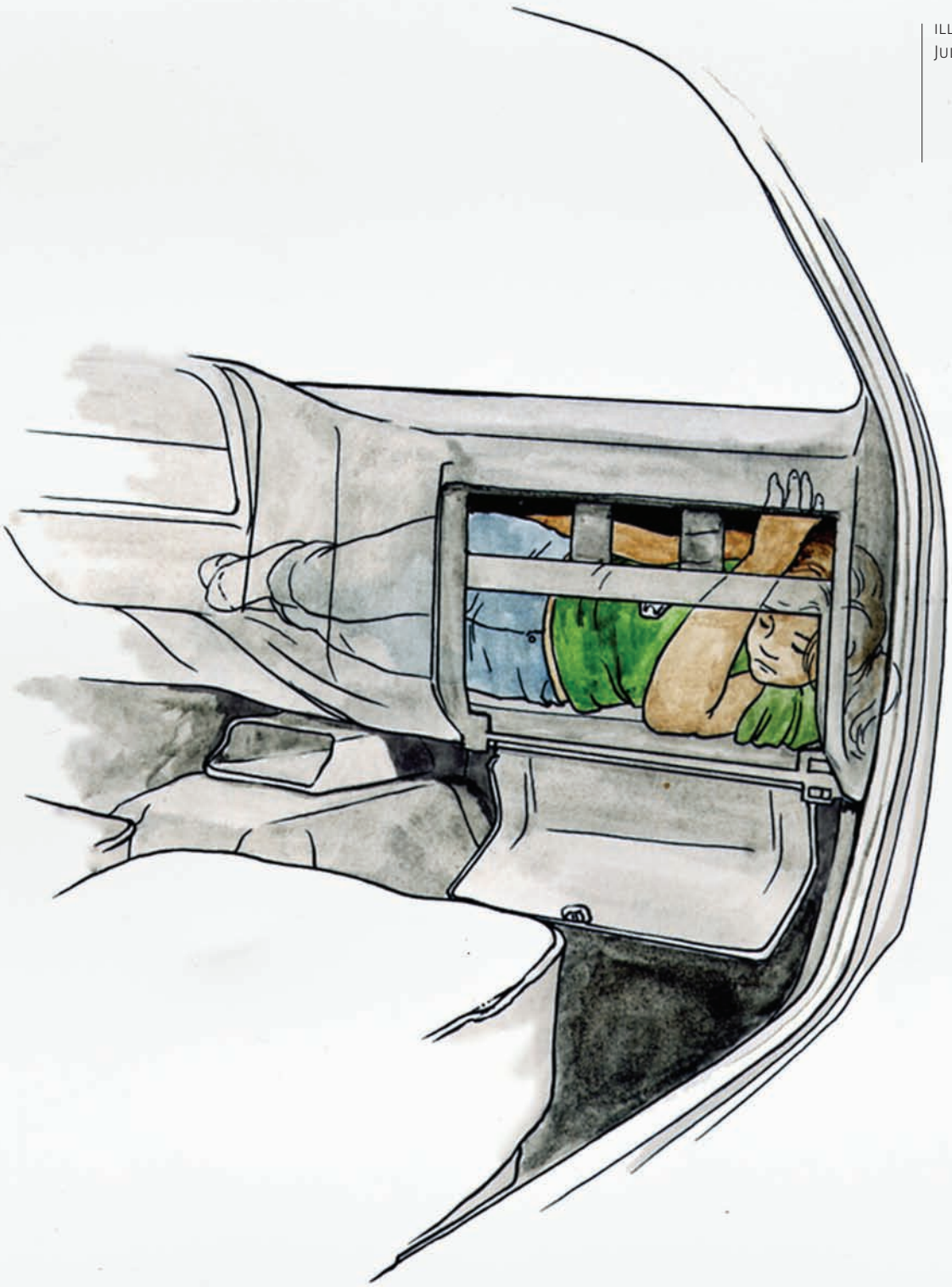
At this time Snyder, Burgos and Frydman have not found anything in Jorge's case that would qualify him for relief. "If he can't get relief he will be forced to leave – they would probably recommend that his parents go with him, but they can't force the parents to go back as well," says Snyder.

"This system absolutely does not work," says Frydman. "I would change the immigration laws completely, and not ever have these kids have to show up in court, and implement policies that actually look at their best interest. Right now, these kids' best interest does not come into immigration law."

"I refuse to believe we cannot make some kind of case for Jorge, because I cannot live with it if he goes back," admits Snyder. "I've been pretty good as a social worker to leave these things at work – you have to in order to be good at your job and not burn out. But with this case, I talk with him and I go to the bathroom and I just start crying, because of all that he's already been through, and not knowing if we're going to be able to help him."

*Names have been changed to protect the clients' identities.

ILLUSTRATIONS BY
JULIO MORALES



BEHIND THE MIRROR

Forensic interviewing Child Adolescent Support Advocacy and Resource Center

by EVA WEXLER

As a Title IV-E student I knew my second year internship was going to be intense. The Title IV-E stipend covers a hefty chunk of my tuition and living expenses and in return, I am indentured for two years work in public child welfare system post-graduation. My academic training requires a focus on preparation for the front lines of Child Protective Services, CPS, and a trial by fire second year internship in a public child welfare agency. When the time came to select my internship I decided to preemptively combat my trepidation about the heavy CPS work by signing up for the most emotionally challenging internship I could find: an Emergency Response position in the Sexual Trauma Unit in San Francisco.

CASARC, the Child and Adolescent Support Advocacy and Resource Center at San Francisco General Hospital, serves children and adolescents who have been sexually or physically abused or who have witnessed severe violence. In addition to medical and crisis management services available 24-hours a day, CASARC also provides psychotherapy for individuals, groups and families as well as trainings for community clinics. The first step for many children who receive these services is a one on one Multi-Disciplinary Interview, (MDI) at CASARC in a room with a one way mirror for all those involved with the protection and care of that child. CASARC plays an instrumental role in Child Protective Services and police investigations for criminal trial cases of sexual abuse. MDIs are legally required as a way to collect evidence for these investigations. Because of the potential trauma of having a child interviewed multiple times, as well as the possibility of bias if the interview is conducted by the person who is investigating the case, each time a child in San Francisco discloses sexual abuse, they are sent to CASARC where they participate in a single (occasionally two) videotaped interview(s) conducted by a specially-trained forensic nurse.

About a month into my internship in the Sexual Trauma Unit, I was given my first case* of suspected child sexual abuse and soon found myself at CASARC crammed into a narrow room with the Assistant District Attorney and Juvenile Inspector from the San Francisco Police Department as we observed the interview behind a one-way mirror. My client was a nine-year-old girl who had recently told someone that she had been fondled for the last two years by her great-uncle. After an initial interview, it seemed likely that she might be able to provide enough information during the videotaped interview for the case to be criminally prosecuted. I watched in awe as the forensic nurse led the girl into a room decorated with colorful posters, child-sized furniture and stuffed animals embracing video cameras mounted to the wall. After sitting down, the forensic nurse introduced herself and explained the ground rules. The nurse directly pointed to the cameras and mirror, indicating to the girl that the interview would be observed and videotaped. Then the nurse began the process of "building rapport" and then "distinguishing between truth and a lie". I later learned the latter is part of a highly structured forensic interview format based upon extensive research on interviewing children as well as collecting legally viable evidence for criminal prosecution. As the interview unfolded I was struck with both disappointment and utter amazement. The young girl wasn't ready to talk. Though she initially was able to say that she was molested, she appeared too traumatized to discuss the details that would be necessary to prosecute her abuser. The nurse had used cartoon sketches of naked children, a forensic interview tool commonly used along with anatomical dolls so that victims can show what happened to them by circling or pointing to body parts. It was decided that the girl would be referred to therapy at CASARC, and, if she decided to disclose later, there could be another MDI.

Photograph & Minature by Nadim Sabella

Observing the interview had been an emotional roller coaster. I was enraged that someone would hurt this child and frustrated that justice would not be exacted on the perpetrator. My heart was heavy from seeing the pain of this child who had suffered so horribly. I felt a small shred of hope knowing that the abuse had stopped and that she would be receiving help from CASARC via therapy and from her family who were unwavering in their support and concern. I wondered how in the world someone could do a job like that, especially while being videotaped and watched by a group of people scrutinizing every move?

This was the first of several MDI's I observed throughout my internship. I was enthralled by the impressive work of the CASARC nurses. I saw so many children disclose horrific incidents of sexual abuse while the nurses retained complete composure, asking objective questions about the details without appearing either cold or overly sympathetic. Details of the abuse were disclosed with accuracy, and the tone set by the nurses made the children feel comfortable to discuss their abuse without feeling embarrassed or scared about their memories.

Intrigued to learn more about the science behind these interviews, as well how CASARC nurses are able to remain objective while being faced with such compelling cases of abuse, I sat down with two CASRAC veterans, Helen and Mary, who between the two of them have a combined 30 years of experience conducting forensic interviews.

Eva: In your work with sexually abused children and adolescents, how are you able to remain objective while hearing such compelling and tragic stories?

Mary: It's an art because you still have to be able to show the kid you care. You're asking them to tell you something that is so horrible, so I if you look like you don't care, then they won't tell you, but if you look like you care too much, you will burn the kid's case.We have all been dinged in court. (She recalls getting grilled on the stand when it appeared she had nodded too much during an interview. The defense attorney played the interview tape and tried to get her to say she was leading.)

Mary: Off camera we can say; "it is not your fault", but if you say it in interview, you have blown the case.

Eva: How have you been able to do this work for so long?

Mary: A couple things: I am a nurse first and I really like working with kids. Over the years, I have become better at it. This kind of nursing, it's a service, and I get kudos for what I think is a good job. I do the best that I can and I give them back to the world and wish them well. I know all I have control over is how I do the interviews. This is a job, and yes we see some of the worst things, but it is still just a job, and you can't let it consume you.

¡FOR THE PEOPLE BY THE PEOPLE!

Venezuela now belongs to all

by YAEL MARTINEZ

Walking down a bustling street in downtown Caracas, the capital city and epicenter of Venezuela, a public bus rushes by, leaving me with the residual a scent of exhaust and the sounds of salsa music in my ears. I look at the back of the bus as it speeds away and I can read the popular national slogan "Venezuela now belongs to all." I am surrounded by political graffiti and of President Hugo Chávez Frias's name in red. Anyone would think that an election is about to take place even though there are no polls to be opened, Venezuela today resonates with excitement, anticipation, and opposition all at once. Even though this was my childhood home, Venezuela now is very different from the politically apathetic country I remember.

Since 1999, Hugo Chávez and the Bolivarian government have been making drastic changes in both government and civic life. As the world's fifth-largest oil producer, Venezuela enjoys high oil profits that have been used to fund social development programs that include agricultural cooperatives, microcredits for small businesses, and poverty reduction programs addressing illiteracy, health, nutrition, and unemployment, all aiming at ensuring equality and bringing to life their national slogan.

As I sip my coffee at a corner bakery, I overhear a conversation between two businessmen and the bakery worker about a news report on a new misión the government has launched. The businessmen argue, "There goes the government again, spending money they don't even have on these programs so they can get political support." They say Chávez is turning Venezuela into Cuba, that investors are leaving the country and soon no one will have a job. The bakery worker jumps in defense of the government, "The government is investing in its people." He states emphatically. "For the first time in Venezuelan history he is doing something about the poor people of Venezuela!" They continue arguing until the businessmen walk out, calling the worker a crazy fool.

The Bolivarian revolution, as it is known, has not been without criticism, particularly from the United States and the upper class Venezuelans who oppose Chávez. Critics are concerned that Chávez's government and policies have divided the country, causing a reactive fragmentation in society. The sentiment of the opposition is that he is yet another failed populist president who will bring the country to ruin and endanger the stability and security of the region. Others wonder how long the movement will last and what will become of Venezuela, once Chávez leaves office.

During the late 1960s and 1970s, Venezuela experienced economic and social prosperity due to oil revenues. In the 1980s, Venezuela suffered a drastic economic and social collapse. Corruption and mismanagement by President Carlos Andrés Pérez, along with the imposition of conditions by the International Monetary Fund (IMF) and the World Bank, caused Venezuela to experience a collapse in oil prices and the devaluation of currency. The poor and the rapidly disappearing middle class were the primary victims of these events. Incomes fell 40 percent and poverty increased from 33 percent to 70 percent. The social and economic climate resulted in the "Caracazo" of 1989, a five-day social uprising and military repression resulting in hundreds of deaths. Chávez and other officers were among the military repressors and subsequently found themselves demoralized and frustrated by having to take violent action against their own people.

Years later, these same officers, along with a growing underground movement lead by Chávez himself, known as the Revolutionary Bolivarian Movement 200 (Movimiento Bolivariano Revolucionario 200), led a failed coup against President Rafael Caldera in 1994. After his pardon and release from prison that same year, Chávez and his followers continued to organize and expand as a legitimate political movement. In 1997, The Fifth Republic Movement (Movimiento Quinta Republica or MVR, V for Roman numeral V) took shape. Chávez's overwhelming victory was a result of his background and charismatic personality. Born to working class elementary school teachers, Chávez represents the majority of the Venezuelan population, as he is ethnically mixed and dark skinned, loves baseball, and like many of other poor Venezuelan men, joined the military as a means to go to college. President Chávez began to make changes in the government policy in order create a more inclusive and democratic society free of poverty, and promised to increased economic opportunities for citizens through what is called "endogenous social development". By 1999, the Venezuelan government convened a new National Assembly that drafted a Bolivarian Constitution to reflect the changes.

Today, as stated in the Bolivarian Constitution, Venezuelan citizens participate in their own governance through citizen which create and influence policy from the ground up. The government also launched a series of poverty reduction programs known as misiones, or social missions, in order to address poverty in Venezuela.

Venezuela's misiones are the core of a "participatory democracy and endogenous development." The aim of the social missions is to achieve and guarantee social equity by addressing the problems of extreme poverty and achieving a higher standard of living for all Venezuelans. The top three goals of these social programs are to develop and expand the national food supply and production; to shift from social exclusion to social inclusion, and to eliminate poverty by the year 2021. The poverty reduction goals of the Bolivarian government have clear and defined parameters including equity through literacy, access to health, and expanded economic opportunities for all.

One example is Misión Robinson I (Mission Robinson I), which aims to eliminate illiteracy among Venezuelan adults. Trained community volunteers and university students teach evening and weekend literacy classes to adults in their neighborhoods. Another example is the Escuelas Bolivarianas (Bolivarian Schools). These schools provide free public education to elementary school-age children. While they are in school, they are given free breakfast, lunch, and a snack. These free meals and day-long schedules are intended to help poor families by allowing parents to work during the day and spend less money on food. This program is expanding to include another school program called Misión Simoncito, a program that will provide free daycare and pre-school education to children younger than six years of age.

The misiones are usually local and run by the neighborhood residents and community leaders. For example, Misión Barrio Adentro (Mission Inside the Neighborhood), are medical clinics located in the Venezuela's shantytowns and low-income neighborhoods, serving Venezuela's poorest communities to provide free high quality dental and preventative health care all over the country. A unique aspect of this mission is that it is staffed by mostly Cuban doctors, who live and work in these neighborhoods for a period of two years or less, through an exchange program with Cuba.

As a social worker here in the U.S., I am amazed by the dedication and support Venezuelans have for the misiones and for the Bolivarian government. It is inspiring to see what is possible when people are given the opportunity to become involved in creating their own social change and take charge of their own development. Chávez and the Bolivarian revolution have gained momentum because of the promise that has been made to end poverty in Venezuela and the Venezuelan people point to the misiones as proof of this promise.

Although there has been evidence of their success, the misiones suffer from great inconsistencies and weaknesses. Like many social service programs, they do not address the concrete structural changes that lay at the root of poverty. In theory, these social missions are tackling the immediate problems and necessities of the very poor. In practice, there is much to be done to make changes at the structural level in order to guarantee sustainable changes in the Venezuelan society. Moreover, there are not enough jobs available for all of the students who will be graduating from the educational programs.

The administration, participation, and execution of the missions is sometimes problematic. Many of the paid volunteers and committees in charge of the literacy missions are not adequately trained, and there is risk of corruption at the administrative level. Another concern is the financial administration and budgeting of the missions, as it is unclear where the funds will go and how much will be needed for future years. There has also been a growing concern that the mission participants are only there to receive the monetary stipends and may not be sincerely interested in benefiting from the other services the program offers.

While visiting La Bandera, one of the neighborhoods in Caracas, I seek out participants of one of the misiones to talk with them about their experiences and opinions about what is taking place in Venezuela. An older Afro-Venezuelan man, with rough hands and sun-worn skin, tells me that the misiones have changed his life. He has learned to read and write, he has access to free health care and low cost food in his own neighborhood, and he is working in a cooperative as a furniture maker. "All that" he says, "is thanks to Chávez and the Bolivarian government". When I ask about what he thinks of critics of Chávez and the misiones, he says, " A rich man once asked me, 'What has Chávez done for you, since you are still poor?' I told him, 'You know what Chávez has done for me? He has given me opportunity and the dignity to stand up to people like you and tell you that you are no better than me.' That's what he has given me and others like me." He laughs and says, "That's what you should tell people up north when they ask you about Venezuela."

Do You Know How It Feels be_____?

Facing class and race difference in social work practice

BY DONNA TAM

In social work, there is no easy way to account for the racial disproportionality of social work clients. People of color make up most of the population in the social welfare and criminal justice system and social workers have to make sure they can help these people get out. Hence to cultural competence.

Dedicated to her field, Jamie Ott strived to be a thoughtful member of the social services workforce. When she worked with probation youth in San Francisco, a majority of her clients were young African American males.

Through her work experience she learned about the importance of cultural competence. She learned about understanding bias and stereotypes. And, she learned to take every client on a case by case basis and not to clump people together in one type of ethnic or racial box.

But when she was held up at gunpoint by two young African American males outside of her Oakland apartment, something changed.

The experience began to affect her work.

"When I saw young African American males walking on the street, I would get nervous," she says of her post-traumatic stress. She had begun associating the men that robbed her with all young African American males.

"I was so mad at those guys, they really fucked me up," Ott, now 27, says. "But it was a privilege too, it let me reprocess my feelings…maybe there was something inside me that I didn't realize."

Despite her sensitivity to culture and race, Ott still had to face her feelings related to bias.

Cultural competence, a phrased used to describe an understanding towards the complexity of ethnicity and race, is an important aspect of social work. Numerous training sessions and classes are devoted to the topic, turning the term into a buzz word in the world of social services. But many argue that it is not so easily learned.

The meanings behind race, culture and identity are so emotional and complex that discussions of these topics can lead to some very loaded situations. According to the National Association of Social Workers, cultural competence is defined as a process that will help social workers to achieve five qualities, which consists of valuing diversity, cultural self-assessment, being aware of how cultures interact, being aware of institutionalized beliefs of cultural understanding, and being dedicated to creating programs that reflect these understandings.

Despite the addition of training programs adhering to these qualities the difficulties that cultural differences create. These difficulties are not easily solved with an hour, or even eight hours, which is probably the maximum time that will be devoted to a session. Even in a seemingly diverse environment like the Bay Area, social workers are predominately white and female

Ott is of the majority, but being white has not kept her from critically listening to her clients. She knows not to base everything on classes or trainings.

"You can't teach about every client you're ever going to run into," she says. "You really just have to interact with your clients and find out about their experiences."

She also tries to do as much research as she can about a client's background through reading or talking to people from the same culture.

Paintings by
Modou Dieng

The aim of art is to represent
not the outward appearance of things,
but their inward significance.

–Aristotle

It is required by the School of Social Welfare at Berkeley that all students achieve a degree of cultural competency through a course titled “diversity”, students can test out of the course in the beginning but most are required to take it.

It might have been more helpful if people who had a good understanding of cultural competence weren’t able to test out of the classes. “I won’t lie, I tried to test out too,” Ott admits. “There could have been better discussions.”

Ott says the diversity classes are not really helpful, but more of a formality.
Kenya Sullivan, 37, a psychiatric social worker in Alameda County, finds that even the many training sessions outside of the required school course are just not sophisticated enough. He says most are “laughable,” finds them outdated, and that all too often, this type of education only looks at groups, not individual people.

“As a middle-class African American male, I’m very different from my working-class African American cohort, or to those of African American aristocracy…there is no homogenous group,” says Sullivan, who recently published a chapter in the book, "Cultural Competence in Process and Practice: Building Bridges."

But Sullivan also points out that you don’t need to be of the same race to connect with a person.

“(White women) have to own their oppression. They think they have white privilege. But they don’t get the same salary and they don’t get the same rights as men do,” he says. “If white women comes to the field and own their oppression then that’s where they’re going to connect to clients.”

Sullivan uses this kind of understanding when reaching out to his clients.

“I have no idea what it’s like to be gay or to be transgender, but I know what it’s like to be stared at,” he says. “I know what it’s like to be an other, to be different.”

For Sullivan, connecting is about relating and finding a common understanding despite any bias you may have. He uses himself as an example. One of his cases involved a young white male who was depressed because his parents were not happy with his mediocre career choice. Sullivan found that bias could have gotten the better of him.

“It became about me and him,” he says, admitting to thinking “‘and that’s your only problem?’”

In order to help his client Sullivan had to step back, examine his bias and focus on the universal feelings of what it feels like to be rejected by your parents, or to feel like you’re not living up to their standards.

“We go to a place where we relate to being human. It sounds hokey, but that’s how I relate,” he says. “The best thing to do is to have a basic understanding of cultural dynamics and most importantly check your issues.”

Since the incident outside her former apartment in Oakland, Ott has moved outside of the Bay Area. She is still a social worker, at a child welfare agency.

Although she will probably always remember the mugging, she has been able to get past it, making her more aware of her perception of race and culture.

“We all have bias and that was kind of a wake up call,” she says, adding that personal bias was actually one thing she did learn first from cultural competence classes.

“You have bias and you try to prevent that from coming into your practice,” she remembers learning. “It really slaps you in the face.”

Puff, Puff, Give.

Research into cannabis culture

by sam devine

Walking inside one of over 40 medical marijuana clubs in San Francisco is like entering an ongoing collision of a café, bar, and your hippy neighbor's living room. A grey-haired couple sits in a small alcove together, playing dominoes quietly. The man wears an orange tie-died shirt and a leather vest emblazoned with an American flag. The woman wears a sundress and smiles absently. A garden-style water fountain bubbles next to a 50-gallon fish tank. A man dressed all in black wearing a bandana, chuckles and lobs small talk at the security guard, who's busy watching a portable DVD player. The café owner wanders in and out in a Brazilian flag colored shirt, making phone calls.

In 1996 California voters passed Proposition 215, making marijuana legal under a doctors care. Local law enforcement isn't paid to prosecute marijuana offenses, so they don't. Federal enforcement, though, is still coming after marijuana offenders. Right now they're going after a 41-year-old mother of two from Oakland, Angel Raich, who smokes cannabis to ease symptoms from scoliosis and a brain tumor.

Federal levels of government remain opposed to medical marijuana, even though there are currently 11 states that have medical legislation regarding cannabis. The National Organization for the Reform of Marijuana Law (NORML) has played a huge role in pushing for change. And Bay Area cannabis clubs are taking potent steps to legitimize medical marijuana, such as insulating their supply and offering services that go beyond simply the provision of pot. Local clubs have started providing a variety of social services such as veteran's support meetings and substance abuse counseling as well as massage, yoga, knitting and bingo.

This particular club, just off Market Street, has a small but well equipped kitchen area. A sign reading "Serve Yourself" hangs above on the wall. This club serves a small community of locals who often walk here.

"We're not making a whole lot of money here," says volunteer Gary Pal. "And we don't really care."

The owner has a number of Super 8 cameras he loans to the patients. They make home films and have movie nights at the club. They also provide clones, marijuana trimmings rooted in green foam, to help patients grow cannabis at home.

"It's easy to grow weed," says Pal while holding a small marijuana bud. His white beard is trimmed neatly; a half smile sits on one side of his face. "It's hard to grow good weed."

He smiles thinly, letting his gaze float in and out of focus, considering things as he talks, head shifting from side to side. With his tightly rolled knit hat and solid red t-shirt, Pal seems like a longshoreman of old. Hands resting on the weathered bar countertop, he is surrounded by baubles and curtains, odd sized jars line a glass case behind him. According to Pal, there are three grades of marijuana: low cost, recreational, and medicinal. Most of the stuff you see in the streets is recreational. "It's hard to get medicinal, something that will really ease your pain," says Pal.

Proposition 215 made it legal, according to California state law, for cannabis to be prescribed for almost any ailment. However, patients say the mad days of being guaranteed a prescription after paying your fees are gone. Some real medical evidence is becoming necessary. Pal has a deformed elbow. "I take a couple of Ibuprofen behind a joint and the pain is gone." Pal says he volunteers nine hours a day, for which he receives two meals a day and one eighth of an ounce of medicinal grade cannabis. Patients can buy up to an ounce per day at most dispensaries.

While there may be a few nonmedical folks getting weed from the clubs, this is the exception. By the ounce, it's still cheaper

to buy marijuana on the black market then in the clubs. There's a mark up in the clubs that's similar to buying a car from a dealership instead of Craigslist. An ounce of quality marijuana costs $350-$400 in a club, while on the black market the price is nearly $100 cheaper. So prescription-bearing patients are paying higher prices for something more than getting high.

"For the most part, I saw people that were there because they had been marginalized by society in one way or another," says Amanda Reiman, PhD, MSW, "Not because they were drug dealers."

According to a recent study conducted by Reiman while at the University of California at Berkeley, cannabis centers are building communities and offering holistic health services. They are not simply drug facilities. They are health care centers.

Harborside Health Center in Oakland is the model cannabis club. They provide an all-encompassing holistic health environment. Harborside has beautiful maple counter tops and natural sisal fiber carpets that look like hemp. Around the building there are water fountains, multi-faith altars, and flowers. Quiet music plays in the background. Three days a week, their free holistic health clinic offers a variety of care: naturopathy, an integrative healing philosophy involving nutritional and lifestyles changes, home gardening classes, hypnotherapy, Qi Gong, a traditional Chinese medicine, and accutonics, a physical therapy something like massage with harmonized tuning forks. In the lower Haight in San Francisco, there is a small basement club, the Vapor Room, where twice a week, a licensed CMT/ massage therapist comes volunteering free massage. The club sets up peer counseling and legal counseling and gives lessons helping patients discover how much of which strain will be effective for their ailments. The Vapor Room also offers a cannabis care delivery service to patients receiving hospice care. They not only deliver medicine, they also stay and smoke with the patient, providing that most necessary of treatments, a companion sitting beside you.

The appeal of the herbal cure is one that has permeated society beyond medical marijuana users. The popularity of holistic treatments in general attest that they help people feel more connected to both the environment and life in general, offering an alternative to the isolating elements of mainstream health care – the pills, needles and fluorescent light bulbs.

A number of clubs are offering gardening classes. Yes, they're going to grow pot in their gardens, but the therapeutic power of gardening has long been a mainstay of the holistic health approach and is advocated by health guru Dr. Andrew Weil.

Hand in hand with gardening, the clubs are compiling botanical databases, tracking the properties of different plant strains and getting the right strains to the right patients. Only since Prop. 215 have researchers and growers been able to truly track strains of Cannabis in America. There are numerous hybrid strains of the plant derived from two species, Cannabis sativa and Cannabis indica.

"We have a database of several thousand strains," says Steve DeAngelo, director of the Harborside Health Center. He says they plan to develop a survey to connect strains with patient response, finding out which strains are most effective for which symptoms. "Strains become very unique. Some strains are good for appetite stimulation, others are good for pain reduction."

"Cannabis is a complex, un-patentable plant with vast pharmacological potential," writes Jeffrey Hergenrather, MD, in a recent issue of O'*Shaughnessy's*, *The Journal of Cannabis in*

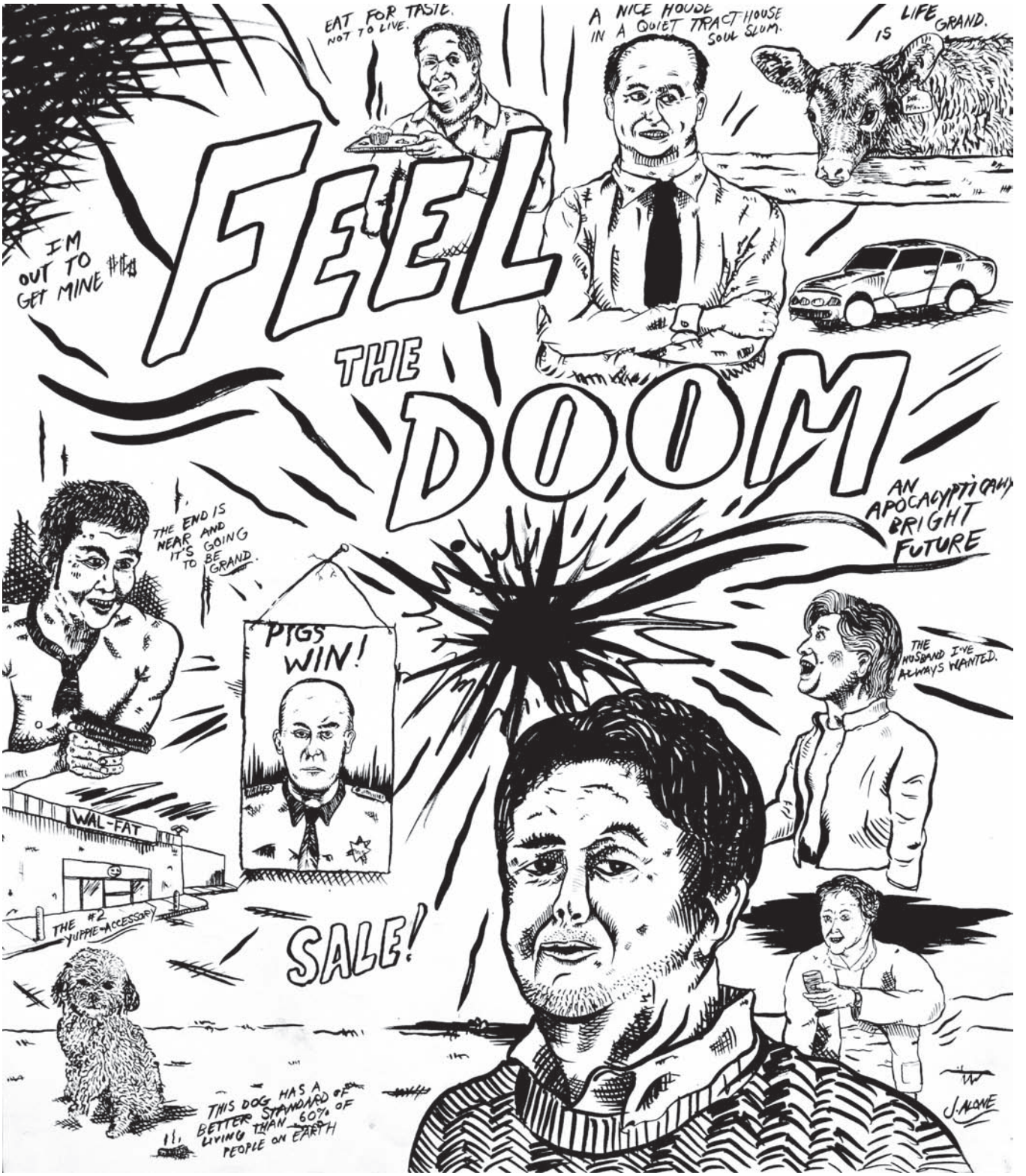


Illustration by
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