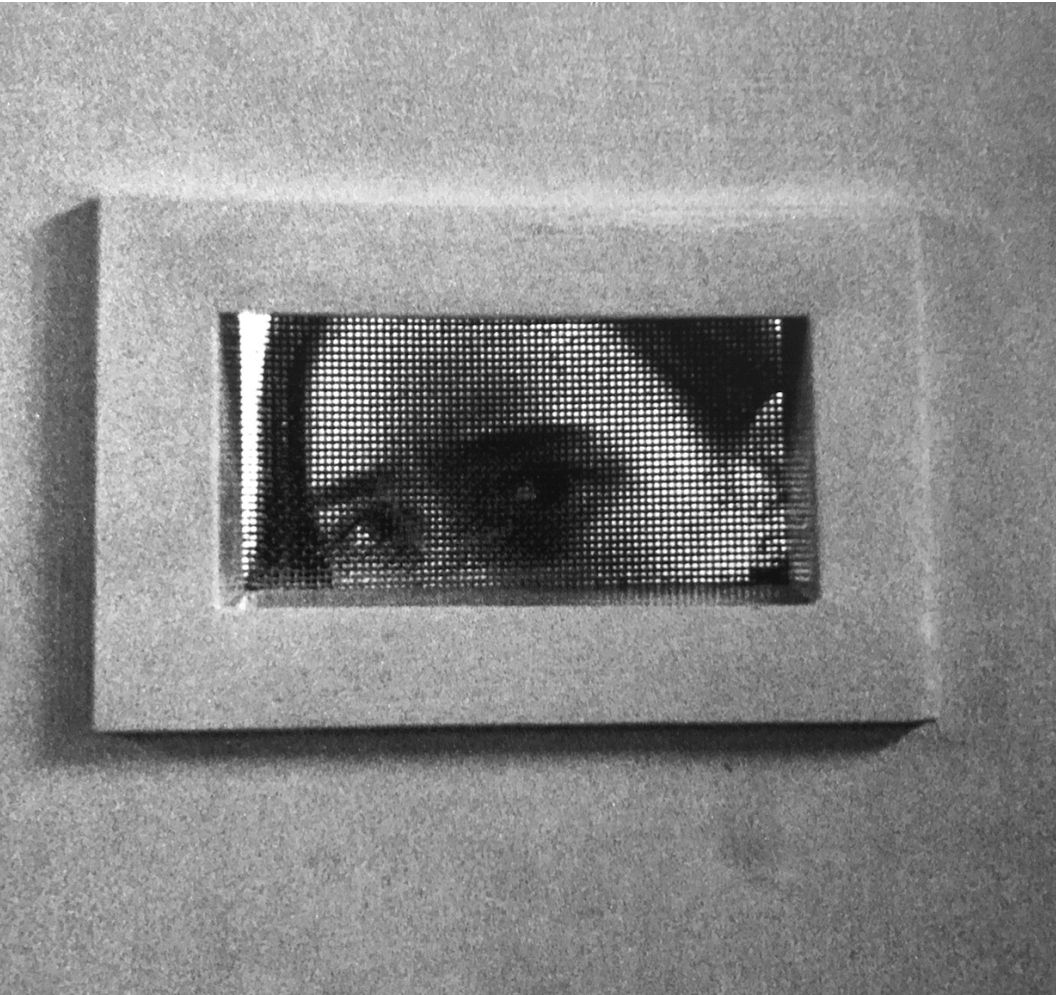


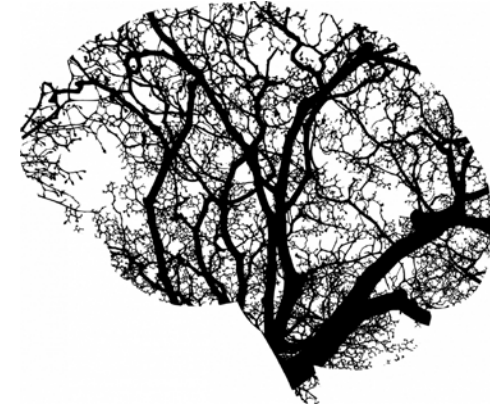
ISSUE NO. 3 | SPRING 2020

# OUT FROM THE VOID 3

AND OTHER ESSAYS BY BRENTON GICKER



***JUDY ANN PARKER AND EUGENE'S  
MISSING MENTALLY ILL***



# JUDY ANN PARKER

## AND EUGENE'S MISSING MENTALLY ILL

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*by Brenton Gicker*  
*Spring 2020*

“My mom is a kindhearted, loving person. She would help anyone in anyway that she could. She loved animals. She raised Pomeranians for many, many years.... Before her surgery and her psychosis, my mom was a nurse for over 30 years. Then she retired. She lived in a house in Tacoma for over 20 years with my stepdad. Raising Pomeranians and doing what she wanted. She worked hard her whole life.”

— Kamara Houston,  
daughter of Judy Ann Parker, 2019

**Judy Ann Parker** was born on December 3, 1944, in San Francisco, California. She was the oldest of two daughters born to the late Leslie Parker and Bette Bruntsch. Her younger sister, Susan, passed away when Judy was in her 50's.

Judy grew up comfortably middle class. Her mother worked as a nurse and her father worked as a truck driver. Judy followed in her mother's footsteps and pursued a career in nursing; a profession that she worked in for more than 30 years, caring for patients at hospitals in California and Washington.

Judy had three children with her first husband (a retired Sacramento County Sheriff): two sons and a daughter, Kamara Houston, the youngest of the three. Kamara was the only family

member interviewed for this story and most details about Judy's life and disappearance were provided by her.

Prior to relocating to Oregon in April of 2014, Judy lived in Tacoma, Washington for many years. According to Kamara, Judy lived a relatively normal existence and never exhibited symptoms of mental illness until October of 2012, after she received an emergency bowel resection surgery. During her stay in the hospital, Judy was given the benzodiazepine lorazepam (also known as Ativan), a sedative-hypnotic

drug commonly given to patients to ease anxiety. Kamara believes Judy's mental illness problems were triggered by this experience and an adverse reaction to lorazepam (Kamara claims that Judy, who was medically fragile and hypersensitive to drugs in general, previously had an adverse reaction to benzodiazepines and had a documented allergy to lorazepam).

However, while benzodiazepine abuse and withdrawal are known to cause transient delirium, it is unlikely that short-term, appropriate use would cause serious

complications. Regardless, Kamara believes her mother was permanently altered by her exposure to the drug as well as the electrolyte imbalances and vitamin deficiencies caused by her gastrointestinal problems.

Regardless of the cause, Judy descended into full-blown mental illness in 2012. At that time, she was retired, twice divorced, single, and living alone. Her house became dilapidated and was eventually condemned and Judy became homeless on the streets of Tacoma.

Judy came to Oregon to live with her daughter in Cottage Grove after being discharged from a hospital in Washington, where she had been admitted for psychosis (initially it was thought that she had dementia but that diagnosis was ruled out).

Unfortunately, after relocating to Oregon, Judy's symptoms continued and she was repeatedly hospitalized for psychiatric reasons, including spending time at the Oregon State Psychiatric Hospital in Salem.

*One of the biggest challenges facing the loved ones of those experiencing a major mental illness is having to respect the rights of mentally ill people even when they are largely incapable of making good decisions.*

Living with her daughter proved untenable because of the severity of Judy's mental illness problems as well as Kamara's marital problems at the time, and Judy was placed in an adult foster home in March of 2016, following one of her hospitalizations. Kamara maintained regular contact with Judy up until she vanished.

Judy was reported as a missing person — by staff from the (now defunct) adult foster home where she lived at 1129 R Street in Springfield, Oregon — on December 31, 2016. Judy's last known sighting was on December 30, 2016, at approx. 9:30am, when a surveillance camera from a business, located near her home, captured her walking along the street.

Judy was 72-years old when she went missing. If she is still alive today, she would be 75 years old.

Judy's disappearance has been agonizing for her daughter and others who know and care about her, and perplexing to the police investigating her disappearance as well as the mental health professionals who have been involved with her care.

Judy's case, in many ways, highlights the complexities and shortcomings of our mental health system.

## **Our broken mental health system**

*“Persons with active mental illness and addiction are some of the most discriminated against persons in society. Today, public services for these individuals in our city, county, state, nation and world, are terrible — when they're available at all.”*

*— Jason Renaud, Mental Health Association of Portland, 2018*

Initially diagnosed with psychosis NOS (meaning psychosis *not otherwise specified* or nonspecific psychosis, a label applied to those who exhibit symptoms of a psychotic disorder without having been diagnosed with a specific illness, such as schizophrenia) and later schizoaffective disorder, Judy is a severely and persistently mentally ill person.

One of the biggest challenges facing the loved ones of those experiencing a major mental illness (such as schizophrenia or bipolar disorder), as well as mental health service providers and law enforcement, is having to respect the rights of mentally ill people

even when it is obvious that they have mentally deteriorated to such an extent that they are largely incapable of making good decisions.

A common scenario is for a mentally ill person — who perhaps has been relatively stable for a period of time — to become highly symptomatic when their support system is disrupted or their medication is no longer working effectively or because they quit taking their medication altogether (perhaps because of undesirable side-effects from the medication or because they believe they no longer need it).

Perhaps this person then begins having auditory or visual hallucinations; perhaps they become manic and reckless (spending all of their money, having sex with strangers, failing to show up for work or school, giving away belongings, etc); perhaps they begin isolating and neglecting themselves, etc.

*Nowadays mentally ill people are largely unable to get assistance until their situation becomes so dire that the system is forced to treat them.*

For the loved ones of this person, it would seem obvious that they need care and that intervention is urgently needed to prevent them from completely self-destructing. However, if the person refuses care, loved ones may have no option but to continue to offer support until the person has declined to such an extent that care can be forced on them;

a far from ideal yet tragically common scenario.

In Oregon, in order for a person to be involuntarily hospitalized for psychiatric reasons, they need to display behavior that indicates they are an imminent danger to themselves or others, such as deliberately harming themselves (by cutting or burning themselves, poisoning themselves, etc), walking in traffic, neglecting themselves to the point that their health is seriously jeopardized, etc.

Behavior such as talking to yourself, saying odd things or posting bizarre comments on the internet, staring into space for prolonged periods, wandering aimlessly, hoarding, etc might be concerning but such behavior by itself is — thankfully — unlikely to result in forced hospitalization: someone should not have their rights taken away just because they are strange.

But, further complicating matters, there is no consensus about when exactly someone's behavior has become imminently



dangerous, and one physician or police officer may believe someone meets criteria for involuntary treatment while others may not share that opinion (police can take someone to the hospital involuntarily on a “POH” — police officer hold, also known as a noncriminal hold — if they believe the person needs immediate psychiatric treatment; physicians can keep people in the hospital for a period of time if they are determined to be a danger to themselves or others).

Getting mental health treatment can be an extremely frustrating process, both because of the lack of accessible and effective mental

health services, and because of the legal complexities involved in deciding when someone is dangerous and/or unable to care for themselves due to mental illness.

Many would say that the pendulum has swung too far in one direction: whereas, in the past, mentally ill people were more likely to be sent off to (often inhumane) facilities merely for being mentally ill, nowadays mentally ill people are largely unable to get assistance until their situation becomes so dire that the system is forced to treat them.

In Judy's case, it seems — retrospectively at least — very obvious that something bad was going to happen, and one cannot help but feel as if the ball was dropped by many different agencies.

In the weeks leading up to her disappearance, Judy had been wandering away from home with increasing frequency (the foster home she lived at was not a lockdown facility and residents could come and go as they pleased), and her psychosis was getting worse. Judy's wandering and odd behavior resulted in several contacts

with law enforcement, mental health personnel, and emergency department staff during the month of December of 2016.

Judy was taken to the hospital by a local mental health agency on December 23, 2016 (a week before she went missing), after she showed up at the bus station in downtown Eugene in a state of psychosis. Judy told first responders that her name was "Camy Phraph" and that she was trying to get home to Washington (Judy was actually able to check into the hospital under the name "Camy Phraph").

According to Kamara, despite being in the throes of a major psychotic episode, Judy was discharged from the hospital back to her foster home, where she had limited supervision and was certain to wander away again.

Judy left home on December 30, 2016 and has been missing ever since. While she was officially reported as a missing person on December 31, 2016, Kamara was not informed that her mother was missing until January 6, 2017 — a week later — when Springfield police notified her. Various agencies were already aware that Judy

*Despite being in the throes of a major psychotic episode, Judy was discharged from the hospital back to her foster home, where she had limited supervision and was certain to wander away again.*



*Above: Judy Ann Parker. Below: Judy recovering in the hospital.*

was missing but did not notify Kamara because of patient privacy rules.

Kamara immediately rallied to draw attention to her mother's disappearance; creating a Facebook profile ("Finding Judy Ann Parker"); doing interviews with the media, and circulating fliers locally and up and down the west coast.

The Springfield Police Department (SPD) put out a press release about Judy's disappearance on January 7, 2017. SPD and the Lane County Sheriff's Office carried out search efforts around the same time but, for





Kamara, it was too little too late: a critical week had passed with little or no effort being made to find her mother.

More than three years later, Judy remains missing and — according to Kamara — there is not “one single shred of anything or any hope of finding her or what has happened to her. I cannot put into words the agony I feel.”

## What happened to Judy Ann Parker?

*“An elderly woman with severe psychosis and a multitude of health issues just takes a walk one day and never returns. And everyone in charge just goes on as if it was okay.”*

— Kamara Houston, 2019

Judy had no history of suicidal ideation and there is no evidence to suggest she was suicidal at the time she disappeared. There is also no evidence of foul play: Judy had no known enemies, she owned very little, and there was very little to gain from taking advantage of her. It is not impossible that she was the victim of violence but there is no evidence for it.

What the evidence suggests is that Judy, in a psychotic state, left her home voluntarily; perhaps to return to Washington or another area familiar to her or to go somewhere that voices in her head commanded her to go. “She had created a world inside her mind that made sense to her,” says Kamara.

Judy had lost a significant amount of weight in the weeks leading up to her disappearance and her frail state made her particularly vulnerable to the winter cold. It is highly unlikely that Judy was prepared to survive sleeping outside and she likely would have quickly succumbed to the elements. But, if so, where did she die, where is her body, and why has she not been found by now?

Another possibility is that Judy is living in another town — how she made it there, who knows — and that she is somehow surviving on the streets as an elderly, mentally ill person. That scenario seems unlikely but such mysterious people can be found anywhere and everywhere.

Perhaps Judy made it to another town where she died a “nobody”, to borrow the words of Eduardo Galeano; an unfortunate,

unidentified person whose death was seemingly nothing more than a mere blurb “in the crime reports of the local paper.”

Or perhaps Judy has been institutionalized somewhere. It seems unlikely that she could be hospitalized or locked up in a facility somewhere without the authorities or family members being notified but, having been deprived of pertinent information by agencies before, Kamara is not so sure.

Maybe “Camy Phraph” is alive in a psych ward somewhere right now.

Regardless, Kamara blames the system for Judy’s disappearance, and she is not optimistic about her mother’s fate. “The people responsible for my mom’s safety failed,” she says. “In an epic way. And it’s cost my mother her life.”

## Other Cases

*“Almost 2,000 people are reported missing every day in America.... The majority are eventually found, either dead or alive — teen runaways, down-on-their-lucks hoping to make a clean start somewhere else, the mentally ill who stray out of their neighborhoods and onto the evening news. But tens of thousands more remain missing, often for decades.”*

— Jeremy Lybarger, *The Encyclopedia of The Missing*, 2018



**Kevin Daniel Elkins** (DOB 12/6/1961) has been missing since September 14, 2005. I encountered him personally several times in the early 2000’s; both as a waiter and as a mental health worker in Eugene. Kevin was disabled, homeless, and mentally ill. He was often loud and his behavior was frequently erratic but he was generally a friendly and pleasant person (I recall him telling me — in

his gravelly voice — that he was expecting a huge inheritance that he intended to donate to White Bird Clinic).

According to Oregon Crime Stoppers, “Elkins was homeless and lived on the streets of Eugene. He often tied things to his clothes such as ribbons, trinkets and feathers. He spoke slowly with a raspy voice. He was 43 at the time of his disappearance.” He would be 59 years old today.

According to The Charley Project, “Elkins was last seen at approximately 11:00 a.m. on September 14, 2005, picking up his weekly money at the bank in the vicinity of 10th and Oak Street in Eugene, Oregon. He has never been heard from again. Few details are available in his case.”



**Jeremy Adam Hayward** (DOB 6/8/76) has been missing since April 16, 1998. Jeremy was approximately 22 years old when he disappeared. Today he would be 43 years old. Jeremy suffered from mental illness. According to The Charley Project, “Hayward was last seen at a hospital in the vicinity of 13th Avenue and Hilyard Street in Eugene, Oregon on April 16, 1998. He has never been heard from again. Few details are available in his case.”

**Laura Lucille Hitson** has been missing from Eugene since September 25, 1994. She was 34-years old when she disappeared. Today she would be approximately 60 years old. According to the National Missing and Unidentified Persons System (NamUs), “Laura was being transported to Sacred Heart ER when she bolted. Please note, she can be violent/aggressive without her medications.”



*Merle LeRoy Ryan has been missing since 2012.*

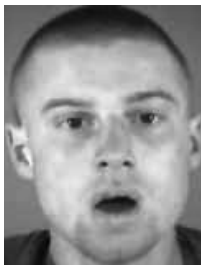
**Merle LeRoy Ryan** (DOB 11/04/1958) has been missing from Eugene since October 17, 2012. He was 53 years old when he disappeared. If alive today, he would be 61 years old. Merle has been known to go by aliases including Moses Enoch, Dimitri Andropv, and John F. Kennedy. According to The Charley Project, “Ryan suffers from schizophrenia and has a history of wandering across the country from state to state. He is often homeless. He was arrested at a park near Cesar Chavez Street in San Francisco, California on October 17, 2012; this is the last indication of his whereabouts. He has never been heard from again.”

**Scott Matthew Sells** (DOB 4/12/84) has been missing since September 12, 2003. He was 19 years old when he disappeared. If alive today, he would be 35 years old. According to The Charley Project, “Sells was last seen in the early morning hours of September 12, 2003, at a family member’s residence in the vicinity of Adams Street and West 4th Avenue in Eugene, Oregon. He was initially believed to have gotten on a bus to Arcata, California, but he never arrived there and it is unclear whether or not he boarded the bus.”

Additionally, The Charley Project claims that “Sells may have been seen in the area of Lane Community College near Eugene in early 2004, but this has not been confirmed. His case remains unsolved.”

As far as I know, I never met Scott personally, but he and I shared a mutual





friend, Alex Castle. In the late 90's and early 2000's, all three of us were members of the local punk rock and heavy metal music scenes.

According to Alex, "My friend Scott Matthew Sells dropped off the face of the earth in 2003 and not one trace of him was ever found. We learned how to ride freight together, and had traveled together off and on for a little bit. His mental health had started slipping a bit before that but he was mostly together."

Alex claims that, prior to his disappearance, Scott had traveled to California's Bay Area, where he began using heroin and meth. At a certain point, he had a positive HIV test, which had a sobering effect on him. However, a followup HIV test was negative, and Scott resumed his dangerous lifestyle.

Alex says that Scott "Ended up getting arrested bathing naked in a fountain on the Berkeley campus. They were going to keep him committed but I believe his father came and got him against his mom's wishes. He came back up to Eugene and came in and out of town a bit. He was still doing some meth and it was apparent that he was suffering from schizophrenia."

Alex believes Scott was planning to go back to California to see a girl he had met at a "Rainbow Gathering." "He was supposed to get on a bus to Arcata", according to Alex, "but no one knows if he did or not."

Scott's parents are now deceased and his case remains a total mystery. "It's just crazy," says Alex, "it's been 16 years and no body has been found."

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Photos of Scott Matthew Sells.

### For more information:



**The Charley Project**  
<http://charleyproject.org>

### The Encyclopedia of the Missing

<https://longreads.com/2018/01/11/the-encyclopedia-of-the-missing>

### Finding Judy Ann Parker

<https://www.facebook.com/Bringjudyhome>

### National Missing and Unidentified Persons System (NamUs)

<https://www.namus.gov>

### Someday Known

[www.somedayknown.org](http://www.somedayknown.org)

### The Unidentified

[www.theunidentified.org](http://www.theunidentified.org)

LOCAL OPINION:

# Addiction sufferers need accessible treatment

By Brenton Gicker  
For *The Register-Guard*  
September 24, 2017

**Any day of the week**, one can find news stories describing the plague of addiction that is ravaging the country.

According to a Sept. 2 story in *The New York Times*: “Drug overdoses killed roughly 64,000 people in the United States last year... Drug overdoses are expected to remain the leading cause of death for Americans under 50, as synthetic opioids — primarily fentanyl and its analogues — continue to push the death count higher.

“Drug deaths involving fentanyl more than doubled from 2015 to 2016, accompanied by an upturn in deaths involving cocaine and methamphetamine. Together they add up to an epidemic of drug overdoses that is killing people at a faster rate than the HIV epidemic at its peak.”

Much attention is being paid specifically to the opioid epidemic, which kills an estimated 100 Americans daily. Other substances — such as alcohol and methamphetamine — usually destroy bodies and minds over time.

Opioids are arguably more benign than alcohol or methamphetamine — which wreak havoc on people in ways opiates do not — but opioids are extremely addictive and easy to overdose on, which is why they kill so many people.

One might think that, considering the carnage caused by drug abuse that is all around us, and the constant media focus on the horrors of addiction — specifically opioid addiction — there would be a concerted effort to enroll addicts in treatment. But that’s not happening.

Narcan — a drug that can potentially reverse an opioid overdose if given early enough — is becoming more readily available to professionals and the public (including addicts and their loved ones), which will potentially reduce the number of opioid overdose deaths.

Primary care providers are being scrutinized for prescribing opioids too liberally — a problem that many blame for the opioid epidemic — and pressured to wean their patients off of them.

Rightly or wrongly, many patients who have relied on opioids for chronic pain management are being tapered off of them.

In some cases, that process is not gradual but abrupt. Given that opioid withdrawal — which typically isn’t a medical emergency though it’s very uncomfortable — is a miserable process.

Patients are often left feeling as if they’re being punished for becoming dependent on drugs prescribers previously encouraged them to take.

But while the media are reporting horror stories and prescribers are changing their practices and medical professionals are educating the public on the use of Narcan, where’s the treatment?

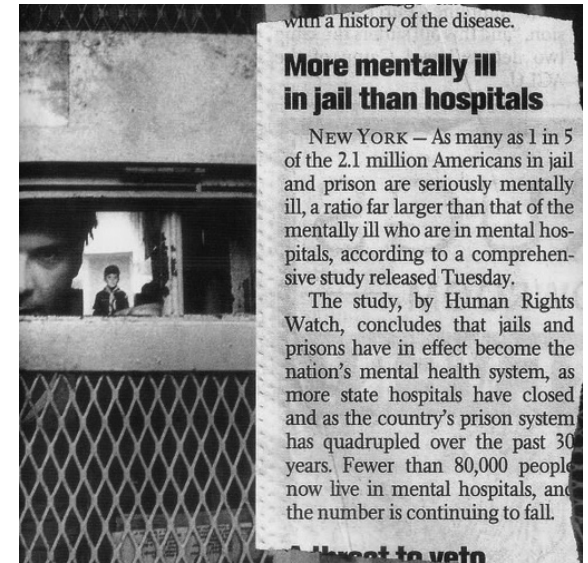
Various local agencies (Emergence, Serenity Lane, White Bird Clinic, Willamette Family Treatment, etc) offer excellent outpatient treatment services.

But for a hardcore addict — you know, the kind of person who is found dead or half-dead in an alley or motel room with a needle in their arm; the kind of person we laugh at when we see their mugshot until we realize we went to high school with them or that they’re a coworker’s child — attending meetings isn’t likely to work.

What they need is inpatient treatment; intensive, holistic treatment — treatment they are highly unlikely to receive without a solid support network and financial resources (which, of course, most addicts don’t have).

Only two local agencies — Serenity Lane and Willamette Family Treatment — offer medical detoxification and residential treatment services.

They are both excellent, essential organizations. But inpatient services offered by Serenity Lane are inaccessible to many because of their insurance and payment requirements. Willamette Family detox and residential



programs are more accessible (they accept Oregon Health Plan) but are often full or may have long wait lists and other barriers.

People stay in absolutely miserable situations — the people you see strung-out all over town aren't having fun — because they don't know what else to do with themselves.

Maybe they've never done anything else. Maybe they've never had the opportunity to do anything else. And — considering the barriers that exist to getting help, real help — why even try?

For emotionally and physically battered individuals, it's just too daunting.

Narcan should be accessible, and doctors should be challenged for turning their patients into junkies. But what is painfully missing are low-barrier, easily accessible treatment facilities — facilities whose message to addicts should be loud and clear: Come to us. We want you to be here. We've been waiting for you.

## For more information:

### *Dr. Gabor Maté*

Addiction Expert, Speaker and Best-selling Author  
[www.drgabormate.com](http://www.drgabormate.com)

### *American Society of Addiction Medicine*

[www.asam.org](http://www.asam.org)

### *Chasing the Scream*

[www.chasingthescream.com](http://www.chasingthescream.com)

### *Coalition to Stop Opioid Overdose*

[www.stopopioidoverdose.org](http://www.stopopioidoverdose.org)

### *Serenity Lane*

24/7 confidential helpline: #800-543-9905  
[www.serenitylane.com](http://www.serenitylane.com)

### *Snohomish Overdose Prevention*

[www.snohomishoverdoseprevention.com](http://www.snohomishoverdoseprevention.com)

### *White Bird Clinic*

24/7 confidential crisis hotline: #800-422-7558  
[www.whitebirdclinic.org](http://www.whitebirdclinic.org)

### *Willamette Family Treatment Services, Inc.*

[www.wfts.org](http://www.wfts.org)





## Born on the Street

by Brenton Gicker

**One day last summer**, after having worked the night shift on the Labor and Delivery unit where I'm a part-time staff nurse, I was awakened by several text messages from my coworker and friend Eric, asking me to call him as soon as possible. Eric and I work as medics and counselors for the Crisis Response Program, or CRP,\* a mobile medical/mentalhealth crisis-intervention team that specializes in working with people who are homeless, have mental illness, or struggle with addiction.

When I called him, Eric told me he had just arrived at the clinic (a social service hub that also serves as the CRP headquarters) for a meeting. Upon his arrival, members of the fire department were there, attempting to evaluate a woman with mental illness who told clinic staff she was in labor. She wouldn't allow them to evaluate her or transport her to the hospital.

The woman, whom I will call "Summer," was known to us as a homeless woman with schizophrenia and a history of being uncooperative with mental-health service providers. I wasn't aware that she was pregnant.

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\*Originally published in *Nursing for Women's Health*, June 2018.  
The name of the program has been changed for this essay.

Eric told me that Summer came to the clinic claiming her "bag of waters had broken." She claimed to be having a baby, yet she also claimed to be having a miscarriage. Her behavior was erratic, and she wasn't making much sense. Because she would not cooperate and did not appear to be in labor, the fire department staff left. Eric told me she wasn't willing to engage with him much either, but a female clinic employee on scene — Salish ("Say") — had a good rapport with her. Say, who is trained as a doula, was counseling Summer in a private room.

Eric was considering calling on-duty CRP staff to request that they speak with her, but they were busy and he wasn't confident she would cooperate with them. Eric asked me to come to the clinic to speak with her, because I have some training in maternity care. (My training is limited; I have been an obstetric nurse only since 2015.)

I was tired and unsure if this was a worthwhile endeavor. Women with mental illness frequently tell us they are pregnant when they are not, so I asked Eric some questions: Is she actually pregnant? If so, how many weeks is she? Is she leaking any fluid? Does she appear to be laboring?, etc.

Eric told me that she was definitely pregnant but did not appear to be leaking any fluid or having painful contractions. However, she was unwilling or unable to answer many questions. I told Eric that it seemed unlikely she would cooperate with me — just as it seemed unlikely she was actually in labor — but that I would come to the clinic to see if I could help out.

I got ready to go. In my disoriented, sleepdeprived state, I grabbed three things from my personal stash of medical supplies: a baby blanket, a cord clamp, and a pair of gloves (all things I kept around just in case of situations like this). As I was leaving my apartment, Eric called me. He sounded urgent. He said he called 911 because Summer was agitated and trying to leave the clinic and her baby was now crowning. "I can see the head," he said. I told Eric I was on my way. I rushed to my car and sped to the clinic. On my way, I passed the fire station. I could see the medics preparing to respond to the call, but I knew I would beat them there.

As I arrived at the clinic, I saw Eric and Say pursuing Summer down the alley as she angrily walked away from them. She was swinging a large stick at them to keep them away. I parked in the alley and got out of my car. As I approached Summer and pleaded with her to cooperate with us, she squatted and made a grunting sound. I could see that between her legs and behind the trench coat she was wearing (in hot summer weather), a neonate's head was now making its way out of her vagina. Before we could

attempt to help birth the newborn properly (or as properly as possible in an alley), it came out and hit the pavement.

I feared that the newborn — who was initially pale and unresponsive — was dead. We rushed to pick it up. Eric and Say and I frantically tried to rescue the newborn while simultaneously begging Summer, who was still trying to get away from us, to cooperate.

I looked at the neonate — a girl — and, immediately after stimulating her with my baby blanket, she began to cry. The newborn was viable. She

was alive. I had never been so relieved to hear a baby cry in my life. I'm an atheist, but at that moment I felt like gods were smiling upon us.

*I was in a daze, and for a moment I just stared at this newborn in my arms, unconcerned with anything else in the world.*

I frantically told Eric to clamp and cut the cord. We didn't have any scissors. I frantically directed Say to get some. A clinic employee now at the scene provided us with scissors. Eric clamped the newborn's end of the cord. "Damnit, we need another clamp!" I said. Eric calmly pinched off

Summer's end of the umbilical cord while Say — her hands shaking — cut above it, releasing the newborn to me.

I swaddled her. A crowd was now gathered, and people were offering to help. I was in a daze, and for a moment I just stared at this newborn in my arms, unconcerned with anything else in the world because I knew she was going to be just fine.

That blissful moment was interrupted by Eric, who had recently started working in the NICU, telling me to trade places with him so he could assess the newborn. We traded places, and he assessed her and assigned her Apgar scores. While he was doing that, I was occluding the umbilical cord dangling from Summer with my fingers. By that time, members of the fire department had returned. They provided me with an additional cord clamp — removed from a dusty obstetric kit hidden away in the ambulance — to clamp it off.

As I sat with Summer, I tried explaining to her that she needed to deliver her placenta, that she was at risk for hemorrhage and infection if she didn't go to the hospital immediately, that the hospital would want to know more about her health history to care for her baby, etc.

Summer said she didn't want her baby (she also told me, "It's not a real baby") and that she didn't want to go to the hospital. She demanded to be allowed to leave. At that point, I was essentially gently restraining her by

holding the umbilical cord that was still attached to the placenta inside her. Members of the fire department — concerned for everyone's safety — called police for help. Police officers soon joined the fracas.

I had seen doctors and midwives deliver placentas many times before, but I had never delivered one myself. When I could feel that the placenta was about to be expelled, I gently pulled it out and placed it in a biohazard bag provided by clinic staff. The placenta appeared intact. I massaged Summer's boggy uterus until a fountain of blood sprayed all over my feet. Her uterus was now firm and her bleeding well controlled.

Medics transported the newborn to the hospital by ambulance. Eric joined them. Say and I rode with Summer to the hospital after she finally agreed to go in with the CRP for postpartum care. (We had to convince her that we weren't going to take her to a "mental institution.") CRP staff met us at the clinic.

When I finally returned to my apartment — after leaving the hospital and going back to the clinic to get my car — I entered the building with a remotely familiar sensation: my shoes and socks, thoroughly soaked in blood, made a squeaky sound as I walked, as if I had gone swimming with my shoes on.

After peeling off my shoes and socks and taking a shower, I laid down to rest and texted a friend: "Sometimes people exit the world in the alley behind the clinic. Today, someone entered the world in the alley behind the clinic."

It was a truly glorious day.

**Epilogue:** Unfortunately, I later learned that Summer stayed at the hospital only long enough for another fundal check and a shower, after which she left against medical advice. She is still on the streets, and her mental illness continues to go untreated. Her baby was born healthy and drug free. She has been adopted by loving parents.

## Acknowledgments

Special thanks to Eric Rowen and Salish Davis.

# Rooting for the Underdog

Everyone needs an advocate

by Brenton Gicker

*Men make their own history, but they do not make it as they please; they do not make it under self-selected circumstances, but under circumstances existing already, given and transmitted from the past.*

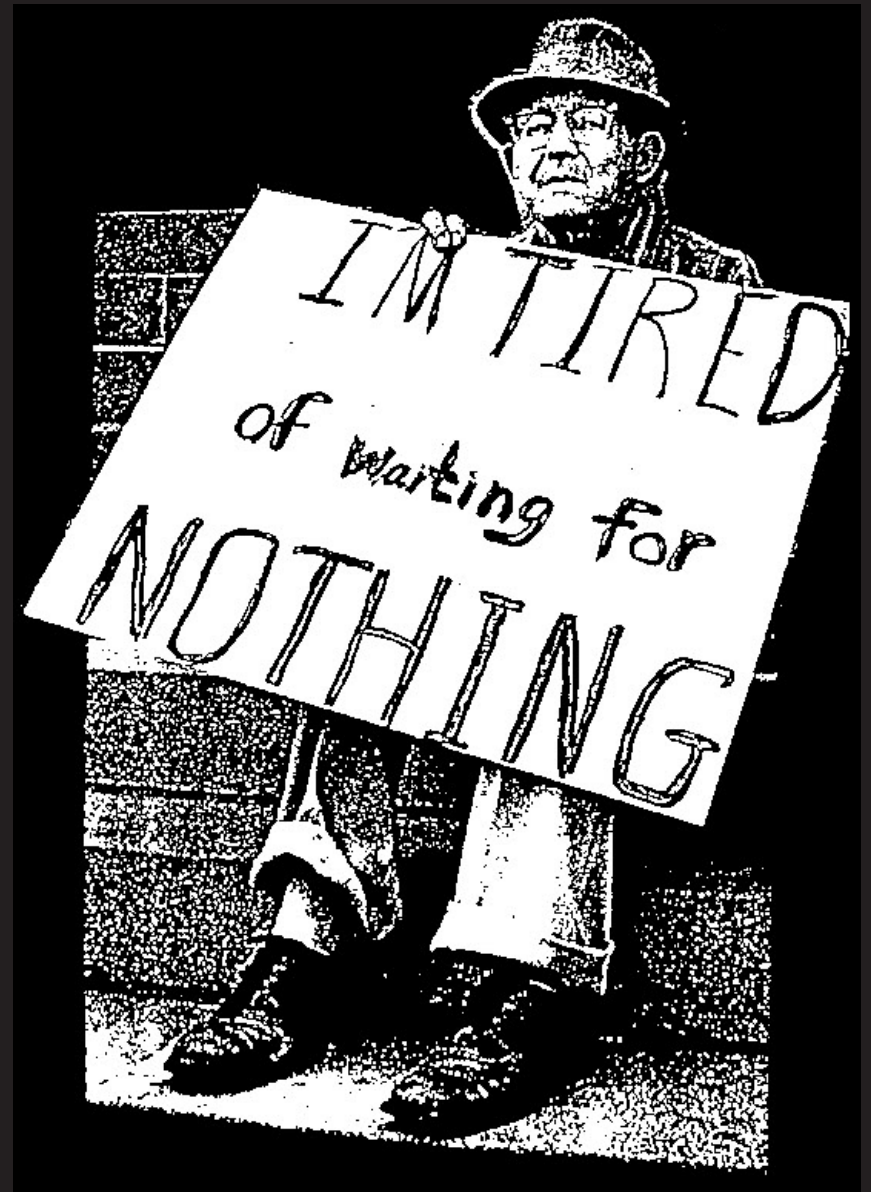
— Karl Marx

**Working for CAHOOTS** (Crisis Assistance Helping Out On The Streets, a program of White Bird Clinic) people often ask how we are able to tolerate the bad behavior of some of our clients and still provide them with respect, patience and compassion. They are usually referring to homeless alcoholics and other addicts we serve, not necessarily the many other people we assist with their medical and emotional needs.

They are referring to our “problem clients”; homeless people who are chronically intoxicated and belligerent. These aren’t necessarily people who are temporarily homeless while they work through bad circumstances, such as a foreclosure, a disabling accident, bankruptcy from hospital bills, etc. (though many homeless do fall under that category). These aren’t necessarily people who are homeless as a result of mental illness (though many homeless fall under that category too).

These problem clients are the ones who “give the homeless a bad name”; the ones who “choose” to be homeless (or, more accurately, have resigned themselves to it); the drunks and aggressive panhandlers; the ones you find passed out on the lawn or fighting in the alley; the ones who spend their SSI checks on liquor when they haven’t eaten in days.

Working on CAHOOTS, we know these people well. Difficult as it may be at times, we try to treat them all with unconditional positive regard. We are paid, to some extent, to root for the underdog. We take our role seriously: Everyone needs an advocate.



*"We are all in the gutter, but some of us are looking at the stars."*

—Oscar Wilde

We all have low points in our lives. Many of us have had periods of extreme depression or excessive drinking due to whatever crisis we were in (a breakup, the death of a loved one, financial woes, etc.). Most of us can tap into our personal and social resources to get through it and move on. But not everybody does: Some people enter a vicious cycle of crippling self-loathing and self-destruction that doesn't end for a long time, if it ends at all. Some people seemingly had no chance to begin with. Imagine, for instance, that as a child, your parents passed you around to provide sexual favors to their "friends" in exchange for money or drugs. Imagine if you grew up living in motel rooms watching your prostitute mother have sex with strange men; or going on drug-fueled crime sprees with your father instead of going to school. Imagine if, as a child, your punishment for mistakes was being burned with cigarettes.

Hopefully, you can imagine how enduring such experiences might lead somebody to having little confidence in or allegiance to a society that maybe they never really understood or fit in with, and how those experiences might cause somebody to mask their emotional scars with substance abuse and antisocial behavior. You can also, I hope, imagine how carrying those experiences around with you might seriously interfere with your ability to be a functional person by societal standards.

*"If you're going through hell, keep going."*

—Winston Churchill

There's only so much that any person can endure. Each of us has a breaking point. I believe the horrors some of the people I've described have suffered could cause any of us to end up in similar circumstances. Many people fall apart from much less.

It is easier to be compassionate to people when you know what hell they've been through, even when they are behaving poorly and may even be heaping abuse upon you as you try to help them.

I've seen people spend years, maybe even decades, digging themselves into a deep, dark pit of addiction and homelessness and criminality and

sickness, decide they want something better for themselves and finally change, seemingly moving on without looking back.

There are people nobody believed were capable of changing who proved everyone wrong by not letting the tragedies of their past taint and define their present and future. These people inspire me to continue rooting for the underdog.

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### About this Publication

*Out from the Void III was originally going to be published in Eugene Weekly but that plan was canceled due to the pandemic. Electronic and hard copies of this pamphlet are available from the author. Please help distribute it far and wide.*



## OUT FROM THE VOID

“Fleas dream of buying themselves a dog, and nobodies dream of escaping poverty: that, one magical day, good luck will suddenly rain down on them — will rain down in buckets. But good luck doesn’t rain down, yesterday, today, tomorrow or ever. Good luck doesn’t even fall in a fine drizzle, no matter how hard the nobodies summon it, even if their left hand is tickling, or if they begin the new day on their right foot, or start the new year with a change of brooms.

The nobodies: nobody’s children, owners of nothing. The nobodies: the no-ones, the nobodied, running like rabbits, dying through life, screwed every which way.

Who are not, but could be.

Who don’t speak languages, but dialects.

Who don’t have religions, but superstitions.

Who don’t create art, but handicrafts.

Who don’t have culture, but folklore.

Who are not human beings, but human resources.

Who do not have faces, but arms.

Who do not have names, but numbers.

Who do not appear in the history of the world,

but in the crime reports of the local paper.

The nobodies, who are not worth the bullet that kills them.”

— Eduardo Galeano, “The Nobodies”, 1989



“Oregon’s chronically underfunded mental health system  
is nearly universally accepted as being broken.”

*The Oregonian*, April 2020