ON THE MORNING of June 6, 2013, Davis Police Department squad cars rolled up to the group home at 2100 Fifth Street. More than a dozen officers in bulletproof vests made their way past the facility’s memorial planter bearing painted handprints of children. They were no
For more than a year, officers had been grappling with problems at the home, one of California's largest residential facilities for emotionally damaged kids. They had repeatedly returned runaways. They had coaxed suicidal teens off rooftops. There were reports of fights, drug use, children having sex with adults. In a single week in the spring, Davis police responded to 74 calls. On May 29, though, there had been a report of a different order: An 11-year-old girl at the home claimed that boys from the facility had raped her. Two boys had been arrested. After months of unraveling, the home had come undone.

Over the next several days, the campus began to empty out as parents turned up, searching for their children and for answers about what had happened to them. Social workers scrambled to find alternate placements, sending some kids to emergency shelters. Others remained in dormitory rooms, where police tracked them down to ask a long-overdue question: Do you feel safe? State officials opened the inevitable investigation, interrogating the staff and combing through records.

In the months leading up to the raid, neither the police nor the Department of Social Services, the state agency responsible for regulating group homes, had prevented the disaster at FamiliesFirst. They didn't step in that spring when there were reports of children living in a homeless encampment in a nearby park. They didn't intervene when a 9-year-old girl, new to the home, wound up half naked on the doorstep of a house in Davis and was later detoxed in a hospital emergency room. A Department of Social Services investigator visited the campus repeatedly in the weeks before the police raid, but the agency never curbed the turmoil.

The breakdown at FamiliesFirst has helped spur California to rethink how it cares for its most troubled children, a question that for decades has confounded not just the state but the country. A panel of experts, officials, care providers, and families has generated a raft of reforms it hopes will soon become law. Over the years, the places that used to be repositories for such children—state psychiatric hospitals and juvenile detention centers—have been shuttered or scaled back, usually in the wake of their own scandals. Group
homes, too, have increasingly been deemed a failed model, yet year after year vulnerable and volatile California children remain housed in them for lack of a better option.

The Davis facility, one of California’s roughly 1,000 group homes, closed for good in September 2013. Spelled out in police records and Department of Social Services files, in budgets and in the recollections of staffers, is the story of negligent stewardship and a state agency’s flawed oversight. It’s a story that continues to haunt those it touched.
Alex Barschat-Li spent the first days of his life in the neonatal intensive care unit at Hoag Hospital in Newport Beach, California. Born on March 12, 1999, he experienced such severe breathing difficulties that his mother, Wendy, worried that he might not survive. She was 29, supporting herself and her husband on a medical assistant’s salary.

Two months after Alex came home, his parents split up. When Alex was 3, Wendy fell into such a deep depression that she checked herself into a psychiatric ward, sending him to his grandmother’s. Upon her release, an aunt proposed that Wendy marry an undocumented Chinese national in exchange for $10,000 in cash. Wendy married Peter Li on the day she met him, and ten years later, they’re still together. “No one’s ever treated me the way he does,” she says. The family eventually moved to Roseville, half an hour north of Sacramento, where Wendy and Peter bought a floor-and-tile-installation business.

According to Wendy, Alex was an easy child the first years of his life. But after he turned 5, she became concerned about his behavior. He’d sit on the brick stoop and sing and wave at cars for hours. At 6, he would grab knives out of the kitchen cabinets and hold them against his neck. At 7, he spent hours underneath his bed, hoarding food and clothing. He obsesses over seemingly insignificant details, refusing to go to school unless his mother gave him a certain kind of pencil or allowed him to wear a particular pair of socks.

Wendy sought help from Child Protective Services, which arranged for counselors and therapists to come to the home. Alex’s behavior, though, grew increasingly violent. He smashed furniture and windows. To protect themselves, Wendy and Peter installed a deadbolt on their bedroom door. Alex’s food hoarding became so extreme that they secured the refrigerator and cabinets with padlocks. By the time Alex was 11, the police had come to the home at least 11 times, and he had been held for psychiatric evaluation seven times. He was diagnosed with a handful of disorders—attention deficit, anxiety, bipolar, oppositional defiant—requiring a complicated set of prescriptions, many of which had side effects.

Alex broke Wendy’s resolve the afternoon he beat her bedroom door down with a kitchen chair. Peter barely managed to restrain Alex until the police arrived. “I was in a panic,” she says. “I knew in my heart that if I didn’t do something extreme he was going to be one of those kids I saw on TV for raping someone or making a bomb.”

Wendy’s options were limited. Only 11 of California’s 58 counties have hospitals that provide psychiatric care, and those that do have few beds. Psychiatrists had suggested that Wendy
get Alex placed in a residential treatment facility. California’s system for group homes is arcane, shaped by decades of litigation and legislation. The homes are classified by levels that range from 1 through 14. The top two levels serve the most troubled children and are required by law to provide intensive psychiatric services.

A child “graduates” from a Level 14 home when it is deemed he or she can function either in a lower-level group home or a foster home, or with a relative or a biological parent. The goal is to get the child to something that most closely resembles a family.

When Alex was 11, he was sent to Compass Rose, a Level 12 group home in Loomis, California. Three months in, on a cold winter morning, he and a friend were found walking alongside the I-80 freeway in shorts and T-shirts. Alex soon ran away again, showing up at a nearby church, where he told a couple that his parents had abandoned him. After police took Alex back to Compass Rose, administrators told Wendy they’d had enough. Alex, they said, needed to be in a more restrictive group home with more intensive therapeutic services.

Alex’s social worker identified two homes: Milhous Treatment Center in Nevada City and FamiliesFirst in Davis. Wendy visited both. The 6.5-acre FamiliesFirst campus, she says, was by far the more impressive. It included a school, a gym, an arts center, and eight nine-bedroom dormitories— with names like Pioneer House and Sapphire House— that looked out onto a large playground and an expanse of lawn.

Alex entered FamiliesFirst on April 7, 2011. He was now among the roughly 750 children in California living in a Level 14 facility.

FamiliesFirst was founded in 1974 by a 26-year-old University of California at Davis graduate named Evelyn Praul. She started with a single foster home, two employees, and three emotionally disturbed boys. Over the next two decades, Praul opened six more group homes for boys in Davis and expanded throughout Northern California. In 1994, Praul decided to build a campus at 2100 Fifth Street in the southwest corner of town. Centralizing the Davis homes, she concluded, would help the organization serve more children and make it easier for staff to respond to emergencies.

Building the campus, though, proved costly, and by the mid-2000s, the facility was running a deficit. The home’s ability to meet its obligations depended on the number of children counties referred to the facility. (The current rate for Level 14 homes is $9,669 per child per month.) As a rule, group homes budget for 90 percent capacity, but the referral stream can
dip and surge from month to month. If the population falls below 90 percent over an extended period of time, a home can quickly go into the red, a situation that the Davis campus found itself in.

There was an additional factor working against the facility. In the mid-1990s, just as FamiliesFirst decided to build the Davis campus, California and many other states were beginning to question the value of group homes. Concentrating troubled children in a residence, many had come to believe, tended to exacerbate their problems and make their disorders more difficult to address. Instead the state was considering a model of treatment known as wraparound care, which involves bringing therapists and counselors into the homes where children reside. Focused attention on the child within a household was viewed as a less disruptive approach that could also closely examine family dynamics.

Deciding it could not make it on its own, in 2009 FamiliesFirst merged with a larger nonprofit called Eastfield Ming Quong, or EMQ, which functioned mostly in the Bay Area and surrounding counties. The deal offered obvious advantages to both organizations. FamiliesFirst worked in regions where EMQ had almost no presence, giving the newly constituted company, EMQ FamiliesFirst, a bigger share of the social-service market. In turn, the more financially secure EMQ could provide stability to the FamiliesFirst operations it absorbed.

When Alex came to the Davis campus, the facility employed more than 130 full- and part-time staff who could look after as many as 72 children. Like many such institutions, the home accommodated a dizzying assortment of children. They ranged from 6 to 18 years old. They came from all over the state, from wealthy families as well as poor. They were white, black, Latino, and Asian. Most had passed through countless sets of foster parents and group homes. Some had been sent by school districts that lacked the resources to respond to their needs. Some had been sent by courts as part of a sentence for a minor criminal offense.

“At any given time about 20 percent of our youth have a diagnosable disorder,” says Dr. Gary Blau of the U.S. Department of Health and Human Services, “and 10 percent have a serious emotional disturbance, which means their disorder impairs their ability to function at home or in the community. The rarer occasion is that they are a danger to themselves, that they warrant hospitalization or residential treatment.”

The children at FamiliesFirst, as in all Level 14 homes, suffered from a spectrum of psychiatric disorders: Asperger’s, autism, attention deficit, bipolar, chronic depression,
obsessive compulsive, schizophrenia. Many were suicidal, nearly all assaultive, and some self-injurious. Many were confused about their sexuality and gender orientation. Many arrived with medical problems caused by malnourishment and neglect. Some had stunted growth. Some had Type 2 diabetes. Several had spent a portion of their lives living in closets, basements, or other confined spaces. One set of twins were said to have been forced by a relative to have sex with each other inside a locked cage. A 6-year-old boy, known at the home as Cowboy Dan, was said to have stolen at least three cars by the time he arrived.

The regimen was strict: out of bed at 7:00, breakfast at 7:30, classes at 8:00. At 2:00, the children retired to the dorms, had a snack, and broke up into small groups. They’d rotate through a treatment program made up of three separate sessions: art, recreation, and life skills. In the life-skills session, children were instructed in mastering the mundane: how to clean one’s feet, for example, or how to figure out what size batteries to buy, or how to board a bus. Each child was expected to have a behavioral goal, usually simple, like saying something nice to someone twice a day.

We had different jobs for different kids. Kids who begged, kids who found bikes for us, kids who went back to campus to get blankets and stuff. We’d be gone for days.

—Alex Barschat-Li, former resident, FamiliesFirst

Just 12 years old when he arrived, Alex was big for his age—five foot two and 163 pounds—with short brown hair and high cheekbones. He was used to imposing himself physically and didn’t take well to the structure. Early on, he got into a fight with a smaller boy and ended up in one of the campus’s many “quiet rooms,” which were meant to give a child in the throes of a tantrum a safe place to “de-escalate.” For Alex, the experience seemed to have the opposite effect. “I got thrown in there all the time,” he says. “I hated it because I would catastrophize. I thought I was being treated like an animal.”

Alternately affectionate and sullen, Alex was prone to radical mood swings, speaking in a rapid staccato one minute, turning almost monosyllabic the next. According to an evaluation report sent to Wendy six months into his stay, he suffered from “an inability to build or maintain satisfactory interpersonal relationships with peers and teachers.” A minor annoyance or a denial of a privilege could set him off, and he would hurl himself at whoever irked him.
In time, though, he began to show signs of progress. In the fall of 2012, he moved into a dorm called Adventurer, which was led by a group of experienced staff who connected with him. He was still easily distracted and easily angered, but the extremes had leveled off. Where once he threw tantrums during chores, he would now take a break in his room, gather his composure, and get back to the task at hand. He was less confrontational, less violent—happier.

Toward the end of 2012, Alex noticed that there were fewer counselors on campus—he had heard there had been layoffs—and that they seemed to be under more stress than usual. They also had become more lenient. He could now walk off the campus without anyone stopping him, and whenever someone had a manic episode, the staff was less likely to employ restraints, the term for the physical holds staff are allowed to use to prevent children from harming themselves or others.

At first, Alex left campus by himself, often hanging out at a bicycle shop where the employees liked him. He went to a Dairy Queen and moped until an employee gave him an order of fries on the house. Soon he was tagging along with a group of eight to twelve children from the home who stole food and clothing from stores around Davis. They started staying out all night, drinking alcohol, smoking pot, and having sex in parks. Before long he and others were hitchhiking out of town. Alex got as far as Sacramento.

“We had different jobs for different kids,” says Alex, whose task was to shoplift. “Kids who begged, kids who found bikes for us, kids who went back to campus to get blankets and stuff. We’d be gone for days.”
Early in the spring of 2013, Alex and his friends took over a homeless encampment on the outskirts of a park, a tangle of blankets and mattresses, abandoned furniture and trash, all jammed into a thicket dense enough to obstruct the view of passersby. It was one of several places where the children began to sleep at night. Another favorite, which Alex calls Plan B, was behind a Comcast building alongside Interstate 80.

The staff rarely told Wendy when Alex wasn’t on campus. Her most reliable way to find out his whereabouts was through his Facebook posts. Alex would go to a library and send her messages or she would see photos on his page that showed him in town. She says she drove to Davis many times looking for him. On June 3, she pleaded with him on Facebook: PLEASE ALEX PLEASE GO BACK TO THE GROUP HOME WHERE YOU ARE SAFE AND SURROUNDED BY PEOPLE THAT CARE ABOUT YOU.

He did return, but on June 6, Wendy found out he’d gone missing again, this time for two days. She drove to Davis and searched all his usual spots. Around 1:00 p.m., she called FamiliesFirst and a staffer told her Alex had turned up and was taking a shower. But when she arrived, she was told it had been a mistake: No one knew where Alex was. Furious, Wendy went looking for him again. At 3:00, staff told her that Alex had been picked up by his social worker and removed from the home. They wouldn’t say where. All they said was
After the merger in 2009, executives at EMQ FamiliesFirst faced a serious challenge: The Davis campus had lost nearly $1.5 million in the previous two years. According to a former financial officer at FamiliesFirst, making payroll every two weeks could be a “real white-knuckle” experience. In early 2010, executives turned to FamiliesFirst’s longtime intake coordinator, Ron Fader, and asked if there was a population of underserved...
children that could keep the beds filled. Warily, Fader said yes: teenage girls.

For years, county social workers had been pleading with the Davis campus to accept girls. More recently, staffers at Community Care Licensing, the division of the Department of Social Services that oversees group homes, had pushed for the campus to go coed; the Sacramento region, they said, desperately needed a Level 14 facility for girls. FamiliesFirst, though, had always resisted. It wasn’t just that girls with mental health needs acute enough to warrant Level 14 care are difficult to treat. They demand a different approach than boys. They would require hiring new staff and retraining old.

“I said, ‘Look, I can fill the beds, no problem, but these girls present some extreme challenges,’” Fader says. “They are cutters. Many have a diagnosis of borderline personality disorder. They’re sexually promiscuous. They’re runners. Their behaviors are very intense, and they could possibly upset the milieu here.”

Despite Fader’s concerns, EMQ FamiliesFirst decided to go ahead, and in the summer of 2010 the Davis home opened its first dormitory for girls. The administration, though, hadn’t established a policy on what boundaries should be set. Should the boys and girls be in the same classrooms? Could they walk to school together? Should relationships be forbidden? Essentially, it was an experiment: mixing highly volatile girls and highly volatile boys, many in the grip of changing hormones.
To Andrea Guthrie, who was a social worker at the Davis campus, it was a dangerous experiment. “Since the merger happened,” Guthrie says, “there was this constant need to put the plane together in the middle of the sky.”

Guthrie had been on staff since June 2000, a year after she graduated from the University of California at Davis. Her first job was as a counselor, for which she was paid $8.35 an hour. She took it mostly to pay her bills while she busied herself with Peace Corps applications. She was hoping to go to West Africa. But the reward of making progress with troubled kids hooked her, and she soon dropped her plans, deciding there was no sense in traveling across the world to make a difference when she could do it 25 minutes from where she grew up. She attended graduate school, earned her master’s in counseling, and, in 2005, was promoted to clinical social worker at the home. Her new salary was $37,500.

The girls filled two dorms, and Guthrie’s colleague Kim Rowerdink, who had some experience counseling girls, was named supervisor of one of them. Guthrie and Rowerdink often discussed how the girls mimicked one another. Outside of a group home, this wouldn’t necessarily be alarming: It could mean girls dyeing their hair the same color or wearing the same clothes. But in an institutional environment it meant an abrupt surge in cutting, running away, or violence. Rowerdink once caught three girls trying to slash their
arms at the same time. As part of their daily rounds, Guthrie helped her scour the dorm for any object that could be used to inflict injury—bobby pins, broken CDs, loose screws, cracked light fixtures. If a girl with a history of harming herself ran off the campus, they’d try to stop her.

“I can tell you that my staff had no specific training whatsoever to address self-injury, suicidality, or anything like that,” Rowerdink says. “It would just be one crisis after the next. A girl would cut herself, we’d take her to the hospital, bring her back, and then she’d do it again. It was like Groundhog Day.”

Rowerdink and others say this was the daily environment for the next two years. During one psychotic episode, a girl tried eating a light bulb. During another, a girl inserted shards of glass into her vagina and anus. Unlike Guthrie and Rowerdink, the vast majority of the staff who interacted with the kids did not have degrees in education, psychology, or social work. Most had received no more than seven days of classroom training, the standard for all employees, which offered an overview of children in Level 14 facilities and instruction in how to restrain them safely.

In the fall of 2012, Audrie Meyer, the home’s director, announced a change in policy. From now on, she said, physically preventing children from leaving campus should occur only when they were in “immediate danger.” If that was not the case, the counselors were instructed to shadow them. The directives perplexed and angered the staff. What did “immediate danger” mean? Did a girl have to be cutting herself or merely reaching for a sharp object? Did a child need to be standing in the middle of the freeway or walking toward it? The staff had always trusted some children to leave the campus and not others. Now what were they supposed to do? Sit back and let any kid take off?

No California law directly addresses whether a child is allowed to leave the grounds of a group home. Nor is there a law that says whether a group home is responsible for the actions of the child once the child crosses the property line. Group-home administrators develop their own policies on how to handle runaways based on their interpretation of three statutes: that a group home is responsible for providing care and supervision for every child it has taken in, that a group home cannot be locked, and that restraints can’t be administered unless children pose an immediate danger to themselves or others.

The act of leaving the campus doesn’t constitute an immediate danger, which means that a group-home counselor is not supposed to prevent a child from leaving. “It’s extremely ambiguous,” says Carroll Schroeder, the executive director for a trade group called the
California Alliance of Child and Family Services. “Our experience has been that folks get caught between the protection of a child's personal rights and requirements to assure a child's safety.”

Michael Weston, spokesman for the Department of Social Services, says that if a child is suicidal or has a reputation for leaving the campus and inflicting harm on herself or others, it's within a group administrator's authority to prevent that child from leaving. But group-home administrators say it’s not as clear-cut as that. The department can cite a home for restraining a child from leaving campus if it believes the action was unnecessary, and it can cite a home for failing to supervise children who leave the campus and harm themselves or someone else.

“It’s such a Catch-22 for our kind of program,” says Steven Elson, the chief executive officer of Casa Pacifica, a group-care company in Southern California. “If we knew that a child had a plan to leave the campus and drink near a park with a 25-year-old friend, we would very likely contain the child. But you don’t know about those things in advance.”

In late January 2013, Guthrie was given an assignment she dreaded. She would be directly responsible for the girls’ care in a dorm called Jade House. To her surprise, though, Guthrie found the girls endearing. They got excited about things that held no appeal for boys. The walls of the dorm were decorated in purple and pink and covered in Hello Kitty stickers, glitter, and posters of pop stars. A trip to Walmart to buy socks sent the girls over the moon. Early on, there were indications she was making inroads. One girl, schizophrenic and violent, no longer exhibited sudden aggressive episodes. Three girls graduated, their behaviors deemed stable enough for them to move in with a relative or into a lower-level home.

As the year went on, though, the victories became less frequent. That winter, EMQ FamiliesFirst had laid off the on-call workers the home relied on to fill in for sick or injured employees, and the staff immediately felt the pinch. “It was a budgeting decision,” says Ron Fader. “Everyone knew it was going to create a house of cards.” When staff became injured or burnt out, no one was now available to replace them. Social workers, therapists, and sometimes management had to supervise the children, an assignment usually designated for counselors, causing paperwork, group therapy, and other duties to slip. Guthrie began putting in 60 hours or more a week. Each morning, she woke up to an email inbox filled with urgent messages requesting that she follow up with children about violent events or disappearances from campus.
“We would dread the on-call rotations,” Guthrie says, “because it was sheer hell—an entire week of not sleeping on top of already being completely exhausted.”

The children began to realize how much they could get away with now that the facility was understaffed and the counselors had all but stopped employing restraints. One child ripped off large pieces of a metal gutter from a dormitory roof and hurled them at the staffers beneath. Others smashed windows and vandalized staff-owned vehicles. By April, Guthrie and other staff could no longer contain their frustration. They worried that it would be only a matter of time before a child was raped or killed or kidnapped.

At an all-staff meeting on April 24, Guthrie and others confronted Meyer, the home’s director. They told her that several girls were coming back to campus with stories of having sex, sometimes with boys from the home, sometimes with adults in the community. Meyer’s response was not what the staff expected. The children, she said, were going to have to learn to avoid such trouble on their own. Guthrie remembers looking around the room and seeing aghast expressions on the faces of her colleagues. “These kids are here because they cannot think like that,” Guthrie says.

That day, a wisp of a girl arrived at Jade House. She was about four and a half feet tall, 75 pounds, and wore her unwashed blond hair at shoulder length. She tried to flirt and sit in the laps of staff. She spoke often of wanting a boyfriend. She adored a pair of high heels she said her mother had given her. She was 9 years old.

“She came in right before s—hit the fan,” Guthrie says. “I was livid. I was like, ‘Really? We can’t even handle what we have right now, and you think that’s an OK environment to bring this young of a kid into a teenage-girl house?’ No.”

It would just be one crisis after the next. A girl would cut herself, we’d take her to the hospital, bring her back, and then she’d do it again. It was like Groundhog Day.

—Kim Rowderdink, dormitory counselor, FamiliesFirst

Soon the girl was leaving overnight with children several years her senior. She told the campus nurse that she hitchhiked to nearby Woodland. She told a counselor that she performed oral sex on an older boy in a park; she said the boy urinated in her mouth. Early on a Saturday morning in late May, Guthrie was asleep in her studio apartment when her phone rang. The girl had been gone since Thursday. The counselor on the line said the
The police had located her and she was now in the emergency room, where she was being detoxed.

When Guthrie returned to work on Monday, she learned that the girl had been found partially naked after she had banged on the door of a house in a quiet residential neighborhood in Davis, begging for help. The girl couldn't recall much. She said she'd been with a group of older kids in an abandoned freight car near the railroad tracks alongside I-80. One of the older boys panhandled for some money to buy dresses for the girls at a Rite Aid and shoplifted some liquor. The crew met a homeless man who joined them for the freight-car party. The girl described him as “really nice.” She said the last thing she remembered was taking a single swig from a bottle of alcohol the kids had passed around.

Guthrie told Meyer the story later that day. Meyer tried to remain calm, but Guthrie could see she was panicked.
Jeff Beasley stood in the parking lot of Harrison Self-Storage. The facility shared a cinder-block wall with a corner of the campus. A police officer for 12 years, Beasley was the department’s liaison to the group home. On this day in spring 2013, he was attempting to persuade yet another teenager from FamiliesFirst to come down off the storage roof. Beasley did what he'd always done. He asked the boy his name, where he was from, and why he was up there.

“F— you. You’re a f—ing cop!” the boy shouted. “I don’t have to listen to you.”

Beasley took a deep breath and shook his head. “Yeah, yeah, that’s fine,” he replied. “But you know, we’re not going anywhere. You want to stay up there all day? You want to climb down? Or you want us to haul you down?”

“No,” the boy said. “It’s getting hot. I’ll come down.”

As he drove the boy back to campus, Beasley thought about the past two years. His fellow officers had talked the same boy off the same roof several times in the previous week. He’d talked at least three kids down off rooftops around Davis over the course of 18 months. The
place was falling apart. The staff should know how to do such things on their own. Would the administration ever address the problems? Couldn't they, at a minimum, put up a barrier along the back wall to prevent children from reaching the storage facility?

For the first five months of 2013, the Davis Police Department received more than 500 calls involving FamiliesFirst. Most of the calls came from staff who were asking for assistance on campus. But many came from town: the Taco Bell on G Street, when children from the home terrorized employees and customers; the Sudwerk Brewery, around the corner from campus, where girls were often found bleeding after cutting themselves with broken bottles. Residents complained about kids harassing pedestrians. Store owners complained about kids shoplifting. Sometimes the kids themselves would call or show up at the station, demanding that the police take them to a psychiatric hospital.

For Beasley and his fellow officers, the calls raised large questions. Was defusing one more ugly and dangerous incident enough? Did the volume of problems at the facility constitute a threat to the welfare of the children and to Davis? Most of the time, in Beasley's judgment, the children weren't doing anything that warranted an arrest. They were already in the social welfare system. Some had done stints in juvenile detention. Sending them back into custody probably wasn't going to improve their situation, but bringing them back to the campus wasn't working, either.

Beasley was singularly qualified to be the department's liaison. He had graduated from Pacific Union College with a bachelor's degree in theology and had served as a pastor at an evangelical church in his 20s and 30s. He later earned a master's in counseling at the University of San Francisco, and, in 1991, accepted a job as a residential social worker in one of FamiliesFirst's three-bedroom homes in Davis. The place was special to him. It was where he met his wife—she was an office manager—and, in his four years there, he and other staffers developed a deep camaraderie, maybe because the work could be so draining.
One day, a 12-year-old boy asked for permission to spend time in a quiet room. When Beasley looked in several minutes later, the boy had smeared feces on the walls and was lying naked. He had blindfolded and gagged himself and was bleeding from his gums. He had torn his clothes and run the shreds through his teeth.

Beasley wanted to know more about where such troubled children came from, to see if he could do something at the problem’s root. In 1996, he took a job as an investigator with Yolo County’s Child Protective Services Department. He has no doubt that he saved lives—he removed countless children from deplorable conditions—but after four years, the job wore him out. At 47, he joined the Davis Police Department.

For a police officer, Davis is enticing. Magazines often cite the city as “one of the best places to live” in the United States. More than half of its 66,000 residents are either employees or students at the University of California, which dominates the south end of town. The violent-crime rate is less than half that of the average American city. Five murders have occurred in the past ten years. The work of police mostly involves traffic stops, burglary investigations, and breaking up the odd bar fight or raucous college party. As Beasley points out, “there is no wrong side of the tracks in Davis.”
When Beasley was assigned as the department's liaison to the group home in November 2012, the two institutions were at an impasse. The home's administrators wanted officers to escort children back onto the campus when they ran away and help subdue them if they became unruly once they arrived. Beasley and another officer named Tony Dias explained that they were not private security guards. Beasley and Dias met with administrators once a month. They tried to come up with a way to handle the increase in calls to the police, a disproportionate number of which involved a group of about 12 children who routinely ran away and slept in parks around town— the group that Alex hung out with.

Beasley was well liked on campus. Fifty-eight years old, with short white hair and a neatly trimmed mustache, he still had a preacher's way, shifting easily from impassioned to contemplative. The children occasionally confided in him about another resident or staff member. He'd mentor some of the counselors in how to defuse situations or calm a disruptive child. Officers learned the backgrounds of many of the children who were leaving the campus regularly and tried to adjust their approaches when they picked them up so as not to retraumatize them. One officer played basketball with the kids on campus; another went on jogs with the kids and counselors. Still, a huge divide existed between how the home approached the children and how the police did. In general, staff thought the officers were too aggressive, and the officers thought the staff were too lenient.

By April 2013, five months after Beasley had become liaison, the relationship between officers and staff had become contentious. Police threatened to arrest staff for allowing children off campus. Counselors explained that policy prohibited them from preventing children from leaving. Beasley and Dias decided that the agency might take the department more seriously if top brass got involved. They turned to their supervisor, Assistant Chief Darren Pytel. He had been concerned about the home since the fall of 2011, when emergency calls from the facility jumped almost threefold from the previous year. But the explosion of calls that began to occur in January 2013 had no precedent.

“Entire shifts were spent chasing around runaway kids,” Pytel says. “The staff, even when they knew where the kids were, refused to come out and pick them up. They wanted us to drive them back, as if we were a taxicab service. Eventually, I couldn’t walk into my office without one of my patrol officers saying, ‘Hey, we've got to do something about this place.”

These minors were not being protected. They were being victimized to a point that was just absolutely shocking.
In late April and then in early May, Pytel and several of his deputies met with administrators from the home. The first time was with Audrie Meyer. According to Pytel, the conversation devolved quickly. He told Meyer that the calls had exhausted his department’s resources. Meyer explained that it was EMQ FamiliesFirst policy not to prevent children from leaving the campus and that doing so would constitute a violation of state guidelines. Pytel asked to meet with her superiors.

At the second meeting, EMQ FamiliesFirst regional director Gordon Richardson and a lawyer for the agency joined Meyer. They told Pytel that the home would revisit the runaway policy and consider transferring some children. Pytel came away convinced the agency’s leadership was hopelessly lost.

“It was really clear that nothing was being done to change what was becoming significant criminal behavior,” Pytel says. “What was so disturbing to me was that this facility was full of social workers and people whose job it was to help these minors, but that was not happening. These minors were not being protected. They were being victimized to a point that was just absolutely shocking.”

Days after the second meeting, Pytel reached out to the Department of Social Services, imploring it to intervene. The department, Pytel says, didn’t seem “to take great interest.” (Department of Social Services spokesman Michael Weston says no record of any discussion was kept, but that the agency was “responsive to law enforcement.”)

In late May, Beasley was assigned to investigate the alleged rape of an 11-year-old girl. She had been at the home just over a month and had fallen in with the children who were leaving the campus for days at a time. She came back one morning, after being out all night, and told counselors that she’d been drinking and smoking in a park with two boys, 13 and 14 years old, from the home. She said they took turns raping her while two other kids pinned her down.

After the staff reported the allegation, Beasley and a colleague spent hours talking to the alleged perpetrators and witnesses. (Another officer interviewed the victim.) The prime suspect drew diagrams for Beasley that showed who was having sex with whom on campus. He told him that adults in the community were providing them with alcohol and pot. He admitted to shoplifting. But he vehemently denied having sex with the 11-year-old. Beasley concluded that if anything sexual had occurred that night, it didn’t rise to the level of...
criminal behavior. His partner came to the same conclusion about the second alleged perpetrator.

Beasley says he expressed his doubts, but that Pytel was adamant: He wanted an arrest. Beasley came away convinced that the assistant chief intended to use the charges to shut down the home. Beasley sympathized with Pytel’s exasperation but was furious at his willingness to charge children erroneously.

Pytel denies Beasley’s accusations. He notes that the local prosecutor wound up pursuing the case. One of the boys pleaded guilty to two felony counts of unlawful sexual battery, and the other was acquitted. He says his intention was never to close the home. “What we wanted,” he says, “was for everything to go back to the way it was before.”

To Beasley, the boys’ arrest was a political move. The police could solve the problem of the home and look like saviors. “When children fleeing a dangerous environment and needing help came to Davis,” he says, “Davis said, ‘Get the f— out.’ Whether it was the police department, FamiliesFirst, licensing, the judicial system, nobody asked, ‘What can we do to help?’ Instead it was, ‘How fast can we get rid of them?’”

THE DIRECTOR
When EMQ FamiliesFirst asked Audrie Meyer to lead the Davis home in July 2012, she was surprised. By her own admission, she was not an obvious candidate. Meyer, who is 58 years old, had spent most of her professional life working as a tech consultant. Holding a master’s in business administration, she helped build information systems for Pepsi and advised the French computer firm Groupe Bull on strategic planning.

She decided to change her career, and in 2008 she earned a master’s degree in counseling and took a job as a social worker at a group home northeast of Sacramento. She left to join EMQ FamiliesFirst in 2011 as an associate director for the Davis facility’s day-treatment program. She had been on the job for seven months when the head of the home resigned and she was asked to serve as interim director. She had been a licensed therapist for just two years.

Meyer was taking over the home at a particularly fraught moment. EMQ FamiliesFirst was beginning to question whether the Davis campus should remain open. Despite the addition of girls, the home continued to operate at a deficit. It was essential, she was told, that
expenses be brought in line. Just as worrisome, the use of restraints on campus was unacceptably high, which was arousing concerns at the Department of Social Services. In 2011, staff employed restraints more than 800 times. In the first six months of 2012, they had already employed restraints more than 500 times.

Meyer enacted policy changes at a furious pace. In November, she lowered the campus’s maximum to 63 children, laying off at least six full-time employees. By December she had eliminated all the part-time workers the home had relied on to fill in for staff absences. According to Meyer, several were made full-time, ensuring adequate supervision of the children.

Meyer also quickly zeroed in on restraints. Her supervisor was Gordon Richardson, who oversaw EMQ FamiliesFirst’s operations in and around Sacramento. Meyer says he asked her to reduce the use of restraints by 25 percent from the previous year. (Like all current employees of EMQ FamiliesFirst, Richardson declined to be interviewed for this story. According to an EMQ FamiliesFirst spokesperson, “Due both to privacy concerns and pending litigation, we have been advised by legal counsel not to engage in further public comments regarding this past matter.”) In October 2012, a staffer broke a child's arm in a restraint, drawing more scrutiny from the Department of Social Services. During the fall, Meyer met several times with Ashley Sinclaire, the department inspector assigned to the home, who warned her that the facility was in danger of losing its license if restraints weren’t decreased substantially.
"For good or bad I got restraints down by 40 percent," Meyer says. "The downside for the program was it made the staff feel unsafe. When the staff feels unsafe, the children feel unsafe. At the same time that we are dropping restraints, licensing shows up and starts hammering me to drop them further, and the Davis Police Department starts threatening to arrest staff for letting kids off the campus."

People who work in the field agree that restraints ought to be used as infrequently as possible—as a last resort. The act can be necessary to maintain safety and order but can also be emotionally unsettling and physically dangerous for both the adult and the child. Overuse of restraints, most authorities say, is almost always an indication of deeper problems at a facility.

Leslie Morrison, an attorney for the nonprofit advocacy group Disability Rights California, is an opponent of restraints and believes that they can be avoided in all but the most extreme circumstances. But she said it’s common for a group home to set a hard and fast goal to reduce restraints without properly teaching staff other means of calming children. "Senior management does this thing," she says, "where they used to go hands-on quite a lot and then, suddenly, they want no hands-on. What you have to do is give your staff a lot of training on alternatives. If you don’t, you are going to have problems."
Meyer acknowledges that all the policy changes were too much too fast, but she also said the staff fought every attempt to reform the campus, even her efforts to have them learn alternatives to restraints.

Staff members insist that what was happening on the ground was much different from what Meyer saw from her office—that the workforce cuts, the belated training, and the new restraint policy had dangerously reduced the quality of care. From their point of view, it was a question of trust. They didn’t believe that EMQ was committed to keeping the facility open. Just look at its history, they said: This was a company that had downsized its two group homes after it had decided that wraparound care was the future. For many of the staff, every budget cut that Meyer enacted was a precursor to EMQ shuttering the place; every policy change was setting them up to fail. According to Meyer, the staff’s fears were not entirely off base. EMQ’s executives never said so outright, but it was clear to her they were considering closing the campus.

Some staff were sympathetic toward Meyer. “I liked her,” says Vivienne Roseby, a consulting psychologist at FamiliesFirst from 2000 until November 2012. “I think she was trying hard to do what EMQ wanted her to do, which was to get it tightened up, more efficient, more coherent. I do think that the pressure that she was under and the speed that she was being asked to make these changes made it difficult, if not impossible.”

Roseby’s, though, was a minority view. Most of the staff came to regard Meyer as distant and negligent, and the flash point was her policy on children leaving the campus. At staff meetings, Meyer repeated the message she’d been trying to get through from almost the moment she had arrived: The children, young and vulnerable as they were, were going to have to examine their own decisions about why they were leaving and what they were doing while they were gone. What happened to the children outside its walls was not the home’s responsibility. California law, she said, was clear on this. Meyer assured the staff there was a logic to her thinking. If the children came to harm, the home could document the problem and perhaps get the children placed elsewhere. “Failing up,” she called it.

“There is something wrong with this woman,” says Kim Rowerdink, the dorm supervisor. “The police kept asking us, ‘What is Audrie doing?’ And we’d say, ‘They keep telling us we’re not responsible for what the kids do off campus. We can let them go.’”

Meyer, for her part, came to regard the staff as too emotionally involved. “It seemed completely foreign to them,” she says, “that any program would not be able to stop a child
from leaving the program. But you can't. I think the staff felt like it was the program's fault if the girls put themselves in harm's way, and I just don't think that's a fair statement.”

Michael Weston of the Department of Social Services says Meyer’s view amounts to a misguided understanding of a home’s role. “The group home,” he says, “is responsible for care and supervision, regardless whether the children are on campus or not.” Referring to FamiliesFirst’s policy guidelines, he says, “Read it right here. It talks about when a child goes off campus, we are responsible for their care and supervision.”

In truth, that’s not quite what the home’s guidelines say. Rather, it states that staff will shadow children who leave the campus and will try to persuade them to return, employing restraints or calling police if they begin to harm themselves or someone else. The problem for the Davis home was that if its staff shadowed all the children who were leaving in the winter and spring of 2013, there would not be enough staff to supervise the children who remained on campus.

Between October 2012 and the beginning of May 2013, records show that Sinclaire and other licensing investigators visited the facility on at least 15 occasions. In late February, Sinclaire did bring up with Meyer the number of children leaving campus and the police’s involvement in returning them. But Meyer says Sinclaire told her that she couldn’t prevent children from leaving the campus by restraining them. (Michael Weston says that the Department of Social Services has no record of Sinclaire giving this directive. Sinclaire declined to comment, saying that she’d been instructed not to talk.)

Every group home in California must file a report to the Department of Social Services for a range of incidents, accidental or deliberate, alleged or substantiated. The roughly 500 reports that the home filed during the first four months of 2013 paint a picture of a facility whose staff and administration were overmatched. Meyer says that by April and May there were likely hundreds more reports that were never filed, in violation of state rules. “The volume went from 300 a month to 1,000 a month,” she says, “and we didn’t have enough trained people to file them.”

From February to May, at least six counselors, therapists, and social workers resigned. “They were quitting faster than we could fill the jobs,” Meyer says. According to people who had worked at the home for years, there’d never been a time when so many staff quit or took stress leave within such a short period. In May, the police received 252 calls, five times as many as they had received in January.
When Meyer made her superiors at EMQ FamiliesFirst aware of the problems on campus, she says, they were “very slow to grasp the seriousness of what was going on.” She recalls several disconcerting conversations with Gordon Richardson: “When I relayed staff concerns about not having enough people, his reflection was, ‘Well, maybe that’s why restraints were down, and that’s a good thing.’”

By late spring, Meyer says she became convinced the situation was hopeless. “I was very, very impacted by what was going on with these kids,” she says. “I was not OK. I saw that it was horrible. When I realized the police weren’t going to respond, and the staff was not getting support, and the kids were getting free rein— that was a horrible situation. I couldn’t see a way to recover at that point.”

Meyer was right. On the morning of June 6, she was sitting in the conference room once again listening to her staff express their frustration when she took a phone call. It was the front desk. Fifteen Davis police officers in bulletproof vests were in the lobby.
On January 9, 2015, California’s Department of Social Services issued a 56-page report to the legislature outlining what needed to be done to care for the kinds of children who lived and suffered at the Davis home. The report called for increased minimum qualifications and training for group-care workers; more-varied therapeutic services; and better screening of children to more appropriately determine their needs and where they should be placed.

Most dramatically, the report called for group homes to be eliminated, or at least limited to offering short-term stays. “It is well-documented,” the report states, “that residing long-term in group homes with shift-based care is not in the best interest of children and youth. Not only is it developmentally inappropriate, it frequently creates lifelong institutionalized behaviors and contributes to higher levels of involvement with the juvenile justice system and to poor educational outcomes.”

As long as group homes exist, they will still present challenges of oversight. The
Department of Social Services report says little about improving its own performance in inspecting and investigating the homes. To many, the department has long been poorly positioned or equipped to monitor Level 14 group homes. Inspections are required only once every five years, and records show they are perfunctory, mostly involving a review of physical conditions, food supplies, and water temperatures. The inspections typically do not include interviews with residents and staff or extensive examinations of records. The department employees charged with performing the inspections are not required to have backgrounds in social work, even though they are often called to look into what for an experienced police officer are the most sensitive kinds of cases—sex crimes and battery involving minors.

This is a once-in-a-generation opportunity to get it right.

—Carroll Schroeder, executive director, California Alliance of Child and Family Services

The state attorney general's office appears to recognize the responsibility for better protecting these children. In February, California attorney general Kamala Harris set up the Bureau of Children's Justice, a new division of the Department of Justice that will focus on holding counties and state government agencies accountable for crimes that concern child welfare.

When it comes to taking care of the state's most damaged children, the California legislature has too often been slow to act and reluctant to spend money. But Carroll Schroeder, the executive director of the California Alliance of Child and Family Services, thinks this time it could be different. “I feel much more optimistic [about it] than anything else I have seen,” he says. “This is a once-in-a-generation opportunity to get it right.” The report’s proposals have been drafted into a formal bill that is expected to move through several legislative committees. It could be signed into law as early as July 1.

Today, the Davis campus is a ghost town. Its classrooms are empty, its hallways silent. For months food rotted in the refrigerators, bedding was piled up in the dorm rooms, and rules on restraints were still tacked on the walls.

EMQ FamiliesFirst, accused by the state of having failed to safeguard the children at the home, signed a stipulation conceding widespread violations. It continues to be one of the largest providers of social services in California. Gordon Richardson, who insisted to the
state that he was not aware of the depth of the home’s problems, remains a senior executive at the nonprofit.

Audrie Meyer was asked to resign in July 2013. Two months later, she signed a stipulation with the Department of Social Services. Without admitting to any of the allegations against her, she agreed never to work for another entity overseen by the department “for the balance of [her]life.” She now runs a private therapy practice in Sacramento.

Andrea Guthrie was laid off in early August 2013. She now has her own family-therapy practice, working primarily with older teens, young adults, and couples. After more than ten years working at the Davis campus, she’s reluctant to work with children.

Jeff Beasley retired in August 2013, two months after the police raid.

Alex Barschat-Li was sent to another Level 14 facility after the raid. He was soon kicked out and moved to still another Level 14 residence. He graduated to a Level 12 facility. This past February, he returned home, and he now attends public high school, where he has joined the wrestling team. Wendy says she feels hopeful, but she’s felt that way before.
This story is part of ProPublica's investigation into the failure of California's juvenile home system. For more coverage, watch the video “Level 14: Sule’s Story,” or read about how we reported this story.

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