Lengthy discussion of the various levels of mental health and forensic interaction including practice implications based on notes from a conference hosted by Elyn Saks at USC

Focusing on Forensics and Achieving Deincarceration

2012

We've always had as one of our target outcomes at the Village keeping our members out of jail and our overall 70% reductions have always seemed fine to me. Even recently when I've noticed that we're discharging 5-10% of our members to jail or prison, I attributed that to the fact that we accept more new members directly out of jail than ever before. My assumption has been that if we consider incarceration a major indicator of "failure of community integration" along with homelessness and hospitalizations when we help our members get better lives in the community we're doing enough to address our members' forensic needs. We've never had a staff specialist for forensics like we've had for housing, employment, education, medical care, or substance abuse.

Last week I attended an excellent two day conference titled "Criminalization of Mental Illness" put on by the Saks Institute at USC which made me wonder if we are really doing enough and opened my eyes to some potential opportunities.

Part of my resistance to getting more involved with the forensic system is that, although both my parents were lawyers and I'm reasonably familiar with the legal system, I just don't like collaborating with it. When I see a police car at the Village, my first reaction isn't "Oh look, a helpful police man to collaborate with." In my own life I try to avoid police involvement as much as possible because I'm scared of them, and I try not to call them to help at the Village, because they're often "bulls in a china shop". My experiences going to court supporting a member have usually included a hard time finding anyone who knows the correct courtroom, the person I'm looking for their case or anyone who has any time to talk at all, and after a long wait, usually a continuance with nothing decided. The few times I've been to jails, I've hated it. The atmosphere of overcrowding, punitiveness, oppressiveness, disrespect, and suffering has been overwhelming enough to cause a visceral reaction. I've never even been to a probation or parole office and don't usually even like writing letters to them. I always felt like I'm snitching on someone and going to get them in trouble.

I've never been convinced I can find any common ground with a system that actively practices confrontation and coercion, defensiveness, mistrust, blocking communication, and valuing the system over people, all while not prioritizing trying to be helpful to anyone, restorative, rehabilitative, accepting, or forgiving. Yet by not getting involved I'm leaving members in their hands often destroying their lives. Maybe I should extend myself.

But who should I attempt to intervene with? There must be a way to distinguish which people "deserve" to be in the forensic system and which ones should be "diverted". The director of LA County DMH opened the conference with a discussion about separating people into five categories that he felt shouldn't be conflated: People whose mental illnesses influenced their criminal behavior, people who make bad decisions, people whose use of substances directly or indirectly led to their charges, "morally evil" people, and people with various brain damage / neurological conditions that aren't traditionally considered part of mental health. His stated reason for dividing people up like this is to proscribe different treatment approaches for each set.

Dividing people like this is very appealing and very logical, but I'm not actually sure it would work. For one thing, most people have a combination of those characteristics and end up in multiple categories. They shared with us statistics that the vast majority of incarcerated people are abusing drugs or alcohol, especially those with mental illnesses. They also said that very few have even average IQ's, most are in the 80's, most drop out by 8th grade, and many have head trauma.

For another thing, many inmates disagree with our assessments – they may not think they have a mental illness, or substance abuse, or brain damage – or, on the other hand they may want to claim one of those things to avoid responsibility for "bad decisions" or being labeled as "morally evil". We were told that 25% of the people sent to the state hospital as incompetent to stand trial were thought to be malingering by the staff there.

Also, different staff, coming from different perspectives, might emphasize one or another trait of a person. Our subjective judgments may get expressed as objective diagnostic differentiations. This may be especially problematic for black people as racial bias colors our determinations and dispositions. (I still remember a man with Bipolar illness who I, along with his wife and 6 year old son, went to court to advocate for diversion for since the fire he'd set was actually in the bathroom of the mental health urgent care center where he'd gone for help within one day of becoming manic again and since he worked and was a good father playing catch with his son. The judge said he's big and black and I'm frightened of him so I'm making sure we're safe by giving him the maximum sentence of 11 years in prison.)

There was some uncomfortable murmuring in the audience about the group of people who were described as "morally evil" but I think that was more because of the religious terminology than because of the idea of this category. Most people think that there are some truly bad people, not just people who made a bad decision for a variety of reasons. We may call these people criminals, sociopaths, or antisocial instead of morally evil, but we would still identify some "bad people" who should be incarcerated. They deserve it. The long term public defender said he'd represented thousands of those people. The state mental health director assured us that although he'd agreed to build a whole new state forensic hospital for sex offenders, that he was sure that none of them had a mental illness and he promised NAMI parents he'd keep them away from their mentally ill family members. The former police man talked about the satisfying connection that police learn between clicking on handcuffs and getting the bad guy off the street. The legal word for this group is "guilty". The legal system doesn't make moral or clinical differentiations.

The trauma researchers added some disconcerting data: Apparently the majority of female inmates have been sexually abused and almost all have been physically abused and a sizable minority of the male inmates have been sexually abused and the majority physically abused. Emotionally, for me at least it's hard for me to see someone as both a severe abuse victim and "morally evil" at the same time. Intellectually I know that the vast majority of perpetrators are also victims, but emotionally I tend to have to choose one identity or the other. I have a similar problem with an old piece of data that the majority of people who meet criteria for antisocial personality show signs of neurological damage. Emotionally I really want to separate out "morally evil" from "brain damaged", but the data doesn't support that differentiation either.

As long as we all agree that there are some people who should be locked up, not just for safety sake, but because they are bad people who should be punished, then all we really have to talk about is if I can convince you not to put someone I care about into that category. I'll try to convince you they have a mental illness, they're a trauma victim, they're brain damaged, racially prejudiced against, or even a victim of the war on drugs so that we can work on diversion together. I'll even offer to "educate you" so you make the same differentiations that I do. Many people, including consumers, family members, and mental health professionals told painful stories about not being able to convince the fragmented, impersonal legal system that they didn't deserve what they got.

My personal belief is that the category of "deserving to be in the legal system" is simply a projection of our own intolerances and fears which includes lots of internal, individual biases. I think the only reason to lock up someone is for public safety, not punishment, and no one deserves the treatment the legal system delivers even if they're dangerous. Therefore, if I'm

going to follow my own principles, I should attempt to intervene with and try to divert everyone who isn't unacceptably dangerous, destructive, or damaging to the rest of us.

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The conference presenters outlined five points in the process where we can intervene: 1) Before arrest, 2) Before trial / conviction, 3) Alternative sentencing, 4) During incarceration, and 5) Community supervision (probation and parole).

1) Before Arrest

This intervention point is usually considered an intervention with the police since they're the ones called to the scene and they're the ones who decide whether or not to arrest someone, but it doesn't have to be that way. First responders could be mental health workers or paramedics. Police have the advantage of being able to use force, but is that a good reason for them to be our first responders?

If police are left to work things out on their own they are likely to pursue actions that keep them safest, take the shortest amount of time, and get the person off the street for the longest amount of time. That would almost always be handcuff them, drive them to the police station and book them.

Collaborations with police have generally been of two types: 1) Educate police about mental illnesses, how to use de-escalation techniques instead of confrontational techniques, and about treatment resources (CIT training). Sometimes this is supplemented with special efforts on the mental health side to accommodate police and make hospitalizations less time consuming for them. In Los Angeles, at least, private psychiatric hospitals haven't been accommodating so police have to take people to the public hospital psychiatric emergency rooms. (Police don't do the required insurance checks before trying to hospitalize someone.) 2) Create special collaborative teams with one policeman and one mental health worker who selectively respond to mental health calls (MET or SMART teams). They have access to both forensic and mental health intervention strategies, treatment resources, and data bases. This is an impressively successful program, with many more people taken to hospitals instead of arrested.

Long Beach has an additional innovative program – the Quality of Life police. This police team responds to calls from the downtown business community. Instead of relying on repeated arrests trying to drive mentally ill people out of downtown Long Beach they try to help them get connected to community resources to live successfully in the community. They have assisted people with social security applications and appointments, connected them with our Homeless Assistance Program including using hotel vouchers we give them, several sober living programs, the homeless services at the Multipurpose Center and even some set aside

psychiatric hospital beds through DMH. In effect, they have a "case load" of people they're working with over time to get off the streets without jailing them. We have a nurse practitioner who rides along with them one afternoon a week to give them sophisticated psychiatric assessment and treatment planning consultations on the street. We talk to them regularly about people we share. We help them enroll people into our FSP program to get ACT level services.

Each of these programs require personal changes by the individual police involved. They have to act differently than police are generally trained to act and expected to act. They risk their lives by not maintaining "police paranoia". They violate police traditions. That's a lot for us to ask of them.

We were told that 88% of the mental health police calls were initiated by families. While there are some neighborhoods in which police are routine participants in family matters, I'd guess that most families would've preferred to call someone else. Many likely did call someone else and were told they couldn't do anything. At least police respond. Police probably should to be called if the call is made out of fear, but not if the call is made out of frustration. Families related that when they called at least they knew their family member would be safe in jail and would get the treatment they needed. Neither is true. It seems likely that if our community mental health programs did better community outreach and response, especially in non-emergencies and if we were more accessible to families and more supportive and informative they'd call the police less. A first step for the Village could be to identify which member's families have called the police on them in the past and try to provide some additional services to those families. Having a family peer advocate would likely help, especially since some of these same families are ones that the members refuse to let their team staff talk to.

It surprised me to learn that this is where Assisted Outpatient Treatment fits in to the overall picture (if it fits anywhere in deincarceration at all. People who have been repeatedly jailed aren't particularly likely to respond to the relatively "toothless" coercion in most AOT programs). A variety of involuntary outpatient commitment laws have been passes around the country and several programs, most notably North Carolina and New York have been studied. These programs have shown powerful effects on people's lives. Most, but not all, of the effect has to do with the formal linkage of the person with an ACT intensity program that forbids either side form dropping out. However, some of the effect does connect to the formal commitment of police and hospitals to assist the community program enforcing treatment when they're called upon.

We were told that these programs were being almost entirely used as aftercare programs after repeated hospitalizations without ongoing community treatment between hospitalizations, not

for people who had been arrested and jailed as aftercare for them. Within that context they do often work. I was left wondering if we really needed an expensive legal process and a judge to force us all to collaborate like that. There is a pilot program in Pasadena attempting to implement Assisted Outpatient Treatment without the legal infrastructure. (I would also note that from what I know, in the one county in California Nevada county, where AOT has been implemented the judge acts much more like the mental health courts I'll describe below than like a typical judge enforcing probation violations.) On rare occasions, the Village has overtly worked collaboratively with the Long Beach MET police team to pressure a member into restarting their medications to avoid hospitalization or incarceration. Maybe we should do so more often.

2) Before trial / conviction

Within our present legal structure our members do very poorly in this stage. They are rarely released without bail (often they have histories of failing to appear) and they are too poor to make bail. This means that they have to stay in jail awaiting a court date. It also means that if they don't agree to a plea bargain they'll have to do more time while their case is continued for a hearing. That puts them, and their public defender, in a poor bargaining position and more likely to have to accept harsher deals (I once heard that people who don't make bail on average have twice as long of sentences for the same crimes as people who do make bail because of this). Even if there is a mental health worker in the court trying to do diversion as we have in Long Beach and Los Angeles, they have no leverage to avoid a guilty plea by offering treatment resources to the prosecutor or the judge. Therefore, our members almost always plead guilty even if there is a "diversion".

Mental health staff often view public defenders as our natural allies. They're working for the defendant aren't they? We don't realize that their job is not to help the defendant. Their job is to help them avoid being punished as much as possible. While we may want to emphasize taking responsibility for your illness, for your bad decisions, or for your substance abuse as an important step towards staying out of jail, the public defender works to reduce punishment by any legal means available. As a result many inmates believe that their lawyer was responsible for their conviction and sentence. Either they got a "bad deal" because they had a "bad lawyer" or they had a "good lawyer" who "got them off".

If we look to the district attorney to emphasize self-responsibility, we'll be similarly disappointed. They represent social responsibility as they pursue convictions, punishment, social order, and especially deterrence, not self-responsibility. If we try to expand their view of social responsibility to include responsibility for social inequities, racism, lack of opportunities,

trauma, exposure to violence, or even care taking and rehabilitation they say that's not their role in the system.

Our goals have no natural allies in the legal system.

People often are surprised that pleas of "not guilty by reason of insanity" are not more commonly used. The simple response is that pleas aren't truthful, they're defense strategies. Even if someone really is not guilty by reason of insanity, it's a bad strategy as a way to reduce punishment because on average you'll spend twice as long confined after that verdict than you would've with a guilty plea. End of story from the public defender's point of view – and it's his point of view that matters.

We didn't discuss why forensic mental hospitals keep people twice as long as prisons do. We didn't even have anyone who worked there to ask. They tend to be in their own world far, far away. I suspect that the answer is that the culture in the state hospital in which release decisions are made is more risk aversive, custodial, and hopeless about community integration than the parole board. I'd wager that if we compare the average length of hospital confinement in the indefinite commitment era with the length of confinement in our current war on drugs, mandatory sentencing era, we'd find that mental health has always locked up people longer than forensics. Mental health is likely to see this as a false comparison because we don't view what we do as punishment, but when we put the guard towers and the barbed wire into the state hospitals it became harder to be sure.

I remember being taught in residency that when we ended long term civil commitments for dangerousness the state hospital was forced to release a large number of patients they didn't feel were safe. A follow-up study showed that only 5% of them did something dangerous after their release. That number was presented to us by a civil rights advocate as proof that we were overly cautious and unnecessarily detaining hundreds of people. I'm not sure that the hospital staff would've agreed. How cautious should we be? What percentage of people that we put on holds should be actually going to do something dangerous? A former state mental health director pointed out to me that our media is much more accepting if a parolee does something dangerous than if a released mental patient does.

I also remember hearing from a state hospital director that his job was to avoid any incident that might embarrass the governor. Given that California's governor is now in a massive conflict with the federal courts because we can't afford to be this risk aversive, custodial, and hopeless about community integration maybe the director's strategies should change.

The community treatment system would probably have to step up and share responsibility with the presently isolated state hospitals. There is a conditional release program, Conrap, which

has been effective and saved money, but few counties, DMHs, or agencies who want to implement this program. Over the years I've generally urged that MHALA not get involved in conditional release programs. Does that attitude make me part of the problem? Should we step up?

How about "incompetent to stand trial"? This is not a plea. It is a factual medical-legal finding relying upon expert psychiatric testimony. This finding creates a burden on the mental health system to restore their competency while keeping them confined. Not only is that a very costly proposition, the goal of getting people better so they can go back to jail to be tried and sent to prison isn't very appealing to either staff or patients. We've restricted the number of beds devoted to this service to avoid it becoming an enormous financial drain on the overall system. This creates a backlog of people in jail who can't stand trial and who can't be released. Making things worse, only a small portion of the inmates are in a designated "inpatient" unit where they can be involuntarily medicated, so most of these "incompetent" inmates can and many do refuse medications prolonging their incarceration even further. This outcome is so disastrous maybe we should consider being by our member's side while they meet with public defenders unable to work with them, as we do with medical doctors, landlords, social security workers, etc.

In some other locations they have radically altered the legal system creating a mental health court specifically to promote services in place of incarceration. The roles of the public defender and district attorney are radically reduced. Plea bargaining is replaced with a team plan with onsite mental health involvement. The judge becomes heavily personally involved. He talks directly to the defendants. He mediates plans, keeps track of progress personally, hands out individualized rewards and sanctions, hosts graduations and even descends from the bench to hug people. Success requires the actual mental health providers be in the court room, not just a mental health representative brokering services. In Orange County a range of social services and NAMI are located in the same building as the mental health court.

At present these experiments all seem to rely on the passion, will, and personality of the judge involved. They are breaking with so many traditional roles and expectations that they are drawing the ire of the professional establishment – it's not ethical for a judge to hug a client. This feels very reminiscent of the reception recovery based mental health professionals have gotten from our professional establishments. It's not that anything they do is really against the law or unethical, it's just not what's always been done – just like recovery. But it's working. Perhaps MHALA should be approaching individual judges in Long Beach to find one to support to create a local mental health court. We do have enough community political connections and access to the social service providers that our direct intervention might make a difference.

3) Alternative sentencing

Each of the criminal courts in Los Angeles has a mental health liaison on the lookout for defendants with mental illnesses to try to intervene in their sentencing. Communication between them and the Village goes both ways. Sometimes we call them to inform them about one of our members coming up for trial. Sometimes they call us to ask for help in "discharging someone to our custody". They act as the broker between us and the lawyers and judge. Often our caseworkers go to court, but usually that's to give emotional support to our member, rather than to actively negotiate the sentence.

The results are highly variable. Sometimes the judge is just glad to see anyone cares about this person and he releases the person to us and leaves it up to us. Sometimes they court order as a condition of release a cookbook series of services - residential treatment, therapy, following doctor's orders, anger management, drug testing and treatment, counseling, etc. some of which are vague, don't exist, or don't have funding sources. We take on the role of supporting someone be responsible enough to follow court orders rather than taking an active role in formulating what those orders should be and then taking responsibility for providing them. Sometimes the judge conditionally releases them into our custody. I'm never sure what legal responsibility that puts upon us or how we're supposed to guarantee anything without any coercive authority. We've gotten into long arguments with the liaison trying to get them to explain to the lawyers and judges that "we don't do that", but they end up making whatever rulings they choose anyway. The liaison begs us, "The judge doesn't really understand, but this will get them out of jail, so please help" and we do. It seems like this could be done better.

But is our own house in order? Do we really know what services to give people to help them not commit crimes? The two main mental health behaviors that seem to predict committing crimes are impulsiveness and anger. We don't offer any services directly targeting either of those behaviors. Remember that the majority of these people have some brain damage and limited intellect and histories of substantial abuse and trauma. Given that, what services might work? Maybe there are some specific therapeutic approaches and skills we should be developing.

The jail mental health staff in Los Angeles' Twin Towers intentionally do not try to influence sentencing for the inmates they're treating. They believe that would badly contaminate their treatment relationships and lead to lots more manipulation and lying. They barely have time to give people treatment in the jail, let alone to respond to "Will you call my lawyer and tell him I'm Bipolar and need help?" They do, however, actively refer inmates to programs like ours to continue their treatment after release. This separation can lead to us getting two, sometimes contradictory, sets of referrals for the same person. It is my belief that although this separation

may be working for the jail mental health staff, it isn't working for the inmates. Often the jail mental health staff have a great deal of information about the person, their mental illness, the services they need, maybe even their family that the court staff do not have and that should be included in determining their sentence, especially if it's a diversionary sentence.

4) During incarceration

Providing ongoing mental health services to inmates during their incarceration in jail and prison has been the direct focus of several legal suits in Los Angeles and California and, as a result, has been the focus of the mental health departments far more than the other interventions. They are being held accountable for making sure everyone gets screened, and then evaluated and treated if needed within the system. Given the enormous volume of inmates moving around the system in complex patterns, just tracking them and getting them treated is an extensive effort. They have done allocated lots of resources to this - recruiting staff heavily, flying staff into prisons on weekends, using telepsychiatry linkages, and raising salaries. In many indirect ways this effort has been a drain on the rest of the system.

When I've met with jail mental health staff, they complained of being overloaded and burned out. They are frustrated as they see the same people return over and over again. They struggle to get anyone on the outside to reach out to their clients when they're released. It doesn't help that if someone is in jail for over a month, their social security and MediCal are cut off so it takes a lot of time and effort to restart them after release while the person is without housing, money, or medications. None of that surprised me.

What did surprise me was that staff felt that the inmates had a pervasive sense that nothing they did made any difference. The inmates weren't the directors of their own lives inside or outside of jail. Life just happened to them. Crucial things were out of their control and decisions made about them arbitrarily and without their input. This pervasive helplessness made almost any efforts to talk to the inmates about controlling their own behavior – including 12-step, cognitive behavioral, recovery-based, and impulse control techniques – feel futile. Adding to the problem, the staff tended to share that feeling of helplessness and randomness. The guards could end their groups or stop them from talking to an inmate whenever they wanted, sometimes to punish mental health staff for advocating for inmates. The staff were subjected to pervasive disrespect and coercion by the sheriff's staff who run the jail. Overall, in my view, the emotional environment in jail is so toxic that any treatment besides pills gets swallowed up.

Family members who think that at least their loved one is safe and receiving treatment in the jail should reconsider. I've seen far more people deteriorate mentally in the jail, some

becoming psychotic for the first time or ending up mute and curled in a ball smearing feces, than I've seen recover there.

Even still, it is helpful, sometimes even lifesaving, to be able to call staff at the Long Beach, Twin Towers, and women's jails and get a psychiatrist to give them their medications there. I try to Fax them histories and medication lists as soon as I find out a member is incarcerated to help them be as efficient as possible.

5) Community supervision (probation and parole)

Another surprise for me was to learn that about 90% of the people who are under legal supervision are in the community already on probation or parole, not incarcerated. It occurred to me that although I routinely ask about probation and parole when I meet new members, I don't actively track how many of my members are on probation or parole or how they're doing with it.

Collectively, people with mental illnesses do much worse on probation and parole than other people. They are reincarcerated at much higher rates than any other group (except maybe illiterate people). However, almost the entire increased rate is due to "technical violations" not to new criminal charges. They aren't going on crime sprees. They're missing appointments and not following up with their officer. Or maybe, their officer is more actively looking for a way to get a people with mental illnesses off their caseload than they normally might.

The prevailing conception is that if these people can be linked to mental health and substance abuse treatment, their conditions would be treated, and they wouldn't be reincarcerated as much. We were told that it turns out that treating mental illnesses and substance abuse does improve their conditions and it even keeps them out of hospitals, but it only lowers their reincarceration rate by 10%. That's because reincarceration depends mostly on who their probation or parole officer is. They hold all the power. Apparently, their preconceptions about the community desirability of people with mental illnesses aren't impacted by effective treatment very much.

In standard conditions when an officer has a large mixed case load, no special interest or training in mental illness, and uses the customary confrontational coercive approach, people with mental illnesses are reincarcerated frequently whether they're treated or not. In contrast, when the officer has a smaller, specialty caseload of people with mental illnesses, some interest and training, and uses a more collaborative approach, then the reincarceration rates drop.

Interestingly, the other 90% of the reduction comes from reducing known "criminogenic factors" – things like past criminal behavior, criminal friends, impulsivity, no job or productive social activity, unstable housing. Helping them get out of "the old lifestyle" is essential in

staying out of trouble. The effective mental health specialist officers focus a good deal of their conversations on these factors, not just on are they taking their meds and staying off drugs.

This part of the conference made me feel déjà vu from things I'd heard in employment workshops years ago and are now engrained into my practice: People with mental illnesses are able to get jobs, not when they get treated or sober (although those things are helpful) and are then linked to standard Vocational Rehabilitation services. They get a job when they have a mental health specialist vocational rehabilitation worker, supportive employment programs, and a mental health team that work together emphasizing changing roles and lifestyles more than reducing symptoms. In the same way we've been working collaboratively with Vocational Rehabilitation (or HUD housing, the disabled student's office, or medical primary care) to help people learn to be a worker (or tenant, student, or medical patient) we should be actively working with specialty probation and parole officers to help people learn to be law abiding.

Presently, Village staff do remind people to go to their probation appointments (and to register as a sex offender) and even go with them sometimes, and we try to help them comply with their orders, whatever they might be. That's all good, but it's not the same as building special linkages and supported programs with probation or collocating in their offices or developing a "legal support" contract with them. Considering how many members we have on probation and how problematic reincarceration is, we probably should be developing these programs. We already know how to do it.

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The conference also included a few "macro level" presentations about how various systems want to avoid involvement with and responsibility for these people and how funding is insufficient and siloed and filled with undesirable incentives. They emphasized how hard it is, politically and economically, to build a consensus to make the kinds of changes we know are likely to work. They talked about how this is slow, long-term work whereas the media and the public have only a short term attention span only captured by dramatic exceptions not likely to lead to good policy, but we have to take advantage of those opportunities anyway.

As I listened, I thought that all of those challenges apply on a "micro level" to each of us too. We're all likely to avoid involvement with and responsibility for people we categorize as "not ours". We're all likely to protect our own resources against this group of people. We're all likely to make decisions that benefit ourselves even while it damages and fragments the system - whether it's the frustrated family member calling the police, the policeman saving time by arresting them, the public defender getting them off, the jail staff refusing to get involved in the sentencing, the state hospital staff being risk aversive, the probation officer reoffending

someone to get them off their case load, the client doing the same destructive things because it won't matter anyway, or me trying to steer clear of the whole thing.

Sometimes the best path to change is just pitching in and working together and seeing where it takes us.

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Last week a 35 year old heavily tattooed, but beaten down appearing, white man walked into the Village looking for me. A friend of his mother's had said I could help him. He told me his story: After his father had died when he was four, he'd been very difficult to deal with getting into lots of fights both at home and at school. He started using street speed at 9, burned up their house twice, and at 17 shot a man twice, crippling him and shooting off several fingers in a macho effort to protect his family. He's spent 13 years along the way since then incarcerated. They tried medicating him in prison without much success. He used heroin and crack and speed up until last year when his third child was taken away by DCFS. He's working hard to get his son back, completing two drug rehabs, going to parenting and anger management classes, and even getting his newly diagnosed diabetes treated. But now it feels like deeper problems are emerging and it seems to him like the interns seeing him are feeling overwhelmed by him. He's on welfare and basically homeless and can't get a job even with his mother's business because he's too hyperactive and scattered and his memory is too impaired to function. And by the way, he's been terribly depressed for two years since his second child was born dead with the umbilical cord wrapped around her neck three days before the scheduled C-Section. He visits her grave in the Babyland section of the cemetery and cries uncontrollably. After an hour of him talking and me listening, he asked if I'd be his doctor and if he could come to our program. I pushed aside a whole set of reasons he's "not mine" and we helped him fill out the paper work to become a member of the Village. Welcome.