

# GREEN OAKS

## Journal of Psychiatric Medicine

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### An Interview with Sergeant Felini and Dr. Martha Felini

We were fortunate to be able to meet with Louis and Martha Felini together to discuss the Dallas model Prostitution Diversion Initiative. Sergeant Louis Felini co-created this innovative program along with Renee Breazeale of Homeward Bound. Louis's wife Martha Felini, PhD, came on board with her expertise in research and epidemiology to spearhead the data collection and measurement of the program outcomes.

*Sergeant Felini is a Deployment supervisor with the Dallas Police Department, and has over 20 years experience in law enforcement. He has developed and implemented numerous multi-agency operations that have involved local, state, and federal law enforcement agencies. In April 2007, he partnered with Homeward Bound to develop the Prostitute Diversion Initiative (PDI), which would be the first law enforcement led program in the country. It would bring services*



Sergeant Louis Felini

#### Thomas M. Collins - President, Chairman & CEO

It somehow seems both timely and appropriate that this issue of the Green Oaks Journal of Psychiatric Medicine is largely focused on a progressive and collaborative community initiative led by a Sergeant of the Dallas Police Department given the news that Chief of Police David Kunkle has decided to resign from his position. Though Chief Kunkle accepts no credit for the New Life Opportunities Initiative, it is not surprising to those of us who have watched the transformation of the Dallas



Police Department under his leadership, that such a "cutting edge" program would be developed by Sergeant Felini with Chief Kunkle at the "helm". We wish you well, Chief Kunkle, and we thank you for the Crisis Intervention Training that you initiated for the department, along

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*directly to the environment where street level prostitutes live and work. Not only was this program designed to approach prostitutes as victims and provide them a complete exit from the sex trade, but to aid law enforcement as a long-term intelligence strategy for transient criminal populations. Sergeant Felini has been the recipient of numerous awards and more than 100 commendations throughout his career, including the State of Texas Award for Valor. He graduated from Tarleton State University in 1988 with a Bachelor of Science degree in Criminal Justice, and is an active speaker for the FBI's Highway Serial Killer Initiative. Sergeant Felini is married to Martha Felini, Ph.D., with the University of North Texas Health Science Center's Department of Epidemiology.*

*Martha Felini, D.C., Ph.D., M.P.H. is an epidemiologist whose*

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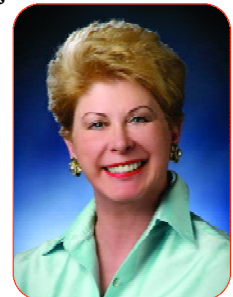
Dr. Martha Felini

#### Interview with Dallas County Commissioner Maurine Dickey

*Dallas County Commissioner Maurine Dickey has spent the majority of her adult life helping others who are less fortunate. Before becoming the County Commissioner representing District 1 in January of 2005, Commissioner Dickey was Chair of the Parkland Health and Hospital System Board of Managers, Chair of the Texas Department of Protective and Regulatory Services, Chair of the Dallas County Youth Services Advisory Board, and a board member of many other important organizations including Dallas CASA; Texans Care for Children; the Community Board Institute; and the YWCA.*

*Commissioner Dickey has a real heart for her constituents, especially those with mental illness. She has a great deal of knowledge and understanding*

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*research focuses on understanding cancer-related health disparities and exploring the influence of environmental and genetic risk factors on health outcomes. As part of her activities, she leads the evaluation analyses of the Prostitute Diversion Initiative and directs the development of its research arm.*

*Dr. Felini was trained as a chiropractor and obtained a Master's in Public Health at Texas A&M University School of Rural Public Health before receiving a PhD in Epidemiology at the University of North Carolina - Chapel Hill School of Public Health. She currently serves as an Assistant Professor in Epidemiology at the University of North Texas Health Science Center and Graduate Professor in the School of Biomedical Sciences. Dr. Felini has received multiple awards including the United States Public Health Traineeship Award, the NIH Loan Repayment Award in Health Disparities, and appointment as Senior Scholar at the UNTHSC Center for Community Health.*

*Can you tell us about the conference you had in November about the Prostitute Diversion Initiative you have here in Dallas?*

Louis: The 3-day National Conference held in Dallas was designed to showcase the Dallas model and develop interest in duplicating our efforts in other cities. The PDI is a comprehensive program that approaches prostitutes as victims rather than criminals and provides a complete exit strategy from the sex trade. Included in this program was a presentation by the FBI's ViCAP Unit that educated attendees on the Highway Serial Killer Initiative. It is believed that there are dozens of serial killers who prey on truck stop prostitutes and operate as long-haul truck drivers. The number of victims is in the hundreds. Their bodies are dumped along the transportation corridors. If a hybrid version of our Prostitute Diversion Program can be duplicated in another city, it would allow us the ability to share intelligence in the hopes of interceding earlier in a serial killer's criminal career or developing leads on offenders who target truck stops for cargo theft, human trafficking, prostitution, etc. Due to the transient nature of the truck stop prostitute, the intelligence effort is to develop prostitutes as collaborating citizens along the transportation corridors. We understand that some of the prostitutes who enter the program will relapse and return to the streets. This allows us the opportunity to educate them on indicators that would identify someone as a person of interest to law enforcement. We also made the argument that law enforcement must take the lead in this effort and coordinate with social services, health department, courts, former prostitutes, etc. to make the program work.

*It sounds like you were hoping for people from outside this area to attend also. What kind of a crowd did you get?*

Louis: The program has received international attention. Law enforcement from around the country and Canada sent representatives to see if the PDI could be duplicated in their cities. Attendees also included judges, district attorneys, defense attorneys, social services, medical personnel, and university professors. The conference brought in more than 200 individuals with a wide base of disciplines that deal with this vulnerable population.

*From what I understand about the programs in the country, this is unique because the police are leading the initiative. How did it happen that way as opposed to social services taking the lead in this particular program?*

Louis: The environment in which the street prostitute works is extremely dangerous, especially at night. The prostitute herself is predatory not to mention the pimps and the unsavory individuals hanging around. Social service personnel are not equipped or trained to provide for their own safety while attempting to help this population. Law enforcement is key to a true street level diversion program. We establish a staging area that is safe for service organizations, and officers bring the prostitutes to them for help. This protects both the prostitute and service personnel. Our approach in Dallas is to treat the prostitute as a victim and attempt to pull her/him away from the sex trade.

*I know supportive housing is one resource that we're lacking in the Dallas area. How does this impact the program? Are there any other areas that we really need to have support in, besides just overall funding?*

Louis: Actually, those are the two biggest issues. Not all transitional housing entities are healthy for this population, and some are actually criminal. In Texas, there is no regulatory commission that oversees transitional housing. In an ideal world, we would like to see these women transfer from inpatient care to extensive outpatient care in transitional housing that is owned and managed by the initial social service organization. This would not only provide needed oversight, but allow access for mentorship programs and soft services. The University of North Texas Health Science Center's Department of Epidemiology has been crucial in establishing the efficacy of this program, allowing participating agencies to apply for grants and approach private foundations for support.

*It's interesting that everyone has gotten along so well in working on this, the Dallas Police Department, the Dallas County Sheriff's department, the Dallas County Public Defender's office, the judges, and the social service agencies. It seems like everyone tries to stay in their area of expertise and offers their help when it seems to fit. This seems to be very unique in the way that it has worked here. How do those pieces fit together so well?*

Louis: It is about doing the right thing. We are going in to rescue these victims from a life not of their choosing, and provide them an opportunity for something better. We also run

it as a paramilitary operation with an established command structure on site for safety and efficiency. Basically, we will bring them to you. It's up to you to do your job. This is service work in its purest form in that you are going to them rather than waiting for the knock on the door. The collaboration is unprecedented, and I know of none like it anywhere in the country outside of natural disasters, terrorism, etc. The focus is always on the victim, and organizations become invested in helping her succeed.

**Martha, how did you end up coming into the picture, besides being Louis' wife?**

Martha: Louis jokes with me that we are both fighters...he fights enemies that are physically visible (in crime) and I fight those that are often physically invisible in cancer research. My training is in epidemiology, a branch of public health, that tracks disease rates in communities (or subgroups) to learn how to best prevent and treat disease. Specifically, I am working to identify the role of genes and environment in susceptibility to brain cancers at the University of North Texas Health Science Center Epidemiology Department. Needless to say, our dinner conversations are quite varied given our diverse areas of expertise. Louis talks about crime and I about public health. To some this may appear dichotomous, but in reality crime is a public health issue as it affects both the health of communities and individuals. When Louis was telling me about the Prostitution Diversion Initiative he was developing, I was immediately interested and offered to bring a skill set to the project that could assist in quantifying its potential success, while at the same time identifying disease or risk factors prevalent in this hard-to-reach subgroup. The data will help us target resources and potential interventions to areas of the program which need it the most and will be critical in strategic development of the PDI.

The opportunity to perform such a project evaluation with the collaboration of participating agencies from multiple disciplines has been icing on the cake. After two years of the PDI, we now need to start thinking about long-term sustainability of the PDI and how we will measure long-term successes. I will be working with colleagues around the nation and utilizing experts at the University of North Texas Health Science Center and its Center for Community Health who are passionate about working with communities in the Dallas-Fort Worth Area to address known health disparities. So, all in all, it just really seemed like a natural fit for me. That Louis was my husband was an extra bonus.

**How do you judge the project right now? How do you rate its success?**

Martha: That's a loaded question. I'll say I'm cautiously optimistic. The data is very promising with nine out of the ten entering treatment remaining off the street within the first year. I know of no other program that has these success rates. The question remains to whether our short-term success can predict long-term success...and at what cost? Overall, the data collected suggests that diverting the sex workers earlier in the process (e.g., on the street) is working. In addition to the critical leadership of law enforcement in this type of initiative, I suspect other factors that will flush out to be significant to the PDI's success will be the mentorship arm and the multi-curricular treatment programs that are part of New Life Opportunities.

**I understand you are working on ways of measuring the success. What do you use, and how did you come on those markers to show success?**

Martha: Measuring success has been and continues to be a major challenge. In order to measure success, we first needed to define success. Each organization participating in the PDI initially had a different definition of what success should be. At the end of the day, each were ultimately able to agree that success in the first year would be defined as getting one sex worker off the street and making available to her resources needed to begin recovery and ultimately contribute productively to society. While crude, it gave us a baseline by which to begin thinking about algorithms for measuring success and researching how other established organizations measure success in similar interventions. What we learned was that established programs across the nation were defining success differently or declined from defining it at all due to its complexity. With the help of key experts in law enforcement, social services, and the judiciary participating in the PDI, we are working toward measuring success from a multi-tiered definition. The challenge is going to be to determine what measure of success will be used to communicate to the media, administrations, and the lay public that will be understood by all and accurately represent the PDI. I anticipate understanding success in this population will be an evolving process.

**I would think that there would be different measurements depending on how long someone was in business. If someone was a 20-year prostitute compared to someone who was a three-year prostitute on the street, I would think their success rate would be different.**

Martha: Based on what we know about the prostitute population, success rates will likely vary based on length of time in the business (as well as a myriad of other factors). The data from previous studies is not clear, though, which of the two would be more successful in diversion programs. Regardless, the measurement of success would need to be standardized across all prostitutes regardless of length of employment in order to more meaningfully interpret the data accurately.

What do we do if Homeward Bound and Nexus are full? Are there backup plans? I know it's so important when somebody commits themselves to do the PDI that they can go through their treatment when they need it and not be put "on hold." Are there any plans to enhance or to increase services?

Martha: Our role is to evaluate the PDI. As far as critical decision making and how the program evolves, we can provide guidance and counsel to participating organizations on how to measure what they want to know. From a research perspective, as the program grows we will need to work to enhance our data sharing capability, if and when new services come on board. In terms of analysis, the most requested inquiries I've received are whether the program is cost-effective and whether we can develop a prediction model that will identify those individuals who are more likely to succeed in this type of program. We have identified these areas as high priority over the next year.

Louis: What we're looking for the University to help with is to be able to identify those individuals, based on the research, who are more likely to succeed in this type of program. This program is not for everybody. So if we're filling up beds with individuals who have no interest or desire to complete this program, other than just using resources, we need to have a vetting process for that. We're only looking at trying to help those who actually want to leave that life. This is going to be our long-term strategic problem. To go back to your earlier question, that is what we are lacking. We don't have the resources to deal with this on a larger scale. That's why we've focused on the truck stop prostitute. We believe they are the most highly motivated out of that population to seek help and exit the sex trade, because they're trading sex for their survival.

**So this becomes the exit strategy.**

Louis: Yes, basically that's right. I know that social services had to revamp the way that they approach this population as well, so it's going to be on them to determine how they're going to be able to expand their own abilities, their own services, and what funding sources are out there. To do this, a big component to getting those funding sources is the research component, so that we can demonstrate that efficacy. It all goes hand in hand, and it demonstrates the need. In the beginning, the only data we would collect is the number of girls who came into the program each night. That would have been it.

As I look at this, it's just at the truck stops now. But, if it goes further and is as successful with the rest of the population as it is with the truck stop population, then, are we at capacity for treating them? Because I know places like Homeward Bound just cannot reserve 20 beds just in case somebody needs one.

Louis: In the beginning, we believed the truck stop prostitute would be highly motivated to enter into the PDI program because most are trading sex for basic survival needs like food. The limit on the number of available beds impacts the number of women eligible for immediate diversion from the street. However, those who are not eligible for immediate diversion, due to the severity of pending charges, can be diverted from special courts later when a bed becomes available. In regards to the monthly operation, uniform police enforcement ends when the number of beds allotted for the night has been filled. The operation has been conducted in other parts of the city which have been identified by the Vice Unit as areas with high incidents of arrests for prostitution. Although each area is unique, the operation has proven just as successful. Unfortunately, you will not see a city-wide operation without available beds and funding to support the program.

**Is there anything else either one of you want to add about the Prostitution Diversion Initiative? Are there any questions that haven't been asked or any information that you really think is important for the reading audience to get from this?**

Martha: As of the end of September, the PDI has contacted 376 girls. Some findings observed from the collected data were expected, while others were very unexpected. For social service agencies, it was likely not too much of a revelation that the very high proportion of drug abuse is likely as a consequence of high prevalence of mental health conditions in this subgroup. For law enforcement and universities, my impression is that they were generally surprised by this finding. So, I think it's going to be a very interesting dynamic that happens as multi-disciplinary organizations continue to work together on this initiative. Our recent conference was a terrific event that provided many an opportunity for information sharing. We all gained perspectives which ultimately led to thinking more "outside the box" toward innovative collaborations. This kind of collaboration is critical if we are to make huge strides in stopping the victimization of these individuals. It was very exciting to see that process at work in the conference.

## Interview with Ms. Renee Breazeale



*Ms. Renee Breazeale has 22 years experience in the mental health industry with a primary focus on working with chemically dependent individuals. She holds a B.S. in Social and Rehabilitation Services from the University of Southern Mississippi and has been a Licensed Chemical Dependency Counselor since 1991. She*

*is currently pursuing a Master's in Counseling with a focus on marriage and family therapy. Ms. Breazeale has been in non-profit management for 18 years and has extensive experience with clinical supervision, program design, policy development and implementation, team management, and accreditation readiness. She has developed volunteer-based support programs as well as quality assurance models to ensure clinical integrity. She is an accomplished speaker specializing in women's issues and trauma, women in the sex trade, adult substance abuse and mental health issues, and clinical strategies for working with co-morbidity. Ms. Breazeale is the recipient of the Liberty Bell Award from the Dallas Young Lawyers Association as well as the State of Texas Association of Young Lawyers of the Texas Bar Association for her work in the community. She is also the recipient of "Women who make a Difference" Community Award presented by My Second Chance Inc. for empowering women in the community (September 2009) and of the Prism Award presented by Mental Health America Dallas in recognition of efforts to address mental illness in the community (October 2009). She is currently employed by Homeward Bound, where she is the Program Director for the Women's Residential Substance Abuse Unit, the Intake/Admission unit, and Special Community Projects, including the Prostitution Diversion Initiative, known as New Life Opportunities.*

**What do you recall about the early days and conversations about the PDI (Prostitution Diversion Initiative) that the city of Dallas and the county of Dallas are doing right now?**

I think probably my earliest memory is the first meeting that I had with Sergeant Felini, Officer Peters, and Lieutenant Stratman, representing the Dallas Police Department. They came to Homeward Bound and they said that they were choosing to meet with us because of our prior experience and prior success in assisting women in exiting the lifestyle of prostitution. They wanted to have a conversation about what we could do collectively to help intervene on a very specified group of prostitutes, those that were working at the truck stops. And so, we sat down and we talked. I oversee the admissions department of Homeward Bound and so their request to me at

that time was to provide the mental health and substance abuse assessments on site. The thing that I always like to give Louis a hard time about is, he always opened it up with, "now I'm not interested in having a health fair out there..." That was just brilliant and kind of telling, because I, of course, was thinking health fair...so it was good that he said that. I thought it made just a lot of sense, because the vision was to take the services to where the people are. There's nothing that we do at Homeward Bound in the intake department that isn't mobile, that we can't pack up and take somewhere else. So, it just was a brilliant and exciting opportunity and it just overwhelmingly seemed like the right thing to do.

**When was this?**

This was in April of 2007.

**Were you kind of surprised that he approached you about this and that a police officer was leading this initiative?**

It was definitely different. Yes, I can't say that I would have ever anticipated a law enforcement individual approaching social services to ask for social services to work collaboratively with them. So yes, it was very different. I've been in the industry for 20 years, and in all that time, I can honestly say I've never, ever had that happen. I have had officers individually bring people to us, but never someone from the force come and say, "how can we collaborate?" And that's truly what he was saying, and I was totally surprised. It was quite an educational process too.

**How do you think the program has grown since that day, two and a half years ago?**

I think the most dramatic growth has been in terms of the volunteers and the agencies that have come forward expressing a desire, an interest, and a willingness to participate in the program. That has been the most wonderful gift, really, because I remember I made a call to 15 friends and colleagues in the community and said "okay, I talked with the police department and blah, blah, blah." We had our first meeting in May of '07 and there were probably 20 of us there. By July of '07, we had 75 people on our roster of volunteers. The word just flew out and people responded. I think that was the most remarkable, most affirming thing; that our community responded with such passion and with such complete willingness. It was just brilliant and unexpected. I just could not believe it. My email list, by the end of 2007, had 110 people on it.

**It sounds like you were building your village.**

It was with just a little bit of education and a little bit of information, because at this point we were still pretty naïve. We still had some things to figure out. But people came. They sat on subcommittees. They helped us devise the assessment form. They helped us devise the process. It was amazing how much time and energy people willingly volunteered to go out and help these men and women at the truck stops. And that has subsequently led to growth and now we're talking about things like a DNA database for post mortem identification. We're

talking about the IDs for New Life participants. We're talking about foundations funding transitional living. We're talking about more comprehensive, more sophisticated services in terms of clinical focus. And so, we have just grown by leaps and bounds and it's been very community driven. That response has forced us to the forefront. Now look where it has brought us, we've just had our first national conference, who would have imagined?

**Yes, can you talk a little bit about how the conference went?**

The conference was a fantastic opportunity for us to educate law enforcement and social service agencies across the nation about working with people in the sex trade. I think it is one of the last taboos and we don't talk about it in our society and our culture. Prostitution has been around for hundreds and hundreds of years but we really don't want to acknowledge it. I think the underlying issues, the trauma issues; the lack of socialization, the lack of opportunity, the lack of choice, there's so much to educate people about. And, so, the conference was a huge vehicle for us to bring that information to folks about the Prostitution Diversion Initiative, how we do it, why we do it, what works about it, and to talk about the profile of the individuals that we're encountering and attempting to lead into a different life. It was an amazing experience to have 200 people from all over the country here just to learn and to talk about the problem of prostitution and how we've been working to make a difference and offer a way out through treatment.

**Now you used the terminology "sex trade" instead of "sex workers". There's a lot of different terminology used in this field. Do you feel the term "sex trade" is a little more exact because a "sex worker" implies that somebody's punching their time clock and going into a regular job?**

I do. For me, it's a personal preference, because it is not a job that one chooses. No one is volunteering for this. No one is saying, "Gosh, I think I'm going to get up and be a sex worker when I'm eighteen or twelve." Human trafficking is part of this issue and these people are being forced into sex slavery. I think the other piece of it is that the term sex trade covers a lot more than just prostitution. We're talking about exotic dancing. We're talking about escort services; and fantasy operatives. We're talking about a whole spectrum of, I guess for lack of a better term, services, that people are forced into. And it is a trade because human spirit and beings are being traded for nominal compensation. Frequently, in the process of that, there is suffering, hardships, and brutality that are unspeakable at times.

**So the old pictures of prostitutes and their pimps, there's still a lot of that going on, as far as them being sent on demand, basically, to do the bidding of their boss.**

Absolutely, there is that dynamic, and I think the thing that is just so heart wrenching about this is the truck stop

prostitutes. Those are the ones that have gone through that full spectrum and are kind of at the bottom of the line.

**They're at the end of their career basically. They can't go any lower.**

That's absolutely, perfectly put. They don't have the pimps. They're older, the median age is 36.

**You might want to reiterate that 36 for a prostitute is like 50 or 60 for somebody else as far as the aging process.**

More like 90 in terms of the aging process, the physicality, the emotional toll it takes. And, remember too, that many of these women started in pre-teen to teen years. And so by the time they're 36, they've been in the business for 24, 25 years. That's not all that uncommon. That's a long time to be subjected to that kind of demeaning, oppressive circumstances.

**What was the audience for the conference besides law enforcement and the social service folks? Did it have a broader reach to people?**

Law enforcement was one arm of it and the judiciary was another part of it. The judges and the prosecutors, the district attorneys, were there to learn too. We had other members of the community and politicians as well. It's really such a difficult subject for people to approach and comprehend. I think that we saw that the community was able to be responsive, and the conference was truly a wonderful mechanism for educating all. We were able to educate them about the efforts that we're collectively doing about who this population really is.

**Now, you've mentioned judges. Are judges involved with this initiative and how have they responded to it?**

They are involved and they've responded beautifully. We have a misdemeanor judge who is running the prostitution court now, Judge Peggy Hoffman. We have a felony court judge, Judge Lana Myers, who is running a prostitution court on the felony side. We also have two community court judges who come out with us every month and they've been out there since the beginning. Judge Williams and Judge Lister-Brown help with the misdemeanors, seeing the quality of life issues, and they actually have their courtroom set up there on site. They do disposition for those issues right there. In addition, Judge Mays has been a wonderful advocate. Judge John Cruzot has also been an advocate. And, there are several other judges that have come on board in terms of assisting us such as Judge Susan Hawk and also Judge Kristen Wade. They've responded wonderfully because they have seen this population in their courts over and over again, and not known what to do. They'll quit using the drugs but they won't quit turning tricks. They won't quit exposing themselves to physical risk and physical harm. The judges have expressed to me that they're just grateful they now feel like they have the means to address some of those types of core issues.

**Well, this is exciting. I know some people might call these activist judges. But, it's kind of nice to see the judges go out and take off their robes, and roll up their sleeves and get**

involved in something that has been around for as long as this has been around.

Yes, absolutely, it is wonderful. Judge Hoffman doesn't have her courtroom out there yet, but at some point she hopes to do misdemeanor disposition there in the field as well. And even though her courtroom's not out there, she comes out every month, just to check and see what's happening, how things are going, and to lend support. I think that kind of mentality is absolutely fabulous! With that we can educate so many people. So, not only did the conference give us the ability to do that, but we had the opportunity to work with many of these people during the conference and to further build on these relationships and strengthen our collaboration for the common cause.

Can you talk about maybe what weaknesses that the PDI has, as it is right now? Also, do you have some long-term goals and ideas about how to conquer those weaknesses?

Sure. I think in terms of the PDI, we're still gathering outcome data and still evaluating processes. I think we are at a point where we can start talking about a "how to" process if we want to share this information with another city. We've learned enough the past couple of years that we can do some of that even though it's still an imperfect process. We still learn things every month. In my opinion, that's not really a weakness, but a place where we are still growing. So, the hope is to compile a "how to," or to define best practices. I think the other shortcoming we have now and an issue that we hope to address in years three and four is to determine evaluative measures for the clinical programming, for the transitional programming, for the mentoring programming, and for various facets of the project that we believe are making a difference. As of now, we don't have the data to support that. And some of the limitations or weaknesses are due to not enough funding and not enough manpower. If we had more manpower and more funding, we could do some of these evaluative processes. So, I think those are our most significant challenges.

So, of course, that's where grant money comes in.

Absolutely, we are always keeping our eyes and ears open. Dallas County Sheriff's department has stepped up and they are taking us under their wings as a 501(C) (3) and we're still in the beginning of board development. So, we're still in the process of developing that part of the project as well, which is very exciting. That brings a mechanism and a tool into play that we didn't have the last two and a half years, to grant money, to fund raise, to focus on the dollars that we need to fund not only the research and the outcome and evaluative studies, but also the services that these folks need.

What about housing? That usually comes up at any talk about someone who has chemical dependency or depression

issues, or both. There's not assisted living or any kind of housing to help them get started before they go out into the world by themselves.

Sure. We have built relationships with a couple of transitional housing providers that work with women only and are familiar with our population. So, that's been critical, I think, to success. These two houses, Grace Adam's My Second Chance and Tabitha Pinion's Vision House have been absolutely phenomenal in working with us, because there hasn't been funding much of the time. Then, we did get some funding from some foundations and so that funding is starting to come to a close, but we're also losing funding for our residential services as well. The city of Dallas has had a cut, and they cut substance abuse funding. That has limited our ability to extend our women's stay to 45 days. So there are still challenges for them. We absolutely recognize, acknowledge, and continue to look for ways to make sure that happens.

Can you describe Homeward Bound's role in the PDI, and how you all have been an integral part of making it tick?

The biggest thing we have brought to the table is not only our expertise in working with this population, but our longevity, and our history. We have a sophisticated infrastructure and we have been able to bring bed space, as well, to the initiative. We're also able to bring detox beds, crisis stabilization beds, as well as the residential beds. But, I really think our biggest gift to the process has been our longevity and expertise in having worked with this population in the past. I certainly don't mean that we haven't learned a lot, because we have. But, because, we have a reputation for working with some of the most challenging individuals in our city and county, that definitely has been vital to us being able to be effective in working with this population.

Can you walk through the process after one of the ladies or gentlemen agree to get help at one of the PDI events at the truck stops? Can you walk us through what happens once they say "Yes, I want to give this line of work up and I need help"?

Typically, if they're going to go to either Nexus or Homeward Bound, Sam Hilliard, represents Nexus Recovery Center out in the field every month and I represent Homeward Bound and so one of us will go and meet the individual. In my case, if it's a man, that's okay too. We'll go greet them and meet them and give them a little information about the facility to help lessen the anxiety and stress that is produced by making that kind of life changing decision.

It's a commitment.

It is a commitment and it's so far removed from where they've been living and what they've been doing, there's just a real fear factor about what to expect. So, Sam and I try to alleviate that. I also am fortunate to have several staff members who volunteer their time and come out with me. They will also take time to go over and meet and greet the individuals, and make them feel comfortable. They let them know that they'll

check with them the next day and things such as that.

**Build up some familiarity with them...**

Start a connection, build some rapport, help them feel safe and build trust. Building trust is such a monumental challenge with this population. From there we will get authorization from NorthSTAR Value Options. They have a representative on-site with us as well. We will contact our respective facilities and make sure the bed's held, and the individual is expected. Then the Dallas Police Department will do a courtesy transfer to our facilities and they are able to go that night. After the assessment is done, the individual is able to go to the Dallas County Health Department mobile screening unit. There, they can get STD screening and treatment as necessary. The court will then do disposition and will excuse any kind of legal issues provided the individual agrees to enter into services and complete those services. So let's say for example, we have an individual who has \$20,000 in fines with the city and the county because of quality of life issues - open containers, loitering, panhandling, those kinds of things...they've got \$20,000 in tickets. This individual, if they go to treatment and they successfully complete treatment, the judge will set aside all of that, so that when they leave, they have a clean slate. No more legal issues hanging over them! They have a place to go because we help them transition to safe housing and they will have a mentor. We want them to have a real opportunity, a real chance. So, the judge right there on-site says, "Okay, here's the deal. You do this, and this is what I'll do for you in exchange". They go to the facility, they're checked in that night. They get a warm bed, they get food. They get whatever they need when they get to the facility, clean clothes, a shower and we typically, at our place, let them sleep the first day so that they get rested. And, then we start programming with them immediately. So, it's a very instantaneous thing, truly, in the scheme of accessing services.

**Do you believe that between you and Nexus, there is enough capacity if this program really blossoms?**

No, I don't. Capacity is an issue we struggle with because there are times when I don't have many unoccupied beds to offer, and Nexus typically will set aside two beds for us, but that's usually all they have. Occasionally, they may have more but not often. And with us as well, capacity is a challenge. The Dallas Police Department will start shutting down the initiative when they know we've filled our capacity because they don't want to bring people in and give them false hope.

**The issue of "lost for good..." I'm assuming these are people with extreme trust issues and when you start building that trust, you can't let anything get in the way of it.**

Absolutely, if you say you're going to do something, you have to do it, period. There's no gray area. So, capacity is definitely a limiting piece. I think if we had more capacity, it

would be interesting to see how that would impact what we were able to do in the community.

**Do you believe that this program could be duplicated in a lot of other major cities in the country and, if you do, how do you think they would take it, having to copy a Dallas model? Would they feel like they have to start from scratch or would they feel like they can utilize something that's been shown successful?**

I think it can be replicated. I think it is a program that will have to take on the nuances and the personality of the community in which it is being implemented. I don't know that every community is going to have the same level of response and the same level of buy-in that our community has had. It has been an emerging force for me over and over the last couple of years, I've become so grateful and I feel so fortunate to be in such an active community that believes in taking care of their own. So, that's a mindset that we have here that I'm not sure other communities share. I think also, the willingness for the police department to acknowledge these people are victims may be different. I think that's huge. Again, I'm not sure what other law enforcement agencies would say at the outset.

**Because it's basically the police saying, "We'll let you decriminalize this. If you give them help, we're not going to pursue them as criminals. We are actually trying to help them as people in need."**

I think that's a huge mindset shift. Now, interestingly we have police departments, I say we, the PDI, Dallas Police Department, has had other law enforcement agencies express interest in it. So we know that there is dialogue happening, which is exciting. If there's interest in changing that mindset, then yes, this program can be replicated. Again, in a manner that suits the community. And the same processes may or may not apply, but there's got to be buy-in from the community. That's the biggest piece. We could put an A to B to Z kind of map together for anybody, but there's got to be that buy-in from the community and it seems that some communities are really ready to do that.

**Do you also think these communities need a champion to lead the cause, to toot the horn?**

Absolutely, there has got to be a Louis Felini, and an Officer Peters somewhere in that process. One of the things about Sergeant Felini is that he genuinely cares about what's happening to these people. He is compassionate. He understands the victimization and he gives credence and validity to it. There's got to be a Sergeant Felini. There's also got to be an Officer Peters who strives in the beat every day, of every month, of every year, collecting information on these people because he cares about what happens to them. There's got to be somebody like that. And Sergeant Felini has been able to take it to the executive level and get buy-in there. That takes a special person, I think. So, we have a real gift and one of the most amazing pieces of all of this is that we speak such different languages, law enforcement and social services, just totally

different languages. But out of all of it, and through it all, there's not been any territorialism. There's been respect for each other's expertise. There's been respect for what everybody brings to the table and there's just genuinely been a very non-ego driven collaboration. Everybody has come to the table and said, "What do we need to do to make it work." We've never had disagreements; we've never had power struggles. We've never had any of that. That's pretty amazing. We've had up to 60 people in a meeting! I attribute that largely to Sergeant Felini's leadership, his vision, and his clarity in what we were going to be doing. That clarity of mission, I think, is critical.

**Did that surprise you coming from the police?**

It did, it truly did. But once I was able to spend some time with Peters and Felini, I understood better about their personal drive and that made sense then. But it's been neat to watch the culture change among the officers who've worked with us month-to-month too. And, not only change on the police side, but also a change on the social service side. I think the social service agencies have a newfound respect for the precarious position that the police get put into and why some of this has to be criminalized. It's actually sometimes a gift. You know, them putting some of these folks in jail keeps them alive. So where social services maybe didn't always have that perspective, I think there's been a much more balanced perception of one another's strengths and weaknesses in terms of law enforcement and social services. And, again, I think that benefits the community.

**Is there anything you want to add that we haven't covered yet?**

No, I think we covered most of the critical elements. Dr. Joel Feiner, who I am a huge fan of, is just a genuinely brilliant physician, in my opinion. He said one day to me "this is the purest community based psychiatric model I've ever seen implemented." I've never be so complimented or so validated in my career. That validated so much for me personally and professionally, that what we were doing was the right thing. The conference was a brilliant opportunity to expose people to new information, for people to seek new information and I think it was a magnificent learning experience. I can't wait for the conference next year!

with the "community mindset" that you have shown and encouraged in the department during your time as Chief of Police in the city of Dallas. Your influence has been felt throughout the seven-county NorthSTAR region as other municipalities have decided to initiate the 40-Hour Crisis Intervention Training model. Both the New Life Opportunities Initiative and the Crisis Intervention Training program have been embraced by the mental health advocacy groups, as well as the officers who participate in them. We feel very fortunate to have had you in that important position over the last several years.

We at Green Oaks appreciate the importance of "community". It seems as though the worst of times often brings out the very best in some people. It's inspiring watching people respond to the victims of the Haitian earthquake with such generosity and compassion. This last year has imposed many hardships on the people even in our very own community and we at Green Oaks have felt the need to reach out and do our part to help some of those in need. Our staff was pleased to be able to "adopt a child" for the holidays through the Salvation Army Angel Program and to participate in feeding the homeless for an entire day at The Bridge. Many of them shared that getting to participate in that kind of giving for the holidays was more rewarding than the most festive of holiday events! We at Green Oaks hope that you also had a rewarding year and holiday season.

As always, I hope that you find this volume of the Journal both timely and relevant. I welcome your thoughts, opinions, and feedback. Please feel free write to me here at Green Oaks or email the publishers/editors of this Journal at [www.Sherry.Cusumano@HCAHealthcare.com](mailto:www.Sherry.Cusumano@HCAHealthcare.com) or [www.John.Dornheim@HCAHealthcare.com](mailto:www.John.Dornheim@HCAHealthcare.com).with any feedback you may have. I hope to hear from you soon.

Thomas M. Collins,  
President, Chairman, and CEO  
Green Oaks Hospital

*of mental illnesses as well. Some of her expertise stems from the fact that she completed a Master of Science in Social Work from the University of Texas at Arlington in May, 1991. Her special concern in this area has been recognized by the National Alliance on Mental Illness here in the Dallas area where she was named the Honorary Chair of the 2007 Dallas area NAMI Walks event. NAMI Dallas will be applauding her efforts again in February of 2010, as they name her as the first Honorary Chair of Community Partnerships for NAMI Dallas.*

*We would be remiss to not mention the fact that she has been married for 42 years to Roland Dickey, of Dickey's Barbecue fame and that they have two grown sons. Maurine, Roland, and their sons are graduates of Southern Methodist University, where she and Roland met.*

*You've been a public servant for more than twenty years... Thirty...*

*Ok, more than thirty years. You're much too young to have been in public service for more than thirty years. Why did you decide to enter the arena of politics after so many years of serving on boards and not having to mix in with that, or join the fray?*

Well, it was just the next step. It seems like I had been training all my life to do what I'm doing now and everything I've done has contributed to it because over the years I have learned how to work in groups with my Junior League experience. I learned how to build coalitions, how to build consensus, how to run boards and how to work on boards. I also learned how to be a servant leader in that way. The different systems I've worked with have also taught me a great deal that has been useful to me as a County Commissioner. I've worked with the juvenile system, the criminal justice system, the child protective service system and, of course, in the healthcare system. I've been very actively involved on boards and volunteer work in all of those systems. So I've learned a number of different systems. Plus, I worked in county government and so have been on many of their boards and commissions, and chaired a number of their boards and commissions, so I learned how the county system worked. All of that has been helpful.

*When you first came into office, did you find any surprises that were unexpected as about being an elected official, compared to being on a board?*

Yes, I find boards that I had served on to be much more ordered and much more organized. People seemed to know what their jobs were, whereas the job of a county commissioner is very non-specific. How they handle it is certainly different with each commissioner. So, it was not done in the organized fashion I had always enjoyed on the various organizations that I had been involved with. On the other hand, knowing all the policies and the culture was something I had to learn. Even

though I knew the structure of the county, being an actual policy maker in the county, and knowing the history that went into those policies, it is something that just takes time. And all the bureaucratic processes that have to be followed, because I came from a family that is in private business. We're in the restaurant business. I was always just of the opinion, you were making a profit and you did what made a profit. Well, you have civil service and if people don't perform you have to go through a huge dance to be able to eliminate them from the county, to terminate them. You can't just terminate them for non-performance or whatever else the problem might be. You have to go through many, many hoops. And so, it was frustrating for me sometimes, because I was used to getting quick action in our business and being able to move quickly and I found nothing moves quickly in the government.

*No matter how much you will it.*

That's right.

*So, it sounds like one of the things you had to learn was to how to let go and not be able to be as driven as you were on the boards because you have road blocks you had no control over.*

Well, I had to learn patience. I won't say that I'm not just as driven, and I still am not patient. I just know that I can't drive as fast, but I still push as hard. But, I've learned there are a lot more hoops to jump through than there are in private business and a lot of those hoops seem unnecessary to me. Again, I just have to learn patience. You see, truly, I'm impatient and I don't suffer a lot these roadblocks easily. Whenever I see a chance to eliminate one, by golly, I do it!

*What do you look at as the major accomplishment so far in your career? I'm saying so far, because you have a long way to go.*

Well, in my career and in my life, it would be my family. I have two successful sons who are grown and they're happily married and happy in what they do. So, I feel like I've been a success as a parent. And then, I've been married 42 years, and so success is in my private life. But as far as my career, I would say that being able to help people in whatever area I was in, has been most meaningful. I don't really care whether what I do is more prestigious than what I did some years ago. The fact is that I did a lot of things that made a difference. I know one of things is, back in 1990, we started Dallas Community Partners. We started the Rainbow Room here in Dallas. The Rainbow Room provided clothes and things that were needed for foster children. There was nothing like that for case workers to get and then we extended that Rainbow Room all over the state. Then, we started Dallas Community Partners, which is a multiplicity of programs and has a board to help children aside from the child welfare board. It does resource type activities for the foster children and children in CPS. It does Adopt-A-Caseworker and all kinds of programs to help the agency and help the children. That's something that now has 110 offices all over the state of Texas.

*That's a huge accomplishment.*

Yes, and I was one of the first board members at the

Advocacy Center. I've seen that grow, thanks to so many people that have helped with it. I guess I've lived long enough to be on the ground floor of so many things because so many wonderful people have just burgeoned and mushroomed into special things. I think one of the things I was always proud of was something I started when I first got married 42 years ago. I was a case worker for the Department of Public Welfare in old age assistance, and the reason I did it was the most selfish of reasons. I couldn't stand sitting in an office and I had this friend that told me that if I would work in the welfare department field, I could go home early. That really appealed to me because the thought of being tied up in an office was horrible. So, I got the job thinking, "Aha, now I'll have some freedom." Well, by golly, it was addictive. I found I loved the work. I started as a Case Worker and 35 years later, I became the chairman of that agency. A lot of people that started as a Case Worker when I did were still working in the agency at that time and they'd been there 30 years. So, I was proud that I was the only social worker who was ever appointed to that agency and became chairman of the agency. I used to love to give the speech at the graduating class for case workers of CPS and tell them that I was a graduate of this program too, so many years ago, and I'm now chairman of the board. I felt that I had a special feel for those case workers and what they went through and I could see it from the other side. Usually, governors appoint just business people who don't have a real feel for the work. I was also proud when I graduated, got my graduate degree in Social Work, and my MSW. I was valedictorian of my class, and probably the oldest person in my class. And I got a 4.0 average. I didn't know how to use a computer at that time, so everyone else used a computer, and I did everything on yellow pads. But, it was important to me because I had been a Junior League volunteer and, you know, "the lady in the silk blouse," and I wanted people to realize I was seriously committed and not just some socialite dilettante that was working. I really wanted credentials and I wanted to know the technical aspect of social work. Then, I made an interesting discovery. I went in thinking I'd like to be a therapist. Back in the late '80s, a social worker either became a therapist or ran a social work agency. I didn't know this, but I discovered I really hated doing therapy. It took me going to graduate school to find that out. I was interested in the broad philosophical aspects of it, but I was not interested in dealing one-on-one, but it hit me what I was really interested in was social policy. That seemed to be not in the realm of social work at that time. Yet what is more important than family policy as far as governance goes? What is more important than effective family policy in juvenile and criminal justice and healthcare? Family social policy is very important and I think sociology is very important in understanding the dynamics of the family. I wondered and I called people trying to find a way to apply this,

and they said, "Well now, are you a therapist?" "No, I'm interested in social policy". Well, they just couldn't figure it out. They just didn't have a script for anybody like that. I really was perplexed because I couldn't understand what I was going to do with it. For three or four years, I worked for the court system and for different attorneys and I did social studies, court testimony and examination of families.

When Bush became governor, he appointed me to be Chairman of Child Protective Services. It was TDPRS, which was child protective, adult protective. We licensed all the child care facilities in Texas. So, I had suddenly had found my calling. I found exactly what it was that I was meant to do. And then, when that term was ending, it was a six-year term and I think there was six and a half years, before they found a replacement for me. But I got on the board of Parkland Hospital. Then, I became very knowledgeable about healthcare and eventually became chairman of that board. I got so mad at the Commissioners because they didn't seem to understand Parkland. So, when my predecessor decided to retire, I decided to run for office. I did and I won, and I've just always felt like I had such a valuable background because I'm the only Commissioner that's ever been on the Board of Parkland. It's nice to be able to see both sides. I used to just be really mad at the Commissioners sometimes, now I see that side too.

**What are your goals for healthcare in the future for the county?**

The ultimate goal that I would like to see in this county is that we see a consolidated hospital district of the contiguous counties. I've worked for that ever since I've been Commissioner, because we get a lot of push back on that. These other counties just feel like if they get the milk for free, why buy the cow? They just don't want to do their fair share. I thought that John Dragovich, the new CFO of Parkland, really had done something good. He is getting matching money for UPL that would go to the various counties so they would have a subsidy that would help pay for Parkland care. That would help pay for indigent care in their county, but if they have to come to Parkland, there might be some form of payment. I think that's the first step. It's like the camel getting its nose under the tent. If we slowly can find a way to provide services and to do it in such a way that the other counties see it's to their advantage to work with us then we'll have met the challenge. I have always felt like the 1965 indigent care law that says that each county is supposed to dedicate 8% of their budget to indigent healthcare was ineffective. None of them do. They use it for building roads and other things. If they would just dedicate, allot, or set aside 2%, or even 1% of that money, and then we could put it in a pool, then we could use it to match federal funds. We could use it to match CHIP, we could use it to match other federal funding systems. If the counties would do that, it would help them in many ways solve their problems. So, we've got to educate them to show them it is to their advantage to do something planful, something besides trying to escape their responsibility.

The other day I was trying to explain about healthcare reform to somebody who was against it. They said, "These people don't need to get services and everything." I replied that, "It's not that they're not getting services. They're going to Parkland and it is costing Parkland the money. If there's insurance for them, then at least it's going to be paid for." Parkland's not going to have to absorb everybody. These people are going to the ER, instead of going to a clinic. And that's where the cost is. What people don't realize is how much more expensive the ER visit is than if there was a community clinic.

Well, somehow, it seems like it's nicer, more politically correct, if we do this happenstance. Let them go to the ER if they have to, but let's don't be planful about it because then you're getting into government assistance or something. Let's do it in a planful way. Let's look at a way where everybody wins. I have people that call me complaining about healthcare and I say "Okay, do you want people lying dead in the streets? Do you want babies born in parking lots? Is that what you want?" "Well, no, but I don't want to pay for them." Well, there you go.

I like what you're saying. The uninsured person shows up in the ERs when they have a health problem. Of course, you have EMTALA, so, just as the law directs, you stabilize them regardless of their ability to pay. Right now, we're already paying for it in the most expensive level of care there is. Another consequence of our current system is that people who can't afford care wait until things are so severe that they can't ignore their health problem anymore, and then they show up in the ER for care. By that time it has gotten much more severe and the cost of treating them becomes much higher due to the severity of the problem. There's no preventive medicine for this population, so they're having a gall- bladder operation when there could have been some preventive measures applied.

That's right. I agree. Well, we've got to have planful, thoughtful healthcare in this country. And I don't think it's all one thing. We can have coalitions of healthcare providers where we can get companies to join together, and we can enjoy the economies of scale to provide basic services and catastrophic care for them. This office, when I became a Commissioner, started a three-share system for the working poor, so that people who work and don't have the money for healthcare are able buy into a pool where they pay a third. We found they could only afford to pay about \$60.00 a month. Their employer pays a third and then we have been working with the safety net hospitals to get them to dedicate some of their UPL dollars to being that other third. In states like Michigan, it's a foundation that pays that third. In that way, these people have the basic services. They have a medical home. They have catastrophic care. They don't have the whole array of services, and certainly, no whistles and bells, but these people have their own medical home and they can get all the preventive things

that keep them from going to the emergency room. Also, our state could match CHIP. We could give a better array of services for CHIP. We could get realistic and realize that these people shouldn't have to re-up every six months. That's a barrier to services considering that 25% of the population, which includes some children in our state, are not insured for any healthcare. I don't think we really have to worry about the ones that are getting it and don't need it. Maybe there's a "t" that's not crossed or an "i" not dotted that says that they might not quite be eligible. But who would get Medicaid or CHIP if they could afford better? I had someone tell me yesterday that people who have Medicaid aren't indigent. What planet are they living on? If you had the resources to get healthcare insurance, wouldn't you rather have any other kind of healthcare coverage than Medicaid? What bothers me right now about the healthcare debate is, we have are a lot of naysayers out there saying "no", but we don't have people offering up solutions. I wish that Obama had offered his own healthcare plan and then let people adjust it and look at the various components of it. I think it would have been better than having the House. Nancy Pelosi probably doesn't really know anything about healthcare. But they're all trying to piece together some sort of product and I wish the President had thoughtfully gotten a healthcare group to present to Congress.

Unfortunately, I believe that he probably wanted to, but because of the economy, it wasn't the right time for him to dedicate that time. I know he thought they had to go together, because they would impact each other, and he had to concentrate on the economy and have his people do a lot of that. It's too bad, but the timing was wrong.

I agree. I think he could have appointed a task force of experts, such as Dr. Anderson. I wouldn't expect Obama to know that much about healthcare, but he had the bully pulpit to appoint the right people to put something together in a short period of time. Because all of these experts have been thinking about it for years, but I think it's unfortunate that we leave it to the in-expertise of Congress and people who are only thinking about their next election.

And, unfortunately, the radio commentators who have stirred people up and given false misinformation or exaggerated it so that people hate any program now. It doesn't matter what it is.

They take the most extreme positions of the most extreme liberals, like all of the talk about euthanasia and "death panels".

Yes, like, end of life counseling which is an option, and is actually a great option, for people who don't know what to do at that point. It's nice that they can get that.

I had a congressman speaking to a group I belong to the other day. He was saying that, after 2013, you won't be able to get any private healthcare. It'll all be government. It was all scare tactics. I finally raised my hand and said, "Excuse me, but, has this bill ever gotten out of the House? Has this bill ever been written?" "Well, no, three versions have just come into the house," none of which had been voted on, and nothing has come out of the Senate, but all we're getting is "scare."

I was at a luncheon the other day, and a well-known civic leader was sitting next to me and he announced to the whole room, “Well, so now Obama's going to kill everybody's parents with his healthcare. They're going to euthanize everybody. They're just going to take everybody out and shoot them.” People keep on hearing all of this stuff and repeating it. It's scary.

I do not agree with the present health care platforms that have come out of the House and Senate. They do not understand the burden this legislation would put on the backs of small businesses. Small businesses make up the majority of the business in our economy. Most small businesses operate on very thin margins. Congress must find other avenues to ameliorate this burden on small business people. In addition, Congress should be more transparent about this process, as they promised they would be.

You have been called by a lot of people, the Sandra Day O'Connor of the Commissioner's Court because you are seen by many as being very thoughtful and unbiased in how you approach things than other members of the Court when looking and deciding on the issues themselves, and maybe not so much on what's politically correct with your party. How do you make that work?

I make it work because I'm only here to do the best job I can. I'm not looking for higher office. I'm not looking behind my shoulder to see if people are going to like me for something. I have basic principles that I believe in and every time I have to make a vote, I look at how that lines up with my basic principles. Principles of government, principles of ethics and oddly enough, it's never been hard for me to make a decision. For instance, one of the most controversial things that I was criticized for was the condom issue. Well, for me that's a no-brainer. If you want to put it in the crassest of terms, you can say that it costs too much for the taxpayer to support more people with AIDS. That's the right thing to do. But, it really hasn't been hard. I have another life and I have a very quiet spiritual background and strength. So, this stuff, it rolls off my back.

It's actually nice to hear someone in higher office not politicize the office and do what's right for the people and not worry about what's right for the party or how people will view you.

Now, we know jails are not the solution for people with mental illness. How do you believe we need to handle this? What do we need to do about the cost of jails and the kinds of problems we've had with the jails? We've had a problem with overpopulation and with understaffing them so that we didn't have enough guards to meet the standards. You know there's a huge population of people with mental illness in there. How do we make this situation work?

One of the things I think we should do is that we should have a separate mental health facility for people that go into the jail as our “frequent flyers” that we know have mental health

conditions. We need to be able to treat them. My dream is that, one of these days we'll have programs to treat these people, just like we're helping particular populations now, like the New Life Opportunities women, and as we've been doing with people with the Way Back House. What we really need to do is have a dedicated facility that has both the medicine that can treat people with illnesses and can also give people mental health treatment. It needs to be in Dallas, the city, not in Terrell, Texas. It needs to be where families can visit and help in the healing process. That's my dream.

That's a great dream. The horrible thing about getting treatment is that supportive housing is missing. When somebody comes out of the jail or out of the hospital, a lot of times that's what they need. They need to live in a boarding house that's safe, that helps them remember to take their meds, helps them eat right and helps them get training so they can find work and get on their own again. The absence of those components let's people down to get back in the system over and over again.

I think that's true. I've seen some good group homes. But I think we have to put felons and misdemeanors separately. Take, for example, if someone committed a misdemeanor but they would still be put in jail. There needs to be a place where they can get some treatment. They shouldn't be just sitting in jail. We ought to utilize that time as an opportunity to help the person. And then, of course, though we'll never have enough money for this, but we have to have aftercare. We have to have follow-up for these people.

They get out and they get lost in the system until another crime is committed.

If we can't afford case managers, we need mentors and people who volunteer their time. I've been surprised at all the people who want to volunteer their time to mentor. It's been interesting. It's as if people don't have enough information and just don't know about it. Then, after they know about it, they just think, “Gee, I want to participate.” There may not be such a dearth of willing people; it just may be that we're not marketing it very well.

That's a good idea. Your involvement has been very important in the PDI - Prostitution Diversion Initiative with Sergeant Felini and the Dallas Police Department, and the Sheriff's Department. They've all worked really well together. Can you talk about the program and the conference that you helped with in November?

Well, I've just been a kind of glue, to bring different resource groups together and form the 501(C) 3. I'm so fortunate to be a Commissioner, so I've had the bully pulpit to be able to do this. I was able to get the conference facility for free instead of \$2500 a day, and I'm just so fortunate to be in a position to help with worthwhile things like that. The conference was a huge opportunity to let people know what we do, to market what we do, and to extend this to other cities, to let people in Dallas know that this volunteer opportunity is here. It allowed us to let

people know about what we're doing. It was a tremendous opportunity that we had. And, that initiative will also be a good basis for growth and applying for grants. We have just got to figure out how much we're going to pay someone. Then, we've got to get a grant to get a full-time person there in that office. Because, as people start calling and inquiring about us, we need the materials to send them and we need to have a real live voice on the phone. If people call that are in need, then we're going to have to develop a capacity for that too. There are just so many things to be worked out. The conference drew people from all over the country as well as in Dallas and the information we were able to share was so well received!

**First, what pieces of the PDI do we have on solid ground? And then, part two, what pieces do we need to kind of put together to make our program as good as we can get it?**

The solid ground is our task force, which meets the First Wednesday of every month, that's on solid ground. Our resource book is on solid ground. I think we've got the 501 (C) (3). We don't have our own, but it has worked very well with the Sheriff's office. I think the other thing we have on solid ground is lots of public acceptance as well as acceptance by the police, the sheriff, and the county. I think that's the solid ground. And those are the foundation for everything else we'll do. But each one of those has to be grown. As time goes by we'll have to meet in multiple places. As time goes by, we can't just do it one Wednesday night a month. We're going to have to be available 24/7. And as time goes by, we're going to have to deal with children. We're going to have to have a relationship with the CPS system, with CASA, and representing those children that are born in the system. We're going to have to deal with pregnant women and provide for counseling over what to do about their pregnancy and what we're going to do when that baby is born. If they choose to keep the baby, then we're going to have to be able to help them with resources. So, we've got that avenue to go into. Then we've got to go into helping them get jobs and I believe that's going to be a very hard nut to crack. Skill training and housing are not anywhere near what we need for them to be to say nothing of mental health training. And of course, aftercare is always going to be the big looming need that we have in order to follow these very fragile individuals.

**I like the way you approach issues. You're very creative about the way you look at things. You don't look at something and say, "It's never been done like that before, so I guess we'll have to move on to the next agenda item." You really do have this way of looking at the big picture, and saying "Why can't we just pull some of this here?" "Why don't we let people know more about this situation and accomplish these goals or resolve these problems in this kind of a creative way?" I watched you do that with the prostitution diversion initiative and I hear that from you as you talk about healthcare and healthcare reform.**

**It's very interesting the way that you look at all the options and think of ways that we could pull together different components to make good things happen here.**

Well, there are no limitations. There's no limit to what we can do. I just look at things as a humanist. We are people who are in a position to do something about the inhumane conditions that these people are living with and we have within ourselves the power to do just that.

**You see there's the social worker in you!**

One good thing that I have is that I see things in swaths and how they should be. But I also have a lot of organizational building skill and vision to see "how do we march forward in the process?" I'm also a bit of a realist. We haven't been in business more than 68 years without being pretty realistic. Restaurants are a hard business to make it in, as you know. A lot of them go out of business. We're now into the third generation with this business. When I go into restaurants, all of these people know me and they know Dickey's, and they'll come over and talk to me. I get to talk to the owners and it's a lot of fun for me. It's kind of a fraternity, because we all suffer the same things.

**You mentioned earlier that you don't have any future political goals?**

Well, I have goals. I don't have any goals to go past commissioner though. I'm not ambitious to rise ahead in politics. I'm very ambitious as far as expanding my office as a County Commissioner to do things that aren't just so orthodox and to break out of the box. I think there's an unlimited amount of things that county government can do. I firmly believe that county government is an extremely important form of government, but somewhat antiquated. It's probably the last form of local government to get into the 21st century. And, I think the possibilities are just unlimited as to what we could do, and, a County Commissioner has so much more power than, say, a State Legislator does. A State Legislator may have 60 or 70,000 people in their district. A City Council person may have that or less. I've probably got 600,000 people in my district and the ability to act. There are only five of us, so you don't have to get 14 votes. It's easier to get things done. We have a district, a bigger budget and we have much more latitude with what we can do. So, if we can channel that power and use it for the good of the community, then we can be very effective at this level. I would not trade this position for anything else. And also, I don't want to have to spend my energy running for office every two years, because that takes a lot of energy away that you can't give back to your work. I do think that being a Senator could be a really good job because they can really be contemplative. You're really working for the whole state. You're not just working for your district, and you can really vote for what you think is best for people without having to worry all of the time about whether or not they'll vote for you because you're not having to run for office as often. And I guess your issues are more complex and you have

## Dickey *continued from page 14*

different areas that are more at odds with each other, yet on the other hand you're kind of an at-large person for the state. That's a better position, but I think that as far as on a state basis and lower, I just think I've got the best job in the world. But also you can have a big picture job, because whether it's transportation or community service, it's all a big picture whereas, if I were a city council person, for whatever city, I would constantly be hearing about potholes and things such as that. Well, I don't want to think about potholes. That's not where I'm at.

**Or the broken water main on Elm Street, or whatever. Is there anything that you want to add, that you want to let everyone know about you or your goals for the county?**

My hope is that people can look beyond party affiliations and just work together as people and I would want people to know that I will work with anybody, wherever they come from. I'm sorry in some ways that we have to be partisan, because sometimes it builds walls instead of bridges. So, I would just hope that as people get to know me, they realize that I'm a person that's going to build bridges and will meet people wherever they come from, wherever they are.

**It's one of those labeling things. You label somebody then you don't look past that. If you label someone a Republican or Democrat, Liberal or Conservative, then many people think "I can't work with that person because they're not ideologically where I am, so I don't want to deal with them."**

Well, you're telling me that I'm seen as a Sandra Day O'Connor of the court is an example. People probably say that because what they're really thinking is, "gee, she's a Republican and she still cares about social work. It's amazing she can be that way and be a Republican." Again, I hope that we can get beyond the labels and work together as people for the benefit of all of Dallas County.

## A New Look for Day Hospital

The Green Oaks Adult Day Hospital has a new and updated look. Completed this Spring, building improvements include wood laminate flooring, new artwork, a fresh coat of paint and comfortable high back chairs.

"We wanted to create a more home-like environment that puts patients at ease," says Mike Ashworth, Ph.D., Executive Director of Outpatient Services. "Our program is unique in that although we are on the main campus, we have our own building, separate from the inpatient units. The Day Hospital building updates are part of Green Oaks' commitment to provide specialized services to meet our patients' needs."

"We have the ability to treat chemical dependency and mental health patients separately in our program," says Tony Liles, Program Manager for Day Hospital. Liles spoke more

about the benefits of Day Hospital. "Our patients see their doctor every day, which is critical when changes are made to their medications. But they also go home at night, which is an important step toward reclaiming their autonomy and facilitating their recovery."

Patients often believe they are alone - that no one else has ever experienced such intense feelings, complex circumstances or volatile relationships. Participation in Process and Skills Groups is a key aspect of learning they are not alone. In these groups, patients learn practical tools to help them cope with their illness. In the Family Program, those who are closest to the patient are educated on mental illness, learn ways to be supportive during treatment and receive additional resources. Daily Medication Management with a staff psychiatrist allows for timely medication adjustments to maximize treatment progress. Patients discuss and prepare for discharge planning, step-down treatment and aftercare with an experienced Individual Case Manager.

Recent patient comments from satisfaction surveys reflect a positive experience. A few examples include:

"It was a very relaxing atmosphere, but allowed for personal and group growth."

"Staff was very caring, friendly and knowledgeable."

"Thanks for giving me my life back."



The Day Hospital program hours are Monday through Friday from 9 a.m. to 3 p.m. with Saturdays available to help patients with unusual schedules. For more information, please call 972-770-0818.

### Additional Outpatient Treatment Options

Green Oaks also offers chemical dependency (CD) and other intensive outpatient programs (IOP) for adults and adolescents in three locations - Dallas, Plano and Las Colinas. We have morning and evening treatment programs that are covered by most private insurance plans. For more information, please call 972-770-0818.

#### Plano

Adult CD IOP  
Adolescent CD IOP  
WorkReturns IOP

#### Las Colinas

WorkReturns IOP

#### Dallas

Day Hospital  
Adult CD IOP

## Interview with Dr. Sharma

by Joel A. Holiner, M.D. Executive Medical Director of Green Oaks Hospital



*Aditya Sharma, M.D. is a psychiatrist with the Holiner Psychiatric Group and Green Oaks Hospital. He did his residency in adult psychiatry and fellowship in adolescent psychiatry at the University of Virginia in Charlottesville. Dr. Sharma received his medical degree from K.G. College in Lucknow, India in 1996, and is*

*board certified in general psychiatry and child and adolescent psychiatry.*

**Dr. Holiner: When did you decide you wanted to be a psychiatrist?**

Dr. Sharma: Honestly, I don't know when the magic "aha moment" occurred. I did not have a personal story or a catastrophic event in my life that would draw me to psychiatry. I studied extremely hard to get a seat in medical school and then labored on. I guess it is during the clinical rotations when you get a feel of what it's like to practice medicine. I could hardly believe that the attending physicians in psychiatry were 'friendly' with the residents and would treat us medical students like human beings unlike physicians in other specialties. They were able to transcend their assumed status and relate to others in a very down to earth manner. The narcissism in medicine or the lack thereof in psychiatry impressed me immensely. As I went through various rotations and started to deal with my own "quality of life" and "personality" issues, it became clear to me that psychiatry was the right specialty for me. For some reason, the big boss of the human body-the brain- is ignored while even the ear lobe gets more attention! We pay more attention to how our hair looks than how our brain feels. I liked the idea that there is more to disease than just a structural defect or damage. When it comes to psychiatry I strongly believe that it is the field that chooses you rather than the other way around. It happened to me and I am sure it happens to others.

**Dr. Holiner: Tell us about your training. What does it take to be a child psychiatrist?**

Dr. Sharma: I started off with my training in India, where I completed a psychiatry residency after medical school. At that time in India you did not have an option to get specialty training in child psychiatry. Some of my friends, however, came to the US for residency training. I stayed in touch with them and learned about the training opportunities here. I definitely became interested, so I took the USMLE and applied to residencies in the U.S. I was accepted at the University of Virginia, where I again completed my adult psychiatry training. I was then fortunate enough to be offered the two-year fellowship in child and adolescent psychiatry at UVA.

I honestly think that the most important thing to being a child psychiatrist is to have a deep affection, love, and care for kids. One has to constantly keep in mind that you are grooming the next generation and the bigger picture of what you are really doing is shaping the future of mankind, one child at a time. There is not much room for error, and you have to try to do what's best. You have to keep yourself abreast with the latest research and development and use your knowledge to best serve struggling kids and their families. Child psychiatry is a rapidly evolving field. I am glad that we have broken away from the age old treatment norm that kids are just miniature adults. Not only do you need to know what treatments are available, effective, proven and safe, but also in this day and age of the internet you need to be aware of all the traps that are laid out for parents offering unsubstantiated, and often times dangerous, treatments.

**Dr. Holiner: How does being a child psychiatrist affect your parenting?**

Dr. Sharma: Most people think that being a psychiatrist leads you to be constantly "analyzing" your family members and kids, but honestly that does not happen. On the other hand, being a parent definitely makes you more attuned to a child's world. It's like seeing the world with a different set of eyes, feeling love more deeply, and having a bigger purpose and truer sense of compassion. There is no rigidly agreed upon definition of "a normal child" and I believe that normalcy lies within a bell-shaped curve. Having kids of your own underlines that fact even further. One thing that does happen though is that you do learn some things about what to do with your kids. Even more importantly, you learn things about what not to do! Kids that I meet through my work continue to teach me on a daily basis. Being a parent affects my practice of child psychiatry much more significantly than being a child psychiatrist affects my parenting. Every time I see a child in the office, I ask myself, "What would I do if this was my child?" This keeps me honest and sincere, encouraging me to do the best I can.

**Dr. Holiner: Do you ever get depressed dealing with kids that have problems on a daily basis?**

Dr. Sharma: More than getting depressed, I feel occasional sadness that can sometimes creep in. This is especially true when you know that a particular child's problems are more deep-seated than meets the eye. Knowing that these problems are likely to be quite resistant to interventions, and that the parents/guardians have high hopes from you for a miracle cure is hard. I am open and honest with the parents in those kinds of situations. I communicate to them very realistic expectations, but it is very difficult for many of these parents to understand. Often, a parent in crisis is more likely to hear only the positives and to tune out the negatives. If you look at the entire medical science, we do not have cures except for maybe infections. We offer treatments which can alter the outcomes to a certain degree but we can't make disease conditions go away. We have a similar problem in psychiatry, with expectations that we will

somehow “fix it” for good. On several occasions when I get home at the end of the day there is a pit in the stomach feeling. Early on I used to get quite disturbed by it and felt hopeless, but over time I have learned to appreciate that feeling, as it eggs me on to work harder and strive for even better outcomes.

**Dr. Holiner: What is your favorite kind of kid to treat?**

Dr. Sharma: The nice ones! Every child's problems are unique and pose a different challenge. Often times I see a kid with what seems like a simple problem, only to find down the line that things are more complicated than I first thought. Likewise, my first impression of a child may be that he or she has quite serious problems and will need quite intensive treatment, only to be pleasantly surprised by the remarkable response to the first treatment offered. The bottom line is that I am in this line of work because I love kids. Nothing brings more joy to me than seeing kids tap their enormous potential and make the most of it. Knowing that you have made a difference in a child's life is the biggest job satisfaction that I could ask for.

**Dr. Holiner: What new treatments do you see on the horizon?**

Dr. Sharma: You know, child psychiatry has come a long way from its earlier days. We have seen the era when moms were blamed for their child's autism leading to a spate of suicides across the country—the term ‘refrigerator moms’ is a blotch on child psychiatry. We now know the biological basis of many conditions. We are beginning to appreciate childhood mood problems. As I said earlier, we are beginning to realize that kids are not miniature adults. In my opinion, that is the first step in the right direction. We still have a disease classification system that uses the same diagnostic criteria for disorders in children and adults, even though we have lots of data emerging that shows that childhood disorders are most likely different entities. When it comes to medications, we still tend to extrapolate data from adult studies and apply it to children because of this fundamental error of belief that the two conditions are the same—just that one comes in a smaller size! I believe with more research not only will we have a clear distinction, but also an increased ability to diagnose childhood problems. I see more child-specific medications in the future.

We are beginning to see more research on the biological underpinnings of conditions like autism, and I am sure that soon we will have better tools at our disposal that can effectively treat this devastating condition. At this time, we have the ability to treat the consequences of this condition, but not the condition itself. This challenge has led to a plethora of alternative treatments that falsely claim to cure the condition. I hope that in the near future we will have data convincing enough to steer parents away from these so called “natural remedies”. There is a big market of natural and herbal

treatments which thrive on parents' sensitivities and sentiments. It's like the new ‘organic’ fad—there's nothing wrong with organic, but in the absence of any replicable or substantiated data to claim victories over extremely complex conditions, it becomes questionable.

Hopefully, we will be able to target the root cause of behavior problems by accurate diagnosis. I often times see that kids with behavioral problems tend to get lumped together as far as treatments are concerned. I can usually predict what medications the child has been tried on when they come to see me for the first time. I think eventually we'll have the ability to test for and treat the actual root cause of the problem.

**Dr. Holiner: What is it like to be part of a psychiatric group practice?**

Dr. Sharma: When I first decided to join a group, my wife was a bit skeptical. She believes that I don't take orders well. She even accuses me of insubordination! I am enjoying being part of The Holiner Psychiatric Group. I get to benefit from an already established setup that works extremely well. I don't have to worry about the details that one has to deal with when starting a practice. The learning opportunities from others' knowledge and experience are tremendous. I feel very fortunate as everyone in the group has been so welcoming and helpful. As the newest person in the group, you have to expect certain things. It's a little bit like being a first year intern in residency, but I think it's going to be an awesome career choice and I hope that I am able to continue my relationship in and be a valuable addition to the group.

**Dr. Holiner: How do you like Dallas so far?**

Dr. Sharma: It's been a Godsend. My wife and I are from New Delhi, India. Dallas is on the same latitude as New Delhi, so the weather is pretty much the same, except that you never get snow there. The Indian community is very strong here, which also helps. I feel that my parents can come and spend time in Dallas and not miss too much about India. I considered a few other options, but after meeting Dr. Holiner we didn't have any doubts left. I still remember my wife saying after meeting with him, “I trust this guy. I think you will like working here”. That sealed the deal! On a more personal note, our kid is not the only non-Caucasian in school, which has been very nice.

Professionally, I think Dallas has provided a wonderful opportunity of growth for us. I hope to continue on this path for a long time.

Joel A. Holiner, M.D.

Executive Medical Director of  
Green Oaks Hospital



## Green Oaks – Community Spotlight

by John Dornheim



This journal's community spotlight focuses on several leaders, and the impact they have had on the mental health community. Dallas Chief of Police David Kunkle is retiring this year, after many good years of reducing crime, returning trust and empowering his department to train street officers in CIT (Crisis Intervention Training).

Good luck in your next endeavor - we have been proud to have you as our chief, as a friend to the mental health community, and as our neighbor.

We are also thankful for the Dallas County Commissioner's Court. The commissioners and the judge studied the needs of the mental health community and showed in their actions and words that they do understand and care about what happens to people with mental illnesses. Commissioners Price and Dickey co-chair the Dallas County Mental Health Transformation Steering Committee, which was convened with the purpose of evaluating the current public mental health system in the community, and to determine ways in which the stakeholders can work together more efficiently and effectively to meet the mental health needs of persons living in our region.

Dallas County Commissioner Maurine Dickey helped spearhead a taskforce and conference, along with Dallas Police Sergeant Louis Felini and Homeward Bound's Renee Breazeale, LCDC for the Dallas PDI (Prostitution Diversion Initiative). The November conference was a great success, with people attending from all over the United States and Canada. Commissioner Dickey was honored at Commissioner's Court with a gift and accolades from the Committee.

Another honor was bestowed upon Dallas County Commissioner John Wiley Price for his support of the PDI and his advocacy for those with mental illness. At their December meeting, NAMI Dallas presented him with the 2009 Advocate of the Year Award. Dallas County Deputy Sheriff Joe Costa also received an award for the excellent work he and his people do at the PDI events, and the great work they did on the PDI Conference.

Mental Health America bestowed PRISM Awards to Sergeant Louis and Dr. Martha Felini, and Renee Breazeale for their work on the PDI. Frank Delgado, a MetroCare employee and advocate, also received a nod from the PRISM committee. Mr. Robert Wright, the man who built Medical City Dallas Hospital, Green Oaks Hospital, and has been a generous benefactor to programs like Dallas Challenge, was also honored by the MHA awards committee with a PRISM Award for his lifetime achievement.

Other events to remember include the NAMI Dallas Gala honoring Pat Peiser and Beverly Tobian for their lifetime of contributions to the community, and the two-day Fall Mental Health Conference at Medical City with MHA, NAMI and the Dallas Police Department, featuring multi-cultural issues the first day, and suicide and first-responder issues the second. The NAMI Texas Conference was held in Houston in October with Houston County Judge Ed Emmett as the Gala Dinner Keynote.

NAMI Walks will once again grace the beautiful grounds surrounding Fair Park, this year on Saturday, May 1, 2010 with Judges Susan Hawk and Kristin Wade serving as honorary chairs and Commissioner Dickey serving as the honorary chair of Community Partnerships. Sign up now to form your own team at the NAMI Dallas website, or join the Green Oaks team! It's free, it's fun, and it's for raising funds and fighting the stigma of mental illness.

Green Oaks' own Celeste Johnson, MSN, RN, was recently elected as the president of the Texas Chapter of the American Psychiatric Nursing Association. She also presented to Richardson ISD School Nurses about "Psychiatric Disorders in Children and Adolescents," and to the Texas Nurses' Association on "Managing to Have Fun While Doing Serious Business." Celeste has also submitted several articles for publication, with topics ranging from "Managing and Decreasing Stress: Nursing Interventions for Patients, Families and Nurses" to "Helping Families Deal with a Child's Illness." She and several other Green Oaks staffers will be presenting at UTA's 24th Annual Psychiatric Nursing Symposium in April.

On a sad note for 2009, Senior Corporal Paul Brummett retired from the Dallas Police Department after 20 years. Paul was a fine officer and did so much to help make the CIT program what it is today. We wish Paul and his lovely family the best.

## Green Oaks Services

### Day Hospital and Intensive Outpatient Programs

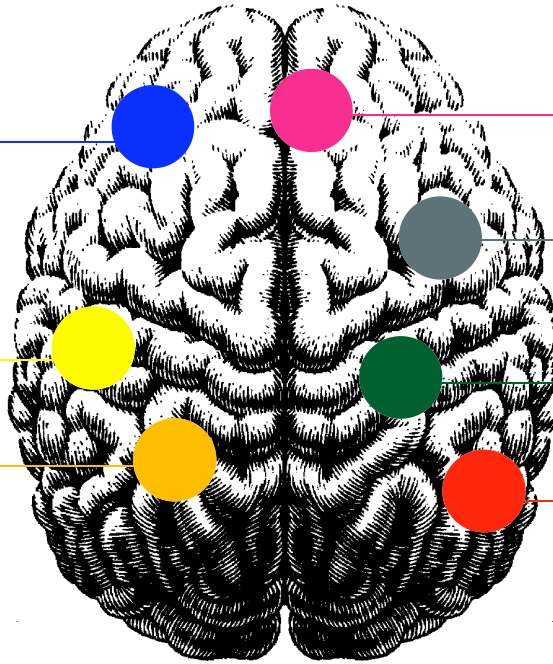
*Life skills and chemical dependency counseling and education for adolescents and adults*

### Dual Diagnosis Services

*Detox/Support Groups/Life Skills*

### Psychiatric Emergency Services

*Triage/ER/23-Hour Observation*



### Adult Psychiatric Services

*Inpatient care for psychiatric disorders*

### Short Term Stabilization Program

*Brief inpatient stabilization for acute psychiatric disorders*

### Adolescent Services

*Inpatient psychiatric care for ages 12 through 17*

### WorkReturns Program

*Educate, support, transition back to work*

*Accredited by the Joint Commission on Accreditation of Healthcare Organizations*

*Licensed by the Texas Department of Health*

*Certified Medicare and Medicaid Provider and a Champus Provider*

*The Plano location is also licensed by the Texas Commission on Alcohol and Drug Abuse*

Adult Adolescent Intensive Outpatient Programs at the Green Oaks Outpatient Clinics at

4001 W. 15th St. • Suite 465 • Plano, TX 75093 • 972.985.1599 and 6800 N. MacArthur Blvd. • Suite 206F • Irving, TX 75039 • 972.831.3992

Green Oaks

7808 Clodus Fields Drive • Dallas, TX 75251 • 972.991.9504

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**Joel Holiner**, M.D., Executive Medical Director

**Roger Butler**, M.D., Executive Medical Director of Network Operations and PES

**Frank Webster**, M.D., Medical Director of Integrated Crisis Services at Green Oaks.

**Gail Barnes**, LCSW, Executive Director of Hospital Operations

**Mike Ashworth**, Ph.D., Executive Director of Outpatient Services at Green Oaks

## Directions to Green Oaks

Green Oaks Hospital  
7808 Clodus Fields Drive  
Dallas, Texas 75251

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Green Oaks is located adjacent to the Medical City Dallas Hospital campus. Medical City is located at the Northwest corner I-75/Central Expressway and Forest Lane. To get to Green Oaks after exiting Forest Lane, go west on Forest Lane. Turn right on Park Central Drive. Turn right on Merit Drive. Turn right on Clodus Fields Drive, and make an immediate right into Green Oaks. Call 972.991.9504 if you need additional help.

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