And it was a book called The Compulsion to Confess. I had no idea what that meant, but I took it up and I started reading it, and it was so weird, but yet, there was a depth to it, there was a connection there. And short story is that, I became interested in Psychiatry from then, and started to try to, you know, approach people, you know, through this notion of, how does your mind function? And I have to tie up my first encounter as a budding Psychiatrist was a dismal failure. There was a girl that I had liked in 10th grade, when I was in 10th grade. And I decided I was gonna learn how to interpret dreams and I did all of that, and I, you know, whatever I could get to interpret dreams, I learned. And then the first day, I asked her, "Well, tell me about your dream last night." She watched me and called me stupid because she said never had a dream in her life. So that killed that. But I went on and then when I got to Howard University, I forgot about Psychiatry, I decided I wanted to be a Linguist. So, I study Romans, languages, Italian, Spanish, French. And I came home the first summer, and ran into a brick wall by the name of Dr. Randall James. And he said to me, because, you know, Dr. James was my idol from the time I was this very young, he was so impressive, he was so powerful. And I wanted to be a doctor when I met him and I wanted to be a psychiatrist in 9th grade, but when I got to college, I wanted to be an interpreter. And he said, "It cost her to [inaudible] everything." I just say, "Yeah." He said, "Why you study in [inaudible] I'm a [inaudible]. What are you studying?" I said, "Romans Languages." He said why are you [inaudible] with that?" Because I wanted to become an interpreter to United Nations." And he stopped talking right there, like he had a heart attack or something. So I watch him and he watched me, and I'm gonna say something that's politically incorrect now, but this is what was said, this is true. He said, "As interpreter of the United Nations? Your father spending money for you to come an interpreter at the United Nations?" Excuse me. I say, "Yes, doc. Yes because [inaudible] be. He say, You better go study something [inaudible] become a doctor," and just like that, just like that. I change my major. But not because of any sexual or identity issues, but, or concerns, but just because Doc James say, that's not a good thing to study on. And my first love was that, so I switched, I went back over and got into medicine, got into psychiatry, and I have to tell you that, it wasn't what I thought it would have been. First of all, when I came home, I wanted to be, I wanted to be a hospital psychiatrist. I wanted to work in a hospital, that was the model I had in my head, that there were something like 80 patients that we had had at St. Elizabeth's Hospital. At that time they had been there, some of them for decades. And I had the opportunity to work with them, but through a program at Howard and George though. And met a lot of people that I knew of or, in one case, one of them took care of me when I was a little boy, which was a totally emotional experience for me, that really still racks my heart, you know. But I came home in '74 and decided that, you know, I'm going to give it a short try because I had to go back, I had some, there was some errors I needed to, you know, jump into that I hadn't jumped into. And then, uh, that was all she wrote. I couldn't get back out. I was the only psychiatrist here for quite, for several years.

- Uh-hmm.

- And Saint Thomas, Saint Croix, Saint John, I remember walking up in houses up, hills up on Saint John. We used to do a lot of home visit in those days, and so, and the psychiatry that I thought I was gonna be doing, almost never materialized, except for the fact that we had to have somebody in the hospital, but I ended up doing a whole lot of other kinds of psychiatry. In fact I think, I did every kind of psychiatry. Other than, you know, including hospital, and I got, and I got not stopped, but I had, I had to keep my feet wet.

- Uh-hmm.

- And I had to keep my foot on the ground, my feet on the ground in terms of community psychiatry, in terms of Geriatric Psychiatry, Correctional Psychiatry, Pediatric Psychiatry or Child Psychiatry, Adolescence Psychiatry, everything because there was nobody else. And that's how it started out. We didn't have any facility, we didn't have a psych unit on Saint Croix, and after I gotten beat up a lot of times, I decided that, you know, I don't think I'm gonna survive this process, but it started out rough to the first week I got home, the cop's brother. Very, very violent patient up to my house and left him there.

- Okay.

- Oh, Jeez.

- Yeah.

- We're doing a great job. We wanna take a break and come right back to your story, in regard to that. And I really wanna touch base about the institutionalization.

- Yeah, right.

- Yes, yes.

- Good morning again, Virgin Islands. This is Archie Jennings, along with Iris Bermudez, and we're here with Dr. Olaf Hendricks. And doc, you were talking about the nature of what the practice of Psychiatry was when you returned back to the Virgin Islands, after your internship in coming to the Virgin Islands. You give any example of what was taking place with regard to persons with [inaudible]

- Yeah. The, you know, back then, we were not as rich in resources as we were in ambition and in drive, and just a desire to, you know, to make a difference. There was not a, and I'm sitting here looking at this word board as in boundary, these two words, and they keep jumping up in my brain all the time. But it's okay, because there was no, some of it, I never felt a sense of these people and those people and us, you know. It was, it was sort of like, and I'm, and I know these songs kind of tired and trite, but it was sort like, there was no sense of, you know, I'm the treater and they're the patients or the clients. It was, like, it was more like, you know, we just have a well individuals here, who needs this particular kind of intervention. And a lot of times it was not medication, it was not hospitalization, it was not institutionalization. It was just, sometimes having a conversation and there are multiple times that worked.

- Uh-hmm.

- You know, and we had a lot of that, we could talk. I mean that's one thing we're trained to do. So that was, you know, limitless, but the other thing too is when the first experiences I had was the courts. Did a thing where, one day realize that there was a psychiatrist here that wasn't living, you know, in two days. They started ordering people to see a psychiatrist, or to get treatment or to have some kind evaluation or something. And the Mental Health Division was there in the back of Charles Howard. It was a, they had gotten a, first one trailer, and then another trailer. And it was supposed to be temporary, I mean temporary. But we started developing, and then, and then around 1976, which was two years after I got home, there was this Community Mental Health Centers Act. And that had to do with the deinstitutionalization of patients, of clients, of people getting treatment, and I don't know the facts, but they were always stories about how these people poured on to the streets of the United States, which is, you know, kind of think, unless stretching, but that process forced an enhancement, a development of the services in the community. And at one time, we provided, like, 13 different kind of services from the division of Mental Health. At that time, we are the Community Mental Health Centers. And Dr. Maxwell Jones, Psychiatrist, I think he was Scottish, had come down from Denver, Colorado with a bunch of his own staff. And recruiting some, you know, more seasoned people, and they started this process of this Community Mental Health Centers thing and this changed the total structure of mental health here. In the meantime, we still had, you know, a bunch of patients up at St. Elizabeth.

- [inaudible]

- And, you know, over the years, I was able to go back and see them. And then in '78, I spent some time getting one of the things that I should have gotten before, which was more experience in Neurosurgery as a service. I was able to go to St. Elizabeth's and be, again, spend about five months with the patients of the Virgin Islands. By then, they were getting, things had started to happen to their programs as well, which was for the better because a lot of them had had a prefrontal lobotomies, and they didn't know it.

- Oh, okay.

- Oh.

- And what, do wanna explain to the community what that entail, because a lot of people don't understand what that was about.

- It was one of those things, where they were going through the front of the head. Basically over their, it's a soft, it's a soft bone under your eye brows. And they would go up in there with an instrument and just obliterate the part of the brain, for our brain that was there. And, you know, it was, of course, a varying success, and varying lethality because it, some people had some very serious responses to it. And it was thought that this would certainly control a lot of the psychosis, especially when people became agitated, they think it would have just controlled that. But what it did, in effect, was to essentially turn a lot of people into what was then called vegetables, which is a stupid word to call to anybody.

- Zombies.

- Right. Also, do you recall if they were still doing electroshock therapy [inaudible]

- Yeah, of course. Of course, of course, of course. Electroshock therapy had slowed down during my time in training, because again they were, the process was crude, and the equipment, and so was not as, you know, as fine and, as it is today. But, and then, and since then it's come back a lot because there were some very serious types of depression that could certainly, were not accessible to the usual different types of approaches to it, including medication. And shock therapy was, again, something that was utilized here in the Virgin Islands at one point, I'm sure it still is, some place at least it was, up to the, maybe about 10 years ago. But it gained such bad reputation because it had gotten some notoriety from some bad results, you know, and the processes. Poor, you know, people just didn't do it, do what they were supposed to do. I suspect. I never did it, by the way. And, but those things were not the majority of things that were done and a lot of our patients in the end were sent back home from St. Elizabeth's because the Washington, DC, it was a federal program at first, and then they turned it over to the DC, and they turned it over to a corporation. And then, so what they did, they decided to do was to take away all the people that didn't belong to DC, that were not of DC. And then back some time, I think it may have been in the '90s, '80s, a bunch of patients came back home, and a lot of them were not ready to reintegrate. And we ended up with quite a few on the Psych Unit of the Saint Croix Hospital at the time. And…

- And Saint Thomas, as I recall.

- Yeah.

- Well, yeah.

- They both…

- Saint Thomas, of course. And then, other programs started doing that like education or human services type programs where they'd had a bunch of people there. And then resources started dictating what would happen. And we started getting about, a lot of people back who had been

institutionalized on the main land. And that created some serious pressure on us here in terms of what do we do, how do we deal with this. And somehow, we worked it out for the most part, you know. And not necessarily with a whole lot of success, but we had to. We were forced to do things we didn't plan to do.

- And was that the result of the change in the federal mandates or the federal funds going to the Virgin Islands, or what do you recall change to circumstances?

- Part of it, of course, was financial, and then on the other hand, you've got new programs coming into the United States. And we always had some, we always had some funding from the federal government, and they would, while the funds were helpful, there was also a lot of, you know, associated, telling you how to do things and what programs would be best, or whatever. And then, after a while, we would end up with a lot of money. We started out with a lot of money. The money is finished, and we ended up with the programs that these moneys had created. And nowhere of supporting these programs, and the staffs just continue to dwindle. But also these programs, some of them in my opinion, were not the most appropriate for our community.

- Oh, I see. One of the things you and I talked about before was that there was St. Elizabeth and then, again, folks returning back to the Virgin Islands. Then there seemed to be a cycle where we are now, we're sending a lot of people to not one institution, but several institutions in Florida, and in Texas. And the funds that we're spending now could be spent here in the Virgin Islands.

- Like about five, seven years ago, I had a conversation with Chris French, and we were talking about the possibility of developing a facility here or a center here that would take care of, that would address the needs of this population. And, you know, from basically acute to chronic, or people who are sort of in between needing care in, you know, in some institution or a program, and just needing to be back in the community, and it would have cost us, I think at the time, about eighteen million dollars, maybe about eight years ago, seven years ago. And now, that figure is probably closer to $30 million. And we certainly don't, and he had a plan to also finance this. It would have been a turnkey project, and we were gonna do it for the, we wanna start up at, on a slope, back in 2005 when Attorney General Alva Swan was there and we had started to develop kind of, so first of all for, as a forensic unit facility, which may not have, which was kind of not well thought of, to be honest, okay? But at least there was some plan to include human services, education, and Department of Health [inaudible] and that just fell apart. Now, I, when I left government service about, at the end of 2013, I knew that the cost of the Virgin Islands government was probably over $12 million a year, and that was insurmountable, and not necessarily the best services.

- Huh.

- I mean, 12 million spent off island or in both Department of Health, education, and…

- Yeah, yeah, yeah. Human services.

- …human services.

- As well as other patients who fell in between. Sometimes the hospital had gotten caught up in some of this through court orders, or what have you. And of course there were private individuals who were caught up in these themselves through having to have their families off island, and not being able to pay for more than six months or so, and that still continues.

- Well, that still continues. One of the things as you're talking about the courts, we're trying to force certain court orders from the Department of Justice, and then there was a ACLU laws with regarding those who were not guilty by reason of insanity, right? And as I recall, you had stepped away, but you, out of your good heart, came back and started providing services at Golden Grove

and other prison facilities. And I think that's still, that is still continuous to have court status conference hearings on trying to alleviate and ameliorate that situation.

- That has confused me for so many years why are we still in that. I, at one time, it came down to policies for instance in the Bureau of Corrections, it came down to policies. The only thing we needed was to have some policies in place, and I could not understand why were the resources pointed or concentrated there, because we had done everything else. And, you know, I'm not, it, this was all above my pay grade, you know. I was called to take care of clients, patients, inmates, detainees, but certainly shut your mouth, you know, we don't really need your input as through this process. But I thought if we had just concentrated, then some of those other things, non-clinical things, that we needed to get past, we would have been out of it by number too, you know, who knows. It's rough. It is. And it's not gonna get better. It is not going to get, we're not gonna recognize the services that are gonna be required in the next five years, so, they're gonna be totally fine to us.

- In what way could, you know…

- It's scary.

- Well, you know, first of all, we have this process where, along with the resources, along with the moneys for these programs come, some very strict criteria, you have to do this, you have to dot this out, you have to cross that T, you got to, and a lot of times it takes you away from what you really need to do. At one time I thought that if, in fact let me just say this straight up because people need to understand this. When the director of the Bureau of Corrections Jamaicans back in the early '90s instituted a lot down at the Bureau of Corrections at Golden Grove, I noticed something that I never noticed before. Although, there were some issues with the lockdown and some, some people are concerned that it was inhumane. And, you know, you look at that and you hear that as you talk to the inmates, but for the first time ever in my, in my life as a psychiatrist, people started to be requiring less, and less, and less medication. Why? Because of the lockdown. So you've, you're medicating people, you're treating people, but the same things that are making them ill in the first place, are still being given to them, for instance, drugs at the time. And it's not just pure marijuana, THC, let's not go there. It is, you know, sometimes some highly tainted drugs at the time that were still getting into jail, this people will get in, alcohol was still getting in there. There was smoking, these guys would smoke Cogentin, you know. I get high off of that. So the medication we were giving them for treatment were also a part of the problem. But the fact is that things were so well controlled that these patients started improving a lot. This also the point where more inmates than ever took courses either in GDs, or these courses you could take online, or through a catalogue. More people graduated who got certificates at that point, which tells me that we needed to look at a different way of treating or dealing with people that were, you know, incarcerated. And the fact is that if we could control the environment to a certain point, these people would get better, get out of there, and lead, you know, probably close to normal lives. But we kept exposing them, I say, "We kept exposing them," because we knew stuff was happening, getting into the prisons, and poisoning these brothers, you know.

- Well, again I think that goes back to the incarceration versus rehabilitation aspect of treating persons who commit crimes. I think, well, Portugal, just dispense with anything with regard, with regard to having drugs as a crime. And therefore, their crime rate and their drug rate went down. Sweden is another one who treats prisoners or as rehabilitation patients, and clients, rather than as prisoners and trying to incarcerate or punish them for something, especially with the drug aspect. As we evolve in the Virgin Islands, what would you like to see in regard to mental health services? Because that's one of the aspects we keep trying to ask various professionals here, as we go through this trying to get [inaudible] moving in a different direction.

- I think we would need to start going back to treating people who are, addressing people's needs in terms of their environment, relative to their environment, and, you know, the society, the community, and stuff like that because to take any entity out of its environment, and say, you're

gonna institute some kind of intervention, or, it's crazy because as soon as they come out the hospital for instance, as soon as they come out of any program, you know, they go right back into that environment, where the dynamics that may have led to some of these things are there. Not necessarily drugs or alcohol, but, you know, and what's happening is more and more. All environment has become quite toxic. And, you know, I was just reading up about some stuff would, about a pressure cooker. I don't know why I saw this out of [inaudible] and I started reading. And that's exactly what we're in right now. And not just locally, but a lot of places in where people live regardless of which country, if this is like a pressure cooker. And we are not aware of the fact that our capacity, our internal capacity to deal with all these stresses that we're facing, that we know of, many of them we don't know of. You know, our capacity is being compromised. And that's what stress is all about. So, we're getting sicker and sicker. People have changed totally, and they're not even aware of what's going on. And I think we need to start dealing with these, and with this kind of situation in a more broad-based level. You know, we don't need to do this thing about, you know, holding somebody up and giving them medications, or doing just a, it is the community that needs also, it is the environment. Not, and I don't mean the climate change and all that. I'm just talking about people are just being worried about real things that are happening in their lives. And that's causing a lot of problems, physical, as well emotional, psychological.

- And that goes to my question to you in terms of what role should psychiatrists play with respect to what's happening here in the field now? I mean based on your experiences, based on what you've seen, what you've dealt with, and the situation we're in now because, yeah, it is volatile.

- I think, I think psychiatrists need to [inaudible] a little bit. And that we are part of a team, we are part of a community, we are part of this experiment we call for instance life here in the Virgin Islands. And we've got to change that model of how we deal with people who come to us with these issues, that sometimes very, very serious, and have some very dramatic times of expressions. In the other hand, you know, we are part of a team and we've always been a part of the team. And we're not necessarily the head of the team, but there are times when, you know, psychiatrists are much more effective when they don't become involved. And if you've got, and listen to this, even two high school students sometimes can be as effective as any medication, any psychotropic medication, just by talking to some of these people. Understanding what it is that they feel is driving them or, and trying to understand, you know, and that's why these notion of something like cognitive behavioral therapy is, has been so successful. And, you know, a lot of psychiatrists, they want to jump [inaudible] people medication. But on the other hand, the thing is that, it's successful because you're teaching people to rethink, you know, to think in a different way. And all of us need to go through that. Even our leaders, of course, need to go through some of that. But once we get people in our community to understand that there are real things out there, there are real dangerous lurking out there, you cannot have a problem or a situation in which you got five different major sources of stress in your household at any one point. And you, and this goes, you know, unattended to. It can't, it can't, this is not long term survival. You're not gonna make it. You're gonna break down at some point. And when you talk to somebody else who has similar problems, if you listen to teachers in the school, if you listen to nurses, if you listen to social workers, you got get a pretty ugly picture. And it's all related, it's all real right here in the Virgin Islands. And so I think that we need to approach, you know, this less, we need to, not so much focus on the individual, as the system, as the environment, and let people become aware of what some of the things are that can trip them up, unless they got an opportunity. Just sit and talk, you know, or just feel that they're human beings too. And that everybody else has some serious problems just like them. You know, and that's what I think we need to start doing.

- And that happened through the school system, and…

- Of course.

- …you know, because there has been programs, institute that I think in Oregon, positive behavioral support systems and starting in the school, then the school districts, and then, which would affected the entire community, which includes cognitive behavior analysis approach.

- Yeah, what we do so poorly is that we take, we have different kinds of people with different kinds of attitudes and beliefs and values that, and we put them all in one basket, and expect everyone to survive, it's not gonna work. You know, we've got to, you know, help people to understand that some of the attitudes are what's holding them back or causing them to deteriorate. And I'm not saying that you train these people, you condition them, you know, you do that. But once we have an understanding and again, through non-psychotropic or non-medical kinds of approaches to dealing with these problems, I think that everyone has a chance. So, more people have chances of, you know, addressing these very deep issues that you've got. You know, I'm going to say this, what's happening now with the Virgin Islands? Right now, in the Virgin Islands is that we have imposed, not necessarily, you know, deliberately, but we have imposed and set up circumstances that are gonna drive people off the edge, you know.

- Yeah.

- Wow.

- Yeah.

- One of things I was also gonna talk to you about is we have sort of a wall right now. I have patients who come to me and ask to get off medication.

- Uh-hmm.

- I have psychiatrists saying, they won't give them a clean bill of health unless they take medication.

- Uh-hmm.

- We're, you know, we cross that barrier where we can try to get something at least for a temporary ban, or a temporary extension, where patients don't have to, so they can see if they can survive off the medication.

- You know, reality is that some patients need some kind of chemical, pharmacological intervention, that may need it for a long time, those not only needed for one or two days. And we've seen all of that. The fact is that's a lot of us don't make those distinctions. We have no way of measuring or determining which ones because we don't, we don't have, we don't utilize the tools, the resources we do have. And which is, again, the softer kinds of approaches to people with mental illness. When we had social workers working with us, they could tell you things and they did things for patients. For instance, if a social worker goes to a home, and a patient, you know, feels that, oh, I'm important. You know, I feel good. They recognize that I'm a human being too. That goes a lot, along the way sometimes under whatever medication. So, we need to just stop saying, okay, this is the one treatment that's there and it's gonna work, it's gonna take years to work, no. I worked in a hospital, and I had to stop giving people medication in 90%, oh, no, 90, more than 90% of the cases after seven working days. You know, that's all I had, that's all I had, you know, the capacity for. And we did it.

- Is it because it's lack of resources, and that's an easier fix than dealing with that person individually on a little long term basis, or what? Because we've changed, we've, the way we provide services has changed. I remember as a social worker, we used to go out in the field. We used to deal with the clients in their homes.

- And it worked.

- And it worked, yeah.

- It worked a lot. And again, less medication because, you know, they're not just depending on this one thing. A lot of interaction and human contacts, and interaction really goes a long way.

- Oh, okay. Thank you. We're gonna take a quick break and get back. Dr. Hendricks, in a few minutes. Welcome back. We are here with Dr. Olaf Hendricks, and we're going over, we just spoke about models. We really need to change certain models of what you were speaking about. Can you give us more of an in depth view of that?

- Yeah. First of all, this notion of mental illness and, or psychiatric or psychoneurological, whatever we label it, this sort is, it's something that I think needs to, we need to relook that, we need to just get back and say, what's really going on here? And when you look at any organism, any human being in any environment, and I use this for an environment very loosely, but what I really mean is where you live, how you live, who do you live with, what are your values and attitudes and beliefs, I love those words. And so, once we start to consider these things, then we realize that what we have taken away from a lot of these people, other things that have, they, that have, they have utilize to develop themselves to the point, you know, for the past [inaudible] out to become adults, all their adult life, they held these beliefs and these values. Some of them, maybe needing to be changed, but the fact is that we can also support people, and let them understand that some of the ways that they're been thinking, or they have been used to thinking, they have used to think in the past are the very things that are poisoning them. And that we can manipulate those things, like I said, for instance, through some form of therapy or meditation, or whatever. And, or even yoga works well. But people don't necessarily need to have, you know, some of these newer medication, some of these new things that they've, they're adverstising about, or this is gonna affect this transmitter system or that transmitter, no, it's not that, because a lot of times, all we need to do is to kind of modify the larger experience of the committee. Right now, right now, as we sit here, for instance, this morning, I read some article, and it has to do with GERs. Everybody that's working for the government now, or everyone that is on retirement, in the back of their heads, at least there's this notion of, "Oh, God, what gonna happen?" You know, and that's not an easy thing, that's like a drip there, constantly, 24 hours a day. And it's causing people to become anxious, it's causing people to become stressed out. A lot of people don't even know whether to work for a shorter period and grab what they can now, or work for a longer period until they get to Social Security, and then by then, of course, the system is all dried up. People are under significant pressure. You don't treat that with medication.

- Right.

- And, but that's been, you know, "Oh, I need something to sleep." What we need to do is to get a better sense of what we're gonna do, what our real options are, how, what's the best way for me to approach this, so that my stress levels can go down because I can't control it.

- Right, right.

- You know, so that's a…

- That's a major community stressor. We, I still get calls on, you know, like, because I did employment work about what's happening from off-island [inaudible]

- Yeah.

One of the stressors you're about to relay is you wrote a article [inaudible] work.

- Federal.

- Yeah. Yeah, yeah, yeah. While I was retiring on Labor Day, I did have Labor Day, back in 2013, I, you know, I've done a lot of things, and I made a lot of mistakes doing my work here as a psychiatrist. I was an experiment myself. Because, like I said, it's, we haven't had, I don't know if there's in, ever been any other psychiatrist that has spent their full, their, all their working career, their whole career, you know, immersed in a society, a community in which they were born or which they grew up. It's tough, it is tough, tough, tough. And things like, you know, everyday people watching or laughing, and saying, see the doctor there, there's the doctor, I'm gonna send you, too. And so many times some of these people get [inaudible] will kill me, you know? And so, but the point is that, you develop this kind of, this kind of image, and it affects the way you interact with your community. But I did it the wrong way. I tried to help everybody. I tried to go outside of the system, which I always thought was too weak, and tried to support the mental health of this community, and I, it caused me signification emotional distress, to the point where one day in 2011, I could not function. I had just gone to see a patient, look at the body of a patient, that died off-island, and then that night I had several calls, maybe three calls to the emergency room. The next day, there was, I had totally run out of gas. Just totally, couldn't function. And that was my wake-up call, and it was, within two years that I resigned after that, but I retired after that. But, you know, I had had a, an informal contract with the people of the Virgin Islands, with the people of Saint Croix. And let me tell you, if I were to tell you all of their motive, contacts, request, services, being asked for by this whole Virgin Islands community, I think people would just simply not accept or believe it. I've had people jump in planes just to come on, try to come up to my house to insist that I do something with them, be, otherwise they gonna hurt themselves, or otherwise, they know they're gonna lose it. And I took this on, I made that mistake, and I don't know what my, what my options were. And so by the time I was getting ready to retire, I realize that I had a whole community that was depending on me for, in this area. Even outside of whatever position I held in government. There were times I would spend hours in the ER, in the parking lot of the Saint Croix hospital, or the correctional system, the prison. Just hours with people who needed intervention. And by the time we got through, sometimes hours after, they felt better, I felt worse. I was dysfunctional. And it continued like that, it just kept draining me, draining me, and the system broke. And because the system broke, they had no choice, and I accepted that. But then came a time, I said, "I'm done. I'm firing this work, because it's unsustainable." So I wrote that, sort of tongue-in-cheek, you know, but I'm just letting people know that I really loved you all, I really love this, there's nothing that I love more than seeing people that I had interactions with, you know, clinically. Or families, I admire the families of so many of these people, man, they stuck with it. They work with their families, they run me down, they stop me, catch me in supermarket, in theater, any place. Even at the horse races. And, yeah, they work for their families, and, so I loved that, I appreciate that. But I had to stop. And when I stopped, I let people know, I can't take it no more. I can't take it no, but, so don't, don't run me down to the post office, and give me no long, long, long, long, long story. It's unsustainable, I need help. My hands are up in the air.

- You surrender?

- You know, yeah, I'm, I need admission. And do what you wanna do with me. But it was also, it was also very heartbreaking for me to get off of that train. And I love, to this day, all the people that I've worked with. Even though and some of them beat me up. But I love it, it was something that, to me, was the greatest gift that I've ever had.

- Well, I mean, sure the community appreciates your, that's why we called you a hero at the beginning of our show. Because you carried a great burden. And we'll come back and in a few minutes. Take care. Good morning. Again, we're here with Dr. Olaf Hendricks, and doctor, we're explaining [inaudible] work, and wrapping up your, into retirement.

- Yeah, I, again, to me, it was, you know, the difference between working in the mainland and working in a place like any island in the Caribbean, especially one that you grew up in, is that, you know, there's total immersion. You don't just work on a patients in emergency room, or someplace else and then turn off, and that's it. You don't see them again. No, you live with them,

you work with them. Sometimes, you eat with them. Other times you go to a party, they're right there. And so you've, you got this constant exposure, they, you are new to them. And it does something to you. It makes a bond, it makes a permanent bond, in which you feel that I am totally aware, I'm responsible, in a sense, for what's going on with these folk. And so, you develop a sense of, a family, you defense, of connectedness. And that has a value, you know, to all of us.

- What advice would you give people working in the helping fields, students, professionals, to deal with burnout? Because you obviously went through burnout.

- Uh-hmm. I have someone who knows you and that you can talk to. I tell him I didn't have a whole lot of access to psychiatrist. And I did not recognize when I was being burned out, and only when it was very late, that I recognize it. So, I always have someone, and it doesn't have to be a professional. It could be, you know, your most, your significant other, your wife, your husband, your parent, if there's a parent that knows you, or a colleague. It's so fortunate when you have people that you can trust and you feel comfortable with, and you say, "Look, we need to talk." You know, but also believe what they're telling you, don't let your ego just be so big that you can't listen to them. People who don't have the kind of experience or training that you have. And that's the most critical thing. Someone to say, you don't [inaudible] notice this or you notice that.

- Right.

- You know?

- Yeah. And, doc, we gotta wrap up here. When one of the things I wanna say to you is that you've given us such great overall exposure to what's happening with the mental health system and here in the Virgin Islands. And we wanna like to make sure you're well-aware of what's going on with the strategic plan, and get your input, as is being implemented, as well.

- I need to ask a question about that. Do you believe that the strategic plan is really, is really something that, to this day, has an, and I don't know the answer, has relevance as far as the type of approach that this community needs.

- Well, one of the things you brought out was the peer to peer. One of the things we're expressing is that overmedication should stop, there should be more services here in the Virgin Islands in developing, or assisting parents and families. There's a parent and family group, support group, as well as developing peer to peer, those who haven't been in on this. Not just support group, but just coming together and speaking about services. So, those kind of things we're looking at as part of the core aspect of the strategic plan, but again, we like to bring you back and, you know, talk about that some more because part of it is, we need to, we're here to help educate the community, and bring them on board about a lot of things you spoke of this morning.

- Don't forget he fired the walk.

- Well, this is [inaudible] this is easy talk.

- Yeah, yeah, yeah, yeah. And I just have to say that one thing I've noticed is that, I used to do my interviews in the hospital with the staff around because I wanted them to learn and to experience this. When you talk to a human being, who happens to be, at that time, emotionally or psychologically compromised, you start off by saying, "Good morning, how are you?" You treat that personally like a human being, as a peer. There's that word.

- Yeah.

- Right.

- You know? And they feel so empowered and so respected, that the process of healing begins right there and then. You know, and people say, "You know, you're different." And that's not bad, it's just that we know, this is who we are. We use our strengths. And one of our strengths is to tell people good morning.

- And that was all part of us, years ago.

- Yes.

- That was all part of us.

- And we're talking about bringing it back and…

- Yeah, bringing it back.

- …making it part of the aspect of healing, that's all about, healing.

- Recognizing the wholeness of the human being.

- Yes. Yes.

- And the last thing I wanna say is this, is that, you know, you can't do any kind of treatment intervention without spirituality. I don't care what you say.

- Right.

- You have to bring that in because people have a lot of their strengths concentrated right there, in there, and you hear, Thank God, please God, pray to God. Or if it weren't for God, utilize that, work with that, and you can be a student in a lot of ways, but don't feel uncomfortable with it.

- Right, right.

- Amen.

Amen. There you go.

- Thank you again, Dr. Hendricks for being here, and Iris…

- Thank you.

- …it's been fun, I think we hopefully got, you know, a lot of information to the community regarding mental health services. And Virgin Islands, take care, enjoy the rest of the centennial weekend.

- Yes. Bye-bye.