Roberto Quiroz talks about an early experience with moving clients toward recovery…

I had worked as part of a team on what we called the Weekend Family Therapy Program, which was a special project in New York City. I worked at that for two to three years under Dr. Clifford Sager [a renowned marriage and family therapist, 1917-2005].

It was, again, working with families, Puerto Rican families, where one of the members had been diagnosed as schizophrenic, and where there had been multiple hospitalizations. And our team consisted of myself, a psychologist, an anthropologist, and a psychiatrist. In fact, it was an anthropologist who really headed this team effort. But basically, it was to involve the family and to provide something outside normal working hours where we could see individuals, where we could provide support services in a variety of issues. It was also a research project, and I think the most effective people that intervened were not ourselves. [There] was a [woman] psych technician, who was Puerto Rican, and then a woman who was another psych tech and she was Irish and lived on the Upper East Side, and it was amazing what they did. But we lost [only] one person to hospitalization during those three years, and the results of the project were very interesting.

There was absolutely the hope that the person would move towards recovery. And I can tell you this, that for persons that had been hospitalized on a multiple basis – what we did also, by the way, was to work with the fathers, the husbands of the family, many of whom didn't understand where some of the dynamics were going. I'll give you one simple example. Margarita Pedroza was her name. I even remember her, the psych tech. And when we did the intakes and accepted, and did a video tape of the persons, they looked so different. They looked unkempt, haggard. You would think they were 10 to 20 years older. Margarita would work with them, in terms of taking them to a beauty shop, working on [their] physical appearance, and I was kind of intrigued. About six months into the project, some of the guys would come in, and they came in only to see why their wives wanted to come to this program on a Saturday, because they felt, "Well, what's going on here?" I would say that it was Margarita, and then Mary McTierny was [the other tech's] name, who really, I think, were the people that empowered and helped. We had a very good psychiatrist assigned to the team. That was just the beginning of medication, as you recall, and I think that the effort was to give less, not more.

So it was an interesting project. It was one of total involvement. It also stimulated my interest in mental health, because what I learned was you can't give up on people that have been diagnosed, some that had been diagnosed accurately, others, inaccurately. But that the main thing was not to give up, to seek empowerment, and then also to look at what are the strengths that they had, that they could come with.

READ THE FULL TRANSCRIPT BELOW.

INTERVIEWEE: **ROBERTO QUIROZ**

INTERVIEWERS: **MARCIA MELDRUM and TROY GABRIELSON**

DATE: **October 27, 2009**

MM: Good morning.

RQ: Good morning.

MM: It's the 27th of October and it's about 10 o'clock in the morning, a little after, and Troy Gabrielson and Marcia Meldrum are here to interview Roberto Quiroz, who was Director of the Department of Mental Health – what? Nineteen eighty-

RQ: From 1985 through May of 1991.

MM: Got it. OK. But we'd like to start in the early days. Tell us a little bit about your background – where you grew up, where you went to school, that kind of thing.

RQ: OK.

MM: What you thought about doing in your early childhood. [she laughs]

RQ: In my early childhood, oh, wow. Well, I was born in Brooklyn. That's where I was raised in New York City. And I'm a social worker. I received my graduate degree from Columbia way back when. 1966. And prior to that, after graduating from, after getting my BA in 1960, I had worked in Child Welfare.

MM: So where did you get your BA?

RQ: I got my BA at Brooklyn College.

MM: But you were working in Child Welfare.

RQ: I worked in Child Welfare, and I think that's where my interest really developed in the human services. We dealt with a lot of situations that required a variety of approaches and services. I was working in Intake, so saw a variety of issues. After that, in 1961, I was inducted into the Army. I was drafted. So I served in the Army from '61 through '63; and following Basic Training, I was assigned to a mental hygiene clinic – the mental hygiene clinic at Fort McClellan [near Anniston, Alabama] – and then at Fort Jackson, South Carolina. And we were what were called mental health technicians at that time. And the responsibility was to work within the mental hygiene clinic and take histories and then to assist the psychiatrists or the other mental health staff, in terms of doing [care] plans, making plans, and working with families. That's where my interest really developed in mental health.

[My interest in the field of mental health developed from a variety of academic, military, and work experiences. After receiving a BA degree from Brooklyn College in 1960, I went to work for the NYC Bureau of Child Welfare, where I was assigned to their Intake Division. We mostly worked with impoverished families and had to assess placement

possibilities, voluntary or involuntary for children who were abused, neglected, or where parents were unwilling to continue providing care. Invariably, we dealt with serious emotional or mental health issues. In 1961, I was drafted and served in the US Army as a Mental Health Technician assigned to the Mental Hygiene Clinics at Fort McClellan in Alabama and later at Fort Jackson in South Carolina. I was a colleague of and worked under the supervision of some of the finest psychiatric social workers (the professional title prior to LCSW certification and psychiatrists. Following my discharge in 1961, I returned to the Bureau of Child Welfare until entering Columbia University School of Social Work, where I received my graduate degree in 1966. The culmination of work, military, and graduate training in the midst of the activism of the 1960s had a profound influence on my belief and commitment to a community mental health approach in dealing with the impact of poverty and racism on mental health issues within low-income, impoverished communities. In addition, I had experienced the negative effects of incorrectly diagnosing individuals due to a lack of language capability or cultural understanding.]

MM: So what kind of problems were you seeing [in the Army]? Was that, like, a lot of post-traumatic stress? I mean, that's what we would think of today.

RQ: Well, it, it was and it wasn't. I think that at that time, we were just beginning to get into the Vietnam War. There wasn't a lot of experience with soldiers that came back from combat. It was in the early throes. We were providing technical assistance in Vietnam. So we didn't really see much of that. I think that there were two issues when I was assigned to Fort Jackson [in] South Carolina, after Fort McClellan in Alabama. And specifically, I was assigned, because there was a Cuban brigade that was being trained by the United States government, to go back to Cuba. You probably heard about the Bay of Pigs, and all of that. And at that time, there were very few monolingual or bilingual therapists. And there was a lot of misdiagnosing going on, so there were a group of us that were assigned from different bases that were bilingual. We were to interview some of the Cuban soldiers again. And we found that, because of the language difficulty, there were people that were being termed schizophrenic that were not schizophrenic, and they were using euphemisms in terms of describing [them]. I could tell you one, but it, it probably wouldn't make sense to you, unless – do you know Spanish a little bit?

MM: A little bit. Troy knows it better, though, I think.

RQ: OK, there was in the Cuban brigade, there were a group of soldiers that were identified as schizophrenic. So when I went to do the re-interviews, one of the soldiers, for example, had, within the diagnosis, the description of cannibalism. And when I interviewed him, he indicated to me that he had gone in, he had landed, and that his feeling was that when he got to the beach, that he was going to – *me los voy a comer a todos* – I'm going to eat 'em all up [the interviewers laugh], and that was literally interpreted as, this guy had evidence of cannibalism, [and] of schizophrenia.
So I became very interested in terms of what was happening with mental health situations in the Army, and when I left, I went to school, I went to Columbia.

My training was in community organization, with some courses in also administration. And, at that time, it was the sixties, so we were talking about community empowerment and things like that. It was also the heyday of community mental health. You had people like Israel Zwerling [1917-93, an early advocate of community-based mental

health care], who was a psychiatrist at one of the medical schools [Albert Einstein in the Bronx]. And it was the heyday of community mental health – the feeling that you dealt with issues of mental health by empowering communities. So that's how it began.

MM: Yeah, that's fascinating. Interesting. OK, so you got your degree at Columbia. And where did you go from there?

RQ: From there, I went to work at Bronx State Hospital [now Bronx Psychiatric Center; Zwerling served as Director there in the 1960s], and I was helping to develop a community mental health program.

MM: OK, so at this point, you were pretty committed to mental health. I mean, you had this degree in community organization, but you saw mental health as a way of doing that.

RQ: Yes, I think so. And even later on, when I went to work, for example, at NASW [National Association of Social Workers], I went to work in the sixties, as Deputy Director for Neighborhood Youth Corps, under [the] Youth Service Agency in New York City. It was all related, I felt, to mental health issues. Even though one of them was – I mean, they weren't necessarily mental health agencies, I still felt that we dealt with a lot of mental health issues and policy.

MM: And so how did you see this as related? I guess that's the question. I mean, you can phrase it better than I do, but is it a question of not understanding the people's needs, interpreting them as being slightly dysfunctional because they actually needed food and housing and better living conditions?

RQ: Well, I think that even in those days, I think there was the feeling [that illness was] biopsychosocial. But I think that for want of a lot of things at that time, there was much more stress on other issues, rather than looking at it in a comprehensive way. I think that with the [Federal] Community Mental Health Act, back in '63, there was a feeling that people that lived in impoverished communities, that had stress, that had substandard housing, that were underemployed or unemployed, that dealt with school issues, that that had an impact on one's mental health, and that in order to address that, particularly in minority communities, that you had to take a total approach – and that being to strengthen institutions that people were dealing with. I think, interestingly enough, years later – I mean, 40, 50 years later – we're probably looking at the same things. And later on, I'll share some thoughts as to why we still have some of those issues here in LA County.

MM: OK, so you started working at Bronx State.

RQ: I worked there for about a year and a half in helping to develop the program. And it was basically a program that extended the expertise, the skills, and the staffing of Bronx State to community clinics in the Bronx. So out-stationing of personnel into community clinics in the Bronx. From there, there was the opportunity to work within the National Association of Social Workers in their office, [which] at that time was in New York City. So I went to work there for about a year and a half, or two years, working with Chauncey Alexander, who was the new director of NASW [Alexander 1916-2005 served as Executive Director of NASW 1969-82]. Very dynamic individual, and really was, I think, energizing NASW to look at policy issues on a national basis and looking at mental health policy, education, training, etc.

I worked there [at NASW] until I got an opportunity in 1972 to go to Pueblo, Colorado. And Pueblo was a community of about a hundred thousand in Southern Colorado, and the community mental health center had just been established and funded, and they were looking for an assistant director. And I applied for that position, and then went to Pueblo. Lived there for seven years, and two years as assistant director and then five years as executive director of the clinic, prior to coming to LA.

MM: Were there any particular things you learned from working at Pueblo that became useful later?

RQ: Wow. I think that it was a strong training ground. In terms of the community mental health issues at that time – I mean, this was 1972. There was the Chicano movement, you recall *Raza Unida*, and all of that [*Partido de la Raza Unida,* or the "Party of the People", was established in 1970]. Pueblo was about 49 percent Latino, Hispanic. Again, it was dealing with the whole issue of empowerment – there were few, very few mental health professionals that were bilingual. So I think that one of the things that we really wanted to focus on was the whole question of training and giving opportunities for people that were bilingual to enter the mental health field. There were issues of education; there were again the same issues of sub-standard housing. But it was a microcosm, I think, of all the issues of disempowered communities, and then – does community mental health have a role in working with these communities? Or was ours strictly a clinical [program], being there to receive and treat people only when they came to us for help. And I think it was a time when the federal government was funding community mental health centers to really take a community mental health approach, and outreach was one of the basic services to go out and basically work with communities.

MM: So they – I mean, was this kind of a fit situation where they were looking for someone with your type of community organization approach to run this program, and there you were? Because, I mean, when we think of mental health centers, we tend to think of psychiatrists and psychologists, and social workers moving into this role is a little different, at least to the uninformed person [she laughs].

RQ: No, I think you're very right. [In fact, social workers were moving rapidly into supervisory and management roles. In addition, we were trained with a psychosocial and community perspective which was more current with a community mental health perspective that the training of psychologists and psychiatrists at that time.] I think it was very, very different, and it's something that later on, I'll explain, as I became director here in L.A. County.

I think there were a couple of reasons [I got the job in Pueblo]. I think one was they did want someone, when they were looking, they did want someone that had some experience with mental health, OK, which I had had – in the mental health field. I wasn't a therapist, but I had worked as part of a team on what we called the Weekend Family Therapy Program, which was a special project in New York City. I worked at that for two to three years under Dr. Clifford Sager [a renowned marriage and family therapist, 1917-2005].

MM: Was it therapy for the whole family?

RQ: Well, it was, again, working with families, Puerto Rican families, where one of the members had been diagnosed as schizophrenic, and where there had been multiple

hospitalizations. And our team consisted of myself, a psychologist, an anthropologist, and a psychiatrist. In fact, it was an anthropologist who really headed this team effort. But basically, it was to involve the family and to provide something outside normal working hours where we could see individuals, where we could provide support services in a variety of issues. It was also a research project, so we had – interestingly enough, this program began, I think, back in 1966, but at the end of three years, of 10 women that we worked with – and I think the most effective people that intervened were not ourselves. I think [it] was a [woman] psych technician, who was Puerto Rican, and then a woman who was another psych tech and she was Irish [Marcia chuckles] and lived on the Upper East Side, and it was amazing what they did. But we lost [only] one person to hospitalization during those three years, and the results of the project were very interesting.

MM: And was there a hope that the ill person would move toward recovery in this way, or was it just a matter of sort of keeping –

RQ: There was absolutely the hope that the person would move towards recovery. And I can tell you this, that for persons that had been hospitalized on a multiple basis – what we did also, by the way, was to work with the fathers, the husbands of the family, many of whom didn't understand where some of the dynamics were going. I'll give you one simple example. Margarita Pedroza was her name.

MM: The psych tech.

RQ: I even remember her, the psych tech. And Margarita would take – when we did the intakes and accepted, and did a video tape of the persons, and they looked so different. They looked unkempt, haggard. You would think they were 10 to 20 years older. Margarita would work with them, in terms of taking them to a beauty shop, working on [their] physical appearance, and I was kind of intrigued. The only way we could get some of the guys in – About six months into the project, some of the guys would come in, and they came in only to see why their wives [MM laughs] wanted to come to this program on a Saturday. You know, because they felt, "Well, what's going on here?" I would say that it was Margarita, and then Mary McTierny was her name, who really, I think, were the people that empowered and helped. We had a very good psychiatrist assigned to the team. That was just the beginning of medication, as you recall, and I think that the effort was to give less, not more.

So it was an interesting project. It was one of total involvement. It also stimulated my interest in mental health, because what I learned was you can't give up on people that have been diagnosed, some that had been diagnosed accurately, others, inaccurately. But that the main thing was not to give up, to seek empowerment, and then also to look at what are the strengths that they had, that they could come with.

MM: OK, and then you were able to bring this perspective to Pueblo.

RQ: Yes. I used a lot of that experience in terms of trying to expand the program in Pueblo.

MM: OK. (to TG) Did you want to ask anything at this point?

TG: Well, I guess we're leading up to how you got first involved with DMH in LA County, which, I don't know if that jumps too far ahead, but it sounds like we're leading in that

direction.

RQ: OK.

MM: Unless there was some other stopover along the way that we don't know about.

RQ: Right. Well, I think that basically – and during the majority of the time that I was executive director in Pueblo, I also had the opportunity to attend some national meetings. In 1979, a couple of people told me about an opening that existed here in Los Angeles. One of them was a guy that I later recruited back to Los Angeles, that worked [here] for many years – Ambrose Rodriguez [Rodriguez founded the Latino Behavioral Health Institute in 1996 and served as assistant director of the Adult Services program at DMH].

And I was told that the program was in the midst of being reorganized, and there was – I'm sure you'll interview him – someone that was named as Director of the program here, Richard Elpers, J.R. Elpers [Elpers served as Director of DHM 1978-84]. And [he was] a young psychiatrist, coming in and reorganizing the program, and I think, doing some very exciting things. One of the things was – the program had separated from the [County] Department of Health Services and it had become its own separate Department.

MM: Yeah, about '78. It would be just before you came.

RQ: Yeah. And at that time, the program was divided into five Mental Health Regions, and I was recruited for the Mental Health Region in the San Fernando Valley. So I became the Regional Director. And that's how – I'd interviewed for the position, and I came here in May of 1979, and was one of the five Regional Directors that had come here.

MM: And so what kind of responsibilities did you have? What did you hope to achieve? What were you looking at doing?

RQ: OK, I think that's a good question [MM chuckles], because the position was brand-new. So I remember some of us – when I came on board, one of the first jobs that we had was to locate an office for us [both laugh]. So, I mean, here we were, the first [Regional Directors]. The other thing that I should mention, which is interesting, is that Dick had also hired two non-physicians – myself and Allan Rawland – Al was the Regional Director for San Gabriel and I was Regional Director for San Fernando, and we were the only two non-physicians. The others were psychiatrists. I think the responsibility was to really develop a mental health system within each of the regions [and] to really work with the community.

There were both public and private agencies. There were public agencies that were under the auspices of the County Department of Mental Health. We had County clinics, and then we also had contract agencies. And I think that one of the issues, one of the first issues we dealt with, was the tension that existed between County-operated clinics, and then also the private agencies. And if I'm not mistaken, I bet that there is still a little bit of that tension going on. But the basic issue was because here County agencies were responsible for a particular target area. The West Valley Mental Health clinic that was located at that time in Tarzana was responsible for the West Valley. And then you had the San Fernando Valley Community Mental Health Center under Lila Berman, that

was responsible for the Valley. And then you had another CMHC that was responsible in Pacoima. I think it was called Hope. You had different ones – Glendale Community Mental Health Center [a private, non-profit center], and then you had East Valley [operated by the County].

So the biggest challenge was how do you develop a system out of that? We also [had to] deal with the tensions and the feeling by the County that the private clinics were going to usurp their responsibilities and take them over. And then vice versa, having the other providers feel, that the County really was not supporting them. And I think that the unique thing about San Fernando – I think the first part in assessing it is that each of these clinics, I think, were playing a vital role, had some unique expertise in their areas. I think that – some people would disagree with me – Lila Berman was a visionary in many ways, and I respected that, and I felt that she needed to be a part, then, of any planning that we did. San Fernando Valley Child Guidance Clinic did excellent work with children, and still does, I think. And there were others – the Glendale Community Mental Health – I mean, I could go on, Hope in Pacoima, etc. So it was a challenge, I think, in terms, because the challenge was, is he going to really protect County services because he does work for the County, and to what extent, on the other hand, is he really going to be supportive of private agencies?

MM: And so what do you think was the thing you did best, then?

RQ: Well, I think that what I tried to do was [to engage agencies in a collaborative manner]. And I think that in the five years, as I look back on it – First of all, it was one of the best experiences I ever had. I think working in the San Fernando Valley was easily one of the best experiences, in terms of seeing the strengths that were in the system. For a long time, I felt that with scarce resources – and they were becoming more scarce – that what we needed to do was to avoid duplication of services.

MM: That makes sense.

RQ: So that if you had – I remember we had a large mental health component in the Valley – in the upper Valley, Olive View [Olive View Medical Center in Sylmar was built in 1920 as a tuberculosis sanitarium. A new hospital opened there in 1987]. A huge mental health clinic in what was a barracks-like setting. And what we [worked on], I think, through [strategic] planning, was how do we redirect some of these resources, and how do we develop things that were needed. So one of the new services that was developed, I think, in two or three years, and it was one of the first of its kind – and Al Rawland and I used to joke about the competitiveness between us, you know, who would develop what first?

But anyway, we developed a crisis intervention, the mobile response team in the Central Valley. So it was the first, I think, Central response team. And we took a lot of the staff that were up here [and closed this particular clinic] and augmented – the [County] San Fernando Community Mental Health Clinic, and we developed that as mostly targeting Latino population. And it was, I think, a very strong bilingual, bicultural clinic. We were fortunate in having really good staff that developed that. And we also had strong support for developing that clinic from one of the Supervisors. And the Supervisor had just come into the area at that time, and also supported us getting into a newer facility. And his name is Mike Antonovich [Supervisor for the 5th District from 1980].

MM: Oh, interesting.

RQ: So he had this reputation that he was very conservative. He may have been, but I have to say, he was very supportive of many of the efforts that we tried in the Valley. So I think that – and I'll tell you later what I felt when I became Director, about going the extra mile in the years ahead, and in terms of the thoughts about the Centers. But I think that what we tried to do was to utilize the expertise of staff, to do an inventory of what are the [unique] skills, and what is the expertise of staff, and then to use that expertise in filling in the gaps of services within the Valley, as opposed to saying, "Everybody's going to be doing the same thing."

MM: And what do you think – I usually ask, what was your biggest failure during this time, or what do you think you should have done that you didn't do, or – ?

RQ: OK. During this particular time in the region?

MM: Mm hm.

RQ: OK. I think that prior to becoming Director – if I had stayed in the Valley a couple of years [longer], we might have been able to pull it off, I don't know. But I felt this – that County staff and County resources should go to the most emergent needs of the County, [similar to] the fire department, the police department, etc. That County resources should go to the most emergent need that the County had. That emergent need was ensuring that the people would be diverted from jails, diverted from institutions, and that we had an emergency response system that could do that. I felt very concerned that people throughout the whole County were ending up in emergency systems and that, because of a lack of availability after five o'clock of bringing someone to a non-hospital setting, that they would go to a hospital, and that once you go to a hospital, then you increase the probability or the chance that then the individual is going to be institutionalized. If the hospital was filled, that individual was going to go to jail. OK.

So at that time, by policy – and again, I want to say this, I think the County staff and the County people and the private agencies have always tried to do the very best with the resources that have been available. I think that's a given. But I think that there was also a need to look at, by policy, what we do. We had a jail program. And the jail program at that time was an excellent program. We still need it, in terms of being able to help individuals that were going to jail. But my feeling was, why don't we develop something outside of the jail, too? And put some of the resources behind that. Instead of having – and let me be clear about what I'm saying – instead of having an outpatient clinic that would operate nine to five, Monday thru Friday, my feeling was, let's look at those resources, and can we develop something that's a crisis management program to work extended hours as an alternative to the hospital?

So we developed one. It was the first crisis management program in Van Nuys. It was developed under this fellow that became, I think he was the director – Ron Klein [currently one of the district chiefs for DMH Service Area II]. I understand he still may be working. You should talk to him. He was a psychologist. And Ron did a fabulous job in terms of pulling the staff together and really doing it. And we had a very dynamic psychiatrist – Steve Wilson – who also was instrumental in getting this program off the ground. So when you say, what was the biggest failure? I felt that we needed to

duplicate crisis management programs throughout the Valley.

MM: And you felt you weren't able to do that?

RQ: No, no. I think that – later on, I'll explain the jump when I became Director; but in San Fernando, I think because of the strength of the community mental health centers, and also, I think the willingness of the staff to look at different things, we developed – we were able to develop the CMC [Crisis Management Center]. [We were able to close the underutilized and large County clinic on the grounds of the old Olive View Hospital in Sylmar and redirect staff resources to establish the Van Nuys Crisis Management Center and augment the County-operated San Fernando Mental Health Center.]

So I think that we were able to begin doing some things that maybe might have gotten us there. But I think that I wanted to see more interchange between our staff – We had an excellent child psychiatrist. There were two child psychiatrists that I can remember, there were probably three, but both that I remember very well, that what I had wanted to do was to expand their role. So that, instead of just being staff psychiatrists to the clinics, they would be able to have a role within the whole system and be able to work with developing medical [and] psychiatric training throughout the private system as well. Because I remember that one of the critiques was well, the private providers were not as clinically sharp [as the County providers]. And I used to say, well, then, let's share staff, even though I didn't necessarily agree with that. I didn't agree with that, so that was, I would say, a disappointment.

We were able to get a CMC off the ground; we were able to develop a bilingual, bicultural program in the San Fernando Valley. I think we were able to develop planning mechanisms, and we had an excellent advisory committee that Dick [Elpers] had wanted to develop in each of the regional areas. And I think we had an assistant director at that time under Dick, Harold Mavritte, who I absolutely loved, and was very supportive in the things that we wanted to do, and so was Dick, in terms of doing these things, so we received a lot of internal support as well. [Harold L. Mavritte served DMH from 1968 until his retirement in 1983. He was briefly Acting Director of Mental Health Services in 1978.]

MM: How was your relationship with Elpers? Did you learn things from him? You say he was supportive of you.

RQ: I feel that – yeah, I would say I definitely learned some things with Dick. I think that he was supportive. I think that in terms of the staff that he brought on board, he was open. We had meetings and bringing us on board to discuss policy issues, etc. So I would describe my relationship as good with him, during that time. And I think he was supportive of innovation and doing some things. He definitely brought a different perspective to the Department, and Dick was very opinionated [MM laughs]. But, in terms of a lot of things that he wanted – the basis for decentralizing the agency, and later, I'll talk about why I felt it needed to go further, but in terms of decentralization of services, [and] working with the community, I think that Dick brought a lot to the Department in that regard.

MM: OK. Just let me ask this one question quickly – so you had really moved, then, from being very much on the front line in clinical work into taking a broader program perspective.

RQ: Yes.

MM: Did you find that transition difficult to make? Did you miss being actively involved in clinical work?

RQ: No, I think that, as you go into administration – the pitfall of administration is whether you want to or not, you're going to get away from the clinical work, and I, again, was never a clinician per se, within the system, so I think it was easier for me to make that transition, not being involved on the work site, as a clinician. But I would say that the key is then to identify and respect clinical expertise where it works, and bring it into the decision-making process. I think that's key.

So, for example – let me give you specifics – one of the first things was to recruit a psychiatrist, and in the San Fernando Valley, we had existing County psychiatrists. Some of them were excellent. One was George Bajor, who was the head of the East Valley Mental Health Clinic, had been in the system for years. Some people felt, well, George doesn't seem very enthused about things, and yet, when you got to know George, he brought a hell of a lot of expertise to the table – very knowledgeable about the system. So one [issue] was how to make best use of George within the system as well. By the same token, bringing somebody in to the central office to give a different perspective to utilizing psychiatrists within the system was needed. So at that time, we recruited Steve Wilson. Steve was a young psychiatrist at that time. I'm not even sure if that was one of his first positions – I don't know. But he brought a lot of energy into the system, and good clinical expertise.

So I guess my response is that yeah, you can be away – as you go up the ladder, you get away from it, but I think the key is, how do you keep that perspective and make sure that those needs are also being looked at? Not always successful, by the way. Not – particularly one in a system as big as LA County, and, I'll have something to say about that, if you're interested [he laughs].

MM: [jokingly] A little bit [she laughs]. OK, so Dr. Elpers eventually left. So tell me about the circumstances that led to your becoming Director.

RQ: I was, at that time, the Assistant Director. Dick had appointed me Assistant Director. And Harold had left shortly after I came on board, or when I came on board. And Dick announced he was leaving the Department of Mental Health, for reasons that you can best discuss with him. And after he left, I was appointed interim Director for about a year. At that time, I will tell you candidly, I did not want to be Director of Mental Health. I wanted to go back to the Valley. And the reason being, I felt the system – not because I felt any trepidation about taking it on, I felt the trepidation about how huge the system was, and politically, the issues that existed. So there was a strong – at that time, and I'm not sure where – there were people that wanted me to become Director. I mean, let me be just as candid as I can. I got encouragement from a lot of people in different levels of the system to be Director.

MM: Who were they, and why do you think that was?

RQ: I got encouragement from people in the private sector, who felt that, I think from the experience in San Fernando, I had something to bring in. I got people internally. There

were also people within the Latino community who were encouraging me to be Director as one of the first Latinos to hold a position within LA County, because LA County did not have hardly any Latinos in positions as Directors.

I got encouragement from two Board [of Supervisors'] offices. And who else? And then from some of the staff, from within. So I think I even threw my hat in pretty late into the game, but just before the deadline; and then went through the process – through the interviews. I had to be interviewed by the Board, and through whatever interview situation had been set up. But I think that it was a challenge. I was the first non-MD that would be considered for the position. First social worker. I mean, there were a lot of firsts – first Latino, first social worker, first non-MD. So that's why I applied.

MM: And you decided – and you accepted. They offered it to you.

RQ: Yeah, I thought about it, and, I think up to the last moment, I really thought long and hard about the issues. And part of the issues are the political dynamics that surround the mental health system in LA County, and the issue that it was a huge, huge system. I shared some of my ideas, at the time that I was being interviewed, with some of the Board members, and basically, it was to decentralize the agency even further, from the five Mental Health Regions.

MM: Put more autonomy to the different Regions?

RQ: I think what we wanted to – the first step, as I laid it out, was to develop eight Mental Health Service Areas, which began under us, which exist today, by the way. And eventually to give them quasi-mental health authority to develop, and [be] truly independent, to be funded by the Board of Supervisors, have the Board and a central Department. Well, I'll get more into that later, if you're interested in hearing about it.

MM: We're sort of at the point of doing that now. So that was sort of one of the goals that you had. Did you have other goals? I mean, what were your other goals?

RQ: I think the other goal was to see what we could do for people that were seriously mentally ill. I think that I worked very closely with AMI at that time – the Alliance for the Mentally Ill [later NAMI, the National Alliance]. At that time, we had Peggy and Don Richardson – Don was in a leadership position, Stella March, that was in a leadership position [The Richardsons and Stella March were members of AMI California, who became active on the National level. Don Richardson served as Executive Director in the early 1980s]. I felt that they were a force for change. They brought a lot of impetus for change to the system.

MM: Change in what way? In providing more services?

RQ: No, I think the impetus in providing more services, but the kind of services, to look at, for example, housing. I was concerned that – when I came on board, one of the things that Dick, at the time that I came on board in the San Fernando region, Dick and Areta [Crowell, then Program Support Director, later Director of DMH, 1992-1998] and a whole group had developed what was called the California Model [a plan to provide community services to the mentally ill as they were de-institutionalized].

MM: Right.

RQ: OK. And at that time, it was almost pretty much the Bible for change, or at least was thought – I had first looked at it [and] liked it in terms of the basic tenet of it was to move people away from the hospital. Where I disagreed with it was to have various levels of housing. So you had a short-term crisis facility. So I used to say, if you feel better in nine to ten days, we're going to get you out of there; how do we know the patient wants to leave there? So we build a short-term crisis facility and then they're out. Then we put them in transitional care. So that's going to be another – and everything was, 15 [to] 20 days – short-term crisis, and then transitional, and then long-term. I can't even remember most of them. But when you asked about change – I felt that housing was a key component of serving people with serious mental illness. You can't put them in a place that looks like an alternative to a state hospital, but is no different from a state hospital. So I used to be really upset when I used to go to a skilled nursing facility or go to a transitional care facility and I would see this 20- 30-bed place and that I would say, "Would I want my child here if something was wrong?" Would I want them here?

MM: So just from one hospital to something named differently, but the same hospital.

RQ: Right. So I felt that the Alliance for the Mentally Ill was very specific in some of the pet peeves that they had. One, they aimed at the emergency system and the failure to keep people away from jails. Absolutely livid about that. And you would hear horror story after horror story. Same thing with housing – the inability to get really good long-term or permanent housing. So one of my goals was to see how we could move the system, and also work in the development of housing that would be permanent housing for people with serious mental illness; and then provide the support *in that housing* – not have them come to a treatment facility, but outstation and provide mobile support in helping them maintain and find employment, if possible. Yeah.

MM: OK. So now you're the Director. So, well, I know one thing that characterized your years as Director was there were continual funding cutbacks.

RQ: It was awful, awful.

MM: So tell me a little bit about how you coped with those.

RQ: Well, I think first was to realize that the funding cutbacks would have a horrendous effect on the system as a whole. In other words, that, as you were looking at cutbacks, you weren't really looking at developing what you had, [building] more of the same. The first thing was the realization of, it ain't going to be existing – more clinics [won't be built]. I think that what LA County was always, I think, fortunate in, and it began under Dick Elpers, was the role of a mental health advisory board. And I think that having a strong group that could participate in the planning, in terms of looking at some of these issues together with administration, and things like that. I think that the first issue, the first big cutback that we had from the State – by the time I became Director, we had become pretty proficient, even under Dick, of developing "cut lists", because Dick Elpers can tell you about the famous "cut list", as well. OK. Because we really began planning in terms of absorbing cuts under his administration as well.

MM: You would think ahead to what you would have to do.

RQ: Right. So we would look ahead at, in terms of prioritizing, developing cuts. And the

interesting thing was that there were two issues – how do you develop a cut list that would get the attention of the Board and the public, and by the same token, how do you develop a cut list that is not going to hurt you as deeply if you really have to do it. That was a tough one. Because if you basically said, "We're going to cut this," we were going to really deal with it. I think that, when I came on board, my feeling as Director was that we were becoming pretty proficient in terms of entertaining cuts and we had to change the paradigm. And the paradigm change was not necessarily there at all levels. What we had to look at in this system that was serving 12 million people – 12 million, ranging from Long Beach to Lancaster, this huge system – was to begin changing the paradigm, so that we could not become necessarily proficient at absorbing the cuts, but become proficient at identifying a new system of care or a different system of care with the resources that we had.

[We needed to look at the current system in terms of critical resources and which parts of the system could effectively deliver prioritized services within a new framework of service delivery. Similar to the fire and police departments, the mental health system had to operate 24 hours a day, 7 days a week, beyond hospital-based emergency care. The goal would be to expand mobile services beyond inappropriate incarceration and hospitalization. We believed that we had to look at the unique skills, capabilities, and strengths of the County and private non-profit providers and redesign services to meet existing needs. It didn't make sense to continue having County and contract providers providing similar services from 9 to 5 in different parts of the County while the mentally ill were housed in the jails and walking the streets. The Skid Row Mental Health Clinic won a national award and was an example of highly skilled County resources meeting a critical need in a non-traditional manner.]

So I embraced the issue of priority-based budgeting. And priority-based budgeting being – if we were able to look at this system with X-amount of millions of dollars and say, rather than "This is what exists and this is what we have to buy into," [say] "If we had to build a system with this base of funding, what we would we build and what would it look like?" And I wanted – there was a person by the name of Jack McDonough [Professor in the School of Management, McDonough came to UCLA in 1984]. Do you know him or [have] heard of him?

MM: I know the name.

RQ: Jack McDonough was the head of Planning at UCLA. He was a professor. And brilliant, supportive, and, I remember that, in sitting down – because what I did was to sit down with some key people and talk about this because it wasn't going to be embraced at all quarters; and I have to tell you, it wasn't embraced at all quarters, and I went to hell and back. Took it on the chin.

MM: Was that your staff? Was that the Board? Who was that?

RQ: No, I think in some places – I have to tell you, the interesting thing about it is that the majority of the Board [were supportive], whether it was Kenny Hahn [Supervisor for the 2nd District 1953-92] or Mike Antonovich or – Who was it?

MM: Edelman?

RQ: [Edmund] Edelman [Supervisor for the 3rd District 1974-94], yeah, to some extent. [The

Supervisors actually voted additional County funding to offset some of the loss of State funding and this was above the State-required County match of 10%. This was a bipartisan vote.]

But I think that, in looking at what kind of support I could get, most of the questions came from people that had been pretty entrenched into the system. I mean, you would think that, somehow, the people that had been there the longest and had been entrenched would embrace some change, and I think some changes were being embraced, and I was supportive of them, but I didn't feel that it was a systems change.

Let me be specific. I worked with a young legislator [Richard Polanco, State Assemblyman representing Northeast Los Angeles 1986-94, State Senator 1994-2002] at that time. But I think that one of the things that was before the State at the time, as people looked at the cutback in funding – and I'll get to how we dealt with that issue – one of the programs that was put before the State was the Intensive Care Program – in other words, there were models that were being developed in Long Beach that was outside the Department [The Village, developed by Mental Health America in 1990] that became the basis for today's program, which targeted people with serious mental illness. And it's a hell of a program – I mean, it's had a lot of successes.

My concern at that time was, in a system that was underfunded for children and adolescents, where kids at that time had $2.000 a year behind their cost of care, that we were then proposing $17,000 a year, per person, to target a hundred and fifty people [per project]. And five projects were set up and we knew that they would be eventually successful because I think [the approach] made a lot of sense. And it was the first – the forerunner of what, today, they call managed care or capitated care. My concern was that there never would be sufficient money in the system, at least in the next four to five years, and [this was in]1986, to develop and duplicate that in all parts of the County.

So I said, in order to have this, we should also then advance legislation that begins [truly] decentralizing mental health services, and taking it out of the governance of the County and develops eight mental health authorities, quasi-independent, that would be provided funding, and that would have the responsibility for planning, organizing, and administering a mental health system within the area. And by the way, Jack [McDonough was part of this] to remember that, we even had down how this would be done; it would be inviting the public and private sector, institutions such as UCLA and USC.

MM: OK, so stakeholders.

RQ: Right. How we dealt with cuts –

MM: But nothing ever came of this legislation?

RQ: Yeah, the legislation – it went through some modification, and if you're interested, I'll look for it.

MM: I'm always interested, yes.

RQ: Yeah, if you would be, the legislation went from – it was massaged. You know how everything gets massaged in Sacramento [MM chuckles]. So it went from developing

these service areas to a study, and it went to a two-year study. And the two-year study would lead to decentralized – in other words, [the study asked,] is a decentralized system in the best interest of the [mentally ill] – but it was a step. And it passed, it got bipartisan support, it got the support of the Republicans and the Democrats, got the support of Mike Antonovich [and] Kenny Hahn. I got all support at the local level for this. And basically, what I said at the time [was] that we're losing resources. We need to come up with a way [to provide services with the resources available]. Crisis breeds opportunity. And we're either discussing these same issues 20-25 years from now, or we'll have a different kind of system of care.

Anyway, it got up to the Governor [George Deukmejian, governor of California 1983-1991], and he vetoed it. And he vetoed it, saying that a different kind of system had been developed – the [Integrated Service Agencies]. Setting up the five pilots [pilot projects]. And I have to say at that time, the Mental Health Association was not too interested in looking at a different system. So when you ask about where [was] the biggest things [opposition] – I think it came sometimes from – people mean well, but I think that sometimes change is very scary.

MM: Hard, yeah. Well, and it can be very difficult.

RQ: In order to deal with the loss of funding, we developed a cut list, but my approach at that time, was to say is, if we have to not only cry wolf, but then do it. If it happens, it happens, and we have to do it. So we combined two things – I put on the cut list five mental health clinics. And we tried to go through the process of identifying clinics through – this was not done [at a] centralized [level] – [it was done] through a decentralized process – which of the clinics are going to be underutilized or least utilized right now? The other thing that I had a concern about was, if you had a clinic that been developed – let's say the clinic existed in 1975, and that clinic had been set up for 17 people; and today it's 1986, and we have a clinic of five people, five clinicians, and three support staff, does this make sense? Any time in the future, are we going to augment that clinic?

I mean, does it make sense in terms of security, in terms of what we had to do? I think one of the low points – I think it was *the* low point of my career in the County was the death of Robbyn Panitch, who was a social worker, working at the Santa Monica Mental Health Clinic. [Panitch was a psychiatric social worker at Santa Monica West Mental Health Service who was killed in her office by one of her clients in 1989.]

MM: She was killed by a patient. Is that right?

RQ: Right. I mean, it was horrible. And the response at the State level at that time was, well, let's put more security and let's put bars. Why didn't you have bars in the clinic sites?

MM: [sarcastic] Yeah, that really helps.

RQ: Give me a break, we were developing jails, or what? So I think that the response was no, we don't need more bars, what we need is more people, and we need decent facilities, instead of facilities that were antiquated. So what I said – if that's not going to happen soon, let's bite the bullet, and let's redirect that staff to other services, and let's close some of the sites. We also tried to cover those sites through neighboring resources. So it wasn't a question – even though it was projected like that, that we were

just leaving everyone out in the cold. It was a horrible time. I didn't like cutting clinics. I mean, there was nobody that can like cutting services.

What I did say is crisis breeds opportunity. Let's do something differently. So what did we do differently? We privatized three clinics at that time – there was an El Camino Mental Health, which was in Santa Fe Springs, and that became a private clinic, a bilingual, bicultural program. But Pacific Clinics won the RFP [Request for Proposal] on that, and they developed a program, and I think the program still exists. It's an outstanding program. Out of the Asian-Pacific County program, we privatized it. It [the RFP] was won by the Asian-Pacific Council. If I'm not mistaken, that program still exists. And then ENKI [ENKI Health and Research Systems, Inc., which offers mental health services and conducts research] won an award for developing a program at what used to be El Centro. [There was] also a County-operated clinic, but El Centro was a private agency at that time, too. But, anyway, what we did was that, again, with the support of the Board, [we] privatized some of the services. And I think people would say that those services have been pretty effective.

MM: So they have continued on a contract basis.

RQ: They have continued, they exist until today, and I think have developed some interesting things. And all of this was done under the aegis that if you're going to lose money, you got to do something differently with some of the resources that you have; you can't continue along the same path.

MM: But [she laughs] not to tell you what you should have been doing – I mean, you talk about when you looked at some of the cuts about crying wolf, because clearly, that's something that obviously the Board needed to know and the State needed to know how painful these were going to be.

RQ: Behind the scenes, and I think also publicly, there was a lot of support for increased funding and we can.— one of the things that gets neglected is that, looking at 1988 and '89 – the Board increased its funding for mental health programs, when it didn't have to because it was a State responsibility. And it was the responsibility of the Board to match it only by ten percent at that time. But yet the Board of Supervisors came through with about 9-12 million dollars' worth of funding to keep some of these services going. So it was a combination of trying to look at some of these resources, and also continuing to advocate and see what we could do to get more funding into the system. And I think some of the Supervisors were behind [us] in terms of getting that funding.

We also developed a strategic plan at that time, which was presented to the Board – I think in 1990. And the strategic plan was along the lines of what I'm talking about. We also laid out what could be purchased with x-level of funding, so that, as the Board said, well, if we did this amount, then this, specifically, can be purchased as part of the system. And, again, the Board never saw it [the strategic plan]. It was kept from the Board by the CAO [County Chief Administrative Officer] at that time. Again, the politics. That somehow it had to be introduced via the CAO. And Jack was the chairperson of the [Mental Health] Planning [Commission]. So, I mean, when I talk of politics, there's a frustration about those political aspects, as well, that probably exist until today because you can plan from here to Doomsday or to kingdom come [but not everything you plan will get through the process].

[The plan was never presented to the Board as the result of a decision by the CAO. the plan had been generated through the leadership of the Mental Health Advisory Board and with broad-based involvement which included intensive planning efforts of the Service Areas Advisory Committees. It was disheartening to see this effort tossed aside and this episode once again indicated the importance of a decentralized governance structure within LA County, more attuned to local strategic planning efforts, effective utilization of existing public and private institutions and resources and a public and private partnership in resource development.]

MM: Did you have any particular strategies for working with the Board? I mean, you've spoken about the support some of them gave you.

RQ: I think that one of the strategies I think is just to work openly with the Board, and being able to provide information. Now you had to make a good relationship with everybody, but you had to jump through hoops at times, to deal with some of the County [rules]. For example, we wanted to buy [or] rent a facility that was right near our old place near MacArthur Park [General Douglas MacArthur Park, a well-known public park in Downtown Los Angeles], and the facility used to be an office of an insurance company or something. So we wanted to move our central office staff. So I looked at the facility. Our person inside that was head of Facilities Management had located this place, and we looked at it, and I loved it. I loved it because it had this huge cafeteria with all of the stuff and all of the equipment that you needed. At that time, Portals House and other agencies were developing services and were developing vocational rehabilitation services. [Portals is a mental health and social service agency. It merged with Pacific Clinics in 2007.] The first thought was, wow, if we could get some of our clients to come in here and operate this [cafeteria] and maybe own it or whatever, through the agency they're working with, this would be really a way to go. So we executed the lease. Now we had to go through the Facilities [office] Downtown, [and they] came in and tore down the cafeteria.

I think that there were issues that came up when we looked at one of the big tensions. And let me talk about it. Latino, bilingual, bicultural services – big tension. L.A. County is a multicultural population, and the system has to adapt. The system has to look at, as we're serving this population, do we have the bilingual capability? Do we have the cultural know-how? Do we have the staffing? Do we have the hours of operation to meet the needs of this population? I think it wasn't just my pushing for it, but I guess that, in pushing for it and in insisting that that be part of our planning, you run the risk that people see you as, quotation marks, "militant." You know, "He has a focus that this is what he wants to do." Well, you bet. If it wasn't there, that was going to be my focus in some of the issues. And it wasn't there. I think that that led to privatizing some of the services, so that today we do have an Asian-Pacific program, etc. So I think that led to some backlash, where the perception is that we were interested only in this, and only in that particular issue.

I think what is forgotten is that that has everything to do with good clinical care. If you cannot accurately diagnose someone and know what is happening, how can you provide good clinical care? What is good clinical care? So I'm proud of what we did, even though it was painful, and even though we went through some backlash internally and stuff like that, I think that what we did was to – some people felt that we gave opportunity or we had people that were minorities as part of administrative staff, or that we moved more minorities – well, we did. We wanted to give opportunity for people to get

experience in administration and to get experience in being able to climb up the ladder. And there were people that were competent and people that could do the job. So I think that –

MM: So we're not talking strictly Latino here. We're talking African-American and-

RQ: Absolutely. We had Asian-Pacific persons. We had really a multi – I mean, when I look back on it, we had really a multicultural staff that was represented at the mid-management and upper-management levels. So it was not – I had very good support from the Asian-Pacific community. Yeah, and I felt this was not just a Latino issue, it had to do with the way that we were providing services to the Afro-American population, and being concerned – I used to say, "If we're not concerned that the majority of people in our state hospitals today are black, what are we concerned about?" I mean, we go into our emergency rooms and what do we see in the inner-city? So I mean those issues – and what I was trying to do as a system is talk about this. Don't get scared about it, just talk about it, and how do we begin addressing some of those?

MM: OK, so among your staff, then, were there people who particularly sort of stand out as being particularly helpful or contributing at this point?

RQ: I think that any success that one has is really due to your staff. I think that some of the staff were just remarkable, and some of them are still staff at the Department of Mental Health today. But I think that some remarkable staff – I remember people like John Hatakeyama [Former director of the L.A. County Department of Children and Family Services and former director of the Asian-Pacific Counseling and Treatment Center], and there was Fernando Escarcega, who had worked in the Valley. I can give you just a list of people that just contributed tremendously – at the administrative level as well as at the clinical level – that really contributed to the development, I think, of the program, as well.

MM: And then, you've spoken of that there was some internal backlash, as well. How did you deal with that?

RQ: You know, you have to develop a thick skin. You really do. And I think that, in some ways, you deal with it and in some ways you don't, to be honest with you. In some ways, it's something that stays with you. You try not to take it home at night, but it does. I think the criticism and you try to explain, and stuff like that. I think that you develop [resilience] by trying to focus on some of the good things that happened within the Department, as well. And some of the little things that you see – for example, in 1988, Skid Row Mental Health Clinic was named the Outstanding Public Mental Health Program in the country, and we traveled to Washington to receive the award from President [Ronald] Reagan at that time. But, I mean, some of the stuff that had been done by some of the staff, in each of these areas. And I think that the expertise that people brought in and people that had – and I mean, you have different staff play different roles for a system, I feel. I mean, it's really interesting. You have some staff that are going to be all revved up in supporting the system [and] some staff that may not necessarily believe in the change, but what they do is to provide a stability for change to take place. And some staff like – one of those staff is Dr. Milt Miller, at Harbor-UCLA, who used to be the Regional Director, and was an incredible guy and ran a very, very good program. So I think that –

MM: So he was part of the stability part.

RQ: Yeah, yeah, because I think that you have enough instability as it is with the cutbacks, and the cutbacks were devastating. There's no way that you can explain – when you ask how about I deal with it – I mean, to understand that you really can't go to a place and say, "You're going to be cut back. The clinic is not going to exist any more," and make somebody feel good about it. So I used to go back – I used to feel like hell about it, and you have people around you that can be very supportive [and] are very supportive. My immediate administrative staff [was] Barbara Johnson, who I understand is still there, and Barbara was a sounding board. [Barbara Johnson has worked at DMH since 1968, serving as Executive Secretary to DMH Directors Roberto Quiroz, Areta Crowell, and currently, Marv Southard.] I would ask her for her opinion on some things, because I'd feel that it would be an accurate take. But you cannot make people feel good about something that they're losing, and you just sort of have to understand that. And the only thing you can do is to try to replace it with somebody else, saying, hopefully, there will be something better off the [road]. And there's got to be a silver lining, a silver lining that with all those cutbacks – we cut sites, but minimally cut staff. Minimally. You can go back and look at the list. We didn't have to issue a lot of layoffs, and that was something that I used to tell people I'd rather have a person there, than have the facility, a person has not lost their job.

MM: Were there any instances in which people actually sort of opposed something you did and made it difficult for you to work with them?

RQ: Oh, yeah. Sure, sure.

MM: So how did you deal – you don't have to be specific, but how did you deal with that?

RQ: I think that the best way that I can answer that is to be damn sure of what you're doing. To be damn sure of what you're doing. If you feel, deep down inside, that you've gone through a process of hearing from people, if you've gone through a process where you trust the judgment of others as well and it's not just you out there baying in the wind, but you've had people that you trust and you respect and that feel, let's go, and it's decision time, then you just bite the bullet and deal with it that way.

MM: So it's key to have people who support you.

RQ: I think to have people that support you and to have their best advice, to look at the issue frontwards and backwards. I don't think to do something impulsive – It may appear impulsive, but I don't think to do something impulsively, but to really look at the issues and have the – at that time, the Mental Health Advisory Board was with us. It was a big thing for me, to be able to have the Mental Health Advisory Board participate in some of this. And other times, you get paid to make decisions – I remember going and I told the group, we need to look at – let me be specific and then you can see the difference, in terms of how you implement policy.

I can't bring a group together to talk about, specifically, what clinic to cut, because it'll generate more conflict. If I bring a group together and ask them, "OK, let's talk about the clinics today we want to cut," I'll be there until Doomsday. I can bring a group together to talk about the criteria for cutting. Once I know the criteria, I can identify the sites. The sites will know that there is a possibility we're looking at this, because I'm going to call in their District Director, their chief, and tell them. But whatever we're going to do, we're

going to try to do quickly and with less pain. With less pain. OK, what does less pain mean? It means that if I'm cutting the San Antonio clinic and I'm privatizing a clinic here, that I'm going to develop a contract that will give this staff first crack at the job, so that they don't lose their job. And that's exactly what happened. They had first crack at the job here. Many of them took it, with some guarantees that would follow that.

Secondly, I'm also going to advise the Board [of Supervisors]. I'm going to – there used to be a term that "you walk the hall." So you walk the hall and say, "This is what we're thinkin' about.". So there's a process that you're going through, but in the end, I think that in decision time, you're lonely [he laughs dryly]. That's the only way I can say it – in decision time, it's a lonely, lonely place to be, and you just have to deal with it.

MM: Troy, do you have some questions you wanted to ask?

TG: Yeah, well, I'm wondering if you think there are lessons from your time – your whole time in DMH, but particularly when you were Director – lessons that you think the Department as a whole, or the Director, or however you want to break it down, maybe could learn or should learn and haven't.

RQ: You mean lessons that –

TG: Lessons in terms of administration, how to handle financial issues, issues at clinical sites – that kind of thing.

RQ: Right. OK. I think that, I mean, in terms of lessons, I'd say you have to build around you, I think, a strong staff that is going to be capable of doing things that you don't know and you may never know. When you talk about financing, you got to have a strong fiscal staff, and you have to have a staff that really knows its stuff. The idea that an administrator knows everything is just hogwash. The idea that an administrator is going to know finance, clinical work, administration, community, planning – it just doesn't happen. So I think that you have to be very honest in terms of assessing what is *your* particular skill, what is the thing that you can bring to the table in terms that you have. OK. I think one would be in terms of a skill set that an administrator should have, particularly in L.A. County – working with people in the community is absolutely key; working with a multi-ethnic community is absolutely key; and working with divergent viewpoints, I think, becomes absolutely key.

I think that, in terms of – you have to have some budget experience. I mean, you have to know how to read the budget, but you also have to know how to make some budget decisions. And I think that, particularly at a time of cutbacks, it really tests you, because you're a great administrator when you're getting bucks and when you can develop programs. Try administrating when the bucks are not there, it really tests your mettle. And I think that you have to be ready – I mean, that is the one time that you can't be all things to all people. Something gives, and I think as long as it's consistent with a larger plan or something that you believe in, I think that's the important thing. I would – for L.A. County right now, it's absolutely critical that an administrator know the political scene. Absolutely critical. Know the Board, know the decision-making process. Know the inner workings of the County. And also, know your program. You gotta get out there, you have to get out.

I think one of the – when you ask about a frustration – is that I couldn't get out often

enough, and when I did, it was – it's just invaluable in terms of being at the clinics and visiting the clinics and hearing from staff, and things like that. So I think that not sitting behind a desk is important. Getting out there becomes very, very critical and important. I think that that's about it.

TG: Yeah. What about how the Department is doing now in terms of care for Latinos? You have talked a lot about the importance of bicultural and –

RQ: I can't address that, because I really don't know. I haven't been part of the Department for a long [time] – I did take part five years ago in a program that was run by Ambrose Rodriguez, and it was LAP – the Latino [Access] Program, and knew somewhat about – but I was mostly focused on working with the staff within the program, so I can't tell you. I don't know what's happening in terms of ethnic issues and stuff like that.

MM: Well let me ask you – you spoke about the importance of having bilingual staff and people in the administration. Are there other – I mean, we talk about cultural competency, and I'm always reading about cultural competency, but people have a hard time defining it. Are there particular issues in dealing with the Latino mentally ill in terms of, not linguistic, but cultural issues – relationships to family is what I'm thinking of in particular, that people need to be aware of? But you might know better than I.

RQ: Right. Yeah, let me tell you – I think that there are so many things that have been written, and something was written that – you can reference SAMHSA – the Substance Abuse and Mental Health Service Agency (Administration). They wrote a report as a result of a national planning process, and I refer you to that, you may look it up. [Athey J and Moody-Williams J. *Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations*, 2003, online at www.samhsa.gov] If you don't have it, I may be able to dig it out, which will answer some of that question. But I can [talk about] what makes cultural proficiency, and today, we call it cultural proficiency. I think that there are two issues that you have to look at, and this is my own personal opinion, and nobody else's, I guess.

MM: Well, that's what we want [she laughs].

RQ: Yeah, I think that, when we treat a person that is schizophrenic or when we are working with someone that is schizophrenic, if we ask the question, is there such a thing as a Latino schizophrenic?, black schizophrenic?, white schizophrenic? – I think that we would be hard-pressed to say that there are major differences. We would say that the manifestation of schizophrenia and what they're evidencing is pretty much cuts across ethnic lines. What may be different is the way that we approach engaging the person in the system and in the way that we approach treating the person. So, for example, there is mistrust in the Latino community, and if we're looking at – let me talk about it now, either an immigrant population, etc. There may be mistrust about going to a clinic because it is a governmental agency, and there is mistrust that I have in sharing some things. In my experience, Latinos do not gush stuff. We're pretty private. I mean, we don't go into a group and all of a sudden want to gush about everything that is affecting us. So what are the techniques and what are the ways? How do we engender trust? How do we build to that trust? And what are the techniques and the approaches that we use? I think in cultural proficiency, you begin identifying some of those issues.

One issue that kept coming up, as we talked to people and we did focus groups was –

we don't get home between nine and five, because we're working two jobs, but we would love to go to a clinic on Saturday. And we, as a system, would say, "That would be pretty good, but let's go on to the next one. How can we really treat you? We want to treat you." So what I'm saying is that some of the things may be as simple as accessibility and doing it through different ways. Is a support group – I know that when- [TG sneezes] God bless you. When I worked in Denver – and by the way, I worked in Denver as Mental Health Director, as well.

MM: We're getting to Denver, yeah.

RQ: But are there support groups that can be developed, as a way of introducing people to the mental health system and bringing them on board? So I think that when I talk about cultural proficiency, I'm looking at to what extent does the system reflect people that have the know-how that may be bicultural. To what extent is there accessibility of the system during [opening] hours? And to what extent does the program that the clinic operate[s] encourage that kind of participation?

MM: I see. I see. OK. So what else would you like to tell us about your time as Director?

RQ: Hmm.

MM: What did you feel best about having done?

RQ: I feel best about the Mental Health Regions. I think developing the eight Mental Health Regions and developing those within the structure, and I think having that as the basis that I understand today, there is more and more autonomy which is planned, even though I don't think it's really there under what I would consider the mental health authority structure. So I think one was the development of the Service Areas as a planning and a service-delivery structure. I think secondly, the importance of crisis management and mobile response. We put a lot of effort – I don't know to what extent that exists today and where it exists, whatever. But we did develop mobile response teams. And the mobile response teams operated after-hours. They were the first stop. Instead of hospitalization, there was a mobile response team that would get called out, and then to tie that in to a crisis management center. I wanted to duplicate CMC's throughout L.A. County. One of my frustrations –

MM: You didn't do that.

RQ: Well, there were a couple of others that were developed. I think Harbor developed a very good one. But not to the extent that I would have really wanted to. So the CMC's. Attention to the plight of the homeless mentally ill. I think developing a strong mental health program in Skid Row, through some of the staff that existed at the time. And I don't want to mention, because I know I'm going to leave somebody out and somebody's going to get insulted. So I think that developing that approach. The importance of housing. And I can share with you – I didn't bring it down 'cause I didn't want to put stuff [in] before you asked about it, but a letter that I got when –

MM: We're going to ask you about stuff anyway, but go ahead.

RQ: Yeah, when I became Director, a letter that I got from one of the agencies downtown regarding my leadership in regard to housing and the development of housing. Big push

in L.A. in terms of developing independent housing. And I still feel that strongly. I developed that in Denver, where we developed independent housing. I think those were some of the things that I think if I pinpoint – and, of course, I don't know if I mentioned it, the three major ethnic nonprofit or private agencies. Yeah, private programs. I think, basically, we did some other things – we reorganized the emergency room at Harbor Hospital, developed some things at Metropolitan [State Hospital]. I mean, there were some things, but I'm sure that [other] directors can point to things that were done in their tenure. And you've asked me about the major things that I felt that, at least for now, that exist today. I would say the Service Area concept. Stuff like that.

MM: What do you think is the biggest mistake you made?

RQ: The biggest mistake. I think underestimating, at times, the political process. And by political process, I mean, in a larger way, the degree of resistance that would be out there to some change. [But] the change in leadership is evolutionary, and I think different people contribute something to the life of an organization, but what has to exist is somehow continuity in the way that people look at it. So what do I mean by that? I mean if you have an administration of three or four – not generations, but three or four different administrations – and what binds [those] administrations [together] is a belief in a community mental health process, a belief in community, a belief in involvement, a belief in planning, and a belief in a system of change that focuses more intensely on people, and with a focus on serious mental illness – then different people coming from different parts may contribute to that. Dick Elpers may have thought completely different from what I did, in terms of what the administration and what the structure should look like in LA County. But I think that, in his commitment to the process and in his commitment to people with serious mental illness, he was there. Areta Crowell, who was part of my Administration, and later Director of Mental Health in San Diego County, and in Los Angeles County, had that strong commitment as well. So I would say that it's evolutionary, and one would hope that during my tenure, that I contributed in some way to the better things that exist today.

Then I came, and hopefully, I was able to demonstrate that commitment as well.

MM: I hope so, too. And so why, then, did you decide to leave the DMH when you did? That was 1991.

RQ: Oh, I was frustrated. We had developed this strong strategic plan with priority-based budgeting. [The gravity of the fiscal situation not only required advocacy for more funding, which we did, but also realistic critical planning, so that we didn't fall into the trap of becoming proficient at developing cut lists which demoralized and destabilized the system. We engaged in ongoing advocacy efforts. The cuts that were made were not random and reflected our best estimates of how we could maintain highly prioritized and critical services in places. Stakeholders did recognize our efforts in this respect.]

I saw it took a lot to develop the privatization, it took a lot to develop the mobile response teams and the crisis management programs, and I think that there's a time that you – I don't know, there's a time you're there and a time that you should leave. I think that, to me, administration is when the adrenaline is running and when you feel excited about it. I don't think you should be there for a hundred years. I think something begins happening to a system. So I believe you gotta be there when you feel you can make a difference, and when you feel comfortable in terms of, hey, I think this is the time to

leave, you should leave. So that's why I left [he laughs].

MM: That's why you left. And you went to Denver. Was there any particular reason?

RQ: I took a year off, and then I went to Denver in 1992. I went to the Mental Health Corporation of Denver, which had been established under funding from the Robert Woods Johnson Foundation as one of the prototype mental health authorities. That's why I went, because I was really interested in that kind of structure – quasi-governmental, in the sense that it was a non-profit. We were not part of the city, but I was responsible to the Mayor. But we had a Board of Directors that I was immediately responsible to, and that Board was appointed by the Mayor, but as independent as can be. It was a different kind of structure.

MM: So kind of an innovative structure.

RQ: It was very innovative, and I feel that I was able to continue doing some of the things that we wanted to do, [and] had very good staff. Again, just having some of the staff – I've been really lucky in terms of working with good people. [We] developed housing; we had some very good clinical programs. I appointed a Medical Director at that time that became the CEO. And he's there today – Carl Clarke, [and] he was very, very good, clinically sharp. It was also a program that served a population of 500,000 – and I felt that it makes all the difference in the world when you can plan and when you can organize and when you can work with a political structure that's over a manageable population area, as opposed to 14,000,000 people.

MM: Yeah. Aside from the size, I mean, were there particular differences between Denver and LA? What kind of system had they had there before? Were there good services in place?

RQ: They had a good system. The Director prior to myself, I think, had been quite good and had begun developing a program which was a very community-based clinical and social support program. I mean, that's the best way that I can describe it. It was a program that was innovative in developing at that time – 1992 – clubhouse models. So we were able to continue doing that. We strengthened the clubhouse model program with clients, and consumers were very much involved in the program; so we had very much of a consumer-oriented program. And consumers organized, and what we did eventually –

I mean, just telling you some of the things we did. There was a consumer that had been a statistician, and we invited him into the program – it grew from this club model – to come in and do some research, and to do research with the people that were seriously mentally ill. And they organized it all. It's a model even today, and it was utilized by the State and duplicated in some other places. But that was particularly heartening. And we used to tell the staff, you know what, we can't bullshit, we have to put our money where our mouth is. So we developed an office and had them be part of the administrative staff and came on board. His [the consumer statistician's] critique [was] no holds barred [MM laughs], but it was very valuable. So I think that it was a very consumer-oriented program. It was a program that also valued good clinical care. But innovative. The housing that – I don't know if you want to hear about that?

MM: Sure. Tell us. Particularly how it's different from LA, but go ahead.

RQ: Yeah. OK, the difference was the ability – let me say it in a nutshell – the ability to get things done. Cutting through bureaucracy, and being able – flexibility –

MM: That was partly, I imagine [because] you had funding. But you –

RQ: We had funding from the State.

MM: But you also had some political freedom.

RQ: Yes. Yes. The Mayor at that time was Wellington Webb, and Wellington was a no-nonsense kind of guy. He was interested in results. "[I want to see] what's new, what's different?" And as long as he saw that, his ego was not tied up in this. I had an excellent Board. The Board was made up of people from the corporate sector, we had people that were attorneys, I had people from the University, so it was almost like a dream board, where you had people from these different sectors, and then the decision-making was that it was an authority board. In other words, they made the decision, and then it was conveyed to the Mayor. It wasn't like, we're going to make a decision and then ask the Mayor if it's going to be all right.

So it was a very interesting kind of structure, but it enabled us – there was a lawsuit in 1989 or something – there had been a lawsuit on behalf of the homeless mentally ill, and that lawsuit was not against the clinic, it was against the State and the City. We were right in between. And the lawsuit was settled; there was a certain amount of money that was given, and the money was far less than I think the money that's committed here. I think we only got about $7,000 per person. And the target was the homeless mentally ill. They also gave about $3,000,000 for the development of housing, which here [Los Angeles] is paltry, but in '90- '92 in that area, it was pretty good. So we had a group that came together, and the group included some of the consumers, and the consumers were the ones who were [telling us], no more transitional [housing] – don't put us in these places where I'm going to feel I'm back in the state hospital. "Well, where do you want to live?" "Well, I want to live in a neighborhood. I want to live in a neighborhood."

MM: Makes sense, doesn't it?

RQ: "And we want to have that choice and we want to go and see it and we want to have it rented to us, and if we like it, we'll buy it. If we don't, you ain't going to put us there." So what was done – the City funded this, and then the City had a mechanism for going out and acquiring. We acquired housing in specific communities in Denver, and the housing could house no more than six people, for the simple reason that if you housed more than six, you'd have to go to the City, and it would have licensing. With six people, you didn't require licensing [as a group home. Our support services were all licensed].

So we had [housing sites in] Southmoor Park in the city [a neighborhood in SE Denver] and North Denver and Southwest Denver and two facilities which were homes. They were actually two-story homes. One of them was two blocks from where I lived. And the homes were purchased [and] renovated – we worked with the community – got some flack, but worked with the community. I mean, I remember attending church on Sundays and talking to the group about, let's remember the Bible [all laugh]. But I remember talking to them about their opposition, and then coming up with some mechanisms to involve people on an architectural committee and stuff like that, little things. But to make a long story short, what we decided to do was to decentralize housing and put people in

real neighborhoods.

MM: Wow.

RQ: Real neighborhoods. We also said that we would have a bus or something pick people up – there was a clubhouse model – and bring people to the clubhouse, but also bring support services when needed. Case management was a big thing. Everybody had a case manager that would intervene on behalf of their person. So that's what we did, and it's a model that still stands today. We housed something like 280 people that were homeless mentally ill. And I think the idea of housing today – when we ask about what is the basic difference – the ability to develop that, the ability for the community to support that, *including the Mayor*, who could have taken some awful flack, and to have people living in a, quotation marks, "normative setting." A normative setting. And I think, as Carl Clarke – I check with him from time to time about how things are going, and he says that it's just amazing how people have a sense of ownership, they take over the place; they have a sense of ownership, caring for it, and many of these have no family members – but this is their place. This is their place.

MM: Sure, sure.

RQ: Others have left and [now have] their own housing.

MM: Yeah. That's great.

RQ: Anyway, so that was the ability to do things, oh, and the ability to have people on the board that could go out and buy facilities, that knew people that could go out and purchase facilities and were not doing it on a profit-making basis, but were doing it because they believed in the mission. Or because some of their kids had been mentally ill or were mentally ill. We had one person like that, who had a son and a daughter that were mentally ill. But the ability to do things – to push a button and get it done.

MM: Interesting. And were they seen in clinics run by the authority?

RQ: The clinic services were all run by this authority. Everything. Later on, what changed was it became a mental health, quotation marks, "center", because what it evolved into was a larger system. Medicaid capitation came to Colorado. Managed care. Medicaid capitation. The whole system had to reorganize in terms of – we still maintained the private agencies, but now there were going to be four superagencies – what we called MHSA's [pronounced "mahasas"], Mental Health Service Agencies – that would be developed to get the capitated money, instead of just the state. And then that capitation – the MHSA – would be in Denver. So we reorganized.

MM: I see.

RQ: And what we reorganized – I'll tell you in a nutshell – is to have the University of Colorado Health Sciences Center, to have the Mental Health Center, and to have the Department of Health Services become the MHSA. And I feel that it's working tremendously.

MM: OK, interesting plan. So, we have a bunch of general questions.

RQ: OK.

MM: And you can, if you want to talk about LA versus Denver at any point, that's fine. But one of them, and we touched on this a little bit earlier, is – how do you see the contract clinics versus the directly operated clinics? You had talked about this. Is it, I mean, you said there was tension between them. Is that sort of inevitable? Should the system be essentially a system of directly operated clinics with contract clinics where special services need to be provided or would it be better to have a system of contract clinics and only have directly-operated clinics where you couldn't get a contract, or is there a value to having this sort of dual system? I guess that's the question. [she laughs] That's a big question.

RQ: OK, let's talk about LA County. And I'm going to take your question and say that's precisely the problem. See, what you said – "We take the contract versus the county-operated," and that's exactly what has existed. Now, I don't know if it exists today, but I know that it existed in my time, and that's exactly what's wrong. I think that the question should be, "Why do we have county-operated clinics and contract clinics?" Why do we? I see a sign – I don't know if it's a new one – I don't venture to ask. But on Washington Boulevard near Sepulveda, there's a new building, and the building says UCLA, and then L.A. County Department of Mental Health on the bottom.

MM: I've seen that.

RQ: Now, if it's an integrated kind of program, I'm all for it because I believe in service integration. That's something I haven't talked about, but I do. But why, if it's going to be a clinic – the only that I ask is why do we have a clinic here if we have Didi Hirsch, that's responsible for this part [of the County] as well? [Didi Hirsch Mental Health Services is a major private provider of services in Los Angeles County.] And you have a Didi Hirsch Mental Health Center that's about three or four blocks down from that particular site. So my question would be – is it best for the system to have a duplication of role which is both county-operated and privately operated, and why is the reason for that, and what are the skills, or what [are the] things that each one does best? And, if we are planning services, wouldn't it be the latter question that drives the day? What are the skills inherent in both systems that would give us the best system of care? What is the best use of the skills inherent in both systems, or, if not skills, then the flexibilities inherent in both systems, that would give us a good system of care?

If we have today a situation where the mentally ill are going in record numbers to jails, shouldn't someone be saying, "How do we develop some intervention before that?" "How do we develop some intervention that is going to offset that?" "And where are the skills and the kind of skills that we need to develop that kind of intervention?" "Where would that intervention be best?" So do we need a County clinic? Let's look at utilization. Let's look at any clinic utilization. Is the clinic being well utilized? Or can you walk in on a given day and shoot a cannon and not hit anybody? So let's talk about utilization. Let's talk about a system – I think it's a billion dollars now – does it operate – and if it doesn't, that's great – [but] does it operate predominantly nine to five, Monday through Friday, or has the system been able to expand its hours of operation? Have we been able to take the program which everybody considers is one of the best programs – that intensive service approach, where you have 150 people [clients], and you're giving your best shot in terms of services, and how do we duplicate that?

One of the concerns that I had is that with Prop 63, there's still some money that has not been spent in that. Well, would Prop 63 not only give us the ability to have that, but would Prop 63 give us the ability to have mobile response? And should that be part of the system, of mobile response capability. When we talk about contract and private agencies, County agencies, this is the interesting thing – it's interesting, we don't talk about, even though it's LAC-USC and it's USC Hospital, what role do the Universities have to play? What role do the Universities have to play in our delivery of services? And even though we had, when I came on board, the regional directors were hired by the University and the Department of Mental Health. There was a dual role.

MM: Oh, really.

RQ: And the dual role was like Milt Miller was hired by Harbor-UCLA, and he was hired by the Department of Mental Health. [Milton Miller, born 1917, was chair of Psychiatry at Harbor-UCLA from 1978 until his death in 2005.] But the question that we have to ask – to what degree has an administrative integration led to service integration, so that there is service integration at all levels? And to what extent does UCLA sit on a policy-making board for the Department of Mental Health? Is there a voice for that?

MM: Yeah, effective. Yeah.

RQ: Because it would not only shape services, but it shapes the training for services. When was the last time that UCLA incorporated some policy issues into its training of physicians to go work in the public sector? When was the last time? Or that we had a curriculum change, or whatever? I mean, it may have. I'm just thinking off the top of my head as to the true –

MM: And I have heard it said that contract clinics can actually provide services more effectively because they have more flexibility. In other words, if they want to hire staff, they don't have to go through a County hiring process. If they want to change their hours, they just change their hours, they don't have to go through a lot of red tape to do it.

RQ: You know, that may be true. think that there is flexibility in terms of things like changing hours. But let me take the question about effectively, because that's a loaded issue in some sense. In terms of providing services more effectively, I also know that there are County-operated services that are provided very effectively, and could not be provided elsewhere, or people would not want to provide them. Let me give you an example – Skid Row Mental Health Clinic. County staff, County expertise. Now, if I would ask County staff, "What is the biggest impediment to your providing services effectively – you're effective, but what is the impediment to developing [higher effectiveness]?" They would probably say, "The bureaucracy – you guys."

"We can't do it. You're more of a hindrance than a help. And we wish, down here, that we had the flexibility. Just let us do our thing and we'll do it." So what I'm saying is that we – there was a study done by somebody within the Department, and I can't remember who it was. There was a woman that had done a study, and the study had to do with morale. I think it was Karen Gunn. [Dr. Karen Gunn is a psychologist who serves as a researcher, trainer, and consultant. Gunn also teaches at Santa Monica College.] And it had to do with morale, County staff morale. And they found out that the staff that had the highest morale was the staff that was in the most difficult situation.

Difficult situation – jail staff, Skid Row mental health staff – because there was a sense of clear mission, purpose, etc. So what I'm saying is that this would be an excellent opportunity, and the opportunity that I wish that I have had. Without everybody thinking [County versus contract], what is the best thing that we can get out of a contract structure? What is the flexibility that we need, and let's identify it not by just the term "flexibility," but actual services that need to be required, and then behind it, does this require a flexibility in administrative structure? And then say, "This should be the purview of the contract agency." What is the thing that we can provide best? County staff, because, at that time, we had something like 40 psychiatrists. And because of the number of psychiatrists that we have on staff, we should be able to provide crisis intervention services.

We have nursing staff, we have psych techs, we have psychiatric staff. So we should be able to provide a top-notch, comprehensive mobile response and crisis management program, which operates independently of the hospitals, or in coordination with the hospitals.

And I think that if that question was asked and if everybody didn't freak out, because I'm sure that you have somebody that, whoever it is – County or contract operator – that's sitting in a clinic and secure in their office, saying, "Oh, why should the world change for me?" Well, in a sense, I think that we're getting more and more to a mental health system without walls. And a system that requires us to be mobile and co-located and [to] be in different parts, where people require services.

MM: Where people actually are, yeah. And we sort of skirted around this – One of the things that we talk about a lot also is stigma. So why do you think stigma continues to persist? It sounds like you had some experiences with that in Denver where you sort of talked to people about combating stigma and allowing people to live in their neighborhoods. So are there other ways in which you've addressed this issue and do you think it's changed at all for the mentally ill?

RQ: I think that sometimes, some of the people that have really helped in terms of fighting the stigma issue have been consumers themselves. In talking to either consumers or going into communities. I think that the stigma issue – and I know that the California Endowment had made a major effort to combat stigma through public service announcements, etc. I think we have to look a little deeper. I think we have to look at what it is that we have in our society today and our job situations, that are the biggest contributors to stigma?

You have, within the medical field, physicians who won't get treatment or won't talk to another physician, because of stigma and because they feel it will affect their practice. You have people that work for the federal government, in a number of agencies, that will not put down that they take medication – or can't put it down – because it'll be a red flag and it'll be a security issue. So when we look at the issue of stigma, the thing that exists today – stigma exists on two levels. It exists on the level of communities that are misinformed and uninformed about mental health issues. So if I go to a Latino community or if I go to an Afro-American community or an Asian-Pacific community, or whatever, to talk about mental health issues, some people may or may not have been exposed to it. So there's a way to approach that.

The biggest stigma exists in some of our middle-income white communities, and upper-middle-class white communities. And it exists because where can an upper-middle-income person that really cannot afford $125 a shot for therapy every week, where can they get service today? So it has broadened out. I mean, when we talk about mental health being inclusive of the populations, the degree of suffering that that family has – and now we talk about a white family whose kid is going to end up in jail because they can't get services anywhere and [that] has nothing to do with income level and has everything to do with stigma, as well, because of the inability to either know where to access services or to access services [comfortably].

Third-party insurance was just passed, thank God. After the Mental Health Association and the Alliance for the Mentally Ill were in the vanguard of fighting for that, and thank God we have that today. I think it'll make service more accessible to people. But I think that the stigma issue is still one where we almost have to go to places of employment, we have to go to insurers, we have to go to – Let's start with the federal government. Maybe we can begin with [President Barack] Obama, issuing some kind of [statement], but asking people to look at their policies and their practices which prevent workers from getting the services that they need today. So stigma is a big issue. I think it should still be very much a part of our education and approach in terms of working with the [mentally ill].

But can I say something else? That is exactly why you've got to bring people into the forefront. That is exactly why you've got to bring corporations, and they have corporate structures, and so many corporations have their community relations and stuff like that. Bring them into a policy-making structure. Bring them into a mental health authority. Let them discuss issues. Let them discuss issues about talking, about getting out there, and we really begin getting to a number of people. Right now, my biggest peeve was before, and it is [still] – we have, like, a captive audience. We talk to ourselves. I mean, the one thing I don't want to do is I don't want to talk to ourselves. I already know [that] the Mental Health Association loves mental health. AMI wants more mental health services, consumers want [more]. We've got to reach out, broaden our scope, broaden our scope of involvement –

MM: Make more people aware.

RQ: And then bring them into decision-making.

MM: So you mentioned Proposition 63 a couple times, and as an observer, do you have a sense of what the impact of this act has been? Good? Bad?

RQ: In all fairness, I've heard it, like, second- or third-hand. At times, I have thought about going to a Mental Health Advisory Board meeting to see what's happening, and then I'm just one that feels that sometimes it's – and maybe it's the wrong thing to think – but you've got to let go. As an ex-Director, you sort of have to let go, and I have very funny feelings about going and being a part of that and stuff like that. My ex-secretary, Barbara Johnson, says, "Oh, Roberto, why don't you come around?" I said, "No, because it's not my time." I hear some things that are – in terms of – I mean, they seem to be going well and some growth that's taking place and development. Certainly there are good things that are said about Marv (Southard), and what he's doing with the Department, and that's good to hear. So I've been curious, but I sort of feel it's not my place, necessarily [to be] going.

MM: Well, a lot of what's happening with MHSA is based on the idea of encouraging wellness – basically, moving patients, moving clients towards normal living in the community, and this is certainly something you've been involved with to a great degree at different times. But there are questions about whether or not that's maybe demanding too much of some people. So I wonder if you have any thoughts on that.

RQ: Well, I think – let me just say this. With Prop 63, the focus of Prop 63 was people with serious mental illness. I mean, that was the starting point for the legislation. I think then, services to children and adolescents were included in some ways, planning was included in other ways. I think that what we have to acknowledge is that there is a model that can be very effective. What we also have to think about are the populations that critically need the services right now as well – children and adolescents. And I know that much has been done in terms of wraparound services. But I think we really have to examine what is happening, and when we hear about child abuse cases that come out, is there a role for mental health? I think that we can't look at any one of those cases and not determine that somewhere along the line, there's a role for mental health. Not one of them. Parents that weren't seen or parents that are receiving medication, whatever. OK. Or children that need that care. So I would say, what is the initiative and what can we do about services that might be needed at that particular level as well?

And [what about] money? Let's begin with a given. I don't know if it's true or it's a rumor – in the last election, there was a group that wanted to take money away from Prop 63, because it had not been expended. OK. What I'm saying is let's not become defensive about it. There may have been very good reasons why that was not expended. It could have been the timeline, to get programs off the rolls. I mean, that's always a solid reason. But if there is, what are other initiatives that can take place?

The other thing that I strongly feel is that while we continue to have a current strategy – I know Service Area Advisory Committees are a big start, but the bottom line [is], do you have the responsibility for setting policy for your area, if you feel it's in the best interest of your clients and community? Do you have the last say in policy? And if the answer is "No, because I've got to take it to five people on any given Tuesday to discuss and see and critique," then I'm saying that we're far from developing a community-based mental health system. Very far from it. So I would hope – if I have contributed anything – that somewhere along the line, 50 years from now, somebody will say, "Well, you know what? Hey, we have [a] Service Area Committee, that gets its funding directly from the County, that is empowered to do planning, organizing, administering services, that hires its Director, hires its [staff], and is comprised of the public and private sector and also the University and others that play a key role."

MM: Sure. OK, well, I actually think that's a good place to end on.

TG: I think so.

MM: Yeah. Thanks very much for your time.

RQ: OK.

MM: We very much appreciate it.

RQ: You're very welcome.