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ORAL HISTORY NARRATIVES MUSCATATUCK STATE DEVELOPMENTAL CENTER WITH CINDIE UNDERWOOD
OCTOBER 22, 2004
INTERVIEWERS: JENNIE TODD AND STEVE SAVAGE
RECORD ID: 149-DO

CU: CINDIE UNDERWOOD
JT: JENNIE TODD
SS: STEVE SAVAGE

[TITLE]

[00:00:12]

JT: Cindie Underwood, Steve Savage, Jenny Todd and it's October 22nd.

SS: And we're here at Muscatatuck. So, we're just here to talk about your experiences and how you got here and what you've been doing for the last few years and what's your reaction to things moving and changing and eventually closing. Start out maybe with just how you got interested at all in working here.

CU: Well, out of college I went to DSI, found out that I could do a little bit better here. DSI was ready for me to move on as well. So in 1989 I came to Muscatatuck as a case manager, stayed on as a case manager for 9 years and went to evening shift administrator and took a brief period of time off after a couple of years of that and came back as a social worker and then got into transitions about the same time that it became more and more evident that we really were going to close the facility. So I've been working in transitions for, well since I did a lot of that in my social work days, too, about 3 years now.

SS: I'm real interested because you live in this area and you've lived in this area all of your life and just kind of the whole . . .

CU: Don't rub it in, Steve.

SS: I didn't mean it that way. I meant it positively.

[00:01:37]

CU: Now I'm depressed.

[00:01:39]

SS: Just the idea that this is such a big employer, was such a big employer, how much influence did that have on your decision making in working here? Did you feel like you had other places to go? I know some of your history of course but I'd rather hear it from you.

CU: Well, my grandmother Elizabeth Underwood, was a night shift supervisor for a million years. My father felt this was the worst place in the world that anyone could ever work and I imagine had he been alive at the time I put in my application here, I wouldn't have.

SS: Why did he think that?

CU: Well, he didn't have a whole lot of respect or affection for the disabled and he didn't have very much respect or affection for the atmosphere out here, which was pretty much a Peyton Place kind of atmosphere. It was pretty wild out here when there were a lot of employees and a lot of clients. He got to hear the good, bad and ugly from his mother once in a while.

JT: Can you tell us some stories around that?

[00:02:43]

CU: I wasn't allowed to know at that age. I've heard some stories. There was a lot of promiscuity out here among the staff and issues with client abuse and with clients being abusive towards staff, things like that. To be perfectly frank, I don't think my father was the most stable person in the world, but that was one thing he said over his dead body would I ever work out here. Then I went to college and studied psychology, which getting only a Bachelor's Degree extremely limited me, especially in this area. If I wanted to stay in Southern Indiana close to my family then I was going to have to go one of a couple or three employers at that time. That was before we had a whole lot of, we had only a couple providers of services, DSI is probably the biggest one and here, of services working with MR populations. I didn't realize at the time I was in college that basically with a Bachelor's Degree that was pretty much the population you were going to be able to work with. If you want to do counseling and you want to work with more average Joe citizens, you're probably going to have to have more advanced degrees. So it's kind of a default thing. It wasn't want I was interested in when I went to college but I did need a job and I wanted to remain in the area so this is where I came eventually. I found that I had some affection for the job. I liked the people I was working with, both the clients and the other staff, found a lot of things that needed to be changed around here, but that was about the same time things were really starting to change. I felt like I was actually being part of a system that was on it's way up. It was improving. We were making homes look more like homes, trying to downplay the institutional atmosphere, there was a whole lot more emphasis on active treatment and what we could be doing to make people's lives better. Of course in old history, that I wasn't here to see but that I've heard about from other people, there was some improved quality of life because people actually worked. People had the farm and they took care of things and the orchards and things and people had some sense of value in that. But I think there was a period of time in between that period of time and the last ten years when there was less value and there was not as much expected of people.

[00:05:34]

SS: You must have known people that went through that period where it was farm, people that still lived here when you first started. Do you remember the stories that they told, any of the discussion around that?

CU: I don't remember specific stories as much as I remember people remembering fondly things. I do remember some stories about the recreational things that would happen. There would be water balloon fights and people would have watermelon out on the hearth and it sounded a little like rush day on a college campus. There was a lot of horseplay, things we could never get by with now. People were having too much fun for what the Medicaid standards would call far. Heaven forbid someone would slip and sprain an ankle while they were having too much fun.

JT: Spitting watermelon seeds.

CU: Spitting watermelon seeds, yeah, those kinds of things. But I think that there was that period of time when people's quality of life was pretty good because it was a family atmosphere. As far as I have known several of the clients who have worked on the farm, who have worked with the cattle and worked in the orchard and different things. But other than just stories that they used to work. I don't remember specifics too much. I think I was kind of on the fringe of that. Those stories were mostly already told and forgotten.

[00:07:01]

SS: I want to spend more time talking about what has been your history but just a couple more things just because they keep showing up in different places. Your grandmother would have been here at a time when there were what they called working girls. Do you have any recollection from her or stories from her about that?

CU: No, not so much really. I do know that my grandmother was very attached to several of the clients that she worked with, as a rule more the low functioning though. She would bring people home with her and things and I got to meet several people from out here in that way. But I was very very young and my father didn't approve of all that so I was kind of sheltered. We immediately moved away from the area, all the way from Butlerville to DuPont. It's that 10 miles that separates the generations. No. Now my other grandmother did work out here also for a short period of time and she had told me stories of abuse, kind of how people would carry their keys on a string and smack someone with their keys if they weren't doing just the right things. That was pretty much reserved for the higher functioning people who they, I think that they felt had a little bit better sense of right versus wrong. I think that the people that used to work were subject to a lot of that kind of thing. And the thing that really surprised me was that I would hear these stories and my grandmother would tell them as if she was a participant but without any apology. There was a completely different mindset than there is now. It was really kind of sad and it just made me happy that I wasn't here then.

[00:09:01]

JT: Sort of they deserved it?

[00:09:03]

CU: Kind of. Well everyone was, and I still have seen this once in a while even today, people being almost blamed for their disability and not much of a degree of empathy for them. When you smear feces you make my life miserable kind of thing, now you're disabled and you don't know the difference between doing this and not doing this. This is kind of a depressed area and I think people are depressed and they don't have a whole lot of sympathy for others or even ability to try to put themselves in someone else's place. And I know this is something that happens in all the populations every where, today and yesterday and it probably will happen tomorrow. But then we have some great people who absolutely love the folks they work with and who get great results with them.

SS: The question of kind of hierarchy within the population is an interesting one for me. So there were certainly people that were considered higher functioning and lowering and all over the map. Talk a little bit about that and the difference, during your time here, how were they separated? If so, how? What was their response to that? Just the whole kind of sense of the difference between, the pecking order.

CU: Well, I came in '89 so what I observed mostly was that people were separated based on their ability and their capacity. The first population I worked with was profound nonambulatory people who really you would be doing good to get eye contact from. They weren't the most medically fragile people who lived on the hospital unit but they were folks that very challenged. As far as a pecking order within the group, there really wasn't one because the folks that I was working with at that time didn't have sense of alpha beta status. They were all being cared for, given complete direct care by staff people. I think that you would find, and I did have some notice that the professionals in the direct care staff who worked with that population, might be considered a little less than the folks who worked with higher functioning people.

JT: Can you talk about that a little bit?

[00:12:01]

CU: Well, I think there was a little bit of a sense that once you did your time and you had better skills, either as a professional or if you were a better DST, that you would be able to work with the higher functioning people. It didn't take much skill to write a program plan for someone who wasn't going to meet a goal anyway. I remember over the 4 to 5 years that I worked in that population being extremely frustrated, trying to get eye contact with someone who didn't know their own name, didn't know why they should look at this ball, didn't know why they should smile, didn't know why they should reach and grasp, those kinds of things. I found that was probably the worst burn out I've ever had, was trying to reach people at the extreme profound range intellectually. Maybe I'm projecting a little bit, maybe the sense of lack of value part of it was my own sense of lack of value because I wasn't achieving anything other than feeding a paper tiger that was going to keep the Medicaid dollars rolling in. I think that there was a whole lot of things that we did out here that was just to meet Medicaid standards that really none of us, professionals, direct care staff, any of us every saw any real value. We saw value in giving good direct physical care, we saw value in trying to improve people's quality of life by making them laugh if they could, by giving them affection, and kind tone of voice, those kind of things. But as far as the value in meeting the Medicaid standards and the training, it didn't. Now back to your original question of how did we see the pecking order develop in the clients. That was something I saw more when I started working in populations that were just a little less homogenous, when you would get into the populations of people who were more severe and then up to the people who were more moderate you would see, and there was

no way to put people who were at exactly the same level together. One thing that I will always think is odd is the higher functioning clients referring to the people that I had worked with earlier and anyone who was a little less able as ‘low grades’.

[00:14:37]

SS: Low grades, I’ve heard that term.

CU: Yeah, people were low grades if they were, and that had to be something that they picked up from staff. You work with the low grades. I don’t know, initially it was probably just like the terms ‘idiots’, ‘morons’, and those things when it was just kind of a way to identify a population and then it turns into a derogatory term. So ‘low grade’ might have mean like we use ‘low functioning’ which is now a derogatory term. I’m sure ‘profound’ will be a derogatory term in the future. But the higher functioning clients, the people in the higher range of intellectual development, I don’t even know what’s politically correct for me to say right now, but they certainly could jump on that. Like I said, I wasn’t here when the working girls, people who actually cared for other clients were there and I haven’t heard very many first hand stories about it but I do understand that they, to some extent a lot of them were like almost adopted towards the lower functioning people and sometimes just like the staff they would be more maternal and sometimes they’d be more abusive. Everyone’s got a personality and they just feed into that.

SS: I’ve only heard from one male, and that was, and I should remember this guy really well.

JT: It wasn’t Leonard but it was something along those line.

[00:16:10]

SS: No. You would know him well too but he had lived out here for a long time. It’s still in Columbus at the workshop. I’ll think of his name in a minute but anyway he talked about he was in that kind of a position too. So I guess it wasn’t just working girls, although most of the men that I’ve heard about were more involved in the farming operations, of course, and that would be traditional, of course.

JT: He described it as if he did some attendant care. He moved people from place to place, he helped people get dressed, he sounds like a pretty hands on . . .

SS: So there were women who actually were kind of acting as attendants but who were actually residents as well, right?

CU: Right. And I don’t believe that they were paid positions. I could be wrong. I don’t think that they had paid positions so much. I think they might have worked for an extra cup of coffee or something like that, that there wasn’t, and I think that was kind of a big part of where the farm went and those kinds of things was because people were basically being forced into labor and not reaping any benefit.

[00:17:29]

JT: Those were some of the stories we heard from people that were here 30 years ago is that there were a lot of working girls and that was the argument, they weren’t being paid, but people loved doing that and then when they weren’t allowed to do that any more because of lack of money, then people were pretty unhappy.

[00:17:47]

CU: Right. Well, in the atmosphere of liability, I don't think that you could let someone do care taking roles with another person who was less capable, who wasn't an employee.

JT: Back to the hierarchy a little bit when you were talking about some of the different names, like 'low grades', were there other names for people or different disabilities that they referred to as groups or was there any more status or was it just pretty much the higher functioning versus the lower functioning that you were describing?

CU: I wasn't part of that to know much about it. I'm sure you would get better information from someone who's been here longer. I've only had 15 years and I think I missed most of that.

JT: So you don't see any of that now where there's no pecking order?

CU: Oh, as of now? Oh, yeah, there's a pecking order but it's no different than the pecking order anywhere. There's people who want to assert their dominance and I almost think it would be wrong to expect there not to be a pecking order because of human nature and I think you would be asking folks who reside here not to have that aspect of human nature that we all have. But, yeah and it's not just that a higher functioning client who's more verbal will be dominant over a person of lesser verbal skills but the bigger client might be more aggressive towards the smaller client or vice versa. We have a situation that I know of where the little client's a real terrier and he's very feisty and he bullies the big client around. So it's just human nature. It's not the best part of human nature.

[00:19:37]

JT: So what's it like here around holidays?

CU: Well, I think because so many of the staff have to work here, there's always the nursing and the direct care staff, I think that they've always tried to make the holidays here as pleasant for the clients as they are for themselves because it makes their holiday easier. They have to be away from their family and I think that kind of brings out the best in people. We were just talking yesterday I believe it was about how some of the Christmases were here. A couple of folks were recalling how one of the RTA, we had therapy assistants who did the shopping for the clients. She would make sure every client had at least 40 gifts. So it was, of course it varied from unit to unit and just how energetic the people who were making the purchases were. We've had issues where clients that we were ready to transition we had to wait until after the holidays because it would become such a period of anxiety and people would be really worried about ho ho. We had one gentleman he would say 'ho ho, ho ho' and that's all he could think about from this time of year on until after January 1st. So we had to postpone a transition based on his obsession with Santa and Christmas and all these things.

JT: It's like tradition.

CU: Yeah. We had a conversation yesterday and assumed that probably a lot of the folks who leave here don't have quite the Christmases out there that they had here.

[00:21:32]

JT: So it was a huge deal.

[00:21:33]

CU: It was a huge deal.

SS: There were auxiliary people that came in and did things?

CU: Volunteers would come in. They would have the Santa's Workshop they called it. Family's gifts weren't allowed to be brought in wrapped. If they did come in wrapped they had to be unwrapped and rewrapped. I don't know who brought a weapon into their son or daughter or what happened but . . .

SS: Files in cakes.

CU: Files in cakes, yeah. But they had to be rewrapped and everything had to be inspected. I will say there was a lot of theft that went on of new client items. Not just before they got marked but sometimes after they got marked they would disappear too. Several people would lift things that they thought their son or daughter might enjoy. We've actually had people come in, especially after the holidays, wearing client owned clothing that had been marked with the client's name. One lady lost her job because she was wearing a pair of tennis shoes that actually had the client's name written inside the instep. So you didn't have to be rocket scientist to work here and a lot of people weren't very, didn't have very good moral values. I think a lot of the more caring staff especially kind of tried to make it up to the clients the rest of the year. Of course they used their own money to do it, a lot of. People's Christmas gifts came out of their account more than not.

SS: The client, right.

JT: Why do you think people came to work here?

[00:23:24]

CU: Well, I think a big part of the same reason people still come to work here. For the amount of physical labor that's expected, for the requirements, it's still a very good paying job. We have DST staff here that make $13 to $18 an hours, which is more than they're going to make in any factory. There's going to be a little more leniency about time issues. The State has wonderful benefits. A lot of people are kind of steeped in the generations. You know, this is where my mom worked, this is where my grandma worked, this is where my grandfather was working. So I think there's a lot of that too.

JT: Do you think many people came to work here because they wanted to work with people with disabilities?

CU: I don't think that was the big pull. Now that's not to say that there aren't a few people. I would say that, I just can't say that that was the biggest reason. There are some people that once they got into the position they really enjoyed the work that they were doing. But I don't think that was the major draw.

JT: So would it be fair to say that initially it was, it could be compared to just a factory job, you're going to go in there and it's a factory job, the same sort of thing day in and day out?

[00:24:54]

CU: I think you could compare it to a factory job in that the requirements were about the same. We might have attracted people who had better people skills to this line of work than you might attract to the factory work. But I don't think it necessarily means that they would be happier working with this population,

working with the elderly or working in a hospital or anything. I think you would find that the people who came out here usually at least at a tolerance for working with people and maybe not a tolerance for working with machines.

[00:25:33]

JT: Did they get a lot of training, new staff would get a lot of training?

CU: Oh, a lot of training.

JT: So they would understand that their job should entail?

CU: And there were a lot of people who came out here with the thought that they would come in and they would do their 4 to 6 weeks of training and then they would leave, that they were coming in to be paid to train, people who do that and then a lot of them who had come in with that idea, well this is a short way to make some money, did stay and stayed 30 or 40 years. But yes there was extensive training and it was paid as if you were on the unit. I think a lot of people thought that was going to be fairly easy.

JT: What about fear? Was there ever a time that you were afraid here or were scared, maybe hurt or injured?

CU: Oh, yeah. I've been hurt. I had my eye blackened and I've gotten bit and different things. No, I was, I've been hurt and I've known it was going to happen but not really afraid. The kind of things of fear that you have around here is like the angst of going through survey. I've been relieved of job duties so many times over alleged abuse because I was evening shift administrator and I was the first line when some one was misbehaving. It was usually someone who was verbal who learned that if I just say Cindie hit me, even though I would never be alone in a room with this person, and there would be 15 people who saw that I didn't hit him, he would know that I'd be off at least a week away from clients because I had to undergo investigation. I took a 6 months stress leave over the anxiety over being relieved duty so many times over those kinds of issues. So not fear for my person but maybe for my profession, for my sanity. I'm fearing for my sanity right, we're in transition.

JT: Would you say other staff maybe who were direct care staff would say they were insure or if they felt. . .

[00:27:49]

CU: I would say you would probably find a few. But I don't think that you would find very many people who stayed that felt that they were physically threatened. I talked with a lady yesterday about a client we're getting ready to place and he has a bad reputation. He's broken jaws; he's been extremely violent in the past. She is his preferred staff. She said he was aggravated and he came up to her really fast. Now this man is 350 pounds. She said, "I thought he was going to rip my head off." She said, "He reached down and grabbed me and he kissed me on the check." So she said, "I thought he was going to kill me but he didn't." Now she might say yeah I had a moment's fear at that point but never to the point it would make her not want to work with that person. I think, at least since I've been here, not to say people haven't been put off duty, we have had some extremely violent people who have lived here but for the most part we usually get help to the people who need it. We've had a rich enough staffing pattern that you wouldn't be alone in the room with someone who was really violent and risk being knocked unconscious before you could get help. I don't think that fear's that big of a deal.

[00:29:10]

JT: So what was the best part of your job, the most rewarding part of your job while you've been here?

CU: Probably now. The most rewarding thing is when we find just the right match of provider and residence for a person to leave here and to get in the community and to do some really cool activity that they would never have a chance to do out here. Yeah, I'd say placement, although when anything goes wrong in placement you're always the one to blame. If a client dies in the community, people die here, but if a client dies in the community that's, I'm getting into my next question because you're looking down at your . . .

JT: That's one of the things we're trying to do. It's hard to interview you and get your stories because you really want to just hear stories. So I guess the things that we want to know are just your memories of this place, good, bad, what you're going to miss, what you've enjoyed. So if you can just talk at will along those sorts of things that would be good too.

[00:30:29]

CU: I have really enjoyed some of my more difficult people that I've worked with. When I was evening shift administrator we had a client here who was extremely aggressive and I bonded with her and I would come over, she would actually have her staff page me to come over and French braid her hair in the evenings and tickle her arms. She's autistic and she'd like to have her arm tickled. Whenever there was a problem they would call me because I was the person that could talk her out of feeling bad and talk her out of hitting people and hurting other people. It's those feelings where you feel like there's something about you that's special to someone else. I've really enjoyed working with the worst of the worst kind of people out here, people who have a reputation. One gentleman who came in staffed by 5 people, is someone that I just have so much affection for now and just to talk and laugh with him and tell him when my birthday is, those things he always asked and just the fact that I've memorized his birthday and that makes him so happy that someone else actually knows his birthday and those kinds of things. Another thing I've really enjoyed is the staff camaraderie. I've always found a way to find it even if I'm not in a really good situation. Like right now we're under a lot of stress in this department but we have great camaraderie and we are so supportive of one another. There's almost never a day that one of us isn't have a really terrible day but you know that you've got at least half a dozen other people who are right there with you and they'll support you and they'll pitch in and they'll help where they can with the job duties. I've worked in several different positions. I've been a case manager in 5 different areas before I became evening shift administrator and every one of those areas I found a way, I found people in that area to have camaraderie with. And that was pretty good.

SS: You mentioned people dying. Obviously people die both in and out of the institution. A story about maybe both situations, just what happened, what do you remember about it? Not a very happy subject. We'll come back to something a little more pleasant after that.

[00:33:12]

CU: Promise?

[00:33:13]

SS: I promise.

CU: I had been working on 14, A floor. I was down to the caseload of just the minimum, 14 A and I had a 12. That's when the case managers were doing basically rehab therapy with their caseload too. I wasn't schooled that. My people weren't willing to rehab because they were all in wheelchairs and they would just sit around. I had 3 favorite clients and inside three weeks two of those people died. One was a gentleman who had been born normal, had developed a brain tumor, which was removed at the age of 6 and his mother told me before the operation he said, "Mommy, will I be retarded when this is over?" Of course mom was terribly scarred over the whole ordeal and him being here and she came to see him every weekend, long drive. There was a degeneration going on in his brain and he ended up, his digestive system shut down and he aspirated because nothing was going out and they had laid him down to sleep and it just came back and in his lungs and he died. Within three weeks I had another gentleman who was a PKU baby. You see these people who you know had they been born 20 years later we'd had been able to fix this, they would be here. He would sit and clap and yell and he would take your hand if you asked him and he would calm down to some extent. I just had a real close feeling with him and I don't know why. It was not like he could talk or he wouldn't even make contact but I just felt very close to him. He had a lung infection and passed away. As far as people dying in the community, I think the thing that's always going to stick in my mind was a lady who left here very high functioning, in fact was mistaken for staff much more than not, better groomed than most of the staff, better read than most of the staff. Somehow she'd managed a diagnosis and she was here for a period of time. She was placed in the community with a provider and although I wasn't the transition person who placed her, I was aware of the case and what was going on at the time. She ended up getting angry in the home, walking off and getting hit by a car in the Columbus area. Because I knew that I never would have asked for any special precautions for this person just because of her level of skill, I would have thought she was as every bit as safe as I would be to walk away, to have a bad day. And it made us all feel terrible when it happened but it was also like the anti placement people rallied behind that to here and it was "see what happens when we let them put our people out? People in the community can't take care of our people." Crap happens everywhere and there was a big part of me that just said 'this is just the kind of thing that happens in the world. The world's unfair." But as far as having a direct effect on me, aside from missing her and feeling terrible that it happened, it was one of the things that made it harder and harder and harder to do what we thought was the right thing in our job here in trying to get more people into the community. I think there was a rallying cry behind that incident but I still will think that the majority of the opposition to placement has been people fearing for their jobs and their livelihood, which is a pretty natural thing. Anyway, that's my take on death.

SS: Thank you, I know that was hard. Positive, let's flip over to somebody that you really liked that's worked out well, just enjoyed them and the outcome has been good.

[00:38:11]

CU: There's just too many really. Yeah, there's a gentleman who lives in Columbus now, really difficult person to like some days, but he had good days too. Now he's out in Columbus and he's mowing yards, like 20 he has. He's a regular entrepreneur. I just heard a story about an older gentleman that did not want to leave, very very adamant that this was home, has been involved in the HIPA Therapy program, come out to meet up with people to go to his regular HIPA Therapy program after he'd been placed in the

community for a week, told the staff, "I sold my house our here. I bought me one in town." When they told me he said that, that was just hilarious. Lots of people have more peace of mind than they've ever had in their life. Not to say that there's not times when people are genuinely bored because they have staff who want to sit around and watch TV. There's things we've got to get around. We've got to find a happy medium between the rigid active treatment expectations of the institution and the more laxed wavier standards to let people kind of get by with uninvolvement. It's not fair. People said, "Well, I would want to sit around and watch TV all day myself if that was my opportunity." But we need to find something in between where people can relax when they're retirement age but yet keep them involved and happy.

[00:40:08]

SS: Leland was the person I was thinking of.

JT: That's right Leland.

CU: I didn't know Leland.

SS: I worked with him in the Columbus workshop. He lived here for probably the first 20 years I think or more.

CU: That's short term out here.

SS: Yeah, maybe into his mid-20's. He's probably about my age. He's in his 50's I guess, early 50's at the latest. Somebody I've kind of tracked as we've gone along through all this, too.

JT: What do you think about this place closing? What's your take on it? I guess two part. What's the transition been like for people that work here and people that live here and then what do you think about the closing?

[00:41:04]

CU: Man, I've always seen everything in shades of gray. I can't say any thing is one way or the other. I know that there are a lot of people who took advantage of educational opportunities, have gotten nursing degrees, have made more of their lives than they ever would have without, and I'm talking about staff right now, without the closure announcement. Some people I don't think will ever really cover. Some people have missed the retirement deadline by weeks, months, probably will never have the income level or the sense of professional accomplishment that they did. Losing two social workers that, and they're laying them off at the end of this months for no apparent reason. There's only the two and they're just going to get rid of them, even though we still have several clients left. I don't like what it's going to become. I don't like the idea that this facility is going to be turned into a Homeland Security training ground. I'm glad they're going to do something with it but all that kind of offends my liberal sensitivities that this is going to be a military installation. On the other hand I think that many people here have an opportunity to have a better life than they ever would have had. Had this facility remained open we never would have had the chance for, many of the people who've left here to have the kind of lives they're going to have, residents. But on the other hand right now with the impetus to cut funding from the waiver program especially, we are fighting tooth and nail to get just the minimal services for people as they're leaving now, to the point that I think the transition team alone is suffering migraines and ulcers at a rate never before. I really don't think that the State's done a good job doing what they're doing. They started

off promising the moon, the stars, the planets to families, telling families they would have a choice and telling families that the services would be at least as good if not better than they have here. I think many people, especially as we get down to the end, are not got to have as good of services as they have here. We have a hand full of people that I truly do feel this was the best atmosphere for them, either because they have a combination of medical and behavioral issues. One gentleman that I've been working with just got turned down by the best nursing home for MRDD populations in Indiana because his behavioral issues are too severe. And now I'm totally stymied on what we can do with him because he needs intensive medical support and intensive behavioral support, which he gets here but yet the systems in the community aren't really set up. One gentleman that will probably end up at Madison State Hospital just because his aggression is so severe I don't think that we would be able to get him the supports he needs in the community, even though that wasn't what his mother wanted. Like I say, just a hand full of people I feel would be as good off, won't be better off. But by and large, all and all, if I try to weigh every ounce of good and bad I think this is just probably the best thing to close. I think more people will benefit from it closing than will suffer from it closing.

[00:45:14s]

JT: Do you think that's the general consensus with most of the staff and most of the communities now after people have had time to accept that you really have to leave?

CU: I don't really have my finger on the pulse of that. We put people out and 9 times out of 10 we hear that the family is real happy with what happened and then because our concentration has to be on putting the next group of people out we don't get to remain attached to that. Perhaps if we get to be an outreach point, of course outreach will probably only be addressing issues of people who are having failings rather than successes, I would say that people forget that they are satisfied quicker than they forget they're unsatisfied. So you're going to hear a whole lot more from families who are not happy with the process, not happy with the result then you'll hear from people who are happy. So I can't say there's that consensus. I know a lot of people are happy.

END OF INTERVIEW