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**ORAL HISTORY VIDEO INTERVIEW WITH
RUTH STANLEY
JANUARY 10, 2013
INTERVIEWER: JENNIE TODD
VIDEOGRAPHER: PEGGY HOLTZ
RECORD ID: 008-DO**

RS: RUTH STANLEY

JT: JENNIE TODD

PH: PEGGY HOLTZ

[00:00:10]

RS: My name is Ruth Stanley. I live in Indianapolis and have spent the last 24 years before retirement working for the Department of Mental Health in Fort Wayne and Indianapolis.

JT: Okay. How and when did you get into this sort of work?

RS: When I graduated from college I moved to San Francisco, and at that point was interested in mental health. So I got a job at the University of California Medical Center in their private psychiatric unit and enjoyed four years of work -- of spending time with hippies from '64 to '68. Continued with that then when I moved to Indiana. Got married. And took a job at Fort Wayne State Hospital.

JT: Okay. And I know that from what I've read is that you spent about 10 years as the Director of Central State Hospital, as well as, the Assistant Director at Fort Wayne.

RS: Yes.

JT: Can you compare the two hospitals in terms of the clientele and the philosophy?

[00:01:22]

RS: It's hard to compare hospitals that were developed for those with developmental disabilities to those who were developed for those people with mental illness. However, towards the end of the institutional life, of both hospitals, they had a lot in common in that people with developmental disabilities frequently also suffer -- no reason they shouldn't -- from mental illness. So there was an overlap, a unit of combination folks in both hospitals.

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[00:02:05]

JT: And we're going to talk more about that down the road doing diagnosis and that sort of thing. So would you say there were any differences in terms of attitude towards people that lived in the hospital by the community and the staff between people with mental illness and people with developmental disabilities?

RS: There was some differences between the two hospitals but it related more to the community, than it did to the patients as I saw it. State hospitals back in those days tended to have a pretty stable attendant and professional staff. That is, people had worked at the same place, either Fort Wayne or Central, for a long number of years. But there was just more turnover in Central. Central State Hospital was less important to the City of Indianapolis than Fort Wayne State Hospital was to the City of Fort Wayne. Population, number of people employed, those kinds of things made a difference. It was hard to know -- I guess I've kind of been on the noticing side of prejudice, attitudes, towards people with mental illness or developmental disabilities or alcoholism.

That's another part that I've spent time in -- addictions, generally -- on the part of the community, as opposed to the part of the staff that worked with them.

[00:03:47]

JT: Do you want to talk about what you noticed?

RS: People who spent time, and usually that's the attendants, if they were very committed in the community, so this is more true of Fort Wayne than it is of Central, got to feel like a family, so that when Central closed I would occasionally meet people, attendants, rehab therapy assistants, more true of the non-professionals than the professionals. I'd meet them in the community and they would tell me that whatever job they were on was not as friendly. And they're not just talking about fellow staff persons; they're talking about the relationship with the clients that we serve. Long term on both sides.

JT: Okay. So what was it like to be an administrator at Central State?

[00:04:53]

RS: It started out to be a big challenge that I liked. And within a couple of years we were able to get joint commission accredited. First time it had ever been accredited and that's exactly the same standards that are used in all the community hospitals. So we then became more like than unlike. Towards the end there was change. There was a lack of a Commissioner of Mental Health for a while, so there was an acting person. There was less [inaudible] more emphasis on cutting costs, saving money, and then, of course, as we got to the end, they closed the hospital with the idea that everybody could be served in the community except for a very few people. The Legislative Services had done a study and we had talked about how to downsize significantly, but it would have been pretty expensive if all the services that the hospital offered, including the recreation, the medical services, dental services -- hospitals offered a full range of services including just plain friendship -- that isn't easily translated into the community.

[00:06:27]

So, I still meet people downtown when I go to a parade or something significant. And they will say to me, "Didn't you used to be Ruth Stanley?" "Yes." [Laugh] But they will also say that they miss the congeniality that they used to have with folks that lived there. Sometimes they're in apartments where people are scared of them. Attitudes have not changed significantly in the general public. They changed, and they're back down again. I say down in that I believe that more people are afraid or dislike people with mental illness, developmental disability, or addictions than those who feel positive about them.

JT: Okay. Can we [cough] -- excuse me -- back up just a little bit and give me kind of a brief background of Central State in terms of -- you were talking about when they got state accreditation. If you could talk about what year that was, a little bit about background in terms of who was referred to Central State as opposed to who was referred to Fort Wayne. What did they look like for people there? That sort of thing. And then, if you would talk about when they closed, why they closed and where people went. That's a lot to do and I can ask you some more, but just some background.

[00:08:00]

RS: I can't tell you exactly when Central State got accredited because it's been a while and my recollection of dates is shaky at best. It was -- I started there in '82 and I left in '92. During that time, one of the things we did was kind of mush around in the basement of the Administration Building a little bit, and came upon some historical records -- people who were referred there early on and Central would have been 150 years old roughly after they closed. It was, I think, 1840 something that they started. So, in the beginning, like most state hospitals, people got referred because somebody wanted them to be referred -- a difficult person, an angry person, a person that didn't act right, a person that didn't seem to understand things, a whole variety of what today are pretty innocuous things -- but in those days, called for a state hospital placement.

As time went on and there was more diagnosis, more physicians got interested. They got divided into basically two areas; mental illness; developmental disabilities. In those days it was called mental retardation. Later the third category of -- first alcoholism and then addictions was added. But that was the first general division and it was thought best to specialize, so the mental illness hospitals took those people who were clearly mentally ill. The developmental disabilities hospitals got everybody else. And they were a little divided by age in that South Bend -- and Children's Hospital and Muscatatuck, which was the hospital for a wide variety of ages, took children.

[00:10:21]

Fort Wayne and Muscatatuck had folks who were the most disabled. They frequently were not able to care for themselves, not able to walk, had to be fed, dressed, bathed, etc. As time went on -- I came to Fort Wayne in 1968. At that point there were two halves of the hospital. One half was the new site; one half was the old site. The new site were all new buildings, and they had started the process of providing programming for those people they thought would respond to that. The old site was for people who were classified generally as severely and profoundly disabled, and those people tended to have not

much more than being kept relatively clean, and neat, and safe. Given medical care if that's what they needed.

[00:11:24]

As time went on, in the '70s and certainly in the '80s, there became clear that folks who were mentally ill could also be developmentally disabled, could also be addicted to alcohol or something else, that folks who were mildly or moderately developmentally disabled could also be mentally ill. I'm sure profoundly and severe folks could be mentally ill, too. But it was more difficult to try and tease that out. And that's when they started having the extra units in the M.I. Hospitals -- Mentally Ill Hospitals. So Logansport, Fort Wayne, Evansville, Richmond all had specific units that were meant for folks who were both developmentally disabled and mentally ill.

And those units were certified by Medicare. Now, of course, this all -- the JCH accreditation and Medicare certification and Medicaid certification, all has to do with collecting money. And the state was beginning to be very interested in that because this is a relatively expensive activity, and if there are hard economic times in the state -- I think anybody who reads the papers these days know that you talk about cuts more than you ever talk about adding or enhancing services.

PH: That good, that was really good. It's nice to hear the history of all the places.

JT: Okay. We're going to talk a little bit more about Central State and then we'll go into the bill diagnosis.

RS: Okay.

[00:13:14]

JT: So, in terms of your tenure at Central State, can you talk about some of the biggest challenges and some of the greatest successes from Central State?

RS: The biggest success -- in fact I've got a Sagamore of the Wabash hanging on my kitchen wall -- was getting the hospital accredited. But the biggest failure was trying to keep topnotch professional staff and keeping the buildings going. I don't know when we didn't have issues with buildings. Windows wouldn't open or close totally. Cleanliness has to be an issue or you don't keep accreditation. But heating was less of a problem. Air conditioning was terrible. I would say our air conditioner went out every single summer and in a place that's that big, to try and repair let alone replace something like that, money is just not there. So every year we would ask for building enhancements, or we would have liked to replace the Bahr Building, which was our locked unit with people who needed more attention for their behavior than anything else, and in just managing to get that done.

[00:14:51]

And I would say my personal issue was I just didn't know how to be as political as I should have been, over the years that I worked at the Department of Mental Health. The state counts that is 24. We were pretty well non-political until we came to a governor who made everything political, and that was in the last years. That was very difficult for me to think about doing. And we had a medical director who was kind of a laissez-faire, great doctor, but unwilling to supervise other doctors. The state did a search, got

a medical director who was only too glad to supervise other doctors. But these people saw themselves as totally apolitical, which most physicians would.

[00:15:51]

And it just got to be ungovernable. The last year that I was there, in fact, shortly before I left, we had a couple of deaths. And anytime you had a death, regardless of why, what happened, whatever. You know, in state government there is always blame. It got to the point where I couldn't deal with it anymore after 10 years. My stress level was high enough to make me quit fulltime employment. And then I did some part-time for a while. When I left, the state realized they had an opportunity, so they put temporary people there for about a year and a half, and then were able to close it with the patients they saw as most difficult to treat, to deal with, to put in the community at all, going over to Larue Carter.

And everyone else was placed in the community in some fashion -- sometimes halfway houses, sometimes group homes, sometimes individual apartments. In all this process, sometime in the '70s, was a process called "normalization." That's a big word. Well, normalization to me always seemed like - - that the only normal was middle-class living, so it didn't matter what background anybody came from. Whatever they got sent to in the community had to be pretty much a middle-class living situation which sometimes was difficult because people who came from a family that wasn't used to this weren't quite sure how to handle it. It partly was the problem in making friends in -- you know, if you're comfortable with it, and somebody talks to you about hearing voices, you can tell them straight out, that their mind is playing tricks on them and that they should listen to other people, check it out, and they need to take their medicines.

And as far as I know, that might be the biggest problem in the community is making sure people take their medication.

JT: Well, I was going to ask you what brought down the close of Central State and it sounds like it was the, you know, with you leaving and then the deaths of a couple of people, which like you say, that's [inaudible] and sometimes things happen. But, you know, if you want to talk a little bit more about actually what brought down the closing and where did you get your orders from? Did you get them from the governor? Did you have a board of directors? I mean, who...

[00:18:55]

RS: I tried to get -- I tried to get a board of directors for Central State Hospital because it was clear to me that I was kind of in over my head politically. So we had a board for almost two years. People on it from the Junior League, psychiatrists in town. We met three or four times a year and tried to get some input that would focus, like other businesses did, on people who looked at the community as whole -- the good of the community as a whole. I was supervised directly by the Commissioner of Mental Health. But, as I said, the last, oh, year, year and a half, which would have been '91-'92, there was no official Commissioner of Mental Health.

[00:19:55]

There was an acting, who was one of the other state hospital's superintendents, but little support was offered. I had no contact with the Governor's Office. Then after I retired in March of '92 – I'd already announced my retirement to the commissioner -- then I understood a grand jury was convened and I became a subject of that grand jury. And it was interesting to me that all the assistant deputy attorneys general who had represented Central through the years called me up to tell me what that meant and how to deal with it, and etcetera. And then, at that point, the Governor's Office -- because I could not be represented by the Attorney General's Office -- the Governor's Office paid for an attorney for me. And, in fact, they gave me some choice. So, while that was 1992, I can describe as a year of hell, when I got through it I understood that it was part of the political process that I did not like and didn't want to be part of.

But, if the Governor's Office paid for my attorney in front of the grand jury and the grand jury never said anything to me because all of my staff went there and talked about all the positive things we had done. It's just hard to go through it.

JT: Mm-hmm. So when Central State closed, what happened to all of the artifacts, the records, you know, everything that was in...

[00:21:38]

RS: Most of those records went, and many of the artifacts went to the State -- am I right? -- The State Museum. I think that's what I mean, Indiana State Museum. They already had a number of things that we had given to them over the years, so, like those cards that talked about the first people that were admitted to Central. They got those things. Some of them probably went to the Indiana Pathology Museum which is still on the grounds and still open occasionally, as I understand, which more tells the history of beginning medical training in mental illness. But it has a fair number of exhibits, too. So between those two places, when the new buildings were built sometime before I came -- I'm guessing the '60s -- Evans and Bolton -- most of the old artifacts of the big old buildings and the cottages, as they were torn down, disappeared, I understand; [laugh] that there were a lot of people in state government that kind of got things.

There was an artist who had painted a lot of pictures and some of those disappeared; but there are still some left, I think, in the History Museum, and there may be other places in official areas, too.

PH: That's good to know.

JT: So, all the little brains that were -- I think that...

RS: All the little brains are still sitting in their little original jars in the Pathology Museum at the back of Central. You go in the gate on Vermont. And I don't know if they have official opening hours every week but, boy, if you want to see something interesting, go there.

[00:23:49]

JT: Okay.

[00:23:49]

RS: It's a wonderful place.

JT: [Cough] Excuse me.

PH: Do you need any water?

RS: No. I'm fine. Thanks.

JT: So do you have any personal stories or anyone you remember that was a resident of Central State or anything like that you'd like to talk about?

RS: [Sigh]

JT: Is there anyone you kind of... ..followed through the years or kind of knew, and then what happened to after they left?

RS: No. I see people every once in a while but stories [sigh] -- it was easier to do that at Fort Wayne where I had more specific time with a smaller population. At Central, while the superintendent gets involved -- so I was on all of the units here and there -- and whatever. It's -- and it's long enough. It's been 20 years since I retired and so, while I can remember very interesting stories about the Haight-Ashbury in the late '60s, [laughter] that was a time that kind of stuck with me more and it was all brand new and etcetera. So I don't know that I have any...

JT: That's fine.

[00:25:17]

RS: ...particular stories. I recognize people.

PH: Maybe -- were there any big events that you put on at either one of the places that, you know, you can remember?

RS: At Central, we started after a while to have a celebration that included staff. It was a staff recognition. But you cannot do something on a campus without including everybody. So the last three or four years, I guess, that I was out there, we had a celebration with games, and food, and etcetera.

JT: Okay. [Noise] Well, now, I'm going to talk to you about dual diagnosis, and so you talked a little bit about this, but, you know, one of the things is how that label came about. Did you see a rise in diagnosis's over the years? What's -- the label was there. And what sort of training came about because there was now that new category of people?

[00:26:24]

RS: Dual diagnosis is a very difficult thing. If you think about looking at just general population, they keep citing 3% for this, 3% for that, and that includes the mentally ill, mental and developmental diagnosis. It's -- there has to be some overlap. I mean people are people.

[00:26:49]

JT: Mm-hmm.

[00:26:49]

RS: That's just the way they are. And there are lifelong mental illnesses and then there are short-term mental illnesses, so that you can deal with either one of those. We were most apt to have lifelong mental illnesses. There also are behavioral problems that are difficult to separate out; hitting, spitting, fighting, refusal to take medication. And it's difficult to sort that out as an inability to understand what's going on or a true mental illness with maybe delusions, hallucinations, etcetera. So, I think, in the beginning when people first started looking at that, they started recognizing that there was an overlap.

At that time, doctors in the DD Hospitals were physicians, and they may have some specialty, but they were not psychiatrists for the most part. The doctors in the MI Hospitals [door closes] were mostly psychiatrists, with a few general physicians. We had an advantage here in Indianapolis in that we had contracts with IU in Wishard and Midtown when we got there, that we would send clients in and out; and so we had more specific medical specialties that might be able to deal with that. The downside of that was that those folks didn't necessarily know anything about developmental disabilities. It's hard for me to say whether there was ever a change in medical training if they didn't have a practice session somehow [door opening] that enabled them to see people with one or the other, [door closes] or with both.

[00:29:07]

And the way I've see medical education going these days, anyway, you have to specialize more and more, and if you've seen the latest DSM-5 you know there are some very interesting diagnoses in there. For instance, the one that attracted my attention was on hoarding. I think they were talking about cat ladies, but who knows. And then you have to wonder are we diagnosing ourselves out of regular -- not so a normality or is there no normality? So that's hard to say. I think what people started seeing, though, was that drugs that were given to people who were mentally ill sometimes could have the same effect which was positive for people who were developmentally disabled. So someone who had a minimal developmental disability, but a lot of behavior problems, if given medication could then begin a process of learning how to take care of themselves, how to live independently, semi-independently, with a few other people in a group home. So that was pretty positive.

JT: Good. So what changes have you seen in philosophy in the types of medication given to people during the years? And then also think about maybe physical and chemical restraints.

[00:30:45]

RS: Rarely do people use physical restraints anymore. They were the only thing -- when I started working in my first job at the University of Minnesota, when I graduated, we used straightjackets because there weren't drugs. Thorazine was really the only drug. And then it was added -- Stelazine, and then, of course, since then they've added hundreds or thousands. Who knows? That has made a big difference. That does have a downside in that it's hard to know when you can get people off, when to reduce. If

people don't take it routinely, you don't really have a good ability to know if their improvement is a real improvement, if it's due to the drug -- there's a lot of ifs. Side effects, I think, have become more important than anything else with drugs.

[00:31:51]

But people seem more inclined, and this is the general philosophical community attitude -- they'd rather deal with side effects than personal physical restraints. I would say the schools might use more physical restraints now than state hospitals, or community mental health centers, or developmental disability group homes, any of those more official organizations. The other big reason there was that Medicare, and Medicaid, and Joint Commission on Accreditation, absolutely did not want physical restraints used. That, in their mind, was unacceptable, old-fashioned, whatever -- however they came about those decisions. So that drugs are the effect -- the treatment of choice for almost all things these days except, alcoholism and drug addiction when there's a little bit of that but they haven't yet got that magic thing down.

The other thing that I would like to add on the -- is that community attitudes changed much for the better in the '60s, '70s, beginning '80s, and as far as I can tell today, they're going back to the '50s. Communities -- many people who are physically disabled have laws; and those who are developmentally disabled have laws that work in their favor. There are laws about you must have disabled parking; you must have curb-cuts; you need to have elevators, escalators. There are a lot of things that help the community welcome in people who are physically disabled. For people who are mentally ill -- I don't care how many movie stars talk about their depression -- rarely does anybody say they're schizophrenic.

[00:34:12]

And there's that one physician in -- she wasn't Virginian. Now I think she lives in Montana. A veterinarian, maybe, who does all kinds of speeches and she is autistic and has worked through that. She just worked hard enough that she got to what everybody else sees as "regular." But the attitudes -- if you're cutting dollars -- if there's something you can let go of -- I think that was true of the community mental health centers. They started out serving lots and lots of folks and, as they've been cut and have had to look at the bottom line rather than, treatment as their most important organizational goal, that shortcuts -- it made, and I haven't seen that peoples' attitudes make that up.

JT: So, would you say -- because one of the things that Arrowwood has talked a lot about in terms of what you were talking about where people that have physical disabilities -- curb-cuts, escalators -- we talk about as a community for all because other people benefit...

RS: Sure.

JT: ...from it other than just people with disabilities...

[00:35:31]

RS: Well, my husband's on a cane right now and we're parked in that blue space out front -- out back.

[00:35:37]

JT: But it sounds like attitudes, if I'm hearing you correctly, attitudes towards people with mental illness is still the same as it was in the '50s, where attitudes toward acceptance of people with physical disabilities, mental -- or developmental disabilities and things of that nature have improved somewhat. But in terms of just hard core mental illness, schizophrenia, hallucinations, that sort of thing, you don't feel that that's...

RS: Magical thinking? Any of that. And I think all you have to do is look at the newspaper and TV these days. For those of us who spent our lives in -- working in mental health, whatever that -- we say to ourselves when we see people as we travel, move around, there's one of ours. And if you look at the man who shot up the movie theater, as you look at the man who shot all those kids, they're one of ours. You can tell by looking at them, they're different, they're strange, they're odd. No one feels any compulsion to try and figure out how you intercept that in any fashion. I think it used to be intercepted decades ago, half the century ago, by teachers or doctors or neighbors, or whatever, who befriended somebody, and tried to pull them out of whatever it was they were working at inside themselves.

That isn't true at all today. Teachers don't have the time. And there's not many other people that are interested.

JT: If this was -- and this is another side to this -- if this was 1950, the people you were just talking about -- the fellow who shot up the movie theater, the schoolyard massacre -- would those kids, do you think, who have been recognized in school and sent to an institution at an early age?

[00:37:44]

RS: It's possible. The other thing is that they would have not -- they would have had more people paying attention to them. So somebody might have taken official action whatever that occurred. Or they also just didn't have access to the weapons that they have today. We didn't have sub-machine guns or whatever they're called. We didn't have the 30 rounds of ammunition that you just chunk in and let it go. So, two things; less interest because the communities aren't as community-oriented, you know, about knowing your neighbors. People just don't stay. I'm the neighborhood nosy lady. It's all that training in mental health. So if I see people, I go outside and I talk to them. If we have new people that live next door, I find out what their names and try to remember them.

It's just not as friendly, even in the rural areas -- although the rural areas can be better than the urban areas. Just because there's fewer, you'll spend more time together. I grew up in a town of a thousand, and there probably isn't much of anything that anybody that I didn't know something of. Would see them at school or church -- or whatever.

[00:39:19]

JT: That was really good. All right. So, we can give you some -- a few more basic questions. In looking -- no -- okay. In looking at your tenure in terms of the field of disability and human services, what are some of the most noteworthy changes for our people with disabilities, whether it's mental health issues, or whether it's intellectual, or developmental disabilities?

[00:39:46]

RS: To me, the real issue back in the '70s, and particularly the '80s and '90s, was that the advocates got together and made something happen. That's where the laws came from, is people at the grassroots level pushing government in, first, the community then the state then the federal government. So laws were passed. That has never happened with people who are mentally ill. That's a positive in that once something is made law, you know, people don't always follow it.

How many young people have you seen jump out of their SUV in the handicap parking space, run in, or just park sideways while they run in and get a cup of coffee over two spaces? So you -- but that's not something you can mandate. What hasn't happened is that that has kept up, and I guess that's one of the attitudes that has puzzled me over the past 10, 12, 14 years, is that the mental health associations and the advocacy associations, in general, are not as active as they used to be. And one of the issues I think there is that we have separated people. We've made them individuals, which is a very nice thing. So most families, these days, instead of placing their child or adult in an institution or a nursing home or something that may have to happen when they die, but not at an early age, but that has fragmented then organizations because people are more focused on and interested in their own circumstances.

And because all of these people with developmental disabilities and mental illness and addiction have different issues and problem -- they're individuals like the rest of us. It's difficult. As long as they were working as a group for everybody, it was a very powerful lobby, and I think it's lost some of that power. They still provide educational services; but those are mostly to parents, family members, maybe professionals if they can get hold of them. But that fragmenting, while it's a good thing maybe for the individual him or herself, it's not positive for accomplishing much more as a total community and/or nation.

[00:42:52]

JT: Okay. All right. So in looking forward, what do you hope for in terms of supports and services to promote [inaudible] the lives for people with disabilities across the spectrum?

RS: Boy, that -- looking for what the future might hold is just -- it's really difficult. You sure don't want to quit when you're -- when you've made some progress. You know we haven't gotten anyplace. And I guess I really don't know. Sometimes I think there's a lot of progress yet to be made, and then other times I think until we have a better understanding of the brain, whether that starts with trying to deal with Alzheimer's which affects a lot of people, or trying to deal with the various cancers that you would occasionally get in the brain, or strokes. I don't want to have a stroke unless I die instantly. It's difficult to say that much more is going to happen. That brain is so much the integral part of who we are.

I'm not sure that until people get more knowledgeable, more comfortable, less concerned about their brain or anybody else's brain that we're going to be able to change perceptions and attitudes much.

[00:44:31]

JT: Hmm.

[00:44:31]

RS: You got to keep working, but it's not a popular cause right now.

JT: [Inaudible] Okay. Do you see future trends? Do you see, you know, where the dollars are going or future...

RS: I think trends will continue to be towards community services. Now, if those tighten for some reason, this issue on payment for health services, Medicare/Medicaid. Some doctors are now refusing that because it's so -- I look at my bills and I think, my gosh, that -- the bill is this, but Medicare pays this. How does that work out? Is it that the bill is so wrong? Is it that we're shortchanging -- is it totally a smoke and mirrors activity what healthcare really costs? Are insurance companies the only people who benefit from healthcare? That is so hard to kind of get your mind around because if you pay attention to what's in the paper or on TV, you get -- or what your doctor says -- you get information that doesn't necessarily go together. It might not be -- but not against each other, but it doesn't fit.

JT: Good. Well -- and some of this you've already talked about. But I was going to ask you if there were any career highlights or anything that you wanted to elaborate on, anything that you remember from your tenure at work.

[00:46:26]

RS: I think the best part is two things happened to me. One, when I spent those four years in the Haight-Ashbury. I worked as a senior staff nurse and then head nurse of the University of California Private Psychiatric Care. So we had the top level, private psychiatrists. So I didn't get into drugs because I could see that in front of me. But otherwise, I got into everything that everybody else got to, except the free sex.

RS: [Giggle] My sister and I were talking about that the other day. But that was such an enlarging process to my brain, to my person, that the rest of my career -- I don't know how many times I've said to people -- and we have close friends that we probably spend a couple times a week with, coming from mental health, too, that -- and my husband worked in mental health; he did addictions, but he also worked for the Department of Mental Health -- how lucky I was to work in the field of mental health. And I'm including developmental disabilities and addictions. That is the most wonderful field because all you do is work with people. People are people regardless of what their titles are. And if that's what your job is, you're just lucky.

JT: That was really nice. It gave us --

PH: I was wondering if you want to talk a little bit about your award.

RS: Nah.

[Laughter]

[00:48:09]

RS: Thank you.

[00:48:10]

JT: [Laughter] [Inaudible] who recommended you.

RS: No

JT: It sounds like you had a wonderful career.

RS: I did.

JT: You had a lot of adventures

RS: Yes, the last year at Central was...

JT: That's [inaudible]

RS: God awful but then I worked part-time with, my husband and I got very interested in penny slot machines [laughter]. And my little sister thought we were addicted, but I worked for about a year and a half, part-time, for the Custer Center which rented beds in Methodist Hospital...

JT: Mm-hmm.

RS: ...and they were an in-patient addictions program. Didn't last long because there isn't money. People aren't willing to pay for that. But I studied those people and decided, no, we weren't addicted. We're fine.

JT: I worked at a day service agency -- in Martinsville -- in the '70s and '80s...

[00:49:07]

RS: Yes

JT: It was when it was Department of Mental Health and the person that I knew, Larry Miller...

RS: I know Larry Miller, sure.

JT: He was the Director of Department of Mental Health. And so, you know, if you needed to know something about that, you could call Larry Miller and then, you know, like I say...

RS: People knew everybody's names.

JT: Right. If you knew who to talk to about what -- but yeah, it was quite different and I hadn't thought about the VS -- and now it's five, since the...

[00:49:36]

RS: I read those diagnoses, and I'm saying we're going to diagnose every child with some disease and then we're going to feel like we have to provide treatment. In the old days, you told them not to do that and you gave them something else to do.

[00:49:51]

JT: Well, yes. I was -- but I was -- when you were saying this, I was thinking, you know, last we knew that that was three. But -- but -- and I remember getting all these reports because I was a social worker, and that's what they needed to ask you, too. But you would look at what their label was based on that manual so you had this idea that...

RS: That's how you get -- that's how you get paid for it.

JT: Right.

RS: But that isn't necessarily the way that you have to deal with -- particularly kids. You better be dealing with their behavior.

JT: So do you want to tell us what your background was? Because I know you said you were a nurse. So can you tell me what your education was?

RS: Yes. I went directly to the University of Minnesota to a baccalaureate degree in Nursing because every member of my family for three generations went to McAllister College in St. Paul, and I said, I'm not doing that. Then in '72 when I was working at Fort Wayne, I was asked to be the nursing consultant for the Department of Mental Health. That's that period between Fort Wayne State Hospital and Central when I visited every state agency, Development Disability Addictions, Mental Illness. So for that I got a Master's Degree in Education. At that point there weren't a lot of opportunities for Master's Degree in Nursing, and they were pretty long. And then when I finished in '93 -- '92, for something to do, I got a Master's Degree in Environmental Planning. And that's what took me into -- help the community mental health centers change from an in-patient -- infection control unit to a whole community handling of hazardous waste kind of things.

[00:51:43]

JT: Well, there's a nice scuff of education. Let me look here. Now can you think of...

RS: I don't have time to get a degree from every Big Ten University.

RS: [Laughter]

JT: And the people from Central State kind of answered that, you said they were all over the place.

[Silence]

PH: Do we want to talk about maybe what it -- a typical day looked like at Fort Wayne and the degree by which -- could you talk about that?

[00:52:12]

RS: That's hard to do, both because of the amount of time. You know, I would just have little bits and pieces here and there, and I kind of said about it in that, in the beginning these people got into some kinds of

activities and the people who were lower functioning did nothing except kind of mill around and that was it. It -- typical days -- it's like every day is a typical day when you're dealing with people.

[00:52:45]

JT: Did you feel those places -- and this -- I meant the other, did you feel those were good places for people -- most of the people that lived there? Did you feel that...

RS: Yes. Fort Wayne improved dramatically because, if you think about it, people milling around the -- maybe were clothed, maybe not, maybe just a diaper, being clean and fed and that's all, so a little altercation going on here and there -- and that's due to the wish of the State of Indiana to make things more official and get like everybody else. And so that the standards are clear. And that's Medicare, Medicaid, Joint Commission on Accreditation, and there's another one for developmental disabilities that I can't dredge up the name of. But those are the standard activities. Central was a little cozier, but even that -- there was a lot of use of physical restraints in the Bahr Building particularly.

That was the locked unit. Every room was locked. They were all individual rooms, and every room was locked because people were combative. That was the behavioral issue. And there were some folks -- two ladies that I can think of that started at New Castle when they were maybe five, six, seven years old with heavy doses of psychotropic medications, and they were not improved when they were in Central 20 -- 30 years later. And that's part of what has to present itself before there can be an improvement. Why did they improve or [door closes] not improve? If you can't say that, then you can't really deal with it.

JT: How many people were at Central State any given time -- how many residents?

[00:54:54]

RS: The biggest number as I understand it, back in the '50s and '60s, was 3500 roughly. So a lot of people in a big building. They always talk about the big building.

JT: All from Indiana?

RS: Yeah. They would have been. And then they also had the farm up on Tibbs. If you go -- the street on the far side of Central State beyond the graveyard is Tibbs. And if you go a little further north on Tibbs, there's the shopping center and some other things that used to be the farm. So people that were capable of working would go up and work on -- it's more like a vegetable farm than a farm farm.

JT: Was it similar to Muscatatuck in that people had chores and, you know, they were somewhat self-sufficient where they had [inaudible]...

RS: In the early days and very, very much before my time. Yeah.

JT: Okay. And the last one I was going to ask you -- the cemetery. You said there was a graveyard...

[00:55:59]

RS: Mm-hmm.

[00:56:00]

JT: So was there a cemetery for people who died...

RS: Yes. And usually they were people who were not claimed. Unknown folks who never had anybody visit them who -- that didn't know -- staff didn't know that there was any family available. There might have been, but in those days you really tended to put somebody away and forget them.

JT: And...

RS: It was a shame.

JT: In your tenure was that still happening? Were there people that were just there...

RSRS: There...

JT: ...kind of abandoned?

RS: Except that between staff, local volunteers -- we had a volunteer director -- and Barry would go out there and pick volunteers for this, that, and the other thing. The local Mental Health Association always came out and did big parties at Christmas time in every ward so that there was -- it was more individual than just a whole hospital. There was a lot of -- there were still people that were never visited by anybody. But if you think about people in a hospital these days, if the family's not very close, or if they've been on their own for some time or if they're drifting from here to there, that's not unusual. But they did not die alone. And I have no idea when the last grave was put in that area. I can remember that there's one of every kind of tree in Indiana on the grounds.

[00:57:34]

JT: Hmm.

RS: They were planted by the Boy Scouts.

JT: That's cool.

PH: I heard most of this week when you said one of the hospitals is having a new program for people who don't have family -- kind of a hospice.

RS: Yeah. Visitor kind of thing. Yeah.

PH: So that they don't die alone.

RS: Right.

JT: And New Castle Hospital -- was that a place that primarily people with epilepsy...

[00:57:59]

RS: It started out that way, but in the end -- that is when I started working for the State, it was simply another developmental disability agency. It was small. So like South Bend it closed fairly quickly.

[00:58:15]

JT: And is Larue Carter still...

RS: Larue Carter is still functioning out on the grounds that used to be the VA Hospital years and years ago.

JT: And it's still a psychiatric hospital?

RS: It's still a psychiatric hospital. It had to change a little bit in that it used to be very closely affiliated with IU, so all the research that was done at IU Department of Psychiatry was done at Larue Carter. However, there were maybe a couple dozen -- I'm not sure exactly how many people went there from Central when Central closed, because they could not be housed anyplace else. They have older children, adolescents. I'm not sure how young their child population is. I suspect not real young, and adolescents. And then adults. The other state hospitals that are still open are Logansport, Evansville, and Madison, but very much diminished in numbers. Richmond -- I think they closed their addictions unit. Or they closed their DD Unit.

JT: And Silvercrest is closed?

RS: Silvercrest?

JT: That was a children's hospital, Southern Indiana.

[00:59:36]

RS: South. Yes. That was Board of Health. Sometimes there was a little overlap between Board of Health institutions and mental health institutions. So that was the Board of Health, but, yes, that's closed. The large -- I'm trying to think. I want to say bed and breakfast. That's not quite right. Institutions...

RS: [Cough] ...at Rockville. It was not labeled an institution but that's what it was. They provided living space, [door closes] meals, medicine. It was a place where people would be supervised enough to make sure they had medicine, they had some level of recreation, and they had some level of medical care. But it was less professionally staffed than the hospitals were, which had everybody that was needed: occupational therapy, [background noise] lots of social workers, psychologists, etcetera.

JT: You know it's kind of interesting, but years ago we interviewed people leaving Muscatatuck...

RS: Uh-huh.

JT: ...and it -- looking at, like you were saying, who -- people that were placed in institutions 30, 40 years ago. And you look at the people now, you know. All the people that -- all the meth labs and all the crack bums, and, you know, people that are just constantly in trouble, would all be people that would be -- would have been quite institutions years ago.

[01:01:14]

RS: Quite possible.

[01:01:15]

JT: And then all the homelessness -- those are people that also might have just been picked up as vagrants and...

RS: If there really were mental health services in the community, easily obtained and easily found, I think all of those things would have been okay. And when we talked with -- I've forgotten who I talked with at the Legislative Services Agency, but before I left Central. And we planned -- and my guess at that point was that probably 80% of the people in Central -- if those services were readily available -- could live in the community quite decently.

JT: Mm-hmm.

RS: Everybody would be happy. But the services aren't as readily available. You know, like you can find a service but if the -- if the person who was the patient doesn't take their medications, maybe that service isn't good enough now and needs to be more, or that service moves on, or the client moves on to someplace different, and it -- there's been so much cuts in state grants to community mental health centers and the local developmental disabilities organizations that they just aren't capable anymore of doing a widespread job.

JT: Well, and I think it's probably hard for people with those issues to go get the services.

[01:02:53]

RS: Let me give you a little off story. I work for the Red Cross as a Disaster Mental Health Specialist. So when we had the floods in '08, I spent three weeks -- shelters in Martinsville and Greenwood, and then the service center in Franklin. And while I was at the service center in Franklin we heard about a trailer park that had been flooded with a lot of damage but managers/owners, I'm not quite sure what -- wouldn't let anybody on there. So they hadn't yet been surveyed by the Red Cross Damage Assessment so that people -- and nobody had come in to the service center from there. Supposedly his managers didn't let people on the grounds. Well, okay. A direct challenge there. So I gathered one of the state police chaplains and the two of us went -- you've always got to go two.

Two of us went over there and I just whipped into the office and said, "Oh, we've been so worried about these people. My name is Ruth Stanley and I was a Disaster Mental Health Volunteer for the Red Cross and I had just come to make sure that they were doing okay." So we went down and we talked and these people were ultra-suspicious of government, and it's surprising to me how many people think Red Cross is government, when they're not. But they all said that there was a person -- and I can't tell you what his name was -- that was dangerous. He went off. That's a professional term you've heard before.

JT: Mm-hmm.

[01:04:35]

RS: Going off. So I said, "Okay, well let's go down there." So one of the women went with me because they thought he would react better with women. And what I did was just -- he came -- standing outside his trailer. I just went up the front porch -- so I'm standing well below him -- and put out my hand and said

"My name is Ruth Stanley, etcetera. I said, "Did you manage to get your medications when you had to abandon your trailer?" And he said, "No." Oh. So we talked. And it was clear he was one of ours. So what I did was first talk to the Red Cross. But they have money limits as to how much they could spend. We found out his medicine cost like \$600 a month. And we could not pay that. So I did two things. One, he'd made some contact with a basic church, one of the -- I'm not sure -- Evangelical kind of churches, Christian churches.

[01:05:46]

So I talked to that lady and said he really needed some help now in getting his medications so that he could get back on it and feel better and help -- be helped to make some good decisions. But I also called up Adult Child Services. He wasn't necessarily theirs but I'm sure he used to be theirs. And having been in the Department of Mental Health I knew many people and mostly directors of Community Mental Health Centers. So again, I identified myself, identified him; said "Can you please send somebody out to talk with him and make an appointment for him, get him in there. He needs to get back on the medicine. And then can you please send your case managers to their files and ask them to look for addresses. Anybody who's in the flood areas, would they please bring them -- come with them to the Service Center."

And the next day a case manager brought somebody to a service cent -- oh. [Clapping sound] I was clapping and clapping with that. If you, at the right time, make the right connection, you can make it happen. But had I not known those people in March this year -- I was in Kentucky last year. I was in Kentucky where I didn't know -- fortunately, I ran into somebody who did know mental health in the state, so we could set up the same kind of connections. Not easy to do these days.

JT: No.

[01:07:33]

RS: They were at -- I cannot say afraid but I was quite firm about whether he was their responsibility or not. Right this minute he needed help. So they needed to figure out how to make it happen. And I also got all those other people to come in by promising to be there when they came in. So I would take them to FEMA which is government and people are afraid of. So I did that.

JT: That was a great story. It's really rough. And then you have -- do you have to be somewhere at 11:30 or...

RS: Oh, roughly, yeah.

JT: Okay. So this is going to end up...

RS: At the museum. Yeah. So, not far.

JT: Okay.

[01:08:16]

RS: I'm really enjoying this, by the way.

[01:08:17]

JT: Well, I was just glad you could talk to us today. You have so many good...

RS: Interesting to try and think about these. I think about these things, and I talk with my husband and my friend, Francis, as we see what goes on around us.

JT: It's just so interesting to watch things change. And, like you say, when the services are cut and people, it's so challenging to find where to go and then to have to talk to so many people to actually get what you need...

RS: And if you're complicated..

JT: They don't want to talk to you.

RS: It's real hard. Exactly.

JT: Right.

RS: Because you'll cost too much in time.

[01:08:57]

JT: Well, just in the VR work that I used to do, I -- I mean, I can remember taking people to see a VR counselor and they would know within five minutes that that person wasn't going to be a successful closure in a short amount of time and would find every excuse in the world to not even take an application. [Laughter] Okay. Isn't this your job. And so -- yeah. And it's much worse now because there's less people and less dollars and...

RS: And a lot more turnover because of the environment. So that people don't spend their lifetime working for one organization and people don't spend their lifetime -- when the community mental health centers started, everybody had a catchment area and if you lived in that geographic area, that's where you went.

JT: Right.

RS: Now, they have the choice. The state rules are that every time they have an episode where they need services, they can choose a new place. Well, that completely negates history. And history is very important.

JT: Now in -- continuity and stability and...

PH: Now they're going to start over every time.

[01:10:09]

RS: Exactly. I'm always glad when I meet somebody downtown who says, "Did you used to be Ruth Stanley?" It tickles me. [Laugh] And I always said "Yes" to it.

[01:10:18]

JT: Yeah, I used to be, but now I'm...

RS: [Laughter] I know exactly what they mean.

JT: Right. Oh, yeah. Bet that's fun. Yeah, it's very different. And we talk about that at work also, because I've been in this field for almost four years, and I got two jobs. And most people -- much young people now have...

RS: Have had 10 jobs.

JT: ...a new job every, you know, two, three years. There's no loyalty. And part of it is, like you were saying, you know, the environment, the turnover. It's just more complicated. There's numbers...

RS: The pressure is on the work you do rather than, on the client's progress, needs, etcetera.

JT: Mm-hmm.

[01:11:02]

RS: If what you do happens to meet it, everybody's happy. But if it doesn't, well, that's too bad. We can't do everything for everybody.

[END OF INTERVIEW]