COMMUNITY MENTAL HEALTH
IN CUYAHOGA COUNTY

In the Beginning: Federal & State Actions that Culminated in the Development of the Cuyahoga County Community Mental Health and Retardation Board

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IN THE BEGINNING –FEDERAL AND STATE ACTIONS:

In 1963, in his last Act prior to his assassination, President John F. Kennedy proposed legislation that shifted the care of the mentally ill from exclusive State level responsibility to a shared responsibility with local communities.

In President Kennedy's words, *The time has come for a bold new approach….I propose a national mental health program to assist in the inauguration of a wholly new emphasis and approach to care for the mentally ill…central to a new mental health program is comprehensive community care.*

Following President Kennedy's direction, the 88th Congress, enacted legislation in 1963, the Community Mental Health Centers Act (PL 88.164). The Act proposed a new model of community- based comprehensive mental health care and appropriated construction funds for such centers. Further it provided grants to states and communities through the Comprehensive Mental Health Planning Project with the requirement that citizens be involved on a regional basis in planning such centers. Later, in 1965, the 89th Congress, with PL 89-105, appropriated funds for the Professional and Technical staffing for such Community Mental Health Centers (CMHCs).

To achieve the Federal mandate, Ohio's then Governor James A. Rhodes, with Martin Janis, Director of Mental Health and Corrections, recognized the complexities and the need to involve local political subdivisions and interested lay and professional groups in the planning process. They contracted with local health and welfare planning bodies to implement the Federal mandate. Through a contract with the Welfare Federation of Cleveland (now called The Center for Community Solutions) a new independent organization was established, the Citizens' Committee, Cuyahoga, Geauga, and Lake Counties Region 1, Ohio Comprehensive Mental Health Planning Project (one of nine such organizations in Ohio).

THE CITIZENS' COMMITTEE

The Citizens' Committee, comprised of 33 members included the Acting Director of the Department of Psychiatry, University Hospitals; the Blue Cross Executive Director; an Academy of Medicine officer; County Health directors; a hospital administrator who was the Chairman of the Regional Hospital Planning Board; a

school superintendent; clergy including the Diocesan Director; legislators; prominent civic and business leaders; the Director of the Cleveland Chamber of Commerce; and other directors of social, mental health and school agencies. William H. Heston, PhD., was the Chairman (later he was appointed the first Provost of the merged CWRU). H. Bernard Smith served as the planning consultant. In addition, some 300 citizens labored on taskforces and subcommittees. The report, “Interaction for Mental Health,” was issued on September 30, 1965.

The report consisted of six major sections: Prevention, Treatment, Rehabilitation and Restoration, Manpower, Legislation, and Continued Planning. Recommendations built upon mental health facilities and care available but recognized gaps in serving high risk and vulnerable populations. The report was over 150 pages including recommendations and appendixes.

A companion document “The Health Goals Project,” was developed by the Cleveland Welfare Federation shortly after the “Interaction” report. The Health Goals Project was a comprehensive study over two years to plan greater Cleveland’s health goals. Section Nine was “A Profile of Existing Programs, Services, and Facilities for the Prevention, Control and Treatment of Mental Disorders in Cuyahoga County.” The Citizens’ Committee Planning Consultant prepared Section Nine, and integrated the findings and recommendations from “Interaction” report into the "Health Goals Project.”

The 1965 “Interaction” report was broad and comprehensive in its scope. It called for programs of prevention, early intervention, treatment and rehabilitation to reduce the incidence of mental illness, as well as to curtail and effect social, economic and community factors that contribute to mental disorders. It envisioned the use of general hospitals, mental hospitals, community mental health clinics, social welfare, and recreational, judicial and educational agencies. It required an interdisciplinary approach of mental health specialists, including psychiatrists, psychologists, social workers, vocational and rehabilitation counselors, and nurses along with collaborative working relationships with other helping professionals such as physicians, educators, clergy, public health nurses, police, and sociologists.

Highlights from both reports are excerpted in the following sections of this historical summary.

COMMUNITY MENTAL HEALTH CENTERS:

The population of Cuyahoga County in 1965 -- 1,700,000 -- suggested eight to 10 mental health centers. The “Interaction” report, however proposed five such centers in Cuyahoga County - three on the east side, two on the west side of the county within the next five to 10 years. A similar mental health center was

recommended for Lake County in the future. A mental health clinic was proposed for Geauga County.

Basically, the center was a program concept. Five essential "elements of care" are required. These are emergency, inpatient, outpatient, partial hospitalization, and consultation and educational services. Additional elements of care are recommended but optional. These are diagnostic, rehabilitation, pre-care and aftercare, training, research and evaluation.

"Interaction" envisioned a possible mental health "center without walls" concept. The required elements of care could be provided through the coordinated activities of related but independent facilities. An example might include Cleveland Metropolitan General Hospital, the CWRU School of Medicine, and the Cleveland Psychiatric Institute. Forming such a center would be more realistic than planning a brand new center with services under one roof.

In the 1970's such developments occurred. The West Side Community Mental Health Center (CMHC) had contractual agreements with the Cleveland Psychiatric Institute to provide its inpatient services; the Murtis Taylor CMHC had similar contractual arrangements with Fairhill Psychiatric Hospital for its inpatient services. In the Hough community, Community Guidance and Human Services also contracted with Fairhill State Hospital for its inpatient services. Marymount Hospital CMHC, the first Center in Cuyahoga County, provided all of the Center's functions under one roof as a sole-source provider.

PSYCHIATRIC EMERGENCIES:

The "Interaction" report found limited psychiatric emergency and suicide prevention services available to the community. The report proposed the establishment of a Psychiatric Emergency and Suicide Prevention Center, to be staffed on a 24-hour basis and to offer consultation and educational services to hospitals, police, and agencies that deal with psychiatrically disturbed persons.

Once the Community Mental Health and Retardation Board was established in 1968, one if its first actions was the funding of the Psychiatric Emergency and Suicide Prevention Center of Cuyahoga County.

HOSPITAL BEDS:

In 1964, in the private sector, there were seven general hospitals with psychiatric units, having a total of 204 beds. These units were at the following hospitals: Cleveland Clinic, Lakewood, Marymount, Mt. Sinai, St. Luke's, St. Vincents, and University Hospitals.

There were also three private psychiatric hospitals with a total of 230 beds. These were Ingleside, Ridgecliff, and Windsor hospitals.

There were four psychiatric State hospitals with a total of 4,491 beds serving Cuyahoga County. Two of these were long-term--Cleveland State, 2,250 beds, and Hawthornden, 1,800 beds; and two short term -- Cleveland Psychiatric Institute, 280 beds and Fairhill, 161 beds.

In 1964 Ohio had 17 State psychiatric hospitals. By 1988 only seven State hospitals remained. This was due in part to the discovery and use of anti-psychotic medication and drugs to treat depression. Although patients' symptoms were often reduced, the medications did not deal with their underlying mental illnesses.

Following the State trend, locally, Fairhill and Cleveland State hospitals were closed. Hawthornden and Cleveland Psychiatric Institute were drastically downsized and eventually operated as Northcoast Behavioral Healthcare under one superintendent.

The Veteran's Administration (VA) operated two psychiatric hospitals-Brecksville, 994 beds and Crile, 40 beds. Today, Crile is closed and Brecksville downsized. Most psychiatric hospital care is provided by the VA in the Wade Park University Circle area in modern facilities adjacent to the CWRU Medial School.

The combined number of adult psychiatric beds including State, VA, general hospital units, and private psychiatric hospitals in 1964 totaled 5,959 serving Region 1 in 1964.

Cuyahoga County in 1964, followed the national trend--more patients were admitted to fewer voluntary beds than to State hospitals, 4,084 compared to 3,693. Similarly more patients were discharged from voluntary hospitals than from State hospitals, 3,918 compared to 3,145. This was accounted for by the average stay for voluntary hospitals: 32.2 days in psychiatric units in general hospital, 24 days in private psychiatric hospitals.

Short term State hospitals, Fairhill and Cleveland Psychiatric Institute, had average length of stays of 60 and 62 days. Long-term State hospitals, Hawthornden and Cleveland State Hospital had average length of stays of 2 years 3 months and 2 years, 7 months respectively. An exception from these rates was reported by these long-term hospitals, 50 per cent of their patients were discharged in less than one year.

The Region 1 (Northeast Ohio) had a favorable policy on the part of Blue Cross of Northeast Ohio in coverage of psychiatric hospitalizations in general hospitals. This policy was first in the country and offered a model of psychiatric hospitalization coverage to the same extent as other medical hospital care. The coverage, however, did not extend to public hospitals (Lakewood, Metro, State and the VA.) Private Psychiatric hospitals were reimbursed at less than full cost. In time this caused the closings of two of the private psychiatric hospitals in the

Region. Patients who could not afford health insurance or a private psychiatrist would inevitably end up in the State system.

"Interaction" recommended:

- The development of additional psychiatric units of 20 to 25 beds be within general hospitals.
- Future development of private psychiatric hospitals be contingent on the establishment of formal working agreements with general hospitals for the general medical care of their patients.
- Psychiatrists be physically based in psychiatric units in general hospitals to better serve the emergency room patients and to provide consultation with other medical specialists to understand emotional problems of their patients.
- Psychiatric inpatient units work be balanced with other "elements of care" to develop comprehensive mental health care programs.

CHILDREN'S SERVICES:

Psychiatric services for children were fragmented and in short supply. No services existed for children under six years of age who were suicidal, homicidal or extremely disturbed. Children aged six through 13 years could be placed in a newly opened 12- bed unit at University Hospitals. Sagamore Hills Children's Psychiatric Hospital (State) had 72 beds. Admissions were limited to patients who could be treated and discharged within one year. The Sagamore Hills program suffered from the inability to attract sufficient professional and nonprofessional staff. Children with severe psychiatric illnesses were placed in adult State hospitals.

Region 1 was fortunate that it possessed three residential treatment centers for emotionally disturbed children who benefited from living in a controlled group cottage environment. In addition to mental health professionals, the total staff of the residential centers included child care workers, counselors, cottage parents, and maintenance staff who provided a supportive milieu. Education was provided in small groups on grounds. These centers were Bellefaire Regional Center, 96 beds (also accepted out-of-state children), ages six to16 years; Children's Aid Society, 34 beds, six through 10 years; and Beech Brook Children's Home, 30 children ages six through 14 years. The average length of stay in these facilities was about four years.

Hawthornden State served 40y adolescents by offering a special education program.

Hanna Perkins Nursery provided a small specialized analytically oriented therapeutic nursery school for children ages two and a half through five years and their parents.

"Interaction" recommended:

- Special schools and classes for emotionally disturbed children to deal with both their educational and treatment needs.
- Specialized day facilities with emphasis on a controlled environment.
- Day treatment community programs.
- Inclusion of services for children and adolescents in the newly formed community mental health centers.

OUTPATIENT SERVICES IN 1964:

Outpatient services in general hospitals and private psychiatric hospitals were limited. University Hospitals was the only hospital, through the use of their psychiatric residents, to provide outpatient services to 628 different adults and 226 different children.

Outpatient psychiatric services in public hospitals, the Veterans Administration, and State hospitals provided aftercare follow-up services to their released patients. Clinic care was limited by the lack of available manpower, particularly in State hospitals.

Outpatient psychiatric services were rendered by mental health practitioners in their private offices. There were approximately 150 psychiatrists, 35 clinical psychologists, and 15 social workers in part-time and full-time private practices. Psychiatrists treated the largest number of patients. The fee scale of these practitioners limited their services to those who could afford the $15 - $30 hourly charge.

Cuyahoga County had substantial mental health outpatient services provided by community social agencies. Over 11,000 individuals and families and more than 90,000 interviews were provided in 1964 by these agencies. Social workers contributed the major manpower resources in these settings helping persons cope with marital, parent-child and job difficulties with frequent psychiatric consultation available.

Family Services of Cleveland and the Jewish Family Services provided assistance to over 6,000 families. The Cleveland Guidance Center served 356 children ages five to 13 and their families; Catholic Counseling Center served over 1,000 children and adolescents, ages five to 20 and their families. Youth Services provided casework services to 895 teenagers with emotional and social problems. Mental Development Center, Western Reserve University, provided mental health services to 500 developmentally disabled children and their families.

"Interaction" recommended:

- Limiting outpatient appointments to one-half hour.
- Providing more extensive use of group therapy sessions.
- Making contractual arrangements to compensate private practitioners for evening and weekend work in clinics.

REHABILITATION:

A major Section of "Interaction" was "Rehabilitation and Restoration." Its objectives are in "The Health Goals Project" and are as follows:

> *Rehabilitation is not what is left once treatment has started. Rehabilitation services are viewed as interdependent with prevention and treatment. It is defined as any activity or intervention directed toward reducing a person's emotional disabilities and handicaps and enhancing his capabilities in a more satisfying and socially acceptable manner. Rehabilitation efforts are directed to the improvement and maintenance of a person's social and occupational roles in the community. To sustain these roles, physical and economic needs must be met, and psychological supports be made available as required. Some persons of marginal skills and aptitudes require habilitative programs aimed at providing them with basic knowledge, attitudes, and skills for acceptable behavior in interpersonal and vocational activities.*

Freeman and Simmons in their book, "The Mental Patient Comes Home," 1963, emphasized the role of family in successful rehabilitation and integration of the patient back into the community. Much had been written, disparagingly, concerning the role of the family in contributing to patients' problems. To maximize gains, improved communications and understanding are crucial in relationships between the providers and patients and families. There was limited contact between them in 1965.

The advent of the National Alliance for the Mentally Ill in 1979, now the National Alliance on Mental Illness (NAMI), dramatically altered relationships between families and professionals. With NAMI's emphasis on mutual support, family education and advocacy on behalf of persons with serious mental illness, providers and families gained better understanding and attitudes toward each other in working together.

NAMI has become the national, State and local voice for the mentally ill and mental illness, with NAMI organizations in every state and in over 1,100 local communities. Cuyahoga County had two NAMI affiliates, one on the east and one on the west side, organized separately in the early 1980's. In 2005 they were consolidated into NAMI Greater Cleveland. (H. Bernard Smith was first national NAMI Executive Director. He and NAMI's first President, Shirley Starr, visited the two separate groups circa 1984.)

At the onset of deinstitutionalization not all former patients returned to their families. Limited substitute living arrangements were available. In family-care or foster homes for the first quarter, 1965, 18 persons were placed in family-care homes from Cleveland State Hospital. An additional 75 patients awaited placement but could not be placed due to lack of family care funds.

There was an inadequate emphasis on rehabilitation in mental hospitals and in the community. Patients especially those in State hospitals were the most disadvantaged, requiring more economic, educational, health and psychological supports. Cleveland State Hospital had a" three-quarter house" and a "quarter-house" where patients supported in group living programs with social, occupational and peer activities were transitioned from the hospital to the community. For patients in the community Cleveland State, Fairhill, and Cleveland Psychiatric Institute each had day treatment programs that fostered social rehabilitation.

Recovery, Inc., a national organization for discharged persons from State hospitals, had 15 groups in the region. Their program essentially offered group support. An evaluation of the effects of the group on its members was unknown at the time.

Hill House, a psychosocial rehabilitation center utilizing the club house model, was established in May 1961 to help released patients "stabilize their social and emotional recovery." A 1964 Technical Report from Hill House stated that 33 per cent of patients released from State hospitals each year needed nonresidential services (1,037 individuals in 1964). It also reported that 22 per cent (660 individuals) were in need of residential social rehabilitation services. Hill House was the only nonresidential rehabilitation program in the Region, served 150 persons each year. It provided individual and group services and maintained a transitional focus. A time limit was placed on the use of the program.

Hill House found that 27 per cent of its clients were rehospitalized within one year after hospital release. This rehospitalization statistic compared favorably with national statistics of 40-50 per cent rehospitalization rates. Further, the longer members participated in Hill House, the lower their rehospitalization rate. For those who attended 10 or fewer times, 42 per cent were rehospitalized. In contrast no one who attended more than 50 times was rehospitalized. Magnolia Clubhouse is the current psychosocial rehabilitation provider, the successor to Hill House.

The Rehabilitation Task Force found need to develop better communication and referral mechanisms between mental health and vocational resources. Most patients released from mental hospitals clustered in the 25-44 years age group, the prime working years of one's life. Whereas most released patients from private hospitals were women who returned to homemaker roles, while public

hospitals released men and women in a 60 to 40 per cent ratio almost totally into the labor force. Obviously, the public hospital settings with their lower economic groups required greater supports for pre-vocational and after-care programs.

Patients with longer term hospitalizations required more social and vocational services prior to their release and transitional supports and follow-up vocational services. The State Bureau of Vocational Rehabilitation had staff placed at State hospitals, nevertheless, such staff was limited; and referrals to community vocational agencies, such as Vocational Guidance and Rehabilitation Services, were underutilized.

Communication difficulties existed between employers and treatment and rehabilitation resources. There was need for greater consultation with mental health and psychiatric resources to smooth the transition from hospital to the on the job community. Local and national education programs dealing with stigma were needed.

Specialized sheltered workshops for the mentally ill were non-existent.

“Interaction” recommended:

- The local community should recognize its primary responsibility for the rehabilitation of its emotionally disabled residents and facilitate additional assistance from State and federal levels.
- Comprehensive mental health centers planned in the region should incorporate rehabilitation within its scope.
- Greater recognition should be given to the importance of vocational counseling in State hospitals and extend through release and after-care programs.
- Mental health and psychiatric consultations should be included in all vocational agencies.
- Specialized sheltered workshop opportunities should be provided
- Hill House and programs for recently released patients should be continued and expanded.
- Residential programs for discharged patients should be provided in the community.
- Visiting nurse programs should be developed to provide supports to recently released mothers with young children.

CONTINUED PLANNING:

From the very beginning of the Citizens’ Committee’s work, there was recognition that a vehicle for mental health planning and implementation of its goals would be required. This concept was one of its major recommendations. As the planning project neared its end, there was a strong concern by the members not to have the report rest on the shelf.

As described in the “Interaction” report, there was a broad array, yet fragmented network, of mental services in prevention, treatment, and rehabilitation programs that bore close relationships with health, education, welfare, and other community services. Since recognized by the State in its initial contract with the Welfare Federation of Cleveland, as the local health and welfare planning body, the Citizens’ Committee viewed the Welfare Federation as the appropriate auspice to plan, coordinate, and facilitate such continued planning.

“Interaction” recommended:

- The local community mental health planning should be continued through the establishment of a mental health planning committee within the Welfare Federation.
- The committee work in cooperation with already established resources such as the Cleveland Mental Health Association, the Society of Neurology and Psychiatry, the county medical associations, and the Regional Hospital Board.
- The committee should promote coordination among mental health community agencies, and State and federal agencies.
- The Committee should serve in an advisory capacity to review and recommend on proposals for community mental health centers.
- The Committee should provide consultative services to the Regional Hospital Planning Board regarding hospital facilities, both inpatient and outpatient psychiatric services.

MENTAL HEALTH PLANNING COMMITTEE, WELFARE FEDERATION:

In accordance with the recommendation of the Citizens’ Committee, Comprehensive Mental Health Planning Project, the Welfare Federation accepted auspice for ongoing mental health planning. H. Bernard Smith, the Citizens’ Committee’s Planning Consultant, now returned to the Federation as Planning Associate and was retained by the Committee as Executive Secretary. William Heston, Ph.D., continued as Chairman, and many of the Planning Committee members continued as well.

Funding for the ongoing work of the Planning Committee was secured through the efforts of Leona Bevis, Associate Executive Director, and W.T. McCullough, Executive Director of the Welfare Federation, from a local Foundation. The Mental Health Planning Committee served as an interim mental health planning committee from 1966 until April 1968 when the Cuyahoga County Community Mental Health Board and Retardation Board was officially established and convened.

Cuyahoga County was the only one of the nine statewide Citizens’ Committees that maintained and continued a community mental health planning process. The State, as a result of recommendations from the State Citizens’ Committee, developed and continued a mental health planning process as part of the

Division of Mental Hygiene of the Ohio Department of Mental Hygiene and Corrections. In addition, an Advisory Council of 11 citizens was appointed by the Director of the Department, Martin Janis. George Harding, M.D., progenitor of the Harding Sanitarium and descendent of President Harding, was Chairman of the State Advisory Committee.

During the planning phase and after, the State planning staff was led by Paul McAvoy, Ph.D., MSW. The State staff member covering the Region was Michael Houlihan, MSW. Houlihan later went on to work for the federal Health and Human Services Chicago Office, which included Ohio. Cuyahoga County was fortunate in having continuity of care with State and federal staff familiar with and knowledgeable of the area and its representatives. The State personnel were qualified and competent and dedicated to the objectives of community mental health. Good working relationships existed between State and local personnel.

The Planning Committee's major priority was to implement a mechanism for ongoing planning and funding of local mental health programs. Toward that end, Smith studied legislation in states that were successful in implementing community based services, such as New York and California. Keys to their achievements were the Community Mental Health Services Boards with combined state and local funds.

Additionally, Smith visited with Harold Visotsky, M.D., in Illinois and Harry C. Solomon, M.D., of Massachusetts, both recognized nationally as outstanding and long-term Commissioners who had survived multiple governorships of different political parties. At that time 32 states had existing Community Mental Health Service Acts.

To achieve a Mental Health Act in Ohio, two approaches were utilized--legislative action through the State legislature and a statewide coalition of communities to support such legislation. Outstanding support was provided by two local members of the Cuyahoga County delegation--Robert Jaskulski of Garfield Heights, and Patrick Sweeney of the Cleveland West Side. Representative Jaskulski had a mentally ill family member. Through them, Smith was introduced to the Ohio Legislative Commission staff and worked with them to develop the appropriate legislative language for the Ohio Community Mental Health Services Act.

The Statewide Coalition met regularly and frequently on Sundays in the Harding Sanitarium north of Columbus under the leadership of George Harding, Jr., M.D., son of Dr. George Harding. Local representation included Heston, L. Douglas Lenkoski, M.D., Chair Department of Psychiatry, University Hospitals, and Chair of the Treatment Taskforce, "Interaction," Smith, and Victor Victoroff, M.D., psychiatrist-neurologist in private practice. Initially, Cincinnati, which received many state grants for its local services, was opposed to the Act. The inclusion of a grandfather clause that guaranteed their base of State support swayed them.

In Cuyahoga County only the Mental Development Center and the Cleveland Guidance Center had been allocated some State monies.

The financing formula proved to be a delicate point of contention. The formula was agreed upon in a special meeting in Cleveland that the Committee arranged with Martin Janis, the Department Director. For this meeting Smith arranged for Curtis Lee Smith, Director of the Cleveland Chamber of Commerce and member of the Citizens' Committee and an ongoing member of the Planning Committee, to be present. Martin Janis was flabbergasted by his presence and said, "Wait until I tell the Governor (Rhodes) who is interested in mental health." This amazement helped secure the State two-thirds and the County one-third formula for funding local mental health services through the Community Mental Health Service Boards.

House Bill 648 was introduced and strongly supported by members of the Ohio General Assembly and was passed in 1967. The two pronged approach, legislative and State coalitions, worked! Thus, Ohio became the 33rd state to enact legislation to establish Community Mental Health Boards.

Once enacted, the Cuyahoga County Commissioners were involved. Smith prepared a position paper "Prospectus, Community Mental Health and Retardation Board."

The "Prospectus" provided background information, history of the Citizens' Committee and the Mental Health Planning Committee, their recommendations and examples of services that could be provided, and staff and costs of the Board. The Prospectus emphasized the flexibility of the Act, the authority and local autonomy vested in the Board to determine the scope and standards for local programs. Two thirds of the Board membership would be appointed by the County Commissioners. The Board would work with and be closely related to the County government.

Heston and Smith met with the Cuyahoga County Commissioners--Patrick Day, Frank Gorman and Seth Taft in early 1968. Although the Commissioners expressed reservations regarding the County's financial commitment, they were uniform in their support for a Community Mental Health Board and local, community-based programs.

In April 1968 the Cuyahoga County Community Health and Retardation Board was convened and began their work.