

Northville Township Historical District Commission

Oral History Interview – Dr. Harold Wright

April 16, 2007

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**Doctor of Child Psychiatry and Director
Of Hawthorn Center**

Interviewers: RA= Richard Allen and JC= John Colling

RA. Today is April 16, 2007. We are visiting with Dr. Harold Wright who was a child psychiatrist at Hawthorn Center. That is the prime goal of our discussion today.

I'm Harold Wright. I spent 34 years at Hawthorn Center.

JC. That's most of the time. They just celebrated their 50th last year. What did you do there?

I started out when it opened in July of 1956 as a resident in child psychiatry. I had had my first year residency in child psychiatry at U. of M. and I had two years residency in Chicago in adult psychiatry. Prior to that, I had two years of residency in pediatrics. I came to Hawthorn to complete my last year of residency in child psychiatry.

JC. And stayed there!

And stayed there. I intended when I was training in psychiatry to return to pediatrics and perhaps do a better job in pediatrics because of the training in child psychiatry, but I never left the field of child psychiatry.

After my residency I was a Staff Psychiatrist and I was also the pediatrician at the Center. In 1970 I became the Director, and remained in that job for 20 years, leaving in 1990 when I retired from Hawthorn.

JC. For those who may be listening to this or reading this when it's transcribed, tell us a little about the Center. A lot of people don't know what it is.

Hawthorn Center was a comprehensive children's psychiatric hospital that included an inpatient service, outpatient service, day treatment program, and a research program. In addition there was a training program for psychiatric residents, psychologists, social workers, and special ed teachers. There were associations with the surrounding universities: University of Michigan, Michigan State, Wayne State and Eastern Michigan. We had students from all of those universities at the Center. It was a unique setting when it first opened. There were really no other facilities like it around here and, in fact, in other parts of the country. Prior to its being built and opened, there were children in Michigan in psychiatric hospitals, but they were in adult psychiatric hospitals on wards with adults, and there were no programs for children. For example, there was no school program in any of the adult hospitals. And so a group of people in the state, particularly a group of women, became very interested in that problem and took it upon themselves to see what might be done to remedy that situation so there would be children's psychiatric hospitals. The groups of women that were particularly interested in that issue were members of the American Association of University Women and the League of Women Voters.

There was one woman in Michigan who spearheaded and organized the whole group. Her name was Mrs. Edward Latulip, and she got permission to visit the adult hospitals and thought that the provisions for the children in the adult hospitals were abysmal and there needed to be a better program. Interestingly how they went about it was unique. They got the Detroit newspapers, The News and The Free Press, interested and their reporters, Alan Shownfelt at The Detroit News and Warren Stromberg at The Free Press who became interested and began writing many articles in the papers about the serious situation of having children in adult hospitals and the enormous need to have appropriate facilities. G. Mennen Williams was Governor at that time, and he was interested and so were legislators from a bipartisan standpoint. The issue went forward rather rapidly. I think it was probably in late 1954 or early 1955 that this impetus started, and monies were appropriated for Lafayette Clinic in Detroit and then for Hawthorn Center in Northville. By the way the name for Hawthorn Center is interesting. It was built on 58 acres on the southeastern corner of Northville State Hospital property, and that acreage abounded with Michigan Hawthorn bushes, and that's where the name came from.

The building was complete—not in its present form, a much smaller form—a major building for the central hospital unit and the five cottages behind it which still exist. The governor had gotten a group of professionals together to plan this hospital. That group included a number of people, particularly a famous psychologist, Dr. Fritz Redl. I understand that the original concept was that this was going to be a summer and weekend facility for emotionally disturbed and mentally ill children in the greater Detroit area. That is not the way it materialized. Upon completion of the buildings, Soapy Williams, then Governor, had this sizable facility with nobody to staff it.

In 1955 to early 1956 as I said, I was in my first year of residency training in child psychiatry with Dr. Ralph Rabinovitch and his wife Dr. Sara Dubo at the University of Michigan. At that time the two of them had decided they were not going to remain in the University of Michigan program because there were some administrative problems that were going on. Dr. R (we called Dr. Rabinovitch Dr. R) received a call from Soapy Williams asking if he and Sara would be interested in coming to Hawthorn and running the children's psychiatric new hospital there. I remember Dr. R telling the six of us who were residents with him that year about this conversation. He wanted to come out and visit Hawthorn, and he wondered if we wouldn't like to come too. I came on the original visit on a rainy late March day in 1956. I remember it very well. When we got in the main building (when you go in the front door you are in the outpatient clinic), it was a great glass structure, one glass office after the other. When Dr. R saw it, he said he never saw such a place. "How would you ever treat children in a glass house like that?" As he went through it he had similar comments. The straw that broke the camel's back was when we went out the back door from the main building to go toward the cottages. As I said, it was raining, and there weren't any sidewalks in as yet. As he walked, he had galoshes on; he lost his footing and fell in on all fours and said, "This is the worst facility I have ever seen for treating children and we will not come to this place." So we went back and visited a couple of other facilities in other cities. One was in Cleveland, and then he reassessed his initial thoughts about the situation. He came to visit Hawthorn several times more and decided that something could be done to remedy problem areas, for example, the excessive glass in the outpatient clinic. By that time all the sidewalks

were in between the main building and the cottages, and he decided to come to Hawthorn. So July 1, 1956, he came with Sara and about 25 staff members from the University of Michigan and started the program. We started with the outpatient clinic first because we didn't have all the staff hired for an inpatient program. I remember, as a resident, it just so happened that I evaluated the first patient who was ever seen at Hawthorn. He was the son of a man who had done some bulldozing on the grounds of Hawthorn. He had a 12-year-old who had a severe reading disability, and that happened to be one of Dr. Rabinovitch's major interests. So it was as though it were planned that this boy came and was seen and was an ideal first case to be seen in the new program at Hawthorn.

The positions at Hawthorn were civil service positions, and in all the adult hospitals at that point the individuals who took care of the patients were attendants without much training. And R said, very rightly, that that wouldn't be appropriate for a children's hospital, and so he had some contact with the Civil Service Commission. He set up a category for child care workers. Child care workers, according to the requirements, were to have had at least two years of college, hopefully in subjects that were appropriate to child psychology and psychiatry and, hopefully, even a Bachelor's Degree which many of them did have. That category was set up and the individuals who worked under the nursing staff with the children were the child care workers. Gradually the staff increased considerably. The inpatient service was opened. The daycare unit was opened. The outpatient clinic continued to see a number of children. In terms of numbers at that time the outpatient staff probably saw about 1,000 new evaluations each year.

In the original hospital there were beds for about 60 patients. Then the day treatment program in the first year or two was housed in one of the cottages, and I think there were 15 children in that program. Gradually there were building programs that went on at least three different times. South wing was built with four 20-bed units. A research wing was built, financed from private funds totally—not from state funds at all. A new day treatment building was added that included about 120 children who attended on a daily basis. The maximum capacity over the years was 162 inpatients, and about 1,000 outpatients per year. There was the research program that included a chromosomal laboratory where various clinical entities were studied and tested. It became a very unusual program. They're really were none like it, certainly in Michigan, even in the country. Gradually there was an interest in establishing more children's hospitals in Michigan. At their peak there were a total of seven: Traverse City, Pontiac, Ypsilanti, Detroit, etc. Unfortunately now today we are back to one: Hawthorn Center. I'll talk about that later—how we got to that point.

The day treatment program worked very closely with the public schools and community clinics. Children were referred by schools, physicians and community clinics. We developed an early intervention program that would take preschool children down to age 2 ½ or 3. Children from that age, 2 ½ and up to 18 were served—initially children throughout the state of Michigan. As it developed there were six other hospitals. Each one served a certain geographic area. Frequently, children were sent from one of the other areas to Hawthorn when they had a special need that could not be met in the local

hospital. Many children with a variety of problems were seen over the years: psychotic children, schizophrenic children, autistic children, neurotic children with a variety of problems including school refusal, obsessive compulsive disorders, children with organic brain damage, children with psychosomatic problems, for example, a physical problem like asthma with concomitant emotional problems, ulcerative colitis, anorexia nervosa, etc. There was great interest throughout Michigan and then rapidly throughout the country about the Hawthorn program. Because it was fairly unique we had people who came from all over to visit. Then we began to get people from other parts of the world, notably England, Europe, and Australia. In a number of instances they came so that, hopefully, they could get some ideas about what type of facility they might develop in their own country or their own area.

A lot of clinical research was done at the Center:

- Clinical studies where you would take a group of children, for example, anorexic patients—mostly girls—and do long term clinical and follow-up study. I was involved in that study with 60 girls with anorexia. We studied them over a prolonged period to see how the treatment techniques that we had been utilizing turned out and reported that.
- Long-term studies of schizophrenics
- Children with reading disabilities
- I was involved in an asthma study that involved allergists from the University of Michigan and psychiatrists from Hawthorn in which the long term results of both medical and psychiatric treatment were studied. It was a fascinating experience to have been in a setting like that where so many different kinds of opportunities were going on to study and treat such a variety of emotionally disturbed children.

In the early years, the legislature and the government continued to be very supportive of the program. In more recent years the situation changed enormously with the feeling that it was important to treat children in the community, not in hospitals. As a result, many hospitals were closed, and in those remaining open, services were drastically cut. In many instances, very sick (from a psychiatric standpoint) children for whom there are no facilities, end up in the judicial system. Many of them are in juvenile detention homes, jails and even prison under court auspice and are not receiving appropriate mental health treatment. But Hawthorn continues to remain open now. As I said, it is the only one of the seven to remain open. Its function today is very different. The average length of stay in the early years was usually something like six or eight months, because these were children who had had a variety of psychiatric interventions before without significant improvement. Now the average length of stay is a week or two weeks and for many of the children who are referred nowadays, it is very unlikely that you could make any significant impact in such a short time. Its an in-and-out process now that the outpatient clinic has been closed, the day treatment has been closed, the research program is closed, and the training program has diminished enormously because they don't have the clinical population now to utilize in the training program. The psychiatric residents, P.H.D. psychologist candidates and some of the social workers are no longer being trained in that program, at least anywhere nearly as extensively as before.

JC. The patients that come here are all referrals?

They are all referral patients and now they are referred exclusively by the community mental health clinics. Not only are they referred by the mental health clinics, but they are usually referred for admission because there isn't any outpatient service or day treatment now. Then the discharge of those patients is determined by the mental health clinic, not by the staff at Hawthorn. It boggles my mind, but that's the way it is. The diagnosis of the children and adolescents who are there now is very different. There isn't the broad spectrum of children going into the hospital now. They are largely children who have had very extensive behavioral problems that have come to the attention of the court and who have exhausted the services of the court and the mental health clinics and who come as a last resort to the hospital. Of course, then, what can be done for those children is quite limited compared to what we could accomplish in the past when we had more say on what child could come into the hospital and the kind of problems that child could have. Now they are very limited regarding which child can be admitted and those situations are determined not in the hospital but in the community clinic. That's not unique to Michigan but is happening all over the country. The situation that's happened here with the closing of the hospitals has happened in all the other states too.

JC. You mentioned some of the things that the patients had. How far a range? I'll use the word relatively, but doesn't mean it's not a problem. Some are relatively more simple and then you get up to schizophrenia ...

Yes. For example, there is a category of child called "children with school refusal", children who for psychological reasons have not been able to attend school and frequently have been out for several years of school at a time, perhaps before they were referred. One would certainly try with such a child to work with him or her as an outpatient or in a day treatment program. But there are some children in that category who don't benefit from that kind of treatment. In the past many years ago, those children came into Hawthorn for a period of in-patient treatment for a school semester or two semesters, and then one worked with them to get them back in the public school back home. Those tend to be very bright children who actually do well in school, but it was the emotional problems they had that kept them from being in school. Now it's not possible to bring that kind of child into the hospital. Whoever is working with them works in outpatient clinics. A professional called me six months ago and said, "Dr. Wright, what can we do? We have a child with a severe school refusal. We've done everything we could in the clinic but she's still not attending school." The answer is: Today with the situation as it is, you can't do anything in a hospital like Hawthorn as we did for many years. A severe anorexic, who has perhaps lost half of her body weight, is probably not treatable as an outpatient and needs to be in a hospital where she can be helped to turn around and can get back to functioning normally. Those kinds of kids are not eligible for a setting like Hawthorn any longer. The guideline to get a child in Hawthorn or another public hospital now is that she has to have committed an act that would suggest she is dangerous to herself or others. For example she has to have stabbed someone or been involved in other similar violent behavior.

There are a number of categories of milder forms of emotional illnesses. Another group I was fascinated with is children who have what is called "elective mutism". They are able

to talk and they talk very well at home, but they typically do not talk at all in school. They can get along well in kindergarten and sometimes early in first grade. As the problems become more complex, their behavior deteriorates, and they don't make appropriate academic progress. Many elective mutes, who are referred early enough, can be helped as an outpatient. But a few cannot be helped and a brief period in a hospital, several weeks, a month or maybe two months, can have an enormously positive effect on these children to help them get started talking in school. In the past, a transitional period in the day treatment program prior to return to their home school was very useful in facilitating the desired talking in school. Again that use of Hawthorn is no longer possible under the current rules.

RA. When they are there for a school term, do you have school for them while they are there?

Yes, I should have talked about that. We had an elaborate school program that went from preschool to twelfth grade. The children were in small classrooms, typically about 10 in a class. The teachers, by the way, were certified for teaching emotionally disturbed children. In addition, if they needed more help than that, tutors were available to work with them directly. For example, if they had a severe reading problem, they would work with them on a daily basis in that regard. If there were behaviors that were significantly affecting adversely the school adjustment, the behavioral problems could be dealt with in the program by the teacher. If the child couldn't make it there, then the therapist would become involved. The children would not be banished from school as they might well be in a public school. The school program was absolutely a vital component of the program at Hawthorn, because the majority of children who came there had school problems, if not primary, secondary to the emotional problems they had: schizophrenia, severe depression, or manic depressive disorders, for example, that interfered.

Meetings would be held on a regular basis to discuss how the child was doing from a therapeutic standpoint, how he was doing in the living situation, how he was doing in school, and members of all the various disciplines were present. At the end of the meeting, there was a statement of a goal: "This is what we're going to try now. Let's see how the problem is, and two weeks later, if we're not getting anywhere, let's have another meeting." All the children had a primary therapist. The therapist was either a psychiatrist, a psychologist, or a social worker whom that child saw two or three times a week or more often if necessary. It was a very comprehensive program that attempted to meet all the needs of the child. I haven't mentioned the needs of the family. The family was also seen regularly by a social worker, and frequently a parent would be involved in some of these meetings, particularly when it came close to discharge so that you could effect the same changes in the home environment that had been produced up to then. In addition to that we were able to develop a liaison with a fair number of placement facilities where some of the children could go after they left Hawthorn if they couldn't go home: St. Francis Home for Boys, Detroit Children's Home, Vista Maria, etc. Those facilities interestingly too have largely closed. They cost money, of course, and with limited monies, many of the facilities have had to be closed. Our Lady of Providence on Beck Road has closed for that reason. That is unfortunate. I wasn't talking about long-term placements, but sometimes short-term placements following hospitalization could really cement the gains

that were made during hospitalization and enable a child ultimately to go home and on to college if he or she was able to do that.

JC. Did you have an organized follow up-program?

Yes, we did. We had the outpatient clinic where that was carried out. If it were possible for the child to be followed locally in the hometown, that was done in the community clinic. If that weren't possible, the Hawthorn outpatient clinic was available for follow up. It was vitally important as you can image. If a child makes a number of gains in the hospital, one hopes that he can continue to make those gains on the outside. Say, he was going back home where maybe part of the cause of the difficulty occurred in the first place, the follow-up was extremely important, and we tried to see that that took place. We also carried out extensive long-term studies involving the patients we had treated in various diagnostic categories.

RA. Hawthorn today is a live-in facility that has roughly how many patients?

The cottages have been closed, and one of the wards closed. I think it's in the neighborhood of 75-80. I'm not sure of that right now, but I think it's in that vicinity. It serves now the entire state because it's the only public facility for emotionally disturbed children in the state. You can imagine what some of the problems are in that regard. If a child comes from the Upper Peninsula here, how in the world do you work with the family and so forth? There are private facilities, but many of those are closing too. The majority of the children do come from the greater Detroit area.

RA. In your time serving there, have you seen a fair amount of change in regard to medication for treatment?

Oh, indeed. That has probably been the biggest change in the past 15-20 years with the ascendancy of psychotropic medications. In some instances, they are extremely helpful, for example, when you are talking about children with attention deficit disorders and the stimulant medications: Ritalin, Dexedrine, Adderall, and so forth, they can be absolutely invaluable. There are now a number of drugs for psychotic or schizophrenic children that can be very helpful too, but in that category the side effects from the drugs must be watched very closely. You probably have read that a number of drugs being used for schizophrenia in adults and children have very untoward side effects: tremendous weight gains and now we are learning that diabetes is a serious complication.

In the arena of depression, there have been a great many extremely helpful medications developed but you have to be careful of the side effects. You've probably read now there's concern about whether or not some of the antidepressants, perhaps, increase the likelihood of suicide in some children. But that's a debatable issue because here we've got a very depressed child, say, who certainly has suicidal thoughts, and if you don't give him any medication there is the likelihood of suicide. So that can be potentially a real problem. Maybe a negative overall effect of medication is perhaps too great a dependency on medication. In instances, for example, of the elective mutes, the children who don't talk, I saw over 80 children with elective mutism. I never put any child on

medication. There was no need to. Now many people think those children should be treated with medication. If they're depressed, they should be. On the other hand, it worries me to be giving children medication when we know there are other methods of treating the entity, for example, psychotherapy, where there isn't going to be the potential for a bad side effect that there could be with some medication. The insurance companies now would, for example, in elective mutism, perhaps, far prefer that the doctor who sees that child use medication because they are hoping that is going to produce a shorter period of treatment. It's a mixed blessing in some ways. But certainly in the areas of depression or manic-depressive disorder, the medications are absolutely invaluable. Some of them in psychosis are very valuable too, but you have to watch so carefully with the side effects that I just touched upon.

RA. Years ago in the live-in community, what age span did they cover?

Many of them were in the 8 to 10 year or teenager range. We sometimes did go down to a five year old level or younger when there was, for example, an issue of unusual language development and the staff in the outpatient clinic had been unable to determine what the problem was. So bringing him in for an observational period of a month or six weeks could be very helpful. The majority of the children were teenagers. Like all the facilities of its kind in the world, as far as I know, the ratio of boys to girls was something like three or four to one. In this field, it's bad to be a male because for almost every entity you talk about except anorexia and depression in adolescence, males outnumber females. Always, we had more boys, so there were more boys' wards than girls' wards. That's true all over the world. There are entities where the boy-girl ratio is much greater: reading disabilities are nine to ten times as common in boys as girls. Presumably we'll be increasingly clear on why that is in the future. It undoubtedly will be related to genetics as we learn more about chromosomes and genes.

It's very exciting to read about the new research in the field of child and adolescent psychiatry. I continued working in the field for 16 years after I left Hawthorn on a part-time basis as a school consultant, and I just retired last June. It's a little hard to retire. For 50 years I was in the field and I kept up with the field by reading the literature. One of my friends said when I retired I would stop reading the literature, but it hasn't happened yet. I can't stop reading. I have to know what's going on with new research. It's been an exciting field to be in because I was certified as a specialist first in pediatrics, then adult psychiatry, then child psychiatry, and when I was certified in child psychiatry in 1960, I think my certification number was something like 150. So it was a new specialty, and I was the 150th person to have the certification. It's fascinating to observe changes in thinking and the effect that has on the treatment of children as you can tell from my discussion of the closure of the hospitals and the change in the functioning the state mandated for Hawthorn. I think it's really too bad that clinical services have been dramatically curtailed, and I would hope the pendulum will swing back some day, but I don't know how far it will swing back. Of course, money was a very major issue. It's interesting when I look back at the history of how Hawthorn was developed, I don't remember politicians early on (Soapy Williams or the legislators) saying that we can't afford this kind of program. The question is if you're not funding it and you're not

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providing services, how much do you pay in the future when these patients end up in the prison system?

RA. That may be the problem if you can't quantify it and put the numbers out there to show that it is cost productive to treat it up front. How you prove that I don't know.

Exactly. It's difficult. The climate is a bit different now. I remember the legislators when we had to go and testify about budget and so forth. In the early years, there were people in the legislature who were intensely interested. I don't know if the name, Joe Snyder, means anything to you, but he was a senator who was an absolutely wonderful guy. He was very much in favor of mental health issues. Actually he had a son who was a troubled boy. It was a joy when you'd go and testify and Joe would be there. There were people on both sides who agreed with him; it wasn't just one political party. I mentioned Soapy many times, but Bill Milliken was equally in favor of these kinds of programs. It was a pleasure to deal with him. The climate is different today. It's hard to find people really interested in this field. The issue is over parity now: medical insurance versus psychiatric insurance. There's not much parity. Maybe we'll get to that, but we're not there at this point.

RA. Thank you very much.

Approved by Dr. Harold Wright on June 27, 2007.

Transcribed by Patricia Allen.