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The ambivalent role of the institution in the history of child and adolescent psychiatry: a case study of the Hawthorn Centre in Michigan, USA

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The ambivalent role of the institution in the history of child and adolescent psychiatry: a case study of the Hawthorn Centre in Michigan, USA

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Abstract

Historians have examined the role of psychiatric institutions in the USA and addressed whether this form of care helped or harmed patients (depending on the perspective of the time period, historical actors, and historians). But the story for children's mental institutions was different. At the time when adult institutions were in decline, children's mental hospitals were expanding. Parents and advocates clamoured for more beds and more services. The decrease in facilities for children was more due to economic factors than ideological opposition. This paper explores a case study of a hospital in Michigan as a window into the different characteristics of the discussion of psychiatric care for children.

Keywords

Adolescent, children, hospital, mental health, 20th century

Introduction

On 5 February 1963, President John F. Kennedy called for a 'bold new approach' based on 'new knowledge and new drugs' that would make it possible 'for most of the mentally ill to be successfully and quickly treated in their own communities and returned to a useful place in society' (Grob, 1994: 256). Later that year, President Kennedy signed into law the Mental Retardation and Community Mental Health Centres Construction Act of 1963, the cornerstone of which was the development of comprehensive community health centres, whose stated goal was to shift the care

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of patients from state hospitals into the community. As many scholars have established, Kennedy's rhetoric and the CMHC legislation were well intentioned, but the shift in the care of mentally-ill individuals from state mental institutions to community care (often funded by the federal government) was fragmented, subject to local circumstances, and dependent on many variables (Mechanic and Grob, 2006). The history of deinstitutionalization is important, both in terms of health-care policies and the real-life patients who lived with the consequences (Grob, 1997). But there is much less known about the timing and consequences of the shift away from institutions for children and adolescents, though Kennedy was concerned about the plight of mentally retarded children, based on his experience with his chronically institutionalized sister (Torrey, 2014: 1–15).

The hospital has had a changing and conflicted role within the history of child psychiatry. The original movements to promote and protect children's mental health started primarily with juvenile courts, outpatient clinics, and enthusiastic psychoanalytically oriented psychiatrists in the first half of the twentieth century (Horn, 1989; Jones, 1999). As Deborah Doroshow has pointed out, residential treatment centres originated in the middle of the century in tandem with a new category – the emotionally disturbed child (Doroshow, 2019). Residential treatment was in vogue from the 1950s through the 1970s, although the number of beds around the country was quite small. Also, the potential for overlap between the categories of emotionally disturbed and juvenile delinquent depended more on circumstance – especially race and class – than clarity of a diagnostic concept (Feld, 1999; Ward, 2012).

The story of the Hawthorn Centre in Northville, Michigan, captures the challenges in the history of institutions for children. It was built in the mid-1950s in response to overwhelming demand for services for emotionally disturbed children. It was run by the state, but was distinct from state hospital services for children. It was intended to manage seriously disturbed children within a therapeutic milieu. Staff were dedicated and innovative. The programming and environment were praised by the advocate group that worked with the centre, and by the popular press. But there were never enough beds to meet the demand. With budget cuts at times of state deficit in the 1980s, services were reduced. In the early 1990s, Michigan's Republican governor shifted responsibility for determining the need for state-funded hospitalizations, including those at Hawthorn, to the local community mental health boards, while penalizing them for choosing the state option. As a result, demand for the centre dropped and its budget was further cut. Since 2015, however, demand has started to increase again, and the state is once again trying to address the need for hospital beds.

Concerns about child mental health

In the decade after World War II, Americans worried about the nation's children. The military experience with the draft suggested that there were major problems with the process of getting young people successfully launched into adulthood (Pols, 2007). People were fearful about the problems of badly behaved children, while the structures to manage them were woefully inadequate (Deutsch, 1950). Mental health professionals, especially psychiatrists and psychologists, had an increasingly public presence as popular literature kept up awareness of the ways in which emotional issues affected functional abilities in both adults and children (Hale, 1995: Herman, 1995). Parents turned to popular advice literature for help in raising their children, especially work authored by the psychoanalytically inspired paediatrician Dr Benjamin Spock (Hulbert, 2003: 3–15). In 1953, the American Academy of Child Psychiatry was founded, and members worked to offer services to children and to other providers who needed help with challenging cases (Schowalter, 2000).

At this time, states were the primary entities responsible for the organization of mental health services, but many states were overwhelmed by increasing demand in the post-war decade. In

Michigan, Governor G. Mennen Williams led a brick-and-mortar strategy that began in earnest to address Michigan's looming mental health crisis, an area of concern widely recognized by various constituents. In October 1949, members of the state's Department of Mental Health warned that there was a lack of mental hospital beds, which was echoed by William J. Norton, Executive Vice-President of the Children's Fund of Michigan, at the Department's annual luncheon. Mr Norton called for more hospital beds, more staff for mental hospitals, and completion of the newest mental institution, the Northville State Hospital, to meet the needs of the Detroit metropolitan area (Anon., 1949). Everywhere in the state, facilities were overcrowded and waiting lists were growing (Goldman, 1950). Even as journalists directed public attention to the lack of availability – and poor conditions – of mental hospitals around the country, state officials emphasized the need for more beds and more space within psychiatric institutions (Deutsch, 1948).

In January 1950, Michigan's Mental Health Commission (with the support of Governor Williams) proposed a 10-year, $106 million hospital construction programme to add 13,250 beds in the state (Anon., 1950a). Leaders within the Michigan Society for Mental Hygiene, however, expressed significant worry that this state programme had too little money stretched over a long time period. Instead, they proposed an $88 million bond issue that would provide 11,000 beds at the end of three years. They pointed out that this would significantly accelerate hospital construction to meet future needs, rather than trying to solve current problems (Anon., 1950b).

Governor Williams was a relative outsider, as a Democrat elected in a state that for decades had relied on Republican patronage politics. As a result, Williams struggled to enact many of his policy proposals in Michigan, especially those that relied on state funds to cover services (Bright, 1996). One of his strategies was to take issues directly to the people through extensive media exposure. Williams was passionate about the need for mental health services in the state, and in the early 1950s he began to focus on the mental health issues of children. In March 1950, Williams outlined a proposal for a hospital for children and was interviewed by the *Detroit Free Press* about the importance of investing in children:

> By treating mentally ill children early in their lives, we can save many of them from lives of unhappiness and suffering. And, of course, every child who is successfully treated represents a saving to the State's future mental hospital costs. (Anon., 1950c)

The Republican legislature, led by Finance Chairman Elmer Porter, approved a much smaller appropriation than the governor had requested, however, and refused to fund a hospital for children (George, 1950).

In September 1950, the *Detroit Free Press* reported that a grassroots committee – an unusual mechanism in the state – had been founded to urge that a $65 million bond proposal be placed on the state ballot in November to support construction of new hospitals. The spokesmen for the Michigan Citizens Education Committee on the Bond Issue for Mental and Tuberculosis Hospitals emphasized that the investment for individual citizens would be small – 40 cents a year – but would have enormous benefits for the state, including construction of 8000 new beds (Anon., 1950d). The bond proposal passed overwhelmingly by a 4-to-1 vote, although months after the November election the state legislature had done nothing to set things in motion to build or expand facilities for the mentally ill (Anon., 1950e).

Unfortunately, as is often the case in politics, legislative disagreement significantly delayed utilization of the $65 million. As a result of the delay due to the political tussle, construction costs then rose due to the Korean War, and the estimate of how many beds could be created was reduced from 8000 to less than 6000 (Anon., 1952). Further, there was a difference of opinion between the Mental Health Commission and the legislature over how exactly to spend the funds. The

Commission insisted that the bond issue should be intended exclusively for expansion of hospital space, and that all improvements and remodelling should be financed from General Fund sources (Anon., 1953b). The legislature, however, appropriated part of the bond for hospital projects other than added bed space, such as additions to an administration building or utility upgrades. But even beyond the specific details of what was going to be funded by the bond issue, there was conflict over the purpose of the beds. Were patients going to be housed in hospitals indefinitely? Or was there a plan to prevent what seemed to be an escalating crisis before patients became stuck within the institution (Tyler, 1953)?

This question played out in the bitter dispute that developed over the location of a much-needed children's psychiatric hospital. The proxies for the debate were a proposed site at Northville, a suburb of Detroit next to the adult state hospital, and a possible location in Ann Arbor at the University of Michigan, 20 miles away (and even farther removed from Detroit). Although supporters of the Northville site emphasized that Wayne State University faculty would be able to contribute academic efforts in that location, many in the state had an almost mythic belief in the power of the University of Michigan in researching and solving major problems. This university had already received considerable funds from the state in terms of support for buildings, and the chair of the Department of Psychiatry was a frequent presence in the state capital, with multiple appropriation wins for his programmes.[1] Opponents of the Northville site insisted that a children's facility next to a state hospital would mean 'warehousing' children. Others argued that no children would be helped if more money was poured into the University of Michigan. Loyalties among legislators were divided between the Detroit area and the university town; also, the fact that experts called to testify about children's mental health came from Ann Arbor confused the situation (Anon., 1953a). By late 1953, Democratic state senators from Detroit lost their argument to locate the hospital at Northville when the more powerful Republican head of the appropriation committee insisted that the University of Michigan would make good on its promise of helping the state's children (Deatrick, 1953).

Members of the Michigan Society for Mental Health, including President William J. Norton and Chairman of the Executive Committee Ray Eppert, strongly criticized the decision. It was their belief that the University of Michigan location would significantly decrease the potential for training other kinds of mental health professionals (Anon., 1953c). Norton further accused lobbyists for the University of Michigan of:

> working undercover to secure the institution for their campus and change it to a general pediatric hospital with a mild emphasis upon a few emotionally sick children . . . The success of the lobbyists in persuading the Senate to vote money for a children's hospital at Ann Arbor means that the mental health bond issue voted by the people has been hijacked of $1,000,000 which was to be used by the Department of Mental Health. (Anon., 1953d)

In fact, the university doubly benefited from the bond because the money went to support not only the new Children's Psychiatric Hospital but also a Mental Health Research Institute in Ann Arbor (DeLoach and Stachnik, 1968).

With tensions rising, Governor Williams inserted himself into the debate with the hope of brokering a compromise. In advance of a vote by the House of Representatives in June, he laid the essential foundation for the Hawthorn Centre, calling for the legislature to approve both Northville and Ann Arbor sites (Anon., 1953e). It took a couple of years and several rounds of legislative wrangling, but the governor followed up on his promise by asking the 1954 legislature to build a children's facility at Northville, to be named the Hawthorn Centre after the Michigan Hawthorn bushes that surrounded the site (Wright, 2007). The governor's new proposal would place Hawthorn

under the Mental Health Department and allow construction of enough buildings to care for 120 mentally disturbed children, at a cost of $1.8 million. Republican Representative Richard L. Thomson rallied 60 House colleagues as co-sponsors of an amendment to attach a $1.8-million appropriation to the capital outlay bill (George, 1954). In the final hours of the session, the legislature finally approved the funds for Hawthorn.

Opportunities and challenges for Hawthorn

Before the hospital was built, officials from Michigan's Department of Mental Health envisioned a residential treatment centre that would have a 'home like cottage-plan' organization to accommodate 120 beds under the Department's jurisdiction. The plans would allow this hospital to be integrated into a state-wide continuum of care with child guidance clinics and other agencies. The main goal would be to treat children who were not appropriate for an outpatient setting. This category was, of course, in the professional judgement of the outpatient providers and was based on the loose diagnostic ideas of the time. This type of child might have been assessed to be experiencing schizophrenic reactions (excessively withdrawn and lonely), neurotic reactions (which included behaviour such as fire setting, aberrant sexual activities), or primary behaviour disorders (children who were causing serious disturbance to the home and community).

As with plans for other residential treatment centres in this period, it was to be defined as much by what it was not as what it was (Doroshow, 2016). As state leaders explained, the proposed centre would not be a corrections facility, custodial institution or foster home placement facility. Nor would it be a substitute for the inpatient services at the leading academic centres in the area (the University of Michigan and Wayne State University), which selected cases for teaching and training purposes. In contrast to existing asylum admission standards, admission to Hawthorn would be by referrals from all sources including courts, but involuntary commitment by the courts would no longer be accepted. Advocates for children's residential facilities believed that they could reduce future costs of long-term hospitalizations in adults by heading off problems before they became chronic. Further, government officials believed that:

> by treating sick children the greatest gain for society is the achievement of happy and productive adults, who can function effectively in family living and avoid unfavorable emotional influences in the offspring which today repeatedly and greatly increase the heavy burden of the emotionally ill. (Mental Health Commission, 1953: 3)

The Mental Health Commission members insisted that treatment of children was prevention rather than 'warehousing'.

The Mental Health Commission's outline plan for a children's hospital was not what was built in Ann Arbor. Instead, the university planners constructed a 75-bed single building designed to be part of a comprehensive hospital for children that would eventually include both psychiatric and medical interventions for children. The chairman of the University of Michigan's Department of Psychiatry was able to convince both the university and the state legislature to construct the psychiatric portion of the building before the general children's hospital, even though there was not a dedicated children's hospital in Ann Arbor (Hirshbein, 2013). At the dedication of the Children's Psychiatric Hospital (CPH), Governor Williams' speech identified the University of Michigan as 'the greatest in the world'. He said that the legislative arguments about the children's hospital had resulted in a decision to focus on research to prevent future problems, rather than just build more beds. State Senator Elmer Porter also spoke and insisted that the university had nothing to do with the state battle. He, like Williams, expressed confidence that an investment in the University of Michigan would result in dividends for the state as a whole.[2]

When Governor Williams praised the new hospital programme in Ann Arbor, he singled out the work of the couple Drs Ralph Rabinovitch and Sara Dubo; they were child psychiatrists who had been at the University of Michigan and were key in the development of child psychiatry there. Williams was clearly in contact with them directly and, when word came shortly after the dedication of CPH that Rabinovitch and Dubo had resigned from the university (Anon., 1956a), he was able to recruit them quickly to the Hawthorn project (Anon., 1956b). Rabinovitch and Dubo took a substantial number of staff members from the university with them to found the new Hawthorn Centre, which allowed them to jump-start their programme when the first inpatients arrived in July 1956 (Richardson, 2006).

Rabinovitch used his experience in opening CPH at the University of Michigan to think more deeply about facilities and programmes. Hawthorn was the first facility in the state with open as well as closed programmes. Open programmes meant family-style surroundings (in cottages) with the freedom of home for those children who improved, together with continued intensive total therapy and schooling in residence. Patients on closed units were managed under a more traditional and strict inpatient model. When the facility opened there were five cottages (four for open inpatients, one for daycare children) and a main building for 24 closed patients, as well as research, school and outpatient services. Initial plans were for children aged from 6 to 15 who had been referred by courts and other recognized agencies, and aimed at an average length of stay of 9 months to a year, with no long-term placement. Children were accepted from across the entire state, with no limitations based on diagnosis, severity of illness, or parents' ability to participate in treatment (Richardson, 2006).

The staff at Hawthorn, like the staff at any of the various residential treatment facilities for emotionally disturbed children that were opened in the mid-twentieth century, needed to remain flexible and adaptive to their new programme and their new environment (Doroshow, 2019). In a feature in the *Detroit Free Press* by reporter Walter Stromberg (1956), the month after Hawthorn opened, Rabinovitch acknowledged that they were treading new ground and were not entirely certain what they were doing. He suggested that children's ongoing relationships with case workers would be key, and also said that medications could be used for this disturbed population. Rabinovitch was confident, though, that Hawthorn had a great deal to offer children of the state.

The Hawthorn Centre did not function in isolation, away from public attention. Stromberg received an award from the American Legion for his advocacy writing that helped to create the public demand and legislative support for the centre (Anon., 1958), and he continued to write about the facility. Further, from the first year of Hawthorn's opening, the centre had a partner in an advocacy committee that was founded to support disturbed children in the state. The Michigan Association for Emotionally Disturbed Children started meeting at Hawthorn in 1957, and chapters of the organization spread throughout the state. The MAEDC (later renamed the Michigan Association for Children with Emotional Disturbance, MACED), which boasted influential parent members as well as knowledgeable educators, advocated Hawthorn's treatment programmes, as well as aftercare options. By the early 1960s, the MAEDC had lobbied to provide school options for children who had been discharged from Hawthorn but were still not able to be assimilated into regular schools. They took the stance that, since so many children in the state were emotionally disturbed (1 in 10 by their estimate), it was imperative that the public schools' extra work on behalf of these children should be recognized and compensated (Stromberg, 1961).

In the late 1950s and through the 1960s, it seemed that almost everyone inside and outside the facility was enthusiastic about what Hawthorn had to offer. In addition to its novel open and closed inpatient design, Hawthorn provided the full continuum of care to patients across four areas: inpatient services, outpatient clinics, day treatment and research. It also had training programmes in psychiatry, psychology, social work, nursing and special education (Richardson, 2006). A

community placement programme ensured that careful thought was given to what happened to the children after discharge.[3] Harold Wright (who had come to Hawthorn as an assistant physician when Rabinovitch and Dubo moved from Ann Arbor and eventually became the medical director) recalled that Hawthorn was able to offer true continuity for patients and their families.[4] For example, many inpatients eventually moved to day treatment, thus allowing the opportunity for a gradual return to the community through carefully planned steps. The key to the programming at Hawthorn was the dedicated staff.

Rabinovitch developed a new category with the Civil Services Commission: the child-care worker. According to the requirements, they had to have spent at least two years at college, ideally in subjects relevant to child psychology and psychiatry, and had to be working towards a degree at the time of employment (Wright, 2007). They worked part time under the nursing staff and were largely students finishing their coursework; they ate and played with the children and slept in adjoining rooms. Newspaper coverage suggested that the innovations in staff – though expensive – were key to improving these vulnerable young patients. As reported by Stromberg (1957), the child-care workers' 'presence tends to bring order to the children's confused minds'.

One of the distressing elements of emotional disturbance for parents and for the public was understanding that children who appeared normal had profoundly different emotional needs and behaviours which were difficult to understand. Public coverage of Hawthorn highlighted the disconnect between severe problems and normal appearance. A journalist, who visited Hawthorn for a newspaper feature directed toward women's issues, was struck by how normal and peaceful everything looked at the hospital. She posed the question to her readers,

> In this relaxed atmosphere, you ask, can this possibly be a psychiatric hospital for children kicked out of school, or children sent there by juvenile court officers? It is. Even the 'violent' children, the ones no one else can train, are here . . . Going down the hall you expect to see bizarre behavior, tears, confusion. It's not like that. There are no bare rooms, no cells, no hospital beds . . . In another room, four boys and a girl in their early teens are playing rummy . . . Nearby, three teen boys are poised, ready for a noon dip in the swimming pool and a little farther on in the gym four more are tossing for baskets. (Sterling, 1962)

This article was reassuring to parents of disturbed children that there were good places where they could get help. But Sterling echoed the theme of many writers of this time: as good as some facilities (such as Hawthorn) were, there were not nearly enough of them to meet the demand. Sterling quoted Rabinovitch as saying that Hawthorn was able to work with about 1000 families a year. But the estimated demand for the state was upwards of 30,000 a year.

In 1964, the Child Welfare League of America surveyed more than 20 residential treatment facilities for children. The original purpose of the survey was to look at costs, but the survey scope was expanded to examine services and structures as well. Hawthorn was included in the study and was comparable with the other facilities surveyed, in terms of staff, facilities and costs. The survey highlighted the rich offerings of a number of high-quality treatment facilities at which, typically, one child was accepted for every six who applied. The high cost for the centres raised questions about the sustainability of this type of programme, though treatment centre staff genuinely believed in the good work they were doing for children and for society as a whole (Hylton, 1964).

Not only did programme staff believe in their work, but also it was striking that Hawthorn was reviewed favourably by parents – and the press – into the 1960s and 1970s. These were decades when institutions for adults were almost universally decried for their lack of therapeutic value and their restrictions on freedoms, and children's mental institutions in general sometimes received a negative press. Even parent advocates for children's institutions made negative comparisons between the deplorable conditions on the children's unit of the next-door Northville State Hospital and the

relatively posh environment at Hawthorn.[5] Hawthorn was consistently mentioned as a progressive, therapeutic facility that stood out from the rest. In 1965, two reporters published an exposé of facilities for mentally-ill and retarded children across the country and condemned the conditions (Ross and Kilpatrick, 1965). In particular, they argued that children were not well selected for facilities – there was no clear method for choosing which children would go to correctional facilities and which would end up in hospitals. They key seemed to be that parents, schools and courts dumped children into institutions. But Hawthorn was identified as 'perhaps the best children's psychiatric hospital in the country' that functioned more like a boarding school with treatment.

Hawthorn staff physician Charles Shaw published a textbook on child psychiatry that highlighted residential treatment, based on research as well as his own experiences. In this book, Shaw (1966) described the most important aspect of residential treatment – the therapeutic milieu. His outline of the elements of the milieu suggested a richness of resources available to children; they had dedicated staff members who communicated among themselves, support services of education and occupational therapy, as well as a variety of activities. Shaw emphasized that the treatment should be short – which he defined as 6–18 months – and that, during their stay, children should be prepared for returning to their communities.

One of the aspects of Hawthorn's treatment that was consistently mentioned in media coverage was its wide array of activities for children. During the 1960s and 1970s, Hawthorn added recreational, pre-vocational and vocational programmes for its patients, including but not limited to horticulture, home arts, a woodwork room, automotive, fine arts, small appliance repair, music and photography (Richardson, 2006). Within the music programme, patients were able to have lessons with a variety of instruments, including drums, bells, guitar, cornet, flute, saxophone, clarinet and accordion. Patients even participated in an annual Christmas concert where they performed in front of the other patients, Hawthorn staff and families. Across the various programmes there was a focus on group activities with an emphasis on socialization and enhancement of self-esteem. Often the patients were referred to as students with an emphasis on learning and development.[6] The staff members were united in their eagerness to bring typical childhood experiences to their troubled young patients.

Programme expansion coincided with physical expansion. Additions to Hawthorn included a research building completed in 1962 and a day hospital that opened in 1965, greatly expanding the number of patients who could get access to some kind of treatment (Richardson, 2006). The centre continued to work with state and federal agencies to expand facilities and services (Anderson, 1969). In 1976, Hawthorn marked its 20th anniversary with a big celebration and the opening of a new, 80-bed wing. The new unit could handle the most emotionally disturbed children, with living quarters, school classrooms for a complete K-12 programme, dining room and recreation facilities (Anon., 1976; Miller, 1976).

Although the press coverage was good and the general impressions of the centre were positive, the expansions of the programming and the centre did not come with a unified leadership. Rabinovitch had become keenly aware of the gap between the resources available to the centre and the enormous expectations for the work. In a move that made front-page news in the Detroit paper, Rabinovitch resigned in 1971 saying that the job as director of Hawthorn was impossible (Anon., 1971). He periodically made comments that were widely reported in the press, including caustic remarks about the state attempting to cut costs in 1981 by moving patients from Hawthorn into group homes (Swickard, 1981). Rabinovitch remained involved with Hawthorn, however, and continued advocacy work with MAECD. He also supported his successor, Harold Wright, who continued to direct Hawthorn until his retirement in 1990. Wright was widely known for his kindness and his emphasis on what was best for children, and was an ideal person to represent the institution to the public (Anon., 1989).

Rabinovitch's formal role as he continued at Hawthorn was in directing its research programme. All the Hawthorn staff were committed to using the opportunity to help children with what they already knew, and also to try to gain new knowledge. Physicians at Hawthorn regularly published articles in the peer-reviewed literature, and explored avenues that were not in vogue within child psychiatry at the time, including medications for childhood depression. Rabinovitch later recalled that those who worked at Hawthorn were extraordinarily lucky to have access to academic connections, most notably with the regular role of residential treatment centre guru Fritz Redl (Rabinovitch, 1991). The quest for new knowledge extended to the work of African-American psychiatrist Harold Lockett, who published on the important issues facing child psychiatric treatment for minority children and families (Lockett, 1972). In 1978, Hawthorn hosted a special lecture by renowned New York child psychiatry researcher Lauretta Bender. Bender, who had trained Rabinovitch and Dubo, brought a perspective of inquiry as well as caring about individual children. Staff psychiatrists at Hawthorn enhanced her lecture by presenting investigations that had taken place at Hawthorn using some of Bender's pioneering research methods.[7]

Deinstitutionalization fervour

Although research and treatment were key features of the Hawthorn programme, they were virtually drowned in the tidal wave that became the move away from psychiatric institutions in the state by the 1970s and 1980s. In response to a national move towards ensuring that only adults who needed treatment could be admitted to hospitals, Michigan created a Mental Health Code that was passed in 1974 with criteria for hospitalization.[8] Children were mentioned in the code, which outlined community mental health (CMH) services, but there was no consideration for what would happen if a child needed services beyond what a CMH system could provide. Moreover, the Education for Handicapped Children Act of 1975 shifted the mandate for children with particular needs from separate educational settings to mainstream schools (Handler, 2011). Advocacy groups noted the explosion of changes and the lack of explicit information for how to address children's needs. As the children's committee within the Michigan Society for Mental Health concluded in 1975, these legislative changes 'and other larger societal problems directly affecting children have created mammoth gaps in information, service delivered (quality and quantity) and an extraordinary need for advocacy/ombudsman services'.[9] The challenges seemed enormous.

In addition to the information and logistical challenges, by the late 1970s there were increasingly issues of cost and priorities. Hawthorn's success and two decades of physical expansion had been impressive, given that it took place as the country was accelerating the shift in care and treatment of the mentally ill from state hospitals to the community. However, this shift caught up with Hawthorn in the 1980s. As Gerald Grob and Howard Goldman have pointed out, mental health policy began to shift from a focus on the states – with state hospitals as predominant means for providing services to patients – to federal policy, mostly through the creation of Medicare and Medicaid. By statute, federally funded payment structures could not be used for state facilities, so administrators in adult state hospitals shifted many older patients to nursing homes that could be paid through Medicaid (Grob and Goldman, 2006). However, the alternative for children in state-funded facilities was less clear, and so, when the state budget in Michigan entered a time of serious shortfall, services at Hawthorn were vulnerable to being cut.

In the early 1980s, a leaner Michigan budget resulted in the elimination of 50 Hawthorn staff members, with a subsequent closure of 26 inpatient beds and 20 daycare slots. The following year, Governor William Milliken laid off an additional 1700 state employees (250 at the Mental Health Department, which included 16 at Hawthorn) after negotiations about wages broke down with the state's largest union, the 29,000-member Michigan State Employee Association. Hawthorn's

Director, Harold Wright, commented, 'We were already down to rock bottom. Now we'll have to go below that' (Chargot, 1982). The 1980 budget cuts marked a significant moment in Michigan's psychiatric facility contraction, and eight additional hospitals closed over the decade.

By the 1990s, differences seemed to be less about budgets and more about ideology, as Republican Governor John Engler dramatically shifted the state away from its role in the care of Michigan's mentally ill (Bachman, 1996). Engler's 1991 budget proposed the elimination of an additional 1700 mental health department jobs and he tasked the new State Mental Health Director James Haveman with the concurrent restructuring of the department, since the cuts would result in additional permanent facility closures (Kresnak and Christoff, 1991). Haveman attempted to frame the mental health cuts as a shift from restrictive settings to the community, but opponents were aghast at what seemed to be the state's abandonment of the mentally ill. Haveman took his case directly to the public, calling his plan of privatizing mental health treatment a 'vision' for the future (Haveman, 1991). He was denounced by the Michigan Psychiatric Society, the Michigan Medical Society and the Mental Health Association for his careless disregard of people with serious mental health needs (Anon., 1991, 1992). But despite public opposition, Engler and Haveman pushed through the changes, with major consequences for state facilities, including Hawthorn.

Very little of the conversation about the move away from state hospitals involved consideration of the implications for children. The rhetoric of least restrictive setting and community care echoed legal challenges to state mental hospitals for adults who were hospitalized (some said incarcerated) for decades. But institutions for children were different. Hawthorn was designed with a length of stay of 6–18 months, even at its peak of services (Richardson, 2006). Children were not being 'warehoused', and they were usually in the centre because they could not be maintained in the community. In fact, advocacy groups had been much more concerned about the need for adequate follow-up plans for post-hospitalization care and wanted to err on the side of keeping children in facilities so that they could get the necessary services for longer (Swickard, 1981). The Hawthorn advocacy groups had been relentlessly pressing state legislators since the 1970s to maintain services.[10]

But the cuts to the state mental health system did not spare the services for children. In 1991, the state shifted the responsibility for authorizing admissions for children to Hawthorn (and other state-run facilities for children) to the CMH boards in the counties across the state. At the same time, the state also strongly discouraged the use of hospital services and used financial incentives (such as funds for staff education) to encourage CMHs to keep children in community-based services. In 1995, MACED and the parents of 22 children who were denied psychiatric services sued the Michigan Department of Health and 12 community health boards to try to alter these practices (Anon., 1995; Kresnak, 1995). The lawsuit did not result in any changes, and Haveman continued his march towards his expressed goal of getting the state out of the business of providing mental health care. He accused his critics of defending unions (hospital employees) rather than defending mental health. Meanwhile the cuts continued to affect services (Stroud, 1997).

The state's policies of strongly discouraging the use of state hospitals resulted in a dramatic decrease in Hawthorn's annual referrals. It could no longer review referrals from its usual sources, including private therapists, psychiatrists, schools, community hospitals, and courts, and instead had to direct them to call the patient's local CMH board. The CMHs were sending fewer patients to Hawthorn as there was a perception that the facility's average length of stay was excessive and should be in the realm of days to weeks rather than months to years. The director at the time – Mr Neil Wasserman (1995–2002) – needed to make dramatic changes or risk Hawthorn's permanent closure. The senior team said that it could quickly move children diagnostically and therapeutically through the programme. Average annual admissions per year increased from 90 to 600, without any meaningful changes in staffing. To achieve this throughput, the staff had to make sacrifices.

For example, they no longer completed full psychological assessments on every child and instead made only cognitive assessments.[11] With this model unsustainable long term, Hawthorn once again reinvented itself in 2003 when Hawthorn director Shobhana Joshi won permission from Central Office to offer short-term and long-term inpatient services beginning in February 2003, with admissions that year increasing from 90 to 450 (Richardson, 2006). However, the decades of budget cuts and changes in policy still took their toll and resulted in continuous reductions in staffing, inpatient beds and clinical services.

Epilogue

In 1971, at the beginning of the wave of change that resulted in the movement of patients out of state hospitals and into the communities, Hawthorn's research director Ralph Rabinovitch addressed the question of whether the time had passed for children's psychiatric hospitals. While he recognized that many people had been suggesting that community resources might be better for children, he reviewed cases at Hawthorn to gather data to illustrate that the centre's services had been necessary for those children where there were no other community options. Rabinovitch concluded with the observation that people often used a stark dichotomy between inpatient and community services. Instead, he said 'The issue is not whether we need children's in-patient hospital beds. The issue is that we need more and better total services, including hospital beds, for Michigan's most troubled children' (Rabinovitch, 1971: 18).

Over the decades of Hawthorn's capacity to take care of emotionally disturbed children and adolescents, there has been clear recognition that there are times when children cannot be maintained in their homes and need some time away. From the 1950s through the 1980s, that time could extend to a year or more. But by the late 1980s and into the 1990s, the concept of residential treatment began to shift. Facilities that had been identified as residential treatment centres diverged into hospitals which had more intensive treatment programmes run by physicians and nurses, and residential treatment programmes that were characterized by less intensive services and were often run by other types of clinicians. However, both kinds of programmes were increasingly subject to third-party payers and their decisions about who needed the higher level of care – and for how long. Time, which was once seen as an essential element of children's hospital services, became increasingly truncated within facilities (Leichtman, 2006).

In Michigan, the push toward deinstitutionalization came from those advocating civil liberties, who wanted to free patients from restrictions, as well as conservatives who wanted the state to get out of the business of mental health care. The administration of Governor John Engler, along with his mental health department head James Haveman, illustrated the ways in which state policy could shape demand for hospitalization – particularly by making it highly disadvantageous for CMHs responsible for patients to choose the state hospital option.

While the trend in the 1990s seemed to be for fewer and fewer hospital beds – with some speculating that hospitalization might be eliminated in the future – it has become increasingly obvious in the past few years that public demand for inpatient psychiatric services is again on the rise. One of the major issues under discussion now is how to create more hospital beds for children and adolescents, especially at places such as Hawthorn that offer longer term treatment for severely disturbed individuals. So the cycle is beginning again. Parents are contacting the state, desperate for services for their children and emphasizing that they cannot manage them at home. The waiting list for Hawthorn in 2018 had more children on it than patients in the hospital.[12] Newspaper coverage is highlighting the serious dangers of suicide, assault, homicide and other crimes that could result from untreated children. Reporters are focusing on emotionally disturbed individuals – though they are using different diagnostic labels – to highlight the deficit of services in the state, especially at

places such as Hawthorn (Mack, 2019). Also, there are large meetings of stakeholders trying to solve the problem of access to services, with ongoing political infighting.[13]

It is clear that the deinstitutionalization movement was an important phase in the history of American psychiatry. But the arc of history with regard to the role of psychiatric beds for emotionally disturbed children and adolescents is not bending in any predictable way. With rising national rates of suicide and major increases in public attention to the mental health of children, hospitals once again seem to be safe and increasingly in demand. While no one wants to return to the old days of months-to-years hospitalization for anyone, especially children, future solutions may end up looking more like past inventions. In this area, as in many others, the history of psychiatry could be a key element to designing a better future.

Notes

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2. Dedication of the Children's Psychiatric Hospital, 11 Feb. 1956, Children's Psychiatric Hospital Folder, Box 2, Waggoner Papers, BHL.
3. Glenina A Nolte, 'Community Placement Programme' [unpublished, undated typescript]; Glenina A Nolte papers, BHL.
4. Interview (by RC) with Harold Wright, 14 May 2018.
5. Flyer for parents (1965), Michigan Chapters. Hawthorn-Northville, 1965–1968, Michigan Association for Children with Emotional Disorders (MACED) Records, BHL.
6. *Hawthorn Centre Bulletin*, Spring/Summer 1977, Harold Lockett Papers, Hawthorn Centre and Related Folder, BHL.
7. *Hawthorn Centre Bulletin*, Spring/Summer 1978, Harold Lockett Papers.
8. The Act has been updated periodically, and the current document includes a detailed history of revisions; accessed (1 July 2018) at: http://www.legislature.mi.gov/(S(c542ymkdorzhozpozs1vhn4d))/documents/mcl/pdf/mcl-act-258-of-1974.pdf
9. James F. Kipfer, Michigan Society for Mental Health, Philosophy and Organization for Reorganization, Administrative Mailings to Board Members, Box 1, Michigan Mental Health Association in Michigan Papers, BHL.
10. MACED Records, Chapters. Hawthorn-Northville, 1976–1980 and 1981–1984, BHL.
11. Victoria Petti, personal communication, 13 Aug. 2018.
12. Oral testimony by Dr George Mellos, Michigan Certificate of Need Psychiatric Workgroup meeting on 15 Nov. 2018, Lansing, MI.
13. See the efforts of the Michigan Psychiatric Care Improvement Project; accessed (26 Feb. 2019) at: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_85156—,00.html

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