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ABSTRACT

Recent years have witnessed a broadening of the role of the behavior modifier to that of "environmental designer" and institutional change agent. As deinstitutionalization policies have been mandated across the country, a major challenge for institutional behavioral programs has been brought to the surface--i.e., generalization and transfer of skills from hospital to community. Viewed within the broader environmental design context, this task has been complicated by a new set of systems variables, which serve as barriers to deinstitutionalization. Identified and discussed are 23 distinct barriers to deinstitutionalization. These barriers are conceptualized within a five-stage hierarchical level of environmental design interventions--individual/family, organizational, community, institutional and societal/ideological. Additionally, the results of a study which employed an instrument designed on the basis of this conceptualization to assess resistance to deinstitutionalization are reported. (Author)

Barriers to Deinstitutionalization: Social Systems Influences on Environmental Design Interventions [1]

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The broader role of the behavior modifier as "environmental designer" (e.g., Jeger, McClure, & Krasner, 1976; Krasner, 1978) has become increasingly popular in recent years. As a result of widespread experience with large-scale behavioral programs in natural settings (industry, schools, hospitals, etc.) behavior modifiers have become sensitive to the broader social systems influences (e.g., Atthowe, 1973; Bourdon, 1977; Jeger, 1977; Reppucci, 1977; Reppucci & Saunders, 1974; Richards, 1975). The federal and state mandates to "deinstitutionalize" mental patients have brought to the surface a major challenge for institutional behavioral programs--i.e., generalization and transfer of skills from hospital to community. Viewed in the broader environmental design context, the task has now been complicated by a new set of systems variables. In the current paper we present a systematic analysis of the major barriers to implementing deinstitutionalization programs. The social systems analysis that we are adopting here is prototypical of the issues inherent in other settings where environmental designers attempt to function as institutional change agents.

Originally advanced as an enlightened alternative and solution to the restrictive, inhumane, long-term hospitalization practices, deinstitutionalization has, in turn, created its own problems. Lacking coordinated services and comprehensive support

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systems, deinstitutionalization programs have degenerated into large-scale dumping of unprepared patients into uninviting communities. The harsh reality is that thousands of individuals have been dislocated, bureaucracies have been created and destroyed, nefarious businesses have prospered, and quality of life in many communities has deteriorated.

While deinstitutionalization policies have contributed valuable critiques of the mental hospital system, mere criticism does not form the basis for an affirmative program. The argument that deinstitutionalization has not yet been tried, and that only "dumping" has, will not hold sway in the public domain. Like all policies, deinstitutionalization will be judged by its consequences and its fate will be determined by how its translated into action.

In this context, then, we must ask: "What forces are at work which have so completely transformed the noble idea of deinstitutionalization into the crass exploitation of dumping?" To operationalize the question: "What are the barriers impeding the efforts of environmental designers engaged in preparing long-term state mental hospital patients for community living?" Knowledge of these barriers is necessary if environmental designers are to implement empirically-guided deinstitutionalization programs.

In the remaining time we will list and discuss 23 distinct barriers organized along a conceptual schema that incorporates

a 5-stage hierarchical level of environmental design interventions. The five (5) levels which encompass the numerous barriers include the:

A. individual/family

B. organizational

C. community

D. institutional

E. societal/ideological

It should be noted that the list of barriers is not meant to be exhaustive, seeking to cover only the salient aspects. Likewise, the pentagonal categorization scheme is not to be seen as being mutually exclusive since many of the barriers indeed operate along several levels. Needless to say, such is the nature of social systems variables.

Following the discussion of the barriers we will share with you the major results of a study in which we developed an instrument based on the barriers to assess resistance to deinstitutionalization among community and student groups.

The Barriers

Individual/Family Barriers

Patient resistance to discharge. Patients who have become dependent upon the hospital, i.e., the social breakdown syndrome, do not wish to leave its sheltered environment for a precarious existence in the community.

Increased burden on families. Previously institutionalized mental patients intrude upon a family's ability to continue with

its set routine of daily living. Patients may interfere with families' leisure activities, work activities, and in general are perceived as a nuisance by neighbors and community residents. The lack of extended families makes it especially disruptive to keep patients at home.

Organizational Barriers

Civil service union pressures. Fearing job loss active campaigns against deinstitutionalization have been launched by many state civil service associations to prevent closing of hospitals. This is illustrated by the inclusion of a blatant ad against dumping in a national magazine (Newsweek, May 15, 1978, p. 93) by the New York State Civil Service Employees Association. The ad appears in the MEDICINE Section heading the page of a major "news" article protesting the "New Snake Pits" (i.e., welfare hotels, S.R.O.'s). As if it were not sufficiently inappropriate to present deinstitutionalization under MEDICINE, a CSEA advertisement is presented as "news."

Resistance from state mental hygiene departments. A comprehensive, coordinated, fiscally sound, and efficient deinstitutionalization program would obviate the need for many services that the departments now render. This would make high level state officials' jobs obsolete.

Building of new state hospitals. Multi-million dollar state hospital complexes are under construction by the very same which are concomitantly planning to phase out the use of hospitals in favor of community-based programs. A more consistent funding

strategy would aim to rechannel these dollars into community support programs for discharged patients.

Duplication of costs. The fact that many existing mental hospitals have not yet amortized their land and buildings would duplicate the costs necessary for new programs.

Resistance from state supported private enterprise. Due to the magnitude of state hospital complexes many vendors stand to lose considerable income from the phasing out of state hospitals. This is true not only for small communities, where hospitals provide the major source of income for many businesses, but also for large urban centers who contract services to private companies. The range of the businesses involved include food providers, linen suppliers, oil and heating firms, construction companies, furniture suppliers, housekeeping suppliers, drug companies, and so on.

Unintended consequences of token economies. Although originally designed to facilitate the training of skills necessary for community living, many hospital token economy programs become enmeshed in the maintenance of the institution. Following the implementation of a token economy in a state hospital, Krasner (1976) observed:

> To the extent that we were successful in developing a token economy program on a hospital ward we were helping maintain a social institution, the mental hospital, that in its current form is no longer desirable in our society.

Similarly, Richards (1975) has argued that:

> It is even possible that token economies in mental hospitals are in the ironic position of being dangerous--dangerous in the sense that if they counteract the effects of institutionalization they serve to support and justify a bad system when it would be preferable to adopt a new one. (p. 619)

The thrust of these arguments are that despite their innovative features token economies are an inadequate vehicle for institutional change.

Community Barriers

Vagrancy and loitering. In communities where former mental patients constitute a significant group, their shabby manner of dress coupled with their lack of planned activity make them negative visible targets. The media is especially receptive to portray patients as lingerers.

Interference with local business. Again, stemming from lack of planned activities, patients tend to congregate in front of stores, often panhandling and interfering with shoppers. Thus, present deinstitutionalization practices have created a situation where patients are viewed negatively by storekeepers and shoppers alike.

Burden on police. The increased loitering and interference with business makes patients in the community an added responsibility of local police. Furthermore, lacking shelter, supervision, and employment, patients have become easy targets for crime.

Declining property values. Concentrations of former mental patients are seen by community residents as a sign of a declining neighborhood which stimulates selling houses at reduced prices. This translates into a more serious concern about the "ghettoization" of entire communities.

The emergence of S.R.O.'s. Previously failing and run down hotels were more than eager to open their doors for occupancy by

government subsidized patients. These government subsidies are supporting sub-standard housing with numerous instances of blatant health and safety violations being condoned.

Zoning ordinances. Housing codes are generally designed to restrict all but nuclear family living arrangements. This presents a particular barrier for establishing small, supervised, home-like, group residences as alternative to hospitals and transient hotels.

Institutional Barriers

American Psychiatric Association and Joint Commission on the Accrediation of Hospitals. Despite growing emphasis of community psychiatry dominant forces within american psychiatry have vested interests in maintaining state mental hospitals which they control. JCAH's extension into the psychiatric domain can be seen as a related institutional force in maintaining state hospitals.

Third party payments. Current reimbursement arrangements tend to emphasize inpatient care. Thus, they serve to reinforce long term stays at the expense of community alternatives.

Community mental health centers. Although a major goal of community mental health centers was eventually to supplant state hospitals their failure to develop community support services and continuity of care for discharged chronic state hospital patients contributed to high recidivism. Indeed many centers used the state hospital as "dumping grounds for the poor and chronically ill" (Chu & Trotter, 1974, p. 33). As it

turned out, many community mental health centers' mode of service delivery (i.e., emphasis on outpatient psychotherapy) based on the private practice model is geared to the YAVIS syndrome and is not suited for maintaining chronic patients in the community.

Criminal justice system. The criminal justice system, as another major institutional force, provides pressure to maintain the mental hospital system. It does so by relying on the hospital to "treat" their so-called criminally insane.

Media. By consistently depicting the negative aspects associated with mental patients in the community it perpetuates community residents' worst fears. Thus, the media stimulates resistance to innovative community programs.

Governmental agencies. As a function of the vast numbers and complexity of federal, state, and local agencies involved in implementing deinstitutionalization programs diffusion of responsibility prevails. As cited in the Comptroller General's report to the Congress pertaining to the plight of the mentally disabled in the communities:

> At least 135 federal programs administered by 11 major departments and agencies of the government affect the mentally ill. (U.S. Government, 1977, p. viii).

Coordination would be required among Health, Education, and Welfare (HEW), Housing and Urban Development (HUD), Office of Management and Budget (OMB), and Department of Labor, to name but a few.

Societal/Ideological

Medical model. As Albee (1968) long argued, the model of human problems that one endorses determines the nature of the institution in which services are to be delivered, which in turn determines the personnel who will provide the services. Thus, a permanent hospital structure for "treating" the "sick" is embedded in the dominant societal value which perpertuates the "disease" model.

The illusion of met needs. As Fowlkes (1975) noted, the existence of state hospitals contributes to the illusion that mental health needs are being taken care of. This diverts attention from demands for additonal programs and services.

Dangerousness of mental patients. A final societal barrier is that mental patients are believed to be dangerous to themselves and to others. This erroneous belief persists in the face of empirical evidence to the contrary.

Assessing Resistance to Deinstitutionalization

In order to measure resistance to deinstitutionalization in a given community, the barriers discussed above can provide the basis for developing an assessment tool. Such an instrument would guide the environmental designer as to the broader systems levels at which he/she must intervene.

Toward this end we have developed an instrument containing items parallel to many of the aforementioned barriers. In our initial study we employed 17 items to determine the attitudes of

several community resident groups and various student groups toward mental patients in the community. The following systems factors, among others, were tapped by means of a 5-point Likert Scale (ranging from Strongly Agree to Strongly Disagree): that patients' loitering interferes with local business; that patients' presence reduces property values; and that patients constitute an added burden on local police.

To summarize the findings, students who completed a community psychology course had the most accepting attitudes toward ex-mental patients in their community. Least favorable attitudes were reported by residents of Long Beach (New York), whose community has been the target of large-scale "administrative discharging" (i.e., "dumping"). Some specific findings follow:
Residents of Long Beach, compared to residents of other communities, and compared to community psychology students were more likely to agree that

1. mental patients are dangerous to themselves and others;
2. patients loiter and interfere with business;
3. patients are a burden to police;
4. patients in the community decrease property values; and,
5. that patients are better off in a hospital.

While this study was largely directed at assessing community barriers, a more comprehensive instrument encompassing items subsumed under the other levels would provide a more complete assessment. Data generated from such a scale would guide interventions at each level that a barrier is operating in a given community.

Summary and Conclusion

The present paper identified and discussed 23 distinct barriers to deinstitutionalization. It conceptualized these barriers within a schema that incorporates a 5-stage hierarchical level of environmental design interventions. Following a discussion of the barriers, the results of a study based on an instrument assessing resistance to deinstitutionalization were reported.

In conclusion, we wish to indicate that the systems analysis suggests the existence of the state hospital as being the central factor impeding deinstitutionalization. Through its very existence the hospital activates and organizes the major barriers at all the 5 levels. Thus, in the final analysis, if environmental designers are to develop succesful deinstitutionalization programs they will need to direct their efforts toward dismantling state hospitals. Cognizant of the fact that as long as mental hospitals "are available as an option they will be used", Rappaport (1977, p. 273) offered a five-year plan for closing the mental hospitals and replacing them with already evaluated alternatives (e.g., the Fairweather Lodge).

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