CHAPTER TEN
Residential Institutions

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The role of institutions in America has changed dramatically in the past two centuries. For example, “jails and prisons have increasingly become America’s social agency of first resort for coping with the deepening problems of a society in perennial crisis” (Currie, 1998, p. 34). Many social workers are or will be employed in large group care settings (Ginsberg, 2001).

DEFINING INSTITUTIONS

Institutions are organizational settings where residents exercise little or no choice about their participation, have virtually no input into how they are treated, and cannot leave without being officially released or discharged. Moore and Starkes (1992) identified three kinds of institutional settings: those that are medically oriented, those that are residential and service-oriented, and those that are custodial and/or correctional. “All provide some mix of custody and treatment,” they note, and the total milieu is considered to be part of the service delivery process. This total milieu idea was emphasized by Trieschman, Whittaker, and Brentro in their book about residential treatment centers for children, *The Other 23 Hours* (1969). They pointed out that what happens in the hours outside of the therapy session may have more of an impact than what happens in it, and that the cook or the groundskeeper, not to mention the recreation therapist and the child-care staff, may play as important a role in the youths’ treatment as their therapists.

Erving Goffman (1961) perceived the defining characteristic of an institution to be the inability of residents to leave at will. Wolf Wolfensberger (1972), on the other hand, believed that it was the features of *de-individuation* that make institutions different from other organizations and residences. These features include numbers of residents distinctly larger than might be found in a large family, a high level of regimentation, a physical or social environment that aims at a low common denominator, and a place in which all or most of the transactions of daily life are carried out under one roof or on one “campus” (Wolfensberger, 1972, pp. 28–29). For example, a traditional children’s residential treatment center might have dozens or even hundreds of residents; it certainly would not be mistaken for a typical single family home even if it were located in a
residential neighborhood. Residents all eat breakfast at 7 a.m. and dinner at 5:30 p.m. whether they are hungry or not; there are craft activities on Wednesday evenings and movies on Fridays; group therapy is offered on Tuesdays and Thursdays. If the neediest resident cannot manage an outing to the mall, then no one can go to the mall. Most residents sleep, eat, socialize, attend classes, study, play, exercise, watch TV, and receive counseling on the same campus, if not in the same buildings, day after day.

At a less coercive level on the continuum are institutional settings where people live for extended periods of time, but are not so isolated from society. These include assisted living centers, halfway houses, group homes, and other community-based facilities. Residents living in these facilities often participate in the same activities, at the same locations, as other community members. For example, children living in a community-based group home are likely to attend a public school and swim at the local Y. At the other end of the continuum are total institutions (Goffman, 1961), those organizations that isolate residents (sometimes called inmates in these settings) from the rest of society and put them under the control of the officials who run the institution. Usually total institutions attempt to resocialize the residents to become more compliant and accepting of institutional and societal norms. Rewards (or more commonly punishments) are used to encourage conformity (Johnson, 1999). The success of total institutions in rehabilitating and preparing their clients for reintegration into society has been strongly and widely challenged.

A BRIEF HISTORY OF INSTITUTIONS

In the mid-nineteenth century, there appeared a well-intentioned effort to provide a new kind of help for at least some at-risk populations. Originally conceived as sanctuaries, asylums were established in the countryside with the intention of resocializing and rehabilitating inmates (including not only prisoners, but also people with mental illness, cognitive impairment, and dependent children) in a wholesome environment far from the chaos, temptations, and exploitations of the city (Rothman,
Physical separation of the asylum from the community was consistently practiced.

At the turn of the century, what began as efforts toward reform had been transformed into a system of custodial and/or punitive care. By the 1950s public attention was brought to bear on the deplorable conditions that existed in asylums. Exposés such as Goffman’s *Asylums* (1961) pointed out the deleterious effects of institutions on the lives of inmates who were given minimal custodial care without treatment (a process called warehousing). At the same time, the growing costs of institutional care, advances in pharmacology, and changes in public assistance policies supported a drive for deinstitutionalization. The term *deinstitutionalization* refers to preventing inappropriate admissions to institutions and developing appropriate alternatives in the community.

The Civil Rights Movement in the United States provided fertile ground for legal action on behalf of institutionalized persons. Reflecting the “due process clause” of the Fourteenth Amendment to the Constitution, several court cases that were heard during the 1970s and early 1980s, augmented by federal and state statutes, public licensing, and private accreditation standards, affirmed the basic rights of institutionalized people (see figure 10.1).

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**FIGURE 10.1 THE RIGHTS OF INSTITUTIONALIZED PEOPLE**

The following are the basic rights of institutionalized people.¹ These include:

- to be housed in the least restrictive setting;
- to receive minimally adequate, reasonable, appropriate, and humane treatment, rehabilitation, or training in the least restrictive manner (e.g., without the unnecessary or excessive use of physical restraints or isolation);
- to receive adequate medical care, or care that generally meets a “community standard”;
- to refuse treatment;
- to refuse to participate in involuntary or uncompensated work for non-therapeutic reasons;
- to be assured of confidentiality of records and privacy in treatment;
- to have personal property (within reason) and to wear their own clothes;
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• to live without supervision in the community if they pose no threat to themselves or others.

1 Although prisoners must be treated humanely, many of these rights do not apply to them. On the other hand, unnecessary restraints and excessive use of seclusion in prisons also have also been ruled unconstitutional. Sources: The Pew Center on the States, (2008); Saltzman, & Proch, (1990).

Unfortunately, the implementation of deinstitutionalization policies often resulted in the precipitous discharge of residents without concurrent development of family support and community resources (DiNitto, 2011). Thus, many patients with chronic mental illnesses became homeless “street people,” while others ended up in places smaller but no less “institutional” than their previous setting, or worse yet, in local jails. This pattern of moving from one institution to another is called trans-institutionalization (Segal, 2008).

ISSUES AND TRENDS

Privatization

A recent trend in institutional care is the privatization of facilities. Large private, for-profit corporations have developed nursing homes, psychiatric treatment centers, and prisons (Karger & Stoesz, 2010). The trend toward privatization in prisons was presented in more detail in chapter 3.

“Revolving Door” Care

The term revolving door refers to a pattern of institutional care that involves repeated admissions and discharges. Although the term also is used currently to refer to the problem of the rehospitalization of elderly patients (Robert Wood Johnson Foundation, 2013), it has been particularly problematic in the case of people with chronic mental illnesses. Although the push for deinstitutionalization has prevented unnecessary, long-term custodial care, it also has encouraged premature discharges and repeated readmissions (Segal, 2008). In general, patterns of mental health admission to institutions now are periodic, temporary, frequent, and
short-term (Moore & Starkes, 1992, p. 173). The term can also be applied to other institutionalized populations. More than half of released offenders return to prison within three years, either after being convicted of a new offense or for probation violations (Pew Center on the States, 2008). (The percentage of convicts who are rearrested is called the recidivism rate.)

Moore and Starkes (1992, p. 173) also note that concern now seems to have turned away from the location of care to issues of continuity of care. The continuity-of-care perspective views institutionalization as only one aspect of treatment and assumes that professionals will develop and implement a plan for working with significant others in the clients’ lives and for appropriate aftercare and follow-up after discharge.

Other trends in institutional care in America vary by population. Some of these patterns have been well publicized, while others are less well known. They are discussed next.

Offenders
There has been extensive press coverage of the explosion in the prison population in this country, thanks in part to data collected by the nonprofit watchdog group the Sentencing Project (www.sentencingproject.org). The United States is the world’s leader in incarceration with 1.57 million people currently in the nation’s prisons or jails. Prison overcrowding continues and state governments are overwhelmed by the burden of funding their penal systems. The Sentencing Project (Mauer & King, 2007) reported that as of 2003, 20 percent of inmate populations at the state level, and 55 percent in the federal system, were drug offenders. Of all persons meeting the criteria as drug abusers or drug-dependent, less than half in state or federal prisons received any treatment or programming since admission.

The exploding inmate population just referenced necessitated a boom in federal and state prison construction. Much of the prison boom has been concentrated in small towns and rural areas. A PBS documentary, Prison Town, USA (Galloway & Kutchins, 2007), reported that 350 rural counties saw prisons open between 1980 and 2001. The possibilities of employment and a boost for local businesses were often part of the campaign to bring prisons to such localities.
The promised benefits, however, were not always realized. Many local workers were not qualified for some positions, such as corrections officer, and those positions were filled by people living outside of the community. Some jobs for which locals were qualified, both inside and outside the prison walls, were performed instead by prison labor (Huling, 2002). Often secondary benefits, such as contracts with local businesses to provide goods or services to the prison, were lost as prison management chose to renegotiate contracts or outsource aspects of the work. A 2003 study of prisons sited in rural communities found that there was no overall effect on local employment, per capita income, or consumer spending, three leading indicators of economic vitality (Galloway & Kutchins, 2007). Other problems include the many incidents of racism that have been documented in prisons in rural areas where correctional officers are predominantly white and prisoners are predominantly people of color (Huling, 2002).

Again, according to the Sentencing Project (Porter, 2012), overall state prison populations declined for the third consecutive year in 2011. Reasons for this decline include state sentencing reforms (e.g., relaxing mandatory minimums, and reducing the length of sentences for possession of crack cocaine) and changes in parole revocation policies. It is unclear whether this pattern will be sustained.

Although prison overcrowding is an ongoing concern, jails currently represent one of the most problematic aspects of institutional care. Jails serve a “catch-all function,” holding individuals pending arraignment or trial, convicted offenders serving short-term sentences, convicted offenders awaiting transfer to prison, probation and parole violators, vagrants, drunks, people who are mentally ill or homeless, and increasingly, juveniles. In addition to being overcrowded, many jails are old and unsanitary, and inadequately staffed (Territo, Halsted, & Bromley, 2004). Problems result from the limited and unstable nature of local taxes, a general lack of public support for jail reform, rapid rates of inmate turnover that make it difficult to develop and coordinate programs, and the immense diversity of risks and needs found among inmates (Bohm & Haley, 2014). Jails are the “revolving door” of the justice system (Siegel & Worrall, 2014, p. 498), but like the prison population, the jail population has also been declining in recent years.
Older Adults

Older adults who were confined to public mental hospitals were the principal beneficiaries of policies of deinstitutionalization. Older adults need long-term care because of disability, chronic illness, or dementia (National Association of Social Workers, 2012a). According to the Centers for Medicare and Medicaid Services (2012), more than 1.4 million U.S. residents were living in nursing homes on December 31, 2011, corresponding to 2.9 percent of the over-65 population and 10.7 percent of the over-85 population. (See table 10.1.)

According to an AARP Public Policy fact sheet (Houser, 2007), even as the number of older adults has continued to increase, the number of nursing home residents has remained constant since 1985; that means the proportion of the population likely to need long-term care has actually decreased. Because of the increased use of nursing homes for short-term post-acute care, however, the number of stays has increased.

In a study ordered by Congress (Fleck, 2002), it was reported that more than 90 percent of the nation’s nursing homes are inadequately staffed, putting residents at risk for bedsores, blood-borne infections, dehydration, malnutrition, and pneumonia. A Consumer Reports investigation (“Nursing Homes,” 2006) found that not-for-profit facilities employ more staff and do a better job of providing good care. The same analysis showed that independently run homes provide better care than

<table>
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<th>TABLE 10.1 Characteristics of Nursing Home Residents</th>
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<tbody>
<tr>
<td>Over age 65</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Non-Hispanic white</td>
</tr>
<tr>
<td>Impairments in ADLs*</td>
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<tr>
<td>Severely incontinent</td>
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<td>On anti-psychotic medication**</td>
</tr>
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Sources: Centers for Medicare and Medicaid Services (2012); Avitzur (2013).
*Activities of daily living (ADLs) include bed mobility, transferring, dressing, eating, and toileting.
**One-third of these had no identified indication for use of the medication.
The nursing home industry blames low rates of reimbursement under federal Medicaid and Medicare programs. Critics counter that government rates more than doubled between 1992 and 1998, and nursing homes chose to use the money to boost profits or to finance takeovers rather than to increase staffing (Fleck, 2002, p. 16).

The *Consumer Reports* (“Nursing Homes,” 2006) investigation found that state officials responsible for overseeing nursing home care have often failed to correct problems. The most usual remedy for violations of standards in nursing home care is a “plan of correction.” In this situation, the nursing homes acknowledge the problem and promise to address it within a specified period. Often the problem is corrected, but it soon resurfaces, a phenomenon regulators call yo-yo compliance, and fines tend to be “absurdly” low (“Nursing Homes,” 2006).

Residential care facilities (RCFs) were developed to provide an innovative and humane alternative to nursing homes. They include assisted living facilities and personal care homes and have become a million-dollar industry. The Centers for Disease Control reported that there were 31,100 RCFs in 2010 with 971,900 beds nationwide (Park-Lee et al., 2011). RCFs serve primarily a private-pay adult population, but the use of Medicaid financing has gradually increased in recent years. About half of RCFs are small facilities with four to ten beds. More than three-quarters are private, for-profit facilities, and about 38 percent are chain-affiliated.

In 2013 PBS, *Frontline*, and ProPublica (Thompson & Jones, 2013) examined the conditions in assisted living facilities in America and came up with some disturbing findings. There are no federal-level standards, and state regulations vary widely; for example, in fourteen states administrators do not need to have high school diplomas and in other states there is no requirement for a licensed nurse to be on staff. Only fourteen states set staff-to-patient ratios; in California facilities housing as many as 200 seniors need no more than two workers on the overnight shift and only one of those needs to be awake. Compared to nursing homes, assisted living facilities receive little outside monitoring. In six states there are no regular inspections and there are few consequences for lapses in care. In California facilities pay as little as $150 in penalties in cases where a resident has died as a result of poor care. The jumble of state laws governing assisted living facilities reflects, in part, the industry’s efforts to fight off tighter regulation.
People with Mental Illness

“The mental health system [in the United States] is fragmented, not welcoming, overburdened, and extremely difficult to navigate, especially by someone who is not thinking clearly,” observed a Virginia state senator who tried in vain to find a psychiatric hospital to take his mentally ill son (Earley, 2013, p. 10a). The son stabbed him multiple times and then killed himself.

According to a report from the Treatment Advocacy Center (Torrey, Entsinger, Geller, Stanley, & Jaffe, 2008), experts suggest that fifty public psychiatric beds per 100,000 people is a minimum number required for adequate services. In 2005, forty-two states had less than half the minimum number recommended. In 1955 there were 340 public psychiatric beds available per 100,000 population; this dropped to 17 per 100,000 in 2005. Because psychiatric beds are not profitable, many HMOs have closed mental health inpatient facilities in favor of more lucrative surgical clinics (Earley, 2013). At the same time, states cut funding for about 4,500 public psychiatric beds, 10 percent of the total, between 2009 and 2012 (Szabo, 2014). The consequences of the lack of an adequate number of public psychiatric facilities include homelessness, inappropriate incarceration, and local emergency rooms filled with patients waiting for a psychiatric bed.

With the absence of community-based alternatives, care of people with mental illness has shifted to detention centers, jails, and prisons (Szabo, 2014); “jail becomes a default mental-health facility because there are no resources to provide care” (Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010, p. 4). According to Bureau of Justice statistics, about two-thirds of jail inmates report having a mental health problem, and 15 percent of all state prisoners and 24 percent of jail inmates suffer from psychosis (Szabo, 2014).

The National Center on Institutions and Alternatives released a major study on jail inmate suicide in 2011. They reported that while jail suicide rates have been declining, suicide is still the single leading cause of unnatural deaths in local jails, and rates are still approximately three times greater than that in the general population. Among jail suicide victims, 38 percent had a history of mental illness and 34 percent had a history of suicidal behavior.
Most mentally ill offenders are arrested for minor offenses such as trespassing, vagrancy, urinating in public, or shoplifting at the corner convenience store. Many of them also have substance abuse problems, but cannot get into drug- and alcohol-treatment programs because of their mental illnesses.

People with Developmental Disabilities

Before deinstitutionalization, many people with developmental disabilities lived in the same institutions as people with mental illnesses. Only those with severe disabilities are now likely to live in other long-term care facilities, but nursing home employees often are not adequately trained to meet their special needs (National Association of Social Workers, 2012a). People with disabilities, however, have been successful in obtaining political support and financial resources due to strong lobbies and a public perception of worthiness (Segal, 2008). Contemporary practice emphasizes habilitation and rehabilitation training, and consumer-driven, highly individualized supports. Most people with cognitive disabilities live with their families or reside in community-based facilities, including intermediate-care facilities, foster homes, group homes, boarding homes, and supervised apartments (Segal, 2008).

Children and Youth

In the United States, the number of children living in institutions reached a low in 1960 and then more than doubled in the 1980s and 1990s, leveling off in 2000 at 144,981 (Segal, 2008). In the last twenty years, child welfare policy has heavily favored placing children in need of care with family-of-origin or kin-based alternatives, thus reducing government funding for residential treatment (Butler, 2006). Some residential centers, particularly unlicensed, unregulated private facilities, have been associated with reports of exploitation and mistreatment of children (U.S. Government Accountability Office, 2007). A study conducted by the American Bar Association found that thousands of children were placed by their parents in privately run, unregulated residential facilities (Behar, Friedman, Pinto, Katz-Leavy, & Jones, 2007). Seductive advertisements,
particularly on the Internet, aim their messages at parents who are struggling to find help for their problematic children. Many of these programs do not require a professional assessment prior to admission and severely limit parental contact.

On the other hand, reputable and accredited residential treatment centers that provide the basic components of a therapeutic milieu (a multidisciplinary care team, deliberate client supervision, intense staff supervision and training, and consistent clinical/administrative oversight) continue to provide a much-needed service for many children and families (Butler, 2006).

Currently there are about 6,000 children under the age of twenty-one living in nursing homes in the United States, because their parents cannot manage the special demands of the care required by their physical and mental disabilities (“Disabled kids living isolated lives in institutions,” 2012). Alternatives to nursing home placement include group homes or the provision of trained aides in their own family home, but waiting lists are lengthy.

UNDERSTANDING INSTITUTIONS

Ecosystems Perspective

Because they cannot voluntarily leave, institutional residents are more affected by the physical characteristics of their environment than people who can come and go at will. Historically, most institutions were immense buildings with high ceilings, long corridors, and large sleeping wards. The recognition of the importance of architectural design in promoting healthier social functioning created an impetus for new institutional facilities. Hutchinson (2008) has summarized the recent history of innovative institutional design in America (see for example Osmond, 1957, 1959, 1966; Sommer, 1969), and several research studies (see for example Cherulnik, 1993; Friedman, 1976; Holahan & Saegert, 1973; Sommer & Ross, 1958; Wener, Frazier, & Farbstein, 1985) documenting the effectiveness of more consumer-centered arrangements in psychiatric hospitals, large medical hospitals, correctional settings, and facilities for people with cognitive disabilities. Large wards were replaced with individual rooms and the furniture in day rooms was rearranged (for example,
putting chairs around small tables in the middle of the room rather than placing chairs and couches around the walls with patients sitting shoulder to shoulder). An example of another innovation in institutional design is the use of enclosed outdoor patio pathways that allow patients with dementia to “go for walks” without getting lost or wandering away from the facility.

The general concept of person-environment fit was discussed in chapter 1. Lawton (1982) and others (see Cavanaugh & Blanchard-Fields, 2014; Lawton & Nahemow, 1973) have suggested that one way of examining the person-environment fit is to look at the individual’s level of competence (his or her capacity to function across several dimensions) and environmental press (the demands of the environment). If competence and press are in balance, there is adaptation. If there are too many demands and too little competence, the result is maladaptive behavior and negative affect. And if there are too few demands and excess competence, the result is still maladaptive behavior and negative affect. This latter condition is applicable to many institutional settings where there is little in the daily routine that might offer a challenge or opportunity for growth to residents. For example, many nursing home staff members assume a lower level of functioning for residents than they are capable of and make decisions for them, causing residents to appear to be even more dependent than they are (Baltes, 1994; Wahl, 1991; Zarit, Dolan, & Leitsch, 1999). When researchers introduced decision-making options for residents, they not only demonstrated higher activity levels and greater well-being, but also lower mortality rates (Langer & Rodin, 1976; Rodin & Langer, 1977; Schulz & Hanusa, 1979).

**Functionalist Perspective**

Functionalists recognize several societal benefits of institutions. Some inmates are in institutions because they represent an immediate threat to society. In removing “deviants” from the community and punishing them, institutions help to reinforce a greater commitment on the part of the conforming majority to conventional norms and behaviors (Henslin, 2014).

A latent function of institutions is providing employment. An example would be a new prison built in a rural area that lacks other kinds of
industries. Functionalists would hold that the employment opportunities and economic growth that result are a positive contribution to the well-being of an area that extends beyond the manifest functions of the institution itself. Studies have shown, however, that the actual outcomes are less encouraging (see chapter 8).

Rational/Social Exchange Perspective

Institutions are a special type of organization, called coercive organizations by many sociologists because, for the most part, residents are there against their will. As organizations, institutions are designed using a bureaucratic model (see chapter 9). That means that they have a hierarchical structure, a complex division of labor, and many rules and regulations that apply to staff as well as residents. One of the major complaints that are made about many nursing homes, for example, is that their programs serve to meet the needs of the institution rather than the needs of residents. Regimented scheduling is valued by such facilities despite arguments by gerontologists that such routines are detrimental to residents’ well-being (Langer & Rodin, 1976).

On an individual level, the rationalist perspective underlies the deterrence theory of imprisonment (see chapter 3). Deterrence theory suggests that harsh prison settings will cause individuals to decide to refrain from engaging in criminal activity.

On a societal level, a cost-benefit analysis of institutional care suggests that not much rational thought has gone into planning. The same amount of money invested in preventive programs and community-based care would improve the lives not only of those who end up in institutions but others as well.

Conflict Perspective

From a conflict perspective, institutions satisfy the need to remove those who are unable to comply with the demands and expectations of the powerful in society. These would include those who are too old to work, those who are chronically ill, and/or those who are a danger to themselves or others. Spitzer (1980) stated it more strongly, saying that institutions are
Residential Institutions

an instrument of social control, used to warehouse the surplus labor population that fails to contribute to capital accumulation.

In institutions, differences in power are everywhere. For residents, freedom of movement is restricted, contact with staff and outsiders is limited, and personal privacy is minimal. Although they are monitored almost continuously, residents have so little power that they may be treated as if they are invisible. Rosenhan (1973, p. 256), for example, reported incidents of ward attendants abusing mental patients in front of other patients, and of a nurse who “unbuttoned her uniform to adjust her brassiere in the presence of an entire ward of viewing men” as if they weren’t there. Although in the past few decades laws and regulations have been put in place to protect the basic rights of many institutionalized adults, the reality is that they are still among the most oppressed of our society’s citizens.

Given the current social climate, the mistreatment of inmates in American prisons and jails is often ignored or even condoned. There is a general attitude that convicted and incarcerated felons have forfeited their rights to be treated as human beings (Stringfellow, 1990/1991); thus the potential for human rights abuses at both large “supermax” facilities and at smaller, overcrowded facilities is great.

Constructionist Perspective

According to labeling theory, labels such as patient or criminal may result in institutional residents accepting and internalizing the attributes of those roles (Goffman, 1961). The impact of labeling is not limited to the label recipient but extends to those with whom she or he interacts. For example, once a person is labeled a psychiatric patient, staff may interpret even normal behaviors as symptoms of mental illness (Rosenhan, 1973).

Preferred Perspectives

Along with deinstitutionalization came a movement for institutional reform called normalization. In simple terms, normalization means making available to institutionalized people living arrangements that closely resemble those enjoyed by other citizens (Nirje, 1976; Wolfensberger, 1972). This approach suggests that facilities should be small (i.e.,
designed for no more than six to eight residents). They should resemble valued homes in the community—there should be no signs in front (or on the program vehicle) that identify the residents inside as different from other citizens. Facilities should be integrated into the community so residents can walk or use public transportation to get to the library, shopping mall, movie theaters, coffee shop, and so forth. Residents should work and receive services away from the facility. There should be a continuum of options available, but residents should not have to move simply because their needs change; instead, services should be adapted so that residents can experience a sense of permanence and security in their living arrangement.

A more recent effort to reform institutions is called the Eden Alternative. This approach was a response to the sterile, pathology-based, treatment orientation of nursing homes that results in loneliness, helplessness, and boredom. Eden Alternative founder William Thomas enumerates three fundamental principles of this new kind of care: acknowledging each resident’s capacity for growth, focusing on the needs of the residents rather than the needs of the institution, and emphasizing quality long-term nurturing care while providing short-term treatment as needed (Thomas, 1994). This new philosophy of care involves “aesthetically transforming the physical environment of facilities with the addition of pets, plants, and children, creating a ‘human habitat’; placing maximum possible decision-making authority in the hands of residents and those who care for them; de-emphasizing program activities by encouraging resident involvement in the ‘human habitat’; and de-emphasizing the use of prescription drugs” (see “Long-Term Care Paradise,” 1999). In contrast to the usual hierarchical, bureaucratic, department-based organizational design of most nursing homes, in the Eden Alternative facilities, staff members form multidisciplinary work teams that assume responsibility for an area, and make their own schedules and work assignments. Thus, a cooperative work environment is cultivated and staff feel empowered.

Calkins (2011) has summarized other trends in elder care in the past decade or two. These include elimination of the nursing stations and med carts; the “household model” of eight- to eighteen-bed residential facilities; and “intentional elder-friendly communities” that have houses that encourage “aging in place”—that is, at least one no-threshold entry, an
accessible bathroom, a kitchen and bedroom on the main level, and doorways/hallways wide enough to accommodate a wheelchair.

**THE IMPACT OF INSTITUTIONS ON INDIVIDUALS AND FAMILIES**

**How Institutions Deter Well-Being**

Erving Goffman was a well-known early critic of psychiatric hospitals and other “total institutions,” such as prisons and concentration camps. In his groundbreaking ethnographic work, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, Goffman argued that institutionalization was a traumatic and “mortifying” experience brought on by isolation, invasion of privacy, regimentation, and labeling (1961, pp. 13–14). Deegan (1993) echoes this sentiment in describing psychiatric hospitalization as the “radically dehumanizing and devaluing transformation from being a person to being an illness” (p. 7).

Conditions in some long-term care facilities continue to raise concerns. For example, overuse of physical restraints and psychotropic drugs for people with chronic mental illness, cognitive impairments or developmental disabilities, and those who exhibit behavioral symptoms of dementia have been reported in many nursing homes (National Association of Social Workers, 2012a).

Even when facilities are well run, most people dread living in an institutional setting because of the expected loss of freedom, control, and privacy. The powerlessness and deindividuation associated with most institutions leads members of many vulnerable populations, such as the aged and those with chronic physical or mental illnesses, to choose marginally adequate living arrangements in the community or even homelessness over inpatient status.

The regimentation of most institutions results in residents becoming institutionalized. *Institutionalization* is a syndrome characterized by apathy, withdrawal, submissiveness, and a reluctance to leave the institutional setting (Johnson & Rhodes, 2007). In other words, residents are re-socialized to become compliant and dependent. In learning to adapt to the institutional environment, they lose the skills and attitudes—such as self-care and independent decision making, assertiveness, and self-confidence—they need to reenter and function successfully in the outside
world. Wirt (1999) suggests “the restrictive environment of institutional settings coupled with oppressive staff [are] capable of producing institutionalism in almost any person regardless of diagnosis, predispositions, or personality” (p. 260). Prolonged isolation in prisons can even provoke severe symptoms of mental illness, such as anxiety, depression, despair, paranoia, rage, obsessive thoughts, claustrophobia, and hallucinations (Human Rights Watch, 2012; Metzner & Fellner, 2010). Solitary confinement can be unendurable for some prisoners, as is evident from the high number of suicides that take place (Metzner & Fellner, 2010). According to the nonprofit organization Human Rights Watch (2012), human rights law does not prohibit solitary confinement in all cases. Nevertheless, prolonged solitary confinement can violate the prohibition on cruel, inhuman, or degrading treatment.

In some institutional settings, particularly those designed for offenders, a deviant subculture develops and imposes its values and patterns on the residents, regardless of what goes on in the rest of the institution (Polsky, 1962; Sykes, 1958). Sometimes called the convict code, inmate subculture, inmate social code, or deprivation model in corrections settings, this theory suggests that an environment of shared deprivation gives inmates a basis for solidarity (Siegel & Worrall, 2014). The subculture represents a functional, collective adaptation of inmates to their environment. Norms of the convict code include not informing the staff about the illicit activities of other prisoners, skill in “conning” and manipulation of staff, and an ability to show strength, courage, and toughness. Criminologists say that there probably no longer exists one overriding inmate subculture, but rather several subcultures that are divided along racial and ethnic lines (Cole et al., 2013; Siegel & Worrall, 2014).

One might ask whether the funds used for institutional care might be put to better use in prevention or community-based services. “The money spent on prisons is money taken from the parts of the public sector that educate, train, socialize, treat, nurture and house the population—particularly the children of the poor” (Currie, 1998, p. 35).

How Institutions Promote Well-Being

For small numbers of individuals, institutional placement is the most appropriate alternative both for them and for the rest of society. Some
people pose a clear danger to themselves or others and need a protective, structured environment. Institutions do have a place in a modern, democratic society. Problems occur when they are overcrowded, underfunded and understaffed, poorly designed, and used by default rather than by plan.

INSTITUTIONS IN OTHER COUNTRIES

In other countries, institutions are still used for purposes that are no longer common in the United States. Despite research that shows that institutional care of very young children is harmful to their development, an estimated minimum of 44,000 children under three years of age are officially recorded as living in institutional care for more than three months within forty-seven countries in the European region (Browne, 2009). “At least nine out of ten children in residential care have one living parent, and are mostly placed in institutions for social and economic reasons in transition countries, and for reasons of abuse and neglect in economically developed countries” (Browne, 2009).

There are investigations that document deplorable conditions in institutions in other places. Recently, for example, Disabilities Rights International, a U.S.-based human rights group, issued a report on the abuse of patients with cognitive disabilities housed in Mexico’s psychiatric hospitals (Rosenthal, Jehn, & Galvan, 2011). Some children have disappeared and may have been subjected to sex trafficking and forced labor. Over the past decade, the same group has documented abuses in institutions in Vietnam, Serbia, Argentina, Romania, Turkey, Peru, and Kosovo (Disability Rights International, 2013).

Couples who adopt from abroad may pick up their babies in orphanages in Russia, Romania, China, or Guatemala. Most of these facilities are clean and well run and now in many countries, babies and young children waiting for adoption are placed with foster families.

SOCIAL WORK IN INSTITUTIONS

Ginsberg (2001) summarizes the many tasks that social workers perform in institutional settings. In hospitals, they work on discharge planning and
help patients arrange for financial support. They not only provide social services in long-term care facilities for older adults, but also provide consultation around licensing issues. In prisons, they may be called upon to provide individual counseling and group therapy sessions and to help inmates stay in contact with their families.

Because most clients in institutional settings are involuntary, social workers have a special ethical responsibility to them. Social workers play an important role of advocacy for appropriate, culturally competent, quality care for those in long-term care facilities (National Association of Social Workers, 2012a). Often “it is social workers who must inform those who have been institutionalized or who face institutionalization of their rights or interpret their rights for them. Many times only social workers are available to act as advocates for those who are institutionalized, insuring that their rights are recognized and respected” (Saltzman & Proch, 1990, p. 360). In a corrections context in particular, and in other institutional settings as well, social workers must be prepared to advocate “for safe, humane, and equitable treatment” (National Association of Social Workers, 2012b, p. 324).

REFERENCES


Earley, P. (2013, November 21). Deeds attack shows that our system is a mess. *USA Today*, p. 10A.


