THE INSTITUTIONAL ENVIRONMENT

AND BEHAVIOR CHANGE*

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As more and more people survive the infectious diseases and live into extreme old age, the need for long term care becomes greater. By and large, this type of care is given in a variety of institutional settings which are thought to have an impact on behavior. In this chapter, the institutional settings and their presumed impact will be described and discussed in the following sections:

1. Definition of and brief descriptions of several types of long term care institutions, which were selected to serve as examples only.

2. Discussion of the long term care facility as a social system for the following points of view: (a) societal need for long-term care institutions, (b) sociological analysis of goals, structure and function of institutions, (c) the role and characteristics of institutional staffs and (d) the role and characteristics of institutional residents.

3. Institutional ecology including a discussion of (a) size, (b) architecture, spatial arrangement and furnishings and (c) psychosocial climates.

4. The relationship between the institution and the physical, social and legal aspects of the external community.

5. The process of relocation and its presumed impact on residents.

6. Potential for institutional change.

7. Summary and conclusions including a discussion of (a) key issues and consistent findings and (b) needed research that might add significantly to an understanding of institutionalization processes, particularly in terms of implications for quality of care and impact on the
on the health, social and psychological status of the recipients of care.

1. Definitions and descriptions of selected long-term care in institutions

According to Reader (1972) from whom most of the descriptions

of institutions given below were taken, "institutions in the United States

constitute a spectrum, based on intensity and complexity of care, that

includes home care, day care, (and the day hospital), infirmary care

(in homes for the aged or retirement communities), nursing homes, extended

care facilities, chronic disease hospitals (terminal care homes), mental

and other specialty hospitals, and acute general care hospitals." Selected

eamples of institutions taken from the above-mentioned paper of Reader (1972)

are described below:

A. Nursing homes: Prior to the 1930's very few nursing homes

existed in the United States. The sick elderly were cared for by relatives

or in almshouses. Since the enactment of the Social Security Act in 1935,

nursing homes began to become numerous. Since then there has been a growing

demand for nursing home beds, a demand given impetus by the Medicare Act.

It is estimated that there are 30,000 beds under construction in New York

State alone. According to Reader (1972), "there are not adequate facilities

for all the chronically ill elderly in the United States, and the nursing

home is likely to continue to be the place where they go regardless of the

of the quality of care provided." (P.10)

B. Chronic Disease Hospitals: Reader (1972) notes that Shanas

and her colleagues (1968) point out the difficulties of classifying types

of institutions cross-nationally in comparisons of the United States, Britain

and Denmark. They found in 1967 that the United States had close to 30,000
beds (38,144 in 1971) listed as chronic while Britain had 65,000 with another 20,000 geriatric beds. Apparently, the term nursing home has a different meaning in different countries. Some American nursing homes resemble British hospitals for the chronic sick but are not so classified. Chronic disease hospitals in the United States are often closely associated with acute general hospitals. Some countries in Western Europe, have developed the geriatric hospital as an entity in itself. Some homes for the aged in the United States closely resemble the British geriatric hospital. Terminal care homes are related to both chronic care and geriatric institutions. Generally, their aim is to make the patient's last days as comfortable as possible. Homes for the aged and retirement communities offer infirmary care to their residents, usually for purposes of treating minor, acute illnesses.

C. Mental Hospitals, V.A. hospitals and other specialty hospitals

About one million elderly are thought to be housed in institutions of all types. What percentage of these are found in mental hospitals and V.A. hospitals is not clear. Nor is it clear why some psychiatrically ill elderly are in mental hospitals while others are in the community. By and large, the care given the elderly in mental hospitals, most of whom have grown old there, may be termed custodial. In New York State, the elderly who require only custodial care are not accepted for psychiatric hospitalization any longer. Only those who can benefit from such care are taken.

2. The Institution as a social system

A. Needs served by Institutions in general

The needs served by institutions may be considered from at least two points of view: (1) from the standpoint of those they are originally
intended to serve, namely the individual, the family and society and (2) from the standpoint of those providing the institution and the service. There is some overlap between the two views, since society is frequently donor, recipient and regulator of services.

In general, in our society, attempts to cope with problems are made at as low a level as possible. Higher levels are only used when a particular circumstance either can not be coped with a lower level or can have a detrimental effect of attended to at a lower level. For instance, an individual with tuberculosis could be cared for by his family, but since this would expose not only the family but also the community to risk, the immediate community, or the larger community, e.g., the state, whichever has the more appropriate resources, takes charge.

At the individual level all institutions, ostensibly, provide personal care, medical attention, and rehabilitation, in varying proportions and of varying types. However, these are not the only needs served by these long term care institutions. As far as the individual is concerned he goes to an institution when neither he nor his family can make other appropriate arrangements for care. For him the institution may be seen as offering other, additional, facilities. It may safeguard him from himself (as in the case of the suicidal patient), protect him from the environment (as in the case of the severely retarded or deviant), and provide him with a home and friends, and shelter from the problems of the world. The latter, however, is reported less frequently from the old age home, where advertising suggests it should occur, than from the mental hospital, which does not view this as one of its functions but where patient manipulation makes it one (e.g., Goffman, 1960; Braginsky, Braginsky, Ring, 1969; Dok, 1971).
For the family the institution has two functions. It cares for a deviant member, doing a task which the family cannot or believes it cannot do; and it consequently permits the family to live a more normal life.

Formal institutions for the care of the mentally and physically ill, the retarded, the convicted, and the elderly abound in our complex society, and in other, similar, complex societies. To some extent, these institutions, and the way they handle and treat the persons they are responsible for, are taken as measures of how civilized a society is, and of how much progress it has made.

B. Institutional life, particularly as it is relevant to the aged, has several meanings, four of which were described by Bennett (1963;1964) and will be repeated briefly again below: 1) the meaning for society 2) the sociological meaning, 3) the meaning for professional and other personnel who staff institutions and 4) the meaning for residents or patients of long-term care institutions.

a. The meaning of Institutionalization for Society: According to Goffman (1960) there are at least five categories of institutions all of which are organized to meet specific societal needs. These are: 1) for persons incapable and harmless, e.g. homes for the blind and aged, 2) for persons incapable and socially threatening, e.g. tuberculosis sanitoria and mental institutions, 3) those which protect the community, e.g. prisons and concentration camps; 4) those for the pursuit of technical tasks, e.g. army barracks and 5) retreats, e.g. monasteries and convents. Efforts are made to remove from society, not only the physically and mentally sick, but those with infectious diseases, the old, the retarded, and persons who, in
questioning society, may suggest changes which society considers too threatening to itself. These persons are removed from society in order for it to continue to function efficiently and provisions are made to care for them (or deal with them), since they cannot be jettisoned. (Szasz, 1961; Medvedev and Medvedev, 1971; Bennett and Sanchez, 1973).

In a simple, perhaps more tolerant, and more flexible society there is room for the deviant individual. The retarde, for instance, can do simple farm chores and household tasks. But as farm and home become more mechanized simple tasks are replaced by complex ones with which the retarde is unable to cope. The retarde is merely an example. The complexity of society, and the stresses it engenders, may result in increasing numbers of persons who cannot maintain themselves in their society, or who maintain themselves in a manner considered understandable, and who therefore require particular care.

In the case of the long-term care institution, it falls into the first category on Goffman's list namely for persons incapable and harmless. While it is the purpose of many institutions to remove persons, often a secondary purpose is to rehabilitate them so that they can return to society. In the case of institutions for the elderly, the best one may be able to hope for is that the institution itself will do its inmates no harm. From time to time, the balance of goals shifts from society's point of view or new techniques may obviate the function of the institution thus leading to the disappearance of certain institutions, e.g. the TB sanatorium. Alternatively, there are new needs which emerge requiring new forms of institutional care. Thus, the emergence of the hospital and the subsequent organization of the
extended care facility to provide a base for nursing care to be delivered to a growing group of feeble and chronically ill aged persons.

b. The Sociological Significance of Long-Term Care Institutions:

The Concept of Total Institution

In the paper which has come to be a classic on the subject of institutions, long term care and other residential institutions are conceptualized by Goffman (1960) as "total institutions" and are described as "Social wards, part residential community, part formal organization.... These establishments are the forcing houses for changing persons in our society. Each is a natural experiment, typically harsh, on what can be done to the self." Goffman (1960) defined a total institution as one which is "symbolized by the barrier to social intercourse with the outside." It is encompassing to a degree discontinuously greater than the organization next in line...." It acts in a way to "break down...the kinds of barriers separating statuses" in that all aspects of life are conducted in the same place, each phase of a resident's daily activity is carried out in the immediate company of others, all phases of the day's activities are tightly scheduled and the contents of the various activities are "brought together as parts of a single rational plan purportedly designed to fulfill the official aims of the institution." (p.450)

In short, the sociological significance of the long-term care is its potential for modifying behavior.
Institutional Goals

All institutions giving institutional care whether of long or short term duration share a number of goals in common. They are designed to provide a range of services to the individual, including maintenance, therapeutic or rehabilitative, and protective or custodial services. Given these responsibilities on the part of the institutional structure, certain subordinating needs emerge. Thus, economic considerations the number and density of given target populations, and the convenience of the delivery of services to the institution, all come into play. The existence of an may serve as the focus for other opportunities and yet other categories of purposes may evolve. Thus training programs, personal power needs, research enterprises and a host of supplementary services may increase the size and complexity of a given unit. In turn, this unit often will need to increase its patient load to justify the increased services appended, thus leading to a phenomenon of spiraling institutional growth.

The hierarchy of needs as actually reflected in practice may be more a function of resources available and the priorities of the supporting structures than of the purposes for which the institution was in fact established. Thus, educational needs may take precedence over therapeutic needs, if the staff is paid as teachers rather than as therapists. Custodial care may replace rehabilitative functions where little support is given those functions and the budget is limited. Institutions may grow in size and complexity as a response to jealously guarded jurisdictional boundaries and agency power gains far beyond their therapeutic or even custodial efficiency.
One of the complex problems associated with an approach to clarifying the goals of long term institutional care involves the complex definition of the patient population as well as of the institutions involved. Chronic disease, according to one medical dictionary, is that which is not acute. According to popular parlance it is incurable. Though there is no particular concern with extent of disability, long term care is similarly confusing.

One approach to defining institutional care, which is of longer duration than normal, is to call it long term care. Other definitions would include 30, 60, or 90 days. The definitional problem is partially contaminated by the open endedness of the time involved. Thus, Medicare limits long term care for an extended care facility to 120 days per bout of illness/year while some facilities, e.g., VA domiciliaries, state hospitals, etc., as well as a wide range of institutions will provide care for the life span.

Vagueness of the meaning of long-term care

The meaning of the term long-term care is vague and thereby hangs a tale of the inherent difficulties of such institutions. In most organizations, jobs to be performed by staffs have observable, often quantifiable outputs by which both administrators and staff members themselves can judge performance on the job. Because of the vagueness of the concept of long term care, approaches to undertaking institutional care have traditionally looked at secondary goal structures, i.e., number of patients cared for, length of stay, remission rate, cost of care, or number of M.D.'s nurses, etc., trained. At present, there is concern with the range of effects that the institution has upon an individual over and beyond the stated purpose for which he is institutionalized. Thus, the institution as a behavior modifier has become
institutionalized. Thus, the institution as a behavior modifier has become a topic of some concern (Goffman, 1960). As yet, none of these serve as specific, concrete criteria of the achievement of the goal of long-term care. Unfortunately in most long-term care institutions are often neither visible nor quantifiable. Nor is it clear what goal achievement means. If patients are not discharged as cured, how can staff members feel they have done a good job? If their performance on the job cannot be judged, how can they qualify for raises or promotions? This is probably most problematic for personnel trained in acute care medical settings where they learned to treat patients for specific ailments and to discharge them as quickly as possible.

The goal of long-term care of maintenance for the duration of an aged person's lifetime where the course may be downhill all the way is almost inherently unsatisfying. Thus, such a goal is one which requires a great deal of respecification and concretization. Probably, this goal has to be redefined to include concrete components such as that of rendering assistance in social adjustment or rendering assistance in restoring personal care skills, as well as other similar concretizations of the overall goal of long-term care. Only then can the job of goal attainment be made satisfying to staff members. By concretizing this goal it becomes possible to establish job performance criteria by which staff members can judge their own performance as well as be judged by administrators and residents and their families who are receiving or purchasing long-term care.
Conflicting Goals

Institutions have many functions, some of these are acknowledged by the institution, some, not necessarily the same functions, are attributed to it by non-institutional sources such as the community. Conflict may arise among staffs with competing goals in either case.

As noted earlier in the section on institutional goals, an institution rarely has but one function. Whenever a multitude of goals must be achieved conflict among them may arise. When an institution is, say, supposed to help patient, train staff, be available for research, maintain its plant, cope with too few funds, and make a profit, problems may arise among any combination of these, Thus, we hear that large patient turnover is desired for instructional purposes but a small turnover is useful for research purposes. In order to reduce hospital running costs (Bok, 1971), there is the need to keep good hospital workers, to cut back on the discharge rate, and consequently on the admission rate because discharge and admission are costly procedures. There are, of course other dilemmas, such as those which occur when an institution intended for temporary stay becomes a permanent abode, as well as the problem of what to do with a patient who still needs treatment but can no longer afford it.

What is, perhaps, needed, is an overt acknowledgement of diverse goals, a grading of these goals with respect to relative importance as they affect the institution and the inmate, a decision as to which goals have highest priority, and a consideration of the extent to which one goal may be subordinated to another. For instance, work carried out by inmates may be seen as being therapeutic. When such work reduces the costs of the institution some decision should be made as to whether the institution is justified in
keeping a patient who can no longer pay for the cost of therapeutic care? How many such persons can it keep, and for how long, before it perils its existence, given that its existence is important and means that others can be treated and helped?

Conflict in goals may also occur when the institution and the community are not in agreement as to the functions of the institution, or do not place similar level of priority on these functions. Perhaps one of the clearest examples of this originally occurred many years ago when the doors of mental hospitals were first unlocked. While this was done for the benefit of the patients, the community felt threatened, and protested. Here the institution was not fulfilling its functions as the community saw them. A more recent example of how the community's idea of how a mental institution should function was reported in the New York Times (Chairman, 1972). The community viewed the institution as a place of segregation; criminals were to be locked up, the mentally disturbed were, for their own safety, to be fenced in. The institution saw its role otherwise, believing it more therapeutic to keep its doors open, and its patients in the community. Not all, not even those in other mental institutions agreed with this approach.

The conflict between the structure of an institution and its function may range from the very general, i.e., conflicts common to many institutions and occurring regardless of specific structure, to the very specific, as when a particular structure does not permit a particular function to be fulfilled, or perverts the fulfilling of that function.
In the most general case there are indications that the sheer presence of an institution may be detrimental to its intended function. Thus, mental hospitals are intended to be the appropriate places for the mentally disturbed to go for treatment, the general expectation being that when symptoms have been cured, alleviated, or contained patients will return to the community. Here speed of return to the community can be, and to some extent is, used as a means of evaluating treatment. It is therefore rather distressing to find that those who enter a mental institution are likely to be kept away from their community for a longer time than are those who receive treatment on the psychiatric ward of a general hospital (Hoenig & Hamilton, 1969). Whatever the explanation may be, these institutions are not fulfilling their functions appropriately. Since studies do not yet appear to be available, we do not know the extent to which institutions which have other main functions also fail to meet those functions, however, Townsend's (1971) report suggests that many institutions which are expected to care adequately for the aged do no such thing.

In a less general view we find that institutions which nominally restrict themselves to performing certain functions, or to specializing in the treatment of, or attention to, certain disabilities in fact perform functions which are both broader than, and different from, those which they officially announce. Thus, we find that various institutions designed to give short term or temporary care in fact end up being permanent residences for certain inmates, while other institutions which may be expected to offer permanent care do not do so.
Mental hospitals and nursing homes fall in the first category -- older persons may enter with the full expectation of leaving (although those responsible for them being there may not have this expectation), and the institution itself has the same expectations. Consequently no attempt is made to arrange at the start for a permanent stay, and both personal belongings and friendships among residents may be discouraged. In a temporary institution such are not needed. The fact that many persons may live out their lives there, or may live there for a lengthy period of time does not appear to be sufficiently recognized to result in a change in approach. In the latter category are homes for the aged which are not in approach. In the latter category are homes for the aged which are not prepared to cope with the sickness and infirmity of age, and which send a resident elsewhere, and may not welcome him back, when he is no longer able to cope by himself, or is disturbing to others.

Different institutions patronized by the elderly officially offer care for different types of problems, (e.g., mental or physical) and do so at different levels of intensity, which may range from total to minimal attention. However, the inmate populations of different institutions differ less in amount of treatment needed, or in symptomatology than should occur if residents were assigned to the most appropriate setting. Thus, we find that patients no longer in need of the specialized attention remain in chronic disease hospitals (1,2,3,4,5,6,7) and general hospitals (Dressler, 1971). In the former case this is attributed to a lack of economic and social resources, in the latter to the complexities of medical insurance. Further examples of the continued unnecessary use of
facilities are undoubtedly present. Diagnostic misassignment is frequently decreed. While the mentally disturbed are expected to be found in mental hospitals, they are also present to a marked extent, in nursing homes, and probably also in other institutions catering to the aged (Engel & Nowell, 1963). This may even occur when the particular institution proclaims that it does not care for persons with such problems (Stotsky, 1970). Certainly, as far as some nursing homes are concerned, they seem to do this unwillingly.

In part misassignment is undoubtedly due to the fact that, while in theory, physical and mental symptoms may occur separately, among the aged they frequently occur in conjunction. Consequently institutions catering to the aged, no matter what the level of intensity of care they offer, must be prepared to cope with a wide variety of problems, which must encompass the social, psychological, physical, and psychiatric. It may be considered a tribute to the staffs of the institutions reported on that they are able to cope with areas of malfunctioning in which they may not be expected to demonstrate any expertise. In future, for many institutions intended for the elderly we should be more concerned with the range of behavior with which they can cope, and we should turn away from our present focus which tends to be on extent of specialization in a particular area.

Let us now turn to considerations of more specific matters. With the belief that the "other 23 hours" are also relevant has come a concern with the total environment in which residents of institutions live. There have been attempts to introduce therapeutic communities (many differing in crucial ways from the example set by Maxwell Jones, 1953), and to consider which types of organizational structure are most appropriate for particular functions (Edelson, 1969). Reported concern with the impact of the environment on the
individual is more evident from mental hospitals and other institutions concerned with patients' treatment and discharge than from other residences for the aged. In part this may simply be a reflection of the number of studies carried out in the various different institutions. In part it may also indicate that in some institutions, in particular those intended for the aged who are no longer considered capable of living in the community, there is no therapeutic intent. The institution is a holding device, in both senses of that term. When an institution has no concrete goals for its residents it cannot be expected to devise ways of attaining those goals. Only when agreement on goals is reached can we expect some attempts at change to occur.

c. The meaning of long term institutional care for staffs

Staff Hierarchy

Having established that there are multiple institutional goals and that these may be vague, competing and/or conflicting, it is taking this line of thought but one step further to say that staffs are structured hierarchically along lines that indicate which of the several, possibly, competing goals are thought to be most important. Very often the hierarchy of a long-term care institution does not match the hierarchy of the acute care hospitals in which most staff members were trained. Needless to say, this often leads to strain and conflict among the various staff groups.

For some institutions hierarchies of staffs are easy to establish. If one of the primary reasons for entry into a short stay institution is sickness then primary of a staff concerned with bedside nursing may be appropriate. Where, however, one is concerned with providing a permanent home for residents another sort of staff member is important, perhaps those who can help the residents recreate a new home for themselves, and encourage them to exercise
the amount of independence they desire. Training may well be required in
the latter role, for there is evidence that those in charge of homes for
the elderly see themselves as ministering nurses, even if they have had
no training in nursing (Townsend, 1962).

A strict hierarchical structure where each person does only that for which
he has been specially trained may be appropriate in a large, short stay,
extended care facility. General indications suggest, however, that a very
different structure is required in a long-term care institution where the
general emphasis should be on creating a pleasant, secure home-like environment,
rather than on making sure that all procedures are performed at set times.
In creating such an environment we should turn away from any strict hierarchy,
and consider the advantages present in a therapeutic community. We should,
perhaps, aim for a situation where there is general agreement among the staff
as to institutional aims, and a common working towards them. This is more
likely to be achieved when there is common recognition of the skills which
each employee has, and when these skills are sufficiently broad (if necessary,
with the aid of special training) so that employees can substitute for each
other in performing a wide variety of tasks. Broadening skills would also
have a further advantage for employees, since it should mean that they now
have open to them a career, a possibility of advancement, where presently
they may only have a deadened job. This, in turn, should make the work
more interesting, and attract a higher calibre of worker. Naturally all
workers could not do all jobs. Certain functions would have to remain with
those who had particular qualifications. Prescribing, for instance, would
remain with the physician. Aside from such special instances, and others
which could affect accreditation, there is little reason why employees should
be limited to performing their traditional tasks. There is already information which indicates that for certain types of patient recordkeeping, nurses may perform better than doctors who have been traditionally concerned with this (Dressler, 1971).

**Conflict among staffs' structure and functions**

Conflict may occur within the structure of the institution, as, for instance, when its manner of hierarchial organization leads to inter-staff pressures when one goal or function can only be carried out at the cost of another, or between structure and function, as when it is not appropriately organized to permit the exercise of a function which it is supposed to perform.

While conflicts within and between structure and function can be and have been considered separately, such separation often tends to be artificial, for underlying many conflicts are the same basic considerations. Among these should be included problems imposed by financial constraints, and ideological considerations. For instance, given inadequate funds to hire staff, fewer, and less qualified personnel may be employed, so placing restrictions on the type of therapeutic involvement available to patients, which in turn affects the physical and mental state of the resident, and influences the discharge rate (where discharge is a relevant consideration). Ideological considerations may determine certain aspects of structure, and result in a conflict between apparent function and actual outcome. For instance, where it is firmly believed that the elderly wish to disengage and are strongly disinclined to to become active participants in programs intended for their benefit (see), we may expect that the elderly people in such a program may well become lethargic, disinterested, and possibly have a higher death rate.

The institutional care which is supposed to be of benefit to the older person
then becomes detrimental.

Conflicts can arise among administratively joined institutions. This can be expected to occur when there is competition among institutions for scarce resources, and when the particular needs of one institution are not recognised by the administration (Jones & Sidebotham, 1962).

Within the institution problems may also occur. Again, most of our information comes from mental hospitals, and typically from larger institutions which seem to be more likely to have a rigid hierarchy (see e.g., Belknap, 1956; Weinberg, 1956; Hyman, 1956; Brown, 1956) consisting of a number of parallel professional and sub-professional hierarchies. Problems arise in a number of areas, including problems related to position in one's own official hierarchy and problems in communicating and working with those in another hierarchy. The problems associated with position within one's own professional group are probably no different than the usual strivings to progress up the ladder. Problems of communication with other employees is a somewhat more unusual problem. Employees tend to be responsible only to those in their own hierarchy, and each hierarchy does what it can to maximise benefits for those in its own group, apparently regardless of the impact of this on other groups. In general a person in one group has no responsibility for, or authority over, a person in another group. This creates problems whenever persons from different groups must work together -- as they must most of the time. In such a situation there rarely seems to be a focus on the patient, and on what is best for him. The focus is on the employee, and on what is best for the employee. In part this may be due to the status of the institution. Mental hospitals, in particular large state mental hospitals, are rarely seen as high status places, where people willingly go to live or to work. By general repute
they are among the last places that people go to seek employment, and they get the poorest applicants. Because of the poor pay offered other institutions for the elderly may also end up hiring unsuitable and untrained applicants. This is not true of all institutions, some of which have a high proportion of college-educated workers (Jones, 1953).

More serious than problems of intra-professional conflict resulting from a strict hierarchial structure are the problems which arise when institutional structure and guidance conflict and cease to exist. Just such an instance has been described by Stotland & Kobler (1965). While certain structures may have a poor effect on the patients and on the staff, lack of structure may result in a complete breakdown.

It is frequently reported that there is a high turnover rate among both professional and non-professional staff. This rapid turnover tends to be decreed. It is expensive for the institution which must constantly devote time to recruiting and training new personnel if it is to maintain its standards. But it is worth noting that a high turnover rate does not necessarily mean that the care given is poor (Maxwell Jones's therapeutic community is frequently cited as a model, yet the personnel turnover rate is high), and it may be seen as an asset since it should permit the more rapid introduction of new approaches.

**Interaction between formal and informal subsystems**

According to Goffman (1960) and Bennett (1963), the staff subsystem and the resident or patient subsystem function alongside each other in the manner of castes. Little intimacy develops across caste lines. The lowest level of staff member is free to sanction or control the activities of any member of the resident or patient subsystem.
Attention has been paid to informal structures, and to the ways in which they affect inmates. However, with rare exceptions, it is the mental hospital which has been studied, and not other institutions responsible for the care of the elderly. While some findings may be transferable, some may not. Thus, reports that staff differences concerning patient treatment may adversely affect the patient (Stanson & Schwartz, 1954), or that the general spirit of competence and hope are important (Stotland & Kobler, 1965) may hold as well in a nursing home or home for the aged as in a mental hospital. Findings from large mental hospitals with rigid hierarchies (as that studied by Belknap, 1956) may be inapplicable to small homes where employees must perform a wide variety of tasks.

Growing out of the studies on internal organizational structure and attempts to create a therapeutic milieu has developed a concern with sociotherapy -- with the appropriate environment for a given treatment approach. Edelson (1970) has gone into some detail concerning the formal institutional structure appropriate for different types of treatment.

Caine & Small (1969) tried to point out that medical and nursing staff in hospitals using different manners of treatment (i.e., physical treatment, group therapy, individual psychotherapy, community therapy, and an eclectic approach) held different attitudes with respect to the patients and other staff in the ward setting. However, since self-selectivity was not controlled we still cannot be sure of what effect the treatment environment has on the staff. By and large, members of the various staffs of long term care institutions gear themselves primarily to the task of facilitating the adjustment of residents, though rarely are they conscious enough of doing so to articulate this as a goal. According to Bennett and Nahemow (1965),
criteria of what constitutes adjustment differ, however, depending on the service to which the staff belongs. Some workers will describe adjustment in terms of participation, others will describe it in moralistic terms and others will describe it in terms of doing what is most individually satisfying. (Bennett, 1963, p. 121). If criteria of adjustment are vague and/or contradictory, it is obvious that confusion will be generated among residents.

d. The role of residents in long term care institutions

Adaptation

If the staff's job is to set and clarify goals and expectations for themselves and residents, the resident's job is to adjust. By and large this is what he does. The resident's capacity for adaptation is usually remarkable. Goffman's (1960) description of patterns of adaptation in total institutions seems to apply to those found in long term care institutions. Usually norms found in the resident subsystem parallel those of the administration. (Bennett, 1963, p. 122). By and large, residents reject intimacy with other residents in the interest of staying out of trouble. Staying out of trouble. Generally, they are interested in associating with staffs because such contacts are rewarding. They often have jobs in institutions, engage in "time-killing" activities, (Goffman, 1960), put out newspapers or "house-organs", give and attend parties and participate in what little there are in the way of integrative activities in the institution. Usually, residents are socialized or oriented to institutional practices by other residents. Also, usually, the full impact of the meaning of adjustment to institutional life does not occur until about the second month of residence.

It is at this junction that they frequently begin to re-evaluate their decision
to enter an institution and start to complain about having to adjust to
difficult roommates or simply to the fact of sharing a room. They discover
that they are progressively becoming insulated from the outside community,
visitors stop coming frequently and they begin to feel they have been
forgotten. (Bennett, 1963). Many residents eventually come to the conclusion
that the demands made upon them by the institution are justified, reasonable
and in their best interest. They believe that staff members have "their own
troubles" and have a hard time managing a large number of people, particularly
old people. They explain that they dislike hearing the complaints of other
patients and, therefore, avoid them. They sometimes explain that old people
are like children, always fighting and complaining. In general most residents
who come into an institution are old women with little or no school, camp,
work or army experience to help them adjust to regimentation. They are not
predisposed to initiating conflicts with others. However, as a result of
observing the complaining and other sometimes irritating behaviors of residents,
they often come to internalize the view that old people or inmates in general
are childish and deserve to be treated like children (Bennett, 1963), p. 124).
The adoption of this point of view attests to one change in self-concept
resulting from institutionalization. It reflects a type of onslaught upon
the self brought about by the "demotion in the age-grading system" which is
often associated with life in total institutions (Goffman, 1960).

As Kahana (mimeo, undated) noted, "the importance of a fit between environ-
mental characteristics and individual needs is explicitly or implicitly
expected to contribute to adjustment." However, the relationship between such
congruence and adjustment has not been systematically studied. Many charac-
teristics may affect the potential for adaptation among residents; similarly
many characteristics of environments may affect the adaptive capacities of
residents. Just what these are, is not known as yet. However some resident characteristics which may affect adaptation will be looked at below.

**Characteristics of residents which may affect adaptation**

In studying predictors of institutional adaptation, Turner and associates (1972) related psychological qualities of the individual to the specific milieu to which he was relocated. Eighty-five elderly persons on waiting lists of three homes for the aged underwent personality assessment three to twelve months prior to admission and again one year post-admission. Those forty-four aged who survived with little or no change and adjusted successfully had active, aggressive, and narcissistic traits. The "tough bird" make it. The "sweet guys" do not. The remaining forty-one, the "vulnerable" group which showed extreme negative change, contained thirteen who died, seven who were ill, and three who refused to be interviewed.

The conformist makes it. The deviant does not. Kahana and Coe (1969) showed that the home for the aged client who conformed to the expectations of the institution was generally well-adjusted. In a pilot study of thirty-three residents in a Jewish home for the aged, these investigators obtained ratings of conformity behavior based on the clients' knowledge and agreements with existing rules. Findings indicate that where there are few formalized, clear and unambiguous rules, the elderly are able to cope. "It may be that in institutions which have few totalistic features and are low on institutional control, conformity may in fact be an indicator of positive mental health" (p. 78). Since little resocialization is necessary in an environment which so closely resembles the previous community setting.

The ex-mental patient adapts pretty well. Dominick et al. (1968) interviewed four groups of nursing home patients, twenty of whom were admitted from general hospitals, twenty from the community and forty from mental...
hospitals. Those admitted from mental hospitals consisted of two groups of twenty each - one group was rated as successfully adjusted, and the other as poorly adjusted. The twenty patients from general hospitals and the community were judged as successfully adjusted. It was found that those well-adjusted, former mental hospital patients, were better adjusted than individuals from either the community or general hospitals. This may have been due to the mental patients' greater familiarity with institutional routine indicating the favorableness of a continuity of prior environment.

The isolate does not make it. He's too desocialized. Bennett (1972) and associates began studying the effects of social isolation on institutional adjustment 17 years ago. In a series of studies they found that old people with a history of social isolation did not adjust well. A simple orientation program would have been enormously helpful for isolates who needed resocializing. But it is possible that the isolate can be helped to adapt if caught in time and subjected to reorientation, resocialization or remotivation programs conducted on admission. Such programs have been found to compensate for desocialization. (Nemeth, 1949; Weiner, 1972; Arje, 1973).

Characteristics of Groups of Residents

The next thing one looks at is how the whole group of residents hangs together. What does it look like with respect to (a) age; (b) sex; (c) ethnicity; (d) physical and mental health and death and (e) presence of isolates.

a) Age - Most research on age composition has been conducted in community housing developments. Rosow (1967) studied a large number of elderly residents of apartment buildings, whose old age concentrations were classed as dense, concentrated, and normal. He found that social integration was associated with residence in buildings of high density of older people, and
that social responsibility to the degree of local concentration of older people was greater among working class than among middle class people. People with varying patterns of social interaction — groups which Rosow named the Isolates, the Sociables, and the Insociables — react to high concentrations of elderly people in their immediate environments with decreased, unchanged, and increased morale, respectively. Similarly, Messer (1967) found that residence in an age-integrated environment appeared to foster relationships between low morale and low level of social interaction, as compared with the absence of a positive relationship between the two in an age-segregated environment.

In some institutional studies where the exposure of the subject to different age densities was experimentally manipulated, however, the results were not favorable to age segregation. Kahana (1967) and Kahana and Kahana (1967) randomly assigned newly admitted elderly patients to standard geriatric, intensive therapeutic, or general adult mental hospital wards. By both cognitive and social standards, those housed in the age-integrated wards improved slightly more after 3 weeks than those in age-segregated wards. In the latter study, only 8% of the wards were aged.

In Lawton's housing study, (1970) applicants preferred or were indifferent to age segregation, while community residents who had not applied for planned housing showed a plurality, but not a majority, favoring age integration. Almost no tenant actively objected to living in an age-segregated environment after being in one for a year, and relatively few would have liked to have children or teenagers there. A sizeable minority, however, would have liked younger adults without children. In one age-integrated site the same
of visiting between older tenants and teenagers of children, and a lopsided limitation of within-building friends named in a sociometric survey to age peers.

b) **Sex** - Picture an old man coming into a place that is 75% female. Aged males constitute a steadily decreasing proportion of all older people as age increase. While there are wide individual differences in the degree to which people move in like-sex or mixed-sex environments, the probability is that most environments consisting of older people will be predominantly feminine unless one makes an active effort to find a male environment. No research has been conducted on this problem. However, this may possibly be related to the high death rate of males on relocation (Blenkner, 1967).

**Ethnic and racial homogeneity.**

Very little research has been conducted on this problem. However one study was conducted indirectly in the course of conducting research in a 200-bed racially heterogeneous, proprietary nursing home. Sources of strain between patients and staff members were studied by Weinstock and Bennett (1969) at the suggestion of the home's consulting psychiatrist. It was his impression that strain resulted largely from staff members' negative attitudes toward caring for the aged. Acting on this assumption, he organized group meetings for nurses to help change their attitudes. On the other hand, it was the impression that staff members' attitudes toward residents were unusually positive despite rather depressing conditions but there was no question about the presence of strain. In order to investigate sources of strain, without straying too much from the original purpose of the study, elderly white and black residents, each group comprising about half of the resident population, were questioned about attitudes toward and mode of
communication with staff members. If strain resulted from negative attitudes toward the aged, it would have been reflected equally by both racial groups and there would have been no difference in adjustment or communication patterns. If, on the other hand, it was the way in which the home's racial composition interacted with its social structure, as was suspected, then the two racial groups would have reacted quite differently.

Differences in reactions and type of communication to nurses were found among white and black patients and indicated that strained interaction between patients and staff members resulted from negative reactions of white patients to the black staff. Strained interaction did not seem to be a function of staff members' negative attitudes toward the aged, since it was reflected mainly in the attitudes of the white group. Black residents felt quite comfortable communicating to black staff members. White patients may have reacted as they did for one or more of the following reasons:

1) Their initially negative reactions toward staff members may have led to retaliation which may have led to greater alienation over time.

2) Black nurses may have been prejudiced in favor of black patients, causing negative reactions among white patients.

3) White patients may have felt stigmatized by being treated as equals of blacks, especially by other blacks in positions of authority.

4) White patients may have been downwardly mobile and resented being welfare recipients, a feeling intensified by being treated by black staff members as inferiors. On the other hand, equality with white persons in a system run by blacks may have accounted for the enthusiasm of black patients.

5) Elderly white persons were confronted with a unique environment which they were unable to adapt due to rigidity brought on by old age and/or
seem to be given greater weight than personal. In Great Britain there is a marked trend to smaller nursing homes having no more than 75 beds, while in the U.S., less than 100 beds is considered economically unfeasible. While the optimum size of a mental hospital has been placed at 200-250 beds in practice State Mental Hospitals tend to number their beds in the thousands.

Straight enumeration of beds may be misleading. Jones and Sidditham (1962) pointed out that a large mental hospital they studied actually consisted of two hospitals, one with a fast turnover, and one with minimal turnover. The present trend towards division in mental hospitals according to geographical intake also indicates that while for administrative purposes a hospital may be large, for therapeutic purposes it may actually consist of a number of smaller hospitals which share certain specialized facilities such as general hospital wards.

Townsend's study indicated the significance of size as a correlate of quality. For the four types of homes compared - work houses, local authority institutions, voluntary, and private homes - the smallest had a tendency to achieve a better quality of care than the largest. (1962). The smallest homes exceeded the largest in numbers of staff, toilet facilities and single and double rooms, and provided more means of occupation and freedom of choice to the residents. To summarize Townsend's findings, he found two principle items which influence quality of care - sponsorship of the institution and its size by number of beds.

As part of a more comprehensive study of the services offered to, and of the characteristics of, patients in eighty nursing homes and homes for the aged in the metropolitan St. Louis area, Beattie and Bullock (1964) used an interviewing schedule to determine whether a home had oriented and organized its services and personnel in a manner capable of adapting to the unique requirements of human beings in their facilities. They found that size and
type of setting were related to their ratings, with the smaller homes receiving a low rank.

Greenwald and Linn (1971) visited twenty-six urban nursing homes and evaluated them in terms of staffing patterns, physical facilities, patient satisfaction, cleanliness, cost, size, and services. After correlating all data, their results favored the nursing homes of smaller size and higher average cost. In disagreement with Beattie's and Bullock's (1964) conclusions Greenwald and Linn (1971) concluded that enlargement of homes does not lead to improved or better quality patient care.

Unfortunately, where it has been so used, size has been confounded with other dimensions, as in studies of nursing homes by Beattie and Bullock, (1964) Anderson, Holmberg and Stone (1967) and Greenwald and Linn (1971). In the first of these studies, small size was associated with an institutional milieu which was, in general, policy - rather than patient-oriented, and with negative staff attitudes. Anderson et al. found size to be positively associated with a structural quality criterion (patients per bathroom) and with staffing quality criterion (variety of staff). Greenwald and Linn found small size associated with high costs. In all cases, small size was confounded with proprietary or nonprofessional ownership and cost per patient day, so that size in and of itself does not emerge as a clearly definable influence.

One matter which should perhaps be noted, is that generally rare services will only be made available when the base is of a sufficient size to justify them. Most services can be conceptualized as having a particular place in a hierarchy of need for services. Only when matters lower in the hierarchy are used to their limit will the demand for less frequently required services become such as to justify providing them. Considerable attention to the
relationship among location, size, services and transferability among services has been paid by McKeown (1954, 1965).

As noted above knowledge of sheer size is uninformative, telling us little about the quality of care. Increasingly there seems to be an attempt to reduce size at the personal level. We have gone from the impersonal orphanage to cottage homes and foster parents, we have divided mental hospitals into separate units according to geographical intake. Neither size alone, nor facilities alone, may be relevant. More crucial to personal functioning may be amount of consistent inter-patient and staff/patient contact, where consistent implies the same others and not a constantly changing group of others. It is possible that indications that small institutions are better than large ones reflects the greater staff/patient contact present (Jones and Sidebotham, 1962; Ullman, 1967; Beattie and Bullock, 1964; Townsend, 1962).

B. Architecture, Spatial Arrangement and Furnishings

Recent work has directed our attention to the impact which the environment can have on the individual (e.g. Pastalan and Carson, 1970; Proshansky, 1970; Low and Funder, 1972; Littleton and Rivington, 1973; Sommer, 1969; and Wolwill and Carson, 1972).

Considerable attention has been paid to increasing safety and reducing architectural barriers. Basically, such work suggests that both internal and external environment must present as few obstacles as possible to the care, self-maintenance, and safety of the individual. Thus, there is legislation intended to reduce fire hazards and an available literature on the appropriate width of corridor, size of doors, height of tables, shape of knobs, etc., all items designed to help the handicapped retain utmost independence. (For thoughtful and exacting specification on nursing home construction see Stotsky, 1970, and Care-of-the-elderly-in-Great-Britain, 1969).
Much of this concern is justified. Our society places a high premium on independence. The major alternative to total independence seems to be total care. Given this, any alteration to the environment which will extend the period of personal independence should be encouraged.

Designing an environment in which the physically disabled -- be they paraplegic, blind, or simply elderly -- can maneuver with minimal help from another person requires an understanding of the functions which remain, and adapting the environment so that these remaining functions can perform a wider variety of tasks. Thus, ramps can replace stairs when climbing steps is no longer possible, and electric outlets can be placed at waist height so that bending is not required. For physical alterations to the environment the more we know about changes related to age and physical deterioration, the easier it should be for us to construct compensatory devices, as either adjuncts to the person or alterations to the environment. It is clear that if we are willing to apply sensibly what we already know (there is no point in having a bathroom large enough for a wheel chair if the door is too narrow or the floor at the entrance is not level), we can provide a barrier-free environment.

While research has indicated that there are also less apparent age-related decrements (in speed of response, perception, hearing temperature adaptation) more attention seems to have been paid to this in industrial settings than in other environments. Only recently has it been pointed out that because of perceptual deterioration some of the elderly may have difficulty distinguishing between risers and treads on stairs, or differentiating walls from floor and ceilings when they are painted the same color. The public needs to be made more aware of laboratory findings and of means of
coping with the problems so uncovered.

Increasingly there is a belief that not only should the environment be barrier-free as far as gross physical impairment is concerned, but that the environment should be designed so that it will induce improved social and psychological functioning -- or at least not prove detrimental in these respects. To that end, suggestions have been made as to the most appropriate internal structure for a hospital (Osmond, 1972). Emphasis being placed on smaller rooms, as opposed to massive spaces, and the reduction of corridors, evidence has been gathered on the type of furniture arrangement most conducive to interaction (e.g., Sommer, 1969; Sommer and Bowyer, 1967). While studies of furniture arrangement provide some indication of how objects in the environment influence personal behavior, they show even more clearly the low status and weak position of the inmate, and the strength, ignorance, and lack of interest in their charges of those on the "therapeutic" team.

Institutions have more than one function. All too often housekeeping appears to be of greater importance than treatment, perhaps because a lack of the former is more noticeable than a lack of the latter. How else can we explain the arrangement of furniture so that housekeeping is facilitated and "appearance" enhanced, although this means that patient interaction is minimized (Sommer, 1969), or the placement of wheelchairs one behind the other such that passage is unimpeded, but conversation among wheelchair occupants is impossible. Probably more important than studies of furniture arrangement are consideration of such matters as providing an informative and non-confusing environment, the need for stimulation, and personal space.

Any person taken out of his home and placed in an institution initially has problems finding his way around. Such problems are frequently more severe among the disturbed and the elderly. The regularity which may make an
institution photogenic, e.g., walls of a uniform shade, all doors the same color, flooring identical throughout, provides few cues for learning location. Multiple cues, however, such as different types of floor covering, wall covering, paint, and even odor, as well as signs, may help the person orient himself more quickly and reduce confusion and disturbance.

The physical aspects of residence may not be as important as the interpersonal -- how people are treated, what they are offered, what hope is held out for them. Architecture can help to foster an environment conducive to satisfactory living, but only people can make sure that this occurs. However as will be seen below it is often difficult to separate physical from interpersonal aspects of the environment.
Spacing: Work done by Lawton and associates (1973) is largely responsible for what we know about spacing of rooms. Lawton, Liebowitz and Charon (1968) matched groups of six severely brain-damaged old people. Six were housed in two traditional multiple-bed rooms and the other six were placed in the same area following conversion of the space into six small single rooms with a directly adjoining common space. This small common space was separated from the main hall by a half-wall. Many hours of direct behavioral observations were made before and after remodeling. There was a gross increase in the number of instances when patients were observed in the areas of the ward beyond the small social space. A further effect was that the hall area surrounding the new, attractive remodeled area appeared to become a behavioral hub for the ward, where previously the only clustering point was the nurses' station at the end of the hall. Apparently, then, these mentally extremely incompetent people were very responsive to environmental changes.

Furnishings: Lawton (1968) notes that in institutions for the elderly, maximum use of common space seems to occur when it is located in the center of activity and when it is furnished with ample seating space. This frequently results in a cluttering of maximum traffic areas and the ignoring of other beautifully planned and furnished but isolated areas, both to the great disgust of management.

In the community, according to Lawton's (1970) study of housing for the elderly, each floor of a housing site had a nicely furnished social room with TV, located at the far end of the hall. The main floor had a similarly furnished, slightly larger, social room which had no TV, but had a clear view of the front door, the lobby, a store and part of the main desk. In ten observation rounds of the building, a total of 13 people were observed in all nine floors' social rooms, while 79 were counted in the main floor room.
C. Psychological climates

Related to size, architecture and spacing are psychosocial climates with regard to (a) degree of institutionality or totality, (b) privacy, (c) dependency, (d) withdrawal, (e) territoriality and (f) friendship formation.

Degree of Institutionality and Totality

Kleemeier (1963) attempted to assess the extent to which a setting was institution-like. He classified them according to three dimensions:

(a) segregate dimension: a continuum at one end of which older people live exclusively among their age groups, and at the other end they are with people of all ages;

(b) institutional dimension: The degree to which an individual must adjust his life to imposed rules, discipline, and means of social control utilized by the administrators, personnel, residents and patients themselves in order to bring about desired behavior patterns;

(c) congregate dimensions: which refers to the group aspects of the setting, not only to the size of the group, but also to the intimacy and privacy it is possible to attain in the setting. In conducting surveys of the aged in various residential facilities, he found that most older people have a generalized negative feeling toward all special settings for the aged.

A totality index, constructed by Bennett (1963) and based on Goffman's conceptualization (1960) lists ten variables to use in determining the totality of long term settings for the aged. The more closely the institution resembles a self-centered community, the higher its rating on totality. A facility which was seen as a temporary residence without regimentation of activities and which permitted freedom and decision making to its clients was considered low on totality.
This index is currently being used in a survey by Davis (1973) which finds a wide spread in degree of totality among nursing homes.

Bennett and Nahemow (1965) report social adjustment criteria are different for the various types of residential facilities for the aged and that differences are related to the degree of totality of the setting. These researchers, using participant observation and interview techniques, studied several institutions to determine the relationships between adjustment and totality. Their findings indicated that nursing homes were generally high in totality, as compared with homes for the aged and other residential settings. As with other institutions which ranked high in totality, e.g. state mental hospitals, adjustment criteria for patients were vague and non-existent.

In a subsequent study, Bennett and Nahemow (1972) selected residential settings because they presumably varied in degree of institutional totality on an index of totality constructed for the research. A mental hospital, nursing home, supervised apartment residence and public housing development with special facilities for the aged, received ratings of extremely high, medium and low totality respectively. The general hypothesis was that social adjustment of new admissions would vary as a function of institutional totality. A subsidiary hypothesis was that isolation and its by-product desocialization would be less important to adjustment in the more total institutions.
housing development tenants. These interviews were obtained with consecutive admissions who were physically and mentally able to complete a series of two to three interviews administered. Data were compared to those collected in earlier studies of the institutional branch of \( \text{a} \), \( \text{a} \), \( \text{a} \), \( \text{a} \).

A curvilinear relation between totality and presence of social adjustment criteria was found. This relation was not anticipated because it seemed logical that in the more total institutions, the rules, regulations, sanctions and adjustment criteria would be very explicit. As it turned out, residential settings with both extremely high and very low totality ratings had in common the fact that adjustment criteria were vague. In both types of settings administrative personnel and residents were unaware of adjustment criteria. In an institution with a rating of middle-range totality, e.g., the apartment residence, adjustment criteria were both present and explicit. In the apartment residence, adjustment criteria were both present and explicit. In the apartment residence, staff members recognized that the institution functioned as a terminal one into which people came to spend the remaining years of their lives. Therefore, they worked at helping them adjust to the institutional setting. In the mental hospital, a setting with a rating of extremely high totality, staff members hoped to discharge patients back to the community despite their advanced age. In the public housing development, a setting with a low totality range little thought was given to the special social needs of the aged and the development did not serve as a community for them. The factor which seemed to determine these results was environmental discordance.

Environmental discordance meant there was too much anonymity and too much heterogeneity to allow for the development of a common culture - e.g., common
values, goals, norms and group solidarity. In such a setting, it might be inferred that someone who was poorly socialized at the outset might be no worse off than someone who was well socialized. In a "concordant" setting which expected more of the resident and which was more cohesive, the unsocialized person would be at more of a disadvantage.

Pincus (1968) presented a "framework for studying institutional environments in homes for the aged" and discussed "a technique for empirically measuring the various dimensions or components of such environments." Pincus defined institutional environment as the psychosocial milieu in which the residents live, as expressed through and/or generated by (a) physical aspects of the setting, including design, location, furnishing, and equipment; (b) rules, regulations, and program which govern daily life; and (c) staff behavior with residents. (p. 207)

Pincus developed the Home for the Aged Description Questionnaire (HDQ) for the purpose of measuring the institutional environment as suggested in his proposed framework. In the HDQ, statements were made describing various aspects of life in the home. Staff in three different homes for the aged acted as participant observers in administering the HDQ. He found four dimensions of institutional environment: (1) public vs. private: the degree to which the resident is able to maintain privacy as he desires; (2) structured vs. unstructured: the extent to which the resident makes decisions, takes initiative or exercises choice; (3) resource sparse vs. resource rich: the degree to which the environment permits the resident to engage in meaningful activities and roles other than that of patient; and (4) isolated vs. integrated: the extent to which the resident is able to interact with the outside community. Pincus (1968) stressed the need to study the relationship of these environmental dimensions
to each other as well as the sources of the resident's satisfaction or dissatisfaction with his environment.

Kahana (undated mimeo) takes Pincus' model one step further and suggests patient traits which would be congruent or discordant with some of the institutional characteristics indicative of totality or institutionality.

Privacy

It is repeatedly pointed out that in our society few persons outside an institution share the type of communal life in which institutional inmates are expected to participate. Recently questions have been raised as to whether inmates should have private rooms. While the suggestion may be true that not all persons grow up enjoying a private room, that in some classes sharing is expected and a room to oneself may be frightening and that those who share rooms prefer doing so. Nevertheless it seems to be clear that individuals need some private space where they will not be intruded upon. There is also evidence that when such space is available it tends to be used in a socially constructive manner (Proshansky, Ittelson and Rivlin, 1970). Possibly, reports (e.g., Nahemow and Bennett, 1968) that residents of nursing homes in contrast to housing projects interact little reflects a lack of private place. Given a private place other areas of the home could become neutral territory, which, according to Durkheim, is an area needed if people are to get to know each other (Proshansky, p. 319). The more total institutions such as nursing homes, mental hospitals and homes for the aged seem to allow few opportunities for the attainment of privacy.

There are a few studies of the effects of room-sharing on the behavior of elderly occupants. Ittelson, et al. (1972) found in a mental hospital, that occupants of single rooms were found to engage in more person-to-person interaction than did occupants of multiple-bed rooms. Private room residents
invited people in for visiting. However, shared rooms were used as if they were private. Therefore, patients in shared rooms interacted less frequently with other because they invited people in less often, say only 1/2 or 1/4 of the time as compared with those in private rooms.

Suggestions for enhancing privacy have been made including (1) opening up space visually to provide a balance for privacy and interaction, (2) balancing of "sociofugal" and "sociopetal" space within a building, (3) arranging tables in dining rooms and (4) using furniture and dividers in two-bed rooms to separate the place of one roommate from that of another.

Lawton (1977) noted that staff attitudes about privacy spill over to residents. A total milieu can be "infected" by the medical model which stresses reduction of privacy by placing small observation windows on all doors and removing locks from all doors. (Actually, observation windows are needed only in intensive care units.)

Lawton (1977) also noted that there is an assumption made in institutions that any kind of task is done better socially than individually. Some tasks such as putting on a play require interdependence. Others, however, are solitary, such as reading or working at a sewing machine.

It might be well to note, however, that privacy in the sense used here of private, personal space is typically lacking in good general hospitals and public schools, places which, as Titmuss (1959) has pointed out, nobody has suggested eliminating, because they have proved to be beneficial. Indeed, in some places communal living is encouraged, and its advantages touted (e.g. a residential although it must be admitted that admission and discharge procedures are somewhat different, and power is differently
Territoriality

Territoriality behavior is also exhibited, Lawton notes (1978), residents guard their "own" places in public rooms of which they are very possessive. Sometimes you get fighting over "squatter's rights," which makes staff members very uncomfortable. However, territorial behavior may be a response to resource-scarcity, memory loss, unpredictable bladder control, etc.

Territorial behavior of schizophrenics was studied in a day room. The most competent patients ranged freely and did not need the security of an area they called their own; the least competent patients also did not exhibit territoriality. Only patients of moderate competence showed territorial behavior.

In another study, DeLong (1967) found that in an old age home even the least competent people exhibited territoriality. However, those with private rooms did not show it. Apparently, where social resources are scarce, fierce territoriality seems to rear its head. Unfortunately, most rooms in homes for the aged have to be shared.

6. Friendship Fostering: According to Lawton (1978), opportunities to develop friendships vary. Studies in institutions indicate that roommates do not become friends, they simply meet to discuss who is to use the room for entertaining at what time. However, a number of studies in community settings have shown that proximity is one of the strongest influences of friendship choices in housing projects for the elderly. Next door neighbors become friends in community housing projects. (Carp, 1966; Friedman, 1966; Simon and Lawton, 1967; Lawton and Simon, 1968)

Doherty (1971) reviewed research conducted since 1940 on social choice behavior, sociometric status and other related variables, and their empirical correlates among and between hospitalized psychiatric patients and staff. While many findings were not consistent across studies, it did appear that frequency of social choice, sociometric status, involvement in a health-oriented
peer group and liking by staff were related to lower levels of pathology. Therefore, long term care institutions might look at their potential for fostering or impeding friendship formation.

Relationship Between Institution and Community

The last set of dimensions to be covered concern the interaction between the institution and the community. This section contains a discussion of (a) location, (b) ownership and (c) regulatory processes.

In the studies of Lieberman (1969), institutional relatedness to the outside community was thought to play a role in patient adjustment. Goffman (1960) and Gelfand (1968) referred to the permeability of the institution. Permeability is the access the community has to the home and the freedom of the resident to maintain his outside contacts. This mutual exchange was found to be significant for the residents' social adjustment. Other factors such as nearness to shopping, transportation, family, physical security, weather and topography have been looked into in relation to the desirability of community housing for the aged but not in relation to institutional housing. (Sherman, et.al, 1969)

Economic considerations are not, of themselves, inappropriate, but they need to be considered with reference to other matters which are relevant to location. Such matters would include present and anticipated prevalence and incidence rates of a particular problem in a particular area, the location of available personnel, and the presence of features to attract and hold such personnel. These features will vary with type of personnel, but could include matters such as the availability of transportation, presence of adequate childcare facilities, and access to continued sources of education and advancement of knowledge.

If either prevalence or incidence is high it is feasible for an institution
to be located close to the source of need, whereas if it is low the institution cannot help but be far from some persons in need of its services. Other matters may override considerations of incidence and prevalence in determining location. Such matters would include the presence of necessary or desired supporting facilities (e.g., water, electricity, local rehabilitation units and sheltered workshops) and the influence of prevailing theories of treatment, e.g., locating TB sanatoria in the Alps, and placing prisons away from human habitation. There the location itself becomes the major part of the treatment.

The relationship between institutional location and the inmates' original home may have implications for length of stay in the institution for "temporary" residents. As distance between the two locations increases, and when transportation becomes a problem because of scarcity, cost or time factors, the number of visitors and the frequency of visits declines (Brown, 1960; Townsend, 1962) contact with pre-institutional life diminishes, length of stay in the institutions can be expected to increase, and the way is set for institutionalization.

While the effect of institutional location on the staff does not appear to have been examined, we might well expect that the more interested and knowledgeable professionals will be less inclined to go to a remote area, or if they go, to stay, unless some special provision is made which takes their interests into account.

Frequently, the physical location of a particular institution is more a matter of the ready availability of a building, than of planned construction, or of lack of objection to a particular site than of particular site selection for therapeutic reasons. Thus, large country homes whose upkeep becomes too expensive are offered for sale as appropriate for use as homes for the aged, or as schools; army hospitals turned over to the public after the war see service
again as mental hospitals; and rehabilitation facilities for the delinquent and
hostels for ex-mental patients must locate away from therapeutically valuable
residential areas because of the protests of the inhabitants. In such cases,
the major consideration is not so much one of what is best for the intended
recipient of services, but what is economically provident for the donor, and
least disturbing to society.

Pattern of Ownership

Related to location and economics is pattern of ownership. Usually homes
are owned by other institutions in the community. An institution is rarely
an entity completely isolated from either other institutions, or from the
community. The relationship it holds to other institutions and to the community
may be either formal or informal. Examples of formal relationships would be
institutions primarily responsible to, and regulated and funded by, a common
State or Regional Board. Depending on governmental arrangements these institu-
tions could be designed to offer services ranging from the identical (e.g. state
mental hospitals), to those which are barely overlapping. Such an arrangement
may have certain marked administrative advantages. For instance, the governing
body may be in a stronger position to obtain funds, to impose higher standards
of care, and to institute certain useful procedures, such as a central registry.

To determine the implications of nursing home ownership on patient care,
Holmberg and Anderson (1968) analyzed data obtained by interviewing administrators
of proprietary and non-proprietary homes. The interview schedule covered all
aspects of nursing home operation, including staff, costs, programs, and patient
characteristics. Findings indicate many similarities between the two types of
institutions. Although quality of care was not dependent upon ownership, such
factors as training, philosophical orientation, and experience of staff seem
institutions. Thus, a patient may be discharged to an apparently suitable placement. If that placement turns out to be undesirable the original institution can help the ex-patient, if asked, but it may have no power, beyond that of non-referral, to improve the undesirable condition.

Earlier we made some mention of the relationship between an institution and a particular environment. The location which may be most beneficial to the inmates of an institution may be the place where they are most welcome. Certain members of the population, particularly those judged to be criminal or mentally ill, tend to be shunned. Few people willingly seek to live beside mental institutions and prisons. This, however, does not hold for all institutions. As Titmuss (1959) has pointed out, there is no move against good institutions such as schools and general hospitals. Indeed, certain institutions may be welcomed as an asset to a community, and these might include not only places of learning, and general and chronic disease hospitals, but also, and particularly in areas interested in attracting the elderly, good extended care facilities, nursing homes, and homes for the aged. With appropriate high standards of care and suitable concern by the community, institution and community should be mutually beneficial.

Unless there is some clear way of assessing relative need, and distributing goods and services appropriately and equitable, conflict may well arise between the institution and the community or money administratively joined units. While they may not be detrimental to the institution which may feel particularly aggrieved Jones and Sidebotham (1961) suggest that the smooth internal functioning of a mental hospital they studied was attributable to just such external problems. Conflict of this nature is more likely to be destructive than constructive. The central administration, be it of a group of institutions or of a single institution, must be sensitive to the needs of the units and the community it is supposed to serve.
Regulatory Processes and Measures of Overall Quality

The community impinges on the institution in still another way. It often sets the standards and guidelines for operating the institution.

With an increasing proliferation of different types of institutions we must begin to be concerned about appropriate standards for each institution, and the relationships among institutions. Thus, Stotsky (1970) has pointed out that, although nursing homes had no mandate to care for the mentally ill, in fact they have done this, and done it creditably. He has also pointed out some of the problems which arise when nursing homes are turned into more profitable extended care facilities, and the nursing home inmates transferred elsewhere where the level of care is poorer. Dressler (1971) has pointed out that there are no standards of care for the ill aged in extended care facilities. A variety of organizations, consumer agencies, institutions and private persons have issued guidelines and standards. They are ANHA (1971), Brecher and Brecher for Consumer Reports (Jan. 1964; Feb. 1964), Larson (1969), AMA (1966), ANHA (1968), Townsend of the Nader Committee (1971) and the Senate Special Subcommittee on Aging (1971).

Braverman's (1970) study reviewed the nursing home licensure standards of 50 states and the District of Columbia in the spring and summer of 1969. He categorized the standards under administrative, patient care, environmental health, and fire safety/construction as required by Federal Medicare and State licensure programs. No attempt was made to learn if standards were maintained.

Shaughnessy and associates (1968), using a sample of 1/4 patients in two nursing homes, identified nursing problems and formulated models of care for individuals and groups of patients. This survey gave evidence of the need for additional study of patient care in nursing homes. McKnight's (1970) nursing
home study attempted to provide data for use in proposing guidelines for minimal staffing requirements for nursing homes. Most nursing personnel staffing patterns follow the traditional ones established in acute care settings. None of these studies-correlated guidelines with what happens in actual practice.

Considerable attention has been focused recently on nursing home and extended care facility quality and performance as a result both of federal standard-setting and campaigns such as those mounted by Ralph Nader's Center for the Study of Responsive Law. This year the White House ordered an upgrading of all extended care facilities under the threat of withdrawing federal reimbursement.

According to Reader (1972)

"The Medicare Act gave great impetus to the development of nursing homes, and at the same time changed the concept and standards of what a nursing home should be. Because organized medicine had waged a long and arduous campaign to prevent any social legislation from emerging from the deliberations of the Congress, the lawmakers who framed the 1965 amendments to the Social Security Act had little help from the medical profession. They therefore proceeded to develop many of the concepts on their own. Title 18 of Medicare defined an extended care facility as including provisions for 24 hour nursing service, a nursing care plan based on personalized needs of individual patients, and proper dietary and medical supervision. Patients were to be admitted only after a three-day stay in a hospital, where presumably they would be properly studied and diagnosed. The intent was to reduce the overall length of hospital stay and provide for a convalescent period under supervision and at a reduced cost compared with the hospital. The legislators conceived of an elderly patient falling ill, entering the acute hospital, convalescing in the extended care facility, and then returning home to receive services from an accredited home health agency. This, of course, completely neglected the relatively large part of the elderly population who are chronically ill and require long-term institutional care. Nevertheless, there was a rush on the part of nursing home proprietors, and would-be proprietors, to establish eligibility for their institutions as extended care facilities. Many in government were surprised to discover that only about 740 of
the 13,000 nursing homes in operation in 1965 could meet the standards of the Act. By 1970 there were 4,656 extended care facilities, of which only 1,274 were in full compliance, and 3,382 in substantial compliance. Nursing homes have continued to be built, and it is estimated currently that there are 30,000 beds under construction in New York State alone. Whether these will be able to meet standards remains to be seen."

Overall Quality Measures

Setting of standards assumes that overall quality is able to be assessed. At this time, this seems to be a tall order. Nonetheless efforts have been made to do so and to correlate measures of quality with other dimensions of institutional care.

Townsend (1962) surveyed 173 institutions for the aged in England and Wales and developed a measure of institutional quality by taking into account factors related to the physical facilities; staffing and services; means of occupation; freedom in daily life; and social provisions. According to his scale Townsend found that all the old workhouses and nearly 60% of the postwar local authority-sponsored homes, plus approximately one-fifth of the voluntary and two-fifths of the private homes scored so low as to be rated 'poor', 'very poor', or 'bad'. More than 40% of the voluntary, almost a quarter of the private, and a small proportion of local authority homes, received a rating of 'good' or 'very good'.

In Townsend's survey, the voluntary homes were the most favorably rated for having better physical facilities and more adequate staffing ratios as well as permitting more freedom of choice to the individual resident.

Linn (1966) constructed a nursing home rating scale covering the broad areas of patient care, administration, staffing, and physical facilities. The scale, suggested as a check list for favorable characteristics of a good home
or as a method of comparing one home with another, required a personal inspection of the home and an interview with the nursing home administrator. The 56 Floridian homes which were scored on the Linn nursing home rating scale, differed the most on staffing patterns and in training of the nursing home operator. Although the scale could be applicable to homes in other areas of the country, the results obtained would vary according to state licensing requirements and community economics.

Overall quality has not been measured directly in relation to impact on residents though Slover's (1972) study of relocated mental patients begins to get at this problem.

Services and Programs

Communities can regulate the services offered in institutions in order to improve overall quality. At the moment, according to Gottesman (1970), nursing homes differ greatly in the scope of services provided, with many supplying basic and medical rehabilitative services and neglecting psycho-social needs. According to Gottesman, the characteristics of the home itself, of its residents, its staff, the public it serves, and its administrator strongly influence the services available. Of these, he saw the selection and training of the administrator as being the "most critical" factor, since the administrator is responsible for introducing psycho-social services.

In an attempt to identify administrative, patient, home and economic characteristics attributable to homes providing various kinds of rehabilitative services and programs, Stone (1969) interviewed administrators of 116 homes in Minnesota. Information was obtained on the above characteristics as well as on the services offered, i.e., medical, volunteer, and activity programs. Stone
concluded that clients are not always matched to homes providing services needed by them and suggested that patients be classified according to their need for medical and psycho-social rehabilitative services, volunteer services and activity programs. Patients could then be matched with facilities providing the required services.

In a recent survey of nursing homes and homes for the aged in New York City, Schwartz (1972) studied one aspect of services - recreation. Of a sample of 101 nursing homes and sixty-four homes for the aged, forty-nine nursing homes responded to a questionnaire. He found that nursing homes were less concerned with the provision of recreation services than homes for the aged and that the religious sponsored facilities usually had better records in the delivery of recreation services in residential settings.

Efforts to change institutions and their overall quality have been made by the introduction of new services. In recent years, without much prior knowledge, but assuming they are critical, many efforts have been directed at changing services, as well as psychosocial climates. Here is but a partial list of such new psychosocial services: intensive treatment milieu therapy (Richman, 1969), sensory training (Richman, 1949), reality orientation (Oberleder, 1968), use of parent-child relationship (Rosen, 1968), crisis therapy (Oberleder, 1968), dance therapy (Siegel, 1968), the buddy system (Kosbab and Kosbab, 1962), social clubs (Smith, Tonge and Hersky, 1965), race (Weiner, 1972), and remotivation (Arje, 1973).

Other efforts, including continuing education programs, were directed at educating institution staffs (Stetsky, 1967a).

Still other programs have been aimed at altering total environments by
developing meaningful roles (Rosenblatt and Taviss, 1965), manipulating physical structures of wards (Lawton, 1968), setting up work programs (Gottesman, 1965), setting up crisis-laden milieus to strengthen egos (Cumming and Cumming, 1963), and structuring graduated activity programs (Margulies, 1968).

Most of these programs that have been evaluated have reported success. Unfortunately, by and large, these are grant-supported programs which are discontinued when the money runs out. Obviously long-term changes cannot be brought about by short-term programs. (Cf. Section on Institutional Change below).

Clearly what is required is a sober assessment of the needs of patients, the characteristics of institutions and the proper fit or congruence between the two (Kahana, mimeo, undated). This is not possible without a sober look at the impact of institutions on individuals.

Impact of Institutionalization

There has been a considerable outcry about the detrimental effects of institutional life. Goffman's (1962) descriptions are perhaps the best known, but the publications of others (e.g., Barton, 1959; Lieberman, 1969) have helped to make clear the deleterious effects of mass custodial care in poor institutions. Descriptions of the personalities of residents who have been subjected to such living conditions have been summarized by Lieberman, Prock and Tobin (1963). Countering these dire findings on the influence of environment are suggestions that at times the patient may manipulate the environment (e.g. Praginsky, Praginsky and Ping, 1969).

Additional work has been done by Lieberman and his associates on what it means to become an institutionalized person (1963) and the effects of institutionalization on the aged. (1968; 1969). (Lieberman, 1969)

How elderly individuals view themselves and their social environments
during and after transition from life in the community to residence in a home for the aged was explored by Lieberman and Lakin (1963). Basic data, consisting of clinical impressions, case histories and interviews, were obtained prior to admission and three to five months following entrance to the institution. The meaning of institutional life varied by sex: males saw it as a loss of power, while females interpreted it to mean that they were rejected or unwanted (1963).

As noted above, Bennett (1963;1964) wrote that institutional life and living has various meanings for the aged residents in such institutions, for the personnel in these facilities, and for society at large. Bennett described four meanings of institutional life: (a) societal - which views long term facilities as terminal residences for the aged; (b) sociological - institutions are social systems which expect various modes of adaptations from their inmates; (c) meaning for staff - staff see themselves as caretakers for a group of powerless clients in need of services, and (d) resident's meaning of institutional life - passive recipients of actions imposed on them by staff. The residents eventually respond to the expectations of institutional life and accept the roles assigned to them by personnel.

After observing activities in many hospitals in the United States, Brown (1961) wrote on the harmful effects of the hospitalization process on patients whose stay in such institutions was short term in contrast to the prolonged stay referred to by Goffman (1960). Brown wrote that although it had not yet been empirically validated, it was widely assumed that the recovery of patients subjected to the psycho-social deprivation of the hospital environment, was hindered and made longer. Referring to
some of the well-known routine procedures accompanying hospitalization, Brown noted that to place patients in situations where their independence, self-respect, and privacy are needlessly violated is non-therapeutic.

While the evils of impersonal custodial care have been well-documented for some time, experimental investigation leading to a better understanding of these phenomena, and a reduction of some of the problems, is fairly new. Thus it has only recently been recognized that certain personality changes may occur before institutionalization. People on waiting lists for old age homes were found to have a personality pattern more similar to that of successful (i.e., surviving) inmates, than to matched others in the community (Lieberman, Próck and Tobin, 1968). Perhaps people with certain personalities are more likely to apply for entry into a Home; perhaps certain precipitants emphasize certain personality patterns.

There is little to suggest that, in general, living in an institution has a beneficial effect on the individual. Possible exceptions would include those who, because of economic problems, lead a marginal existence in the community. There are indications that those who survive in institutions, and adapt best, have personalities congruent with the practices of the institutions in which they reside and do not exhibit symptoms which the institution cannot handle (Turner, Tobin and Lieberman, 1972; Stotsky, 1970; Weinstock and Bennett, 1971). These personality factors do not necessarily make for good interpersonal relations with other inmates, and are probably mal-adaptive outside the institution.

We should, perhaps, question why institutions, even those which are probably 'good' by institutional standards, are set up to require behavior
which is maladaptive under normal circumstances, and which may hinder the running
of the institution. Why is there an emphasis on aggressiveness, a playing down
of helpful interpersonal relationships, and a discouragement of actions poten-
tially useful to the running of the institution and the well-being of the in-
mates? We know that there is no one particular institutional climate. Dominick
(in Stotsky, 1970) states that nursing homes intended for different ethnic
groups differed widely in climate. It should therefore be possible to intro-
duce a style which is in closer agreement with what is culturally acceptable
in the broader community. This should facilitate transfer from one institu-
tion to another, and reduce the distinction between institutional and com-
munity residence.

All adaptation and change need not be detrimental. There is evidence
that cognitive functioning can improve after entry into a home, although this
improvement may not continue. Entry into an institution, and transfer from
one institution to another has frequently been reported to be dangerous, re-
sulting in a higher death rate within a short time of transfer (e.g. Aldrich and

Aside from institutions which may be specifically used as places to
die (Mearson, 1970), and institutions which are so negligent that they should
not be permitted to exist (Townsend, 1971), recent reports questions the ne-
cessity for such deaths or, for that matter, whether they do, in fact, occur
(Kasl, 1972; Baer and Gaitz, 1971; Goldfarb, 1971). There are indications
that certain persons are at greater risk, e.g., the depressed, the psychotic,
the severely brain-damaged, the field dependent, males institutionalized at
a comparatively early age (Jasmin, 1967; Marcus, Blenker, Bloom and
There are also indications that when personal desires are taken into consideration, and careful, individualized help, information and counseling are given, transfer need not result in an increased death rate or a poorer level of personal functioning (Jasnar, 1967; Lentz and Paul, 1971; Ogren and Linn, 1971). In fact, if the move is at the client's behest, or is to a physically preferable setting, length of life may be increased, and deaths diminished (Ogren and Linn, 1971).

The detrimental effects of institutional life can also be mitigated with appropriate environmental alteration, and by adequate training of staff. Thus, Wing and Brown (1970) report an improvement among long-stay schizophrenics who participated more in activities in the institution, and for whom the environment became less restrictive, and Stotsky (1970) reports a decrease in the death rate of inmates when nursing home staffs were given further education and support. This decreased death rate persisted even after the educational intervention ceased.

Given the large number of studies on institutionalization or relocation impact, it seemed a good idea to classify them to see if any consistent findings turned up. They were classified according to a combination of variables including type of sample studied, institution of destination, and whether or not there was a control group. The following four classes of study were derived which may or may not prove useful:

1. Mass or intra-institution relocation studies.
2. Institutionalization studies.
3. Re-location or post-discharge studies.
4. Alternatives-to-institutionalization studies.
1. **Mass or Intra-Institution Relocation Studies:**

Mass relocation studies refer to those conducted on a group of unselected patients or residents who are moved en masse within a single institution or from an old building to a newer one, usually studied without a control group to which to compare them. The pioneering studies of Knight Aldrich and associates (1963; 1964) probably were the first of this kind conducted on the aged. Their findings showed that more elderly patients died upon relocation than had been true in the past, as indicated by death rate statistics. After checking on their health status in records, relocation deaths were attributed to neurotic personality traits such as rigidity and dependency, traits which are typically found in any group of inmates and which seem to render them incapable of adapting to change. Similar studies of what came to be called relocation stress were conducted by Blenkner (1967) as well as others, who found other traits to be related to relocation impact; for example, more men than women died on relocation. By stretching the classification scheme a bit, Tobin's (1972) study may be classified both as a mass relocation study and as an institutionalization study. It is like a mass relocation study when he looks at waiting list people as if they are institutionalized already in order to contrast them to a community group. Those waiting list persons and institutional inmates show signs of deterioration if they also are passive, dependent types, a finding in line with those of Aldrich referred to earlier. Mass relocation studies of which there are many and which are reviewed in some detail in Marlowe's paper (1972) tend to lead to pessimism about the relationship between relocation and stress. As has been noted by Lawton and Yaffe (1970) most mass relocations described in research are involuntary and the voluntary or involuntary nature of relocation may be crucial in determining outcome.
According to Slover (1972) and Marlowe (1972) positive or negative quality of the institutions into which discharged patients are relocated have positive or negative impacts on sensitive or responsive persons.

Tobin's (1972) study is unique in terms of design because he observed a community sample which seems comparable to the waiting list and institutionalized groups. By so doing, he was able to learn that waiting list persons are more like institutionalized persons than like community persons. Thus, he calls attention to the possible adverse effects of identifying oneself or being identified as a candidate for institutionalization. Perhaps, such persons suffer from stigmatization.

Some institutionalization studies, as noted earlier, have reported no change or improvement on institutionalization on some measures. For example, Nancy Anderson (1964) found that institutionalization had no effect on those admitted to an institution as compared to waiting list persons. A study by Lieberman, Prock and Tobin (1968) showed some positive as well as negative effects of institutionalization. Findings of a study by Weinstock and Bennett (1971) showed higher scores on tests of cognitive performance in all categories of residents as compared to waiting list persons with waiting list persons showing improvements on tests after admission, which former newcomers' and oldtimers' scores tapered off.

Effects of quality of institution is an issue raised by the studies included in this class. Institutionalization into a good place may cause improvements; institutionalization into a bad place may cause deterioration. We will have to begin to assess quality of institutions in order to determine the extent to which it makes a difference upon relocation.
3. Re-relocation or Post-discharge Studies:

Related to studies of institutionalization by design, that is, by whether or not there is a control group but not identical are re-relocation studies. These studies are of about-to-be-discharged inmates, contrasting those who are detained in an institution with those who are discharged. In general, this type of study comes up with findings which cause us to be optimistic about re-location as Marlowe (1972) notes in her paper's review of the literature section, that is, until she conducted the study on which the paper reports.

Stotsky (1967a; 1967b) was concerned with whether or not the nursing home is an appropriate community resource for discharged mental patients. He compared a group of patients discharged to nursing homes with a group regarded as candidates for placement in nursing homes but who remained in the hospital. He found that for the two groups of patients, short term changes favored those in the nursing homes. For long term changes, results were less straightforward.

The papers by Slover (1972) and Marlowe (1972) fall into the class of re-relocation studies. Slover, like Stotsky, found no short-term deterioration in relocated patients, who remained the same as controls. However, long-term effects of relocation were decidedly negative and non-therapeutic, though non-lethal in Slover's study. Slover carried his study further than Stotsky did. He looked at how quality of the institution into which inmates were placed affected outcome and found that warm, humane, independence-fostering environments are related to positive outcomes. Slover's and Marlowe's lists of environmental dimensions constitute a mandate to conduct large-scale surveys of institutional quality.
Findings similar to those of Slover and Stotsky were obtained by Sainsbury (1969) in England. His findings showed that the mentally ill aged at home were neither better nor worse off than those in hospitals. In fact, an important finding of Sainbury's study was that elderly patients who returned to their homes were not a burden to their families as had been feared.

On the other hand, Marlowe's findings give us cause for pessimism in that re-relocated inmates were worse off than the control group and did have a high mortality rate as compared with earlier hospital rates and the control group rate.

Generalizations based on re-relocation studies probably cannot be made to studies of other types. Re-relocation studies have been conducted on mental hospital inmates who have been relocated at least once before, from the community into the hospital; conceivably, most had been relocated several times before discharge. Therefore, those who have survived may be the hardiest of such patients, their weaker counterparts probably died upon initial institutionalization. Therefore, Marlowe's findings that this assumedly hardy group of re-relocated patients do badly are distressing, especially in light of earlier studies discussed earlier, in which re-relocated mental patients do no worse than their counterparts in hospital. However, before getting too pessimistic, her findings suggest we look into a number of prior relocations experienced by mental patients, as well as quality of their destinations.

4. Alternatives-to-Institutionalization Studies:

It can be asserted with some degree of confidence that there is no research comparing an institutional group in need of long term care with an identical group being maintained by an equivalent alternative in the community.
Probably, such a study would be easier to do in England where there are many alternatives such as geriatric clinics in mental and general hospitals (Whitehead, 1965; Barton and Whitehead, 1968), psycho-geriatric hostels (Jones, 1948), day hospitals (Frocklehurst, 1970) and hospital-run home care programs (Hoenig and Hamilton, 1967). According to Jerome Kaplan (1972) in a recent editorial in *The Gerontologist* there are no real alternatives to institutionalization of care in the United States. Therefore, it seem premature to condemn institutionalization.

The only study which may be put into this class by stretching it considerably is one done by Nahemow and Bennett (1968) in New York comparing non-randomly assigned, probably non-comparable new admissions to a nursing home, geriatric ward of a mental hospital, home for aged, supervised apartment residence for the elderly and public housing project with apartments designated for the aged. The findings indicated a linear relationship between presence of isolates in an institution and attitudinal dependency. Nursing home patients were worst off, then followed mental hospital patients, then home for the aged patients, then apartment residence persons, with public housing tenants best off.

Needless to say, in order to determine which type of institutional or treatment program is most ameliorative and which is most destructive, random assignment of samples is necessary. However, as we all know, few if any general hospitals or other referred agencies are willing to assign patients on a random basis to long-term treatment programs though they gladly randomly assign for drug experiments. As of now, there seems no way to get around the problem.
The socialized countries have solved many of the problems of organization and financing, but the profusion of types of geriatric institutions in the United States is an expression of a free enterprise, pluralistic society that allows for such innovation and experimentation.

When we consider how change occurs in an institution we can look at it from two points of view -- from that involved in the broader perspective of national trends which may lead to general pressures for change in a particular direction, or we may examine it from the narrower perspective of how certain particular circumstances create pressures resulting in change. We will look first at the latter, before turning to the more general case.

Change in an institution is not always planned, for it frequently appears that change occurs in response to a variety of pressures which may not be under the direct control of the institution. Thus, we learn that funding procedures strongly influence the intake and discharge rate at a V.A. hospital (Kennard, 1957; Ullman, 1957) inmate census being tied more closely to maximizing hospital income than to treatment needs of patients. Similarly, there have been suggestions that when an institution receives a larger payment for the care of a bedridden patient than for one who is mobile, fewer attempts to improve the status of the bedridden patient will be made since, if successful, this will mean a reduction in income to the institution. Here a basis for remuneration which may appear to be quite reasonable may induce inferior and detrimental care. It is quite possible that given a different basis for funding, such as cash reward for improving self-care status were such improvement is possible, quite different results would be obtained.

Imitation appears to be another potent avenue of change. At times an
investigation will show that certain alterations will result in a significant improvement in relevant areas at a marked saving in cost.

For instance, it has been shown that when long stay mental patients who had worked as a group for their common discharge continued to live as a group afterwards, length of time outside the hospital increased greatly, and cost to the hospital was much reduced (Fairweather, et.al., 1969). This procedure was copied and adapted by other agencies, even when the original program could no longer obtain funding. The spread of new practices, such as milieu therapy, may in part work the same way.

Closely akin to such copying is the pressure which different hospitals, or different groups in a hospital can exert on each other. If a hospital is set up such that certain sections become partially autonomous, as occurs when a mental hospital is divided into units which each serve a different geographical region of the total catchment area, competition among units to see which can achieve certain standards may arise. Such competition may result in non-complying units coming closer into line. In one hospital, for instance, the discharge rate in one unit was well below that in the others. When this was recognised the tardy unit quickly improved its performance (Jarrahizadeh, 1971).

Occasionally new information obtained as a result of an emergency situation results in a change in operation. It was just such a situation, in this case a strike of hospital employees, which led authorities at the Bronx Municipal Hospital (Clurman, 1972) to realize that many of their mental patient inmates could function adequately outside the hospital, and which eventually led to the introduction of a community clinic to prevent undue hospitalization. What perhaps differentiates these authorities from others is their willingness
to recognize a serendipitous finding, and an openness of approach which did not assume that the pre-emergency way of doing things was the best.

Any situation which prevents a usual form of management must result in change of some kind if the organization is to continue. Depending on outlook and facilities this change may improve or worsen an inmate's position. Thus, when there are staff shortages various forms of coping are possible -- inmates may either be regimented so that at least their basic wants can be efficiently attended to, or some inmates could be trained to help themselves and each other, so permitting skilled personnel to concentrate on the more disabled. One approach potentially has a detrimental effect, the other a beneficial. The manner of coping which is finally selected will probably be closely related to the attitude held regarding the abilities of inmates.

Certain new findings, in particular pharmacological, seem to be readily accepted, perhaps because they fit in well with the medical treatment model, perhaps because they make the patient more amenable. Other advances or changes in thinking which are passed on through formal instruction generally take longer before they have a practical impact. Unless the person with the new knowledge is in a position of authority, and has sufficient power to enforce the desired new approaches, any change will be gradual for those with the more recent information will generally be in a minority and have a weaker position than others operating under the old scheme who are already established in the institution.

These are but some of the continuous ongoing factors inducing changes in our institutions. Other factors, operating on a larger scale, are also at work, and particularly at present. Thus, in the past twenty years there has been a remarkable increase in nursing home and other care facilities for the
elderly. This increase has frequently been attributed to the availability, through the Social Security Administration, Federal Housing Administration, Small Business Administration, the Kerr-Mills Act, and most recently Medicare, of funds for these purposes (Stotsky, 1970; Townsend, 1971). This increase in provision of facilities has so far carried with it little enforcement of standards from either relevant financing sources, or from the major "professional" organization involved (Townsend, 1971; American Nursing Homes Association, 1971). Indeed, where standards of personal care are concerned, more attention has been focussed on the physical plant, especially with respect to fire-prevention, than to determining and enforcing appropriate standards of health care such as the proportion of trained staff from different disciplines for given numbers and types of residents, or worrying about personal considerations such as the optimal number of residents from the residents' point of view, whether they should have single rooms or sleep on wards, have their own furniture or not, control their environment or be controlled by it.

Dismay with some of the terrible conditions present in many facilities has led to protests, exposes and court cases (Henry, 1953; Townsend, 1971).

The present situation closely parallels that present in late eighteenth century England which led to mental hospital reform. According to Jones (1955) three factors were relevant at that time -- exposés of the terrible conditions present in private madhouses, the affliction of Charles III, and an apparent increase in insanity among prominent educated members of society. We are presently undergoing our exposés of institutions, we have no parallel to an individual as visible as the king, but we do have an increasing older population
which because of sheer numbers alone is becoming increasingly evident. In addition, just as the English had the Retreat at York as an example of how to treat the mentally disturbed, and used this as a model for their new asylums, we have an increasing body of information based on research which can be used as a basis for designing appropriate facilities for those of our aged population who wish, or need, to avail themselves of such resources.

In addition the elderly are now the repository of our most common unconquered diseases (e.g., cardiovascular disease, cancer). Consequently those who wish medical science to progress must pay attention to this group.

Pressure resulting from exposes, an increase in the number of elderly requiring services (and hopefully an increased selectivity on their part), and interest on the part of established and respected medical sciences should ultimately result in an upgrading of the services offered to the elderly, extend the variety of services, and improve the professional calibre of those tending the elderly. These, in turn, will enhance each other so that eventually, while we may still disagree as to the most appropriate way of treating the elderly (e.g., Home or home) we can be assured that the medical, and hopefully also the psychological, aspects of care will be beneficial rather than detrimental.

Change, per se, is not necessarily good. If we wish to determine which changes are desirable some means of evaluation is required. We will pay some attention to this here, and consider some of the issues which must be taken into account when evaluating change. These issues will center around the institutionalized person, the treatment program, the listed personnel and the outcome.
In evaluating the institutionalized person we need to examine closely the relation among social, physical, psychological and psychiatric factors in reaching a diagnosis and deciding on a plan of treatment.

Careful attention must be paid to the timing of the initial diagnostic evaluation. Entry into an institution can be an exceedingly disturbing experience, especially when the individual has not been helpfully prepared beforehand. An evaluation at this time may not be an accurate assessment of level of functioning. We need to determine both the factors which led to and resulted in institutionalization, and the pre-disturbance level of functioning. Only then can an appropriate diagnosis and treatment program be formulated.

Where the institution is specifically intended to be a permanent residence, as in the case of a home for the aged, concentration on improving the level of adjustment within the institution may be justified. However, where the institution is officially a temporary residence, e.g., a mental hospital or a hospital for chronic diseases, such limitation is not desirable, and may be self-defeating.

In evaluating treatment programs in institutions it is necessary to consider not only impact on the target population, but also impact on the institution and on the assigned personnel.

The type of inmate selected for treatment and the basis for selection are important. With chronic back ward patients almost any kind of intervention appears to be beneficial. The very presence of an experimental program may have a beneficial effect on non-participant controls (Greenblatt, York and Brown, 1955).
The treatment program itself represents a special situation. Also, apart from the generally atheoretic approach of hospital programs for the aged and their limited scope, the hospital-bound quality of such programs limits them to improved hospital care, and fails to provide the patient with sufficient support following discharge.

Adaptation to the treatment program may be different from adaptation to the hospital situation on the whole. Patients may require specialized approaches prior to full entry into the treatment program and then upon discharge from the hospital.

Certain properties of treatment program personnel have been found to be relevant to outcome. Such variables as amount (or lack) of training, whether volunteer or professional, age, and sex have been found to be relevant to patient outcome and change. Rappaport, Chinsky and Cowen (1971) have surveyed relevant studies which have used volunteer help. If only intramural staff are involved the question arises as to whether all are capable of functioning in the manner desired by the program, or whether only the more flexible persons, those superior in some way, are selected. In the latter case it is essential to determine whether adequate controls have been taken, such as by rotating personnel through both experimental and control units (e.g., Fairweather, et.al.)

Further considerations relevant here are attitude to the program and to those responsible for it. The institution, or relevant members in it, may perceive the program to be threatening, and, by non-cooperation, require any alteration in the treatment design (e.g., Rappaport, Chinsky and Cowen, 1971), or even its elimination.
In trying to evaluate the effects of the program on the individual for whom it is intended it is necessary to take into consideration who is doing the evaluating, and what are the variables being measured. If the same person makes both pre- and post-treatment evaluations he may try to justify his initial diagnosis, or he may be moved by his biases concerning the treatment program. If these evaluations are made by different persons it is necessary to ensure that they used the same criteria.

The variables measured by the investigation in the new treatment situation will be limiting factors in evaluating the effectiveness of the program. The relevancy of the dependent variables and the scope of the measurement cannot be too carefully conceptualized, and often only field studies generating empirical data can supply significant leads. Thus changes in health have occurred with psychologically oriented treatment programs and more rapid hospital discharge. As indicated earlier, the relevance of the interaction among physiological, psychological, psychiatric and social factors in the adaptation of the aged must be considered. In addition, the limitation of one set of factors on the other should be recognized. Persons with irreversible physical defects will have a limited repertoire of behavioral change. Perceptual or cognitive loss may affect self-care and physical state as well as interpersonal behavior. The use of a sliding scale to evaluate change in individuals with certain types of deficits might well be a worthwhile, novel approach, thus broadening the sample to be treated and studied.

Just as it is possible to set up criteria for assessing change in the individual who has been treated, it is also possible to set up criteria for
the success or failure of the program itself. Assessments need to be made not only when the treatment program is in force, but also after the program has been withdrawn, or, if the program involves an intended manipulation of the environment as in milieu therapy, after the change has become routine. There is some evidence which indicates that when active treatment ceases the situation may return to its original state (Visher and O'Sullivan, 1970). If a treatment program is supposed to have some partially permanent effect (at least), then its effects must be self-sustaining to some extent.

The reports of innovations in treatment appear to come more often from mental hospitals than from other residences for the elderly. The reasons for this may be innumerable and themselves require investigation. They may range from a lack of investigative staff, lack of interest in studying the elderly, discouragement about the possibility of change and a lack of goals. After all, a mental hospital, as Bennett and Nahemow (1965) have pointed out, is officially a temporary residence, while homes for the aged are permanent. Since one emphasis of a mental hospital should be on discharge, the mental hospital may well be prepared to try alternative methods of treatment which might facilitate discharge. Homes for the elderly (including nursing homes, which should not, but may be seen as final stations) do not have this impetus. They are seen as the final resting place of the living, and until they aim at some optimum level of functioning for their residents their incentive to try new methods to help them increase their effectiveness will be absent.

Suggestions for what the appropriate functioning of residents should be have been made, in particular by Townsend (1962). Reaction to the reported detrimental effects of a restrictive environment and custodial care suggests
that at the interpersonal level each person needs to be helped to maintain himself as far as possible as a responsible individual. Since institutions require that numbers of persons live together these persons should be encouraged to aid and support each other. At the administrative level, since the institution ostensibly exists for the support of its residents, those residents should be encouraged to voice their opinions, have a hand in running the institution, and be responsible for their suggestions and action in this regard (Harel and Kahana (1972) describe one such institution: This, of course, means elimination of purely custodial care, and a re-orientation of staff attitudes, for the residents would no longer be the powerless base of the staff/patient heirarchy.

There are sufficient reports, mainly from mental hospitals, on the effects of various adaptations of milieu therapy and group involvement, which indicate that, when patients in a group are responsible for each other's behavior this responsibility is used appropriately and can result in a functional improvement of members of the group. If the group stays together this improvement may continue outside the institution (e.g., Fairweather et al., 1969).

It has been very forcibly argued that "...few, if any, persons are ever "on their own" that we are all dependant on people, that we are sustained and shaped through the support of our family, friends, coworkers, and, indeed, through the social networks and associations in which we are located." (Iennard, Epstein and Rosenthal, 1972 p.883) While made in the context of espousing group involvement and support over the methadone approach in treating drug addiction it is noteworthy that similar interpersonal methods have been successfully used with other problems (e.g., alcoholism, obesity), and that they lie at the base of the early "moral treatment".
There are no grounds for thinking that older persons become irresponsible on entering an institution. They need to be encouraged to continue appropriate actions they carried out as members of the larger community, and they can probably be best helped to do this in a general context of interpersonal responsibility.

**Conclusions**

Some conclusions probably are called for. First, it must be said that no one set of dimensions of institutional life can be deemed as more important than any other at the moment in studying impact on behavior. Many environmental dimensions which are possibly implicated in affecting patient behavior were discussed after a discussion of the long term care facility as a social system. The dimensions went under the subheadings of (1) Institutional ecology, (2) The relationship between the institution and the community, (3) The process of relocation and (4) Potential for institutional change. Large scale surveys of institutions are needed to determine which of these dimensions are important for achieving the goals of long-term care and for assisting the elderly.

It is important to stress the belief that stems from work with and research on the elderly which is that in comparison to any other group, the aged are as sensitive if not more sensitive to their environment. Rendered vulnerable by poor physical condition, continual crisis, prejudice and isolation, the aged are easily victimized by uncongenial environments. Therefore, a major task for researchers is to carefully evaluate environments in order to determine how they best can be used to support the aged. And, a major task for practitioners is to provide the environmental supports needed by the elderly to replace those which have fallen away from them. The aged, at any level of competence, will respond.

- The END -
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