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Institutions in Modern Society: Caretakers and Subjects

The training, retraining, and rehabilitation of people in urban, industrial California—a view of the future?

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Only some 30 years ago California was known as a haven for elderly, retired persons, as a sunny and pleasant locale in which to vacation, and as an agricultural region abounding with broad expanses of colorful orange groves. It was known, of course, for Hollywood. In 1940, the population of the state was estimated at 6,907,387 (*1*, table BK-1, p. 9).

In 1969 California was on the verge of becoming the nation's most populous state, with an estimated 19,834,000 persons. During this same year, overall urbanization in California was 86.4 percent, second only to New Jersey (99.6 percent); and within its boundaries there had developed the nation's second largest manufacturing complex (*1*, p. vii), the largest being that of New York.

The three interrelated processes of population growth, urbanization, and industrialization have tended to bring about changes in the overall organization of the institutions of the state, including those that deal with education, social welfare, mental and physical health, and incarceration. As in other states, subsystems have evolved out of California's institutions. Through these subsystems, the state has become involved in the training of youth, the problems of unemployment, and the care of dependents, the blind, the disabled, the ill, and the incarcerated. The formal institutions involved in these activities represent efforts to achieve certain ends that have been designated as either desirable or necessary by the legislature and the courts. Within their respective institutional structures, all of these functions are claimed to be generally oriented toward the philosophy, if not the practice, of rehabilitation, in the broadest sense of the term. In short the major purpose of these institutions is to engage in processes and programs that lead toward the entry or the reentry of citizens into the "productive sector" of society.

In an urbanized, industrialized, and still-growing state such as California, how extensive are these efforts on the part of the aforementioned institutions? During a defined period of time, how many people are under institutional care or control in one form or another? What questions arise with respect to current trends? And what are the implications for the future of our society and for the assignment of priorities?

Institutional Reports

The most complete data available on the number of citizens involved in the state's institutions of education, social welfare, health, and penology (either in the capacity of employee or recipient of services) are the annual reports issued by the institutions concerned. However, such reports do not contain information on overlap of functions and rates of recidivism. Thus, the most sensible approach to assessing the total number of people involved in such state activities is to form an estimate for any given day, thereby minimizing overlap and recidivism. With this in mind, one may ask how many people are either employed by these institutions or in their care during any given day in 1969, the most recent year for which data are available.

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For the institutions in question, the average daily census and the 1-day census comprise the best sources of information. Such information is available for public schools (kindergarten through grade 12); private schools licensed by the state (kindergarten through grade 12); adult and children's programs in social welfare; the mentally ill under institutional care; youth authority wards, camps, ranches, homes, and correctional schools, as well as juvenile halls; county and city jails; and the hospitals and their related facilities. Similarly information is available regarding the number of employees engaged in institutional activities in the state for any given day during 1969.

The Institutionalized

Whenever individuals come under the care of the institutions of education, social welfare, health, and penology, they undergo a change in civil status, a change that tends to regulate their behavior. For example, the young who attend public schools do so under mandate of law; failure to attend school normally results in state or local action to enforce attendance. In much the same manner, people who become recipients of social welfare undergo a change in civil status, as do patients in hospitals and those who are incarcerated, on parole, or on probation.

In addition to legal sanctions, informal restrictions come into play once a citizen comes under the care of one of these institutions. The individual, then, must live under a set of taboos and restrictions that normally do not characterize a "free" civil status. The taboos and restrictions of institutions go beyond simple behavioral and interpersonal rites of passage, since they are set forth and legitimized by legal means that control the individual's ingress and egress, and they may be brought into play the moment that the student, the indigent, the sick, or the criminal transgress the prescriptions that accrue to their status as institutional beings.

Toward an Assessment

People who are involved in the major institutions outlined above fall into two broad categories. First, there are the caretakers, those who are in charge of, and administer, the various programs and services. Second, there are the subjects, those who are under direct institutional care and control in one form or another. It must be emphasized once again that, in all cases in which individuals become subjects of caretaking, the transfer is accomplished under specific legal processes that control entry into or release from institutional care. The same does not pertain to other aspects of society, in which entry, tenure, and withdrawal are not accomplished by the same legal processes and sanctions.

With this in mind, an assessment of the total number of people under institutional care in California on an average day during 1969 exceeds 7 million (Table 1). This assessment is based on 1-day census figures and the average daily census for the hospital population. Certain problems arise because of the possibility of overlapping caseloads (for example, when a child is simultaneously a charge of a school and receiving welfare assistance). In such cases, individuals are counted twice. At the present time, there are no data that would compensate for this overlap. However, it seems that whatever overlap may exist is compensated for when the yearly totals in the categories listed in Table 1 are taken into account. For example, while the adult felon population numbers 102,042 for a 1-day census, during 1969 there were 198,157 adult felony arrests. In the same manner, the average daily census for hospitals was 103,468. During the same year, however, inpatient hospital admissions totaled 2,827,501. Thus, the estimate for a 1-day population of institutionalized people is, in all probability, a minimal figure in the total for the year.

Table 1. The subject population in California (an assessment based on a 1-day census in 1969 by corresponding institutions).

Institution	Subjects (No.)
Law enforcement	
Adult felons (*3*, table I-11, p. 37)	
Prisons	23,018
Parole	13,027
Adult probation (*3*, p. 124)	102,042
City and county jails (*3*, table I-13, p. 41)	27,918
Youth authority wards (*3*, table XI-1, p. 182; table XI-2, p. 183)	
Detention	5,908
Parole	14,778
Juvenile probation, active (*3*, table X-3, p. 156)	94,724
Juvenile hall (*3*, table X-13, p. 174; *4*)	4,182
Total	285,597
Social welfare	
Cash grant (*5*)	1,540,571
Certified, medical assistance only (*5*)	212,593
General home relief (*5*)	83,012
Total	1,836,176
Hospitals	
Mentally ill (*6*)	
Resident and on visit	16,116
Extramural care	5,406
Mentally retarded (*6*)	
Resident and on visit	12,545
Extramural care	11,591
Tuberculosis* (*7*)	232
General, long-term, other special* (*7*)	6,491
General, short-term, other special* (*7*)	51,087
Total	103,468
Schools	
Kindergarten through grade 12	
Public (*8*, table 37, p. 64)	4,645,000
Nonpublic (*8*, table 46, p. 71)	407,800
Total	5,052,800

* Average daily census.

Institutional care, of course, requires staff and administration. For the categories outlined in Table 1, there is a corresponding group of caretakers. Table 2 is an assessment of the caretaker population required to fill this need. When the caretaker population (647,988) and the subject population (7,278,041) are added together, the total number of people involved in the aforementioned institutions in 1969 approaches 8 million (7,926,029). In addition, the figures available for the caretaker personnel pertain primarily to the professional levels, therefore excluding such auxiliary personnel as secretaries, janitors, cooks, and the like.

The significance of the institutional population for any given day in 1969 is highlighted by comparing it to the civilian labor force as itemized for the state for the month of June 1969 (Table 3).

Discussion

The scope of institutional involvement in California suggests questions and problem areas the ramifications of which are yet to be fully explored or understood. What, for example, are the long-range trends? What are the long-range prospects? Certainly other states are experiencing similar developments. Do they parallel the California experience? For the present, some problem areas that seem most salient with respect to urban-industrial life concern social control and social institutions, social mobility, organizational behavior, minority peoples, and the extension into the community of institutions that had previously been limited by geography.

Institutional Care and Control

Once established by legislative and legal means, social control of all subject populations becomes a function of the rules and regulations that govern the admission, release, and status of subjects. However, social control does not end at the boundaries of legal sanctions, for extralegal standards and norms of behavior often come into play as means by which social control may be exerted informally, not only between the caretakers and the subjects, but within each group as well. Examples of extralegal social control may include standards of dress (reflecting status to a high degree), personal grooming rules (controlling the dress of students in public schools), punishment or ridicule of children for speaking Spanish on a schoolground (or for speaking English with a Spanish rather than a domestic accent), taboos on sex practices while a patient in a hospital, a contrite demeanor before officers or judges, and a host of other, similarly informal means by which behavior may be regulated.

Social Mobility and the Caretakers

The concept of social mobility has been closely allied to the belief that, through a variety of means, individuals will strive toward a higher level in the economic and class structure. Once that goal has been achieved, certain changes in personal, familial, and intergenerational life-styles are said to follow. This concept has been widely used to explain the emergence of the American middle class. However, it does not, as such, apply to the ever-increasing number of people who have entered, are entering, or are preparing to enter society as members of the caretaker population. Judging from the present enrollment in colleges and universities, the majority of people who are working toward entry into the caretaker population are already members of the middle class. Given the relatively low social status and economic potential of caretaking, it is clear that becoming a caretaker does not automatically constitute an elevation in class. It seems that the personal and societal forces that influence those who strive to become caretakers differ somewhat from those forces that guide others to become socially mobile.

While caretakers may differ in this respect from members of other sectors of society, they tend to hold a general philosophy of training and rehabilitation, no matter what their particular institutional affiliation. Although the specifics of that philosophy may differ from agency to agency, the common, primary concern is for the entry (or the return) of the subject population into the nonsubject, or "productive," sector of society. When viewed in this perspective, caretakers can be seen as responsible not only for the general institutional welfare of the subject population, but also as gatekeepers for society at large. The control of deviation, however that deviation may be defined, thus becomes their prime programmatic, operational, and bureaucratic concern.

Table 2. The caretaker population (1969).

Institution	Number
Corrections (*9*, p. 22)	22,242
Public welfare (*9*, p. 21)	29,842
Police protection (*9*, p. 21)	51,114
Public schools (*9*, p. 19)	315,165
Hospitals (*7*)	212,125
Private schools (*8*, table 54, p. 77)	17,500
Total	647,988

Caretakers and Subject Organizations

In addition to managing the organizational bureaucracy of schools, hospitals, and welfare and penal systems, the caretaker population has organized itself relatively well into professional groups based on various fields of specialization. Thus, there have been developed organizations for administrators, educators, school counselors, psychologists, nurses, and technicians, as well as associations of police and law enforcement, and auxiliary personnel. For the most part, these are voluntary aggregates, composed of people who have come together because of mutual professional interests, parallel purposes, and common projected goals. Members of the subject population, however, have been noteworthy for their lack of organization. This has been so, in all probability, because of the status of the subject, who has traditionally been viewed as a transient. Recently, however, there have been indications of change in this traditional difference between caretakers and subjects. Some sectors of the subject population are beginning to exhibit organized behavior. For example, student organizations in secondary schools are now addressing themselves to the status of the student per se, and to the question of student input areas previously reserved for caretakers. The largest such effort has been on the part of Los Angeles Chicanos (Mexican-Americans), whose school walkouts spread beyond the borders of California and resulted in reforms in school curriculums and in educational procedures dealing with testing and bilingual education.

Other segments of the subject population have launched efforts directed at health, education, and welfare. Indeed, recipients of welfare have demonstrated, as local groups, an organized interest in the administration of local welfare programs. People are banding together to form welfare rights groups. In addition, increasing numbers of local poverty groups are orienting their efforts toward community-determined health centers and even a community-based definition of mental health. In much the same vein, prisoners, as well as the recently released, are participating in such organized activities as Synanon, the Seven Step Foundation, EMPLEO (El Mexicano Preparado Listo Educado y Organizado), and other emerging ex-convict organizations.

Thus far, the caretaker organizations have not addressed themselves in any substantial degree to the needs expressed by the organized subject population.

Table 3. The civilian labor force and employment (June 1969) (*1*, table C-1, p. 19).

Employment	Civilians employed (No.)
Agriculture, forestries, fisheries	359,000
Mineral extraction	33,000
Construction	380,000
Manufacturing	1,678,000
Transportation, utilities	484,000
Trade	1,687,000
Finance, insurance, real estate	406,000
Services	1,612,000
Government	1,413,000
Total employed	8,052,000
Total civilian labor force	8,440,000

The Question of Minorities

According to the 1960 census, there were in California 1,426,538 persons with a Spanish surname, as well as 883,861 Negroes, 157,317 Japanese, 95,600 Chinese, 65,459 Filipinos, and 39,014 American Indians. These minor-

ities comprised 16.9 percent of the total population. The number of minority peoples has undoubtedly increased in the intervening years. For example, although no data are available for 1969, recent reports indicate that some 3,140,000 Californians have Spanish surnames, of whom 2,980,000 (14.9 percent of the total population) are Chicanos (*2*). It is estimated that the combined minority groups now approach 25 percent of the state's total population.

The members of these groups, with some possible exceptions, comprise but a very small fraction of the caretaker population, while their representation in the subject population is relatively high. This condition has been a source of friction in the past. To a great degree, the subject-oriented organizations tend to cleave primarily along ethnic lines.

Extensions of the Institutions

People do not necessarily have to be physically placed within the geographical boundaries of an institution in order to undergo a change in civil status and come under institutional care. On the contrary, with current trends toward "outpatient" philosophies, it is more and more common to find individuals who are under institutional regulations living in the community. Examples include adults and juveniles on parole or probation, patients on leave from a hospital, mental patients released to the community but not medically released, the aged under some forms of care, children under foster care, those under some forms of welfare, and students on vacation from school. Similarly, overcrowding in hospitals, jails, camps, juvenile halls, and the like often result in more releases to the community.

With institutions that are geographically bounded and to which people must go or be taken under various conditions, there seem inherent social and economic limitations to the construction of buildings. However, there are no such limitations under the philosophy of community release and the outpatient system. Thus, potentially at least, institutional influence and control become increasingly less limited by geographic boundaries and facilities. Under the outpatient philosophy, therefore, institutional care and status can become a more integral part of everyday community life.

Conclusions

The problems that relate to the outermost limits of institutional care, if such limits exist, will certainly be among the most salient problems during the coming years—no matter whether such care proceeds on an inpatient or an outpatient basis. Whatever course may be taken will certainly affect the lives of every citizen in urbanized and industrialized society. At present in California there is considerable shifting of individuals from one care status or category to another, in efforts to find accommodations that will better reflect the realities of modern existence. However, such shifting of caseloads as the moving of individuals from nursing and convalescent homes to hospitals and back again does not constitute a change, either from the standpoint of the subjects involved or from the standpoint of significantly affecting the overall caseload. Most commonly, the shifting of caseloads has been merely jurisdictional. Much the same can be said of the transfers from a police agency to welfare, or vice versa. Similarly, a shift from inpatient status to outpatient status does not constitute a significant change. Such transfers from one jurisdiction to another reflect a reduction in caseload for one agency, but a corresponding increase in caseload for another. Thus, there has been no significant change in the subject population as such.

Jurisdictional transfers are often merely caretaking actions that reflect bureaucratic decisions. Equally often, such decisions do not address themselves to the basic priorities that guide the functions of caretaking. Explicitly stated priorities must supersede jurisditional transfers if the concept of caretaking is to include better resources for human development and if the subject population is to participate in the managing of institutions.

On any given day during 1969 in the state of California, virtually 8 million people from an estimated population of 19,800,000 were under some form of institutional care or in some institutional program, or were employed to provide the care and administer the programs. Clearly this is a vast effort toward the training and retraining, as well as the rehabilitation of people, in the traditional sense of these words. The salient problems that have emerged from this context of urban and industrial development involve social control, social mobility, organizational behavior by caretakers and subjects, minority peoples, and the extensions of institutions into communities. Given these developments, is it not proper to ask whether or not the nature of urbanized and industrialized society has changed to such a point that a return to the past (and past solutions) is no longer feasible? Is it not also proper to ask what voice the subject population will have in helping to guide the urban and industrialized state into the future? And certainly there is a question that virtually everyone will ask: What percentage of tax revenues (whether shared or under direct programs) shall be destined to better meet the problems of this future society, which, it seems, is already upon us?

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