RESEARCH ARTICLE

Study on the Medialistic orientation, behavior of hospital and mental health treatment

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Abstract

This research uncovers the practical consequences of liberalizing legal reform in the mental health system for the staff of a large public psychiatric hospital. The examined reform grants psychiatric inpatients more rights to determine their own compliance with mental health treatment. Two dominant schemas that are currently used to understand the hospital's working culture are examined in light of the role of ward staff. A new paradigm, the "ward control outlook," is developed to reflect the unique responsibilities of the staff and the daily challenges they face on the wards. This model predicts that staff in a mental hospital will behave less like rights advocates or psychiatrists and more like patrolling police officers whose primary job is to enforce rules. Ethnographic research took place in one mental hospital in the United study finds that the behavior of hospital staff on the wards conforms to the expectations of the new ward control model. Hospital staff valued the enforcement of rules and the maintenance of order as part of their daily work on the wards, and liberalizing legal reform was seen as a threat to the ability of the staff to perform their jobs effectively. The mandates of the reform conflicted with what the staff perceived as the most effective way to deal with problems on the wards. This created a frustrating situation of workplace anomie that staff relieved by endowing with increased social importance the coercive measures of control still available to them.

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–Ken Kesey, One Flew Over the Cuckoo's Nest

"The conjecture that saw the birth of reform is not...that of a new sensibility, but that of another policy with regard to illegalities."

–Michel Foucault, Discipline and Punish:

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I. Introduction

Ken Kesey's celebrated novel One Flew Over the Cuckoo's Nest was published in 1962 at the beginning of an extended period of legal reform aimed at providing mental patients with more rights in and influence over their own psychiatric treatment. Kesey's novel is set on the ward of an American psychiatric hospital in the 1950's and follows the involuntary commitment of an energetic Irishman named R.P. McMurphey. While it becomes clear that McMurphey is not actually mentally ill, he is eventually forced into invasive psychiatric procedures including Electroconvulsive Therapy (ECT) and a lobotomy. These "treatments" ultimately cripple and dehumanize Kesey's hero. The novel not only dramatized the nature of the psychiatric treatment of the previous era, but also indicated the start of a shift toward increasing the power of mental patients to make decisions concerning their own care in a mental health setting.

The patients' rights movement of this new period represented a change from one conception of mental health treatment to another. The formerly dominant notion of psychiatric care, characterized as a "medicalist orientation," gave doctors and psychiatrists a large amount of discretionary power to commit patients and treat them as needed, with or without their consent (Fennell 104). This approach has given way to a kind of "new legalism" that not only intends to protect against unjustified commitment or medication, but carries with it an "ideology of entitlement" that bestows patients with positive rights to determine their own care and treatment (Fennell 105).

Much of this legal reform is intended to give patients rights to equalize the power that psychiatrists hold over them. However, simply bestowing rights on committed patients may not be sufficient to correct the imbalance of power in the mental health system. In attempting to equalize the sometimes-coercive interaction between a patient and his or her doctor, the new lawmaking ignores another influential and yet unexamined relationship on the wards of a mental hospital: the relationship between a patient and the ward staff. Ward staff spend a significant amount more time dealing with patients under the constraints of the new legal reforms than do the doctors at the hospital, and they arguably have the most influence over the day-to-day running of the wards. In the face of reform that overlooks the status and activities of ward staff, it is possible that the practices of ward staff might blunt or directly contradict the impact of patients' rights reform.

This research utilizes an ethnographic research design to explore whether rights-oriented reform has unintended consequences on the ground for the staff who work with patients on the wards of mental hospitals every day. To investigate this question, research was conducted at a large public psychiatric hospital. The field data gathered included observations of the wards and interviews with a number of professionals in the mental health system. This research uses sociological inquiry to predict and identify the mechanisms by which ward staff carry out (or fail to carry out) liberalizing reform in an institution such as an inpatient psychiatric hospital.

The ward life depicted in One Flew Over the Cuckoo's Nest dramatized the limited amount of decision-making power afforded to patients in the mental health system in the 1950's. As the 1960's approached, the problems of Cuckoo's era psychiatric care became a matter of public, legal, and academic concern that were eventually addressed through legal reform. A 1967 article from the Columbia Law Review, for example, reports that prior legislation in New York was structured such that psychiatric inpatient admissions often happened hastily, with poor information, and without consulting the patient for additional insight (Columbia 674). In another example, a 1976 report from the Michigan Law Review focused on the use and regulation of ECT (Electroconvulsive Therapy), a form of treatment for some mental disorders that resulted in uncomfortable and sometimes harmful side- effects for patients. The Michigan report on ECT emphasized the need to adopt a review panel that would regulate the administration of electroconvulsive treatments, observing that it is unjust to endow psychiatrists with complete power over a patient's treatment, as their judgments are often subjective and can risk forcing "intrusive treatments" on unwilling but possibly competent patients (Michigan 390).

By 1979, the Yale Law Journal could note that the judicial system had begun to question the amount of unilateral power doctors would be able to hold when it came to the treatment plans of mental patients, and was exploring the amount of protection available to such patients (Yale 850). Such legal reform attempted to provide patients with more rights in their own treatment and focused mainly on the role of doctors and psychiatrists in the treatment of patients on the wards of a hospital. Such reform was aimed at equalizing the doctor-patient relationship, which was seen as coercive and disadvantageous to the patient (Michigan 385). The areas of mental health treatment that were addressed by patients' rights-oriented reform included requiring informed consent before administering mental health treatment and medication, increasing outpatient

care services, and eliminating indefinite periods of hospital commitment. While the rights of patients who had voluntarily sought treatment at a hospital received a significant amount of attention, there has also been a great deal of legal wrangling over the procedure of involuntary commitment, as well as the rights of patients who undergo such a commitment.

Right now, every state in the U.S. as well as the District of Columbia has some form of an involuntary civil commitment law (Stavis). "Involuntary civil commitment" is defined as "a legal procedure used to compel an individual to receive inpatient treatment for a mental health disorder against his or her will" ("Involuntary Hospitalization"). While the exact policies and timetables vary by state, the power of the government to involuntarily detain a person in a mental hospital is most often justified on the grounds that civil commitment procedures prevent the committed person from harming him or herself or others, whether intentionally or unintentionally (Dworkin 294).

Just as previous legal reform increased the rights of voluntary mental patients, a general trend of increasing the rights of involuntary patients has been observed. Unlike laws dealing with voluntarily committed patients, however, the area of involuntary civil commitment has been a particularly sensitive one for patients' rights advocates. Whereas voluntary patients want to receive some kind of help for their illness, involuntary patients have shown no such initiative and assumedly do not want any kind of medication.

Many of the more recent changes to this legislation have focused on modernizing involuntary civil commitment procedures. One such act is the District of Columbia Mental Health Civil Commitment Modernization Act of 2004, which modified the existing law governing civil commitment of involuntary patients in D.C. This revision is now commonly known as the Ervin Act (Title 21, D.C. Code §501-592). Among the changes made by this reform were an elimination of indeterminate periods of commitment by limiting commitments to one year, and greater emphasis on treating patients in the least restrictive setting possible (Library of Congress). Prior to Ervin Act reform, D.C. also saw mental health legislation that drastically limited the use of involuntary physical and chemical restraints on patients who were involuntarily committed to the hospital.

In a public statement in support of the new legislation, D.C. Delegate Eleanor Holmes Norton argued that these reforms were important in order to "reinvigorate the rights of people with mental illness" and "modernize the way mental health services in the District of Columbia are delivered" (Library of Congress). A house report on the act asserted that the lawmaking was needed in order to "increase the involvement of [patients] in their treatment and recovery process" (THOMAS). Other laws providing increased protection of patients' rights in D.C. were supported alongside the Department of Mental Health's promise that these new reforms would "provide patients with the right to complain and be heard" ("DMH Initiates..."). Similar legislation in California, the Lanterman-Petris-Short Act, set goals of "protecting mentally disordered persons...from criminal acts" and "safeguarding individual rights" (California Welfare and Institutions Code §5000).

Rights-oriented reform such as this has had a number of positive outcomes for both the patient and for the community. Looking at D.C. in particular, a March 2005 speech by a representative of the Department of Mental Health (DMH)—an entity created by the reform—spoke of a number of the department's accomplishments in the face of this reform:

[DMH succeeded in] creating Care Coordination and the Access HelpLine, a whole new accountability system, and opportunities for agencies to provide community mental health services. [We also expanded] housing opportunities and services to persons who are homeless, add[ed] new [patients'] rights requirements, moderniz[ed] commitment statutes, creat[ed] a new grievance system and contract[ed] with an external advocacy organization to advocate on behalf of [patients] ("Testimony").

Additionally, patients' advocates would tell you that these legal changes have reduced the number of observable rights violations on the wards (Erin, Zoe, Kate, Claire).

Although this sounds positive, the fact remains that the role played by hospital staff on the wards in the successful execution of patients' rights legislation remains relatively unexamined. Thus far, while reports explore aspects of the conservative social control power held by psychiatrists or the community-based ideals of the reformers (Steadman 263), sociological and legal literature lack a critical look into the role that staff play in the implementation of legal reform within the public mental hospital.

Literature review

There exist two ideal types that can serve as yardsticks in predicting the outcomes of patients' rights legislation in the above areas of working life at the hospital: the new legalistic outlook of reformers and the medicalistic outlook of doctors. These outlooks are named after Fennell's two orientations toward mental health legislation (104-5). It should be noted that these outlooks function simultaneously on the two distinct levels of the practical and the theoretical. The practical level of the outlook attempts to capture the phenomenological aspect of the legislation, focusing on the way in which reforms are experienced by staff. On a theoretical level, the outlooks function as paradigms in social science, helping to increase the understanding of a larger system or trend.

The New Legalistic Outlook

According to this outlook, the hospital environment is seen through a more community-oriented lens. This stance is reflected in the written forms of the new legal reforms, which allows inpatient hospitalization only if it is the "least restrictive form of treatment available" for a person who is found to be at risk of harming himself or others.15 In cases where a doctor wants to involuntarily

commit a patient, the law requires a series of legal hearings in which the hospital must prove that the patient needs to remain in the hospital. Under this view, the hospital should only keep a patient in the hospital until they are stable enough to receive services as an outpatient in the community.

According to the mandates of new legalism, the hospital staff are responsible for administering a basic level of care without violating the informed consent of the patient. While hospital staff retain discretion in emergency situations, the majority of control over treatment shifts to the patient. The role of reform in this setting is patient-oriented, and ensures that patients have the right to be involved with and consent to their own treatment. The new legalistic view does not seem to consider how such reform might impact on the job of the hospital staff.

The Medicalistic Outlook

In this view, a large degree of power is granted to psychiatrists and medical science to determine the best course of treatment for a given patient, which in this schema is often chemical (Yale 854). The role of the doctors in this outlook is synonymous with almost complete control over most aspects of a patient's care, including the ability to change or eliminate medical records (Yale 855). Often, the ability of the doctor to determine treatment remains intact, even when the doctor is unable to perform an unbiased evaluation (Michigan 390).

Hospital staff serve as instruments of the doctors' power. In fact, the control that staff are able to exercise on the wards is limited by preference of the doctors, who are viewed as having the ability to control and manipulate staff (Yale 855). Reform in such a setting would focus on bringing the power dynamic between the doctor and the patient to a more equal level (Michigan 385).

A New Model: The Ward Control Outlook

Note that neither the new legalistic nor the medicalistic viewpoint directly applies to the unique relationship between patients and hospital staff. The new legalistic view celebrates the community- and patient- focused goals of legal reform rather than the reality on the wards, and could be criticized for its idealism. Meanwhile, the medicalistic outlook describes the power of psychiatrists and doctors—both of whom are more highly trained, better paid, and more distant from the daily realities on the wards than are the staff. Furthermore, medicalism assumes that the hospital staff comply with the instructions of the doctor. Neither view truly captures the day-to-day, face-to-face reality of social control on the hospital wards.

To remedy the shortcomings of these outlooks, I propose a third schema that more accurately represents the dynamic of working life in the mental hospital: the ward control outlook. This outlook is based not on legal expectations of human rights nor on notions of medical power, therapy, nor anything relatively clinical as might be expected. Rather, it is founded on theories of police patrolling behavior. It might seem strange to suggest that employees in a therapeutic setting such as a psychiatric hospital behave in ways similar to police officers on patrol. However, there is sociological literature and ethnographic evidence to suggest that this might be an effective comparison. My approach in testing this model focuses on the practical level of the ward control outlook—the way in which reform is experienced and interpreted by staff—in the hopes of using practical-level findings to develop a theoretical paradigm that can contribute to a larger body of sociological analysis.

The ward control outlook considers power and interaction in the hospital from the perspective of the staff members, whose job requires the enforcement of rules and the maintenance of control. In order to meet the demands of their jobs, staff seek to retain a wide scope of discretionary power when it comes to the treatment of patients on the wards of the hospital. The role of the ward staff under my ward control outlook is similar to what Howard Becker called a "rule enforcer" (156). As rule enforcers, it is the responsibility of the staff to see that protocol is followed and order is maintained on the wards, and they would be provided a large amount of discretion to discharge this duty (Becker 159). The inability to use such discretion in enforcing these rules is directly threatening to the enforcer's sense of purpose (Becker 161). Leonard Pearlin conducted a study along these lines called "Sources of Resistance to Change in a Mental Hospital," in which he found that ward hospital staff are very resistant to changes in policies and procedures on the wards, particularly in cases when such change makes it more difficult to do their jobs (November 1962: 325). As a result, hospital staff become entrenched in their preexisting procedures and norms (Dowdall 91).

Given that the ward control outlook views staff discretion as centrally important in the discharge of daily duties, it follows that staff would need this discretion in order to preserve control over the wards and maintain their decision-making autonomy (Turner 138). This perception of staff power on the wards is very similar to the function of discretionary power in policing literature. In his study on police discretionary behavior, James Q. Wilson compared mental hospital staff to patrolling police officers, for whom occupational discretion also plays a large role (1968: 410-11). Egon Bittner's study of police behavior on skid-row is particularly relevant to staff behavior in mental hospitals. Bittner's description of skid row is strikingly similar to an acute ward in a psychiatric hospital, as both are full of people who seem unable to live a normal life and are presumed to be incompetent by enforcers (October 1967: 705). Bittner predicts that the result of such an environment would lead staff to be consistently aware of the threat of violence (Bittner October 1967: 706).

Liberalizing legal reform under this schema could be seen as a threat to the staff's ability to maintain and use discretion in their day-today interactions with patients on the wards. A loss of discretion would correspond to a loss of control over an already chaotic environment. Reform in an institution is an example of an occupational uncertainty

(Burawoy 79) that would create what Bryan Turner calls a "dual system of authority" (156). Under this dual system, there would be a conflict between the governing laws and the methods employed by ward workers, resulting in a "fractured" environment (Turner 156). The splitting nature of this environment can lead to feelings of frustration and powerlessness (Townsend 178), or increased work for staff. The response to this situation, according to Bittner, could be an increased exercise of coercive control for the purpose of regaining order (October 1967: 713).

In 1957, Robert K. Merton wrote about the kind of institutional instability that patients' rights reform could create by using the language of Durkheim's "anomie." Anomie represents a feeling of normlessness created when "the technically most effective procedure, whether culturally legitimate or not, becomes typically preferred to institutionally prescribed conduct" (Merton 135). Workers attempt to minimize the strain of anomie by resorting to "innovation" in situations where the institutionally proscribed means of achieving a goal—for example, the specific restrictions detailed in the legal reform—are less effective than a non-proscribed means, which could be any number of approaches including physical or chemical coercion (Merton 141). Merton calls these "control mechanisms" (180-1).

According to Anselm Strauss, any employee is capable of breaking the rules and turning to these control mechanisms to cope with a situation of workplace anomie (395). The necessary stimulus for breaking the legally proscribed rules in this case could be the series of legal reforms that took away some degree of discretion or convenience for the staff, thus creating a challenge for maintaining order and fulfilling duties on the wards. The question that must be answered by this research is whether or not the reform created such an anomic situation, and if so, whether such a situation engendered rule-breaking or rule-bending innovation on the part of the staff. If it did, an examination of the consequences of this reform can improve the way in which similar lawmaking is implemented in the future.

Hypothesis and predictions

Can such a model attempting to predict the behavior of employees in a psychiatric hospital be accurate when it is based largely on theories describing the attitudes and responses of police officers who deal with trouble-makers and criminals? And if my ward control model of staff working culture proves to be valid, how this schema predict the staff's reaction to recent patients' rights-based reforms?

Hypothesis

Using legal reform to change the institutionally proscribed means of achieving the goal of modernized mental health treatment does not change the ward control culture of power on the hospital wards. Rather, it changes the technical process required to reach an ends. The conflict between a new legalistic proscribed means and the ward control staff orientation creates a situation of workplace anomie in which the institutionally proscribed conduct is not interpreted by staff as the most effective way of dealing with problems on the wards. Staff alleviates this conflict by resorting to innovation—whether rule-breaking or rule-bending—to accomplish the ends of the reform.

Predictions

If the hypothesis is correct and the culture of ward control exists— and prevails—in spite of the new legalistic changes to institutional procedure, we can expect to observe the following:

Prediction One: Ward staff perceive their job as that of a rule- enforcer in a skid-row environment. As a result, staff feel they are entitled to a significant degree of discretionary control on the wards.

Prediction Two: The power of patients to be involved in their own treatment will be seen as at odds with the role of staff to exercise discretionary control over patients. The loss of this discretionary control would be believed to compromise the ability of the staff to maintain their role on the wards and enforce rules on patients.

Prediction Three: The loss of discretion and the reduced ability to enforce rules on the part of the staff will be seen as a threat to the ability of the staff to do their job.

Prediction Four: The patients-rights reform creates workplace anomie once "the technically most effective procedure, whether culturally egitimate or not, becomes typically preferred to institutionally prescribed conduct" (Merton 135). The institutionally prescribed conduct—the new legislation—will not be seen as the most effective procedure and staff will seek to alleviate this strain through some form of innovation.

Description of research site

This research focuses on the opinions, observations, and experiences of staff at a large public psychiatric hospital in a major metropolitan city on the East Coast. The hospital was formerly a federal institution, but ownership and control shifted to the city in the late 1980's (Wikipedia.org). The hospital has a total of 315 beds, 123 registered nurses and 31 residents (Hospital Map). 175 acres of the grounds are in use. Of the buildings in use, there are several long-term care buildings, a short-term care building, and a forensic pavilion for criminal offenders. There are also several administrative buildings, one of which is used for selected legal procedures involving the involuntary commitment of patients.16

The long-term care buildings have anywhere from one to six occupied wards. The short-term care building has eight wards, at least one of which is reserved for geriatric patients. The acute and sub-acute wards are in this building. The acute ward receives patients when they are first sent to the hospital, whether voluntarily or involuntarily. Once their behavior becomes less extreme or they are placed on a steady regimen of medications, they are considered stabilized and are sent to the sub-acute care ward. The

layout of these two wards is the same.
In order to better visualize these wards, let us follow a visitor walking through the acute ward. We will call this visitor Emile.
Standing in front of the door to a ward—or unit—Emile may initially have some trouble gaining access to the inside. All of the doors in the hospital, except for the ground-floor entrance to the stairwell and the stairwell exits, can only be opened with a key. None of doors in the wards lock automatically. Rather, everyone with a key must be careful to manually lock the doors behind him when they are opened. The front door is no exception. The doors to the unit are old and heavy, coated with dark green paint that is coming off in places. There are signs on the front of the doors—"Attention visitors!"—advising guests to leave behind matches, lighters, and sharp objects. As long as he does not look suspicious, Emile will not be searched; there is an honor system. If Emile does not have a key to the door, he can ring a doorbell on the outside of the ward and wait for staff to let him in. If he does not want to bother the staff with the doorbell, there is a narrow window in the ward door he can poke his head through to get the attention to any official-looking person with a clipboard.
Once Emile gets past the main door, he will find himself in a long, brightly-lit hallway. Doctors and their teams of residents use the rooms nearest to the ward door for conference rooms and break rooms. As Emile walks further down the hallway, he will see one or two patient bedrooms at the end, each housing no more than four patients. Continuing to walk away from the ward door, the hallway will dead- end at a dark green door to the porch, which is also locked. As a visitor, Emile may be allowed access to the porch, where he might see a public defender meeting with patient who has legal questions in relative privacy. Other patients, however, can only gain access to the porch when staff periodically open it to allow cigarette breaks. If Emile steps onto the porch, he will find himself in a square room with two adjacent walls that are open to outside air, but are completely enclosed in a thick black screen. There are a few chairs on the porch of varying comfort and softness available for Emile to sit on.
When Emile leaves the porch, the main hallway will steer him into the center of the ward. Emile will be standing in a large, open common area filled with fat, blue, foam-rubber chairs. Some of these chairs are pushed together to make sofa-like objects. On occasion, Emile will overhear daytime talk shows or movies that are brought in by the staff and shown on a small television. If Emile stays on the ward for the day, he will see that patients spend most of their time in the common room. During the day in the common room, patients can be found staring at the television, sleeping on the chairs, or walking around engaged in conversation—sometimes with another person. If Emile needs to use the restroom while he is on the ward, he might want to avoid the patient restrooms and showers that adjoin common room and ask to use the staff bathroom, instead. It is most likely cleaner. Emile will find the majority of the patients' bedrooms lining the outer border of the common room. An extension of the common room is set off to the side of the main part, although it is still open and visible. Since the walls near this area are lined with windows, it is sometimes referred to as the sunroom; although Emile will probably feel that it lacks much of the typical warmth and quaintness associated with the term. Emile will not notice the solitary confinement room in the very back corner of the ward, diagonal from the main door.
Whatever Emile needs while he is on the ward as a visitor, he will have to ask the staff. Emile will find the staff on the ward behind a long, raised desk that resembles the wall to a fortress. The desk faces the common room and the bulk of the patients, some of whom pass the time by persistently talking to staff, requesting to use the phone or smoke cigarettes when it is not the designated phone or cigarette time, or asking staff to please release them. There is usually at least one patient at the desk doing at least one of these things, and staff might invite Emile behind the desk if he is being bothered by the patients in front of it. Behind this desk, he will find a number of staff areas, including a phone room, a supplies/records room, a refrigerator, sink, and a converted break room—formerly a second solitary confinement space. On weekdays, the desk is usually manned by between two and four semi-skilled staff members or psychiatric nursing assistants (PNAs) and one registered nurse who is in charge of the staff. Additionally, each ward has a records clerk who is in charge of aintaining patients' records and photocopying these records upon request from attorneys.
Staff are responsible for providing some degree of activity for the patients, and this often occurs in the form of staff-led activity "groups." Groups range from dancing to board games to discussion groups. All patients are supposed to attend group, but Emile might not know this from the number of people who actually sit in group. It is a regular occurrence that some patients cannot be roused from their sleep on the thick blue foam chairs to move into group, and Emile will see many others sitting in group but not participating in the activity.
When Emile is ready to leave the ward, he can either use his key to unlock the main door or ask a staff member to walk him out. If he lets himself out, he will walk through a handful of patients who usually wait by the ward door or who have followed him to it. They may ask to be let out, or they may wait quietly, eyeing the door. Emile will have to be vigilant not to let anybody else out with him, and he should be certain to lock the door behind him.

Methodology

The data collected consists of three parts: independent research in journals and databases; personal observation while on the ward; personal interviews with staff, administrators, and legal professionals; and primary materials provided by the institution and various departments within it.
The independent research component of this study used

a number of online databases and other sources of literature. Articles from Jstor.org provided information about short-term experiments and studies conducted in mental hospital settings, and helped expose staff- patient relationships and perspectives. Lexus-Nexus was utilized to provide information on written mental health laws in the city under examination. These laws were used as a subjective backdrop against which the analysis of staff behavior on the wards took place. Online databases of congressional hearings were used to acquire transcripts and reports from discussions pertaining to the mental health reform. Statements made by lawmakers represent the intended goals of the new legislation, and these are contrasted with empirical evidence from the wards. Finally, online archives from local newspapers were helpful in revealing the local perception and understanding of conditions at the hospital, as well as any news-worthy incidents that took place at the hospital in the periods before and after the reform. Much of this information from these sources was disguised as it discloses identifying information of the research site, which must remain confidential.

Interviews

Before conducting interviews, this project underwent a review process at Yale University, where my research proposal was approved and I successfully completed an online course in ethical research procedure. The approval process at the hospital in question was relatively more strenuous—the research proposal underwent several revisions and was discussed in a committee meeting of the Institutional Review Board, where it was provisionally approved and then forwarded to the city's relevant governmental departments and the unions of the hospital staff, nurses, and doctors to receive their approval.

Data collection at the hospital was conducted in two different interview sessions over three different trips. On one of these trips, no interviews were conducted due to logistical difficulties with the Institutional Review Board of the hospital. The majority of the opinions gathered in interviews are those of the daytime ward staff who work from morning until 3:30pm on the acute and sub-acute intake wards, as these employees have the most daily contact with patients who are awake. Additionally, patients on these wards have just arrived at the hospital and their behavior is not yet stabilized. As a result, more patients on the acute and sub-acute wards refuse medication, causing the staff to confront on a daily basis the new reforms that regulate the administration of involuntary and emergency medication.

The first series of interviews took place over the summer after my internship with the Public Defender ended and consisted of nineteen interviews. Those interviewed were: two attorneys for the Attorney General's office; two Public Defender attorneys; one Public Defender investigator; two staff doctors; two judges on the mental health circuit; and twelve members of the hospital ward staff, including nurses, PNAs, and record clerks. PNAs make up the bulk of the ward staff, and thus they also make up the bulk of the interviews conducted.

During a second trip in February, one additional staff member was interviewed at length, along with a hospital administrator who is responsible for training residents and doctors. Additionally, two more public defender attorneys were interviewed. One of these attorneys was a key figure in the reform of the civil commitment and mental health laws for this city, and has detailed knowledge of the pattern of legal change over the last five years. Lastly, a follow-up interview was conducted with one of the doctors on the acute intake ward.

Interviews followed the technique set out by Smith and Smith, which is itself a variation on Norman Denzin's interpretation of interviewing:

In conducting interviews...we probed for "stories" rather than "epiphanies." The idea here was to collect episodes that were in some ways typical of lifeworldly experience but nevertheless sufficiently vivid and illustrative to have stuck in the informant's mind (Smith and Smith 10).

The interview was not concerned with garnering the details of staff's factual understanding of the law, but rather their perceptions of their job in the face of concrete procedural changes at the hospital. A sample interview is reproduced in Appendix A.

Most interviews were tape recorded. Several subjects refused to be tape recorded, so for these interviews handwritten notes were taken. All subjects were presented with an informed consent form that explained their participation in this re-search and promised confidentiality. A copy of this form can be found in Appendix B. A total of twenty-four personal interviews were conducted, lasting approximately twelve hours and spanning over 120 pages of transcripts. The majority of participants were African American and female. They averaged more than sixteen years of working in the hospital. In this research, all interview subjects are identified by a codename and their job position in order to protect their identities. Their real names were not recorded at any point in this research. A table of the codenames, jobs, and subject demographics can be found in Appendix C.

The Mental Health Division of the Public Defender Service, which works with the patients at this hospital and whose offices are on the grounds of the hospital, provided a number of documents relating to legal reform in the hospital and in the city, as well as the training manual provided to their employees and interns. A security guard at the hospital provided me with a small pamphlet that celebrated a milestone in the age of the hospital and contained historical information.

Results

Presentation of the results will proceed by addressing each sociological prediction in order. In attempting to judge whether the prediction was observed on the wards, interview data will be presented and interpreted in light of the theoretical argument.

Prediction One: Ward staff perceive their job as that of a

rule- enforcer in a skid-row environment. As a result, staff feel they are entitled to a significant degree of discretionary control on the wards.

In order to address this prediction, we must first answer the embedded questions about the role of staff as rule-enforcers and the skid-row nature of the ward.

The Role of Staff as Rule-Enforcers

The hospital staff overwhelming presented their job in terms of maintaining order, or keeping patients "under control" rather than offering therapy. In interviews, staff displayed a strong sense of responsibility when it came to enforcing rules and maintaining order on the ward. Jack, a psychiatric nursing assistant (PNA), was asked how he perceived his responsibilities to the client, and he answered, "to make sure that they are safe, to make sure that they don't get hurt, [and] to make sure they don't hurt anybody else." The idea of a regulator or enforcer was also evident in the response of Maya, a Licensed Practical Nurse (LPN) who said "one of my biggest responsibilities is to ensure their safety. The safety of my clients, their peers, and all the staff I work with." Here, Maya extends her responsibility beyond one solely to the client, or patient, but to everyone on the ward.

Townsend suggests that this broader conception of staff responsibility causes staff to experience positive emotions as they create a "more powerful self" that is capable of handling challenges effectively (9). Naomi, who is also a PNA, contextualized this "more powerful self" when she recounted a time when her role as a rule- enforcer and order-maintainer was tested:

I remember one nurse used to fuss at all the nurses because they'd associate with the PNAs [Psychiatric Nursing Assistants]. And this one nurse—oh, she was real high on her horse, honey—"you're not supposed to have anything to do with PNAs." Until one day a patient jumped on her and the PNAs was there, and nobody helped her. [laughs] She got creamed! [laughs] When she came back, she was singing a whole different tune. "Hi! How you doing!" You know? She had to learn. She had to learn (Naomi, PNA).

What this nurse "had to learn" was that it is the job of the staff to enforce the rules of behavior and maintain order on the wards. When the PNAs refused to help her, there was nobody left to protect her from a violent patient. This role perception, as Becker predicted, is central to the fulfillment—or non-fulfillment—of PNA duties.

Staff emphasized not only their feeling of responsibility when it came to enforcing rules, but also the perceived importance of their need to do so. Without enforcement of behavioral and social rules on the wards, staff repeatedly mentioned the possibility of ward-spread chaos. "One client" who is rowdy or misbehaving, according to a licensed practical nurse (LPN) named Becky, "can cause others to escalate." Turner points out that this situation would be unacceptable, as a large aspect of staff's role involves maintaining control over the situation on the wards (138).

The Intake Ward as Skid Row

Several pages back, the work of Egon Bittner was discussed for its analysis of police behavior in a "skid row" environment. According to Bittner, the police view skid row as "the natural habitat of people who lack the capacities and commitments to live 'normal' lives on a sustained basis" (October 1967: 705). He also identifies the important elements of police perceptions on skid-row as being "the presumption of incompetence" and the constant feeling of impending violence (Bittner October 1967: 705-6). Both of these attitudes can be found among the ward staff.

Presumption of Incompetence

The tendency to presume incompetence is challenged by the new reforms. Relevant citations in the laws indicate that "The [patient] may revoke his or her consent to the participation or authorization for notification...at any time," and "The [patient]'s treatment preferences shall be followed...and shall never be overridden for the convenience of the department or other provider.17 Specifically, the section of the law entitled "Retention of civil rights" delineates that "[patients] shall be presumed legally competent and retain all civil rights, unless otherwise limited by order of the court."18 According to one of the attorneys interviewed, the court rarely limits the civil rights of a patient. New legalists embrace the presumption of competence. Attorneys for patients stress that, in accordance with the new laws, it is not their job to make plans or decisions in a patient's best medical interest, but rather to navigate them through the legal system to help them meet their own personal goals (Kate).

As Marla, a PNA, observed, the patients "get in their opium meds, they feel good, they get back out, they feel like they don't need their meds, then it starts all over again."

Threat of Violence

An element of Bittner's work on skid row that is particularly salient in the ward environment is the sense that staff is "constantly attuned to the possibility of violence" (Bittner October 1967: 706). The threat of violence is a dark cloud that hangs over the acute unit and was evident in almost every interview. Brandy framed the issue precisely when she said of the patients, "They really don't know how to control their temper as you and I know how to control ours. And if they feel like striking, they'll just strike and they don't care about the consequences." Most staff members had a story about violence they had either experienced or observed at the hands of patients:

People getting assaulted, doctors getting abused. I seen a doctor get stabbed. That was really terrifying. And I got assaulted, twice. I'm still here, though. You hear about things. General stuff, a bunch of stuff. General stuff. But that's just part of the job, you know? (Brandy, Record Clerk.)

Naomi shared a recent incident in which a patient told her that he would "break [her] neck one day."

This incident highlighted the constant sense of

possible violence on the wards which was only exacerbated when "they still did not give him any medication because they said he wasn't taking any."

The Entitlement to Discretionary Control

The combination of these factors—the rule-enforcing role of staff and the skid-row nature of the intake ward—lead to the main part of the prediction: whether these two factors result in a feeling among the staff that they are entitled to discretionary control over the available resources of coercion—namely involuntary and emergency medication, like PRNs. In examining the interview data, this feeling was indeed prevalent.

PRN is an abbreviation for a Latin phrase Pro Re Nata, that means "as needed." A PRN is a dose of medication, often anti-psychotic or sedative medication—that is administered to a patient when his behavior becomes dangerous to himself or to others, and other methods of calming a patient down have failed. Sometimes, a patient will request a PRN from the hospital staff when they feel they need one. Erin, an attorney for the public defender service and an individual intimately involved in the construction of the new legal reforms, noted that the PRN is intended to "supplement" a patient's normal round of medications. She compared a PRN to cough medicine, in that one only takes cough medicine when a cough becomes troublesome. Likewise, a PRN is prescribed "for a flare-up in a psychiatric condition" (Erin). When a PRN is administered against a patient's will, as it often is, it is considered involuntary and provided in the form of an injection (Erin). This injection is not effective as an anti-psychotic, since it is in a large, immediately-released dose; rather, its immediate effect is that of a sedative (Leonard). The staff often tried to downplay this aspect of the PRN. For example as Naomi told me of PRNs, "It's not so much that we're trying to keep you 'snowed under,' or anything like that, but we're trying to keep you calm enough that you sleep." It should not be necessary to point out the argument of patients' rights advocates in this case: that the line between keeping a patient calm enough that they stay asleep and using the medication as a tranquilizer is a thin one, at best.

Staff often expressed the need for coercive measures like PRNs and restraints using the vocabulary of control, tying the measures back to a need to prevent violence or minimize the constant, unmitigated threat of violence that the staff deals with on a daily basis. When Marla spoke of the importance of using a PRN on an out-of control patient, she said that, "A lot of times all it will do is put them to sleep for a minute or two. But that minute or two could be enough to calm them down to have them listen to you when they wake up." Here, as in the observation from Brandy, the need for coercive measures is closely tied back to the importance of the staff's job in rule-enforcement. Ward staff often described patients in terms of an in control/out of control binary. Staff almost always indicate that a patient who is on medication is in control, while a patient who refuses medication has a high likelihood of becoming out of control. Becoming out of control is synonymous with physical violence. As a result, refusing medication seems to become synonymous with the tangible threat of physical violence, which only enhances the staff's need for control and the threat of allowing patients to refuse medication.

Incidentally, many patients' rights advocates and mental health attorneys agreed that in instances where a patient is out of control and dangerous, the staff must be able to somehow control the patient. Many new legalists indicated approval of the use of PRNs, but only after all other means of control or diffusion of the problem had been completely exhausted.

Prediction Two: The power of patients to be involved in their own treatment will be seen as at odds with the role of staff to exercise discretionary control over patients. The loss of this discretionary control would be believed to compromise the ability of the staff to maintain their role on the wards and enforce rules on patients.

Prediction one—that hospital staff feel the need for discretionary control in their jobs—seems to be observable on the wards. Moreover, it seems that staff exhibit feelings of powerlessness in the face of the threat of removing aspects of their control. What happens, however, when the new legalistic approach grants patients the right to refuse treatment? Can the rights granted in the new reform coexist with the existing culture of control on the wards? My prediction is that they cannot.

When staff were asked the effects of patients' rights legislation on their ability to perform their jobs on the ward, they often shared the opinion that this reform removes a notable amount of their power over patient care and their ability to enforce rules. This created a feeling of powerlessness among the staff in the response to their compromised ability to perform the functions of their job.

Nature of Patients Rights-Based Reform

There were several elements to the series of patients' rights- oriented legal reforms in the examined city. One aspect of the reform made it much more difficult for hospital staff to restrain or involuntarily medicate a patient. Whereas the definition was once more loose, the law now demands that doctors run through a lengthy gauntlet of paperwork and legal proceedings before the staff are allowed to administer involuntary medication on a regular basis. Additionally, while doctors can authorize staff to use involuntary medication in the case of an emergency, the law became clearer on the definition of such an exigency, establishing:

Emergency: situation in which [patient] is experiencing a mental health crisis and in which the immediate provision of mental health treatment is, in the written opinion of the attending physician, necessary to prevent serious injury to the [patient] or others.

This law also eliminated the ability of the staff to place patients in both physical and chemical restraints. The law specifically forbid a physical restraint technique known as "four-point restraint," in which the four limbs of a patient

are tied to the four corners of a bed. "Chemical restraint" refers to the deliberate administration of medication to sedate a patient, effectively restraining him or her (Erin). The reform meant that involuntarily committed patients could refuse medication regardless of a doctor's prescription, with the exception of valid orders for emergency medication and PRNs.

While PRNs are still allowed, the freedom of PNAs to administer them has been limited. The public defenders felt a strong sense of pride in the new restrictions on medications and restraints that the new laws enacted. Claire, a public defender, commented that, "It used to be that you would see clients overly medicated quite often because of their behavior. The law has changed some to kind of limit the use of PRNs." Patients' rights advocates saw these changes as a positive step. Zoe, the public defender and patients' rights supporter, acknowledged that the reform can be perceived as less than positive for the staff, but that such interest is outweighed by that of the patient:

A psychiatrist or even someone else on a treatment team might have ideas about what they think a person needs, and those ideas might be right on—no one would disagree—but until a person is able to accept those things themselves, I don't think that the treatment can be effective (Zoe, Public Defender).

These changes are central to the new legalistic spirit of the reform: to encourage mentally ill people to seek voluntary treatment rather than be forced into treatment at a hospital (Kate).

Despite such community-oriented attitudes of new legalism, the ward control culture of the staff persisted. The very passage of these new laws was perceived as discouraging for them, as reform took away some amount of their discretion and power. Jack, a PRN, commented matter-of-factly on legal reform, saying that when "there's something that is passed, we'll get it at a level where we are told, you know, 'don't do this any more.'" Chuck, a PNA in the sub-acute ward, said, "Whatever the legal system does, it's out of our hands." Marla captured this feeling of powerlessness and indignity emerging inherently from patients' rights-based reforms, when she answered,

"Do you feel like you have any rights? No, we've got none. We were told that we signed up to be punching bags. That's what we do."

Loss of Discretion Attributed to New Laws

Patients' ability to refuse medications is an aspect of the reform that most dramatically reduces the coercive discretion once held by the staff. Erin proudly noted, "If a patient now wants to refuse medication, it can't be administered to them over their objections." The results of this change were certainly perceived by the staff. PNA Naomi spoke of a patient who availed himself of his right to refuse medications:

Yeah, we got a nurse that been out for two years because a patient refused medications and the doctor wouldn't let the nurse force any medications on him. The patient went out in the dayroom, decided, "I'm not taking no m-f medication," and he broke the collarbone of a nurse (Naomi).

The sociologist Elizabeth Townsend noted that "Participation engages people as activists in shaping their own lives. In contrast to the one-way dependence that underlies caregiving, participation is enabled in two-way, interdependent processes that generate empowerment for us all" (Townsend 3). In the post-reform hospital, removing staff discretion limited "two-way, interdependent processes" and created a disempowering experience for the staff. Leonard, a hospital administrator, commented that patients' rights reform "creates more work for mental health staff, because the whole thrust of the patients' rights movement is to stop seeing people as patients who receive treatment from on high and to make the relationship more equal" (Leonard). In Leonard's view, then, a patient self-monitoring his own illness simply made "more work" for others. Because the staff tie their discretion to use coercive measures so closely to the ability to fulfill the central rule-enforcing aspect of their job, feelings of defeatism and discouragement resulted when their discretion over these measures was threatened by reform that equalized their relationship with the very people they must keep under control.

New legalists are not always sympathetic to the negative aspects of the reform for the staff. One public defender expressed her shock that increasing patient's rights, particularly the right to refuse medication, could be seen as a negative change by staff on the wards when she sighed, "I cannot believe that a professional would feel like someone's choice to take medication or not is interfering with that person's treatment" (Zoe). Rights advocates point out that the decision regarding treatment must rest with the patient. New legalists often justified this by comparing mental illness to any other non-psychiatric illness such as a cough or pneumonia, in which a patient can chose whether or not to be compliant with his or her medication (Erin, Claire). The right to decide whether or not to take one's medication, according to these reformers, should not be taken away simply for reason of mental illness (Claire).

However, without the coercive option, staff said, "there's nothing you can do, just be available" (Marla). When PNA Jack was asked for his opinion on a patient's right to refuse medication, he answered, "Well, it hampers their treatment plan when they refuse to cooperate with the plan and we don't really have a whole bunch of alternatives when they don't. Usually, until they decide to be something more, you just wait it out." The result is a feeling among the staff of fatalistic disempowerment.

Ultimately, the increase in patients' decision-making power did affect the way in which staff were able to enforce rules and fulfill their jobs on the ward. When she explained her hope to retire early, Naomi said, "If they would give us back the freedom, and really let me do what I was trained to do—because I think I'm pretty good at it—then maybe I would stay longer. But long as you restrict me, I feel useless. I feel like a babysitter. Because you not letting me help anybody."

Prediction Three: Loss of discretion and the reduced ability to enforce rules on the part of the staff will be seen as a threat to the ability of the staff to do their job.

Naomi's comment regarding her role as a "babysitter" frames a reaction to patients' rights-based legal reform that reduced or eliminated staff discretion in the everyday order-maintenance and rule- enforcement aspect of the staff's jobs. As Naomi illustrates, these reforms and the resulting powerlessness to enforce rules and fulfill job responsibilities pose a direct threat to the hospital staff. When staff were probed on their feelings in the wake of the patients' rights reform, they echoed a sentiment consistent with the ward control schema—that this reform and the resulting losses of discretion and power were threatening to them. Staff perceived these threats as both physical and psychological challenges that seemed to occur on a daily basis, threatening their personal safety as well as their perceived role and status as a staff member in the hospital.

Physical Threats Posed by Reform

The physical threats perceived by the staff as a result of the legal reform were not difficult to identify. The greatest threat the staff faced was the possibility of being violently assaulted on the wards. This should be distinguished from the possibility of violence discussed earlier, as it is not just a general possibility of violence, but a threat that is perceived to emerge directly from the recent legal reforms.

The most controversial of the reforms in the eyes of the staff was the right of patients to refuse the medication recommended to them by their doctors. Those staff members who disagreed with this right made up at least one half of the interview population. For most of them, their negative feelings toward the patient's right to refuse medication were rooted in an idea Brandy expressed, that "a lot of staff and someone in [the interviewer's] position could get hurt from them not taking their medication." Brooke, a PNA, lowered her voice when said gravely:

Many things happen in here. Patients—well, you may not hear a lot about patients hurting staff, but they do because they're sick, and when you try to restrain them people get hurt because the patient is very sick and can be out of control. Until you get some medication in them and they get able to control their behavior. And that can happen (Brooke, PNA).

Without the ability to administer involuntary medication, the staff's fears of violent outbreaks were sometimes confirmed. Naomi told the story of a patient who continually refused medication while on her ward, and was eventually moved to the sub-acute ward. Naomi and the other staff on the ward with her suspected that the patient would "flick off," or have an outbreak, but he continued to remain within his rights to refuse his medication. Eventually, the patient did erupt into violence on the sub-acute ward:

By the time they called help—a code thirteen—that's where all staff get together and try to restrain the patient—it had already been like three staff members all together got hurt. One had to go out in an ambulance. But all that could have been prevented. All of it could have been, if they would have just said, okay, regardless of what he say, give him some medication (Naomi, PNA).

Even though serious incidents do not happen daily on the wards, a bitterness is created in the wake of the threat, as Naomi insists, "When I signed that contract to work here, I did not sign up to be somebody's punching bag."

Even the members of the hospital staff who acknowledged that the reform was a good thing for patients and was the right step to take often followed this concession with an equally strong sense that staff somehow suffered as patients were given more rights. Laurie, an LPN (Licensed Practical Nurse) called this a "Catch-22," in which "what is good for the patients can also be a danger to society." Jack also agreed that the reforms were a good thing for patients. When asked how he felt the reforms affected him in his job, he responded, "somebody has to suffer for somebody else to straighten up."

Jack's idea that somebody has to suffer for somebody else to straighten up seems to apply to the staff on both counts. According to Turner, line staff are in a difficult position, as they will be subject to regulation of both a bureaucratic and a professional nature. The staff are the ones expected to change their behavior to conform with liberalized ideas of patients' rights—to straighten up, as Jack said—but it is also the staff who suffer many of the consequences of this liberalization. In the face of this threat, Naomi spoke of the overly- critical hospital administration and commented, "They wonder why half the staff stay behind the desk. It's because it's safe back there! (laughs) You have more rooms to run to back here! It can be really hairy up here sometimes."

Psychological Threats Posed by Reform

In interviews, a threat less tangible than physical assault emerged. The psychological consequences of patients' rights-based reform did not sit well with the staff. The psychological threats posed by the reform seemed to fall into two main categories: the frustration of occupational uselessness; and the threat to staff members' identity and sense of self-competence resulting from an increase in patients' decision-making rights.

Occupational Uselessness

The occupational uselessness aspect of psychological threat stemmed from a feeling that the staff's job no longer accomplished any kind of goal. Laurie said that, despite the fact that her job was "very stressful," she felt that if "the little you do can help them recover fully or to some extent, you feel satisfied that you contributed to their betterment." Becky echoed the psychological rewards that Laurie discussed when she explained that, "This job is about changing people, helping them to be better by taking meds." However, they perceive their inability to make patients take their medications to be the reason patients do not get better. The high rate of recidivism on the wards led many staff members to comment in frustration that the ward door almost seemed to revolve.

Emily observed, "Patients come in, we hope that they get better, but a lot of them leave and come back—it's like a revolving door." In fact, when I made my second visit to the hospital in February 2006, I was surprised to see a familiar name on a label outside of one of the patient bedrooms—I recognized the patient as one who had been committed to the hospital several times over the summer, and he had returned again.

This revolving door effect has a greater psychological consequence for the staff. As Townsend notes, a positive job outlook comes from the perception that work is being accomplished, and that life is being managed effectively (9). In contrast, the environment created on the wards is one that Brooke the PNA characterized as "a downer." The negative staff outlook can often be traced back to the feeling that "I love to see them make progress and be able to help them. But sometimes...you don't see any progress" (Brooke). PNA Naomi agreed: "And it's sad to see them come right back in the door, come right back in the door. And that's sad." Allison, a PNA, addressed the psychological toll of recidivism as well:

And the turnover is so frustrating. You know, you see them get better and leave, get better and leave, you feel like you've done something. But now, it feels as though you not doing anything, because they're coming back...Like cats, how many times have you been back through here? (Allison, PNA).

In this, the feeling of uselessness and frustration are explicit, and the toll they take on the staff is exhausting and demoralizing.

Threat to Identity/Status

Leonard Pearlin wrote that new legalistic policies such as those under examination "are indicators of conditions of patient freedom, autonomy, and decision-making actually extant on wards" (November

1962: 331). The flip side of this coin is that when an increase in patient rights such as these occur in an area of ward life when the patients oppose the staff—such as the choice to take medication—then more "freedom, autonomy, and decision-making" for the patients necessarily means less of all three for staff.

As a result, the legal protection of a patient's right to refuse medication is often seen as a direct threat to the competence and identity of the staff. Erin said: The doctor thinks, "I'm the doctor, I'm the one with training. I think you have bronchitis, I think you have schizophrenia, I think you have something. I'm recommending this treatment, and you're not going to do that?"...they have that same tension of doctors thinking, "I know what's right, I know what's best, and you're ignoring me" (Erin, Public Defender and Legal Reformer).

The preference of reformers to prioritize the opinions of mentally ill patients over the doctors and the staff is a direct challenge to the status identity and self-image of hospital staff.

Beyond frustration, multiple staff members recounted the frustration of seeing a patient who clearly needs medication in their opinion, but is refusing that medication and getting worse. Brooke spoke exhaustedly about patients who "clearly...need medication and they're able to refuse to take it and you see them getting worse, their behavior is getting more out of control...and they're still not getting any medication." Maya also addressed the frustration stemming from these reforms:

Because I guess things are changing...I know why restraints were taken out and why it's a necessary issue with that, but it's like, certain patients can come in for treatment. They get the right to refuse medication, and then you see them escalating and you see all this behavior and you can't medicate them. They have the right to refuse (Maya, LPN).

The element of identity threat emerging from the reforms—the feeling of deep upset that staff sometimes expressed when it came to a patient's right to refuse medication—might seem conservative or heartless to new legalists at first glance, but within the context of their job at the hospital, one can understand how staff would be so affected by this aspect of the reforms. The staff are the ones who spend the most time with the majority of patients. They have the most opportunity to observe the patients, talk casually with the patients, and form bonds with them. It is the hospital staff who offer medications to patients daily; it is to the hospital staff that the patients who refuse their medications address their refusals; and it is this same staff that no longer has the ability to administer these medications against the will of the patient.

The right to refuse medication seems to pose such a psychological threat because, to the staff, the need for patients to be medicated is visible to them every day. According to Naomi, it is "obvious:"

After three days, you should give the involuntary medication. Because it's obvious this person—if you observe the person and the person is rattling all the time talking to voices and so forth, but don't want medication, it's obvious. They need some kind of help (Naomi, PNA).

Giving the patients the right to refuse their doctor-prescribed medication is interpreted as a choice between the perceptions of the patient and the perceptions of the staff. When the perceptions of the patient win out, the staff feel their competency is undermined. New legalists respond that while staff might be frustrated by a patient's refusal to take medication, they must accept this as an indispensable part of the job (Zoe). However, this attitude does not necessarily take into account the depth of the negative reaction to such institutional changes. Becky expressed this sentiment beautifully when she said, "A nurse was beaten here, but nobody needs to be maimed. ...It feels like the patients say, 'I know my rights, I know this, I know that.' Well, who am I?"

Prediction Four: The patients-rights reform creates workplace anomie once "the technically most effective procedure, whether culturally legitimate or not,becomes typically preferred to institutionally prescribed conduct" (Merton 135). The institutionally prescribed conduct—the new legislation—will not be seen as the most effective procedure and staff will seek to alleviate this strain through

some form of innovation.

In reporting on this prediction, we must establish the presence of workplace anomie by illustrating both the perceived ineffectiveness of the "institutionally prescribed conduct"—the legal reform—and the perceived "most effective procedure," which could be anything else but will be shown to be the old system of greater staff discretion.

Perceived Ineffectiveness of New Legislation

In interviews, staff often expressed the opinion that the new legislation was not effective in dealing with problems on the ward, or was not realistic "on the ground." Tobias, a ward psychiatrist, stated this directly when he said, "The new law flies in the face of accumulating knowledge that we're not treating pneumonia that can be treated in 10 days or two weeks or three weeks." For the most part, ward staff agreed that the reform hindered their occupational role of maintaining order on the wards.

It should not come as a surprise that patient's rights reformers did not think the law was as ineffective as the staff did—many of the rights advocates noted the positive accomplishments of the law:

There were close to 500 people who were committed under the indeterminate commitment and remained committed. My impression is that the department has only sought recommitment in maybe 100 of those cases, and maybe is going to file for recommitment in 50 to 100 more. So, less than half the people who had been committed for indefinite periods of time, when someone was really forced to look at it and say "Can you justify continuing this?" they couldn't (Erin, Public Defender, Legal Reformer).

However, several staff members spoke of ineffectiveness emerging from an administration or from lawmakers like Erin who have no idea how their legal policies work "on the ground." One attorney for the hospital could not answer any of my questions regarding life on the wards, suggesting I talk to staff who know more about "the everyday" (Stella). This distance resulted in a feeling like Naomi's, that "patients got all these rights, but [lawmakers] never come on the unit and really see what the patient needs."

The feeling of increased hospital bureaucracy was also a hindrance to the acceptance of the legal reform on the wards:

We have to do a lot of bureaucracy. I have a problem with bureaucracy and I have a problem when it's time to Xerox and you all come to me after I've done all this work and say the patient has been made voluntary. I think they should know, they should give us more time. I don't think you should come to me if you have two weeks and you come to me today and you want the charts of a patient that they've had for two weeks down the road, and I have to do all this stuff, why don't you just bring it down closer? I think it's crazy (Lily, Record Clerk).

Staff both observed reform that was ineffective in solving problems on the wards, and worked under a bureaucracy they felt was ineffective and distanced. This created a preference for the old systems of regulation and control.

Workplace Anomie

The perceived ineffectiveness of the new legislation created an anomic feeling of frustration. This anomie resulted from a conflict between the legally prescribed procedure and what the staff felt was the most effective way of dealing with a problem on the wards. Maya spoke of her inner conflict between what she thinks must be done and what her job requires she do when she sees a patient on the wards who needs to receive medication, but is refusing to take it:

We're sitting here and they're responding to voices, getting agitated and they get to refuse their medication for as long as they're up here. I believe that they need to have emergency meds that they used to be able to do that they can't do anymore (Maya, LPN).

The staff's anomic conflict between institutionally prescribed conduct and the most effective procedure was particularly acute when it came to the sometime-consequences of patients' refusal of medication: violence against staff. Becky talked about a nurse who was hit in the jaw by a patient. Instead of being able to respond with emergency medication, "the nurse had to call a code, fill out papers. Then it is frustrating to be told you should have done it differently when you're the one with the broken jaw and the client is still out walking around. You think it's kind of stupid." In this case, the prescribed procedure was seen to be bureaucratic and ineffective compared to other alternatives.

Resulting Reliance on Coercive Means of Control

One surprising observation relating to workplace anomie was the way in which staff acted to alleviate the pressures of anomie. Relieving this feeling of disempowerment, according to Townsend, comes down to taking action during the course of a normal day that "actually [does] something" to regain control. As Anselm Strauss warned, "...all categories of personnel are adept at breaking the rules when it suits convenience or when warrantable exigencies arrive" (395). When Laurie the LPN explained of a patient's right to refuse medication, she insisted, "They have this right just like any other patient, but we should have other avenues to make sure that the patient is medicated if they are dangerous to themselves or others. Medication is needed to control behavior." The use of these "other avenues" is observable in staff interviews, and includes the use of verbal threats and warnings as well as the administration of emergency and PRN medications.

Verbal Coercion

Verbal efforts at regaining lost discretionary control can come in the form of coercive remarks or meanness. Many members of the staff indicated that when a patient refuses medication, they often respond by telling them that they will not be able to leave the hospital until they begin taking their medication. While there is an element of truth to this—often, a doctor will hold a patient who is refusing medication longer than one who isn't—many patients in-

terpret this to mean that they must take medication to be released, which is incorrect. Marla tells those patients who refuse medication that they "need to think about it, because a lot of times you won't leave until you get it."

In speaking with Tobias, the ward psychiatrist, about his responsibilities to the ward staff, Tobias revealed an interesting aspect of the coercive control used by staff when he explained why he does not interfere when he thinks staff are "speaking harshly, loudly, scoldingly, belittlingly, contemptuously to patients:"

I do not feel that it's my job, this is for political reasons, to tell staff when I think they are being unkind and sadistic as happens even on the wards...I don't feel it's my role for political reasons—by political I mean interpersonal, respecting quote "staff territories"—to tell staff when I feel they are not being benign. I mean, I would like to be able to...but I do not, as I would with my own supervisees, say, "you know, I think you might be better to say x and y in a somewhat different tone" (Tobias, Psychiatrist).

It is telling that a staff member could engage a patient in a "harsh" or "contemptuous" manner, and this behavior would fall squarely within the grounds of "staff territories." That verbal interaction, of whatever nature, still falls within the discretion of staff members. As Tobias predicted, removing that discretion would create a fallout so negative that it is better to allow the staff to continue to be verbally coercive.

Chemical Coercion

The law in this city specifies that "[patients] have the right to be free from seclusion and restraint of any form that is not medically necessary or that is used as a means of coercion, discipline, convenience, or retaliation by staff."20 However, the use of available chemical means of control to relieve the anomic stress created by the new legislation seemed to be evident on the wards. While it is more difficult to give emergency and involuntary medication, staff still maintain the ability to administer a PRN once a doctor has written a PRN order for a patient. Recall that medication like a PRN is only meant to be given in cases when the patient is posing an immediate danger to himself or to others. When asked about staff administration of PRNs, Tobias noted that after an order is written, patients who are "very loud and annoying" probably get PRNs when "talking to a patient in a gentle and empathic way would probably be quicker and equally effective." The public defender shared this view, as Kate observed:

I think they get used too much. I think that PRNs should be for when somebody's out of control. Okay? And I think sometimes they're used for when people are just a pain in the ass. They're coming up asking

too many questions, they're using the phone too much, and they're used just as a way of controlling them, and that's not what they should be used for (Kate, Public Defender).

[A worker] clings to the possibility of a last remnant of joy in his work... Even when the details of performance have been prescribed with the utmost minuteness...there will be left for the worker certain loopholes, certain chances of escape from the routine, so that when actually at work he will find it possible now and again to enjoy the luxury of self determination (78).

In this case, the "last remnant of joy" and the last possibility for self determination among the staff is some means of coercive control. It is this control which perhaps allows ward staff to "escape from the routine" dictated in the new legislation and once again feel in control and relieved of anomic pressure.

Erin, who has worked on the grounds of the hospital as a public defender for many years before helping to create the reform, noted:

It used to be you would walk on a ward and there was almost always someone in a locked seclusion room. There was almost always somebody walking around with wrist restraints, leather restraints, or someone tied to a bed in what they call four-point restraints. You rarely see that at this point (Erin, Public Defender and Legal Reformer).

Given that staff no longer have the discretion to utilize these more visible forms of restraint, administering PRN medication seems to be a vital alternative. Moreover, such an act would help ease the anomic discomfort caused by the patients' rights-based reforms. Erin confirms this suspicion when, after describing the staff's reduction of physical restraint at the hospital, she continued by asking, "Are they chemically restraining [patients] as an alternative? Maybe."

Interestingly, several interviewees presented examples of an alternate scenario in which staff maintained a greater amount of discretion in the operation of the wards and the care of patients. In these instances, staff spoke more positively about their jobs and portrayed the environment as calmer, downplaying the need for mechanisms of coercive control like the PRN. Naomi, who usually works weekdays but was interviewed while working a Saturday shift on the ward, talked about Saturdays as a time when hospital administrators do not report to work and she has more discretionary control over the happenings of the ward. The Saturday ward environment that I observed was markedly different on this day than it was during the week. As Naomi described:

I just put on a DVD and let them relax. Doors are open all day, make sure they get their cigarettes, and that's it. It be nice and calm on the weekends, I love it. But during the weekday, come Monday morning, oh boy. Totally different (Naomi, PNA).

No evidence was found to show that the incidence of PRN administration rises on the weekends. The work environment on Saturdays and Sundays, while it may indicate a more relaxed "weekend effect," also illustrates what the ward might look like if the stress factors inspired by the legal reform and resulting losses of discretion were removed, or if the staff could better adapt to them.

Another unexpected effect observed on the wards was the increased social importance that the staff placed on the forms of control still contained within their discretion,

namely PRNs. According to Maya:
PRNs are needed. They're needed. Because especially like I said for some that don't take medications and then they escalate and stuff like that, PRNs are the only thing we have to help us. We can't restrain them, we can't do anything else. I believe the PRNs are very much needed (Maya, LPN).
Maya was not the only person to hold the view that "PRNs are the only thing" that can help the staff fulfill their job. When asked about PRNs, Brooke the PNA agreed, "Well, it's needed. Because if a person is out of control, you need to give them PRNs...You can't control them without it." Stressing the vital role that the PRN played in the arsenal of the ward staff felt like an effort to preserve staff's right to exercise this discretion. Staff often thought of PRNs and emergency medications as the last—and sometimes only—line of defense and treatment in the wards, and clung to it as such. One of the most poignant comments on the renewed importance of the PRN in the face of the legal reform came from Becky the nurse:
One minute, a client could be sitting there...and the next minute you turn around and they're hitting someone else, and [the administrators/lawmakers] not here to see that. I mean, I haven't been in this ward that long, and I heard about overmedication, but I think they need to get everybody's opinion. I believe a lawyer who's not here working or a doctor that's not here for 8 hours or 16 hours when we have to stay over and you're seeing all this behavior and you really don't have anything but your PRN (Becky, LPN).

Recommendations

Although patients may not be worse off on the wards now than they were before the patients' rights legislation, the negative side- effects of such reform do not need to occur. Leonard Pearlin wrote in his examination of the alienation of nursing personnel at a large mental hospital that a mental hospital must not only attempt to meet the needs of the patient and the community, but must also satisfy "the diverse aspirations and opportunities sought by its members" (June 1962: 320). By recognizing the ward control culture of the staff, cities that expect to make significant changes to mental health reform in the future could minimize the negative ramifications of patients' rights-oriented changes.
It should be noted that the scope of this project did not include a thorough analysis of alternatives to the existing legal reform, nor was the purpose of this research to explore the feasibility of such alternatives. This study was not an evaluative study, and that does not place me in the strongest position to suggest extremely detailed policy changes. That being said, these general recommendations can be offered:
1. Provide greater emotional and psychological validation for staff during periods of change. Staff members are likely to feel confused, challenged, or threatened by reform that takes away their discretionary power on the wards. Establishing a program that is effective in addressing staff concerns would minimize the feeling held by many of the staff that they were completely powerless in the administration of the hospital and the reform of procedures. This, in turn, would help decrease the feeling of workplace anomie.
2. Along these lines, invite members of the hospital staff to sit on the committee that designs the reforms. Such an act would lessen the distance that staff feel lies between them and the administrative policies to which they are subjected. By featuring hospital staff on law-making committees, cities seeking to increase patients' rights can show deference to the role and identity of the hospital staff while still accomplishing reformist goals.
3. Increase funding for mental hospitals. In interviews, a significant complaint of the staff was the decrease in funding to the hospital over the years. This decrease in funding meant that staff had fewer resources to work with and disintegrating grounds on which to work, and low pay for which to do it. The positive effect of having a financial influx, even in the face of discretion-reducing reforms, could create more loyalty to the administrators and lawmakers and thus less pressure between the mandates of the lawmakers and the way in which they perceive a problem should be dealt with on the wards.

Conclusions

The evidence gathered demonstrates that the two existing paradigms for conceptualizing the mental hospital—the new legalistic and the medicalistic models—do not accurately capture the worldview of ward staff. The dynamics of this occupational culture cannot be predicted by turning to community-oriented schemas or familiar outlooks from social theory involving medical power. Rather a new view of working life at the hospital is required—this was named the ward control model. The conception of the hospital staff as "rule enforcers" who more closely resemble police officers than doctors or rights reformers informed this outlook and sheds light on the way rights-based legal reform is implemented on the wards of the hospital.
The data presented in this research strongly suggests the recent changes in mental health law have had unintended consequences for both patients and hospital staff. The reform that gave patients an increasing number of rights to regulate their own treatment took away power from the staff without providing them with an effective and legitimate system through with to enforce rules and maintain order on the wards. This posed a conflict for the staff between the procedures mandated by the new legislation and the procedures that the staff believed would be most effective in handling situations on the wards. These remaining means of control—verbal warnings and PRNs—took on great importance and were ultimately portrayed by many staff members as an indispensable last resort in fulfilling

their jobs.

In Michel Foucault's landmark book *Discipline and Punish,* he suggests that legal reform would not actually eliminate or reduce the power of staff, but rather would better distribute their power so that it moves from being visible to being invisible (81). Erin spoke of walking through the wards without seeing patients in wrist restraints, as used to be customary. Zoe remembered a time when she would see notes in the charts of a patient who was refusing medication that read "give PRN meds if person continues to refuse." According to Zoe, "that's blatantly wrong, that's a violation of DMH's own policy that PRN meds would be given just for refusal to take meds." The ward control model seems to show, as Foucault suggests, that the power of the staff to exercise their own discretion does not actually disappear from the wards and the charts as new legalistic outlook would hope, but is rather dispersed among remaining staff powers in such a way that it becomes invisible. The danger is that this invisible power is unchallengeable; when held by the staff on the wards, it can only work to the disadvantage of new legalistic goals.

Whether these results could be observed in the absence of the legal reform is unclear. It is impossible to know pre-reform attitudes and behavior with any degree of certainty. Judging from the content of the interviews, however, the ward control model is upheld, and ultimately staff members indicated in their responses a paradoxical increase in the social importance of coercive control for ward staff in the execution of their daily tasks post-reform.

In arriving at this conclusion, my intention is not to argue that patients' rights-based reforms were a step in the wrong direction, or that they left patients worse-off than when they started. Rather, what should be taken from this research is that such lawmaking must consider the unique ward control nature of working life on the hospital grounds. Without taking the ward control schema into account, new legalistic reform jeopardizes the rule-enforcing ability of the staff and risks unnecessary negative consequences. The staff's desire to reduce the strain resulting from these negative social consequences seems to lead to a tightening of control over coercive mechanisms that ultimately infringe upon the rights of patients and work to their disadvantage. Additionally, such reform seems to lower staff morale, which might lead to recruitment and retention problems. In interviews, Jack said that it was important to "think about the money aspect of it" in order to stay motivated, but as Marla suggested, "How about a higher pay for us? We don't make half enough. Believe me." In an environment with an unstable population, high staff turnover could be devastating to the progress of patients and could result in large-scale aggressive outbursts (Wulbert 5).

Working at a psychiatric hospital combines a volatile work environment with fundamental questions about identity and power. As the patients' rights movement proceeds, it is important for reformers to recognize that the social situation of the staff at the hospital cannot be understood using the existing models of new legalism or medicalism. Rather, the relationship of the staff to hospital patients must be considered in light of a ward control model that recognizes the nature of power and control in the staff-patient interaction in the hospital. This understanding is vital to making provisions to ease staff through new patients' rights lawmaking, which would otherwise be a difficult legal transition. Considering reform in light of the ward control culture of hospital staff will inform—and make more effective—future attempts at legal change within such institutions.

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