Patient Evaluations R Us: The Dynamics of Power Relations inside a Forensic Psychiatric Facility from the Bottom Up

Jeffrey Ian Ross, Ph.D.
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Editor’s Introduction: Professor Ross was a psychiatric assistant in a correctional facility hospital that provided mental health evaluation and care for individuals charged with crimes, sentenced to jail or prison, or about to be released from correctional facilities. He identifies and discusses the power dynamics within the forensic unit from a frontline staff perspective and provides a frank retrospective narrative and analysis of contradictions between the mission of the (Continued)

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Over the past 4 decades, a hybrid organization incorporating elements from both hospitals and correctional facilities has been created in most advanced industrialized countries. These are generally called forensic units and are typically located in selected jails, prisons, or hospitals. There is considerable variability with respect to their missions, policies, procedures, workers, and clientele. Some are primarily detention centers, while others are pass-through institutions that psychologically assess individuals with criminal charges or convictions and then remand them (i.e., send them to another organization in the criminal justice system).

In 1980, I enrolled at the University of Toronto as a “mature student.” I had successfully completed a special program that allowed individuals like myself who had never finished high school to be conditionally admitted to the university after having completed a bridging course. I was slightly older than the average student and had more work-related experience. I began with a course of study that would result in a psychology degree, with the hope of becoming a clinical psychologist.

To gain a bit of firsthand experience in my desired career, I did some volunteer work in the psychogeriatric unit at Queen Street Mental Hospital—which was, at the time, one of the oldest and largest mental health facilities in the province of Ontario. I quickly discovered that I did not care for this type of clinical setting, which primarily consisted of feeding and listening to psychotic patients, and moved on to the volunteer program at the Clarke Institute of Psychiatry. Here, I worked on the forensic ward, which served me better than my previous volunteer experience but not by much, as opportunities for interaction with patients were limited. Over time, I grew dissatisfied with the Clarke volunteer program, so I tried yet another opportunity offered by the organization and its actual operation, including a failure to truly implement a Total Quality Management (TQM) style. Ross identifies specific problems in the course of providing lessons for staff–management relations, and he points out some sources of employee stress and responses to them (good and bad). Although his coworkers and he found it difficult to achieve the ideal goals of their unit, Ross’s experience as a shop steward demonstrated how dissatisfied employees can work toward improving the workplace.
Crisis Intervention Unit at the East General Hospital in Toronto. This was a much better fit than the other two experiences—it was fast paced, and the patient’s concerns were more pressing (i.e., violence toward oneself and others). In June 1982, I began working as a psychiatric assistant (pejoratively referred to as a head banger) at Midway Forensic Evaluation Center, the pseudo name I use for a forensic mental health evaluation facility located in a major city in Canada and run by the provincial government. I held this job until August 1986. During the school year, I worked part-time; during the summer, I worked full-time. Between January and August 1986, I also worked full-time.

During my 4 years at Midway, I had the opportunity to work on both the ward and the division’s Brief Assessment Unit (BAU). These locations allowed me to experience the inner dynamics of a unique organization that was one part hospital, another part correctional institution, and still another part teaching facility. My access and expertise enables me to provide an in-depth analysis of the function and inner dynamics of Midway and the role of a psychiatric assistant (or P.A. for short). I worked all three shifts: days, evenings, and nights (also referred to as the graveyard shift); so my narrative is not simply confined to a single time of day. Although my experiences may be akin to a snapshot in time and there may be jurisdictional and cultural peculiarities, considerable lessons can be learned from my experience.

The P.A. position is generally akin to that of a psychiatric orderly. However, the latter term does not adequately address the so-called professionalism of the position. In general, my job was, along with the correctional officers, to assist the nurses with unit or ward management (in other words, to maintain order). In many respects, the P.A.s were the most important day-to-day workers on the ward because (1) they had the most interaction or contact with the patients; (2) they mediated among the patients, nurses, correctional officers, and psychiatrists; and (3) they helped to keep the unit functioning smoothly (i.e., with a minimum of conflicts among patients and staff).

I urge the reader to curb the thought that this reflective essay is simply self-serving—a manifestation of my overly cynical personality; some version of sour grapes on my part; an opportunity to blame, poke

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2 I struggled with identifying the institution by its proper name or keeping the institution anonymous (as I have so done). Although using a pseudonym is a bit disingenuous because anyone scratching below the surface into my bio would immediately recognize the institution, in the interests of editorial preferences I have gone with the pseudonym.
fun, or belittle others; or an unconscious need to elicit sympathy from readers. To safeguard against some of these possible perceptions and to sharpen my analysis, I sent drafts of this chapter to former Midway colleagues for comment and review. Although some of the institution’s policies, procedures, and problems have changed since the time I worked there, my sources tended to indicate that my interpretation remains relevant and valid.

**OVERVIEW OF THE INSTITUTION**

Midway was established in 1977 by the province to assist the provincial criminal courts by providing “fitness/competency to stand trial” evaluations of individuals who had been charged with criminal offenses. Midway also evaluated felons to determine their proclivity for violence during the presentence, postsentence, prerelease, and postrelease stages of their criminal cases. The institution, physically located within another provincial hospital in the economically depressed part of the city, was jointly supervised by the Ministry of the Attorney General, the Ministry of Health, and the Division of Corrections. It was also part of a larger psychiatric institute, which I will call Parent Psychiatric Institute, that maintained research and teaching functions associated with a large prestigious university.

In most Anglo-American democracies, many people who are charged with a crime and who appear to be suffering from a mental illness are remanded to a state-appointed psychiatrist to be examined. More typically, these individuals are sent to a forensic facility for a 1-, 30-, 60-, or 90-day assessment. The length of the evaluation depends on the particular jurisdiction’s law and the difficulty involved in determining the mental health diagnosis. In addition to the psychiatric evaluation, doctors may identify other health-related issues (e.g., diet, medical, or dental problems). If the accused individual cannot understand the nature of the charges or the proceedings and/or if one is unable to adequately work with one’s legal counsel, then the person can be declared incompetent, or unfit, to stand trial. When this happens, the legal proceedings are typically suspended and the individual is confined to a mental hospital for an indefinite period until a review board decides that he or she is fit to stand trial.

The decision-making process that determines if a person is fit to stand trial is often flawed. Unfortunately, situations occur in which a person may spend a considerable period of his or her life in confinement
for a relatively minor crime because she or he has been identified as being unfit to stand trial. A sentence that involves confinement within a mental hospital can potentially mean a longer stay than the person would have received had she or he been found fit to stand trial, found guilty, and sentenced to time in jail or prison.

Although the majority of patients who came through our institution were diagnosed with antisocial personality disorders or labeled psychotic or delusional, a considerable number of them were charged with or had committed what many of us considered to be heinous or bizarre crimes (e.g., bestiality, sexually assaulting senior citizens in a retirement home, and dropping babies from apartment balconies). Because those who were admitted were not quite patients and not really inmates—and since they were not in a traditional correctional facility, we often fell back on referring to them using the nondescript term clients. Perhaps motivated by trying to stay out of jail or prison, some patients faked mental disorders, and it was our ward’s duty to determine if these individuals were in fact suffering from underlying mental illnesses.

**REFLECTION FRAMEWORK**

This reflective essay contributes important contextual information concerning management in corrections. Started in 1966 by the Federal Bureau of Prisons (FBOP), unit management is designed to break the correctional facility into small parts, push decision making downward, and try to increase contact between correctional workers and prisoners (Seiter, 2005, pp. 317–318). During the 1980s, building on this initiative and recognizing that the old style of managing correctional officers (COs) would not work so well, state Departments of Corrections (DOCs) started experimenting with and in some cases implementing both corporate and participatory methods for running their correctional facilities. The corporate management model “emphasizes modern management techniques and participant management. Lines of authority and accountability are clear; feedback and quantitative evaluations are widely used” (Bartollas, 2002, p. 261). The most dominant change was called Total Quality Management (TQM). It emphasized “work force empowerment, process improvement, customer obsession, and strategic planning” (Anschutz, 1995, p. 1). In general, TQM is intended to improve staff–staff and staff–inmate communication and improve employee morale. This is fostered by having the staff offices
located right on the tiers (i.e., the floors where the prison cells are located). This innovation was supported by the FBOP’s National Institute of Corrections, and in 1993, it started offering TQM training (Stinchcomb, 1998). Nevertheless,

It did not take long for correctional administrators to discover that the new management theory did not solve the problems they faced in American prisons. By the late 1980s, most of these correctional administrators saw that in spite of private-sector management theory, most prisons had more violence, worse conditions, and fewer programming opportunities than they had had under the autocrats of old. (Bartollas, 2002, pp. 261–262)

During the 1980s, many DOCs abandoned the shared-powers model. They started moving toward a system where inmates yielded considerable power. The problem with this state of affairs was that prison gangs made up the power vacuum (Bartollas, 2002, p. 262). TQM was not without its problems, including “employee resistance,” “negative attitudes,” “fear,” “lack of leadership support,” “finding sufficient time to” introduce TQM, and lack of money for implementation (Stinchcomb, 1998, pp. 133–134). But almost completely ignoring staff input and treating it symbolically is sometimes worse.

People going into corrections and similar environments must be prepared for these kinds of problems, whether or not they go into management. The chapter identifies several difficulties that occur when management disregards the potential and actual contributions and well-being of frontline staff, especially when it does not involve staff in important decision-making processes. The general lesson here is that when management treats staff members poorly and does not take their input seriously, it ignores valuable “frontline knowledge” that management may not have and end up fostering poor morale among a large number of employees who are essential to achieving the goals of the institution. This all comes back to hurt managers, who then have the daunting task of dealing with the ensuing headaches. Moreover, my coverage of my role as shop steward illustrates how effective a frontline worker can be in improving the quality of the workplace. In the end, management cannot just give lip service to egalitarianism; otherwise, it will have negative repercussions to the organization. A managerial ideology or set of principles that calls for an increased role of staff in decision making—something that contrasts with authoritarian styles—is needed.
MY EXPERIENCES

The Front Line: P.A.s, Nurses, and Correctional Officers

Most of the psychiatric assistants were young white males ranging in age from their mid-20s to their mid-30s. Nearly all were full- or part-time university students in their last few years of undergraduate studies or recent bachelor’s degree recipients. There were also a few master’s students and doctoral students who did not finish their dissertations. Although Midway had a human resources department located as a geographically separate entity, most P.A.s were recruited through word of mouth. Whenever there was a vacancy, one of us usually told the head nurse that we had a friend who might be appropriate for the job. In these matters, she usually heeded our recommendations. Training was minimal and basically consisted of learning on the job through a trial-and-error process. Granted, we were eventually taught basic first aid and cardiopulmonary resuscitation (CPR), but the daily duties—how to chart on patients’ behavior and how to deal with patients (interchangeably referred to as clients or inmates)—were usually learned only from experience.

Some of the more entrepreneurial P.A.s started their own part-time businesses on the side, specializing in consulting or importing and exporting. If they could do most of their hustling during the day, then at night they could kick back and read the newspaper or catch up on paperwork or accounting. Many of my fellow P.A.s, feeling that it was time to move on, were constantly applying for other jobs. But the flexibility of the work—especially if you had a child, were going to school, or were starting a part-time business—was an undeniable draw. On an evening shift, it was entirely possible to squeeze in at least an hour of studying or balance your small company’s books. On a night shift rotation, for example, if you did not sleep much, you might be able to do at least 3 hours of personal work.

The majority of a P.A.’s time was spent facilitating the patients’ progression through the daily schedule. We charted their behavior (typically at the end of the shift), restrained them when needed, and escorted them in and out of the ward. We also accompanied nurses on their rounds (to ensure the safety of the unit); essentially, we, along with the correctional officers, were “the muscle.” A considerable amount of this work involved opening and closing locked doors and continuously counting patients, or clients, to make sure everyone was accounted for. To our credit, the patients often saw us as being more
reasonable than the nurses and correctional officers. In fact, for P.A.s, it seemed that the biggest obstacles on the job were not the patients but rather the head nurse and middle management.

On any given day, patients would be allowed to exercise, watch television, or participate in *group time* (a process that borrowed some features from group therapy). Although the rationale for the regimen was rarely questioned, these activities offered only mundane opportunities to observe the clients in different settings or situations and chart on their behavior. Similar to the practice of *diesel therapy* or “tuning up” identified in corrections literature, it seemed that many interactions were designed to agitate and observe, or as we pejoratively called it, to “provoke and chart.” For example, a patient might be confronted by frontline staff who presented a low-level stressful situation (like a bedroom search). The patient’s response was then observed and recorded. If the client became upset, it would give us something to include on his or her chart. It then became part of the official record. In short, the job entailed a lot of observation, recording, and the occasional restraint of patients.

Each P.A., correctional officer, and nurse was assigned a group of patients (2–8) for each shift. At the end of an 8-hour rotation, we were responsible for charting on all patients under our supervision. The chart typically identified several categories of behavior that served as a guide for staff to observe, record, and comment on the patient’s behavior. Each patient was assigned a psychiatrist, and it was assumed that over the course of the patient’s stay, the assigned psychiatrist would not only periodically interview the patient but also regularly read the individual’s chart. Each patient would normally require a social worker’s report, a physical education report, and a psychometric evaluation. Although the charting seemed like a logical, straightforward task, it was difficult (for many P.A.s and correctional officers) to see any noticeable relevant behavior with the selected items because the patients’ behaviors were not easily categorized into discrete events. A considerable amount of time was spent by staff in the nursing station, located in the central portion of the unit. Most of the time, staffers were either responding to patient’s mundane requests, charting, or chatting amongst themselves.

Many P.A.s (and nurses) were under the impression that most of the nurses had chosen the field of psychiatric nursing because they either did not like the classic *bed pan nursing* (i.e., being at the beck and call of needy patients) or because they had a fascination with patients’ bizarre behavior. Although management liked to tell us that we were the nurses’ equals and that we engaged in milieu therapy, most of the
P.A.s recognized that they lacked the training and experience the nurses possessed. Many of the nurses were unnecessarily quite rigid and provoking in their approach to patients and coworkers. Their demeanor often led to unnecessary conflicts with patients and fellow employees. Alternatively, female nurses who were single and seen as attractive were often “hit on” (e.g., asked out on dates) by patients, P.A.s, and correctional officers. It was not uncommon for single nurses to date their fellow workers.

Most of the correctional workers were men with rough demeanors. They typically were seconded to us (i.e., temporarily lent) because the Ministry of Corrections was grooming them for more senior-management positions. Thus, they wanted to broaden their experience, and a stint at Midway could provide cross-training that might be useful in their future work endeavors. Alternatively, the position provided a place where they could be “parked” if they had an administrative problem with the Ministry of Corrections. Many seconded workers had difficulties adjusting to the new work environment where the inmates—whom they were now instructed to refer to as patients—were afforded more liberties than that traditionally given to convicts.

Management

Although Midway’s chain of command was rather simple on paper, there was considerable ambiguity in reporting relationships. This gave management ample room to manipulate (e.g., confuse) the P.A.s and other frontline staff. For example, no one was quite sure who was in charge. In general, psychiatric assistants and correctional officers answered to nurses. Charge nurses on each shift were supervised by the head nurse. The head nurse (who worked only days), in turn, answered to the unit administrator and to other senior administrators. The senior administrators were accountable to Parent Psychiatric Institute, and the three provincial ministries (Solicitor General, Corrections, and Health).

During my employment at Midway, there were two successive head nurses. The first was, by the time I joined, a seasoned nursing administrator in her 40s. She appeared to have mastered all the ambiguous catch phrases as to why we could or could not do something on the job. One of my most salient memories of her involved her display of dissatisfaction with the way a desk counter had been recently installed around the interior walls of the nursing station—she chose to slam her clipboard into it several times. When she retired and her successor was announced, we knew we were in for trouble. Her replacement was a
fellow nurse with minimal supervisory experience, someone with whom some of us had socialized. It was apparent that, at least initially, she lacked the necessary training and experience to successfully carry out the required duties her position entailed. For instance, she had a temperamental disposition and appeared to be unable to write an articulate memo.

The unit administrator spent the majority of the day inside his office with his door closed. Like a groundhog in spring, he periodically came out of his office to see what was happening on the ward. This was not your textbook senior management walk around. Invariably, he would find something that we had done wrong, which he would interpret as “goofing off.” He would make a public spectacle and then retire to his office. The unit administrator, along with other members of management, would periodically reprimand us in front of the patients, which we interpreted as a sad effort to undercut our perceived minimal authority and reassert their power.

Middle- and upper-management jobs are designed so these individuals are rarely present on the ward. Most of the senior psychiatrists were rarely visible. They were absent because they either needed to attend meetings at the Parent Psychiatric Institute or were distracted by the pressures of running a private practice, testifying in court, or conducting research and presenting papers at conferences. Midway was physically separated by two floors; the inmates, or clients, were housed on the second floor, and the administrators, psychiatrists, and psychologists were located on the first floor. This arrangement symbolically represented and reinforced middle and upper management’s lack of visibility and care. This perception was reinforced by their periodic inane or irrelevant comments and diagnoses that appeared to be made on the fly during their infrequent visits to the unit. This increased our perception, and maybe the reality, that management did not care enough about what happened on the ward. In general, the nursing staff considered them to be rather incompetent and out of touch with the day-to-day issues involved in running a psychiatric ward. To keep up pretenses, the professional staff (i.e., psychiatrists and psychologists) would periodically lead a group. Under the label of group therapy, this “drama” was really another opportunity to provoke and evaluate patients, as otherwise quiet patients might speak up, which would be a chance to develop content for the patients’ files. And for this reason, it became clear to many of us that this process was a coercive display of sleight of hand. In sum, we got the impression that senior management really did not care about the patients.
Contradictions

Because Midway is a government institution, many of the factors that go into cost-benefit decisions appear to be much different than those traditionally expected in the private sector. For example, decisions to admit individuals for psychiatric evaluations over a longer period of time were not necessarily made based on the demand presented by the patient (i.e., how complicated the symptoms appeared and the necessity of providing an accurate diagnosis) or at his or her lawyer’s request but rather on the availability of bed space. It appeared as though if upper management determined that we needed more beds filled to keep our enrollment numbers high, then there would be a greater pressure to admit rather than reject candidates. Also, while management complained about the fact that P.A.s were putting in a lot of overtime, nothing realistic was done to resolve the root problems such as the inflexibility of management in granting leave time.

My fellow P.A. employees and I had difficulty understanding the underlying logic of administrative decisions and thus accepting the numerous and contradictory policies, procedures, and job expectations of the institution, as well as the behavior of most of the nurses, supervisors, and administrators. Inevitably, this contributed to an us-versus-them mindset and unnecessary stress. Specific problems included the following:

1. Ward policies and practices were constantly in a state of flux. Many were not written down in a policies and procedures handbook, posted on an announcement board, or generally available for patients and workers to read. This caused an incredible amount of confusion for patients and nursing staff alike. As a result, administrators were able to manipulate the patients and some workers who didn’t know any better because they weren’t aware of the appropriate ward policies and practices and past practices.

2. Midway, through its job descriptions and periodic subtle communications, emphasized the professional nature of the P.A. position. However, administrators were willing to hire people who lacked a counseling or psychology background. Indeed, the duties of the job did not truly require a bachelor’s degree, but candidates needed to be reasonably rational adults.

3. The institution was established to provide high quality mental health assessments. Ironically, some of the staff appeared to suffer from character flaws, and at least one of the administrators seemed to have
a serious anger management problem. Additionally, some employees engaged in poor work-related decision making. For instance, on several occasions, female nurses would, without hesitation, go into an interview room alone to speak with an alleged or convicted sex offender, which was considered to be institutional taboo.

4. Although we were responsible for patients’ health and safety, it took management a considerably long time to put us through any sort of appropriate training (including the previously mentioned first aid and CPR courses). Moreover, the safety-related equipment that we were issued for out-of-unit escorts and visitor searches was typically broken. When we went on external transport duty, the walkie-talkies we used to keep in contact with the nursing station were rarely functional. The same could be said about the handheld metal detectors used when patients had visitors. Despite the number of times we complained to supervisors about these problems, the equipment was not fixed or replaced. On the other hand, we were told (in a reassuring fashion) that although the devices did not work properly or were broken, they nevertheless served as symbolic deterrents.

5. Midway assessed and cared for the mental health of patients, but was unwilling to grant days off for staff, even if they were requested reasonably well ahead of time. Consequently, the burnout rate seemed high and naturally contributed to distress and lower staff morale.

6. Although the institution claimed that it used milieu therapy, this was more symbolic than an actual practice. Milieu therapy emphasizes the idea of an egalitarian workplace in which decisions concerning patient care and unit management are made collectively. It was clear, however, that there was a professional hierarchy and that, in reality, psychiatrists actually called all of the shots. P.A.s and correctional officers clearly remained on the bottom of the job ladder. Lip service was given to employee participation in ward management and to workplace decision making. Once a week, we were required to attend the nurses’ meeting. Most employees found convenient excuses to miss the meeting (e.g., emphasizing the need to maintain a certain level of coverage on the unit), which was typically treated as a joke by most attendees because none of the problems raised (particularly safety issues) would be addressed by the head nurse or senior management. For newcomers, these meetings were usually a means of blowing off steam and often involved middle management making
excuses. Since we were technically not nurses, it was difficult to hold management accountable. Although minutes were judiciously taken at these meetings at the beginning of my P.A. career, in the final half of my tenure at Midway, this practice was abandoned. Mysteriously, old minutes of the meetings began to disappear from the binder located in the nursing station. Although they may have been misplaced, most of the nursing staff interpreted this as another way that management was controlling dissent or minimizing accountability.

7. Periodically, academic researchers would visit the unit to conduct a study, and we would later obtain the resulting report or publication (e.g., journal article). The findings were often replete with what we believed were outlandish interpretations that reflected a rudimentary understanding of ward procedures and practices. This underlined the practitioner–researcher dichotomy found in many fields.

The contradictions of the work environment encouraged the loss of commitment to the ideals of the organization and, ultimately, disengagement. The differences between what was said (policy) and what was done (action or practice), led to absenteeism, apathy, cynicism, and antagonism. After witnessing or experiencing numerous conflicts or contradictions within the organization, frontline staff—P.A.s, correctional officers, and nurses—either increased their participation in union activity or began to mentally and emotionally disconnect or disengage. Part of the response may have been demonstrated through recreational drug use, alcohol use, and sexual promiscuity among staff members. Staffers would also work to rule, or do no more than what was required.

Loss of commitment was also manifested in passive-aggressive behavior. For example, each year management asked employees to fill out the self-evaluation section of their annual performance evaluation—initially a typical source of anxiety among many of my coworkers. With the union’s blessing, I as shop steward at the time instructed our staff that this was no time for modesty and to give themselves As for each of the categories listed. When confronted by the head nurse regarding this alleged act of “self-deception,” as she put it, we coyly asked for an explanation of why we didn’t in fact deserve such high marks for our performance. Also, in an attempt to deal with the head nurse’s failure to grant a shift change, P.A.s would often phone in sick with short notice or at the last minute. Although most of this sickness was legitimate, some was also the result of a passive-aggressive response toward
the head nurse and institution as a whole and was actually a somewhat effective method used to adequately manage a healthy social life. The thought, though rarely verbalized, was that if management wouldn’t grant a request for a day off, then the worker would simply phone in sick—though upon returning to work, the P.A. would most likely have to endure inane questioning by the head nurse.

P.A.s also took advantage, as much as possible, of their unused sick days; they would often combine sick days with vacation time. Although this employee strategy became a headache or nuisance for the charge nurse (and, in turn, the head nurse), coworkers believed that if middle management had been more flexible, then staff would not resort to these more devious methods. Alternatively, those who had lost faith in the organization would try, as much as possible, to work the evening or night shift, which would reduce the hours of contact we would have with not only the head nurse and middle management but also the patients.

When shift changes took place, the charge nurse would brief the incoming team. During this time, the nurse would orally review each patient’s progress with the incoming staff. Periodically, the charge nurse would go into elaborate detail about a patient. In an attempt to inject some levity into the situation and perhaps to make an underhanded comment on the futility of the process, some of us would say, in unison, “no significant change.” In all seriousness, it was difficult to find something new to say about many of the patients from one shift to the next. Similarly, in the context of reviewing what happened with a patient who had a history of acting out (a euphemism for being aggressive), the nurse related a story about how the person had been a pain that day. Alternatively, we would roll our eyes when the nurse would use catch phrases like the person is “coming to grips with the situation,” or is “showing insight” into his or her difficulties. It seemed as if all we were doing was processing people all day, and the ability to make meaningful contact or promote individual change was next to impossible.

Getting Involved

During the time that I started work at Midway, I also became more interested in politics. Specifically, I was interested in how a majority of mental health problems seemed to be a result of poor funding, an unequal distribution of wealth, and other socioeconomic, political, and social problems. I also came to question if people in positions of power
in mental health agencies (e.g., psychiatrists, many of whom became administrators) had a vested interest in maintaining but not necessarily changing the system. In September 1982, I entered my 3rd year at the University of Toronto and went on a part-time, on-call status at Midway. I continued at this level for another 2-and-a-half years, working full-time in the summer and over the Christmas and winter breaks and part-time during the school year. In January 1986, after I finished my undergraduate studies, I attempted to switch to full-time status. Following my previous boss’s footsteps, the new head nurse—in violation of the collective bargaining agreement—blocked my candidacy. Consequently, in an effort to redress the perceived wrong, I told a number of coworkers that I planned to launch a grievance. Within 24 hours, I received a call from the new boss with the job offer. I accepted and almost immediately asked the unit’s shop steward if I could take over his position. He happily agreed, as he found the responsibilities of the position to be an unnecessary burden.

The P.A.s, along with the cleaning crew and kitchen workers, belonged to the Service Employees International Union (SEIU). Despite the SEIU’s current strength in the American labor movement, it was probably mismatched for the type of work we did. Nevertheless, most P.A.s were averse to involving the union in their labor disputes. The situation later reminded me of Lukes’s (1974) and Gaventa’s (1980) theoretical and empirical work concerning the “Third Face of Power,” in which people, after having been beaten down numerous times, became resigned to not participating in political matters. Also, it appeared as if everyone perceived themselves to be white-collar workers who would soon leave the institution, and thus, they did not want to speak up, or make waves, out of fear that it would lead to a negative job recommendation.

I assumed the role of shop steward in an effort to retain a modicum of sanity and to protect workers from threats, violations of the collective agreement, and unfair labor practices by supervisors. I was responsible for representing 22 workers, including P.A.s, cleaners, and kitchen help. I memorized the union’s collective agreement, took a steward training course, and shortly thereafter launched the first grievance in the 9-year history of the institution. As frontline personnel, we were required to attend the weekly nurses’ meeting. The head nurse would schedule staff meetings in the mid-morning hours. This meant that if someone on the evening or night shift had a complaint, he or she would have to come in on off hours. For some, the meeting occurred during the time that they would normally be sleeping, going
to school, or taking care of their children. More importantly, those who came in to attend the meetings were never reimbursed for their time. Since this had been a recurring bone of contention, I used the issue as a test case for not having to work certain days of the week and for being properly reimbursed. While management was trying to figure out its response, I helped one of my coworkers—a 40-something Jamaican man who was suspended without pay for leaving work early because of a demonstrable sickness—get his job back without loss of pay and a permanent negative memo being added to his personnel file.

My fellow workers subsequently felt more empowered and came to respect my analysis, actions, and intent regarding our collective workplace justice issues. Shortly after these incidents, a business agent position (similar to that of a regional manager) opened up in the main office of the union. When I told my business agent about my desire to apply, he appeared to be very uncomfortable. Although it appeared as if it was an open competition for the job, the senior management at the union seemed to have already selected someone to fill the position. Eventually, I learned that both management and the labor union were, in effect, playing games with workers in their local (i.e., part of the union). To make matters worse, the chief shop steward worked out of Parent Psychiatric Institute and thus was not physically present in the same building as us. He was notoriously unreliable. When a grievance arose, both he and the union business agent were typically out of town. (This perception of disengagement was reinforced when the chief shop steward told us that his most favorite pastime was golf.) This incident and its outcome allowed me to better understand the political and organizational culture of my union.

**CONCLUSION**

In many respects, this chapter depicts a workplace where most of the managers are either ill-informed, poorly skilled, disingenuous, and/or corrupted by power. Indeed, an alternative explanation might be that the management and work related systems that were in place were well designed but had unintentional negative consequences, that some of the managers were well-meaning and tried their best with the constraints. Yet in my recollection, I cannot find any evidence to support this point. Most decisions were made a priori by the management and either announced to the frontline staff or introduced to my fellow
workers as it was something management was considering, and if there was some opposition, the language but not the essence was passed through a wordsmith, or carefully massaged. Management, to the best of its ability, also waited out the individuals whom it thought would be opposed to specific policy changes. Management hoped that employee fatigue and eventual quitting or retirement would help it prevail in the long haul. In general, however, managers used what one might consider to be a neglectful, authoritarian, routinized managerial approach in which staff members were treated disrespectfully and excluded from decision making, which led to low morale, poor working conditions, and tougher management tasks. Perhaps if a genuine TQM kind of approach had been taken, many of the problems could have been avoided and institutional management would have improved. In situations like this and all too often, typically staff respond to “the screwed up institution” with deviant adaptations (destructive to the agency and self)—calling in sick, manipulating sick and vacation days, exhibiting cynical and/or passive-aggressive behavior, excessively using alcohol and drugs, and so on. My work as shop steward, in which I helped my fellow employees, shows the beneficial impact that staff can have on the workplace. Also, it is a good example of a legitimate adaptation to unjust circumstances; instead of just griping about problems, I attempted to do something constructive about them.

In the end, most of us P.A.s got lucky. Some transferred to the forensic ward at Parent Psychiatric Institute. This provided a change of scenery and a temporary respite from the characters, policies, and practices that we’d had to deal with at Midway. Others finally graduated from their courses of studies and found different and hopefully better (i.e., more rewarding) jobs. As for me, I went to graduate school in the United States. In retrospect, the experience at Midway was not all dim. It provided me with the opportunity to rule out my desire to be a clinical psychologist. My stint as a P.A. also gave me an introduction to an often neglected branch of the criminal justice system that I had previously not encountered. Moreover, having practical experience in the criminal justice system has also allowed me a measure of legitimacy in my profession. As an added plus, my time spent working at Midway provides me with a source of countless anecdotes on which I occasionally rely during social functions and/or in my criminology–criminal justice classes. Midway allowed me to further understand the contradictions of the workplace and served as a good source of training for work as a college professor.
REFERENCES


RECOMMENDED READINGS


DISCUSSION QUESTIONS

1. If you worked with prisoners in a psychiatric unit or hospital, how would you view them—mostly as prisoners, mostly as patients, prisoner–patients, or something else? Explain your answer. Also, describe how your view of them might affect the way you act toward them.

2. If you had an entry-level job (with limited power) in a correctional facility and you thought that there were problems with supervision, administration, or organizational policies and procedures, what would you do in response to them? Explain why you would choose this response.

3. Imagine that you are a supervisor in a correctional facility and will be holding a staff meeting intended to teach staff members how to better get along and work together in reaching the organization’s goals. Based on Ross’s experiences, what advice would you give to the staff?