Neo-liberal politics of otherness in Italian psychiatric care. Notes on a team ethnography in six acute psychiatric wards

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Notes about a team ethnography in six acute psychiatric wards[i]

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Prologue: Psychiatric care in Italy before the psychiatric reform

Italy is the county where the Basaglia's psychiatric reform closed the the asylums and pushed psychiatric care into a new era (Foot 2015). Over the 1970s social movement contesting psychiatry challenged both 'institutionalization' (Goffman 1961) and coercive practices such as mechanical restraint. The "Mental Hygiene Act" (law n. 36) entered into force in Italy in 1904 and lasted for over seventy years almost unchallenged. It pursued the goal of managing, controlling and segregating people showing any form of otherness who were unable to cope docilely with – and adapting to – the extant Italian liberal, social and economic hegemonic imperatives. It prescribed the involuntarily admission to public asylums of people due to two main reasons: 1) alleged dangerousness and 2) public scandal. Involuntary admission resulted in a record on the person's criminal record. From 1904 until 1978 many political dramatic changes took place – twenty years of Fascism, WWII, a referendum on the abolition of the monarchy, and the promulgation of the Constitution of the Italian republic in 1948; then the 60s and 70s followed and new social movements emerged. Notwithstanding the changes occurring over the decades, the *politcs of otherness* maintain their neo-liberal footprint. Back then, just as it still occurs today, in fact, psychiatrists would often 1) *improperly hospitalize people* showing a form of otherness not always framed into a psychiatric disorder; and 2) *restrain patients* in order either to control their abnormal behaviour or even to allegedly cure it.

Segregation continued also after the slow introduction and spread of neuroleptics in Italy, which started over the 50s and the 60s; nonetheless, antipsychotics did greatly help the staff to control and "cure" the patients ameliorating the condition for both the patients and health staff. Paradoxically, the introduction of the neuroleptics facilitated the new phenomenological model of psychiatric care which emphasised the role of both interaction and dialogue between patients and clinical staff rather than the old model that was grounded in coercion and sedation (Babini 2009). Such approach would hardly be possible with acute patients before the introduction of those psychotropic drugs. Approximately over the same period, many Social Movement Organizations (SMOs) would start challenging some of the neo-liberal assumptions taken for granted so far in Italy and beyond; issues concerning civil rights, divorce, abortion, gay's and lesbian's emancipation, ecology, prison reforms entered both the political and the public agendas. Eventually, social movement contesting psychiatry introduced the issue of "mental hygiene" in the public arena (Crossley 2006).

Psychiatric care in Italy after 1978: the outcome of the deistitutionalization

In 1978, the organization of psychiatric care changed radically in Italy as a result of the entry into force of the Basaglia Law (Law n. 180/1978) that ordered to close the asylums and the development of community care. This reform – others would call it revolution – eventually occurred due to the work of some Italian radical psychiatrists (Foot 2015; Babini 2009); yet, Basaglia alone took the credit for it (Foot 2015). Basaglia stressed the relationship between mental health problems and socio-economic status with the sensibility of a sociologist; moreover, he claimed that the asylum was iatrogenic, and mental patients needed both freedom and rights instead. Policies and practices of inclusion regarding housing, work, social activities for the "mentally ill" entered into the picture for the first time in Italy back then. At the same time, patients with severe condition could continue to be involuntarily admitted and treated in the newly opened emergency psychiatric wards (S.p.d.c.)[ii] prescribed by Basaglia's law inside Italian hospitals; de facto at the national level only about a third of hospital do host an acute psychiatric ward and most of the psychiatric cure is carried out in community-based services. That law also regulated involuntary admission and treatment injecting, as a side effect, some form of accountability into the system. The reform made mental health cure very attractive for private companies who understood quickly the possibility of revenues that the mental health services could produces. It is not any exaggeration in Italy, nowadays – borrowing the Franco Basaglia's words – to talk about the *Business of Madness*. Moreover, the regionalization of the Italian NHS, back in 1978, affected the level of cure (and of mental health cure in particular) that each region can offer to its citizen, which now varies significantly from one region to the other depending (among other factors) on the regional' economic wealth characterizing one region or the other. Giarrelli describes the Italian National Health Service (NHS) eloquently by saying that it is difficult to understand it as a whole; rather it would be easier to describe the Italian NHS as a sum of twenty very different regional Health Systems. The implementation of Basaglia's reform reflected such heterogeneity. While some psychiatric hospitals shut down over the year following the reform, the last three shut down in 2000. Defined the historical background, let us now turn to psychiatric treatment today.

Psychiatric care in Italy nowadays

After the Basaglia revolution the Italian social and political climate has changed dramatically: populism and prejudice against otherness has grown significantly. Over the last decade or so, the Italian NHS performed expenditures cuts and reduction of investments, as well as the re-organization of mental health departments with the goal of economic efficiency, productivity and budget cuts, in a logic of neo-liberal philosophy. In light of a *Neoliberal market rationality*, *managerialism* the *New public management* spread

within the Italian NHS, thereby challenging the philosophy of Basaglia's reform, targeted on the suffering subjects and their social contexts. Reducing psychiatric-patients ratio, challenging the implementation of "anti-economic" policies of inclusion, pushing psychiatrists' productivity to the fore, and delegating to the GP the recourse to psychotropic drugs instead of other forms of slower, more effective – yet more expensive – relational therapeutic approaches. are only four of the relevant extant trends that challenge the practical application of the Basaglia reform. Moreover, new neoliberal managerialism entered the wards' hierarchies and clinical practices. Basaglia's more democratic models of managing the wards became outdated.

Our fieldwork suggests that it is important to bear in mind that working in an acute ward is demanding for all staff (Cardano, Gariglio, Ferrero Camoletto 2020). It is also important to bear in mind that being an inpatient is difficult. Vulnerable patients' cohabitation with other patients acting out, on one side, and staff difficulty in managing "disruptive", "abusive" and "violent" patient's behaviours while, concurrently, trying to provide care to vulnerable patients, on the other side, are 'business as usual' within any acute ward day in day out. We think that such a demanding context deserves to be taken into account of any further consideration. The dramatic cuts of resources and the huge heterogeneity of patients' profile for which medical staff are not equipped result in an impoverishement of the therapeutic relation frequently focused only in the medications somministration. A plastic representation of the phenomenon emerges from the the main results of our team ethnography in six acute psychiatric wards.

Two persisting politics of otherness emerging from a team ethnography

After approximately one year, the team ethnography (Erickson and Stull 1998; Cardano 2020) we are conducting in six Italian acute psychiatric wards, shows that the two politics of otherness – improper hospitalization and extreme body restraint – that had been characterizing the asylums before Basaglia law (1978) are still relevant, yet in different degrees, in extant acute psychiatric wards (Cardano, Gariglio, Ferrero Camoletto 2020). Nowadays, people are often still improperly hospitalized and restrained when – it is said – "the situation calls for it". This might well occur for some Boudonian "good reasons" (Boudon 1995); yet, subjects who experience improper admission and or mechanical restraint can be seriously affected by such experiences, if not traumatized.

Two issues remain open: 1) it is well-known that there is a certain percentage of inappropriate inpatients in any ward at any time (McDonagh, Smith, Goddard 2000); this is wrong both for the patient and for the health care system; 2) different forms of what we call 'extreme body restraint' are considered legitimate as an instrument of last resort in hegemonic medical discourse; yet, struggles are directed mainly against particular forms or restraint – *in primis* mechanical restraint – rather than against restraint and coercion as such. In what follows improper hospitalization and extreme body restraint measures will be analysed.

Improper hospitalization

Before delving into the topic at stake, a few words are needed on how to define improperor proper a psychiatric patient's hospitalization. This issue is quite controversial among psychiatrists in Italy and there are very different positions regarding it that can be represented by two idealtypes, emerging from our data, which we name, the inclusive and the choosy psychiatrist.

The inclusive psychiatrist role is played by Luca, a 49 male who expressed his position on the topic clearly saying that historically psychiatry had always cured, controlled and segregated a broad set of people and that, nowadays, it simply continues to do so.

> In the asylum a plethora of very different people entered the institution: the poor, abandoned babies, cripples, beggars, people in a state of misery, drug addicted, homosexual, neurotic and psychotic patients: sometimes they lived side by side, some others separated into different wards within the same psychiatric hospital. The problem shouldn't be that we don't want to admit improper patients. The real problem would be to find a way to define what a proper or an improper patient would be in psychiatry. I'd rather accept anyone if only I had enough beds to keep them all (ethnographic interview with a psychiatrist directing an acute ward).

The choosy psychiastrist, here represent by Marco, a 54 male, has expressed his concerns for the presence of a surfeit of inpatients who do not have any psychiatric diagnoses. He appear to construct more clearly who a 'proper patient' ought to be. He does it by pointing out those who do not fit and ought to be expelled from the system (others ought to care for them).

> Usually, we hardly have any empty bed in this ward because they think we are the garbage can. All sorts of people are sent here by the social services, the police, and so on and so forth, for any reason rather than an acute psychiatric crisis: homeless, petty criminals, refugees and so on. This is not acceptable because by so doing we cannot proprerly do what we are supposed to do: to treat mad people acting out and other people with serious psychiatric diagnosis that cannot be treated elsewhere. It is true, I know that there are not other similar services [similar to acute psychiatric wards] opened seven day a week round the clock. But, we cannot be required to accept anyone for whatsoever reason. We should refuse to do it. Yet, we keep on doing it. And patients pay for it (ethnographic interview with a psychiatrist directing an acute ward).

The first of the 'Politics of otherness', *improper hospitalization*, can be interpreted into two different forms: 1) considered as organization, acute *wards can be used improperly* to respond to some particular needs that can hardly be responded to by any other organization. 2) taking into account the patient, improper hospitalization can refer to the psychiatrist's construction of the improper (or the proper) patient. We start with the first form. Psychiatric wards are supposed to admit patients at any time, day-in-day-out, all year round[iii]; wards' main-doors are either locked up or controlled by nurses either formally or informally and neither patients nor other people can exit or enter without permission; for those reasons, acute wards are requested by different public authorities – such as other NHS's departments, hospital's wards, the social service, the judicial system and so on – to admit to , or to control coercively, any person acting out because the proper organization who is supposed to do it is unable (due to limited opening hours or staffing) or unwilling to do so. At this level, a web of cooperation and resistance shape the relationship between what we called public authorities and the only kind of ward in which involuntary admission and treatment as well as extreme body restraint (see below) are in place routinely. This point is crucial. Some

psychiatrists expressed clearly their concern about a situation in which they feel to be the "garbage can" rather than a normal hospital ward just like any other one. Those psychiatrists had a common refrain challenging a situation in which they denounced that whoever and for whatsoever reason can be controlled by pretending to lock them up into a closed acute psychiatric ward. They define the situation unacceptable and unsustainable.

The broader issue at stake here, would be to think about what the issue of 'improper uses of acute wards' is all about. There is little consensus about such definition. Moreover, what other kinds of facilities might be needed to respond to the urgent (and/or compulsory) needs of acute cure and/or control of people who apparently do not show any behaviour that psychiatrists would label symptoms but need to be coercively controlled? When and why would it be legitimate to lock up people who do not show any psychiatric symptom into an acute psychiatric ward? And for how long? From a certain point of view, it seems that the psychiatric institutions performed the role of the workhouses, during the period which precede the so-called "great confinement" (Foucault 2006, original edition 1972). The workhouses were the institutions in which were relegated all the people who do not fit with the emergent market system. The acute psychiatric wards – if the hyperbole can be admitted – carry on in this role, mainly for a short time, collecting individuals who do not fit the Neoliberal system.

The second form of improper hospitalization refers to psychiatrists' construction of the improper patient. Their expertise, a variable degree of consensus within their professional community, the local hegemonic professional culture, as well as institutional practices would produce and reproduce a particular label for a particular person on a particular ward. A psychiatrist has the duty, the authority, as well as the legal responsibility, to decide whether or not to admit a patient to a particular ward either voluntarily or – if necessary – involuntarily following a lawful procedure regulated by the Basaglia law. The Hippocratic oath should imbue any clinical decision, guiding clinical work all the times. However, the determination of a particular psychiatrist might sometimes also be influenced by intervening neoliberal factors. In fact, all of physicians working in any hospital wards – either acute psychiatric ones or not – in the Italian regionalized neoliberal NHS are indeed supposed to follow a set of managerial goals, which for the better or for the worse will influence, if not determine, their clinical decisions and practice. The evaluation of psychiatrists in the contemporary Italian neo-liberal system stresses *productivity*: managerial goals are paramount in regulating contemporary hierarchical professional relationships and might include among others: i) the minimum and maximum number of inpatients that are supposed to be accepted in any particular context; ii) the appropriate minimum and maximum number of inpatients' nights on the ward (the length of their stay);[iv]iii) the budget allocated to each patient's clinical examination and iv) the budget allocated to each patient for medications. On more than one occasion we have been told that an incentive-disincentive-based approach was in place in order to incentivize physician's compliance with the hospital's managerial

goals. From this point of view, the hospital is asked to follow the company discipline, sometimes sacrificing the cure and care functions imposed by the Hippocratic oath.

Considering both the construction of the improper patient and the organizational imperative of the hospital and the broader social-economic milieu of which the hospital is part, we might argue that the improper use of acute wards could possibly also be a strategic response to achieve the productivity target, quite independently of the level of care they provide to their patients, that not surprisingly have become "clients". On the one side the psychiatrists working in acute psychiatric wards can help discretionally other public authorities to solve their problem with some people not perfectly suitable to the institutions they are in charge of, by admitting them into their ward. On the other side, by accepting or refusing, admitting a person to the ward or discharging her or him/her from it, a particular psychiatrist could also regulate the ward's productivity and, in doing so, the hospital's interests (as well as their personal economic and career interest). In other words, the psychiatrists' decision might be also influenced by managerial targets suggesting to have as many inpatients per year as possible – with the prescribed average length of stay – rather than responding to each and every patient's needs and problems providing him/her with the best cure and the best care that are feasible.

An efficient economic policy is paramount in any organization; however, productivity does not seem to be the most appropriate measure to evaluate a physician's performance if we are to consider her or his primary mission: to care and to cure their patients as well as possible. In this perspective the risk is putting too much of an emphasis on the economics of treatment and rather too little to cure and to care as such and to patients' needs. Moreover, the presence of improper patients in the acute ward affect the possibility of "proper" patients in and out of the wards to receive adequate clinical attention. On one side proper psychiatric patients in the community (psychotic patients and other psychiatric patients) could experience delay in their admission in case of necessity due to improper allocation of beds. On the other, proper psychiatric *in*patients could not find an adequate attention due to the presence of very different extra-psychiatric and demanding needs to which psychiatrists and other staff can hardly find solution, if at all. Occasionally, another good reason to admit improper patients might be to get a potentially docile improper patient rather than a disruptive proper one who might be next to arrive; this might be another way to manage productivity, costs and risk (see below).

It goes without saying that helping improper patients can of course also reflect humanitarian, rather than strategic, reasons. It must also be born in mind that without the help of acute psychiatric wards in managing a plethora of different situations responding to very different improper requests, many situations *ceteris paribus* would simply become unmanageable at the local level or left unnoticed by turning a blind eye.

In the last part of this section we will point out briefly four of the allegedly more frequent set of cases of improper patients offering a short description and brief sociological assessment . The *first* case of improper patients would be: the extremely poor who do not cope with the hegemonic goal of the minimum productiveness and/or etiquette required of them by their status. Although "being" or acting bizarrely would *not* be strange for an artist, or intellectual working on TV; "being" or acting bizarrely and doing nothing productive while begging barefoot on the street, singing loudly, could be read as a possible symptom deserving psychiatric attention. The emergence of any form of potential violence or scandal-provoking behaviour (e.g. nudity) would possibly call for involuntary treatment[v]. This case can be described as the *(coercive) punishment and medicalization of the poverty* (Wacquant 2009, Rapley Moncrieff, and Dillon 2011). We observed a clear case of medicalization of poverty the very first day in the field in one of the acute psychiatric wards. This is the pertinent extract from the fieldnotes, related to Andrei a 50 years old Romanian tramp, that we met in E.R.

> They found Andrei wandering barefoot along the highway. He stopped to pee in a place where he was not supposed to do so. They called the Police who eventually took him to the E.R. [...]. The man is lying on a stretcher with his arms tied to it. In a small room, with him there are two nurses, three doctors and a cultural mediator. The latter asks Andrei a few questions to conclude rapidly: "he is hallucinating, he has got hallucinations". Andrei speaks out loud, in a very excited way. The mediator asks him what his name is; Andrei answers something that seems to me «Nu stiu», which is translated by the mediator as "I don't know". From the short exchange of ill-understood words on both sides and with a really modest help from the mediator, it emerges that Andrei is worried about his shoes and the jacket that he had with him at the time of the hospitalization. His things are in a big transparent plastic bag. They show him, but Andrei wants them close to him and and the staff complies with his request . He hugs the bag firmly and continues his bewilderment. Medical staff decide to give him a Lorazepam [it is a benzodiazepine medication] and an intramuscular antipsychotic in two successive injections. Andrei is turned on his side, and just says «Ahi» with a grimace of pain. He does not oppose therapy. The nurses decide, with the agreement of the psychiatrist, to wait for Andrei to fall asleep to complete the restraint to the lower limbs. [...] I do not attend the completion of the restraint, which is however carried out because when he arrives in SPDC Andrei is tied hands and feet to the stretcher, with leather cuffs, anchored to the stretcher with bandages (team-ethnography fieldnote).

The *second case* would be *the (coercive) medicalization of addictions* (alcohol, drugs, gambling, sex) in which the "abnormal" frequency of a conduct would be constructed as a pathology deserving a psychiatric assessment, rather than a habit. Third, any person's conduct that does not fit in extant society's goals can be neutralized and controlled by using an appropriate psychiatric label selected ad hoc from the DSM: for example, "antisocial disorder". We can call this the *(coercive) medicalization of deviance*; lastly, criminals, or patients showing repeated very abusive or violent behaviour are usually admitted for their abnormal and disruptive behaviour while on a waiting-list elsewhere in a secure ward for offenders (REMS) where they are supposed to be cured and controlled for as long as necessary to be sent back to the community afterwards; we can call this the *(coercive) medicalization of crime*.

All these categories of 'improper psychiatric patients' as well as others – such as eating disorders – are fuzzy, socially constructed and unstable (Johansson, Skärsäter, Danielson 2009); they can vary both in time and spacially. One patient that we met in the field introduced the topic of medicalization talking with a psychiatrist about homosexuality.

Umberto [a guy with a mystic orientation and bizarre thoughts] has been moving nervously back and forth in the ward's corridor for a while. By entering into a room, he is face to face with a psychiatrist, Maria. Umberto talks pretty loudly and with entitlement

tells her [almost pretending to teach her]: "Homosexuality was considered [by psychiatrists] to be a disease to be cured with medicines until twenty years ago, or so. Now, that's not the case anymore. I do respect Homosexuals, […]. I just say this in order to say that things can change [and do change] and to remember that what is read as a disease today [maybe referring to his "mystic delirium"], might be well read differently in the future" (team-ethnography fieldnote).

Notwithstanding homosexuality has ceased by the publication of the DSM 3R (1987) to be considered a disorder (which could occur with different degrees of severity), it is not equally well known that gender dysphoria still continues to be medicalized. Medicalization, following Conrad, "describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders" (Conrad 1992: 209). The broader issue at stake here, would be stopping thinking about what is more or less appropriate for a particular type of ward and starting instead to concentrate all efforts and budgets on trying to cope and to respond, if not care, as well as possible to the growing complexity, multiple, multifaceted needs that many vulnerable people experience day-in-day-out in our neoliberal society, trying to get along with their difficult lives.

Extreme body restraint: mechanical and anaesthesiological restraint

The second politic of otherness is the 'extreme body restraint'. The next two subsections will focus on *two relevant aspects* of *extreme body restraint*: 1) the discretionary construction and definition of a particular behaviour as 'unmanageable disruptive behaviour', which consequently is likely to trigger extreme body restraint; 2) the heterogeneity (and moral hierarchies) of the forms of extreme and less extreme body restraint; 3) eventually the discussion will delve into the difference and similarity as well as pros and cons of mechanical and anaesthesiologic restraints as means to manage 'unmanageable disruptive behaviours.'

The construction of the 'unmanageable disruptive behaviour'

By the expression 'construction of the 'unmanageable disruptive behaviour' we refer to the social process occurring in all of acute wards that is likely to lead towards the use of *extreme body restraint*. It is a discretionary process we observe in the field. Psychiatric staff's definition and construction of what an 'unmanageable disruptive behaviour' is like, and how to deal with it, vary significantly, between wards - each inhabited by a locally hegemonic culture – and to a certain extent also within wards, where local antihegemonic forms of resistance are at stake more or less visibly. One particular psychiatrist in one particular ward may decide to restrain one particular person in one way or another due to her/his clinical condition during the day and not to restraint her/him with the same clinical condition during the night justifying his or her decision on clinical grounds. Being sociologists, we do not pretend to judge any clinical decision; yet, we did observe that in managing crises, other organizational issues were also at stake and this is clearly visible in the quantitative data on mechanical restraint that the psychiatrist part of our team collected (Claudio Carezana, personal communication). Usually, the 'construction of the unmanageable disruptive behaviour' does not occur formally, nor explicitly (although there might be a critical event

logged); rather we observe it indirectly in the field doing ethnography. The hegemonic ontology of mental health and illness embedded in any particular ward culture (from phenomenological, to purely biologically oriented ones), as well as different levels of staffing, education, reputation of patients, and personal psychological orientation of personnel strongly influences the discretional staff attitude towards constructing any particular behaviour in a particular context into a 'unmanageable disruptive behaviour' that needs to be tackled urgently.

Empirically, though, it is clear that by defining any behaviour as an 'unmanageable disruptive behaviour' more often than not staff would evoke a 'state of necessity',[vi]which refers to a situation of 'unmanageable disruptive behaviour' and very dangerous for oneself or another that is regulated by the Italian Penal code (art 54). We will elaborate on how the unmanageable disruptive behaviour is managed in the Italian acute psychiatric ward in the following sections.

The heterogeneity of extreme body restraint techniques

The 'implicit coercion logic' (Gariglio 2018: 81–101) is a key feature of coercive organizations: anyone involved in any particular interaction knows that staff can use coercion when the situation calls for it. Acute psychiatric wards, and asylums, prison and migrant detention centres alike, are – in different measure – 'coercive organizations' (Etzioni 1961). Acute psychiatric wards are locked or controlled by nurses or security staff. Neither in "closed" nor in "open" wards inpatients are allowed to exit the wards without formal or informal permission to do so. Asylums were mostly oriented towards coercion and control. Acute psychiatric wards shifted their focus towards cure and care and mainly for a short period of time; nowadays, they have to balance, concurrently, cure, care and control of inpatients. All of the Italian acute wards provide at least the minimum necessary medication, exams and treatments without any cost for the patient; in other words, all provide *cure* to their inpatients to some extent. By the same token, independently of the forms of extreme body restraint adopted in any particular ward to tackle what we called 'unmanageable disruptive behaviour', the relative emphasis put on *care* or *coercion* is paramount to distinguish wards (and wards' culture) from one another. While extreme forms of coercion occur in all wards, their frequency and the staff's attitude towards such practices varies significantly from one ward to the other. Concurrently, the orientation towards care varies too[vii].

Mechanical restraint versus anaesthesiological restraint

The extreme body restraint techniques aim to take control over the embodied otherness of the psychiatric patients. The first technique is mechanical restraint. In Italy, it has persisted over the years of Basaglia's reform imbuing everyday staff-patient interactions in most Italian wards; that technique was indeed the "trademark" of most, if not all, of the Italian psychiatric hospitals; the frequency of use of that extremely

coercive technique varied from one psychiatric hospital to the next. Our team ethnography, as well as the extant Italian literature (Piccione 2018; Mauceri 2017), suggests that not only do Italian acute psychiatric wards show a continuity with the past in terms of coercive measures and techniques, but also, that they show some innovations that were introduced in an effort to challenge and get rid of mechanical restraint. Nowadays, on the one side, the majority of the psychiatric wards use mechanical restraint frequently if "the situation calls for it" showing, by doing so that mechanical restraint is taken for granted. On the other, another extreme form of body restraint has come of age, silently and quite invisibly bringing chemical restraint to a new level: 'anaesthesiologic restraint'. Chemical restraint is the use of psychotropic drugs – benzodiazepines and antipsychotics – as the means to control the behaviour of patients, rather than curing them, by reducing their resistance, inducing or forcing cooperation, and partially or totally impairing their body functioning and mobility. By anaesthesiologic restraint we describe the newer practice of transferring inpatients from the acute psychiatric ward where they are treated for psychiatric symptoms to some kind of intensive or semi-intensive care wards to control them. Adopting anaesthesiologic restraint anaesthesiologists and other intensive or semi-intensive care staff practice deep sedation, if not general anaesthesia, to the person under clinical monitoring, to avoid using mechanical restraint. Anaesthesiologic restraint can last from a few hours to a couple of days, while mechanical restraint can last – in extreme and deplorable cases[viii] – some weeks.

It is noteworthy that here, a proper on-label psychiatric treatment with psychotropic drugs, which induces sedation as side effects is not considered chemical restraint. By the same token, people intoxicated with alcohol or other drugs, or showing organic or neurological problems that are treated at the E.R. for clinical reasons cannot be considered under the label 'anaesthesiologic restraint'; rather it would be simply considered emergency care, which by the way, more often than not is practiced with the patients fastened to the bed. We only consider anaesthesiologic restraint, the practice of using anaesthesiologic drugs in order to control the behaviour of an uncomplying and disruptive proper psychiatric patient showing 'unmanageable disruptive behaviour' (see above) in those wards in which mechanical restraint is out of the picture.

It is important to note that mechanical restraint is very common and normalized in many Italian wards (Mauceri 2017); in contrast, anaesthesiologic restraint is still very rare and it is considered an innovative emergency procedure. It is also important to underline that deep sedation – referring to our field experience – is ruled by a protocol between the psychiatric ward and Intensive care unit. While we agree with those who try to challenge mechanical restraint, in this chapter we interrogate both practices and try to be critical of both of them.

The relevant topic is the level of care that wards are able to provide to their inpatients. Our research seems to suggest that wards showing a higher level of reflexivity on their practice and on coercion – whatever the

version might be – are more likely to provide a high standard of care; the opposite is not necessarily the case.

Both forms of extreme body restraint (as well as chemical restraint) are, first of all, means to control the 'unmanageable disruptive behaviours' rather than a therapeutic measure; by adopting those measures staff can control patients who do not obey to the Neoliberal credo of industriousness and obedience to the social rules. The expression 'extreme body restraint' acknowledges (and assumes) that both mechanical and anaesthesiologic restraint coercively enforce the annihilation of the person into an unoffensive inpatient's body; both are ethically problematic; however, whether or not any of these particular practices are *extra legem* or *contra legem* is so far unclear and contested; its lawfulness might vary from case to case (Algostino 2020). The experience of extreme body restraint, although occasionally necessary, can only stress, reinforce, and perform both physically and symbolically another aggression against the patients' agency and therefore ought to be avoided as much as possible. Annihilating patients' body and their agency appears to be a way to get rid of the organizational and moral problem that a severe crisis creates. However, within acute psychiatric wards, a form of extreme body restraint might be necessary to respond to 'unmanageable disruptive behaviour' in an effort to lower the risk of injury to anybody at the scene[ix].

Both practices of annihilation seem to refer – although differently – to the ontology of the 'broken brain' (Andreasen 1984). The moral innocence imbuing the practices of mechanical restraint that we observed in the field seems to shift towards an ontology of a *broken brain*; on the contrary, a shift towards an ontology of a *temporary broken brain* imbues anaesthesiologic restraint. It is important to bear in mind that the adoption of anaesthesiologic restraint is a means by which psychiatrists try to stop mechanical restraint: in other words, it is their moral imperative urging them to use the first rather than the last. In most of the wards mechanical restraint is simply normalized and very little reflection on it, if at all, takes place. Moreover, our fieldwork seems to suggest that the importance of care was more likely to be emphasized in wards showing very critical attitudes towards mechanical restraint adopting it as infrequently as possible, if at all; on the contrary, the importance of social control, security and risk was more likely to be emphasized in the others.

Conclusion

In this chapter we delved into two politics of otherness that emerged in an ongoing team ethnography in acute psychiatric wards that shows some continuity between the old and the new model of acute psychiatric care across the institutional and organizational transformations introduced by the so-called Basaglia Law: 1) improper hospitalization; 2) extreme body restraint. After problematizing the idea of improper hospitalization, we introduced some ideas that might help us understand the phenomenon. Notwithstanding the majority of the psychiatrists have informally suggested that "the improper usage"

would be a critical issue emerging from general demographic trends such as the aging population, international migration and the consumption of new synthetic drugs. A few psychiatrists considered "the improper usage" unproblematic since in the asylums back then happened exactly the same. Some psychiatrists read it as a contemporary challenging problem draining resources to proper psychiatric patients in need of treatment; others consider it a sub-optimal yet pragmatic organizational solution for managing acute crises in a health-care system as yet incapable to respond to the need of those "non-psychiatric" patients. In the last part of the chapter we focused on the similarities and differences between mechanical and anaesthesiologic restraint (and chemical restraint in between). Despite the different motives pushing some psychiatrists to opt for the adoption of mechanical restraint and others for anaesthesiologic restraint, we suggested that both forms of extreme body restraint are indeed deeply problematic; yet, the use of anaesthesiologic measure is decisively rarer – and clinically controlled in an emergency department – compared to mechanical one. Moreover, we share what some psychiatrists explained to us: none of the extreme body restraint practices is safe; both practices are risky for the patients' wellbeing and for their mental and physical health for different reasons and in different ways. The decision whether or not to use one or the other form of extreme body restraint – or other less extreme ones such as holding or seclusion – ought to be always considered deeply problematic and must be considered as a temporary deep erosion of the citizenship rights. In conclusion, a crucial point is that in the extant neoliberal market rationality which infected progressively the Italian NHS, as well as the new public management seem to reinforce, rather than contrast, the spread of the two politics of otherness we briefly sketched in this chapter. By doing so we suggest that the philosophy that informed Basaglia's Law, which centred health policies on the suffering subject rather than on neoliberal imperative is at least partially put aside at the advantage of new economic targets. Although newer forms of managerialism have come of age and spread all over the country, some particular organized or unorganized groups of psychiatrists try resisting the neoliberal trends and in particular the two forms of otherness, more or less successfully.

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[i] This paper is the outcome of the initial stage of a team ethnography, which is part of a larger project on psychiatric care within Italian acute psychiatric wards (SPDC). The team also includes Raffaella Ferrero Camoletto , Eleonora Rossero, and Valeria Quaglia.
[ii] Psychiatric Ward for assessment and cure. In Italian: *Servizi psichiatrici di diagnosi e cura*. These wards has not more than 16 beds, on average occupied by patients 13 days (Starace and Baccari 2019: 27).
[iii] In some hospitals, if not everywhere, the director of the E.R. has the authority to compel the director of the Acute psychiatric ward to admit any E.R. patient in their wards. Very disruptive, violent patients can more easily be controlled – and possibly restrained – coercively within a closed ward imbued by an 'implicit coercion logic' (Gariglio 2018) rather than in a chaotic and open E.R. where it is more difficult to manage uncooperative people.
[iv] In one particular ward a psychiatrist told us: "if any patient doesn't stay at least for three night, we do not get any economic reward of it; Neither are we supposed to let inpatients to stay in excess of 12 nights. Both situations are inconvenient for our managerial target. Both are independent of the particular clinical condition of the patient".
[v] Paradoxically even patient potentially suffering from acute form of psychosis whose behaviors remained hidden in the fringe of society without provoking problems or disturbing the productive society would not gain any psychiatric attention nor any care.
[vi] In one ward they told us that before using coercion over inpatient, they would inform the police that they are going to coerce the patient soon by activating article 54. Usually, staff do not inform the police when using force; Police are contacted only when the situation in unmanageable otherwise. According to Penal Code Article 54, State of Necessity, "Anyone who has committed an act having been compelled to do so by the necessity of saving himself [sic] or others from the present danger of serious bodily harm, a danger not voluntarily caused by him [sic], nor otherwise avoidable, shall not be punishable, provided the act is proportionate to the danger [….]" (Edward M. Wise (translation) (1978) in The Italian penal code, which is in the book series The American series of foreign penal codes, published by Sweet &Maxwell Limited, London.
[vii] The literature shows that extremely violent environment can trigger new violence, malpractices (and even crime). The low-visibility of those contexts and a low degree of accountability might facilitate a process of normalization, if not banalization of violence.
[viii] Our team witness only one of those extremely long cases, durung the hospitalization of Umberto. After his release from prison due to severe psychiatric disorders he was taken involuntarily to the acute psychiatric wards to control him waiting for an empty bed in the forensic psychiatric service (REMS). Umberto had a reputation to be disruptive and violent and this was the reason for which he ended up to be restraint for more than a month "preventively" in order to avoid the risky situation to have Umberto moving freely back and forth in the ward.
[ix] In few occasions we have seen patient's asking the staff to be restraint; this might be interpreted either an expression of agency and self-awareness or as a sign of institutionalization. Moreover, we encountered some psychiatrists and nurses who consider restraint as a crucial part of the cure.