

The Value of Social Positioning Inside a Forensic Psychiatry Service. An Ethnographic Account from a Residence for the Execution of Security Measures (REMS)

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The Value of Social Positioning Inside a Forensic Psychiatry Service. An Ethnographic Account from a Residence for the Execution of Security Measures (REMS). In 2015, following the closure of Judicial Psychiatric Hospitals, the Italian NHS launched new forensic facilities: the Residences for the Execution of Security Measures (REMS). Inside REMSs, healthcare professionals work to rehabilitate individuals who have committed crimes and who have been judged both socially dangerous and mentally ill. Based on an ethnographic project within a REMS in Northern Italy, this contribution explores how healthcare workers balance their care role with the demands for social control imposed by the institution. The findings reveal that staff members often navigate conflicting roles, sometimes employing informal resistance strategies against institutional demands that conflict with their professional ethics: in this way they are able to negotiate their identity and agency in a highly controlled environment, particularly when managing sensitive issues like patients' sexuality.

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Introduction

This contribution deals with peculiar residential healthcare facilities, where offenders considered mentally ill and socially dangerous are hospitalised: The Residences for the Execution of Security Measures (REMS)². The first REMS was opened in 2015 and today there are 32 of them, variously distributed throughout Italy (Allegri et al. 2022). REMSs were introduced in Italy by the law 81/2014 with the intention of replacing high security forensic psychiatric hospitals. The administration of REMSs and their operations fall under the authority of the Ministry of Health, while security and external surveillance activities are conducted in collaboration with local judicial authorities.

The legal mandate of the REMSs consists in the rehabilitation of forensic patients: inside the REMSs, in-patients receive daily care, enacted by a team of healthcare professionals, aimed at their social rehabilitation. Since, however, REMSs' patients are sentenced to a custodial security measure, inside the facilities their personal freedom is highly restricted. Therefore, the various forms of healing treatment inside the facility are necessarily provided by the internal

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staff. Where rehabilitation and support are usually conceived as intersubjective practices, in which the significant relations of the patients also participate, for those hospitalised inside a REMS, care mainly comes from the healthcare staff of the facility. Because of this, the care relationship inside REMSs is built through creative and intensive engagement between patients and staff. As primary caregivers, the staff in this context face unprecedented expectations and relational dynamics due to the proximity in time and space with patients, which is dictated by the custodial and residential nature of the facility, leading to unique challenges and opportunities in patient care.

Despite their caring mandate, REMSs are nonetheless deeply rooted, like any other psychiatric institution, in that particular area of law that deals with curbing deviance. In fact, REMSs were designed to accommodate mentally ill offenders with a custodial sentence. The political objective of controlling the bodies of those hospitalised in REMSs is achieved through the legal mechanism of social dangerousness, which is enforced based on a psychiatrist's prognostic judgement and subsequently approved by a judge. At the core of the repressive need articulated by REMSs lies the collective challenge of managing deviance, which is tamed and excluded from political, critical, and public discourse through a process that oversimplifies the complex human experiences of those affected. This simplification is enacted through the use of legal and medical categories – such as mental incapacity or social dangerousness – that allow the displacement of embedded, real, concrete events onto an impersonal level, which on the one hand abstracts and compares life stories and on the other hand conceals the structural violence (Farmer 2004) that, in most cases, represents the real matrix of the experience of social suffering (Kleinman et al. 1997) of the offenders. This contribution aims at investigating how care is co-constructed between patients and healthcare staff within these facilities, given the structural constraints on which they are set.

Outline

This article delves into the issue of providing care for forensic psychiatric patients within a controlled environment. The data hereby presented were collected during research inside a REMS in the north of Italy. The research, approved by the Local Health Authority, the Department of Mental Health, and the REMS Management, aimed to explore how REMS personnel critically reflect on their practices and attitudes during a notable period in the facility's history. The research was carried out at the height of the Covid-19 pandemic, using qualitative methodologies specific to the ethnographic endeavour, such as in-depth interviews and participant observation. Accordingly, ethnographic materials such as interview excerpts and extracts from my field diary will be presented throughout this contribution to sustain my argument.

The goal of this contribution is to deepen the link between care and control that can be established in a forensic psychiatric context. I will present the ways in which the REMS' organisational environment pressures social actors into carrying out practices of social control and then I will show how behaviours and beliefs of the caring team can interact with the demand for social control made by the institution. To do so, I will first present the methodology, and the theoretical and ethical standpoint of my research. I will then illustrate the context in which my study took place: the reform of Italian forensic psychiatry that resulted in the birth of the REMSs and the REMS in which I conducted my fieldwork, detailing its most salient features. Having connected the individual and collective tensions observed during my research periods among staff members to the institutional context in which REMSs were established, I move forward to present my thesis: when a request of social control made by the institution is perceived by the team to be antithetical to its deontological conceptions, staff members can implement a number of informal resistance strategies, such as deviating from the rule. I will show how deviation from the rule can be enacted through the use and contextualisation of social positioning of individuals in relation to the group. This argument will be illustrated through the analysis of a specific theme, namely the management of patients' sexuality. I will demonstrate that through informal collective strategies aimed at mitigating the imposition of social control, the care team negotiates which elements are incorporated into the treatment relationship with patients, within the confines of a highly structured facility.

Methods: negotiating research in a time of crisis

The aim of this section is to explain the way in which my research experience inside a REMS was carried out. My access to the field was made possible by a scholarship launched in July 2020 by the Local Health Authority of a large city in Northern Italy, devoted to enhancing the self-reflective skills of the local REMS' staff. I obtained the scholarship that allowed me to enter a highly institutionalised context during a time of health emergency. The topic and timing of the research were decided by the Local Health Authority, but despite this initial direction, my contacts with the administrative offices were very sparse.

In October 2020, I began to physically attend the REMS – that will be renamed, throughout this contribution, “Villa Fiorita”³ – but the number of hours allocated by the Department to carry out the research was fragmented by the worsening of the pandemic situation. At times, I was unable to attend the facility – due to lockdown or periods of preventive isolation. During these

³ The names of the people and places that appear in the article have been changed, to protect the anonymity of those involved.

times of physical absence from the field, my work mainly consisted in attending staff meetings (which had been taking place online since March 2020) and conducting telephone interviews. Since the time allotted for conducting observant participation gradually crumbled, I was granted an extension in my scholarship to February 2021. However, I continued to work remotely to achieve the research goals set by the Department until April 2021. The outcomes of the study were shared with staff and patients in early summer 2021 and later turned into a report which I delivered to the Department in August 2021.

During the periods in which I could physically attend the facility, I agreed with Villa Fiorita's management to a weekly schedule that allowed me to introduce myself to the life of the REMS. Most of the hours were managed by me in total autonomy and mainly dedicated to participating in the daily life of the facility. The rest of the time was devoted to attending team meetings and patient group meetings. I did not attend the clinical activities that make up most of the days at Villa Fiorita (such as the patients' internships, therapy management and clinical interviews). Therefore, group meetings allowed me to access a dialogical space in which everyday problems – regarding the organisation model of the facility, the communal life, the therapeutic projects – were recounted and discussed.

My work plan was built in agreement with the two managers of the facility (a psychiatrist and a nurse who were part of the Villa Fiorita caring team) and periodically shared with both staff and patients. My first two months of fieldwork were devoted to conducting exploratory qualitative interviews with the staff. The goal of the interviews was to circumscribe in a co-constructed manner a specific theme to which to devote the final part of the study project and around which to organise a conclusive, horizontal and collective discussion. At a time of structural precariousness, such as the one lived by Villa Fiorita during the height of the Covid pandemic, I felt that the legitimacy of the research project had to be built inside the facility, not only towards the Local Health Authority, but first and foremost with the people I was meeting every day. Therefore, I tried to collect issues that were felt as 'urgent' and make the research a space of investigation that could resonate with the needs of the social actors involved.

The time of my enquiry was marked by a frenetic reorganisation of the facility to protect staff and patients from contagion, at the same time carrying on with the therapeutic projects in a condition of under-staffing and alternating periods of sickness among the workers. It was difficult to find space to conduct interviews, also due to my sporadic attendance. Although fewer in number than planned, in this context interviews seemed to have taken on greater emotional intensity: at a time of precariousness, they became a moment of outlet, where interviewee could go beyond the pressing immediacies of daily work.

In January 2021, I anonymously summarised interview results for the management. The most relevant data was a general sense of stress and fatigue. All staff members interviewed reported a sense of difficulty in working in teams and testified to tensions within the group. This situation was also confirmed by patients during our informal chats. To exacerbate the team's sense of unease was their awareness that the tensions within the group had possible consequences on the quality of relations with patients. At the heart of the issue lay different interpretations on the mandate of the caring team. Therefore, we decided to dedicate the last months of the project to investigate the different conceptions of health and care inside Villa Fiorita. I was also interested in understanding how the staff members, both individually and as a team, view their work and how their views influenced the way they build relationships with those they care for. My intention was to explore these topics in depth using focus groups and collective interviews. However, organising collective interviews during a health emergency and a staff shortage was going to be difficult. The two managers also raised the issue of representativeness: my research had not involved all the staff members up until this point (I managed to interview only 12 people out of a group of 27 workers). Therefore, we agreed to use a questionnaire to investigate, both with patients and staff, the different representations regarding the care work carried out by the team starting from the notion of 'good health'. In June 2021, the results of the questionnaires, collected anonymously, were presented to the two managers, who suggested organising a meeting to share my findings with the survey participants. The presentation to patients and staff was the final moment of the project and of my presence inside the REMS.

On one hand, the use of the questionnaire turned out to be partially unsuccessful: although designed to collect the staff members' opinions as extensively as possible, little more than half of the workers adhered to the survey. On the other hand, the questionnaire proved to be a valuable tool: not only did unexpected testimonies emerge from it, but the presentation of the questionnaire results became a collective and fruitful discussion with staff and patients about care, health and control.

Theoretical standpoint

In the course of this article I will bring together two sociological traditions seldom associated with anthropological works, yet particularly relevant given the nature of the data emerged during my fieldwork, pertaining the ways in which social actors can feel compelled within an institutional context to enact requests of social control or to resist them.

The first body of literature on which I will draw is the neo-institutional theory (Lounsbury – Zhao 2013; Scott 2008), a framework born within organi-

sational sociology that examines the influence of institutions on individuals and organisations. According to the neo-institutional theory, institutions – understood as established norms, rules and routines that guide social behaviour, formal or informal (Sedgwick 2017) – provide stability and meaning to organisational life. Central concepts in institutional theory on which I will draw upon are isomorphism (Powell – Di Maggio 1991), which describes the process by which organisations within a particular field become increasingly similar over time due to different types of pressures, and the pursuit of legitimacy that organisations follow to ensure their survival. Neo-institutional theory provides a comprehensive understanding of how institutions influence organisational structures, emphasising the significance of social and cultural factors in shaping the dynamics of organisational life. I believe it can provide an apt lexicon to deepen the embodied experience of my research participants who, working in a highly institutionalised environment, felt compelled to adopt or reject certain organisational styles based on different institutional pressures.

The second body of literature to which I will refer is social positioning theory (Harré – Van Langenhove 1991) that explores how individuals are positioned in social interactions and how these positions shape their identities and behaviours. Positioning theory emphasises the dynamic and relational nature of identity construction, continually negotiated and redefined through interaction. Language and discourse play a crucial role in this process (Barlett 2006), serving not only as a medium of communication but also as mechanisms that construct social reality and maintain social order. Positioning theory provides a framework for understanding how individuals actively participate in the construction of their identities within social contexts, emphasising the role of language, discourse strategies, and relational dynamics in shaping social interactions and identity formation processes. The element of positioning is crucial to my argument: I will try to demonstrate through the application of this theory to ethnographic material that, in order to resist to institutional pressures that ask staff members to adhere to an organisational model rooted in social control, social actors are able to exploit their own social positioning to reject the request.

Ethical dimensions

The intention of this contribution is not to ignore the structural, political and ethical difficulties that characterise research in a context of limitation of personal freedom, but to show how the research project and my presence within the REMS were shared with research participants. In an environment characterised by a hierarchical organisation, such as the health sector, where social recognition is detailed also by professional qualifications, the lack of recognition of the anthropological profile left open spaces of action that played, in the course of

my experience, both to my advantage and disadvantage: since I did not have a health professional qualification, my figure was not entirely superimposable on that of a caregiver, even though I was present in situations where patients were excluded and had access to privileged contacts with staff and management. On the other hand, thanks to my attempts to clarify on every possible occasion the mandate of my presence in the residence (i.e. research focused mainly on the work of the staff) and to share the results of my observations with the patients as much as possible, I was never fully included in either group or rejected. Selected, partial information was shared with me by both patients and staff, and they were all aware of this. My presence, albeit brief, was negotiated by staff members and patients, on their own terms, by choosing in which moments to include me and in which to exclude me. At the same time, over the course of the four months I physically spent in the facility, I perceived that my role at Villa Fiorita was gradually being inserted into the daily negotiations and power dynamics: for some, my work could be an opportunity to raise certain topics for collective discussion or to the attention of the management. For others, my interlocution with the Department could be strategic in bringing attention to Villa Fiorita and its understaffed conditions.

My positioning was in fact characterised by multiple loyalties (Pels 1999), mainly towards the staff and the patients, but also towards the Department: I had to be 'truly present' (Good 2012: 526) to what was being said to me while achieving the goals of the research project. Aware of the challenges, I tried as much as possible to open dialogues, with all those who participated in the life of the facility, seeking the company also of those who had said they were not interested in my work, to demonstrate that my presence was motivated not only by the need to complete a project of the Department, but also by my desire to be there. Whenever I deemed it necessary, I was generously granted (in a moment of extraordinary urgency) a space to intervene in group meetings to give updates on research progress.

Trying to fulfil the different bonds of loyalty that have always characterised anthropological ethics (Cefkin 2017), while using anonymity, I still find myself producing a report with 'circumspection' (Scheper-Hughes 2000): because of the peculiarities that characterise the facility with which this contribution deals, some elements (such as a more specific examination of my contractual framework; of the subject matter of the investigation commissioned by the Department; some of the content that emerged in the course of my work, in particular the results of the questionnaires) will not be discussed, convinced that the usefulness of the anthropological lens is not defined by its ability to 'represent', but by its ability to 'evoke' (Kilani 2012: 131) in dialogue and collaboration with other professionals and sensibilities.

Birth of a New Institution

The opening of REMSs represents the outcome of an important legislative, organisational and cultural change in the care of mentally ill offenders. In fact, in Italy, up until 2015, forensic psychiatric patients, if judged to be socially dangerous, were interned in Judicial Psychiatric Hospitals – a new name for the old criminal asylums, created at the end of the 19th century. Although the law prescribed a collaboration between the Judicial Psychiatric Hospitals and local public health services, these facilities were inadequate to provide effective care for their patients. Over the years, numerous complaints about the therapeutic shortcomings of the Judicial Psychiatric Hospitals were expressed by staff, activist groups and jurists. Nevertheless, their closure was a long and troubled process. In 2008, a parliamentary commission was set up to investigate the living conditions inside Judicial Psychiatric Hospitals, which at the time were six and had more than 1,500 inmates. The investigations reported information on the facilities' administration and hygienic and sanitary conditions. Among the considerations developed by the commission, the problem of physical and pharmacological restraint occupied a prominent position. The enquiry therefore ascertained the need for a legislative reform of forensic psychiatry (Saccomanno – Bosone 2011).

After numerous decree-laws, Judicial Psychiatric Hospitals were abolished⁴. While policy makers were trying to figure out where the patients who were previously interned in the Judicial Psychiatric Hospitals should go, the creation of a new institution was drawn up: the name 'Residences for the Execution of Security Measures' appeared for the first time in the very first decree-law that spoke of definitively overcoming Judicial Psychiatric Hospitals. The new facilities were to have radically different characteristics from their precursors. First, REMSs were to contain fewer patients, to prevent overcrowding. Secondly, the internal staff was to be entirely medical and not judicial. And thirdly, the administration of the REMSs was to be entirely placed under the authority of the Ministry of Health. These changes, foremost of legislative nature, and secondly of organisational nature, however signalled a cultural change as well: by moving these facilities under the authority of Ministry of Health, the Italian Government acknowledged that the care of forensic patients was to be placed in a predominant position over their detention. The reform allowed the elaboration of a new therapeutic and organisational model in the care of forensic psychiatric patients, but also the elaboration of a new semantic paradigm in their conceptualisation, that shifted from the institution of punishment to the insti-

⁴ By the law 9/2012, which, at article number 3-ter had as an object 'Provisions for the definitive overcoming of Judicial Psychiatric Hospitals'. For a more extensive discussion of the legislative process that led to the closing of Judicial Psychiatric Hospitals, see Allegri, Miravalle, Ronco, Torrente (2022).

tution of care. In this sense, their entrustment to healthcare facilities rather than prisons has been an arduous struggle for the affirmation of the constitutional rights of forensic psychiatric patients. However, although Judicial Psychiatric Hospitals were abolished by law in 2012, the last Judicial Psychiatric Hospitals closed in 2017. And some of the issues that those structures were based on are still at work in the new facilities, such as the difficulty of enacting a care relationship inside an institution built on the premise of social control.

The REMS Villa Fiorita

The REMS Villa Fiorita is a spacious three-story building, located on the outskirts of a northern Italian city. It is surrounded by a well-kept garden, and it would look more like a small school than a security institution if it were not fenced off by wire mesh and barbed wire. The entire building is surrounded by cameras, controlled by a security guard.

Inside the facility are hospitalised twenty patients, male and female, who committed a crime and who were sentenced to a security measure after having been judged to be affected by a mental disorder and socially dangerous. Patients can move freely inside the facility, in compliance with its rules, sharing the space with the staff: apart from the cleaning crew, security guards and the occasional visitors (such as lawyers, volunteers or external workers), Villa Fiorita is primarily dwelled by patients and healthcare personnel. The relationship between these two groups is necessarily close: the bond between patients and staff is based on therapeutic techniques shared by the entire team – legacy of years of joint training – and it represents the mainstay of the resocialization activities inside the facility. Due to the physical absence of the patients' significant others, the staff members are the only other social actors to be physically there: everyday, together, staff and patients shape the complex treatment process. Staff members become in the eye of the patients, for the duration of their security measure, parents, therapists, agents of repression, educators and more. This symbolic charge placed on the figures of staff members entails a significant dose of responsibility towards the way in which each worker relates with each patient. In fact, healthcare workers are faced with the task of building meaningful relationships calibrated to the needs of each individual patient, but also not to present themselves as inconsistent before the patients' group. Similarly, since the team is composed of about thirty workers (between nurses, orderly, psychologists and psychiatrists) patients are called upon to modulate their expectations and reactions towards a high number of different personalities. Consequently, the care relationship within REMS is strongly characterised by the need, demanded of both parties, to know how to position themselves in a processual and contextual manner, demonstrating the ability to respect the rules and, at the same time, accept discretion.

Since hospitalisation inside a REMS represents a security measure, it also entails confinement, which is managed, administered and controlled by a wide universe of regulations. Upon entry, patients must sign two documents that will regulate their stay: the personalised treatment plan and the Facility Regulations. The treatment plan represents the institution's healthcare vocation and consists of daily activities that take place inside and outside of the REMS enacted to achieve an evolution in the patient's health state. The personalised treatment plan is drawn up for each patient and implemented both by the facility staff and by that of the Mental Health Department. In it, great importance is placed on occupational therapy and the maintenance, where possible, of meaningful relationships with family members and the patients' social network. Outings also represent a central activity in the therapy of patients, who are given permission to leave the facility, accompanied by a staff member, to go on work placements, sports and cultural or social activities.

Alongside the individual dimension, represented by the personalised treatment plan, work and life inside the REMS requires constant collective alignment with the rules of the facility, represented by the Facility Regulations. The Facility Regulations were drafted by the facility's staff before the opening of Villa Fiorita, aided by judicial experts provided by the Court who added the rules pertaining to detention facilities. The Facility Regulations include rules of different nature, from the abstract to the specific, that organise every aspect of communal life: they lay down the ethical direction of the community, organisational aspects and practicalities. The Facility Regulations, consisting of a 20-page long document, clarify which objects may be possessed by patients, define mealtimes, the frequency of visits and so on. Within the Facility Regulations there are rules that come from different authorities: some have been written by the facility staff - mainly those that describe the principles of living together and lay down the ethical dimension of the care relationship. Others depend on the REMS being a healthcare facility: therefore, the management of smoking, nutrition, and the choices regarding the self-management of patients' health are very similar, in some ways, to the rules we must attend in a hospital. Others still depend on the fact that REMSs are also detention facilities, therefore subject to a number of prohibitions and prescriptions regulated at state level: patients cannot possess a cell phone; visitors have to be authorised by the Court; rooms are regularly inspected; certain items cannot enter the facility (such as pornography; drugs; alcohol; sharp items; lighters).

A part of patients' rehabilitation consists in learning to follow these rules. In fact, theoretically, all patients are expected to follow the same behaviour once they arrive at Villa Fiorita. However, it is very clear both to patients and staff that this is not possible: some patients, for example, do not speak Italian; others are not able to understand the meaning of regulations. Others criticise them and

refuse them. Therefore, every day at Villa Fiorita, rules are deviated from, both by patients and health workers. In fact, the rules that must be respected in the REMS embrace not only the patients, but also staff and visitors, who must comply not only with the Facility Regulations, but also with a code of ethics provided by the Department of Mental Health as well as the work goals that the team sets internally. Staff and visitors should not use mobile phones inside the facility; personal belongings should be left in a locked room; staff should wear a safety device strapped to their arm that triggers an alarm when pushed. Since the rules to respect inside the facility come from different authorities – who do not necessarily share an identical view of the work to be done in the REMS – it is sometimes difficult to trace back to the reason why a rule came into being. Prescriptions made externally by the Department of Mental Health, such as those regarding the use of funds for patient projects, or by the Court, can be perceived by staff as hindrances to their work. Internally imposed rules can also be challenged, as will be further detailed in the following section. Rules are not automatically adopted, neither by the staff nor by the patients, and sometimes are even challenged, on multiple levels and with multiple tactics: the staff may contest choices made by the Department; a group of workers may criticise decisions made by the managers; patients may reprimand the staff; staff and patients may denounce decisions made by the Court and so on. Within this context, deviation from the norm can result in a counter-hegemonic⁵ narrative, especially for the team when it is treated by external pressure as an agent of social control towards the patients.

Facing control

During my time in the field, an episode occurred that was particularly representative of the kind of tensions that shook the team during autumn 2020. It became known that a patient had managed to get hold of drugs - the use and possession of which is forbidden at Villa Fiorita. The drugs had been handed over to the patient during a patient-family meeting and the fact had remained unknown to the team for several days. This happened at the same time as a dramatic increase of Covid-19 infections and the subsequent adoption of additional safety measures to limit its spread.

After the staff became aware of the event, the management announced during a staff meeting that from then on, all meetings between family and patients (which had only been suspended with the first lockdown in March 2020 and reintroduced as soon as possible) would have to be supervised by at least one staff member. In other words, patients would not have been able to receive

⁵ By using the notion of hegemony, I refer to the legacy of Antonio Gramsci's work on critical anthropology (Ciavolella 2021). If hegemony refers to the use of moral and intellectual leadership to obtain political control, counter-hegemony is the action of subaltern subjects to resist their exploitation (Kurtz 1996: 108).

visits unless a staff member was present to monitor its whole duration. This decision caused great distress between the team, and the meeting in which this choice was communicated to the group was almost entirely devoted to discussing this new rule. Many were uncomfortable with having to supervise such an intimate and private moment in the daily lives of hospitalised persons. Others felt cornered by the knowledge that if they did not give their availability, uncovered visits would probably be missed.

Valerio, the administrative manager, was ambiguous in explaining the reasons behind this choice. On the one hand, he explained that theoretically every meeting should always have been supervised, and therefore the measure taken was a reparation for a shortcoming of the team itself. On the other hand, he highlighted the seriousness of what had happened and the responsibility of the staff team in not preventing it. Ultimately, Valerio presented this new rule as a decision taken by the Mental Health Department to ensure that during meetings patients and family members kept a safe distance to avoid possible contagion. There was also a practical question to be defined: in conditions of understaffing (such as the one in which Villa Fiorita was working in 2020) requiring a staff member to be present for two hours for a conversation between a patient and a family member meant making them unavailable to the team on duty. Here are some notes I took during that meeting:

Lorenza [educator]: "You can't have someone watching over a patient-family meeting for two hours: it's not sustainable!".

Stella [psychologist]: "If there aren't enough people to cover all the visits, it is better to suspend them all".

Davide [head nurse]: "Being on call at visiting times makes us feel good about our conscience, but we don't follow all the rules: when patients drop their masks⁶, we don't say anything".

Carlo [nurse]: "We could shorten the visits, so it's more sustainable for us to supervise them".

Stella [psychologist]: "So, if someone drives two hours to visit a patient at Christmas, you give them only 10 minutes?".

Daniele [orderly]: "Maybe we should ask the other REMSs how they are organising to avoid spreading Covid".

Fabio [health manager]: "You're right, I'll get to that this afternoon".

Lorenza [educator]: "We are talking about too many things and getting confused. What's the problem, why are we monitoring the meetings? Is it because of the risk of Covid contagion or something else? Because for me it makes all the difference!".⁷

⁶ At the time this meeting took place, it was compulsory to wear protective masks inside health care facilities.

⁷ My field diary, notes taken on 20/11/2020.

Discussions of this kind were frequent during the period of my participation in team meetings. At the centre of the discussions was the need to deal with a mixture of care and control that characterised working in REMS. The stress was also caused by the conditions in which the facility was working in 2020: the team was fatigued by the management of the Covid emergency and by the under-staff situation in which it had been operating for some years (at the time of my attendance, Villa Fiorita's team was down of three units). In such a situation, the process of negotiation between the professional and ideological positioning of each practitioner and the formal and informal demands of control inherent to the REMS environment gave rise to discussions, rooted in the organisational, political and cultural model in which the REMS was inscribed.

The team of Villa Fiorita was mostly composed of professionals from the field of psychiatry who had voluntarily chosen to work in REMS. The group consisted of many professionals trained within the radical psychiatry movement (Foot 2014), convinced that psychiatric services were to be organised in a community direction. Most of them had believed in the possibility of democratic projects within psychiatric services. Not everyone was convinced that REMSs were the place where this could become possible, but many had been willing to try. As the years passed, the staff, although convinced of the therapeutic potential inherent in the REMS project, was confronted with the implicit and explicit demands for control made by the institutional environment. The demands, constant over the years, responded to the organisational requirements of the institutional context in which the REMS is inserted. The structure of organisations, in fact, is determined not only by the strategies and objectives set by the management, but also by the progressive absorption of rules coming from the actors institutionally in charge of planning and external control of particular activities (Scott 1994) – in this case the Department of Mental Health, the Court, the Ministry of Health and, by extension, the State.

Why and how organisations change is the question at the heart of neo-institutional theory (Powell – DiMaggio 1991). Despite criticisms (Alvesson – Spicer 2019), since its inception in the 1980s, institutional theory has been a useful tool for interpreting the behaviour of organisations, understood as heterogeneous fields composed of multiple social actors in a highly interactive relational space (Wooten – Hoffman 2017). According to the neo-institutional theory, organisations are driven to produce goods by technical and economic pressures, but their survival is also linked to the ability to gain social legitimacy (Powell – DiMaggio 1991). Organisations have to adapt to an environment that constantly poses demands, politically and culturally determined (by laws, courts, interest groups, public opinion, etcetera). Driven by these pressures, the standardisation of work practices responds not only to an actual technical need, but also to the possibility of obtaining legitimacy from stakeholders – and

consequently more resources. Similarly, the rules that structure work in Villa Fiorita are modified and transformed within a conflicting relationship between the staff and the external institutions⁸ (i.e. the Mental Health Department and the Local Health Authority). Institutional pressures to change organisational models such as the one expressed by Valerio to supervise patient-family meetings, in response to an unspecified solicitation from the Department, contribute to the standardisation and control of the care work within Villa Fiorita, by implementing pre-established standards of procedure, applied to other similar, but not equal, psychiatric facilities.

In analysing the relationship between institutions and organisations, DiMaggio and Powell (1983) introduced the concept of isomorphism, understood as a process aimed at establishing structural conformity. Isomorphism helps explore how hierarchical organisational models respond to the stresses of the institutional environment. Isomorphism can be coercive when enacted by pressures, both formal (such as legislative acts) and informal (such as persuasion) that institutions exert on social actors placed under their influence. In the ethnographic example quoted, this aspect would be represented by the decision, communicated to the staff by the Department of Mental Health via Valerio's figure, to supervise patient-family meetings. Mimetic isomorphism is based on the adoption of an external model perceived as valuable, assuming particular importance within contests marked by uncertainty (DiMaggio – Powell 1983: 150). This type of isomorphism is represented by the request made from Daniele to know how other REMSs had responded to the spread of Coronavirus. During my research, Villa Fiorita was under pressure from both these types of isomorphism. However, as pointed out by Wooten and Hoffman (2017: 66) the field in which organisations live is not “a collective of isomorphic actors, but an intertwined constellation of actors who hold differing perspectives and competing logics with regard to their individual and collective purpose”. In fact, neo-institutional theory does not view social action merely as a result of external pressures but encourages researchers to enquire how the institutional environment shapes, mediates and channels social choices.

When pressured to regulate care work, conflict arose inside the team. In the narrowness of the emergency, health personnel did not automatically adhere to requests. On the contrary, staff members evaluated each request in relation to their ethics and when the request was felt as non-relevant or detrimental to their work, they implemented antagonistic actions. In this sense, the relations between social actors and organisation does not move in just one direction: the relations between social actors takes place inside a structure resulting from the

⁸ Whereas organisations are intended as legal identities, institutions are to be understood as “larger contexts that have ... powerful effects on the larger society in which that organisation, and institutional context is found... An organisation is a hospital which stands within the institution of the healthcare system (Sedgwick 2017: 61).

organisation's activity that limits the possibility of action but that is constantly reproduced and transformed by actors themselves. In this sense, this relationship can be seen as a

“a recursively structured process. Agents do not create the field out of nothing. They recreate, reproduce or transform it from preexisting structures that make their actions potentially possible. Nevertheless, even though they are considered pre-existing, these structures only continue to exist through the reproduction and/or transformation of other structures that the agents find in their social actions in a specific combination of praxis and structure, historically and temporally localized” (Machado-da-Silva et al. 2006: 47).

Management of sexuality at Villa Fiorita

As aforementioned, the final months of my research were devoted to investigating what, according to the staff and patients, constituted a good health state. My interest was also to collect the staff's representations regarding their care work at Villa Fiorita. Of course, discrepancies may exist between representation and practices. During interviews, staff presented their professional identities as carers, adherent to the sphere of medical healthcare. The caring identity – strategically implemented within contextual contingencies – was brought into play sometimes in an essentialised manner (Baumann 1999: 81), sometimes more reflexively. Inside Villa Fiorita social actors positioned their professional identity in multiple ways: a healthcare worker might decide to refrain from carrying out a gesture that they consider inconsistent with their conception of care (like Lorenza in relation to the task of supervising patients during family meeting), but reprimand a patient who is not wearing protective mask, or incite them to take the therapy. This discretion can be explained by positioning theory (Harré – Van Lagenhove 1999).

Positioning theory, stemmed from social psychology (Davies – Harré 1990; Harré – Van Langenhove 1991) and later adopted and influenced by several disciplines, tackle the theme of how social actors position themselves through the “performance of socially meaningful (often discursive) acts within an ongoing storyline” (Barlett 2006: 117). Positioning is understood as a process, occurring in a specific time and place, through which subjectivities are produced (Holland – Leander 2004) and it can be useful to enquire the links between production of subjectivity and agency inside a social discourse⁹. Opposed to a static view of self and identity, positioning theory sees the process through which social actors position themselves inside a social context as a constant

⁹ Here the notion of ‘discourse’ is taken from Foucault (1969), where it is understood as an institutional infrastructure that “provide opportunities and constraints for individual action and cognition” (Deppermann 2015: 370).

back and forth, where “different facets of identity are relevant in different discursive contexts” and “people interacting with each other co-construct positions by their action” (Deppermann 2015: 370). The result of the social interaction is the microproduction of a social position that is always flexible, locally designed and socially shared. What I intend to prove in this last part of the contribution is that within Villa Fiorita the process through which staff members position themselves is not only a practice of negotiating and affirming one’s identity as a carer in a context of social control, but also as a way of expressing agency and opposition to the demands made by the institution.

In the course of my research, several patients shared with me, during our informal chats, a deeply intimate suffering, namely the absence of autonomy in managing their affective and sexual relationships. Inside REMSs, patients are forbidden to have sexual relations or possess pornographic material, as stated in the Facility Regulations. I decided to tackle the subject during interviews with the two managers. It was during these moments that it was made clear to me how positioning could become an agential practice.

“Amalia: Do you think there has ever been a relationship between patients inside the facility?

Fabio [health manager]: Look, it's probable, but I am not sure. However, as long as I don't suspect that this is happening in a violent way, either implicitly or explicitly, [that] there are no implications for sexually transmitted diseases and pregnancies... I don't know if they are still there, but once – you should ask Valerio [administrative director] – there was even a talk regarding leaving condoms around for patients to find. I think we still have them somewhere... for a while they were in an open drawer, easily accessible on purpose. I don't know if they are still there. Maybe they have expired. Anyway, they had been distributed during a meeting that we organised in collaboration with the Mental Health Department, when an educator came in to talk to patients about affectivity and sex. They were put inside a self-service bowl, something like that. But I can't tell you because I wasn't there.”¹⁰

According to Fabio relationships between patients probably happened inside the facility, even though they are theoretically forbidden. Goffman (2017) had already pointed out how total institutions are constantly traversed by dyscrasias that generate gaps between the normative structure – hierarchised and rigidly regulated – and the real, flexible and discretionary nature of the institution. Gaps are necessary to maintain the institution itself, since if the set of rules that regulate the facility were literally applied, they would paralyse the agency of the social actors involved. This makes it possible for Villa Fiorita’s staff to

¹⁰ Interview with Fabio, health manager, on 24/11/2020.

sustain an attitude of tolerance towards the non-compliance of the rule. Not all rules, of course, are transgressed: the rules that can be disregarded are selected as much collectively as individually and are profoundly influenced by the positioning of the social actors, their biographical trajectories and political and deontological convictions.

Fabio himself makes explicit the way in which he selects the rules relevant to his work. It is clear from his statement that he does not feel that he has to control the relationships between patients; this area is pertinent to his work only if it involves in some way the possibility of harming the well-being of the patients (such as in the case of violence, sexually transmitted diseases or pregnancy). Fabio also makes explicit the tactic that makes possible for him to resist the social control that, as health manager, he is formally supposed to preside over. By not knowing (or stating that he does not know) whether or not relations between patients took place or if and where contraceptives are in the facility, and by attributing greater involvement to Valerio (who, as administrative manager, has less responsibility) Fabio creates a space of uncertainty and, consequently, greater freedom: formally, he cannot be certain that relationships took place and that the rule was violated. Therefore, he is not compelled to perform acts of control.

Fabio particularly appreciated the discussion of this topic, which we carried on over the course of several conversations. One day we tackled the topic of possession of pornography and masturbation inside the facility, following a patient's request for pornographic material.

“Masturbation is a very complicated issue. I am quite against the use of pornographic material in a judicial facility because some of our patients have offences that have a sexual component. Pornography contributes to reifying the body of the other, which is one of the mechanisms by which sexual offences occur. On some patients, the use of pornographic material seems to me actively contraindicated. On others, not so much. It would be nice to be able to make it a customised aspect... The big complication is that if I let pornographic material into the REMS, I cannot let it in for someone and not someone else. It would be unequal towards the patients, but apart from that they would lend it out! It is difficult to find the right fit for these topics... In fact, I would be very curious to know how they have organised it elsewhere [in other REMs]. So, in general I think that is absolutely right to promote workshops on sexuality and affectivity. I think it is a fundamental discourse. Then there is always the issue that the aspect of sexuality in prison conditions is in any case an extremely contradictory aspect. I don't think we solve the contradictions by providing *Playboy*. Whereas I think that talking about these contradictions with a person is very helpful. On this, however, I would prefer it to be someone from the outside. I mean, I think I would be able to do groups on sexuality - I am also a certified sexologist - but I think I would be taking on too many roles at once and would inhibit the need

for patients to be able to talk about it in a natural way. So, on these things I don't see any absolute contraindications, I'd like to get it right, but we rarely have the conditions.”¹¹

This second affirmation paints a multifaceted situation, characterised by contradictions that cannot necessarily be resolved. For Fabio, reflecting with patients on sexuality and affectivity is an important aspect, but it must be calibrated and co-constructed. He cannot ignore the fact that they are nonetheless in a detention facility and that the possession of a pornographic magazine could hurt the psychological and emotional well-being of some of them. Nevertheless, Fabio does not dismiss the introduction of pornography in an oppositional and simplistic manner, but he shares with me the extent of his reflections. He recognises the contradictions inherent in Villa Fiorita concerning the topic and by virtue of these he prefers to wait until he can offer patients a horizontal discussion space managed by an external person. This choice also reflects the attempt to calibrate the personalisation of the rule for each patient to the need felt by the staff to treat each patient equally. I have already emphasised how inside the REMS the staff maintains a dual attitude towards patients: on the one hand, theoretically all patients should follow the same rules; on the other hand, it is necessary to personalise not only the therapeutic treatments but also the interpersonal relations between patients and staff members by virtue of the individual characteristics of each. Such duplicity allows the maintenance of a multifaceted and elastic working regime, but it places the practitioners in front of the challenge of having to justify why certain patients are treated differently. This duplicity does not disregard the universe of affective and sexual relationships: theoretically all patients are forbidden to have relationships and possess pornographic material. However, Fabio feels that this universal rule is limiting because some patients would be able to manage the possession of pornographic material. He thought about introducing a customised behaviour towards each patient. However, acting in a personalised manner would not be possible: the magazine, if given to one, quickly gets into everyone's hands. The point he concludes on is that the structural, organisational set-up of the REMS does not always allow for 'getting things right'.

Nonetheless, Fabio's speech shows a great ability to put his position on the line and look for alternatives. He makes explicit the challenge of reasoning out all the instances contained in his multiple positions - that of health director of a facility for patients subjected to a detention security measure, that of psychiatrist and sexologist. He could hold the workshops on sexuality and affectivity himself, but he sacrifices this possibility, declaring that he would rather not even be present. This choice is motivated by allowing patients to express

¹¹ Interview with Fabio, 10/01/2021.

themselves more freely but also to avoid a role overload. In fact, the team can open spaces of freedom and derogation from the rule by means of a mechanism for distributing responsibility according to each person's position. The mechanism would be burdened if Fabio took on too many roles at once, increasing his own responsibility in an unbalanced manner with respect to the others: it would be too difficult for him, by taking on too many roles, to participate in the rule deviation.

The mechanism is explicitly explained by Valerio, the administrative manager, with whom I addressed the same question. He confirmed what Fabio said:

“On sex life. Well, there are differences here. As a nurse, I am an advocate for promoting a discourse on sexuality within the facility. I even made attempts to get *Playboy* to a patient. But about this, the physicians are much more concerned. A couple of years ago, I called an ex-colleague of mine to come and organise a group on sexuality and affectivity here. Because I believe that sexual life and masturbation are very important themes. But here one cannot ignore that inside a REMS patients cannot have sex. What do you want to do about it? However: they cannot have sex, but my colleague had brought condoms and had put them in a place where they could take them. Because I believe that even for sexuality, your mum says ‘don't do it’, your aunt says ‘when you want to do it, come to me and I'll give you money to buy condoms’ – where there is teamwork, where everyone has their role. My role is to say to patients that they cannot. But someone else might have a different role [...]. Then, it should be talked about more, but it is not always possible to do so.”¹²

Valerio also paints a multidimensional and contradictory positioning. Firstly, he makes explicit his professional posture as a nurse, presented as distant from that of physicians, who are more concerned, in his words, with discussing such issues. His experience as a nurse leads him to believe that autonomous management of sexuality and affectivity in patients' lives is fundamental. However, he knows his role is to reiterate the prohibition (although, on an ideological level, he does not adhere to it). He expresses how important it is for everyone in the team to know their role in relation to everyone else's. This awareness allows teamwork (like between mother and aunt) to achieve a common goal – in this case, greater freedom for patients to make decisions about their health and intimacy.

Conclusions

Concerns about positioning are deeply rooted into the history of the anthropological enterprise (Cefkin 2017). During our scientific ventures we must be

¹² Interview with Valerio, nurse and administrative manager, 5/12/2020.

aware of where we are standing, in relation to ourselves, our interlocutors on the field and to the scientific community to which we belong. These same tasks are faced by the people we work with. In this article I tried to shed light on how Villa Fiorita staff members have to manage multiple positions, juggling the demands of the Department, of patients, of their bosses, individually and as a team. Sometimes they have to grapple with “simultaneous but nearly opposing gazes” (*Ibid.*: 122) as healthcare workers hired to perform care work in a situation of social control in which the patients’ freedom depends on their rehabilitation.

The birth of the REMSs is inscribed into the history of Italian forensic psychiatry, which during the 20th century expressed itself through the establishment of Judicial Psychiatric Hospitals. Because of it, the REMSs, however under the authority of the Ministry of Health, maintain a close dialogue with judicial authorities. What constitutes care work inside this type of facility is therefore a constantly negotiated matter: is it part of the staff’s duties to control patients’ sexual relations or monitor family meetings? Often this type of dilemma arises after an external explicit request to standardise the service provided by the staff. If read with the theory of neo-institutionalism, these requests can be seen as expressions of institutional isomorphism, a process aimed at establishing structural conformity inside institutions (DiMaggio – Powell 1983). However, Villa Fiorita’s social actors found a very compelling way through which derogate external requests felt as incoherent with the care work carried out inside the facility. That is by distributing responsibilities using social positioning. Staff members can co-construct for themselves flexible and non-standardized social positions by positioning themselves in relation to each other’s responsibilities, opening spaces where to deviate from the demands of social control made by the institution. That was the case of Fabio and Valerio, the two managers of the facility, that thanks to their strong self-reflexivity were able to position themselves in a way that allowed other social actors, with less responsibilities, to deviate from the norm, for example providing condoms to patients hospitalised in a secure facility. In this way, my interlocutors are able to calibrate their response and their eventual opposition to institutional isomorphism. By taking on multiple, sometimes contradictory positions, the staff of Villa Fiorita seek alternatives to the role that the institution they work for urges them to assume.

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