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Learning to labor in prison: How healthcare workers navigate carceral settings and the prison's legal culture

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Abstract

Taking the case of prison healthcare reform in Italy as an empirical basis, the article explores the ways in which legal intervention is materialized in the social relations, cultural horizons and operational practices of prison healthcare workers, focusing on the concept of (embedded) "legal culture". Drawing on the findings of ethnographic research conducted over the last nine years, the article explores the relationship between clinical and legal languages in everyday prison life: observations are made about the processes through which clinical assessments can be "translated" and "reinterpreted" into the language of legal codes specific to the prison setting. The results suggest the possibility of partially questioning readings that identify the processes of prisonization of healthcare operators as the sole cause of the reproduction of governmental elements in prison health practice. The legal cultures of prison staff and health professionals do not appear to be as different as at first sight.

Key words

Prison healthcare; law and psychiatry; languages; legal culture; ethnography

Resumen

Tomando como base empírica el caso de la reforma de la sanidad penitenciaria en Italia, el artículo explora las formas en que la intervención jurídica se materializa en las relaciones sociales, los horizontes culturales y las prácticas operativas del personal sanitario de las prisiones, centrándose en el concepto de "cultura jurídica" (arraigada). A partir de los resultados de una investigación etnográfica llevada a cabo durante los últimos nueve años, el artículo explora la relación entre los lenguajes clínico y jurídico en la vida cotidiana de las prisiones: se hacen observaciones sobre los procesos a través de los cuales las evaluaciones clínicas pueden ser "traducidas" y "reinterpretadas" al lenguaje de los códigos jurídicos específicos del entorno penitenciario. Los resultados

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sugieren la posibilidad de cuestionar parcialmente las lecturas que identifican los procesos de prisionización de los operadores sanitarios como única causa de la reproducción de elementos gubernamentales en la práctica sanitaria penitenciaria. Las culturas jurídicas del personal penitenciario y de los profesionales sanitarios no parecen ser tan diferentes como a primera vista.

Palabras clave

Sanidad penitenciaria; derecho y psiquiatría; lenguas; cultura jurídica; etnografía

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1. Introduction

Prison is a social and institutional context that, since its origins, has been affected by continuous reform processes aimed at tempering its numerous criticalities (Vianello 2019). Yet, despite these efforts of the law, it is challenging to envision prison as a social context embedded in transformative dynamics (Mathiesen 2006, Pavarini 2007, Scott 2018). Although the numerous reforms over the years have contributed to "renewing" the world of prisons and penal enforcement, they have also encountered resistance from an institutional field that often reproduces itself through informal dynamics, established practices, and local norms (Sarzotti 2010). In this sense, the provisions of the law struggle to find a faithful practical transposition in the prison context, becoming entangled in a relational network where they are subject to daily negotiation processes among the various groups working within and passing through it (Salle and Chantraine 2009, cf. Ronco 2014, Kalica 2014, Sarzotti 2016, Vianello 2018, Maculan and Sterchele 2022, Sbraccia and Vianello 2022, Verdolini 2022).

Regarding the Italian context, the case of the so-called Prison Health Reform (which is indeed configured as the outcome of a long and composite process of legal interventions in the field of health and health care in prison) appears emblematic in this sense (cf. Sarzotti 2016). Approved in 2008 following regional experiments, the reform marked the definitive separation of health sectors from the organizational chart of the Prison Administration, transferring responsibilities to the Ministry of Health and entrusting the organization and management of prison health services to local health authorities (cf. Starnini 2009). This division of competences, *de facto* giving the Regions the responsibility for implementing the regulation, has produced rather uneven results throughout the country. The inherently particularistic nature of the Italian prison system has thus been reproduced on the level of healthcare, introducing healthcare services as a further diversification factor in the configuration of what Pietro Buffa (2013) called "prison individualism", i.e. the idea (and the fact) that "each prison is a world unto itself".

Several years after the reform's approval, it is worth examining the concrete transformations it has brought about in local contexts. It is not merely a matter of assessing whether the reform has been correctly and fully "applied", but rather of sounding out the effects that the regulatory intervention has produced in the transformation of social relations between health workers, inmates and prison staff and the way in which these changes have taken root. These effects appear to be rather heterogeneous, mirroring the diverse local realities in terms of available resources to the health agencies, relationships between professional areas within the prison, characteristics of the inmate population, "vocation" of the institutions (in the famous distinction, entirely informal, between "treatment" and "punitive" prisons - Torrente 2018), management and governance "styles" (Signori 2016), and entrenched local legal cultures (cf. Sarzotti 2000, Prina 2018).

A comprehensive analysis of the reform's effects on the operational practices of prison health workers must consider two intertwined dimensions: one has to do with a more purely practical level, i.e. with the effectiveness of the principle of operational *autonomy* that the law granted to health workers with respect to the objectives and goals of the prison itself. These aspects primarily involve the modalities of interaction that have

come to be structured following the reform between prison health workers and prison administration staff, first and foremost with prison officers. These aspects, including encounters between different legal cultures, have been extensively studied (Cherchi 2016, Ronco 2018, Maculan and Sterchele 2022).

The other dimension focuses on the symbolic level, exploring the articulation of legal and professional cultures of actors and groups and the way in which these are situated in a more or less "external" position with respect to the cultural frames imposed by the prison, that is, with respect to its local legal culture (Sarzotti 2000, Prina 2018, Maculan and Sterchele 2022). This article will focus on this second aspect, illustrating how regulatory intervention can transform legal cultures and, conversely, how particularly entrenched local legal cultures sometimes end up depressing the transformative ambitions of the law. It is important to emphasise how the concept of legal culture is adopted here to account not only for cognitive schemes that more or less legally orient action, but also to indicate a set of representations and practices incorporated by the actors themselves, akin to Bourdieau's concept of "legal habitus" (cf. Bourdieu 1994, Brindisi 2009).

As a conclusion to the work, an attempt will therefore be made to instill some doubts regarding the cogency of the processes of prisonization in the "radical" transformation of legal cultures otherwise devoid of disciplining and controlling elements. From the research conducted, indeed, it appears possible to discern an empirical continuity of the elements of governmentality inherent in medical-psychiatric work between "internal" and "external" domains.

2. The path of the Prison Healthcare Reform in Italy

As mentioned above, the decision on the transfer of healthcare functions from the Department of Prison Administration to the National Health Service was legally formalised in 2008, following a long and composite debate between those who considered such a passage unjustified and counterproductive and those who instead saw it as indispensable for an effective application of Article 32 of the Italian Constitution (Sarzotti 2007). Until that time, the delegation of medical and health services to the administrative bodies of the prison, in some way, incorporated the health of the inmates into the components of the treatment pathway. This pathway encompassed all the activities envisioned for the re-education and future social reintegration of the prisoner. The regulatory paradigm shift aimed at externalizing the service by assigning the regional healthcare system (ASL) the task of providing healthcare protection for inmates. This move detached these services from the Ministry of Justice, thereby leading to the apparent and partial adaptation of the network of prison health services to the model of care provided for every free citizen. This transformation aimed for a more transparent adaptation of health services to the standards expected at the international level (Stern *et al.* 2010, Alves Da Costa *et al.* 2022), with the goal of enhancing the quality of the service provided (Piper *et al.* 2019) and implementing more effective and consistent governance and accountability practices (McLeod *et al.* 2020).

These guidelines identified the penitentiary institutes with the greatest need for health care and defined the necessary requirements for the respective Operating Units. The ASLs (Local Health Authorities) operating in the territories where prison institutes are

located then took steps to establish Simple Units with Departmental Valence (UOSD), situated in the Socio-Health Districts with territorial jurisdiction. Additionally, several regional laws further specified the services to be provided by these Operating Units, which include both general and specialist medicine, services related to the management of addictions, emergency management, nursing care, distribution of drugs, and social-health facilities, as provided for by the Essential Levels of Care (Livelli Essenziali di Assistenza - LEA) of the National Health Service. In order to better and more comprehensively perform their functions, the Operative Units of the Health Service in prison will collaborate, when necessary, with the Mental Health Department, the Addiction Department, the Prevention Department, the Social and Health District, and the territorial hospital network, aiming for integrated care and follow-up with a holistic approach (cf. Tadros *et al.* 2023). The configuration that health care has assumed in Italian prisons has thus taken the form of a system of health care facilities organized into hubs and spokes, differentiated by institution into multi-specialist or specialist cores depending on the care load and the size of the facility.

It is not possible here to provide a detailed description of the various healthcare facilities present in Italian institutions. For this information, reference should be made to the individual prison reports published on the Observatory website, coordinated and conducted by the Associazione Antigone. What we are more interested in delving into, with respect to the presentation of the research results that will follow, are the general dynamics that have affected the new paradigm of health care in prison following the regulatory innovation.

2.1. Prison Healthcare Reform in Italian Prisons

Taking a panoramic view of the effects of the reform in Italian penitentiaries, it seems that the objectives it set have been fully achieved on paper: in all the institutions, the health departments appear to be independent from the prison administration and directly linked to the local health authorities. However, this fact, while ensuring a dimension of formal independence that would enhance the service offered to detained users by moving towards equality in the enforceability of the right to health, appears more complex and nuanced upon closer examination. In this regard, several important questions arise: How is this independence manifested "in the field," i.e., in the concrete relations between healthcare and prison staff? How are the relations, now more explicitly triangular, between healthcare areas, prison staff, and prisoners reconfigured? What effects do these mechanisms produce regarding the objectives of enhancing healthcare for the prison population that the reform aimed to achieve?

The researches carried out over the last twenty years at the Italian and international level on the transition of prison health sectors to the National Health Services, while not failing to emphasise a general improvement in the forms of care (Ronco 2018, Piper *et al.* 2019), have reported some non-negligible critical elements. On a first level, it is highlighted how the health protection activities of inmates clash on a daily basis with inherent structural problems of contemporary Italian prisons: these have to do – as well as with the constitutive pathogenic bearing of the institution (Ronco 2018, Sterchele 2021) – first and foremost with the effects that a chronic situation of severe overcrowding produces both on the health of the inmates and the availability of staff and resources responsible for providing healthcare services to a user base with significant care needs

(Ronco 2018, Verdolini 2022). In this regard, inadequacies in the equipment and premises available to health workers are sometimes noted (Ronco 2014, Cherchi 2016), as well as general difficulties in guaranteeing inmates the possibility of leading healthy lifestyles (Smith 2002, Ronco 2016, Novisky 2018). What makes this finding more significant is a dynamic of general growth of an inmate population in conditions of increasingly strong social marginality, with problems related to mental health and/or drug addiction, in addition to the increase in the average age of an inmate population that is becoming older (Verdolini 2022). This dynamic, also noted at an international level (Turner *et al.* 2018, Peacock *et al.* 2018), confronts the health operational units operating in prisons with the need to take charge of a population with ever-increasing health needs and expectations of care – varying according to the social capital of health available (Novisky 2018, cf. Cardano 2008) – that the services themselves sometimes struggle to meet.

At a second level, what undermines the "independent" pursuit of treatment goals are the relational dynamics that characterise the prison environment, where – despite a dimension of "autonomy" legally recognised for health professionals – the imbalances of power that characterise the relationships between actors in the field actually re-perimetrate this operational freedom within a narrower framework (Cherchi 2017, Ronco 2018, Sterchele 2021). Indeed, the research conducted in Italy after the approval of the 2008 reform seems to indicate that, given the substantial reorganisation of health services in Italian prisons, certain frictions have emerged between health areas and those of prison administration. The widespread presence of these frictions, sometimes and in part due to conflicts between operators arising from operational divergences regarding the contingencies that affect the daily life of the prison, highlights the specificity of a socio-spatial and organisational context in which the action of the law only partially undermines the protocol rigidity of a set of cogwheels that often prove resistant to change (Salle and Chantraine 2009, Vianello 2018).

Health care workers in prisons often speak of being perceived as a "foreign body" within the organisational scheme of the institution (Sterchele 2021). This recurring metaphor testifies to a fundamental symbolic rupture within the monolithic unity of the prison, where the inclusion of a reality that now refers to a different horizon from the intramural – and operates in close contact with the territory – has created some difficulties in the daily organisation of institutional life. Research shows that the limited (and sometimes difficult) "cooperation" between groups is often reported as a common criticism from both sides (Sterchele and Toso 2022). On the one hand, health care professionals seem to be critical of the perceived overly procedural and standardised working methods of prison staff, which make the performance of some specific health care activities rather complex due to the institutional objective of maintaining internal security (cf. Maculan and Sterchele 2022). On the other hand, the surveillance staff and other actors under the administration, for their part, complain of a lack of willingness to cooperate on the part of health staff, who are accused of giving excessive and unjustified priority to the inmate's privacy dimension, which is described as a "wall" leading to considerable incommunicability (Ronco 2018). In this sense, these contrasting elements do not seem to be reducible to management difficulties linked to specific episodes, but recall a dimension of mutual otherness of the parties involved in terms of objectives, performance priorities, modes of action within the field and relational "styles" with respect to the "user" (cf. Maculan and Sterchele 2022). Indeed, it is not uncommon to be

told that these are two very different working "philosophies", articulated in different ways, both substantively and formally. In this sense, the need felt by medical staff to "meet" the demands and restrictions imposed by the prison administration – particularly, at a concrete level, by prison officers – sometimes requires certain "compromises" in order to ensure a daily working life free of obstacles and hindrances (Sterchele 2021, Maculan and Sterchele 2022). In this sense, it seems necessary to problematise the concept of "equivalence of care", as it is a harbinger of the risk of reproducing and reinforcing social health inequalities that pre-exist detention and which it risks reinforcing and exacerbating (Ronco 2018, Scallan *et al.* 2021).

In addition to the above-mentioned criticalities in the relationship between actors belonging to different administrations, research also identifies some "internal" difficulties in the field of health care itself, which, however, should not be understood as referring exclusively to the prison context, but as being present *tout court* in the field of health care. These have to do, in part, with the heterogeneity of health professional cultures, which – as far as this article is concerned – translates into a diversification of the legal cultures of health professionals themselves (Scivoletto 2018). Furthermore, the compartmentalisation of "health" into different professional domains, while allowing for more targeted and specialised interventions, sometimes risks being translated into a fragmentation of interventions, even in contexts of particular "concentration", such as the prison (Tadros *et al.* 2023). Once again, the possibility of implementing an integrated approach to health is affected, which then shows its most critical angles in terms of continuity of care when the transition from prison to the territory occurs at the end of the sentence (Rodelli and Sterchele 2022, cf. Byrd 2016).

The critical aspects highlighted above are also reflected in research that has examined the changes in prison health care from the point of view of the users, i.e. prisoners. Again, the problems highlighted are related to waiting times to access services that are prolonged by the bureaucratic pace of prison practices; the lack of staff, equipment and resources; the marked recourse to pharmacology in the face of the difficulty of providing more comprehensive and in-depth care; and a situation of generalised suspicion that permeates infra-mural relations (Sbraccia 2018, Ronco 2018, Fraser 2021, Zaitzow and Willis 2021).

Precisely from this last consideration, it seems interesting to propose an analytical lunge on the "legal cultures" of the operators (Sbraccia and Vianello 2016, Vianello 2018). Declining more specifically the analysis on the legal cultures of prison health staff, this article proposes to delve into a little-explored side of health work in penal institutions. This has to do with a study of the symbolic and practical frames adopted by health staff and how these have contributed to shaping the concrete effectiveness of normative interventions, in line with studies in the sociology of law that focus on the analysis of legal cultures (Nelken 1995, De Felice 2022). The analysis that follows will therefore aim to reflect on the role of the legal cultures of the various actors involved in the prison health sector, taking into account their transformation and resistance to change, and the ways in which they "absorb" and rework the regulatory frameworks of the prison context in the light of a transformed legal framework. In particular, the mobilisation of the concept of "legal culture" is aimed here at exploring the ways in which the encounter/clash between a legal culture "external" to the prison field (Sarzotti 2000) and

the local legal culture specific to this field (Prina 2018) impacts on the health protection practices implemented by health professionals. The latter, faced with sometimes conflicting regulatory elements and experiencing a daily tension with regard to the binomial of care-safety objectives (where the former is presented as an objective proper to the health sector, the latter as proper to the institution in which it operates), finds itself "vitalising" some legal elements to the detriment of others. This paper, based on empirical research, is intended to be part of a strand of studies that, in recent years, have examined certain aspects of the relationship between law and scientific knowledge in the sociology of law. In particular, as De Felice (2014) points out, these have been concerned with exploring the types and modes of "conflict" that can potentially arise between the two forms of knowledge; the types of conflict that exist within the scientific environment itself and the ways in which these are reproduced at the legal level; and the conflicts that arise from an interpretation of expertise as an activity of mediation between science and legal regulation. All these aspects will find their place in the presentation of the research results that follow.

3. Methodology

The analyses proposed in this article refer to some ethnographic research work carried out by the author over the last nine years in various penal institutions in Northern Italy (see Sterchele 2021, Sterchele *et al.* 2023). The aforementioned research took place mainly in two different periods, details of which will be given separately: the first, coinciding with the author's PhD, in the years between 2016 and 2020; the second, characterised by shorter research on different territories, between 2020 and 2023. The temporal continuity of the research work is provided by the numerous visits to prisons in the same geographical area that the author has been able to make regularly over the years as an NGO activist (with the exception of a significant restriction during the pandemic period), which can be framed as temporally extended forms of step-in/step-out ethnography (Madden 2022, cf. Cardano and Gariglio 2022). These, although configured as more sporadic research activities, have guaranteed the author the possibility of stitching together a continuity in the processes that have affected the Italian prison system in recent years.

The first phase of the research involved three prisons (Case Circondariali), all located in the same region of northern Italy: Zobeide, Ipazia and Maurilia. The aim of the research was to study the daily work of psychiatrists, doctors and other health professionals in the above-mentioned prisons, chosen for the presence of specialised clinical-psychiatric units. The empirical work was carried out using two main research techniques: participant observation within the penitentiaries and discursive interviews with health professionals working in the region's prisons. All three institutions had a predominantly male population, although each had smaller sections for female inmates. At the time of the research, Zobeide Prison had approximately 900 inmates, while Ipazia and Maurilia had 500 and 400 inmates respectively. All three establishments, located in urban areas, were rather overcrowded (120% for Maurilia and Ipazia and 180% for Zobeide) and characterised by a high percentage of foreign inmates (almost 60%). During the period of the study, the three prisons adopted an "open cell" regime, except for the presence, again in all three prisons, of one or more "closed" sections used for disciplinary purposes on the basis of reward-sanction assessments.

The participant observation within the three institutions lasted a total of six months (between the end of 2018 and the beginning of 2019), during which I entered one or the other prison two or three times a week during the morning hours (for a total of approximately 150 hours of observation, equally distributed between the three institutions). The participant observation took place mainly in the health care areas of the institutions under consideration: this made it possible to follow closely the daily work of the health care workers and their frequent interactions with inmates.

The participant observation was enriched by 20 discursive interviews with doctors, psychiatrists and other health workers on duty in the regional prisons (12 of which were audio-recorded, the others partially transcribed as they took place). These were conducted during the participants' shifts, mostly in their offices outside the prison. The fact of being in a place "other" than the prison undoubtedly favoured greater freedom in the exchanges, during which there was no shortage of critical remarks about one's own work, that of one's colleagues and that of the prison staff. The interviews lasted between 1 and 2 hours and were transcribed verbatim.

The various shorter-term research projects carried out in the second phase (between 2020 and 2023) focused mainly on four prisons in northern Italy. The first, an all-female prison, had around 80 female inmates and a regulatory capacity of 112 places. The second, an exclusively male prison with a small section reserved for transgender female inmates (cf. Vianello *et al.* 2018), had around 250 inmates, with a regulatory capacity of around 200 places (hence 125% overcrowding). The third, an all-male prison, had about 150 inmates, which is the planned capacity. The fourth, a large prison with about 1,200 places, had about 1,400 inmates (116% overcrowding). In these four institutions, the research activity was more intensive, with prolonged stays of about 10 hours a day for a week each, falling within what Cardano and Gariglio (2022) call "rapid ethnography". Again, the observation activity was enriched by numerous discursive and ethnographic interviews with the staff of the institutions under study.

During these nine years, the observation was also extended to ten other prisons in the same geographical area (Northern Italy), where access was granted as an activist of an NGO. Although this led to a more sporadic access to the prison (about 70 hours of observation in the years), the different position of the observer made it possible to reconfigure the regimes of visibility granted by the institution, guaranteeing access to almost all the places of detention alongside one or two prison officers.

In all cases, access to the field was made possible by formal authorisation from the Regional Prison Administration Board (PRAP) to carry out research activities. My position as a researcher was constantly negotiated with the participants throughout the observation period. An attempt was made to always make my position as a researcher explicit to the participants, and it was my belief that my stance in relation to the dynamics at play in the field did not remain a mystery to the participants, who always consented to my presence and answered my frequent questions with care and patience. I have tried to be as transparent as possible, considering the best way to respectfully report episodes and excerpts of sporadically overheard conversations. To ensure the privacy and anonymity of the participants, their names and those of the prisons in which the research took place have all been replaced with fictitious pseudonyms.

4. Learning prison. How healthcare workers get along with prison culture

The transfer of prison health functions introduced by the 2008 reform, as mentioned above, resulted in health professionals employed by the National Health Service entering and working in prisons. However, the transformation resulting from the regulatory intervention should not be seen as an abrupt and radical renewal of the organisation charts, but rather as a process of gradual transfer of operators (who in many cases were already working in prisons) from one public administration to another (Sarzotti 2016). Indeed, the reform has entailed a significant transformation of the health sector, stimulating the recruitment of new operators and redefining the intervention priorities of the entire sector (Sbraccia and Vianello 2022). This path has entailed the transposition to the level of prison health care of certain critical issues that, over the years, have come to affect the world of health care tout court.

Firstly, there has been a degree of precariousness in the prison health sector, whose structures have proved to be rather unstable due to the high turnover of certain personnel, especially general practitioners (Mancinelli *et al.* 2020, Rodelli and Sterchele 2022). This is partly due to the unattractiveness for many staff of working in prisons, which puts them in the position of having to deal on a daily basis with a population perceived as "difficult". This reluctance has become even more pronounced in recent years, as the growth of the private sector in the Italian health care system has led to a growing organic "crisis" in an NHS that is struggling to guarantee the availability of operators even outside the prison system. This growing precariousness implies, among other things, greater difficulties for the staff on duty to counteract the processes of prisonization that tend to invest all the social actors operating within the prison (Ronco 2018, Sbraccia and Vianello 2022).

Secondly, the 'handover' of prison health responsibilities to the NHS saw a significant role of the "pre-reform" prison doctors in mentoring and training the new operators in the new working context. In fact, in many cases, the "territorial" doctors were "hand-picked" to enter the prison service by those who already had some experience in the sector. The need for accompaniment is in itself significant, as it testifies to the specificity of a context "other" than the hospital or the territory. The new operators would thus have had the opportunity, through the accompaniment, to learn certain skills that are certainly considered important and specific, but also the frameworks of normativity and consolidated routines of a context such as the prison, with significant effects in terms of the reproduction of cultures and practices. In other words, following Sarzotti (2016), "the innovative capacity of the social actor legitimised by the reform was largely conditioned by its own internal composition, even if the latter has never been empirically verified with ad hoc investigations aimed at verifying the extent to which past routines have influenced the reform implementation process" (p. 146).

The dynamic of "accompanying" the new operator in the socio-relational context of the prison has thus allowed the reproduction – albeit to varying degrees and with heterogeneous results – of legal and professional cultures that are well established in the moral horizon of the prison, triggering a cycle of self-reproduction that seems to continue to this day. Indeed, when new health professionals take up their posts in a prison, they are quickly introduced not only to the organisational practices and

bureaucratic structures that characterise the new task, but also to the frames of meaning within which they are expected to graft their evaluations and practices.

The path of cultural assimilation, which leads to the sharing of the moral and symbolic horizon of the prison by the prison healthcare workers themselves, although it develops gradually and plausibly in different ways, sometimes intervenes in a clear and decisive way from the first moment the new worker sets foot in the prison.

> I have coffee with the doctor on call, who has been working at the institute for about a month. Earlier, I had asked her about her brief experience in the field: she said, with a hint of complicity, 'Then I'll tell you all about it, so I can blow off some steam too'. As we drank our coffee, she told me that on her first day here, a prisoner had tried to hang himself, and another had turned up with a deep cut on his arm that was still visible ('it's still swollen'). The other doctors also warned her early on that everyone here would try to ask her for something, that everyone would want drugs and that she should be careful about giving them: 'all the first day', she told me with a grave smile. (Ethnographic Diary, Maurilia Prison, 2019)

The example of the doctor cited in the footnote is undoubtedly significant in illustrating the pedagogical mechanisms that intervene when a new worker joins the health team of a prison, which, in this case, are reinforced by a gender dimension (cf. Ferreccio and Vianello 2015). What happens immediately is not only the clash with the rough reality of prison life – constantly punctuated by episodes of violence and related emergency interventions – but also the introduction to the meanings and attributions of sense appropriate to the context. The newcomer is immediately warned against an "instrumental" (cf. Ronco 2018, Sbraccia 2018) user who abuses drugs and needs to be regulated and disciplined in the way he experiences the health service. In this sense, the ability to identify certain categories of inmates who are not particularly deserving of medical or specialist care is seen as a necessary skill for the health worker working in prisons, both to avoid giving in to requests that would then have security repercussions, and to reduce the complexity of daily activity in an institutional world characterised by a structural lack of resources (cf. Torrente 2016).

It is evident how these processes of socialisation to the new context end up depotentiating the objectives of a normative intervention that aimed, albeit implicitly, to undermine the adherence of health professionals to the securitarian culture of the prison (Cherchi 2017). As a result, even the aspiration to equivalence of care is ultimately weakened when the doctor-patient relationship, instead of being based on trust, is forced into a framework of "suspicion". The reform thus clashes with the rigidity of a sclerotic local legal culture that rejects or shows little permeability to regulatory incursions perceived as detrimental to the local regulatory framework (formal or informal).

This rigidity is particularly evident when it is translated into practice. Here, too, it is a dimension of "experience" that takes on primary importance, to be read as knowledge of the contextual normative schemes against which the greater or lesser appropriateness of social action is measured.

> I look at my notes while the doctor examines a prisoner. At one point I hear her – who has only been working in the prison for a short time – asking the nurse something, and the nurse replies: 'Yes, yes, we usually give him Tachipirina'. Obviously, the doctor is not sure which drugs she can give to prisoners without having problems. A little later, the same situation is even more obvious. The doctor has just finished examining a

> prisoner to whom she has prescribed Tavor. As the man leaves the infirmary, the doctor asks the nurse: 'I took him off Vatran, I changed him to Tavor, is that OK?' Sensing the unusual nature of the question, the nurse raises her hand slightly and replies: 'Well, you are the doctor... but he doesn't seem to be a dealer [the prisoner] ... you only gave it for a short time anyway, right? Then we'll see...'. (Ethnographic Diary, Maurilia Prison, 2019)

The reversal of professional roles and hierarchies produced in this example is particularly indicative of the importance of "prison cultures" in the overall redefinition of medical and psychiatric knowledge. Tachypirin and Valium cease to be 'normal drugs' and their prescribability is scrutinised on the basis of its appropriateness in relation to the regulatory framework of the prison. The drugs are thus examined through the lens of security (Drake 2012) in order to explore the possible social uses to which they might be put (cf. Sterchele 2023). In this way, the nurse – who, unlike the newly arrived doctor, has a long experience of working in the prison – herself becomes the central actor in the socialisation process of the new doctor, validating the decision to distribute some drugs (Tachipirin) and expressing some reflections on the prescription of others that are apparently more exposed to "inappropriate" uses (Valium).

In particular, when the drug is identified as a "drug of abuse", the administration generally becomes more cautious, going so far as to consider in-depth evaluations of the patient who submits the request. It is through such a process that the figure of the "dealer" mentioned in the nurse's note is elaborated and identified, i.e. the prisoner who uses the drug purely instrumentally, using it as a "bargaining chip" to obtain other goods in exchange, or simply abusing the sedative or sometimes euphoric effects it produces (see Sterchele 2021). Here too, the economies of suspicion are preferentially directed against certain "racialised" prisoners, for whom a certain "toxicophilic tendency" is described as a characteristic cultural trait (cf. Sbraccia and Vianello 2022).

All these dynamics highlighted so far denote, in a different key, the peculiarities of legal and professional cultures that, while retaining specific traits, end up contaminating with the "local culture" of the prison, which is sharply expressed in health care practices and in the relations of doctors with their patients. These specificities mean that normatively oriented action is actively directed towards a centripetal hierarchy of norms. At the centre of this is the primary rationale of the normativity – again, formal and informal – of the penitentiary, which is primarily aimed at maintaining internal order and security from the perspective of institutional self-reproduction (cf. Torrente 2016). In this sense, the process of socialisation to norms, and thus the transmission of a localised and specific legal culture, takes on a completely transversal direction with respect to professional hierarchies, redefining their structuring in a complex scheme within which positions of power and moral authority take on a contingent and not immediately identifiable dimension.

A certain awareness of the risk of subordinating the actual mission of the health sector to the logics and established practices of the institution is sometimes present in the operators' reflections. Reflecting on the changes that have taken place in the post-reform period, a coordinator of the psychiatric sector expresses his concerns as follows.

> What worries me the most, and my director doesn't think otherwise, is exactly the opposite excess, that is to say, that they end up working only as prison doctors, because

> they gain experience and they have acquired it and they are highly esteemed and appreciated and so on, so they know how to move around, they know the environment well and – how to say? – the specifics of prison psychiatry, which is true, it's different from ordinary psychiatry, let's say, but it's also very risky... that is to say, the risk of going back to 'the way it was before was better', because you end up either willingly or unwillingly falling into a very prison-like logic...so you think in terms of simulation, in terms of instrumental use, you start talking about 'newcomers' ('nuovi giunti') instead of new entries...the vocabulary is also important, you start taking on the prison culture that cannot but enter you... (Interview with the coordinator of the psychiatric area, Zobeide prison, 2018)

The acquisition of a "prison culture" is described here as the result of a process of cultural assimilation of the actors, who would gradually internalise the languages, categories, frames and practices specific to the prison context. In this sense, the risk of "going back to the way it was before" is averted, i.e. the frustration of the most radical intentions of reform, which would be thwarted by the reproduction of a strongly prison-centred legal culture. In fact, this process runs the risk of reducing the dimension of autonomy that the reform would have wished to give to the health sectors, and of undermining the principle of equivalence of care, if prison patients end up being placed in categories that are properly carceral in nature, in order to maximise their control (cf. Seddon 2007, Sterchele 2022).

5. Lost in translation: contended definitions between clinical and juridical

One of the central aspects that emerges from the interview excerpt reported in the previous paragraph has to do with the process of assimilation of the "prison languages" by health workers. The categories of "simulation", "instrumentality", "guarding" ("piantonamento") end up becoming part of the symbolic arsenal of health professionals and are mobilised with a certain frequency in the clinical encounter. The question of languages – from which practices are then derived – has emerged as a relevant issue in the context of the researches carried out, particularly with regard to the relationship between the spheres of meaning attributed to medicine and psychiatry on the one hand, and to law on the other.

In their work, prison health professionals – particularly doctors and psychiatrists – are sometimes confronted with the need to "translate" clinical assessments into legal language. In other words, certain clinical classifications can be matched with legal classifications that have a direct impact on the penal execution trajectory of imprisoned patients. Relevant in this sense are classifications related to the risk of suicide, mental health assessments aimed at the possible transfer or reallocation of the inmate/patient to more therapeutically appropriate spaces (Sterchele 2021), drug addiction certifications that may allow placement in institutions or sections with reduced custody (cf. Sbraccia and Vianello 2022), and so on. In all these cases, the process of specialist medical or psychiatric assessment – formulated and formalised through a language appropriate to such knowledge – must then be adapted and brought back to a code provided by the prison regulations, through a process of reformulating it in legal terms.

This process is not to be understood as neutral, but as intimately permeated by the local legal culture specific to the prison context. As De Felice points out in relation to the use of scientific knowledge in procedural contexts, "the legal language does not simply

borrow the scientific one, leaving the meaning of the utterances unchanged, but performs a work of reinterpretation in the light of the criteria of validity with which the legal decision is constructed" (De Felice 2014, 37). Similarly, the reconfiguration of clinical assessments in legal terms is closely linked to the criteria set by prison regulations, which in turn intersect with more localised normative expressions – as for example circulars – and sometimes informal ones. In this transition between different languages, the meaning of the product of knowledge also changes radically.

Indeed, it is clear that the two different languages serve as many different purposes: on the one hand, the reading of a symptomatology tends to formulate a diagnostic generalisation for the purposes of a therapeutic takeover. On the other hand, attention to symptomatology can also be relevant for the purposes of a legal formulation (and, also in this case, generalisation) aimed at modulating the subject's course of penal execution. The latter does not necessarily correspond to the objective – proper to the field of health – of guaranteeing or promoting the patient's well-being. It is inevitably intertwined with the governmental objectives – in the Foucauldian sense – of the prison, implementing a kind of measurement towards criteria of "adequacy" and "conformity" of the prisoner/patient to ordinary prison life.

It is obvious how, in this process, the chimerical 'purity' of a clinical discourse, which is allegedly free of disciplinary evaluations, is profoundly contaminated by them.

> While I was waiting in the corridor, I noticed a young doctor talking to Gustavo and Mario, two psychiatrists. They were talking about a prisoner for whom the doctor had asked for visual surveillance, but both doctors were telling her not to do it. Gustavo tells her: 'It's not up to us to ask for visual surveillance, you are putting yourself in a difficult situation... also because who is going to take it away? You, if you see that there is a danger and you think there is a risk, you give a C or a D, then it goes to the emergency room and eventually the doctor of the emergency room will make his assessments... it's also a way of protecting yourself, eh, since we are no longer in the Ministry of Justice, you can do it this way. Also because by asking for visual surveillance, from a clinical point of view, what have you done? Eh, nothing... you put a C or a D, then they'll see'. (Ethnographic Diary, Zobeide Prison, 2018)

From the quoted excerpt, several crucial points emerge with regard to the discourse mentioned so far. Firstly, the two psychiatrists – who have greater seniority in the prison context – reprimand the young doctor for formalising a regulation that does not concern the sphere of medical intervention. In fact, a doctor's request for a prisoner to be placed under "visual surveillance" implies the assumption of responsibility on the part of the health care team, which is called upon to carry out periodic re-evaluations of the patient and, ultimately, to declare that there is no longer any need for it. However, if the prisoner/patient were to commit suicide after a doctor's order to remove on-sight supervision, the degree of responsibility borne by the doctor himself would be quite significant. The focus on acting in a procedurally irreproachable manner, in order to then avoid possible repercussions, sometimes outweighs the clinical objective, configuring an action centred on a paradigm of "defensive medicine".

Secondly, the reported note reveals a dimension of inter-sectoral conflict that can be identified as a side effect of the 2008 reform (Cherchi 2016, Sbraccia 2018). This has to do with the demarcation of the respective areas of competence, which depends on the way in which each area – and, at the scale, each practitioner – interprets their role within the

field (cf. Scivoletto 2018). In the reported case, the two psychiatrists claim the dimension of independence guaranteed to them by law, refusing to "get their hands dirty" with tasks pertaining to the administration, however much these are based directly on their assessments. In fact, this is the crux of the matter, which has to do with the way in which the classification – resulting from a specialised medical or psychiatric assessment and oriented in a clinically relevant sense – can possibly be translated into a legal provision of "visual surveillance". In this case, the possibility of a legal reinterpretation by the doctor is rejected by the other two specialists. While it is true that this difference in position may be partly due to a difference in seniority, and therefore a different view of the dynamics that govern relations in the prison environment, it is also true that the positions of the health professionals in this respect are quite different and sometimes conflicting.

> Psychiatrist A, Psychiatric Observation Ward, Perinzia Prison: '111', '148' and 'mentally handicapped'[1] mean nothing from a clinical point of view! You can get anything from the calm and quiet guy to the Arab who smashes everything (sic!) (...). The strong message is that the clinic is in charge, not the patient.
>
> Psychiatrist B, Mental Health Protection Articulation of Maurilia prison: But still '148' or '111' will be someone who has been subjected to the judgement of a fellow psychiatrist.
>
> Psychiatrist A: Yes, but I don't trust my fellow psychiatrists. I do more or less 50 observations a year on people who are sent to me in the Psychiatric Observation Ward, but to have major psychiatric disorders they may be in 3 – and this despite the fact that before they were sent to me they were seen by a psychiatrist who said: 'OK, it's a 148, let's send him there'. So I send them back, because otherwise you run the risk of becoming the punishment section, and the feeling of being the dustbin is never pleasant. (Ethnographic diary, training session between prison doctors and psychiatrists, 2017)

The exchanges reported in the footnotes do not only reveal a certain heterogeneity between the professional and legal cultures of doctors and psychiatrists working in prisons (Scivoletto 2018). The crux of the matter has even more to do with the overlap between "clinical" and "legal" in professional assessments. The categories mentioned by the first psychiatrist ("111", "148", "mentally handicapped") are all afferent to a universe of meanings that are not only proper to the legal, but – according to the speaker – exclusive to it, and thus only comprehensible and endowed with meaning within a legal framework to which the clinical does not belong. It is certainly true, as the second psychiatrist says, that the work of "translation" was carried out by a clinical actor, but this does not seem to provide any guarantee as to the permanence of a clinically valid meaning. In other words, something is lost in the translation process. Or rather, we could say that the clinical content is partially or totally undermined by a purely disciplinary rationale that is, in fact, peculiar to the legal devices put in place in the regulatory framework of the prison.

[1] The psychiatrist refers here to art. 148 of the Italian Penal Code, which provides for the deferment or suspension of the sentence in the event of mental illness occurring during the execution of a prison sentence, with the consequent transfer of the inmate to special psychiatric institutions or sections; to art. 111 of the Prison Regulation, which defines the characteristics of the inmates to be assigned to such institutions or sections, as well as the type of staff to manage them; to the concept of "mentally handicapped" ("minorati psichici"), which is still present and significant in both legal texts.

Moreover, research on the Italian prison field shows how the fragmentation of the penitentiary landscape into specialised "circuits" materialises the constitutive ambivalences of treatment paths on the protection/sanction binomial (cf. Santorso and Vianello 2017). The use of transfers to some more "punitive" institutions or to specialised sections in the clinical sense constitutes a disciplinary strategy often used in the management of inmates "unsuited" to the context (Sbraccia 2018), often configured as a coercive mechanism in itself (Sterchele 2022).

It is because of this awareness that the psychiatrist quoted in the footnote states that he "does not trust psychiatrist colleagues", who sometimes end up producing and attributing legal classifications to patients/inmates on the basis of assessments in which clinical knowledge acts as a mere instance of legitimation and validation. The "psychiatrist colleague" is therefore seen as either subordinate to the prison authorities (and therefore unable to exercise the autonomy guaranteed by the reform); or directly involved – one could say "colonised", using Goffman (1961) – in the prison culture, with which he shares (latent) objectives and priorities. If the objective of maintaining order within the section or institution becomes the priority in the daily work of all social actors in the prison (Sbraccia and Vianello 2016), medical and psychiatric personnel play a decisive function in this sense, supporting purely governmental purposes with assessments borrowed from the domain of clinical knowledge and re-interpreted in legal terms.

The following note further illustrates the rationale behind the formulation and application of "psychiatric articles", i.e. those legal provisions drawn up following a clinical evaluation. In contrast to the previous note, here we note the reaction of a psychiatrist who has come under "friendly fire" from colleagues in other institutions.

> Commenting on the incoming transfers to Zobeide's Articulation for the protection of mental health in prison, the operators agreed that the case of D. (a young Nigerian woman currently placed there in Art. 148) was an obvious attempt by the 'sending' institution to 'offload' the management of the patient from one prison to another. One of the psychiatrists, reflecting on the possibilities of 'managing' the patient in the articulation unit, suggested that 'anyway, we have to remove her the 148…there is no way out of this situation (…) We have to remove her art. 148 so we can dispose her transfer (to a 'ordinary section', NdA), that's the only one... the shit they did was to apply the 148 to her'. (Ethnographic Diary, Zobeide Prison, 2019)

The suspicion shared by the health professionals quoted in the footnote is that the transfer of D. to the Mental Health section of Zobeide prison – and thus the application of Art. 148 – was motivated not so much by a concern to protect the patient's health as by purely governmental objectives. If the device of transfer is a central technique of body management in the penal system (Sterchele 2022), in this case it is reinforced by the clinical classification that justifies and legitimises it, making it even more difficult to oppose. In other words, the governmental objective is here subverted and rejected as an intervention "for the good of the patient", a motivation that acts as a neutralisation technique towards an operation that is perceived by the health workers themselves as problematically entangled in disciplinary frameworks (Johnston and Kilty 2016).

The entanglement thus created between the dimensions of care and control, however problematised and criticised by the operators of the receiving team, is also reproduced

by them in their management of the situation created. The hypothesis of "taking away the 148" is in fact the viaticum to allow the transfer of the patient to the ordinary detention spaces of other institutions, thus producing a further "discharge" effect. If the application of the measure by the prison of origin seems to have been the result of an ambiguous evaluation which sees its fundamental feature in the mixture of clinical and disciplinary elements, this ambiguity is confirmed crystal clear and reproduced in the équipe debate in Zobeide.

Thus, the topic of the translation of clinical evaluations into legal classifications sees the distance that should exist between two different rationales in terms of objectives and operational modalities reduced, finding a particularly cogent point of synthesis in the institutional rationale (cf. Torrente 2016, Vianello 2018). In the same way, it could be observed that the heterogeneity and diversity of the legal cultures that coexist in the field of prisons end up being partially subsumed within a self-referential and self-reproductive framework, a common and shared characteristic of the different groups.

6. Conclusions

The aim of the article was to address, at least in part, the complexity that characterises the impact of legal action in the prison field. Using the process of prison health reform in Italy as an important point of observation, it attempted to recapture the dimension of "inertia" that characterises a social field that, although it has been subject to continuous reform processes over the years, has proved to be little permeable to change.

The approach adopted was to go beyond a reading that was confined to the dimension of the "application" or "non-application" of the norm, and to look instead – within a framework appropriate to the sociology of law and the study of legal cultures – at the way in which legal intervention is materialised in the social relations, cultural horizons and operational practices of those who live and pass through its field of application. In this sense, the results of the research that is the subject of this article make it possible to note the profound dialectical dimension that exists between law and cultural frameworks, taking into account both the way in which legal intervention produces transformations in the cultural assets of social actors, and the way in which the latter reshape law itself – in its 'vitality' – in the light of material and symbolic contingencies.

With regard to the case of prison healthcare, it has been noted that, with reference to the first point, legal intervention has made it possible to generate dynamics of "resistance" – or, at least, of subtraction – on the part of health professionals with regard to the objectives of the institution in which they work, being able in this sense to act in accordance with their professional mandate by refusing certain interferences that would tend to redecline the therapeutic mission in a governmental key. With regard to the second point, however, we have also seen the limits of legal intervention which, in this case as in others, has been deprived of its power by the "shield" of legal cultures which, however heterogeneous they may be, are often entangled in a securitarian framework and oriented towards institutional self-reproduction. Both sides are visible in the constant tension surrounding the care-security binomial, within which constant oscillations are produced.

The empirical sections have thus attempted to delve into the complexity that characterises the juxtaposition of two spheres of knowledge that are incommensurable

because they use different codes of communication, but whose coexistence finds significant points of synthesis in a "symbolic understanding" on the priority of the objectives of the "field " (Bourdieu sensu). In this sense the socialisation processes of the health workers take on significance, since they are not only introduced to the operational and protocol peculiarities of prison work, but also to the frames of meaning, to the "appropriate" practices, to the pursuable objectives of the institution. This process of cultural assimilation is particularly evident in the everyday relationship between clinical knowledge and legal tools. In this sense, the article has attempted to provide some tools for understanding the relationship between the two forms of knowledge in the prison context. There is certainly an "opportunistic" relationship in which the translation and legalisation of clinical classification is aimed at ensuring a dimension of security and "tranquillity" within the section/department. At the same time, there is no lack of reflexivity towards such practices, which are perceived as inconsistent with a professional mandate that one would like to see freed from those components of "control" that have historically influenced psychiatric knowledge and practice (Basaglia and Ongaro Basaglia 1975).

It is precisely in giving an account of this dissonance – that which is produced between a cognitive and professional scheme oriented towards a non-controlling dimension of care and a daily practice that is instead also produced with reference to disciplinary elements – that some broader conclusions seem significant. The dimension of "symbolic understanding" produced between legal and professional cultures that one would like to consider incommensurable – the medical/psychiatric on the one hand, the carceral on the other – cannot be read exclusively within the framework of the supposed "exceptionality" of the prison. In other words, to attribute the reproduction of governmental discourses and practices by health professionals solely to the poignancy of prison cultures – and thus to assume that this is produced in cultures that have nothing to do with such apparatuses – risks being reductive and misleading. On the contrary, and in dialogue with sociological works on health and medicine, we should consider how these governmental mechanisms are an integral part of legal cultures that, although "external" to the prison field, include those same elements, which are in many ways similar in different institutions, from hospitals to residential psychiatric facilities. Discipline-oriented action is produced in the prison field in a way that is not entirely dissimilar to that found in ordinary psychiatric units. Even in these fields, as various studies have argued, the primary objective of legal and professional acting remains directed towards the horizon of safety and working tranquillity (Monahan *et al.* 2005, Molodynski *et al.* 2016, Sjöström 2016, Cardano *et al.* 2020).

The 2008 reform did indeed introduce "external" cultures, but it is important to remember that practices aimed at maintaining security and working calm were fully part of these same cultures and were ultimately imported – and partially accepted – within the prison framework. In this sense, the practices described should not be read as misrepresentations of otherwise "clear" professional cultures forced by the "invasiveness" of the prison apparatus, but rather as elements that are partly – and to a certain extent – "shared" by those professional groups that for a long time have worked within similar "total institutions". In conclusion, the article aims to stimulate an interpretation of healthcare practices of control and governmentality within prisons that places them in a continuity both with the same practices outside and with those which

are considered proper of the prison staff. This would certainly make it possible to identify some common features between legal and professional cultures which, although they present themselves as radically different, end up discovering a distant kinship.

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