

# THE REMARKS ON EUROPEAN LEGAL INSTITUTIONS OF HEALTH CARE

## UWAGI O EUROPEJSKICH PRZYSĄDOWYCH INSTYTUCJACH OPIEKI ZDROWOTNEJ

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### ABSTRACT

The article presents theoretical opinions on the problem of health protection of offenders who are brought to justice. It shows especially its institutional aspect. The author tries to show it from the viewpoints presented by social sciences, criminology and medical sciences, which become a starting point for the analysis and in a further perspective – for the research on some theoretical models. The author compares the institutions existing in Poland with those from Old Western Europe. He describes their different kinds and shows possible directions of such institutions development. To summarize all, the author formulates some more general remarks. The issue of health care for jurisdiction “clients” became significant in Western Europe after World War II. It remains an integral part of the social and penal policy of the EU member countries. Poland seems to be a bit behind, however in recent years a clear progress in the development of societal sector has been observed.

**KEY WORDS:** European Union, justice, medico-social institutions, convicts’ health care.

### STRESZCZENIE

Artykuł ma charakter poglądowo-teoretyczny. Podejmuje problematykę ochrony zdrowia osób, które stoją przed wymiarem sprawiedliwości karnej. Jest to ważne zadanie państwa. Autor pokazuje zwłaszcza jej aspekt instytucjonalny. Porównuje instytucje istniejące w Polsce z instytucjami w tzw. Starej Europie. Opisuje różne ich rodzaje, próbuje je uporządkować. Podejmuje próbę analizy aksjologicznych podstaw ich funkcjonowania. Wskazuje ponadto możliwe kierunki rozwoju tych instytucji w Polsce. W zakończeniu podkreśla konieczność rozwoju prywatnego sektora tych instytucji, jak również zharmonizowania tego rozwoju z rozwojem sektora publicznego.

**SŁOWA KLUCZOWE:** Unia Europejska, wymiar sprawiedliwości, sądowe instytucje opieki zdrowotnej.

Health protection for people facing jurisdiction in consequence of different types of crime starts to be an issue of great importance, especially in connection with the “social” opening of the Polish penitentiary system after 1989. Although the problem is vital, the Polish penitentiary thought seems to pass it over, which can be noticed especially in penitentiary sciences, focusing mainly on the crisis in penitentiary reeducation [1]. From this point of view the problem is a bit “one-tracked”. There are many voices pointing at the essence, causes and consequences of the mentioned problem for working with people, who came into collision with the law – in the wide perspective for state’s penal policy, but solution proposals are still few. Usually they limit to an analysis of single action programs, description of therapeutic activities in a particular prison, etc. This perspective lacks the possibility to generalize mentioned descriptions of successful experiences to the status of scientific theory. This is the main reason why in the Polish penitentiary thought standstill prevails. It causes that instead

of extrapolating mentioned programs to a higher level than analytic sentences most of theorists tend to reach penitentiary classics like Michel Foucault [2] or Erving Hoffman [3].

The problem of crisis may be defined as the “problem of crisis in scientific thought” about reeducation, its aims, elements and methods. The solution, however, requires a new theory of influence adequate to nowadays challenges and standards.

The present paper is then a part of a trend to find the premises for the theory construction. The author will try to combine the point of view presented by social sciences, criminology and medical sciences, which will become a starting point for the analysis and in a further perspective – for the research on some theoretical models.

The issue is not as simple as it may seem – it begins on the level of a definition of the reeducation itself. It is a fact that to this day it remains impossible to work out one, universal concept of reeducation. In the face of

controversies classics always give the best solution – in their understanding reeducation is the process of change done in persons' personality, which aims to eliminate or reduce social disadaptation. For S. Jedlewski, and especially for C. Czapów [4], reeducation is a system of caring, educational and therapeutic actions (influences). It seems that a mentioned triad is broad in meaning, so it may refer to different age categories in people affected by these actions. Unfortunately, the confrontation with "real reeducation", especially penitentiary one, falls out not really well.

Therefore, despite the fact that the possibility of the moral revival in people, who are in collision with the law, is nowadays often remonstrated, which may be argued with the opinion that prison has not improve anybody yet – there appears a question concerning specification of current priorities.

Taking into consideration a classical reeducation thought and the author's former papers on social work [5], the author would like to propose here a system of factors influencing people, who are in collision with the penal law:

1. Therapy.
2. Social reinforcement.
3. Education.

It is easy to notice that this system is alike to one presented in author's former papers [6], but here appears a legible turn in priorities towards treatment and social support. It goes with trends present in so called "old EU members", especially in the United Kingdom and France [7].

More precise characteristics of mentioned actions should be preceded by a comment concerning social reinforcement. So – it can be defined as a supreme aim, which can be realized by protection of convicts' health. After B. Dubois and K.K. Miley the author will present it here as "the way in which people, institutions and communities obtain control over their lives" [8]. According to J. Rappaport, "the idea of reinforcement (authorization) suggests both – the person deciding about his/her live and his/her democratic participation in the life of community, often realized via institutions like schools, neighborhood, churches and other voluntary organizations. Reinforcement brings the psychological sense of control and influence on things that happen with and to a person, it also refers to the possibility of having a real influence on society, politics and law. Therefore, it is a multi-level construct, which applies to single citizens and institutions or local communities, it suggests studies on people in a certain context" [9].

Reinforcement is then both – the aim and the process. As an aim it signifies an ultimate state, e.g. when

a person under charge obtains power to complete integration with surrounding community. As a process it is expressed by facilitating, making possible and favoring or promoting the ability to competent, adaptive functioning. It is obvious that in this process actions aiming to maintain a good state of health play a leading role. The above mentioned conclusion lays on a belief that: "people, as long as they have proper support from milieu, are fighting, active organisms, able to organize their lives and develop their hidden potentials" [9].

From supporting convicts actions model perspective, a direction of efforts to obtain change is determined by a basic problem, which is the client's "departure" to dregs of society in consequence of committing a crime. In case of juveniles it brings a threat to their physical, mental and social development, so the threat of demoralization, which is often connected with family pathology and upbringing in the environment, socially downgraded, where health care is usually on a very low level. On the latter issue the process of causing change in a convict, judged in consequence of getting into collision with penal law, should be oriented.

An initial condition of success is the maintenance of a relatively good state of convict's health. The already described perspective process of "health repair" should be proceeded on three basic levels:

- single person work level,
- group work level,
- social institutions level, making no difference for convicts placed in prison, so – in isolation, and those, who are released (especially in the conditions of probation supervision).

The issue of levels needs a few words of comment. It seems that the fact of convict's isolation from society by imprisonment, is not an obstacle for health supporting actions for the convict and family. These actions are complex and may be proceeded simultaneously inside and outside the prison. The fact that the prison system nowadays, more open to the society, is not meaningless here – this is why the problem of convicts' health cannot remain hidden from the society, as it happened before. The prison openness, which is worth emphasizing, enables to include in prisoners supportive actions services and institutions of health care and social assistance, which operate in the open environment. Therefore, convicts during imprisonment may be interested in cooperation.

Mentioned institutions may also focus on convicts' families. So – casework in health protection is typical for cases commissioned by court. It is taken on a base of legal mandate, like judgment made by court (e.g. absolute imprisonment or conditional stay of the carrying out of a sentence connected with probation). It domi-

nated in the old EU member countries and in Poland in 1960s. It pressures direct work with individuals. Five basic orientations can be pointed here:

- traditional, i.e. medical,
- psychosocial,
- functional,
- problem-oriented,
- socio-behavioural.

Focusing on social reeducation of convicts (but – formulated individually) is common for all orientations in the work context.

In the middle of 1950s in Western Europe some attention focused on taking care of families of justice administration clients. At the beginning working with family was a part of casework. Still quite soon ward's (prisoner or person under probation in open environment) behaviour started to be perceived not as a personality product, but as an effect of family interactions. It all started familial approach, which is a basis for framework program of taking care of dynamic system individual (patient) – surrounding. The British system of helping prisoners based on supporting bonds with family during imprisonment (which is often a difficult situation for relatives, also affecting health [10]) can be an example here.

A general familial approach relies on acknowledging the influence of familial processes, roles and the way that state of health in family members affects health of an individual included in executive penal proceedings. At the beginning the focus was on individual pathology, but quickly family pathology was centered, especially health negligence – it all caused forming four approaches to work on health issues with families.

Thus, in 1950s a psychodynamic approach was used. It involved taking into consideration the influence of family members' personalities on their health and convict's health. In the early 1960s theorists initiated an approach involving denying the possibility to communicate about health in dysfunctional families. The following was a structure approach, which dominated in the 1970s. Its aim was to work with disorganized families and serve as a way to study environmental influences, family development stages, and organizational factors like interaction patterns and rules. It served health interventions in cases of family crises using the method of planned, short-term problem solving. In the 1970s an eclectic approach to ward's families' health occurred – it involved using techniques of evaluation and intervention strategies from different theoretical models, e.g. psychodynamic model, communication theory, structural model or crisis intervention model. Together they presume existence of

many factors, which should be taken into consideration by medical and social staff to understand family's functioning, intervention aims and potential possibilities and forms of pro-health actions.

Group-work methods were applied to professional social work in the 1930s, and group-work theories were created on 1940s. Group-work is defined as a planned effort made for change, based on a conviction that people experience through interactions and group processes, because a group is an organism in which mentioned processes occur on many levels. In other words, people responsible for convicts' health care should use a group structure and group processes to evoke change in single group members. Helping practice concerning convicts' health care should then use both – the medico-social context of the group itself, and means which are used by group members to sustain or change attitudes, interpersonal relations and develop abilities of effective coping and preserving a good state of health in their surroundings. It is necessary to notice that a group therapy may be preceded only in small groups.

The English author G. Konopka describes in this context group-work as a method of medico-social work. This should help a single person to improve functioning in a society through intentional experiencing within a group and lead to more effective coping with one's problems concerning the group or community, especially those related with health care [11].

As a method of acting in legal cases in an open environment group-work did not become popular as much as the familial approach mentioned above. One of the main reasons is a peculiar character of criminal circles. They create hermetic systems of values difficult to modify, they are usually closed structures, rarely submitting to interventions. Specific solidarity of their members and the following high level of inner integration cause the existence of informal groups, which are an alternative for those created by medico-social staff – directed by administration task groups. Despite all, it seems to be a promising method of medico-social work, whose meaning will grow with the process of opening prisons to the society. Prisons were the place where the group therapy proved to be effective (e.g. addiction therapy programs like duet for convicted alcoholics) [1]. The character of institutions favours creating by penitentiary service special purpose groups for prisoners.

A version of group-work is combining individual actions taken by every social worker with the work done in interdisciplinary teams. The level of complication in convicts' problems is often high, so social workers face the necessity of cooperating with different specialists (e.g. psychologists, psychiatrists and doctors of many other specialties).

The last level of convicts' health care refers to its institutional dimension. Some comment on organizing local communities' health care seems necessary here. Medico-social staff actions in community involve arrangements, but also assistance organizations development and conducting reforms in health service. It is acting on macro systems, focusing on community organization models and following conclusions for social policy and the process of its administration.

General philosophy of arranging local communities is based on the following assumptions:

1. Human communities often require help to satisfy their needs in terms of health care.
2. Human communities may develop a capacity of solving their problems, especially those concerning health.
3. People wish for change and are able to alter.
4. Democracy requires participation in health protection, taking actions concerning community problems and for people to acquire abilities, which enable this participation.
5. People should participate in making, adjusting or controlling crucial changes in health protection, in the community premises.
6. Changes in communities live, made or prepared by its members, have the meaning and permanence, impossible for imposed ones.
7. "Holistic" approach enables dealing with those problems, which are insoluble using a "fragmentary" approach. It is crucial for solving health problems.

The holistic model of convicts' health care seems to be the most effective for its protection, especially in the process of social reeducation. The standard of its realization depends on society's wealth, i.e. possessed funds, and public opinion support in addition. However, the European public opinion is not always well oriented in the topic. Furthermore, at the beginning of the 21st century it becomes a bit populist towards methods of treating criminals, with an attitude rather towards punishing than supporting [12]. This is why, the model probably will come to life<sup>1</sup>. However, it may not speak against the comparison the institutions system in the "old EU member-countries" and in Poland engaged in convicts' health protection. This comparison will be the last part of the present paper. It was based on following documents:

1. Rapport from conference „L'insertion des jeunes en difficulte et le fonds social europeen. Approche comparee en Europe”, which took place in Vaucreeson near Paris at 15–17.10.2007 (organization: Centre

National de Formation et d'Etudes de la Protection Judiciaire de la Jeunesse).

2. Report from "Practice into Policy conference", which took place in London at 20–21.11.2007 (organization: Centre for Economic & Social Inclusion –London).

The author took part in both mentioned above.

Furthermore:

1. Studies: *Prise en charge Medicio-psycho-sociale*, ed. Le Comede, Comite Medical pour les Exiles, Hopital de Bicetre, Le Kremlin, Paris 2005.
2. Administration Penitentiaire. *Rapport annuel d'activite 2006*, ed. Ministre de la Justice, Paris.
3. *Le guide de sortant de prison. Observatoire International des prisons*, ed. La Decouverte, Paris 2006.

The analysis presented below is a first stage of the comparative analysis of the mentioned system and Polish institutions, it includes the confrontation of information from cited documents and concerning both compared areas.

To characterize the present system of health care institutions for convicts in Western Europe it is necessary to notice that it formed under the influence of tradition developmental social services. The evolution of these services in the 20<sup>th</sup> century in the EU countries took place in the following five basic stages:

1. The stage of a gradual passage from charity and voluntary work to professional actions (1900–1920).
2. The stage of forming working methods based mainly on North-American experiences (1920–1940).
3. The stage of inner differentiation of social services, caused by variety of realized tasks (1940–1955).
4. The stage of "casework as a basic method of acting" re-discovery (1955–1960).
5. The stage of a "comprehensive approach" to working methods, based on acting in reliance on the group and local communities (after 1960).

The French author, C. de Robertis, notices that an equally important moment for the social services development like the passage from the voluntary to professional work, was combining the occupation of a social assistant and social nurse in one called a social worker. It happened before World War II (in France in 1938) [13]. After World War II, other specialists and professionals working and helping people in difficult situations, who impede integration with the society, were included to a group of social workers. They were employed in a variety of institutions, like social assistance houses and prisons. They were not a homogenous group anymore, because institutions created new places of actions, aims and tasks.

Currently, medico-social staff works with such a heterogeneous group of people needing help and support like: elderly, disabled, homeless, unemployed, mentally

<sup>1</sup> Edgy penal populism was seen in Poland during the rules of Jarosław Kaczyński (2005–2007).

distorted, socially unadapted people or criminals, etc. They face the problems like children abuse or neglect, lack of care or incapability of elderly people, lack of accommodation, poverty, addiction from drugs or chemical substances and crime. They prepare reports for courts concerning topics like: health care, treatment possibilities – original and consequent, health support for families, gerontology, possibilities of creating prevention systems, unemployment counter acting, etc. In following presentations the author will focus on this group of socio-medical staff, whose aim is convicts' health protection.

The second important developmental factor for the modern convicts' health care institutions system was a gradual cessation of private funds for medico-social services. In consequence currently the core of health care institutions for this group is located in a public sector. Still, the sector of societies and foundations is an important "supplement". It seems necessary to emphasize that although means for the institutions are transferred from public funds, both institutions and money are administrated by societies themselves or private persons.

To sum up, the current division of health care institutions for convicts contains following categories (Table 1).

From the above presented table it appears that:

1. When we compare institutions of health care for convicts in public and societal sectors in the "old EU member countries" and in Poland it turns out that in

the first case both sectors developed proportionally. In Poland there are no departmental services in the societal sector, which makes the public sector a monopolist in the scope of health services for convicts. In the same time the public sector in Poland is inefficient in providing health care for all demanding convicts, especially in situation of prisons overpopulation, so it needs a kind of institutional support. One of the possible ways contains table 1.

2. The situation looks much better after the analysis of both sectors concerning medical services and institutions supporting departmental medical services. Except medical services in schools the rest of services developed in both – old EU member countries and in Poland, however some differences to the detriment of Poland occur<sup>2</sup>. In our country this sector is less extended, which may be caused by the fact that it has developed for quite a short time. Furthermore the old EU member countries are wealthier, so they have greater funds, which may be allocated in health care.
3. The situation referring to sanitary services and social assistance is quite alike. In Poland the societal sector, although represented on the level of all se-

<sup>2</sup> For recommendations for mentioned services check already cited in footnote no. 6: *Prise en charge Medicipsychosociale...* See also a guide for released convicts: *Le guide du sortant de prison...*, pp. 254–275, *Le suivi medical. Le suivi psychiatrique*.

**Table 1.** Institutions of health protection for jurisdiction clients in the old EU member countries and in Poland (2006)

Types of social services	Sectors characteristics			
	Public		Societal	
	Old EU members	Poland	Old EU members	Poland
Basic medical services and institutions Departmental				
1. Prisons medical services	+	+	+	–
2. Juridical medical services	+	+	+	
Supporting (universal health service – medical services for convicts )				
1. Health care, prevention, and treatment institutions	+	+	+	+
2. Specialist health institutions (specialist hospitals, clinics, mental hospitals, rehab institutions)	+	+	+	+
4. Schools medical services	+	+	+	–
Sanitary and social assistance institutions				
1. Regional services of the social hygiene	+	–	+	–
2. Social actions of Armed Forces	+	–	–	–
3. Municipal services and social assistance offices	+	+	+	+
4. Medical and social services for emigrants and and profit-emigrants	+	+	+	+
5. Charity institutions	–	–	+	+
6. Religious Congregations	–	+	–	–
13. Red Cross	+	+	–	–
14. Others	–	–	+	+

+ exists, – does not exist.

Source: author's own study after: *Prise en charge Medico-psycho-sociale*, ed. Le Comede, *Comite Medical pour les Exiles*, *Hopital de Bicetre*, *Le Kremlin*, Paris 2005, and: *Le guide de sortant de prison*. *Observatoire International des prisons*, ed. La Decouverte, Paris 2006.



rvices and institutions, except those created by religious congregations, is poor. The reasons resemble these presented in point 2.

It seems that the further evolution of health care institutions for convicts judged by common courts will be connected with both – consolidation of the public sector in the old EU member countries and the more definite state and social support for the societal sector in Poland. Practice and hitherto experiences of the old EU member countries prove that this sector has large developmental possibilities. It also enables flexibility in administrating health protection institutions and possessed funds, so it is a vital support for the health care institutions system traditionally located in the old EU countries and in Poland in the public sector.

The table analysis would be incomplete without an indication of the fact that European health care institutions working for jurisdiction may be divided according to the type of the environment they act in or according to the subordination to the Ministry of Justice concerning the latter organizations located formally inside and outside jurisdiction. The first group consists of:

- medico-social services in probation services,
- medico-social services in educational institutions and reformatories,
- medico-social services in prisons organized as autonomous services or as a part of probation services.

In Poland there are no medico-social services in juridical probation service<sup>3</sup>. In the second group following European institutions and medico-social services are located:

- childcare centers,
- centers of medical and social service for family,
- institutions and organizations of common health service,
- mental health clinics,
- medical and social services for schools.

All kinds of these services are present in Poland.

To sum up, institutions and services included in the first group may be named as proper medico-social services in Justice (services medico-sociaux aupres de la Justice), those from the second – supporting (subordinate to Ministries, e.g. Ministry of Public Health; services authorized by Justice – services habilités par la Justice).

In practice these services cooperate closely and their tasks often overlap. It is worth emphasizing that courts may order to both, however the scope of competencies is defined by the law and authorizations done by the Minister of Justice (habilitation). It is worth to notice

<sup>3</sup> The bill from 27 July 2001 on probation officers, Dz. U. No. 98, pos. 107 with further changes do not stipulate its creating.

that in the first group public sector services prevail, in case of prisons it has monopoly on medical services for people during imprisonment.

In the majority of Western European countries institutions and organizations dealing with health care of convicts are a part of the public sector, while those from the societal sector are taking care of cases recognized by courts in a guardianship procedure.

To the complete comparison of present medico-social service systems in the old EU member countries and in Poland it should be added that in both exists a separate network of medico-social services for juveniles and adults subordinate to the Ministries of Justice. In Poland this network is less developed. In France it is an organizational part of a great system of legal youth protection, which have their own autonomic General Directory (Protection Judiciaire de la Jeunesse) in the Ministry of Justice [14].

To summarize all what has been said in the present paper concerning the comparison of institutions of health protection for people, who are brought to justice in the old EU member countries and in Poland some more general remarks should be formulated.

The issue of health care for jurisdiction "clients" became significant in Western Europe after World War II. It remains an integral part of social and penal policy of the EU member countries. In consequence the whole system of medico-social institutions located in public and societal sectors are harmonizing. Poland seems to be a bit behind, however in the recent years a clear progress has been observed. Its determinants are e.g. the constant extension of the public sector as well as creating and developing the societal sector. This direction should be held, because consequences for jurisdiction are consequences for the whole society.

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