Abstract: In this article an attempt was made to describe a segment of penitentiary reality pertaining to people with disabilities in light of their aid efforts. The essence of the idea is: how to help a “doubly” marked person – due to their disability and prison isolation – regain personal dignity and independence, to the extent of their capacity and needs, and participate in social life. Based on the holistic model of disability, the situation of imprisoned inmates was considered from an interactive perspective, taking into account actions directed at people with disabilities (therapeutic/rehabilitative actions) as well as their physical and social environment (normative activities). As a result of the analysis of available resources (literature of the subject, reports and journalistic materials), numerous shortcomings in the organization and the course of aid activities undertaken in penitentiary units for disabled prisoners were pointed out, which in turn resulted in their negligible effectiveness.

Keywords: Penitentiary isolation, disability, therapeutic effects, normalization.

Disability as a complex and multidimensional phenomenon is of interest to representatives of various scientific disciplines. Among the multiplicity of theoretical and empirical studies on the issues of disability and psychosocial functioning of people with disabilities, there are still neglected, abandoned or absent problem threads that require further in-depth research penetration. Such “white spots” in
the scientific discourse include issues concerning the penitentiary reality of people with disabilities and the effectiveness of aid measures (rehabilitation and social rehabilitation) taken towards them.

**Structure of detainees with disabilities in penitentiary units**

The fact that there is no precise data on the total number of disabled detainees held in penal institutions and detention centers proves that there is not enough interest in the above issues. From the available sources it can be concluded that this is not a completely marginal number, which is estimated at a couple of thousand people (Stanisławski 2008). According to the Chief Doctor of the District Inspectorate of Prison Service, there are even a few prisoners with disabilities per unit (Korona 2013, p. 19). The Prison Service does not have statistics not only on the total number of prisoners with disabilities, but also on the type, degree and etiology of their disabilities. The only data they have concern prisoners qualified for therapeutic wards for persons with non-psychotic mental disorders or with intellectual disabilities (without distinction between the two categories of disability), including those with disorder of sexual preferences. The analysis of prison statistics for the last sixteen months (January 2016 – September 2017) shows that the percentage of prisoners with non-psychotic mental disorders and intellectual disabilities qualified for therapeutic wards remained at a similar level, with a slight upward trend clearly noticeable from 2017 (Fig. 1). In the third quarter of 2017, their number amounted to 1690, of which 1536 persons were staying in therapeutic wards and 154 persons outside those wards. This is a higher number (by 65 persons) compared to the data recorded in the third quarter of 2016 (1625 persons). The lack of accurate statistics makes it impossible to verify the reasons for the reported state of affairs, namely to what extent it is conditioned by the dynamics of growth in the overall number of prisoners with mental and intellectual disabilities in prisons, and to what extent it is a result of intensified efforts to provide this group of prisoners with appropriate therapeutic care. On the other hand, it is worrying that such a large number of persons qualified for therapeutic wards remain outside them. Such a state of affairs, conditioned, inter alia, by staying for medical treatment and participating in court proceedings, results in prisoners staying in units where they are deprived of appropriate therapeutic effects (Iwanowska, Jezierski, 2014, p. 49–50).
The research shows that in the prison population, depression and various types of psychoses are the most common mental disorders. About 50% of convicts have incomplete symptoms of depression, while 30% of all inmates have full symptoms of depression. The most severe depression symptoms are observed in the youngest prisoners (below 20 years of age) and in persons serving their first prison sentences (Boothby, Durham 1999, p. 116–117). Disorders of dissocial personality are equally frequently diagnosed. The proportion of people with these disorders is estimated to be between 5 and 52% (Ostrihanska, 1989; after: Niewiadomska, 2007, p. 196). Among the inmates there are also people with mild or moderate intellectual disabilities, with a diagnosis of psycho-organic syndromes, epilepsy or neuroticism (Gordon, 2006, p. 211). In many cases these are people with double or even triple diagnosis, usually because of a confirmed addiction to alcohol or psychoactive substances with coexisting non-psychotic disorders or intellectual disabilities (Iwanowska, Jezierski, 2014, p. 47).

The fact that prisoners with mental disorders and intellectual disabilities who, due to the different specificity of psychosocial functioning require different methods and forms of therapeutic measures from the staff, are qualified to the same therapeutic ward, is controversial. Furthermore, it should be borne in mind that we are dealing with groups of people, each of whom is very diverse internally. Putting them in the same therapeutic ward with people with disorders of sexual preferences also seems to be an ill-considered decision, both in substantial and in practical terms. The research conducted by the Ombudsman Office in every fourth Polish penitentiary unit (the motive for undertaking such research were, among
others, cases of prisoners publicized in the media) shows that some of the convicts with mental disorders or intellectual disabilities should never have been put in prison. The deprivation of liberty of those persons should be a measure of last resort, proportionate and taken in conditions adapted to their needs. The report states that “these people are now being taken to penitentiary units because information about disabilities escapes attention or is not considered relevant:

— policemen do not record such information,
— prosecutors do not appoint experts in case of doubts concerning the mental health of a given person,
— courts ignore indications that a person may have difficulty exercising their rights (no mandatory defense is provided!) and there are sentences that do not take into account the convict’s ability to serve his/her sentence,
— probation officers request imprisonment of people who have not paid the imposed fine or performed socially useful work as indicated in the sentence – without seeing the person, and the court does not check whether such a person is able to perform the sentence at all,
— Prison Service officers do not provide important information about detainees to prosecutors, courts and prison judges. They do not know how to react in such a situation, because they are not sufficiently trained.
— the prison judges do not receive signals that would lead them to take action within the scope of their competence: to meet a prisoner whose situation requires intervention, to make recommendations to the Prison Service, to apply for a break from their sentence1.

A separate group are prisoners with disabilities detained in wards with regular regimes. These include people with physical disabilities (e.g. reduced mobility) and sensory impairments (hearing, visual impairments). As already mentioned, the statistics do not include details of the medical certificate or the type of disability. It is therefore difficult to estimate how many people with disabilities are serving imprisonment outside the therapeutic system. Prison as a kind of forced social isolation leads to a high intensity of auto-aggressive behavior (Babiker, Arnold 2003, p. 406). As Marek M. Kamiński (2006) states, auto-aggression inside the prison is being used in order to achieve a specific goal. In most cases, self-harm is not an irrational act but a pragmatic method by which prisoners try to achieve something, e.g. a break in their sentence, a change in an unfavorable decision of the court, transfer to hospital, postponement of the trial, etc. (Jaworska, 2012). Auto-aggression, unfortunately, often becomes a cause of permanent damage to the body (vision, motion or hearing).

1 Ombudsman. Prisoners with intellectual or mental disabilities. The Ombudsman talks about findings of research carried out in prisons and what they will do to help people who should never have been sent to prison, https://www.rpo.gov.pl/pl/content/wiê¿niowie-umyslowosc-dziec-chorzy-psychicznie-rpo-opowiada-o-wynikach-badan-w-wiezieniach [access date: 15.10.2017].
The material presented briefly illustrates how important, and at the same time complex, social phenomenon we are dealing with is. The essence of the issue is: how to help a “doubly” marked person – due to their disability and prison isolation – regain personal dignity and independence, to the extent of their capacity and needs, and participate in social life.

**Model strategies for assisting people with disabilities**

In the literature, strategies for assisting people with disabilities are presented in the context of three basic concepts of disability: medical, social and holistic (developmental and functional).

In the traditional (medical) approach the phenomenon of disability is reduced to one dimension – the biological condition of the individual (damage to the body / loss of fitness) with complete disregard for psychological aspects (personal experiences, needs and resources of the individual), as well as social and interactive aspects. It is considered as a personal problem of the individual, which can only be solved through medical intervention or rehabilitation carried out by specialists. The goal of these assistance activities is such a “medical rehabilitation of an individual (i.e. “healing” or “correcting”), so that they could adapt to living in the society and meet its requirements, just like a person without disabilities. The presented model strategy for assisting people with disabilities is called “directed diagnosis”, thus indicating that it reduces a person to a disorder, illness or deficit that affects the individual, thus making them objectified” (Wiliński, 2010, p. 75).

A person with disabilities is positioned as a double victim: 1) disadvantaged, and 2) deprived of the possibility of making independent decisions.

Extremely opposed to the medical strategy of influencing the problem of disability is the strategy of providing assistance focused on the process of emancipation. This method of action closely corresponds to the social model of disability. It assumes that “(...) injury is in no way part of the definition of disability. The existence of any personal injury or functional impairment shall not be the basis for treating a person as disabled, only the lack or restriction of participation in the life of the community or of normal functioning shall be such a basis. The factor that constitutes this lack of opportunity to participate and lead a normal life are various barriers: 1) physical – related to the occurrence of obstacles and difficulties (e.g. to move freely) within an environment that has been transformed by a human at least minimally 2) social – connected with the occurrence of stigmatization, stereotypes and beliefs related to the difference between persons with bodily injuries and those modifying attitudes towards them presented by a “fully functional (normal)” part of the society” (Vilnius 2010, p. 79–80). Therefore, the problem of disability has a social dimension and is reduced to those aspects that hinder, restrict or prevent an individual with disabilities from integrating into the
normal structures of society. According to the social concept of disability, it is the
society that must change and adapt to the needs of people with disabilities (e.g.
by eliminating physical and mental barriers), while the individuals with disabilities
themselves are positioned as a client – customer.

In recent years, a paradigmatic understanding of disability has become com-
mon, taking the form of a holistic model (integrating medical and social mod-
els), which underlies the International Classification of Functioning, Disability and
Health (ICF). Disability is treated as a multidimensional phenomenon resulting
from the individual’s interaction with the physical and social environment. This
means that the axis around which thinking about a person with a disability fo-
cuses is not the person themselves but their position in the system of mutual in-
teractions and links with other social systems. The ecosystem approach therefore
implies a two-track approach to undertaking assistance measures, i.e. targeted:
1) to an individual with disabilities – assistance should focus not only on over-
coming the limitations of the individual, but above all on strengthening their
resources and capabilities and using them to achieve optimal functioning of
the individual. A person with a disability is treated as a subject, as an origi-
nator of direction and dynamics of activity;
2) to their living environment (physical and social) – by creating such conditions
of existence and organization of social space which will enable the maximum
use of potential skills and abilities of the individual to achieve the greatest
possible independence and activity (standardization activities).

The assistance strategy understood in this way, based on the principles of
subjectivity and normalization, creates an opportunity to achieve the intended
objective, which is to prepare a person with disabilities, according to their needs
and abilities, to perform specific social roles in a dignified manner and ensuring
their self-realization (social inclusion). It is also an optimal solution in the pur-
suit of social readaptation and reintegration of disabled prisoners in penitentiary
institutions.

**Persons with intellectual and physical disabilities in the therapeutic system of penitentiary measures**

The solution to ensure separate conditions of serving sentences by people with
disabilities is a therapeutic system, implemented in therapeutic wards with speci-
fic specialization: for people with intellectual disabilities or non-psychotic mental
disorders, addicted to alcohol, addicted to narcotic drugs or psychotropic sub-
stances, with physical disability (with medical indications for rehabilitation). The
current legal regulations clearly define the entities subject to separate treatment,
the principles of directing them to separate wards and appropriate procedures
for the performance of tasks in this respect (Kalaman, Kalaman, 2012, p. 139).
Piotr Braun (2013, p. 139) presents an example showing that, in therapeutic wards, people with intellectual and physical disabilities stay together with other people with various disorders: with organic disorders, personality disorders, addictions not eligible for treatment in wards for addicts, having sexual preferences disorders, affected by somatic diseases, and showing difficulties in adapting to the conditions of detention.

From the point of view of treatment (therapeutic) needs, each clinical group requires different measures, which illustrates the complexity of the problems undertaken by the team of specialists. This accumulation of people with different adaptation problems does not enable prevention of additional difficulties and the necessary interventions that disrupt the planned work. These assumptions are confirmed by Katarzyna Korona (2013, p. 14), who also points out that these difficulties concern not only interpersonal relationships, but also the lack of personnel and suitable premises.

The aim of the conducted therapeutic measures is as follows: preventing the deepening of pathological personality traits, restoring psychological balance, shaping the ability of social coexistence (applies to people with intellectual disabilities and mental disorders), preventing deterioration of their health (applies to physically disabled people), as well as preparation for an independent life (Braun, 2013, p. 136). The therapeutic work uses both individual forms of psychological therapy as well as various forms of group work, i.e. psychological trainings and workshops, educational classes, occupational therapy, physical culture and sports activities, education and prevention in terms of addictions, cultural and educational activities, including interest groups (computer, film, foreign language learning and so on, depending on current needs and opportunities), as well as activities compensating for educational deficiencies (learning to write and read) (Braun, 2013, p. 138). A wide range of therapeutic and educational measures is to ensure the possibility of rehabilitation as a triad consisting of therapy, correctional education and social support (within the framework of post-penitentiary assistance as an aid in ensuring conditions allowing for living in accordance with the law: in terms of accommodation, material support, counseling, etc.). The duration of therapy in the therapeutic ward is individualized and depends on the progress of the convicted person in therapy (Kalaman, Kalaman 2012, p. 140). However, it seems unrealistic and insufficient to achieve therapeutic effects as a result of short-term programs in the case of people with intellectual disabilities,. Meanwhile, by definition, this is a transitional system, from which – after the application of specialist measures – there will be a transfer to the system of ordinary or programmed measures (Braun, 2013, p. 136).

People with intellectual disabilities constitute fairly large proportion of prisoners. According to Irena Dybalska (2012, p. 37–38), in 2010, 31.4% of people staying in therapeutic wards were people with intellectual disabilities, including 29.4% with a disability of a mild degree, 4.4% of a moderate degree, and even 0.1% (4 people) of a severe degree.
The work with prisoners in therapeutic wards, from the very beginning of their existence, has essentially focused on the use of various programs of psychological measures. Currently, varied programs based on a cognitive and behavioral approach are considered to be the most modern ones in the penitentiary work. According to supporters of such an approach, the arguments in favor of using such programs are: precisely formulated procedures of application, defined time frames and emphasized belief in their high therapeutic effectiveness (Barczykowski, 2013, p. 87–113). As Henryk Machel (2010, p. 185–187) points out, the basis of modern rehabilitation programs in penitentiary work, apart from behavioral methods, are the introduced exercises of mental capacity or elements of “training of consciousness”, discussions, persuasions aimed at triggering deeper reflection on the causes, and above all on the effects of negative behavior, emphasizing the change in thinking. It should be noted that professional psychological therapy programs, based on mental work processes, are often intended for people within the so-called intellectual standard and are difficult to adapt to the needs of people with intellectual disabilities. Even a mild intellectual disability causes the thought processes to stop at a perceptual level, which means that people with a mild degree of intellectual disability are able to refer only to the specific situation they are currently experiencing (Orzeł 2013, p. 82). They also show difficulties in perceiving, focusing, remembering content, they have limited ability of abstract thinking, generalizing, comparing, making conclusions and cause-effect reasoning. People with more severe (moderate and severe) cognitive development disabilities remain at the pre-operative level, which means that they are slower to notice and recognize even few elements, often misidentifying the links and relationships between phenomena (Matczak, Sobczak, 2014). Therefore, people with intellectual disabilities find it very difficult to conclude that punishment is the result of their improper conduct, and the process of making them aware of the extent of their guilt requires special psychophysical rehabilitation programs adapted to their abilities (Kiev, 2013, p. 46). The problem is also the considerable susceptibility of these people to suggestions, which poses a particular risk of being undesirably influenced by the prison environment. An important issue determining their social and personal development is the inability to meet the requirements of the environment (Matczak, Sobczak, 2014, p. 100). It should be emphasized that people with intellectual disabilities may reach even the average level of social development, but usually external factors cause its deconstruction or inhibition (Matczak, Sobczak, 2014, p. 100). Prison isolation can undoubtedly be considered as one such factor.

Among people with more severe intellectual disabilities there are also people who require care in performing basic self-service activities, including hygienic ones. Their presence is undoubtedly a heavy burden and, in principle, gives rise to objections as to whether they should actually stay in prison. Similar observations are made by Beata Tomecka-Nabiałczyk (2016, p. 125–127) in relation to people
Persons with disability in penitentiary isolation – appearances and reality

with severe, four-limb forms of cerebral palsy. Meanwhile, institutions which are unable to provide them with appropriate care expose them to degrading living conditions. The Prison Service tries to solve this problem by placing this group of prisoners with people without disabilities, who help them in their daily hygiene and health activities, although such a solution is contrary to international standards. However, there are situations where people without disabilities oppose such a situation, and after a certain period of time prisoners refuse to provide such services (Braun, 2013, p. 140).

Summarizing the applied strategy of measures carried out within the therapeutic system, it can be noticed that its feature is medicalization consisting, among others, in the fact that non-medical problems, i.e. those related to both disability and the committed act, are defined in categories of illness and disorders. As a consequence, overcoming problems consists mainly in medical intervention (Wiliński, 2010, p. 68), in this case mainly in the use of pharmacology and psychotherapy (included in non-invasive treatment methods), aiming at restoring missing or correcting deficit functions. Thus, the object of influence is not a person in all its complexity, but some “defect” isolated within it, resulting in more or less serious limitations and reduction of the scope of control that an individual can have over their own life, behavior and cognitive or emotional processes (Wiliński, 2010, p. 72).

A major disadvantage and the reason of criticism of such a bio-psychophysical approach is the ineffectiveness and inadequacy of medical interventions for the majority of people with disabilities, at the same time neglecting, underestimating and not using other possible measures. Objections concern too marginal treatment of educational measures of rehabilitation or satisfying other needs of disabled persons – both persons with intellectual disabilities and persons with physical disabilities.

According to the currently applied approach in rehabilitation, therapeutic work with people with disabilities is based primarily on positive/functional diagnosis – assessment of their adaptability and coping with difficulties in everyday and social life. These remaining opportunities form the basis of the concept of participation, which consists in supporting development as a process of becoming a member of society, acquiring specific skills, learning values and attitudes as well as functioning in social roles (Żółkowska, 2011, p. 80–82).

The professional role of adults with disabilities is particularly important in their life, as it enables them to acquire the social competences necessary to manage their own lives. As Tadeusz Majewski (2011, p. 90) points out, most people with intellectual disabilities have a specific professional potential and are able to perform specific activities. However, it is necessary to recognize the existing possibilities and develop them by selecting appropriate educational and rehabilitation measures.
People with mild intellectual disabilities having vocational training can work in the open labor market. They need properly selected tasks and supervision. People with moderate intellectual disabilities can learn simple professional activities. A severe degree of disability allows people to master only simple everyday activities and uncomplicated works (Majewski, 2011, p. 95). People with more severe degree of disability require broad support from other people, which is provided under a new, special form of the so-called supported employment (Domańska, 2016, p. 91–97).

The form preceding employment is occupational therapy workshops, where work is one of the elements of therapy aimed at increasing independence and resourcefulness. They prepare to take up employment, as far as possible, under the conditions of sheltered employment (Ratajczak, 2006, p. 55–56).

An important task is also to prepare people with intellectual disabilities to organize their leisure time independently. Good conditions for such understood approach to the process of interactions in the work with prisoners with disabilities are created by current, yet underestimated, forms of educational work, i.e. occupational therapy, educational or sports activities, and in particular those using creative working methods, which activate the development potential of a disabled person. Their role should not be limited to filling spare time and alleviating the effects of prison boredom. The theoretical basis for their use, in accordance with the modern approach to rehabilitation, is provided by the concept of creative rehabilitation of Marek Konopczyński (2006). It seems that the already applied practices of including prisoners without disabilities in work with people with disabilities may apply to the creation of opportunities for various forms of rehabilitation work with people with intellectual and physical disabilities on the basis of assisted participation.

Standardization of social and living conditions in prisons in terms of adapting them to the needs resulting from different types of disability remains an issue independent from the system of serving sentences.

**Normalization of living conditions of prisoners with disabilities in penitentiary isolation – reality or fiction?**

In order to achieve positive changes in the attitude and behavior of prisoners with disabilities, apart from therapeutic and rehabilitation measures, it is also necessary to provide them with decent social and living conditions, adequate to their needs and development possibilities. This problem affects all prisoners with disabilities, in particular prisoners with physical disabilities and impaired vision.

Currently, there are several dozen penitentiary units in Poland adapted to the needs of people with disabilities. Unfortunately, according to reports of the National Preventive Mechanism, there are still many prisons that do not meet the basic
Persons with disability in penitentiary isolation – appearances and reality

functional requirements. An example can be the Bydgoszcz-Fordon Prison – a penitentiary unit for people with disabilities, in which prisoners with reduced mobility and sensory disabilities (sight and hearing) are detained. According to experts, the movement of a person with reduced mobility, particularly in wheelchairs, in prison conditions is in most places significantly impeded by the presence of numerous architectural barriers: door thresholds (exceeding the height of 2 cm), too narrow doors, lack of adequate maneuvering space, e.g. at the entrance to the waiting room, medical facility, court hall, dental office, in cells or in the bathroom, lack of railings on both sides of the stairs. Many problems for prisoners are caused by incorrect placement of basic devices (light switch, call system, hangers, shower seat, hand shower positioned too high) and inappropriate furniture (e.g. too high beds, no chairs with armrests in the rooms). There is also no designated communication route. There are also cases of prisoners with reduced mobility being placed in cells located on the floors of residential pavilions, which makes it impossible for them to function efficiently – to go down to the walking area, to the bathhouse, to the visitor's room, etc., by on their own.

A similar condition can also be observed in the case of inmates with impaired vision. Physical barriers hindering their proper, everyday functioning in conditions of prison isolation include, among others, the lack of contrast between stairs steps, the use of different textures and colors of surfaces (Report of representatives of the National Prevention Mechanism on the visit at the Bydgoszcz-Fordon prison on the state of perception of people with disabilities, 2016).

Detainees with various deficits also have limited access to information. As an example, one may point to inappropriate (too high) location of information boards or location of computer stations with access to the Internet and a kiosk with Public Information Bulletin on the upper floors of penitentiary units, which makes it impossible to use these sources for people with reduced mobility, including in particular people in wheelchairs. Placing telephones too high makes it difficult for them to communicate freely with their families and the loved ones. Visiting rooms are not always located on the ground floor of a residential building. In addition, computer workstations are not suitable for people with manual disabilities, nor are they equipped with reading programs for the blind or visually impaired prisoners.

In many penitentiary institutions, deaf people are not provided with assistance from a sign interpreter, which translates into numerous problems in communication with the staff of the institution and co-prisoners (Report of the Commissioner For Human Rights, 2014; Report of representatives of the National Prevention Mechanism, 2016).

The functioning of prisoners with disabilities in penitentiary units characterized by poor technical condition and lack of equipment adequate to their needs proves the degrading treatment of this group of detainees. It is also common practice to place disabled prisoners in multi-bed cells. This is connected with the
complete deprivation of privacy in the daily life of prisoners and generates situations of danger, conflict and violence due to different ways and levels of their functioning (Report of representatives of the National Prevention Mechanism on the visit at the Bydgoszcz-Fordon prison, 2016). The above situation, unfortunately, takes place in many penitentiary units (Report of the Commissioner For Human Rights, 2014).

In recent years, the living conditions of prisoners with disabilities have improved. Measures were taken to adapt selected penitentiary units to the needs of these persons, in particular prisoners with reduced mobility (Jarecka, Wolak, 2008, p. 693–694). Due to the increase in their number in prisons, in some prisons and detention centers separate units for prisoners with mobility disabilities are being set up.

An example of a penitentiary unit that has undergone positive changes is the Detention Center in Gdańsk, which has been operating a unit for disabled prisoners since 2003. The building in which the ward is located has been adapted to the location and communication needs of people with disabilities, at the same time eliminating all architectural barriers limiting their efficient functioning. The structure, location and size of residential cells for people with reduced mobility were changed, doors of individual rooms were widened, entrance thresholds were eliminated, the number of stairs separating prisoners from all forms of life outside the residential cell (i.e. the visiting room, walking area, chapel) was limited, an external platform was installed to allow prisoners moving in a sitting or lying position to get to the ward on the lowest floor of the pavilion, where there is a physician’s office, day-room, ward office. The accommodation spaces were equipped with direct communication (intercoms), facilitating contact with the ward and cameras enabling continuous observation of patients’ condition. A modern lift provides disabled prisoners with access to the educator’s office, psychologist’s office, therapeutic room and bathhouse. Equipment of the rooms in which prisoners with disabilities stay was adapted to their capabilities and needs. Cells with an increased surface area ensure the free movement of prisoners on wheelchairs (Jarecka, Wolak, 2008).

In addition to social and living conditions, an important element of the characteristics of the situation of people with disabilities staying in penitentiary institutions is their place in the community of prisoners. A characteristic phenomenon among all prisoners, including those with disabilities, is the existence of informal relations between prisoners, called the second life (the so-called prison subculture). Within the framework of the functioning subculture, prisoners develop their own code of conduct, which they follow; the dialect they communicate with, and many other, relating solely to them, elements regulating their mutual relations. The created hierarchy determines the functioning of each individual (Braun, 2013).

The prisoners with disabilities, because of their mental and physical limitations, have occupied the lowest position in the prisoners’ hierarchy for many
years. They have often been exposed to humiliation, persecution and abuse. Over the years, along with the *ongoing* transformations of the subculture, especially in terms of role performing, the situation of people with disabilities has changed. Currently, the position of convicts in the structure of their second life is determined not by prison experience, criminal fame, steadfastness, courage or physical strength, but by their financial resources. The subculture of prison jargon turned into the so-called subculture of money (Miszewski, 2005, p. 74). At the same time, the phenomenon of alliance of participants of the second life with wealthy prisoners in order to derive specific material benefits is significant (Przybyliński, 2006, p. 87–88). Although people with disabilities are not among the richest social groups, in penitentiary isolation their position in this respect improves significantly. They receive various financial benefits from the State. These amounts are relatively low in freedom, while in prison they provide a certain standard of living. By providing material assistance to other prisoners, a disabled prisoner, despite their limitations, dominates on the ward in which they are detained. It also happens that the high position of such a person in the subcultural hierarchy results from their belonging to a criminal group and the functions they fulfill within this group. People convicted of organized crime enjoy special respect in prison. This is the case for many inmates with physical disabilities. The situation of prisoners with intellectual or psychological disabilities is different. They do not gain the respect of their fellow prisoners, but, on the contrary, are exposed to harassment, humiliation and violence. It is therefore necessary to protect this group of prisoners by placing them in separate wards, including therapeutic wards (Braun, 2013).

An important role in the process of social rehabilitation of prisoners with disabilities is played by the attitude of prison staff towards prisoners.

Prison staff and officers often have specialist training to deal with people with disabilities. However, it is not possible for them to have a comprehensive knowledge of the specificities of the functioning of each group of prisoners. There are groups of disabled prisoners whose real needs are not always properly understood and met. These include, in particular, prisoners with impaired vision and intellectual disabilities. It is therefore necessary to conduct a series of training sessions on the specific treatment of prisoners with different types and degrees of disabilities. Both the penitentiary and administrative units staff should be trained, as well as those of the security units – prison guards who are in constant contact with the convicts (Braun, 2013).

The very fact that the Prison Service is treating the problem of revalidation of people with disabilities, especially mobility impairments, may also be a cause for concern. “Emphasizing the relationship between the low level of activity of prisoners with reduced mobility and the programs and leisure activities offered to them, as well as the difficulty of working with them because they are obsessed with their own illnesses, they consider this situation to be a reality in prison” (Łapińska, 2012, p. 24). An important problem that is noticeable in the peniten-
tiary reality is the instrumental approach to disabled prisoners. The most common irregularities in the treatment of disabled prisoners include those related to the use of direct coercion (Report of the Commissioner For Human Rights, 2014). Cases of vulgar and humiliating attitude of officers towards prisoners with disabilities, unjustified raising of voice, unwillingness to help in dealing with matters or lack of ability to provide information necessary to function in the unit are still not solitary (Report of the Commissioner For Human Rights, 2014; Report of representatives of the National Prevention Mechanism, 2016).

In the process of social readaptation of detainees, education is given an important role. Unfortunately, the situation of people with disabilities in this area is also unfavorable. In the case of inmates with musculoskeletal disorders, attendance at prison schools is to a large extent limited, and sometimes even impossible, due to the lack of appropriate architectural and equipment solutions. In turn, the lack of specialized education for people with intellectual disabilities (Braun, 2013) means that this group of prisoners is practically deprived of the possibility of education in prison isolation.

Due to the specific nature of their dysfunction, prisoners with impaired vision are also faced with serious difficulties. Detained blind and partially sighted prisoners complain about the lack of rehabilitation classes, including basic and necessary for their efficient functioning in prison conditions spatial orientation classes, lack of permission to have specialist equipment to help them in everyday life, difficulties in correspondence, access to books and newspapers in Braille (Braun, 2013; Tomaszewski, 2011). This situation, according to the report of the representatives of the National Preventive Mechanism (2016), has significantly improved.

The work carried out by prisoners is also an important element in the social rehabilitation of prisoners. For many years, apart from many actions addressed to prisoners with disabilities, there have been few activation measures that could improve their employment situation both in and out of prison. Currently, the situation in this respect is changing, i.e. there are numerous programs for the professional activation of disabled inmates (e.g. the project “Social and professional activation of disabled prisoners and persons sentenced to imprisonment on the basis of Articles 209 § 1 and 207 § 1 of the Penal Code”, the contract for project financing No. UDA-POKL.01.03.04-00-028/08 of 25 July 2009). An important element of projects of this type is the obligatory employment of their participants during their imprisonment in order to acquire appropriate practice in the field of their profession (Nicgorski, 2011). There are not many such initiatives in the prison system, however, which certainly does not improve the situation of people with disabilities after leaving prison.
Conclusions

The problem of serving prison sentences by people with disabilities in recent years has been noticed in prisons. First of all, they have started to identify such people and take important initiatives to address their problems. These include: assistance to prisoners in obtaining a certificate of disability, provision of compensatory measures, adaptation of rooms to their needs, as well as projects aimed at activating this group of inmates and involving prisoners with disabilities in assistance activities for people with disabilities. However, these are still only bottom-up initiatives of the Prison Service, which are not based on systemic solutions or legal regulations. A person with a disability does not have a separate status defining his or her right to adapt the conditions of serving a sentence to the needs resulting from the disability.

The reality of the penitentiary system proves that many penitentiary institutions still do not meet the basic functional or social-living requirements to ensure that detainees with reduced mobility or visual impairments can function efficiently and independently. In addition, the instrumentalism observed in the approach of Prison Service staff to prisoners with disabilities proves their insufficient knowledge of the specific needs of this group of inmates. They are seen mainly through the prism of weaknesses and limitations. In the light of the above, in order to increase the effectiveness of social rehabilitation activities, it is considered necessary to undertake two types of standardization activities – aimed at: 1) physical environment – improving living conditions and organization of spaces for prisoners with disabilities, and 2) social environment – educating prison staff to change the way in which people with disabilities are perceived as having a specific potential for abilities and opportunities to be maximized and used in their social readaptation and reintegration.

In penitentiary rehabilitation, particular importance is attached to work. In particular, it is stressed that it provides prisoners with the opportunity to acquire many new skills and, after leaving prison, to cope better with further social adaptation (Kierepka, 2016, p. 17). Unfortunately, in the current social rehabilitation and therapeutic solutions and activities addressed to people with disabilities, their professional rehabilitation remains omitted. The indicated current trends in the social rehabilitation of people with disabilities, including intellectual disabilities, indicate the need to focus the impact on supporting their employment opportunities and preparing them to undertake professional tasks to the best of their abilities. It should also be emphasized that the Convention on the Rights of Persons with Disabilities (Article 27) ratified by Poland provides them with the right to work on an equal basis of others. Criminal record shall not deprive such persons of any right to assistance or support. Social rehabilitation activities, which are an
integral part of the rehabilitation of people with disabilities, should also follow the changes and trends that take place in an open environment.

References

Persons with disability in penitentiary isolation – appearances and reality


Documents

Internet sources


