EDUCATIONAL IMPLICATIONS FOR PENITENTIARY PEDAGOGY, REHABILITATION AND RESOCIALISATION

IMPLICAÇÕES EDUCACIONAIS PARA A PEDAGOGIA PENITENCIÁRIA, A REABILITAÇÃO E A RESSOCIALIZAÇÃO

IMPLICACIONES EDUCATIVAS PARA LA PEDAGOGÍA PENITENCIARIA, LA REHABILITACIÓN Y LA RESOCIALIZACIÓN

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ABSTRACT: The study analyzes aggregate administrative data from the Czech Prison Service, including health status, medical interventions, and crisis behavior indicators. Using a descriptive and exploratory approach, it assesses what conclusions can legitimately be drawn from such data. The findings indicate a high accumulation and interconnection of health and social vulnerabilities among prisoners. However, the data do not establish causal relationships between service fragmentation and specific outcomes, nor confirm the effectiveness of integrated care models. The article argues that aggregate data should be interpreted as indicative rather than confirmatory evidence. It contributes to the debate by clarifying the analytical limits of commonly used data sources and framing integrated care as a policy orientation requiring further empirical validation. To strengthen its educational relevance, the analysis also frames prison as a pedagogical and resocialization environment involving educators, social workers, health professionals, and security staff in individualized rehabilitation, learning, and reintegration pathways.

KEYWORDS: Correctional education. Penitentiary pedagogy. Resocialisation. Educational policy.

***RESUMO**: O estudo analisa dados administrativos agregados do Serviço Penitenciário Tcheco, incluindo estado de saúde, intervenções médicas e indicadores de comportamento em situações de crise. Utilizando uma abordagem descritiva e exploratória, avalia quais conclusões podem ser legitimamente extraídas desses dados. Os resultados indicam um alto nível de acumulação e interligação de vulnerabilidades sociais e de saúde entre os detentos. No entanto, os dados não estabelecem relações causais entre a fragmentação dos serviços e resultados específicos, nem confirmam a eficácia dos modelos de atendimento integrado. O artigo argumenta que os dados agregados devem ser interpretados como evidências indicativas, e não confirmatórias. Ele contribui para o debate ao esclarecer os limites analíticos das fontes de dados comumente utilizadas e ao enquadrar o atendimento integrado como uma orientação de política que requer validação empírica adicional. Para reforçar sua relevância educacional, a análise também enquadra a prisão como um ambiente pedagógico e de ressocialização, envolvendo educadores, assistentes sociais, profissionais de saúde e equipe de segurança em percursos individualizados de reabilitação, aprendizagem e reintegração.*

***PALAVRAS-CHAVE**: Educação correcional. Pedagogia penitenciária. Ressocialização. Política educacional.*

***RESUMEN**: El estudio analiza datos administrativos agregados del Servicio Penitenciario Checo, que incluyen el estado de salud, las intervenciones médicas e indicadores de conductas de crisis. Mediante un enfoque descriptivo y exploratorio, evalúa qué conclusiones pueden extraerse legítimamente de dichos datos. Los resultados indican una elevada acumulación e interconexión de vulnerabilidades sociales y de salud entre los reclusos. Sin embargo, los datos no establecen relaciones causales entre la fragmentación de los servicios y resultados específicos, ni confirman la eficacia de los modelos de atención integrada. El artículo sostiene que los datos agregados deben interpretarse como evidencia indicativa y no como confirmatoria. Contribuye al debate al aclarar los límites analíticos de las fuentes de datos comúnmente utilizadas y al enmarcar la atención integrada como una orientación de política que requiere una mayor validación empírica. Para reforzar su relevancia educativa, el análisis también enmarca la prisión como un entorno pedagógico y de resocialización en el que participan educadores, trabajadores sociales, profesionales de la salud y personal de seguridad en procesos individualizados de rehabilitación, aprendizaje y reintegración.*

***PALABRAS CLAVE**: Educación correccional. Pedagogía penitenciaria. Resocialización. Política educativa.*

INTRODUCTION

The interface between social and health care represents one of the most dynamically evolving areas of contemporary public policy, particularly in contexts where client needs are complex, long-term and multidimensional. The traditional institutional separation of health and social services has repeatedly been identified as insufficient in addressing situations in which biological, psychological and social factors are deeply intertwined (Dogbe et al., 2016; Spreat, 2020). This limitation becomes especially visible in the penitentiary environment, where individuals often enter the system with accumulated health burdens, social disadvantages and a history of limited access to public services (Tomeš & Šámalová, 2017).

The prison population is widely recognised as a group characterised by a high prevalence of chronic diseases, mental disorders, addictions and social exclusion (Council of Europe, 2013, 2020; United Nations, 2015). International frameworks, including those developed by the World Health Organization and the Council of Europe, emphasise that prison health care cannot be reduced to the provision of medical services alone, but must reflect broader social determinants of health and ensure continuity of care beyond institutional boundaries (World Health Organization, 2014, 2021). The principle of equivalence of care further underlines the need to provide prisoners with access to services comparable to those available in the general population, including coordinated social support (Eichelberger et al., 2023).

The development of the number of prisoners in the Czech Republic over the last decade shows that the prison system remains a stable part of social reality with significant impacts on health and social care. According to the Czech Statistical Office (2025), the Czech Republic has long been among the leading countries in Europe in terms of prison population size. However, Czech prisons have undergone turbulent developments over the last 30 years. After the extensive amnesty of 1990, when the number of prisoners fell by almost two-thirds year-on-year, the prison population grew steadily until 1999, reaching a record of approximately 23,000 individuals. A significant turning point occurred in 2013, when a presidential amnesty led to the release of 6,471 prisoners, resulting in a sharp decline in the prison population. Since 2014, however, the number of prisoners has been rising again, peaking in 2016 at 22,481 inmates. In subsequent years, the numbers gradually declined to 18,748 in 2021, when the average occupancy rate of Czech prisons fell below 100% for the first time since 2015. This trend was reversed in 2022, and by 2024 the prison population had increased again to 19,430 individuals, while capacity utilisation remained at approximately 97%.

These developments indicate that the prison system constitutes a relatively stable institutional environment with long-term implications for both health and social policy. Each individual entering prison brings with them a complex set of needs, including untreated somatic illnesses, mental health conditions, addictions, unstable housing situations, indebtedness and disrupted social relationships. Penitentiary institutions thus function as a point of intersection between health care, social work, education and security structures (Ben-Moshe, 2017).

In the field of educational policy and management, the relevance of this topic lies in the fact that imprisonment is not only a security or health issue. Contemporary penitentiary practice also includes educational work, vocational preparation, social learning and the construction of conditions for resocialisation. The prison can therefore be analysed as an institutional learning environment in which health, social assistance and education intersect in the formation of post-release life trajectories.

In response to these challenges, the concept of integrated social and health care has gained increasing prominence in both policy and academic discourse (Spreat, 2020; United Nations, 2015). In the Czech Republic, this development is reflected in recent legislative changes that formally define the social-health borderline as a specific area requiring coordinated provision of care. This reform represents an important step towards addressing long-standing fragmentation between systems and towards creating a more coherent framework for supporting individuals with complex needs.

Despite the strong normative support for integrated care, a critical question remains insufficiently explored: to what extent are claims about its necessity empirically supported by available data? Existing discussions often assume that the complexity of prisoners' needs directly justifies the implementation of integrated care models. However, this assumption is rarely subjected to systematic analytical scrutiny, particularly in relation to the nature and limitations of the data on which such claims are based.

This article addresses this gap by examining the extent to which aggregate administrative data from the Czech prison system can support claims about the necessity of integrated social and health care for prisoners. The study focuses on commonly used indicators, including data on health status, the intensity of medical interventions and manifestations of crisis behaviour.

Methodologically, the article adopts a descriptive and exploratory approach. Rather than attempting to establish causal relationships, it seeks to clarify what kinds of interpretations can be legitimately derived from aggregate data and where the limits of such interpretations lie.

This approach reflects a broader concern with the epistemic foundations of policy-oriented arguments, particularly in areas where empirical evidence is frequently used to support normative claims.

The contribution of the article is twofold. First, it provides an empirically grounded description of the health and social profile of the prison population in the Czech Republic. Second, it offers a critical reflection on the analytical limits of aggregate data in supporting strong claims about the effectiveness or necessity of integrated care models. By doing so, it reframes integrated care not as a self-evident solution, but as a policy orientation that requires further empirical validation.

A third contribution is educational: the article highlights that integrated care models in prisons should include the pedagogical dimension of rehabilitation. This includes the role of correctional educators, programmes aimed at basic and vocational education, socio-emotional competencies, health literacy, preparation for employment and continuity between prison-based learning and community-based support after release.

The prison environment is thus approached not only as a site of practical intervention, but also as a specific analytical setting in which broader questions about the relationship between empirical evidence, institutional constraints and policy design can be explored.

GENERAL CONTEXT AND DEVELOPMENT OF THE SOCIAL-HEALTH BORDERLINE IN THE CZECH REPUBLIC

This section provides the conceptual and legislative background necessary for interpreting empirical data on prison populations. It clarifies how the social-health borderline is defined within the Czech context and how it is framed in policy and professional discourse on integrated care. At the same time, it establishes the analytical framework for examining the extent to which these conceptual assumptions are reflected in empirical evidence.

The term social-health borderline refers to a specific structural and functional space between the social services system and the health services system, where the needs of people whose life situation and health condition require simultaneous, long-term and interconnected social and health care are concentrated. In the professional and conceptual discourse of Czech social policy, this term is used to describe a long-term unsatisfactory situation in which the traditional institutional division of care does not correspond to the real nature of the needs of target groups, in particular people with chronic diseases, functional disabilities, reduced self-sufficiency or a combination of health and social disadvantages (Ondrašek et al., 2014).

The social-health borderline does not arise as a new field of needs, but as a consequence of the historically conditioned segmentation of care between two separate departmental systems. While health services in the Czech environment have traditionally been conceived as interventions focused on treatment, stabilisation or prevention of health conditions, social services have been oriented towards supporting social functioning, self-sufficiency and social integration. However, for people with long-term health problems, these dimensions form an inseparable whole, as health limitations fundamentally affect social functioning and, conversely, social conditions determine the course and management of health problems. It is this interdependence that forms the basic theoretical basis of the concept of the social-health borderline.

In the professional literature, the social-health borderline is characterised as an area with an increased risk of fragmentation of care, institutional ambiguity and the transfer of responsibility between providers. Clients in this area often move between systems without a unified coordinated care plan, which leads to duplication, delays in service provision, and even situations where care is not provided at all because it does not clearly fall within the competence of any of the systems. This situation has been repeatedly identified as unsustainable in terms of both quality of care and efficiency of public spending (Bartůněk & Ptáček, 2013; Citoreš, 2024; Ondrašek et al., 2024).

From a conceptual point of view, it should be emphasised that the social-health borderline is not only a practical coordination problem, but also a systemic challenge that requires new institutional, legislative and professional arrangements. It is therefore not a "supplementary" area of care, but a structural intersection of two different logics—health and social—which differ not only in their objectives, but also in their methods of financing, quality management, professional roles and accountability mechanisms. The social-health borderline therefore requires an integrative approach that transcends traditional departmental boundaries and emphasises continuity and coordination of care from the client's perspective.

In the Czech context, the term social-health borderline has gradually established itself as a technical term denoting not only a problem area but also a starting point for the creation of a new model of care. This model is based on the assumption that a certain range of services must be provided as a social-health service, i.e. a service that is both social and health in nature and is anchored as such in legislation, organisation and finance. The social-health borderline has thus evolved from an originally informal and difficult-to-grasp area into a defined area of

public policy aimed at eliminating discontinuities in care and ensuring a dignified and effective support system for people with complex needs.

From a terminological point of view, it is also necessary to distinguish the social-health borderline from the broader concept of long-term care. While long-term care covers a wide range of health, social and support interventions, including rehabilitation, palliative care and psychiatric care, the social-health borderline focuses on a specific area where the simultaneous and coordinated implementation of social and health services within a single institutional framework is necessary (Holmerová, 2015; Průša, 2021; Válková, 2015). This distinction is essential for understanding the subsequent legislative and organisational solution that is gradually being introduced in the Czech Republic.

The legislative anchoring of the social-health borderline in the Czech Republic represents a fundamental step in the systematisation of care, which requires the simultaneous, coordinated provision of social and health services to people with complex needs in the long term. This step was implemented through Amendment Act No. 38/2025 Coll (Act No. 38/2025, 2025). which amends several key laws in the field of social and health policy and came into effect on 1 March 2025. This amendment reflects the joint efforts of the Ministry of Labour and Social Affairs and the Ministry of Health of the Czech Republic to respond to the long-identified institutional fragmentation of care, which the traditional separation of social and health services was unable to address effectively (Association of Social Service Providers of the Czech Republic, 2025).

The essence of the legislative amendment is the introduction of the category of “social and health services” within the Social Services Act (Act No. 108/2006, 2006). The new Section 36 defines social and health services as “the coordinated provision of social and health care to a person whose condition requires the simultaneous provision of social and health care”. This wording is significant in that it explicitly states the interconnection of both types of care as a necessary condition for the successful and continuous fulfilment of the needs of clients who, in the traditional care model, would face ambiguities in the approach and responsibilities of both sectors (Association of Social Service Providers of the Czech Republic, 2025).

Another key provision of this amendment specifies the types of facilities in which social and health services may be provided, and only on condition that the provider is authorised to provide social services and, at the same time, authorised to provide health services in accordance with the Health Services Act. This elimination condition is groundbreaking, as until now, healthcare in some social services has been defined by exceptional regimes or contractual

links that did not address the fundamental problem of the different legal regimes of the two sectors. The new regulation thus provides legal certainty to both providers and clients that social and health care is provided within a uniform and legally defined framework.

The legislative reform is designed as a gradual transformation that will allow existing social service providers to adapt their organisational and professional structures so that they can obtain registration to provide health services and thus provide full social and health services. For example, the transitional provisions of the law tolerate the provision of health care under the current regime under certain conditions until the expiry of the transitional period (e.g. until the end of 2026) in order to mitigate the impact on providers and the continuity of client care. This element of temporary adaptation is strategically important for minimising sudden shocks in care provision and enables a systemic shift without disrupting existing capacities.

The amendment also introduces the concept of "social and health inpatient care", which is defined as a reimbursed health service, with the client's accommodation and meals being reimbursed under the Social Services Act. This model significantly strengthens the continuity of care, as it allows clients with long-term health and social needs to stay in a facility that is able to offer integrated services corresponding to their complex situation without unnecessary transfers between different types of facilities or services (Act No. 38/2025, 2025).

Institutionally, this legislative change means that social and health services will transcend the traditional boundaries between the Ministry of Labour and Social Affairs of the Czech Republic and the Ministry of Health of the Czech Republic, both in terms of management and quality standardisation and in terms of financing. The amendment also changes the Public Health Insurance Act (Act No. 48/1997, 1997), creating mechanisms for the reimbursement of the health part of services provided within the framework of social and health services; this is essential for the financial sustainability of the model and for its integration into existing reimbursement and public health insurance systems.

The institutional framework of the social-health borderline is therefore built on the principles of interdisciplinarity, coordination and legal clarity (Larsen et al., 2022). In this way, the law not only removes existing legal barriers to the integration of social and health services, but also creates a legislative basis for future standardisation of practice, quality of care, protection of clients' rights and accountability of providers in a jointly defined field of social and health services. This new framework represents a significant shift from a fragmented model of care to one that meets the complex needs of people with long-term health conditions and cumulative social disadvantages.

The social and health care model in the Czech Republic is built on several key components that together form a new framework for integrated care. These components cannot be understood in isolation, as their functionality is based on the interconnection of legislative, organisational, professional and financial elements. The basic premise of the model is that people with complex needs cannot be effectively supported through parallel systems, but require coordinated and continuous care provided within a single institutional framework and guided by a unified client-centred approach (Association of Social Service Providers of the Czech Republic, 2025).

The first key component is the integration of social and health care provision at the service level. Social and health care is designed as a unified service, not as the sum of two separate types of care. This means that social support (e.g. assistance with daily activities, support for self-sufficiency, social work) and health care (especially nursing care, health monitoring, application of treatment procedures) are provided in a coordinated manner, based on a joint care plan and within a single organisational structure. This approach fundamentally surpasses the previous model, in which healthcare tasks in social services were often handled on an ad hoc basis, without systemic interconnection and long-term responsibility.

The second important component is the emphasis on coordination and continuity of care, which is understood as one of the basic quality features of the social-health continuum. Care coordination includes both horizontal cooperation between individual professions (social workers, general nurses, doctors, other professionals) and vertical continuity of care over time, especially in the event of changes in health status, transitions between types of facilities, or when a client returns to their natural social environment. Continuity of care is intended to prevent situations where clients repeatedly "fall through the system" as a result of institutional boundaries, which was typical in the past in the social-health border area (Ministry of Labor and Social Affairs of the Czech Republic, 2024a).

The third component of the model is a clear definition of the target groups for which the social and health service is intended. This is not a universal model of care for all users of social or health services, but a targeted intervention focused on people with long-term poor health, reduced self-sufficiency or a need for regular nursing care, which cannot be effectively provided within the framework of regular outpatient health services or standard social services. Typical target groups include seniors with polymorbidity, people with chronic diseases, people with dementia, people with combined health and social disadvantages, and other groups in which

health and social determinants of quality of life overlap (Association of Social Service Providers of the Czech Republic, 2025).

The fourth key component is the professional and interdisciplinary dimension of the social-health borderline. The new model places increased demands on cooperation between professions that have so far been educated and socialised into different professional cultures. The social-health borderland presupposes a shared understanding of care goals, mutual respect between professions, and the ability to jointly plan and evaluate care from the client's perspective. This may have a significant impact not only on the organisation of work, but also on the requirements for staff competencies, further education and professional development. Interdisciplinarity is not understood here as formal cooperation, but as the functional integration of professional roles in everyday practice.

The fifth component is the financial and reimbursement mechanism, which is one of the most sensitive areas of the entire model. The social-health borderline is based on combined financing, where the health part of care is covered by public health insurance and the social part of care remains financed according to the rules of the Social Services Act, including client co-participation. This model reflects the duality of care, but at the same time creates space for its integration at the provider level. Transparent and predictable financing is a key prerequisite for the long-term sustainability of social and health services and their development in practice.

The sixth, equally important component is the normative and standardisation framework, which is designed to ensure the quality and safety of the care provided. Social and health services are subject to both social service quality standards and health service regulations, which places high demands on organisational management, care documentation, the protection of client rights and the professional competence of staff. This dual regulatory framework is also one of the main challenges of implementing the social-health continuum, as it requires the harmonisation of two previously relatively autonomous systems of quality control and evaluation (Ministry of Labor and Social Affairs of the Czech Republic, 2024b).

From an analytical perspective, it is important to distinguish between the conceptual and legislative framing of the social-health borderline and the empirical evidence that may support or challenge its implementation. While policy and professional discourse present integrated care as a coherent response to complex needs, the extent to which this assumption is supported by available data remains an open question. The following sections therefore examine to what extent aggregate data from penitentiary practice correspond to these conceptual assumptions and what analytical conclusions can be legitimately drawn from them.

PENITENTIARY EDUCATION AS A COMPONENT OF INTEGRATED CARE

In the context of the present article, education is understood as a constitutive part of integrated penitentiary care. It refers not only to formal schooling or vocational courses, but also to pedagogical work oriented towards resocialisation, health literacy, self-regulation, communication, responsibility, preparation for employment and the reconstruction of social ties. Such an understanding makes it possible to connect the social-health borderline with the educational mission of prison institutions.

Correctional education occupies a strategic position because it translates health and social diagnoses into daily practices that may support change. For example, a prisoner with addiction, chronic disease or mental health difficulties may require not only medical treatment, but also educational activities that develop coping strategies, literacy regarding health risks, professional skills and the ability to plan life after release. In this sense, education functions as a bridge between care and reintegration.

Therefore, the integrated model discussed in this article should be interpreted as a multidisciplinary model in which teachers and correctional educators are not peripheral actors. They participate in the identification of learning barriers, the adaptation of educational activities to health limitations, the strengthening of motivation and the articulation between institutional rehabilitation and post-prison social inclusion.

HISTORICAL DEVELOPMENT OF THE RELATIONSHIP BETWEEN HEALTH AND SOCIAL CARE IN PENITENTIARY PRACTICE

This section provides a concise historical overview of the relationship between health and social care in penitentiary practice, with the aim of contextualising current policy assumptions about integrated care. Rather than offering an exhaustive historical account, the focus is on identifying key moments in which the coordination of health and social dimensions of prisoner care emerged as a systemic issue relevant to contemporary debates.

The coordination of social and health care in the penitentiary environment is a historically conditioned process, the development of which is closely linked to changes in the concept of punishment, the understanding of human dignity and the gradual establishment of penitentiary science as a separate interdisciplinary field at the intersection of law, medicine, social work and pedagogy. Although healthcare for persons deprived of their liberty is currently perceived as a standard part of the execution of detention and imprisonment, historical

developments show that its institutional anchoring and systematic coordination with the social aspects of prisoner treatment were the result of a long and uneven process (Jůzl, 2010, 2017; Kučerová, 2013; Řezáč, 1995).

The Enlightenment brought about a real breakthrough in the humanisation of prisons and in the systematic approach to healthcare. English reformer John Howard laid the foundations for modern penology and penitentiary science by pointing out the inseparability of prisoners' physical and mental health from the purpose of punishment (Stárek et al., 2025). In his seminal work, *The State of Prisons in England and Wales*, he formulated comprehensive requirements covering hygiene, nutrition, access to water, fresh air, prisoners' workload, differentiation of the prison population and staff education. Howard's approach can be considered the first comprehensive concept of social and health care coordination in the prison system, as he understood prisoners' health not only as a medical problem, but as an integral part of their moral rehabilitation and resocialisation. Howard's ideas were followed up on a continental level by the development of modern psychiatry, represented in particular by Philippe Pinel, who, by symbolically removing the shackles from the mentally ill in the Paris institutions of Bicêtre and Salpêtrière, paved the way for more humane treatment of people with mental illness, including those who had come into contact with the criminal justice system (Jůzl, 2017; Kučerová, 2013; Řezáč, 1995).

In the Czech environment, František Josef Řezáč played a key role, whose work from the mid-19th century represents the first systematic attempt to theoretically grasp the prison system as a complex system. Řezáč explicitly includes doctors among the key professionals ensuring the running of prisons, alongside teachers, clergy and administrative staff. This approach clearly reflects the need to coordinate the health, social and educational functions of prison institutions. The fact that medical care was also enshrined in the legislation of the time, particularly in Act No. 117/1852 Coll., confirms its institutional stabilisation as a natural part of the execution of sentences (Jůzl, 2017; Kučerová, 2013; Řezáč, 1995).

This historical reference is particularly relevant because it shows that prison reform has long been associated with pedagogical concerns. The presence of teachers alongside doctors and clergy indicates that resocialisation was historically conceived as an educational, moral and health-related process, rather than as a purely punitive or medical intervention.

Historical developments thus clearly show that the social and health coordination of care in the penitentiary context did not arise suddenly, but gradually took shape in response to health risks, social changes, humanistic ideas and changes in the understanding of the purpose of

punishment. From a random and repressive medical presence, the development has shifted to a systematic, legislatively anchored and interdisciplinary model of care, which forms the basis of current penitentiary health and social systems in the Czech Republic and in the broader European context.

From an analytical perspective, the historical development of penitentiary care demonstrates that the relationship between health and social dimensions has long been recognised, yet rarely fully integrated at the institutional level. This persistent tension between disciplinary separation and the need for coordination provides an important background for interpreting contemporary policy efforts aimed at integration, as well as for assessing the extent to which current empirical data reflect or challenge these historical patterns.

PENITENTIARY PRACTICE AND THE SOCIAL-HEALTH BORDERLINE

This section analyses the characteristics of the prison population and the organisation of care within penitentiary practice, with a particular focus on how health and social needs intersect. The aim is not to establish causal relationships or to evaluate specific models of care, but to examine how available evidence reflects the complexity of these needs and what kinds of analytical conclusions can be drawn from it.

The prison population represents a specific target group whose health and social needs accumulate, are interdependent and often exacerbated by the institutional environment of the prison itself. From a social-health border perspective, this is a population with significantly higher levels of health risks, social deprivation and structural vulnerability compared to the general population, which makes the traditional separation of health and social care in a penitentiary context analytically problematic (Gormley, 2022). An analytically highly informative example of an environment in which the limitations of a fragmented care system are fully apparent.

The health profile of persons serving prison sentences has long been characterised by an above-average prevalence of chronic diseases, infectious diseases, mental disorders and addictions. Research and official statistics repeatedly confirm that there is a significantly higher incidence of psychiatric diagnoses, personality disorders, depressive and anxiety disorders, as well as somatic diseases related to long-term risky lifestyles, neglected preventive healthcare and low accessibility of healthcare prior to imprisonment among prisoners. Moreover, these

health problems are often long-term and require continuous care, not just acute medical intervention.

At the same time, the health status of persons serving prison sentences is closely linked to their social situation, which is usually characterised by an accumulation of social disadvantages. Typical features include low levels of education, unstable or completely absent employment history, indebtedness, disrupted family and social ties, experience of social exclusion, and limited skills for independent functioning after release. These factors not only increase the risk of deteriorating health during imprisonment, but also significantly affect the chances of successful treatment, rehabilitation and subsequent resocialisation.

A specific feature of the prison environment is the fact that health and social needs are not only parallel but deeply intertwined (Miller et al., 2024). For example, mental illness fundamentally affects a person's ability to adapt to the prison regime, cooperate in treatment or participate in resocialisation programmes, while social deprivation, isolation and loss of social roles can lead to a deterioration in mental and physical health. In this sense, the prison environment can be understood as one that not only reveals but often exacerbates existing social and health problems.

From a socio-health perspective, it is also important that the execution of a sentence represents a time-limited but intensive period of intervention during which there is potential for stabilising health, developing social skills and preparing for reintegration into society. However, this potential can only be realised if the care of prisoners is not reduced to isolated health services or partial social programmes, but is designed as an integrated process that reflects the complex needs of the individual in their bio-psycho-social entirety.

Within this period of intervention, educational programmes may operate as structured opportunities for rebuilding routines, developing work habits, improving basic competencies and strengthening the prisoner's capacity to participate in social life. For this reason, the analysis of social and health needs should be complemented by attention to educational needs, since untreated health conditions, low schooling, limited vocational experience and social exclusion often reinforce one another.

Special attention should be paid to specific subgroups of prisoners whose social and health needs are particularly acute. These include, in particular, the ageing prison population, people with chronic and degenerative diseases, people with severe mental disorders and people with multiple disabilities. These groups clearly illustrate the limitations of a care model that

strictly separates the health and social dimensions of support and are consistent with the need for coordinated, long-term and institutionally anchored social and health care.

From an analytical point of view, it can therefore be said that the prison population corresponds to the basic defining characteristics of the target groups of the social-health borderline: long-term needs, their complex nature, the need for continuous care and a high risk of care failure in the event of its fragmentation. This is precisely why prison practice represents not only a legitimate but also a particularly relevant analytical context for considering the social-health borderline as a systemic model of care. The way in which the health and social needs of persons serving prison sentences are understood and addressed can thus serve as an indicator of the maturity and functionality of this model in conditions of high institutional burden and structural constraints.

The current model of health and social care in penitentiary practice in the Czech Republic is characterised by significant institutional and functional differentiation, which reflects the general division of competences between the health and social systems, but takes on specific forms and limitations in the context of imprisonment. Health care for persons serving prison sentences is provided within the framework of the Czech Prison Service system through prison health care facilities and contracted health care providers, while social work is carried out primarily by educators, social workers and other professional prison staff. This dualistic model is formally functional, but from a social and health perspective, it has a number of structural limitations that affect the quality, continuity and coordination of the care provided. A research analysis supporting the mental health of prison staff points to the primary stressors for prison staff, highlighting the manipulative behaviour of prisoners, administrative overload, and a lack of institutional recognition (Vlach et al., 2025). Only a minority of respondents considered the existing mental health support systems to be effective.

Health care in the penitentiary environment is primarily focused on ensuring the basic right of prisoners to health protection, and its provision is significantly influenced by the security and organisational conditions of the execution of sentences. Health services are designed primarily as health care in the narrower sense, focused on the diagnosis, treatment and management of acute and chronic health conditions. Although specialised services, including psychiatric care and addiction treatment, are available in some prisons, the health component of the system is structurally separated from social work and resocialisation programmes, which limits the possibility of systematically linking health interventions with social support for prisoners.

Social work in penitentiary practice, on the other hand, is primarily focused on resocialisation and adaptation processes, including addressing the social problems of convicts, preparing them for release, maintaining contact with their families, securing housing and employment after serving their sentences, and addressing debt issues. Social workers and educators play a key role in the social stabilisation of prisoners, but their activities are often limited by the high number of clients, administrative burdens and limited opportunities for deeper interdisciplinary cooperation with medical staff. Social interventions are thus often carried out separately from the client's health context, even though the health status of a convict can significantly affect their ability to participate in resocialisation programmes.

From a systemic perspective, a characteristic feature of current penitentiary practice is the absence of a unified integrated care model that would explicitly link the health and social dimensions of support. Cooperation between health and social care staff is largely dependent on informal mechanisms, personal ties and local customs in individual prisons, rather than on a standardised institutional framework. This situation leads to inequalities in access to care between individual facilities and to the risk that the complex needs of prisoners will not be systematically identified and addressed.

Another specific problem with the current model of care is the limited continuity of care during transitions, particularly upon admission to prison and upon release. Medical records and social information are not always effectively shared between the prison system and external care providers, which complicates follow-up care after release and increases the risk of relapse of health problems or social destabilisation. It is precisely this discontinuity that represents one of the key weaknesses of the current system from a socio-health perspective, as interruptions in care during critical periods significantly reduce the effectiveness of previous interventions.

From an analytical point of view, it can be said that the current model of health and social care in penitentiary practice is functionally differentiated but structurally fragmented. Although the individual components of the system fulfil their legal obligations, their activities are not sufficiently integrated to reflect the complex nature of the needs of persons serving sentences. This situation is contrary to the principles of the social-health continuum, which emphasise coordination, continuity and unified management of care from the client's perspective. Penitentiary practice in its current form thus represents an environment in which the limits of the traditional departmental approach are clearly evident and, at the same time, can be interpreted as creating conditions for considering the implementation of an integrated social-health model.

The current situation can therefore be understood as a transitional model, which provides a basic level of health and social care but is unable to fully respond to the cumulative and long-term needs of prisoners. This finding is consistent with arguments for considering the application of the principles of the social-health borderline in penitentiary practice, as this context highlights the importance of linking the health and social dimensions of care.

The following considerations are presented as analytical implications derived from the observed characteristics of the prison population and institutional arrangements, rather than as empirically verified outcomes. They illustrate potential directions for the organisation of care, while acknowledging the limits of the available data.

The application of the concept of the social-health continuum in the context of penitentiary practice can be understood as an innovative and systematically grounded approach to the long-identified barriers to the integration of care in the prison environment. Given that the prison population has highly complex needs, which include the simultaneous presence of health, nursing and social aspects, the social-health continuum model offers a framework that aims to address the fragmentation of the existing system and creating conditions for integrated care focused on stabilising the client, preventing complications and supporting resocialisation.

One of the key ways of applying this model is to organise integrated care teams that would bring together experts from the fields of medicine, nursing, social work, psychology and resocialisation intervention programmes. In practice, such multidisciplinary teams could operate on the basis of a jointly developed and regularly updated individual care plan for each convict, reflecting both their health diagnoses and needs, as well as the social determinants of their lives and goals related to their return to free society. This care would be coordinated through a centralised management system that would minimise duplication of interventions and ensure continuity of support throughout the sentence.

In this configuration, correctional educators and teachers should be explicitly included in the integrated team. Their participation is necessary because educational engagement may be affected by medication, mental health conditions, disability, addiction, motivation, family problems and expectations regarding release. Joint planning can therefore help adapt pedagogical activities to individual health and social conditions.

A concrete example of such integration is the possibility of sharing medical and social documentation within prison structures and during transfers between facilities. Sharing information about health status, medication, treatment progress and social difficulties, such as family ties, housing or employment opportunities after release, may contribute to improving

the quality and effectiveness of interventions. In practice, this means that the healthcare team will not only work with the clinical profile, but will also have access to relevant social information that may influence treatment decisions. Conversely, social workers will have access to information about health limitations and treatment plans that can significantly affect the client's social adaptation.

Another dimension of the application of the social-health interface is the involvement of prison and external service providers in a continuous care network. This network would include the prison's internal health department, contracted external specialists (e.g., psychiatrists, rheumatologists, or geriatric specialists), social services specialising in the preparation of released persons, and non-governmental organisations providing support for reintegration into the community. An important aspect here is the creation of clear mechanisms for care transitions that minimise information loss and interruptions in treatment or social interventions during transfers between prisons or upon release. This model is consistent with the general principles of the social-health interface, which emphasise continuity of care as a key determinant of the effectiveness of integrated interventions.

In addition to interdisciplinary coordination and information sharing, staff training and professional development play an important role. The integration of social and health dimensions requires professionals to have not only specific professional competencies, but also a shared understanding of the target group and a common conceptual orientation towards the client. This includes further professional training in gerontology, mental health, nursing in a social environment, crisis intervention, communication with at-risk groups, and knowledge of the legal aspects of care provision in the context of imprisonment. It is also necessary to establish standardised coordination roles to ensure liaison between health and social teams, both within prison facilities and in cooperation with external institutions.

Such training should also include the educational workforce. Teachers working in prison settings need preparation to deal with heterogeneous schooling backgrounds, disability, trauma, addiction and resistance to learning. Their pedagogical role includes not only content transmission, but also the creation of learning environments that support dignity, responsibility and social reintegration.

Another important application of the social-health interface is the development and implementation of standardised care-oriented processes and protocols that reflect the complex needs of specific groups of prisoners. For example, for people with chronic illnesses or mental disorders, a modular care system could be created that combines medical interventions, nursing

support and a social work approach to adaptation and stabilisation in prison conditions. Standardising care in this way not only contributes to improving the quality of service, but also creates conditions for evaluatingthe effectiveness and efficiency of these interventions, which is important for long-term strategic planning and resource allocation.

Another important aspect is the focus of care on the social determinants of health, which significantly influence the resulting health and social functioning of individuals after release. This means that integrated interventions should include not only treatment and stabilisation of health, but also support in the areas of housing, employment, social ties, financial literacy and legal advice. The inclusion of these elements in the broader context of care is in line with the concept of health in all policies and can be understood as a shift from a medically oriented model of care to a comprehensive approach that combines the determinants of an individual's health and social functioning.

Last but not least, the application of the social-health frontier represents a strengthening of the system for evaluating the quality and effectiveness of care through the implementation of monitoring and evaluation mechanisms. This component includes the definition of care outcome indicators that would monitor both the health and social dimensions (e.g., clients' level of self-sufficiency, rate of recurrence of health problems, success of reintegration into society after release). Such indicators are important for a valid assessment of the impact of the integrated model on individuals and the system as a whole and can also serve as a basis for further policy decisions and optimisation of practice.

In summary, the application of the social-health continuum in penitentiary practice consists not only in the conceptual acceptance of care integration, but also in the practical, systematic and sustainable implementation of interdisciplinary mechanisms that ensure coordination, continuity, standardisation and evaluation of care. This approach can be interpreted as a potentially transformative approach that can be interpreted as an approach that seeks to respond to the cumulative and complex needs of persons serving sentences and may contribute to improvements in the quality of care, its effectiveness and the results of the resocialisation process.

CHALLENGES AND RISKS OF IMPLEMENTING THE SOCIAL-HEALTH INTERFACE IN PENITENTIARY PRACTICE

From an analytical perspective, the implementation of integrated care in penitentiary settings must be understood not only in terms of its potential benefits, but also in relation to the

structural, institutional and ethical constraints that may limit its effectiveness. The implementation of the social-health borderline in the penitentiary context, although associated with potential improvements in the quality and effectiveness of care, also faces a number of challenges and risks that need to be carefully analysed. These challenges take the form of institutional, legislative, personnel and ethical barriers that can significantly affect the success of the integrated care model in the prison environment.

One of the main barriers is institutional fragmentation and differences in the governance of health and social care. The Czech Prison Service is primarily focused on the security aspects of the prison system, which complicates the integration of health and social care, requiring flexibility and the interconnection of multiple professional systems. This structural inconsistency can lead to resistance to change and slow down the implementation of the integrated model.

Another important obstacle is the legislative framework, which represents a significant challenge. The personnel capacities and legal competences of individual staff members require a clear definition of responsibilities and possibilities for intervention within the new model. Changes in legislation and the need to harmonise legal regulations between the health and social services ministries may complicate the implementation of the model in practice.

A specific challenge is the financing of integrated care. The coordination of social and health services requires interconnected financial mechanisms that must ensure sustainability and continuous care provision without duplication or gaps in the financing of individual components of care.

Ethical issues arise primarily from the conflict between the welfare of prisoners and security priorities. Prioritising security may limit the scope of social and health interventions, while the ethical imperative of care requires respect for the rights and needs of the client. Continuity of care after release from prison is another significant risk, as interruption of care can lead to relapse of health problems or social destabilisation.

Last but not least, resistance to reform and cultural barriers within prison institutions must be taken into account. The introduction of an integrated care model requires organisational and cultural change, the acceptance of new roles by staff, and the ability to adapt to a systemically interconnected care model.

The application of the social-health interface in penitentiary practice brings a number of significant challenges and risks that need to be identified and addressed in advance. A holistic approach that takes into account institutional compatibility, the legal framework, human

resources, ethical aspects, financial sustainability and continuous evaluation is essential for the successful implementation of this model. Only such comprehensive changes can contribute to the expected results in the form of better quality and more effective care for prisoners, with an emphasis on their health and resocialisation prospects.

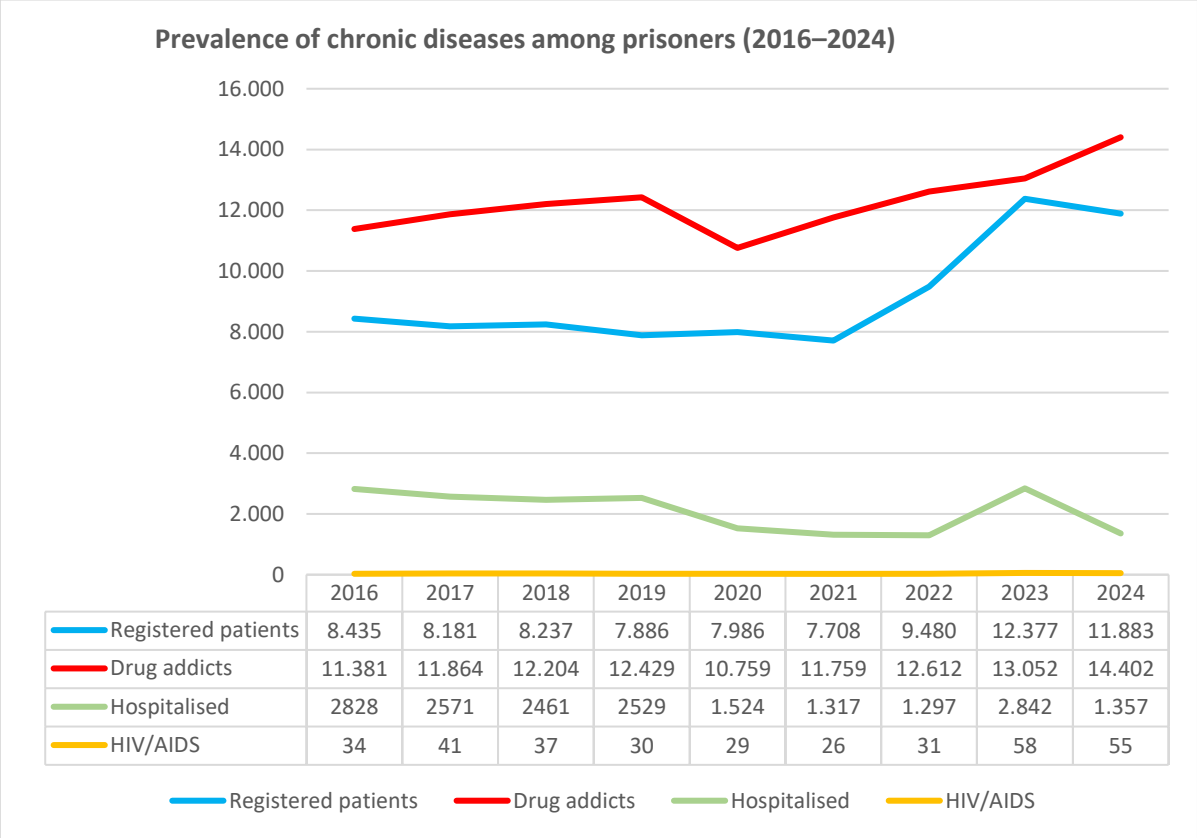
DATA AND STATISTICAL CONTEXT AS AN ARGUMENT FOR THE SOCIAL-HEALTH INTERFACE

The text so far points to the fact that the social-health interface in the penitentiary environment is not only a matter of organisational coordination of services, but above all a reflection of the real profile of the prison system's clientele. While the previous sections have outlined the conceptual and legislative background of the social-health borderline, empirical data provide insight into the characteristics of the prison population and the complexity of their needs. Rather than demonstrating the necessity of integrated care, these data illustrate patterns that are consistent with arguments for closer coordination between health and social services.

A key starting point is the health burden of prisoners, which in its structure and intensity significantly exceeds that of the general population. People entering prison bring with them an accumulation of risks that arose even before their imprisonment, including long-term unemployment, homelessness, addictive behaviour, limited access to primary health care and often distrust of institutions. Prisons thus concentrate individuals who were previously difficult to reach from the perspective of the health system. This helps to explain the high proportion of untreated or late-diagnosed diseases, which subsequently require complex interventions combining medical treatment, social support and educational components.

Figure 1.

Prevalence of chronic diseases among prisoners



	2016	2017	2018	2019	2020	2021	2022	2023	2024
Registered patients	8.435	8.181	8.237	7.886	7.986	7.708	9.480	12.377	11.883
Drug addicts	11.381	11.864	12.204	12.429	10.759	11.759	12.612	13.052	14.402
Hospitalised	2828	2571	2461	2529	1.524	1.317	1.297	2.842	1.357
HIV/AIDS	34	41	37	30	29	26	31	58	55

Nota. Statistical Yearbooks of the Prison Service of the Czech Republic (2016–2024).

The data presented in Figure 1 illustrate several important patterns. Firstly, there is a notable overrepresentation of psychiatric diagnoses and addictions, which frequently co-occur with other somatic conditions. This combination complicates standard medical procedures, as the effectiveness of treatment is closely linked to the stabilisation of the patient's social situation, continuity of medication and the level of patient motivation. Secondly, there is a high incidence of lifestyle-related diseases, including cardiovascular conditions, respiratory problems and hepatitis, which may be associated with long-term social disadvantage and insufficient preventive care.

The interpretation of these data has important implications for understanding the social-health borderline. In this context, prison doctors cannot be understood as fulfilling solely a clinical role, just as social workers cannot address social problems without taking into account the client's health limitations. Figure 1 thus suggests that, for a significant proportion of prisoners, the boundary between "health" and "social" problems may be difficult to distinguish. Mental health conditions can affect the ability to work, addiction may limit participation in

rehabilitation programmes, and somatic diseases can constrain engagement in educational or therapeutic activities.

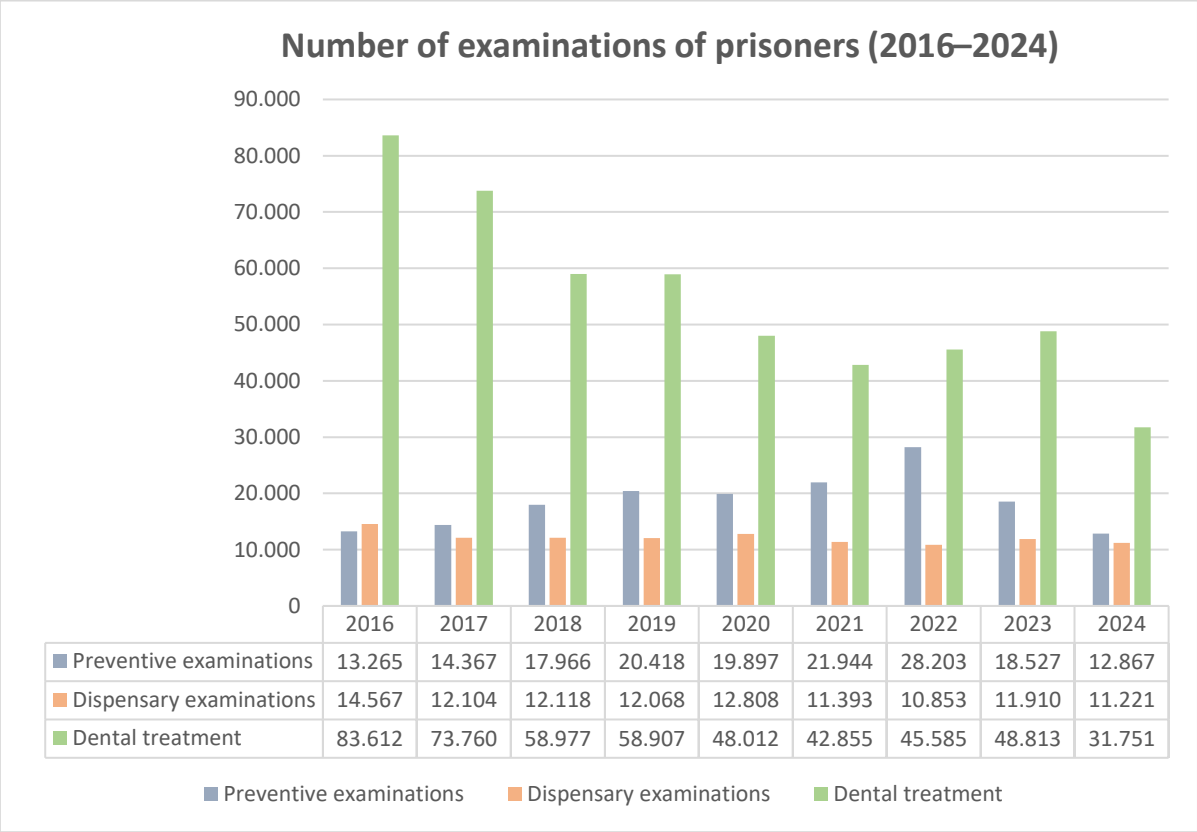
The same data also have educational implications. Chronic illness, mental health problems and addiction may affect concentration, attendance, motivation and the capacity to participate in training or resocialisation programmes. For this reason, educational planning in prisons should be connected to health assessment and social work, rather than being organised as an isolated institutional activity.

From the perspective of penitentiary practice, these findings suggest that healthcare in prison can be understood as part of a broader resocialisation process, rather than solely as a service aimed at maintaining basic physical condition. In this context, screening and diagnosis upon admission to prison appear particularly important for the development of individualised treatment plans. At the same time, the absence of continuity with community services after release may limit the longer-term effects of prison healthcare, which can subsequently be reflected in broader reintegration outcomes.

Figure 1 therefore not only provides a descriptive overview of the health status of the prison population, but also illustrates the interconnection of health and social factors discussed in the previous theoretical sections. It suggests that the prison environment represents a context in which the social-health borderline becomes particularly visible in everyday practice, rather than remaining only an abstract concept of public policy.

The number of examinations shown in Figure 2 is also relevant.

Figure 2.
Number of medical examinations of prisoners



	2016	2017	2018	2019	2020	2021	2022	2023	2024
Preventive examinations	13.265	14.367	17.966	20.418	19.897	21.944	28.203	18.527	12.867
Dispensary examinations	14.567	12.104	12.118	12.068	12.808	11.393	10.853	11.910	11.221
Dental treatment	83.612	73.760	58.977	58.907	48.012	42.855	45.585	48.813	31.751

Nota. Statistical Yearbooks of the Prison Service of the Czech Republic (2016–2024).

Figure 2 provides insight into the intensity of contact between prisoners and the healthcare system within penitentiary settings and allows for a more nuanced interpretation of how care is delivered. The data indicate that the volume of examinations performed is relatively high, which may suggest a significant level of access to healthcare services. However, a closer interpretation shows that the frequency of medical procedures alone does not allow conclusions about their quality or their connection to social interventions.

The predominance of acute and one-off examinations suggests that a substantial proportion of contacts may be driven by immediate health issues rather than by a systematically planned, long-term treatment process. In this context, the data are consistent with the assumption that a high number of examinations does not necessarily correspond to the existence of integrated care. If medical interventions are not accompanied by social assessment, work with client motivation and links to resocialisation programmes, they may remain relatively isolated actions with limited impact on the overall health and social condition of prisoners.

This limitation also applies to educational indicators. A prison may report the existence of schooling or vocational activities, but such information alone does not show whether

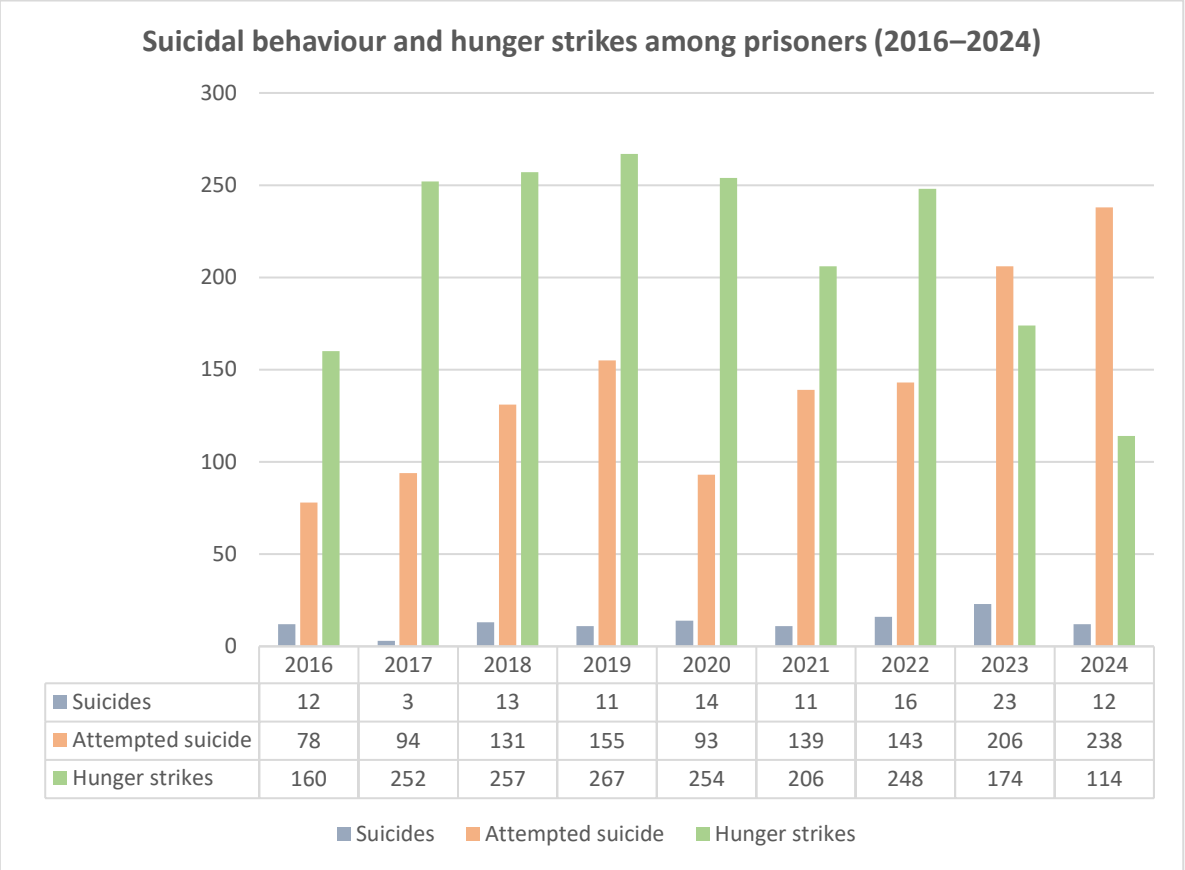
education is coordinated with health and social care or whether it contributes to meaningful reintegration. Future studies should therefore include data on educational participation, completion of courses, learning support and continuity with post-release employment or training opportunities.

Differences between types of examinations reflect the specific characteristics of the prison environment, including the need for initial screenings, ongoing monitoring during imprisonment and responses to acute or crisis situations. These patterns may point to the importance of strengthening interdisciplinary approaches in which medical care is more closely connected with social work, psychological support and preparation for reintegration into society. The number of examinations can therefore be understood not only as an administrative indicator of healthcare activity, but also as an indirect indicator of how the system responds to the complex needs of prisoners across different dimensions of their life situations.

One of the most sensitive, yet analytically informative, indicators of care in the prison environment is the incidence of suicidal behaviour and hunger strikes. These phenomena can be interpreted not only as individual manifestations, but also as reflections of broader tensions between the mental state of prisoners, the conditions of imprisonment and the system's capacity to respond to crisis situations in a coordinated manner. They are particularly relevant in the context of the social-health borderline, as they bring together health, social, ethical and security dimensions of care.

Suicidal behaviour in prisons is traditionally understood as primarily a psychiatric problem. However, practical experience shows that the decisive trigger is usually a combination of factors: loss of social ties, debt, fears of criminal proceedings, conflicts in prison, insufficient communication with family, or feelings of hopelessness. Hunger strikes are similarly complex in nature – they can be an expression of protest, a cry for help, but also a consequence of mental decompensation. These phenomena cannot therefore be reduced to a medical diagnosis; they require coordinated intervention by health professionals, psychologists, social workers and educators.

Figure 3.
Suicidal behaviour and hunger strikes among prisoners



	2016	2017	2018	2019	2020	2021	2022	2023	2024
Suicides	12	3	13	11	14	11	16	23	12
Attempted suicide	78	94	131	155	93	139	143	206	238
Hunger strikes	160	252	257	267	254	206	248	174	114

Nota. Statistical Yearbooks of the Prison Service of the Czech Republic (2016–2024).

The data presented in Figure 3 indicate that crisis manifestations represent a significant aspect of penitentiary reality rather than isolated incidents. Fluctuations in the number of suicide attempts and hunger strikes across individual years may be associated not only with changes in the composition of the prison population, but also with the system's capacity to identify and respond to risk signals in a timely manner. Factors such as the availability of psychological care, the nature of regime measures, and broader contextual conditions—including opportunities for contact with family, work placement or perceived fairness of staff behavior—may all play an important role.

From the perspective of the social-health borderline, these data can be interpreted in several ways. Crisis behaviour may be understood as reflecting the challenges associated with coordinating different types of services within the prison environment. In situations where healthcare, social work and regime measures operate in parallel rather than in a coordinated manner, information about the client may become fragmented. A psychiatrist may assess clinical risk, but without insight into the client's social situation, the intervention may remain

incomplete; similarly, a social worker may address relational or family issues, but without timely clinical support, the effectiveness of such interventions may be limited. In this sense, the data are consistent with the importance of a preventive dimension within the social-health interface.

Suicidal behaviour is often preceded by warning signs, such as loss of motivation, social isolation, interpersonal conflicts, refusal of food or emerging somatic complaints. The timely recognition of these signals may depend on the extent to which information from different professional perspectives is combined into a more comprehensive understanding of the client. In this context, integrated approaches to care can be understood as having not only a therapeutic, but also a preventive potential.

Hunger strikes and self-harm can also be interpreted as expressions of tension between the security-oriented logic of penitentiary institutions and the approaches of helping professions. While regulatory measures may contribute to short-term risk management, the absence of interventions addressing underlying factors—such as indebtedness, family relationships, addiction or mental health conditions—may limit longer-term effects. The data thus suggest that the social-health borderline can be understood as a space in which different institutional logics interact, rather than as a simple combination of services.

From a practical perspective, these findings may point to several relevant directions for consideration, such as:

1. The development of multidisciplinary crisis teams that facilitate closer coordination between health and social services;
2. Systematic sharing of information about at-risk clients, with due respect for ethical and legal standards;
3. The strengthening of programmes focused on stress management, coping strategies and the restoration of social ties;
4. Improved linkage to community-based services after release, as risks associated with crisis behaviour may persist beyond imprisonment.

Figure 3 therefore not only provides an overview of selected crisis indicators, but also illustrates how the quality of care in the prison environment may be related to the system's capacity to respond to complex and acute situations. In this sense, the social-health interface

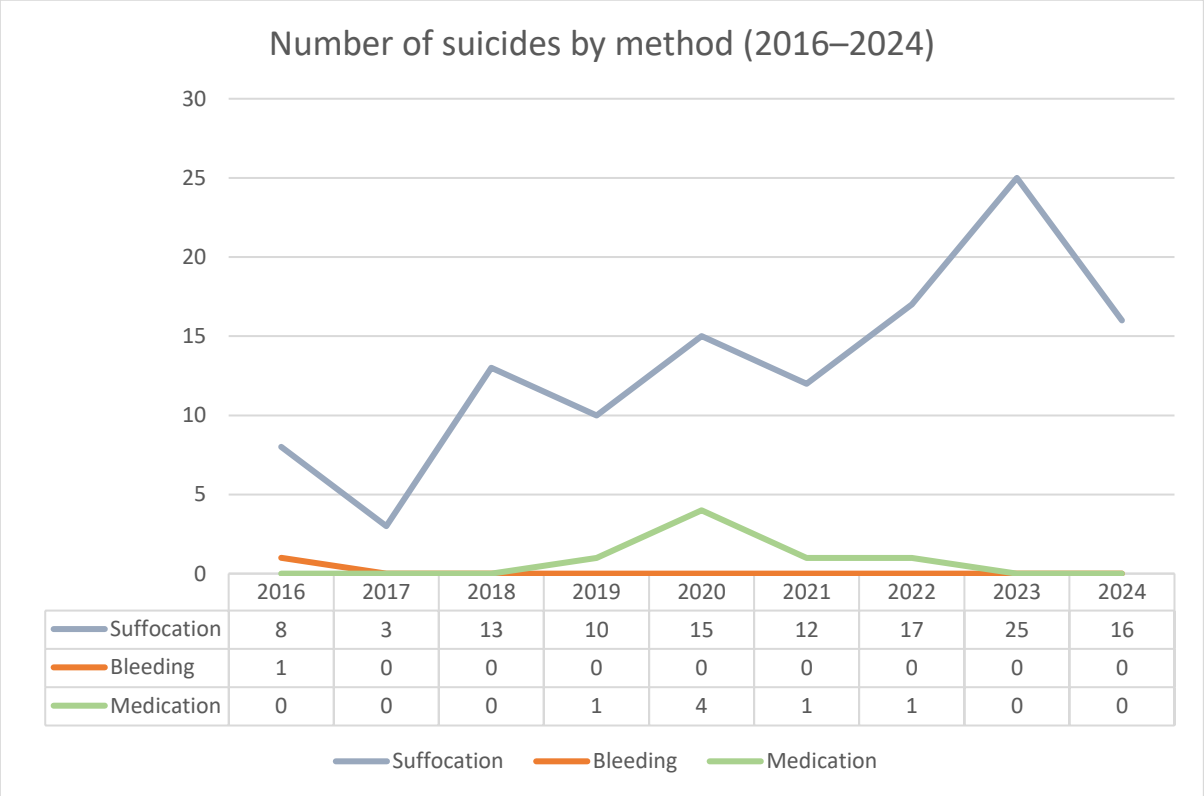
can be interpreted as a potentially important mechanism for linking medical supervision with an understanding of the broader social context of distress.

While the previous analysis focused on the overall incidence of suicidal behaviour and hunger strikes, a closer examination of the methods used in suicide attempts may offer additional insight into the nature of crisis situations in prisons. The choice of method may be associated not only with the availability of means, but also with the individual's psychological state, level of impulsivity and the characteristics of the institutional environment. These data can therefore be understood as a sensitive, yet analytically relevant, source of information for the development of preventive and intervention strategies.

Research in penitentiary psychology suggests that situational forms of suicidal behaviour, closely linked to acute stress, loss of perspective or conflict with the environment, may be more prevalent in prison settings than long-term planned acts. This may place increased demands on the ability of staff to recognise risk signals in a timely manner and to coordinate health, social and regime-based responses.

Figure 4.

Number of suicides by method



	2016	2017	2018	2019	2020	2021	2022	2023	2024
Suffocation	8	3	13	10	15	12	17	25	16
Bleeding	1	0	0	0	0	0	0	0	0
Medication	0	0	0	1	4	1	1	0	0

Nota. Statistical Yearbooks of the Prison Service of the Czech Republic (2016–2024).

The data in Figure 4 show that the structure of methods reflects the specific nature of the prison environment—limited access to resources, high levels of supervision and, at the same time, strong psychological pressure on individuals. The dominance of certain methods may suggest that some forms of suicidal behaviour can be interpreted as expressions of acute distress rather than solely as deliberate acts. This finding may have important implications on the concept of the social-health borderline: intervention may not be sufficiently addressed if limited to medical prevention, but must include work on relationships, communication, meaning and social support.

Figure 4 also suggests that the risk of suicide is closely linked to institutional factors—the quality of accommodation, the degree of isolation, the possibility of contact with family, and the nature of staff treatment. These variables lie largely outside the traditional remit of healthcare, yet they have a direct impact on the client's mental state. This suggests that the boundary between the health and social spheres in prison practice is artificial and that the prevention of the most serious crises requires the shared responsibility of multiple professions. From the point of view of client work methodology, several implications can be deduced: the need for systematic risk mapping upon admission to prison; the linking of psychiatric care with intensive social support in the first weeks of imprisonment; an emphasis on interpersonal relationships and the availability of crisis communication; and the involvement of family and community services in relapse prevention after release.

From the perspective of the social-health borderline, these findings suggest that the protection of life in prison may not be sufficiently ensured by technical measures alone, but may depend on a more comprehensive system of care addressing both health and social dimensions.

DISCUSSION

The description of the social-health borderline in the penitentiary environment suggests that the traditional division of care between departments may no longer correspond to the actual nature of the needs of the prison population. The empirical data presented in the previous section indicate that the health problems of prisoners are closely linked to their social situation, the length of their sentence and the availability of support services. The discussion of these findings cannot therefore remain limited to the description of individual indicators, but should

also consider the broader systemic contexts that may influence whether prisons function as spaces of resocialisation or, conversely, as environments in which social exclusion is reinforced.

A key issue concerns the extent to which the prison system may compensate for limitations in primary health and social care in the civilian environment. The data presented in the previous section suggest that a significant proportion of individuals enter prison already affected by untreated chronic diseases, addictions and psychiatric conditions. In this sense, prisons may function as a setting in which clients are systematically diagnosed for the first time and where initial interventions are initiated. At the same time, this situation can be interpreted as reflecting a broader systemic tension, in which an institution primarily designed to enforce punishment also assumes functions typically associated with community-based services. The social-health borderline can therefore be understood not only as an internal issue of penitentiary practice, but also as part of a wider discussion on the organisation of public services.

The second area concerns the issue of continuity of care. Data on the length of sentences and the number of examinations suggest that the intensity of health interventions may be relatively high, but often fragmented. Short-term sentences may limit the development of a comprehensive therapeutic process, while long-term sentences may be associated with risks of institutionalisation and a weakening of connections to the natural social environment. In this context, it is important to consider how prison and community services can be more effectively linked so that care may continue after release. Without such continuity, the social-health borderline within the prison may represent only a partial approach, the effects of which may diminish after return to society.

The third topic concerns the tension between the security and support functions of prisons. Indicators of suicidal behaviour and hunger strikes suggest that the crisis behaviour of prisoners may not be attributable solely to individual psychopathology, but can be understood as a complex response to the loss of autonomy, social roles and future prospects. Where responses rely predominantly on regime measures, there is a risk that symptoms may be managed without addressing underlying causes. In this context, the social-health borderline can be interpreted as a space in which the logic of security interacts with the logic of care. The outcomes of this interaction may be influenced by factors such as institutional culture, staff education and the extent to which competences are shared across professional groups.

The measurement of the effectiveness of such approaches also represents an important issue. Traditional indicators, such as the number of examinations performed or the capacity of healthcare facilities, may provide only a limited insight into the actual impact on the lives of

prisoners. This highlights the relevance of developing more comprehensive indicators that take into account quality of life, the degree of health stabilisation, the capacity for social integration and, more broadly, reintegration outcomes, including recidivism. From this perspective, the social-health interface can be understood as an approach whose relevance may be assessed in relation to longer-term changes in life trajectories, rather than solely through administrative performance indicators.

From an educational policy perspective, the effectiveness of integrated care should also be assessed through indicators related to learning and resocialisation, such as participation in educational programmes, acquisition of qualifications, vocational preparation, development of socio-emotional competencies, continuity with community education and employment after release. These indicators would make it possible to understand whether prison functions only as a place of custody or also as a structured environment for rehabilitation.

The personnel and ethical dimensions also represent important aspects of the discussion. Integrated approaches to care may place increased demands on the competencies of professionals operating at the intersection of several disciplines. Healthcare professionals may benefit from a greater understanding of social contexts, while social workers may need to take into account health-related limitations, and educators may need to engage with security requirements. In the absence of systematic training and supervision, there may be a risk of professional burnout and resistance to change. The ethical dimension is equally significant, as work with persons deprived of their liberty involves balancing the protection of society with respect for human dignity. In this context, the social-health borderline can be understood as a framework that may help to address this tension, particularly when based on principles of participation and an individualised approach.

From a legislative perspective, the introduction of the social-health borderline can be interpreted as an important development, although it does not in itself ensure changes in practice. The discussion highlights the possibility of formal implementation, in which existing structures are redefined without substantial integration of processes. In this regard, attention may be directed towards areas such as funding arrangements, information sharing and the clarification of responsibilities between relevant institutions. The prison environment may also be considered as a context in which the applicability of the model can be explored in relation to longstanding structural fragmentation.

The interpretation of the empirical data suggests that the implementation of the social-health borderline in the penitentiary environment may be associated with a set of interrelated

considerations at the level of service organisation, client work and system management. One important aspect is the development of stable multidisciplinary teams that connect medical, nursing, psychological, social and educational components of care. Such teams may operate more effectively when supported by joint planning, shared documentation and regular evaluation of individual care processes. Clear coordination of responsibilities may help to reduce situations in which professional roles overlap or, conversely, where gaps in care provision occur.

The second area concerns the strengthening of continuity of care between prison and the community. During the sentence, it may be beneficial to establish contact with future service providers, such as general practitioners, addiction centres, mental health services or municipal social workers. Release from prison can otherwise be associated with interruptions in treatment or a loss of social support. In practice, case management models, in which the client is accompanied by a single coordinator across institutional settings, have been presented as a potentially effective approach. In the absence of such continuity, the effects of interventions initiated in prison may diminish over time, which may also be reflected in reintegration outcomes, including recidivism.

The third area relates to systematic work with risk groups identified through data on health status, length of sentence and crisis behaviour. Screening upon admission to prison may benefit from including not only medical examinations but also social and psychological assessments. On this basis, it may be relevant to differentiate between programmes for individuals with short sentences, those with long-term illnesses, and clients with addictions or psychiatric conditions. A uniform approach may have limited effectiveness and may not adequately reflect the diversity of needs within the prison population.

Staff training can also play an important role. Prison staff, health professionals and social workers may benefit from developing competencies in communication, crisis intervention and interdisciplinary cooperation. Regular supervision and measures aimed at preventing professional burnout may be particularly relevant in this demanding environment. In the absence of adequate staff support, changes in institutional culture towards more integrated approaches to care may be more difficult to achieve.

Another practical consideration concerns the development of information systems that may enable the secure sharing of relevant data between health and social services. The current fragmentation of documentation may complicate the planning and evaluation of interventions.

In this context, standardised procedures, shared indicators and a transparent flow of information can be understood as important elements for the functioning of the social-health interface.

Last but not least, it is necessary to strengthen preventive programmes focused on mental health, stress management and the restoration of social ties. For example, drawing on ideas from the school environment—such as Bačová (2025), which discusses socio-emotional skills and ideas of inclusion (Daněk & Klugerová, 2023). Empirical data on suicidal behaviour and hunger strikes show that crises can only be prevented through a combination of professional care and humane treatment. The involvement of families, non-profit organisations and community services extends the scope of assistance beyond the prison itself.

In this regard, the article's dialogue with studies on inclusive education and socio-emotional skills should be made more explicit. Principles traditionally discussed in school contexts, such as inclusion, emotional regulation, respectful communication and support for vulnerable learners, may be adapted to penitentiary pedagogy. This adaptation does not erase the specificity of prisons, but it reinforces the argument that educational practices are central to rehabilitation and cannot be separated from health and social interventions.

The above recommendations aim to ensure that the social-health borderline is not seen as an administrative novelty, but as a practical tool for improving the quality of care and safety in society. The prison environment can be a place where the new model is tested in practice and becomes an inspiration for other areas of long-term and comprehensive care. Overall, it can be said that the social-health borderline opens up a perspective in which the convict is understood not as an object of punishment, but as a person with complex needs. The empirical findings of the article support this perspective, but at the same time reveal a number of barriers—temporal, institutional and cultural. The discussion therefore does not lead to simple solutions, but to a gradual transformation of the system, which will require the cooperation of the state, professional institutions and the non-profit sector.

FINAL CONSIDERATIONS

This article has focused on describing and reflecting on the social-health borderline in Czech penitentiary practice and has sought to connect theoretical, legislative and empirical perspectives on this emerging area of public policy. The analysis was based on the assumption that the prison population represents a group with complex and interrelated needs, in which health problems, social disadvantage and forms of risky behaviour are closely interconnected.

The empirical data and subsequent discussion suggest that the traditional separation of health and social services may not fully reflect this complexity. Statistical indicators indicate that individuals entering prison are often affected by a combination of chronic illnesses, addictions and mental health conditions, which may be further shaped by the length of their sentence, the intensity of their contact with healthcare services and the availability of social support. Taken together, these factors point to the importance of coordination across professional domains.

In this context, the social-health borderline can be understood as an approach that seeks to respond to the interconnected nature of these needs, rather than as an additional or isolated component of service provision. The legislative anchoring of this concept in the Czech legal system can be interpreted as an important step towards a more systemic approach. At the same time, the analysis suggests that legislation alone may not be sufficient to ensure changes in practice, which may also depend on organisational culture, staffing capacities and the development of mechanisms supporting continuity of care. The discussion has also indicated that the evaluation of such approaches may benefit from focusing not only on the volume of interventions, but also on broader outcomes related to quality of life and reintegration.

The article also indicates that the educational dimension should be treated as a necessary component of this approach. If the goal of imprisonment includes resocialisation, then prison-based education, vocational training and socio-emotional learning must be connected to health care and social work. This connection is what brings the article more directly into the field of educational policy and management, especially when the prison is understood as an institution that may either reproduce exclusion or create conditions for learning, rehabilitation and social reintegration.

The study is limited by its reliance on available aggregate data, which does not allow for detailed analysis of individual trajectories. Future research could therefore focus on longitudinal designs linking health, social and criminological indicators at the individual level. Further attention may also be directed towards the evaluation of specific pilot programmes of integrated care and their potential impact on recidivism, health outcomes and social inclusion. Overall, the findings suggest that the social-health interface can be understood as a potentially relevant approach to addressing the longstanding fragmentation of services and to viewing prisoners as individuals with complex needs and capacities for change. In this sense, penitentiary practice may represent a context in which the protection of society is considered alongside respect for human dignity, and where the goals of punishment and resocialisation can be examined in a more integrated manner.

A specific limitation concerns the absence of detailed educational data in the analysed administrative sources. The article therefore cannot evaluate the concrete impact of prison education on health, social inclusion or recidivism. This limitation should guide future research towards mixed-methods designs that combine administrative indicators with interviews, institutional case studies and longitudinal monitoring of educational trajectories before, during and after imprisonment.

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