Research paper

Inequalities in healthcare for prisoners in Europe: a review

Morag MacDonald PhD
Social Research and Evaluation Unit, Faculty of Education, Law and Social Sciences, Birmingham City University, Birmingham, UK

James Williams PhD
Social Research and Evaluation Unit, Faculty of Education, Law and Social Sciences, Birmingham City University, Birmingham, UK

David Kane MPhil
Social Research and Evaluation Unit, Faculty of Education, Law and Social Sciences, Birmingham City University, Birmingham, UK

What is known on this subject
- The provision of healthcare for detainees is very different across the European member states.
- The point of arrest and subsequent detention is often the first contact that the detainee has with any form of service or treatment.
- Pockets of good practice exist across EU member states, but provision of throughcare is inconsistent.

What this paper adds
- It provides an analysis of the availability of healthcare for detainees in the criminal justice systems.
- It discusses the meaning and components of throughcare in different parts of the criminal justice system in a selection of EU member states.
- It highlights the links between the provision of throughcare and prisoners' successful reintegration into the community.

ABSTRACT

Detainees are a particularly vulnerable group in society and face a wide range of health issues that are often associated with their offending behaviour, yet many fail to receive the healthcare that they need. The authors' research indicates that continuity of care, sometimes known as *throughcare*, is essential to successfully reducing recidivism among offenders and helping them to become contributing members of society. This article uses the prisoner's journey as its framework and draws from two major European research studies funded by the EU to identify the requirements for building a successful and equitable throughcare process for detainees. The key findings are that, at every stage of the prisoner's journey, there are gaps in throughcare, allowing prisoners' health problems to go undetected and untreated, which in many cases leads to offending behaviours, recidivism and the 'revolving door' into prison.

Keywords: detainees, equivalence, healthcare, police detention, prisoners, throughcare

Introduction

The provision of healthcare in detention is an important but often overlooked issue relating to equality and diversity in contemporary society. The international principle of equivalence of healthcare, where the standards of healthcare in detention should be equivalent to those provided in the community at large, is

now largely accepted by commentators and researchers (Møller *et al*, 2007, p. 7). However, in reality, prisoners face particular difficulties in gaining access to effective healthcare. This is inherently contrary to their human rights, as the United Nations *Basic Principles for the Treatment of Prisoners* states that 'Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation' (United Nations, 1990, cited by Møller *et al*, 2007, p. 7). It is also important because, for many prisoners, unresolved health issues are a key factor in their offending behaviour (Hult, 2011; Social Exclusion Unit, 2002). A particular need that has been identified in the provision of equitable healthcare is the effective implementation of *throughcare*, sometimes referred to as *end-to-end offender management*. However, although this term is popular, it focuses on management of offenders rather than care. Throughcare is resurgent in the European context, because 'offender management' shifts the emphasis away from empowering the offender to one of managing resettlement, which, as Moore (2012) has pointed out, ignores previous marginalisation. Thus the focus should be on careful integration, not managed reintegration into a former setting that led to offending behaviour in the first place (MacDonald *et al*, 2012; Møller *et al*, 2007, p. 104) (see Box 1). Providing throughcare is generally regarded as vital to establishing equitable access to healthcare for prisoners, but studies from around Europe indicate that its provision is at best patchy. At every level of the prisoner's journey, significant issues arise affecting the effective provision of drug services and healthcare treatment. A key element in throughcare is the help given to prisoners to enable them to desist from further criminal activity. The desistance approach, discussed below, accepts that the integration of ex-prisoners into the community is a complex process.

Approach

This paper is based on research undertaken during a six-country European comparative project on 'Throughcare for Prisoners with Problematic Drug Use' (MacDonald *et al*, 2012), which was coordinated by the lead author and funded by the Directorate General Justice of the European Commission. The empirical data in this paper are largely drawn from interviews, focus groups and surveys that were conducted as part of the project. The project involved the following partners: Caren Weilandt (Germany), Ivan Popov (Bulgaria), Daniele Berto (Italy), Kristina Joost (Estonia), Emanuel Parasuanu (Romania) and Morag MacDonald (UK).

The project's fieldwork phases, which are available on the project website (www.throughcare.eu), are mined and synthesised for this overview. In addition, data collected for previous EU studies by the author on prison healthcare, provision of drug services and healthcare provision at the point of arrest are used to augment these findings (MacDonald, 2005; MacDonald *et al*, 2008; Walmsley, 2005). The countries covered by the studies by MacDonald (2005) and MacDonald *et al* (2008) were Bulgaria, Romania, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia. The study by Walmsley (2005) involved the prison systems of 25 countries in central and Eastern Europe. An overview of two empirical studies (MacDonald *et al*, 2008, 2012) is undertaken in order to draw out the key issues of the prisoner's journey from the point of arrest through the criminal justice system and back to the community. The majority of the material cited is from the partners in the two studies.

The paper illustrates the provision of continuity of care by documenting a typical prisoner's journey through the criminal justice system. This will include the point of arrest, detention in police houses, prison sentence and release back to the community. For many prisoners, their first contact with healthcare services may well be at the point of arrest, and research has indicated that there are serious inequalities in healthcare from this point compared with the wider community.

Box 1 Throughcare

Throughcare is a term in current use in many spheres in the UK, including throughcare of children leaving care homes (see www. scottish throughcare.org.uk), and support for victims of domestic violence or forced marriage (see www.throughcare.com) as well as prisoners (see www.glasgow.gov.uk/en/Residents/Care_Support/CriminalJustice/Throughcare) (all websites accessed 27 June 2012).

Comparative research

When analysing and comparing data from different EU countries, care has to be taken to ensure that a common understanding is reached in the use of terms and the functions of organisations involved in the criminal justice system. Since the advent of European funding, comparative research involving groups of EU countries has become more common. Comparative research has problems as well as advantages. The approach is not new, as it has been utilised in cross-cultural studies as a means of identifying, analysing and explaining differences and similarities in different societies. The methods adopted for the empirical studies drawn upon in this article (MacDonald, 2005;

MacDonald *et al*, 2008, 2012; Walmsley, 2005) are in essence no different from those used in national studies, because data are collected at the local level and then results are compared and contrasted at the macro (European) level. However, particular attention needs to be focused on the identification of key terms and common understandings of key concepts (University of Surrey, 1995), as it is easy to assume that a common term involves a common understanding (for example, the term *probation* has different meanings across Europe).

There are considerable advantages to cross-cultural comparative research. Comparisons can lead to fresh, exciting insights and a deeper understanding of issues that are of central concern in different countries. They can lead to the identification of gaps in knowledge, and may point to possible directions that could be followed and about which the researcher may not previously have been aware. They may also help to sharpen the focus of analysis of the subject under study by suggesting new perspectives. Cross-national projects give researchers a means of confronting findings in an attempt to identify and illuminate similarities and differences, not only in the observed characteristics of particular institutions, systems or practices, but also in the search for possible explanations of national similarities and differences. Researchers undertaking cross-national comparisons have to engage with different cultural perspectives, to learn to understand the thought processes of another culture and to see it from the native's viewpoint, while also reconsidering their own country from the perspective of a skilled external observer (University of Surrey, 1995).

Cross-cultural research does raise key ethical problems that need to be rigorously addressed. Ethics is the first agenda item at the first project partner meeting prior to the commencement of any of the EU-funded research discussed in this article. The projects all involve prisoners who are vulnerable research subjects. In cross-cultural research it is important to have clear research objectives, and to be aware of and respect the concerns of the individuals and communities that are being studied. This requires that the research be consistent with ethical standards of all participants. Research that involves prisoners and minority ethnic groups requires that attention be paid to issues of consent and potential risk (Taylor, 1994).

In the original research under discussion in this article, the following key ethical issues were discussed and agreed.

1. The rights of prisoners and staff working in sample prisons had to be assured. It was important to provide consent sheets to ensure that the interviewee could withdraw at any time, and also to ensure that they had not been coerced into participating.
2. The management and conduct of the research must be framed in line with ethical principles to ensure that all partners adhere to the agreed ethical framework.
3. Sensitivity to cultural and social differences was discussed in order to clarify and agree a shared understanding of concepts and an understanding of potential conflicting interests.
4. Anonymity and confidentiality were ensured by not identifying the sample prisons, police stations, individual prisoners or staff.

Desistence

Many prison services focus on reducing recidivism, and tailor their provision for prisoners with problematic drug use to those services that they consider will lead to a reduction in the number of prisoners who return to prison. The impact of access to health and drug services on the resettlement of offenders was a key research question. For some problematic drug users, the point of arrest may be the first time that they engage with health and drug services. One tenet of desistance theory is that social control and social capital come from the family, school and stable employment, and can be seriously harmed by imprisonment. The negative impact of imprisonment might increase offender recidivism on release and increase involvement in crime (Sampson and Laub, 1993, 1995).

The concept of assisted desistance provides a better understanding of the ways in which services, individuals and organisations can help ex-prisoners to reduce offending (McNeill *et al*, 2005). Previously, desistance research has focused on how offenders use their own initiative to give up crime, rather than focusing on the impact of interventions (Farrall, 2002). The *Throughcare Toolkit* (MacDonald *et al*, 2012) was designed to help practitioners to focus on the needs of prisoners when they leave prison. This toolkit is underpinned by the idea that good throughcare will reduce recidivism and facilitate reintegration.

What is throughcare?

For prisoners with multiple health needs, particularly problematic drug use, continuity of care (throughcare) is vital for increasing their successful integration into the community (Møller *et al*, 2007). Where throughcare services are in place, ex-prisoners are less likely to return to their drug use or to reoffend (Holloway *et al*, 2005). In Europe, the provision of throughcare for prisoners with problematic drug use is an under-researched issue. Most studies focus on

interventions within the limited context of the UK and the USA (Webster, 2004). In many studies there is a lack of attention to holistic throughcare and an emphasis on access to drug services (e.g. methadone programmes, therapeutic communities) that ignores the social factors that affect successful resettlement.

The term 'throughcare' has been defined in several ways, but the most comprehensive is that developed by Fox *et al* (2005, p. 49), who argue that 'Throughcare refers to arrangements for managing the continuity of care which started in the community or at an offender's first point of contact with the criminal justice system through custody, court, sentence, and beyond into resettlement.' The Prison Service for England and Wales defines throughcare as 'the quality of care delivered to the offender from initial reception through to preparation for release establishing a smooth transition to community care after release' (HM Prison Service for England and Wales, 1999). Throughcare is therefore conceptualised as the continuous, coordinated and integrated management of offenders from the offender's first point of contact with correctional services to their successful reintegration into the community and completion of their legal order (Clay, 2002, p. 41). The emphasis is therefore on a coordinated and smooth progression of care through the healthcare system (Sainsbury Centre for Mental Health, 2008).

The prisoner's journey

These definitions of throughcare suggest a progression through the criminal justice system. Officially, the journey begins at the point of arrest, because it is impossible to generalise about individual offending behaviours that usually begin over a prolonged period of time before the first contact with the criminal justice system. After arrest, a prisoner will be held on remand, sentenced to a jail term, serve the sentence and then be released. In many cases this is a cyclical process, because many offenders often return to prison, a phenomenon that is referred to as the 'revolving door' (see Figure 1).
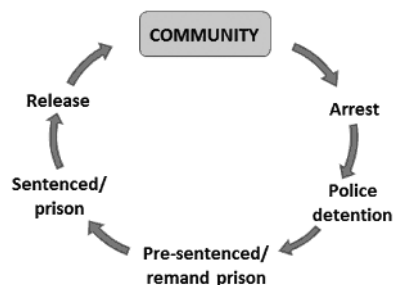
Figure 1 The prisoner's journey. (Adapted from MacDonald *et al*, 2012, p. 4.)

Community

Offenders often enter prison without ever having been in contact with community health services. Many, for example, are not registered with a GP or a dentist. For instance, in Bulgaria, 'when entering the prison, [problematic drug-using] offenders usually do not have any medical files. As a result, it is very difficult for prison experts to make a reliable evaluation of a prisoner's real health status' (Popov, 2012, p. 13). Alternatively, previous contact with healthcare services might have been sporadic. Durcan (2008, p. 7) found that many 'had previous contact with mental health services but had not been followed up and had lost touch.' A lack of social and intellectual capital can also be problematic, with individuals often being unable to access available support because they are simply unaware of its existence.

Failure to access healthcare is concomitant with strong evidence that prisoners often suffer from significant and often multiple health problems, which are often unseen, undiagnosed and untreated in the period before contact with the criminal justice system. For example, research indicates that 70% of Europe's prisoners have a mental health problem (Møller *et al*, 2007). In addition, a significant proportion of prisoners in Europe are problematic drug users.

Prisoners are often drawn from the most disadvantaged socio-economic groups. In addition, young men and ethnic minority groups are over-represented. It is also evident that an increasing number of women are being incarcerated, and that the prison population is ageing.

Arrest

Poor mental health is a frequent underlying cause of offending behaviour, a factor which puts the police in a key position to divert appropriate individuals into health and social care services at the point of arrest (Bradley, 2009). Police detention is the least effective part of the criminal justice system with regard to liaison with health and drug services, and 'yet it [police detention] provides the greatest opportunity to effect change through improving access to services for detainees, improving safety for individuals and the public, and providing valuable information to agencies at the later stages of the criminal justice system' (De Viggiani, 2010, p. 5).

Detention in police custody can be either relatively short (in police stations) or for longer periods (in police arrest/remand houses) (MacDonald *et al*, 2008). Irrespective of the police setting, access to healthcare is generally more problematic in police detention, when requests for medical attention can be ignored or take time to be dealt with (MacDonald *et al*, 2008). This last point was corroborated by HM Inspectorate of Prisons

and Inspectorate of Constabulary (2011, paragraph 6.10) report on police custody suites in Sussex, in the UK: 'In our prisoner survey, none of the respondents seen by a health professional rated the quality of care as good or very good, against the comparator of 29%.'

Medical care, other than emergency intervention, is perceived as a low priority in police detention. Provision varies both within and between countries, from a dedicated forensic service (in England and Wales, and Germany) to provision by the Ministry of Health (in Lithuania and Hungary), reliance on an emergency service at police stations (in Italy, Estonia and Bulgaria), and provision by the Ministry of the Interior (in Romania). Provision is poorer in arrest houses (detention centres) under the control of the Ministry of the Interior than in those where detainees went directly to pre-sentence prisons under the control of the Ministry of Justice. In general, the evidence indicates that medical care provided in police arrest houses is not comparable to that either in the community or in prisons (MacDonald et al, 2008).

Healthcare in custody should be equivalent to that in the community, yet prisoners' rights with regard to this issue are regularly infringed (MacDonald et al, 2008). At the very least, some minimal level of qualified medical care should be accessible in police custody to enable the assessment of the risk that detainees pose to themselves, to identify those who need to be transferred to hospital, and to provide regular medical care such as that provided by custody nurses in some police forces in England and Wales. A pilot scheme in one area of England, in which round-the-clock medical care was provided by custody nurses, confirmed that this 'lays the foundations for putting into operation the logic of interrupting re-offending by treating underlying causes. Similarly, the goal of reducing the risk of deaths in custody may well be brought closer by this pilot through its enhanced capacity to address more immediately and effectively vulnerabilities in the mental health of detainees' (De Viggiani, 2010, p. 41). In other countries there is frequently a reliance on the emergency services or the forensic medical service (MacDonald et al, 2012).

Overall, the standard of healthcare available in police cells and remand houses is inconsistent. In some countries there were significant differences in healthcare provision between urban and rural settings. The condition of police cells and police arrest houses and the facilities available raise questions about their suitability for detaining individuals with acute healthcare needs, mental health problems and addiction problems. Lack of suitable consultation rooms, equipment and resources constrains the provision of medical care. The Police Complaints Authority (2004) report in England and Wales concluded that 'the police service is simply not equipped to deal with the complexity of extreme alcohol intoxication, and does not have the systems in place to offer adequate care to this population. Unless there are vast improvements in custody staff training, detainee risk assessment, the extent and quality of medical support and organisations' commitments to effective detainee management, there is no alternative but to conclude that drunken detainees should not be taken to police stations in other than the most extreme circumstances' (Joint Committee on Human Rights, 2005, paragraph 160).

Improving healthcare in police detention is important both in itself and to meet the basic human rights of detainees. The conditions in which prisoners are held in police detention can be harmful to health, and it is evident that reform is necessary.

In prison

For many offenders, prison is often the first place in which they have an opportunity to gain access to effective healthcare services. As Dr Nata Menabde, of the World Health Organization Regional Office for Europe, noted, 'They are certainly reachable for a certain period at least' (quoted in Møller et al, 2007, p. vii). Ironically, it is often only when they are in prison that offenders encounter opportunities for diagnosis and treatment. These opportunities need to be taken by the prisoners but also facilitated by the prison authorities, which is not always the case. Diagnosis is the first stage in developing a treatment plan, but this is not always achieved. In some cases, diagnosis occurs randomly. There are few standard procedures for identifying whether a prisoner has a significant health problem. There are no standard approaches for mental health problems, self-harm, and histories of domestic or sexual abuse, and disclosure is dependent on a range of random occurrences, such as personal disclosure or a prisoner presenting with unusual behaviours.

The first stage in the treatment of prisoners is assessment of their needs (MacDonald et al, 2012). Overall, tools for assessing the state of prisoners' health were not available in most of the countries in the research of either Walmsley (2005) or MacDonald et al (2008). Even where assessment took place, prisoners were often 'disinclined to identify vulnerabilities within the prison environment, [while] staff undertaking screenings can appear rushed and uncaring, and prisoners were concerned around exposing themselves to bullying' (Anderson and Cairns, 2011, p. 6). Nevertheless, there were some signs of progress. For example, in Germany, Article 5 of the Penal Law states that prisoners should undergo medical examination on admission (Weilandt, 2012). This examination includes testing for possible substance use and the potential risk of suicide. Assessment such as this occurs only patchily across Europe, and there are

other models. For example, the Offender Assessment System (OASys) (Moore, 2009) predicts the likelihood of a prisoner re-offending. It has been used in Bulgaria since 2002, where it has highlighted significant health issues (Popov, 2012). In the UK, health screening for prisoners is based on the revised reception health screening tool (F2169A), which was formally adopted by the Prison Service in 2004. This tool consists of a mandatory assessment to be completed by a health-care worker on the first night that a prisoner is in custody (Offender Health Research Network, 2008).

Once an assessment has been made, the development of a treatment plan requires collaborative working between senior prison management and agencies. There are examples of good practice, such as the Berlin model and the Bremen Entlassungsvorbereitung (EVP), both of which involve bringing together key agencies and the prison authorities in order to develop a care plan for individual prisoners (MacDonald *et al*, 2012). In Germany, for example, lack of inter-agency cooperation is partly responsible for the gaps in assistance on release (Weilandt, 2012). The situation is further complicated by the length of sentence. Short sentences mean that there is little time in which to make a difference.

Release

The point of release is a crucial moment in the prisoner's journey. How treatment work started in prison will be continued in the community is an important issue (Møller *et al*, 2007). On release, ex-prisoners often have little option but to return to the communities from which they originally came, which are often poor, deprived areas with high levels of substance abuse (Turnbull and McSweeney, 2000). In many instances they simply return to drug use, do not continue with treatment and/or do not know where to go for support.

Ex-prisoners are often unwilling to look for or access support independently, highlighting the need for trusted individuals to accompany them to appointments and provide a smooth transition from prison to the community. In the UK, for example, the 'Through the Gates' scheme in London supports prisoners and encourages the use of appropriate services before, during and after their release (Park and Ward, 2009). Similar activities occur in other countries, such as the Netherlands (Association of Dutch Municipalities, 2009). A few projects also exist in Germany. For example, in Baden-Württemberg, the non-governmental organisation 'Projekt Chance' (www.projekt-chance.de) provides personnel to accompany juvenile prisoners and establish contact with relevant service providers before, during and after release (Weilandt, 2012). The physical distance between

prison and home can be particularly problematic. For example, in Estonia, all prisoners with diagnosed problematic drug use are housed in Tartu Prison, a specialised facility (Joost, 2012). In the UK, women prisoners are usually held in one of 13 single-sex prisons, and as a result they are incarcerated on average 57 miles from their homes (Ministry of Justice, 2012; Prison Reform Trust, 2010, p. 25). In some countries, attempts have been made to ensure that prisoners are held closer to home. In the Netherlands, for example, the municipalities and prisons have taken shared responsibility for prisoners.

The UK's Ministry of Justice (2011) and many other agencies advocate a holistic approach to prisoner treatment. The UK 'pathways of offender management', which were adopted in 2004, recognise that different aspects of offenders' lives, such as housing, education, training and employment, finance and welfare, children and families, are often intertwined (National Offender Management Service, 2004).

Accommodation is important, because many prisoners either have no home to go to on release, or are forced to return to homes shared with individuals who encouraged their offending behaviour. Often prisoners fear moving back to the area in which they lived at the time of their offence, as many of their friends and acquaintances are engaged in criminal activity or have health problems such as problematic drug use (MacDonald, 2012b). Some initiatives have sought to address this problem, with limited success: 'Halfway houses provided by prison and probation authorities provide only a short-term solution' (Quaker Council for European Affairs, 2011, p. xiv). It is clear that more could be done to increase the chances of successful rehabilitation.

Education, training and employment play an important part in maintaining prisoners' self-esteem and reducing recidivism (Freeman, 2003). In the partner research conducted as part of the Throughcare Project, prisoners often referred to the need for work and the difficulties that they faced in finding employment (MacDonald *et al*, 2012).

Family and relationships are regarded by several authorities as important in supporting prisoners through their journey, but little research has been undertaken in this area. Work in the field indicates that, in some cases, families who are involved in the prisoner rehabilitation plan can be instrumental in reducing recidivism.

Monitoring throughcare services

Throughcare clearly depends on effective systems of monitoring at every level of the prisoner's journey. However, partners engaged in the Throughcare Pro-

ject found that there was very little monitoring of throughcare activities. Several factors contributed to this lack of scrutiny. In Estonia and the UK, for example, a lack of routinely collected data means that there is a lack of information about which interventions are successful and which are not (Joost, 2012; MacDonald, 2012a). In Bulgaria, the problem is related to the structure of the penal system: 'each prison has its own approach and, if throughcare services exist in one prison, they are usually delivered without evaluation, consistency or follow up' (Popov, 2012, p. 14). In the UK, resources were an important issue for many agencies that wanted to evaluate their services (Fox *et al*, 2005). Additional concerns about data sharing and client confidentiality meant that some agencies were reluctant to provide information about referrals made after release (Farrell and Marsden, 2005).

Conclusions

Throughcare has the potential to improve the health of prisoners and reduce inequalities in healthcare for a particularly vulnerable group. Despite the shift towards the language of offender management, the concept of throughcare has enormous value in shifting the focus to care for offenders, who are in many cases suffering from severe health problems. Continuity of care is clearly important to prisoners. It can help to improve their health, and it also helps to address other issues, including employment, education and accommodation.

There are many examples of good practice in throughcare from across Europe, but they are patchy. Healthcare provision for prisoners with problematic drug use is inconsistently applied at every stage of their journey. From the point of arrest, through detention in police stations, detention houses and into prison, there are opportunities for addressing particular healthcare needs. Many people who enter the criminal justice system not only have healthcare needs but may also have experienced related issues such as problematic drug use, domestic violence and abuse. Gaps in throughcare that allow prisoners' health problems to go undetected and untreated can, in many cases, lead to offending behaviours, recidivism and the 'revolving door' into prison.

The period of detention provides an important opportunity to address detainees' needs in preparation for release back into the community. Indeed, for many prisoners, detention provides their first contact with any form of service or treatment. Assessment at the beginning of the prisoner's journey is essential for ensuring appropriate care and interventions while they are in prison and after their release.

The prisoner's journey is an effective way of identifying key weaknesses in the provision of healthcare. There are opportunities to address health needs at each stage of the journey, from arrest through to release. At the point of arrest the police are potentially in a position to refer offenders with problematic drug use to appropriate services. Screening for prisoners' throughcare needs at the time of entry to prison is important both for identifying needs (e.g. for accommodation, training and employment, family support) and for preparing them for release.

Continuity of care after release is hampered by multiple factors. Effective cooperation and networking between prison services and external organisations are essential if throughcare is to become effective, but in many countries this needs to be developed. Prisoners with addiction and/or mental health problems require well-organised and holistic throughcare. As Webster has argued:

> There is a consensus that there are many difficulties to overcome and that meaningful partnership between criminal justice and treatment agencies planning aftercare services within prison and in the community by means of a carefully designed case management system is perhaps the best way forward.
>
> (Webster, 2004, pp. 19–20)

Well-organised throughcare is important for enabling ex-prisoners to overcome the obstacles that may arise as a result of their being in prison. It helps them to address their practical needs for accommodation, training and employment, as well as to cope with the social stigma of having been in prison.

REFERENCES

Anderson S and Cairns C (2011) *The Social Care Needs of Short-Sentence Prisoners.* London: Revolving Doors Agency. www.revolving-doors.org.uk/documents/the-social-care-needs-of-short-sentence-prisoners (accessed 12 October 2011).

Association of Dutch Municipalities (2009) *Guide to the Cooperation Model for Aftercare of Adult Detainees and Ex-Detainees: Municipalities/Ministry of Justice.* The Hague: Association of Dutch Municipalities.

Bradley K (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health.

Clay C (2002) *Case management and throughcare: can it work?* Paper presented at the 5th Annual Conference of the Case Management Society of Australia, 'Case Management: Cohesion and Diversity', The Wentworth Hotel, Sydney, 21–22 February 2002. www.corrections.sa.gov.au (accessed 13 May 2005).

De Viggiani N, Kushner S, Last K *et al* (2010) *Police Custody Healthcare: an evaluation of an NHS commissioned pilot to deliver a police custody health service in a partnership between Dorset Primary Care Trust and Dorset Police*. http://eprints.uwe.ac.uk/8253 (accessed 5 May 2012).

Durcan G (2008) *From the Inside: experiences of prison mental health care*. London: Sainsbury Centre for Mental Health. www.centreformentalhealth.org.uk/pdfs/From_the_Inside.pdf (accessed 4 November 2011).

Farrall S (2002) *Rethinking What Works with Offenders: probation, social context and desistance from crime*. Cullompton: Willan Publishing.

Farrell M and Marsden J (2005) *Drug-Related Mortality Among Newly Released Offenders 1998 to 2000*. London: Home Office.

Fox A, Khan L, Briggs D *et al* (2005) *Throughcare and Aftercare: approaches and promising practice in service delivery for clients released from prison or leaving residential rehabilitation*. London: Home Office.

Freeman R (2003) *Can we close the revolving door? Recidivism vs. employment of ex-offenders in the U.S.* Paper presented at the New York University Reentry Roundtable, New York University Law School, 19–20 May 2003. www.urban.org/uploadedpdf/410857_freeman.pdf (accessed 22 October 2012).

HM Inspectorate of Prisons and HM Inspectorate of Constabulary (2011) *Report on an Inspection Visit To Police Custody Suites in Sussex, 7–11 February 2011*. London: HM Inspectorate of Prisons and HM Inspectorate of Constabulary. www.hmic.gov.uk/sitecollectiondocuments/sussex/CUS_SUS_20110602.pdf (accessed 29 June 2011).

HM Prison Service for England and Wales (1999) Paragraph 6.12. In: *Appendix 1. Memorandum by HM Prison Service. Drugs and Prison*. www.publications.parliament.uk/pa/cm199899/cmselect/cmhaff/363/363ap02.htm (accessed 27 February 2012).

Holloway K, Bennett T and Farrington D (2005) *The Effectiveness of Criminal Justice and Treatment Programmes in Reducing Drug-Related Crime: a systematic review*. London: Home Office. http://library.npia.police.uk/docs/hordsolr/rdsolr2605.pdf (accessed 28 June 2012).

Hult L (2011) *On Mental Illness, Inmates, and Recidivism*. Reno, NV: Science 2.0. www.science20.com/ptsd_navigating_mindfield/mental_illness_inmates_and_recidivism (accessed 22 February 2012).

Joint Committee on Human Rights (2005) *Third Report*. www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/1502.htm (accessed 28 November 2007).

Joost K (2012) *Literature Review: Estonia*. Throughcare Working in Partnership. http://throughcare.eu/reports/throughcare_estonia_lit_review.pdf (accessed 23 February 2012).

MacDonald M (2005) *A Study of the Health Care Provision, Existing Drug Services and Strategies Operating in Prisons in Ten Countries from Central and Eastern Europe*. Helsinki: HEUNI.

MacDonald M (2012a) *Literature Review: United Kingdom*. Throughcare Working in Partnership. http://throughcare.eu/reports/throughcare_uk_lit_review.pdf (accessed 23 February 2012).

MacDonald M (2012b) *Research Report: United Kingdom*. Throughcare Working in Partnership. http://throughcare.eu/reports/throughcare_research_report_uk.pdf (accessed 23 February 2012).

MacDonald M, Atherton S, Berto D *et al* (2008) *Service Provision for Detainees with Problematic Drug and Alcohol Use in Police Detention: a comparative study of selected countries in the European Union. Executive summary*. The European Institute for Crime Prevention and Control (HEUNI) Paper No. 27. Helsinki: HEUNI.

MacDonald M, Weilandt C, Popov I *et al* (2012) *Throughcare Services for Prisoners with Problematic Drug Use: a toolkit*. Birmingham: Birmingham City University. www.throughcare.eu/reports/throughcare_toolkit.pdf (accessed 27 February 2012).

McNeill F, Batchelor S, Burnett R *et al* (2005) *21st Century Social Work: reducing re-offending: key practice skills*. Edinburgh: Scottish Executive.

Ministry of Justice (2011) *Timpson works with prisons to turn around lives*. www.justice.gov.uk/news/features/features-180111a (accessed 26 July 2012).

Ministry of Justice (2012) *Women Prisoners*. www.justice.gov.uk/offenders/types-of-offender/women (accessed 26 July 2012).

Møller L, Stöver H, Jürgens R *et al* (2007) *Health in Prisons: a WHO guide to the essentials in prison health*. Copenhagen: World Health Organization. www.euro.who.int/__data/assets/pdf_file/0009/99018/E90174.pdf (accessed 12 October 2011).

Moore R (2009) *Predicting Re-offending with the OASys Self-Assessment Questionnaire*. London: Ministry of Justice. www.justice.gov.uk/publications/docs/oasys-research-summary-05–09.pdf (accessed 12 October 2011).

Moore R (2012) Beyond the prison walls: some thoughts on prisoner 'resettlement' in England and Wales. *Criminology and Criminal Justice* 12:129–47.

National Offender Management Service (2004) *Reducing Reoffending: national action plan*. London: Home Office Communication Directorate.

Offender Health Research Network (2008) *An Evaluation of the Receptions Screening Process Used Within Prisons in England and Wales*. www.ohrn.nhs.uk/OHRNResearch/RecepScreen.pdf (accessed 5 May 2012).

Park G and Ward S (2009) *Through the Gates – Improving the Effectiveness of Prison Discharge: first half-year evaluation, August 2008 to January 2009*. www.stgilestrust.org.uk/media/22/492/ttg-report-final.pdf (accessed 27 February 2012).

Popov I (2012) *Literature Review: Bulgaria*. Throughcare Working in Partnership. http://throughcare.eu/reports/throughcare_bulgaria_lit_review.pdf (accessed 23 February 2012).

Prison Reform Trust (2010) *Bromley Briefings Prison Factfile. December 2010.* London: Prison Reform Trust. www.rcpsych.ac.uk/pdf/bromley%20briefings%20FactfileDec10smallprison%20reform%20trst.pdf (accessed 26 July 2012).

Quaker Council for European Affairs (2011) *The Social Reintegration of Ex-Prisoners in Council of Europe Member States.* Geneva: Quaker United Nations Office. www.cepprobation.org/uploaded_files/rprt-reintegration-full-en-may-2011.pdf (accessed 24 February 2012).

Sainsbury Centre for Mental Health (2008) *On the Outside: continuity of care for people leaving prison.* London: Sainsbury Centre for Mental Health. www.centreformentalhealth.org.uk/pdfs/on_the_outside.pdf (accessed 12 October 2011).

Sampson R and Laub J (1993) *Crime in the Making: pathways and turning points through life.* Cambridge, MA: Harvard University Press.

Sampson R and Laub J (1995) Understanding variability in lives through time: contributions of life-course criminology. *Studies on Crime and Crime Prevention* 4:143–58.

Social Exclusion Unit (2002) *Reducing Re-offending by Ex-prisoners.* London: Office of the Prime Minister. www.thelearningjourney.co.uk/file.2007–10–01.1714894439/file_view (accessed 12 October 2011).

Taylor MF (1994) Ethical considerations in European cross-national research. *International Social Science Journal* 46:523–32.

Turnbull PJ and McSweeney T (2000) *Drug Treatment in Prison and Aftercare: a literature review and results of a survey of European countries.* www.pompidou.coe.int/English/penal/prison/dmop-e041.htm (accessed 4 May 2012).

United Nations (1990) *Basic Principles for the Treatment of Prisoners. Adopted and proclaimed by General Assembly resolution 45/111 of 14 December 1990.* New York: United Nations.

University of Surrey (1995) *Social Research Update. Issue 13. Comparative research methods.* http://sru.soc.surrey.ac.uk/SRU13.html (accessed 4 May 2012).

Walmsley R (2005) *Prisons in Central and Eastern Europe.* HEUNI Paper No. 22. www.heuni.fi (accessed 25 May 2012).

Webster R (2004) *Effective Aftercare for Drug Users Leaving Prison: a review of the literature.* London: Greenwich Drug and Alcohol Action Team.

Weilandt C (2012) *Research Report: Germany.* Throughcare Working in Partnership. http://throughcare.eu/reports/throughcare_research_report_germany.pdf (accessed 23 February 2012).

CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Dr Morag MacDonald, Social Research and Evaluation Unit, Faculty of Education, Law and Social Sciences, Birmingham City University, Birmingham B42 2SU, UK. Tel: +44 (0)121 331 6305; email: morag.macdonald@bcu.ac.uk