Special Commission of Inquiry into the Drug 'Ice'

STATEMENT OF Mindy Sotiri

23 August

Name	Mindy Sotiri
Address	251-253 Canterbury Rd, Canterbury, 2193
Occupation	Program Director, Advocacy, Policy and Research at the Community Restorative Centre

On 23rd August, I, **Mindy Sotiri**, state:

1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give in court as a witness. The statement is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I will be liable to prosecution if I have wilfully stated in it anything that I know to be false, or do not believe to be true.

2. My current role is as the Program Director, Advocacy, Policy and Research for the Community Restorative Centre. I have worked in criminal justice system settings, primarily in the community sector in post-release and reintegration for more than twenty years (as a social worker, advocate and researcher). In my current role, I am responsible for researching, developing and implementing evidence based best-practice and programs for people at risk of recidivism with multiple and complex support needs. In 2016 I was awarded a Churchill Fellowship to continue research into best practice in post release, and I am currently (as part of my role at CRC) overseeing a NSW health funded research project into best-practice for people with problematic alcohol and other drug issues on release from custody. This research project is in partnership with UNSW.

3. The Community Restorative Centre is the lead NGO in NSW providing specialist support to people affected by the criminal justice system, with a particular emphasis on the provision of post-release and reintegration programs for people with multiple and complex needs on release from custody. Established in 1951, CRC has over 67 years' specialist experience in this area. All CRC programs aim to reduce recidivism, break entrenched cycles of criminal justice system involvement, and build pathways out of the criminal justice system. CRC works holistically to do this, addressing issues such as homelessness, drug and alcohol use, social isolation, physical and mental health, disability, employment, education, family relationships, financial hardship and histories of trauma.

CRC employs 50 staff across five sites; Canterbury, Liverpool, Penrith, Broken Hill and Wilcannia. CRC receives funding from 22 different funding streams (primarily government-both State and Federal-and a small- but growing number of philanthropic donors) and with this supports between 500 and 600 people on release from prison each year using the intensive long-term support model described below. If we were to take a snapshot now, our caseworkers across all of our teams are actively supporting 275 clients. This does not include the clients we provide telephone, advice, referral and short term support each year

(more than 1000), or the men and women we support in groups inside prisons (in both our arts and music programs and in our pre-release groups).

To give the post-release service some context, although we are the largest provider of post-release and reintegration support in NSW, and over the last year have supported intensively over 500 people leaving prison, if you look at the NSW Corrections discharge data, over the last year, close to 20,000 adults were released from NSW prisons. We estimate (using Justice Health data) that close to 4000 people are being released each year into homelessness. We are only connecting with a tiny portion of those who require reintegration and post-release support.

4. We are a specialist organisation so all of our programs require clients to either be in prison, or at risk of imprisonment. All of our programs are also voluntary. Aside from those two factors, the details of the eligibility criteria depends on the funding stream.
For instance our Far West project is funded through the Indigenous Advancement Strategy, and we only work with Aboriginal populations in that region. Some of our services have geographic boundaries determined by funding providers (ie, AOD support in Western Sydney), some are specifically for women (ie, The Miranda Project), some are focused on people at risk of homelessness (all of our GHSH projects) and some have a particular focus (for instance support post-release for people with a diagnosed mental illness or cognitive impairment).

Aside from the eligibility criteria determined by funding providers, we prioritise populations who have multiple and complex support needs. That is, we tend to work mainly with populations who as a consequence of their complex needs, have tended to be 'managed' in criminal justice system settings, *rather* than supported in the community. Almost all of our clients are facing homelessness on release, are at risk of relapse into problematic AOD use, are at risk of re-offending, have ongoing and chronic health conditions, and are often extremely socially isolated. We prioritise working with people who have been actively excluded from community based services, because of their long criminal justice histories, and because of their complexity of need. Our AOD programs also work with people in active addiction, who (for a range of reasons described below) are often not able to access many mainstream rehabilitation services.

5. Most CRC programs use a long-term holistic support model which incorporates wherever possible three months of pre-release engagement and 12 months or more of post-release support. In our experience, building a pathway *out* of the prison system takes time. Especially for populations who have frequently spent more time in custody than they have in the community. People with long histories of trauma in combination with the "referral fatigue" experienced by criminalised populations, require long-term support in order to build engagement and trust with their case-workers, and also to survive not just the high risk three month period after release, but to build on, and sustain the significant changes

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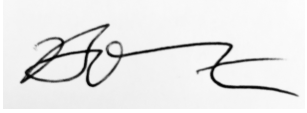

people often make during times of crisis. CRC clients are used to being shuttled between multiple services, over short periods of time. This can be deeply destabilising, and for clients who are having to re-tell their stories to many different caseworkers over short periods of time, this can also be re-traumatising. For many people, connecting with a CRC case-worker inside prison, who is able to commit to providing support over the long term, is itself profoundly different to what tends to be on offer in the current service landscape which is dominated by crisis support, referral support and short term support only. Long-term support not only allows people the opportunity to develop the skills required to navigate frequently hostile or unwieldy service systems, it allows them to practice forming trusting relationships with a worker. The significance of the relational aspect of long-term support is acknowledged in research exploring desistance from crime. On a very practical level, it is very difficult for our clients to access social housing unless we are able (as a support provider) to provide support for 12 months.

6. CRC currently receives approximately $4 million per annum from 22 different funding streams. These are primarily government (state and federal) although we now have a small but growing group of philanthropic donors. Each of these 22 funding streams is time-limited. The longest we receive funding for is three years, although much of our funding is for shorter periods. The challenges we face are comparable to most small and mid-sized community sector services, in that there is constant uncertainty with regard to our capacity to continue delivering core services. We frequently do not know if services will be able to continue from one year to the next. Aside from having to work very hard (and sometimes running at a loss) to avoid this impacting on our service model and the quality of service delivery, it also of course has a flow on impact for staff. We have been very fortunate to build a team of very dedicated and skilled caseworkers, and we manage to support staff retention in what is often a precarious funding landscape. We would however be keen to see a shift to longer funding periods, particularly for those services which have been successfully achieving their outcomes and goals over many decades. Despite the multiplicity of funding providers, many of our projects are very similar in terms of their scope and service model. And yet, we have 22 different reports, acquittals and data sets that we need to oversee which poses a significant administrative burden on the organisation. We would love to see a consolidated state based approach to supporting people leaving custody led by community sector expertise. We would also be keen to see a less siloed strategic response at the level of government to the unique reintegration needs of people leaving custodial settings.

Although all CRC programs work with people with long histories of drug and alcohol use, we also have a specific AOD outreach team. This team has five different funding contracts with NSW health, Federal Health via the NGOTGP, Central Eastern Sydney PHN, and Western Sydney PHN. We employ 11 staff, three of whom are identified Indigenous positions. There is one project specifically focused on working with remand populations, another is focused on working with people with co-occurring mental illness. Wherever possible we work with people three months prior to their release. The time-frame for post-release support is

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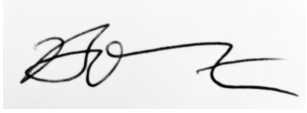

dependent on each individual, but for many people it is approximately 12 months. There are however some clients (particularly those with intellectual disability) who we support for longer.

Eligibility for the program is based on;

- Clients having a history of drug and/or alcohol use which has impacted on their criminal justice trajectories (ie they identify that their AOD use is directly or indirectly related to their offending)
- Willingness to participate in post-release AOD support (clients must be voluntary).
- Clients must also belong to one of the following groups which impacts on their ability to access other mainstream services: people with mental illness, people with cognitive impairment, Women with dependent children, Aboriginal populations.

It is probably also useful to note that we work with people wherever they are in their change process, including when people are still using and in active addiction. We also do not exclude on the basis of offence type.

7. The vast majority of the clients we work with are poly-drug users. We would estimate that most of the people we work with have at some point used Crystal-Meth, but less than 50% identify it as their primary drug of choice in the Greater Sydney Metro Region. In other regions (specifically Far West NSW), the increased use of Meth is more pronounced. However, again, it is used in conjunction with alcohol and marijuana in those regions. Many of our AOD clients in Sydney still use heroin as their primary drug (which might be because we skew towards a slightly older population than the prison population). The needs of clients using ice as their primary drug of choice are in many ways very similar to the needs of other poly-drug users when released from custody. However, there are a number of factors that are specific to people who have Methamphetamine as their primary drug of choice. This includes increased risk of associated mental health conditions and increased risk of hospitalisations as a consequence. The behaviours associated with some forms of ice use, and managing use in a way that minimises harm (in terms of safe injecting, as well as the impact of the drug itself on health and well-being) also requires specific attention.

I am aware that the Special Inquiry is most likely very familiar with the social demographic detail of the prisoner population in NSW, so I don't want to spend too much time talking about that here- but I do think it is important to point to a couple of key issues, because when we are talking about access to AOD services with populations who also spend time in prison, I think it's really important to acknowledge that there are a number of factors which can make accessing services for this population very challenging because of the complexity of need of the people who require AOD support.

We know there are currently 13,403 people locked up in prisons in NSW- although the flow through population- that is people leaving prison each year, is closer to 20,000. We know about 1/3 of that population are on remand. We know that people on remand suffer all the

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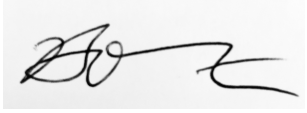

same hardships as sentenced prisoners but with almost no services or post-release support. We also know that 10% of people in prison have come from primary homelessness, and around 26% have come from unstable accommodation – or secondary homelessness. We can estimate conservatively that at *least* 4000 people each year are released from prison into homelessness. We know that around 70% of people in prison have problematic alcohol and other drug use. We know that around 60% have mental illness, and around 15% have a cognitive impairment. We know that close to **24%** of women in prison were themselves in Out of Home Care as Children. We know that Indigenous people are massively over-represented at all stages in the criminal justice system. We know that the majority of people in prison are themselves victims of crime. **70%** of women in prison are themselves survivors of trauma as children or adults.

The reason I want to point all of *this* in this context - is that access to drug and alcohol services and rehabs and detoxes form only *one* part of what is clearly a very complex picture for people who are locked up in NSW prisons. And although they are a *critical* and currently utterly *missing* part of this picture in many regions in NSW, I think it is really important to give consideration to what needs to be wrapped around services such as this –so that they don't operate necessarily as discrete programs- but rather are rather embedded into what is currently an extremely fragmented service system for people leaving custody. The reason most of the people we work with wind up in prison is because of their drug and alcohol use, so of course that needs to be addressed. But that is really just one piece of the puzzle. The reasons *why* people use drugs and alcohol, and why particular populations are criminalised as a consequence of this use, also needs to be explored. Not in an abstract philosophical sense, but in terms of how to build service system responses.

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Quite aside from the acute shortage of beds in residential rehab services, there are significant additional barriers for people who have also been involved in the criminal justice system. There are still many AOD services which will not accept people directly from custody. For some clients, they are caught in a bind in that their parole conditions might require them to attend a rehab, but in practice there is no rehab that will take them. This is especially the case in remote and regional areas (for instance Far West NSW) where there are no residential rehabilitation services. Even in regions where there is more access, there are many services that will not accept clients with any history of criminal justice system involvement. There are many services who will not accept people who have ever committed a violent offence, and others who have policies that will not allow them to take people straight from court or custody. Our clients regularly experience exclusion from services.

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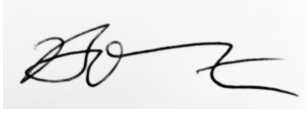

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A couple of weeks ago, we were working with a young woman, who wanted to go directly to a residential rehab from prison. She was keen to build on her time in prison during which she had detoxed, and wanted to start addressing the causes of her drug use more comprehensively. The proposed rehab and the referring community corrections office exchanged information (including the fact that this client had faced some internal disciplinary matters in prison) and on the basis of this exchange, the rehab declined to accept her. When we advocated on her behalf, they said very clearly that they couldn't take her because they felt she was too high risk. This client had not been convicted of a violent offence. She had in fact, over twenty years of offending only received one conviction for a violent offence. All her offences were drug related. It is a heart-breaking thing when people are at the point in their cycle of change, when they are desperately motivated, and they are reaching out for help, and services turn them away. For many people, remaining motivated in the face of this is incredibly difficult. It is a large part of our work at CRC- assisting people to stay focused and stay hopeful when there are multiple structural and systemic barriers to receiving help. Additional barriers for people with AOD support needs on release from prison:

- Barriers in terms of access (both explicit exclusion on the basis of criminal justice histories, and simply a lack of beds)
- Problems with cultural dissonance (specifically the enormous cultural divide between prison and therapeutic communities). Even when people *are* able to access rehabs after custody there are often struggles to reconcile the very different requirements of prison and residential rehabilitation – and many people who come from prison struggle to complete their time. There are fundamentally different expectations about 'how' to behave and how to be in the different settings. In prison information about yourself is used as currency and tends to be guarded closely in order to stay safe. In rehabs there is a requirement to share. In prison, the code requires that you *never* dob on anyone. In rehabs, there is often a requirement to 'level' or share information about other people publicly. In prisons certain behaviours (ie, pacing and very colourful language) are incredibly normal. In rehabs these can be seen as threatening, and in fact have resulted in our clients being booted out.
- There is also sometimes suspicion and/or uncertainty in the AOD sector regarding the motivation of clients who participate as a consequence of a legislative mandate (as opposed to of their own volition).
- There is still a lack of information in the AOD sector regarding criminal justice system clients and the related perception that this group is fundamentally 'different' from other service users. This means in some services different kinds of risk assessments are used for people coming from custody. They are subject to different kinds of surveillance compared to other populations requesting treatment.
- There is in the community a general absence of programs designed to work with clients who also have intellectual disability or other forms of cognitive impairment

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Populations with multiple & complex needs: Understanding the interaction of disadvantage

While there is little contention about the high levels of disadvantage of imprisoned populations, working with post-release populations requires an approach that moves beyond understanding each section of disadvantage in some kind of discrete package. The complexity of working with this group is actually about understanding how this disadvantage *interact*s. For people leaving custody who are requiring AOD support, there are two layers to the interaction that need to be accounted for in post-release services; individual and structural.

Individual circumstances

On an individual level, for instance, there might be a complicated relationship between drug/ alcohol misuse and mental illness (drugs might be used as a form of self-medication, but then mental health is impacted dramatically by drug use) or the relationship between mental illness and intellectual disability and imprisonment, or the relationship between a history of trauma and the experience of imprisonment. Post-release programs need to understand these interactions in order to tailor services accordingly.

Structural circumstances

The second, structural layer requires even greater attention, as it is currently one of the greatest barriers to post-release success for this population. On a very practical level, this group are frequently excluded from programs and services in the community *because* of the complexity and multiplicity of their need. Criminal justice system clients are often not able to access mainstream rehabilitation services because they have a co-existing mental health condition or intellectual disability. Or they are not able to access a specialist disability service because of their drug and alcohol use. Some people are excluded from services on the basis of their criminal history (and this is clearly exacerbated if this history includes violent or sexual offences). Many criminal justice system clients are excluded or banned from services because of active drug and alcohol addiction. As a consequence, post-release populations tend not to 'land' in any one service in the community. For populations with multiple and complex needs, the post release experience tends to be defined by repetitive exclusion from potential support services, referral fatigue, high levels of exhaustion and frustration, followed by relapse into familiar patterns of drug use, associated re-offending, and ultimately re-imprisonment. Successful post-release services require organisational flexibility to work with complexity, in addition to highly skilled workers who can confidently 'hold' multiple issues as they arise.

Life after Prison: Key issues during transition and post release

There is now consensus in best practice research that the post-release period (particularly the first three months following release) is a time of high risk in terms of re-offending, relapse into problematic drug and alcohol use (and associated violent behaviour) as well as

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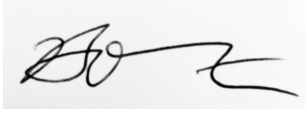

risk in terms of mortality (in terms of suicide and drug overdose). These risks are exacerbated for people who are homeless, have mental illness, have cognitive impairment, have long histories of generational unemployment, and are in other ways disengaged from family and community. 25% of re-offending occurs in the first 12 weeks following release[i] and post release mortality is extremely high. Death rates for people in the first year of release are ten times higher than rates for people in prison, and 1/3 of these deaths happen in the first four weeks of release into the community, with suicide accounting for a significant proportion of these.

Not surprisingly, people on release from prison report high levels of stress, social isolation, financial hardship, as well as experiencing referral fatigue, exclusion from services and very often homelessness. There are frequently multiple bureaucratic and justice related appointments that individuals are required to attend in the first 24 hours of being released (Centrelink, Housing, Parole, and medical including connecting with methadone providers), and often very limited support or financial capacity during this time. It is frequently the case that people are released from prison with no identification, no appropriate clothing, and very limited pre-release planning, making the transition from the routine environment of the prison to the often chaotic world outside even more jarring.

For people attempting to make significant changes in their lives (for instance, abstinence from drug use), this period can be particularly challenging in terms of loneliness. It is frequently the case for people who have been repeat recidivists, that their social world has been related to drug use and associated crime. When the decision is made to move away from this world, it can frequently be incredibly isolating. There is a need in the service landscape for post-release programs that are able to deal with both complexity of need (without immediately referring on) but also there is a need for programs to facilitate the building (often from scratch) of reintegration pathways that are meaningful in terms of social connection. While the building of these pathways needs to commence as soon as somebody is released from prison, there is also a need for ongoing support over the medium to long-term, to ensure that links to the community are strong enough to prevent the very easy reversion back to damaging patterns of behaviour.

8.

Program	Staff #	Funding Stream	Target Group	Client # p/a	Support Period	Location
Extended Reintegration Service	3	Corrections NSW	Community Corrections clients on Parole	20	12 months	South West Sydney

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			LSI-R Medium to High. Complex needs. Diagnosed Mental illness and/or cognitive impairment			
Newtown Boarding House Project	1	FACS GHSH via partnership with Newtown Neighbourhood Centre	Homeless or risk of homelessness. Willing to reside in Boarding House. Complex needs. Pre and post-release intensive support	40	12 months +	Sydney Metro (Inner West
Nepean Transition	2	FACS GHSH via partnership with Wentworth Housing	Homeless or risk of homelessness. People with complex needs. Looking to reside in Nepean region. Pre and post-release intensive support.	42	12 months +	Hawkesbury/Nepean

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Indigenous Transition	4	Indigenous Advancement Strategy (Prime Minister and Cabinet)	Homeless or at risk of homelessness. Aboriginal people with complex needs. Pre and post-release intensive support.	120	12 months +	Broken Hill/Wilcannia
Transitional AOD Program	11	Central Eastern PHN, Western Sydney PHN, NSW Health, NGOTGP	Complex needs. Self-identified problematic AOD use. Pre and Post release support and counselling	150 (long-term) + 130 (Short term)	12 months +	Central Eastern Sydney, Western Sydney, South Western Sydney, Greater Sydney Metro
Inner City Women's Transition	2	FACS GHSH via partnership with B Miles Foundation	Homeless or at risk of homelessness. Women with complex needs. Pre and post release intensive support	82	12 months +	Inner City Sydney
The Miranda Project	2	Women NSW	Women at risk of criminal justice system involvement and	80	12 months +	Penrith (Greater Sydney Metro)

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			domestic violence			

9. Of the $5.8 million worth of funding that Corrective Services is spending on supporting people post-release though its funded partnership initiative, more than $5.4 million is designated to projects that provide only short term (12 weeks or less) support. While this includes 30 beds in services that provide critical short-term specialist accommodation services for people on release, there is an urgent need for funded longer term more holistic support. Corrections programs are also very focused on addressing 'criminogenic needs', a highly individualised and narrow approach to both understanding and responding to offending. Within this framework 'treatment' in the form of psychological programs tends to be prioritised over key structural and social issues such as sourcing housing, and responding to trauma. In these projects, Corrective Services is responsible for determining the goals of the case-management plan according to the identified criminogenic needs, and the community sector provider is required to adhere to the corrections case plan. The only people eligible for these programs are people that have LSI-R scores of medium high to high, and are on parole. CRC currently receives some Corrections transitional funding for the one, long-term support program it funds (the Extended Reintegration Service), but all of our other funding comes from outside of the Justice Portfolio, and allows a level of flexibility in terms of implementing what we would consider to be best-practice in reintegration. This is outlined below, and differs in significant ways to the current approach adopted by NSW Corrections.

10. There is a great deal of inconsistency in terms of our capacity to access health information from custodial settings. This is not a critique of the individuals working in this space, rather than perhaps one of the most pervasive structural by-products of working with a closed institution, with systems that are not often set up to share information with services on the outside. It is frequently the case that people we work with, are released and have either lost, mislaid, or never received their release papers, their scripts, and key referral information. AOD team staff report that if clients are connected to the Justice Health Connections program prior to release they are less likely to be missing paperwork. However, if they are not connected in this way, they often do not have critical referral and health information (including medical records and reports from inside custody), and when they have been released, it is very difficult for them to reconnect with Corrections in order to obtain these from the outside.

We have had clients with significant mental health and AOD conditions released with no scripts, medication, and only limited support. Last year we supported a client who we knew was on a very high dose of Seroquel and yet was released with absolutely nothing. He spent the first 24 hours on release from custody unable to sleep at all, and highly anxious. When we looked into what had happened, it turned out his medication and script had been placed

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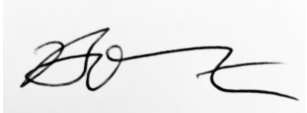

in his property, but no-one told him that this had happened, and because he didn't think he had any property, he never went to collect it.

There are also circumstances in which information which should not be shared is passed on to services in ways that compromise both privacy and access. For instance, detailed information about offending history (including information about Juvenile Justice histories, and disciplinary history inside custody) is sometimes shared, and then used to deny access (as described above in the example of the woman attempting to gain entrance to a rehab). There are significant privacy considerations related

Part of the issue for the community sector is that there are no streamlined processes of referral or connection. That is, there is not usually a single point of contact that a worker on the outside can rely on to obtain relevant referral information, or to pass information on to the client inside (aside from visiting). Although there are many positions within both Corrections and Justice Health that are there to support people, the reality for many clients that we support, is that they *never* have access to this support. We regularly rely on people within Correctional Centres who go above and beyond what their official role within the prison is, to enable us to obtain appropriate referral information, and to begin the process of connection. Sometimes this might be a SAPO, sometimes this might be a Community Corrections officer, sometimes this might be a case-manager, sometimes a chaplain. When solid referrals are made from the inside, this is often because of these relationships, rather than because a solid system of community connection exists.

11. Our experience, in both service delivery, research, and in providing specialist training in partnership with FACS and Corrective Services, as well as the Network of Alcohol and other Drug Agencies (NADA) across the state for many years, leads us to believe ***there is a need for a state-wide specialist service for people leaving custody and their families***. There is a need for services that are able to cross geographic boundaries (in recognition of the fact that 80% of people incarcerated in NSW prisons are not incarcerated anywhere near their intended place of residence in the community). There is a need for services that are resourced and able to incorporate the critical element of pre-release engagement and in-reach into the correctional centres. Workers must be able to visit clients and begin the process of engagement prior to release in order to sustain connection during the extremely chaotic post-release period. There is a need for services that are long-term (building sustainable pathways outside of the criminal justice system takes time, especially for people who have survived trauma, and have spent their lives being managed in such settings). Services must have the capacity to be intensive, and primarily outreach. This often means picking someone up from prison on the day of release, and working intensively over the first high risk three months, and then slowly and flexibly tapering support down over 12 months or more. Services must also have housing front and centre of their service delivery design. We believe that the community sector has an enormous amount to offer in terms of both research, practice expertise, and innovation. Unfortunately we are frequently not consulted

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when decisions are being made with regard to the allocation of resources.

The evidence base that we work according to (and backed up by both our own research and international reintegration research) include the following key best-practice principles.

- **Reintegration framed outside of the lens of rehabilitation**. There is a need to create and facilitate pathways for people leaving prison that are not explicitly focused on *addressing offending behaviour,* but rather focused on the creation of an identity *outside* of the criminal justice system.
- **Service delivery incorporating systemic advocacy.** Service delivery must include a significant advocacy component that addresses structural barriers for individuals (such as access to housing, employment, education, health and social security benefits), and advocates systemically for change when this is required (for instance in the case of discriminatory employment practices).
- **Pre-release engagement**. Meeting and working with people prior to release is necessary with respect to building the engagement necessary to sustain the case-work relationship, building trust between someone in prison and the community organisation on the outside, and practically planning for re-entry into the community with complex needs populations.
- **Holistic, relational and long-term casework models**. People with long histories of trauma in combination with the "referral fatigue" experienced by this group, require long-term support in order to build engagement and trust. Long-term support also allows people the opportunity to develop the skills required to navigate frequently hostile or unwieldy service systems.
- **Community based outreach**. Services that work with people with long histories of criminal justice system involvement need to operate outside of the criminal justice system, and *in* the communities in which people are living.
- **Housing first approaches** (and in some jurisdictions, employment first approaches). Support must be concrete. Most people require a solid base from which they can try and make the changes required to stay out of prison
- **Genuine collaboration and work with people with lived experience of incarceration** at all levels of program delivery. The expertise of people who have themselves been to prison is critical in both the design and the delivery of community based reintegration services

See: Hunter et al, 2016, Nunn et al, 2010, Gilbert et al 2015, Elison et al, 2016, Department of Justice, Victoria, 2014; Scott et al, 2013; Serin et al, 2013; Kinnear 2007; Baldry 2007; Walsh 2006; Mears & Travis 2004; NACRO 2003 Halsey (2013), Maruna (2012), Pettus-Davis (2011), Lowthian (2010), Rowe, (2007) National Justice Chief Executive Officers' Group and the Victorian Government Department of Justice (2014), McDonald, D & Arlinghaus, S (2014) Walsh (2004), Ferguson, H (2003), McNeill et al(2005)

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