'Why Can I Lock Kids Up But I Can't Ensure They Receive Treatment?'[1]

The case for effective mandated substance abuse treatment for young people

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Churchill Fellow 2014, Victoria

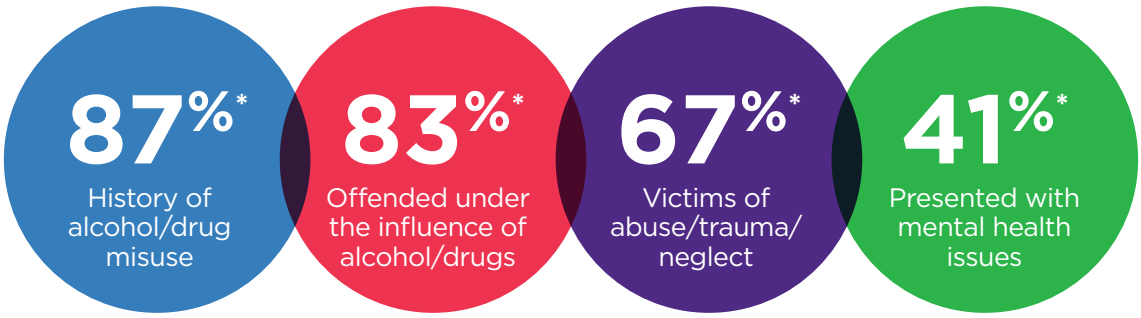
Too many children and young people[2] appearing before Children's Courts[3] have severe substance abuse and/or mental health issues and do not engage in treatment. This leads to a revolving door of substance abuse and offending. The 'What Can be Done' (WCBD) Model of Court-ordered, mandated treatment aims to break this cycle and steer young people in a different trajectory. It is informed by key learnings from international models of adolescent facilities in Sweden, England, Scotland and New Zealand.

'What can you do? I am watching my son die before my eyes.' These were the words uttered by a desperate mother supporting her son Greg[4] in the Children's Court. His offending involved thefts of bottles of vanilla essence.[5] His daily dependence on alcohol and cannabis was so significant, he had more than 20 admissions to hospitals for alcohol poisoning and to psychiatric wards for deteriorating mental health.[6] Despite being bailed on three separate occasions to attend a seven-day residential centre to 'detox' from alcohol and drugs, he left each time within only hours of attending. It was clear his life was spiralling out of control. His offending escalated to assaulting his own mother and vandalising their home when she refused him money to buy cannabis. Police attended, an intervention order was taken out and he was remanded in custody. Whilst in custody he was severely assaulted.

This is the tragic story of too many young people. Many have experienced significant trauma and disadvantage. A significant proportion of young people charged with criminal offending have a history in child protection.

Figure 1. Statistics of young offenders in detention in Victoria

Source: Annual Reports of the Youth Parole Board of Victoria. *Statistics are the average between 2014/15–2018/19.



Too often, young people become entangled in substance use, most commonly alcohol, cannabis, crystal methamphetamine ('ice'), and many use multiple substances.

The inextricable link between substance use and criminal offending is evident in data published in the Annual Reports of the Youth Parole Board of Victoria, with most offences taking place under the influence of drugs or alcohol (**Fig 1**). Almost half of the young people have mental illnesses and as many as two-thirds of those in custody are victims of significant abuse, trauma or neglect. In the child protection system in Victoria, magistrates issue, on average, 130 emergency care search warrants every week for young people missing from their residences. The statistics regarding substance abuse and mental illness of these young people in child protection largely replicate those in detention.[7]

Aboriginal and Torres Strait Islander children are vastly over-represented in both the youth justice and child protection systems.[8] Aboriginal children in Victoria are 13 times more likely than non-Aboriginal children to be in detention[9] and 16 times more likely to be in out-of-home care.[10] Andrew Jackomos, former Commissioner for Aboriginal Children and Young People, highlighted the sad trajectory of many who have started in out-of-home care,

"Two thirds of Aboriginal children in the youth justice system have graduated from out-of-home care and it is understood that two thirds of those in adult prisons have graduated from youth justice."[11]

Current treatment options for these young people are limited to 'detoxification' programs, residential rehabilitation or attending counselling for one hour a week. Dr Sasha Hvidsten, a psychiatrist I visited at Huntercombe Hospital, Stafford, England, says,

"Attending once per week is a drop in the ocean ... it isn't going to work."[12]

The Victorian Youth Justice Review and Strategy Report highlighted the inadequacy of existing systems to address the complexity of young people's issues.[13] The services lack the intensity and duration needed for real impact.

My depression turns to anger from the pain it's brought to me
Is there anyone to blame, or is this how it's meant to be?
I crave for something in the distance, too far for eyes to see
My sense of logic figures that it is a sense of tranquillity ...

I pray for a Saviour, to help me conquer my compulsive behaviour
Which keeps leading me into trouble and life threatening danger
I feel weighed down and burdened with responsibility
Having to work on getting better and back to normality.

It seems like it's all too much, after years of such fuss
I'm prepared to give up and declare that I've had enough
If I am to die, please keep in mind that I did try
Tears come to my eyes, at times I've contemplated suicide.

'Greg'—poem written whilst in custody.

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Research shows that young people with substance abuse and mental health problems, particularly those most troubled, are reluctant to seek professional help.[14]

It is too easy to blame young people with complex addiction and mental health problems, and who typically lead chaotic lives, for their apparent lack of willpower. Generally, they lack the insight into the problems the substances cause and do not see the need for help. They often self-medicate to mask their trauma and lack clarity of thought, or developmental capacity, to understand the consequences of their actions. Given this, the chances they will attend or remain engaged in voluntary treatment services is minimal.

The consequent health implications are also profound. Every day the Court sees countless young people without hope in their eyes, helpless, without any sense of a positive way forward. It may be the 14-year-old girl chroming daily on toxic substances such as spray paint and functioning at the level of a seven-year-old child, the 16-year-old girl already pregnant and using heroin daily, or the 15-year-old boy with severe pain of pancreatitis due to alcohol abuse.

Dr Danny Sullivan[15] states that early use, poly-drug use and dosage are three critical factors that inevitably lead to long-term problems, including psychosis from methamphetamine use,

"If you take a population of teenagers—those who don't use methamphetamine and those who do—and you follow them up over time, 11 times the number in the methamphetamine group will have had contact with psychiatric services with a diagnosis of a drug psychosis, a psychosis or schizophrenia … over time, the brains of people who use stimulants (which include methamphetamine) become depleted of dopamine, and in long term use we see a syndrome which is similar to Parkinson's disease …"

There must be a trajectory towards better health and wellbeing for these severely troubled young people. Currently, there is no mechanism for mandating therapeutic treatment for those who have not engaged in voluntary treatment.[16]

The purpose of my Churchill Fellowship was to ascertain whether a secure therapeutic residential facility should be established in Victoria.

Critical to answering this question was to determine the following:

1. Could mandated treatment be effective?
2. If yes, what legislative changes would be required? and,
3. What would be the critical features of a model to provide optimal treatment?

I visited adolescent facilities[17] in Sweden, England, Scotland and New Zealand ranging from psychiatric hospitals for involuntary and voluntary patients, to secure homes, voluntary drug residential programs, and substance use outreach programs. At these facilities I had the opportunity to speak to numerous professionals including psychiatrists, psychologists, addiction specialists, nurses, social workers, and most significantly, the young people themselves. They confirmed the problems confronting their youth were the same as for our youth in Australia. This is what I found …

1. International models show that mandated treatment can be effective

Overwhelmingly, the views expressed by the practitioners and young people with whom I spoke were that mandated treatment *can* be as effective as voluntary treatment—provided there are certain critical elements present.[18,19] A selection of the comments made by experts/key people that I spoke to in each country are as follows:

"There is not really any difference between those who volunteer and those who are here as part of a court order in terms of how effectively they engage in treatment."[20]

"Once there, it's about the exposure to some of the thinking and reflection that goes on—and that's the most important thing."[21]

"If you can get away with voluntary without mandating, that's great, but where there's absolutely no volunteerism and there's risks to self and other people, the situation is very clear: you can't keep harming other people and their property."[22]

"When I worked with addictions previously, we did have people coming to us when it was compulsory for them to be there. But, over time, they wanted to be there because they liked what they were seeing; they liked how they then started feeling; and having a bit of time out, especially some young kids whose families are chaotic as well. So what choice, really, would they have if you were not making things compulsory for them?"[23]

"For a long time, we considered treatment had to be voluntary ... but here, they studied groups, one mandatory and the other voluntary, and they couldn't see any difference [in outcomes]."[24]

"I didn't want to come here. But I couldn't do it on my own. I'm really scared to think of what could have happened if I hadn't come here ... I could have died."[25]

These views concerning the efficacy of mandated treatment are supported by the very senior and experienced members of the WCBD Steering Committee I established.[26] The Committee advocates that the WCBD treatment model is an essential option for this group of young people. The view that 'you can lead a horse to water, but you can't make it drink' does not reflect behavioural change programs with adolescents. Rather, research and clinical experience shows that therapeutic engagement is a central ingredient in intervention programs, irrespective of whether the programs are voluntary or involuntary.[27]

I have given a great deal of consideration to the human rights implications of mandatory treatment when devising the proposed WCBD model (**Fig 3**). The *United Nations Convention on the Rights of the Child* (CRC) and the *Charter of Human Rights and Responsibilities Act 2006* (CHRRA, Vic) state that these rights include the right to liberty,[28] the paramountcy of the best interests principles of a child,[29] cultural rights,[30] rights to equality and non-discrimination,[31] privacy,[32] and freedom from medical treatment without consent.[33] Significantly, the CRC also provides for children to have the right to live a full life, including that they develop healthily,[34] and that there is an obligation on governments to find ways to protect children from dangerous drugs.[35]

The best interests of a young person would be addressed by a **Youth Therapeutic Order** (detailed below) by providing: access to quality health treatment; an opportunity for their trauma to be addressed in a safe environment; a therapeutic alternative to youth detention and secure welfare; and an opportunity to re-engage with education and training.[36] The proposed Order is reasonable, proportionate and necessary[37] for a young person with such significant substance use and mental health issues.

2. Urgent legislative change is required

Legislative change is required for children's courts to have the power to make Youth Therapeutic Orders for young people with significant substance abuse issues and who do not voluntarily engage in treatment.

The objectives of the Youth Therapeutic Order are to:

- Intervene to provide a safe environment for young people with significant substance abuse issues;
- Provide a therapeutic, medical and trauma informed response to address a significant health and welfare problem for young people not currently receiving treatment;
- Divert young people from entrenchment in the criminal youth justice and/or child protection systems;
- Break the intergenerational cycle;
- Reduce the adult prison population;
- Improve community safety by reducing the level of offending and, accordingly, the number of victims; and,
- Reduce the future health and economic costs associated with psychiatric illness, welfare benefits, criminal investigations, prosecution and imprisonment. Research indicates that for every $1 spent on alcohol and drug treatment, the return is a saving of $8 in future savings to health and justice related services.[38]

The proposed Youth Therapeutic Order enables a young person to commence by 'detoxing' in a safe, secure environment. The word 'secure' does not imply a draconian, austere prison-type institution. As Dr Dickon Bevington[39] observed,

"There is ample evidence that it [treatment] doesn't work in a draconian lock up punitive environment."

Many of the secure homes in Sweden, England and Scotland were homely and young people were treated with respect and in a way that models appropriate behaviour for them (**Fig 2**).

The focus of mandated treatment for young people needs to be on therapeutic engagement that motivates them to make meaningful gains. The Youth Therapeutic Order provides the opportunity for rehabilitation. A unique feature is that it would not, of itself, be a sentence. The Court would take into account the time spent on the Youth Therapeutic Order and the rehabilitative progress made when determining the outcome of charges. Regarding child protection/intervention order proceedings, the young person's rehabilitation may result in that individual returning home, child protection potentially withdrawing, or the young person now being eligible for a lead tenancy. These are constructive steps in the trajectory of each young person.



Figure 2. International examples of therapeutic treatment facilities

Examples of secure yet homely facilities visited are Huntercombe Maidenhead Hospital, England (left), and Huntercombe Hospital, Stafford, England (centre). Both of these hospitals were converted manor homes. Right: an example of a minimally secure facility is Odyssey Youth, Auckland, New Zealand.

3. Critical features of the 'What Can Be Done' model

The integrated Youth Therapeutic Order treatment model (**Fig 3**) incorporates the best features of therapeutic community models[40] I observed overseas, commencing in a secure home, progressing to step down residences on site, followed by a planned, supported transition to the community. Whilst each young person's journey is individual, the advice was that it takes between four to six months to effect meaningful change. The model involves a detailed assessment of the young person, ongoing risk assessments and constant reviews of progress in treatment, including reports being provided to the Court. There would be democratic principles within the therapeutic environment,[41] committed and high quality staff, external scrutiny,[42] education, training[43] and recreational facilities. The therapeutic relationship with the expert clinicians commences in the secure home and, significantly, needs to continue for the period of the Youth Therapeutic Order, as continuity in treatment is essential to successful outcomes.[44]

A critical and significant feature is culture.[45] A Youth Therapeutic Order made in either the Koori Court or mainstream Court placing an Aboriginal young person in a culturally safe, initially secure home, conducted by an Aboriginal Community Controlled Organisation, could commence redressing Aboriginal over-representation. The healing powers and strength of Māori culture I observed at Te Waireka, New Zealand, provide evidence of the important role culture plays in successful trajectories.

The cost for such facilities depends on whether residences have to be built or existing buildings can be renovated/utilised. However, even at an estimated cost of $30 million to build a 36-bed facility with a $20 million annual operating budget, the cost estimate per person per day ($1,522) is comparable with the average cost for youth detention per person per day for 2018–2019 in Australia ($1,579).[46,47]

Support for this proposed model, in addition to the earlier mentioned senior, experienced WCBD Steering Committee, is found in the Final Report of the Parliamentary Inquiry into Youth Justice Centres in Victoria, which made the following recommendation:

"That the Victorian Government establish a trial program of Youth Therapeutic Orders based on the 'What Can Be Done' model."[48]

Further, the Executive Summary of the Youth Justice Review and Strategy stated that,

"There is also merit in considering a youth therapeutic order for court-mandated therapeutic treatment for young offenders. This has been proposed to address these deficiencies by Magistrate Bowles (2014) and the 'What Can Be Done' Steering Committee."[49]

Policy recommendations

1. That state and territory governments throughout Australia legislate for Children's Courts to have the power to make Youth Therapeutic Orders.

2. That funding be provided for the establishment and operation of secure therapeutic homes, step down residences and onsite education and training facilities.

3. That funding be provided to ensure effective after care and transition arrangements for young people on a Youth Therapeutic Order.

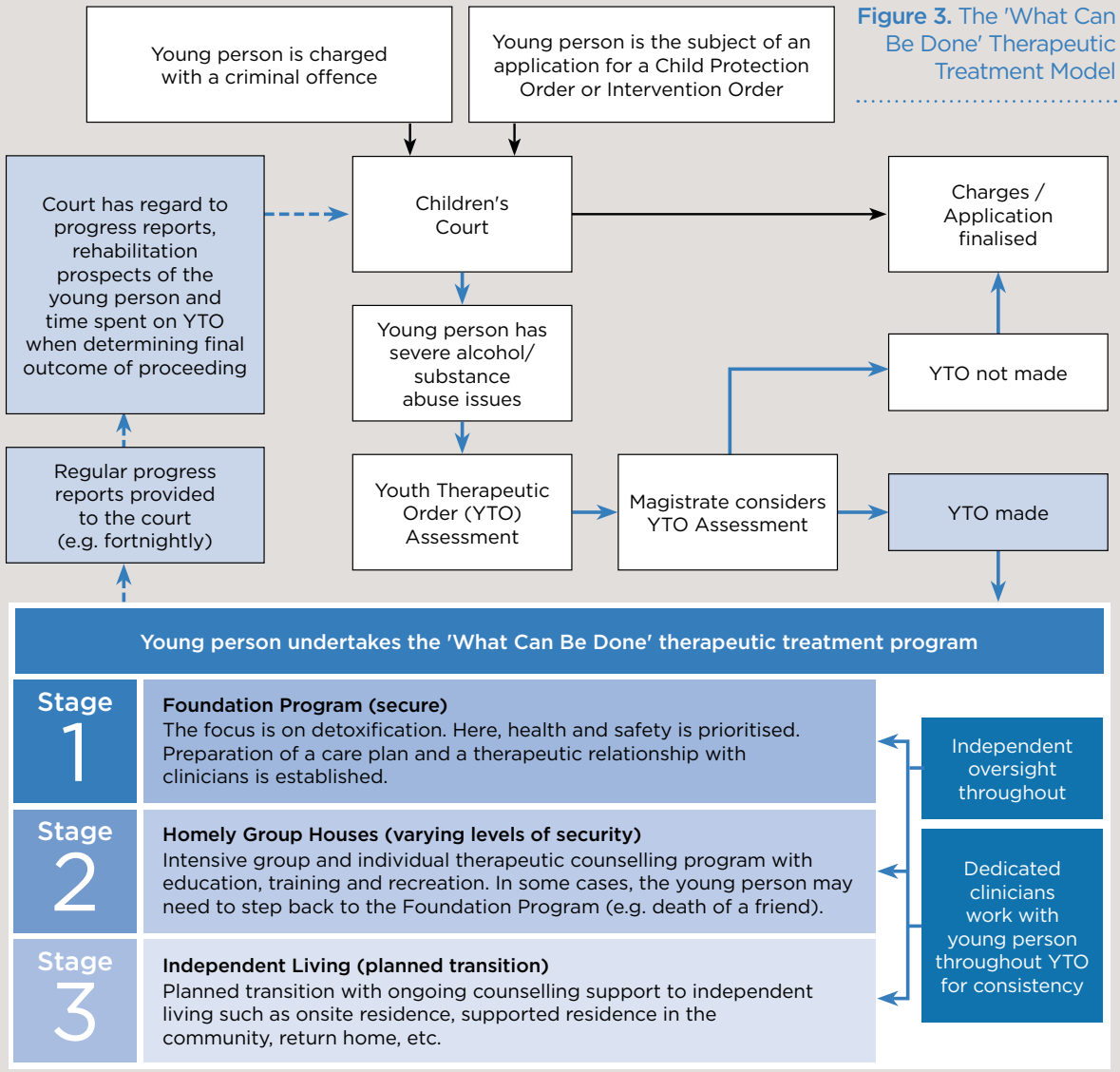

Figure 3. The 'What Can Be Done' Therapeutic Treatment Model

Black arrows denote standard court proceedings; **Blue arrows** denote WCBD model.

Stakeholder consultation

Stakeholder consultation has included presentations and/or discussions with the Victorian Premier, Attorneys-General, other state government ministers and members of Parliament, advisers, department secretaries and senior government officers. Support for the implementation of the Youth Therapeutic Order model has been received from the Victorian Alcohol and Drug Association (VAADA), Victorian Aboriginal Community Controlled Health Organisation (VACCHO), Centre for Forensic Behavioural Science (Swinburne University and Forensicare), Youth Support and Advocacy Service (YSAS), Odyssey House Victoria, Windana Drug and Alcohol Recovery, Taskforce Community Agency, Centre for Excellence in Child and Family Welfare, Victoria Police Association, young adults with lived experience, addiction experts, forensic psychiatrists, clinical psychologists and lawyers. My Fellowship Report also contains lists of international and Australian professionals with whom I consulted in the course of my research.[50]

Acknowledgments

I would like to acknowledge and thank my peer reviewers Professor James Ogloff AM and Associate Professor Yvonne Bonomo for generously giving their time, sharing their expertise and providing advice. Any errors or omissions are my own.

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Endnotes and References

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1. Judge Jane McMeeken, Presiding Judge, Youth Drug Court, Christchurch, New Zealand [approved variation in July 2020 to original interview quote, October 2014].
2. Adolescents aged between 10 and up to 18 years are referred to as 'young people' (YP).
3. Criminal Division – YP charged with criminal offences; Family Division – child protection proceedings and intervention order proceedings.
4. A pseudonym.
5. Vanilla essence has approx. 35% alcohol content.
6. Greg is now 29 years old and has had in excess of 100 admissions to hospitals and psychiatric wards, including Thomas Embling Hospital.
7. Children's Court of Victoria. *Parliamentary Inquiry into Homelessness in Victoria: Children's Court of Victoria Submission,* 31 March 2020, 16 – snapshot data (substance abuse/mental illness/ alleged criminal offending) for children missing from care: https://parliament.vic.gov.au/976-lsic-lc/inquiry-into-homelessness-in-victoria.
8. "Among young people aged 10–17, about 57% of those in detention in the June quarter 2019 were Aboriginal or Torres Strait Islander, ... young indigenous Australians made up 6% of the Australian population aged 10–17." – Australian Institute of Health and Welfare (AIHW), "Youth detention population in Australia 2019", Bulletin No. 148, February 2020, 11.
9. Commission for Children and Young People (CCYP). "Commission for Children and Young People: Annual Report 2013–2014," Melbourne: Victorian Government, 2014, 17.
10. CCYP, 'Annual Report 2013–2014', 37.
11. CCYP, 'Annual Report 2013–2014', 6: Mr Andrew Jackomos PSM (then Commissioner for Aboriginal Children and Young People).
12. Bowles, J. *What Can be Done? – Residential therapeutic treatment options for young people suffering substance abuse/mental illness.* Churchill Fellowship Report: The Winston Churchill Memorial Trust, 2015, 19. https://www.churchilltrust.com.au/fellow/jennifer-bowles-vic-2014.
13. Armytage, P, and Ogloff, J. "Youth Justice Review and Strategy – Meeting needs and reducing offending – Executive Summary", Melbourne: Victorian Government, July 2017, 13.
14. Turning Point. "Adolescent Pathways to Seeking Help for Substance Use Disorders", November 2010–October 2012. https://turningpoint.org.au/
15. "Methamphetamine – 'Ice' Psychiatric Perspectives". Dr Danny Sullivan, Assistant Clinical Director, Victorian Institute of Forensic Mental Health (Forensicare), Presentation at the Magistrates' Court of Victoria Conference 10 October 2014. Transcript p 10.
16. The only compulsory treatment which may be ordered requires the criteria prescribed under the *Disability Act 2006*, *Mental Health Act 2014* and the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*. The only compulsory containment in the criminal division is custody/detention, and in the family division is secure welfare.
17. I also visited a number of adult facilities.
18. Bowles, 'What Can be Done?' 43–54.
19. Winters, K, Botzet, A, Stinchfield, R, Gonzales-Cas-taneda, R, Finch, A, Piehler, T, ... Hemze, A. "Adolescent Substance Abuse Treatment: A Review of Evidence-Based Research" In Leukefeld, C. and Gullotta, T (Eds.). *Adolescent Substance Abuse*: *Evidence-Based Approaches to Prevention and Treatment*. New York, NY: Springer Science, 2018, 144.
20. Pat Williams, Compliance and Quality Manager, Odyssey House, Auckland, New Zealand [recorded interview, 21 October 2014].
21. Chris Rewha, A/Manager Te Puna Wai o Tuhinapo Youth Justice Residence, Christchurch, New Zealand; Nigel Laughton, Clinical Director, Odyssey Youth, Christchurch, New Zealand [recorded interview, 1 December 2014].
22. Dr Dickon Bevington, Consultant Child and Adolescent Psychiatrist, Children & Adolescent Substance Abuse Service, Cambridge, England. [recorded interview, 11 November 2014].
23. Lorraine Fraser, Manager, James Shields Project, Glasgow, Scotland [recorded interview, 29 October 2014].
24. Asa Wallengren, National Coordinator and Project Manager 'Young Offenders Violent Offenders', Swedish Prison and Probation Service, Sweden [recorded interview, 21 October 2014].
25. Peter (pseudonym), 18 years old, Sundbo (secure home), Sweden [16 October 2014].
26. What Can Be Done (WCBD) Steering Committee of 27 members, including: CEOs of AOD services, addiction specialists, forensic psychiatrists, clinical psychologists, a young Aboriginal man with lived experience, and lawyers.
27. Abdel-Salam, S, and Gunter, WD. Therapeutic engagement as a predictor of retention in adolescent therapeutic community treatment. *Journal of Child & Adolescent Substance Abuse*, 23, 1 (2014), 49–57.
28. *Charter of Human Rights and Responsibilities Act 2006* (CHRRA, Vic) s 21.
29. CHRRA s 17(2), *The United Nations Convention on the Rights of the Child* (CRC) Art. 3(1), *Children Youth and Families Act 2005* s 10.
30. CRC Art. 30, CHRRA s 19.
31. CHRRA s 8.
32. CHRRA s 13(a).
33. CHRRA s 10(c). See also s 7(2).
34. CRC Art. 6, 24, 25, 27.
35. CRC Art. 33.
36. Other considerations include: the YP would be legally represented; engagement in voluntary treatment has been considered, and the principle of reciprocity is met.
37. Refer to *Re Beth* [2013] VSC 189, 23 April 2013, http://austlii.edu.au/au/cases/vic/VSC/2013/189.html.
38. Coyne J, White, V and Alvarez, C. *Methamphetamine: Focusing Australia's National Ice Strategy on the problem, not the symptoms.* Barton: Australian Strategic Policy Institute, 2015.

39. Consultant child and adolescent psychiatrist, The Bridge, Cambridge, England [recorded interview, 11 November 2014].
40. The definition I have adopted of a 'therapeutic community' is '... a participative group-based approach to .... drug addiction ... it includes group psychotherapy as well as practical activities,' Wikipedia, 6 February 2015.
41. For example, at Glebe House, YP are on the interview panel for the selection of all staff, including the CEO, a YP also chairs the group meetings.
42. There would be fortnightly progress reports provided to the Magistrate who made the Order. Other forms of external scrutiny that I observed overseas included: the Ombudsman for Children in Sweden, the Mental Welfare Commission in Scotland and the Care Quality Commission in England.
43. For example, hairdressing, motor mechanics, etc.
44. "One thing with secure (accommodation) is that you can get a lot of treatment and not have breakdowns in treatment ... breakdowns in treatment are very bad for youth." Associate Professor Tove Petersson, Head of Department of Criminology, Stockholm University, Sweden. [recorded interview, 15 October 2014].
45. Law Reform, Drugs and Crime Prevention Committee. *Inquiry into the Supply and Use of Methamphetamines, particularly 'Ice', in Victoria – Final Report – Volume 1,* Melbourne, Victoria 2014, 270. The report identified the need for "Aboriginal-specific holistic healing centres to adequately cater for the specific needs of Aboriginal communities ..."
46. Steering Committee for the Review of Government Service Provision, "Youth Justice Services," *Report on Government Services 2020*, Canberra: Productivity Commission, 2020, s 17, 17.25. Note: There are significant variations in costs between the states and territories but the figure quoted is the average cost for Australia. In Victoria the relevant cost per day for 2018-2019 was $1,748. (Table 17A.21).
47. In relation to cost estimates regarding child protection for a service with similarities to the WCBD model, refer to: KPMG. *A Proposed Contained Therapeutic Treatment and Care Service, (released under FOI),* Report for the Department of Health and Human Services, 2016, 40. The cost range per person per day for a 16 bed facility ranged from $1,298 to $1,979 (depending on the model).
48. Parliament of Victoria Legislative Council Legal and Social Issues Committee, March 2018, Recommendation 19, 102.
49. Armytage and Ogloff, 'Youth Justice Review', 14.
50. Bowles, 'Churchill Report', 7–11, 83, 84.

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1. User Voice. Accessed 17 June 2020, http://www.uservoice.org/our-story/.
2. Victorian Ombudsman, "Prisons failing to keep us safe," 17 September 2015, https://www.ombudsman.vic.gov.au/.
3. Victorian Ombudsman. *Investigation into the rehabilitation and reintegration of prisoners in Victoria*. Melbourne: Victorian Government Printer, 2015, 2.
4. Victorian Ombudsman, 'Prisons failing'.
5. Victorian Ombudsman, 'Prisons failing'.
6. Australian Bureau of Statistics (ABS), "Corrective Services, Australia." Accessed June 2020, https://abs.gov.au/ausstats/abs@.nsf/mf/4512.0.
7. Seppings, C. *The rehabilitative role of ex-prisoners/offenders as peer mentors in re-integration models – in the UK, Ireland, Sweden and USA*. Churchill Fellowship Report: The Winston Churchill Memorial Trust, 2015. https://www.churchilltrust.com.au/fellow/claire-seppings-vic-2015.
8. JustLeadershipUSA. Accessed June 2020, https://jlusa.org/about/.
9. User Voice. Accessed June 2020, http://www.uservoice.org/about-us/our-services/peer-support/.
10. Lightowler, C. "The Road From Crime", 18 July 2012. https://iriss.org.uk/resources/videos/road-crime.
11. SCRGSP (Steering Committee for the Review of Government Service Provision), *Report on Government Services 2019*, Productivity Commission, Canberra, 2019: Table CA.4.
12. Bushnell, A. "Like Trump, Australia Must Focus On Reoffending To Make Communities Safer," Institute of Public Affairs, 9 February 2020, https://ipa.org.au.
13. SCRGSP (Steering Committee for the Review of Government Service Provision), *Report on Government Services 2020*, Canberra: Productivity Commission, 2020.
14. Lewis, N, and Lockwood, B. "The Hidden Cost of Incarceration." The Marshall Project, 17 December 2019. https://themarshallproject.org.
15. Borzycki, M. *Interventions for Prisoners Returning to the Community*. Canberra: Australian Institute of Criminology, 2005, 10.
16. Millar, R, and Vedelago, C. "Prisons to focus on rehabilitation not recidivism: Minister." The Age [online], 28 June 2019, https://theage.com.au.
17. Clinks. *Unlocking Potential: How offenders, former offenders and their families can contribute to a more effective Criminal Justice System*, York, UK: Clinks, 2008, 3.
18. Purposely Podcast By Mark Longbottom, "Mark Johnson founder of User Voice and bestselling author." 2 July 2020, https://anchor.fm/mark-longbottom2/.
19. User Voice. Accessed June 2020, https://www.uservoice.org/home/what-we-do/our-stories/.
20. Save Our Streets. Accessed June 2020, https://courtinnovation.org/programs/save-our-streets-sos.
21. Center for Court Innovation. Accessed June 2020, https://courtinnovation.org/programs/save-our-streets-sos/more-info.
22. Sefton CVS, "Merseyside Offender Mentoring". Accessed 12 April 2018, https://seftoncvs.org.uk/projects/mentoring/.
23. The Mentoring and Befriending Foundation. *Transforming Lives: Examining the positive impact of mentoring and befriending*, London: NCVO, 2015, 24.
24. Graffam, J. *"Straight Talking": A Peer Mentoring Program For Released Prisoners: Program Delivery and Final Report*. Melbourne: Deakin University, In press.
25. Graffam, 'Straight Talking,' [pers. comm. during project development], 2017.