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update

Issue 68 • Winter 2014 •
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Criminal justice matters

By Susan Helyar, Director, ACT Council of Social Service Inc. (ACTCOSS)

This newsletter explores diverse experiences in the criminal justice system in the ACT. It aims to strengthen our collective understanding of the social determinants of crime, and the factors that determine whether a person can live safely and contribute well in their community. The social determinants of crime are the circumstances of an individual's life which greatly increase the risk of that person ending up in contact and/or re-contact with the criminal justice system (e.g. mental health issues, poverty, brain injury, intellectual disability, long-term unemployment, alcohol and other drug misuse, history of trauma, experience in the out of home care system, disengagement in education).

ACTCOSS has recently developed a suite of position statements on areas relating to our strategic plan and advocacy aims, including justice and corrections. I encourage all ACTCOSS members to review these statements and provide input and comments. Please contact us on 02 6202 7200 or email actcoss@actcoss.org.au.

The ACT community sector has many years of strong and persistent involvement in public debate and advocacy on criminal justice issues. We care because we know that involvement with the criminal justice system is often the result of failures in other parts of our social infrastructure. We know that people who are offenders are often also the victims of crime. We put effort into this advocacy agenda because if we take the time to respond well to the needs of prisoners, remandees and their families, we can break cycles of deprivation and harm, and we can improve community safety.

The articles brought together in this publication share stories of resilience and recovery and good practice models of service provision. We have also included articles that suggest how we can more fully express our commitment to human rights as a foundation on which our justice system is built.

ACTCOSS is honoured to take this opportunity to showcase the wisdom and dedication of our members on this critical social policy issue.

Hep C, prison, treatment and renewal

An interesting, smart, reflective man with a cheeky smile and a life history plenty colourful is telling his story. He is twenty-something and nearing the end of a prison sentence at the Alexander Maconochie Centre (AMC)—the ACT's prison. Youth, drugs, crime, disease, and prison are predictably all parts of this story. The twist in the tale is less familiar and more positive—recovery, personal growth, hope and love. These are his words.

I would do it again you know—hep C treatment—if I had to. The hepatitis nurse told me the side effects might be difficult but a long-term hep C infection isn't pretty either. Some people get very unwell and I know it can end in liver failure and liver cancer. That's what killed Chopper Read.

[A week before this story was told, Mark 'Chopper' Read had died. Depending on whom you ask, Chopper was a celebrity, a reformed criminal, an artist and entertainer, a father or a taxpayer. He died of liver cancer resulting from hepatitis C infection contracted in prison years prior. Chopper's disease was preventable, as was its progression to serious liver disease and an early death. Others will go that same way, sadly and unnecessarily.]

Considering treatment

I contracted the virus at the age of 17 and was diagnosed about a year later in Canberra at a residential drug treatment service for young people. I was lucky to be diagnosed early, I suppose, but like many people with hep C my diagnosis didn't lead to the offer of treatment. Another year later I was starting a prison sentence at the Symonston Detention Centre [the predecessor to the Alexander Maconochie Centre] when I bumped into the hepatitis nurse who did my liver health assessment. She helped me realise that this prison sentence represented a window of opportunity in what was an otherwise chaotic lifestyle. It could be the best chance I had to treat hep C.

Genotype 3 meant I faced six months of treatment with a combination of Interferon and Ribavirin. I knew that the next six months would be tough but being treated in prison offers benefits over being treated in the community. For a start, I had support structures in place in prison to help me deal with the side effects. In the community I would have had better access to illicit drugs and I knew they would look more appealing than Interferon if I got sick. I decided to go for it while I had the chance.

Undergoing treatment

Other prisoners were a big support. People knew I was struggling and helped me out. Sometimes they made sure I ate when eating was the last thing on my mind. Treating prisoners for hep C in the ACT was a new thing at that time, so I felt like a guinea pig in some ways. For example, Justice Health didn't really know how best to support my loss of weight and appetite, so they gave me Sustagen and told me I could drink some salt water to replace minerals. My weight loss was dramatic and I bottomed out at around 49kg, having lost a third of my body weight.

Hopefully I'll never need to do treatment again. Aside from weight loss, fatigue was the hardest thing to deal with. Sometimes I had just enough energy to clean my cell. I was into weight training and fitness back then, but I couldn't maintain that routine due to treatment side effects. My muscle mass just slipped away but there seemed to be a clear choice between keeping body weight and beating hep C. I knew that to beat hep C I needed to choose the thing that was most important. It also helped to remind myself that some people have a worse time on treatment than me.

After five weeks of treatment the virus was undetected and I really wanted to stop. The Health staff encouraged me to continue though, to give myself the best chance, and I knew it was the right thing to do. Thankfully treatment was successful, and two or three months after completing treatment I was feeling 'normal' again.

Staying hep C free

Preventing reinfection is now the critical thing for me, and since finishing treatment I have declined every opportunity to share needles with other people in the prison. I remain vigilant about the risk factors. As prison is such a high-risk place, I get tested periodically to assure myself that I'm still clear. It's not always as easy as it should be to access testing though, and both Corrective Services and Justice

Health can create barriers for prisoner-initiated testing. You shouldn't ever have to give a reason why you want to be tested for hep C in prison. That's just unnecessary.

In the Alexander Maconochie Centre there are a lot of blokes with hep C. I'm told that access to treatment is better in prison than in the community, but there's only about ten people getting treated at any time in here so access to treatment in the community must be pretty poor. It would make sense for more people to be getting treated for hep C in prison. A needle and syringe program could prevent infections and reduce sharing, and most prisoners support the concept.

Many prisoners have a good general knowledge about blood borne viruses. Awareness and knowledge about treatment for hep C is generally low, but most know about transmission risks. Unfortunately for many people in prison the immediate benefits of using drugs outweigh the immediate benefits of hep C prevention. People don't have good access to clean injecting or tattooing equipment and access to bleach is usually poor. If the cost of providing bleach is the reason why it's so hard to get, they should make it available through buy-ups. People would pay for better access.

Would I recommend treatment?

Sometimes people ask me about my treatment experiences and whether it was worth it or not. I'm happy to talk about treatment and hep C. I hope that my story can help other people.

There are people in prison with hepatitis C who won't consider treatment because they think they'll have twelve months of hell in front of them. Sure, the side effects aren't the best, but they're sometimes exaggerated. Like I did, people considering treatment need to weigh up the odds... will you lose from doing treatment or will you gain from doing treatment? In prison, most people have fewer responsibilities than on the outside. It would be much harder doing treatment and having to go to work, pick the kids up, and manage life in the community.

When I came into prison I had hep C, and I'll be going out without it. I know plenty of people unfortunately who do it the other way around, so it's a good feeling to know that I'm bucking the trend. It's also good to know that I'm not a transmission risk any more. I've got a daughter and lots of nieces and nephews, and I can't wait to get physically involved in their lives again. Playing sport and games, rolling around in the park, and not having to worry about scratching myself and potentially exposing them to infection—I know there's a very low risk from that sort of stuff, but it weighs on my mind.

Freedom

My daughter and I have an amazing relationship now and I'm working towards resuming custody after I'm released. She's only young and she lives with my mother. We get to see each other often and we speak on the phone a lot too. She's one of the reasons why I'm loving life. Some people wouldn't think I could say that, being locked up in here, but it's true. I completed a drug treatment program in prison and have been abstinent from drugs for the longest time since I was 16 years old. I have self-esteem and the respect of others. I get treated differently now I think, and I have my health back.

Looking to the future, I just want to have a normal life. My vision for the next ten years is to remain drug free, hep C free, and to stay out of prison. I can see myself having a tidy place to live with my family around me. Stable employment will be an important part of the picture too. I'm not looking to create anything extravagant... just a humble, healthy and happy existence.

Looking at stars though bars

Nearly all of my last 11 years have been behind bars. I'm 31 years old and was first sentenced at age 20. In many ways I've followed the footsteps of my Dad.

I first gazed at the stars on a beach with him. We were yarning about life and stars began to fill the night sky. Those same night skies have remained a symbol of freedom for me—of reality, possibility, and dreams. I also remember as a kid watching him shooting up.

My own drug use started with some colourful types at a panel shop in Queensland. There as a kid I was introduced to speed. Later in Melbourne when I was working for Dad I had my first taste of heroin. I'd cycle to St Kilda from the city every time.

At Wellington prison I was diagnosed with hep C but wasn't told much about it. Thankfully it was different at the Alexander Maconochie Centre (AMC) where a nurse explained that the disease could kill me and that Interferon treatment could cure it. I felt she was genuinely concerned about me and I trusted her. I jumped at the opportunity to commence treatment and that was the first step I took to get my life back.

It was tough and many times I wanted to stop. I was really encouraged when tests showed the virus was undetectable after four weeks, but I still had to complete treatment. The doctor put me on methadone for my opiate dependency. Methadone really doesn't agree with me but more of that later.

Released before I had finished Interferon, I ended up completing all but three of the scheduled 48 weeks' treatment. I was soon back behind bars, though. facing the nurse's wrath for falling short. My hep C test came back negative and I promised I'd pull my head in and be a responsible father to my boys who I love so much.

I was determined to take advantage of the various courses available such as the Cognitive Skills self-change program. Prison is a difficult place. You've got to stand up for yourself—be assertive. If you don't, people will walk all over you. I've had no good role models and knew only assertiveness that got me into trouble. The program taught me heaps about myself, communication, and healthy boundaries. These were skills that very soon I had to draw upon.

After three months on methadone I was still unstable and had sores breaking out all over. It doesn't work well for everyone and it made me feel unclean. Some officers were suggesting that my clean urine tests were faked and that I should 'just get off drugs'. I was at breaking point and just about to use again.

Fortunately I met a hepatitis educator in my cell block who listened to my problems with methadone and my need to be on Suboxone. Previously Suboxone had helped me to not use drugs. We both knew I was in danger of throwing away the investment that the health centre and I had both made in hep C treatment.

I was scared shitless of catching it again. Getting a syringe in prison isn't difficult but getting bleach to clean things can be. We talked about where I might get help and I found hope. I contacted advocates and support networks and was amazed at what unfolded. I received replies to my letters but nothing seemed to happen fast. By taking myself off methadone my health improved, but still I waited.

The doctor and I had a frank exchange of views about potential reinfection and the implications of being denied treatment that was effective and available in the community. I disclosed that I had scored some drugs and, even though I didn't want to, had already used twice.

The weeks seemed like years but eventually I commenced Suboxone. Things went well early, attending the health centre daily where I took the medication under supervision. Prisons don't like Suboxone and seemingly fear its diversion and misuse much more than the frequent diversion and misuse of methadone. Justice Health in NSW seems to manage Suboxone well enough.

After a fortnight I started getting pressured by nurses—being accused of diverting the medication even when two officers watched me consume it. My relations with nurses reached a low point when on one occasion they demanded to check my mouth for a fourth time.

In the end my new-found cognitive skills came to my aid. I saw the doctor and told him I was being pushed off Suboxone for the wrong reasons. I stood up for myself and had corrections officers on my side too. With the doctor's support we worked out how to continue dosing in a way that the nurses could be satisfied. There were no problems for six months

and I felt nearly ready to start reducing.

But in the final run to the post things have gone awry. I was again accused of diverting and was taken off the program. This, of course, has upset me but I channel my frustration into a focus on my health, cleanliness and fitness. I treat my body as my temple and you might therefore understand why my adverse reaction to methadone makes that medication so repulsive.

I am grateful to the AMC for the chance to obtain my Certificates III & IV in Fitness. I'm very proud, as I left school at year nine without any confidence in formal education. Fingers crossed I can serve out the last few months of my time at the AMC without compromising my health. Wish me luck!

The AMC may not have bars but it has fences and wire to spoil the night skies. I do have a lot to live for and am determined to be there for my three precious sons and their mum who has stood by me. I am determined that they will see the side of me that is loyal, caring, and trustworthy. I am convinced that my life is about to begin again.

This article is a true account of an AMC detainee's lived experience, re-told here by a third party with the detainee's approval.

Suboxone factbox

Suboxone is a pharmacotherapy for people with an opioid dependence. It is an alternative to methadone and to Subutex (buprenorphine).

Suboxone is the trade name for a mixture of buprenorphine and naloxone.

Buprenophine (bupe) works on the same receptors as opioids like heroin but it is more effective at binding to receptors. Bupe can 'knock' other opioids off the receptors and can send a person who has recently taken opioids into withdrawal.

A tiny dose of naloxone was added by manufacturers to bupe.

The naloxone can precipitate opioid withdrawal if it is injected. The amount of naloxone in Suboxone doesn't act if swallowed, however.

Suboxone come as strips of film that stick to the inside of the mouth, making it almost impossible to remove once it is applied.

The reason for this is to dissuade people from 'diverting' or passing it on to those for whom it is not prescribed.

It was hoped that Suboxone would enable longer periods of unsupervised dosing for stable and long-term patients.

Some people feel better on bupe and some people feel better on methadone. The key is that options for treatment encourage better treatment outcomes.

For more information about pharmacotherapy please feel free to call CAHMA on 02 6279 1670.

Winnunga Nimmityjah Aboriginal Health Service: Holistic Prison Health Care Model

By Winnunga Nimmityjah Aboriginal Health Service

Winnunga Nimmityjah Aboriginal Health Service is an Aboriginal community controlled primary health care service operated by the Aboriginal community of the ACT. Winnunga sees around 4000 clients per year, with an average growth rate of approximately 75 new patients per month. Winnunga's primary purpose is to provide culturally safe and holistic health services to the Aboriginal and Torres Strait Islander people of the ACT and surrounding areas.

Winnunga is committed to responding to the needs of Aboriginal and Torres Strait Islander people in the ACT and region, which includes outreach services to Aboriginal and Torres Strait Islander people at Bimberi Youth Justice Centre (Bimberi) and the Alexander Maconochie Centre (AMC). The overall imprisonment rate for Aboriginal and Torres Strait Islander people in Australia is 15 times higher than for non-Indigenous people. In 2013 Aboriginal and Torres Strait Islander people made up 18% of the ACT prison population.[1]

With these statistics in mind, in 2007 Winnunga developed the Winnunga Holistic Prison Health Care Model prior to the opening of the AMC in 2009.[2] The Winnunga Holistic Health Care Prison Model addresses the needs of prisoners and ex-prisoners and their families, and manages the cycle of incarceration. The model's premise is that post-release needs should be addressed as a priority at reception into prison, and the focus of imprisonment is release into an environment which provides accommodation, employment, health services, and reintegration into the family and community. The model reflects the first contact with the justice system. It then takes into consideration the holistic care necessary for remandees and sentenced prisoners and their families (in prison and on release). The model also shows that family, health and spirituality are the three supporting components of those incarcerated and on release into the community. At the centre of the model is the need to develop a strong sense of identity which is crucial in coping with prison and community life. The ability to do this is dependent on the environment, safety, physical, psychological, and community support. Finally, health service coordination, and reintegration strategies into the community combine to manage the cycle of incarceration. The model is also in use at Bimberi. Members of the Winnunga Social Health Team regularly visit Aboriginal youth in the centre and maintain that contact when they are released.

The Winnunga Phase 1 Study *You do the Time, You do the Crime* identified the need for culturally sensitive health programs that target early detection of chronic diseases and health promotion activities in prisons. This means specific programs for physical, social and emotional wellbeing, primary care for diabetes, heart disease and other circulatory system diseases, respiratory diseases, women's health including sexual health, maternal and child health, mental health, alcohol and drug programs, and testing for hepatitis B and C and HIV on entry and release from prison, with informed consent and appropriate counselling.

Particular note was made of the prevalence of health needs relating to substance abuse, mental health, communicable diseases, and women's health. Study comparisons between Australian and overseas practices indicated the need for diversionary measures for people with mental health problems, and treating substance abuse as a health issue as opposed to a law-enforcement matter. The study noted that early intervention with Aboriginal women (addressing lack of education and employment) and treatment for sexual and physical abuse, mental health, and alcohol and drug abuse problems would reduce contact with the criminal justice system.

The Winnunga Holistic Health Care Prison Model has three parts:

- Part 1: Incarceration—provides holistic care during incarceration and planning for release.
- Part 2: Release from Prison—provides post-release health service coordination, and family and community reintegration strategies.
- Part 3: Managing the Cycle of Incarceration—provides early family, and other intervention strategies.

In 2011 Winnunga carried out a Phase 2 Study into the needs of Aboriginal prisoners and their families

in the AMC.[3] This research found that the Winnunga Holistic Health Care Prison Model is relevant to the needs of the people in the AMC and their families. Following the Phase 2 Study Winnunga increased its services at the AMC from weekly medical health care assisted by an Aboriginal Health Worker (which Winnunga has delivered to prisons in New South Wales, Juvenile Justice Centres and Remand Centres in Canberra over a period of 13 years) to additional Winnunga Aboriginal Health Workers delivering weekly individual case management and pre-release planning, social and emotional wellbeing counselling, court support, and art classes. In addition, Winnunga supports Aboriginal women in the AMC with weekly visits, and the Winnunga Healthy Lifestyle Worker organises sporting activities each Friday at Bimberi Juvenile Justice Centre.

Following the philosophy of Winnunga's Prison Health Care Model, health care during pregnancy and early childhood, good parenting and mentoring programs, assistance with employment, housing, education and access to Winnunga's numerous social health and wellbeing programs are critical components in breaking the cycle of crime and violence. In 2012-13 Winnunga had 260 client encounters across both the AMC and Bimberi, with the majority (92%) being at the AMC.

Winnunga Nimmityjah Aboriginal Health Clinic/ Health Service (ACT) Inc.

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Visit Winnunga on the web: www.winnunga.org.au

See page 14 for footnotes.

The experience of a person with an intellectual disability in the criminal justice system

By Kate Pensa, Project Manager Operations, Koomarri

Mark* came to the attention of police when he was attempting to commit an armed robbery... he was the scapegoat... given the task of going into the bank before his mates, holding a toy gun at the staff whilst trying to spray paint the security cameras black, ahead of being joined by his accomplices to do the deed. Mark was intercepted by police before his accomplices could join him and took the rap for the crime.

Mark was not unfamiliar to the police. In fact, Mark had spent a good proportion of his adult life either in prison or on treatment orders (intended for people with mental illness) he was unable to fulfil. Mark had a rap sheet that told the story of a person who on the surface seemed not to care about his actions or the resulting consequences and, who in fact, was a person with an intellectual disability—in the borderline percentile, who understood very little and was extremely vulnerable to being unduly influenced by people who preyed on his lack of understanding. Mark had no stable home, a history of 'non-compliance' with support services and repetitive offending behaviour.

Intellectual disability has been associated with higher rates of recidivism in young people. High rates of co-occurring health problems and cognitive disabilities in people with mental illness and possible links between these issues and recidivism provide a clear rationale for best practice diversion and support programs to engage with general health and disability supports.

Intellectual disability is broadly defined by a multi-dimensional approach, with the need for difficulties in adaptive behaviour being one of the three main identifying components. This is evidenced by the need for support in day-to-day activities. The other two are an IQ score

of less than 70, and conditions manifesting before the age of eighteen. There is strong argument to include people with IQ of up to 80 (borderline) as this group is most highly represented in the criminal justice system.

Intellectual disability differs significantly from mental illness which is diagnosed by a clinical set of symptoms, many of which are treatable. Yet the criminal justice system still tends to cluster its programs, assessments and treatment plans towards an assumption of mental illness, and a definitive lack of understanding around intellectual disability.

Why are people with intellectual disability over-represented in the criminal justice system?

- A person's offending behaviour may be highly visible, impulsive and lack afterthought and planning to avoid detection
- The person may have been scapegoated by their peers into acting as an accomplice to crimes and are left to shoulder the blame for the crime
- The person may have co-morbid mental health issues which impact on the person's behaviour
- The person's intentions may have been misinterpreted by others as threatening
- The person may express their sexuality in ways that others may deem inappropriate or morally immature
- The person's level of social disadvantage, such as homelessness or unemployment, may inadvertently encourage criminal behaviour

How do we better support people with intellectual disability in the justice system?

- Providing service responses to small and highly complex groups of offenders—women and Aboriginal and Torres Strait Islander people, for example, who experience multiple disadvantage
- Attracting and developing a workforce skilled in working with offenders with a disability as a highly specialist area
- Enhancing community intervention/support to work more effectively with offenders on a Community Correction Order, and better supporting prisoners reintegrating into the community

Visit Koomarri on the web: www.koomarri.asn.au

*Mark is not the subject's real name.

KOOMARRI

Social exclusion of drug users as the consequence of drug policy

By Bill Bush, Families and Friends for Drug Law Reform

Drug policy is an intimate in our lives. It makes it a crime to ingest into our own body certain substances and to possess those substances for that purpose.

In defiance of severe penalties, illicit drug use is widespread among young people. Around a quarter of young people have used illicit drugs 'recently'.[1]

Drug laws are notoriously ineffective. They foster a system of peer-to-peer marketing that is impossible to control. For families this is a tragedy. The State fails in its commitment to keep drugs from their children, makes criminals of them and disempowers parents from helping them. They and their children are marginalised and stigmatised.

Drug users are only rarely sent to prison for drug offences but two thirds of prisoners are addict drug users.[2]

There are three widely accepted explanations of the causal link between drugs and crime. First, where the offending behaviour is caused by the offender being intoxicated at the time (Psychopharmacological). Second is property crime motivated to raise funds to support a drug habit (Economic compulsive). Third are crimes from engagement in 'drug market' activity

(Systemic). Few people are imprisoned in the ACT for Systemic crimes.

Crime costs in 2004-05 attributable to illicit drugs on these three grounds were large, namely $4 billion. This was far more than the $1.7 billion attributable to alcohol.[3] This conservative estimate of $4 billion amounted to 0.48% of the nation's GDP.[4]

But the story gets worse. The three causal links between drugs and crime used to compute these costs exclude what is known about the interplay of risk and protective factors and the social determinants of health. Crime and imprisonment signify a breakdown in social cohesion that these concepts focus upon.[5] There is a concentration of disadvantage in crime and prison. 'The bulk of crimes are committed by people from low socio-economic background with limited formal education, suggesting some form of association between disadvantage and crime.'[6] This relationship between social disadvantage and high rates of imprisonment is 'long established.'[7]

Illicit drug use is likely to be associated with a range of personal, family, social or behavioural risk factors.[8] Applying the processes of the criminal law to respond to the drug use serves only to intensify social exclusion, particularly if the offender becomes addicted. Thus, a youth given to risk taking who is struggling at school and socially isolated, might be tempted by money and gifts to engage with a deviant peer group in direct marketing of drugs among acquaintances. Every step the young man takes weakens his links to mainstream society. Those suffering from depression and other mental health problems[9] are at particularly high risk of taking up drugs. They become dependent and thus acquire a further recognised mental health condition for which the law decrees punishment rather than treatment.

Thus, many drug users find themselves in prison. Tony Vinson, drawing on his experience as a prison administrator and social researcher, wrote: 'Imprisonment by its very nature disrupts individuals' life opportunities. It can reflect and help to sustain limited education, unemployment, poverty, homelessness and associated social difficulties.'[10]

Imprisonment renders some people less able to cope in the community.[11] Drug laws and prisons infringe free market libertarian principles. In prisons the lives of inmates are micromanaged and their capacity to survive and thrive in the community undermined.

Moreover, imprisonment is not very effective. The NSW Bureau of Crime Statistics and Research has found that incarceration may even increase reoffending rather than reduce it:[12] which is, of course, consistent with prison increasing the risk factors for crime.

With its commitment to human rights and recognition that prisoners are drawn from the most disadvantaged sector, the ACT has committed substantial funds to foster resilience and protective factors among prisoners. Prof. Vinson and Jesuit Social Services have argued for years that it would be a better investment to implement remedial programs of some seven or eight years to strengthen the social bonds in localities of high disadvantage.[13] He has advocated following the model of 'the Groundwork network of trust, which has operated since the early eighties throughout much of England, Wales and Northern Ireland.'[14]

The World Health Organization is advocating world wide a more radical approach, arguing that social cohesion cannot be achieved in highly unequal societies. This draws on research that is hard to refute, such as the proposition that social exclusion and lack of social cohesion is linked to violent crime.[15] The criminal law pushes drug users to the margins of society. This social exclusion '... prevents people from participating in education or training, and gaining access to services and citizenship activities. People who live in, or have left, institutions, such as prisons, children's homes and psychiatric hospitals [as drug users disproportionately experience] are particularly vulnerable.'[16]

Visit Families and Friends for Drug Law Reform on the web: www.ffdlr.org.au

See page 14 for footnotes.

Alcohol and other drugs: Cost-effective and meaningful justice system reforms in the ACT

By Amanda Bode, Alcohol Tobacco and Other Drug Association ACT (ATODA)

Alcohol and other drug (AOD) use is a major contributor to offending and reoffending, including amongst prisoners. Australian research indicates that a history of drug use is associated with an increased likelihood of being reincarcerated within months of leaving prison.[1] In the ACT, approximately two-thirds (67%) of prisoners in the Alexander Maconochie Centre (AMC) have a history of injecting drug use and 79% reported being under the influence of drugs at the time of committing their most recent offence.[2]

However, we are fortunate that there is a strong evidence base to support the ACT to make both cost-effective and meaningful justice system reforms for the community and offenders, particularly those prevention and sentencing options specifically related to alcohol, tobacco and other drugs (ATOD).

Alcohol and drug diversion

Drug diversion programs are 'alternatives to imprisonment as effective as demand reduction (e.g. drug treatment) strategies that promote public health and public safety'.[3] Further, they are the most widely used drug-related offending intervention in Australia.[4]

The National Drug and Alcohol Research Centre, in a recent Federal Parliament submission, summarised the following about diversion programs in Australia:[5]

Reduced offending, time to first reoffence and likelihood of imprisonment: For example, a national review of 12 police diversion programs in Australia found that the majority of people did not reoffend following diversion.[6] Moreover, compared to a match sample NSW drug court participants have been found to be 17% less likely to be reconvicted for any offence, 30% less likely to be reconvicted for a violent offence and 38% less likely to be reconvicted for a drug offence at any point during the follow-up period.[7]

Reduced drug use, frequency of drug use and/or harmful use: For example, the proportion of offenders who self-reported as regular cannabis users decreased from 95% to 74% pre and post undertaking the Queensland Police Drug Diversion Program[8] and participants in the Western Australian Pre-sentence Opportunity Program also reported significant reductions in self-reported drug use and self-reported frequency of desire to use.[9]

Increased cost-effectiveness of responses: For example, studies of the NSW Magistrates Early Referral Into Treatment court diversion program revealed that drug diversion offered savings equivalent to $2.98 for every $1 invested.[10] This was attributed to reductions in the costs of police investigation, hospitalisation, criminal activity and prison and probation supervision costs. Moreover, an evaluation of the cost-effectiveness of the Victorian drug court showed that for every dollar invested, the community benefited to the value of $5.81.[11]

The ACT can be proud of its leadership in its alcohol and drug diversion programs. There are five diversion programs in the ACT: the Court Alcohol and Drug Assessment Service (CADAS); Simple Cannabis Offence Notice (SCON); Police Early Intervention and Diversion (PED); the Early Intervention Program (EIP, formerly the Early Intervention Pilot Program); and the Youth Drug and Alcohol Court (YDAC). For more information visit http://health.act.gov.au/health-services/mental-health-justice-health-alcohol-drug-services/programs/alcohol-drug-service/diversion-services

Alcohol and other drug treatment can reduce offending

Alcohol and other drug treatment can be effective at addressing AOD problems, reducing offending behaviour, and diverting offenders from the justice system. It has also been shown to be less expensive than incarceration for some populations, such as Aboriginal and Torres Strait Islander people.[12] A 2006 meta–

analysis of 28 evaluations of AOD treatment programs found that offending following treatment was significantly lower among people who had participated in treatment programs than amongst the comparison groups.

The ACT alcohol, tobacco and other drug sector provides a range of programs to support offenders in custody and in the community.[13] For more information on programs available in the ACT visit www.directory.atoda.org.au

Comprehensive infringement scheme reform

Following advocacy work there have been recent reforms to the ACT infringement system including the establishment of an ACT Community and Work Order Program.

However, this reform is limited to traffic infringements and ATODA believes this reform should be expanded to encompass all infringements, including the following infringements made for ATOD-related behaviours:

- Drink driving offences[14]
- Drug driving offences
- Smoking in cars with children[15]
- Smoking in a no smoking areas[16]
- Individual offences under the Liquor Act[17]
- Simple Cannabis Offence Notice Scheme (SCONs)[18]

People who receive such infringements or fines are likely to have ATOD problems. Many are also likely to be disadvantaged. Providing means whereby these infringements and fines can be paid without placing relatively excessive financial difficulties on those individuals while promoting access to treatment may help to prevent the deterioration in financial, social, and health, which are known to contribute to crime and offending behaviour.

This article was produced by the Alcohol Tobacco and Other Drug Association ACT, the peak body representing the non-government and government alcohol, tobacco and other drug sector in the Australian Capital Territory. For more information visit: www.atoda.org.au

See page 14 for footnotes.

ATODA
Alcohol Tobacco & Other Drug Association ACT

Report on the treatment of women at the AMC

By the ACT Human Rights Commission

A new report has found many areas of positive practice regarding the treatment of women detainees at the ACT's adult prison, the Alexander Maconochie Centre (AMC), but also makes recommendations for improvements.

On 15 May 2013, Dr Helen Watchirs OAM, the ACT Human Rights and Discrimination Commissioner, released her Human Rights Audit Report examining the treatment of women detainees at the AMC.

The report makes 61 recommendations for improvement, such as the development of a prison industry to provide more structured employment opportunities for all detainees. The report also highlighted areas for consideration over the longer term, such as women's facilities for transitional release, and therapeutic residential program for drug addiction. It assesses the law, policy and practices of the AMC, which has been operational for five years, in relation to the treatment of women detainees against the benchmark of international human rights norms enshrined in the ACT Human Rights Act.

The ACT is a small jurisdiction with a single full-time prison facility, the AMC, accommodating both male and female detainees within separate precincts. The number of women detainees in the AMC, including remandees, is low, with a daily average of 14 women in 2012-13, compared with 252 men. In this period, women detainees made up just 5.2% of the total prison population in the ACT, compared to the Australian average for women detainees of 7.5%. While there are a small number of women detainees serving long sentences at the AMC, the average stay for other women detainees is around 100 days, including time on remand.

Overall, many of the issues identified in the audit reflect the significant challenges posed by the small and fluctuating population of women detainees with a diverse range of individual needs.

'I recognise that there are genuine challenges posed by the small number of women detainees in the ACT and the need to accommodate women of different classifications and needs within one prison. There have been real efforts made to improve the conditions of detention of women at AMC, and the report highlights many positive developments,' said Dr Watchirs.

'There were large improvements in terms of the humane treatment of women at the AMC, compared to the 2007 Audit of the Belconnen Remand Centre—in particular there was less strip searching, use of force and segregation.'

As part of the audit, current and former detainees, staff and stakeholders were interviewed; and key policies, procedures and records examined. Public submissions were received from eight organisations, including ACTCOSS, the Coming Home Program (Beryl Women Inc, Toora Women Inc, Canberra Rape Crisis Centre), Winnunga Nimmityjah Aboriginal Health Service, Women's Legal Centre, and the Women's Centre for Health Matters and the ACT Women and Prisons Group.

In general, the report found that women detainees at AMC are treated humanely in custody, and that correctional staff and management are respectful of the particular needs and vulnerabilities of women.

'The cottage accommodation and facilities provided within the women's precinct provided a normalised environment which encourages women to maintain and develop living skills,' said Dr Watchirs. 'The extended Throughcare Program to support detainees during the critical months after release from prison is a welcome development,' said Dr Watchirs. 'I was pleased to find this is available to all women released from the AMC, including those held on remand.'

'Nonetheless, rehabilitation services available to women detainees are more limited than those available to men. Women detainees have significantly less access to structured employment opportunities within the prison. Women are also not able to access some facilities such as the Solaris Therapeutic Community, and the Transitional Release Cottage,' said Dr Watchirs.

'Another area of particular concern is the operation of the Women and Children's program at the AMC,' said Dr Watchirs. 'I also have concerns regarding women detainees with ongoing mental health needs residing in the Crisis Support Unit (CSU) at the AMC for extended periods (over 100 days). However, there have been recent improvements at the CSU with a new multi-disciplinary approach.'

While a number of stakeholders raised concerns regarding the co-location of women detainees in a precinct within a predominantly male prison, the Commissioner found the issues of scale would not be resolved by the establishment of a separate women's prison in the ACT. Instead, the Commissioner made recommendations to improve existing facilities and programs for women.

'Advantages include access to health and dental services, education programs, library, and generous visiting program.'

The ACT Human Rights Act protects specific rights recognised in International Law, largely covering 'Civil and Political Rights' such as equality, humane treatment in detention, freedom of expression and privacy.

During the review, the Human Rights and Discrimination Commissioner received specialist advice from the Health Services Commissioner, the Disability and Community Services Commissioner, and the Children and Young People Commissioner.

The report *Human Rights Audit on the Conditions of Detention of Women at the Alexander Maconochie Centre* is available on the ACT Human Rights Commission website: www.hrc.act.gov.au

ACT HUMAN RIGHTS COMMISSION
Australian Capital Territory

Time for justice reinvestment

By Simon Rosenberg, CEO of Northside Community Service, Treasurer of ACTCOSS, and Co-Chair of the Throughcare Governance Group

> We must deal first of all with the social roots of offending. You can have the shiniest, best prison in the world, but if we are not moving upstream to try to do something about the very readily identifiable factors that seem to put people on the path to breaking the law, then what's the use of the prison?
>
> - Tony Vinson, speech to Christians for an Ethical Society Forum, Feb 2008

The ACT Government recently announced it would meet the growth in prisoner numbers with 110 new beds. The Alexander Maconochie Centre (AMC) will then be just short of 500. This is necessary, but not sufficient. We need to focus more on what keeps people out of prison, and stops them from returning.

As with any complex social problem, the best answers stem from a focus on causes rather than symptoms. 'Justice reinvestment' does just that. It redirects funding away from building more prisons, and invests instead in community-based initiatives that tackle the root causes of criminal behaviour. Justice reinvestment cuts crime and saves money.

Most prisoners come from backgrounds of entrenched disadvantage. This often includes a complex and toxic mix of poverty, unstable housing, intergenerational unemployment, poor educational outcomes, low literacy, family conflict, mental illness and poor physical health.

For Aboriginal and Torres Strait Islander prisoners, these issues are often more pronounced than for the general population, and combined with the experience of racism and discrimination, contribute to the appallingly high rates of Aboriginal and Torres Strait Islander incarceration—around 14 times the average. For female prisoners, there is a high incidence of childhood abuse and domestic violence, with associated trauma which has generally never been addressed prior to imprisonment. Many adult offenders have been juvenile offenders. This is a cycle we need to break.

The evidence suggests that such factors are often clustered locationally. A Victorian study by Tony Vinson noted that 25% of prisoners came from just 2% of postcodes.

Justice reinvestment suggests that the smart thing to do is to address disadvantage. We do this by targeting evidence-based programs at the communities and populations experiencing the highest disadvantage.

There are four key elements: data mapping to get the best information on which communities house the highest concentration of offenders; developing the evidence-based programs that are most likely to reduce offending; targeted implementation in those communities; and rigorous evaluation to measure the impact and help adjust the effort to be most effective.

While justice reinvestment has not yet taken root in Australia, it is tried and tested elsewhere, particularly in the US. Far from being a pipe-dream of the bleeding heart left, it has been the conservative states—like Texas and Kansas—that have embraced justice reinvestment. This was driven by fiscal necessity, as prison budgets blew out, with no corresponding reductions in crime.

Since moving funding from new prison construction and operations to areas like effective parenting programs, alcohol and drug rehabilitation, community development initiatives and job creation, these US States have seen a reduction in their prison population and crime rates. It has improved public safety, and the life chances for a generation of disadvantaged children.

ACTCOSS is advocating the introduction of a justice reinvestment trial in the ACT. This would complement the pilot Throughcare Program which supports prisoners coming out of the AMC and is showing some great early results. For the nine months to the end of March this year, 158 detainees have exited AMC as clients of the Throughcare Program, and only 18 have returned to custody. This very low 11% recidivism rate should be treated with caution given the short time the program has been operation, but the program shows promise for breaking the cycle of reoffending.

Justice reinvestment stops people coming into prison in the first place, and throughcare stops them from coming back.

Despite the fact that in many ways the ACT is an ideal location for a bold move like justice reinvestment, there are implementation issues which probably cause policy makers to take a deep breath before taking the plunge. One of the virtues of Canberra is that there are no postcodes, or even suburbs, that are obvious pockets of disadvantage in the way we find interstate. We tend to have a much more salt and pepper approach to our socio-demographics. This means our data mapping may need to be more fine-grained and concentrate on vulnerable populations, or very specific locations.

With recent work done on developing a Human Services Blueprint for the ACT, trialling justice reinvestment would be an excellent early test of its potential.

Justice reinvestment is just that:- an investment, not a quick fix. Results may not become apparent within one electoral cycle, and it will require a bold, long-term commitment. This investment would ensure that the AMC does not grow beyond 500 beds.

Finally, my thanks to Bill Bush for Tony Vinson's words from 6 years ago, not long before the AMC opened. They are even more relevant today.

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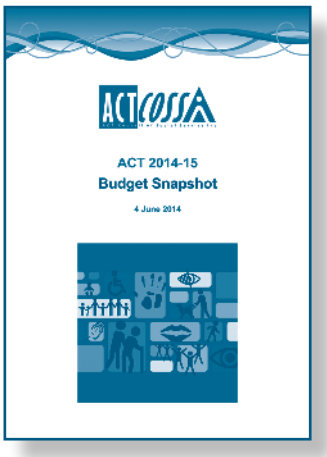
ACT 2014-15 Budget Snapshot

Each year, ACTCOSS prepares an ACT Budget Snapshot outlining relevant funding, initiatives and how the Budget may effect the community sector and people experiencing disadvantage in the ACT.

ACTCOSS has signalled cautious support for the ACT Budget for 2014-15, recognising a number of welcome measures but suggesting that there are missed opportunities for the ACT Government in supporting Canberra's most vulnerable households.

Find the *ACT 2014-15 Budget Snapshot* at the ACTCOSS website: www.actcoss.org.au



Next issue:

***Update* Issue 69, Spring 2014 edition**

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Members are welcome to contribute articles on the theme.

Copy deadline: 11 August 2014

Space is limited! To guarantee your spot, let Suzanne know as soon as possible.

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The ACT Council of Social Service Inc. (ACTCOSS) is the peak representative body for people living with low incomes or disadvantage, and not-for-profit community organisations in the Australian Capital Territory.

ACTCOSS acknowledges Canberra has been built on the land of the Ngunnawal people. We pay respects to their Elders and recognise the strength and resilience of Aboriginal and Torres Strait Islander peoples. We celebrate Aboriginal and Torres Strait Islander cultures and ongoing contributions to the ACT community.

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Update is a quarterly newsletter that provides an opportunity for issues relevant to ACTCOSS' membership to be discussed and for information to be shared. Views expressed are those of individual authors and do not necessarily reflect the policy views of ACTCOSS.