10 Keeping diversity in mind

Research tells of the serious and compounding emotional problems experienced by people with mental health issues emerging from discrimination on account of ethnicity, race, culture or sexual orientation.

This section commences with a discussion of generic principles and practice for keeping diversity in mind in recovery-oriented practice and follows with some specific guidance for working with people and communities who are:

- Aboriginal and Torres Strait Islander
- from culturally and linguistically diverse backgrounds, including refugees and asylum seekers
- of different ages, including children, young people and older people
- lesbian, gay, bisexual, transgender and intersex
- living in rural and remote communities
- experiencing socioeconomic hardship and stress
- experiencing coexisting conditions and complex needs
- involved in the criminal justice system (including youth justice).

Some generic principles and practice[5]

Biological, psychological, physical, environmental, economic, social and political factors all impact on health and wellbeing at a personal, local and global level. Practitioners and services need skills for identifying potentially adverse or isolating impacts on a recovering person, and acting to prevent or mitigate those experiences. Recovery occurs within a web of relations including the individual, family and community, and is contextualised by history, culture, privilege or oppression and the social determinants of health. Recovery also occurs within the context of gender, age and developmental stages.

Recovery approaches are alert to the impacts on health and wellbeing, both positive and adverse, of diversity—whether they are socially, culturally or language based (Ida 2007, p. 49). Culturally and socially responsive practice entails an understanding of:

- a person's cultural identity as a basis for understanding how they see self, kinship and relations with the broader community
- a person's explanatory models of illness, distress and wellness
- experiences of torture, trauma, displacement, loss, racism and discrimination
- internalisation of stereotypes of mental illness and the burden of hiding personal identity (Deegan, G 2003)
- how spirituality, community, kinship and family can support recovery processes
- the impact of the practitioner's own language, cultural beliefs and values on the therapeutic relationship
- barriers to service.

5 The report written by Rickwood for the National Mental Health Promotion and Prevention Working Party, *Pathways of recovery: 4As framework for preventing further episodes of mental illness* (2006) commenced this discussion.

Practice skills are required that enable service delivery to:

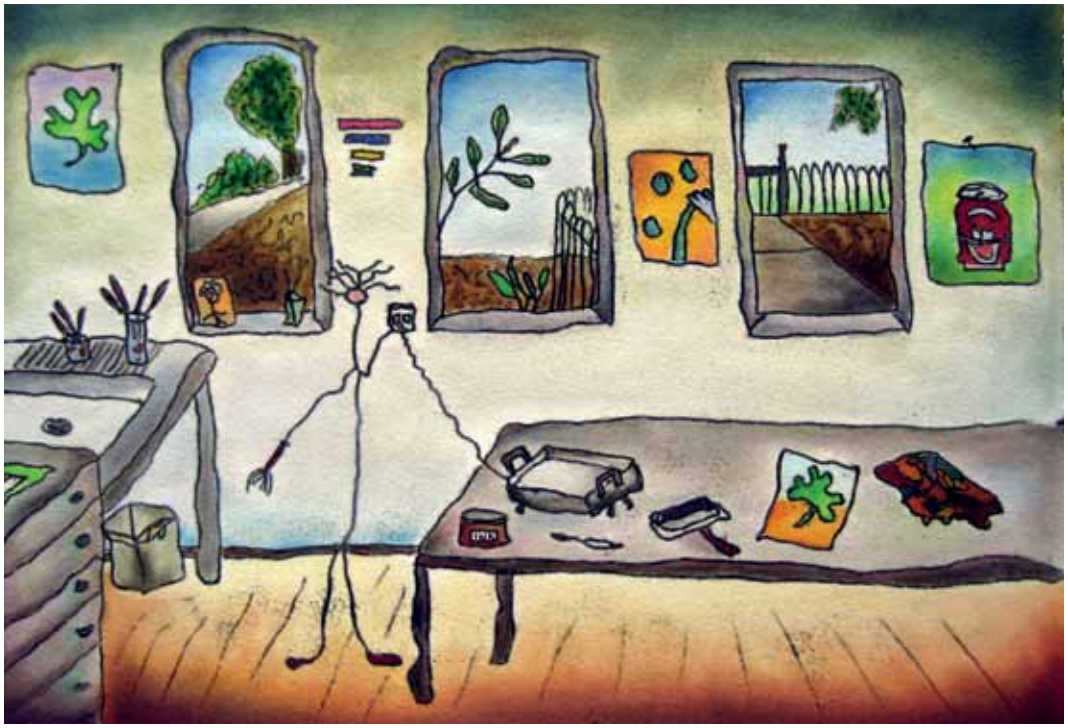
- be in an appropriate ethnic or social language using the help of interpreters, bilingual counsellors, cultural advisers, peer support workers, community-based organisations and community leaders
- accommodate both collective and individual experiences of identity and respect specific spiritual, emotional, psychological and religious traditions
- be alert and responsive to the potential impact of an inherited history and continuation of collective trauma
- be multidisciplinary, multiagency, cross-sectoral and partnership based.

Culturally and socially sensitive service delivery requires customised procedures to:

- acknowledge the importance of relationships in an individual's recovery
- work with families, close relationships, support networks, elders, interpreters and cultural advisers from different cultural traditions
- provide physical and emotional environments in which people of differing ages and developmental stages and with differing cultural and social backgrounds feel safe and supported.

Integrating primary health, mental health, drug and alcohol and community and family services will support people who are trying to recover by reclaiming culture and reconnecting with community.

> Recovery is not the same thing as being cured. Recovery is a process not an end point or a destination. Recovery is an attitude, a way of approaching the day and facing the challenges. Being in recovery means recognising limitations in order to see the limitless possibilities. Recovery means being in control. Recovery is the urge, the wrestle, and the resurrection ...
>
> Pat Deegan (1996)



There Are Many Points of View Pauline Miles ©

Aboriginal and Torres Strait Islander people

The social and emotional wellbeing concept (SEWB) developed by Aboriginal and Torres Strait Islander peoples is broader than mainstream concepts and recognises not just the physical wellbeing of the individual but the social, emotional and cultural wellbeing of the whole community. It also includes the cyclical concept of life–death–life (NAHSWP 1989).

Aboriginal and Torres Strait Islander constructs of self, identity and meaning are complex and diverse, incorporating families, kinship and extended clan groups. These constructs sit alongside an elaborate set of relational bonds and reciprocal obligations. They may also incorporate a profound sense of continuity through Aboriginal law, spirituality and Dreaming. Far from being anthropological artefacts, they directly influence daily interactions in urban, regional and remote settings.

The process of malignant grief that occurs in Aboriginal and Torres Strait Islander communities as a result of persistent intergenerational trauma and stress is invasive, collective and cumulative. It causes individuals and communities to become unable to function. Many people die of this grief (Milroy, cited in Parker 2011).

Many Stolen Generation survivors struggle their whole lives to heal from their experience of trauma. They are vulnerable to the retriggering of memories and feelings associated with their experience of forcible removal. Survivors maintain that these are human reactions not necessarily connected to mental health issues.

Implications for practice

- Learn about the diversity of Aboriginal and Torres Strait Islander experiences, cultural values and processes.
- Interpretations of health, mental health, mental illness and wellbeing are vital first steps in achieving culturally competent and safe practice.
- Support to cope with the distress invoked by triggers is part of the healing process for the Stolen Generations.
- Trauma-informed strategies can help to manage the risk of unintentionally triggering unresolved trauma.

Implications for service delivery

- Some common Western service models and responses can be inappropriate for Aboriginal and Torres Strait Islander people. For example, hospitalisation can be traumatic for some people due to their being removed from community and traditional ways of life. It can also trigger pain, trauma, loss and grief associated with invasion, colonisation, segregation, assimilation and more recent policies.
- Give priority to culturally appropriate practice and service alternatives, including Aboriginal community-controlled organisations.
- Seek advice and guidance from:
  - Aboriginal and Torres Strait Islander health and mental health practitioners
  - social–emotional wellbeing workers
  - Elders and leaders
  - cultural consultants
  - traditional healers
  - Aboriginal community-controlled health/SEWB organisations.
- Explore connections with Aboriginal and Torres Strait Islander services and local Indigenous-specific knowledge.

Resources

Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice (Purdie, Dudgeon & Walker eds. 2010).

'Guthlan' Carolyn Fyfe discusses her journey of recovery and healing.

> The art is called the 'Journey' ... The journey of recovery and healing starts from the outer circle identifying the challenges that a person would experience. The colours:
>
> Brown—the challenges to make the change in your thoughts/emotions (trying to move ahead)
>
> Black are the dark times (depression)
>
> Mauve—identified the reasons and have moved forward
>
> White—you have the control
>
> As you get closer to the centre it represents the wellness of health—socially, emotionally and spiritually.
>
> It is a long journey and you need to have people who can let you explain your story and they theirs.

Journey 'Guthlan' Carolyn Fyfe ©

People and communities experiencing socioeconomic hardship

There are well-established links between physical health, mental health and wellbeing and social and economic hardship (Wilkinson & Marmot 2003) arising from interrupted education and training, unemployment, economic displacement, poverty and income insecurity, reduced access to affordable and nutritious food, housing stress, homelessness and isolation.

Implications for practice and service delivery

- Use principles of participation, engagement, empowerment and community development to form alliances and partnerships to advocate for action on socioeconomic factors impacting on health and wellbeing.

Culturally and linguistically diverse populations

People's experiences and relationships are mediated by cultural, social and historical contexts. In some cultures, individuality and personhood are not emphasised as much as kinship and family ties. Deference to community leaders—traditional healers, priests, elders and community leaders—regarding personal decision making is a strong tradition in some communities. Other important drivers are maintaining harmony within the family, obligations to engage in acts of charity, facing adversity with acceptance, and the importance of engaging in ritual–spiritual practices. All of these factors will be at play and have an influence on a person's experience of recovery.

Implications for practice

- Be mindful of the impacts of trauma and distress arising from racism, sexism, colonisation, genocide, torture, sexual and physical assault, poverty and natural disaster as well as the stigma and shame associated with having mental health issues. These impacts frequently last for generations.
- Specific skills are required for working with families, elders, interpreters and cultural advisers and being aware of cultural differences in verbal and non-verbal communication.

Implications for service delivery

- Service environments should make people feel safe. They should support healing and recovery.
- General practitioners are often the first, and sometimes the only, point of contact for some immigrants and refugees, because the stigma and shame they feel about mental illness may prevent them from using specialist mental health services. Recovery-oriented mental health services can support general practitioners in their role.
- Ida (2007) emphasises the importance of integrating primary health, mental health and drug and alcohol services while simultaneously helping people to reclaim their culture and community as part of their recovery.

Lesbian, gay, bisexual, transgender and intersex people

Many lesbian, gay, bisexual, transgender and intersex people are adversely affected by multilayered discrimination, marginalisation and stigma. Risk factors for their mental health include violence, bullying or rejection and discrimination from school, family, friends, and workplaces and from society more generally. Risk factors for intersex people can also include rejection and harassment, being forced to conform to gender norms, or pain and scarring from childhood genital surgeries or forced hormone use (Haas et al. 2011).

Lesbian, gay, bisexual, transgender and intersex people are helped in their recovery by their families, by educational institutions and workplaces, by their friends and partners, and by mainstream services and community-specific support and community groups. Mental health services that are culturally competent can also be instrumental in assisting recovery (National LGBTI Health Alliance 2012).

In demonstrating considerable resilience lesbian, gay, bisexual, transgender and intersex people share a similar narrative with people who have experienced mental health issues, particularly in how they have overcome self-stigma arising from identity issues, loss of self-esteem and discrimination.

Implications for practice

- The recovery concepts of self-determination, self-management, personal growth, empowerment, choice and meaningful social engagement are consistent with affirmative practice and with the processes of coming out.

Implications for service delivery

- It is important to ensure that lesbian, gay, bisexual, transgender and intersex people do not feel marginalised within mainstream service delivery—either from service providers or from other consumers. It is essential that peer support programs are inclusive and safe, and welcome all to participate.

Resources

Supporting LGBT lives: a study of the mental health and well-being of lesbian, gay, bisexual and transgender people (Maycock 2009).

Gender

People's life experiences and circumstances are shaped by socially constructed roles, responsibilities, identities and expectations assigned to men and to women within and across cultures (Women's Centre for Health Matters 2009, p. 2). Systemic disadvantage and barriers to health care can arise from gender roles, stereotyping and discrimination.

Implications for practice and service delivery

- Be sensitive to gender and impacts of gender constructs.
- Be alert to systemic disadvantage and barriers to services arising from gender roles, stereotyping and discrimination.

Infants, children and families

Early relationships and the early years of development (prenatal and the first three years) are critical determinants of a child's capacity for resilience, learning, health and wellbeing throughout life. The mental health and wellbeing of infants and children is closely connected to stages of growth and development—cognition, emotional regulation, language, play and social relationships (Centre for Community Child Health 2012).

Implications for practice

- Parenting competence is an important concept in recovery processes. Research indicates that the routine addition of parenting support has the potential to greatly enhance recovery-focused practice (Reupert & Maybery 2010).
- Siblings, extended family members and kin of all ages can contribute to the child's recovery process.

Implications for service delivery

- Recovery-oriented approaches with infants and children draw on perspectives of growth, health and wellbeing related to development, resilience and family systems.
- Recovery-oriented practice and service delivery with infants and children occur in collaboration and partnership with a wide range of services.[6]
- Support programs for children, siblings and parents in families experiencing mental health issues, while assisting recovery, also offer important prevention and early intervention strategies for enhancing the wellbeing of individuals and families.

Resources

Underlying principles for the right of children and young people to be nurtured by their parents and family are outlined under Principle 5 of the *Charter on the rights of children and young people in healthcare services in Australia* (Children's Healthcare Australasia 2010).

> ... parenting functioning is intimately related to the recovery process and functioning in other major life domains ... Nicholson (2010) found that children often give parents the strength and will to 'keep going' thereby promoting hope (a key element of recovery). Additionally, 'being a parent' and effectively assuming the parenting role, provides parents with meaning and purpose (another element of recovery). Parenting may also contribute positively to parents' lives in the community by providing opportunities for meaningful interactions and activities with others. Thus, identifying and supporting an individual's parenting role can provide hope, a sense of agency, self-determination and meaning, all consistent with a recovery approach.
>
> Reupert & Maybery (2010)

Adolescents, young people and emerging adults

Recovery approaches with adolescents and young people are focused on prevention, early intervention, building resilience and enhancing wellbeing. They also support transition through developmental phases and where necessary, a return to expected developmental trajectories.

Young people risk identifying strongly with an illness identity at a time when they are discovering and shaping their sense of self. How and where young people seek help for mental health issues—and the services they are prepared to use—changes as they mature (Rickwood D, 2006). The transition to adult mental health services can be stressful.

6 General practitioners, prenatal and perinatal, women's health, paediatricians, community child and infant health nurses, speech therapists, early parenting and family support, men's health, support and mentoring programs, drug and alcohol services, housing, disability services, migrant resource centres, employment services, neighbourhood centres, recreational, sporting and fitness clubs, cultural associations and groups, playgroups, preschools and day care centres, schools and relevant government-based services.

Implications for practice

- Support young people to:
  - maximise learning opportunities as they increasingly assume control over decision making
  - connect with their inherent resilience, capacities and possibilities for the future
  - transition through developmental phases and, where necessary, to return to expected developmental trajectories.
- Encourage young people in:
  - positive health behaviours that promote mental health
  - early help-seeking behaviour.

Implications for service delivery

- Services should comprise a comprehensive mix of clinical and support services linked with services for younger age groups and spanning across adolescence and emerging adulthood.[7] A primary focus is on family and peer relationships and education and vocational needs.
- An integrated approach across mental health and allied service systems[8] is required to provide flexible and individually tailored connections between child, adolescent, and adult-focused services, both hospital-based and in the community.
- Service responses are coordinated with other youth agencies and other specialist mental health services to ensure continuity of care across the service system and during developmental transition points. A 'no wrong door' approach is emphasised and maintained. Headspace and early psychosis prevention and intervention services are recent service developments that are based on these principles.
- Mechanisms for joint planning, developing and coordinating services include young people in ways that match their developing maturity.

Older people

Older people may have a persistent or recurring mental illness, may have experienced a more recent issue as the result of bereavement, physical illness or injury (Daley et al. 2012), or be suffering from dementia or other degenerative neurological conditions. Social isolation becomes particularly acute as a person ages.

Older people have particular developmental needs, including the need to look back on life and feel a sense of fulfilment, increased interdependence between their personal and close relationships, and changing patterns of worry as people worry less about self, more about others and more about health care (McKay et al. 2012).

For older adults who have experienced a lifetime of mental health issues, the notion of recovery—its underpinning concepts, expectations and practice emphasis—can be alarming or challenging. Many deeply fear admission to an aged care facility, viewing this as 'reinstitutionalisation' (McKay et al. 2012).

7 Services provided include vocational counselling, illness management skills, training in stigma countering and disclosure strategies and context-specific social, personal and relationship skills (Rickwood D, 2006; Lloyd & Waghorn 2007). Also important are approaches that focus on physical activity as a vehicle to addressing emotional and psychological issues: sport, fitness, exercise, adventure training, art, dance, drama, music and other performing arts and recreational activities. These approaches might be provided through partnerships with community organisations, clubs and groups.

8 Primary health, mental health, alcohol and drug services, education, employment and training, parental support, recreation, physical activity, art and performing arts and community support services.

Implications for practice

- Early engagement is important so that practitioners and services understand a person's values, expectations, preferences and life choices and can act according to their wishes at times when their capacity for decision making is impaired.

Implications for service delivery

- Older people need support to connect with each other as well as with others in the community. Other priorities include:
  - establishing partnerships among mental health services, general practitioners, community nursing, aged care services, accommodation and residential facilities, disability support, Home and Community Care and other community support services
  - supporting aged care facilities and services to become more responsive and relevant to the needs of people with mental health issues
  - supporting spouses or partners, family members and close friends who may be elderly and frail themselves
  - providing opportunities for recreation, physical activity and fitness
  - responding to the increasing cultural and linguistic diversity of Australia's older population (Daley et al. 2012; McKay et al. 2012).
- Services should develop tailored recovery-oriented approaches for older people who:
  - have Aboriginal and Torres Strait Islander background
  - are living in boarding houses or unstable housing
  - are living in rural and remote communities
  - are in or are exiting prison.

Rural and remote communities

Service delivery in rural and remote communities is challenged by issues related to distance, isolation and fewer formal services, higher levels of stigma associated with mental health issues and stoicism that influences people's help-seeking behaviours (Rickwood D, 2006).

Implications for service delivery

- Services should foster partnerships that increase local access to primary health care, specialist physical health care, allied health care, psychosocial rehabilitation and recovery support.
- Non-health services, community groups, local leaders and naturally occurring support networks are vital recovery partners in rural and remote communities, as are schools, churches, the police, local businesses and clubs. Servicing more remote communities with fewer formal services will require broader collaboration.
- Tailored responses will be required to particular groups in rural and remote communities, including:
  - older people, many of whom experience high levels of disadvantage
  - Aboriginal and Torres Strait Islander people (whose populations are frequently younger than the Australian average)
  - fly-in/fly-out workers and communities, many of whom experience high levels of isolation
  - people from immigrant and refugee backgrounds who may feel isolated due to absent family or a lack of ethnospecific community networks.

- Services should give priority to:
  - increasing awareness, understanding and acceptance of mental illness, increasing help-seeking behaviours and supporting communities to develop their capacity to assist people with mental health issues and their families
  - using information and communications technologies to overcome issues of distance, isolation, lack of services, lack of peer support and limited opportunities for professional support and development
  - facilitating affordable options for those wishing to access mental health care away from their local communities.

People with coexisting conditions and complex care needs

Experiencing coexisting conditions is normal for people, not exceptional (Graham & White 2011). Rates of mental illness are high for people with intellectual disability, autism spectrum disorders, alcohol and drug use, physical disability, brain injury, problematic gambling, and those who are experiencing homelessness. Multiple physical health problems are also commonly present.[9] Yet many people with high and complex needs remain undiagnosed and not effectively connected to mental health services. General practitioners and community health centres play a key role in recovery for people with coexisting conditions by offering medical advice and help for physical and mental health needs (including substance use).

The experience of coexisting conditions frequently goes hand in hand with socioeconomic hardships, isolation and a lack of personal, family and social support at key transition points.

Implications for practice

- Share information with people and their families and friends about self-help and peer support groups that are relevant to their needs and circumstances.
- In the absence of family or other natural supports for advocacy, psychiatric advance directives can assist people with complex needs to have some control over what happens to them when they become unwell.
- Form close relationships and share information with other practitioners and services to respond to events and ensure that people's recovery goals coalesce and complement each other to form an integrated support and wellbeing plan.
- Assist people to gain maximum benefit from the services and programs they offer.
- Support people to reconnect with family and close friends as well as to build new personal relationships and support networks (Graham & White 2011).

Implications for service delivery

- Services should be responsive irrespective of a person's entry point and should not prioritise the needs arising from one condition over another.
- Responses should be multidisciplinary and include primary health care and specialist health services.
- Understanding of recovery paradigms used in other fields—for example, in the alcohol and drug sector (Best 2012)—need to be incorporated into jurisdictional-wide and local guidelines for working with people and families with coexisting conditions.
- Services should take the lead in challenging stigma, myths and stereotypes and low expectations about particular groups with coexisting conditions.

9 The experience of coexisting conditions commonly involves multiple health problems, especially physical health issues—heart disease, diabetes, hepatitis C, liver issues, oral health, skin conditions, effects of poor nutrition and effects of musculoskeletal and orthopaedic conditions.

... I'm born with an ABI mild Brain Damage and profound disability... plus I'm borderline Autistic too ... Bugger ... Ya! ... Where there's a will there's a way ... that's what I keep saying to myself ... I've done a lot of things on my own with little to no help. I've been going to workshops and conferences on my own to help me in my hidden Intellectual Disability World that I was born into ... being labelled both ways doesn't help but its who I am and I am tapping into funding when I can YA! I just do the best I can each day ... I am growing.

Participant in the framework consultations

People with unresolved trauma issues

- The possibility of trauma in the lives of people accessing services should be a central organising principle of care, practice and service provision. Many people who have experienced trauma have adopted extreme coping strategies in order to manage the impacts of overwhelming traumatic stress, including suicidality, substance use and addictions, self-harming behaviours such as cutting and burning, dissociation, and re-enactments such as abusive relationships. Although awareness and treatment of trauma may be pivotal to the process of recovery, in many mental health settings trauma is seldom fully identified or addressed.

Implications for practice and service delivery

A trauma-informed recovery-oriented service:

- commits to and acts upon the core organising principles of safety, trustworthiness, choice, collaboration and empowerment
- considers and evaluates all parts of the system in the light of a basic understanding of the role that violence and abuse play in the lives of people seeking mental health and drug and alcohol services
- applies this understanding to the design of service systems that accommodate the vulnerabilities of trauma survivors, that deliver services in a way that avoids retraumatising people and facilitates people's participation in their treatment
- trains staff in trauma-informed care and practice
- develops collaborative relationships with practitioners experienced in traumatology wherever possible (Fallot & Harris 2009).

Trauma survivors still experience stigma and discrimination and unempathetic systems of care. Clinicians and mental health workers need to be well informed about current understanding of trauma and trauma-informed interventions.

Professor Louise Newman in *Practice guidelines for treatment of complex trauma and trauma informed care and service delivery* (Kezelman & Stavropoulos 2012).

People in the criminal justice and youth justice systems

Many mental health services working within Australian criminal justice, youth justice and forensic systems have in recent times implemented recovery-oriented approaches. They face many challenges operating in environments that limit liberty and autonomy and enforce obligations for legal accountability and treatment compliance.

Providing services in settings controlled by other authorities

Mental health services operating in courts, correctional facilities, community correctional settings, juvenile justice facilities and community-based programs and probation and parole programs do not have administrative control over the settings and programs in which they operate. The recovery aspirations, goals and plans of a person in the criminal justice, youth justice and forensic settings can be contrary to the responsibilities of the mental health service to maintain security and manage risk. Implementing recovery-oriented approaches in these settings involves considerable and persistent cross-agency negotiation and collaboration as well as open and transparent communication with the people who are in their services.

Understanding and navigating complex layers of coercion

People in facility- or community-based institutional settings are frequently not motivated to engage in treatment because their mental health assessment, treatment or placement was ordered by courts or correctional authorities. People deprived of their liberty frequently view such orders as double jeopardy and fear that forensic patient status might delay their return to the community. Complex layers of coercion within these settings, and the obligation of practitioners to satisfy certain requirements (such as reporting) affect a person's willingness to accept a therapeutic relationship or mental health services. Transparency and open discussion of legal responsibilities are critical while practitioners actively seek opportunities to support people's exercise of choice, self-management of risk and access to opportunities for learning, growth and development.

Strengths-based practice models are useful in embedding recovery practice in institutional settings. Wellness recovery action plans or similar recovery tools are also helpful.

Working with people who have experienced considerable adversity

Recovery-oriented practice and service delivery acknowledges that many people in criminal justice, youth justice and forensic settings have experienced considerable social disadvantage and childhood adversity and trauma. Many have been in some form of care for significant periods. Their health is often poorer than other people with mental health issues. They may suffer from intellectual disability, acquired brain injury, alcohol and drug use and physical disabilities. Their involvement in the criminal justice system may compound an already poor sense of self-worth and efficacy. Responses need to be multidisciplinary, multiagency, cross-sectoral, and collaborative. Services need to reach out to the community and provide opportunities for community services to reach in.

Recovery approaches in criminal justice settings employ rehabilitation and throughcare[10] models that support progressive recovery and focus on life skills, meaningful activity, education and vocational training and increased reconnection with the community (Simpson & Penney 2011). People are supported to reclaim control to the extent possible in the circumstances (Kaliski & de Clercq 2012). Follow-up is particularly important to ensure that recovery gains are not lost when a person returns to the general prison population upon discharge from forensic mental health facilities.

Incarceration adds to the isolation experienced by those who have already faced prolonged disconnection from their families (Dorkins & Adshead 2011). Recovery approaches support reconnection and the building of healthy relationships with family and friends.

Supporting people to reclaim meaning

Recovery-oriented practice supports people in custodial settings to reclaim meaning and to build new identities. This includes:

- incorporating aspects of their former lives and acknowledging the events that led to their incarceration
- understanding the impact of their actions on their own lives and on the lives of others (Dorkins & Adshead 2011)
- managing their personal potential for risk.

In supporting people to rebuild their identity, recovery approaches create opportunities for peer support (Simpson & Penney 2011). The sharing of personal stories promotes hope and helps to reduce shame and isolation.

Supporting the recovery of people who are detained for long periods

Some people will reside in maximum-security facilities for long periods, some indefinitely. Recovery-oriented practice and service delivery in criminal justice and forensic settings offers a means of optimising the lives of these people (Kaliski & de Clercq 2012). Practitioners seek to engage them in optimistic and hopeful discussion about their mental health issues, and their views on treatment and support. They seek to increase people's self-esteem and create opportunities for building life skills, by enabling a better use of time, and by offering hope for eventual return to the community, a place to call home, autonomy, skills, a job, family and friends.

10 Throughcare is the coordinated, integrated and collaborative delivery of programs and services to offenders to reduce the risks of reoffending and enable successful integration into the community. Services are provided both during incarceration and after release (NSW Department of Corrective Services 2008; ACT Corrective Services 2010; Borzycki & Baldry 2003).