# T R A N S C R I P T

# LEGISLATIVE COUNCIL LEGAL AND SOCIAL ISSUES COMMITTEE

## Inquiry into Victoria's Criminal Justice System

Melbourne—Monday, 6 September 2021

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**WITNESS** *(via videoconference)*

Ms Charlotte Jones, General Manager, Mental Health Legal Centre.

**The CHAIR**: Hello, everyone. Welcome back. We are very pleased to be joined by Charlotte Jones, who is the General Manager of the Mental Health Legal Centre. Charlotte, thank you so much for joining us. I am joined today by Ms Kaushaliya Vaghela, Ms Sheena Watt and Ms Tania Maxwell.

If I could let you know that all evidence taken today is protected by parliamentary privilege as provided by the *Constitution Act* but also the standing orders of the Legislative Council. Therefore anything that you say here today is protected by law. You are protected from any actions for what you say during this hearing; however, if you were to repeat those statements outside this hearing, you would not have the same protection. Any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament.

Thank you again for joining us. We have got Hansard in the background. They will be providing you with a transcript after this and I would just encourage you to have a look at it to make sure that we have not misheard you or misrepresented anything that you are telling us today.

We would like to hand it over to you for some opening remarks and then we will open it up for committee discussion. Thanks very much.

**Ms JONES**: Thank you. Firstly, I would like to start by acknowledging the traditional owners of the land on which we meet. I am sure a full introduction was done at the beginning.

I work at the Mental Health Legal Centre where we work in three distinct areas: people who are subject to compulsory treatment, people who are homeless or at risk of homelessness through our Health Justice partnership in the community with the Bolton Clarke Homeless Persons program and people who are incarcerated through our Inside Access project delivering supports to people in the Dame Phyllis Frost Centre and the Ravenhall Correctional Centre.

MHLC is uniquely placed to observe how people enter into the criminal justice system and the direct impacts and effects of their incarceration. We are primarily focused on resolving civil law matters but responding to our clients flexibly and a willingness to address the multiplicity of their needs. Our clients often sit at the intersections of mental health, poverty and legal issues, experiencing complex, multiple and compounding factors of disadvantage, and given the very vulnerable Victorians we work with, their capacity and ability to navigate these systems and manage legal matters to resolution varies considerably. The large majority of matters we deal with do not qualify for legal aid. Our clients need a lawyer. MHLC managed over 1000 criminal cases last year through the day service. This does not include the legal advice and information for families, carers, services and consumers who needed help and support on minor criminal matters. We receive around 1000 phone calls a month, and wherever we can, we provide legal assistance, information, advice, referrals, casework and representation. We rely on philanthropy to underpin MHLC, to enable us to respond to client-centred management and seek diversions and undertakings to prevent incarceration.

The legal system was not designed with our clients in mind; they are often referred to tools they cannot use. Our clients require support to self-advocate or self-help, alongside services that are open. For our clients, accessing a duty lawyer on the day of a hearing is immensely stressful and often impractical. Duty lawyers are invariably overwhelmed, and our clients are often told they are not able to help. Living at the intersections of disadvantage, our clients are more likely to commit poverty-related offences—minor shoplifting, travel infringements. These accumulate and spiral. For clients experiencing deteriorating mental health and distress, there is the increased likelihood of a criminal damage charge. These offences carry prison sentences, and the impact on a client being threatened with prison when they are unwell or just beginning their recovery can result in devastating consequences.

Our HJP was developed six years ago. It was a direct response to the community nurses identifying that legal problems were causing their clients significant impact on their health and wellbeing and that legal assistance was hard to find. Since November 2015 this HJP has managed more than 1000 legal problems. About 20 per cent of these are criminal. Not one client who has been represented by Lucy, our health justice partnership lawyer, has been returned to prison. So why does it work? The consistency of the legal practitioner, the easy

and direct contact, the trust relationship with the medical team, the ability to obtain supporting documents and the work of the team in seeking stable accommodation—when all these factors come together, futures are changed. The most common criminal legal issues for HJP clients are escalated civil law matters, intervention order breaches, shoplifting, minor theft, assault, drug possession and property damage.

The use of reports and information at court is essential. MHLC ensures that we gather all the evidence available, all of the resources we have, because we have a dedicated lawyer who has got direct access to many members of the medical team. As such, we have a complete picture. We understand what the acquired brain injury looks like and their intellectual capacity, alongside their mental health issues with the impacts of drugs, alcohol and medication.

Intervention orders, to the MHLC, are a blunt tool that does not address the complex problem it is trying to deal with, and this is a systemwide failure. Intervention orders are not tailored enough. The use of caveats to access children, during which communication is not allowed, is fraught. These matters are complex, but they lead to breaches. And these breaches lead to jail, further frustrating any contact, and the cycle continues. At least 90 per cent of our HJP clients told us without the HJP providing easy access to a lawyer, they would not have sought any help. When legal matters escalate, they impact on health, wellbeing, safety and security and capacity to stabilise recovery.

About 12 years ago MHLC recognised there was a problem with the prisons. This led to the creation of Inside Access. Inside Access has taken on 3640 client matters since 2015. We evaluate our services particularly through our clients' experiences of them. As one client said, 'Without Inside Access, I'd not have had the courage to keep going'. We have mixed skills of lawyers in the prisons. At DPFC, for instance, we have generalist lawyers, supported by a child protection lawyer, a family violence and a victims-of-crime lawyer, along with support to manage the fines. In Ravenhall we have a generalist lawyer and a fines clinic, but we also run a specialist NDIS clinic, ensuring support is given to men during and exiting prison to ensure adequate NDIS packages are in place. This includes men on remand and, like all of our services, was designed in response to identified client needs. Many clients have identified as needing an NDIS plan during sentencing in their criminal matter. Through these reports, which are available on court records, we start a journey to gather evidence.

In both prisons we run extensive community legal education programs, resolving civil legal matters—tenancy, debt, fines, access to children—helping people to return to the community with more opportunity to stabilise and connect with services and supports. Inside Access reduces the risk of recidivism. MHLC is extremely fortunate. To deliver this work we are supported by both the Department of Justice and Community Safety through DPFC and GEO at Ravenhall. We do still, however, work with men and women frequently after their release through our social work and legal teams. The most well attended program by men in the prison is the intervention order education session. We think there are two reasons for this. Many of the men do not understand their orders, simply because the orders are confusing and complicated, and it is compounded by a cultural bias to agree when they are served. Many incarcerated men have acquired brain injuries, intellectual disability, limited education and struggle to comprehend.

We also know that debt, fines, housing and child contact issues are overwhelming, and this is specifically for the women. They are all at play in impacting the clients. From 2018 to 2020 we dealt with $3 million in fines in DPFC alone and $2.1 million in Ravenhall. Our financial counselling team in the women's prison works with remand only and is currently working to save three homes from the banks. For the women in particular we see different drivers, and the vast majority of our clients in DPFC have children. The situation is often sadly the same: a home where the history of family violence was strong, the response was to remove the children, often despite mum and dad's best efforts to protect them. The spiral now really starts: the drugs come, then comes the crime and the next stop is prison.

Remand means limited access to full programs and services, so many of the women have served their sentences before they even start. As such, they leave unsupported and destabilised. Changes to the bail laws had a big impact, along with the responses to family violence. We need greater access to CISP and the ARC list, and more opportunities regionally would have an impact on the number of people remanded. Adequate, stable housing is a huge factor. Again, the impacts of family violence are relevant here. When people are leaving prison, one of the most effective things we started to do was to get their cars out of the impound, because this becomes their home. If community circumstances continue to worsen whilst they are incarcerated, then on

release there is an increased likelihood of return. They go back to their old friends, self-medicating with alcohol and drugs. Suitable housing is essential. We know clients seek supports, but there is often a complex referral roundabout. As people exit prison there is an opportunity to make changes and see impacts, and we found with clients who have been supported and where this has worked but these supports have to be thoughtful. The attempts to keep families together must be a priority. People do not fit in boxes, and we need more inventive responses to family violence.

For the younger people, one of the most common issues is drug use, masking serious underlying mental health issues. We need to review how this is addressed by the system. We recognise the courts have an overwhelming task, and we recognise that orders are often made with no other party present. Undoing those then is immensely complex, time consuming and difficult. Judges and magistrates need more options. It is so clear that many in the judiciary have a deep understanding of the complexity of the people that appear before them, but they need more available options: intensive case management supports alongside consistent legal representatives. We need to be able to ensure that clients have equal access, metro and regional, to the programs, supports and housing.

When we look at issues such as family violence and the need for change, we also need a rational response to how we work with people in communities who have little or no understanding of why behaviours are wrong. Programs such as Strengthening Families, Strengthening Communities by the Race Equality Foundation in the UK may well work to support child protection matters and in turn family violence matters. Drug diversion courses could be run through the police rather than the courts. The CARA project in UK was an example of a diversion course for first-time domestic violence offences with strong evaluation outcomes. These are just some examples.

As you are all aware, sentenced and remand populations are increasing in a way that is too expensive for the system and too costly for the community. Prisons as warehouses for people experiencing social disadvantage, poverty, mental illness and addiction do not work. Communities are safer if we invest in community-based responses to community challenges, increasing the health and wellbeing of the community and its members. We believe there is a need to divert clients, including mental health clients, away from the courts and use community treatments, programs and supports, which will work for them and our communities as a whole.

**The CHAIR**: Thank you, Charlotte. You managed to get a lot in there in a limited period, so well done. I am trying to focus. There was so much to look at there, and I think given the disturbing number of people with mental ill health who are being incarcerated and going through the justice system, you are dealing with quite a wave of people. But you just mentioned the intervention orders and you mentioned that they were a blunt instrument and they were rarely understood by your clients. I wondered if you could make some suggestions or recommendations to us about how we could improve the intervention order process, particularly for your clients.

**Ms JONES**: I think one of the biggest problems is that intervention orders are often made without anybody being present, so there is no understanding of the person they are being made against. That is immensely complicated because they are often brought forward in urgent circumstances. They are often sought by the police. But we have had occasions where intervention orders have been sought by the police where neither party wanted them, and the intervention order has actually been in existence where both people live in the same house. So then we have removed one of the parties to prison, despite the fact that actually the problem had self-resolved. They were working forwards and moving forwards. So I think in those more nuanced responses we need better processes within the courts. When people are actually referred to services you could say, 'Okay, is this what you want? Is this what you need? Is this going to help? If not, what is?'.

**The CHAIR**: Are you saying that an intervention order should actually trigger other activities?

**Ms JONES**: Yes. At a very basic level, and if nothing else, it must be explained to the person it applies to, because they breach not understanding how they breach. There is actually so little understanding. I think it is something like 50 per cent of the remand population in Ravenhall—Ravenhall is a 1300-bed prison, so we are talking about 300 men here who are there for breaches of intervention orders.

**The CHAIR**: Yes. Thank you, Charlotte. I will keep going. I am conscious of time. I will go to Kaushaliya then Tania then Sheena.

**Ms VAGHELA**: Thanks, Chair. Thanks, Charlotte, for your time today and the work you do at the legal centre. I understand you have experience working at a prominent UK law firm. Can you please reflect on some similarities or differences between that jurisdiction and the Victorian jurisdiction? What could the Victorian criminal justice system learn from the UK or other jurisdictions in your view?

**Ms JONES**: I think one of the most important things that I saw as I was leaving—and it is a long time ago now; it is close to 10 years since I have really actively practised in the UK—was the way in which the case management approaches were being undertaken and developed at places like St Mungo's was really different. We had big, wraparound supports where you would have psychologists who would be working with people with mental illness and how we address those services within the mental health community so that people were being picked up and supported. There was a great deal of difference in how people were treated within the mental health system in particular. It was notable that I would frequently be rung by doctors and asked to come in and support clients and give help in maintaining their housing, sorting out intervention orders, figuring out exactly what had gone wrong and then working to see how we could move that forward. And also probably the biggest difference is people leave our system with a plan, and that plan involves everybody coming together and agreeing who is responsible for what. It is very detailed and it is very organised. And because everybody has to own their bit of the plan, it means that they are accountable for it. So what often happens is people might say, 'Well, my service is designed to do this'. But nobody has got it written down somewhere, saying, 'You have to do this. That's what you promised at that meeting and that's what you'll follow through with'. So it is those kinds of events that I think are really important and really different and the things that I would really like to see.

The other big difference that I see is the lack of Medicare in the prisons. The fact that somebody can go in with their medication and then not be given it is horrifying to me. Just the idea that your medications are removed is unconscionable, and the fact that Medicare does not follow you in is a huge issue and a huge concern. I know most people do not actually realise that happens, but it is a real problem. Because medications are seen as trade in the prisons—they can be traded—it becomes really, really difficult to access. There are really frightening stories of people who have had major and extensive surgery being told, 'It's okay. You can have one Panadol' or 'We can't give you those drugs because you have a history of drug use'. So it is really, really important that we address those kinds of things, because when we brutalise people in the system it is very hard for them to come out and say, 'Okay, I trust you now. Now you're here to help me'.

**Ms VAGHELA**: Charlotte, now that we have got only women members left in this inquiry, why don't we focus a little bit more on your women clients. What percentage of your clients are women? How do you service them? Are their needs different and what are their reasons? Are they different to the men's reasons for needing help—all those sorts of things? I just would like to know more on the differences.

**Ms JONES**: Well, of our clients, we see 500 women per annum in the Dame Phyllis Frost Centre. We also follow them through to Tarrengower, so they make up a considerable amount of our major client base. We see less men in the prison system than we do women. So we actually see 50 per cent more women, roughly. We also make sure that those women are dealt with in a very specific way. Ninety per cent of women before they enter the criminal justice system identify as having had a mental health issue in the 12 months prior.

The biggest difference we see for women in the criminal justice system is the impacts of not seeing their children and the impacts of child protection matters; hence why we have a specialist child protection lawyer who works with the women. One of the biggest factors is that although children may be removed, there is often a place in the final orders that were made that the women can still talk to their children, and one of the things that we actively seek to do is to ensure that contact is made. So we also use our social work team to facilitate that. Lawyers are a bit of a blunt tool when it comes to negotiating with families and different families, I have often found. We talk a lot about rights and doing rather than 'Wouldn't it be useful if we'—using those kinds of systems in that way.

The other thing that we do, which I think is really important with the women, is in the mental health system we look at where they are located with men, because obviously we have issues around women being incredibly vulnerable, particularly when mentally unwell and particularly within the hospital system. It is also linked to them leaving the hospital system and then the police are sent to bring them back to the hospital system. So we have a level of complexity around women and mental illness that is harder to unpick. We have a level of complexity around women in prison that is centred around their children and family violence. They come from

such embedded histories of trauma—they are really complex—and normally around 85 per cent of them are also victims of crime, which is a horrifying statistic.

**The CHAIR**: It is.

**Ms VAGHELA**: Thank you. I will come back if time allows.

**The CHAIR**: Thank you. Tania.

**Ms MAXWELL**: Thank you, Chair. Charlotte, thank you so much. You spoke of the need for a detailed plan. I think all of us here would be very surprised that that is not just something that happens. That astounds me, as does the Medicare not following prisoners. I think we are probably learning a great deal from you today in this short time. But I am really concerned and wondering if you can enlighten us: there have been some serious incidents where residents of Thomas Embling have been released unsupervised in the community and have gone on to reoffend, some committing absolutely abhorrent, serious offences, such as murder and rape. Can you provide us with an overview of the process at Thomas Embling which enables those residents to reintegrate into the community with or without supervision? And what role does the justice system in Victoria play in enabling that safe reintegration into the community?

**Ms JONES**: Well, I can give you some overview, although I have not done a lot of cases in the Thomas Embling, I will admit. I do have a client there at present, and that I cannot speak to.

**Ms MAXWELL**: And I would probably assume that, Charlotte, given that your introduction just talks about in-treatment facilities in prisons.

**Ms JONES**: Yes. So I have had clients who previously have been in Thomas Embling who have been released without any supervision orders or security orders in place because their criminal sentence had expired and they were not held under any security orders, so they were just treated as mental health patients within the Embling and then were able to leave. So it is which process you have entered Thomas Embling under as to how you are then exiting that system. I think Thomas Embling is an immensely complex environment. There are levels of wards within Thomas Embling that people traverse through, and those systems are immensely complex. People are placed in different categories within the system and then they move through them in a very different continuum of care and treatment.

Now, Forensicare, which runs Thomas Embling, also operates within Ravenhall prison, so we have a lot of Forensicare staff and treatments working within Ravenhall, and they deal with those prisoners there too. And again they are often released without any treatment orders because you can only be treated on a treatment order in the prison system if you are held in Thomas Embling, so you can only be forcibly medicated in Thomas Embling. So if you are held in Ravenhall and you do not like your medication that they try and give you because it is different to the medication you had outside of the prison which worked really well for you, they cannot do anything unless they can get an order to transfer you into the Embling and then forcibly medicate you. So the system has got these design flaws in it that just do not work around how people are treated.

So when we are in the Embling and then people are coming out and they are not on orders, it will be because they entered as a prisoner, and when they are leaving the only thing that could then happen is that the Thomas Embling would apply to the local community to then get a community treatment order, but they have to transfer out of the Embling to the community treatment team, and then it becomes their responsibility. It is only if you have got a supervision order, which means that you entered under the different process at the Embling and you are a security patient within the Embling. Does that make sense? It is a really strange legal concept to explain.

**The CHAIR**: You have explained it well. I do not think it makes sense, but you have explained it well.

**Ms MAXWELL**: It is very complex; we know that.

**Ms JONES**: I also think there is a lot of information that comes out of the Thomas Embling, and the situation in that environment for the people who work in it is incredibly difficult. I was heartened to see the royal commission say that they would expand the bedding and the number of beds, and I am hoping that will also encourage a better, safer working environment up at the Embling, because the number of staff assaults up

there is very high. It is a very complex and very difficult environment, and I think recruiting and training staff there is equally as complex.

**The CHAIR**: Of course. Sheena.

**Ms WATT**: Thank you. And thank you, Charlotte, for your presentation today. I took a bunch of notes, but I just wanted a couple of things clarified from your opening remarks, if that is all right, before I jump into a question. One, you talked about the health justice partnership with Bolton Clarke. Now, is that limited to people at risk or currently experiencing homelessness, your health justice partnership?

**Ms JONES**: Yes. It is one lawyer. It is a complex funding model at present. It will no longer be funded come December, having dealt with over a thousand legal matters, but it is very targeted at the community that we want to work with. There are 52 nurses, and they have however many hundreds of clients they see every year. So they just ring Lucy and say, 'This is the problem the person has. Here's the phone'. That is how simply it works.

**Ms WATT**: All right. There you go. That is something to note. Also you spoke earlier about people agreeing to conditions that were laid on them culturally not understanding about pushing back. Can you go into that a little bit more? Because I was really interested in it and I think there are some additional layers when it comes to people from culturally and linguistically diverse communities as well as Aboriginal and Torres Strait Islander communities and then if that is additionally layered with people experiencing mental health challenges, that piece in particular I am interested in—and where that plays out.

**Ms JONES**: So in particular where we see that—about 30 per cent of our clients in Ravenhall have an Aboriginal or Torres Strait Islander background, and often when they are served with papers, particularly relating to intervention orders, it will be said to them 'Do you understand this?' and they will automatically say yes. They will not say no. It is ingrained that they say yes despite the fact they cannot read. It has not been read to them, it has not been explained, they have no idea what it says, but they have been taught 'Just say yes, because then this will go away. Just say yes'.

**Ms WATT**: Okay. That is so challenging to me, and I have probably got a lot that I want to get into with that, understanding that is also layered by, you know, cultural expectations around speaking up to authority and others that are experienced by many of those Aboriginal communities as well. Okay, so that is around intervention orders. Is there anywhere else where that sort of plays out with communities, that agreeing despite not having knowledge, particularly if you are talking about people with some mental health challenges?

**Ms JONES**: Well, I think the other thing is that coercion and coercive control is pretty common throughout the mental health system, and I think the prison system is probably no different once you are inside it. Power and control are exerted in so many different ways and in particular for people who feel vulnerable in those environments, so I think that coercive control plays out throughout all of those places. Where we see it most commonly is with agreeing to things for prison guards or agreeing to take medication that people know they do not respond well to because they do not want to face the anger of the person they are dealing with when they do not comply.

**Ms WATT**: Also, post release, keeping track of medical and medication adherence, is that a problem as well with your clients?

**Ms JONES**: We tend to find that the right clinics in the right places work really well with some of our clients, but they tend to have a stronger, more coherent staff base that has been in existence for a long time. One of the problems and one of the challenges within the mental health sector has been the movement of people. So where people can build up a rapport they can start to trust a case manager, for instance. Common problems with mental health medication are everything from weight gain through to sexual dysfunction. Trying to say to somebody you do not know well things like that is really complicated, so is it easier just not to show up for the appointment, because then you do not have to have the medication?

**Ms WATT**: No doubt there is a connection there with recidivism. Thank you so much.

**The CHAIR**: Thank you so much for today, Charlotte. I think all of us were madly taking notes, and please pass on our regards to Lucy. We heard a lot about the magnificent Lucy throughout the homelessness inquiry as

well. She is quite a star in the community. So thank you so much. We very much appreciated your time today. As I mentioned, you will receive a transcript of today. Please have a look at it and make sure we captured everything you said today.

**Witness withdrew.**