Law Reform Commission Papers 5-8
People with Cognitive and Mental Health Impairments in the Criminal Justice System

Juvenile Justice Submission

Juvenile Justice

Juvenile Justice is responsible for the supervision of young people sentenced to community-based or custodial orders, providing support for young offenders meeting the conditions of bail, supervision of young offenders who are on conditional bail, supervision of young people remanded in custody pending finalisation of their court matters, and the preparation of reports for the consideration of the courts in determining sentences. Juvenile Justice also administers the Youth Justice Conferencing program.

Juvenile Justice operates within a complex statutory framework which includes but is not limited to the *Children (Detention Centres) Act 1987,* the *Children (Community Service Orders) Act 1987,* the *Youth Offenders Act 1997,* the *Children (Criminal Proceedings) Act 1987,* and the *Children (Interstate Transfer of Offenders) Act 1988.*

While supervising young offenders, either in custody or in the community, Juvenile Justice works to assist young offenders with programs and services aimed at reducing the risk of re-offending through addressing underlying issues and behaviours.

Juvenile Justice Client Profile

The factors that lead young people to become involved in crime are complex and varied, yet research points to a number of predictive risk factors. These can include family dysfunction, alcohol and substance abuse, disengagement from education or employment, age of first contact with the legal system, intellectual disability, mental health issues, Aboriginality and homelessness.

The challenge for Juvenile Justice is the over representation of vulnerable young people with mental health issues and intellectually disabilities.

These young people are particularly disadvantaged and a custodial setting is at times used as a last resort and it is difficult for such a system to meet their special needs.

The criminal justice system can be a complex one and it is not uncommon for young people in custody to be confused about the circumstances of their arrest and Court appearance. Clearer language is needed and especially in the area of bail, true informed consent is required. It is not uncommon for a young person with complex needs to be unaware of their bail obligations, often resulting in breaches to bail conditions, further Court appearances and risking additional time in custody.

People with mental health and cognitive impairments are significantly over-represented within the juvenile justice system. The preliminary findings of the (yet to published) *2009 Young People in Custody Health Survey* identified:

- 77.3% of young people in custody on remand or control orders were in the Low Average IQ Range or below.
- 13.6% of these young people scored in the Extremely Low Range for IQ – that is an IQ level below 70
- A further 32% who have an IQ between 70 and 79 – by definition a score that indicates borderline intellectual disability.
- 87% of survey participants had at least one psychological disorder.
- 73% had two or more psychological disorders.
- 59% were diagnosed with Conduct Disorder.
- 63.5% were diagnosed with some form of Alcohol or Substance related disorder.
- 20% had Post Traumatic Stress Disorder.
- 17% experienced major depression.
- 16% had considered suicide, with more than half of these having made a plan about attempting suicide.
- 59.9% experienced at least one form of abuse or neglect.
- At least one third of respondents reported having experienced physical abuse, emotional abuse, physical neglect or emotional neglect.
- Around 10% had experienced sexual abuse.
- 89% had used illicit drugs, with 65% reporting having committed crime to get drugs or alcohol.
- 75% reported having experienced a head injury

Within the current system, there is scope for young people who are forensic patients to be detained in juvenile justice centres (rather than mental health facilities). The number of forensic patients is very limited and although these young people are not convicted offenders, they are subject to the same controls and discipline as convicted offenders.

As a minimum standard, courts should work to ensure that these patients receive the best possible care and treatment in the least restrictive environment enabling the necessary care and treatment to be effectively given.

Juvenile Justice - Aboriginal Issues

Aboriginal young people are over-represented within the juvenile justice system. While Aboriginal people make up less than 2% of the NSW population, they represent nearly 50% of the juvenile detention population. Aboriginal young people are 28 times more likely to be detained than non-

Aboriginal young people[1] and more than twice as likely to have their matters proceed to court[2]. While Aboriginal over-representation is highest in the detention population, Aboriginal offenders are over-represented in all of the agency's service streams.

Of the 2,363 Aboriginal young people who came into detention in 2007/08, 85% were on remand. Many of those refused bail and remanded into custody are under 15 years of age.[3] The three most common barriers to bail being granted to Aboriginal juveniles are:

- Lack of a fixed residential address;
- Lack of parental support and;
- An inability to meet monetary and surety requirements.

These barriers speak to social and financial issues rather than questions of criminality.

General Comments

Evidence indicates that prevention, early intervention and diversion are preferred and proven methods of addressing the underlying causes of antisocial behaviour and preventing the entrenchment of young people within the juvenile justice system.

This is particularly true for those young people who the Courts determine should be diverted from the Court system under Sections 32 and 33 of the *Mental Health (Forensic Provisions) Act.* It is evidenced by the findings of the 2009 Young People in Custody Health Survey that these provisions for juveniles are not as effective as they could be at diverting young people with cognitive disabilities and mental illness from the criminal justice system.

Children and young people are not 'little adults'. Research indicates that their ability to control their emotions and actions, to fully comprehend the consequences of their actions, and their prospects for rehabilitation, differ drastically from adults. These differences are particularly evident when considering young people with cognitive and mental health impairments.

Juvenile Justice operates on specific legislation with policies and procedures governing its community and custodial operations tailored to the unique needs of young people.

Juvenile Justice proposes that a separate set of conditions should apply to children and young people with cognitive and mental health impairments in the criminal justice system. The diagnosis, treatment, and rehabilitative prospects of children and young people differ drastically from adults.

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[1] Steering Committee for the Review of Government Service Provision (SCRGSP), *Overcoming Indigenous Disadvantage: Key Indicators 2009*, Productivity Commission, 2009

[2] Richards, K, *Juveniles' contact with the criminal justice system in Australia,* Australian Institute of Criminology, 2009 pg27, pg 41

[3] Evaluation of the Aboriginal over-representation Strategy, June 2006, p.9 (CPD)

Applying separate standards to children and young people is appropriate in terms of the medical differences in development and diagnosis, and would acknowledge that the early treatment and rehabilitation of children and young people is appropriate to their special needs and would result in long lasting benefits to society and to the individual.

Consultation Paper 5 – An Overview

Special considerations for definitions of terms specifically regarding adolescents with cognitive and mental health impairments

Juvenile Justice recommends that a clearer definition of a forensic patient be developed for children and young people.

Clarity around the definition of cognitive and mental health impairments as they apply in the adolescent stage of development would enable the legal terms to be clinically informed and diagnoses by psychologists and psychiatrists to be adequate for both legal and clinical purposes.

Clearer definitions of cognitive and mental health conditions would also assist in the criminal justice response being more appropriate to the needs and presentation of the young person.

Special consideration for young people under the *Mental Health (Forensic Provisions) Act 1990* (MHFPA) is also appropriate given that mental illness and/or cognitive impairment may be emerging or becoming evident during adolescence. If these conditions can be properly diagnosed and any causal relationship to offending identified, then the provision of services to support the young person may lessen the likelihood of re-offence and aid rehabilitation.

Unlike adults, young people are developing both mentally and physically, irrespective of the presence of a mental illness or cognitive impairment. This distinction between children and young people, and adults, needs to be considered both in terms of definition and the associated legal consequences.

Recent medical research into brain development has confirmed that young people's brains are not fully developed until they reach their early twenties. As a result, 'the adolescent mind works differently [to adults]. Their brains are physiologically underdeveloped in the areas that control impulses, foresee consequences and temper emotions'[4].

The diagnoses of relevance for this report fall into three main areas:

- developmental disorders
- cognitive impairments
- mental illness.

The nature and impact on a person's functioning as a result of such disorders is not limited to a particular age. Rather, adolescence is often when a mental illness emerges, childhood is when developmental and cognitive disabilities become evident, whilst Acquired Brain Injury (or other acquired cognitive impairments) can occur at any age. Consequently, the psychiatric diagnostic

[4] Amicus Brief to the United States Supreme Court 2005

manual (DSM-IV-TR) distinguishes disorders that are usually diagnosed during childhood and adolescence as a "convenience" rather than a reflection of any clear distinction between "childhood" and "adult" disorders.

That said, there is need for special consideration for young people because of the developmental stage of adolescence. A young person is likely to be less entrenched in a criminal lifestyle than an adult and an adolescent's prospects for rehabilitation are considered greater.

Issue 5.1: Should a broad umbrella definition of mental health impairment, incorporating mental illness and cognitive impairment, be included in the MHFPA? What practical impact would this have*?*

Because mental illness diagnoses are applied in a more conservative way to adolescents and cognitive impairment becomes evident prior to adulthood, this issue needs special consideration for young people. Some diagnoses apply only to children and adolescents. For instance, Attention Deficit/Hyperactivity Disorder is diagnosed in children and adolescents but its presence in the adult population is controversial.

The use of an umbrella definition does not remove the need to define the other terms used in the MHFPA. Therefore, the simpler option may be to define each of the terms that are used without introducing an umbrella definition.

The definition of "mental illness" described in the MHA gives this term some clarity. It is able to encompass various diagnoses of severe impairment.

During the adolescent developmental stage, mental illness may be emerging and therefore difficult to diagnose precisely. More caution is practiced by psychiatrists and psychologists in applying a definite diagnosis of a mental disorder (such as "schizophrenia"). Therefore, the definition of this term in the MHFPA needs to incorporate the difficulty in reaching a firm diagnosis during adolescence.

The umbrella definition "mental health impairment" does not easily apply to cognitive impairments. It can be seen as synonymous with, or referring to, "mental illness". This umbrella term does not apply well to individuals with intellectual disability as they may not have mental health issues.

Cognitive impairment encompasses a number of disorders/disabilities. Intellectual Disability and Developmental Disability become evident prior to adulthood but the terms in the MHFPA lack clarity and would benefit from improved definition.

In practice, defining these terms in the MHFPA would assist the Court. Firmer definitions in the MHFPA would clarify application of the Act. Juvenile Justice employs Forensic Psychologists whose role includes assessing cognitive

impairment and mental illness and these assessments are available to the Court.

Other practical impacts are dependent on how wide the application of the MHFPA is made (see below).

Issue 5.2: If an umbrella definition were to be adopted, would it be appropriate to state that mental impairment includes a mental illness, cognitive impairment, or personality disorder, however and whenever caused, whether congenital or acquired?

The application of these terms may differ from adolescence to adulthood. The breadth of the proposed umbrella definition would have wide-ranging consequences.

Mental illnesses such as Psychosis, which appear in DSM-IV-TR as Axis I Disorders, are episodic in nature, and symptoms will go into remission with appropriate psychiatric/psychological treatment. However, disorders such as Personality Disorders appear in DSM-IV-TR on Axis II, and are considered to be stable and enduring in nature, and therefore resistant to treatment. Some of the behavioural aspects of a personality disorder are amenable to treatment but the personality trait characteristics are not.

This is further complicated in application to adolescents, where those disorders that may have a trajectory into adult personality disorders, such as Conduct Disorder, appear in DSM-IV-TR on Axis I.

A diagnosis of “Personality Disorder” is applied differently during adolescence (and childhood). Whilst the traits of a personality disorder will often appear during adolescence, it is only diagnosed in unusual instances. The exception is the diagnosis of “Antisocial Personality Disorder” (ASPD), which cannot be diagnosed until a person is an adult. It is this diagnosis that is most commonly found amongst adult offenders. One of the diagnoses most commonly found amongst adolescent offenders is that of “Conduct Disorder”, and its presence prior to age 15 years is required if an adult is to be diagnosed later in life as ASPD.

There needs to be some clarity around the status of personality disorders for adults and Conduct Disorder for adolescents. These constructs are highly predictive of re-offending. Yet, if they were included in a diversionary provision under the MHFPA, then approximately 60% of adolescents in custody could potentially be eligible for diversion. If substance-related disorders were included under the MHFPA, then 63.5% of young people in custody could be eligible. 73% of young people in custody have two or more mental disorders, most often Conduct Disorder together with a substance-related disorder. There has been at least one occasion in the Children’s Court where this combination led to a matter being dismissed under Section 32 in recent years.

In addition, 13.6% of young people in custody have an IQ consistent with intellectual disability[5].

These statistics illustrate the difficulties that could arise when utilising terms with a wide definition such as “mental health impairment”; “mental disorder” or “mental condition”.

The diagnoses of “Intellectual Disability” and “Developmental Disability” that are most often diagnosed during childhood/adolescence are more reliable diagnoses than the occurrence of mental illness in adolescence. These impairments have an ongoing impact on functioning and behaviour, rather than being episodic like a mental illness.

Cognitive impairments can be more reliably diagnosed during adolescence. “Cognitive Disability” is generally defined clinically as an IQ two standard deviations below the mean plus adaptive functioning deficits. These assessments are conducted by psychologists; the measures of intellectual and adaptive functioning require significant training and expertise in psychology.

Issue 5.3: Should the term “mental illness” as used in Part 4 of the MHFPA be replaced with the term “mental impairment”?
And
Issue 5.4: Should the MHFPA continue to refer to the terms “mental condition” and “developmentally disabled”? If so, in what way could the terms be recast?
and
Issue 5.5: Alternatively, should the MHFPA include a definition of cognitive impairment or disability? If so, should that definition be “a significant disability in comprehension, reason, judgment, learning or memory that is the result of any damage to, or disorder, developmental delay, impairment or deterioration of, the brain or mind”?

A term that encompasses a wider range of potentially relevant disorders, such as “cognitive impairment”, is desirable. This could include pervasive developmental disorders and acquired brain injury.

The suggested definition refers to a “disability” rather than “impairment” and this would require further consultation for its applicability to young people.

Issue 5.6: Should the MHFPA be amended to create a general power of the court to order an assessment of an offender at any stage during proceedings? If so,

a) Who should conduct the assessment?

[5] Juvenile Justice & Justice Health *2009 Young People in Custody Health Survey*

In the Local and Children's Courts, Magistrates are able to request reports to assist in sentencing..

Sections 32 and 33 of the *Mental Health (Forensic Provisions) Act* enable magistrates to arrange for the care and treatment of persons suffering from mental health problems. Section 32 applies to an accused person who suffers from a mental deficiency but is not mentally ill within the terms of the Mental Health Act 2007. Section 33 applies to an accused person who is mentally ill within the terms of the Mental Health Act.

Under Section 32 and 33 of the *Mental Health (Forensic Provisions) Act* Magistrates already have the power to request an assessment and / or treatment of the young offender.

They can :

(a) order that the defendant be taken by a police officer (or other officer such as a Corrective Services or a Juvenile Justice Officer) to a hospital and detained there for assessment. This may include the additional condition that if the defendant is not found to be a mentally ill or mentally disordered person, he or she is to be brought back to court; or

(b) discharge the defendant into the care of a responsible person, unconditionally or subject to conditions; or

(c) make a community treatment order, for the mandatory treatment of the defendant, under the *Mental Health Act*. The order may be made only if the Magistrate could have made it under the *Mental Health Act*. The effect of this is that before an order can be made, a health care agency must have an appropriate treatment plan and be capable of implementing it. The Magistrate must notify the Chief Health Officer before making any such order.

The Justice Health program is able to provide *screening* for possible mental illness quickly and provide reason to refer for a psychiatric assessment. Juvenile Justice Forensic Psychologists are able to provide *assessment* of cognitive impairment/disability and mental illness, although an adjournment would be required.

Juvenile Justice employs Forensic Psychologists in the community and psychologists in each juvenile justice centre. It is currently the role of the Forensic Psychologists to provide the agency with such assessments and the court, when requested. This avenue could be more fully utilised.

While it is understood that the inquiry's terms of reference do not include the power to examine and evaluate service availability, it would be counterproductive for the court to enhance and expand its referral capacities with no enhancements to existing mental health services. In order for this power to work in practice, sufficient resourcing would be required to meet the costs of an increase in the numbers of such assessments.

b) What should an assessment report contain?

An assessment should contain a treatment plan for a young person. For instance, Juvenile Justice Forensic Psychologists providing assessment of cognitive impairments are able to also suggest appropriate treatment options e.g. whether the young person is a likely candidate for the services of ADHC.

In Local and Children's Courts, Juvenile Justice Forensic Psychologists have provided assessment reports where a young person is found eligible for diversion under Section 32. When this section is utilised, Juvenile Justice do not have an ongoing role under the legislation to supervise the young person unless the court has imposed a condition for Juvenile Justice to supervise the young person subject to an order under s 32 of the *MHFP Act*. Therefore, it may be beneficial to the young person to have Juvenile Justice maintain contact to supervise compliance with the treatment plan in more instances.

The assessment report could also contain a recommendation to the court on which diversionary programs would be most appropriate for the young person, taking into consideration their ability to meet conditions based on the assessment.

c) Should any restrictions be placed on how the information contained in an assessment report should be used?

Special consideration needs to be given for how such information is managed in the case of young people. Issues would include:

- what happens to the report once the person reaches adulthood?
- what is a carer's role in providing consent for use of information?
- under what circumstances is consent to be sought from the young person to share/restrict information?

Consultation Paper 6 – Criminal Responsibility and Consequences

Juvenile Justice supports the general thrust of the Paper 6 recommendations as a positive step towards the development of a best-practice legal model dealing with people with cognitive and mental health impairments in the criminal justice system. The issues identified within Consultation Paper 6 are apt and the recommendations are broadly supported as being of benefit to this group and to the criminal justice and social services systems.

However, it must be noted that changes to the legal system will not have the anticipated individual and social effects unless agency and community staff and programs are given the additional resources required to deal appropriately with these people.

Juvenile Justice makes the following specific comments:

Cognitive Impairment Focus

The legislation and Mental Health Review Tribunal (MHRT) primarily focus upon mental health issues rather than cognitive impairment. Juvenile Justice supports any measures that would ensure that greater consideration is given to the special needs of people with cognitive impairments.

Legal Guardians

In the case of an adolescent, consideration needs to be given as to whether a legal guardian has a role in assisting the young person and what the limitations of that role may be. The legal guardian needs to be, at least, notified of proceedings and outcomes. In a similar way to the Mental Health Act (MHA), this should be included in the Mental Health (Forensic Provisions) Act (MHFPA).

"Doli Incapax"

Another general consideration is the age of criminal responsibility (10 years) and what effect the existence of an impairment may have on this. The age nominated (14 Years) under which Police must ascertain that a young person knew his/her actions were wrong, is an arbitrary one.

The MHFPA should note that it is not appropriate to hold young people in an adult facility, either Mental Health or other facility.

Fitness for Trial:

Children and young people, especially those with such impairments, lack the maturity and awareness of an adult. Therefore, the application of the *Presser* standards requires special consideration regarding adolescents.

The ability of an adolescent to understand the nature of legal proceedings and the effects of providing a defence or of evidence given in Court are likely to be more limited than for an adult. The existence of a mental health or cognitive impairment further disadvantages such a young person. The fact that adolescence may be a time when mental illness is emerging and a definitive diagnosis is difficult may impact on the application of the *Presser* standards.

Procedure following a finding of unfitness

The participation or role of a legal guardian of an adolescent requires special consideration.

The effect of a delayed hearing following a finding of unfitness may have greater impact on children and young people given their stage of development. Children and young people are still dependent on adults to provide and care for their needs. A lengthy time of detention in a facility during adolescence can have a significant impact on an adolescent's prospects for a prosocial lifestyle as an adult. Disruption during a time when the young person is developing/consolidating employment and living skills is likely to have a more detrimental impact on a young person with a mental or cognitive impairment. Such a young person develops skills more slowly and takes longer to recover from significant disruption.

Therefore, flexibility in a delayed hearing may be more appropriate for a young person and consideration needs to be given as to what flexibility may be needed.

Defence of Mental Illness

Issue 6.20: The power to divert a young person into a facility for treatment of mental illness or cognitive impairment is limited by the lack of available services. Juvenile Justice has found it difficult to find suitable services for young people with such impairments, especially in rural and remote areas. Such services often have difficulty in providing an appropriate service for a young person who also has criminogenic needs.

The *M'Naughten* Rules face the previously discussed difficulties around a definition of mental illness. Please refer to the preliminary advice given concerning CP5 in regard to young people.

In regard to *Issue 6.22: Personality Disorders*, young people are generally not given such diagnoses. However, Conduct Disorder (CD) as a juvenile is a

prerequisite for the diagnosis of Antisocial Personality Disorder or Psychopathy in adults. It is noted that such diagnoses are present in the majority of adults (and CD in adolescents) that commit crimes. This would enormously broaden the application of the MHFPA. A similar caution applies to the issue of intoxication (Issue 6.30). Please refer to other advice regarding young people in the preliminary advice given concerning CP5.

Powers of the Court

Issue 6.60: Special consideration needs to be given to the notification and participation by carers or legal guardians of young people.

Sentencing Principles and Options

This section requires special consideration for young people. Young people are considered to be less entrenched in a criminal lifestyle and prospects for rehabilitation are given greater weight in sentencing.

Children's Courts

Anecdotal evidence suggests that the scarcity of Children's Court Judges in rural and remote areas of NSW can have an impact upon the harshness of sentencing. A greater availability and geographic spread of experienced Children's Court Judges may be beneficial in terms of diversion of young people from unnecessary detention.

Mandatory Support Person

Juvenile Justice supports the expansion of the Criminal Justice Support Network, run by the Intellectual Disability Rights Service. This Network provides volunteer support workers for people with an intellectual disability who are in contact with the criminal justice system. A support worker is allocated to a person with an intellectual disability seeking assistance at police interviews, courts and related legal appointments whether they are victims, witnesses, suspects or defendants.

Currently, trained support workers are only available in Sydney, Southern NSW and the Hunter region. Juvenile Justice would advocate for resources to be allocated to expand the provision of this type of service to encompass a greater coverage of NSW, and to broaden its remit to include people with mental illness.

Juvenile Justice also notes that this program is voluntary on the behalf of the person with an intellectual disability. Consideration could also be given to entrenching the rights of people with cognitive and mental health impairments to the support of an independent person, similar to the Independent Third

Person scheme run in Victoria. The Victorian scheme puts the onus on Police to organise for an Independent Third Person whenever a person with a mental impairment is interviewed, asked to undertake a forensic procedure, asked to give fingerprints or to do a strip search. When an Independent Third Person is not present, a court may decide the police cannot use information gathered as evidence.

Limiting Terms

The current framework for imposing limiting terms is based on the principle that a person found to have committed an offence should not be subject to detention for a period longer than would have been the case if he or she had been convicted of the offence. In practice, forensic patients do not have access to non-parole periods and are therefore not eligible for early release. Forensic patients can therefore actually be detained for a longer period than a convicted offender.

A lack of available community post-release support services, particularly in rural and remote areas, can compound the reticence of the Tribunal to consider conditional release.

Non-custodial orders available to the courts

There are a variety of non-custodial options available to sentencing bodies. Further use of existing provisions, especially the use of the *Young Offenders Act,* could divert vulnerable young people from custody.

Assessment reports could contain a recommendation to the court on which diversionary programs would be most appropriate for the young person, taking into consideration their ability to meet conditions based on the assessment.

Courts to provide clear instruction regarding agency responsibilities

Juvenile Justice supports a requirement for courts to provide detailed information regarding accommodation supervision for a young person set by the courts for mental health assessment. Legal mandates which instruct a young person to be taken for a mental health assessment can be at times confusing regarding instruction for the accommodation of the detainee and who is responsible for the young person. If the young person is assessed as not having a mental health issue, and they are not admitted to a mental health facility, the mandates often do not instruct as to whether the young person is to be taken back to a detention centre and held until the next court appearance, or released into alternative accommodation. Juvenile Justice requires clear instruction regarding its responsibilities in such cases.

Breaches of 'Reside as Directed' Orders

A 2009 study by the Bureau of Crime Statistics and Research found that only 34 per cent of juveniles who breached bail had committed further offences. The remainder (66 per cent) had only breached a condition of their bail. The most common bail conditions breached were not complying with a curfew order (35 out of 50 cases) and not being in the company of a parent (29 out of 50 cases)[6].

These statistics highlight a need for the courts to give closer scrutiny to accommodation and supervision concerns prior to making reside as directed orders. The resulting impact of bail conditions and breaches on the juvenile justice population has been dramatic, with the average daily number of young people in custody rising by almost one hundred young people per day since 2006-07[7].

As noted by the Wood *Report of the Special Commission of Inquiry into Child Protection Services in NSW, '*access to bail is of particular significance for young people charged with criminal offences in diverting them from potentially unnecessary contact with a delinquent group and in limiting the interruption of their education and family connection'[8].

The unnecessary incarceration of young people on social grounds, such as lack of appropriate accommodation, rather than legal grounds, is highly inappropriate and represents a failure of the current system to adequately meet the needs of these young people. The provisions of bail should not be more onerous for young people than for adults.

[6] BOCSAR Report 2009 - Recent trends in legal proceedings for breach of bail, juvenile remand and crime
[7] Juvenile Justice Annual Report 2008-09, p52
[8] Commissioner James Wood, Special Commission of Inquiry into Child Protection Services in NSW

Consultation Paper 7 – Diversion

Juvenile Justice agrees with the Issues identified in Consultation Paper 7.

As a general point, Juvenile Justice would assert that the entirety of the issues raised should be managed differently with regard to the special circumstances of children and young people.

Section 32 Orders - Breaches

Juvenile Justice would appreciate some clarity on the role of Juvenile Justice in breaching young people subject to a s32 order under the *Mental Health (Forensic Provisions) Act 1990* (MHFP Act).

Where a court specifically orders a young person to 'reside as directed by Juvenile Justice', or to 'accept ongoing services from Juvenile Justice' or a condition of the order made under s 32 of the *MHFP Act* for supervision by Juvenile Justice, then Juvenile Justice has a responsibility to advise the court if that young person breaches such bail conditions. However, the legislation is silent as to who is responsible for ensuring that a young person complies with any other conditions imposed by a Magistrate if there is no specified condition naming Juvenile Justice.

Additionally, there is no clear legislative obligation for Juvenile Justice to provide supervision under the MHFP Act. It may be necessary to explore the possibility of a 'supervision' protocol with the court to clearly indicate what is expected of Juvenile Justice.

While there is no legislative basis for Juvenile Justice supervising young people under s32, Juvenile Justice endeavours to do so as best practice. However, Juvenile Justice does not have adequate funding or resources to supervise young people who are developmentally disabled or suffer from a mental illness or condition, without the provision of additional support from other agencies.

Consultation Paper 8 – Forensic Samples

In response to a recent review of the *Crimes (Forensic Procedures) Act 2000*, Juvenile Justice opposed a recommendation to require suspects who are acquitted or whose charges are discontinued, to apply to have their DNA and other records destroyed. This was opposed on the basis that it would disadvantage children, young people, and other categorises of vulnerable young people who are unlikely or unable to make informed decisions and exercise their full rights.

Many Juvenile Justice clients have low literacy levels, unstable or itinerant accommodation, intellectual disabilities or mental health issues, and poor social and family supports and networks. As well, the negative experiences many Juvenile Justice clients have had with police may influence their willingness to have ongoing contact with them.

In the above context, Juvenile Justice supports the automatic destruction of forensic samples as soon as practicable following a diversionary order issued under s32 or s33 of the *Mental Health (Forensic Provisions) Act 1990*, or a verdict of not guilty on the ground of mental illness, or where a young person has been found unfit to be tried at a special hearing.