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CRIMINAL AND MENTAL HEALTH LAW – SECTION 32 APPLICATIONS

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INTRODUCTION

Preparing and presenting an application pursuant to s.32 *Mental Health (Forensic Provisions)* Act 1990[1] can be significantly more challenging for a criminal law practitioner than appearing on sentence or running a defended hearing in the Local Court. In *Perry v Forbes*, one of the earliest decisions of the Supreme Court on Section 32, Adams J said:

> " Cases involving an element of mental disorder or mental illness sometimes occasion difficulties for courts and the accused's legal representatives… Explaining and making applications to have s.32 applied may be difficult ".[2]

Making a Section 32 application in relation to serious offences, traffic offences or offences when a client has a comorbid substance abuse disorder can be especially challenging. Nevertheless, successful Section 32 applications have and can be made in such matters and practitioners ought not assume such applications are doomed to fail. Given the wide discretion afforded to Magistrates, the latitude permitted as to the decision that may be made and the breadth of the inquiry involved[3], different Magistrates will approach the diversionary regime in different ways:

> "It is a discretionary judgment upon which reasonable minds may reach different conclusions in any particular case."[4]

Fearless advocacy is the duty of the advocate and practitioners should not overlook Section 32 diversion as an option in having a criminal charge disposed of in the Local Court merely because a practitioner takes the view a Section 32 application is too difficult and/or is doomed to fail. Some Section 32 applications made by the writer in relation to serious offences and traffic offences in recent years have been surprisingly successful and ultimately proceeded without the resistance or difficulties originally anticipated.

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[1] Hereafter "Section 32" and "MHFPA"
[2] *Perry v Forbes Anor,* Smart J, Supreme Court of New South Wales, Unreported, 21 May 1993 at p.5.
[3] *DPP v El Mawas* per McColl JA at [74]
[4] *DPP v Confos* [2004] NSWSC 1159 per Howie J at [17]

On other occasions, an issue or difficulty has emerged without warning in the hearing of a Section 32 application that had initially been perceived to be relatively straight forward. By way of example only:

- On some occasions I have obtained Section 32 orders without making any submissions at all;

- Some Magistrates will narrow the focus of the inquiry by identifying specific issues of concern. In these situations it can become unnecessary to address on each and every consideration relevant to the exercise of the discretion and the proceedings can be shortened;

- On one occasion where I asked the Magistrate to consider narrowing the focus of inquiry by identifying any issues of concern, the Magistrate refused to do so and it was necessary to make submissions on each and every relevant consideration. The Magistrate then expressed concern about the time I was taking;

- A Magistrate in the Children's Court, before whom I used to regularly appear, would often ask the prosecutor to address on Section 32(1)(b) first. This assisted in isolating the areas of contention and shortened the proceedings significantly;

- In a Section 32 application involving two charges of *Assault Occasioning Actual Bodily Harm* the consent of the prosecution and victims were secured prior to the hearing. Nevertheless, the Magistrate indicated submissions were required in relation to Section 32(1)(b). Unfortunately, reference to the decision in *Mantell v Molyneux* (the ability of a Magistrate to extend "by a considerable margin" the court's period of supervision)[1] was omitted. In summing up, the Magistrate referred to the court's inability to supervise a Section 32 order beyond a period of 6 months. The Section 32 application was rejected primarily on this basis.

Every magistrate is different and a practitioner needs to be flexible in their approach. When it comes to court, my motto is "*anything and everything can happen and often does*". The focus of this paper is on some of the difficulties and seemingly insurmountable challenges a practitioner is likely to face in the preparation and presentation of Section 32 applications in the Local Court. It does not address the basics of running a Section 32 application. For a discussion on the legislation and common law relevant to Section 32 and its historical development see the author's

paper *"To Section 32 or Not? Applications under s.32 Mental Health (Forensic Provisions) Act 1990 in the Local Court"*[5]. For helpful tips on what to do after a Section 32 application is refused, including the relevance of mental ill-health and the making of submissions on sentence, see the author's paper *"What to do after a s.32 application is refused"*[6].

All practitioners acting for clients charged with a criminal offence(s) ought to be thoroughly familiar with Section 32. While the legislative provisions concerning Section 32, including relevant provisions in the *Mental Health* Act 2007 ("MHA") can appear to be a quagmire, determining when a client is eligible for possible Section 32 diversion is relatively straightforward. It is important for practitioners to become well apprised of the true extent of mental ill-health amongst offenders.

THE EXTENT OF MENTAL ILL-HEALTH

An awareness of the extent of mental ill-health amongst offenders and within the wider community provides a backdrop to the preparation and presentation of Section 32 applications in the Local Court. Consider the following:

- Mental ill-health is relatively common. One in five adults will experience mental illness in any year[7]. The rate is around 1 in 4 for those aged 18-24 years[8]. Almost half the Australian population (45.5%) experience mental illness at some point in their life time[9]. Mental ill-health affects young people disproportionately with the majority (75%) of "adult psychiatric morbidity" first becoming evident before 24 years of age"[10]. One person takes their own life every four hours and around 75% are males . Many others try without success. More people die from suicide each year than are killed in transport accidents ;

[5] K Weeks (2010) 48(4) Law Society Journal at 49 (copy attached) or download via www.cmhlaw.com.au (see the page Section 32 Guides).
[6] K Weeks (2013) 51(1) Law Society Journal *at* 66 or download via www.cmhlaw.com.au (see the page Section 32 Guides).
[7] Australian Government, *"National Survey of Mental Health and Wellbeing 2007"* retrieved from http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/national-surveys-1
[8] McGorry P, Purcell R, Hickie I & Jorm A, (2007) *Investing in Youth Mental Health is a Best Buy*, Medical Journal of Australia; 187 (7 Suppl): S5-S7.
[9] Australian Government (2007) Ibid.
[10] McGorry P et. al. (2007) Ibid.

- Most people with mental ill-health, especially young men, have little, if any, access to suitable services or treatment. It has been said that only 13% of young men with mental ill-health have access to *any* services[11];

- Most people with mental ill-health are not dangerous[12];

- However, mental health problems, both substance and non-substance related, are over-represented amongst offenders in custodial settings[13]. In a 2011 study of young people in custody, 87% were found to have at least one psychological disorder and 73% had two or more. Similar findings have been made in relation to adult inmates;

- The over-representation of people with mental health impairments in the criminal justice system has been acknowledged by the State government[14];

- The cost of mental health services, especially those targeted at early intervention, ought to be considered against the enormous costs associated with the incarceration of juveniles and adults and the high rate of recidivism amongst offenders with mental health disorders as confirmed recently by a NSW Bureau of Crime Statistics and Research (BOCSAR) study[15]. The rate of reoffending is significantly higher for prisoners with a comorbid[16] substance abuse disorder. BOCSAR's Director, Dr Don Weatherburn, concluded:

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[11] McGorry P, during discussion at the *First International Youth Mental Health Conference*, 29–30 July 2010, Melbourne.

[12] Purcell R. "The Relationship between Violence and Mental Illness" February 2011, *Orygen Youth Health Research Centre Policy Briefing*, www.oyh.org.au.

[13] Smith N and Trimboli L. "Comorbid substance and non-substance mental health disorders and re-offending among NSW prisoners" (2010) *Crime and Justice Bulletin* (No 140),retrieved from http://www.bocsar.nsw.gov.au/lawlink/bocsar/ll_bocsar.nsf/pages/bocsar_mr_cjb140.

[14] In responding to the NSWLRC Report 135 On 23 August, 2012 the Attorney General, The Hon Greg Smith SC said *"people with mental impairments are overrepresented in our courts and jails and the report's recommendations aim to reduce their reoffending by ensuring their impairments are identified early and they have access to appropriate treatment and support*". See the Media Release issued on 23 August 2012, retrieved via http://www.lawlink.nsw.gov.au/lawlink/Corporate/ll_corporate.nsf/pages/LL_Homepage_news2012#cjs

[15] Smith N and Trimboli L (2010). "Comorbid substance and non-substance mental health disorders and re-offending among NSW prisoners" *Crime and Justice Bulletin* (No 140),retrieved from http://www.bocsar.nsw.gov.au/lawlink/bocsar/ll_bocsar.nsf/pages/bocsar_mr_cjb140

[16] See Comorbidity below.

> "Increased investment in treating prisoners with a comorbid disorder would not only make the community safer … it would save money by reducing the rate of re-offending and return to prison".[17]

- The New South Wales Law Reform Commission ("NSWLRC") recently found Section 32 is underused in relation to defendants with intellectual disability and other cognitive impairments[18];

- Of all charges finalised in the Local Court in 2012 only 0.9% were dismissed pursuant to the *Mental Health (Forensic Provisions)* Act 1990[19].

Given the statistical over-representation of people with mental ill-health in the criminal justice system it is highly likely a criminal law practitioner will have clients who are eligible for Section 32 diversion. It is therefore incumbent on a criminal law practitioner, when taking initial instructions and advising a client in relation to an alleged offence, to consider the potential application of Section 32.

ETHICAL CONSIDERATIONS

Practitioners are duty bound to advise a client about the availability of Section 32 in the Local Court just as they must advise a client they have the option of pleading guilty or not guilty to a criminal charge. The *Revised Professional Conduct and Practice Rules 1995 (Solicitors Rules)*[20] provide:

> ***Duty to a client***
>
> A.16. A practitioner must seek to advance and protect the client's interests to the best of the practitioner's skill and diligence, uninfluenced by the practitioner's personal view of the client or the client's activities, and notwithstanding any threatened unpopularity or criticism of the practitioner or any other person, and always in accordance with the law including these Rules.
> A.17 A practitioner must seek to assist the client to understand the issues in the case and the client's possible rights and obligations, if the practitioner is instructed to give advice on

[17] Media Release, 17 June 2010, NSW Bureau of Crime Statistics and Research. Retrieved from
[18] NSWLRC Report 135 (2012) *People with cognitive and mental health impairments in the criminal justice system – Diversion* at [4.85] retrieved via http://www.lawlink.nsw.gov.au/lawlink/lrc/ll_lrc.nsf/vwFiles/r135.pdf/$file/r135.pdf
[19] This includes orders made pursuant to s.33 MHFPA. See BOCSAR, NSW Criminal Court Statistics 2012.
[20] Retrieved from the website of the Law Society of NSW at http://www.lawsociety.com.au/ForSolictors/professionalstandards/Ruleslegislation/SolicitorsRules/index.htm

> any such matter, sufficiently to permit the client to give proper instructions, particularly in connexion with any compromise of the case.
> A.17A. A practitioner must inform the client or the instructing practitioner about the alternatives to fully contested adjudication of the case which are reasonably available to the client, unless the practitioner believes on reasonable grounds that the client already has such an understanding of those alternatives as to permit the client to make decisions about the client's best interests in relation to the litigation.
> A.17B. A practitioner must (unless circumstances warrant otherwise in the practitioner's considered opinion) advise a client who is charged with a criminal offence about any law, procedure or practice which in substance holds out the prospect of some advantage (including diminution of penalty) if the client pleads guilty or authorises other steps towards reducing the issues, time, cost or distress involved in the proceedings.

Criminal law practitioners must bear in mind that their client will not necessarily be aware they have any underlying mental ill-health issues that may be relevant to an alleged offence(s) or that a statutory diversionary regime exists that they could be eligible for. Having determined a client may suffer from mental ill-health a practitioner will then need to consider the jurisdictional requirements of Section 32 before any further preparation of a Section 32 application commences.

JURISDICTIONAL REQUIREMENTS - THE FIRST LIMB - s.32(1)(a)

The eligibility criteria for the Section 32 diversionary regime is found in Section 32(1)(a) MHFPA. Satisfying this first limb, on the balance of probabilities, is the first step in the hearing of a Section 32 application. Section 32(1)(a) provides:

> "If, at the commencement or at any time during the course of the hearing of proceedings before a Magistrate, it appears to the Magistrate:
> (a) that the defendant is (or was at the time of the alleged commission of the offence to which the proceedings relate):
> (i) developmentally disabled, or
> (ii) suffering from mental illness, or
> (iii) suffering from a mental condition for which treatment is available in a mental health facility, but is not a mentally ill person …"

Thus, a person with a developmental disability, mental illness or mental condition for which treatment is available in a mental health facility will be eligible for Section 32 diversion. However, a person who is "mentally ill" is not. The Section 32(1)(a) criteria has caused a great deal of confusion. In 2008, a survey of Magistrates undertaken by the Judicial Commission of NSW found Magistrates:

> "…expressed concern with the broadness and imprecision of the mental disorder criteria, which was especially vexing to them in cases where differing or equivocal diagnoses were

> received in respect of a particular accused. Some magistrates suggested that mental disorder should be 'serious' or 'connected' to the offence (that is, criminogenic). This raises the question of how should a 'serious' mental disorder be defined? Further, precisely how closely should any mental disorder be 'connected' to an offence? From a policy perspective, 'serious' and 'connected' then become contested levers, whereby therapeutic jurisprudence is made available to some mentally disordered accused but not others. Ultimately, some things are irreducibly complex. Mental disorder is such an issue.
>
> … The irreducible complexity of mental disorder is naturally difficult to deal with. But in the case of s.32, the legislature has responded to this complexity by dealing with a broad issue in broad terms and increasing the discretion of magistrates. Ultimately, all that is required is an *appearance* of a mental disorder. [21]

If a person appears to be a "mentally ill" person a Magistrate can make an order pursuant to s.33 MHFPA. "Mentally ill" in s.32(1)(a) has the same meaning as "mentally ill" in the MHA where the term determines who can be detained involuntarily in a mental health facility. **A "mentally ill" person is a person whose care, treatment or control is necessary to protect the person or others from serious harm**.[22] "Mentally ill" within the meaning of Section 32(1)(a) MHFPA and the MHA therefore has a very narrow application as opposed to the broad criteria in s.32(1)(a)(i)-(iii).

It is very important practitioners ensure a client does not satisfy the criteria of a "mentally ill" person when making a Section 32 application otherwise their client could end up losing their liberty. If a Magistrate makes an order pursuant to s.33 MHFPA the person is taken to a mental health facility by police for a mental health assessment. If a doctor determines the person is "mentally ill" the person is involuntarily detained. If not, the person is returned to court.

While the eligibility criteria is broad in application, the terminology in Section 32(1) is imprecise and may operate to exclude some people from the opportunity for diversion, including persons with an intellectual disability[23]. To overcome the limitations arising from the current terminology, the NSWLRC has suggested the adoption of an "umbrella definition" which includes mental and cognitive impairments, mental illness, or personality disorder, however and whenever caused, whether congenital or acquired which:

> " … would, for example, cover senility, acquired brain injury, and drug and alcohol abuse to the extent that it has caused a mental illness, personality disorder or cognitive impairment. Such a proposed definition, by applying to an impairment regardless of how and when it was caused, would also overcome the difficulties currently associated with the term

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[21] T Gotsis and H Donnelly (2008) *Diverting Mentally Disordered Offenders in the NSW Local Court* p.25.
[22] s.3 MHPFA and s.14 MHA.
[23] NSWLRC CP5 at p.68

> "developmentally disabled". Mental illness could then be defined to have the same meaning as in the MHA, and cognitive impairment could be separately defined. A definition along these lines would only be for the purpose of establishing the threshold criteria for identifying those defendants whose mental impairment may warrant special consideration during sentencing, or would act as a qualifying condition for diversion, or for consideration of unfitness, or of the defences of mental illness or substantial impairment. Defendants would still need to meet the eligibility criteria that would have to be specified for each of those tests and defences."[24]

Despite the confusion surrounding the eligibility criteria in Section 32(1)(a), Section 32 has been described as broad and malleable[25]. The breadth of the criteria was confirmed by the Supreme Court in *Perry v Forbes Anor.* when Smart J said:

> "The *Mental Health (Criminal Procedure) Act 1990* contains a series of provisions dealing with criminal proceedings involving persons affected by mental illness and other mental conditions. The Act endeavours to introduce a more flexible scheme which recognises the variety of mental states which may exist and to overcome some of the rigidity which had previously existed".[26]

In my experience, the jurisdictional question in Section 32(1)(a) is often conceded by the prosecution. Nevertheless, it is essential that any expert report writer assisting in the matter touches on the issue and the practitioner must ensure that the expert is specifically requested to address the Section 32(1)(a) criteria in the report to ensure the Section 32 application does not fail at the first hurdle. In *Khalil v His Honour Magistrate Johnson & Anor*[27], Hall J was critical of the lack of medical evidence available to the Magistrate on this issue. While his Honour found that procedural fairness had been denied by the Magistrate, his Honour dismissed the appeal on the basis that the psychologist's report tendered in the Local Court did not address the s.32(1)(a) criteria[28].

An appeal to the Supreme Court in *Edwards v DPP* [2012] NSWSC 105 suffered the same fate after Hislop J found the report of forensic psychiatrist Dr Bruce Westmore had failed to address the s.32(1)(a) criteria. In that case Dr Westmore opined the plaintiff did not have a mental illness but did suffer a mental condition. Unfortunately, and for reasons that were not readily apparent, Dr Westmore had also not confirmed treatment was available in a mental health facility for the mental condition. The Court held the preconditions to enlivening the s.32(1)(b) discretion had not been

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[24] NSWLRC CP5 at p.69.
[25] Gotsis & Donnelly (2008) at p.26
[26] Supreme Court of NSW, Unreported, 21 May 1993 at p.3.
[27] [2008] NSWSC 1092 at 107.
[28] His Honour was also critical of the lack of expert opinion confirming a diagnosis from a medical practitioner.

established as this requirement was "*as much an essential ingredient in enlivening the court's jurisdiction as are any of the other tests*" in s.32(1)(a)(i)-(iii)[29].

It must also be remembered s.31 MHFPA limits the application of Section 32 to offences that can be finalised in the Local Court. It provides:

> "(1) This Part applies to criminal proceedings in respect of summary offences or indictable offences triable summarily, being proceedings before a Magistrate, and includes any related proceedings under the *Bail Act 1978*, but does not apply to committal proceedings".

Section 32 does not apply to strictly indictable offences or Table 1 or 2 offences where an election is made. It is therefore essential a practitioner investigates whether a charge(s) is capable of being finalised in the Local Court at the outset of a matter before the preparation of a Section 32 application commences[30].

Given the breadth of the eligibility criteria in Section 32(1)(a) and provided the expert report touches on the issue, the first limb of a Section 32 application will almost always be established on the balance of probabilities with little difficulty. Where a diagnosis confirms a disorder such schizophrenia, bipolar disorder, borderline personality disorder, depression, post traumatic stress disorder, anxiety or an autistic spectrum disorder, including Aspergers syndrome, it is likely the prosecution will concede the point and the practitioner will not be required to address the court on the jurisdictional issue.

In contrast, if the diagnosis is solely Attention Deficit Hyperactivity Disorder/ Attention Deficit Disorder ("ADD/ADHD")[31] or a substance abuse disorder[32], the jurisdictional issue should be anticipated to be a likely point of contention and the practitioner should be well prepared.

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[29] at [15]-[17]

[30] In one Section 32 application in which the author appeared, the possession of a relatively small amount of "ecstasy" (3 tablets) was overlooked in a long string of summary charges. With an initial weight (including the weight of the bag the tablets were contained in) slightly exceeding the traffickable quantity of 0.75g the offence was one of Deemed Supply s.29 *Drug Misuse and Trafficking* Act 1987 ("DMTA") and was strictly indictable. The Section 32 application could not proceed until an Analysts Certificate was obtained to determine the correct weight excluding the bag. On Analysis the weight came down into the small quantity, the charge of Deemed Supply was withdrawn and replaced with a charge of the Possess Prohibited Drug s.10 DMTA after successful representations were made and the Section 32 application finally proceeded many months later.

[31] In relation to ADD/ADHD see pp. 12, 13, 16, 23, 24, 26, 27 & 29.

[32] See p.29

"IT'S JUST ADD/ADHD"

Despite the foregoing, practitioners are encouraged to make Section 32 applications for clients with ADD/ADHD as such clients **are** eligible for diversion. ADD/ADHD is a "developmental disability"[33] and as noted in the author's 2010 paper[34], criminal law practitioners are very likely to see clients with ADD/ADHD. There is much misinformation and misunderstanding of ADD/ADHD amongst the police, the profession, the judiciary and wider community. Practitioners should be well prepared and armed with the facts when making a Section 32 application for a client diagnosed with ADD/ADHD as some Magistrates will greet the application with great scepticism.

ADD/ADHD is a serious disorder associated with significant impairments across a range of domains[35]. The core features of the disorder involve executive function impairments which include:

- difficulties with response inhibition (impulsivity);
- poor judgment;
- poor consequential thinking;
- inability to plan or follow through;
- inattention to detail;
- distractibility.

People with ADD/ADHD have a propensity for participating in high risk behaviours (for example, driving fast) and have a significantly higher risk of having other mental disorders (comorbidity) including substance abuse disorders, mood and anxiety disorders and various personality disorders[36]. They are more likely to be involved in accidents and receive traffic infringements[37] . Practitioners should be aware that ADD/ADHD can continue into adulthood where patients present with inattention rather than hyperactivity. It has been noted that:

> "Identification of severe ADHD symptoms at childhood and age-specific comorbid patterns throughout the developmental stage is important to offset the long-term adverse psychiatric outcomes of ADHD"[38] .

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[33] See p. 8 above.
[34] Weeks, K., (2010) Ibid at p.52
[35] Sobanski E., "Psychiatric Comorbidity in Adults with Attention Deficit Hyperactivity Disorder (ADHD)" (2006); *European Archives of Psychiatry and Clinical Neuroscience*, v.256, pp.26-31.
[36] Sobanski E. (2006) Ibid.
[37] Anthshal, K., Faraone S.V. & Kunwar A, "ADHD in Adults: How to Recognise and Treat"
[38] Gau S et. al. "Psychiatric Comorbidity Among Children and Adolescents With and Without Persistent Attention-Deficit Hyperactivity Disorder", *Australian New Zealand Journal Psychiatry* (2010) Vol. 44, No. 2, p.135. See http://informahealthcare.com/doi/abs/10.3109/00048670903282733

Moreover, an association has been established between ADD/ADHD and Bipolar II Disorders or Bipolar Spectrum Disorders. In a recent study of 93 patients diagnosed with ADHD as children, 49.5% were found to have ADHD in adolescence, although a significant progressive decline in the symptoms of hyperactivity, inattention and impulsivity were found. This group was more likely to have oppositional defiant disorder, conduct disorder, mood disorders, bipolar disorder and sleep disorders at adolescence than controls.

SUBSTANCE & ALCOHOL MISUSE - THE COMORBIDITY CONUNDRUM

Many practitioners may have heard Magistrates make statements to the effect of "*the defendant's real problem is drug and alcohol abuse*".

Many Magistrates appear to take the view that if a defendant has cognitive or mental health impairments and has abused alcohol or drugs, the defendant should not be given the benefit of diversion because of the drug and alcohol use. The suggestion that such people are somehow less worthy of Section 32 diversion is illogical and does nothing to reduce the stigma attached to, as well as the resultant marginalisation of, offenders with cognitive and mental health impairments.

In my experience, drug and alcohol abuse rarely occurs without underlying mental health issues. It is often the case a client's underlying mental health issues predates their use of drugs and alcohol use and is often well documented. In any event, it is a *chicken-and-egg* type argument which can rarely be resolved.

According to the United States' National Institutes of Health:

> "Numerous studies have documented an increased risk for drug use disorders in youth with untreated ADHD, although some suggest that only a subset of these individuals are vulnerable: those with comorbid conduct disorders. Given this linkage, it is important to determine whether effective treatment of ADHD could prevent subsequent drug abuse and associated behavioural problems"[39].

Nevertheless, a practitioner should be prepared to encounter some difficulties in persuading a Magistrate to exercise the discretion if the diagnosis is solely a substance abuse disorder or where there is a dual diagnosis (comorbidity).

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[39] United States Department of Health and Human Services, *National Institute on Drug Abuse* (NIDA) "Comorbidity: Addiction and Other Mental Illnesses" (2010) at p.1.

What is comorbidity / dual diagnosis ?

Comorbidity is the existence of more than one disorder at the same time, for example, the co-existence of a mental disorder and substance abuse disorder. Additional challenges can confront a practitioner contemplating a Section 32 application when a client suffers from both a mental disorder and substance use disorder. Research indicates comorbidity of mental disorders and substance use disorders is widespread, especially among young people[40]. Co-occurring substance use is common rather than exceptional among people with serious mental health problems and disorders[41].

As noted above, the re-offending rate of NSW prisoners with a substance use disorder and a non-substance use disorder (eg: anxiety, depression or personality disorder) was significantly higher at 67% than those with a mental health disorder alone[42].

Comorbidity is associated with adverse outcomes:

> "Dual diagnosis is typically associated with poorer outcomes across a number of key life domains. Both the signs and symptoms of the disorders themselves, as well as associated disabilities, can have far-reaching and enduring consequences. Research suggests that when compared with those experiencing a single disorder (a mental illness or a substance use disorder), people experiencing dual diagnosis have higher rates of:
>
> • severe illness course and relapse
> • violence, suicidal behaviour and suicide
> • infections and physical health problems
> • social isolation and family/carer distress
> • service utilisation
> • antisocial behaviour and incarceration
> • homelessness."[43]

In a comprehensive report on comorbidity, the United States' National Institute for Drug Abuse (NIDA) explained the causation difficulties as follows:

> "The high prevalence of comorbidity between drug use disorders and other mental illnesses does not mean that one caused the other, even if one appeared first. In fact, establishing causality or directionality is difficult for several reasons. Diagnosis of a mental disorder may not occur until symptoms have progressed to a specified level (per DSM); however, subclinical symptoms may also prompt drug use, and imperfect recollections of when drug use or abuse

[40] Victorian Government, Department of Human Services, "Dual diagnosis: Key directions and Priorities for Service Development", 2007, Melbourne, Victoria, at p.4.
[41] Ibid.
[42] Smith & Trimboli, Ibid at p.2.
[43] Victorian Government (2007) Ibid.

> started can create confusion as to which came first. Still, three scenarios deserve consideration:
>
> 1. Drugs of abuse can cause abusers to experience one or more symptoms of another mental illness. The increased risk of psychosis in some marijuana abusers has been offered as evidence for this possibility.
>
> 2. Mental illnesses can lead to drug abuse. Individuals with overt, mild, or even subclinical mental disorders may abuse drugs as a form of self-medication. For example, the use of tobacco products by patients with schizophrenia is believed to lessen the symptoms of the disease and improve cognition …
>
> 3. Both drug use disorders and other mental illnesses are caused by overlapping factors such as underlying brain deficits, genetic vulnerabilities, and/or early exposure to stress or trauma.
>
> All three scenarios probably contribute, in varying degrees, to how and whether specific comorbidities manifest themselves"[44].

Comorbidity can also create difficulties for the client in terms of accessing appropriate treatment. It is obvious that treating one disorder and not the other is unlikely to meet with great success. Practitioners would be aware of the difficulties their clients experience in accessing good drug and alcohol services. The problem is further compounded when treatment is also required for a mental disorder. Some drug and alcohol services are not designed or equipped to deal with underlying mental health issues. While schemes such as the Magistrates Early Referral into Treatment (MERIT) are commendable and worthy of support, MERIT is neither designed or fully equipped to deal with offenders who also have a co-occurring substance abuse disorder and mental disorder.

"BUT IT'S A TRAFFIC OFFENCE !"

Practitioners should not be discouraged from making a Section 32 application in a traffic matter. There appears to be a view held by some Magistrates and prosecutors that Section 32 cannot or should not be utilised in traffic offences because of the court's inability to disqualify the defendant from driving. There is no legislative basis for such a distinction, the case law is silent on the issue and Section 32 orders have been made in relation to such offences[45].

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[44] NIDA (2010) Ibid. at p. 3

[45] The author has obtained Section 32 orders in recent years on a number of occasions for traffic offences including *Drive with High Range PCA*, *Drive with Mid Range PCA*, *Drive with Low Range PCA* and *Drive Under the Influence of a Drug*. Furthermore the Local Court's website contains a copy of the decision of Barnett LCM in *Police v Deng* [2008] NSWLC 2 where a charge of Negligent Driving Occasioning Death was dismissed pursuant to Section 32.

If a Magistrate rejects a s.32 application in relation to a traffic offence, the Magistrate is likely to suggest it is in the "public interest" to do so. A practitioner should ensure the report writer addresses the issue of whether the client poses any danger to himself or others if s/he is allowed to drive. In many instances it can be argued the client poses no danger having benefitted from diagnosis and treatment.

It can also be submitted the Roads and Maritimes Service ("RMS") is the appropriate authority to determine whether a client is a "fit and proper person" to hold a licence. A Magistrate can be asked to include a condition in any Section 32 order that copies of the court papers be forwarded to the RMS for this purpose. Sometimes a Magistrate might do it of their own volition. Accordingly, practitioners should be mindful of the possibility the RMS could cancel their client's driver's licence after a Section 32 application is successful. If this occurs, it will then be necessary to lodge a licence appeal in Local Court.

SERIOUS OFFENCES

The seriousness of the alleged offence is a relevant consideration on which a decision to refuse a Section 32 application is often based. While the seriousness of the offence is a mandatory consideration[46], it is not a factor that will necessarily exclude an eligible offender from diversion.

While there appears to be a view that Section 32 application won't succeed in relation to serious offences, including offences of violence, the decision of the Court of Appeal in *DPP v El Mawas* makes it clear that Section 32 diversion is available to serious offenders as long as it is regarded as more appropriate:

> "I accept … the s.32 diversionary regime is available to serious offenders as long as it is regarded, in the Magistrate's opinion, as more appropriate than the alternative. No doubt a Magistrate considering that question will consider whether proceeding in accordance with s.32 will produce a better outcome both for the individual and the community".[47]

THE ROLE OF NEUROSCIENCE IN THE COURT ROOM OF THE FUTURE

There is much debate about the use of neuroscience to explain behaviour including criminal behaviour. While our understanding of the brain and how it functions has developed significantly in recent decades, especially since the advent of functional

[46] *DPP v El Mawas* per Spigelman CJ at [7], *Confos v DPP* at [17], *Mantell v Molyneux*, Ibid at [40].
[47] *DPP v El Mawas* per McColl JA at [79].

magnetic resonance imaging (fMRI)[48] and other brain imaging techniques, there remains much about the brain that is unknown. Despite the advances that have been made, and will continue to be made in neuroscience, it is unlikely the criminal law will develop with the same speed. Nevertheless, criminology is being shaped by these developments. Some criminologists now adopt a biosocial model where neurobiology has an important role in looking at criminal behaviour:

> "The neurosciences have made remarkable strides in the last quarter-century, particularly with regard to understanding the mechanisms of many of the concerns of criminologists such as drug addiction, attention deficit hyperactivity disorder (ADHD), low self control, the gender ratio in criminal offending, schizophrenia, psychopathology, and a number of others"[49].

For Walsh and Bolen, genes and the environment are important in understanding individuals:

> "The question for criminologists is no longer whether genes influence criminal behaviour, but how they do".[50]

Like a number of others, they assert the neurotransmitters serotonin and dopamine are of central importance:

> "The neurotransmitters serotonin and dopamine … are the chemicals underlying approach and avoidance behaviour. Many of the problems associated with criminal behaviour involve an imbalance between the behavioural activating and behavioural inhibiting functions of these two neurotransmitters"[51].

Acknowledging the major roles environment and culture play in explaining violence in society, Walsh and Bolen also support findings from research elsewhere:

> "There is also a relationship between low levels of serotonin and violent behaviour, probably reflecting the relationship between serotonin and impulsivity, which has been called "perhaps the most reliable findings in the history of psychiatry". Serotonin levels are highly heritable, but most of the effects are attributable to the environment and may reflect social position in local status hierarchies"[52].

The importance of neuroscience to law is perhaps best described by Professor Owen D Jones of Vanderbilt University Law School:

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[48] A procedure that measures brain activity by detecting associated changes in blood flow.
[49] A Walsh & J D Bolen, *The Neurobiology of Criminal Behaviour,* Ashgate Publishing Limited, Surrey, 2012.
[50] Ibid at p.15.
[51] Ibid at p. xii
[52] Ibid at p. 131

> "Law exists mainly to effect *a change in behaviour* from how people would have been behaving in the absence of legal intervention …. Which is where brains – and ultimately neuroscience-come in. Because law is, at base, about changing behaviour, and because behaviour, at base, comes from brains, it follows that deeper understandings of the relationships between brain and behaviors (and, relatedly, about perception, judgment, decision making, and the like) may aid efforts to increase the effectiveness, efficiency, and justness of law"[53] .

Not surprisingly however, the "experts" do not always agree:

> "But reading too much into brain scans matters when real world concerns hang in the balance. Consider the law. When a person commits a crime, who is at fault: the perpetrator or his or her brain? Of course, this is a false choice. If biology has taught us anything, it is that "my brain" versus "me" is a false distinction. Still, if biological roots can be identified – and better yet, captured on a brain scan as juicy blotches of colour – it is too easy for nonprofessionals to assume that the behaviour under scrutiny must be "biological" and therefore "hardwired", involuntary or uncontrollable. Criminal lawyers, not surprisingly, are increasingly drawing on brain images supposedly showing a biological defect that "made" their client commit murder….. Problems arise, however, when we ascribe too much importance to the brain-based explanation and not enough to psychological or social ones … The key to this approach is recognizing that some levels of explanation are more informative for certain purposes than others".[54]

LEGISLATIVE REFORM

It remains to be seen whether and how far the criminal law in NSW will be shaped by developments in neuroscience. In the short term however, it is highly likely we will see significant legislative reform affecting Section 32 and other areas of the criminal law relevant to people with cognitive and mental health impairments in the criminal justice system, given the NSWLRC's recent and extensive consultation papers, reports and recommendations[55] in the area.

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[53] Owen D Jones, *Seven Ways Neuroscience Aids Law*, 15 June 2013 retrieved via http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2280500
[54] S Satel & S O Lilienfeld, Brainwashed, *The Seductive Appeal of Mindless Neuroscience*, Basic Books, 2013 New York.
[55] See further http://www.lawreform.lawlink.nsw.gov.au/lrc/lrc_index.html