CMH Lawyers

CRIMINAL AND MENTAL HEALTH LAW – SECTION 32 APPLICATIONS: AN UPDATE

LAW SOCIETY OF NSW
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INDEX

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1. INTRODUCTION[1]

1.1. SCOPE

Statistics suggest that the chances of a person charged with an alleged offence having a cognitive or mental health impairment are high. Taking instructions from and acting for such clients can be difficult and stressful. Dealing with psychiatrists, general practitioners, psychologists, hospitals and other health service providers can be time consuming and frustrating. A measure of patience and understanding is required.

The provisions of the *Mental Health (Forensic Provisions)* Act 1990[2] and the *Mental Health* Act 2007[3] can cause a great deal of confusion and uncertainty for legal practitioners, health care professionals and the judiciary. This appears to be particularly so when it comes to s.32 MHFPA[4] .

Preparing and presenting a section 32 application 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".[5]

Nevertheless, if a practitioner is to secure a good outcome for his/her client the potential for section 32 diversion should not be overlooked and a practitioner ought to resist any temptation to put it into the "too hard basket". Fearless advocacy is the duty of the advocate and practitioners should not overlook section 32 diversion merely because it appears a section 32 application may be too difficult and/or is doomed to fail.

The New South Wales Law Reform Commission confirmed the importance of the legal practitioner in the section 32 diversionary regime recently:

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[1] This paper is an updated version of a paper presented at the Law Society of NSW on 18 July 2013.
[2] hereafter the MHFPA
[3] hereafter the MHA
[4] hereafter section 32
[5] *Perry v Forbes Anor,* Smart J, Supreme Court of New South Wales, Unreported, 21 May 1993 at p.5.

> "Obviously, s.32 will fail at the outset if defendants cannot be systematically and effectively identified as potential candidates for its diversionary measures. It is not a foolproof method of detection to leave the responsibility solely in the hands of a defendant's legal representative … Defendants with a cognitive impairment remain at risk of missing out on the benefits of these diversionary measures in the absence of a more systematic means of assessing their impairment".[6]

While most practitioners haven't benefitted from tertiary study in medicine, psychiatry, psychology or neuroscience and key concepts may be difficult to comprehend there is a wealth of information available on Section 32, especially online. Practitioners are duty bound to advise a client they have the option of pleading guilty, not guilty or making a section 32 application, if eligible.

1.2 TERMINOLOGY

At the outset it is necessary to sound a warning about terminology. Terms such as "mentally ill" and "mental illness" are often used loosely and/or their meaning derives from the context in which they are used. A great deal of the confusion stems from the interaction of the common law, the MHFPA and the MHA[7] :

> " … concepts such as "mental illness" and "cognitive impairment" are multi-faceted and encompass medical, scientific and social criteria. In practical terms, a mental illness or disorder is a dysfunction affecting the way in which a person feels, thinks, behaves and interacts with others. The term covers a vast group of conditions, ranging in degree from mild to very severe, episodic to chronic. Common forms of mental disorder include depression, anxiety, personality disorders, schizophrenia and bipolar mood disorder.
>
> Generally, a cognitive impairment or disorder means a loss of brain function affecting judgment, resulting in a decreased ability to process, learn and remember information. A cognitive impairment may manifest itself in conditions such as Alzheimer's, dementia, autism and autistic spectrum disorders, multiple sclerosis, and acquired brain injury. The term also encompasses intellectual disability, interpreted to mean a permanent condition of significantly lower than average intellectual ability, or a slowness to learn or process information.
>
> The concepts of cognitive impairment and mental illness are often confused and conflated. An important difference is that "intellectual disability is not an illness, is not episodic and is not usually treated by medication. The inconsistent terminology adopted in the law to address cognitive and mental health impairments is an issue that is specifically addressed in CP5 and raised throughout CP6 and CP7.
>
> Here, as in CP5 we use the terms "cognitive and mental health impairments" to refer to a broad spectrum of conditions that can result in reduced capacity for mental functioning or reasoning. These conditions may be congenital or acquired and encompass both chronic and episodic conditions, as well as those that may improve over time with treatment … definitions

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[6] NSW Law Reform Commission ("NSWLRC") Consultation Paper 7 *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion* (2010) at p.49.
[7] NSWLRC Report 135 *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion* (2012) at p.132.

> or diagnoses that may apply to adults can, for various reasons, be difficult to apply to young people"[8].

One of the questions raised by the NSWLRC for consideration was "whether a broad umbrella definition of mental health impairment, incorporating mental illness, cognitive impairment and personality disorder, however and whenever caused, whether congenital or acquired", be included in the MHFPA[9]. Ultimately, the NSWLRC determined that separate definitions of cognitive impairment and mental health impairment be used and recommended the MFPA and MHA be amended where appropriate[10]. Throughout this paper the terminology recommended by the NSWLRC, "cognitive and mental health impairments"[11] is used.

1.3 THE EXTENT OF MENTAL ILL-HEALTH

An awareness of the extent of mental ill-health within the community and criminal justice system places the section 32 diversionary regime in context.

1.3.1. *Mental ill-health in the community*

Mental ill-health is relatively common:

- one in five adults will experience mental illness in any year[12];
- the rate is around 1 in 4 for those aged 18-24 years[13];
- almost half the Australian population (45.5%) experience mental illness at some point in their life time[14];
- one person takes their life every four hours and around 75% are males[15]. Many others try without success;

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[8] NSWLRC Consultation Paper 11, 2010, Y*oung People with Cognitive and Mental Health Impairments in the Criminal Justice Syste*m at pp.5-6.
[9] NSWLRC Consultation Paper 5 *People with Cognitive and Mental Health Impairments in the Criminal Justice System: An Overview* at p.69. See the discussion below in relation to s.32(1)(a) and "developmental disability".
[10] NSWLRC Report 135 at pp.135-143
[11] In addition to the term "mental ill-health" that has no legal meaning.
[12] 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
[13] 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.
[14] Australian Government (2007) Ibid.

- More people die from suicide each year than are killed in transport accidents[16];
- Death by suicide is almost 10 times the rate of death by homicide[17].;

Mental ill-health affects young people disproportionately with the majority (75%) of "adult psychiatric morbidity" first becoming evident before 24 years of age"[18]. Any practitioner working in the Children's Court and/or those who act for persons in their late teens or early to mid-twenties need to be particularly alert when taking instructions from clients in these age groups given the onset of mental disorders is most likely to occur in late adolescence and early adulthood:

> "Epidemiological data indicate that 75% of people suffering from an adult type psychiatric disorder have experienced its onset by 24 years of age, with the onset for most of these disorders – notably mood, psychotic, personality, eating and substance use disorders – mainly falling into a relatively discrete time band from the early teens to the mid 20s, and reaching a peak in the early 20s".[19]

Tragically, only 25 % of young people with mental disorders have access to mental health care. The figure is only 13% for young men. Early detection and comprehensive care in the first few years after diagnosis improves outcomes, saves money and lives.[20]

1.3.2. *Mental ill-health in the criminal justice system*

Most people with mental ill-health are not dangerous[21].

However, mental health problems, both substance and non-substance related, are over-represented amongst offenders in custodial settings[22].

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. According to one study the overall incidence of any psychiatric

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[15] Australian Bureau of Statistics, *Causes of Death Australia 2008*, retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/Products/3303.0~2008~Chapter~Suicides?OpenDocument
[16] Ibid. 1151 people were killed in transport accidents, either as pedestrians (183), motor cycle riders (226) or occupants of a car (742).
[17] Ibid. 260 people were the victims of homicide in the 2006-2007 year.
[18] McGorry P et. al. (2007) Ibid.
[19] Ibid. p.1.
[20] Ibid, p.1.
[21] Purcell R. *The Relationship between Violence and Mental Illness*, 2011, Orygen Youth Health Research Centre Policy Briefing, www.oyh.org.au.
[22] 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.

illness was 80% for prisoners compared to 31% for the community.[23] The over-representation of people with mental health impairments in the criminal justice system has been acknowledged by the current State government[24].

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[25]. The rate of reoffending is significantly higher for prisoners with a comorbid[26] substance abuse disorder. According to the Director of the BOCSAR, Dr Don Weatherburn:

> "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".[27]

The NSWLRC recently found that when it comes to the diversionary provisions in the MHFPA[28] the rate of discharge of people with cognitive and mental health impairments is less than 2% of all defendants appearing in the Local Court[29]. More recent figures from BOCSAR are discouraging. Of all charges finalised in the Local Court in 2012 only 0.9% were dismissed pursuant to the MHFPA[30]. In 2009 the figure was 1.7%[31].

The NSWLRC found Section 32 is particularly underused in relation to defendants with intellectual disability and other cognitive impairments[32].

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[23] Richardson E. & McSherry B, *Diversion down under - Programs for offenders with mental illnesses in Australia* (2010) International Journal of Law and Psychiatry 33:249-257 at p.249 citing Butler et. al. (2006) *Mental disorders in Australian prisoners: A comparison with a community sample*, The Australian and New Zealand Journal of Psychiatry, 40:272-276

[24] In responding to the NSWLRC Report 135 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*". Media Release 23 August 2012. retrieved via http://www.lawlink.nsw.gov.au/lawlink/Corporate/ll_corporate.nsf/pages/LL_Homepage_news2012#cjs

[25] 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

[26] See Comorbidity below.

[27] Media Release, 17 June 2010, NSW Bureau of Crime Statistics and Research (hereafter "BOCSAR").

[28] This includes diversion pursuant to section 32 and s.33MHFPA. Unfortunately, the statistics do not differentiate between those diverted pursuant to section 32 or s.33.

[29] NSWLRC Report 135 (2012) *People with cognitive and mental health impairments in the criminal justice system – Diversion* at p.72 at [4.85]

[30] BOCSAR, *NSW Criminal Court Statistics 2012*.

[31] BOCSAR *NSW Criminal Courts Statistics* 2009 at p.21.

[32] NSWLRC Report 135 (2012) Ibid at p.72 at [4.85]

1.3.3. *Mental ill-health in the legal profession*

Many legal practitioners are aware of the high rates of Depression and other mental disorders within the legal profession and judiciary[33]. Solicitors considering acting for those with cognitive and mental health impairments must maintain objectivity and detachment from their client's situation if they are to preserve their own mental health and wellbeing.

1.4. DIVERSIONARY REGIMES IN AUSTRALIA AND OVERSEAS

The high imprisonment rate of individuals with mental illness does not seem to be abating[34]. Perhaps it's not surprising then that community based alternatives to conviction and imprisonment are receiving increasing attention from researches and policy makers[35]. Court diversion schemes exist throughout Australia, England, Wales and New Zealand[36] with mental health courts being more popular in the United States[37].

How the criminal justice system deals with offenders with cognitive and mental health impairments varies enormously within Australia.[38] In NSW, the MHFPA provides for diversion via section 32 and via section 33 for those who are "mentally ill" with the meaning of the MHA. However, diversion is only possible for those who have been charged with offences that can be dealt with summarily[39].

Given the statistical over-representation of people with mental disorders in the criminal justice system and the relatively low rate of diversion via sections 32 and 33, it would seem criminal law practitioners are not utilising the diversionary regimes in the MHFPA and/or Magistrates are not exercising their discretion as much as they could. This is unfortunate.

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[33] See for example Hickie I (2008) *The mental health of Australian lawyers: A challenge for the law schools and the profession,* retrieved via http://sydney.edu.au/bmri/research/mental-health-clinical-translational-programs/jepsonslides.pdf

[34] Richardson and McSherry Ibid at p.240 citing Lamb H.R. *Reversing Criminalization,* The American Journal of Psychiatry, 166(1), 8-10.

[35] Heilbrun K & DeMatteo et. al. (2012) *Criminal Justice and Behavior April* 39(4): 351-419

[36] James, D.V. *Court diversion in perspective*, (2006) 40(6-7):529-38

[37] Richardson and McSherry Ibid at p.249.

[38] For an overview of mental health courts and diversion programs operating in Australia for offenders with mental illness see Richardson & McSherry (2010) Ibid.

[39] See s.31 MHFPA. For a case where learned Counsel failed to appreciate the jurisdictional limitations and sought section 32 diversion in the District Court for offences of aggravated break enter and steal, see *Hanania v R* [2012] NSWCCA 220.

Section 32 orders have the potential to produce positive outcomes.[40] The diversionary regime created by section 32 has been described as a legislative innovation"[41] embodying a "therapeutic justice initiative"[42]. When legislation amending s.32 was introduced into Parliament in 2005 it was said:

> "It is estimated that close to one in five people in Australia will be affected by a mental illness at some stage of their lives. The trend over the past five years indicates a substantial increase in the numbers of people with a mental illness who come before the courts. The prevalence of mental illness in the New South Wales correctional system is substantial and indicative of the high incidence of defendants in court who have mental illness ….
> … The purpose of s.32 of the Act is to allow defendants with a mental condition, a mental illness or a developmental disability to be dealt with in an appropriate treatment and rehabilitative context enforced by the court".[43]

One significant difficulty with the section 32 diversionary regime arises from the very wide discretion give to Magistrates. The level of understanding of mental ill-health and its relationship to offending issues varies greatly within the judiciary and while some Magistrates appear to be quite willing to utilise section 32 others routinely refuse to do so. As a result diversion will be available to some eligible offenders but not others. The success of the diversionary regime also rests on the availability of appropriate treatment services which are particularly vulnerable to governmental cost cutting measures:

> "Without adequate mental health care resources, the flow of mentally disordered accused appearing before the courts will likely continue — if not increase — and the effectiveness of initiatives such as s 32 will remain in doubt …a failure to provide adequate resources for s 32, if proved, consigns the policy objectives behind s 32 to the level of rhetoric … put simply, a lack of resources will undermine the policy objectives expressed by the Parliament in s 32"[44].

While there may be a reluctance on the part of some Magistrates to utilise section 32, an increasing awareness and use of section 32 by practitioners will assist in giving effect to the intention of the legislature.

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[40] Douglas L., O'Neill C. and Greenberg D. *Does Court Mandated Outpatient Treatment of Mentally Ill Offenders Reduce Criminal Recidivism? A Case Control Study,* 2006, as cited by T Gotsis & H Donnelly, Ibid. p. 29.
[41] Gotsis T. & Donnelly H. *Diverting Mentally Disordered Offenders in the NSW Local Court*, Judicial Commission of NSW, Monograph 31 March 2008, at p. 29.
[42] Ibid. p. 20.
[43] Parliamentary Debates, *Legislative Assembly*, 8 November 2005 at p.19214
[44] Ibid at p.31.

2. THE CLIENT ENGAGEMENT AND PREPARATION

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 a client(s) eligible for section 32 diversion.

When taking initial instructions from a client in relation to a Local Court criminal matter a practitioner is duty bound to consider and advise the client is relation to the potential application of section 32. .

2.1. THE FIRST CONFERENCE AND TAKING INSTRUCTIONS

Criminal law practitioners must bear in mind that their client(s) will not necessarily be aware they have a cognitive or mental health impairment that may be relevant to an alleged offence(s) or that a statutory diversionary regime exists for which they may be eligible.

Many people with cognitive and mental health impairments lack insight or awareness of their impairment(s). For some, contact with the criminal justice system is the first signal alerting the individual or his/her family to difficulties. A client who is young could be exhibiting symptoms of an emerging disorder that is in its early stages. Other clients may have gone undiagnosed and untreated for many years. Clients who have been sexually assaulted may not volunteer information that assists the practitioner.

Frequently, clients with cognitive and mental impairments that present with an alcohol and drug problem can simply be overlooked merely because of the presence of the latter and a false assumption that substance misuse is the cause of his/her difficulties.[45].

Taking detailed instructions from the client is essential to the identification of a matter for potential diversion. A practitioner should start from the client's early years at preschool and primary school moving through to high school, adolescence and early adult life. Family members can be a valuable source of information (Mums can be particularly useful when obtaining a detailed history of the client !).

[45] See further below.

As there can be a genetic component to many mental disorders, a detailed history of the mental ill-health of the client's extended family will often be helpful. Family histories of disorders that include Anxiety, Depression, Schizophrenia, a Bipolar Disorder, ADD/ADHD and substance or alcohol misuse should sound warning bells.

For a list of matters that a practitioner should seek instructions on see the writer's 2010 and 2011 papers.[46]

2.2. 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.

Particular attention must be given to Rules 4 and 7 of the *NSW Professional Conduct and Practise Rules 2013 (Solicitors Rules)* which commenced on 1 January 2014. They provide, inter alia, that a solicitor must act in the best interests of a client (Rules 4) and must advise a client so the client can understand the legal issues, make an informed choice and consider any alternative to a fully contested adjudication of a case (Rule 7) [47].

2.3. GATHERING THE EVIDENCE

All relevant documentation should be gathered by the practitioner during the preparation of a section 32 application, including copies of any clinical notes from general practitioners, hospitals and other health professionals. The client and his/her family may have old psychiatric or psychological reports. Such documentation can be helpful to prove the existence of cognitive and mental health impairments prior to the alleged offence and/or of a causal nexus between any impairments and the alleged offence.

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[46] Weeks K (2010) *To Section 32 or Not: Applications pursuant to Section 32 Mental Health (Forensic Provisions) Act 1990*, Law Society Journal 48(4) at p. 49 and
Weeks K, (2011) *Dealing with Clients with Cognitive and Mental Health Impairments in the Local Court*, Legalwise Seminars, 25 March 2011. Papers can be downloaded via www.cmhlaw.com.au (Section 32 Guides page).

[47] Retrieved via http://www.lawsociety.com.au/cs/groups/public/documents/internetcontent/803185.pdf

2.4. EXPERT REPORTS AND TREATMENT PLANS

The availability of a qualified expert(s) to provide a report, prepare a treatment plan (or case plan[48]) and/or provide treatment is critical to the success of a section 32 application. The existence and contents of a treatment plan is a mandatory consideration in the exercise of the discretion. For section 32 applications made on behalf of those with mental disorders, a section 32 application is unlikely to succeed without a treatment plan. In *Perry v Forbes* Smart J said the Court needed to have before it evidence of a treatment plan that would, if implemented, prevent a repetition of the alleged offending behaviour.

In the writer's opinion, the psychological or psychiatric report(s) must confirm:

- the client meets the jurisdictional requirements in s.32(1)(a)[49];
- the psychologist or psychiatrist is prepared to provide treatment to the client and/or will supervise treatment; and
- the psychologist or psychiatrist undertakes to advise the court of any breach of a section 32 order, should one be made by the Court.

Where the report writer is not the treatment provider, an additional report from the treatment provider should also be obtained. This is often the case where the report writer is a forensic psychologist or psychiatrist as they will often be unable or unwilling to treat the client.

Assuming a practitioner has successfully engaged the services of a psychologist or psychiatrist to provide a report and treatment plan, the practitioner will need to ensure the report and treatment plan contains all the necessary information. It will not be sufficient for the report writer to address the jurisdictional criteria in s.32(1)(a) in general terms. The report writer should specify with precision whether the client meets the criteria in s.32(1)(1)(a)(i), (ii) and/or(iii) and why.

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[48] The NSWLRC considered the issue of treatment plans in Consultation Paper 7 *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion* at p.50. The Intellectual Disability Rights Service favours "case plan" given there is no treatment for intellectual disabilities.

[49] see further below at 3.1.

Note, there have been a number of recent decisions where section 32 applications have been refused in the Local Court and the Supreme Court has dismissed an Appeal after the report writer failed to address with precision the criteria in s.32(1)(a)(i), (ii) or (iii) in their reports:

- In *Khalil v His Honour Magistrate Johnson Anor*[50] the report writer was Dr Chris Lennings, an experienced and eminent clinical psychologist. Dr Lennings did not *inter alia* specify whether the offender's mood disorder satisfied s.32(1)(a)(i), (ii) or (iii). The section 32 application was refused by the Magistrate and Khalil appealed to the Supreme Court. Hall J found there was insufficient evidence to satisfy the criteria in s.32(1)(a) "the primary issue of eligibility".[51] The Supreme Court refused to grant Khalil leave to appeal, even though it found the Magistrate had denied the applicant procedural fairness in the hearing of the section 32 application;

- In *Edwards v DPP*[52] a report from Dr Bruce Westmore, a very experienced and eminent forensic psychiatrist, was tendered in the Local Court in support of a section 32 application. Dr Westmore opined the offenders did not have a "*mental illness*" but did suffer from a "*mental condition*" (alcohol related organic brain damage)". Unfortunately Dr Westmore omitted the words "*for which treatment is available in a health facility"*. On appeal, the Supreme Court found s.32(1)(a)(iii) *"mental condition for which treatment is available in a health facility*" was an essential ingredient in enlivening the court's jurisdiction as any of the other tests in s.32(1)(a)[53]. Hislop J found it was open to the Magistrate to find there was a lack of evidence of an essential pre-condition to dismiss the section 32 application[54].

Ultimately it is the responsibility of the practitioner to ensure the report writer addresses the jurisdictional criteria correctly before a report is tendered in a section 32 application. Ideally, the legal practitioner should be given an opportunity to peruse the report writer's draft before the final report is settled so that additions or changes can be made to ensure a report fails to meet the eligibility criteria.

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[50] [2008] NSWSC 1092
[51] [108] and [112]. His Honour also found the report writer had not "articulated the substrata for his opinion that there was a causal nexus" between the mood disorder and the offence [108].
[52] [2012] NSWSC 105.
[53] at [15] and [17].
[54] at [20]

In terms of other content recommended for inclusion in a treatment plan see Gotsis and Donnelly who offer a practical guide for practitioners and health professionals[55].

It is the writer's experience that Magistrates have different views in relation to the level of detail required in a treatment plan. Some Magistrates have been satisfied with a general discussion of the proposed treatment within the general body of the report. For other Magistrates this has been insufficient. Ideally, a separate document readily identifiable or labelled as the "treatment plan" that describes the components of the proposed treatment should be attached to the report. Treatment plans are discussed further below.[56]

2.4.1 A psychiatrist or psychologist?

There is likely to be disagreement amongst practitioners as to whether a section 32 report should be obtained from a psychologist or psychiatrist. It is the writer's view that a report from a psychiatrist is generally not required for a successful section 32 application. A good report from a reputable clinical psychologist or neuropsychologist should suffice and is preferable, in the writer's opinion, given the report writer's conclusions will often be based on objective psychological or neuropsychological testing.

However, practitioners should be mindful of the decision of Hall J in *Khalil*[57] wherein a report from an experienced and well regarded clinical psychologist without medical qualifications was the subject of some criticism. It is arguable Hall J's decision doesn't sit comfortably with the exception to the hearsay rule for opinion evidence, as provided for in s.79 *Evidence* Act 2005 - "*specialised knowledge based on the person's training, study, or experience*" . Further, with the advent of clinical nurse consultants assisting Local Court Magistrates in some Local Courts, such a restricted view ignores the reality that reports from persons without medical qualifications are tendered and relied upon by Magistrates on a daily basis.

Practitioners should consult their colleagues for referrals to good report writers.

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[55] (2008) Ibid at p.18
[56] at 4.2.1.5. Refer also to the papers from the seminar's morning session which include a comprehensive overview of expert evidence prepared Mr Bernard Brassel, Garfield Barwick Chambers.
[57] Ibid.

2.5. PRACTICAL DIFFICULTIES

2.5.1. *Fees*

At the earliest opportunity a client should be given an estimate of fees. A practitioner should explain that, because of the preparation involved in a section 32 application, it will be a more expensive option for the client than a plea of guilty. Often the preparation involved can make a section 32 application a more expensive option than a defended hearing. When dealing with a client's mental ill-health Pandora's Box can often be opened.

When the client is reliant on the public health system, preparing a section 32 application can be quite challenging. Psychologists at community health centres will often decline to provide written reports for court. Obtaining a report from a busy psychiatrist in a public hospital can be difficult. Those who live in regional areas may find access to psychologists and psychiatrists limited although the use of services such as Skype can bridge the gap.

Even where a client has access to private funds, finding a health professional(s) who is skilled and available to provide treatment can be difficult. Waiting lists for psychiatrists in the city can be lengthy and the skills and expertise of psychologists can vary enormously. Establishing therapeutic relationships between a client, general practitioner, psychologist and/or psychiatrist can be difficult. Often a multi-disciplinary approach is required for treatment which requires significant coordination by the legal practitioner.

2.5.2*. Adjournments*

It is likely the practitioner will need to adjourn the proceedings on one or more occasion before setting the matter down for the hearing of a section 32 application. Ideally, the hearing should take place after a treatment plan has been obtained and implemented. Arguably, a section 32 application will be stronger if significant improvement in the client's condition can be demonstrated at hearing.

Obtaining a lengthy or multiple adjournments can be difficult if no plea has been entered. If the court refuses a further adjournment, accept a date for the hearing of a section 32 application but allow enough time for the report writer to complete the assessment and report:

2.5.3. *Entering a plea*

Time standards in the Local Court, driven largely by considerations of economic efficiency, place a great deal of pressure on Magistrates to finalise proceedings without delay. In turn, those charged with a criminal offence will often be required to enter a plea at an early stage. However, a section 32 application can be made at any stage of the proceedings[58] and whether or not a plea has been entered.[59]

In my view, a plea should not be entered before a section 32 application is heard unless the client has specifically instructed otherwise (for example to secure the maximum discount on an early plea of guilty if the section 32 application fails).

Practitioners should not be bullied into entering a plea by a Magistrate. It is open to practitioners to indicate to the court a plea of guilty will be entered if the section 32 fails. This could be relied upon in submissions of sentence if necessary.

If the client's instructions are to enter a plea of not guilty if the section 32 application fails, the Magistrate can be advised of this during the hearing of the section 32 application. While it might not be a consideration strictly relevant to the exercise of a Magistrate's section 32 discretion, a Magistrate must take into account likely sentencing outcomes on conviction[60]. Query whether in some cases a Magistrate might be more attracted to section 32 diversion knowing a defended hearing (with further delay) would otherwise result with the prospect of having no supervision over an alleged offender if he/she is acquitted..

2.5.4. *Setting the matter down for hearing*

If possible, a practitioner should avoid having a section 32 application listed at 9.30am on a list day. Consider asking for the application to be listed on hearing day or on a list day after the morning tea or luncheon adjournments (some clients with cognitive or mental health impairments will struggle if they have to wait for extended periods of time). Provide the court with an accurate estimate of how long the application will take allowing sufficient time for the court to consider the documentary material and your submissions.

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[58] Section 32(1)
[59] *Perry v Forbes* at p.4.
[60] see below 4.2.1.4.

Copies of any reports should be served on the prosecutor at least 7 days before the hearing. This is often ordered by the Court. In some circumstances it will be necessary to ask the prosecutor to obtain an up-to-date criminal or traffic history before the hearing. Drafting a chronology for tender can assist a Magistrate at hearing.

On the day of the hearing or afternoon beforehand, speak to the police prosecutor to seek their consent to the section 32 application or narrow the issues in dispute. As with any other matter, knowing what Magistrate is hearing the application *before* you walk into the court room is essential.

2.5.5*. When Section 32 is not appropriate*

While practitioners should be cautious about categorically excluding clients from consideration for section 32 diversion, there will be some instances where it will be obvious that a section 32 application should not be made. This could include a client:

- who has no mental health or cognitive impairments and can't satisfy any of the s.32(1)(a) criteria. Beware of abusing section 32 diversion simply so the client can avoid a conviction and the benefits that may flow such as the avoidance of licence disqualification;
- who is "mentally ill" under the MHA (in which case he/she can be the subject of an order pursuant to s.33 MHFPA which will result involuntary detention (something the client may not be grateful for);
- for whom no report or treatment plan can be obtained;
- who specifically instructs their cognitive or mental health impairments are not to be raised because of stigma or otherwise.

2.5.6. *Potential consequences of a Section 32*

Beware of any sting in the tail! Practitioners must be alert to the potential ramifications of a section 32 order. For example, unintended adverse consequences on a client's employment or in respect to any licences or insurance policies could result.

Having determined a client may suffer from a cognitive or mental health impairment a practitioner will then need to *carefully* consider whether the jurisdictional requirements of section 32(1)(a) can be established.

3. JURISDICTIONAL REQUIREMENTS & DIFFICULTIES

In considering a section 32 application, a Magistrate is required to make 3 decisions[61]:

- The first decision is the jurisdictional question, whether the defendant is eligible to be dealt with under s.32(1)(a). This question involves a finding of fact.[62]

- The second question is whether, having regard to the facts or such other relevant evidence, it is *more appropriate* to deal with the defendant under s.32 otherwise than in accordance with law[63]. This calls for the exercise of subjectivity or value judgments in which no single consideration and no combination of considerations is necessarily determinative of the result[64]. It is a discretionary decision in which the Magistrate is permitted latitude confined only by the subject matter and object of the Act. The discretion cannot be exercised without regard to the seriousness of the offending conduct[65] although the diversionary regime is available to serious offenders as long as it is regarded as more appropriate.[66]

- The third decision is whether to make orders under s.32(2) or s.32(3).[67]

3.1. THE FIRST LIMB - s.32(1)(a)

The eligibility criteria for the s.32 diversionary regime is found in s. 32(1)(a). While the criteria creates a great deal of confusion and certainty it is the writer's experience that difficulty in establishing the first limb is rarely encountered provided the expert report addresses the criteria in s32(1)(a)(i), (ii) and (iii) correctly.

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[61] *DPP v El Mawas*, McColl JA at 75.
[62] Ibid.
[63] see further below 4.1.-4.3.
[64] Ibid.
[65] Ibid. citing Howie J in *Confos v DPP* [2004] NSWSC 1159 at 17.
[66] *DPP v El Mawas*, McColl JA at 79.
[67] Ibid at 80.

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** …" [emphasis supplied]

Note, it must only appear to the Magistrate that one of the conditions in s.32(1)(a) is satisfied. Proof is therefore on the balance of probabilities.

The confusion in the current terminology and the NSWLRC's recommendations were discussed above[68]. While broad in application, the terminology in s.32(1) is imprecise and may operate to exclude some people from the opportunity for diversion including persons with an intellectual disability[69]. The Judicial Commission's 2008 survey confirmed the s.32(1)(a) criteria caused confusion for Magistrates who:

> "…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. [70].

Despite the confusion, s.32 has been described as *broad and malleable*[71]. The breadth of the criteria in s.32(1)(a) was confirmed by the Supreme Court in one of the earliest decisions concerning section 32[72]. In *Perry v Forbes Anor.* Smart J said:

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[68] see pp.2-3.
[69] NSWLRC CP5 at p.68
[70] T Gotsis and H Donnelly (2008) Ibid at p.25.
[71] Gotsis & Donnelly (2008) at p.26

> "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".[73]

Despite the confusion as to what is and what is not a developmental disability, mental illness of mental condition for which treatment is available in a health facility, the jurisdictional question in s.32(1)(a) is rarely contested and is always, in the writer's experience, conceded by the prosecution provided the report writer specifies with precision whether the client falls within s.32(1)(a)(i), (ii) and/or (iii). As discussed above[74], recent authority confirms that any omission on the part of the report writer to sue the correct wording could prove fatal to a section 32 application.

So, where the expert report confirms a diagnosis of a disorder such schizophrenia, bipolar disorder, depression, post traumatic stress disorder, anxiety or an autistic spectrum disorder (which includes including Asperger's syndrome), it is unlikely a practitioner will need to address the court on the jurisdictional issue.

In contrast, if the diagnosis is ADHD/ ADD[75] or substance abuse disorder[76] debate on the jurisdictional issue should be anticipated and the practitioner must be well prepared. Despite the abundance of medical literature and research on these disorders many fail to appreciate they are often associated with significant cognitive and mental health impairments and give rise to eligibility for section 32 diversion.

3.1.1. *Developmental disability*

Developmental disability is not a term that is defined in the legislation and has no precise meaning. It can co-occur with a mental ill-health. Doubt exists whether "developmental

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[72] note, s.32 MHFPA was formerly s.32 Mental Health (Criminal Procedure) Act 1990. For a history of the legislative provisions see Weeks K (2010) Ibid at pp.50-51.
[73] Supreme Court of NSW, Unreported, 21 May 1993 at p.3.
[74] see 2.4 at pp.10-11.
[75] In relation to ADD/ADHD see pp. 12, 13, 16, 23, 24, 26, 27 & 29.
[76] See p.29

disability" covers the same ground as "intellectual disability" or "intellectual impairment".[77] According to the NSWLRC:

> " … the diversionary power contained in s 32 may also be used in relation to defendants who appear to a magistrate to be "developmentally disabled", a term which is not defined in the MHFPA, or used elsewhere in the Act. It is also not a term for which a comprehensive clinical definition exists … Although no guidance is given in the MHFPA regarding the definition of developmental disability, and there is no detailed discussion of the meaning of the concept in case law, it has been interpreted as including conditions that arise during the developmental phase, stemming from either an intellectual or a physical cause. It would seem capable of including conditions such as cerebral palsy, attention deficit hyperactivity disorder, learning or communication disorders, autism or Asperger's syndrome, and intellectual disability, but not conditions that develop later in life, such as dementia, or acquired brain injury".[78]

Gotsis and Donnelly suggest developmental disability is broad enough to cover all of the *"Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence" in the DSM IV including Mental Retardation, ADD/ADHD, learning disorders and communication disorders*".[79] ADHD/ADD is a developmental disability and is discussed further below[8081].

Developmental disability does not cover cognitive impairments arising from acquired brain injury or illness.[82]

3.1.2. *Mental Illness*

Like "*developmental disability*", the term "*mental illness*" in s.32(1)(a)(ii) is not defined in the legislation. It is the use of the terms "*mental illness*" and "*mentally ill persons*" within 32(1)(a) that cause much confusion and uncertainty.

In the context of s.32(1)(a) "*mentally ill person*" (for whom section 32 diversion is *not* an option) does not mean a person who suffers from a "*mental illness*" . "*Mentally ill person*" has a very narrow meaning. Its definition comes from the MHA.[83]

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[77] NSWLRC CP5 at p.62
[78] NSWLRC CP5 at pp.60-61.
[79] (2008) Ibid. at p.26
[80] at 3.2.
[81] Weeks, K. (2010) Ibid. at p.52.
[82] Gotsis & Donnelly (2008) Ibid at p.27. Note mental retardation is no longer a clinically valid term and does not appear in the DSM V, the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, American Psychiatric Association.
[83] See further at 3.1.1.4 below.

Furthermore, *"mental illness*" in s.32(1)(a) has a different meaning to the terms "*mental illness*" in s.39 MHFPA which deals with the "*defence of mental illness*" (M'Naghten's rules). The term "*mental illness*" in the context of s.32(1)(a)(ii) has a much broader meaning than in s.39 MHFPA but what is and is not a "mental illness" for the purposes of section 32 diversion is not entirely clear.

3.1.3. *Mental condition for which treatment is available in a mental health facility*

Unlike "*mental illness*" in s.32(1)(a)(ii), "mental condition" is defined in s.3 MHFPA to mean:

> " a condition of disability of mind not including either mental illness or developmental disability of mind".

Mental health facility" is also defined in s.3 MHFPA as having the same meaning as it has in the MHA where it is defined in s.4 as a "*declared mental health facility*" or a "*private mental health facility*"[84].

According to the NSWLRC, "mental condition" is "*so vague as to be meaningless*"[85] and:

> "… has been interpreted broadly as a "catch-all" provision to recognise a wider range of mental states than those covered under the MHA. For example it has been held to include severe mood disturbances, uncontrolled anger or emotions, irresistible impulse and acquired brain injury. Although originally intended to encompass drug and alcohol dependency, we are unaware of any cases involving this as the sole cause of a mental condition".[86]

Limiting s.32 diversion to a mental condition for which treatment is available in a mental health facility was criticised by the NSWLRC in 1996 as being unduly restrictive[87] and the restriction may not take into account advances in pharmacotherapy and community treatment programs[88]. Magistrates surveyed in 2008 indicated the term was "archaic and confusing".[89]

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[84] see s.4 MHA, where they are further defined as "*premises subject to an order in force under section 109*" (which deals with public mental health facilities that have been declared by the Director-General) and *"premises subject to a licence under Division 2 of Part 2 of Chapter 5*" (which deals with licensed private mental health facilities), respectively.
[85] NSWLRC CP5 at p.72.
[86] NSWLRC CP5 at p.59 & 60 and Report 135 at p.109.
[87] NSWLRC (1996) Report 80 *People with an Intellectual Disability in the Criminal Justice System*.
[88] Report 135 at p.109
[89] Gotsis & Donnelly (2008) Ibid. at p.28

3.1.4 "*Mentally ill" persons*

A "*mentally ill person*" is not eligible for section 32 diversion in accordance with s.32(1)(a).

"*Mentally ill person*" is defined in s.3 MHFPA as having the same meaning as in the MHA[90]. Section 14 MHA provides:

> "(1) A person is a mentally ill person if the person is suffering from mental illness **and**, owing to that illness, there are reasonable grounds for believing that **care, treatment or control of the person is necessary**:
> (a) **for the person's own protection from serious harm**, or
> (b) **for the protection of others from serious harm**.
> (2) In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account.
>
> [emphasis supplied]

Therefore, the term "mentally ill person" in s.32(1)(a) has a very narrow application and applies to those who can be detained involuntarily pursuant to the MHA.

If a client satisfies the narrow definition of "*mentally ill*" in the MHFPA and MHA the correct application is under s.33 MHFPA not section 32. It can be seen that that "mentally ill person" in this context means something very different to the ordinary very day meaning of the term "mentally ill" to refer generally to someone who suffers mental ill-health.

While the jurisdictional issue will rarely be contested in a section 32 application in some circumstances a practitioner will need to be prepared for debate. If a report writer has solely diagnosed ADD/ADHD or a substance abuse disorder it may be the police prosecutor and/or Magistrate takes the view that the jurisdictional criteria in s.32(1) is not satisfied.

3.2. ADD/ADHD

As noted above, ADD/ADHD is a developmental disability and therefore a client with the disorder is eligible for section 32 diversion pursuant to s.32(1)(a)(i). The NSWLRC is also of this view[91]. Nevertheless the writer is aware of two Magistrates who have expressed the view that ADD/ADHD does not give rise to eligibility for section 32 diversion. Practitioners are encouraged to make s.32 applications for clients with ADD/ADHD where appropriate and must resist the urge to fall victim to stereotypes. There is much misinformation and misunderstanding of ADD/ADHD amongst the police, the profession, the judiciary and wider

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[90] s.3.
[91] NSWLRC CP5 at p.61. See also Gotsis & Donnelly Ibid at p. 26.

community. Many fail to appreciate the nature of ADD/ADHD or the underlying neurobiology of the disorders. Some dismiss the disorders simply as an excuse for poor parenting or the over-prescription of stimulant medications to benefit wealthy pharmaceutical companies.

Practitioners should be well prepared and armed with facts when making a s.32 application for a client diagnosed with ADD/ADHD as some Magistrates will greet the application with great scepticism. It is beyond doubt that ADD/ADHD can extend into adulthood[92] where the disorders can continue to have a significant impact on functioning. Impairments across a range of domains including education, employment and relationships are common[93]. Early identification of ADD/ADHD is important:

> "identification of severe ADHD symptoms at childhood and age-specific co-morbid patterns throughout the developmental stage is important to offset the long-term adverse psychiatric outcomes of ADHD"[94]

The core features of ADD/ADHD involve executive function impairments which include:

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

People with ADD/ADHD also 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 or a

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[92] 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 were more likely to have oppositional defiant disorder, conduct disorder, mood disorders, bipolar disorder and sleep disorders at adolescence than controls. Only 17% had recovered. See Gau S et.al., *Psychopathology and Symptom Remission at Adolescence Among Children With Attention-Deficit–Hyperactivity Disorder*, *Australian & New Zealand Journal of Psychiatry* (2010), Vol. 44, No. 4 , pp. 323-332 .

[93] Sobanski E., (2006) *Psychiatric Comorbidity in Adults with Attention Deficit Hyperactivity Disorder (ADHD*) European Archives of Psychiatry and Clinical Neuroscience, v.256, pp.26-31.

[94] 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

personality disorder[95]. They are more likely to be involved in accidents and receive traffic infringements[96] .

In the writer's experience looking at a client's driving history can be very revealing and if it is more than 3 or 4 pages in length one of the first questions that should be asked is whether the client has ever had a diagnosis of ADD/ADHD as a child. This is consistent with research that confirms the introduction of ADD/ADHD medications can improve driving.[97]

Practitioners ought to be aware of the association between ADD/ADHD and bipolar disorders, especially bipolar spectrum disorders. Those with ADD/ADHD who are undiagnosed or who are not receiving optimal treatment will commonly present with a comorbid substance abuse disorder. 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"[98]

3.3. SUBSTANCE MISUSE AND COMORBIDITY

At some point a practitioners is likely to have heard a prosecutor or Magistrates make a statement to the effect of "*the defendant's real problem is drugs and alcohol*". If a report writer diagnoses a substance abuse disorder a practitioner may need to be prepared for the jurisdictional criteria in s.32(1)(a) to be in issue.

From the writer's perspective, the view that an offender who misuses alcohol or drugs is somehow less worthy of section 32 diversion is illogical. Such views do little to reduce the stigma attached to and the marginalisation of some offenders. The proponents of such views often argue that as the consumption of alcohol or drugs is voluntary, the person who

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[95] Sobanski E. (2006) Ibid.
[96] Anthshal, K., Faraone S.V. & Kunwar A, *ADHD in Adults: How to Recognise and Treat*
[97] Jerome L Segal A & Habinski L,(2006) *What We Know About ADHD and Driving Risk: A Literature Review, Meta-Analysis and Critique*, Journal Canadian Academy Child Adolescence Psychiatry 15:3 See also Barkley RA (2004). *Driving impairments in teens and adults with attention-deficit/hyperactivity disorder*. Psychiatric Clinics of North America, 27, 233-260.
[98] United States Department of Health and Human Services, National Institute on Drug Abuse (NIDA) *Comorbidity: Addiction and Other Mental Illnesses* (2010) at p.1.

decides to misuse alcohol and drugs is entirely responsible for the consequences and entitled to no leniency from the courts. This is simplistic and ignores the research-based evidence that confirms complex changes occur in the brains of those who misuse alcohol and drugs. These changes impact upon the decision to consume alcohol or drugs and the ability to control consumption. Changes in the neurotransmitter Dopamine, a brain chemical responsible for reward and pleasure, lie beneath substance abuse disorders and other addictions including gambling[99].

Furthermore, there will often be evidence available confirming a person's misuse of alcohol or drugs occurs *after* difficulties or symptoms associated with mental ill-health emerge. In the writer's experience, a substance abuse disorder rarely travels without a mental disorder. While a substance abuse disorder will often aggravate a mental disorder, it is the writer's experience that, more often than not, the mental disorder will predate the substance abuse disorder.

In any event, it's a chicken-and-egg type argument which can rarely be resolved. In a comprehensive report on comorbidity, NIDA explained the causation difficulties as follows:

> "The high prevalence of co-morbidity 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 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 co-morbidities manifest themselves"[100]

Research indicates comorbidity is widespread, especially among young people[101] where it is common rather than exceptional[102] . As noted above, the re-offending rate of NSW

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[99] NIDA (2010) Ibid.
[100] NIDA (2010) Ibid. at p. 3
[101] Victorian Government, Department of Human Services, "Dual diagnosis: Key directions and Priorities for Service Development", 2007, Melbourne, Victoria, at p.4.
[102] Ibid.

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[103]. To exclude offenders with a substance abuse disorder from section 32 diversion is absurd.

From a practical perspective, a client with a substance abuse disorder running a section 32 application can create additional challenges for the practitioner. 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.[104]

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Co-morbidity can 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 that a client may encounter accessing good drug and alcohol services especially via the public health system. The problem is 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 nor fully equipped to deal with offenders who also have comorbid substance abuse and mental disorders .

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[103] Smith & Trimboli, Ibid at p.2.
[104] Victorian Government (2007) Ibid.

4. THE SECTION 32(1)(B) DISCRETION - MORE APPROPRIATE ?

Despite the significant confusion and uncertainty surrounding the eligibility criteria in s.32(1)(a), in most section 32 applications a practitioner will encounter little difficulty satisfying the first limb. Section .32 applications are won or lost on the second limb. The second limb requires a court to undertake a balancing exercise to determine whether the exercise of the section 32 discretion should be exercised. While much will come down to the Magistrate of the day, thorough preparation by the practitioner is essential.

Magistrates considering s.32 applications are given powers of an inquisitorial or administrative nature and can inform themselves as they see fit[105]. The power has to be exercised in accordance with procedural fairness requirements[106]. Magistrates have a very wide discretion[107]. While the list of relevant considerations is not exhaustive, some considerations are mandatory. Assuming the jurisdictional requirements in s.32(1)(a) are satisfied, section 32(1)(b) provides that diversion can take place if the Magistrate decides:

> "…on an outline of the facts alleged in the proceedings or such other evidence as the Magistrate may consider relevant, it would be more appropriate to deal with the defendant is accordance with the provisions of this Part than otherwise in accordance with law"

The question of whether diversion is more appropriate:

> "... calls for the exercise of subjectivity or value judgments in which "...'no one [consideration] and no combination of [considerations] is necessarily determinative of the result .... In my view, as Howie J concluded in *Confos*, it involves a discretionary decision in which the Magistrate is permitted latitude as to the decision which might be made, a latitude confined only by the subject matter and object of the *Act ....".*[108]

There has been relatively little judicial consideration of s.32[109]. A thorough understanding of *El Mawas* is essential. Familiarity with the remaining decisions is desirable. When making submissions on the second limb, it is recommended that each and every relevant consideration be touched upon in submissions.

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[105] *DPP v El Mawas*, McColl JA at [71]-[80].
[106] Ibid.
[107] Ibid. per Spigelman CJ at [4].
[108] Ibid, per McColl JA at [76]
[109] *DPP v El Mawas*, McColl JA at [59].

4.1. THE BALANCING EXERCISE

A balancing exercise must take place before an order for s.32 diversion can be made. It requires a Magistrate to:

> "balance the public interest in those charged with a criminal offence facing the full weight of the law against the public interest in treating, or regulating to the greatest extent practical, the conduct of individuals suffering from any of the mental conditions referred to in s 32(1) or mental illness (s.33) with the object of ensuring that the community is protected from the conduct of such persons"[110]

In *Confos v DPP* the balancing exercise was described by Howie J in the following terms:

> "…the Magistrate has to perform a balancing exercise; weighing up, on one hand, the purposes of punishment and, on the other, the public interest in diverting the mentally disordered offender from the criminal justice system. It is discretionary judgment upon which reasonable minds may reach different conclusions in any particular case. But it is one that cannot be exercised properly without due regard being paid to the seriousness of the offending conduct for which the defendant is before the court. Clearly the more serious the offending, the more important will be the public interest in punishment being imposed for the protection of the community and the less likely will it be appropriate to deal with the defendant in accordance with the provisions of the Act. It should be emphasised that what is being balanced is two public interests, to some extent pulling in two different directions. It is not a matter of weighing the public interest in punishment as against the private interest of the defendant in rehabilitation" [111].

4.2. MANDATORY CONSIDERATIONS

There are a number of matters that a Magistrate must consider in the exercise of the section 32 discretion.

4.2.1. *The Facts*

Section 32(1)(b) requires a Magistrate to consider the alleged Facts. However, there is no requirement the defendant is required to accept them.

4.2.2. *Seriousness of the offence*

The objective seriousness of the alleged offence(s) must also be considered by a Magistrate and will often be the basis for any decision refusing a section 32 application. While the seriousness of the offence is a mandatory consideration[112] it is not a factor that will

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[110] Ibid. per McColl JA at [71]
[111] [2004] NSWSC 1159 at [17].
[112] *DPP v El Mawas* per Spigelman CJ at [7], *Confos v DPP* [2004] NSWC 1159 at [17], *Mantell v Molyneux* [2006] NSWC 955 at [40].

necessarily exclude an eligible offender from diversion. *El Mawas and Confos* make it clear that section 32 diversion is available in respect to serious offences 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".[113]

The writer has obtained section 32 orders for offences including Drive with High Range PCA, Drive with Mid-Range PCA, Police Pursuit/ Not Stop/ Drive in a Manner Dangerous, Drive Whilst Disqualified, Drive Under the Influence of a Prohibited Drug, Possess Prohibited Obtain Benefit by Deception, Malicious Damage, Assault, Common Assault, Assault Police, Resist Officer in Execution of Duty. Further, a former Superintendent of police recently had offences of Give False Evidence to the Police Integrity Commission[114] dismissed pursuant to section 32 at the Downing Centre Local Court[115].

4.2.3. *Antecedents*

Like the Facts, a Defendant's antecedents will always be tendered in a section 32 application. In addition, a Magistrate can consider any prior section 32 orders made and the defendant's response to them[116]

4.2.4. Likely sentencing outcomes

A Magistrate is bound to consider the realistically available sentencing outcomes in the event *of conviction and a practitioner ought to address on this issue.* In *El Mawas* McColl JA agreed that while section 32 does not expose a defendant to punishment in the strict sense, it may involve the imposition of conditions restricting a discharged defendant's freedom of movement and actions[117].

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[113] *DPP v El Mawas* per McColl JA at [79].
[114] 4 counts pursuant to the *Police Integrity Commission* Act 1996
[115] The Crown considered an appeal to the Supreme Court but ultimately decided not to pursue one.
[116] *Mantell v Molyneux* [2006] NSWSC 955 at [41].
[117] *DPP v El Mawas*, McColl JA at 73

Practitioners ought to address on this issue if there is likely to be any suggestion or concern the defendant is looking for a "get out of gaol free" card[118]. A section 32 order can often be more onerous than a section 9 or section 12 bond.

4.2.5 *The existence and content of a treatment plan*

As noted above, the existence and content of a treatment plan is a mandatory consideration in the exercise of the discretion and it must be clear and effective.[119]

4.2.6*. Risk of reoffending*

In *Perry v Forbes* Smart J found the Magistrate in that case should have had placed before him a treatment plan that was likely to ensure there would not be a repetition of the incident in question or the occurrence of some other unfavourable incident[120].

4.2.7. *Period of supervision*

Some Magistrates will refuse a section 32 application citing the court's limited period of supervision. Section 32(3A) provides a Magistrate with the power to call up a defendant on a suspected breach but only within 6 months of the order having been made. The decision of Adams J in *Mantell v Molyneux* makes it clear that a Magistrate can extend the period of six months "*by a considerable margin*" by adjourning the proceedings pursuant to s.32(2) after the tests in s.32(1)(a) and (b) are satisfied or in accordance with a Magistrates general power to grant adjournments. Practitioners should address on this issue and draw the Magistrate's attention to His Honour's decision*:*

> "... It seems that, for the reasons given, the Magistrate may have been able (if he had made a determination that diversion was appropriate under s32(1) to deal with the appellant under s32(2) and then, when satisfied that the discretion under s32(3) should be exercised, doing so at that point. This could have extended by a considerable margin the six months' limit to which his Honour referred"[121].

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[118] p.31 below.
[119] *DPP v El Mawas*, per Spigelman CJ at [10]. See also *Perry v Forbes* at [15]
[120] Ibid.
[121] at [45]

The ambiguity in relation to the period of the court's supervision was considered by Gotsis & Donnelly who concluded it was:

> "… a drastic step to imply a six-month limit into the language of s.32(3)"[122]:

Further:

> "Section 32 suffers from textual ambiguity on the question of what is the maximum permissible length of a conditional order that can be made under ss 32(3) and 32(2). This ambiguity has arisen since the introduction (in 2004) of the breach provisions which provide for a call-up procedure up to six months from the imposition of a conditional s 32(3) order. The Commonwealth equivalent of s 32, found in s 20BQ of the *Crimes Act* 1914 (Cth), sets a three-year limit for the term of the order. Sections 32(3) and 32(2), on the other hand, are silent on the issue. It was assumed at first instance and on appeal in *Mantell v Molyneux* that a conditional order under s 32(3) could not be made beyond the six-month period that the order could be enforced. Section 32(3) was read down to ensure there was symmetry between the enforcement provisions and the substantive order. Given that the enforcement provisions were inserted after the enactment of s 32 and the Parliament chose not to expressly limit the duration of s 32(3) orders at that time, we doubt whether the rules of statutory interpretation would permit such a restrictive interpretation. The implication (of a six-month limit) cannot be regarded as necessary for the operation of the section. Magistrates have since been encouraged by the Supreme Court in *Mantell's* case (at [45]) to utilise the broadly expressed interlocutory provisions in s 32(2) with the effect of extending "… by a considerable margin the six-month limit". …. the issues of what exactly is the maximum permissible length of a s 32(3) order and what is the relationship between interlocutory orders and final orders may require legislative clarification".[123]

4.3 OTHER CONSIDERATIONS

4.3.1. *A causal nexus ?*

A causal nexus is not a mandatory requirement for the exercise of the section 32 discretion. However, the existence of a causal nexus will provide a solid foundation for a s.32 application.

If a causal nexus is absent, a practitioner ought to emphasise that a causal nexus is not a mandatory requirement for s.32 diversion.

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[122] (2008) Ibid at p.15.
[123] Ibid at p.3.

4.3.2. *Effective supervision and enforceability of orders*

Some Magistrates appear to be reluctant to utilise s.32 because of a belief the court lacks the powers to enforce the orders. Practitioners should address this issue in submissions on s.32(1)(b). Gotsis and Donnelly note:

> "The issue of enforceability is central to the ability of s.32 orders to provide an effective therapeutic jurisprudence mechanism for offenders with mental disorders".[124]

A report writer should include in the report undertakings to advise the court of any non-compliance. While the undertakings could not be enforced, it might give a Magistrate some confidence the client will comply with any section 32 order.

4.4. CHALLENGES

Difficult problems and questions frequently emerge for consideration and resolution during the preparation and hearing of s.32 applications.

4.4.1. *The hostile bench*

Practitioners should not be discouraged from making a s.32 application simply because the Magistrate is known as being reluctant to utilise the s.32 diversion powers. Read the exchange between the practitioner and Magistrate in the decision of *Khalil* [125] in preparation.

4.4.2. *Serious offences*

As discussed above, section 32 orders can be obtained in respect of serious offences and the potential application of section 32 to such offences should not simply be ignored.

4.4.3. *Traffic offences*

Likewise, practitioners should not be discouraged from making a s.32 application in a traffic matter. There appears to be a view held by some Magistrates that 32 cannot or should not

[124] Ibid. p. 22.
[125] [2008] NSWSC 1092

be utilised in traffic offences because of the court's inability to disqualify the defendant from driving. There is no basis for such a distinction and the case law is silent on the issue.

As discussed above, section 32 orders are made in respect of traffic offences. In *Police v Deng*[126] a charge of Negligent Driving Occasioning Death was dismissed pursuant to section 32.

If a Magistrate rejects a section.32 application in relation to a traffic offence, the Magistrate is likely to suggest it is in the "public interest" to do so. Therefore, a practitioner should ensure the report writer addresses the issue of whether the client poses any danger to himself or others if 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 argued the Roads and Maritimes Service (RMS) is the proper authority to determine whether a client is a "fit and proper person" to hold a licence. The court can be invited to send copies of the court papers to the RMS as part of any section 32 order. This can circumvent any suggestion a section 32 application is being made simply to avoid licence disqualification.

Therefore, if a s.32 application succeeds on a traffic offence, practitioners should be mindful of the possibility of the RMS cancelling a client's driver's licence on the "fit and proper person" ground. If this occurs, it will then be necessary for the client to lodge a licence appeal in Local Court. A client should be appraised of this possibility (and the extra costs involved) from the outset.

4.4.4. *Multiple section 32s*

There is nothing in the legislation which precludes the court from making a second or subsequent section 32 application in relation to second or subsequent offences[127].

4.4.5. *The client who lives interstate*

It is not clear to me whether a court could or would make a conditional s.32 order where the client resides outside of NSW and the treatment plan is to be implemented outside of the jurisdiction. I suspect jurisdictional issues could be a significant hurdle in this situation. In

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[126] [2008] NSWLC 2

[127] The writer has obtained four s.32 orders for a young person with Borderline Personality Disorder within a period of 2 years. In addition, two s.32 orders have been obtained for young person with ADHD and Paediatric Bipolar Disorder.

one recent case in which the writer appeared the Magistrate made an unconditional section 32 order as the client had moved to Western Australia.

4.4.6. *Commonwealth offences*

Section 32 is not available in the Local Court for Commonwealth offences but a similar diversionary power is provided for by s.20BQ *Crimes Act* 1914 (Cth). While it is in substantially similar terms, the provision appears to be more narrow in its application[128].

4.4.7. *Breaches*

Unless a client is required to be of good behaviour as a condition of any section 32 order, committing a further offence within 6 months of the order being made does not place the client in breach. This view is supported by Gotsis and Donnelly[129]:

> "A failure to comply with a s.32 order is technically about non-compliance with a condition of a treatment plan, rather than further offending. Spiers argues that s.32 orders are not a type of bond, so conditions to be "of good behaviour" do not accord with the legislative intent of s.32.[130]

[128] Richardson E and McSherry B Ibid.
[129] (2008) Ibid. at p. 20.
[130] Citing M Spiers "Summary Disposal of Criminal Offences under s.32 Mental Health (Criminal Procedure) Act 1990 *"*(2004) 16(2) *Judicial Officers' Bulletin* 9

5. WHEN A SECTION 32 IS REFUSED

For a detailed discussion on making a second or subsequent section 32 application in the Local Court or on appeal in the District Court, applications to have a Magistrate disqualified on the grounds of bias and the relevance of cognitive and mental health impairments in sentencing, please refer to the writer's 2013 paper.[131]

It is essential the practitioner is well prepared in the event a section 32 application is refused.

Sometimes it will be possible to persuade the Court to exercise the section 10 discretion instead[132].

If the Magistrate makes an error of law in refusing a section 32 application, the matter can be reviewed by the Supreme Court.

The recent decisions of the Supreme Court in *DPP v Soliman* [133] and *DPP v Lopez-Aguilar*[134] would tend to suggest that practitioners ought to bear in the mind the possibility of a Crown appeal, especially against any section 32 order that might be made at Fairfield Local Court! Together with the decisions in *Khalil* and *Edwards* practitioners and Magistrates need to pay careful attention to the manner in which section 32 applications are prepared and determined

6. OTHER OPTIONS

There will be occasions where practitioners will need to consider options in addition to section 32.

People with cognitive and mental health impairments charged with a criminal offence that can be finalised in the Local Court also have available to them the common law defence of insanity (M'Naghten's Rules), although it is very rarely run.

For those persons who are very unwell, section 32 may not be an option.

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[131] Weeks K., (2013) *What to do when a Section 32 Application is refused*, 51(1):66. Download via www.cmhlaw.com.au (see the Section 32 Guides page).
[132] s.10 *Crimes (Sentencing Procedure)* Act 1999
[133] [2013]NSWSC 346
[134] [2013] NSWSC 1019

Unfitness to plead may be an issue that requires resolution at the outset of proceedings.

Section 33 diversion is available to Magistrates for those who are "mentally ill" within the meaning of the MHA. As it will often result in involuntary detention practitioners must tread carefully when they suspect there client is "mentally ill".

6.1. SECTION 33 DIVERSION

If an offender is "mentally ill" within the meaning of the MHA section 32 is not available.

Section 33 MHFPA provide for diversion from the criminal justice system for these people.". It is used less frequently than section 32 since the criteria is extremely narrow.

Note, the result of a section 33 order is often involuntary detention in a psychiatric facility so section 33 should be used with great care.

Also note, where an order is made pursuant to s.33(1)(a) there is a great deal of uncertainty and confusion as to whether the order is interlocutory or final. [135]

6.2 DEFENCE OF INSANITY IN THE LOCAL COURT

The common law defence of insanity (M'Naghten Rules) is available in the Local Court and has not been displaced by statute, despite the belief of some practitioners and Magistrates. However, the M'Naghten's defence is rarely used given the diversionary regimes available in sections 32 and 33. If the defence succeeds the accused must be discharged as there is no machinery for the MHRT to supervise an accused. The MHRT has jurisdiction over those who are the subject of a special verdict of not guilty on the grounds of mental illness in the

[135] See for example the Local Court Bench Book at p. 1556 where it is suggested the proceedings should not be adjourned by a Magistrate who has made a section 33(1)(a) order as the order has been executed once the person is detained and admitted to hospital following an assessment. The author suggests the proceedings are therefore finalised although the police can seek to have the matter relisted. The NSWLRC also examined the uncertainty in the provisions in Report 135 (2012) at p.279.

District and Supreme Courts pursuant to s.39 MHFPA. See the NSWRLC's recent report for further information.[136]

6.3 UNFITNESS TO PLEAD IN THE LOCAL COURT

The common law relating to fitness to plead remains in the Local Court. Where an accused is unfit to plead and sections 32 and 33 are not utilised it seems the accused must be discharged.[137]

7. FUTURE DEVELOPMENTS

7.1 RECOMMENDATIONS OF THE NSWLRC

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[138] in the area.

See Report 135 for the recommendations in relation to section 32[139].

7.2. THE ROLE OF NEUROSCIENCE

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

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[136] NSWLRC (2013) Report 138 *People with cognitive and mental health impairments in the criminal justice system : Criminal responsibility and consequences* at pp.341 and 357.
[137] *Mantell v Molyneux* Ibid at [28]-[37]
[138] See further http://www.lawreform.lawlink.nsw.gov.au/lrc/lrc_index.html
[139] esp pp.138-143

magnetic resonance imaging (fMRI)[140] 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"[141].

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".[142]

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"[143].

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"[144].

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

> "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,

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[140] A procedure that measures brain activity by detecting associated changes in blood flow.
[141] A Walsh & J D Bolen, *The Neurobiology of Criminal Behaviour,* Ashgate Publishing Limited, Surrey, 2012.
[142] Ibid at p.15.
[143] Ibid at p. xii
[144] Ibid at p. 131

> decision making, and the like) may aid efforts to increase the effectiveness, efficiency, and justness of law"[145] .

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".[146]

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[145] Owen D Jones, *Seven Ways Neuroscience Aids Law*, 15 June 2013 retrieved via http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2280500
[146] S Satel & S O Lilienfeld, Brainwashed, *The Seductive Appeal of Mindless Neuroscience*, Basic Books, 2013 New York.