Dealing with Clients with Cognitive and Mental Health Impairments in the Local Court

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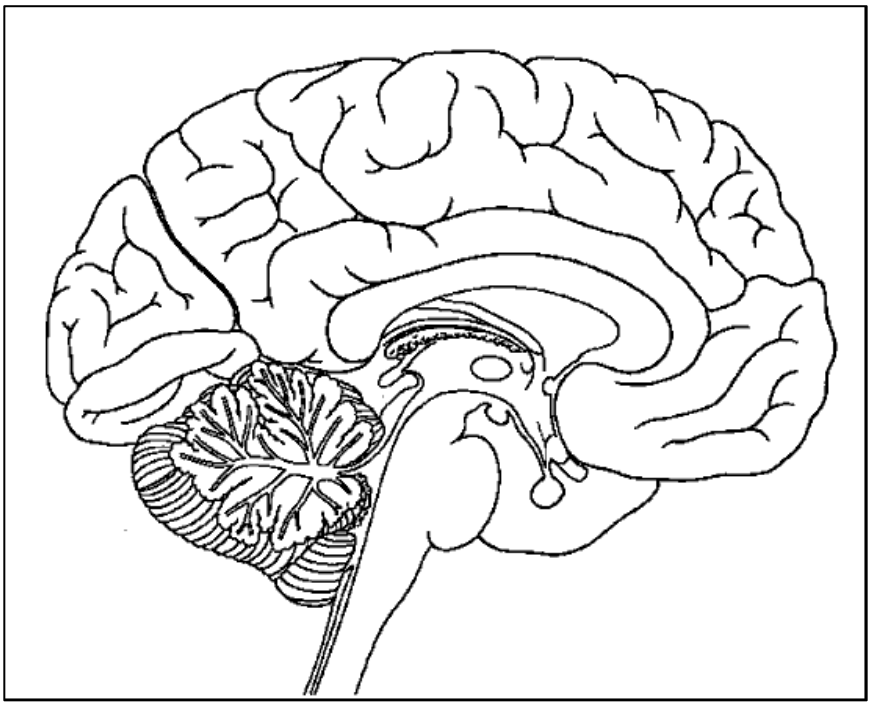

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“ Cases involving an element of mental disorder or mental illness sometimes occasion difficulties for courts and the accused’s legal representatives… Explaining and making applications to have s.32 applied may be difficult “

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Supreme Court NSW, Unreported,
21 May 1993 at p.5.

DEALING WITH CLIENTS WITH COGNITIVE AND MENTAL HEALTH IMPAIRMENTS IN THE LOCAL COURT

1. INTRODUCTION

One person takes their own life every four hours[1]. Many others try without success. In 2008 there were 2,191 registered deaths from suicide. Over three-quarters (78%) were males[2]. More people die from suicide each year than are killed in transport accidents [3]. Death by suicide is almost 10 times the rate of death by homicide[4].

While 2010 saw the issue of mental ill-health discussed at kitchen tables around the country, misinformation, misunderstanding and stigma remain. Sufficient additional government funding has not yet materialised and funding remains the major obstacle to mental health reform. Consequently, those in need of mental health services, especially young people and those within the criminal justice system, are often unable to access any appropriate treatment services.

Many people who come in contact with the criminal justice system do so because of cognitive and mental health impairments. These people need to be identified at the earliest opportunity, given the high risk of reoffending.

Legal practitioners appearing in the criminal jurisdictions of the Local and Children's Courts are in a unique position to assist with the identification and diversion of people with cognitive and mental health impairments from the criminal justice system into treatment services.

The diversionary regime created by section 32 *Mental Health (Forensic Provisions) Act* 1990[5] (hereafter "s.32") has been described as a legislative innovation"[6] embodying a "therapeutic justice initiative"[7]. Section 32 orders have the potential to produce positive outcomes.[8] 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".[9]

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[1] *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
[2] Ibid.
[3] Ibid. 1151 people were killed in transport accidents, either as pedestrians (183), motor cycle riders (226) or occupants of a car (742).
[4] Ibid. 260 people were the victims of homicide in the 2006-2007 year.
[5] Hereafter the "MHFPA".
[6] Gotsis T. & Donnelly H. Judicial Commission of NSW, Monograph 31, "Diverting Mentally Disordered Offenders in the NSW Local Court, March 2008, at p. 29.
[7] Ibid. p. 20.
[8] 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.
[9] Parliamentary Debates, *Legislative Assembly*, 8 November 2005 at p.19214

Data from NSW indicates that s.32 is not being used as often as one might expect. In 2009, 241,858 charges were finalised in the jurisdiction. Only 4,107 (1.7%) were dismissed either under s.32 or s.33 of the *Mental Health (Criminal Procedure) Act 1990*, as it was then known[10].

Legal practitioners are in a unique position to facilitate and assist in the identification, diagnosis, treatment and diversion of those with cognitive and mental health impairments from the criminal justice system.

SCOPE

You will note I have changed the title of the discussion to "clients in the Local Court with *cognitive and mental health impairments*" from Legalwise's brief "clients who are *mentally ill*". The confusion surrounding the meaning of "mentally ill" is discussed further below and the terms cognitive and mental health impairments are preferred by the NSWLRC[11]. They are adopted here.

This paper updates and expands on my paper published in the *Law Society Journal* in May 2010. It focuses solely on section 32 applications[12]. Discussion does not extend to:

- applications pursuant to s.33 MHPFA (where a client is "*mentally ill*" or "*mentally disordered*" under the *Mental Health* Act 1990[13]);
- fitness to plead (although s. 32 or s.33 MHFPA may be relevant where the issue arises in the Local and Children's Courts[14]);
- intellectual disabilities, although s.32 can sometimes apply[15] and parts of the following discussion will be relevant;
- the common law defence of mental illness (the M'Naghten Rules) which is available in the Local Court.[16]

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 their meaning derives from the context in which they are used. According to the New South Wales Law Reform Commission (NSWLRC):

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[10] NSW Bureau of Crime Statistics and Research, "NSW Criminal Courts Statistics 2009" at p.21. Unfortunately, the statistics do differentiate between the numbers dismissed pursuant to s. 32 or s.33.

[11] See the discussion on Terminology p.3.

[12] Weeks K., "To Section 32 or Not ? Applications under s.32 Mental Health (Forensic Provisions) Act 1990 in the Local Court" (2010) *Law Society Journal* 48:4. A copy can be retrieved from www.brrt.net.au under the tab "Mental Health" - http://www.brrt.net.au/BakerRyrieRickardsTitmarsh1762/Page/19741/MentalHealth.aspx

[13] Hereafter the "MHA". Contact the Mental Health Advocacy Service (MHAC) or the Mental Health Review Tribunal (MHRT) for further information. See also John Feneley (2009) "Applying the Amended Mental Health (Forensic Provisions) Act 1990 and Rethinking the Defence of Mental Illness", retrieved at http://www.lawlink.nsw.gov.au/lawlink/pdo/ll_pdo.nsf/pages/PDO_applyingamendedmentalhealthrethinkingdefence.

[14] See New South Wales Law Reform Commission Consultation Paper 6 "People With Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences"; **(**2010) at p.21. See also Mark Ierace SC, "Fitness to be Tried", paper presented to the University of NSW CLE day 5 November 2010 and Lester Fernandez "Fitness to be Tried in the Local Court and Children's Court", paper presented to the NSW Bar Association Criminal Law Conference, 10 September 2010.

[15] See the discussion on s.32(1)(a) and "developmental disability" below. For assistance with clients with intellectual disabilities contact the Intellectual Disability Rights Service. At the time of writing the IDRS were in the final stages of preparing a Step by Step Guide to Section 32 Applications for Persons with Intellectual Disabilities; See also IDRS (2005) "Chiselling the Bars – Section 32 of the Mental Health (Criminal Procedure) Act 1990 (NSW)" and IDRS "Acting for Clients with an Intellectual Disability in Contact with the Criminal Justice System", retrieved from www.idrs.org.au.

[16] See NSWLRC CP6, Ibid, at pp.89 & 90.

> " … 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 or diagnoses that may apply to adults can, for various reasons, be difficult to apply to young people"[17].

One of the questions raised by the NSWLRC for consideration is "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[18].

Throughout this paper the term "cognitive and mental health impairments" is used in the context of s.32 applications[19].

THE EXTENT OF MENTAL ILL-HEALTH

Mental ill-health is relatively common. According to the Australian Government one in five adults will experience mental illness in any year[20]. The rate is around 1 in 4 for those aged 18-24 years[21]. Almost half the Australian population (45.5%) experience mental illness at some point in their life time[22]. Mental ill-health affects young people disproportionately with the majority (75%) of "adult psychiatric morbidity" first becoming evident before 24 years of age "[23].

[17] New South Wales Law Reform Commission, Consultation Paper 11, 2010, "Young People with Cognitive and Mental Health Impairments in the Criminal Justice System" at pp.5-6.
[18] NSWLRC New South Wales Law Reform Commission Consultation CP5 "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".
[19] The term "mental ill-health" is used by Professor McGorry and others and is used here in a more general sense. It has no legal meaning. If terms such as "mental disorder" are used it is because the term was used in the source material considered.
[20] 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
[21] 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.
[22] Australian Government (2007) Ibid.
[23] McGorry P et. al. Ibid.

THE AVAILABILITY OF TREATMENT

Unfortunately, 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[24]: Having regard to the enormous cost of incarceration, the high rate of recidivism amongst offenders with mental health disorders and the economic and human costs involved, the argument that greater investment ought to be made in mental health services, especially in early intervention programs targeted at young people, is very compelling. The availability of treatment is critical to the success of a s.32 application and of the diversionary scheme generally.

MENTAL ILL-HEALTH AND OFFENDING

Most people with mental ill-health are not dangerous[25]. However, mental health problems, both substance and non-substance related, are over-represented amongst offenders in custodial settings[26]. In a recent study a high rate of reoffending was found amongst prisoners with a mental health disorder In NSW. The rate of reoffending was significantly higher (67%) for prisoners with a co-morbid disorder[27] (those prisoners who had both a substance abuse disorder and a non-substance abuse disorder such as anxiety, depression or a personality disorder)"[28]. Dr Don Weatherburn concluded:

> "Increased investment in treating prisoners with a co-morbid disorder would not only make the community safer … it would save money by reducing the rate of re-offending and return to prison".[29]

Preliminary data from the second Young People in Custody Health Survey (YPICHS 2009) confirms the high rate of mental health problems amongst young people in NSW juvenile detention centres. 90% of female detainees and 80% of male detainees were found to have a diagnosed mental disorder[30]. Approximately 90% of females and almost 70% of males had two diagnosed disorders.

SECTION 32 - A THERAPEUTIC JUSTICE INITIATIVE

Section 32 is a legislative innovation of therapeutic jurisprudence[31].

One of the problems with the s.32 diversionary regime arises from the wide discretion give to Magistrates. Some Magistrates appear to be more willing to utilise s.32 than others and the level of understanding of mental health issues amongst Magistrates varies. The success of the diversionary regime also rests on the availability of appropriate treatment services:

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[24] McGorry P, during discussion at the *First International Youth Mental Health Conference*, 29–30 July 2010, Melbourne.
[25] Purcell R. "The Relationship between Violence and Mental Illness" February 2011, *Orygen Youth Health Research Centre Policy Briefing*, www.oyh.org.au.
[26] 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.
[27] See Comorbidity below.
[28] 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.
[29] Media Release, 17 June 2010, NSW Bureau of Crime Statistics and Research. Retrieved from
[30] New South Wales Government, Department of Juvenile Justice and Justice Health, "Young People in Custody Health Survey 2009", data presented by Dr. Claire Gaskin (Clinical Director, Adolescent Mental Health, Justice Health) to the *First International Youth Mental Health Conference*, Melbourne 29–30 July 2010. As at the date of writing the findings of the survey had not yet been published.
[31] See further Gotsis & Donnelly (2008) Ibid. at p.29.

> "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"[32].

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

THE IMPORTANCE OF THE LEGAL PRACTITIONER

As noted above, practitioners appearing in the criminal jurisdictions of the Local and Children's Courts are in a unique position to assist with the identification and diversion of people with cognitive and mental health impairments from the criminal justice system into treatment services.

Taking instructions from and acting for clients with cognitive and mental health impairments can sometimes be difficult and challenging. A measure of patience and understanding is required. The legislative provisions are confusing. Most practitioners haven't benefitted from tertiary study in medicine, psychiatry, psychology or neuroscience and key concepts may be difficult to comprehend. Dealing with psychiatrists, general practitioners, psychologists, hospitals and other health service providers can be time consuming and frustrating.

You may already know something about mental ill-health if you, a family member, friend, colleague or employer has suffered from mental or cognitive impairments. I encourage you to put aside any old-fashioned notions of mental health that you may harbour. You should think twice about acting for clients with cognitive and mental health impairments if you don't think you will have the time, interest or inclination to act for them otherwise you may do your client and yourself a disservice. Refer the client on if you are in any doubt.

The NSWLRC confirmed the importance of the legal practitioner in the s.32 diversionary regime:

> "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".[33]

[32] Ibid at p.31.
[33] New South Wales Law Reform Commission Consultation Paper 7 "People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion" (2010) at p.49.

2. WHAT QUALIFIES A CLIENT TO BE DEALT WITH UNDER SECTION 32

In considering a s.32 application, a magistrate is required to make 3 decisions[34]:

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.[35]

The second question for determination 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. 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[36]. 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 can not be exercised without regard to the seriousness of the offending conduct[37] although the diversionary regime is available to serious offenders as long as it is regarded as more appropriate.[38]

The third decision is whether to make orders under s.32(2) or s.32(3).[39]

A practitioner must be prepared to make submissions in relation to all three questions.

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

The eligibility criteria for the s.32 diversionary regime is found in s. 32(1)(a) which 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 …"

The confusion in the terminology was discussed above.[40] It should be noted that if your client satisfies the narrow definition of "mentally ill" in the MHFPA and MHA the correct application is under s.33. "Mentally ill" in this context defines who can be involuntarily detained. It applies to those persons where their care, treatment or control is necessary to protect the person or others from serious harm.[41] "Mentally ill" in this sense is different to "suffering from a mental illness" in s.32(1)(a). Section 32 is much broader in application. 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 s.32 diversion.

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[34] *DPP v El Mawas*, McColl JA at 75.
[35] Ibid.
[36] Ibid.
[37] Ibid. citing Howie J in *Confos v DPP* [2004] NSWSC 1159 at 17.
[38] *DPP v El Mawas*, McColl JA at 79.
[39] Ibid at 80.
[40] p.3.
[41] See the definitions of "mentally ill" person in s.3 MHPFA and s.14 MHA.

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[42].

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. [43].

As noted above[44], to overcome the limitations arising from the current terminology, the NSWLRC has suggestion 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 "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"[45]

Despite the confusion, s.32 has been described as broad and malleable[46]. The breadth of the criteria in s.32(1) was confirmed by the Supreme Court in *Perry v Forbes Anor.* 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".[47]

[42] NSWLRC CP5 at p.68
[43] T Gotsis and H Donnelly (2008) Ibid at p.25.
[44] p.3.
[45] NSWLRC CP5 at p.69.
[46] Gotsis & Donnelly (2008) at p.26
[47] Supreme Court of NSW, Unreported, 21 May 1993 at p.3.

In my experience, the jurisdictional question in s.32(1)(a) is often conceded by the prosecution. Nevertheless, it is essential the report writer touches on the issue. In *Khalil v His Honour Magistrate Johnson & Anor*[48] 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. His Honour was also critical of the lack of expert opinion confirming a diagnosis from a medical practitioner.
In my view where a diagnosis relates to disorders such schizophrenia, bipolar disorder, borderline personality disorder, depression, post traumatic stress disorder, anxiety or autistic spectrum disorders, including Aspergers syndrome, it is unlikely a practitioner will need to address the court on the jurisdictional issue.

In contrast, if the diagnosis is ADHD/ ADD[49] or substance abuse disorder[50] debate on the jurisdictional issue should be anticipated and the practitioner should be well prepared.

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 disability" covers the same ground as "intellectual disability" or "intellectual impairment".[51] 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".[52]

Developmental disability does not cover cognitive impairments arising from acquired brain injury or illness.[53]

As noted in my 2010 paper, ADHD/ADD is a developmental disability[54]. The NSWLRC is of this view[55]. 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".[56] Nevertheless, many people fail to appreciate the nature of ADD/ADHD, the underlying neurobiology of the disorder, the cognitive impairments associated with the condition and the significant impact in can have on the functioning of children and adults[57].

[48] [2008] NSWSC 1092 at 107.
[49] In relation to ADD/ADHD see pp. 12, 13, 16, 23, 24, 26, 27 & 29.
[50] See p.29
[51] NSWLRC CP5 at p.62
[52] NSWLRC CP5 at pp.60-61.
[53] Gotsis & Donnelly (2008) Ibid at p.27.
[54] Weeks, K. (2010) Ibid. at p.52.
[55] NSWLRC CP5 at p.61.
[56] (2008) Ibid. at p.26
[57] ADD/ADHD is discussed on pp. 12, 13, 16, 23, 24, 26, 27 & 29.

Mental Illness

Like "developmental disability", the term "mental illness" in s.32(1)(a) is not defined in the legislation. As noted, above there is confusion surrounding the term "mentally ill" and the term "mental illness" in the context of s.32(1)(a) is different and much broader in application than the term "mentally ill" in the MHFPA and MHA (where it is narrowly defined for s.33 and the provisions relevant to involuntary detention).
The meaning of "mental illness" in s.32(1)(a) is also different to the meaning of "mental illness" in the context of the defence of mental illness (the M'Naghten Rules).

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

"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"

According to the NSWLRC, "mental condition" is "*so vague as to be meaningless*"[58]. It:

> "… 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".[59]

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[60]. Magistrates surveyed in 2008 indicated the term was "archaic and confusing".[61]

"Mental health facility" is 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*"[62].

In the majority of s.32 applications a practitioner makes on behalf of the client, there will be little difficulty satisfying the first limb, the jurisdictional issue. Most s.32 applications will succeed or fail on the second limb, whether it is *more appropriate* the defendant be diverted than dealt with in accordance with law.

THE SECOND LIMB - s.32(1)(b)

If the jurisdictional issue is satisfied, the court must be then be satisfied diversion pursuant to s.32 is *more appropriate* than dealing with the person in accordance with law.

Section 32(1)(b) provides that if the jurisdictional requirements are met, diversion can take place if the Magistrate decides:

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[58] NSWLRC CP5 at p.72.
[59] NSWLRC CP5 at p.59 & 60.
[60] New South Wales Law Reform Commission Report 80 "People with an Intellectual Disability in the Criminal Justice System" 1996.
[61] Gotsis & Donnelly (2008) Ibid. at p.28
[62] These terms are also defined in s.4 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.

> "…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' ": *Coal and Allied Operations Pty Ltd v Australian Industrial Relations Commission* at [19]. 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*: *Coal and Allied Operations Pty Ltd v Australian Industrial Relations Commission* (at [19].

There has been little judicial consideration of s.32[63]. A thorough understanding of the decision of the Court of Appeal in *DPP v El Mawas*, the leading authority on s.32, is essential. Familiarity with the remaining decisions should assist practitioners in their efforts to persuade a magistrate to divert a client from the criminal justice system, especially where a Magistrate appears reluctant to do so. In the writer's experience, few magistrates appear to have a comprehensive understanding of the authorities.

When making submissions on the second limb, it is recommended that each and every relevant consideration be touched upon in submissions. On two occasions when I have not specifically addressed the Magistrate on whether the court's supervision of a s.32 order is limited to six months, the s.32 applications were refused on this basis. Practitioners normally won't be given an opportunity to address on an issue which is only mentioned when the Magistrate is summing up. Magistrates will rarely narrow the focus of a practitioner's submissions by specifying the issues that may cause them concern.

A wide discretion

Magistrates considering s.32 applications are given powers of an inquisitorial or administrative nature to inform themselves as they think fit[64]. The power has to be exercised in accordance with procedural fairness requirements.[65]

Nevertheless, Magistrates have a very wide discretion when determining whether a defendant should be the subject of s.32 diversion[66]. A wide variety of considerations can be taken into account. What is discussed below is not exhaustive.

The balancing exercise

A balancing exercise must take place before an order for s.32 diversion can be made. A Magistrate is required 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

[63] *DPP v El Mawas*, McColl JA at [59].
[64] *DPP v El Mawas*, McColl JA at [71]-[80].
[65] Ibid.
[66] Ibid. per Spigelman CJ at [4].

> mental illness (s.33) with the object of ensuring that the community is protected from the conduct of such persons"[67]

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" [68].

The Facts

Section 32(1)(b) requires a Magistrate to consider the alleged facts. There is no requirement the defendant is required to accept them.

The seriousness of the offence

The seriousness of the alleged offence is a relevant consideration on which a decision to refuse a s.32 application is often based. While the seriousness of the offence is a mandatory consideration[69] it is not a factor that will necessarily exclude an eligible offender from diversion.

While there appears to be a view that a s.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 s.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".[70]

Antecedents

A Defendant's antecedents is a relevant consideration. In addition, a Magistrate can also consider any prior s.32 orders and the Defendant's response to them[71]

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[67] Ibid. per McColl JA at [71]
[68] [2004] NSWSC 1159 at [17].
[69] *DPP v El Mawas* per Spigelman CJ at [7], *Confos v DPP* at [17], *Mantell v Molyneux*, Ibid at [40].
[70] *DPP v El Mawas* per McColl JA at [79].
[71] *Mantell v Molyneux* [2006] NSWSC 955 at [41].

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 *DPP v El Mawas* McColl JA agreed that while s.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[72].

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[73]. A s.32 order can in practice be more onerous than a s.9 or s.12 bond[74].

The nature of the cognitive or mental health impairments

Practitioners should address the nature of the Defendant's cognitive or mental health impairments in submissions on s.32(1)(b).

For example, if a Defendant has been diagnosed with ADD/ADHD, a practitioner should highlight the executive function impairments associated with the disorder which include, inattention to detail, difficulties with attention and planning, distractibility, impulsivity and poor consequential thinking. Similar executive function impairments can be seen in Bipolar Disorder and Depression.

Any neurobiological basis for the disorder or impairments should be highlighted. For example:

- in the case of ADD/ADHD, low levels of two key neurotransmitters, Dopamine and Noradrenaline, are responsible for the executive function impairments described above.
- Biological causes of Depression involves dysregulation of Serotonin.

Medications including anti-depressants, anti-psychotics and those for ADD/ADHD are designed to influence the neurotransmitters responsible.

In my view, emphasising the underlying neurobiological processes can strengthen a s.32 application. While the Magistrate may not completely understand the science involved, an explanation of why the impairments arise and how they relate to the client's decision making at the time of the offence can provide a solid foundation for a.32 application.

A causal nexus ?

Often a causal nexus can be established between a client's cognitive and mental health impairments and the offence. A causal nexus can also provide a solid foundation for a s.32 application.

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

[72] *DPP v El Mawas*, McColl JA at 73
[73] p.31 below.
[74] Sections 9 and 12 *Crimes (Sentencing Procedure)* Act 1999.

Period of supervision

Some Magistrates will refuse a s.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)[75] or in accordance with a Magistrates general power to grant adjournments. Practitioners should address on this issue and draw the Magistrate's attention to the decision*:*

> " It is difficult, therefore, to see the purpose of inserting s.32(2) in Part 3 unless it were intended as widening in some way the general powers of the magistrate, perhaps by permitting an interim position to be brought about before determining whether to make the order referred to in s33(3). It is important to note that the power given by s32(2) can only be exercised when the magistrate has made the decision required by s32(1)(b) so that, for example, an adjournment under s32(2)(a) could not be made for the purpose of considering whether it was more appropriate to divert a defendant rather than dealing with him or her in accordance with law. At the same time, the general power to adjourn proceedings must permit a magistrate to do so before making any decision under s31(1). I note also that it appears from the terms of s32(3) that the magistrate is not bound to make an order dismissing the charge although, having decided that the conditions of s32(1) are satisfied and having decided not to take action under s32(2), it seems inevitable that an order must be made under s32(3). I mention these matters simply to demonstrate that it might have been open to the learned Magistrate to have adjourned the proceedings in exercise of his Honour's general power to see how the appellant was coping with the regime then in place pursuant to the bond."[76]

And further:

> "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"[77].

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)"[78]:

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

[75] An adjournment pursuant to s.32(2) can only be made after the eligibility criteria in s.32(1)(a) has been satisfied and the Magistrate has determined it is more appropriate to divert the Defendant pursuant to s.32(1)(b).
[76] at [43]
[77] at [45]
[78] (2008) Ibid at p.15.

> 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".[79]

The existence and content of a treatment plan

The existence and content of a treatment plan is a relevant consideration in the exercise of the discretion.[80] In fact, it can be considered to be a mandatory requirement for a s.32 as without one a s.32 application is unlikely to succeed.

If practitioners are uncertain as to what should be included in a treatment plan, refer to the detailed guide prepared by Gotsis and Donnelly[81] . Treatment plans are discussed further below[82].

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".[83]

It is suggested a practitioner could consider having the report writer give undertakings in the report to advise the court on any breach. While the undertakings could not be enforced, it might allow a Magistrate to have a greater degree of confidence the client will comply with a s.32 order.

In my experience, most clients who have been the subject of a s.32 order are committed to continuing with treatment after a charge is finalised. Becoming involved in the criminal justice system can be a catalyst for change. While there appears to be very few instances where breach action is commenced by Magistrates, it is arguable an offender who does not comply with the conditions of a s.32 order in continuing with treatment is at risk of reoffending and is therefore likely to come to the court's attention at a later stage

[79] Ibid at p.3.
[80] *DPP v El Mawas*, per Spigelman CJ at [10].
[81] (2008) Ibid at p.18.
[82] p.16
[83] Ibid. p. 22.

3. PREPARATION FOR AN APPLICATION

AT THE FIRST CONFERENCE

Given the likelihood a practitioner will be instructed by a client with cognitive or mental health impairments, it is my view the s.32 option should always be canvassed with the client together with the client's options of pleading guilty or not guilty.

A practitioner should not assume the client will necessarily volunteer information about any cognitive or mental health impairments they may have. Some clients may lack insight and be unaware there is any problem. This may be the case where the client is a young person or where the client is in the early stages of exhibiting symptoms of a disorder or has not been assessed or diagnosed previously.

Some clients may find it difficult to raise certain issues for discussion with the practitioner. Victims of trauma, such as sexual assault, are unlikely to disclose relevant information to the practitioner at the first conference. A practitioner will therefore need to consider advising a client of the s.32 diversionary option in general terms.

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 s.32 application, it will be a more expensive option for the client than a plea of guilty.

TAKING INSTRUCTIONS

Taking detailed instructions from the client is essential for the preparation of a s.32 application.

A practitioner should start from the client's early years at preschool and primary school moving through to adolescence and adult life. Family members can be a valuable source of information. Mothers are particularly useful when obtaining a detailed history of the client.

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 abuse should sound warning bells.

While the following list is not exhaustive, a practitioner should seek detailed instructions as to whether:

- the client has been diagnosed previously, including any prior diagnosis of ADD/ADHD as a child[84]. It should be remembered that diagnosis of mental disorders in young people can be difficult. A clear clinical picture may not emerge until late adolescence or adulthood. Nevertheless, a diagnosis of ADD/ADHD in childhood is indicative of the presence of cognitive impairments at a young age;
- the client has a history of behavioural disorders in childhood;

[84] ADD/ADHD is discussed at pp. 12, 13, 16, 23, 24, 26, 27 & 29. There can be an association between ADD/ADHD and Bipolar II Disorder.

- the client experienced difficulties at school with reading, learning or concentration or was hyperactive, easily distracted, dreamy or inattentive. School reports can be particularly helpful;
- the client has ever experienced difficulties with sleeping;
- the client has ever taken or been prescribed any medication including anti-depressants;
- the client has ever had any difficulties with drugs or alcohol or participated in drug and alcohol counselling or rehabilitation;[85]
- there is a history of offending, including traffic offences. Multiple convictions for shoplifting offences, PCA offences or offences of violence should sound alarm bells;
- there is any history of suicidal ideation or self-harm;
- the client has experienced difficulties maintaining relationships or in employment;
- there is a gambling problem;
- the client has ever sustained a head injury or periods of unconsciousness.

OBTAINING A REPORT AND TREATMENT PLAN

The availability of a suitably qualified expert(s) to provide a report, prepare a treatment plan (or case plan[86]) and/or provide treatment is critical to the success of a s.32 application. As noted above, the existence and content of a treatment plan is a relevant consideration in the exercise of the s.32 discretion and without one a s.32 application is unlikely to succeed[87]. A section 32 application is also unlikely to succeed unless there is a psychological or psychiatric report(s) that confirms:

- the client meets the jurisdictional requirements in s.32(1)(a);
- the psychologist or psychiatrist is prepared to provide treatment to the client.

Where the report writer is not the treatment provider, an additional report from the treatment provider will be required. This is often the case where the report writer is a forensic psychologist or psychiatrist as they will not become involved in the treatment of the client.

The limited availability of mental health services for those in need was discussed above.[88] Many offenders who are eligible for a s.32 order will not be diverted from the criminal justice system pursuant to s.32 simply because they are unable to:

- find a health professional(s) to complete an assessment and prepare a report;
- meet the costs of the assessment and/or a report; and
- find a health professional(s) who can provide treatment.

Those who are reliant on the public health system are at considerable disadvantage. In my experience, psychologists at community health centres will not provide reports for court. Those who live in regional areas are likely to experience greater difficulty in accessing psychologists and psychiatrists than their city counterparts.

[85] A client may self-medicate with alcohol and drugs to alleviate the symptoms of a disorder, especially when they are undiagnosed and untreated. See the discussion on co-morbidity below at pp. 28 & 29.
[86] The NSWLRC considered the issue of treatment plans in CP 7. According to the IDRS a preferable term is “case plan” given there is no treatment for intellectual disabilities (at p.50).
[87] p.12.
[88] p.4.

Even where a client has access to funds, it can be difficult finding a health professional(s) who is skilled and available to provide treatment. Waiting lists for psychiatrists in the city can be lengthy. The client will need a health professional whom they can trust and with whom they feel comfortable. Establishing therapeutic relationships between a client, general practitioner, psychologist or psychiatrist can be difficult. Often a multi-disciplinary approach is required for treatment which requires significant co-ordination by the legal practitioner (and therefore increases costs).

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 the necessary information. As noted above, the report should address the jurisdictional criteria in s.32(1)(a). The report writer should also be asked to address the issue of whether, in their expert opinion, diversion is more appropriate and why.

In terms of the content recommended in a treatment plan, Gotsis and Donnelly offer a practical guide for practitioners and health professionals[89].

In my experience 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. This has been insufficient for other Magistrates who have virtually required a separate document labelled "treatment plan" which lists and describes each component of the proposed treatment.

PSYCHIATRIST OR PSYCHOLOGIST?

There is likely to be disagreement amongst practitioners as to whether a s.32 report should be obtained from a psychologist or psychiatrist.

It is my view that a report from a psychiatrist is generally not required for a successful s.32 application. A <u>good</u> report from a reputable clinical psychologist should suffice. However, practitioners should be mindful of the decision of Hall J in *Khalil*[90] wherein a report from an experienced and reputable clinical psychologist was the subject of criticism and the absence of a report from someone with medical qualifications was a critical issue. For this reason, if a s.32 application fails in the Local Court and a further s.32 application is made in the District Court[91], a practitioner ought to consider obtaining a report from a psychiatrist.

Practitioners should consult their colleagues if they do not know who to approach for a report. I have seen good and bad reports from both psychologists and psychiatrists and I am always very wary of opinions based on a short consultation and/or in the absence of any psychometric, psychological or neuropsychological testing.

SUPPORTING DOCUMENTATION

All relevant documentation should be gathered by the practitioner during the preparation of a s.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 reports. Old reports can be helpful and can sometimes establish the client may have been unwell or has

[89] (2008) Ibid at p.18
[90] Ibid.
[91] On appeal against conviction and/or sentence. See further below p.32.

suffered from cognitive and mental health impairments well before the commission of the offence.

AT THE FIRST MENTION

A s. 32 application involves more preparation than a plea of guilty and practitioners will need to allow sufficient time to collect all relevant documentation and obtain a report before the application is heard. In addition, time to enable the client to start the treatment plan can be helpful in the s.32 application. Magistrates appear to be generally aware of the delay which can be encountered in arranging appointments with report writers and obtaining reports. Nevertheless, a practitioner should be aware of the pressures placed on the Local Court to finalise matters efficiently and within specified time standards.

At the first mention I normally seek a 2 to 3 week adjournment (without entering a plea) to enable the client to arrange the initial appointment with the report writer.

When the matter returns to court on the second occasion, a further adjournment of 2 to 3 weeks is sometimes necessary, especially if report writer has not yet seen the client and there is some uncertainty as to how long the report will take. If the court refuses a further adjournment, accept a date for the hearing of a s.32 application but allow enough time for the report writer to complete the assessment and report:

- if possible, a practitioner should avoid having a s.32 application listed at 10.00am on a list day;
- consider asking for the s.32 application to be listed on a 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.

Should a plea be entered?

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

Practitioners should not be bullied into entering a plea by a Magistrate. There is no requirement a plea be entered before a s.32 application is made. A s.32 application can be made at any stage of the proceedings, whether a plea has been entered or not.

It is open to practitioners to indicate to the court a plea of guilty will be entered by the client if the s.32 fails. This could be relied upon later if the s.32 application fails and a plea of guilty is entered.

If the client's instructions are to enter a plea of not guilty in the event the s.32 application fails, the Magistrate can be advised of this during the hearing of the s.32 application. While it might not be a consideration strictly relevant to the exercise of a Magistrate's s.32 discretion, query whether in some cases a Magistrate would be more attracted to s.32 diversion knowing a defended hearing (with further delay) would otherwise result.

As the matter progresses

The practitioner should ensure their client is aware that much of the preparation of the s.32 application takes place "behind the scenes". Most clients involved in criminal proceedings have some anxiety about their proceedings. For those with cognitive or mental health impairments, the level of anxiety can be much greater. Practitioners should ensure their client understands there will be delay.

In some cases, a practitioner will need to remind a client of any appointments. On one occasion I have personally escorted a client to the rooms of the report writer to ensure his attendance. The report writer might also need a subtle reminder of the date by which a report is required. A practitioner should ensure the report writer's fee has been paid. Most psychologists and psychiatrists will not release a report until full payment has been made.

A practitioner may need to update their fee disclosure as necessary.

Preparation immediately before the hearing

Preparing a chronology for a s.32 application can be helpful. It is likely to be of great assistance to a Magistrate, especially where there are lengthy mental health or criminal histories, complicated issues arise for consideration or the relevant documentation is voluminous.

Spoon feeding a Magistrate with the information and evidence on which they can base a decision to divert under s.32 will rarely be a waste of time. While a practitioner might have a thorough understanding of their client's life and the matter the Magistrate is unlikely to ever reach a similar level of understanding during the proceedings.

Practitioners should prepare a short list of points to be canvassed in the practitioner's submissions on s.32(1)(a) and s.32 (1)(b). The list can be cross-checked during the application to ensure all relevant considerations have been addressed.

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 history before the hearing.

Written submissions are not encouraged. In my view tendering written submissions could make it more difficult to succeed in the Supreme Court if an error of law is made by the Magistrate. The Supreme Court can a review a Magistrate's decision to refuse a s.32 application where there has been an error of law[92]. This includes a denial of procedural fairness. A denial of procedural fairness can arise when a Magistrate fails to consider all relevant consideration(s) in the exercise of the s.32 discretion. Handing up written submissions puts all relevant considerations squarely before the Magistrate and the Magistrate will already have enough to read.

As with any matter, on the day prior to the hearing of the s.32 application, the practitioner should contact the court to determine who the Magistrate is likely to be. In smaller courts where there is only one Magistrate this will be unnecessary. For practitioners in larger areas, it is essential, in my view, to know who the bench is before you walk into the court room. Speak to colleagues if the Magistrate is not known to you.

[92] see for example, *Mantell v Molyneux* Ibid at [38] and *Khalil* Ibid.

The hearing

On the day the s.32 application is listed for hearing, the practitioner should arrive at court early to speak with the police prosecutor:

- make sure the prosecutor has a copy of the report(s) on their file;
- make sure the prosecutor has copies of all other material, which will be relied upon, including the chronology if one has been prepared;
- obtain a fresh copy of the client's criminal history if necessary;
- ask the prosecutor whether the jurisdictional issue in s.32(1)(a) will be conceded;
- ask the prosecutor whether the prosecution will consent to the matter being dealt with pursuant to s.32.

Knowing who the Magistrate is before you walk into the court room is essential. Submissions should be tailored to the particular likes and dislikes of the Magistrate. Every magistrate is different and a practitioner needs to be flexible in their presentation. My motto is "*anything and everything can happen and often does*". By way of examples only:

- on some occasions I have obtained s.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 address on each and every relevant consideration. The Magistrate then became impatient at the time my submissions were taking!;
- a Magistrate in the Children's Court before whom I regularly appear often asks the prosecutor to address on s.32(1)(b) first. This assists in isolating the areas of contention and shortens the proceedings significantly;
- in a recent s.32 application the consent of the prosecution and victims were secured prior to the hearing. Nevertheless, the Magistrate indicated submissions were required in relation to s.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)[93] was omitted. In summing up, the Magistrate referred to the court's inability to supervise a s.32 order beyond a period of 6 months. The s.32 application was rejected primarily on this basis.

In addition to the s.32(1)(b) considerations, the intent of the legislature in enacting s.32[94] should be emphasised in submissions. In conclusion, a practitioner should be able to submit the client is a suitable candidate for diversion and that having regard to the intent of the legislature and the balancing exercise involved, diversion is in the public interest.

[93] See p.13 above.
[94] See p.2 above.

4. CONUNDRUMS THAT ARISE AND POSSIBLE SOLUTIONS

"Conundrum" is defined in the Oxford dictionary as:

> " (noun) a confusing or difficult problem or question"

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

The following represent some of the conundrums that might confront a practitioner (in no particular order). Practitioners should not be discouraged from making s.32 applications if it appears there are obstacles and hurdles at every turn. Speaking to colleagues can often be of great assistance.

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 Defendant 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. The issue arose in a recent application after the client moved from Sydney to the Gold Coast. A psychologist in Tweed Heads was found to provide treatment. Ultimately the issue never arose for determination as the client moved back to Sydney.

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).

BREACHES

Unless a client was required to be of good behaviour as a condition of the s.32 order, committing a further offence within 6 months of the s.32 order being made does not place the client in breach. This view is supported by Gotsis and Donnelly[95]:

> "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.[96]

MULTIPLE s.32s

There is nothing in the legislation which precludes the court from making a second or subsequent s.32 application in relation to further offences[97]. A Magistrate may greet additional s.32 applications with great scepticism. In many cases it can be argued that it

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[95] (2008) Ibid. at p. 20.
[96] Citing M Spiers "Summary Disposal of Criminal Offences under s.32 Mental Health (Criminal Procedure) Act 1990 "(2004) 16(2) *Judicial Officers' Bulletin* 9
[97] 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.

takes time to implement a treatment program and perfect a medication regime. Misdiagnosis might be relevant[98].

THE "TOO-HARD BASKET"

Practitioners should not place s.32 applications in the "too-hard" basket. There is a wealth of information freely available to the practitioner who has limited or no experience with s.32 applications.

A practitioner should consider referring a client elsewhere if the client appears to be eligible for s.32 and the practitioner is unable or unwilling to act.

"BUT I CAN'T GET A TREATMENT PLAN"

The difficulties a client is likely to meet in accessing mental health services and obtaining appropriate treatment have been highlighted throughout this paper. Obtaining a report and treatment plan will be an obstacle for many clients eligible for s.32 diversion and the situation is unlikely to change until significant additional funding is injected into the sector by governments:

> "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"[99].

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. In making s.32 applications in the Local Court practitioners can help raise awareness of issues surrounding persons in the criminal justice system with cognitive and mental health impairments. The client can also make a further s.32 application on a conviction or severity appeal in the District Court (assuming the client has the funds to pursue an appeal).

"BUT IT'S A TRAFFIC OFFENCE !"

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 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.

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 he is allowed to drive. In many instances it can be argued the client poses no danger having benefitted from diagnosis and treatment. It should also be argued the Roads and Traffic

[98] See below p.25
[99] Gotsis & Donnelly (2008) Ibid at p.31

Authority (RTA) can determine whether a client is a "fit and proper person" to hold a licence and cancel a driver's licence if it is not satisfied.
driver's licence if it is of the view

Therefore, If a s.32 application succeeds on a traffic offence, practitioners should be mindful of the possibility the RTA will cancel 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.

"IT'S JUST ADD/ADHD"

Practitioners are encouraged to make s.32 applications for clients with ADD/ADHD. Such clients are eligible for diversion. ADD/ADHD is a "developmental disability".[100] As noted in my 2010 paper[101] criminal law practitioners are very likely to see clients with ADD/ADHD. ADD/ADHD is a serious disorder associated with significant impairments across a range of domains[102]. 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 (co-morbidity[103]) including substance abuse disorder, mood and anxiety disorders or a personality disorder[104]. They are more likely to be involved in accidents and receive traffic infringements[105] . ADD/ADHD can continue into adulthood:

> "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"[106]

There can be an association between ADD/ADHD and Bipolar II Disorder. 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

[100] See p. 8 above.
[101] Weeks, K., (2010) Ibid at p.52
[102] 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.
[103] See below. p.29.
[104] Sobanski E. (2006) Ibid.
[105] Anthshal, K., Faraone S.V. & Kunwar A, "ADHD in Adults: How to Recognise and Treat"
[106] 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

defiant disorder, conduct disorder, mood disorders, bipolar disorder and sleep disorders at adolescence than controls. Only 17% had recovered[107].

Practitioners 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 community. 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.

"THERE'S BEEN NO s.32s BEFORE !"

Magistrates may also greet with scepticism a s.32 application where a client has a criminal history, no prior s.32 applications have been made and/or the client facing a custodial sentence on conviction.

In some situations a practitioner will be able to submit that the client has not previously had the benefit of an assessment and diagnosis. Where the client has been previously assessed and diagnosed, misdiagnosis may be an issue.[108]

A client's instructions should always be sought as to whether their former legal practitioner(s) advised them in relation to the s.32 option.

This situation underscores the importance of the legal practitioner in the early identification of clients with cognitive and mental health impairments within the criminal justice system, as emphasised above.[109] It also demonstrates the unfortunate consequences that can flow from a practitioner's decision to put s.32 applications into the "too hard basket"

"s.32s HAVEN'T WORKED BEFORE"

Magistrates can also be sceptical of s.32 applications where clients have received a s.32 order(s) previously. Reoffending after s.32 diversion can occur for a number of reasons, including misdiagnosis[110] and the difficulties which can arise in getting a medication regime right. It does not necessarily mean s.32 diversion has failed and shouldn't be considered again. In the case of a client with an intellectual disability, numerous s.32 orders might not be unusual given there is no treatment or "cure".

In my view, the existence of a prior s.32 order(s) can sometimes make it easier to persuade the Court to make a further s.32 order. A prior s.32 order(s) is evidence a client has cognitive or mental health impairments that may be relevant to his/her offending. Such a submission addresses any scepticism that s.32 is being used merely to avoid criminal responsibility.

[107] 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 . See http://informahealthcare.com/doi/abs/10.3109/00048670903487233
[108] See below .
[109] p.5.
[110] See below.

THE PROBLEM OF DIAGNOSIS & MISDIAGNOSIS

One of the more common difficulties I have encountered in preparing s.32 applications is the issue of diagnosis and misdiagnosis.

An accurate diagnosis is absolutely critical if a client is to receive treatment appropriate to their mental disorder or impairments and is essential to the effectiveness of s.32 diversion in reducing the rate of recidivism.

Practitioners may need to consider seeking a second opinion in relation to diagnosis in some circumstances;

- if a client has been diagnosed and treated yet continues to exhibit symptoms, offends and/or finds any medication ineffective the possibility of misdiagnosis needs to be considered;
- if a client continues to struggle with drugs and alcohol an underlying mental disorder may have been missed;
- any client diagnosed with ADD/ADHD in childhood ought to be assessed again in adulthood. There can be an association between ADD/ADHD and Bipolar II Disorder, which is often misdiagnosed, or other disorders.[111]
- any diagnosis made by a general practitioner ought to be the subject of a second opinion from a psychologist or psychiatrist, particularly where Depression has been diagnosed given Bipolar Disorder is often misdiagnosed as Depression.

On some occasions diagnosis can be difficult, particularly in young people. Substance misuses can cloud the picture. Misdiagnosis of a bipolar disorder can have significant consequences. Like ADD/ADHD, criminal law practitioners are likely to receive instructions from a client with a bipolar disorder at some stage. In some cases, the client won't have been diagnosed.

Bipolar Disorders

As noted above, the importance of a correct diagnosis is particularly important in cases of bipolar disorders.

Bipolar disorders encompasses a spectrum. It includes Bipolar I (formerly known as Manic Depression) and Bipolar II. While many people are familiar with Bipolar I (formerly known as Manic Depression) there is a general lack of awareness of Bipolar II which is thought to affect between 5 and 10% of the population.

> "Bipolar depression is now known to exist as a spectrum of disorders rather than a single disease entity. Bipolar II disorder exists on this spectrum as a condition where the depressive episodes are as severe as in bipolar 1 disorder, but where the mood elevation states are not as extreme. This combination can lead to a failure to detect a condition … ".[112]

Practitioners acting for clients with charges in the Local Court are likely to receive instructions from a client with a bipolar disorder. It is a common disorder. Often, a client with a bipolar disorder won't have been diagnosed and/or treated. Identifying clients with a bipolar disorder is important for s.32 diversion. Identification can result in correct diagnosis and treatment thereby minimising the risk of re-offending . However, it is also important

[111] ADD/ADHD is discussed at pp. 12, 13, 16, 23, 24, 26, 27 & 29.
[112] Blackdog Institute, http://www.blackdoginstitute.org.au/aboutus/blackdogbooks.cfm.

because early diagnosis and treatment can improve a client's outcomes across a range of domains, including education and employment. It also has the potential to save lives.

Bipolar has been described as "*perhaps the most lethal of all psychiatric disorders*"[113]. The statistics in relation to diagnosis and misdiagnosis are startling:

> "Currently, many patients experience a significant delay between the onset of their first symptoms and their diagnosis with bipolar disorder. One study indicated that only 53% of patients were correctly diagnosed with bipolar disorder in the first year, while in the remaining patients it took an average of 7.5 years until a correct diagnosis was made".[114]

Early intervention in young people has been shown to improve future outcomes[115] and medications can offer neuro-protection. Diagnosis of Bipolar II is becoming more common. Bipolar II can be associated with ADD/ADHD, as noted above[116].

> "… recent Australian data indicate that bipolar disorder is one of the most common psychiatric conditions, with an estimated lifetime prevalence of 1.2%1 and a 12-month prevalence of 0.5%.2 Furthermore, it is perhaps the most lethal of all psychiatric disorders, predominantly because of the substantial suicide risk, with estimates showing that, in people with bipolar disorder in the 25–34-year age group, suicide risk is between 18% and 19%.3 The onset of bipolar disorder characteristically occurs during adolescence,4 yet there is a substantial delay to diagnosis and the initiation of treatment concordant with treatment guidelines for bipolar disorder, particularly in young people.5 Because of these issues, individuals with bipolar disorder may have increased rates of unemployment, relationship breakdown and poorer overall functioning,2 outcomes that, with appropriate therapy, have more likelihood of improvement than in other comparable illnesses".[117]

Practitioners regularly appearing for young people in the Children's and Local Courts are likely to receive instructions from a young person with a bipolar disorder. Likewise, practitioners in the Local Court are likely to receive instructions from young adults with a bipolar disorder. As noted above, sometimes a client with a bipolar disorder has already been diagnosed. However, it more likely the client's bipolar disorder has not been diagnosed and/or treated appropriately. Committing an offence and coming into contact with the police can often be the first sign a client is exhibiting signs of an emerging mental disorder.

Where a client has been diagnosed with ADD/ADHD as child or adolescent practitioners are encouraged to query whether the client has a bipolar disorder. If there are signs a client's functioning has failed to improve with age or medication or where a pattern of offending is emerging, a second opinion ought to be considered. Inappropriate treatment of a bipolar disorder can have a negative impact on the course and severity of the disorder[118]. According to the World Health Organisation, Bipolar Disorder is the sixth leading cause of disability worldwide[119].

As a result of a delay in diagnosis there is a delay in appropriate treatment:

> "There is often a substantial delay between the onset of bipolar disorder and the introduction of mood stabilising medication with one study reporting a delay of 9.3 years …".[120]

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[113] Berk K, et. al. (2007) Ibid.
[114] Ibid at S12.
[115] Ibid.
[116] pp.23-24.
[117] Berk K., et. al. Ibid.
[118] Blackdog Institute, Ibid.
[119] Ibid.
[120] Berk K., et. al. Ibid.

When appropriate treatment is delayed, adverse outcomes arise:

> "Delayed treatment initiation is linked with an adverse impact on many clinical variables, including poorer social adjustment, more hospitalisations, increased risk of suicide, increased rates of comorbidities (particularly, substance abuse), forensic complications resulting from committing felonies while unwell, and impairment in age-specific developmental tasks".[121]

The catastrophic consequences which can flow from misdiagnosis of Bipolar Disorder were highlighted by the NSW Coroner during a recent inquiry into the death of Charmaine Dragun[122]. The Coroner found Charmaine had committed suicide by jumping to her death at The Gap after there were deficiencies in her management by her health professionals (including General Practitioners, a Psychologist and Psychiatrist). At the time of her death, Charmaine was suffering from the effects of "cross tapering" (side effects when one medication is withdrawn and replaced by another). In addition, Charmaine had been misdiagnosed with Depression when she had Bipolar II Disorder:

> "A Bipolar 2 Disorder is thought to be 5 to 10 times more common that [sic] a Bipolar Disorder (previously known as "manic-depression") and is associated with a very high risk of suicide – higher than Bipolar 1 Disorder. The reason for the difference is probably that a Bipolar Disorder is more easily missed and therefore goes untreated in the vast majority of cases".[123]

The Coroner concluded that had Charmaine's health professionals made a correct diagnosis of a Bipolar II Disorder, Charmaine would have been properly treated with a mood stabiliser and probably would not have committed suicide:

> "Their failure to diagnose a Bipolar II Disorder was therefore causative of Charmaine's suicide".

In acknowledging the difficulties that can sometimes arise in diagnosis, the Coroner emphasised the importance of a diagnosis being accurate:

> "It was clear from the expert evidence that the diagnosis is all important because it drives the treatment. If you do not get the diagnosis right, and I accept that in some cases that is a difficult task, then the treatment could be, at best unhelpful and at worst, exacerbate the condition".[124]

The Coroner recommended these issues be bought to the attention of those health professionals who may be called upon to treat people with signs and symptoms of depression, including:

> "The need for increased awareness by health professional of the need to exclude a bipolar disorder in all patients presenting with signs and symptoms of depression".[125]

Two months after the Coroner's report became available the Sydney Morning Herald carried a story about misdiagnosis of bipolar disorders. Professor Gordon Parker was quoted as

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[121] Ibid. at S12.
[122] Report of the Deputy State Coroner, M. MacPherson, State Coroners Court Glebe, 15 October 2010, Executive Summary.
[123] Ibid [115]
[124] Ibid [24.]
[125] Ibid [203]. A direction was also made by the Coroner that copies of the findings and Executive Summary be provided to the Royal Australian College of General Practitioners, the Counsellors and Therapists Association of New South Wales, the Australian Psychological Society and the Royal Australian and New Zealand College of Psychiatrists so that an increased awareness reduced the number of suicides and attempted suicides as a consequence

saying people were dying because doctors were not screening them for bipolar disorder and diagnosing them with depression instead[126].

Substance & Alcohol Misuse - The Co-Morbidity 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 s.32 diversion is illogical and does nothing to reduce the stigma attached to and marginalisation of some 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 documented. In any event, it's a chicken-and-egg type argument which can rarely be resolved. Drug and alcohol misuse is a disorder in itself – 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"[127]

Nevetherless, 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 (co-morbidity).

What is co-morbidity / dual diagnosis ?

Co-morbidity 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 co-morbidity of mental disorders and substance use disorders is widespread, especially among young people[128]. Co-occurring substance use is common rather than exceptional among people with serious mental health problems and disorders;[129]

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[130].

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[126] *Sydney Morning Herald*, 11-12 December 2010, "Fatal Flaw: Doctors Miss Bipolar Diagnosis"
[127] United States Department of Health and Human Services, *National Institute on Drug Abuse* (NIDA) "Comorbidity: Addiction and Other Mental Illnesses" (2010) at p.1.
[128] Victorian Government, Department of Human Services, "Dual diagnosis: Key directions and Priorities for Service Development", 2007, Melbourne, Victoria, at p.4.
[129] Ibid.
[130] Smith & Trimboli, Ibid at p.2.

Co-morbidity 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.[131]

In a comprehensive report on co-morbidity, the United States' National Institute for Drug Abuse (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"[132]

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 their clients experience in accessing good drug and alcohol services. 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 or fully equipped to deal with offenders who also have a co-occurring substance abuse disorder and mental disorder.

[131] Victorian Government (2007) Ibid.
[132] NIDA (2010) Ibid. at p. 3

5. WHEN IT IS NOT APPROPRIATE TO DEAL WITH A CLIENT UNDER THE SECTION

While practitioners should be cautious about categorically excluding clients from consideration for s.32 diversion there will be some instances where it will be obvious that a s.32 application ought not to be made, for example:

- where a client can't satisfy the first limb s.32(1)(a) (i) because, for example, your client is mentally ill under the MHA or doesn't satisfy the criteria in s.32(1)(a);
- where no report or treatment plan is available;
- the client specifically instructs you not raise their cognitive or mental health impairments because of stigma or otherwise

There are other instances where a s.32 application may not be appropriate.

PLAYING THE "GET OUT OF GAOL FREE" CARD

Section 32 applications with little or no foundation should be discouraged as there is enough scepticism of s.32 diversion amongst some Magistrates currently. Where the s.32 application is no more than a technical device to avoid a conviction and its consequences (for example licence disqualification) you will do everyone a disservice including (and mostly) yourself. You will lose credibility with the court which is likely to make the next application for you and/or colleague that little bit harder.

ADVERSE CONSEQUENCES ON EMPLOYMENT

Practitioners should also be alert to the ramifications of a s.32 order on a client's employment especially where mental health issues could impact on the client's ability to perform their duties.

For example, a soldier for whom I recently acted was medically discharged from the army after being diagnosed with Bipolar disorder. The client was successful in obtaining a section 32 order on a fourth charge of Drive with High Range PCA. While he welcomed the discharge, another soldier for whom I recently acted was concerned a diagnosis of Bipolar Disorder (from which his mother suffered) would end his career in the army. He was ultimately diagnosed with a major depressive order, was diverted pursuant to s.32 on a charge of drive with high range PCA and retained his employment in the army.

6. SOME ALTERNATIVES FOR SENTENCING

When making a s.32 application, a practitioner will need to be prepared to make submissions on sentence if the s.32 application fails and the client provides instructions to enter a plea of guilty.

The report tendered in a s.32 application can be relied upon.

McColl JA confirmed the significance of mental illness in the sentencing exercise in *DPP v El Mawas*.[133]

In appropriate cases, the practitioner should address the Magistrate on the exercise of the discretion in s.10 Crimes *(Sentencing Procedure)* Act 1999. A person's "mental condition" is a factor to be considered.[134] A deferral of sentence pursuant to s.11 is a further option to be considered if a s.32 fails.

It could be argued on sentence:

- the client's moral culpability is reduced because of their cognitive or mental impairments;
- the client is not an appropriate vehicle for general deterrence;
- greater weight can be given to rehabilitation;
- the risk of re-offending is low (if the client has responded well to treatment)

A detailed discussion on the sentencing on persons with cognitive and mental impairments can be found in NSWLRC CP 6[135] where the decision of Sperling J in *R v Hemsley*[136] was discussed[137]. The decision summarises the ways in which mental illness is relevant in sentencing:

> "First, where mental illness contributes to the commission of the offence in a material way, the offender's moral culpability may be reduced; there may not then be the same call for denunciation and the punishment warranted may accordingly be reduced…
> Secondly, mental illness may render the offender an inappropriate vehicle for general deterrence and moderate that consideration…
> Thirdly, a custodial sentence may weigh more heavily on a mentally ill person…
> A fourth, and countervailing, consideration may arise, namely, the level of danger which the offender presents to the community. That may sound in special deterrence "

[133] Ibid., at [72] citing Spigelman CJ in *R v Israil*[133]
[134] s.10(3)(a)
[135] Ibid, from p.225.
[136] [2004NSWCCA 228
[137] NSWLRC CP6 at p.229.

APPEALS

In the event a s.32 application fails, a client pleads guilty and is sentenced an appeal to the District Court against sentence can be lodged and a further s.32 application can be made at the hearing.[138]

If the Magistrate makes an error of law, the matter can be reviewed by the Supreme Court.

Karen Weeks

23 March 2011

[138] See for example *Mackie v Hunt* (1989) 19 NSWLR 130 at 138.