TO SECTION 32 OR NOT?

Applications under s.32 Mental Health (Forensic Provisions) Act 1990 in the Local Court

By KAREN WEEKS

"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": *Perry v Forbes Anor*, Smart J, Supreme Court of NSW, unreported, 21 May 1993 at p.5.

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SECTION 32 OF THE *MENTAL HEALTH (FORENSIC PROVISIONS) ACT 1990* (s.32) creates a diversionary measure[1] which allows a person with a developmental disability, mental illness or mental condition to be diverted from the criminal justice system to be treated in an appropriate rehabilitative context enforced by the court.[2]

If an order is made in accordance with s.32:

- there is no finding of guilt;
- the charge is dismissed without conviction; and
- the applicant is discharged conditionally or unconditionally.

The application can be made at any stage of the proceedings[3] and whether or not a plea has been entered.[4]

The benefits which can flow from a s.32 order for a client are potentially substantial.[5] A s.32 order can often mean a better result than an order in accordance with s.10 of the *Crimes (Sentencing Procedure) Act 1999* (s.10). Criminal law practitioners should be encouraged to consider the potential application of the section when they are taking instructions from clients charged with criminal offences that can be finalised in the Local Court.

Given the prevalence of mental disorders among those who come before the

courts,[6] practitioners are bound to have clients who are eligible for s.32 diversion. However, identifying those clients, obtaining the services of a good expert to make a diagnosis and prepare a report, establishing links with treatment providers and ultimately persuading a magistrate to utilise the section can be very challenging indeed.

The extent of the problem of mental health in Australia

There has been a growing awareness of mental health issues in Australia in recent years. That awareness has gained momentum with the appointment of Professor Patrick McGorry as the 2010 Australian of the Year.[7] The honour recognised McGorry's work in campaigning for better treatment for mentally ill young people. According to McGorry:

- 4 million Australians have mental health problems in any given year;
- 65 per cent of Australians have no access to treatment whatsoever;
- 1 million of those with mental disorders are young Australians aged 12 to 25;
- only 25 per cent of young people with mental disorders have access to mental health care (the figure is only 13 per cent for young men); and
- early detection and comprehensive care in the first few years after diagnosis improves outcomes, saves money and lives.[8]

The scale of the problem has been overlooked for many years.[9]

It is significant to note the following:

- Most experts accept the brain does not reach maturity in those parts that control decision making, impulsivity, planning and the consideration of consequences (that is, in the prefrontal cortex which controls executive function) until a person is in their 20s and as late as 25 years.[10] The long-held position that a person reaches maturity at the age of 18 years therefore has questionable scientific validity.
- The onset of mental illness is most likely to occur in late adolescence and early adulthood. According to a 2007 *Medical Journal of Australia* article by McGorry, Purcell, Hickie and Jorm: "Epidemiological data indicate that 75 per cent of people suffering from an adult type psychiatric disorder have experienced its onset by 24 years of age, with the onset for most of these disorders – notably mood, psychotic, personality, eating and substance use disorders – mainly falling into a relatively discrete time band from the early teens to the mid-20s, and reaching a peak in the early 20s".[11]
- And from the same article: "Up to one in four young people are likely to be suffering from a mental health problem, most commonly substance misuse or dependency, depression or anxiety disorder or combinations of these ... There is also some evidence that the prevalence may have risen in recent decades."[12]

Important issues therefore emerge in terms of how the criminal justice system deals with children and young adults who have mental disorders.

Early intervention in the treatment of mental illness has been shown to be critical.[13] Intervention before a pattern of offending develops has enormous costs benefits. Present estimates suggest accommodating a juvenile in a detention centre costs the community around $150,000 per year. You don't need to be a rocket scientist to determine where valuable resources are better utilised.

The intent of the legislature in enacting s.32 clearly involves diverting those with mental disorders out of the criminal justice system, away from its punitive consequences and into a rehabilitative and treatment context. When legislation amending s.32 was introduced into Parliament in 2005, it was said on behalf of the Attorney-General:

"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 NSW 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".[14]

While there may be a reluctance on the part of some magistrates to utilise the section, an increasing awareness and application of it among criminal law practitioners would arguably assist in effecting the intention of the legislature. As the provision has been in existence for 27 years, every criminal law practitioner should be thoroughly familiar with it.

Legislative history

The precursor of s.32 was enacted in Parts 11A and 11B of the *Crimes Act 1900* in 1983 as "part of the substantial reforms of the law relating to the mentally disabled".[15]

It was found in s.428W of the *Crimes Act 1900*. The Supreme Court considered its application in *Mackie v Hunt* (1989) 19 NSWLR 130. Campbell J confirmed the discretionary nature of the provision, finding it "is entirely a matter for the learned magistrate".[16]

In 1990, the provisions were taken out of the *Crimes Act 1900* and re-enacted (without change) in separate legislation with the passing of the Mental Health (Criminal Procedure) Bill 1990. The Bill

was introduced into Parliament with the Mental Health Bill 1990. In repealing the *Mental Health Act 1983*, the then Minister of Health said the principal object of the new legislation was "to remove the stigma that had attached to mental illness".[17] The *Mental Health (Criminal Procedure) Act 1990* commenced operation on 3 September 1990.

On 14 February 2004 s.32 orders became enforceable for the first time as a result of amendments introduced by the *Crimes Legislation Amendment Act* 2002, "largely in response to concerns expressed by magistrates".[18]

In 2005 major amendments were made to the *Mental Health (Criminal Procedure) Act* 1990 as a result of the *Mental Health (Criminal Procedure) Amendment Act* 2005. Section 32 was amended and the changes commenced on 1 January 2006. Section 32A was inserted into the Act to facilitate breach proceedings. The provision was also extended to allow magistrates to consider the application of the section if the offender satisfied s.32(1)(a) at the time of the offence, even though they may have recovered by the time they appeared before the court. The obligation of a magistrate to disqualify themself after deciding not to apply the section was removed as a result of concerns about forum shopping. The common law position in relation to actual bias remains.

On 1 March 2009 the *Mental Health (Criminal Procedure) Act 1990* became the *Mental Health (Forensic Provisions) Act 1990*.[19] No changes were made to s.32.

The NSW Law Reform Commission is currently undertaking a general review of the criminal law and procedure applying to people with cognitive and mental health impairments. The terms of reference encompass s.32.

Section 32 applies to criminal proceedings in respect of summary offences or indictable offences triable summarily and bail proceedings, but does not apply to committal proceedings.[20] (The section is reproduced in the accompanying box.)

Definitions

"Mental condition" is defined in s.3 of the Act to mean "a condition of disability of mind not including either mental illness or developmental disability of mind"

Section 3 also defines "mental health facility" as having the same meaning as it has in the *Mental Health Act 2007* (MHA) where it is defined in s.4 MHA as "a declared mental health facility or a private mental health facility."

"Private mental health facility" is defined in s.4 MHA as "premises subject to a licence under Division 2 of Part 2 of Chapter 5 of the Act".

Section 32 does not apply to a "mentally ill person"[21] within the meaning of the MHA where a "mentally ill person" is defined in s.14 MHA as follows:[22]

"Section 14(1): A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:

(a) for the person's own protection from serious harm, or

(b) for the protection of others from serious harm.

"(2) In considering whether a person is

MENTAL HEALTH (CRIMINAL PROCEDURE) ACT 1990

Section 32 Persons suffering from mental illness or condition

(1) 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, and
  (b) that, 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 in accordance with the provisions of this Part than otherwise in accordance with law, the magistrate may take the action set out in subsection (2) or (3).

(2) The magistrate may do any one or more of the following:
  (a) adjourn the proceedings,
  (b) grant the defendant bail in accordance with the Bail Act 1978,
  (c) make any other order that the magistrate considers appropriate.

(3) The magistrate may make an order dismissing the charge and discharge the defendant:
  (a) into the care of a responsible person, unconditionally or subject to conditions, or
  (b) on the condition that the defendant attend on a person or at a place specified by the magistrate for assessment of the defendant's mental condition or treatment or both, or
  (c) unconditionally.

(3A) If a magistrate suspects that a defendant subject to an order under subsection (3) may have failed to comply with a condition under that subsection, the magistrate may, within 6 months of the order being made, call on the defendant to appear before the magistrate.

(3B) If the defendant fails to appear, the magistrate may:
  (a) issue a warrant for the defendant's arrest, or
  (b) authorise an authorised officer within the meaning of the Criminal Procedure Act 1986 to issue a warrant for the defendant's arrest.

(3C) If, however, at the time the magistrate proposes to call on a defendant referred to in subsection (3A) to appear before the magistrate, the magistrate is satisfied that the location of the defendant is unknown, the magistrate may immediately:
  (a) issue a warrant for the defendant's arrest, or
  (b) authorise an authorised officer within the meaning of the Criminal Procedure Act 1986 to issue a warrant for the defendant's arrest.

(3D) If a magistrate discharges a defendant subject to a condition under subsection (3), and the defendant fails to comply with the condition within 6 months of the discharge, the magistrate may deal with the charge as if the defendant had not been discharged.

(4) A decision under this section to dismiss charges against a defendant does not constitute a finding that the charges against the defendant are proven or otherwise.

(4A) A magistrate is to state the reasons for making a decision as to whether or not a defendant should be dealt with under subsection (2) or (3).

(4B) A failure to comply with subsection (4A) does not invalidate any decision of a magistrate under this section.

(5) The regulations may prescribe the form of an order under this section. ❑

a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account."

If you are confused thus far, you are not alone. The Judicial Commission's 2008 survey of magistrates found that "magistrates ... expressed concern with the broadness and imprecision of the mental disorder criteria, which was especially vexing to them in cases where differing or equivocal diagnoses were received in respect of a particular accused. Some magistrates suggested that mental disorder should be 'serious' or 'connected' to the offence (that is, criminogenic). This raises the question of how should a 'serious' mental disorder be defined? Further, precisely how closely should any mental disorder be 'connected' to an offence? From a policy perspective, 'serious' and 'connected' then become contested levers, whereby therapeutic jurisprudence is made available to some mentally disordered accused but not others.

As Gotsis and Donnelly observed in a 2008 monograph fo the Judicial Commission of NSW: "Ultimately, some things are irreducibly complex. Mental disorder is such an issue. This is stated candidly in the introduction of the *Diagnostic and Statistical Manual of Mental Disorders* [4th ed] (DSM-IV): 'although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept of "mental disorder". The concept of mental disorders, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations ...'

"The inherent complexity and fluidity of mental disorder is only magnified when viewed through the perspective of the legal system ...

"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."[23]

The breadth of the criteria in s.32(1) was confirmed by the Supreme Court in one of the first decisions concerning the section after the major legislative reform of 1990. 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."[24]

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*[25] 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.

It is also my experience that where the diagnosis relates to disorders such schizophrenia, bipolar disorder, borderline personality disorder or an autistic spectrum disorder such as Aspergers syndrome, it is unlikely the practitioner will need to address the court on the jurisdictional issue.

In contrast, if the diagnosis is ADHD/ADD, debate on the jurisdictional issue should be anticipated and the practitioner should be well prepared. Unfortunately, many lawyers and magistrates fail to appreciate the nature of the disorder, the serious impairments which can plague patients throughout childhood and into adulthood, and the relevance of the disorder to any involvement they may have in the criminal justice system.

"In many cases a s.32 order will produce a better outcome for the client than a s.10 or penalty imposed in accordance with law."

Attention Deficit Disorder (ADD) & Attention Deficit Hyperactivity Disorder (ADHD)

ADD refers to the broad class of attentional deficit disorders while ADHD specifically refers to ADD with symptoms of hyperactivity.

ADD/ADHD is arguably a developmental disorder.[26] It is also arguably a mental illness or mental disorder for which treatment is available in a mental health facility. It has been in the DSM-IV since 1980, although was first described in the medical literature many years previously.

When considering ADD/ADHD, it is important to sort fact from fiction. ADD/ADHD has a strong neurological basis. The condition involves abnormally low levels of two important neurotransmitters: dopamine and noradrenaline. The prefrontal cortex and executive function is affected by these imbalances resulting in difficulties with response inhibition (impulsivity), poor consequential thinking, inattention to detail, inattention and distractibility, viz: "Significant functional impairment in educational, marital, interpersonal, and occupational realms and in motor vehicle operation is common in adult ADHD.

In fact, recently published longitudinal research findings indicate that ADHD in adults is a far more impairing disorder than many other disorders (for example, anxiety and mood disorders) across multiple domains of major life activities, especially educational and occupational functioning, money management, and management of daily responsibilities.

In an article by Anthsel, Faraone and Kunwar, the authors suggested that "Adults with ADHD are more likely to receive speeding violations and have their driver's license suspended …Elevated prevalence of substance abuse/dependence has consistently been reported in adults with ADHD."[27]

Any practitioner who has worked in the Children's Court can probably confirm, anecdotally, the high rates of young people with a diagnosis of ADD/ADHD who come before the court. Drugs and alcohol may be used by these patients to alleviate the symptoms of the disorder (self-medication). Not surprisingly, dopamine and noradrenaline levels rise with the consumption of alcohol, cannabis and amphetamines.

Diagnosing mental disorders in young people can be difficult and a clear clinical picture often does not emerge until the child becomes a teenager or reaches their early twenties. Recent Australian data indicates bipolar disorder is one of the most common psychiatric disorders and is "perhaps the most lethal".[28] In children, mania is frequently misdiagnosed as attention deficit hyperactivity disorder.[29] A thorough assessment, correct diagnosis and treatment is therefore extremely important: "Features of bipolar disorder that overlap with those of ADHD include distractibility, inattention, impulsivity and hyperactivity … misdiagnosing bipolar disorder as ADHD can result in treatment with psychostimulants, which may induce mania or rapid cycling in a truly bipolar patient".[30]

A number of my clients who, as children have had a diagnosis of ADD/ADHD, have later been given an additional diagnosis of other disorders, such

as bipolar disorder, after a comprehensive assessment has been undertaken for the purposes of s.32 proceedings.

Practitioners are therefore encouraged to explore with such clients the possibility that there are underlying disorders present which have not been diagnosed or treated.

The authorities

There has been little judicial consideration of s.32.[31] A thorough understanding of the decision of the Court of Appeal in *DPP v El Mawas*, the leading authority on s.32, is essential.

The following principles emerge from *DPP v El Mawas*:

- s.32 confers a very wide discretion;[32]
- s.32 is a diversionary measure;[33]
- 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 mental illness (s.33) with the object of ensuring that the community is protected from the conduct of such persons";[34]
- a magistrate is required to make three decisions;[35]
- the first decision is the jurisdictional question, whether the defendant is eligible to be dealt with under s.32(1)(a). The question involves a finding of fact;[36]
- the second question is whether, having regard to the facts or such other relevant evidence, it is more appropriate to deal with the defendant under s.32 otherwise in accordance with law. This question "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".[37] 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,[38] although the diversionary regime is available to serious offenders as long as it is regarded as more appropriate;[39]
- the third decision is whether to make orders under s.32(2) or s.32(3);[40]
- 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;[41]
- magistrates are given powers of an inquisitorial or administrative nature to inform themsleves as they think fit; and
- the existence and content of a treatment plan is a relevant consideration.[42]

Another consideration relevant to the exercise of the s.32 discretion is the likely sentencing outcome if the defendant is dealt with in accordance to law.[43]

In relation to the balancing exercise involved, it was described by Howie J in *DPP v Confos* as: "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."[44]

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 my experience, few magistrates appear to have a comprehensive understanding of the authorities. I have encountered magistrates who have made comments to the effect of 'this isn't a normal s.32', as if there were such a thing. The authorities do not support such a view, nor do they support what appears to be a belief among some magistrates that s.32 cannot or should not be utilised in traffic offences. A recent survey of magistrates confirmed a reluctance to apply s.32 to traffic offences.[45] I have persuaded magistrates to make s.32 orders in relation to charges of drive with high range PCA and drive while suspended, and the decision of Barnett LCM in *Police v Deng* [2008] NSWLC 2 provides a further example – the charge in that case being one of negligent driving occasioning death.

To section 32 or not?

As noted above,[46] in many cases a s.32 order will produce a better outcome for the client than a s.10 or a penalty imposed in accordance with law. As s.10s involve a finding of guilt, they are often deemed to be convictions in various Acts.[47]

In other cases, having an offence dealt with in accordance with s.32 can have more onerous consequences for a client than a sentence imposed according to law. In *DPP v El Mawas* McColl JA noted, referring to the submissions made by the counsel for the appellant: "Significantly, [Mr Haesler SC] contended that adopting the diversionary alternative available in the Act did not mean a defendant escaped 'punishment', pointing out that although not characterised as 'punishment', an order under either subs.32(2) or 32(3) can substantially limit a person's freedom and curtail their liberty. In this context he also observed that a defendant who is diverted from being dealt with at law pursuant to s.32, loses the opportunity of pleading not guilty and having the prosecution prove their guilt."

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. Obtaining expert employment law advice ought to be considered in such circumstances.

Taking instructions

Given the prevalence of mental disorders among people who come before the courts, criminal law practitioners should be alert to the possibility of a client having a mental disorder that may be relevant to the offence(s) with which they have been charged. Some offenders with mental disorders who come before the courts will not have had the benefit of previous diagnosis or treatment. It should be remembered that a client may have underlying mental health issues which are not immediately apparent or which they are reluctant to reveal. Where the client is a young person, the client's parents may be a valuable source of information.

In determining whether one should investigate a possible s.32 application, a practitioner should seek instructions in relation to the following:

- ❑ whether the client has been diagnosed with a mental disorder previously, including any diagnosis of ADD/ADHD as a child (remembering young people with mental disorders will often have had such a diagnosis as a child with a clear clinical picture of other mental disorders not emerging until late adolescence or beyond);
- ❑ whether medication has ever been prescribed (for example, Ritalin, Dexamphetamine, or anti-depressants such as Zoloft);
- ❑ whether the client has a history of behavioural disorders as a child, difficulties at school and with learning or concentration;
- ❑ whether the client was hyperactive as a child;
- ❑ whether the client has ever experienced difficulties with sleeping;
- ❑ whether the client has had any drug or alcohol issues (patients with a variety of mental disorders will often self-medicate with alcohol or drugs to alleviate the symptoms of the disorder, especially when they are undiagnosed and untreated);
- ❑ whether there is a history of offending; for example, multiple convictions for shoplifting offences, PCA offences or offences of violence should sound alarm bells;
- ❑ whether the client has had any history of suicidal ideation;
- ❑ whether the client has had difficulties in maintaining relationships or employment;
- ❑ whether the client has a problem with gambling;
- ❑ whether the client's mother or father have had any mental health issues; and
- ❑ whether the client has ever sustained a head injury or suffered periods of unconsciousness.

Practical considerations

- ❑ The application can be made at any stage of the proceedings, so can be made without a plea having been entered, when a plea of guilty or not guilty has been entered, after a finding of guilt and where the defendant may be innocent.
- ❑ There is no comparative provision in District or Supreme Courts.
- ❑ The availability of a suitably qualified expert to provide a report, prepare a treatment plan and to deliver care and treatment in accordance with the order is critical.
- ❑ There must be a treatment plan before the court can exercise the discretion under s.32(3)(a).[48] In relation to what should be included in the treatment plan, see the information suggested by the authors of the Judicial Commission's 2008 survey.[49]
- ❑ Clients who do not have sufficient resources and /or who are reliant on the public health system will experience great difficulty in obtaining adequate diagnosis and treatment. These issues must be considered carefully when considering the application of s.32.

Supervision and breach proceedings

Section 32(3A) provides a magistrate with the power to call up a defendant on a suspected breach, but only within six months of the order having been made. Some magistrates are reluctant to use the section, because they are of the belief the court lacks the powers to enforce the orders,[50] or six months is not a sufficient period of time. As 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".[51]

The decision of Adams J in *Mantell v Molyneux* makes it clear that any concerns that six months is an insufficient period of time can be addressed by the making of interlocutory orders in accordance with s.32(2). After the magistrate has determined the s.32(1)(b) issue (that it is more appropriate to divert a defendant under s.32), the proceedings can be adjourned before orders are made under s.32(3) dismissing the charge and discharging the defendant.

Adams J held: "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 s.32(3). It is important to note that the power given by s.32(2) can only be exercised when the magistrate has made the decision required by s.32(1)(b) so that, for example, an adjournment under s.32(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 s.31(1). I note also that it appears from the terms of s.32(3) that the

ENDNOTES

1. *DPP v El Mawas* [2006] NSWCA 154 per McColl JA at 72.
2. Parliamentary Debates, Legislative Assembly, 8 November 2005 at p.19214.
3. Section 32(1).
4. *Perry v Forbes* at p.4.
5. For example, a client for whom I recently acted, and who had been diagnosed with attention deficit hyperactivity disorder, bipolar disorder and post traumatic stress disorder, made an application for a s.32 in relation to a fourth high range PCA offence. A custodial sentence, a lengthy licence disqualification period and a habitual traffic offender declaration was likely upon conviction. A successful s.32 application resulted in diversion. In another example, a client was not subject to the mandatory disclosure provisions in the Commonwealth aviation legislation as there was no finding of guilt or conviction. In a further example, a 16-year-old male youth with numerous sets of offences including assault and robbery was diverted via s.32. The young person had been diagnosed with ADHD and bipolar disorder. After re-offending again (while a treatment program and medication regime were being implemented), a second s.32 application was made and was successful. The young person was facing a control order of 6 to12 months if dealt with in accordance with law and sentenced upon conviction.
6. See further below.
7. Professor McGorry is a Professor of Youth Mental Health at the University of Melbourne and Director of Headspace, Australia's National Youth Mental Health Foundation.
8. See the transcript of the interview by Tony Jones with Professor McGorry on *Lateline*, broadcast on ABC1 on 13 March 2010. See also P.D. McGorry, R. Purcell, I.B. Hickie and A.F. Jorm, "Investing in Youth Mental Health is a Best Buy" (2007) *Medical Journal of Australia* 187 (7 Suppl) S5 – S7.
9. During the same *Lateline* interview, Professor McGorry said: "I think the scale of it is now coming to the fore".
10. See, for example, *Adolescence, Brain Development and Legal Culpability*, American Bar Association, Juvenile Justice Centre, January 2004, *www.abanet.org/crimjust/juvjus/Adolescence.pdf*.
11. P.D. McGorry, R. Purcell, I.B. Hickie & A.F. Jorm (2007), op cit p.1.
12. Ibid.
13. Ibid.
14. Parliamentary Debates, Legislative Assembly, 8 November 2005 at p.19214.
15. *DPP v El Mawas*, McColl JA at 54.
16. At 138.
17. Parliamentary Debates, Legislative Assembly, 22 March 1990 at 885.
18. T. Gotsis and H. Donnelly, *Diverting Mentally Disordered Offenders in the NSW Local Court*, Judicial Commission of NSW Monograph 31 – March 2008, at p.19.
19. *Mental Health Legislation Amendment (Forensic Provisions) Act 2008*.
20. Section 31.
21. Section 32(1).
22. Section 3.
23. T. Gotsis and H. Donnelly, op cit at pp.25-26.
24. At p.3.
25. [2008] NSWSC 1092 at 107.

magistrate is not bound to make an order dismissing the charge although, having decided that the conditions of s.32(1) are satisfied and having decided not to take action under s.32(2), it seems inevitable that an order must be made under s.32(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 ...

"It seems that, for the reasons given, the magistrate may have been able (if he had made a determination that diversion was appropriate under s.32(1)) to deal with the appellant under s.32(2) and then, when satisfied that the discretion under s.32(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."[52]

If there is a failure to comply with a s.32 order, the magistrate can deal with the defendant as if the defendant had not been given the s.32 discharge.[53]

It is my view that committing a further offence within six months of a s.32 order being made does not place a discharged defendant in breach of the order *unless* the order contained a condition requiring the discharged defendant to be of good behaviour. This view is supported by Gotsis and Donnelly: "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."[54]

In addition, there is nothing in the legislation which precludes the court from making a second or subsequent s.32 application on further offences.[55] A magistrate may greet additional s.32 applications with great scepticism, but in many cases it can be argued that it takes some time to implement a treatment program and perfect a medication regime. I have successfully had s.32 applied for at least one client on three separate occasions.

Appeals

It would appear that a magistrate's decision not to deal with a matter under s.32 is an interlocutory order for the purposes of s.53(3)(b) *Crimes (Appeal and Review) Act 2001*. Accordingly, an appeal to the Supreme Court only lies in relation to a question of law and only by leave. It is necessary to establish an error as described by the High Court in *House v The King* [1936] HCA 40;(1936) CLR 499.[56]

Alternatively, a s.32 application could be enlivened in the District Court on an appeal against conviction or sentence. In *Mackie v Hunt* Campbell J said: "Whilst it is true that if the learned magistrate does deal with the defendant by way of conviction and sentence following upon his plea of guilty, on appeal to the District Court the same application could be made. The District Court judge could pursuant to the *Justices Act 1902*, s.125(1), exercise the power of a magistrate."[57]

Section 125(1) of the now repealed *Justices Act 1902* can be found in s.28 *Crimes (Appeal and Review) Act 2001*.

Section 32 and unfitness to plead

The decision of Adams J in *Mantell v Molyneux* also makes it clear the common law requires a defendant to be discharged by a Local Court if they are found not fit to be tried.[58] According to Gotsis and Donnelly:[59] "as s.32 is a threshold diversionary mechanism, it should be considered before issues of unfitness arise."

Conclusion

Criminal law practitioners can play an important role in encouraging the court to intervene early in the treatment of people with mental disorders. This is especially important for young people, as research shows that 75 per cent of mental disorders will manifest before the age of 24 years.[60]

Section 32 has been described as a "legislative innovation"[61] embodying a "therapeutic justice initiative".[62] One study has suggested s.32 orders have the potential to produce positive outcomes.[63] Obtaining good outcomes for a client is the objective of any legal practitioner. Criminal law practitioners are encouraged to respond with much enthusiasm to the great s.32 challenge. ❑

26. T. Gotsis and H. Donnelly, op cit at p.26.
27. K. Anthshel, S.V. Faraone and A. Kunwar "ADHD in Adults: How to Recognize and Treat" (2008) *Consultant* Vol. 48 No. 12, November 1, 2008 at pp.2 and 3.
28. M. Berk, K. Hallam, N. Lucas, M. Hasty, C.A. McNeil, P. Conus, L. Kader and P.D. McGorry "Early Intervention in Bipolar Disorders: Opportunities and Pitfalls" (2007) *Medical Journal of Australia* 187 (7) S11-S14 at p.1.
29. M. Berk et. al. Ibid at p.4.
30. K. Ranga Rama Krishnan "Psychiatric and Medical Comorbidities of Bipolar Disorder" (2005) *Psychosomatic Medicine* 67: 1-8 at p.3.
31. *DPP v El Mawas*, McColl JA at 59.
32. Spigelman CJ at 4.
33. McColl JA at 72.
34. Ibid at 71.
35. Ibid at 75.
36. Ibid at 75.
37. Ibid at 76.
38. Ibid at 75 citing Howie J in *Confos v DPP* [2004] NSWSC 1159 at 17.
39. Ibid at 79.
40. Ibid at 80.
41. Ibid at 73.
42. *DPP v El Mawas*, Spigelman CJ at 10.
43. *Mantell v Molyneux*, Adams J, Supreme Court of NSW, Unreported, at 40.
44. [2004] NSWSC 1159 at 17.
45. T. Gotsis and H. Donnelly, op cit at p. 29.
46. At p.1.
47. See, for example, s.198(2) *Road Transport (General) Act 2005* which relates to habitual traffic offenders and s.5, *Criminal Records Act 1991*.
48. *DPP v Albon*, Dowd J, Supreme Court of NSW, unreported, 13 September 2000. See also *Perry v Forbes* at 15-16.
49. T. Gotsis and H. Donnelly, op cit at p.18.
50. Townsden LCM made remarks to this effect in October 2009 in a matter in which I appeared.
51. Op cit, p.22.
52. *Mantell v Molyneux* [2006] NSWSC 955 at 43 and 45. See also *DPP v El Mawas*, McColl JA at 80.
53. Section 32(3D).
54. Citing M. Spiers "Summary Disposal of Criminal Offences under s.32 *Mental Health (Criminal Procedure) Act 1990"* (2004) 16(2) *Judicial Officers' Bulletin* 9.
55. The writer has obtained three s.32 orders for one young female client with borderline personality disorder within a period of 12 months. In addition, two s.32 orders have been obtained for a young male person with ADHD and BPD.
56. *Mantell v Molyneux* Adams J at 38.
57. (1989) 19 NSWLR 130 at 138.
58. Adams J at 28.
59. 2008, op cit at p. 23.
60. P.D. McGorry et al (2007) op cit at p.1. and see also *Early Intervention in Youth Mental Health*, HeadSpace, *www.headspace.org.au/home/information/research/*.
61. Op cit, p. 29.
62. Op cit, p. 20.
63. L. Douglas, C. O'Neill and D. Greenberg "Does Court Mandated Outpatient Treatment of Mentally Ill Offenders Reduce Criminal Recidivism? A Case Control Study" (2006), as cited by T. Gotsis and H. Donnelly, op cit at p. 29. ❑