benchtv
a benchmark production

Précis Paper

Mental Health and Section 32 Applications

A discussion of mental health in the criminal process, and the diversion of persons from the justice system to the health system

Discussion Includes

- Law Reform Commission's inquiry, findings & recommendations
- Outline of the current eligibility criteria
- Practical difficulties of s 32 applications, and how to overcome them
- Treatment plans, and what they should contain
- Client's fitness & practitioner's ethical obligations
- Community Treatment Orders

Précis Paper

Mental Health and Section 32 Applications

1. In this edition of BenchTV, Karen Weeks (Principal Solicitor, Criminal and Mental Health Lawyers, Sydney), the Hon Gregory James AM QC (Barrister, Eleventh Floor Garfield Barwick Chambers, Sydney), and Evan James (Barrister, Eleventh Floor Garfield Barwick Chambers, Sydney) discuss section 32 applications under the *Mental Health (Forensic Provisions) Act* 1990 (NSW), and provide practical advice to practitioners for the preparation and delivery of such applications.

Introduction

2. Karen and Evan are practitioners who confront the difficulties with s 32 applications in Local Courts, and on appeal to the District Court, every day.

3. In his former role as President of the Mental Health Review Tribunal, Hon Greg James AM QC looked at the consequences of mental illness outside the legal system proper - that is, the criminal justice system. During his time there, he gained considerable insight into what might be available by way of treatment facilities for persons who were suffering from a mental illness or mental condition.

4. During this time, s 32 had first come into operation. It permits the diversion of persons from the justice system to the health system, and particularly to the care and treatment that was reviewed by the Mental Health Tribunal. But there has been some examination, since then, by the Law Reform Commission, of what diversionary mechanisms might be put in place to enable s 32 to be even more effective.

Law Reform Commission's inquiry, findings & recommendations

5. In 2012 and 2013, the Law Reform Commission conducted a far-reaching inquiry, and recommended a number of changes be made to the diversionary regime (both s 32 and s 33). The Commission also found that s 32 in particular was underutilised. According to the Bureau of Crime Statistics and Research, only 1.4% of criminal charges in the Local Court last year (2016) were the subject of s 32 orders. So one of the concerns of the Commission was that the provisions were not really being used as they should have been.

6. The Commission was concerned with the over-representation of people with mental health and cognitive impairments in the criminal justice system, and diverting them out of the system for treatment to address some of the causes of crime, and reduce re-offending.

7. S 32 is a provision that is designed for, where appropriate, and having regard to the seriousness of the conduct, a Local Court to divert a person charged with offences at any stage of the process (before plea, or on sentence) from the criminal justice system and into the health system in a way that can enable such a person to be discharged, and, after treatment, put the allegation of the offence behind them.

8. S 33 is the Local Court's answer to the conundrum presented by no specific statutory provisions for unfitness for trial. S 33 permits a magistrate, even on their own motion, where a person appears before them to be seriously ill, to have that person removed to a hospital and there treated – if, of course, the police officers who are doing the removal, can persuade the hospital to take such a person. There is no compulsion that operates on the hospital.

9. Making a s 32 application is a three-step process. The first step is to meet the eligibility criteria. On 28 August 2017, the legislation was amended to widen the eligibility criteria. The amendment follows a recommendation made by the Law Reform Commission. It is the only recommendation from the Commission that we have seen result in legislative change to date.

10. Under the old law, the initial requirement of having either a mental illness or mental health condition, had to be satisfied. That included, under the mental health condition definition, a developmental disability. The words 'developmental disability' are, at the least, ambiguous and restrictive.

11. The Law Reform Commission recommended:

    - a widening of the jurisdictional requirements
    - the extension of s 32 to the District Court
    - that the limit of only 6 months for the treatment to be carried out in consequence of a magistrate's order be extended (even though, under s 11 of *the Crimes (Sentencing Procedure) Act 1999* (NSW), and according to Justice Adams, the period could be extended by adjournments (at least up to 12 months)

12. The upshot of this is that we are now left with many of the old problems – for example, the difficulty of inappropriateness. But we now have an expanded area of persons to whom the section can apply.

<u>Outline of the current eligibility criteria</u>

13. Cognitive impairment is defined in s 32 (6) of the *Mental Health (Forensic Provisions) Act 1990* (NSW). Mental illness is defined in the *Mental Health Act 2007* (NSW).

14. 'Cognitive impairment' has replaced 'developmental disability'. It is defined in the Act as:

Ongoing impairment of a person's comprehension, reasoning, adaptive functioning, judgment, learning or memory that materially affects the person's ability to function in daily life and is the result of damage to, or dysfunction, developmental delay or deterioration of, the person's brain or mind, and includes (without limitation) any of the following:

(a) intellectual disability
(b) borderline intellectual functioning
(c) dementia
(d) acquired brain injury
(e) drug or alcohol related brain damage, including foetal alcohol spectrum disorder
(f) autism spectrum disorder

15. The restriction on 'mental illness' is that the illness must be one to which the Mental Health Act applies. The restriction on 'mental condition' is that the condition must be one for which treatment is available at a mental health facility. Now with this expansion in the legislation, it is a matter of whether *in practice* the magistrates will apply s 32 to a wider group of people.

16. The amended definitions will assist practitioners because it had been the case that practitioners were unsure of whether or not their clients' diagnoses fit within the Act, and tended to err on the side of caution – and rather than running a s 32 application, would instead run a plea in mitigation (seeking to rely on medical evidence).

17. The expanded definition in the Act now allows practitioners, when they have an initial diagnosis, to know with more confidence whether or not they can actually run a s 32 application. It also allows a prosecutor some degree of certainty that a condition does fit, and that the appropriate argument to have is the balancing argument rather than the first limb argument. This will have a knock-on effect on the magistrates, by allowing them to, when they are reading the medical material, either:

    - have a greater appreciation of how those conditions affect a person's judgment, and the appropriateness of a s 32; or
    - have a greater ability to assess criminality, and apply an appropriate penalty (if a s 32 is not granted)

18. During the time in which a person is treated (in the 6 months in which a s 32 order is in operation) the person gets the assistance of a psychologist. Very rarely is there access to outpatient care at mental health hospitals.

19. These conditions allow treatment by professionals who are in a wider group of professionals than those to which s 32 originally applied. However, we are still confronted with the difficulty of how best to determine whether or not a s 32 application should be made.

20. In *DPP (Cth) v De La Rosa* [2010], Justice McClellan set out various conditions for mental illness, in particular to be recognised on a plea. They are, however, somewhat restrictive too, in that they point to the mental illness having to be causative to some degree. S 32 does not require this. Yet many magistrates seem to require the existence of a causal relationship, even though there does not seem to be anything in the authorities that requires any such existence. This is most likely because magistrates are concerned about (particularly in relation to serious offences) making a s 32 order, and it being perceived as a them granting essentially a 'get out of gaol free' card.

21. The decision in *Mantell v Molyneux* [2006] made it abundantly clear that if the Court's general powers to adjourn are not used, there are powers to adjourn under s 32 (2), assuming the s 32 (1)(a) jurisdictional criteria, and the s 32 (1)(b) balancing exercise, are both satisfied.

22. The reluctance of magistrates to simply 'let an offender go' by way of a s 32 order is unfounded, at least to the extent that s 32 does simply 'let offenders go'. S 32 is just another legislative provision that must be considered when determining what course to take. It is not (as it is commonly treated) illegitimate somehow. It is not a matter of considering that sending someone off to hospital (for treatment) instead of sending them to jail (bail refused) is some sort of an illegitimate option, particularly in circumstances where it is quite clear that the person concerned is suffering from mental illness to such an extent as not to be able to play their part in the criminal process.

<u>Practical difficulties of s 32 applications, and how to overcome them</u>

23. Practitioners have to be thoroughly prepared if they are running a s 32 application.

24. Sometimes it is necessary to obtain multiple expert reports, particularly if the offence is serious. An extremely important part of being prepared is to know who is going to be on the bench.

25. In considering a s 32 application as an option, practitioners will also have to turn their minds to other options in order to properly advise their clients, like, for example, the common law defence of insanity (otherwise known as the M'Naghten rules). If available, the M'Naghten rules obviously strengthens a s 32 application.

26. Section 32 diversion/discharge may be a more attractive option to a magistrate than a complete acquittal where a client meets the s 32 eligibility and also lacks the necessary intent and/or has the M'Naghten's defence available.

27. The other thing to look at when preparing the reports is to serve them early, and to speak to the prosecutor, because the more agreement both sides can be in before the defence presents the application, the quicker the application can be presented, and the more

effective it will be. So if there are a multitude of reports to be served, serve them early, and speak to the prosecutor beforehand.

28. It is also wrong to see a s 32 as an adversarial application. It is more an inquiry, akin to a Royal Commission, rather than a defended hearing as such. So, again, it is important to have a word with the prosecutor beforehand to limit the issues in contention, and to see how both sides can best inform the magistrate, rather than running an adversarial application.

29. Probably the single most important feature of getting a s 32 application up is the treatment plan. Some magistrates, without a separate document headed 'Treatment Plan', will refuse to consider a s 32 application.

Treatment plans, and what they should contain

30. What is contained in the treatment plan should really come from the health professional who is responsible for delivering the treatment. Most importantly, there needs to be an undertaking to the Court from the report writer stating that if the Court does make a s 32 order on the condition that the client continues with their treatment, that they undertake to the Court to advise if there is any non-compliance, because the Court will want some sort of mechanism in place for effective supervision.

31. Indeed both the Law Reform Commission and the Judicial Commission of NSW found that magistrates were sometimes reluctant to make s 32 orders because they believed that they could not be effectively supervised.

32. If appropriate, the client should themselves specifically sign up to a treatment plan, and include in it a provision that the client will attend a hospital, if reasonably required to do so by the treating professional.

33. In circumstances where a person has chronic mental illnesses or mental conditions, particularly those who suffer from cognitive impairment, magistrates have been known to refuse s 32 applications on the basis that that person has already had one granted to them – ostensibly, without success.

34. But, again, there is nothing in the legislation or the authorities that preclude second, or subsequent, s 32 orders from being made. Magistrates have tended to regard a s 32 as akin to a s 10 under the *Crimes (Sentencing Procedure) Act 1999* (NSW). The point has to be made when making a s 32 application that this is not true.

35. There is a great difference between a s 32 and a s 10. A s 32 is an ongoing process. Each person's circumstances are unique, as are their medication and treatment regimes. So a s 32 is about an ongoing process of treating a person, rather than a s 10, which is about offering a

person a chance to show the Court that they have changed. However, if a s 32 is refused, then making an application for a s 10 bond, with similar or the same conditions, can be a good backup because the case law makes quite clear that a s 10 bond is a real punishment under law.

36. Indeed, in the Supreme Court decision of *David Morse (Office of State Revenue) v Chan* [2010], it was determined that in cases where s 32 is not appropriate, a s 10 will be.

37. It is important not to be afraid of going part heard in front of the magistrate.

38. The treatment under a s 32 order is not designed to be punishment with a deterrent effect. It is intended to treat as the condition is seen to be by the health professionals at the time.

39. In every major local courtroom throughout NSW, we now have the Justice Health and Forensic Mental Health Network. The Justice Health and Forensic Mental Health Network is the court liaison service, presided over by Professor Greenberg. It provides health services to those in contact with the forensic mental health system and NSW criminal justice system.

Client's fitness & practitioner's ethical obligations

40. A practitioner needs to be well-versed in their ethical obligations, and the *Legal Profession Uniform Law* (NSW), which confirms the common law position that legal practitioners have duties to the Court that override their duties to the client. When a question arises in relation to a client's fitness or unfitness for trial or to plead, the practitioner is compelled by their ethical obligations to raise this with the Court at the earliest opportunity. Then everything stops, and the Court must conduct an inquiry.

41. If a client is unfit, the practitioner is ethically bound to raise it. The court liaison service can assist with this.

42. With a bit of luck, the client can be admitted to hospital. The hospital can detain the client and furnish reports to the Court. If the client is detained under a compulsory process, his or her progress in the hospital will be reviewed by the Mental Health Review Tribunal, and the Mental Health Review Tribunal will also provide reasoned determinations that will be available to the Court.

43. All of this maximises the information the Court can have available either:

- to decide whether a s 32 should occur, or
- to decide what disposition should occur in terms of any sentencing order in accordance with the principles in *DPP (Cth) v De La Rosa* (2010)

Community Treatment Orders

44. A Community Treatment Order (CTO) is a legal order made by the Mental Health Review Tribunal or by a magistrate. It sets out the terms under which a person must accept medication and therapy, counselling, management, rehabilitation and other services while living in the community.

45. Another concern magistrates have is that it is not really the role of the Court to supervise medical professionals in administering treatment, and yet s 32 does seem to envisage that such a thing might occur.

46. One of the purposes of CTOs is that the magistrate can, in effect, pass such responsibility to the specially-constituted body – the Mental Health Review Tribunal – set up by the legislation (consisting of a judicial officer, a psychiatrist, and any persons otherwise qualified) to continuously review the involuntary patient at least every six months.

47. So far as assessment is concerned, a clinical psychologist will rely on structured professional judgment and also various well-validated tests, which can supply independent support for the psychologist's description of the condition.

48. It is not for the psychologist to diagnose medical phenomena. On the other hand, mental health conditions are not merely medical phenomena. Often, the psychiatrist would be stepping out of their area of expertise if they were to look at such things as cognitive impairment.

49. Almost invariably, those who wish to restrict access to psychologists fail to take into account that it is enormously difficult to get psychiatrists to be able to deal every day with persons who have everyday problems.

50. The legislation makes it quite clear that a magistrate can inform themselves as they see fit (which does not limit it to psychologists, or psychiatrists, etc.).

51. There should not be difficulties put in the way of putting into place a legislative regime that is intended to be ameliorative, rather than punitive.

52. A practitioner will need to be able to show why mental health treatment under s 32 will protect the community. Another aspect to this problem is that unfortunately within correctional system, the facilities are grossly overloaded when it comes to treatment.

53. Persons with a comparatively minor mental health/mental illness disability are *unlikely* to be able to get the treatment that is *likely* to protect the community. They will end up being discharged into the cycle of offending, re-attendance, and progression through jail, ultimately becoming a chronic problem, unless the cycle can be broken by appropriate mental health treatment.

54. People should not have expectations of mental health treatment that are too high. We must bear in mind that we are dealing with people that have problems for the rest of their lives. We are concerned with their treatment, and minimisation of harm to the community – and often, jail is not the solution.

BIOGRAPHY

Karen Weeks

Principal Solicitor, Criminal and Mental Health Lawyers, Sydney

Karen has more than 22 years of experience in private practice as a criminal defence lawyer in both serious and minor criminal matters, specialising in the area of mental illness. Karen regularly speaks at legal seminars on criminal and mental health law and has authored many papers in the area including two published in the Law Society Journal. She has run fitness inquiries and the defence of mental illness in the District Court. In the Local Court Karen frequently runs section 32 and section 33 applications for her clients who have a wide range of cognitive or mental health impairments.

The Hon Gregory James AM QC

Barrister, Eleventh Floor Garfield Barwick Chambers, Sydney

Greg has returned to the bar after serving as a Supreme Court Judge and Royal Commissioner. He advises and appears in criminal and administrative appeals, commissions and inquiries. He also prepares special leave applications, including to the High Court. Greg was also the former President of the Mental Health Review Tribunal of New South Wales.

Evan James

Barrister, Eleventh Floor Garfield Barwick Chambers, Sydney

Evan commenced practice as a solicitor in 2010 and was called to the Bar in 2014 where he specialises in criminal law, mental health law and the associated Tribunals and Sports Law and the associated Tribunals. Evan has appeared in Royal Commissions and other Commissions of Inquiry, including the Northern Territory Inquiry into Stella Maris, the NSW Crime Commission, the Australian Crime Commission and ICAC. He has also appeared in such tribunals as the Racing Appeals Tribunal, Administrative Decisions Tribunal (now NCAT) and regularly appeared at the Mental Health Review Tribunal. Evan is a member of the Disciplinary Tribunal of Touch Football Australia.

BIBLIOGRAPHY

Cases

DPP v El Mawas [2006] NSWCA 154

Director of Public Prosecutions (Cth) v De La Rosa [2010] 79 NSWLR 1; [2010] NSWCCA 194

Mantell v Molyneux [2006] NSWSC 955

David Morse (Office of State Revenue) v Chan [2010] NSWSC 1290

Eastman v The Queen [2000] HCA 29; 203 CLR 1

Legislation

Mental Health (Forensic Provisions) Act 1990 (NSW)

Crimes (Sentencing Procedure) Act 1999 (NSW)