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What's new with section 32?

Diversion under the new *Mental Health and Cognitive Impairment Forensic Provisions Act* 2020

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1 Introduction

This is an updated version of a paper I presented at the Reasonable Cause CPD seminar in March 2020.

Since I wrote that paper, the *Mental Health and Cognitive Impairment Forensic Provisions Act* 2020 (NSW) has been enacted. It received assent on 23 June 2020 and is expected to commence when it is proclaimed sometime around March 2021.

The new Act will replace the current *Mental Health (Forensic Provisions) Act*. Like the existing Act, it will cover diversionary procedures in Local and Children's Courts as well as procedures applicable to superior courts (fitness, mental health/cognitive impairment defence, forensic patients, etc).

The new Act implements some (but by no means all) of the recommendations made by the NSW Law Reform Commission in 2012 and 2013. For more detail about the NSWLRC's recommendations, including those that were unfortunately not implemented, see part 11 of this paper.

In relation to diversion at least, the changes made by the new legislation are very minor. Accordingly, much of the existing common law around section 32 and 33 will continue to apply. This paper will provide an overview of the new provisions as well as a summary of the current law relating to sections 32 and 33. I will also attempt to dispel some of the more common myths about section 32 as well as psychologists' qualifications to make diagnoses.

Attached to this paper is a comparative table setting out the old and new provisions side by side.

2 Summary of the diversionary provisions in the new Act

2.1 Overview

Part 3 of the current Act (which contains sections 32 and 33) will be replaced by Part 2 of the new Act.

The changes made by the new legislation are very minor and include:

- some new definitions
- an increase in the enforcement period of section 32 orders from 6 months to 12 months

- a list of factors a Magistrate may consider when dealing with a section 32 application, and
- the extension of section 33 to mentally disordered persons.

2.2 Changes to definitions

The new Act retains the concept of "cognitive impairment" but provides a slightly amended definition in section 5 of the Act. This definition is set out, alongside the current definition, in part 3 of this paper.

The current concepts of "mental illness" and "mental condition" will be replaced by the concept of "mental health impairment" which is defined in section 4 of the Act. This definition is set out, with some discussion, in part 3 of this paper.

The new definitions of "mental health impairment" and "cognitive impairment" were arrived at after extensive consultation with both legal and mental health professionals.

Other terms such as "mentally ill person" and "mentally disordered person" are not defined in the new Act but section 3(2) provides "Words and expressions used in this Act have the same meanings as in the Mental Health Act 2007".

2.3 The new section 32 (Part 2 Division 2)

The former section 32 is now broken up into several different sections, mostly contained in Part 2 Division 2.

Section 12 sets out the eligibility for a section 32 type order. It is the same as the current section 32, except that the concepts of "mental illness" and "mental condition for which treatment is available in a mental health facility" have been replaced by "mental health impairment".

Section 13 provides for adjournment of proceedings for various purposes. These include enabling the person's mental health or cognitive impairment to be assessed, the development of a treatment or support plan or the identification of a responsible person.

Section 14 sets out the final orders that a Magistrate may make. These are identical to the final orders currently available under s32(3).

Section 15 is a new provision setting out a list of factors that a Magistrate may take into account when dealing with an application. These largely reflect the current common law. Note the use of "may" (not "must") and the inclusion of a catch-all: "other relevant factors".

As with the current s32, a Magistrate may make an order at any time during the proceedings. The new s9 adds "whether or not the defendant has entered a plea" and also makes clear that an order may be made on application or on the Magistrate's own initiative.

Section 16 provides that a person may be called back before the court for failure to comply within 12 months of the order being made. This is of course an increase from the current 6-month period. Whether it will encourage more Magistrates to make section 32 orders remains to be seen.

Section 17 replicates the current s32A, and provides that a "treatment provider" may report a person's failure to comply. It retains the flaws of the current provision, which does not reflect reality, e.g. it does not provide for the "responsible person" to report a breach, and provides for a report to be made to an officer of the Department of Communities & Justice (i.e. Community Corrections), who have never had a legal mandate to supervise section 32 orders. In practice, responsible persons or treatment providers generally report breaches directly to the court.

2.4 The new section 33 (Part 2 Division 3)

The former section 33 is split into several provisions which are mostly found in Division 3.

In substance these provisions are identical to the current section 33, except they now apply to “mentally disordered persons” as well as “mentally ill persons”.

The definitions of “mentally ill person” and “mentally disordered person” are set out in part 3 of this paper.

Although orders under the new equivalent to section 32 will now be enforceable for 12 months, the new equivalent to section 33 has retained the 6-month period.

3 Definitions

3.1 Cognitive impairment

Current Act

This is currently defined in s32(6) of the *Mental Health (Forensic Provisions) Act* (as amended with effect from 28 August 2017):

> “Cognitive impairment” means 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.”

New Act

The new definition is set out in s5 of the new Act as follows:

> (1) For the purposes of this Act, a person has a cognitive impairment if—
>
> (a) the person has an ongoing impairment in adaptive functioning, and
>
> (b) the person has an ongoing impairment in comprehension, reason, judgment, learning or memory, and
>
> (c) the impairments result from damage to or dysfunction, developmental delay or deterioration of the person’s brain or mind that may arise from a condition set out in subsection (2) or for other reasons.
>
> (2) A cognitive impairment may arise from any of the following conditions but may also arise for other reasons:
>
> (a) intellectual disability
>
> (b) borderline intellectual functioning,

(c) dementia,

(d) an acquired brain injury,

(e) drug or alcohol related brain damage, including foetal alcohol spectrum disorder,

(f) autism spectrum disorder.

Discussion

Cognitive impairment is a broader concept than "developmental disability", the term formerly used in section 32. It includes conditions arising in adulthood such as acquired brain injuries and dementia.

A cognitive impairment *is not a mental illness* and cannot be "treated" (although, of course, a person with a cognitive impairment may also have mental health issues).

Perhaps the most common type of cognitive impairment dealt with in section 32 applications is intellectual disability. It is not defined in the legislation but its meaning is generally well understood (at least by people with relevant expertise).

Intellectual disability is a condition that does not change significantly over time and which affects cognitive functioning (reasoning, memory) and adaptive skills (communication, literacy, daily living skills, social and recreational skills).

Generally accepted categories of intellectual disability are:

- Borderline (IQ range 70-84)
- Mild (IQ range 55-70)
- Moderate (IQ range 40-55)
- Severe (IQ range 25-40)

Even a mild intellectual disability is a significant impairment. A person in this category generally functions at a level in the bottom 2-3% of the population. A person with a *moderate* intellectual disability may be impaired to the extent that they are unfit to be tried.

The Intellectual Disability Rights Service (IDRS) has a *Step-by-step guide to section 32 applications*: https://idrs.org.au/resources/section-32/. Although the legal content is now outdated, and is currently under review, the guide still contains some helpful information about intellectual disability and its impact.

3.2 Mental illness

Current Act

This term is used in the current Act, although it is not defined in the Act.

However, according to s4 of the *Mental Health Act* 2007:

> "mental illness means a condition which seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:
>
> (a) delusions,
>
> (b) hallucinations,
>
> (c) serious disorder of thought form,
>
> (d) a severe disturbance of mood,

(e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)-(d).”

New Act

For the purpose of the new equivalent to section 32, the concept of “mental illness” has been replaced with “mental health impairment”.

However, the definition of “mental illness” remains relevant to the question of whether a person is a “mentally ill person” for the purpose of the new equivalent to section 33.

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

This concept is relevant to the current section 32 but will not be carried through into the new Act.

Current Act

“Mental condition” is defined in s3 of the *Mental Health (Forensic Provisions) Act* 1990 as “a condition of disability of mind not including either mental illness or developmental disability of mind”.

A broad range of things would qualify as a “mental condition”, including possibly a personality disorder. To be eligible for diversion under s32, it must be capable of being treated in a mental health facility.

A “mental health facility” is defined in the *Mental Health Act* 2007, and can either be:

- A declared mental health facility, which is a premise subject to an order in force under s109.
- A private mental health facility, which is a premise subject to a licence under Division 2 of Part 2 of Chapter 5.

In practice this means a public or private hospital with psychiatric facilities. This could include outpatient treatment as well as inpatient treatment (so, for example, it may apply to a person with a borderline personality disorder who attends a Dialectical Behavioural Therapy (DBT) program at a public hospital).

Names of declared mental health facilities are published from time to time in the Government Gazette. According to Appendix 4 of the *Mental Health Act 2007 Guidebook* (6th edition, April 2019) https://www.heti.nsw.gov.au/__data/assets/pdf_file/0009/457983/Mental-Health-Act_2007_Guide-Book_6th-edition-2019-published-07.08.2019.pdf, a list of declared mental health facilities can be obtained by emailing the Mental Health Branch at MOH-mentalhealthbranch@health.nsw.gov.au.

3.4 Mental health impairment

New Act

The new Act introduces the concept of “mental health impairment” which is defined in s4 as follows:

(1) For the purposes of this Act, a "person has a mental health impairment" if--

(a) the person has a temporary or ongoing disturbance of thought, mood, volition, perception or memory, and

(b) the disturbance would be regarded as significant for clinical diagnostic purposes, and

(c) the disturbance impairs the emotional wellbeing, judgment or behaviour of the person.

(2) A mental health impairment may arise from any of the following disorders but may also arise for other reasons--

(a) an anxiety disorder,

(b) an affective disorder, including clinical depression and bipolar disorder,

(c) a psychotic disorder,

(d) a substance induced mental disorder that is not temporary.

(3) A person does not have a mental health impairment for the purposes of this Act if the person's impairment is caused solely by--

(a) the temporary effect of ingesting a substance, or

(b) a substance use disorder.

Discussion

The inclusion of "significant for clinical diagnostic purposes" has caused some concern. However, the intent is merely to screen out ordinary human emotions.

As the Attorney-General, Mark Speakman, said in the Second Reading Speech (Legislative Assembly Hansard, 3 June 2020, https://www.parliament.nsw.gov.au/Hansard/Pages/HansardResult.aspx#/docid/'HANSARD-1323879322-110558'):

> "The requirement that the disturbance be "significant for clinical diagnostic purposes" means that the temporary or ongoing disturbance must be serious enough to result in a mental health diagnosis. Sadness, grief or anger would not suffice for the purposes of meeting the definition."

The Attorney-General also said:

> "The temporary effect of taking drugs or having a substance-use disorder is expressly excluded from the definition. This means that a person who commits a crime while on drugs or intoxicated, with no other clinically significant mental health impairment or cognitive impairment, will not be a person with a mental health impairment or cognitive impairment for the purposes of the bill."

It is clear that intoxication and "addiction" are excluded from the new definition.

Whether a drug-induced psychosis is included is unclear. If it is the typical amphetamine-induced psychosis which resolves within a few days after ceasing to take the drug, this might not meet the definition of "mental health impairment" because it is "caused solely by the temporary effect of ingesting a substance".

In *DPP v Sheen* [2017] NSWSC 591, there seemed to be no dispute that the accused, who was admitted to hospital with a drug-induced psychosis, was a "mentally ill person" within the ambit of s33.

However, there are other cases which suggest that a drug-induced psychosis is not a mental illness, at least not for the purpose of a mental illness defence. See, e.g., *R v Zhen Fang (No 3)* [2017] NSWSC 28 (especially at [110]); *Zhen Fang v R* [2018] NSWCCA 210 (at [95]-[105]); *R v Tran* [2019] NSWDC 644. In *R v Zhen Fang (No 4)* [2017] NSWSC 323, a drug-induced psychosis was not held to be mitigating on sentence and was treated in much the same way as self-induced intoxication.

There is also a divergence of views as to whether a personality disorder is a mental illness and whether it is appropriate to deal with such a person under section 32. Certainly personality disorders are defined in the DSM, and some of the symptoms and

behaviours fit within the definition of mental illness. For a helpful discussion of personality disorders and why they are, in many cases, to be regarded in the same way as mental illnesses, see *Brown v The Queen* [2020] VSCA 212.

My understanding is that personality disorders do come within the new definition, as long as they cause the sort of disturbance and impairment referred to in s4(1).

3.5 Mentally ill person

Confusingly, a person may have a "mental illness" but not be a "mentally ill person". Essentially a "mentally ill person" is someone who meets the criteria for involuntary admission to hospital, or some less restrictive form of coercive treatment such as a Community Treatment Order.

According to section 14 of the *Mental Health Act* 2007:

> A person is a mentally ill person if the person is suffering from a 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.
>
> In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration of the person's condition and the likely effects of any such deterioration, are to be taken into account.

3.6 Mentally disordered person

According to section 15 of the *Mental Health Act* 2007:

> A person (whether or not the person is suffering from mental illness) is a mentally disordered person if the person's behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary:
>
> (a) for the person's own protection from serious physical harm, or
>
> (b) for the protection of others from serious physical harm.

4 The current section 32 (and the new Part 2 Division 2) - basics

4.1 Application of section 32

Section 32 applies to matters being dealt with summarily (i.e. summary offences, and indictable offences being dealt with summarily) in the Local or Children's Court.

It does not apply to offences that are strictly indictable or where the DPP has made an election.

Section 32 is a *diversionary* procedure which allows the court to dismiss charges (usually subject to conditions) instead of proceeding "according to law" in the normal way.

A s32 application may be made at any stage of the proceedings without the need for a plea to be entered. However, if there has already been a guilty plea or a finding of guilt, this does not preclude a s32 application.

A s32 discharge does not amount to a finding that the offence is proved; nor does it amount to an acquittal. It will appear on the defendant's criminal history (bail report) but not on their conviction record.

Section 32 is not applicable to Commonwealth offences *(Kelly v Saadat-Talab* [2008] NSWCA 213). However there is a broadly similar provision in the Commonwealth *Crimes Act* (s20BQ).

None of this will change under the new Act.

4.2 The test for a section 32 application

There are two limbs to the section.

Firstly, the defendant must have (either at the time of the alleged offence or the time of the court appearance):

a. a cognitive impairment (this replaced the term "developmental disability", with effect from 28 August 2017),

b. a mental illness, or

c. a mental condition for which treatment is available in a mental health facility,

but must not be a "mentally ill person" at the time of the court appearance.

Secondly, the Magistrate must decide it is more appropriate to deal with the matter under s.32 than according to law.

It was suggested by the Court of Appeal in *DPP v El Mawas* [2006] NSWCA 154, and now seems widely accepted, that there is a third limb, i.e., is there an appropriate case plan or treatment plan? See "Case/treatment/support plans and responsible persons" below.

Fundamentally this will not change under the new Act. The only changes are the new concept of "mental health impairment" to replace "mental illness" and "mental condition", and the fact that the new provisions exclude "mentally disordered persons" as well as "mentally ill persons".

4.3 Types of orders the court may make

A court may make interlocutory orders under section 32(2). The court is empowered to make these types of orders in any event, so there is nothing special here.

More significant are the final orders available under section 32(3), which involves the Magistrate dismissing the charge and discharging the defendant either:

(a) into the care of a responsible person, either unconditionally or subject to conditions:

The responsible person will often be the client's treating psychiatrist, psychologist or GP. However, the responsible person does not have to be a medical or mental health practitioner.

In practice the discharge into the care of a responsible person will usually be accompanied by conditions requiring the defendant to adhere to a case plan.

See further discussion on "Case/treatment/support plans and responsible persons" below.

(b) on the condition that the defendant attend on a person or at a place specified by the Magistrate:

(i) for assessment or treatment (or both) of the defendant's mental condition or cognitive impairment, or

(ii) to enable the provision of support in relation to the defendant's cognitive impairment

An order under this paragraph may be appropriate where there is no individual to nominate as a responsible person but where the client regularly attends a community mental health centre or other service.

Saunders v Director of Public Prosecutions (NSW) [2017] NSWSC 760 held that the specified place or person must be named. In this case, the Magistrate was dealing with a defendant who was about to be released from custody and was still not certain where he would be living. The Magistrate discharged him under s32(3)(b) on condition that he attend his closest community mental health centre for treatment.

R A Hulme J in the Supreme Court held that this was impermissible and that a specific person or place must be nominated.

His Honour discussed the importance of there being a regime for enforcement of s32 orders (at [45]). He then said:

> [47] A failure to name a particular person or a particular place renders the enforcement provisions in relation to a conditional discharge under s 32 virtually nugatory. In the present case, there is no guarantee that "a psychiatrist" who may be consulted by the defendant "for a medication review" will know that he or she is seeing the defendant pursuant to a court order. In those circumstances, there is a most unlikely prospect of such psychiatrist knowing that he or she may report a failure to comply (s 32A).

See also “Case/treatment/support plans and responsible persons” below.

(c) unconditionally:

Unconditional dismissals are fairly rare but may be appropriate for trivial matters, or for old matters where the client has undergone a long period of treatment and has stabilised.

It is worth noting that the requirement for a case plan or treatment plan is not set in stone (or even in legislation!). It arises from common law, and was originally set out in *Perry v Forbes*, in the context of relatively serious and persistent offending.

See further discussion on “Case/treatment/support plans and responsible persons” below.

The final orders available under the new Act are exactly the same.

4.4 Enforcement

A s32 order is binding on the defendant only and cannot compel any agency to provide services (see *Minister for Corrective Services v Harris & Karpin* (1987) SCNSW). This is well-understood by most Magistrates.

The above case has sometimes been interpreted as meaning that a person named as the “responsible person” does not have any obligations under the order. This is not what the case says. However, it is clear that the “responsible person” has no legal mandate to supervise the s32 order (unlike, say, a probation officer or JJO supervising a community-based sentence).

Nor is there any legislative framework for requiring the responsible person to sign an undertaking (cf. a surety or acceptable person under the *Bail Act*). The Magistrate will often ask the responsible person to undertake to notify the court in the event of a breach, but I am not sure how enforceable these undertakings are.

Until 2003 there was no way of enforcing compliance with s32 orders or bringing the defendant back to court if they breached a condition. This meant Magistrates were often reluctant to dismiss charges under s32. Subs(3A) now provides that a defendant who is dealt with under s32 may be brought back to court at any time within the next 6 months to be further dealt with (this is similar to a provision that already existed in relation to s33).

Section 32A provides for treatment providers to report non-compliance with s32 orders. Originally it was envisaged that Community Corrections or Juvenile Justice would supervise people on s32 orders, but this has never been implemented (except to a limited extent in the context of the Cognitive Impairment Diversion Program), and so the section does not really operate as intended. However, it is open to a treatment provider or "responsible person" to report non-compliance directly to the court and for the court to deal with the matter as it sees fit.

Note that there is no *obligation* for a treatment provider or "responsible person" to notify the court in the event of a breach. Sometimes a Magistrate dealing with a s32 application will ask the proposed "responsible person" for an undertaking that they will notify the court in the event of a breach (but, as I have already mentioned, I am not sure how enforceable these undertakings are).

Proceedings for breach of s32 orders are rare.

If the court calls the defendant up to deal with the breach, the aim is not to punish the defendant for non-compliance but to tweak the case/treatment plan so that it works better. However, persistent non-compliance may result in the defendant being required to enter a plea and have the matter dealt with "according to law".

Note that, unlike a bond/CRO/CCO, a fresh offence does not constitute a breach of a s32 order (unless the Magistrate has specifically made good behaviour a condition of the s32, which is rare). However, a client who offends while subject to a s32 probably won't be dealt with so favourably for the fresh offence.

This will not change under the new Act, except that the period of enforceability will be extended from 6 months to 12 months.

5 The current section 33 (and the new Part 2 Division 3) – basics

5.1 Application

Section 33 applies to a person who is, at the time of their court appearance, a "mentally ill person".

A client may be a "mentally ill person" even if they are not unwell enough to require immediate hospitalisation. A client who is on a Community Treatment Order, particularly where that CTO is likely to be continued, would technically fall within s33, as it is a pre-requisite to the making of a CTO that the person be a "mentally ill person".

Like s32, s33 only applies to matters being dealt with summarily, and can be used at any stage of the proceedings without the need to enter a plea.

Section 33 is more likely to be used at an early stage of the proceedings, to have an acutely unwell defendant sent to hospital.

This new Act extends the application of these provisions to a "mentally disordered person" as well as a "mentally ill person".

5.2 Types of orders

Section 33 can be used on either an interlocutory or final basis.

Under s33(1), a Magistrate may order that the defendant:

> (a) be taken by police, Corrective Services or Juvenile Justice to hospital for assessment;
>
> (b) same as (a), but with an additional order that if the defendant is assessed not to be a "mentally ill person" (and therefore not admitted to hospital) he or she is to be brought straight back before the court; or
>
> (c) be discharged, unconditionally or subject to conditions, into the care of a responsible person.

Order (a) or (b) above may be made by an "authorised officer " (e.g. a bail justice sitting in a weekend bail court) (s33(1D)).

A Magistrate also has power to make a Community Treatment Order (s33(1A)), but only with the agreement of the relevant community mental health service.

Unlike s32, s33 does not expressly require a Magistrate to consider whether it is "more appropriate" to deal with the defendant in this way. However it is still a *discretionary* decision to apply s33 (the Magistrate "may", not "must", make orders under s33).

The orders available under the new Act are exactly the same.

5.3 Interlocutory orders

If the court sends a defendant to hospital under s33(1)(a) or (b), without any further order, this will have the effect of finalising the proceedings unless the defendant is brought back to court within 6 months (see further discussion below).

Subs(1) provides that an order may be made under para (a), (b), or (c) "*without derogating from any other order the Magistrate may make in relation to the defendant, whether by way of adjournment, the granting of bail in accordance with the Bail Act 2013 or otherwise*".

So, if the court wants to ensure the defendant is assessed and/or treated, but doesn't want to finalise the proceedings, the court may make an order under ss33(1)(a) or (b) and another order adjourning the substantive proceedings.

Unless the charge is relatively trivial, the court will often send the defendant to hospital under s33 and make a separate order adjourning the proceedings, with a view to finally disposing of the charges once the defendant's condition has stabilised. If the defendant ends up in hospital for a long period, the Magistrate might end up making a final order under s33. If the defendant is discharged from hospital and makes good progress in the community, the matter might be finalised under s32. In other cases, the matter may end up being dealt with according to law.

5.4 Does the defendant have to be present?

The JIRS Bench Book commentary about *DPP v Wallman* [2017] NSWSC 40 says "Orders under s 33(1) must also be made with the defendant present and not in chambers in the absence of the parties".

However, this is not what the case says. It simply says that a s33 order must not be made in chambers without giving the parties the opportunity to be heard.

For example, your client might not be at court because they are an involuntary patient in hospital. If you have sufficient material available to make a section 33 application, it may be appropriate for the Magistrate to finalise the matter by making an order under s33(1)(c), discharging the client into the care of his or her treating psychiatrist.

5.5 Effect of an order under s33(1)(c)

An order under s33(1)(c) is similar to a final order under s32. It has the effect of dismissing the charge unless the person is brought back to court within the next 6 months.

Generally the only way the defendant would be brought back to court after a s33(1)(c) order would be if they breach the conditions.

5.6 Effect of an order under s33(1)(a) or (b)

It used to be thought that an order under s33(1)(a) or (b) would also amount to a dismissal of the charges (at least in situations where the court does not make an order adjourning the substantive proceedings, and where the defendant does not immediately bounce back from hospital).

However, the case law has now made it clear that an order under s33(1)(a) or (b) does not necessarily have the effect of finalising the proceedings, even where the defendant is admitted to hospital and remains there for some time.

A defendant who is admitted to hospital, but who remains in hospital for less than 6 months, may be discharged into police custody (see s32 of the *Mental Health Act*) and then returned to court (having been either granted or refused bail) for the proceedings to resume.

Even if the accused is discharged from hospital into the community, it is open to the prosecutor to re-list the proceedings and bring the defendant back to court if the 6 months have not elapsed.

For those who have a JIRS subscription, the Local Court Bench Book has a good discussion of this.

See also the following cases (most of which are summarised in the JIRS commentary):

DPP v Wallman [2017] NSWSC 40

Director of Public Prosecutions (NSW) v Sheen and The Local Court of NSW [2017] NSWSC 591

Police v DMO [2015] NSWChC 4

Police v Thomas Stafford Roberts, Lismore LC 22/08/14

Police v Pines [2013] NSWLC 3

6 Some common myths about section 32

As the changes made by the new Act are minimal, I expect that some of these common misconceptions will persist, and most of the current case law will still be applicable.

6.1 "Some offences are just too serious"

Seriousness is relevant but not determinative: *DPP v El Mawas* (2006) 66 NSWLR 93, [2006] NSWCA 154.

In *El Mawas*, the court affirmed that there is a broad discretion available and did not expressly rule out s32 for serious offences.

6.2 "It's all about treatment vs punishment"

Although a s32 application is often said to be a balancing exercise between treatment and punishment (e.g. in *DPP v El Mawas* (2006) 66 NSWLR 93, [2006] NSWCA 154), remember s32 is *diversionary*, not simply a sentencing option.

If a matter is dealt with according to law, it does not automatically follow that the defendant will be convicted and sentenced.

For example, the defendant may be unfit to be tried, and therefore able to apply for a permanent stay or discharge on the basis that they will never receive a fair hearing (as was the case in *Mantell v Molyneux*). Or maybe the client lacks mens rea and would have a NGMI defence available.

While the case law does not expressly support this approach, it is appropriate to ask the Magistrate to turn their mind to these issues, and take a pragmatic look at what might actually happen if a s32 is refused, rather than focusing exclusively on the likely penalty in the event of conviction.

6.3 "The illness/condition/disability must have caused the offending"

Causal link is relevant but not determinative: *DPP v El Mawas* (2006) 66 NSWLR 93, [2006] NSWCA 154.

6.4 "The defendant knows the difference between right and wrong so section 32 is not appropriate"

No. A person who "knows the difference between right and wrong" and is capable of forming criminal intent can still be appropriately dealt with under s32.

Remember that impaired judgment is a feature of many mental illnesses. Even if the defendant was not so unwell as to lack mens rea at the time of the alleged offence, the illness may have impaired his/her ability to make rational choices about his/her behaviour.

The IDRS step-by-step guide to section 32 applications (see link above) is very helpful in explaining links between intellectual disability and offending behaviour.

However, if a person was so impaired at the time of the offence that they could *not* form mens rea, this would be a powerful argument in favour or a s32 disposition. If a s32 application is refused in such circumstances, the defendant may need to consider a "not guilty by reason of mental impairment (NGMI)" defence, which is rare in the Local Court but is nevertheless available at common law.

It is worth noting that, in *Sullivan v Director of Public Prosecutions (NSW)* [2020] NSWSC 253, Hamill J said (at [48]), that "s32 is not merely a diversionary scheme with a protective purpose, but also a provision that ensures that criminal liability is not attributed to somebody who was mentally ill at the time of the offence.''

Sullivan concerned an application to annul a Local Court conviction following a successful application to the Minister under s5 of the *Crimes (Appeal and Review) Act*. This case is mainly about annulment applications, and is worth reading for that reason.

6.5 "It's about whether the defendant is fit to be tried"

No it's not: *Mackie v Hunt* (1989) 19 NSWLR 130

6.6 "It's got nothing to do with fitness to be tried"

That's not correct either: *Mantell v Molyneux* [2006] NSWSC 955. Unfitness is relevant but not determinative.

In *Mantell v Molyneux,* the s32 application was refused and the unfit defendant was subsequently discharged because there was no regime in place to accord her a fair trial in the Local Court.

If the defendant has been assessed as unfit, this will be a strong argument in favour of a s32 application, because of the difficulties involved in dealing with such a person "according to law". Taking a pragmatic view, most Magistrates would prefer an unfit defendant to be subject to a s32 order for 6 months than to be simply discharged.

6.7 "The facts must be admitted, or findings of fact made, before the s32 application can be determined"

No. Go back to the legislation, and remember it's a diversionary procedure, not a sentencing exercise.

See also "Procedural issues (and does the defendant need to enter a plea?)" below.

6.8 "Section 32 is inappropriate for traffic or other strict liability offences"

Not necessarily: *Police v Deng* [2008] NSWLC 2, where the defendant was discharged under s32 for an offence of negligent driving occasioning death.

Some Magistrates have expressed the view that s32 is not appropriate for strict liability offences which do not require proof of mens rea. This view has no basis in law and fortunately is not as widely-held as it used to be.

Another view is that s32 is inappropriate for traffic offences because it does not allow the court to impose any disqualification and therefore the protection of the community is compromised. With respect to those who hold it, this view rests on a simplistic and misguided assumption that disqualifying a mentally ill defendant will actually stop them from driving! In such a case you might argue that requiring the defendant to obtain treatment for 6-12 months would better promote road safety than simply fining and disqualifying the defendant without any follow-up.

The Magistrate may refer the matter to the RMS after a successful s32 application, so the RMS can consider whether the defendant is a fit and proper person to hold a licence. This is what occurred in *Deng*. This may result in the RMS requiring them to provide medical or psychiatric evidence that they are fit to drive. In my experience, clients are usually able to retain their licences as long as they remain in treatment and do not continue to drive while acutely unwell.

6.9 "The defendant must be present at court for an order to be made"

No. A section 32 or 33 order may be made in the absence of the defendant. It is not a bond and doesn't have to be entered into.

However, orders shouldn't be made in chambers without the parties being heard: *DPP v Wallman* [2017] NSWSC 40.

6.10 "The 6-month time limit on enforceability is not long enough"

It is permissible for the matter to be adjourned to keep the defendant under supervision for longer: *Mantell v Molyneux* [2006] NSWSC 955.

Now, of course, the new Act has extended this period to 12 months.

6.11 "You must always have a case/support/treatment plan"

Not necessarily, but for relatively serious offences you need one: *Perry v Forbes & Anor* (1993) NSWSC, unreported; *DPP v Albon* (2000) NSWSC 896). The case law is summarised in *Saunders v Director of Public Prosecutions (NSW)* [2017] NSWSC 760 at [34] – [37].

See also "Case/treatment/support plans and responsible persons" below.

6.12 "The responsible person must be a named individual"

No, but the person or agency must be clearly identified: *Saunders v DPP* [2017] NSWSC 760.

Also be mindful that the responsible person:

- need not be a psychiatrist or mental health professional
- doesn't have to be at court or to sign anything
- can't be compelled to provide services: *Minister for Corrective Services v Harris & Karpin* (1987) SCNSW, unreported
- may report a breach (s32A) but can't be compelled to do so
- does not have to undertake to the court to report non-compliance (although, in practice, some Magistrates will refuse to make a section 32 order without such an undertaking)

See also "Case/treatment/support plans and responsible persons" below.

6.13 "A psychologist can't diagnose a mental illness"

Yes they can, but check their qualifications. See "Capacity of psychologists to diagnose mental illnesses or conditions" below.

7 Procedural issues (and does the defendant need to enter a plea?)

Although the current Act does not spell out in terms that no plea needs to be entered, this is clear from the provisions of the Act:

- Firstly, ss 32 and 33 both apply “at the commencement or at any time during the time during the course of the hearing of proceedings before a Magistrate”.
- Secondly, both sections provide that a dismissal under one of these sections “does not constitute a finding that the charges against the defendant are proven or otherwise”.
- Finally, s36 provides that the Magistrate “may inform himself or herself as the Magistrate thinks fit, but not so as to require a defendant to incriminate himself or herself”.

Section 9 of the new Act makes it clear that a plea does not have to be entered.

Practitioners have recently been reporting an increased incidence of Magistrates and Registrars insisting that pleas be entered before the matter will be set down for a s32 application.

This appears to be an attempt to comply with the time standards and case management requirements of the general criminal Practice Note Crim 1.

There is nothing in the Practice Note that specifically addresses s32. [Part 8 is headed “defendants with a mental illness”, but it deals with s33 applications and provision of psychiatric reports to correctional facilities.]

In most cases the rationale for the courts’ insistence on a plea is to keep the matter moving, especially if the matter is to be defended if not dismissed under s32. While adjourning the matter for a s32 application, the court may make brief service orders and/or set a hearing date which can be vacated if the matter is dismissed under s32.

One or two Magistrates take the view that, if a matter is to be defended or if there is a substantial dispute on the facts, the hearing should take place and the facts resolved before any s32 application. With respect, this view is wrong in law and misapprehends the diversionary nature of a s32 application.

Section 32 is not just an alternative sentencing option for people with cognitive or mental health impairments. Diversion also includes accommodating defendants with cognitive and mental health impairments who may have great difficulty with traditional criminal justice processes and especially with defended hearings.

8 Case/treatment/support plans and responsible persons

8.1 Case plans, treatment plans, support plans

A pet hate of mine is the use of the term “treatment plan” in relation to a person with a cognitive impairment. A cognitive impairment, such as an intellectual disability, is not an illness and cannot be “treated”!

Even for a person with a mental illness who is receiving treatment, social support is often crucial to their recovery.

For these reasons, I prefer the term “case plan” or “support plan”.

The new Act uses the term “treatment or support plan” (see s7).

The court usually won’t grant a s32 application unless you can present them with a good case plan.

This principle is well-established and (although some people seem to think it has legislative backing) it arises from common law (*Perry v Forbes* (1993) NSWSC

Unreported, and *DPP v Albon* (2000) NSWSC 896). The case law is summarised in *Saunders v Director of Public Prosecutions (NSW)* [2017] NSWSC 760 at [34] – [37].

It is important to note that the Supreme Court in *Perry v Forbes* emphasised the need for a case plan in the context of serious and/or repeat offences.

If you are dealing with a minor offence which would normally be dealt with by way of fine (or s10 or 10A), be mindful that one of the relevant considerations in a s32 application is the likely penalty if the offence is proved and dealt with according to law. In this case an unconditional s32 may be appropriate and there is no need for a detailed case plan.

8.2 Responsible persons

This will often be the client's treating psychiatrist, or psychologist or GP.

However, there is nothing in the legislation or case law to say that the responsible person must be a psychiatrist or other mental health professional. They could be a counsellor, caseworker, carer, or even a family member, who is responsible for co-ordinating the case plan by ensuring that the person attends relevant appointments, takes their medication, etc.

The defendant is discharged into their care but not their custody, so a responsible person does not have to be present at court. However, some Magistrates do prefer the responsible person to be at court, and/or to undertake that they will notify the court if the client doesn't comply with the case plan.

Some registry staff have been known to insist that the client cannot leave the court house until the responsible person has signed a copy of the s32 order. This view has no basis in law and the court staff have no power to impose this requirement. It seems that they have been informed of their error and have now stopped doing it.

In my view, the responsible person has no legal obligations (unless they have made an undertaking to the court to report a breach, and even then, I query how this undertaking would be enforceable).

There is also some discussion in *Saunders v Director of Public Prosecutions (NSW)* [2017] NSWSC 760 about a responsible person's obligations and the enforceability of section 32.

In *Saunders* it is suggested that the "responsible person" should be a named individual (rather than being nominated by their role, e.g. "treating psychiatrist"). RA Hulme J said:

> [40] One of the options under s 32(3) is to discharge the person "into the care of a responsible person". The provision does not explicitly require that the "responsible person" be named. But it is inescapable that in exercising the discretion to discharge a person in this way under s 32(3)(a) the "responsible person" would have been identified in the evidence and specifically nominated in the Magistrate's order.

Although this is *obiter* only (the case was really about s32(3)(b)), since *Saunders*, Magistrates have increasingly been requiring the case plan to clearly identify a responsible person.

In my experience it is common practice for a Magistrate to discharge a defendant in to the care of a named individual "or their delegate" (in the event that the nominated individual changes employment, the client moves to another area, etc).

9 Capacity of psychologists to diagnose mental illnesses or conditions

9.1 Psychiatrists and psychologists – similarities and differences

The Royal Australian and New Zealand College of Psychiatrists website provides a summary of the difference between psychiatrists and psychologists at https://www.yourhealthinmind.org/psychiatry-explained/psychiatrists-and-psychologists.

The Australian Psychological Society website provides some information about psychologists, their qualifications, different types of psychologists (e.g. clinical, forensic), and how they differ from psychiatrists at https://www.psychology.org.au/for-the-public/about-psychology.

As to diagnosis:

- Psychiatrists are qualified to diagnose mental illnesses and conditions.
- Psychologists with particular qualifications and experience (particularly *clinical* or *forensic* psychologists) are also qualified to diagnose mental illnesses and conditions.
- The use of psychometric tests to assess cognitive functioning is the exclusive realm of psychologists.

As to treatment:

- In general, psychologists and psychiatrists are both qualified to treat clients through psychotherapy and counselling.
- However only psychiatrists, as medical practitioners, are qualified to prescribe medication.

9.2 Types of psychologists and their competencies

Australian mental health professionals generally use the **Diagnostical and Statistical Manual** (DSM) to diagnose mental illnesses and conditions (The latest version, DSM-5, was published in 2013).

DSM-5 is published by the American Psychiatric Association and was developed by clinicians from different disciplines including psychology, psychiatry, neurology and social work (see “The people behind DSM-5” at https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/dsm-5-fact-sheets).

The Introduction to DSM-5 states that “Clinical training and experience are needed to use DSM for determining a diagnosis” but nowhere does it stipulate that such training and experience must be in the field of psychiatry.

The **Australian Psychological Society** website provides information on different types of psychologists, their skills and competencies: https://www.psychology.org.au/for-the-public/about-psychology/types-of-psychologists

The “Skills and competencies of clinical psychologists” are said to include:

> *Clinical psychologists are trained in the assessment and diagnosis of mental illnesses and psychological problems and are qualified to provide advice in clinical and compensation areas.*

“Skills and competencies of forensic psychologists” include:

> *Collecting and reporting (both in written reports and oral) evidence of a psychological nature for use in legal and quasi-legal proceedings.*

Psychological assessment and report writing.

Psychological formulation and diagnosis.

The **Psychology Board of Australia**, which is part of the Australian Health Practitioner Regulation Agency, issues *Guidelines on area of practice endorsements* at https://www.psychologyboard.gov.au/Standards-and-Guidelines/Codes-Guidelines-Policies/Guidelines-area-of-practice-endorsements.aspx

See in particular the "Competencies required for clinical psychology endorsement" "Competencies required for forensic psychology endorsement". These guidelines make it clear that clinical and forensic psychologists must have particular specialist skills "In addition to the generic competencies demonstrated by all registered psychologists".

9.3 Case law - general

For a discussion of relevant case law, see pages 31-36 (especially paras 107-111) of *Fact Finding on Sentence* (2018) by Riyad El-Choufani and Daniel Pace: https://www.legalaid.nsw.gov.au/__data/assets/pdf_file/0019/29323/Judicial-Fact-Finding-on-Sentence,-Riyad-El-Choufani-and-Daniel-Pace.pdf. Although this paper is about sentencing, many of the comments are equally applicable to s32:

> 107. The Court of Criminal Appeal has, on occasion, expressed some concern about a psychologist, and not a psychiatrist, purporting to diagnose the existence of a mental illness: see *Lam v R* at [2015] NSWCCA 143 [74]-[82] per Hoeben CJ at CL; *Jung v R* [2017] NSWCCA 24 at [41] per Johnson J; *Zuffo v R* [2017] NSWCCA 187 at [73] per Price J. Nevertheless, a psychological report tendered without objection will form part of the evidence before the sentencing judge; it will be given as much weight as it deserves: *Jung v R* at [42]. The sentencing judge may attribute less weight to conclusions in a psychological report which are not based upon the expert's specialised knowledge: *Lam v R* at [82].
>
> …
>
> 111. The capacity of a forensic psychologist to comment upon matters that might strictly fall within psychiatric expertise appears unsettled. It is perhaps a question which cannot be answered definitively; it may fall to be assessed on a case-by-case basis.
>
> Nonetheless, the different approaches in the superior courts may serve to highlight the importance of:
>
> - Briefing an appropriately qualified expert for the purpose of sentencing.
> - Speaking to the expert if you anticipate a challenge to the diagnosis (or indeed, any other opinion expressed in the report). For example, carefully consider the expert's curriculum vitae - is the opinion expressed properly based upon the expert's specialised knowledge? Does the opinion address inconsistent evidence or competing inferences? Are the reasons proffered in support of the opinion sufficient?
> - If necessary, ensuring that the expert is available to give evidence (including adjourning the sentence hearing to secure the expert's attendance).
> - If necessary, adjourning the sentencing hearing to address weaknesses in the report or to obtain an opinion from a more suitably qualified expert.

9.4 Cases supporting the capacity of psychologists to diagnose mental illnesses or conditions

***Jones v Booth* [2019] NSWSC 1066**

Mr Jones, a psychologist, prepared a report for a section 32 application. He expressed the opinion that the defendant was suffering from post-traumatic stress disorder, attention deficit/hyperactivity disorder and a major depressive disorder.

The Magistrate expressed reluctance to rely on the report because, in his view, the psychologist was not qualified to report on matters relevant to s32. The proceedings were adjourned and the application subsequently came before a different Magistrate, who accepted the psychological report and granted an order under s32.

Jones sought declaratory relief in the Supreme Court to the effect that he was qualified to report on matters relevant to s32. He alleged that the first Magistrate's comments had impacted upon solicitors' willingness to engage him for s32 applications.

Johnson J dismissed the application for declaratory relief, but made helpful comments in relation to the capacity of psychologists to make diagnoses for s32 applications.

> [55] … The Local Court should consider the qualifications and expertise of the author of any report which is sought to be tendered at the hearing of an application under s.32 MHFP Act, together with the contents of the report, to determine whether the report should be admitted at the inquiry and what weight should be given to it.
>
> …
>
> [57] A Magistrate would fall into error if a blanket approach was adopted so that reports of psychiatrists only could be received on applications under s.32 MHFP Act. The type of report which may be appropriate will depend very much on the particular case.
>
> …
>
> [59] As the present case makes clear, there are areas where a psychologist may report and conduct testing which bear upon these issues. In reality, there is no bright line test which delineates, for the purpose of s.32 MHFP Act, areas where a psychological report can or cannot be received.
>
> …
>
> [63] It may be accepted that psychologists play a significant part in the provision of reports for applications under s.32 MHFP Act, and the operation of treatment plans for individual defendants who may be subject to a s.32 order.

Johnson J noted further matters that support the capacity of psychologists to diagnose under s32:

- That psychologists frequently report on conditions (especially within the realm of cognitive impairment) by administering well-recognised tests: [58].
- A number of leading cases (e.g. *El Mawas*) on s 32 involved the reliance on psychologists' reports: [62].
- Although there exist cases which criticise reliance upon psychologists' reports, there is also case law which criticises the undue rejection of psychologists' reports: [64]-[66], citing *R v Whitbread* (1995) 78 A Crim R 452 at 460-461; *R v Arnold* [2004] NSWCCA 294 at [63]-[64].

***R v JK* [2018] NSWSC 250**

Sentence proceedings for murder. Per Hamill J:

> [43] The report of Mr Watson-Munro denies that there is any major psychiatric disturbance, or evidence of any childhood trauma, but says it is clear that the offender "has suffered longstanding symptoms of depression, anxiety and features of an Adjustment Disorder arising from his earlier life in Malawi and his subsequent attempts to better himself in Australia." Mr Watson-Munro says that in the absence of treatment for this depressive illness, the offender developed a significant dependence on alcohol. There is an abundance of evidence of the offender's abuse of alcohol. The agreed facts say he was drinking up to "8 litres of wine a day" and the offender's lawyers have extracted the many references to the offender abusing alcohol disclosed in the prosecution brief of evidence.
>
> …
>
> [45] While the opinions of Mr Watson-Munro are based on the self-reported and untested assertions of the offender, the psychologist was not cross-examined. As Allsop P explained in *Devaney v R* [2012] NSWCCA 285 part of the professional skill and expertise offered by witnesses such as Mr Watson-Munro is the ability to provide opinions based on the history provided set against what is known and hypothesised by the expert. As Allsop P noted, it is one thing to discount self-serving statements made to an expert witness when the source of those statements is not called to give evidence, but it is another thing to criticise the professional opinions of an expert in the absence of cross-examination. Mr Watson-Munro formed his opinions based on the history, supported by the independent evidence of the high levels of alcohol consumption, and psychometric testing administered in the course of the examination. It is significant that the assessment was conducted after the letter written by the offender to his solicitor. It is unlikely in the circumstances that the offender was attempting to manipulate the psychologist, or exaggerating or misreporting his symptoms.
>
> [46] No submission was made suggesting that Mr Watson-Munro was not qualified to provide the opinions he proffered. I accept the opinion of Mr Watson-Munro that the offender was suffering from a long-standing depressive disorder but that he did not have any major psychiatric disturbance. However, that finding does not lead to any automatic consequence, let alone an automatic reduction in the sentence.

***R v Arnold* [2004] NSWCCA 294**

A forensic psychologist provisionally diagnosed the appellant with severe borderline personality disorder. The primary judge did not accept the diagnosis on the basis that a psychologist had "…*no entitlement to express opinions about mental disorders*…": at [62].

Adams J (Wood CJ at CL and Kirby J agreeing) concluded that the primary judge had erred (at [63]-[64]):

> [63] "In my view, the learned trial judge's refusal to give any weight to Dr Lennings' report because it is not that of a psychiatrist is a serious error. There was no objection by the Crown to the tender of the report or to the admissibility of any opinion expressed in it, nor did the Crown contend that only qualified weight should be given to Dr Lennings' conclusion, though it was (in some respects only) expressed to be provisional. The attitude of the Crown is not surprising, having regard to the obvious care with which the report is compiled and Dr Lennings' curriculum vitae, which indicates, amongst other things, that he is a clinical psychologist with a Masters Degree in Clinical Psychology, he has a Doctorate in a relevant field (personality), and he has had extensive experience over many years both for Government and private clients in making assessments of the kind he made in this case. This is not to say that the court is obliged to accept his opinions, but to reject them because he is a psychologist

> rather than a psychiatrist, especially when no such objection is made by the other party, strikes me as arbitrary and unreasonable."
>
> [64] "All the evidence about Arnold's mental and emotional condition demonstrated that, at the very least, he had been a very disturbed individual for a considerable time, almost certainly since well before he was ten years of age. It seems to me that the view of this matter expressed by the sentencing judge in the above passages not only wrongly fails to take Dr Lennings' opinion into account but also substantially and unfairly understates the considerable psychological and behavioural problems exhibited by Arnold from a relatively early age and the significant impact on his mental functioning of his early introduction – long before adulthood – to amphetamines and other addictive illicit drugs…"

***Nepi v The Northern Territory of Australia* NTSC [1997] Unreported**

Martin CJ allowed the appeal on the ground that the Trial Judge had erred in law in making a finding that the psychologist had crossed his barrier of expertise.

Martin CJ referred to *Whitbread*:

> "The most prominent and recent case dealing with the difficulties which can sometimes arise as between psychology and psychiatry is Whitbread (1995) 78 A Crim R 465, where the view was expressed that once the question of medical treatment of mental illness is put to one side, there is no reason why a psychologist may not be just as qualified, or better qualified, than a psychiatrist to express opinions about mental states and processes, per Hampel J. at p460".

***R v David Joel Whitbread* [1995] Vic CCA Unreported**

Hampel J:

> "In my opinion the assumption on which his Honour proceeded, namely that the witness [a psychologist] was an expert in his field and therefore able to express opinions of the kind which were to be proffered, was perfectly correct…"
>
> "There is nothing in the definitions or the literature about the functions of psychologists and psychiatrists which differentiates between them on the basis that one has more or less understanding and knowledge of the nature and functioning of the mind in its normal or abnormal state. It is, I think, common knowledge and experience that some psychologists have a greater knowledge and qualifications in the science which is concerned with mental states and processes of the mind than some psychiatrists. Once the question of medical treatment of mental illness is put to one side there is no reason why a psychologist may not be just as qualified or better qualified than a psychiatrist to express opinions about mental states and processes."

9.5 Cases where diagnoses made by psychologists were not accepted or were given limited weight

***Lam v R* [2015] NSWCCA 143**

This case has been used by some to argue against the validity of diagnoses made by psychologists. However, it is *not* authority for the proposition that a psychologist cannot diagnose a mental illness or condition.

This was a sentence appeal. The sentencing judge had rejected a psychologist's opinion that the accused suffered from a depressive disorder which was causally related to his involvement in the offences. The question on appeal was whether the sentencing judge had erred by rejecting the opinion.

The psychologist had given an opinion based on the history provided by the offender. *The court rejected the psychologist's opinion largely because it did not accept the history given by the offender*.

Hoeben CJ at CL, with whom both Johnson J and Beech-Jones agreed, at [58]:

> "His Honour's rejection of the opinion of Dr Jacmon was based on his Honour's rejection of the history upon which that opinion was based. That is a legitimate basis for rejecting the conclusions in an expert's report."

Further, at [73]:

> "The facts in dispute were resolved in a way adverse to the applicant. Since the opinion of Dr Jacmon was predicated on a resolution of the facts favourable to the applicant, the rejection of the applicant's position substantially undermined that opinion. That made the findings by the sentencing judge almost inevitable. The process which took place did not involve any denial of procedural fairness."

Hoeben CJ at CL also expressed a view that the particular psychologist (not psychologists in general) lacked the qualifications and experience to arrive at particular conclusions.

Hoeben CJ at CL made further comments at [74]-[83] which are clearly *obiter* but were nonetheless stated to have been provided for the "guidance of lower courts".

His Honour accepted that the psychologist could give opinions, including that the applicant's "functioning was impaired by a major depressive disorder", that were based on the results of tests performed and the history provided [at 79]:

> "The first part of the conclusion, i.e. that the applicant's "functioning was impaired by a major depressive disorder at clinically significant levels", was a conclusion available to Dr Jacmon based on the BDI test results. The history taken by Dr Jacmon could also inform that conclusion."

However, his Honour rejected an opinion as to the *cause* of that impairment on the basis that the psychologist was not appropriately qualified [at 79]:

> "Where I have difficulty is in understanding how Dr Jacmon could reach the next conclusion, i.e. "the impairment is likely to have resulted from the breakup with his long term girlfriend in Hong Kong". That is a medical diagnosis for which I can find no basis in the specialised knowledge or training available to Dr Jacmon."

His Honour also rejected the opinion linking the condition and the offending as being beyond the psychologist's expertise. [80]

The psychologist in *Lam* had a Bachelor of Science and a Master's and a Doctorate in Education. "His work history and published research showed that he had considerable experience and expertise in the treatment of depression and other psychological ailments" (see para [78] of the judgment). However, he was not a clinical or a forensic psychologist.

It is suggested that more weight would be given to the opinion of a clinical forensic psychologist, who will generally have greater expertise in diagnosing mental conditions. However, the sentencing judge may attribute less weight to conclusions in a psychological report which are not based upon the expert's specialised knowledge [82].

The observations of the Court of Criminal Appeal in cases such as *Lam v R* appear to sit uncomfortably with Hamill's J comments in *Luque v R,* that sentencing mentally unwell offenders ought not be undertaken "in an unduly technical or restrictive way".

***WW v R* [2012] NSWCCA 165**

This case built on *Peisley* (see below)**,** which stated that a psychologist could not "enter the field of psychiatry".

The Court accepted that a psychologist could diagnose a mental illness or condition, but could not necessarily offer further opinions beyond diagnosing. The report-writer in this case was simply described as a “psychologist”, without any further detail about his qualifications.

Hoeben JA (with whom Johnson and Button JJ agreed) said:

> “[57] The applicant submitted that his Honour erred in failing to have any regard to the opinion of Mr Mahoney that "individuals with ADHD may have particular difficulty in conforming to the expectations of this environment such as attending to instructions on taking on tasks that require extended periods of attention". The applicant submitted that his Honour should have taken that opinion into account on the question of whether his experience of imprisonment would be more difficult than that of the general prison population. The applicant submitted that this was an important principle to be taken into account on sentencing. Its importance had been recently affirmed in *Muldrock v The Queen* [2011] HCA 39; 244 CLR 120.
>
> [58] His Honour was entitled to treat the evidence of Mr Mahoney in the way in which he did. On that issue, the cautionary observation of Johnson J in *R (Cth) v Petroulias (No 36)* [2008] NSWSC 626 is pertinent. There his Honour said:
>
> > "A number of psychologists gave oral evidence. In approaching their evidence, I keep in mind that it is important that psychologists do not cross the barrier of their expertise. It is appropriate for persons trained in the field of psychology to give evidence of the results of psychometric and other psychological testing, and to explain the relevance of those results, and their significance so far as they reveal or support the existence of brain damage or other recognised mental states or disorders. It is not, however, appropriate for them to enter into the field of psychiatry: *R v Peisley* (1990) 54 A Crim R 42 at 52."
>
> [59] An analysis of the report of Mr Mahoney indicates that he did cross that line. Having reviewed the applicant's medical history, Mr Mahoney said:
>
> > "In relation to the offending behaviour, it is extremely difficult to determine to what extent Mr W's ADHD may have caused or contributed to either his inattention at the time of the accident or his leaving the scene of the accident. In part this is also due to the fact that Mr W has significant difficulty remembering details of the accident due to his own trauma around the event. What is clear is that he was not receiving treatment (medication) at the time of the offending behaviour. It is also clear that throughout his life (including at the time of the offences) he has had general problems with inattention and impulsivity. Therefore it is likely that Mr W's ADHD condition affected him to some degree at the time of the offence, particularly around the area of inattention on the road. There is little evidence to suggest he would have intended to have caused harm to the victim. It is highly probable that his impulsiveness (also a factor in ADHD) contributed to his rash decision of leaving the scene of the accident immediately after it occurred.
> >
> > With regard to commenting on the impact of a custodial sentence on Mr W given his history of ADHD, there is some research about the vulnerabilities of people with ADHD in the prison system. In detention, individuals with ADHD may have particular difficulty in conforming to the expectations of this environment, such as attending to instructions or taking on tasks that require extended periods of attention. People with ADHD symptoms who are incarcerated have been found to be

> more disruptive (verbal aggression, damage to property) than a non-ADHD control group."
>
> Of significance is a further observation by Mr Mahoney that despite his ADHD "he does not suffer from a serious mental illness".
>
> [60] It was open to Mr Mahoney to test the applicant for indications that at the time of testing he was suffering from ADHD. He could describe the characteristics of the condition of ADHD. What he could not do as a psychologist was to express an opinion as to whether and to what extent the ADHD condition affected the applicant at the time of the offence. Counsel for the applicant, in the sentencing proceedings, could make a submission to his Honour linking the test results and the characteristics which can be experienced by somebody with ADHD. His Honour could accept that submission but was not obliged to do so."
>
> …
>
> [62] In relation to Mr Mahoney's evidence concerning the impact of a custodial sentence on a person with ADHD, Mr Mahoney was entitled to bring to his Honour's attention some research on that issue. That research indicated that "individuals with ADHD may have particular difficulty in certain aspects of their imprisonment". He could not say and did not say that this would affect the applicant in such a way. There was no evidence to that effect."

***R v Terrence Matthew Peisley* [1990] NSWCCA Unreported**

In this case, Wood J accepts that clinical psychologists are qualified to give evidence as to "the existence of brain damage or other recognised mental states and disorders" but not to "enter the field of psychiatry."

Wood J:

> "*I do not wish to depart from this appeal without expressing some concern as to one aspect of the evidence…related to the opinion of Mr W J Taylor, a clinical psychologist, whose opinion on this issue was objected to by the Crown…"*
>
> *"I consider it necessary to observe once again that it is important that clinical psychologists do not cross the barrier of their expertise. It is appropriate for persons trained in the field of clinical psychology to give evidence of the results of psychometric and other psychological testing, and to explain the relevance of those results, and their significance so far as they reveal or support the existence of brain damage or other recognised mental states and disorders. It is not, however, appropriate for them to enter into the field of psychiatry, and in the present case Mr Taylor's opinion was entirely unsupported by the psychiatric opinion.*

It is not clear precisely what his Honour meant by "the field of psychiatry". If this is taken to mean that a psychologist is not qualified to diagnose a mental illness, it is respectfully suggested that this view is not supported by the more recent authorities.

9.6 Cases where court did not take a definitive view

***Ryan v Regina* [2017] NSWCCA 209**

Concerns about the psychological report were raised by the Crown on appeal, but not at first instance. As the report had already been admitted unchallenged by the sentencing judge, the CCA did not find it necessary to form a view on the capacity of psychologists to make diagnoses.

Hamill J (with whom Leeming JA and Button J agreed) said (at [9]):

> "On appeal, but not at first instance, the respondent submitted that "this Court has previously expressed concern where a psychologist, and not a psychiatrist, purports to diagnose the existence of a mental illness". Reference was made to a number of cases where judges sitting in this Court made observations as to the experts who have the appropriate expertise to make psychiatric diagnoses [*footnote*]. In the circumstances of the present case, it is not appropriate for this Court to gainsay the diagnosis made by a psychologist and admitted without objection before the sentencing judge. The diagnosis was not in dispute in the sentencing hearing, the expertise of Ms [x] was not challenged, and she was not required for cross examination. The diagnosis appeared to be consistent with the symptoms exhibited by the applicant which is no doubt why the diagnosis was not challenged by the prosecutor. It is, therefore, unnecessary to consider whether the earlier observations made by Judges of this Court accurately reflect the law in this area."

The following cases were referred to in the footnote: *WW v R* [2012] NSWCCA 165 at [58]-[60]; *Lam v R* [2015] NSWCCA 143 at [78]-[82]; *Jung v R* [2017] NSWCCA 24 at [39]; *Zuffo v R* [2017] NSWCCA 187 at [73]. *WW* and *Lam* have been discussed above. *Jung* and *Zuffo* are both examples of cases in which no objection was taken by the Crown at first instance to the admission of a psychological report, and the appellate court did not offer an opinion as to the capacity of the psychologist to diagnose.

Zuffo v R [2017] NSWCCA 187

Per Price J:

> "[73] Concern has been expressed by this Court where a psychologist, and not a psychiatrist, purports to diagnose the existence of a mental illness: Jung v R [2017] NSWCCA 24 at [41]; Lam v R [2015] NSWCCA 143 at [78]–[82]. However, as no objection was taken by the Crown, Mr Gorrell's opinion of a Major Depressive Disorder formed part of the evidence before the judge.
>
> [74] In his sentencing remarks, the judge did not mention Mr Gorrell's assessment of a Major Depressive Disorder at the time of his offending and concentrated his attention upon the psychologist's assessment that the applicant "currently" did not suffer any major psychiatric/psychological condition. When considering Ms Coetzee's report his Honour referred to Ms Coetzee's assessment of the applicant's depression, anxiety and stress and remarked that "these things… are not unusual where people are facing very serious penalties for serious offences" (ROS 4).
>
> [75] The lack of consideration in his Honour's sentencing remarks to Mr Gorrell's assessment may have been engendered by the applicant's evidence and by the failure of his counsel to direct his Honour's attention to the issue in oral submissions. Nevertheless, the question had been directly raised in the applicant's written submissions (Ex 9, p 3):
>
> > "The Court on sentence can take into account the applicant's major depressive state at the time he committed these offences…"
>
> [76] In my respectful opinion, the judge erred in failing to give any consideration to Mr Gorrell's opinion that the applicant was suffering from a Major Depressive Disorder at the time he committed the offences."

***Jung v R* [2017] NSWCCA 24**

Johnson J (with whom Hoeben CJ at CL and Latham J agreed) said:

> "[41] This Court has expressed concern where a psychologist, and not a psychiatrist, purports to diagnose the existence of a mental illness: *WW v R* [2012] NSWCCA 165 at [58]- [60]; *Lam v R* [2015] NSWCCA 143 at [78]- [82], [90].

[42] Given that no objection was taken to the psychological report at first instance, it formed part of the evidence before the sentencing Judge to be given such weight as it deserved. A fair reading of the report rather suggests that the Applicant, at the time of the commission of the offences, was a somewhat driven professional person who worked very hard. Although his wife had given birth to their second child in May 2014, the Applicant's mother was living with them and was able to assist the family with practical aspects arising from that development."

10 Services and programs for people with mental health and cognitive impairments

10.1 Justice Health Court Liaison Service

Most criminal lawyers would be aware of the Mental Health Court Liaison Service run by Justice Health. It operates in a number of Local and Children's Courts across NSW (I am not sure of the exact number; the Justice Health website seems somewhat out-of-date and unclear).

Those of you who have access to this service may know how helpful they can be in performing assessments (with additional input from psychiatrists if necessary), making referrals and assisting to formulate treatment/case plans for section 32 applications.

Unfortunately the service is still not available at all Local and Children's Courts, and is generally not equipped to assess cognitive impairments.

10.2 Cognitive Impairment Diversion Program (CIDP)

The Cognitive Impairment Diversion Program commenced in 2017 as a two-year pilot program at Penrith and Gosford Local Courts. For further information see https://idrs.org.au/what-we-do/cipd/.

Screening and assessments were performed by psychologists employed by the Justice Health Court Liaison Service. Additionally, CIDP support workers provided case management with a view to linking people with NDIS services if eligible. Additionally, diversionary orders made under s32 at the conclusion of the program may be monitored by Community Corrections.

I understand that, regrettably, the funding was not extended beyond 30 June 2020.

10.3 Justice Advocacy Service (JAS)

The Justice Advocacy Service (JAS) is run by the Intellectual Disability Rights Service (IDRS).

The service commenced on 1 July 2019, and is similar to the Criminal Justice Support Network (CJSN) which it replaced.

The JAS provides support for victims, witnesses, suspects and defendants in the NSW criminal justice system who may have a cognitive impairment.

Referrals may be made by calling 1300 665 908.

Further information is available at https://idrs.org.au/jas/.

11 NSW Law Reform Commission recommendations

Many of you would be aware that the NSW Law Reform Commission conducted a reference on "*People with cognitive and mental health impairments in the criminal justice system*" between 2007 and 2013: https://www.lawreform.justice.nsw.gov.au/Pages/lrc/lrc_completed_projects/lrc_peoplewithcognitiveandmentalhealthimpairmentsinthecriminaljusticesystem/lrc_peoplewithcognitiveandmentalhealthimpairmentsinthecriminaljusticesystem.aspx

This resulted in two major reports:

- Report 135: *Diversion* (August 2012)
- Report 138: *Criminal responsibility and consequences* (June 2013).

Key recommendations from the NSWLRC's Report 135 on *Diversion* include:

- Adopting new definitions of "cognitive impairment" and "mental health impairment" (Recommendations 5.1 to 5.5);
- Expanding the Statewide Community and Court Liaison Service to all Local Court locations and to people with cognitive impairments (Recommendation 7.1) and further recommendations regarding information and training (Recommendations 7.2 and 7.3);
- Pre-court diversion options (Recommendations 8.1 to 8.6);
- Reforms to section 32, including the removal of the provision that excludes a "mentally ill person" from the application of section 32 (Recommendation 9.1);
- A list of factors to be taken into account by the court in a section 32 application (Recommendation 9.2);
- Some changes to the diversionary options available (Recommendations 9.3 to 9.5);
- Clarification of the court's power to adjourn proceedings under s32, including for the development of a "diversion plan" (Recommendations 9.3, 9.6 to 9.9);
- Amendments to section 33, including allowing interlocutory section 33 orders to be made in committal proceedings (Recommendations 10.1 to 10.8);
- The establishment of a "Court Referral for Integrated Service Provision" (CRISP) list in the Local and District Courts with a support team attached, to support defendants with a cognitive or mental health impairments (Recommendations 12.1 to 12.9);
- The extension of sections 32 and 33 to the District and Supreme Courts in some circumstances, and also the amendment of section 10(4) of the Act (Recommendations 13.1 to 13.3);
- Reforms relating to juveniles, including amendments to the *Young Offenders Act* (Recommendations 14.1 to 14.3), pre-court diversionary options for young people (Recommendation 14.4); and the expansion of the Adolescent Court and Community Team to all locations where the Children's Court sits (Recommendation 14.5).

One of the main problems identified by the NSWLRC, and reflected in their recommendations, is the lack of resources available to provide assessments, treatment and support to those who need them.

Unfortunately most of the NSWLRC's recommendations on diversion have not found their way into the new Act. It seems that the NSW government is unwilling or unable to provide the funding needed to implement significant and effective reforms.

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