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Preserving the Dignity of the Mentally Unwell: Therapeutic Opportunities for the Criminal Courts of New Zealand

Prepared by
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Ian Axford (New Zealand) Fellowships in Public Policy

Established by the New Zealand Government in 1995 to reinforce links between New Zealand and the US, Ian Axford (New Zealand) Fellowships in Public Policy provide the opportunity for outstanding mid-career professionals from the United States of America to gain firsthand knowledge of public policy in New Zealand, including economic, social and political reforms and management of the government sector.

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Educated in New Zealand and England, Sir Ian held Professorships at Cornell University and the University of California, and was Vice-Chancellor of Victoria University of Wellington for three years. For many years, Sir Ian was director of the Max Planck Institute for Aeronomy in Germany, where he was involved in the planning of several space missions, including those of the Voyager planetary explorers, the Giotto space probe and the Ulysses galaxy explorer.

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Lisa W. Lunt
Wellington, August 2017

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EXECUTIVE SUMMARY

A core purpose of the justice system is to make the country safe and just. It is hard to make big strides toward this goal without healing the people who are harming others. The country cannot lock up its criminal offenders indefinitely; every day they walk out of the country's prisons. Are they more damaged, however, having spent months or years in a prison cell? Yes, many are, and the ones experiencing mental health issues are among the most harmed. Let's envision an alternative: a justice system that provides therapeutic opportunities to appropriate individuals much earlier in their cases, keeps many with the highest needs out of prison while keeping the community safe, and at a significantly lower cost than prison.

Proverbially, prison sits at the bottom of the cliff. Record numbers of New Zealanders are falling through its gate. In 2016 the number of adults convicted and sentenced increased nine per cent over the previous year despite an overall crime rate lower now than it was ten years ago. One day in late 2016, someone entered the New Zealand prison system and tipped the daily prison population to 10,000, a first for New Zealand. The current prison population equates to roughly 210 of every 100,000 New Zealanders living behind bars, ranking it number seven of the 35 countries of the Organisation of Economic Cooperation and Development (OECD). Māori are disproportionately represented in prisons—over 50 per cent despite comprising just 15 per cent of the country's population. The baseline cost per day to house a prisoner is $273, though anyone with a mental health issue costs more. The vast majority of prisoners have mental health disorders; 91 per cent have been diagnosed with one sometime in their life after the age of 16. From 2005 to 2016, 72 prisoners died of unnatural deaths, likely some who were mentally unwell.

Close to one third of the prison population is made up of those on remand–or, incarcerated–while waiting for resolution of their cases. Remanded individuals are housed in overcrowded prisons without access to the same recreational, work or rehabilitation programmes that are available to persons who are serving a sentence. For persons with mental health and addiction issues, the lack of treatment programmes available in prisons can have catastrophic and even life-threatening consequences. Further, remanded individuals are housed in close quarters with experts in criminal conduct, gang members eager for new recruits and others ready to exploit weakness. Those with mental health issues are especially vulnerable to victimisation. The longer one spends in prison on remand, the more his or her outside life crumbles.

Court represents an opportunity to keep some of the remand population from slipping off the cliff and divert them from the damaging effects of prison into treatment and programming in the community. A person's first appearance in court constitutes a key transition point. The desire to change direction–kick a drug habit, stop hanging with a certain crowd, be a better parent and partner, get help–is powerful when someone sees his or her world about to collapse. Currently district court judges have a stark choice at a bail hearing: remand or release, perhaps with limitations on where a person may go.

The time is ripe to develop a third path, an alternative to incarceration but more than simple release or electronic monitoring with a 24-hour curfew, which is essentially prison at home. This path that I propose would offer a treatment plan to stabilise released individuals–especially those with mental health and addiction issues–in the

community. The programme would also serve individuals with low-level charges who flow through court.

Many jurisdictions in Canada, Australia and the United States run pretrial programmes that offer screening of criminal cases as they come in the door and assessment of an individual's pretrial risk of danger to the community and flight. Pretrial officers provide supervision and monitoring, and they connect charged individuals to treatment and social service support. Pretrial programmes operate at a fraction of the cost of prisons and have been effective at reducing remand populations while keeping the community safe and ensuring individuals' appearances in court. New Zealand has no pretrial or comparable programme with these objectives.

This report proposes that a therapeutic court team be trialled in courts–perhaps as a springboard to a pretrial programme–that can be implemented much more quickly and at a lower cost than building a pretrial programme from the ground up. In meetings with over 80 people involved in the justice and health sectors, I am confident that the country can mainstream therapeutic ideas and create opportunities to divert from prison some of those struggling most. Not only is this approach likely to bring a measure of balance and healing to the lives of many individuals, but it will make communities safer in both the short and long-term and will cost less than the prison alternative.

If New Zealand reduced its incarceration rate to the OECD average of 127 per 100,000[1] it would amount to a 40 per cent reduction in the prison population and savings of close to $400 million. Even if New Zealand achieved a much more modest 10 per cent reduction in its prison population, it would save close to $100 million annually. As a basis of comparison, the Alcohol and Other Drug Treatment Court in New Zealand operates at a net cost of $1.3 million per annum.

The transformation to a model of a therapeutic court that focuses on the individual is not new to many operating in the country's district courts. Innovative judges, public defenders, police prosecutors, other court professionals and community groups have deliberately changed the status quo and now work collaboratively to offer charged individuals a pathway to treatment and an alternative to prison. In various courts around the country one finds therapeutic programmes, including solution-focused courts and a community court, and therapeutic resources such as court liaison nurses and alcohol and other drug clinicians. As inspiring and effective as these practices are, they are few and far between. Many individuals going through the court system have no access to these special programmes and resources.

As one Wellington High Court Justice expressed to me, it is time to "repersonalise a depersonalised system." Given the high numbers of persons entering court with debilitating mental health and substance abuse issues, it is time to harness the power of the justice system to "get personal" with those defendants who want help. Collectively, my proposals set out a vision of a court team that can provide a treatment pathway to defendants and restore balance to people's lives, with the potential to reduce the remand population, lower reoffending rates by those released on bail and save money.

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[1] I have omitted the United States from this calculation, given that it is an extreme outlier with 666/100,000 incarcerated, vastly higher than Israel, which sits at #2 with 265/100,000.

Conclusions and recommendations

My recommendations vary in scope, but the policies, programmes and people on the list share the common goals identified above. It is conceivable many could be implemented simultaneously, as they constitute a comprehensive package designed to bolster and "personalise" the services available in the justice sector. My recommendations are as follows:

- Create a new position in court, the Health Navigator
- Expand the role of the court liaison nurse
- Expand the role of the alcohol and other drug clinician
- Collaborate with iwi and others to develop community-led supervised accommodation
- Consolidate calendar of defendants with mental health issues
- Provide additional judicial support in the form of additional resources and also specific training on various mental health and neurodevelopmental and cognitive disorders.

I also discuss two larger programmes that could be considered for future implementation:

- Pretrial Service Programme
- Mental Health Court

TABLE OF CONTENTS

PREFACE

Contrary to my initial assumption that New Zealand's criminal justice system likely resembled Finland's,[2] in fact the country is a study in contrasts. Its youth justice system has been studied worldwide with admiration.[3] The country's thorough embrace of restorative justice is an example of how the system took a leap to incorporate a practice and philosophy focused not on retribution but on healing. Yet the data tells another story. For instance, increasing adult imprisonment rates disproportionately impact Māori especially and account for an ever-expanding budget. In prisons nine out of ten persons had a mental health diagnosis at some stage in their life since age sixteen, with almost two thirds diagnosed in the prior twelve months.

I also assumed–erroneously, as it turns out–that the health system in New Zealand could be counted on to provide reasonably accessible and effective treatment for mental health and addiction issues. The availability of treatment providers is an essential part of a model of an effective mental health court, which was the original focus of my research. Within a month of conducting research, however, I learned that the mental health system in New Zealand is struggling to cope with demand, including significant pressures from the justice sector. Access, especially for people who are marginalised, is particularly challenging. A drug addict waits for months, even up to a year, for an in-patient treatment bed. It seems that every week another agency or NGO publishes a report on the mental health crisis in New Zealand.

In spending time in criminal courts around the country, however, I could see that practitioners were helping individuals who came into the criminal justice system with mental health issues as well as other needs. These efforts were not part of a pretrial programme, such as we have in most jurisdictions in the United States and in many parts of Australia and Canada. Rather, these initiatives were ad hoc, created in response to problems so clearly evident to the practitioners on the frontline.

I found enormously dedicated judges, public defenders and other court professionals who are committed to bringing a therapeutic role to their work. From more formal solution-focused courts like the Alcohol and Other Drug Treatment Pilot Court in Auckland and Waitakere to a lower-profile court like the Special Circumstances Court in Wellington, individuals lucky enough to be admitted to these programmes can experience genuine transformation in their lives. Participation in therapeutic courts in New Zealand has profoundly impacted the lives of participants, their whānau (family) and friends, as well as the court team members.

It became clear that many of the elements of therapeutic courts that account for their success around the world could be mainstreamed throughout New Zealand's court system. After all, the country's justice system is quite small and as proven in the past, capable of making big changes. Already practitioners in some courts are taking different approaches, relying on what is apparent to them as a practical and all-

[2] Finland, similar in population to New Zealand, is known to possess one of the most advanced and efficient criminal justice systems in the world. As of 1 January 2017, its prisons held 3,174 persons, a rate of 57 per 100,000. The remand population was 20.7%. See World Prison Brief. Its recidivism rate of 35% is one of the lowest rates in the world. See Ekunwe, I. and Jones, R. (June 2012).

[3] For a fascinating paper contrasting New Zealand's youth and adult justice systems, see Lynch, N. (2013).

encompassing approach to working with charged individuals with a host of health and socioeconomic disadvantages.

The audience for my work is primarily policy makers and practitioners in the criminal justice field, including those in health policy. But I also hope that my emphasis on the importance of a therapeutic role for a criminal justice system reaches the general public, both in New Zealand and the United States.

In the last few months, the topic of mental health has taken a centre stage in New Zealand government circles, as policy-makers strive to identify opportunities to make treatment and care more accessible to those with mental health disorders. It is also a very personal topic; most New Zealanders have a story to tell of their own or of a loved one or friend who has lived with a mental health disorder. The court personnel that I interviewed demonstrate passion and purpose to not let the most vulnerable coming into criminal courts be left behind. Given the climate surrounding mental health disorders, and with my nearly twenty years representing individuals charged in criminal courts–many with mental health disorders–I have deliberately written a paper with a more qualitative focus. I discuss the quantitative research behind my recommendations, but the true stories and experiences of charged individuals walking into court, as well as those of the frontline court personnel who interact with them every day, add the detail behind every data point.

1. THE MENTALLY UNWELL AND THE JUSTICE SYSTEM

It's a disorder, not a decision.

~ Anonymous, Pacifica Quotes Board

The terminology surrounding mental health and addiction conversations varies according to setting. Before diving into research and recommendations, I start this report with a definitions section.

Individuals appearing in district courts and later in prison present with a wide spectrum of mental health disorders. A therapeutic approach necessarily means working with each individual to identify these and other socioeconomic needs.[4] The initiatives that I am recommending target the majority of individuals with mental health disorders, generally mild to moderate, but it is worthwhile to identify first the small per cent I am not targeting and, second, the kinds of disorders in the remaining population.

A tiny percentage of individuals–"the 1%," as they are sometimes identified–coming into court on new charges have acute disorders so severe that they trigger concerns about their fitness or competence to stand trial.[5] This is not the population that would be able to benefit from my proposals. In fact, this group of mentally unwell offenders, as Professor Warren Brookbanks writes: "have had a relatively high profile in New Zealand … [s]ince the late 1980s, when the Mason Committee released its findings and recommendations in the Psychiatric Report 1988."[6]

Beyond the severe issues presented in "the 1%," it is helpful to identify the disorders that court practitioners are seeing. The initiatives I recommend target "the 99 per cent," those individuals who present disorders but do not trigger the issues of fitness to stand trial. Both legal and mental health practitioners tend to identify many of the 99 per cent as those with 'mild to moderate' mental health issues. There seems to be consensus that a service gap exists in New Zealand for this group.[7]

Mental disorder: The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V), which is the definitive resource of diagnostic criteria for all mental disorders, defines mental health disorder as "a syndrome characterized by clinically

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[4] The idea of a "therapeutic" aspect of justice is not new. The concept of "Therapeutic Jurisprudence" (TJ) was co-founded by American Professor David Wexler. He describes TJ as follows: "it concentrates on the law's impact on emotional life and psychological well-being. It is a perspective that regards the law (rules of law, legal procedures, and roles of legal actors) itself as a social force that often produces therapeutic or anti-therapeutic consequences. It does not suggest that therapeutic concerns are more important than other consequences or factors, but it does suggest that the law's role as a potential therapeutic agent should be recognized and systematically studied." See Wexler, D. (1999).

[5] The fitness issue revolves around an individual's ability to contribute to one's own defence with one's defence team and be able to participate meaningfully in the court process. Defendants who are unable to do so are deemed unfit to stand trial. In 2016 less than 1% of charged individuals had a court record reflecting that they triggered legal concern regarding fitness. Fink, Jo (2017), MOJ Analysis (unpublished).

[6] Brookbanks, W. (2014).

[7] See, e.g., Interview with Nigel Fairley, Director of Area Mental Health Services for the Capital and Coast District Health Board, 2 March 2017.

significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behaviour (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above."[8]

Alcohol and drug addiction are mental disorders because "addiction changes the brain in fundamental ways, disturbing a person's normal hierarchy of needs and desires and substituting new priorities connected with procuring and using the drug. The resulting compulsive behaviours that override the ability to control impulses despite the consequences are similar to hallmarks of other mental illnesses."[9]

The DSM includes criteria for drug use disorders, distinguishing between two types: drug abuse and drug dependence. Drug dependence is synonymous with addiction. By comparison, the criteria for drug abuse hinge on the harmful consequences of repeated use but do not include the compulsive use, tolerance (i.e., needing higher doses to achieve the same effect), or withdrawal (i.e., symptoms that occur when use is stopped) that can be signs of addiction.[10]

Comorbidity is the co-occurrence of one or more diseases or disorders with a primary disease or disorder. Comorbidity is essentially a word for co-occurrence in the context of medical pathology and is largely interchangeable when used in this way. Many people in the criminal justice system have co-occurring disorders of mental health and alcohol or substance use. Providing integrated treatment to address co-occurring mental and substance use disorders is optimal to achieving positive outcomes such as reduced substance use and future offending.

Other disorders: Judges around New Zealand see people who are experiencing mental impairments outside of the traditional scope of mental health disorders. The following are impairments that individuals present with regularity in court: intellectual disability, personality disorder, acquired brain injury, neurological disorder including dementia, autism spectrum disorder and neurobehavioural disorder such as foetal alcohol exposure.

From the perspectives of a judge, defence attorney and others in the court space, although fitness is not an issue for the majority of people coming into court, they have a sincere desire to understand a diagnosis. It is common to hear questions like:

- What is causing repeat criminal behaviour?
- Why is someone exhibiting bizarre or unusual behaviour?
- What kind of help does someone need?

[8] American Psychiatric Association (2013).

[9] National Institute of Drug Abuse (2010).

[10] Ibid.

Seldom is a single mental health disorder the only unmet physical need. Charged individuals present with a host of issues impacting their health and stability, including hunger, lack of stable housing, joblessness, failure to receive welfare benefits to which they are often already entitled, lack of identification documents, poor education, literacy issues, involvement in an abusive relationship, disconnection from family and socially positive friends and low self-esteem. A therapeutic approach involves looking at the whole individual and recognising that if one aspect of life is in tilt, it is an unbalanced life.

Te whare tapa whā / the Māori model of health

The Māori model of health, te whare tapa whā, contemplates four cornerstones of health: taha tinana (physical health), taha wairua (spiritual health), taha whānau (family health), and taha hinengaro (mental health).[11] Given the high numbers of Māori in the criminal justice system, te whare tapa whā is an appropriate and highly useful concept in understanding the holistic approach necessary to support individuals–not just Māori–who enter court in an effort to stabilise their lives and minimise the likelihood of reoffending.

Under te whare tapa whā, if one of the four dimensions is missing or in some way damaged, a person may become 'unbalanced' and subsequently unwell.

With its strong foundations and four equal sides, the symbol of the wharenui (meeting house) illustrates the four dimensions of Māori well-being.

The Mason Report and subsequent major legislation

In the late 1980s, in the wake of a high number of prison suicides and an assault in the community by an ex-psychiatric patient, the New Zealand government established an inquiry committee. The result was the Report on Procedures Used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Released on Leave of Certain Classes of Patients (The Mason Report). The Mason Report detailed recommendations regarding mental health service delivery in New Zealand, aimed at

[11] Sir Mason Durie developed this model. See Rangatari tu Rangatira, (undated).

addressing the deficits in this area. Included was a framework ensuring that a mentally unwell person could access care at any point on the justice system continuum. The government established regional forensic mental health services that provided varying levels of care within a range of settings, from secure inpatient services to outreach in courts, prisons and follow-up in the community.

In particular, the 1988 Report recommended that the importance of taha wairua, taha whānau (family health) and tikanga Māori (customs) be recognised in all assessment and management decisions made in relation to psychiatric patients. This Report led to the passage of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA).

In more recent years, major legislative change has produced two highly significant outcomes. First, the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CP(MIP)) has led to an increase in the number of cases where the issue of unfitness to stand trial is inquired into by the courts.[12]

Second, the enactment of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR) has led to identification of a new group of special needs offenders, for whom a "novel regime of care and management has been established."[13] Cases involving unfitness to plead and the disposal of offenders with an intellectual disability now dominate forensic mental health services, and far exceed cases involving legal insanity.

Mental health disorders and criminal behaviour

Only a small percentage of crimes committed by people with serious mental disorders are directly related to symptoms of mental illness. Research does not support the premise that simply increasing treatment engagement in offenders with mental illness reduces reoffending rates. Consequently, a programme with a narrow goal of providing treatment for mental health disorders in an effort to curb future offending is an empirically unsupported policy model. Research has shown that reduced recidivism in the population of individuals with mental health disorders is closely connected to effective interventions that address a variety of risk factors as well as behaviourally-based disorders.[14]

Substantial research has identified the following eight risk factors most predictive of criminal behaviour:

1. Antisocial history
2. Attitudes
3. Friends and peers
4. Personality patterns
5. Substance abuse
6. Family discord

[12] In the majority of cases offenders are found to be fit to stand trial.

[13] Brookbanks, W. (2014).

[14] Fisler, C. (2015). Carol Fisler is Director of the Mental Health Court Programs at the Center for Court Innovation in New York. Her article cites the preeminent studies assessing recidivism and mentally disordered offenders.

7. Lack of success in education and employment
8. Lack of positive leisure activities.[15]

Because these factors are common to the general criminal justice population and to the sub-population of those with mental health disorders, American mental health agencies and criminal justice agencies are embracing a framework that integrates a "risk-needs-responsivity" or "RNR" model with behavioural health factors.[16] The RNR framework has three prongs:

- *Risk principle: who to target*. A portion of criminal justice resources should focus on interventions for people at highest risk of re-offending or who present with a high number of the central eight criminogenic factors. Addressing those at highest risk will most effectively reduce reoffending rates.
- *Need principle: what to target.* Justice systems should provide interventions to high-risk individuals that target their particular criminogenic needs, which are dynamic.
- *Responsivity principle: how to address criminogenic needs.* An individual's capacity to respond to an intervention depends on learning style, motivation, culture and ability. Interventions must be adapted to various responsivity factors.[17]

Though mental illness plays very little part in the majority of offending, it is central within the RNR framework as a responsivity factor. A mental health disorder may impact an individual's ability to respond to interventions that address needs.[18] Treatment is not irrelevant. Increased treatment engagement is likely to enhance an individual's ability to respond to efforts to address risk factors.

Court

A 2015 Ministry of Justice (MOJ) analysis reflects that a large portion of people charged in court have an indicator of mental illness (including substance use/dependence). Using the Statistics New Zealand's Integrated Data Infrastructure (IDI), analysts at MOJ have measured mental health service use twelve months before or after being charged in court (Figure 1).[19] Forty-two per cent fall into this category.

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[15] Ibid. p. 11.

[16] Ibid.

[17] Ibid.

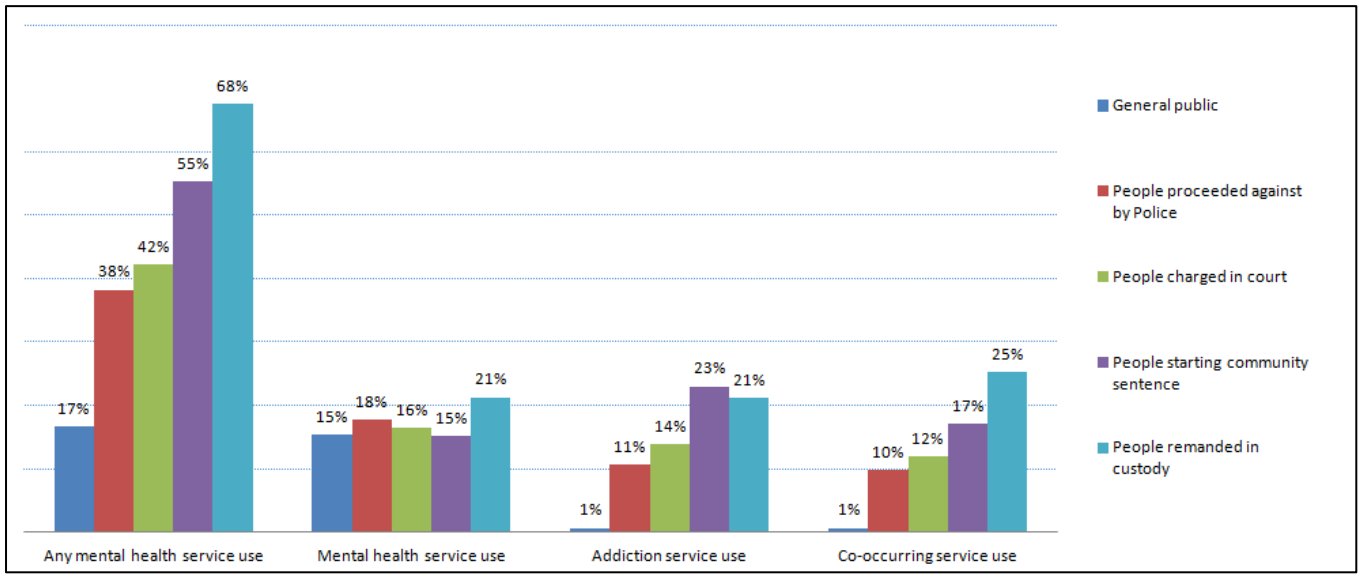
[18] Ibid.

[19] Horspool, N., *et al*. (2015). The measure of service use is not a clinical diagnosis; rather it relies on health data identifying health service use 12 months either side of being charged in court in 2012, using mental health activities in secondary health services, drugs dispensed related to mental illness, and hospital discharges with a mental illness diagnosis. The results in this analysis are an undercount of mental illness prevalence for several reasons: many people with mental illness do not use the health services at all or the ones from which this data was drawn, and police data reflects that they record many mental health incidents that would not be captured here because the incidents involved people who are not charged (often because no crime occurred).

Please note the following with regard to all analyses in this report relying on IDI data: Access to the data presented was managed by Statistics New Zealand under strict micro-data access protocols and in accordance with the security and confidentiality provisions of the Statistics Act 1975. These findings are not Official Statistics. The opinions, findings, recommendations, and conclusions expressed are those of the researchers, not Statistics NZ, the Ministry of Health or the Ministry of Justice.

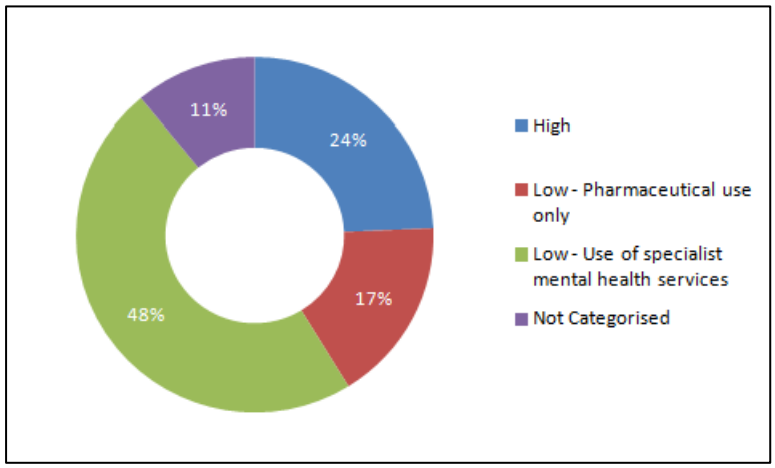
A high rate of people charged in court have used addiction services (23 per cent), compared to 1 per cent of the general public. Of the 42 per cent charged in court who have some type of mental health service use in the defined period, 1 out of 4 has used co-occurring mental health services (that is, both mental health and addiction services).

Figure 1. Mental health service use of people interacting with the justice sector



Well over half of the charged persons who have accessed mental health services as defined above, or 65 per cent, are low use in terms of mental health service and pharmaceutical use only (Figure 2). The high number of people in the low use category is somewhat consistent with anecdotal information I have received from judges, lawyers and other court officials who see many individuals come through the court system with mild to moderate mental health issues. Veteran PDS lawyer, Leah Davison, states: "Almost everyone coming into court has some kind of mental health issue, at the very least an anxiety disorder."[20]

Figure 2. Interim level of mental health service use



[20] Interview with Leah Davison, 28 February 2017.

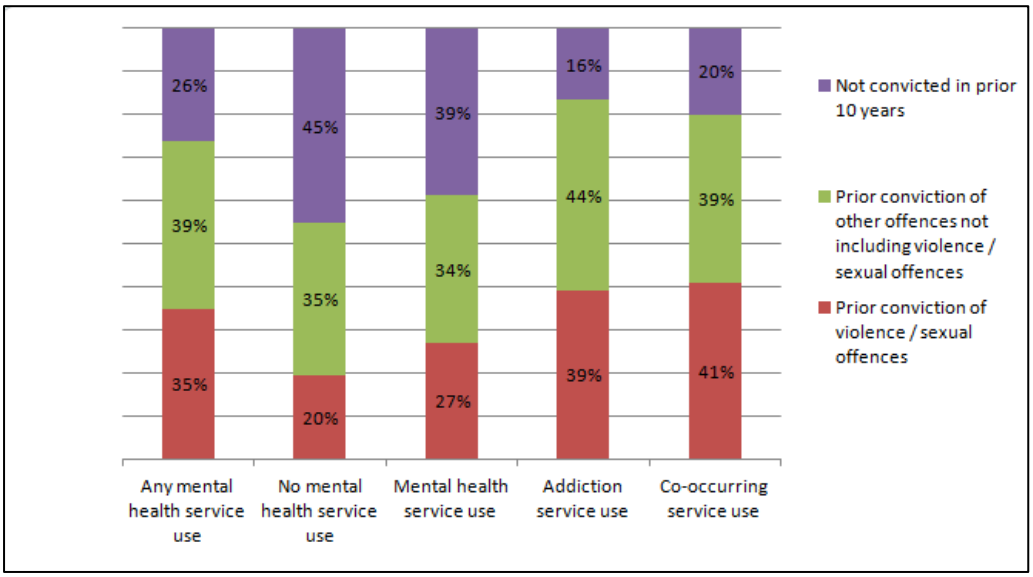
Socioeconomic characteristics. A deeper look using the IDI reveals more about this group of individuals who have accessed mental health services twelve months before or after being charged in court. On almost every measure, the group of individuals who used co-occurring mental health and addiction services also exhibit the highest rates of socioeconomic disadvantage. Relative to the two other classifications, substance abuse (only) and other mental health service use (only), the data shows that those with co-occurring mental health and addiction service use have the following characteristics:

- Lower education level
- Lower rates of employment
- Less time employed in past 12 months and past 5 years
- More address changes in past 12 months and past 5 years
- More on benefit in past 12 months and past 5 years
- Longer on benefit in past 12 months and past 5 years
- More on health condition or disability benefit in past 12 months and past 5 years
- Longer on health condition or disability benefit in past 12 months and past 5 years
- Higher youth disengagement in past 12 months (as measured by not being in employment, education or training – NEET).

Those who used co-occurring services exhibit these characteristics in significantly higher numbers than the general public.[21]

Criminal history. When compared to the other two groups studied, those who used co-occurring services demonstrate higher rates of the following: (1) prior convictions for violence/sexual offences in the prior 10 years (Figure 3) and (2) having been proceeded against for violence/sexual offences in the prior 3 years. All three groups score higher on these criminal history measures than the group with no mental health service use.

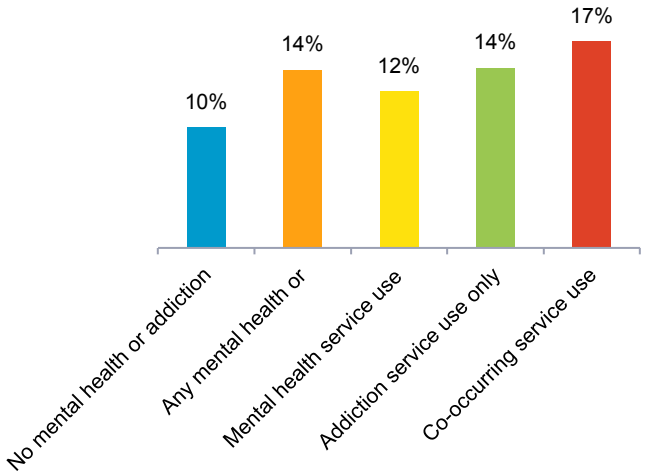
Figure 3. Prior conviction rates



[21] Appendix 1: MOJ: Opportunities in NZ courts for people with mental health and addiction disorders.

Breach of bail. People who used mental health and addiction services are more likely to breach bail. Those with co-occurring service use indicators breach at the highest rates.

Figure 4. Rates of breach of bail, by mental health and addiction service use group



For people charged in court in 2011 with charges not dealt with on same

Prison

"Prisons are a moral and fiscal failure," famously stated Finance Minister–now Prime Minister–Bill English at a Families Commission Forum in 2011. Despite this oft-cited statement, New Zealand has not been able to de-escalate the growth of its prison population, which includes a very high number of individuals with mental health and substance use disorders.[22]

Five years after Mr English's pronouncement, the prison population had increased from 8,433 (199 per 100,000) to 9,914, an eighteen per cent increase. And in November 2016 the population nudged over 10,000. As of the writing of this report in May 2017 New Zealand incarcerates 210 per 100,000 citizens, ranking it number seven of 35 in the Organisation for Economic Co-operation and Development, higher than Australia, England and Wales, Scotland and Canada.

Māori disproportionately make up the prison population at 51 per cent but just 15.4 per cent of the New Zealand population. Māori women account for 58 per cent of all women incarcerated.

The impact of New Zealand's rising prison population has a "moral" cost in addition to the fiscal one. Currently prisons are operating above their designed capacity, which has resulted in a number of changes affecting the daily lives of inmates and the safety of corrections officers. These changes include double-bunking, longer daily lockdowns (5pm to 8am) and increasing staff size, according to the Corrections Association of New Zealand ("CANZ"), the union for Corrections workers.[23]

[22] The Government has committed to increasing capacity at existing facilities and constructing a new prison.

[23] Corrections Association of New Zealand (undated).

Double-bunking is the practice of placing two people in one cell for months, or sometimes even years. Corrections Chief Executive Ray Smith has said that: "It's not ideal in some circumstances, but I think if you do it well, then it can be fine."[24] Measures such as double-bunking, according to CANZ however, affect the safety of corrections officers, and CANZ has asked for response teams at all high-security prisons.[25]

Today in New Zealand many inmates are locked up with each other in their 6.5-square-metre cells for sometimes 14 to 23 hours a day. Overcrowding can lead to a rise in gang membership.[26] Already New Zealand prisons grapple with the influence of gangs, with 11.5 per cent of sentenced inmates identified as gang members.[27] As prison conditions worsen with practices like overcrowding, the protection that prison gangs offer on the inside becomes even more valuable.[28] Drug use becomes more prevalent as a prison's population grows with more drug related offenders, and the 87 per cent of prisoners in New Zealand with a lifetime addiction issue represent a prime market. It is easy in a crowded prison for drug users to establish social relationships and pass on their drug habit, making prison an effective vehicle for spreading drug use.[29] Additionally, lengthy lock-down times and lack of programming foster boredom, which increases the likelihood of drug use.[30]

The Corrections 2016 Comorbidity Report

The Department of Corrections ("Corrections") published a comprehensive paper in June 2016 with the results of a 2015 study of the prevalence of mental health disorders experienced by New Zealand prisoners.[31] After interviewing 1200 prisoners across 13 prisons in 2015, researchers found that nearly everyone in New Zealand prisons, or 91 per cent, has been diagnosed with a mental health issue sometime in life, and 62 per cent had this diagnosis in the last 12 months.[32] This compares to 21 per cent of the general public with such a diagnosis in the last 12 months.[33]

Figure 5. Mental disorders summary, 2015 prisoner population

[24] Sachdeva, S. (2016).

[25] Corrections Association of New Zealand (undated).

[26] Lessing, B. (2016), p. 7.

[27] Corrections Department NZ, (2003).

[28] Lessing, B. (2016).

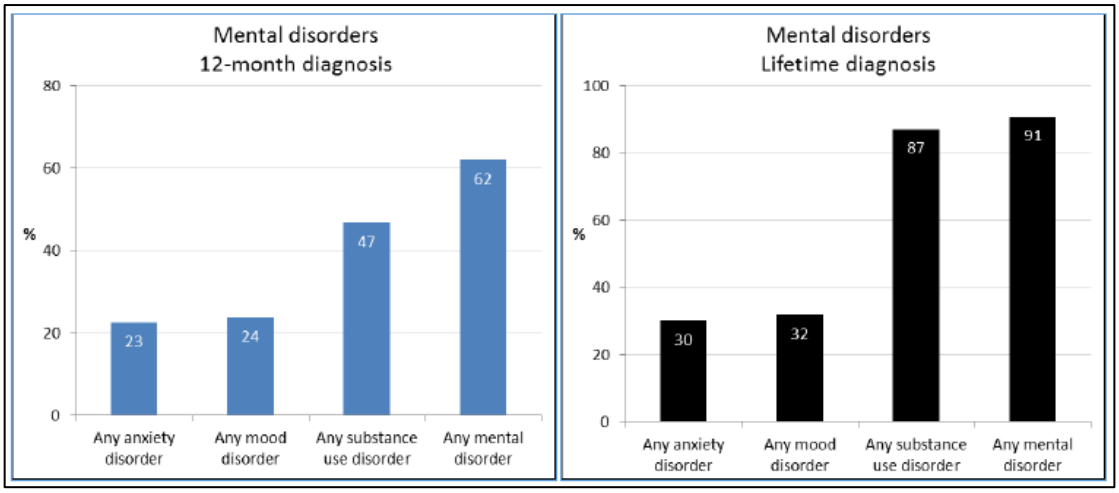
[29] Penal Reform International (2015), p. 4.

[30] Ibid.

[31] Corrections Department NZ, (June 2016).A similar study was conducted in 1999 but did not consider the co-existence of mental health and addiction issues. For a discussion of definitions of mental health disorder and related terms, see pp. 3-4.

[32] Ibid, p. v.

[33] Ibid.



Data reveals the following:

- 91% of prisoners in Corrections have had lifetime diagnosis of mental health issue[34]
- 75% of women had 12-month diagnosis of any mental health disorder (compared to 61% of men)
- 87% of prisoners had a lifetime diagnosis of a substance use disorder, and 47% had a 12-month diagnosis of such
- 42% of prisoners were found to have a lifetime comorbid mental health and substance use disorder, with 20% diagnosed in the prior 12 months.

Further details are helpful in understanding the complexity of needs:

- 87% lifetime substance abuse disorder
- 30% lifetime anxiety disorder
- 32% lifetime mood disorder
- 33% clinically significant personality disorder
- 66% had two or more lifetime diagnoses of a mental or substance use disorder
- 28% experienced psychological distress in the past 30 days
- 35% had ever thought of suicide, 17% had ever made a suicide plan, and 19% had ever attempted suicide.

Prisoners were magnitudes more likely than the general population to experience these disorders. Researchers concluded that prisoners had "high rates of mental health and substance use disorders, including high rates of comorbidity which were often undetected and under-treated."[35]

Comparison–Australia and the United States

As in New Zealand, the prison populations of Australia and the United States reflect a higher rate of mental health indicators than in the general population. An Australian 2010 study of mental health issues in prison entrants found that 31 per cent had an indicator for a mental health disorder (including drug and alcohol abuse) in their

[34] Ibid.

[35] Ibid. p. vii.

lifetime, about 2.5 times higher than the general population.[36] Rates of illicit drug use were much higher in the Australian prison population than in the general population, with 66 per cent of prison entrants using illicit drugs in the previous 12 months.

A 2011-12 study in the US examined indicators of mental health disorders reported by two groups: prisoners and jail inmates.[37] Data reflect that 37 per cent of prisoners and 44 per cent of jail inmates had been told by a mental health professional in the past that they had a mental health disorder.[38]

Although the Australian and American studies are not perfect data comparisons to the Comorbidity Report or data on mental health indicators for people charged in court, they also reflect higher rates of mental health indicators in the justice sector population than in the general public.

Prison experience for vulnerable populations

"Prisons have become mental health facilities."[39]

The Department of Corrections runs an extensive medical service with the goal of treating any physical and mental health disorder. In November 2016 after publication of the Comorbidity Report, Corrections dedicated an additional $14 million to address the needs of persons with mental health issues.[40] The package is funded for two years, and Corrections will conduct a "robust evaluation" of engagement in mental health services, participation in rehabilitation programmes, and education and employment activities. They will also monitor incidents of harmful behaviour, suicide and self-harm rates of compliance with sentence conditions.[41] The evaluation of this investment has not yet been completed and made public.

As part of a package of new initiatives announced in 2016, Corrections has implemented a Mental Health Screening Tool as part of the Initial Health Assessment that is carried out in the first seven days after a prisoner arrives in prison. A registered nurse conducts the screening. Prisoners are referred to Regional Mental Health Services if they screen as positive. If prisoners are found to have a primary mental health issue, they are to receive treatment in prison. Prisoners with a mild to moderate mental health need can be referred to a contracted provider for counselling (e.g.,

[36] Australian Institute of Health and Welfare, (June 2012).The study also found that relative to other prison entrants, those with poor mental health also had more extensive imprisonment histories, poorer school attainment, higher unemployment rates and higher rates of substance use. Further, the association between substance use and mental health disorders was stronger in the prison population than in the general population.

[37] US Department of Justice, Bureau of Justice Statistics, (June 2017). The jail population includes those incarcerated at regional facilities called jails rather than prisons.

[38] Ibid. Prisoners were most commonly told they had a major depressive disorder (24%), a bipolar disorder (18%), post-traumatic stress disorder (PTSD) or personality disorder (13%), and schizophrenia or another psychotic disorder (9%). Nearly a third (31%) of jail inmates had previously been told that they had major depressive disorder and a quarter (25%) had been told they had a bipolar disorder. About 18% of jail inmates had been told they had an anxiety disorder, 16% had been told they had PTSD, and 14% had been told they had a personality disorder.

[39] Interview notes.

[40] $14m to help offenders with mental health issues retrieved 16 June 2017 from https://www.beehive.govt.nz/release/14m-help-offenders-mental-health-issues.

[41] Corrections Department NZ, (June 2016).

cognitive behavioural therapy) or other treatment.[42] Some prisoners with mild to moderate mental health needs–stress, anxiety or depression, for instance–may not meet the threshold set by Corrections enabling them to get treatment from a mental health professional. They would be seen by a General Practitioner (GP).[43]

Despite the identification of disorders and perhaps counselling, spending time in prison often is a deeply damaging experience, especially for the most vulnerable and sick. Those struggling with mental health and addiction issues suffer in prison more than inmates with minimal health needs. Auckland University of Technology Professor Warren Brookbanks, who has long been advocating for reform of the justice system especially in its treatment of those with mental disorders, has written that "mentally vulnerable individuals are susceptible to victimisation and exploitation and in the course of lengthy remands or unduly protracted assessment periods may suffer a decline in their mental health."[44] As clinical social workers have told me over the years, fundamentally prisons are not places of safety and trust, both necessary for an optimal treatment and healing environment. Prisoners are four times as likely to have ever attempted suicide.[45] From 2005 to 2016, 72 individuals have died "unnatural deaths" in prison, which include suicide, homicide and drug overdoses.[46]

Unsurprisingly, the high number of individuals with mental health disorders in the prison population is a matter of significant concern for corrections officials, who must manage the needs and challenges of such inmates on a daily basis.[47] Issues of mental impairment and behavioural dysfunction amongst prisoners are increasingly compounded by emerging evidence of the high incidence of neuropsychological disorders, traumatic brain injury, Foetal Alcohol Syndrome Disorder and substance abuse amongst the prison population.[48] This has the potential to turn prisons into highly psychogenic environments and breeding grounds for violence, abuse and emotional degradation.[49]

When it comes to accessing treatment, the remand population is more disadvantaged than those serving sentences. For instance, those on remand with substance use disorders generally lack the ability to engage in a full treatment programme.[50] Presently Corrections offers several drug and alcohol treatment programmes—a brief intervention and intermediate support programme, but many are not in custody long

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[42] Corrections Department NZ, (June 2016), Comorbid substance use disorders.

[43] Interview with Jill Oetgen.

[44] Brookbanks, W. (2006), p. 13.

[45] Corrections Department NZ, (June 2016), Comorbid substance use, p. 67.

[46] "Unnatural death" is defined as found by the coroner to be caused by homicide, suicide, accidental cause or a drug overdose, or where there is sufficient evidence to suggest to Corrections that these are the most likely cause of death. http://www.corrections.govt.nz/resources/research_and_statistics/deaths_in_custody.html.

[47] Brookbanks, W. (2014).

[48] Ibid.

[49] Ibid.

[50] Though beyond the scope of this Report, studies have also confirmed that pretrial detention leads to increased conviction rates, increased likelihood of incarceration and increased length of sentence for both felony and non-felony cases. See, e.g., Oleson, J. and others (2014), p. 2.

enough to finish a programme. Just the same, screening at this stage certainly has value.

Release

Individuals with mental health problems released from prison are at particular risk of a variety of adverse outcomes in the early days after release.[51] New Zealand researchers found that suicide risk was nearly seven times higher than the general population. Individuals with untreated schizophrenia presented three times the risk of violent behaviour. Overall, this released population had poor rates of post-release community mental health engagement.[52] Any stability that they were able to build prior to imprisonment has likely crumbled while they served their sentences, and psycho-social needs can be significant. Upon release many face a new reality where they have lost a job and housing, damaged family and community relationships and interrupted any consistency of treatment they were receiving.[53] Consequently, when some of these individuals are released, not only has their mental health deteriorated, but they also need to rebuild a life from scratch. This is particularly difficult given that this person now has a (or another) criminal conviction, which frustrates the ability to find housing or work. A subtler impact of imprisonment is the stigma and shame that a released individual bears, which permeates his or her attempts to reconstruct a stable life.

A portion of Corrections' dedicated $14 million addresses release challenges experienced by persons with mental health issues coming out of prison. The Corrections budget has allocated for the following:

- $2 million over two years on supported accommodation for the small number of offenders with significant mental health concerns or intellectual disabilities
- $877,000 on social workers and counsellors to work with female offenders dealing with trauma, and support them with parenting and whānau issues
- $920,000 for a wrap-around post-release support service for prisoners and their families with multiple mental health needs.[54]

Understanding the particular challenges facing this vulnerable population within prison and upon release, the Department of Corrections acknowledges the need to divert some offenders with complex mental health needs. As researchers conclude in the Comorbidity Study:

> The findings of this report provide important evidence to assist with identifying areas for improved detection, early intervention, treatment and rehabilitation and diversion away from the criminal justice system.[55]

[51] McKenna, B. and others (2015).

[52] Ibid. pp. 430-431.

[53] Fader-Towe, H. and Osher, F. (2015), p. 9.

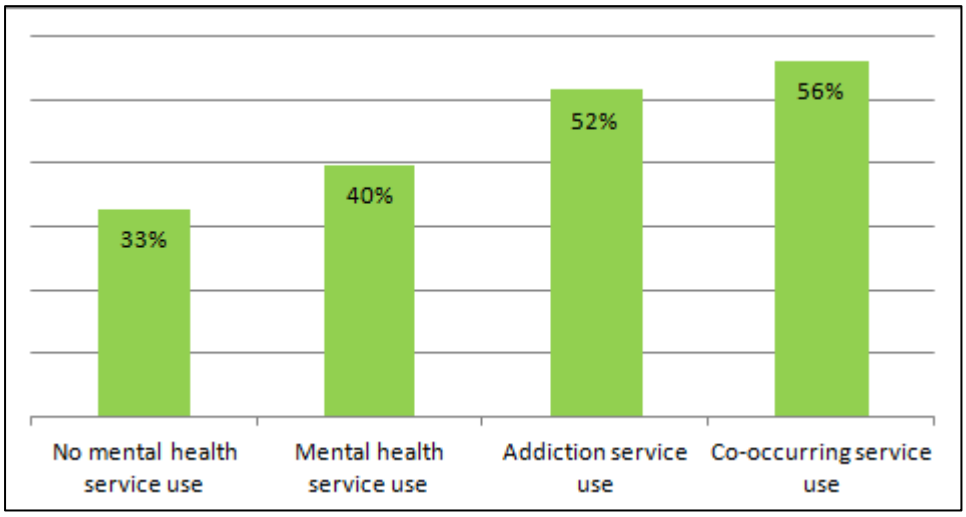
[54] $14m to help offenders with mental health issues retrieved 16 June 2017 from https://www.beehive.govt.nz/release/14m-help-offenders-mental-health-issues.

[55] Corrections Department NZ, (June 2016), Comorbidity study, p. 79. The Report does not provide details on researchers' recommendations regarding using the data to explore diversion options.

Re-offending

What is happening to the flow of individuals leaving prison, especially those with mental health and substance use disorders? All three groups analysed by MOJ–substance use (only), other mental health service use (only) and co-occurring mental health service use–are associated with higher reconviction rates than the group with no mental health service use. Of the three sub-groups, those with co-occurring service use have the highest rate of reoffending.[56]

Figure 6. 2010 re-offending rates by mental health service use categories



2. METHODOLOGY

One goal of this report was to identify court resources and programmes in New Zealand that specifically target individuals facing criminal charges who experience mental health disorders, including substance use disorders. A second goal was to identify any gaps and generate a series of initiatives that could fill them.

My research consisted of three parts. First, I observed almost all of the solution-focused courts operating in New Zealand as well as viewed non-specialised court proceedings.[57] I conducted semi-structured face-to-face interviews–a few by telephone–with a wide range of individuals engaged in the justice and health sectors. In total, I met with over 80 individuals during the course of my research to gather information and background. These included individuals charged with criminal offences, judges, defence lawyers, prosecutors, other court professionals and staff, the Chief Science Advisor to the Ministry of Justice as well as individuals working in academia, politics, criminal justice reform, NGOs providing services to offenders, the

[56] Horspool, N. (2017). The Ministry of Justice measures re-offending in this analysis with data of proven re-offending–that is, people who re-offend within two years after being proven of an offence. A court outcome that indicates that offending has been proven includes conviction, discharge without conviction (that is, where the offender was discharged but was found guilty or pleaded guilty) and adult diversion.

[57] As noted by Dr Katey Thom, a recognised expert in mental health law and policy including therapeutic initiatives within the New Zealand criminal justice system, the term "solution-focused" rather than "problem-solving" is widely used in Australia and increasingly in New Zealand to "reflect the belief that courts should be encouraging the person to address factors relating to their offending behaviour themselves via an individualised plan monitored by the court." Thom, K. (2015), p. 326.

Independent Police Conduct Authority, District Health Boards, the Ministries of Justice, Health, Corrections, Social Development, Oranga Tamariki, New Zealand Police and mental health treatment organisations. Second, I worked with analysts at the Ministry of Justice to generate new data on the target population and finally, I conducted a literature review.

Having practised as a criminal defence lawyer for 19 years, the last 13 as an Assistant Federal Public Defender in the US, I have found that New Zealand's adult criminal justice system bears similarity to the one in which I work. As such, my practical experience has been quite useful. I have been able to rely on my general knowledge of court systems, my understanding from representing hundreds of defendants of the experience of being charged with a crime as well as the particular challenges faced by those in the criminal justice system who are suffering from mental health and substance use disorders.

Given the sensitivity to any individual's history with the justice system or having been identified with a mental health or substance use disorder, I have referenced these persons or conversations in a manner to provide maximum protection of privacy.

3. THE COURT SETTING

The district courts that I visited in New Zealand constitute the bustling, dynamic frontline, crackling with energy and anxiety. Dedicated court staff, from security officers to judges, interact with some of the most troubled and disadvantaged members of society and their families. Since my proposals offer opportunities for courts, it is helpful to provide a background of the court experience for a charged individual.

Early hearings

In 2015/2016 approximately 137,000 criminal cases were reported in the 58 District Courts around New Zealand.[58] Charged individuals are either arrested and held in police custody or sent a court summons. At a first appearance, an individual will hear the charges, enter a plea of guilty or not guilty or ask that the case be remanded to seek legal advice. Those without a lawyer may speak with the Duty Lawyer (also known as Duty Solicitor) at the court.

Normally, bail will be granted unless there is reason to believe that someone will be a danger to the community, including potentially interfering with a witness or evidence, or may fail to appear in court.[59] In cases where bail is uncontested, individuals leave court after a first appearance having filled out a legal aid application to obtain a court-appointed lawyer if they can't afford one and they receive a future court date. Those persons not released after a first appearance are remanded pending a bail hearing, where the judge contemplates whether release conditions can be put in place to ensure that the defendant appears in court, does not interfere with any witness or evidence in the case, and does not commit any offence while on bail.[60]

[58] District Courts of New Zealand (2016), p. 35.

[59] *Bail Act 2000*, s. 8.

[60] *Bail Act 2000*, s. 30(4).

A judge has the ability to impose strict conditions of bail that would entail electronic monitoring (EM) at an approved address with varying permission to leave the residence. Conditions might be very limited, enabling a person to leave perhaps only for court appearances or attorney visits.[61] Essentially these strict conditions equate to a lockdown in one's home. Conditions may be more expansive, permitting someone to work or obtain treatment while on EM. Conditions can change over time. Probation officers monitor EM compliance with the conditions set by the judge and may make referrals to programmes that could assist offenders.

In addition to the ability to impose an EM condition, a judge may impose "any other condition … reasonably necessary" to ensure the goals of appearance in court and safety of the community.[62] This broad phrase permits a wide variety of conditions and as discussed further in this paper, some judges rely on this section extensively to impose release conditions with a therapeutic goal.

Research results

At a first appearance before a judge the primary concern for people facing charges is whether they'll walk out of court that day or be remanded. Very few have any notice that they will be arrested and brought to court on new charges. For the majority, a first appearance is a deeply disruptive event and for many it is also a catalyst for change.

Individuals who are released try to resume their "normal" lives though often with a high level of anxiety associated with the pending criminal proceedings. A pending criminal charge is stigmatising, making it difficult to maintain one's regular routine. If someone has been remanded pending a bail hearing, he or she may return to a destabilised life. Imprisonment may have resulted in loss of a job and housing, decline of relationships, interference with treatment, and a feeling of shame. Probation officers may provide EM monitoring, but several frontline people that I interviewed commented that the role of the probation officer has changed in the last twenty years and most focus primarily on compliance rather than linking individuals to services. As noted by one individual who was a probation officer approximately thirty years ago: "Probation officers no longer have a pastoral role."[63]

Court professionals describe the period of time pending the outcome of a criminal case as one in which many individuals experience an increased level of depression and anxiety. Depending on where someone has a pending case, he or she might be able to obtain some assistance from either an alcohol and other drug clinician, a court liaison nurse or a defence lawyer. As detailed below, however, the type of attention an individual receives from court professionals varies according to local resources.

Therapeutic professionals

Court Liaison Nurse

Court liaison nurses (CLNs) have been part of a court service for approximately 25 years. An early court liaison nursing service started in Auckland in 1987 and was described as efficient and effective.[64] The Mason Report recommended rolling out

[61] Ibid. s. 30(2).

[62] Ibid.

[63] Interview notes.

[64] Mason, K., *et al*. (1988) (The Mason Report).

this service. In the early 1990s court liaison services and the role of the CLN were formally implemented.[65]

The service objectives are as follows: (1) consultation and liaison services to the Ministry of Justice/Department of Corrections, the Court, police and Community Mental Health Services Crisis Intervention teams, and (2) conduct informal assessments, reports and recommendations to Court Judges, and information and advice to justice and mental health services about the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA).[66]

A nurse will conduct an assessment in the cells if someone is in custody or elsewhere in court if someone is out of custody. Some nurses have their own office; some share an office, which presents challenges since the nurse is obligated to protect the confidentiality of conversations with individuals she or he is assessing. The primary purpose for assessment is to identify if someone presents with an issue acute enough to trigger concerns about his or her fitness to stand trial.

Many nurses also serve as a Duly Authorised Officer (DAO) for purposes of the MHA.[67] DAOs are health professionals who have been designated and authorised by a Director of Area Mental Health Service to perform certain functions and use certain power under the MHA. This appointment is statutory, and there is an expectation that DAOs have training and experience so that they can contribute to the assessment and treatment of persons who are mentally unwell.[68] A nurse who believes that fitness is an issue follows a proscribed path under the MHA and provides her or his assessment to the judge.

At Auckland University of Technology Patsy-Jane Tarrant conducted her DHSc research on the role of the CLN.[69] She identified the following complications encountered by nurses practicing in court:

- Bridging disciplinary boundaries
- Ethical concerns
- Organisational processes
- Barriers to negotiating care and appropriate outcomes for people seen at court.[70]

In light of these challenges, she recommends the following requirements for sustaining and maintaining practice:

- Education preparation
- Education regarding cultural and disability factors
- Professional support structures
- National consistency.[71]

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[65] Tarrant, P. (2014).

[66] Ministry of Health (2013).

[67] Tarrant, P. (2014), p. 71.

[68] Ibid.

[69] Ibid.

[70] Tarrant, P. (2014), pp. 176-187.

[71] Tarrant (2014), pp. 188-195.

Based on her research, Tarrant makes the following suggestions:

1. Establish a framework of standards and competencies for practice, an ethical framework and an educational pathway for the CLN role
2. Develop credentialing in support of these frameworks
3. Articulate a common understanding of the CLN role, which is broader than the current definition
4. Implement a path for advanced practice roles and specialist opportunities.[72]

One of Tarrant's main concerns is that nurses are not educationally prepared to practice in a legal environment, yet overall she concludes:

> These nurses perform a crucial role in working with people with mental health concerns in courts and advocating for health interventions for the person. CLNs have a vast amount of valuable knowledge regarding the intersection of mental health and justice systems. It is hoped that bringing together the CLNs' experiences and knowledge into the public arena of mental health nursing will stimulate and motivate others to continue the drive for acknowledgment, continuity and ongoing evaluation of this important and necessary nursing role.[73]

Research results

"If better resourced, we could do a lot more."[74]

The nurses I observed and interviewed have developed their practice without standards or training or certification particular to the role of a forensic mental health nurse practising in the court setting. Given the lack of any national unifying practices and the variety of District Health Boards (DHBs) under which the nurses work, regional differences are apparent. Yet all come to the role with experience working with the mentally unwell and they are deeply committed to their primary identification as a nurse.

Based on my interviews, they operate in the same general manner. A nurse receives referrals in several different ways. Prior to a court list day, a nurse obtains the names of individuals appearing in court and cross-references them in her or his DHB database to see if they have a DHB record. If they do, the nurse is on alert to possibly assess the person who comes into court. Additionally, any of the court professionals–lawyers, judges, police–might alert a nurse to meet with someone coming into court.

Given that my research is focused on individuals with mild to moderate mental health disorders, I was particularly interested in the role of the CLN for persons that did not trigger the CP(MIP). Besides doing her work screening people for fitness/insanity issues, one nurse "provides advice for people who are not in the custodial setting and come into court and might have a mental health issue."[75] She added that this now included people with intellectual disabilities.[76] This might include identifying a

[72] Tarrant (2014), pp. 201-206.

[73] Tarrant (2014), pp. iii, 206.

[74] Interview with CLN.

[75] Interview with Jill Oetgen.

[76] Ibid.

treatment provider and perhaps facilitating a meeting. I observed other nurses performing this role, too, consulting with individuals coming into court and making efforts to connect them with primary care services.

The focus, however, for the CLNs was primarily on identifying those who might trigger the CP(MIP), with a less consistent and forward-thinking focus on others coming into court with less than acute issues. Whether and the degree to which the CLN assisted someone, for instance, in connecting them to a service provider varied from day-to-day and from one nurse to another. It did not appear that the CLNs considered their role to encompass continued case management with individuals they may have seen at a first appearance. One CLN expressed that she might recognise someone in court whom she had suggested should see a GP. In that case, she might do some follow-up and inquire if that visit had taken place. This particular nurse believed she could take on more of a case management role and it would likely be helpful to individuals.

I interviewed four nurses from different parts of the country, and all stated that they had no particular training for the role of court liaison nurse. Several with whom I spoke had practised in the UK as a Court Psychiatric Nurse, a role similar to a CLN. The CLNs supported each other, with experienced ones conducting ad hoc training for new CLNs. They formed their own informal peer networks. CLNs meet once a year, but some DHBs do not provide much financial support for these meetings or any professional development throughout the year.

Resources for CLNs vary around the country. Some have their own office, which is highly valued given the ethical obligation to protect the confidentiality of information. Others share space or have no designated office at all. Some nurses have a roster of forensic psychologists available to write clinical reports, and others spend days trying to find someone to write a report.

Based on my interviews of practitioners in the courts, nurses often serve a valuable role not only in conducting assessments for those most acutely unwell but also in assisting those with mild to moderate mental health disorders. Their ability to help everyone in need is subject to time constraints. In the Wellington district court, where I had the most number of opportunities to observe, the nurse is valued as part of a therapeutic team that works cohesively to develop a treatment path for an individual.[77] The team includes the defence lawyer, AOD clinician and often community service providers.

Alcohol and Other Drug Clinician

In 2001 Nelson welcomed the country's first alcohol and other drug (AOD) clinician into its district court services after DHB staff observed some court sittings and noticed the same people in court as they were seeing at their service. They suggested the placement of a permanent court clinician, funded by DHB, to streamline the treatment

[77] Two CLNs work at the Wellington District Court though not usually at the same time. Both are regarded by the other court professionals as integral members of the therapeutic team.

services.[78] As of August 2016 AOD clinicians were working in nine of the 58 district courts in New Zealand.[79] The AOD clinician's role is defined as follows:

> The AOD clinician in court service is a judiciary-led initiative to improve the health information available to judges to inform their sentencing decisions. Depending on the judge, these decisions can include case determination, which can influence individual therapeutic and broader social outcomes (including reoffending rates).[80]

The clinician is available to conduct assessments in court of offenders who have entered a guilty plea with the goal that an earlier assessment and immediate access to clinical advice would be helpful to judges for sentencing purposes but also in better understanding an individual's needs.[81] She or he also serves as a liaison between the courts and community treatment services.

The clinicians interviewed identified other components to their role:

- Build relationships with judges and lawyers
- Provide general AOD information to judges
- Reduce the need for adjournments by returning same-day advice
- Provide a trained/specialist/medical opinion to the court to confirm or challenge the non-specialised professional advice from Probation Services
- Offer care and support for offenders
- Access referrals that have come through the diversion programme.[82]

All clinicians proactively screen for coexisting problems like gambling, suicidal ideation and other mental health disorders, homelessness, unemployment and family issues.[83]

Because the AOD clinician service developed "in a piecemeal way" across the system,[84] practices vary, and each clinician operates in a way that she or he has developed to best serve in a particular court. The Ministry of Justice conducted research in order to assess the processes, utility and effect of the AOD clinicians' service in district courts. The MOJ Report, published in 2016, concludes that "there is no uniform or best practice framework for the AOD clinician services across sites."[85]

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[78] Ministry of Justice (August 2016), Alcohol and other drug (AOD) clinicians in court, p. 11.

[79] Ministry of Justice (August 2016), Final Process Evaluation. In 2005 the Tauranga District Court in conjunction with the local DHB launched an AOD clinician in court service. In 2008 MOJ and the Ministry of Health launched a joint initiative in conjunction with DHBs, which resulted in clinician service being implemented in Northland, Kaikohe, Wellington, and Porirua District Courts. In Wellington the DHB has subcontracted to the Salvation Army Addiction Service.

[80] Ibid. p. 14.

[81] Ibid.

[82] Ibid.

[83] Ibid. p. 20.

[84] Ibid.

[85] Ibid. p. 6.

Researchers found multiple differences between the five district court sites they examined in terms of the following:

- Facilities provided to the clinician
- Where referrals originated (i.e., lawyer or judge)
- The type of cases referred to clinicians
- How clinicians broadly operated (e.g., treatment philosophy, record keeping)
- How assessments were conducted, including their duration
- The screening tools used
- Whether sentencing could be delayed for treatment.

Although researchers lacked data needed to assess key impacts of the clinician service, they identified the following impacts of the service:

- Judges reported strong confidence in the expertise of the AOD clinicians;
- Participants claimed having an AOD clinician in court increases the number of comprehensive AOD reports ordered and the number of offenders referred to treatment;
- Judges and clinicians noted barriers to access and successful completion of treatment (i.e., timely availability of treatment places and the proximity of services); and
- All participants in the study supported having the AOD clinician in court.[86]

Research results

Judges and defence lawyers whom I interviewed speak very highly of the AOD clinician's role. It also appears that the role has been broadened organically in some courts to include not just an AOD assessment but a more concentrated involvement with the charged individual.

With the support of judges and other court practitioners, an AOD clinician in one district court is involved not only post-plea but also from the earliest stage of a case.[87] The clinician in this court works with the defence lawyer, the CLN and community organisations to develop a treatment path for charged individuals that can be presented to judges long before the plea stage in a case.[88] Relying on work of this team, a defence lawyer in this District Court will often be able to present a comprehensive release plan to a judge prior to a bail hearing, a plan that involves appointments to see treatment providers and addresses other socioeconomic factors. If release is not contested, this clinician will still develop a treatment path for charged individuals, and she will assist them in getting appointments for various services, as well as conduct follow-up.

Defence lawyer

An individual has a right to a lawyer if questioned, detained or arrested by police.[89] The legal aid system in New Zealand provides Government-funded legal assistance to those who are unable to afford a lawyer. Individuals can hire their own lawyer or

[86] Ibid. p. 8.

[87] Interview with AOD Clinician, 5 April 2017.

[88] Ibid.

[89] New Zealand Bill of Rights Act 1990, s. 23(b).

request an appointed lawyer. A defence lawyer's primary responsibility is legal work—to navigate a client's case through the court, evaluate the evidence, consider possible challenges to the case either via motions or at trial, explain options to a client, including pleading guilty and the potential consequences and taking a case to trial and the potential consequences if unsuccessful.

Additionally, defence lawyers perform the work of social workers and counsellors, usually despite little training in this area. Few of those I interviewed have a degree in social work or are specifically trained as mental health or alcohol and other drug experts. Consequently, lawyers are dependent on the courthouse professionals in the areas of mental health and addiction and on each other to learn about treatment options.

Because defence lawyers spend more time with individuals charged in court than the other courthouse professionals, they have the best opportunity to identify needs or detect a change in someone's stability. A tension exists, however, for lawyers when it comes to seeking treatment for a client. Situations may exist where the lawyer acquires information about a client's needs but would be compromising an aspect of the case if she discloses it to others in the courthouse. Other courthouse professionals also need to understand the legal professional privilege that exists between a lawyer and client. If a client is the source of information to his or her lawyer, the lawyer has a duty to keep it confidential.

Research results

I spoke to at least fifteen criminal defence lawyers in New Zealand's Public Defender Service (PDS), and every one considers a client holistically and makes impressive efforts to identify ways to help stabilise a client's life outside of court. Based on my observations, the ones who are most successful at achieving both these goals enjoy a trusting relationship with the court liaison nurse and AOD clinician (if there is one) in their court, and the court professionals function as a team while respecting their separate roles and obligations.

Solution-focused courts and dockets

The New Zealand judiciary and community stakeholders have made significant contributions to the landscape of solution-focused courts both within the country and internationally, as they have developed their own responses to deal with the root causes of offending.[90] Specialty courts now exist that are aimed at alcohol and other drug addiction, homelessness, family violence and a range of issues that contribute to youth involvement in the criminal justice sphere.

Such specialist courts are well developed in the United States, Canada, United Kingdom and Australia. The first evolved in Miami, Florida, in 1989, where an involved judge took a "personalised" approach to offending linked to drug addiction, particularly to crack-cocaine. Rather than impose a prison sentence, he assigned a treatment disposition. As of June 2015, over 3000 drug courts and 300 mental health courts are operating in the US.[91] Many other specialised courts in the US are focused on particular issues and populations, including the following: domestic violence court,

[90] Thom, K. (2015), p. 326.

[91] National Institute of Justice (US), (2017); The Council of State Governments (US), (undated).

driving under the influence (DUI) court, sex offences court, prostitution court, re-entry court, veterans' court, youth court and community courts.[92] The number of solution-focused courts in the US is perhaps a reaction to its historic punitiveness and very high incarceration rates.

Outside of the US, England is furthest along in transplanting variations of these American court innovations.[93] Commencing in 1998, England has operated three types of problem-solving courts: drug court, domestic violence court and community court.

In Toronto Canada separate drug and mental health courts were launched in 1998. Since then many more of both kinds of courts have been established around the country, along with domestic violence court, aboriginal court, and community court.

In Australia, drug courts, family violence court, mental health court and to some extent community justice court have become part of the justice landscape.[94]

Advocates speak of problem-solving courts as a "paradigm shift," a "dramatic wave of court innovation," and even a "revolution" in criminal justice.[95] Problem-solving courts bring with them a hopefulness to those who perceive the justice system "as suffering from a range of dysfunctions."[96] In conventional courts, judges complain of feeling isolated, unappreciated, misunderstood, and frustrated with the endless stream of repeat offenders cycling through their courtrooms.[97] Judges and practitioners in particular find problem-solving courts more personally satisfying:

> As they see it, in problem-solving courts, judges enjoy greater discretion, more personal interactions with defendants, and a feeling that they are actually effecting change.[98]

Youth Courts

New Zealand's youth justice system has been called the "incubator of innovation."[99] It operates significantly differently from the adult justice system and is codified in the Children, Young Persons, and Their Families Act 1989 (CYPF Act). The CYPF Act is a "unique and innovative" piece of legislation that provides powers to deal with young persons and their families in the contexts of care and protection and youth justice.[100] The family group conferences (FGC) serve as the lynchpin of the decision-making process,[101] with the aim of "shifting much of the responsibility for dealing

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[92] Re-entry courts provide close supervision, links to social services, and intensive case management to offenders returning to the community after incarceration.

[93] Nolan, J. (2011), p. 43.

[94] Richardson, E., Thom, K., and McKenna, B. (2013), p. 186.

[95] Nolan, J. (2011), p. 7.

[96] Ibid. p. 8.

[97] Ibid.

[98] Ibid.

[99] Lynch, N. (2013); Thom, K. (2015), p. 331.

[100] Lynch, N. (2016), p. 142.

[101] Ibid. p. 142.

with young people's offending from the state into the hands of communities and their families."[102]

- *Te Kooti Rangatahi and Pasifika Courts*

The Rangatahi Court received the 2015 Australasian Institute of Judicial Administration Award (AIJA) for Excellence in Judicial Administration reflecting the international recognition it has garnered.[103] There are fourteen Rangatahi Courts around the country and two Pasifika Courts in Auckland. Rangatahi Courts operate in the same way as the Youth Court but are held on marae and follow Māori cultural processes. Pasifika Courts also operate in the same way as the Youth Court, but are held in Pasifika churches or community centres and follow Pasifika cultural processes. These courts are designed to help young Māori and Pacific Islanders and their families and communities engage in the youth justice process. The courts work within the Youth Court legal structure, with the same laws and consequences applied as they would in the Youth Court.

The Rangatahi and Pasifika Courts are for young people who have admitted the charges that they are facing. After the FGC has decided on a plan for how the young person can take responsibility for what they did, as well as working out how to make sure the young person doesn't offend again, the young person can choose to have this plan monitored by the Rangatahi or Pasifika Court. This means that all Court appearances until the plan is completed will be held on the marae or at a Pasifika venue. Normally, the young person will appear at the Court every two weeks, and each hearing will usually involve the same Judge.

All young offenders must first appear at the Youth Court but may be asked if they want their next hearings held at a Rangatahi or Pasifika Court. Only young people who haven't denied the charge against them can go to a Rangatahi or Pasifika Court.

These courts support tikanga Māori and Pasifika cultures, but they are not exclusively for Māori or Pasifika youth. A typical hearing at a Rangatahi Court will start with a pōwhiri (welcome/calling) of manuhiri (visitors) onto the marae. A morning tea will be served. The hearing of each young person's case then starts. Each hearing begins with the young person receiving a mihi (talk) from the kaumātua (respected elders), showing respect to that young person and acknowledging their whānau, hapū and iwi links. The following will also be at the hearing: the judge, police, kaumātua/kuia, social worker, court staff, whānau, a Youth Advocate (the young person's lawyer), Lay Advocate and victims if they choose to attend.

During the time that the young person attends the Rangatahi Court, it is expected that they will learn their pepeha (traditional greeting of tribal identity) with the assistance of their Lay Advocate. At each hearing, the young person will practise delivering their

[102] Thom, K. (2015), p. 331, citing Cleland, A. and Quince, K. (2014). Family group conferences are used to determine whether prosecution can be avoided and also to determine how to process cases that are admitted or proved in the youth court. FGCs are designed to involve the youth, their families and the victim, with the aim of reaching a group consensus on a "just" outcome. A family group conference plan is the result of the conference and includes methods of addressing the victim's needs and concerns, accountability issues, the young person's treatment plan, and other relevant issues such as education and cultural reports. Thom (2015), p. 331.

[103] Ministry of Justice (1 July 2016).

pepeha. The young person may also be encouraged to attend a tikanga wānanga to help them learn more about their cultural identity.

The Rangatahi Courts are part of a suite of initiatives that has reduced offending by young Māori since 2009. In 2015, over 1000 fewer Māori aged twelve to sixteen appeared in the Youth Court compared to 2009, a reduction of 47 per cent.[104] Initial research suggests that in the following year, participants committed fourteen per cent fewer offences and were eleven per cent less likely to commit new offences.[105]

A typical Pasifika Court hearing will involve a briefing between the Judge and the elders to discuss how each young person is progressing with their plan. Each case will start and end with a prayer. An elder that is from the same cultural background as the young person will talk to the young person and their family, offering encouragement and guidance.

- *Christchurch youth drug court and Intensive Monitoring Group (Auckland)*

Judge John Walker established the Christchurch youth drug court in 2002 as an enhanced Youth Court process. Judge Jane McMeeken currently presides over this court. The Court admits young persons who are considered serious offenders, have a diagnosed drug or alcohol dependency, and where the offending is linked to the dependency. The FGC recommends transfer to Drug Court and the FGC Plan is presented at court. Once the judge and young person discuss the plan and agree on it, the young person is admitted and attends Drug Court every fortnight.[106]

In 2007 the Intensive Monitoring Group (IMG), modelled heavily on the Christchurch youth drug court, was established in Auckland. Stakeholders developed it differently to reflect the complexity of cases presenting and the nature of Auckland youth forensic services that had a mental health and addictions focus.[107] Its entry criteria included mental health concerns as well as alcohol and drug use disorders, and it was limited to moderate to high-risk offenders with the initial goal of taking the ten most challenging cases.[108]

The criteria expanded quickly to address the wide variety of mental health issues presenting, including neurodisabilities, and those in the care and protection system soon became a core focus.[109]

Te Whare Whakapiki Wairua/The Alcohol and Other Drug Treatment Court

The Alcohol and Other Drug Treatment Court (AODTC) is designed to work with offenders facing up to a three-year prison sentence who have an alcohol and/or other drug (AOD) dependency that drives their offending. Once accepted into the AODTC programme, the participants are supervised through a judicial process (courts) and a treatment programme that will help them address their AOD issues and prevent them from committing further crimes.

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[104] Ibid.

[105] Ibid.

[106] Drug Foundation (2013).

[107] Thom, K. (2015), p. 333.

[108] Ibid.

[109] Ibid.

The Court aims to "break the cycle" where offending is fuelled by these unresolved alcohol and other drug issues. The goals of AODTC are to reduce reoffending and AOD consumption and dependency, as well as the use of imprisonment.[110] Further, the Court aims to positively impact health and wellbeing and be cost-effective. The AODTC began operating in November 2012 in Auckland and Waitakere District Courts.

The AODTC pilot (the pilot) is a joint initiative between the judiciary, the Ministry of Justice, the Ministry of Health, New Zealand Police and the Department of Corrections, and is part of government's Addressing the Drivers of Crime work programme (Ministry of Justice 2011).[111] The Government has supported the court with $1,930,000 per year for the first five years of the pilot,[112] and in May 2017 the Government committed to funding an additional three years of AODTC operations.[113]

The Court is based on a post-plea, pre-sentence model in which the sentence is deferred while the court participant engages in a treatment plan approved and monitored by the court.[114] A participant generally completes the plan in twelve to eighteen months. Capacity for the court is 100 participants; currently the court is full, with a waiting list. The professional team includes the AODTC judges, court coordinators, case managers, defence counsel, police prosecution, te pou oranga (AODTC cultural advisor), probation officers and peer workers.[115]

The Court adheres to the international best practices, summarised as follows:

1. Integrate alcohol and other drug treatment services with justice system case processing
2. Use a non-adversarial approach
3. Identify eligible participants early and promptly placed in the drug court program
4. Ensure access to a continuum of alcohol, drug and other related treatment and rehabilitation services
5. Monitor participants frequently via alcohol and other drug testing
6. Use a coordinated strategy to govern participants' compliance
7. Maintain ongoing judicial interaction
8. Monitor and evaluate programme effectiveness
9. Continue interdisciplinary education for the team
10. Forge partnerships among drug courts, public agencies, and community-based organisations, which generates local support and enhances drug court effectiveness.[116]

[110] Ministry of Justice (August 2016), Final Process Evaluation, p. 3.

[111] Ibid. p. 7.

[112] Thom, K. (2015), p. 339.

[113] Vote Justice, retrieved 1 July 2017 from file:///F:/RESEARCH/LWL%20-%20Vic%20Uni%20desktop%20docs/MOJ%20docs/MOJ%20budget%202017.pdf.

[114] Thom, K. (2015), p. 339.

[115] Ibid.

[116] Bureau of Justice Assistance (1997).

As described by Dr Katey Thom, who has written in detail about the AODTC, the court operates as follows:

> Following eligibility determinations whereby a potential participant is considered against a set of criteria by the professional team, a treatment plan is created by the case managers tailored to his or her individual needs. Participants then undertake a three-phased programme. Phase one involved intensive treatment and rehabilitation, random drug testing and frequent appearances in court for judicial monitoring. In phases 2 and 3, treatment and random drug testing continue but court appearances decrease and there is a focus on courses and programmes, training, employment and personal goals. As with drug courts worldwide, incentives and sanctions are used along the way and participants exit via graduation following successful completion of the three phases or termination. At the graduation, the AODTC judge takes into account the successful completion of the programme in sentencing.[117]

The AODTC has evolved since its inception in distinct ways. A new team member, te pou oranga, was added in October 2013. Te pou oranga brings knowledge of te reo (language), tikanga Māori and culturally attuned experience of addiction recovery and treatment. The AODTC commences and closes using tikanga Māori (cultural rules) through waiata (song) and karakia (prayer) led by te pou oranga.[118] Te pou oranga supports all participants, regardless of ethnicity, as they move through the court phases, as well as their whānau when appropriate. [119] In particular te pou oranga aims to reconnect individuals with their Māori world, which he currently does through forming strong relationships with AODTC participants and their whānau outside of court.

Te pou oranga is also uniquely positioned to ensure that the court and services provided through the court enhance and protect mana. Mana is a Māori concept or principle with many shades of meaning including prestige, authority, control, power and influence.[120] All aspects of mana are interdependent on each other. Mana-enhancing practice, or manaaki, is values-based and has a spiritual quality to which one aspires and is a way of engaging with others by caring for the spiritual, emotional, physical, and intellectual dimensions of a person.[121]

Treatment providers in the AODTC introduced an additional role of the peer support worker. The four individuals currently in this role are living in recovery themselves and have also been trained in peer support.[122] Further support comes from the 12-step fellowship, referred to as "friends of the court." The team encourages participants' attendance at 12-step fellowship meetings as a connection to a recovery community that can sustain participants after they graduate from AODTC.

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[117] Thom, K. (2015), p. 340.

[118] Ibid. p. 341.

[119] Ibid.

[120] Huriwai, T. and Baker, M. (2016), p. 5.

[121] Ibid.

[122] Ibid.

The Ministry of Justice completed a process evaluation in August 2016. This evaluation does not contain data on reoffending rates or a cost-effectiveness analysis of the court. Evaluators for the MOJ assessment made the following findings:

- Implementation of the AODTC is broadly consistent with its original design and best practices;
- Tikanga Māori are now a normal and essential part of AODTC and daily operations;
- The AODTC team is effective and able to negotiate their role and inter-agency boundaries;
- Processes are working well, although efficiency can be improved;
- Participant access to residential treatment beds and safe and sober housing was a challenge, sometimes requiring that new entrants wait in custody for up to two months;
- Treatment services and relationships have strengthened;
- Processes for keeping victims informed have become more systemised; and
- Experience of AODTC for participants and their whānau is positive and substantially different from their previous court experiences. Participants and whānau describe the AODTC as inclusive, caring and non-judgmental; court processes as fair, with clear and consistent sanctions when breaches occur.[123]

In concluding, evaluators found the following:

> [T]he consensus amongst stakeholders, participants and whānau is that the AODT Court is resulting in transformational change for graduated participants and their whānau. For current participants and some of their whānau members, the court has reduced AOD-related harm. Exited participants also benefited from the AODT Court, in particular understanding the recovery journey and services available like the 12-Step programme. More time is needed to determine whether the outcomes achieved by graduates can be sustained.[124]

Further, preliminary analysis of a small number of participants over a short time period suggests that participation in and graduation from the AODTC reduces likelihood of reoffending by around fifteen per cent when measured against matched offenders who go through the standard court process.[125] Factoring in savings that could be expected from reduced reoffending by this group (based on the seven studied graduates who reoffended within twelve months), it is estimated that:

[123] Ministry of Justice (August 2016), Final process evaluation, p. 114.

[124] Ibid.

[125] Ministry of Justice Cabinet Social Policy Committee, (2017). The large effect measured for graduates is confined to a period of 12 months after graduation, during which they are being managed under a community-based sentence typically imposed and monitored by the AODT Court. It is understood that graduates often continue to receive some amount of support through relationships established in the AODT Court. Measuring reoffending patterns over a longer period would be necessary for a reliable comparison between participants with more independence from the AODT Court and their matched offenders released from prison. The MOJ expects in late 2018 it will be in a position to study whether a larger group of graduates continue to reoffend at a lower rate once they are no longer interacting with and receiving support from the AODT Court.

- A 25 per cent reduction overall would be needed to generate enough crime-related savings in the short-term to recover the estimated $1.3 million per annum of AODTC investment; and
- A reduction of 10 per cent, if sustained over the lifetime of participants, would generate net savings of around $30,000 per participant.[126]

Early analysis also suggests around 60 prisoner places may be directly saved by the two Courts in which the pilot is operating. As noted by the Ministry of Justice:

> Savings can be achieved not only through avoiding the direct costs of imprisonment, but also by reduced risk of reoffending, improving health, employment and other outcomes for offenders and their families, particularly children. There is evidence that having a parent in prison is a strong risk factor for children experiencing adverse life outcomes."[127] In recommending that the pilot be extended for three more years, the Ministry of Justice concludes that early indications are that the AODTC is capable of delivering considerable benefits but that outcomes need to be measured over a longer period to provide confidence that it provides good return on investment.[128]

Dr Katey Thom and Stella Black have recently completed *Nga Whenu Raranga/Weaving Strands*, a study of the AODTC aimed at exploring the meaning and application of the term "therapeutic" in the AODTC. The study consists of four parts: Therapeutic Framework, Processes, Roles and Challenges Faced.[129] The first report examines how the AODTC "weaves together the separate sectors of justice, health and social services through a strong focus on recovery from addiction to reduce reoffending."[130] As concluded by the researchers, "This focus radically transforms the traditional role of the law, legal processes and the roles of legal professionals." Thom and Black acknowledge the AODTC's strong underpinning of the existing best practices. They found that the Court, by addressing cultural needs of offenders, was adhering to the principles of the Tiriti a Waitangi (Treaty of Waitangi) by weaving together aspects of tikanga into the justice system.

The researchers' second report focuses on processes of AODTC and illustrates how law, best practice, recovery and lore are "woven together in unique, dynamic and changing ways."[131] Roles of the AODTC team and other key stakeholders are the focus of the third report, and Thom and Black found that the AODTC reflected the collective interweaving of philosophy and practice. The fourth report details some of the challenges of the AODTC, as noted:

- Team members' had overwhelmingly positive views of working as a team in the legal setting but faced ethical issues surrounding, for instance, the sharing of information;

[126] Ibid.

[127] Ibid.

[128] Ibid.

[129] Thom, K. and Black, S. (2017).

[130] Ibid.

[131] Ibid.

- Demanding workloads with clients who required significant levels of support led to working overtime with no compensation and causing stress, or inability to provide optimal support;
- Lack of ongoing professional development, supervision and training in stress management and self-care, addiction and recovery, cultural competency;
- Lack of access to professional supervision and counselling;
- Inability of community organisations to meet the AODTC needs, i.e., treatment providers, adequate housing; and
- Inadequate Māori representation on the team.[132]

Philosophical challenges have arisen, too, including the following:

- The coercive therapeutic framework of AODTC is at odds with the addiction-related providers' central requirement of self-motivation;
- Unacceptable behaviour for which participants are being treated resulting in discharge from the treatment provider; and
- Tensions between the different professionals involved in the coordination of addiction treatment, given their respective priorities.[133]

Thom and Black acknowledge that the lack of input from participants in AODTC was a research limitation. In conclusion, they acknowledge that a specialist approach might be warranted for high-risk/high-need offenders and locating such courts in larger urban areas could generate efficiencies. They also acknowledge that mainstreaming therapeutic approaches is one way to ensure equal access by the broader population of individuals coming into court with addiction and other health needs.[134]

Te Kooti o Timatanga Hou / The Court of New Beginnings (Auckland)

The New Beginnings Court (TKTH) was established in Auckland in 2009 and attempts to deal with multiple issues of homelessness, mental health and drug dependency in individuals with low-level persistent offending. Offenders are not eligible if they have committed serious offences.[135] The aim of the New Beginnings Court is to ensure that the necessary social and health supports are provided to address the underlying causes (legal, social and health-related) of the offending and the homelessness while also holding offenders accountable and ensuring that victim's issues are addressed.

The Court currently sits one half day per month. A professional team involving representation from police, probation, duty lawyers, social workers from Lifewise and the Auckland City Mission, restorative justice facilitators, Work and Income New Zealand (WINZ), and Housing New Zealand assists the judge in running the programme.[136] A dedicated court coordinator oversees a plan developed for the participant who is monitored by the court. Judge Tony Fitzgerald has presided over this court since its inception.

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[132] Ibid. pp. 9-13.

[133] Ibid. pp.14-15.

[134] Ibid. p. 16.

[135] Thom, K. (2015), p. 337.

[136] Ibid.

The Ministry of Justice conducted an evaluation of TKTH in 2012 and found the following:[137]

- The number of people arrested and number of times they were arrested dropped
- Bed nights in prison were reduced
- Court participants led a healthier lifestyle, were dealing with substance abuse issues and had higher self-regard
- Emergency department visits dropped
- Rough sleeping numbers decreased
- A number of participants received a Work and Income benefit and managed their own finances
- Some participants reported better relationships and more frequent contact with family.

The following critical issues emerged from the evaluation:

- Delay in access to some services were hampering the efficacy of TKTH
- Housing and dedicated AOD treatment beds were needed immediately
- Need for new treatment options to help people with solvent-abuse issues
- Some perception of lack of buy-in from key agencies
- Managerial buy-in from participating agencies and commitment of resources to enable work was necessary to support staff
- The cultural framework could be strengthened by developing stronger partnerships with Māori service providers and to support Māori participants to reconnect with hapu and iwi.[138]

Researchers concluded:

> The issue of homelessness is complex. Nonetheless, there are early indications that TKTH, with its case management approach and commitment to ending rough sleeping and homelessness, may be having a positive impact on the homeless court participants covered in this review. It has been identified by at least some of the participants as a catalyst in addressing the issues underpinning their offending. Although the court has only been operating for a short time, the approach appears to be promising in addressing the underlying causes of offending behaviour and reducing homelessness.[139]

Regarding cost-effectiveness, researchers stated that generally TKTH provided a cost benefit to the criminal justice system.

Special Circumstances Court (Wellington)

The Special Circumstances Court (SCC) in Wellington District Court has been operating since 2012 when Judge (now Justice) Susan Thomas, Public Defender Leah Davison and a Salvation Army staff member launched it with the goal of reducing reoffending by supporting offenders in accessing local resources through Governmental agencies and NGOs to assist offenders with their rehabilitation, with

[137] Woodley, A. (2012).

[138] Ibid. pp. 5-6.

[139] Ibid. pp. 50-51.

the first step being to find them stable accommodation.[140] SCC operates post-plea and excludes individuals with serious charges, such as high-end violence or sexual offending. Participants must be homeless and they must want help with an identifiable need, i.e., alcohol or drug addiction, mental health, accommodation or benefits.[141]

The court meets monthly. Two district court judges, Barbara Morris and Bill Hastings, share judicial duties, but the professional SCC team consists of a public defender, AOD clinician, court liaison nurse, police prosecutor, probation officers, NGO representatives, including a trained staff member from Literacy Aotearoa, and peer counsellors.

The court's AOD clinician serves as the court coordinator, and with input from the stakeholders she develops a treatment plan for each participant that would include, for instance, a path to secure housing, mental health and substance abuse treatment, meaningful employment, strengthened family ties, etc. Case management is done by the most appropriate community agency.

SCC operates with no extra funding from outside agencies. No formal evaluations have been conducted of this court.

One of the other assets to SCC is the group of volunteers from the Wellington Community Justice Project (WCJP). WCJP is a law student-led society at Victoria University of Wellington. The WCJP has twin aims—to improve access to justice in the Wellington and New Zealand community, and to give volunteers opportunities to develop their legal skills. The WCJP works to achieve these aims through volunteer projects and events.

The WCJP service started in SCC, though it has now expanded to cover District Court list courts on Mondays and Fridays. Law students are available to help people in need of practical assistance relating to their welfare.

To Kooti o Matariki (Kaikohe, Northland)

In 2010 the late Chief District Court Judge Russell Johnson took steps to initiate a specialist court in Kaikohe with an aim of increasing the use of section 27 of the Sentencing Act 2002 to allow the whānau, hapū and iwi of an offender to address the court at sentencing and to provide wrap-around services including the programmes and services similar to that offered by programme providers.

The core needs or problems that this court aims to address are:

- The over-representation of Māori in the criminal justice system, in particular in prisons
- A potential adverse view of the justice system for Māori
- That justice system processes are not necessarily designed from the Māori perspective
- The limited use of legislation that supports the involvement of whānau, hapū, and iwi in the court process
- The limited use of te reo Māori at court.

The agreed purpose of the court is to:

[140] Neill, F. (2016), p.19.

[141] Ibid.

- Increase the involvement of whānau, hapū, and iwi in the court process
- Encourage the inclusion of tikanga Māori by actively promoting the use of legislation that supports this in the District Court, such as section 27 of the Sentencing Act 2002 and section 4 of the Māori Language Act 1987 (right to speak te reo Māori in legal proceedings)
- Facilitate offender access to wrap-around services and alternative pathways to address the underlying causes of their offending via section 25 of the Sentencing Act 2002.[142]

In practice, where a person pleads guilty to an offence, but before the court imposes a sentence on that person, the court will allow the offender to participate in a culturally appropriate rehabilitation programme. The offender's iwi, hapū and whānau may be involved in developing the rehabilitation programme. If the offender successfully completes this programme, the court will take this into account when it determines the final sentence.

Family Violence Court

The first Family Violence (FV) Court in the country was established in Waitakere in 2001, followed by Manukau FV Court in 2005. Presently, eight FV courts have been implemented. These courts have the following objectives:

- Provide a more holistic response to family violence than that currently available
- Provide a more timely response to family violence
- Enhance safety for victims and families experiencing family violence; Encourage accountability among offenders
- Provide specialist services to victims, offenders and those involved in the operation of this court.[143]

The most recent evaluation of these courts was conducted in 2008, contracted by MOJ. At the time only Waitakere and Manukau FV Courts were operational. Researchers identified positive aspects of both courts and concluded that: "Clearly proponents of FV Courts are doing much to improve the way courts respond to family violence."[144] The report contained several recommendations, which likely have been addressed in the last nine years, especially given that the FV Court programme has been rolled out to six more jurisdictions.[145]

Sexual Violence Court

Starting in December 2016, a two-year pilot was launched in district courts in Whangarei and Auckland in which courtrooms were set aside with specially-trained judges for all jury trials involving serious sexual offending.[146] The pilot aims to take

[142] http://www.hauauru.org/reports/other-reports/1210.

[143] Knaggs, T., Leahy, F., Soboleva, N., and Ong, S. (2008).

[144] Ibid.

[145] Presently MOJ is in the process of comparing reoffending rates for offenders appearing in a Family Violence Courts for a FV offence with offenders who committed FV offences in other courts. Publication of a final report is forthcoming.

[146] http://www.lawsociety.org.nz/practice-resources/practice-areas/litigation/specialist-courts-their-time-and-place-in-the-district-court.

simple, practical steps that help cohesive and consistent application of existing law. To reduce delays and improve the court experience for participants, it will apply pro-active, best-practice trial management and also improve judicial education. Central to the initiative is an education programme on sexual violence for trial judges, and Best Practice Guidelines developed by the pilot's governance board to drive tighter pre-trial case management.

The first cases were expected to be heard by mid-2017.

Community Justice Centre

The concept of court as a hub of social services is known in justice circles as a community/neighbourhood justice centre model. Judge John Walker, currently the Chief Youth Court Judge and a long-time district court judge, visited the Community Justice Centre in North Liverpool, established in 2005 and modelled after the original community justice centre in Red Hook, Brooklyn, New York. Judge Walker believed that such a centre would be effective in New Zealand, but he and supporters were unable to secure the physical space to create such a centre. Using the concept of bringing community providers into the justice sphere, in 2010 Judge Walker began working with community groups in Porirua to create such a similar model. Judge Walker details the genesis and growth of the Red Hook Community Justice Centre:

> In 1992, in Red Hook, then one of New York's toughest areas, a popular high school principal was shot and killed, caught in the crossfire between two rival drug dealing gangs. The area was already regarded by many as too dangerous to live in or operate a business. Shop fronts were boarded up. People were moving out. What moved in was a new form of court–the Community Justice Centre. In 2000 it took up residence in a disused schoolhouse. The building was large enough to house, not only the court room but all of the intervention services which a court might need to use a problem solving approach to attempt to deal with the underlying causes of offending.
>
> The centre houses social workers, drug treatment services, mediation services, health care, job training, domestic violence counselling programmes, community volunteers. Three District Attorneys and three defence lawyers are based at the centre. The court has a single Judge, Judge Alex Calabrese.
>
> The structure of the court and the services provided was the result of extensive community involvement and the community continues to be involved in the work of the court. The services attached to the court are available to anyone in the community not just those who have committed offences. Victims, families of offenders, and even those who have no connection with the court process at all, can come to the centre for assistance. The court is seen as relevant and connected to the community which it serves.
>
> The result has been a decrease in crime, and a substantial increase in community satisfaction with justice. Businesses have been reopening.[147]

Consolidated list day for the mentally unwell

Judge Walker started a practice in Porirua District Court where he created a special list of all matters related to his cases that involved mental health issues and

[147] Walker, J. (2010).

intellectual disabilities. He heard these cases exclusively during one particular block of time during the week, not scattered through his other list days as would normally occur.[148]

The impetus for specially arranging his court calendar was seeing the "enormous stigma" that individuals suffering from these disorders experienced when they appeared in open court. With the retooled list day, Judge Walker was able to run a more relaxed court, where the stress level is lower and discussion by all court participants is appropriate to the level of understanding of the charged individual.[149]

In contrast to a normal list day, where people flow in and out of court often, Judge Walker's consolidated list for this population was quieter and less chaotic. Everyone was especially sensitised to the particular charged individuals appearing, who were treated with respect by everyone from the police deputies in lockup to the judge.[150]

Solution-focused courts and dockets–Research conclusions

Based on my observations of AODTC, TKTH and SCC, the following characteristics are readily apparent and typical of solution-focused courts around the world:

- **Intense resourcing**–prior to the convening of court, the team meets to discuss the progress of each participant and what will occur at court. The AODTC pre-court meeting I observed involved the judge, eight stakeholders from probation and NGOs, five defence attorneys, and court staff. It lasted for over two hours. The pre-court meeting of TKTH involved the judge, eight individuals and four defence lawyers. And sitting at the SCC pre-court meeting table the day that I attended were the judge, five stakeholders from probation and NGOs, one defence lawyer and two students. In each instance, the stakeholders were present in court when it was convened.
- **Team approach**–the team approach is apparent not only in the large number of people with different expertise focused on the participants, but also in the mutual respect accorded to team members.
- **Flexibility–**there is an expectation that the participant's journey through one of these courts will not be seamless. The team expects bumps in the road and is somewhat dubious if there are none. There is both an understanding that a participant's needs are dynamic and also a collective willingness to understand and address changed circumstances.
- **Procedural justice**[151]–even if a judge were addressing a participant who had violated a condition set by the court, it was done with respect. Judge Tony Fitzgerald, who has always presided over the TKTH, commented that participants like the opportunity to address the judge. Giving a participant the

[148] Interview with Judge John Walker, 16 March 2017.

[149] Ibid.

[150] Visit to Porirua District Court, 23 March 2017.

[151] Researchers like Tom Tyler of Yale Law School have distilled procedural justice to a handful of key elements, namely that court users feel that: (1) They are treated with dignity and respect; (2) They understand the process; (3) They have a voice; and (4) Decisions about their case are made neutrally. For a variety of publications and videos on procedural justice see http://www.courtinnovation.org/topic/procedural-justice.

space to share what is transpiring in his or her life is a way of showing respect. I never sensed that participants were being rushed through their time on the schedule.

- **Cultural sensitivity—**I observed a graduation at AODTC in Auckland, which starts with a haka (ceremonial dance). Seeing the haka performed in such a close setting and watching the faces of the graduate, his family, and the other court participants, it was apparent how moving and emotional the graduation ceremony is. The graduate did not identify as Māori, but he was active in the haka and spoke of his intense experience learning about Māori culture. Incorporating tikanga Māori through waiata and karakia led by te pou oranga appeared to be meaningful to everyone in court, not just Māori.
- **Gratifying experience for court professionals**–the criminal court setting is generally one of gravity, yet the atmosphere of these courts was quite different. Though they expressed different opinions at times, team members appeared entirely unified in their quest to be part of the healing process of participants. The emphasis on healing rather than on punishment enabled team members to perceive their traditional function differently and more positively.

I spent a day in a Rangatahi Court in West Auckland at the Hoani Waititi Marae, where Judge Heemi Taumaunu presided. The day commenced with a powhiri (Māori ritualistic welcoming ceremony on a marae involving speeches, dancing, singing and finally the hongi, or Māori greeting involving pressing one's nose and forehead against another's) where everyone, including the young persons, their family and friends, and all guests of the court, is involved. The powhiri is profoundly moving. Situating a court proceeding on a marae and observing tikanga Māori was a demonstration of great respect for tradition, culture, the young person and his or her whānau (family) and support network.

The many court participants sat around the u-shaped table in each young person's proceeding, from the judge to kaumātua (respected elders) to the police. They balanced the appropriate solemnity of the occasion with a warmth and familiarity that is seldom seen in traditional court. Collectively the participants around the table made up a large community that wanted the young person to know that it cared deeply about him or her, expected the person to repair the harm caused, and would not judge future prospects by mistakes that the young person had made. My overriding thought was that if any process was likely to succeed in steering a young person off a troubled path, Rangatahi Court was it.

The MOJ evaluation of the AODTC quotes many individuals involved in that court, both stakeholders and participants, who found the court "transformational". This word seems apt in describing the potential that these solution-focused courts have for participants as well as practitioners.

Mainstreamed therapeutic programme (Wellington)

For the last few years, the philosophy and processes of the Special Circumstances Court (SCC) in Wellington have been largely mainstreamed in the district court. Given that many of the people walking into that court have some kind of "special circumstance," the SCC case coordinator now offers her "case coordinating" assistance to individuals in court who are not in SCC. The expansion of her role is due in large part to her willingness to take on more work and her deep grasp of community services. Public Defender Service (PDS) lawyer Leah Davison, who is the duty lawyer for the court and duty lawyer supervisor for the courts in Wellington and

Hutt Valley District Courts, and also a major driver of the SCC, has encouraged PDS and other defence lawyers to work with the SCC case coordinator to address some of their clients' needs outside of SCC.

Defence counsel know that the SCC case coordinator can advise a client how to access services. The SCC case coordinator has personal relationships with all of the NGOs and community organisations that offer services to people facing criminal charges, including those with prior convictions. She has up-to-date information on the criteria, for instance, of all alcohol and drug treatment facilities in New Zealand, and she can identify the best one for a particular person and work to get admittance as quickly as possible.

The SCC case coordinator provides "brief intervention services."[152] She focuses on educating the client and creating a treatment plan. In some cases she assists individuals in preparing the paperwork necessary for a particular service. She has been able to flag potential literacy issues and has a contact at Literacy Aotearoa to whom she will refer someone.

Research conclusions

As the SCC case coordinator says, "A little kindness goes a long way."[153] She provides that "kindness" and conducts quick assessments of clients referred to her outside SCC so that she can evaluate their needs. If an individual presents with a mild to moderate mental health issue, typically the SCC case coordinator will ask if someone sees a GP and if yes, she will try to re-establish the relationship. If no, she will try to identify a GP in a convenient location and make an appointment for someone. She identifies many people who present with mild issues of anxiety and depression who "would go a long way with a little help."[154]

Having been in the courthouse for five years has enabled her to build very good relationships with the court professionals and staff. Rather than push off issues that are not in her specialty, she works fluidly with the CLN as they collaboratively try to identify needs. The SCC case coordinator's goal of finding a treatment provider for individuals with addiction issues is frustrated by the shortage of providers, especially those that will accept someone directly from prison. Further, for those presenting with co-occurring mental health and substance abuse disorders, other than CADS (Community Alcohol and Drug Services) it is very difficult to locate agencies that treat both needs.

Ms Davison is a major force in this mainstreamed practice, too, for building a team approach around any individual and suggesting how to build a treatment plan.

The mainstream assistance that the SCC case coordinator provides is ad hoc; she does not conduct systematic screening of individuals.

[152] Interview with Bianca Fernando.

[153] Ibid.

[154] Ibid.

4. TENSIONS WITH THERAPEUTIC COURT PROGRAMMES

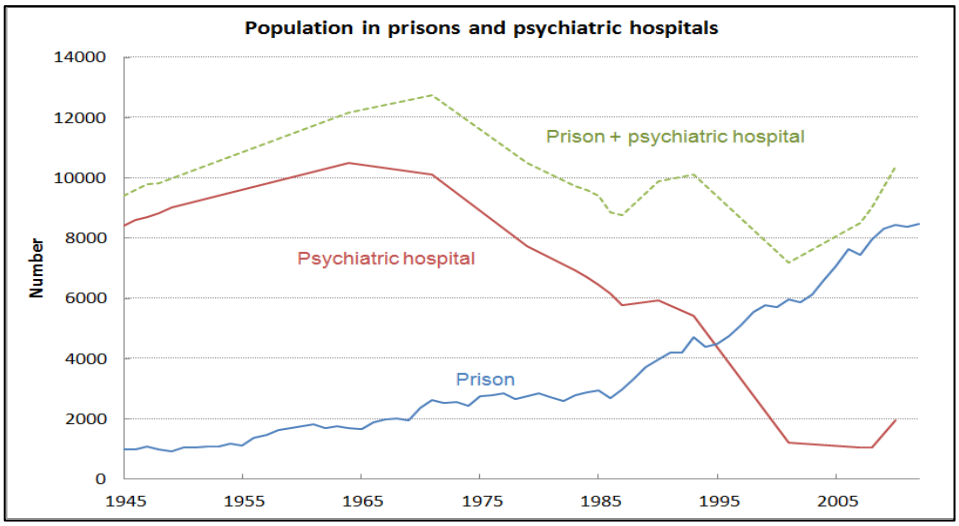
The creation of programmes in the justice system to respond to the high numbers of criminally charged individuals with mental health disorders presents a host of tensions. These incongruities are inherent in both larger practices such as a solution-focused courts and smaller, lower-profile initiatives or practices that provide special attention to a particular kind of individual coming into court. Therapeutic court programmes can generate the following tensions:

- Failure to address root of the problem
- Zip code justice
- Punitive coercion
- Net-widening
- Queue-jumping
- Proportionality
- Personality-dependent programme.

Failure to address root of the problem

One of the tensions surrounding therapeutic court programmes is their inability to address the root of the problem, which in many jurisdictions is asserted as the failure of the public mental health system to provide criminally charged individuals with needed services.[155] New Zealand underwent deinstitutionalisation, or the discharge of patients from psychiatric hospitals, starting in the 1960s (Figure 7).[156] Current New Zealand Criminal Bar Association member Tony Bouchier of Auckland has stated

Figure 7. Population in prisons and psychiatric hospitals



[155] Council of State Governments, Training & Advocacy Support Center (October 2006), Fact Sheet: "Mental Health Courts", p. 5.

[156] Brunton, Warwick (2011). Planning for new psychiatric hospitals ended in 1963 and no extra beds were provided from 1973. Instead, from the 1970s psychiatric services came to emphasise outpatient care, community-based treatment and more modern facilities. Every mental hospital patient was assessed, and 26% of psychiatric and 46% of mentally disabled patients were recommended for accommodation outside the major psychiatric hospitals.

that the lack of mental health institutions is a major cause of the rise in prisoner numbers. He says: "One of the main reasons the prison muster is so high is that our prisons are our proxy for our mental health institutions which we no longer have."

Indeed there is a historical association–not evidence of causation–between the rising prison population and declining psychiatric hospital population.[157]

In addition to a legacy of deinstitutionalisation, availability of mental health treatment–including substance abuse treatment–is limited, and many find it challenging to access. One judge in Canterbury stated:

> We are in a mental health crisis here in Christchurch. Our services are stretched since the earthquake. We didn't get many more resources after the earthquake and now we are reaping the cost in terms of mental health.[158]

While acknowledging that many health providers make major contributions to individuals' well-being, advocates for change have identified "chasms" in mental health service provision.[159] Coroners' and media references to serious service shortfalls and breakdowns have elevated the discussion around the need to transform the mental health system.[160]

If the mental health delivery system is as strained as many believe, creating therapeutic opportunities in court may be especially challenging. As referenced earlier, even participants in the AODTC, well-funded and optimised for quick access to treatment, face delays of up to several months to obtain in-patient treatment.[161]

> Jessica is in her early twenties and under intensive supervision with the court prior to sentencing. She is a P (meth) addict with mental health issues, but she has been clean for 4 months. After being charged with a drug offence, she spent the first two months in prison, then another two in a community shelter in Auckland. She is waiting for a 28-day in-patient treatment bed. According to the judge in her case, she might wait "up to a year" for a bed.
>
> ~Observations at Auckland District Court

Zip code justice

Specialist court programmes in certain parts of the country and practitioner-led therapeutic initiatives in particular courts create a system of inequality. Access to these programmes depends on where one lives, or more precisely, the district in which one is accused of offending. In many cases these programmes are diversionary from prison, sometimes even from conviction, and they offer a holistic support network that simply does not exist in mainstream court. The opportunity for justice–or for a chance

[157] Christie, S. (2013), MOJ Analysis (unpublished) of published New Zealand Official Yearbook data.

[158] Interview with Christchurch District Court Judge.

[159] Elliott, M. (April 2017).

[160] See, e.g., PSA (11 May 2016); McBride, N. (23 May 2017): Shadwell, T. (26 March 2017); Wesley-Smith, M. (22 April 2017).

[161] Judge Tremewan, one of the presiding AODTC judges, frequently repeats a mantra that the justice system has "50 days" to most effectively connect an addict to treatment.

to leave the criminal justice system in a considerably more stable place than at entry–hinges serendipitously on one's postcode.[162]

Many involved in the criminal justice–from practitioners to policy-makers to academics to reformers–believe mainstreaming practices are the antidote to zip code injustice. Barriers certainly exist to unifying court practices around New Zealand, but mainstreaming therapeutic opportunities addresses the present inequality of access to them.

Punitive coercion

With most solution-focused courts, including all in New Zealand (except youth courts), individuals charged with crimes must admit guilt in order to become participants in those specialty courts. The alternative is to challenge the state's case and be punished more severely–often incarcerated–if convicted. This raises a coercion dilemma.[163]

Solution-focused courts receive their caseload only after the entire team of judge, prosecutor, defence attorney, probation officer and treatment professionals together assess the case and determine whether an individual meets pre-determined criteria including a commitment to treatment. Factual guilt is assumed and legal guilt is scarcely an issue.[164] If the team finds someone eligible, it is the defence attorney's job to convince the defendant to plead guilty or face usually incarceration if insisting on legal innocence. It is the judge's job to accept the guilty plea and set the client on the team-mandated treatment path, as well as to preside over regular post-conviction hearings which the participants will attend to demonstrate compliance over time.[165] Problem-solving courts almost eliminate the guilt phase entirely in the name of helping the offender and the community.

Judges often take on the role of social workers in solution-focused courts. In describing the role in one such court, a critic has written that:

> The judge is not an impartial person, wearing a black robe, looking down on participants . . . the judge works to achieve justice and public safety while solving participants' problems, such as homelessness.[166]

Some argue that these new "courts" are "not courts at all, but actually are correctional agencies."[167] In examining the proliferation of drug courts in the United States thirty years ago, it has been posited that judges became more hands on because they could not turn over offenders to probation services, which were starving for resources.[168]

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[162] Judge John Walker uses the phrase "zip code justice." Thom & Black reference the labels "justice by geography" or "postcode justice" generated in Australia in response to the small numbers of offenders who can participate in a solution-focused court. See Thom, K. and Black, S. (2017), p. 16.

[163] McCoy, *et al.* (2015).

[164] Ibid. p. 164.

[165] Ibid.

[166] Ibid. p. 168.

[167] McCoy, *et al*. (2015), p. 162.

[168] Goldkamp, J. (2000). Although my research did not focus on the probation phase, many of those I interviewed asserted that probation officers carried a heavy caseload and did not serve in a holistic role as they had done in the 1980s.

Proponents of solution-focused courts claim that the black robe impresses court participants, and they are therefore willing to "harness the symbolic power of the court to create better communities and persons."[169] Judges increasingly take on other functions as they use the law not as proof-finding and evidence-testing in determining guilty but as "instrumental for achieving policy goals."[170]

A small portion of solution-focused courts around the world admit participants prior to pleading guilty and upon successful graduation, charges are dismissed. Such a course avoids one aspect of the coercion dilemma.

> To be admitted to the AODTC, a client must admit all charges. Some clients say that they are guilty of some charges but not guilty of others, but they must relinquish their right to innocence on everything. And if a client is exited from the Court before graduation, it presents challenges to a defence lawyer because my client is stuck with having pleaded guilty to all charges and we need to try to vacate the plea. In normal plea-bargaining, the client would not need to admit to all offences.
>
> ~Interview with criminal defence lawyers

Net-widening

Net-widening is defined as the "process of administrative or practical changes that result in a greater number of individuals being controlled by the criminal justice system. The net of social control is widened to manage the behaviour of a greater number of individuals."[171] Relying on the metaphor originated by social control theorist Stanley Cohen, Dr Elizabeth Richardson analyses net-widening in the context of mental health courts in Australia, but the structure she uses is applicable to any of New Zealand's therapeutic programmes.[172] She identifies three ways in which the "net" is expanded—it may be wider, denser or different.[173]

Looking at such programmes, one examines whether more people are being caught in the "net" of a programme, kept there for longer and made subject to more intense programmes or sanction or treatment than they would have received but for the new programme.[174]

Wider nets. Wider nets, also known as front-end net-widening, is "the process that may occur when the offender first comes into contact with the criminal justice system

[169] McCoy, *et al.* (2015), p. 168.

[170] Rubin, E. (1991).

[171] Leone, M. (2002).

[172] Richardson, E. (June 2016). Dr Richardson identified net-widening problems found at the front-end of mental health courts: in eligibility criteria, selection and assessment processes, informed consent procedures and acceptance into mental health courts. She also discusses concerns with the way in which that mental health courts operate at the back-end such as the length of the program, use of conditions, assessment of compliance and use of sanctions and rewards.

[173] Ibid. pp. 23-24.

[174] Ibid. p. 125.

and is drawn in as a result of the programme, even though the person was not at risk of prison or other serious sentence."[175]

Denser nets. Denser net-widening occurs when:

> [P]articipants are subjected to more intense sanctions than they would have received if the diversion programme did not exist. This can occur in a number of ways: through longer programme times, intensification of programmes and conditions, monitoring and surveillance, and sanctions and rewards. This is also known as back-end net-widening and arises from further sanctions or technical violations when the offender is already serving a sentence or undertaking a pre-sentence program.[176]

Different nets. Referencing Cohen, Richardson suggests that "programs such as diversion and community-based 'alternatives' to prison can lead to new agencies and services supplementing rather than replacing the original set of control mechanisms: that is, different nets."[177] And individuals may move back and forth from old net to new net, i.e., the offender may be moved from the criminal justice net to the treatment net and back again to the justice net if not successful in the programme.[178]

> If a client is admitted to AODTC, completes part of the programme and then exits, either by the court or on his own, he winds up right back in the regular district court, but he has spent months adhering to very strict requirements set by the court. The client may have benefitted from being part of AODTC, but no credit is automatically given for this time of partial compliance and restriction.
>
> ~Interview with criminal defence lawyers

Queue-jumping

One policy issue that has been raised surrounding solution-focused courts is that rather than creating more services–drug or mental health treatment–the justice system has simply moved a group of people to the head of the queue for these services.[179] The effect of this queue-jumping means that the previously served people, or those who had been in the queue, become unserved in a system with the same fixed resources as existed before the implementation of a solution-focused court.

> Why should criminals get access to services in New Zealand before the rest of us?
>
> ~Uber driver comment when hearing about my research, February 2017

[175] Ibid. p. 126. Often there is pressure to focus resources on lower risk offenders who appear more cooperative and motivated to comply with treatment demands than high risk offenders. Subjecting low-risk offenders to interventions intended to reduce criminal behaviour, however, can actually increase their likelihood of reoffending. Bonta, J. and Andrews, D. (2007), p.10.

[176] Ibid. p. 130.

[177] Ibid. p. 149.

[178] Ibid.

[179] Steadman, H., Davidson, S., and Brown, C. (2001).

Proportionality

The Sentencing Act 2002 requires that a judge in sentencing "hold the offender accountable for harm done to the victim and the community by the offending."[180] This could be interpreted as requiring an element of retribution to achieve justice. Retributive justice requires that an offender receive punishment that is in proportion to the severity of the offence and the culpability or blameworthiness of the offender.

Critics of specialty programmes assert that less overtly punitive initiatives such as solution-focused courts or other diversionary initiatives pay little heed to proportionality or parsimony.[181]

Proponents of therapeutic programmes defend them, stating that mental health disorders manifested by individuals charged with offences is understood in therapeutic circles as rendering them less culpable and more amenable to prevention through treatment than ordinary offenders who commit similar crimes. Thus the principle of proportionality would prescribe punishment that is less severe than that applied to unimpaired offenders who commit similar offences.[182]

Personality-dependent programme

A judge often initiates the development of a solution-focused court and through passion and commitment generally drives the court's progress and evolution. As noted by one researcher, the judge is "on the 'front-stage' as in a drama, speaking personally and carefully to each participant with a supportive and [parental] demeanour."[183]

The AODTC Final Process Evaluation included the following notes about the role of the two AODTC judges:

- The judges are seen as hugely committed to the vision and goals of the court;
- [T]he passion and drive of the AODT Court judges is widely acclaimed by stakeholders, and participants and their whānau;
- The AODT Court judges have a special relationship with participants, which contributes positively to their recovery journey; and
- Efforts are made to ensure relieving judges are kept informed of changes to policies and processes to ensure consistency within the court, as they attend court infrequently. However, this was noted by some as an area to strengthen further.[184]

The AODTC judges have been described to me as the "heart and soul" of the court.

Concerns frequently arise that a court and court participants depend excessively on the judge or other particularly engaged members of the therapeutic team. As such, the perception is that the loss of the one of these persons would strike a blow to the court and impede progress for its participants. A deeply involved member of the therapeutic

[180] Sentencing Act 2002 s. (7)(1)(a).

[181] Tonry, M. (2013).

[182] Schopp, R. (2013), pp. 165-66.

[183] McCoy, *et al*. (2015), p. 168.

[184] Ministry of Justice (August 2016), Final Process Evaluation, pp. 39-40.

court team in another solution-focused court told me of worries that the court's future would be jeopardised if this person left.

5. COURT GAPS FOR THE MENTALLY UNWELL

The criminal justice continuum is long, running from an interaction with the police to probation or parole and everything in between. I have seen innovative practices in all agencies on the continuum. For instance New Zealand Police are piloting Iwi Panels (with involvement of the Ministry of Justice and Department of Corrections)[185] and Watch-house Nurses.[186] The Department of Corrections is identifying additional opportunities for individuals in and after prison such as Out of Gate, developed in conjunction with the Ministry of Social Development. This programme helps offenders prepare for release and makes sure they can access community support after release to address their specific needs such as housing, health, income, family and employment. Because I have spent much of my professional legal career physically in courts, I have focused on that point on the continuum.

The spectrum of disorders seen in court is wide, spanning disorders from mild depression to psychotic breaks. Many people I interviewed identified a gap for those with "mild to moderate" disorders, encompassing substance use disorders. This is a group whose needs appear to be unmet in any kind of systematic manner in court. As one CLN told me: "I've been here long enough to see people with moderate issues come through again and again."[187] Others have commented that in some cases, the experience of going through the criminal justice system triggers a mental health issue like anxiety or depression.

From what I observed in district courts around the country, a small portion of charged individuals with mild to moderate mental health disorders are being served exceedingly well by court programmes, but an opportunity exists to address more widely those individuals cycling through courts in all parts of the country. Below I describe generally the benefits that could be provided by filling the gaps:

- Standarised assessment tool
- Pretrial programme as alternative to prison
- Therapeutic assistance if bail is uncontested.

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[185] An iwi panel is a meeting at which a panel of community members, an offender, victim and their whānau discuss the offence committed. They work together to address harm caused, develop a plan that addresses factors related to the offending, and help get the offender's life on a more positive path. Māori and non-Māori adults who commit a "low-level" offence such as shoplifting or careless driving can be referred to the panel by Police before they're charged. They're invited to participate in finding a solution or to remedy the effects of their crime. Panels adopt a problem-solving approach to address factors that contribute to offending. Akroyd, S., *et al*. (June 2016).

[186] The Watch-house Nurse (WHN) initiative began operating at the Christchurch Central and Counties Manukau Police station watch-houses on 1 July 2008 and 1 August 2008 respectively. The initiative was intended to run as a pilot project until 30 June 2010. The initiative places appropriately qualified nurses within these two watch-houses to assist the Police to better manage the risks of those in their custody who have mental health, alcohol or other drug (AOD) problems. Where appropriate, the nurses also make referrals for detainees to treatment providers. Paulin, J. and Carswell, S. (August 2010).

[187] Interview with CLN, 21 March 2017.

Standardised assessment tool

Unwell individuals flow through the courts daily. If they are remanded they find themselves in prison where, within seven days according to Corrections policy, a mental health specialist will assess them. Defence lawyers have told me that this does not always happen so quickly and that some may be back in court for a bail hearing prior to a prison mental health assessment. Many unwell individuals who experience mental health disorders that are determined to be less than acute (in which case they follow a path proscribed by the CP(MIP) Act) are released either after their first appearance or after a bail hearing, most walking back out of the door to chaotic lives. Many have serious, undetected, and untreated mental health needs, as well as a host of other day-to-day challenges.

Presently, no standardised assessment tool exists in courts to identify mental health and substance use disorders. At times, it is obvious to court practitioners that an individual has these issues and other socioeconomic disadvantages. The CLN or AOD clinician may have been alerted to see an individual and will conduct a quick assessment. If an issue has been identified but determined not to be acute, and the individual is released, no system is in place to connect him or her to any medical or social service help. Some defence lawyers may try to find appropriate referrals for their clients, and some CLNs and AOD clinicians may give referrals to an individual they interview. There is no consistency, however, across the system.

At other times, mental health and addiction issues are not obvious. I asked one CLN whether she ever missed someone with a mental health issue, and she responded: "of course."[188] CLNs are not tasked with doing systematic screening; they only screen someone who has appeared in the DHB database or been flagged for them by another court professional, i.e., a defence attorney or police officer.

Pretrial programme as alternative to prison

Even if a court practitioner has identified an individual with a mental health or addiction issue, no system-wide court programme is in place where a designated person provides organised access to treatment or social services. Well resourced, coordinated assistance is available if someone has been admitted to one of a handful of solution-focused courts in the country. Other individuals may face criminal charges in a district court where a member of the court team has time, energy and knowledge of local resources to put together a treatment pathway. The justice system, however, does not provide equal access to such professional, therapeutic assistance; it has been called a system of zip code justice.

The lack of equal access results in groups of people–based on geography–being dramatically disadvantaged. First, if someone's release is not contested, he or she leaves court without a coordinated process to address his or her needs. Second, if release is at issue, someone's chances of release are diminished because the system provides no therapeutic path as an alternative to prison. Almost all of the judges I interviewed expressed frustration at the lack of information they had about an individual at the bail stage. Not only do judges desire to know more about someone's needs, but they may be willing to entertain release if a plan–a treatment pathway–is in place to address those needs. Judges must ensure safety of the community.

[188] Interview with CLN.

Pretrial services programmes, commonly found in the United States, Canada and Australia, offer the court alternatives to prison by offering a viable option to manage charged individuals in the community. They can be a valuable resource for making significant improvements in the criminal justice system because they are implemented in the early stages of a case. Charged individuals and the community benefit because someone on pretrial can maintain a job, support their families and are not a burden to the taxpayer. Additionally, these individuals can access treatment services provided by community resources that are not available if the charged individual is incarcerated. Further, pretrial programmes operate at a fraction of the cost of prisons.[189]

Implementing a pretrial programme would be a significant undertaking for New Zealand. My recommendations for creating a Health Navigator role and enhancing roles of other professionals in court constitute a set of initiatives that are easier and less expensive to implement and could be a springboard to a pretrial programme.

Therapeutic assistance if bail is uncontested

Court is a consequential stop along a chaotic path for some of the most marginalised in society. As noted by Peter Hutchinson, a lawyer who has been practising criminal law for close to 20 years, many persons charged with low-end offences turn up in court with a "cluster of issues."[190] If bail is uncontested, these individuals with multiple needs may spend very little time in court. At times it is obvious that someone has issues; she is not wearing shoes and looks like she has been sleeping for days in the same clothing, or he reeks of alcohol. Others present moderately well, but after a conversation, a lawyer might learn that their living situation is unstable and that they appear to be in a depressive state.

Currently, no court systems are in place to identify any health and socioeconomic needs and–equally important–to address needs that are revealed. As noted earlier, some charged individuals might get assistance if they are admitted to a solution-focused court or if their lawyer or another court professional has the time and access to resources and can make a referral or develop a treatment plan. Access to treatment or, more comprehensively, to skilled professionals who can develop a treatment plan, is inconsistent across the country.

The physical structure of court itself presents an ideal opportunity to provide assistance to the most needy. The market of individuals who need assistance is substantial in court. Given the consequences of what might happen in a criminal case, appearing in court also represents a critical point on the life continuum, where individuals may be more open to change or receiving help. Viewing court strictly as a building where people process through their court case rather than a community hub is a missed opportunity.

6. THE SOCIAL INVESTMENT QUESTION

A core purpose of New Zealand's justice system is to make the country safe and just. The court system exists for the people of New Zealand, particularly for those flowing through courts. As Andrew Bridgman, Secretary of Justice, stated: "If we think [the

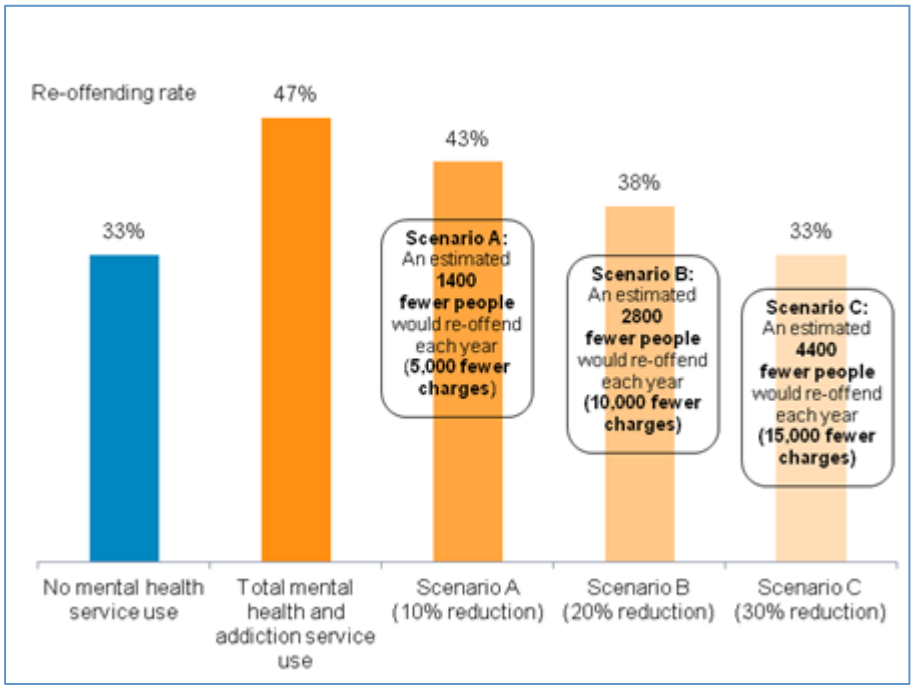
[189] I discuss pretrial programmes in more detail starting at p. 57.

[190] Interview with Peter Hutchinson, 9 March 2017.

court system] is about them and not about us, we must continually think about what their needs are and whether the court system meets those needs."[191]

Individuals charged with crimes make up one of the justice system's largest and costliest customer groups, many with mental health needs that are currently unmet in the court system. As depicted in Figure 8, targeted initiatives for people with mental health and addiction needs could reduce offending significantly.[192] A 20 per cent reduction in this group equates to 2800 fewer individuals reoffending and 10,000 fewer charges.

Figure 8. Re-offending reductions with targeted initiatives



With the data that the Ministry of Justice has generated of people charged in court with an indicator of mental health needs, it is apparent that those with co-occurring disorders have the most serious criminal histories, present with the widest array of socioeconomic disadvantages, and have the highest reconviction rates. Using the Bonta and Andrews framework, this is the high-risk/high-needs group.[193] Focusing on this population is likely to yield the greatest return on investment.

Simply adding specific mental health treatment options to individuals in the court system is not enough; their needs are much wider, though treatment is indeed an important one. Practitioners in solution-focused courts understand the range of needs that many court participants present. The holistic approach is an essential ingredient to their design. Seldom if ever does an individual present with just one need. Rather,

[191] Bridgman, A. (19 November 2015).

[192] Horspool, N., Analysis, Ministry of Justice 2017. Access to the data presented was managed by Statistics New Zealand under strict micro-data access protocols and in accordance with the security and confidentiality provisions of the Statistics Act 1975. These findings are not Official Statistics. The opinions, findings, recommendations, and conclusions expressed are those of the researchers, not Statistics NZ, the Ministry of Health or the Ministry of Justice.

[193] Bonta, J. and Andrews, D. (2007), p. 10.

the alcoholic is estranged from her family and living in a home with an abusive elder. Or the man with major depression has been unemployed for a year, and he has no identification or stable address.

Investment should be in the person rather than the need and must be culturally appropriate. Te whare tapa whā health model is instructive here. To optimise the chance of keeping an individual out of the justice system in the future, the goal should be to repair and restore each of his or her four dimensions–physical, spiritual, mental and family health.

7. RECOMMENDATIONS

Judicial and practitioner innovation account for many of the most dynamic and transformative court programmes in New Zealand. Such ground-up change is not entirely surprising; no one is closer to the challenges or more practical with solutions than the persons who work on the frontlines every day. Further, those who have worked in criminal court for decades have a unique ability to identify gaps in the system. They have a clear window into the damage that individuals have experienced and caused. It is common for a judge or practitioner to be able to remember distinct details about a defendant and case from many years earlier. Cases are not primarily about outcomes for most who practise criminal law; they are about humans.

In a country as small and historically agile as New Zealand, system-wide change is entirely possible. Reconceptualising the justice system as one with therapeutic goals and mainstreaming innovative ideas already operating in courts around the country would revitalise a system that serves "customers" who often have been slipping through gaps since childhood. As other government sectors, e.g., police, corrections, health, education, and social development, scrutinise their own capacities for improving well-being for their customers, the court space is where the Ministry of Justice takes the lead.

To capitalize on the opportunities that I have outlined, I recommend the following to the justice and health sectors:

- Create a new position in court, the Health Navigator
- Develop a Pretrial Service Programme
- Expand the role of court liaison nurse
- Expand the role of alcohol and other drug clinician
- Collaborate with iwi and others to develop community-led supervised accommodation
- Consolidate court calendars of defendants with mental health issues
- Provide additional judicial resources and specific training on various mental health and neurodevelopmental and cognitive disorders
- Consider future implementation of a Mental Health Court.

An overall challenge in implementing these initiatives is for government agencies and community partners to work together and tailor their services to meet the individual needs of New Zealanders who flow through the justice space. Continuity of care must be an overarching goal rather than bolting on a programme here or there and risking service gaps. Prior to implementation of any of my recommendations, the following key issues need to be resolved:

- Accountability
- Funding

- Ownership of and access to information obtained
- Effective handoff to other agencies.

Focusing on customer well-being implies that, rather than investing in pilots that take time to evaluate and trigger many tensions, as addressed above, the justice system would be well-served by exploring investment in a pretrial services programme that mainstreams ideas that have been proven effective in other jurisdictions. Perhaps a model similar to that found in the United States or Canada or Australia can be developed over time for implementation.

More immediately and as a springboard to a formal pretrial programme, I recommend creating a new role in courts, the Health Navigator. This person would work closely with the CLN and the AOD clinician, whose roles could be enhanced and better supported. Collectively, these individuals as well as the defence lawyer and other professionals and community organisations found in court, would constitute a therapeutic team with goals of identifying needs in an individual facing criminal charges, developing a treatment plan and assisting the individual in accessing treatment and services.

Practices that have proven meaningful and effective in pockets around the country that could be mainstreamed with the help of this therapeutic team are as follows:

- Non-adversarial approach (emphasis on healing & treatment)
- Procedural justice
- Team to maintain supportive, socially positive environment
- Early intervention
- Direct supervision
- Individualised treatment/assistance plan
- Reducing stigma/shame
- Cultural awareness
- Peer support.

A model similar to my proposed therapeutic team is operational in the Wellington District Court, as noted earlier in this Report.

Health Navigator

A new addition to the court professional team, the Health Navigator, would assess and assist clients to address issues that affect their health, wellness and connection with the community they live in.[194] The ideal Health Navigator is an experienced social worker, ideally with alcohol and drug assessment skills, with an understanding of the justice system and deep connections to local community services. She or he should be

[194] I deliberately chose the title "Health Navigator" based on several reasons. The role of these skilled professionals is fundamentally about te whare tapa whā, all dimensions of health. Good health and well-being are only achieved with balance in life through obtaining mental health and addiction treatment and also finding a stable home, income, relationships, etc. "Navigator" is a role in the services provided by Whānau Ora, an approach that places families/whānau at the centre of service delivery, requiring the integration of health, education and social services, which is improving outcomes and results for New Zealand families/whānau. The Whānau Ora Navigator seeks to work with Māori not enrolled with a medical service and their whānau to link with general practice services or alternative health care teams. Whānau Ora Navigator Service, (undated). Retrieved 2 July 2017 from http://whakapaihauora.maori.nz/information/whānau-navigator-service-i-27.html.

trauma informed, as a large number of individuals facing criminal charges have trauma histories.

The goals of the Health Navigator should be as follows:

- Conduct assessments of health and socioeconomic needs of individuals in court facing criminal charges
- Identify and facilitate access to appropriate health care services, including alcohol and drug treatment, for such individuals
- Develop a complete treatment plan by addressing other socioeconomic needs such as housing, employment, education, literacy, benefit access, family and community relationships, lack of identification documents, and also provide education about and referrals to community services
- In cases where bail is contested and the court requests it, provide a treatment plan to the court
- Draw on the team of court professionals and NGOs and existing networks and connections in the community to meet the needs of a client in a culturally appropriate manner
- Send reminders of court appearances
- Assist in any restorative justice processes as appropriate
- Maintain continued contact to support the individual up to resolution of the case.

Assessments

Given the high number of individuals flowing through some courts, screening of every single person, as least initially, is unrealistic. The following three groups should be screened: (1) individuals in custody, (2) individuals where bail is contested, and (3) those referred by a defence lawyer or other source, i.e., CLN, family member, or community provider that is familiar with the individual facing charges.

The goal of the assessment is for the Health Navigator to explain his or her role clearly and to identify health and socioeconomic needs for purposes of creating a treatment plan. The tool should be a set of questions to quickly gather information about the following: residential history, family, education, employment, physical health, mental health, substance use and treatment history, and whether on any benefits. A defence lawyer can be present for these assessments. Information on the assessment would be self-reported, which may not always be the most reliable, but it enables the Health Navigator to compose a plan.

Health Navigator supervision as alternative to prison

The Health Navigator is ideally positioned to create a treatment plan and offer to supervise or oversee an individual if released, ensuring some degree of contact for an individual with a member of the court professional team. Where bail is contested, the Health Navigator should be prepared to share a treatment plan and engage in dialog with the court. Judges whom I interviewed were hungry for more information at the early stages of a case. The Health Navigator would not be equipped with or trained to use risk assessment instruments akin to those used by pretrial service programmes around the world. Despite lack of information from these instruments, which might be implemented in the future, a judge would have more information with the Health Navigator's input that could inform a decision regarding release or remand.

> Roger lost his first bail hearing and was remanded. Just the same, with help from the AOD clinician, Roger's lawyer devised a treatment path for him. This constituted a change in circumstances, and at his next bail hearing his lawyer presented a package to the judge that included an appointment with a general practitioner for a mental health assessment, enrollment in an 18-week anger management class, and a stable housing arrangement with a strict relative. Roger was released with a 24-hour curfew.
>
> ~Notes from interview with a public defender, 16 June 2017

Health Navigator and therapeutic assistance for low level offenders

Most individuals coming into court have never received help in navigating outside health and social services as the Health Navigator could offer. Many present with a "cluster of issues" at an especially pivotal point in life. The Health Navigator is situated to generate referrals, make appointments and provide solutions to what may be relatively straight-forward issues but that can be overwhelming. Court presents an opportunity to stabilise some of the chaos of people's lives.

> Mr W was 55 years old when he faced another round of burglary and intimidation charges in District Court. He committed his first burglary at age 7 and had spent 33 years of his life in prison. Everyone in court knew him. Through the efforts of a team in court, Mr W found suitable housing, a meaningful job, and for the first time as an adult built a stable and calm life for himself. He was sentenced to 6 months supervision with "counselling as directed". Today he is sober, runs a community space, mentors other individuals who have similar stories, supervises people doing community service work and serves as a Māori cultural liaison for other persons going through the court system.
>
> ~Interview with PDS lawyer, March 2017

Other aspects of the role

The Health Navigator would work with the CLN, AOD clinician, lay advocates, community treatment providers, court staff, NGOs and any other professionals or treatment providers with services to offer. In courts where predominantly Māori individuals face charges, hiring a Māori Navigator is optimal. At the very least, the Navigator should be trained in cultural issues especially relating to Māori and Pasifika, and should maintain strong relationships with both communities. The

AODTC provides practical and valuable illustrations of weaving tikanga Māori into the court philosophy and practices.

For those who have a relatively stable life but lack employment, the Health Navigator could seek to connect an individual to Work and Income New Zealand (WINZ) or elsewhere for tools to enable someone to support him or herself and family.

Providing notification of upcoming court appearances (including phone calls, recorded phone messages, mail notification, text messages and emails) has been shown to be highly effective at reducing the risk of failure to appear.[195] The Navigator should be able to design an effective notification system except for those who do not have a stable residence or cell phone. In other cases, notification should be straight-forward and not time-consuming.

Cost and risk are low if MOJ were to trial a Health Navigator in four courts, for instance, over the course of three years. Based on available information, the cost would likely include salaries of four Navigators, estimated between $65,000 and $85,000 per year, management overhead, project management and evaluation, plus office equipment, including computers.[196] Data should be kept and anonymised, and later used to evaluate the effectiveness of the role.[197] All such evaluations should be made public.

In many respects, the SCC case coordinator/AOD Clinician serves in this Health Navigator role in Wellington District Court. Although she would not have the capacity to serve as the Health Navigator in the robust role I envisage, she serves as an example of innovation that sprang up to address a need so evident to those on the frontline in Wellington court.

Enhance the role of court liaison nurse

Enhancing and supporting the role of the CLN would further improve service from this highly valuable specialist. Currently CLNs enjoy a great amount of autonomy but generally feel that their work in the court is primarily for the judge. Expanding this to support a commitment to work equally for the "patient" or "client" would bolster their mission to provide assistance not only to those with acute issues but also to those presenting with mild to moderate mental health disorders.

The CLN is uniquely qualified to conduct assessments with a broad goal of identifying any mental health issue, not just acute issues that might raise issues of fitness or sanity. With the CLN as a consistent resource to conduct initial assessments of people presenting with a potential mental health issue, the court therapeutic team can better fashion a treatment plan. Further, the CLN might be the right team member to do some case management of particular individuals, perhaps if the primary presenting issue is a mental health disorder.

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[195] See, e.g., Rouse, M. and Eckert, M. (1992); Jefferson County Court Notification Program Six Month Program Summary, Jefferson County, CO; Herian, M. and Bornstein, B. (2010); Kainu, M. (2014).

[196] These costs are derived from materials referencing salaries for individuals in similar roles.

[197] It would be beneficial to get this data into the IDI to be able to track people (anonymised) through time as a measure of effectiveness. Therefore, the Health Navigator would need a system of collecting personal identifiers for the purposes of linking into the IDI.

Given that forensic mental health services are funded to work with the people with serious mental health issues, expanding the role of the CLN will require a reformulation of their role. Additional resources would likely be needed to support an expanded workforce.

As recommended in a study of the role of CLNs, the following would improve the service of this workforce:

- Establish a framework of standards and competencies for practice, an ethical framework and an educational pathway for the CLN role
- Articulate a common understanding of the CLN role, which is broader than the current definition
- Implement credentialing, which would ensure a framework, identified measurable competencies, education, support structures and a means for evaluation
- Create path for advanced practice roles and specialist opportunities.[198]

Integrate DHB databases

In a country of 4.8 million, with health service being divided into twenty district health boards (DHB), integrated health databases would be beneficial. Presently a CLN has access only to the database of the DHB where she practices. Further, some DHB databases store records electronically for a limited amount of time. The Auckland DHB database goes back to 2009. In contrast, the Canterbury DHB database retrieves information as far back as the 1990s. Although it does not store earlier records, the system will provide a "legacy alert," signalling that a person has had earlier clinical contacts.

The DHB database is one of the most valuable sources of information for the CLN. Currently, the information retrieved is an incomplete record that can lead to costly, time-consuming procedural problems. I recommend that all DBH databases be integrated.

The most natural, straightforward and cost-effective way to achieve integration for research, analysis and policy development purposes is likely within the IDI. The IDI already contains quite a bit of data from the Ministry of Health, so privacy concerns are solvable.

> Joe was 41 and charged with a domestic violence offence in Auckland District Court. He had been convicted 40 times, mainly on domestic violence charges. His sentences ranged from community service to intensive supervision to prison. The CLN nurse had no health history for him via the DHB database, and he presented well enough when she quickly interviewed him. Joe pleaded guilty in the case. Probation's Pre-Sentence Report reflected that Joe had received services 10 years earlier and had been under the oversight of a Regional Intellectual Disability Community Care Agency. Several reports later, an expert concluded that Joe had an IQ of 40. His guilty plea was vacated. Two more reports were ordered after which Joe was unfit to stand trial in his case. A fifth report, this time regarding disposition, was ordered, recommending that he become a care recipient under IDCCR. Joe presently lives in a community care setting. ~PDS lawyer

[198] Tarrant, P. (2016), pp. 201-206.

Enhance the role of the AOD clinician

MOJ researchers suggest areas for improvement for the AOD clinician service, including the following:

- Implement a uniform or best practice framework
- Improve data collection and access to better evaluate the service impacts and design improvements
- Improve awareness and uptake of the service
- Improve the resources available
- Expand the service model and consider evaluations of all charged individuals
- Provide training to AOD clinicians particularly on court processes
- Ensure that the AOD clinician service is culturally appropriate
- Improve record-keeping, communication and information sharing[199]

All district courts should have access to an AOD clinician, even someone on-call or part-time for less populous parts of the country. They are a valuable resource. Given the gap in services in court for those with mental health and other socioeconomic needs, AOD clinicians should be members of a therapeutic team, not working in isolation. Not only are they available to assess individuals for addiction issues, but they can work with other professionals to develop a treatment plan for every referred individual and assist in pursuing the treatment opportunities.

If Health Navigators are implemented across the country, it may obviate the need for an AOD clinician if a Health Navigator with AOD assessment skills could be hired. It may be possible to convert the AOD clinician role to the Health Navigator by up-skilling the nine AOD clinicians currently in courts and ensuring that they have the resources to outsource formal AOD assessments.

Iwi and other community-led supervised accommodation

Some individuals who are currently remanded qualify for release in all respects but one: they lack a suitable residential address. Without one, judges must remand rather than release. Consequently, the justice system is paying top accommodation fees–$273 per day–to house individuals who may have been engaged in treatment or working or sharing family responsibilities. Many jurisdictions around the world have developed alternative housing that is secure, safe and operates at a much more sustainable cost. Justice Joe Williams has suggested that iwi-led supervised accommodation would be a solution to these situations.

Such an idea would likely achieve many goals. It would enable someone pending resolution of one's case to pursue a treatment plan to stabilise one's life. Finding that stability would likely increase if the treatment occurred in a culturally sensitive environment with an opportunity to build a strong, socially positive support network. Having seen the Rangatahi Court and an iwi panel, both held on marae, I was impressed with the iwi resources and their unique ability to instil pride and belonging to an individual.

I recommend that the justice sector work with other agencies, NGOs, iwi and other communities to develop a comprehensive alternative housing plan for those with pending criminal charges.

[199] Ministry of Justice (August 2016), AOD Clinician Report, pp. 8-10.

Consolidated list of defendants with mental health issues

I recommend that each district court implement the practice of consolidating appearances of those with mental health issues, especially those who have triggered the CP(MIP), into one time slot. Appearing in a busy court with the movement of court staff and many others may be confusing and potentially shaming for those with certain mental health issues, from acute to less serious. Creating a designated time and place for each judge to hear cases involving mental health issues does not seem to present obstacles that would outweigh the dignity accorded to the individuals appearing in those slots. Further, structuring such a consolidated list ensures a level of privacy to the proceedings appropriate given the stigma that often attaches to mental health issues.

Judicial support

"I just vomit out sentences." ~ High Court judge

Many judges whom I interviewed feel that they work in a broken system, one in which the same people cycle through over and over, and they lack the tools to break the cycle. Some judges despair at the lack of community resources to treat the people who appear in front of them. With pressure to move cases quickly, as another judge put it: "sometimes everyone is so busy, things [mental health issues] get missed."[200]

Many judges, including those who preside over solution-focused courts, work long hours to sustain their therapeutic practices. They, as well as those who do not preside in a specialty court, recount stories of having seen "healing happen." They see the healing as transformational, and to be part of that process breathes new life into their role as a judge. Judge Bill Hastings describes SCC as "so gratifying." Judge Barbara Morris, who shares judicial responsibility for SCC with Judge Hastings, describes SCC as "the best experience I've had as a judge in my career."[201]

Time and training seem to be the two general ways that MOJ could further support judges. Hiring more judges would enable them to spend more time on cases to be sure nothing is missed. Training would equip judges to better understand the health issues that they see, especially as they see individuals with a wider variety of cognitive and neurodevelopmental impairments appear before them.

Potential programmes for the future

The recommendations above can be trialed or implemented in the near future, which may be helpful given the intense focus on the demand for programming for persons with mental health and addiction disorders. I also recommend that the justice sector consider two other initiatives, a pretrial services programme and mental health court. Both involve a heavier resource commitment than my other recommendations but have been part of the justice system in various other countries for decades.

Pretrial Services Programme

A pretrial services programme offers an opportunity for community-based supervision and treatment to reduce the demand for jail beds while maintaining public safety. Such programmes have been implemented in the United States, Canada, and

[200] Interview with District Court Judge, April 2017.

[201] Interview with Judge Barbara Morris, 3 July 2017.

Australia. Many jurisdictions have significantly reduced their need for expensive jail beds by implementing pretrial programmes that use assessment instruments to determine risk and then release detainees who are low risk both for committing new crimes and for flight on their own recognisance or with some form of supervision.

Such programmes have three main functions:

1. Collect and present information to the court about newly arrested individuals
2. With the use of a risk assessment tool, advise the court of available release options and recommend conditions to be set for release prior to trial
3. Supervise released individuals during the pretrial period to ensure compliance with release conditions and reduce failure to appear rates.

A pretrial services officer normally conducts a very quick interview with a charged individual, either in the cellblock or not, uses a risk assessment tool on the information gathered through the interview and databases, and provides a report to the court with recommendations on release and conditions.[202]

Should New Zealand choose to invest in a pretrial services programme, many programmes have been evaluated, providing a wealth of research to examine. Many jurisdictions in the US have implemented pretrial services programmes. Standards of the American Bar Association (ABA) recommend every jurisdiction establish and use a pretrial service programme to gather information about defendants, assess each defendant's risk of endangering the community or failing to appear in court, and use that information to make recommendations to the court.[203] Additionally the National Association of Counties advocates each county be capable of screening all arrestees to help inform judges' pretrial release decisions.[204]

Other national criminal justice associations in the US have issued policy statements supporting risk-based pretrial release decision making and various supervision options to mitigate identified risks. These associations include: the Association of Prosecuting Attorneys; the American Council of Chief Defenders; the International Association of Chiefs of Police; the American Jail Association; and the American Probation and Parole Association.[205]

The benefits of a pretrial services programme include:

- Better informed judges
- Cost savings[206]

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[202] Green, A, (2016), (unpublished), p. 7. The form that a pretrial officer's advice takes varies from one jurisdiction to another.

[203] ABA Pretrial Release Standard 10-1.10. The ABA, with 410,000 members, is the largest professional bar association in the US.

[204] National Association of Counties, 2009-2010 Justice and Public Safety Platform and Resolutions.

[205] Copies of these policy statements can be found at: http://www.pretrial.org/OurServices/Advocacy/Pages/default.aspx.

[206] For specific examples of cost savings from a variety of jurisdictions see: VanNostrand, Marie (2010) (evaluating pretrial services programmes in Iowa, showing pretrial services resulted in cost savings of $15,393 per defendant and a cost avoidance of $5.33 million in the 2008 and 2009 fiscal years); Tanner, M., Wyatt, D., and Yearwood, D. (2008) (evaluating pretrial services programs in North Carolina which had average cost savings of $1.05 million based on 2005-2006 fiscal year);

- More proportional and fair sentences
- Improved plea bargaining[207]
- Better predictions of defendants' pretrial misconduct[208]
- Better predictions of risks posed to a community
- More efficient pretrial decision-making.

Pretrial release services programmes should be evaluated by cost effectiveness. A relatively small upfront investment in a pretrial services programme often produces significant cost savings. These savings come from freeing up jail space and saving on the costs associated with incarceration (feeding, housing, building maintenance, staff, etc.). Okaloosa County, Florida, a county with a population of about 200,000, provides an example of such savings. In fiscal year 2007, the population of the county jail averaged 695 inmates each day, which was 117 per cent of capacity. That same year the county planned a major expansion of bed space at the jail at an estimated construction cost of $12.5 million with an annual operating cost of $3.5 million. In 2008 before proceeding with the expansion, the county invested in improving its pretrial services programme in order to safely reduce its jail population. By March 2011, the average daily population dropped to 464 inmates, 22 per cent below capacity, and saved the county $27 million. The county then placed on hold its plans for the jail expansion.[209]

The costs of pretrial release programmes vary dramatically, usually because of variations in jurisdiction size. In 2009 about 26 per cent of pretrial programmes reported an operating budget of less than $200,000. Another quarter of the jurisdictions had costs of at least $1.5 million. Generally new programmes tend to be established in smaller jurisdictions and accordingly have smaller costs.[210]

Numerous jurisdictions have had great success implementing pretrial services programmes. Below are some notable examples of these programmes:

- Currently 80 per cent of defendants in the District of Columbia pretrial services programme (population 680,000) are released either on their own recognisance or with non-financial conditions individually tailored to each defendant. Fifteen per cent of defendants are held without bail, principally

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Human Rights Watch (2010) (evaluating pretrial detention in New York City which saves $161 per inmate per day in lieu of incarceration); Taylor, B. (2011).

[207] See Goldkamp, J. (1979) (showing that defendants receive more severe sentences, are offered less attractive plea bargains, and are more likely to become "reentry" clients for no other reason than their pretrial detention—regardless of charge or criminal history); Feely, M. (1992) (demonstrating four times as many defendants serve time pretrial than are incarcerated after conviction); Manns, J. (2005).

[208] The risk assessment tools used by pretrial release programmes predict pretrial misconduct more effectively than professional judgment alone; see The Advocate, *KY Supreme Court Bail Project, Method of Assessing Risk, Varying Release Rates and Unchanged Failure to Appear Rates, and Initial Appearance Counsel at* https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B2aU9MljC05GMjU1YzZlYmItOTY1OC00MjBkLWI0ODAtOWQ2Y2VhYTA4MmZj&hl=en_US&pli=1.

[209] Pretrial Justice Institute (2011).

[210] Pretrial Justice Institute (2009), 2009 Survey of Pretrial Services Programs, pp. 18-19; Pretrial Justice Institute (2009), Pretrial Services Program Implementation: A Starter Kit, pp. 17-18.

because no condition can reasonably assure the safety of the community or the defendant's appearance in court. Only five per cent have a financial bail set. Of the defendants who are released, 97 per cent finish the pretrial period without being arrested on a new felony charge and 91 per cent without being arrested on a new misdemeanor charge. Eighty-eight per cent make all their court appearances. The average cost of supervision is $18 per day per individual (compared to approximately $80 per day for incarceration per person). DC's pretrial (or remand) cases account for twelve per cent of the jail population.[211]

- The Commonwealth of Kentucky (population 4.5M) established a statewide pretrial services programme in 1976, the same year that it outlawed commercial bail bonding for profit. Recent figures from Kentucky Pretrial Services show that 74 per cent of defendants are released while their cases are pending. Of those who were released, 92 per cent made all their court appearances, and 93 per cent completed the pretrial period without a new arrest.[212]
- Another jurisdiction with a successful pretrial services programme is Allegheny County (Pittsburgh), Pennsylvania (population 1.2M). In 2007 court officials transformed an outdated, limited service programme into an evidence-based programme that conforms to ABA standards. The programme went from recommending a money bail in most cases to using a validated risk assessment instrument to identify defendant risks and recommend appropriate release conditions based upon individual risk levels.[213]

A pretrial services programme exists in the very large US federal justice system in which I practice. In 2012, the average annual cost of remanding someone pretrial was ten times the cost of supervision of that person by a pretrial services officer (Table 1).

Table 1. Costs of pretrial services

Pretrial Services	Daily	Monthly	Annually
Pretrial Detention	$ 73.03	$ 2,221.22	$26,654.69
Supervision by Pretrial Services Officers	$ 7.24	$ 220.29	$ 2,643.50

Ontario, Canada has been using a bail verification and supervision programme, similar in its goals to American pretrial programmes. In Australia, the states of Victoria, Queensland and New South Wales have implemented pretrial services programmes.

[211] Pretrial Justice Institute (2010); Pretrial Justice Institute (undated).

[212] Austin, *et al*. (2010).

[213] Pretrial Justice Institute (2007).

Mental Health Court

In the future, mental health courts may find their way into New Zealand's constellation of solution-focused courts. Mainstreaming roles and practices as I have described, however, is not only manageable in a country of 4.8 million people but it will help more people and better and more quickly achieve MOJ goals of reducing reoffending rates and keeping the country safe. In the US, where drug courts have had a place for 30 years and are generally considered very successful, the conversation now is about mainstreaming best practices. The AODTC adheres very closely to the international best practices for drug courts; it is a "bible" for their practice. In contrast, a body of research on mental health courts is still evolving, and agreed upon "best practices" do not exist yet. As such, investing in such a court may be more prudent in the future.

Academics have proposed establishing mental health courts, and the Ministry of Justice has generated an assessment of their potential value in terms of investment.[214] Many within the justice system advocate for mainstreaming practices rather than setting up more specialty courts. Given the lack of a mainstreamed pretrial programme, it seems that the best investment in the near future is one that has a system-wide reach around the country and is based on practices already effective in parts of New Zealand.

CONCLUSION

New Zealand has an opportunity to re-envision the site of district court as not only a gateway to prison but also to a community of skilled persons dedicated to working therapeutically with charged individuals to address factors that likely led to criminal charges. Those struggling with mental health and addiction often have multiple socioeconomic needs but often lack the ability to navigate their way to help. As one victim of a violent crime expressed about offenders getting mental health treatment:

> Plenty of victims would say lock 'em up, [but] my family is pragmatic. If an offender has mental health issues, it's better to be treated in a mental health facility than sent to prison. Prison breeds more mental health issues than treats them.[215]

Unlike other common law countries, New Zealand does not have a pretrial services programme like those in many other jurisdictions. Such programmes have been shown to be successful in improving outcomes for individuals charged with crimes, reducing the prison population, and saving money while keeping the community safe. Given the time and resources needed to build such a programme, an initiative such as the Health Navigator and enhanced roles of other court professionals could fill the gap more quickly and at a relatively modest cost. This bolstered therapeutic support team in essence would mainstream some of the most effective features of the solution-focused courts both in New Zealand and abroad such as the team approach, a case coordinator, connection to community services, and procedural justice. Practitioners hunger for the opportunity to stop patterns of reoffending.

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[214] Brookbanks, W. (2006); Toki, V. (2010); MOJ evidence brief (unpublished).

[215] Interview, 19 July 2017.

New Zealand is small enough and creative enough to launch an internationally recognised model of justice that restores dignity to those who are mentally unwell and uses its resources smartly to keep them out of prison and in the community leading productive and meaningful lives.

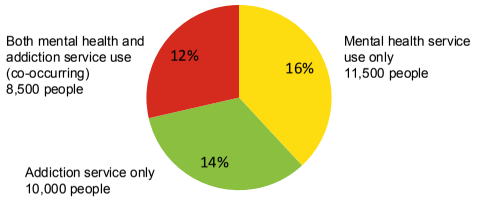
APPENDIX 1

MOJ: Opportunities in NZ courts for people with mental health and addiction disorders[216]

[216] Access to the data presented was managed by Statistics New Zealand under strict micro-data access protocols and in accordance with the security and confidentiality provisions of the Statistics Act 1975. These findings are not Official Statistics. The opinions, findings, recommendations, and conclusions expressed are those of the researchers, not Statistics NZ, the Ministry of Health or the Ministry of Justice.

People used a range of mental health or addiction services

Overall 42% of people charged in court in 2013 have a record of using mental health or addiction services. This graph shows the type of services used in the 12 months before and after being charged in court:



People with a record of co-occurring service use are the most disadvantaged across socio-economic measures

We compared the socio-economic characteristics of people charged in court by the mental health and addiction categories above. People with a record of using mental health or addiction services were more disadvantaged across a range of measures. People who used co-occurring services (that is, both mental health and addiction) were the most disadvantaged, including:

Employment
- Lower rates of employment
- Less time employed in past 12 months
- Less time employed in past 5 years

Education:
- Lower educational attainment
- Higher youth disengagement in past 12 months (as measured by not being in employment, education or training – NEET)

Benefit:
- More on benefit in past 12 months and in past 5 years
- Longer on benefit in past 12 months and in past 5 years
- More on health condition or disability benefit in the last 12 months and in past 5 years
- Longer on health condition or disability benefit in the last 12 months and in past 5 years

Housing instability:
- More address changes in last 12 months
- More address changes in past 5 years

People charged in court with a record of using mental health and addiction services are more likely to have criminal histories

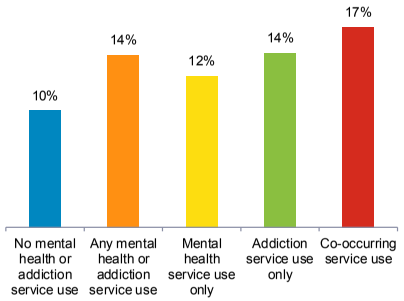
For people charged in court in 2013, per cent with violence or sexual offence conviction in prior 10 years

People charged in court with a record of using mental health or addiction services are more likely to have convictions for violence or sexual offences. Specifically:

- **35%** of people who had used mental health or addiction services had a prior violence or sexual conviction
- **20%** of people with did not use mental health or addiction services had a prior violence or sexual conviction

People charged in court with a record of using mental health and addiction services are more likely to breach bail

Proportion who breached bail 12 months either side of first court date



For people charged in court in 2011 with charges not dealt with on same day

What would a Health Navigator do?

Crime and Justice Insights

The Health Navigator proposed by Lisa Lunt should be an experienced social worker, ideally with alcohol and drug assessment skills, with an understanding of the justice system and deep connections to local community services. The Health Navigator goals are to:

- Conduct assessments of health and socioeconomic needs of individuals in court facing criminal charges
- Develop a treatment plan to address individuals' needs
- Identify and facilitate access to appropriate health and social services
- In cases where bail is contested and upon court request, provide a treatment plan to the court
- Send reminders to individuals of court appearances
- Assist in any restorative justice processes as appropriate
- Maintain continued contact to support the individual up to resolution of case

What is a Pretrial Services Programme?

A Pretrial Services Programme serves a similar role to the Health Navigator but as modelled in the US, Australia and Canada, it provides two other significant functions:

1. Employs use of a risk assessment tool to advise the court of available release options and recommend bail conditions
2. Manages supervision of released individuals during the pretrial period to ensure compliance with release conditions

This programme has been largely successful when utilised internationally. For example, for the Pretrial Services Agency for Washington DC (pop. 680K):

- Remand population accounts for 12% total prison population
- 80% of charged individuals released pretrial
- 97% of those released without new felony arrest; 91% without any new arrests
- 88% appear for all court hearings
- Daily cost is US$18 per person compared to $80 daily cost for jail

Though mental health disorders play very little part in the majority of offending, they may impact an individual's ability to respond to interventions that address needs.

About the authors

Lisa Lunt is a 2017 Ian Axford Fellow (New Zealand) in Public Policy. She works in the US as an Assistant Federal Public Defender in Maryland. Her report is available at http://www.fulbright.org.nz/news-publications/publications/axfordreports/. The recommendations made in this paper are hers and not from the Ministry of Justice. Please contact at lisawlunt@gmail.com.

Natalie Horspool is a Senior Analyst within the Ministry of Justice Sector Analysis and Modelling team. For questions or feedback about the data presented here, please contact natalie.horspool@justice.govt.nz.

Use of mental health and addiction services includes:

1. **Specialist** mental health and addiction services
2. **Pharmaceuticals** dispensed related to mental health or addiction
3. **Hospitalisation** with mental health or addiction as the principal diagnosis

Beware of incorrectly implying causation

These results indicate the complex association between mental health and offending.
Be careful not to misinterpret this analysis to conclude that mental illness caused offending behaviour. This analysis has not addressed the issue of causation.

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- Jane Bodkin, MOH, 17 February 2017
- Warren Brookbanks, Professor, AUT Law School, 10-11 March 2017
- Roger Brooking, AOD Clinician, 11 April 2017
- Sir David Carruthers, Judge and Authority Chair Independent Police Conduct Authority, 21 February 2017
- Jill Clendon, MOH, 15 February 2017
- Kerry Cole, MOJ (many)
- David Collins, High Court Judge, 20 July 2017
- Rachel Crowley, MOJ (many)
- Leah Davison, Lawyer, Public Defender Service (many)
- Robert Dobson, High Court Judge, 5 May 2017
- Sir Mason Durie, Professor of Māori Studies, Massey University, 9 June 2017
- Stephen Enright, MOH, 8 February 2017
- Nigel Fairley, Director of Area Mental Health Services for the Capital & Coast District Health Board, 2 March 2017
- Bianca Fernando, AOD Clinician (many)
- Judge Tony Fitzgerald, Court of New Beginnings for homeless (28 April)
- Laura Garrod, Court Liaison Nurse, 9 March 2017
- Sarah Goodall, Independent Police Conduct Authority, 21 February 2017
- Aphra Green, MOJ (many)
- Bill Hastings, District Court Judge and Chair of the Immigration and Protection Tribunal, 25 March & 10 May 2017
- Brenda Hamblyn, NZ Police, 6 April 2017
- Amy Hamerton, MSD, 5 April 2017
- Ruth Harcourt, Public Defender Service, 10 April 2017

- Natalie Horspool, MOJ (many)
- Peter Hutchinson, Public Defender Service, 9 March 2017
- Peter Kennerley, MOH, 3 April 2017
- Annette King, MP, 24 May 2017
- Florence Leota, MOH, 3 April 2017
- Ian Lambie, Chief Science Advisor, MOJ, 8 February 2017
- Judges of Wellington District Court, 23 May 2017
- Madeleine Laracy, Director, Public Defender Service, 7 February 2017
- Nessa Lynch, Senior Lecturer School of Law, Victoria University, 2 May 2017
- Chris Marshall, Diana Unwin Chair in Restorative Justice School of Government, Victoria University, 8 February 2017
- Kristin Maynard, 14 February 2017
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- Janine McIntosh, Director, Institute for Judicial Studies, 5 May 2017
- Stephanie McIntyre, Downtown Community Ministry, 12 May 2017
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- Jeremy Skipworth, Clinical Director, Auckland Regional Forensic Psychiatry Services, 12 May 2017
- Rob Stevens, Public Defender Service, 17 May 2017
- Michael Sluyzberg, MOJ (many)
- Staff, Auckland Regional Forensic Psychiatry Services, 11 May 2017

- Judge Heemi Taumaunu, District Court Judge, 10 May 2017
- Alison Thom, Māori Leadership ~ MOH, 15 February 2017
- Katey Thom, University of Auckland (many)
- Kate Townsend, MOJ (many)
- Lisa Tremewan, District Court Judge, 15 March 2017
- Genevive Vear, Public Defender Service, 11 May 2017
- John Walker, Principal Youth Court Judge of New Zealand, 16 March 2017
- John Walsh, District Court Judge, 31 March 2017
- Anni Watkin, Youth and Cultural Development, 10 April 2017
- Joe Williams, High Court Judge, 5 May 2017
- Kim Workman, 12 April 2017
- Warren Young, Independent Police Conduct Authority, 21 February 2017

I also interviewed several others who shared their experiences with the criminal justice system and wished to remain anonymous. I am grateful to those who shared their stories with me.

GLOSSARY

Aotearoa. The Long White Cloud, New Zealand.

Aroha. Love and compassion.

Haka. Ceremonial dance.

Hapū. Kinship group, clan, tribe, subtribe.

Hongi. Pressing noses in greeting.

Iwi. Extended kinship group, tribe, nation, people, nationality, race - often refers to a large group of people descended from a common ancestor and associated with a distinct territory.

Kaumātua. Respected elders.

Karakia. Prayer, blessing.

Kawa. Protocols or correct processes, practices that need to be followed.

Mana whenua. Refers to the Māori people of the land, who have power, authority and jurisdictions.

Mana. Prestige, authority, control, power, influence, status, spiritual power, charisma - *mana* is a supernatural force in a person, place or object.

Manaaki. Support, hospitality, caring for.

Manuhiri. visitors.

Marae. Courtyard - the open area in front of the *wharenui*, where formal greetings and discussions take place. Often also used to include the complex of buildings around the *marae*.

Mihi. Speech of greeting, acknowledgement, tribute.

Ngā Whenu Raranga. Weaving strands.

Pepeha. Tribal saying, tribal motto, proverb (especially about a tribe).

Pōwhiri. Ceremony that takes place to welcome manuhiri (visitors) on to a marae.

Te pou oranga. Translates in English to 'the healing post'. A member of the AODT Court team who provides cultural support to the AODT Court team members and participants, ensures meaningful incorporation of tikanga in the AODT Court and active engagement with whānau, hapū, iwi and the wider community.

Te whare tapa whā. The Māori model of health, contemplates four cornerstones of health: taha tinana (physical health), taha wairua (spiritual health), taha whānau (family health), and taha hinengaro (mental health). From the work of Sir Ian Durie.

Te reo. Māori language. The Māori language is an official language of Aotearoa New Zealand.

Tika. To be correct, true, upright, right, just, fair, accurate, appropriate, lawful, proper, and valid.

Tikanga. Customary system of values, principles and law.

Tūpuna. Ancestors.

Tiriti o Waitangi. Treaty of Waitangi. An agreement signed between Māori chiefs and representative of the Crown in 1840. For more information see All About the Treaty available at www.treaty2u.govt.nz.

Waiata. Song.

Wairua. Spirit, spiritual aspects. Te taha wairua acknowledges tāhuhu existence in the greater scheme of things.

Whānau. Family or blood kin, today this has been extended to various special interest groups who function as kin.

Whānau ora. An approach that places families/whānau at the centre of service delivery, requiring the integration of health, education and social services and is improving outcomes and results for New Zealand families/whānau.

Whare. House

Wharenui. Meeting house, large house - main building of a marae where guests are accommodated.