MINISTRY OF JUSTICE
Tāhū o te Ture

Alcohol and other drug (AOD) clinicians in court

Research report

Preface

The Research and Evaluation Team of the Ministry of Justice undertook this research. The ministry acknowledges and thanks the key informants who willingly gave their time to participate in the research.

The ministry has taken all reasonable steps to ensure the accuracy of the information contained in this report, no responsibility is accepted for the reliance by any person on any information contained in this report, nor for any error in or omission from the report.

Acronyms

AOD	alcohol and other drug(s)
BOP	Bay of Plenty
CMS	Case Management System
DHB	District Health Board
EBA	excess breath alcohol
FTE	full time equivalent
MOH	Ministry of Health
MOJ	Ministry of Justice
PAC	Provision of Advice to Court

Research and Evaluation Team
Sector Group
Ministry of Justice
August 2016

Contents

Preface ii

Acronyms ii

Contents iii

1 Executive summary 5

1.1 Purpose of this report 5

1.2 The AOD clinician in court service 5

1.3 Key questions and methodology 5

1.4 Main findings 6

1.5 Suggestions for improvement 8

2 Background 11

2.1 AOD clinicians in court 11

2.2 Context for this research 11

2.3 Key research questions 12

2.4 Methodology 12

2.5 Limitations 13

3 How the service works 14

3.1 Aim of the role 14

3.2 Uptake of the service 15

3.3 Process similarities and differences 17

3.4 The key outputs of AOD clinicians 22

3.5 Use of other reports 23

4 Quality and consistency assurance 26

4.1 Differences between and within courts 26

4.2 Family violence training 29

5 The impact of the service 30

5.1 Views on the value of the service 30

5.2 Impact of the service 30

5.3 Sentencing decisions 33

5.4 Treatment referral and completion 35

5.5 Family violence cases 37

5.6 Comparison sites 38

5.7 Cost and efficiency 39

5.8 Views on expanding the service model 40

6	**References**	**42**
7	**Appendices**	**43**
7.1	**Appendix 1: History of the service**	**43**
7.2	**Appendix 2: Previous evaluation**	**44**
7.3	**Appendix 3: Methodology**	**46**
7.4	**Appendix 4: Intervention logic model**	**49**
7.5	**Appendix 5: Process chart**	**50**
7.6	**Appendix 6: Information sheet**	**51**
7.7	**Appendix 7: Consent form**	**53**
7.8	**Appendix 8: Interview guide**	**54**
7.9	**Appendix 9: Court observation sheet**	**59**
7.10	**Appendix 10: Administrative data**	**60**
7.11	**Appendix 11: Data comparison tables**	**62**

1 Executive summary

1.1 Purpose of this report

This report presents the findings from research on the processes, utility and effect of the alcohol and other drug (AOD) clinicians' service in district courts. The Ministry of Justice (MOJ) Research and Evaluation Team conducted this research.

1.2 The AOD clinician in court service

The AOD clinician in court service is currently provided in nine of the 63 district courts in New Zealand. The clinicians are available in court to conduct a brief assessment (screening) of offenders who have entered a guilty plea. Compared to a comprehensive AOD report, the intention of the AOD clinician in court service is to provide an earlier and more efficient way to identify the existence of AOD issues, with immediate access to clinical advice. This clinical advice provides district court judges (and community magistrates in some sites) with health information — which some judges use purely to inform their sentencing decisions, but others use to inform a broader 'therapeutic jurisprudence approach'[1].

1.3 Key questions and methodology

The research aimed to answer 11 specific questions grouped into the following three overarching questions.

How does the service work? What are the processes for the delivery of the service? Are there any differences in family violence cases?

How is quality and consistency of practice assured? What training, tools and methods are used to ensure high quality advice, including in family violence cases?

What is the impact of the service? What is the impact on judges' sentencing decisions, proportion of referrals to comprehensive AOD assessment, and offender treatment outcomes? Are there any differences in family violence cases?

Semi-structured, face-to-face and telephone, interviews were conducted with key stakeholders. The majority of interviews took place at three sites (referred to as the main sites) that offer the AOD clinician service. In addition, two participants were interviewed from two other sites that offer the AOD clinician service thus providing some information on practice from fives sites with clinicians. To allow comparisons between courts, district court judges from two courts that do not offer the service were also interviewed. In total 25 participants were interviewed from across seven sites.

To triangulate the interview data, court proceedings were observed at the three main sites. The purposive sampling[2] method used to select people to take part in this research meant that the views expressed are not necessarily representative of the judiciary or other key stakeholders as a whole.

---

[1] Therapeutic jurisprudence is a holistic approach that focuses on the emotional and mental health of people in the context of the legal system.

[2] Purposive sampling involves selecting a group of people based on their knowledge of the particular area being researched.

Administrative data from relevant providers was also analysed (see Appendix 3 for more details on the methodology).

1.4 Main findings

HOW THE SERVICE WORKS AND HOW QUALITY AND CONSISTENCY OF PRACTICE IS ASSURED

1.4.1 Respondents agreed that the primary activity of AOD clinicians was to screen for AOD abuse problems and indicate appropriate follow up in a report to the judge

A broadly similar assessment pattern was in place across all courts which generally included the following elements: building rapport, AOD history, AOD treatment and motivation to change. All clinicians used screening tools to base their reports on and screened for coexisting problems. Following consultation, offenders were either:

- referred for a comprehensive AOD report
- referred to in-patient or out-patient treatment programmes or another service (eg mental health nurse)
- identified as high-risk and in need of supervision
- identified as lower risk and in need of a brief intervention
- identified as having no AOD-related needs.

Some offenders were assigned to multiple pathways.

1.4.2 The AOD clinician service is used in a small proportion of all cases and is reportedly under-utilised at times and across district courts

On average the AOD clinicians across the three main sites are referred a small proportion, only about 6% on average, of all new business[3] in courts. The proportion referred to AOD clinicians also varies considerably on a monthly basis as well as across the court sites (from 2% to just under 10%). Judges and clinicians claimed that not all judges use the service to the same extent, especially visiting judges, and there may be times when the service is used less (perhaps busier periods) and not enough for some conditions, such as 'other drugs'.

1.4.3 AOD clinician in court service practices varied from court to court

There is no uniform or best practice framework for the AOD clinician services across the sites. The research found multiple differences between the five district court sites in terms of:

- facilities provided to the clinicians
- where referrals originated (ie lawyer or judge)
- the type of cases referred to clinicians
- how clinicians broadly operated (eg treatment philosophy, record keeping)
- how assessments were conducted, including their duration
- the screening tools used
- whether sentencing could be delayed for treatment.

Differences in practice were expected because the service developed in a piecemeal way across the nine District Courts that have this service. The Ministry of Justice deemed it appropriate for services to develop in response to local needs (Conner and Walfisch, 2011). However, it means offenders are not necessarily receiving the same level or quality of service. The use of stand-downs is more prevalent in courts with AOD clinicians, but prevalence of this practice also varies between courts with clinicians. This made court comparisons in this research difficult.

[3] New business includes new cases, cases created from charges(s) being split off another case, and reactivated cases for rehearing. It is a proxy measurement for the total workload of a given court.

1.4.4 There were no consistent or clear differences in how family violence cases were addressed in courts with a clinician

The presence of the AOD clinician in court did not appear to make any difference to how family violence cases were dealt with in the courts compared to non-family violence cases. Several judges and clinicians commented that AOD issues were more important in the context of family violence cases. Judges in courts both with and without a clinician acknowledged an awareness of the need to manage risk when making decisions in family violence cases.

1.4.5 AOD clinicians and judges did not report having specific family violence training

Participants were asked about the extent of specialist family violence training they had received, if any. The provision and uptake of this training seemed to be haphazard across all sites. Of note, there was no consistent programme of family violence training given to the AOD clinicians or judges, though most judges cited extensive experience in dealing with such cases.

THE IMPACT OF THE SERVICE

1.4.6 Key impacts of the service could not be assessed due to difficulties in accessing data

We were unable to obtain the data needed to assess the impact of having the AOD clinician in court on key outcomes of interest. Existing court administrative data is not designed for this purpose, or stored in a manner that enables this analysis. In addition, client data (such as treatment outcomes) is not linked to information held by relevant providers.

While the court holds a copy of the clinician's report on individual hard-copy files, there is no flag or other entry in the court administrative data to identify which offenders received an AOD brief assessment from the clinician at court. Providers of the service hold the data, however, currently there is no system in place to link the AOD brief assessment to sentencing outcomes.

1.4.7 Judges reported strong confidence in the expertise of the AOD clinicians

The judges' confidence in the clinicians meant that they felt safe relying on reports from the clinicians, and felt more assured in their own decision-making. Judges considered AOD clinicians to be experts, and thought their presence in the court improved the chance of identifying offenders with AOD issues. All judges said the service was helpful and they placed great reliance on the advice provided by clinicians. Judges generally adopted recommendations included in the clinicians' report.

1.4.8 Participants claimed having an AOD clinician in court increases the number of comprehensive AOD reports ordered and the number of offenders referred to treatment

Participants claimed that having an AOD clinician in court has increased the number of comprehensive AOD reports ordered in courts where they are available. They argued this was because more AOD issues are picked up by the AOD screening/brief assessment service. All participants were unequivocal in their claims that the presence of the clinician meant more offenders were being referred to AOD treatment. However, we were not able to corroborate or refute these claims because we were not able to get access to data to track clients across court and health administrative documentation.[4]

1.4.9 Barriers to treatment access and completion

Some judges and clinicians noted some barriers to access and successful completion of treatment. This included timely availability of treatment places and the proximity of services, particularly in rural areas. They also noted that in some areas treatment services are provided on weekdays, which clashes with employment obligations for some clients. Given the importance of employment, including its role as a

[4] The information is held either in paper form and/or on provider databases.

protective factor against offending, some judges were reluctant to refer these clients to treatment. They indicated a need for more after-hours and weekend treatment options.

1.4.10 Some participants claimed that sentencing was more likely to be deferred in AOD clinician courts

Some participants suggested that, in courts with clinicians, sentencing was more likely to be delayed while AOD treatment could be completed. However, this is probably not a universal effect since not all judges favoured the option of delaying sentencing for the offender to complete treatment. We were not able to access data to verify these claims.

1.4.11 We were not able to assess the impact of having an AOD clinician in court on convictions and type of sentence imposed

Some judges said they were more lenient in final sentencing towards someone who had successfully completed their treatment (on rare occasions discharging without conviction). For some offenders this could mean the difference between a custodial sentence and community sentence. However, not all judges took this approach.

We were not able to assess the overall impact of having an AOD clinician in court on the most serious conviction, type of sentence imposed or whether an AOD condition was stipulated as part of a sentence. This is because we did not have access to the data to do this analysis.

We did a crude comparison of district court sites with and without an AOD clinician, looking at the most serious conviction and the most serious sentence imposed, and the proportion of people who had an AOD condition stipulated as part of their sentence. This did not show any clear differences (including when limited to traffic offences), but we cannot interpret from this that the AOD clinician does not have a significant impact because AOD clinicians are referred in only a small proportion of all cases (about 6%).

1.4.12 All participants supported having the AOD clinicians in court

Judges, clinicians, defence lawyers and probation officers expressed their support for having the AOD clinician in district courts. They believed that it raised awareness of AOD issues, provided expertise and helped offenders along the path towards rehabilitation. There was also general agreement among participants that having stand-down referrals to AOD clinicians sped up court processes in comparison to adjourning cases.

1.5 Suggestions for improvement

1.5.1 Data access and analysis to inform service investment and improvement

To evaluate the AOD service impacts and to help design improvements, better data collection and access to existing data is needed. In particular, the ability to identify and track information on offenders referred to the AOD clinician in court, including their assessment, treatment and sentencing outcomes.

Investigation of options on the most feasible and effective way to do this is required as it could involve significant costs. One option would be to make changes to how data is captured in the court administrative Case Management System so that it identifies:

- which offenders received an assessment with an AOD clinician in court
- the course of action recommended by the AOD clinician
- which offenders received referral to treatment following AOD clinician assessment
- whether sentence obligations were fulfilled.

Possible options for enabling outcomes analysis are:

- to investigate making changes to the CMS to facilitate outcomes analysis

- matching MOJ data to relevant data held by the service providers.

SUGGESTIONS MADE BY RESEARCH PARTICIPANTS

Several suggestions for other improvements were made by participants and are outlined below. It is beyond the scope of this research to comment on the practicality, implications or appropriateness of these suggestions.

1.5.2 Improve awareness and uptake of the service

- Improve education and awareness of the AOD clinician service among judges, lawyers and other district court users. In particular:
  - provide pamphlets and posters around the court
  - increase visibility of the AOD clinician in court to encourage judges and lawyers to make more referrals and generally raise awareness of the AOD clinician service
  - raise awareness of 'other drug' issues so AOD clinicians are less exclusively focused on alcohol-related referrals.

1.5.3 Improve the resources available

- Ensure the AOD clinician has suitably-resourced, accessible and private rooms at court to conduct their assessments.
- Ensure sufficient AOD clinician resource is available when courts are running two lists concurrently (when one AOD clinician cannot keep up with demand)
- Increase availability of treatment options in the community to reduce waiting lists for AOD treatment, allow rehabilitation programmes to be completed without extending supervision timeframes, and ensure people can access the help they need. In particular, more options are needed on evenings and weekends, as well as in rural locations.

1.5.4 Expand the service model and/or reach

- Some participants suggested expanding the service so that AOD clinicians are available to conduct brief interventions at other stages of the process eg at the police station soon after arrest, at bail hearings.
- Some clinicians and judges would like AOD clinicians to assess all offenders.
- Expand services so AOD clinicians are available for all district courts around the country.

1.5.5 Changes to current processes could potentially improve the service

- Encourage referrals via defence lawyers because it:
  - is more efficient for the court since assessments can be conducted before court starts for the day, whereas judge-referred assessments are done while cases are stood down
  - increases availability and visibility of the clinician in court. Conducting assessments before court will ensure the clinician is available in court to provide ad-hoc advice.
- Ensure all AOD clinicians screen for coexisting problems (CEP).
- Offer specialist family violence training for clinicians and other key stakeholders.
- Provide training for AOD clinicians to help them understand general court processes.
- Ensure the AOD clinician service is culturally appropriate.
- Facilitate professional networking between AOD clinicians around the country, as well as between judges, lawyers, Probation Services, police prosecutors and AOD clinicians at the same court.

1.5.6 Improve record-keeping, communication and Information sharing

- Require common record-keeping standards and practices.
- Establish direct communication channels between judges and AOD clinicians.
- Facilitate information sharing to improve clinicians' access to corroborating information about offenders. Most commonly requested sources were summary of facts, criminal history, background health information and prior involvement with treatment providers.
- Improve information sharing and data matching between agencies.

2 Background

2.1 AOD clinicians in court

The first AOD clinician in court service was introduced in Nelson District Court in 2001 after the District Health Board (DHB) AOD service observed some court sittings. They noticed the same people in court as they were seeing at their service and suggested there be a permanent in court clinician, funded by the DHB, to streamline the services. The service then expanded to Blenheim, with the same AOD clinician working in both courts[5].

In 2005, the AOD clinician in court service was launched at the Tauranga District Court[6] in collaboration with the Bay of Plenty (BOP) DHB Mental Health and Addiction Services. Following an evaluation of the Tauranga service in 2007, which deemed the service successful, a joint initiative was launched in 2008 between MOJ and the Ministry of Health (MOH), in conjunction with DHBs. This resulted in the introduction of the service to the Northland, Kaikohe, Wellington and Porirua District courts, initially as a pilot[7]. In Wellington the DHB has subcontracted the Salvation Army to provide the service.

A further evaluation of the Tauranga AOD clinician service was completed in 2014[8] and a plan was put in place for further service improvements based on this advice. The piecemeal way the current service has developed over time means the way the service works and judges' access to AOD information varies between courts.

2.2 Context for this research

The Stronger Response to Family Violence cabinet paper in July 2014 proposed exploratory research to look at the role of AOD clinicians in court in supporting judicial decision-making in family violence cases.[9] The paper called for agencies, MOJ, MOH and DHBs to work together to assess the impact of current practice, where possible with a view to developing advice on a preferred approach for providing information for judges on offenders mental health and AOD dependency. This research was undertaken to partly address that proposal.

AOD clinicians primarily operate to inform judicial decision-making. Some members of the judiciary perceive a benefit in having health information available to the court, particularly when clinicians deliver this information on the same day it is requested. There is also increasing public interest for the presentation of more information before courts, particularly in family violence cases, with the view that it will help judges make better bail and sentencing decisions (see Section 6 for references).

In addition, the Family Violence Death Review Committee (2014) recommended that comprehensive information be provided to judges in order to facilitate safe and robust decision-making. Their report

---

[5] See Appendix 1: History of AOD clinician in court initiatives

[6] The AOD clinician service at this site is known as the 'addiction assessment in court'. For consistency, the generic description is used throughout. However, the service in Tauranga operates slightly differently, with the clinician also attending the community magistrates' court and other types of list courts.

[7] The service was also established in two Youth Courts at this time.

[8] See Appendix 2 : Previous evaluation of the Tauranga AOD clinician in court service

[9] Action Area 3: Supporting judicial decision-making in cases involving domestic violence, p. 9. http://www.justice.govt.nz/publications/global-publications/f/family-violence-cross-government-package/documents/a-stronger-response-to-domestic-violence

considered that 31% of family violence deaths occur in the context of social gatherings featuring heavy alcohol consumption and among families with known AOD issues.

A briefing to Minister Adams contended that, while the presence of AOD issues may make continued family violence offending more likely, this information could not necessarily be ascertained in a brief assessment by an AOD clinician in court (29/05/15, CJS-29-12). The briefing suggested that AOD information is most useful when provided by health services as part of a wider assessment carried out by a cross-agency panel or group skilled in family violence. It concluded that, in the absence of specialist family violence advice, health information was of limited assistance in understanding family violence offending in particular.

In this context, the Ministry asked Research and Evaluation to research the processes, utility and effect of having AOD clinicians in court, with a particular focus on family violence cases. The Stronger Response to Family Violence Programme Board (including New Zealand Police, Department of Corrections and MOJ) funded this research. This report has been prepared for the Family Violence Policy Team Manager, and the Sentencing and Rehabilitation Team Policy Manager.

2.3 Key research questions

This research aimed to answer the following research questions.

2.3.1 How does the service work?

1. What are the processes around the role of AOD clinicians, including initial engagement in a case and how information is passed between an AOD clinician and a district court judge?
2. At what stage of the court process are AOD clinicians providing advice to judges?
3. What information sources are used by AOD clinicians in providing this advice?
4. What information is being provided to the judiciary by AOD clinicians?

2.3.2 How is quality and consistency of practice assured?

5. What decision-making tools and standardised assessments are used by AOD clinicians?
6. Do the clinicians have any family violence training or understanding of the dynamics of this type of offending?
7. How do AOD clinicians and the judges receiving AOD advice ensure some consistency of advice and decision-making between different areas?

2.3.3 What is the impact of the service?

8. What is the impact of the information provided by AOD clinicians on judges' decision-making, particularly around family violence cases?
9. What flow-on effect does this information have on bail, sentencing and treatment outcomes for offenders?
10. Is the presence of AOD clinicians affecting the number of referrals for comprehensive AOD assessments?
11. Is there a difference between family violence cases and others in:
    - how the information is used
    - the flow-on effects in terms of bail, sentencing and treatment outcomes?

2.4 Methodology

Semi-structured, face-to-face and telephone interviews were conducted with key stakeholders. The majority of interviews took place at three main sites that offer the AOD clinician service. In addition, two participants from two other sites that offer the AOD clinician service were interviewed. To allow

comparisons between courts, judges from two district courts that do not offer the service were also interviewed. In total 25 interviews were conducted with stakeholders from across seven sites.

To triangulate the interview data, court proceedings were observed at the three main AOD clinician locations. Administrative data from relevant providers was also analysed (see Appendix 3 for more details on the methodology).

2.5 Limitations

It was not possible to identify in the court data those offenders who had undergone an AOD assessment in court. Therefore, certain objectives could not be addressed, namely those relating to the flow on effects in terms of bail, sentencing and treatment outcomes, and comparing family violence and non-family violence cases.

Purposive sampling[10] and small sample sizes can introduce positive bias because selection criteria are subjective in nature. For example, judges with an interest in AOD issues may have been more willing to participate. We did try to recruit judges from sites that offered the service and who were not regular users of the service, but it was difficult to identify such individuals and secure interviews with them. Hence, the information presented here may not be representative of the views of the judiciary or other key stakeholders as a whole.

Results shown in the tables and graphs can not necessarily be attributed to the presence of AOD clinicians in the court. There might be other explanations for the results shown, including differences in resident judges' sentencing philosophies, offence type, or rural or urban location of court.

[10] Purposive sampling relies on the researchers' judgement to select participants. This means the sample is chosen with a specific purpose in mind, and participants will have specific characteristics of interest to the research.

3 How the service works

3.1 Aim of the role

3.1.1 The stated purpose of having AOD clinicians in district courts is to provide judges with information to inform sentencing

The AOD clinician in court service is a judiciary-led initiative to improve the health information available for 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). An indicative intervention logic[11] in Appendix 4 sets out how the service is intended to work to achieve immediate and longer-term outcomes.

One clinician drew a line between what they saw as the 'essence' of their role, and what their job entailed. This clinician felt their job was to discover whether someone had an AOD problem and explore what rehabilitation components might be incorporated into any sentence. However, they also said their job focused on understanding the context of individual offending and exploring patterns of AOD consumption. These sentiments were also expressed by other AOD clinicians.

One judge summarised the role of the AOD clinician as providing a 'reality check' for the court about offenders with AOD issues.

3.1.2 Almost all respondents thought the primary activity of AOD clinicians was to screen offenders

The aim of the screening was to identify substance abuse problems. Some described this as a 'triaging' process. Following consultation, offenders were either:

- referred for a comprehensive AOD report
- referred to in-patient or out-patient treatment programmes
- identified as high-risk and in need of supervision
- identified as lower risk and in need of a brief intervention
- identified as having no AOD-related needs.

Some offenders were assigned to multiple pathways.

3.1.3 Other components to the role were identified

Participants expressed other components of the AOD clinician role, in particular to:

- 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 (one clinician commented that some offenders 'are seeking a human connection' and said this was a key component of the role)
- assess referrals that have come through the diversion programme.

[11] This intervention logic is indicative only because it has not been reviewed by all key stakeholders.

3.2 Uptake of the service

Overall, participants thought a high proportion of offenders had AOD-related issues. Many of the judges and AOD clinicians gave estimates ranging from 60% to 70%of general criminal offending and up to 90%of family violence offending[12].

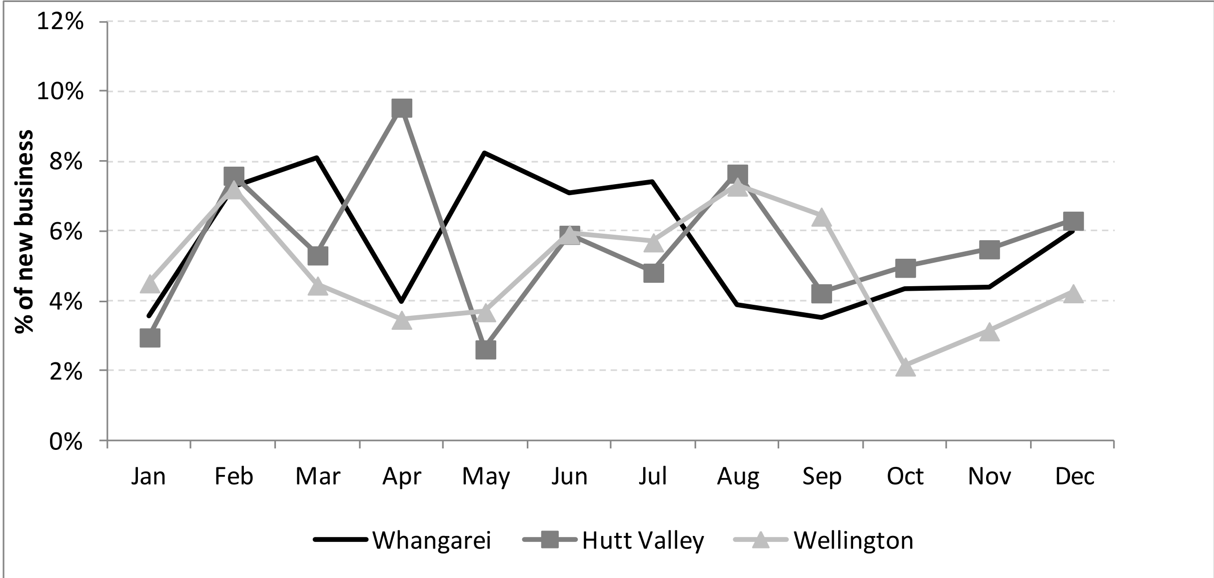
3.2.1 The proportion of AOD assessments varies more within than between the district courts

In 2015, the AOD clinician at Whangarei District Court assessed 260 people; the Hutt Valley clinician assessed 221 people; and the Wellington clinician 157.

Figure 1 shows the number of assessments performed by AOD clinicians at the participating district courts, as a proportion of new business[13], for each month of 2015. Over the course of the 2015 year, the assessments averaged 7% of new business for Whangarei, 6% for Hutt Valley and 5% for Wellington District Court. These referral rates are remarkably low given participants' estimates of the proportion of criminal offending involving alcohol and/or other drugs.

Figure 1 shows the large variation in monthly referrals ranging from 2% to around 10% of new business. The variation is also greater within district courts than between them, with Whangarei being the most varied. An example was given of how Police activity can contribute to variations in this data eg a focus on drink driving in an area can result in an increased number of EBA cases coming through the court (see 3.3.4).

Figure 1: Assessments performed by AOD clinicians, as a percentage of new court business, at three district courts in 2015[14]



Source: Capital and Coast DHB, Northland DHB, the Salvation Army

3.2.2 Indications that the service is under-utilised at times and other times under-resourced

AOD clinicians reported some days where they did not get any referrals. The number of assessments per day ranged from zero to eight at most sites[15]. However, the clinician at one location reported a

[12] We do not have data to corroborate these perceptions.

[13] 'New business' includes new cases, cases created from charge(s) being split off another case, and reactivated cases for rehearing. It is a proxy measurement for the total workload of a given court.

[14] Results shown in the tables and graphs can not necessarily be attributed to the presence of AOD clinicians in the court. There might be other explanations for the results shown, including differences in resident judges' sentencing philosophies, offence type, or rural or urban location of court.

maximum of 12 referrals per day in the Magistrate's Court, where the reports were used almost exclusively for excess breath alcohol (EBA) cases.

During one day of court observation, our researcher saw four cases that made use of AOD reports. A clinician who felt their time was not being fully utilised noted the low referral numbers.

> *When I sit in court and I hear what the prosecutor reads out, I see alcohol related issues and they're not referred to me. I feel powerless [about] the fact that I can't do much and I only get the ones that have been referred to me by the solicitors. There are times when I've said 'well I should have at least seen some' because I'm here the whole day and I'm a resource here, why not make use of my time? Even within the duty solicitors, half of them want to help the client get treatment and they refer them to me, [but] the others just want to get the job done [and] then they just move on.*
> — AOD clinician

The variation in referrals shown in Figure 1 provides at least face-value support for claims that the service is under-utilised at times.

In addition to providing examples of how the service is under-utilised at times, Judges and AOD clinicians provided examples of other situations where the service was under-resourced. Several participants suggested it would be useful to have more clinicians available, or have an existing clinician work longer hours (in courts where they work part time). Further, when a court was running more than one list concurrently, the single clinician was unable to manage referrals from more than one court.

Understanding the reasons for this variation would be useful to inform improvements to service design.

3.2.3 Both judges and AOD clinicians thought it was important to increase the use of the service

The need for the service to be more publicised was a consistent theme among participants, particularly AOD clinicians themselves. At least one clinician took it upon themselves to promote their service by networking with Public Defence Service lawyers and other private defence lawyers; some had met with judges. One participant thought it would be useful to display promotional material such as posters around the court.

Clinicians said judges called upon them more frequently if they could see them sitting in court. In order to increase time spent in court and improve visibility of the service, AOD clinicians thought it would be useful for lawyers to make more pre-emptive referrals instead of relying on judges to refer cases. Clinicians could then conduct the majority of assessments in the morning, before court started, and focus on being visible while court was in session.

A couple of judges suggested that clinicians should speak out in court when they saw a case that may benefit from referral. While two clinicians reported that the judge addressed them in court to ask questions, the clinicians did not seem comfortable with the idea of addressing the judge themselves during court.

3.2.4 Several key participants raised the issue of visiting judges not necessarily knowing about the service

A resident judge said that visiting judges used the AOD clinician service in a very 'ad hoc' way, and another said they 'may not know the drill'. However, another resident judge commented that 'they [visiting judges] are so rare that it wouldn't be a problem'. One clinician said they gave registrars information to pass on to visiting judges; one judge said that visiting judges were told about the service. However, consensus was that visiting judges did not use the AOD clinician service. One judge

---

[15] Courts with a Community Magistrate (CM) have a criminal list cap (including sentencing) of 35 people per day, those without a CM, 45 per day. Source: National Judicial Capacities (CAPS) extracted from MOJ intranet on 15/4/16.

surmised that 'if there is no expectation from the bench then you don't create a culture for it'. The impact of visiting judges varied because some courts needed them more regularly.

3.3 Process similarities and differences

While there are varying practices in different courts, there are broadly accepted processes regarding what the AOD clinician does[16]. These are explained and discussed in sequence, with any differences noted.

REFERRALS

Overall, referrals were decided using three main sources of information: the summary of facts, offender's criminal history, and any contextual information provided by lawyers. Lawyers and judges also used discretionary judgement on a case-by-case basis.

3.3.1 For the most part, referrals came via presiding judge or defence lawyer

Police prosecutors and probation officers were not actively involved in referring offenders for AOD assessment at any of the three locations, although occasionally they would draw judges' attention to AOD issues they felt had been overlooked. One explained:

> *It is not my place to make the decision to request a report…the judge has the same information from which to base their decision so I will only say something about getting an AOD clinician's report if I think it has been missed by the judge.*
> — Probation officer

On occasion, self-referrals came to the attention of AOD clinicians, although these were a minority of referrals. In one location, the AOD clinician received 'lots' of self-referrals and explained these were usually from people who wanted to make their case look favourable to judges.

When referrals came through a judge, the assessment with the clinician would be performed while the case was stood down. Referrals coming through defence lawyers would be assessed before court commenced for the day. The latter was acknowledged as more efficient, and one judge said it was 'superb' when lawyers pre-emptively referred their clients for assessment.

Stand-downs for judge-referred AOD assessments were thought to be preferable to the longer adjournment (usually two to three weeks) required for comprehensive AOD reports.

3.3.2 Sometimes referrals for an AOD assessment came from the Police Diversion Officer

Two clinicians noted that sometimes referrals for an AOD assessment came through the diversion programme instigated by the Police Diversion Officer. In these instances, the outcome sought would be some education and a referral to a relevant service provider for a brief intervention. The aim of this practice is to keep people out of the court system.

3.3.3 AOD clinicians reported some differences in referral processes for family violence court cases

Two of the courts ran separate family violence and criminal lists. The referral pattern varied between lists at one of those courts, where the AOD clinician reported that the judges presiding over family violence lists would order AOD assessments while the case was briefly stood down. The lawyers representing family violence cases tended not to request AOD assessments ahead of time as they did with criminal list cases. A probation officer at that same court said the family violence list was often more hectic so judges would make impromptu assessments themselves — based largely on the victim impact statement — and impose a sentence without ordering an AOD assessment. This respondent thought it would be interesting to see the standard practice change to lawyers initiating referrals before court (as happened with criminal list cases). It is unclear why this difference began or was

---

[16] See Appendix 5: AOD clinician in court process chart

continued, but several judges, clinicians and lawyers agreed it was better to pre-emptively refer clients earlier in the day and avoid the stand-down period.

One AOD clinician, from a court without a separate family violence list, said they saw very few offenders on family violence charges despite many of these cases coming through the court. This clinician said they mostly assessed offenders on alcohol-related charges like EBAs. Some other differences noted by participants were as follows.

- One judge reported using the clinician's reports slightly more for family violence cases; another felt the AOD clinician probably saw more family violence case referrals. It was suggested that AOD caused loosening of inhibitions and revealed anger or relationship issues, and perhaps this was more highlighted in family violence.
- One clinician said they occasionally received referrals from victims referring their abusive partners who they thought had AOD issues.

3.3.4 Each court employed multiple and varied ways of identifying which offenders should be referred for assessment

All courts agreed there were 'obvious' indicators of substance abuse that would usually trigger automatic referral to the AOD clinician based on the types of current and previous charges an offender faced, eg numerous EBA convictions, exceptionally high first-time EBA readings (over 1000mcg per litre of breath), or explicit reference to substance abuse in the summary of facts. This was seen during court observation.

> *First driving with EBA offence. Very high reading of 1108 mg. Judge was provided with an AOD assessment supporting brief intervention (no stand down required). Sentenced to a period of supervision to undertake AOD treatment as directed by Probation Services. Fined $1100 and disqualified from driving for six months.*
> — Researcher's court observation notes

3.3.5 AOD clinicians received a disproportionate number of referrals for alcohol-fuelled crimes (eg EBA charges, wilful damage, etc) rather than other drug-related crimes

This was because alcohol issues seemed more apparent than drug abuse. One of the defence lawyers thought this was because the effects of alcohol consumption were more obvious (particularly smell and obvious changes to demeanour), compared to the effects of drug use. Based on this, the service could benefit from more targeted referrals for people with drug problems.

There was general agreement that substance abuse issues often fuelled wilful damage and drug charges, so these would usually be referred to the AOD clinician. However, some situations were not clear cut so referral was at the discretion of the judge or defence lawyer. One lawyer gave the example: 'if they come to court p*ssed' then that would be grounds for referral.

3.3.6 Different views on whether and which types of offences should warrant automatic referral to the AOD clinician

One court (not one of the main sites for the research) was considered the 'gold plated standard' by some participants as it screened every offender where there was a hint of alcohol involvement. There was some support amongst participants for this practice. One clinician explained 'all people coming through have the potential for change; everyone is a target'.

There were differing opinions on whether AOD clinicians should assess first-time EBA offenders. One said 'there is no hard and fast rule' but also noted 'I can't see how more referrals could hurt'. They also pointed out that treatment programmes were available even for low-level offenders. One judge had increased referrals for first-time EBAs based on what they had heard at a seminar they had attended. However, not all judges and defence lawyers saw it as necessary. Generally, first-time EBAs were not referred unless they had a very high reading or the offender was particularly young.

At the other end of the offending spectrum, individuals with extreme substance abuse problems would usually bypass the AOD clinician's services; judges or lawyers would make a direct referral for a comprehensive AOD report. One judge explained that the services of the AOD clinician were not useful if the offender was facing a substantial prison sentence. In these cases, AOD treatment was more likely to be pursued by Corrections so the clinician's assessment was unnecessary.

BRIEF ASSESSMENT / SCREENING

3.3.7 A broadly similar assessment pattern was in place across all courts

LENGTH OF THE ASSESSMENT PROCESS

The length of face-to-face contact between the AOD clinician and the offender varied in each court. In one court, the consult lasted about 10 minutes; at another, it took up to 60 minutes for the AOD clinician to gather the necessary information. One clinician commented that the work was very time pressured and there could be tensions working with stressed or distressed clients while judges and lawyers are waiting on the information, wanting it as quickly as possible.

This difference was also a matter of individual philosophy. The clinician who conducted shorter screenings said they favoured a 'sharp' intervention because they thought 'an early brief intervention can make a difference'. A clinician with longer session times said they were 'not comfortable' gathering enough information in a shorter period of time to make an informed recommendation to the judge. However, the assessment pattern generally included the following elements: building rapport, AOD history, AOD treatment and motivation to change.

BUILDING RAPPORT WITH THE CLIENT

Most of the clinicians were keen to emphasise the therapeutic importance of their role. Two AOD clinicians lamented meeting hardened offenders who had never received appropriate help in all their years traversing the court system. One clinician said the number of such people was 'shocking'. Another observed how 'they present as very staunch, but will start opening up; many say it's the first time they have talked about certain traumas'.

> *Sometimes people are just waiting to be asked what is going on and if they are okay.*
> — AOD clinician

> *They [clients] are seeking a human connection and I try to provide this within a limited space of time … Building rapport is a key part of the job … success lies in being a point of contact where there is no judgement.*
> — AOD clinician

3.3.8 A few participants questioned the credibility of offenders' self-reported information

Reportedly, some clients would exaggerate and others would minimise their AOD use when talking to the AOD clinicians. One police prosecutor thought offenders would choose whichever option would advance their case. This prosecutor also questioned whether an offender would actually admit to using illegal drugs. Of note, the AOD clinicians usually had access to the summary of facts and offence history to check for misrepresentation. Clinicians also perceived offenders were being generally honest with them.

Several other participants — including judges and lawyers— thought offenders were generally honest with the clinician but said they may not be as honest with lawyers or probation officers. AOD clinicians supported this view, with one clinician commenting that 'talking to the clinician gives offenders a voice'.

> *I know that it's made a difference to some because they've said thank you, or they've cried, or they've said 'oh my gosh my life is crap and I need to get help' when they might not have [otherwise] because there was no-one at the court or no-one to ask them that question. The lawyers say 'how do you get these people to talk to you because what you're giving to me is nothing like they've given to me as their*

> *lawyer' and I've said 'well as their lawyer you're not going to ask them if they've been sexually abused, or if they have no money in the bank and are stealing to feed their kids'.*
> — AOD clinician

SCREENING AND BRIEF ASSESSMENT TOOLS USED

A variety of assessment tools was used. One common tool was the Alcohol Use Disorders Identification Test (AUDIT), which scored respondents across a 4-point Likert scale and asked questions like 'how many drinks containing alcohol do you have on a typical day when drinking' and 'how often during the last year have you had a feeling of guilt or remorse after drinking'.

Other tools included the Alcohol and Drug Outcome Measure (ADOM v2), Drug Abuse Screening Test (DAST), Cannabis Use Disorder Identification Test (CUDIT-R), Diagnostic and Statistical Manual of Mental Disorders (DSM), Eight Gambling Screen, Mental Health Screening Form III (MHSF-III), Alcohol, Smoking and Substance Involvement Screening Test (ASSIST v3), and Coexisting Problems (CEP) screening.

All clinicians were proactive in screening for coexisting problems like gambling, suicidal ideation and other mental health conditions, homelessness, unemployment or family issues. One AOD clinician described this approach as 'integrated' and said all AOD clinicians in New Zealand should be considering co-existing problems during their assessments. If a mental health condition was evident the clinicians would refer the offender to the mental health nurse.

All clinicians said they used these screening tools as the basis for writing their report. One clinician said they used their intuition and background medical training in addition to formal assessment tools. Another clinician said the 'social context' of offenders was sometimes overlooked in the current court process. This AOD clinician described their role as 'holistic' and tried to include as much information as possible about the offender's circumstances when writing their report to the judge.

One clinician commented that they are able to get interpreters in if necessary, and can work with family members to gather more information if required.

ADDITIONAL CONTEXTUAL INFORMATION

All AOD clinicians said it was normal practice for them to receive a copy of the summary of facts, but on occasion, they would not have access to this information and would need to rely on other sources (eg MOH or DHB databases if available). If AOD consumption was not alluded to in the summary of facts, clinicians would rely on what they were told by lawyers and the offender.

Some clinicians conducted further investigation beyond what offenders simply told them. One clinician referred to gathering 'collateral' information from MOH databases to check whether the person had been using other treatment or health services. However, only two clinicians had access to the DHB database in the court setting. Two AOD clinicians commented that they also work closely with the mental health forensic nurses, supporting each other in their roles as they often have shared clients.

Another AOD clinician said that sometimes whānau attended the assessments and would offer extra information. An example given was family members revealing a dramatic increase in drinking following the death of the offender's father. The clinician then included reference to these family circumstances in the report to the judge.

A strategy used in one court was to ask the offender to complete a simple assessment form. This provided the AOD clinician an opportunity to detect any literacy or obvious learning difficulties.

TREATMENT PLANS

CLIENT MOTIVATION AND READINESS TO CHANGE

3.3.9 Opinion varied on the importance of client motivation and readiness to change

Opinions varied on the importance of client motivation and readiness to change. Some respondents thought motivation was an important precursor to change. One AOD clinician said 'people need to be motivated for residential treatment; the facilities don't want them if they don't want to be there'.

On the other hand, there was increasing recognition of the benefits of mandated treatment. The rationale was that some intervention would be better than none. One judge explained how they used to believe that motivation was necessary, but changed their opinion after reading research to the contrary. This judge said they now prefer 'the carrot and stick approach' because they felt it was more likely to succeed. An AOD clinician commented:

> *Sometimes they know that residential treatment at [facility] for 18 months is going to be really hard work, and sometimes they're just not interested in that, they say 'hey I'll just take prison and get in there and then just get out'. Those are the people who might not make many changes. However, there are enough people who do take the chance, and say 'why didn't someone do this earlier, I've been in and out of prison, why haven't I been offered this chance', and they're like 'well here's a chance to do it'.*
>
> — AOD clinician

Various participants explained that therapeutic sentences[17] were often used to encourage offenders to get treatment. In some cases, sentencing would be deferred so treatment could be sought; if the treatment was completed this would then be considered favourably in the final judgement.

One judge reflected on how offenders' motivation levels can change over time, and said extending offenders' supervision could be useful to ensure motivation is maintained in the long term.

While assessing an offender's motivation and readiness to change, the AOD clinicians would try to establish any changes that needed to be made in order to address AOD issues. A common example of this was men with underlying anger management issues.

3.3.10 Often treatment plans conflict with employment obligations

Once the main assessment was complete, clinicians usually discussed or negotiated a treatment plan with offenders. A common difficulty arose when employment obligations conflicted with treatment plans recommended by the clinician. One AOD clinician said they were 'a great believer' in the protective value of employment so tried to suggest weekend treatment options where possible. This clinician had also petitioned one of the local treatment providers directly, asking them to offer treatment options outside of business hours.

Another AOD clinician sympathised with the potential conflict between employment and treatment. However, they clarified it was not their position to make this decision and said it rested with the judge. They explained:

> *I say 'look you would benefit from doing some treatment around your AOD issues and that's the only thing I can recommend here to lessen your risk, but what I will do is I'll note in my assessment that you're really concerned about your employment'. It's only fair for me to do that and I leave it to the judge to make that decision. They can navigate their way through that. There's no weekend provider or after hours stuff so it can have massive consequences. However, depending on how serious their offending is, sometimes it's engaging in those community sentences versus a custodial sentence…but this is the consequence of their offending.*
>
> — AOD clinician

Judges mostly agreed it was important to get information about employment.

[17] In this context, specifically supervision.

3.3.11 Clinicians recommend to judges whether an AOD sentence condition[18] would be useful, not what the sentence should be

Judges and clinicians shared the view that the clinicians did not instruct judges on what sentences to pass on an offender. One judge said:

> *The clinicians don't inform judges what the sentence should be, but rather if an AOD condition would be useful, though some [clinicians] may give more detail in their recommendation than others.*
> — Judge

In most cases, judges said that if an AOD clinician recommended referral to a particular programme, they would listen to that. If a more general recommendation was made, the judges would apply their own wisdom, or rely on Probation Services to decide.

Overwhelmingly, judges adopted recommendations included in the AOD clinician's report. This view was expressed by judges, clinicians, defence lawyers and probation officers.

3.4 The key outputs of AOD clinicians

3.4.1 Offenders with no obvious AOD dependency issues are provided with education about sensible drinking

Where offenders were assessed as not having AOD dependency issues or borderline-problematic consumption, the clinician would provide a brief intervention in the form of education and advice on sensible drinking. Often this would be in the form of pamphlets that outline what constitutes a standard drink. One AOD clinician commented that offenders 'just don't know this information, they're drinking three drinks and thinking it is just one drink'.

Some AOD clinicians referred to this as a 'brief intervention, but the terminology was used to refer to a range of practice. For one clinician a 'brief intervention' was actually one or two treatment sessions plus education; for others, it was simply the provision of education aimed to reduce harm.

One clinician also mentioned the importance of educating people how to stay out of the court system.

3.4.2 The primary output from AOD clinicians was an assessment report presented to the judge

This AOD clinician report to the judge would recommend one or more of the following options.

- No further action[19]
- Better suited to another service (eg forensic mental health nurse, Man Alive anger management)
- Education to be provided
- Brief intervention[20]
- Comprehensive AOD assessment
- Community-based programmes (eg Drive Sober)
- One-on-one counselling
- Group counselling
- Residential treatment.

AOD clinicians said they would include information about whether the client agreed with their recommendation or not. This was said to 'show the judge where they [the client] are at, whether they

[18] An AOD condition imposed as part of a sentence may include further AOD assessment, counselling and/or treatment.

[19] Participants said this was a relatively uncommon recommendation. This may suggest that referrals to AOD clinicians were being made judiciously in the first place, or reflect the view of some clinicians that it was better to act preventatively before it became an issue.

[20] Sometimes the provision of education was the brief intervention.

have insight into their own behaviours or not'. The assumption being that if an offender opposed any of the recommendations it would reinforce the necessity of treatment.

3.4.3 Variation in length and depth of reports

The length of reports ranged from one paragraph of individually tailored recommendations to several pages of case history and discussion. This difference was again explained by individual philosophy. The clinician who wrote one paragraph was a proponent of the 'sharp' intervention model; the clinician who wrote longer reports preferred to conduct more thorough assessments (refer to section 3.3.7). This person hoped their reports would provide insight into the context and drivers of AOD consumption and offending. There was some variability within in the length of reports depending on the unique circumstances of each offender.

3.5 Use of other reports

Aside from reports provided by AOD clinicians in court, the following reports were available to judges to inform sentencing decisions.

- Provision of Advice to Court (PAC) reports and stand-down reports from Probation Services.
- Comprehensive AOD report (only available in a few courts).

Judges can call for reports under Section 25 of the Sentencing Act 2002[21]. This section allows the court to adjourn proceedings in respect of any offence, after the offender has been found guilty or has pleaded guilty, and before they are sentenced or otherwise dealt with. This is done for several purposes, including enabling inquiries to be made or to determine the most suitable method of dealing with the case. Under this section judges can call for a comprehensive AOD report or other reports. However, judges are not the only ones who order comprehensive reports, as shown in this observed example:

> *EBA charge. Judge orders a [PAC] report. Questions whether an AOD [clinician's] report is necessary. Offender thought he was over the limit but actually wasn't when he blew. Judge decides AOD [clinician's] report is necessary given previous conviction. Lawyer requests a comprehensive [AOD] report instead and the case is remanded.*
>
> — Researchers court observation notes

One participant indicated that an offender may undergo several assessments in a short space of time starting with the AOD court assessment, probation pre-sentence assessment, and one or two different treatment provider assessments depending on where they get referred to. Some of these assessments may use the same screening tool.

3.5.1 Provision of Advice to Court (PAC) Report

PAC reports are provided by Probation Services, and are standard reports used in all courts. According to one probation officer, Probation Services has a memorandum of understanding with the courts allowing 13 working days to complete the reports. PAC reports are written following a full interview with offenders. Sometimes the Judge directs Probation Services to look specifically for AOD issues in the report. These reports are provided free of charge to the courts.

According to one participant, Probation Services was previously criticised for having lengthy and unnecessarily detailed reports. As a result, Probation Services changed to a shorter template for PAC reports. While some judges thought the AOD clinician and Probation Services were 'on the same page

[21] District Courts may, under Section 25 (1) (a) of the Sentencing Act 2002, order an AOD assessment report be completed by a Health Professional as part of the sentencing process.

and saying the same thing', some judges expressed dissatisfaction with the reports provided by Probation Services[22].

Two judges, including one from a comparison site, commented on the PAC reports now being too short and leaving out important information such as employment status or relationship status. One of the judges acknowledged that it was very hard to get the appropriate level of detail, but they expressed uncertainty about the qualifications of Probation Services report writers.

A defence lawyer said that Probation Services staff were not being trained to assess AOD issues and, therefore, the expertise of the clinician was important; 'it's beyond ticking a box'. However, one of the probation officers had received some training about AOD interventions. Probation Services also provided offenders with an alcohol diary to start a conversation with offenders about their AOD use.

Another type of report was also mentioned by some participants and referred to as the 'same day' stand-down report from Probation Services. These reports were said to recommend sentencing outcomes but not focus on AOD issues. One judge preferred to order the two stand-down reports together, saying this was simpler and more streamlined.

3.5.2 Comprehensive AOD reports

AOD specialists employed independently, or by the DHB, can provide comprehensive AOD reports to the court on request. These take around two weeks to prepare, and include an in-depth assessment as well as background information about the offender and their situation. The reports are funded by MOJ and according to participants, cost between $400 and $1,000. Judges were conscious of these costs and one judge said they would 'always' get an AOD clinician's report first — which may then recommend a more comprehensive assessment.

Comprehensive AOD reports are not available in all courts. One of the courts that took part in this research did not have access to comprehensive reports, and participants cited lack of funding as the reason[23]. The AOD clinician at this court said their own service plus a PAC report would provide most of the comprehensive report information anyway.

A lawyer or judge, irrespective of whether an AOD assessment has been made by an AOD clinician, can request comprehensive AOD reports.

Judges said the comprehensive reports were not just limited to AOD issues, but provided a full background of the offender and were very useful. The reports include details of any mental health history, experiences of abuse, relationship status, family status, and onset of substance abuse. One judge said these reports were not always needed in cases of minor offences.

3.5.3 In some circumstances judges may bypass the clinician to order a comprehensive AOD report

Some judges also said that they may bypass the clinician and order a comprehensive AOD report where AOD abuse was self-evident. The following examples were given of situations where a request may be made directly for a comprehensive AOD report.

- The offender was on a second charge and has seen the AOD clinician previously.
- The offender was experiencing some form of emotional crisis.
- Anyone appearing on charges of disorderly behaviour, possession of cannabis, shoplifting, possession of drug paraphernalia.
- Anyone with multiple EBA convictions or an extremely high EBA reading.
- Where no AOD clinician service was available or clinician not present in court.
- The AOD clinician suggested a full report.
- The offender was appearing on a number of charges committed close together.

[22] The 2016 Ministry of Justice District Court Judges Survey found that 51% of judges were satisfied with Corrections reports.

[23] We have been unable to confirm if this is the reason for all courts that don't access the reports. Other possible reasons given were that not all courts were part of the Comprehensive AOD report Purchasing Framework referred to in Appendix 1.

3.5.4 Indications that judges in comparison sites may use PAC reports more than comprehensive AOD reports

Judges at comparison sites did not report much use of the comprehensive reports, with only one of the three judges indicating a preference for them over the PAC reports. The others tended to rely more on information in PAC reports. One comparison site judge said they did not use comprehensive AOD reports, despite describing the reports as ‘covering everything from womb to tomb’, because the reports always said the offender had ‘a predisposition and would benefit from counselling’. This judge said the report writer and Probation Services used the same screening tool so there was no extra benefit. While counsel sometimes asked this judge to order a full report, they said:

> *I take some persuading because of the cost and the time [of ordering a comprehensive AOD report], and the fact I’m not getting any more information than what Probation Services are telling me.*
> — Judge

4 Quality and consistency assurance

4.1 Differences between and within courts

4.1.1 There is no national framework in place relating to how the AOD clinicians in court should be delivering their service

There were several points of difference between courts.

- **Facilities provided to the clinicians**. Some clinicians had access to their own office along with full internet and phone services. Others did not have any of these services, and relied on public meeting rooms at the courts. One DHB provider said their local AOD clinician did not have a room to use, or even access to the DHB system where they could access MOH data as some other clinicians did.
- **Type of cases referred**. We were advised that only one district court screened every offender if the offence was connected to AOD, even first time EBA offenders. We did not visit this court, however, this court was considered to be the 'gold plated standard' by some participants. Not everyone agreed. These issues are discussed further in section 3.3.6.
- **Method of referral**. At some courts, judges referred cases to the AOD clinician during a stand-down period; at others it was the defence lawyers who referred cases early in the day. One court had different practices for family violence and criminal list cases. These issues are also discussed in section 3.3.3.
- **Location of court**. Offenders in rural locations experienced difficulty accessing treatment, and there were regional differences in the availability of treatment outside of business hours. These issues are explored further in section 5.4.3.

4.1.2 There were different approaches to delivering the service

The individual approach of the AOD clinicians affected some of the practices such as the length of assessments and reports, and attitudes to mandatory AOD treatment. Participants also expressed other individual views.

- Support for **different models of therapy**. For example, believing one-on-one counselling was more or less effective than group counselling. This is discussed further in section 5.4.3
- Whether to **screen every person** going through the court system, including very low level offending and first-time EBAs, and the cost-benefits of doing so. This is discussed further in section 3.3.6.
- Prioritising **health outcomes over justice outcomes.** The AOD clinicians would focus on the health needs of the offender rather than what the appropriate justice outcome might be. For example, the clinician would suggest sentencing conditions for AOD treatment and supervision if it was in the best interests of managing an offender's health, regardless of whether that was the appropriate sentence in terms of a justice outcome.
- Prioritising **competing employment and rehabilitative needs** (see sections 3.3.10 and 5.3.4).

4.1.3 There were some differences between clinicians

AOD clinicians spent varying times on conducting their assessments with offenders and used a variety of assessment tools.

At one court, the clinician said all offenders coming through the service would automatically become a client of the DHB, and they would be recorded as an 'event' in the DHB database. This did not appear to be the case in the other areas.

This clinician also indicated that they would enter data from the alcohol and drug outcome measure into the MOH system, and this was increasingly becoming mandatory. Not all AOD clinicians are employed directly by DHBs.

4.1.4 One of the main differences between judges was the level of engagement with the AOD clinician

This varied both from court to court, and within courts. However, judges in two courts indicated fairly consistent ways of utilising the AOD clinician. They reported that all resident judges used the service and said this consistency meant lawyers did not need to 'judge shop' as they did in some courts.

This was not the case in the other courts, where both judges and AOD clinicians commented on inconsistent buy-in from judges. We were unable to secure interviews with any judges who did not use the service at courts that offered it, so it was difficult to ascertain possible reasons for this. Other participants, however, reported the following factors as contributing to judges' inconsistent uptake of the AOD clinician service.

- Judges not being interested in AOD issues.
- Judges not being properly advised of the service, its purpose and benefits.
- Inconsistent staffing and availability of the service, with some courts having experienced periods of high turnover of clinicians.

Several participants felt judges needed to see the clinician sitting in court, which would remind them to use the service (see section 3.2.3). Without prompting, a couple of judges made it clear they would not support the introduction of guidelines to address inconsistency of use. There were also other differences between judges.

- **Types of cases they referred.** As discussed in section 3.3.3, judges vary in the types of cases they refer to the AOD clinician.
- **Different philosophies**. One judge said the AOD clinician was part of their 'prevention focused framework'. Other judges, including those from comparison sites, favoured a 'therapeutic jurisprudence approach'[24].
- **Whether they specified treatment** programmes in their sentencing. Some did stipulate which programme had to be undertaken, while others preferred to rely on defence lawyers or Probation Services to advise the best option.

4.1.5 Lawyers were very engaged with the AOD clinician service at some courts, but there seemed to be less engagement at others

There were also observed differences between private and publicly-funded lawyers. Reasons for these differences included:

- **Motivation**. Reportedly, some defence lawyers 'genuinely wanted' not only the best justice outcome for their client, but what was the best overall outcome for their clients. In some cases, there was a tension between obtaining a reduced sentence, or getting treatment (and the accompanying longer sentence) that might ensure a better longer-term outcome. One

[24] Therapeutic jurisprudence is a holistic approach that focuses on the emotional and mental health of people in the context of the legal system.

clinician reported that some private lawyers were 'just interested in getting through their caseload'.

- **Level of experience.** One defence lawyer thought that inexperienced lawyers did not always see the need for the service.

4.1.6 The level of interaction between AOD clinicians and Probation Services varied

In two courts, the probation officers said they would sometimes discuss offenders with AOD clinicians. This would happen when someone had been assessed and handed over to Probation Services, or in cases where an assessment had not been done, but Probation Services wanted advice on how to manage a particular client.

4.1.7 All the AOD clinicians saw relationship building as an important aspect of their job

There were two main components to these relationships: establishing good professional relationships with judges, lawyers and treatment providers, and establishing therapeutic relationships with clients.

The success of these relationships was integral to perceived success of the AOD clinician service, and was often recognised in interviews with participants. For example, one defence lawyer praised the clinician before saying 'they know the judges well and are attuned to the judges and what they want'.

The importance of relationship building was also obvious from situations where an established relationship was absent — usually with visiting judges who did not know the clinician and were often visiting from courts without the service available. This meant that even those who were told about the service would simply forget to use it.

AOD clinicians were sometimes unsure how assertive they should be in front of judges. One said 'I would never go directly to a judge and suggest a referral, always through the lawyer'. This same clinician said judges only 'occasionally' asked direct questions of them in court. However, at another court, one of the probation officers said judges 'often' spoke directly to the clinician.

The breakdown of professional relationships was talked about by one AOD clinician. They spoke of a 'couple of lawyers' who had stopped sending referrals because they were unhappy with the clinician's previous assessment recommendations. The clinician agreed it was possible some clients were missing out because of these fractious relationships, but believed they would be the exception.

4.1.8 Most clinicians thought the service they delivered was culturally appropriate

Among AOD clinicians, there were broadly similar views on whether the service met the needs of different ethnicities. Most thought it was culturally appropriate and could be tailored to meet specific needs if required.

One AOD clinician emphasised how having the clinician in court utilised whanaungatanga — the building of relationships through shared experiences. For example, this clinician felt that meeting the client at the courtroom for the initial assessment made them more likely to attend follow up courses and follow through with referrals. The AOD clinician contrasted this with Probation Services, who often struggled with poor attendance and lack of compliance.

Māori clients could be referred to kaupapa treatment programmes, and people with English as a second language could receive assistance.

Another AOD clinician said that they were certified to provide a multicultural service and worked to assess individual needs. People who identified as Māori would not automatically be referred to a kaupapa service if this was not what they wanted. However, one of the clinicians said they were 'quite hamstrung by the [range of] existing providers'.

A probation officer commented that one AOD clinician was not issuing many referrals to Māori or Pasifika providers, and instead relying on certain mainstream providers. The probation officer said this did 'not sit well' with them.

4.2 Family violence training

4.2.1 AOD clinicians did not have specialist family violence training to inform their decision-making

Participants were asked about the extent of specialist family violence training they had received, if any. The provision and uptake of this training seemed to be haphazard across all sites. Of note was that there was no consistent programme of family violence training given to the AOD clinicians.

One AOD clinician was scheduled to receive training in the month following the interview — 12 months after starting in the role — but had received some education on the topic when at university. Another AOD clinician felt they had 'a lot to learn' about family violence dynamics and had not received specific training but thought this would be 'very useful'. A third AOD clinician had background experience working with victims of family violence, so felt they had a 'good awareness' of the issues.

4.2.2 Judges did not report having specific training in family violence, but most cited extensive experience in dealing with such cases

The annual judicial conference in 2015 provided 150 district court judges with professional development on family and sexual violence[25].

Probation officers did receive family violence training to varying degrees. One officer described it as 'minimal' and another said it was 'good', but noted it required managers to take initiative and register their staff.

The police prosecutors who took part in this research reported that NZ Police provided comprehensive family violence training though the officers interviewed had not undertaken it. One added they had 'lived and breathed and tasted it [family violence cases] for twenty years on the street and prosecuted it for ten'.

[25] Source. NZ Family Violence Clearinghouse website extracted 18/4/16 https://nzfvc.org.nz/news/judges-receive-professional-development-family-violence

5 The impact of the service

5.1 Views on the value of the service

5.1.1 Broad support for AOD clinicians in court

There was broad philosophical support for the concept of having an AOD clinician in court from participants across all seven sites. Many participants said they believed it was a way of providing early intervention. One judge thought it played an integral role in a 'solution focused court' environment.

There was a general perception among all participants that providing judges with more information would lead to better decision-making. This was also apparent among judges at the comparison sites, who perceived they were missing out on a tool that would improve the quality of their rulings.

It was uncommon for offenders to disagree with a clinician's recommendations. One of the defence lawyers said offenders were usually 'happy' with the report, and attributed this to the clinician being good at their job — adding 'the reports are very accurate from my perspective'.

While judges were overwhelmingly supportive[26] of information provided by AOD clinicians, one commented that the reports were occasionally 'ambiguous' and this made them 'sometimes frustrated'. An example given was where the report might mention risky drinking behaviour but only make a recommendation for education. This may be explained by differing interpretations of an appropriate risk threshold.

5.2 Impact of the service

An impact analysis using administrative data was unable to be completed as part of this research. This was because of the inability to identify in the available court data those offenders who had undergone an AOD assessment in court, or offenders who had received sentences with mandatory AOD treatment components. As a result, some of the key questions relating to flow on effects in terms of sentencing and treatment outcomes are not definitively addressed. However, the data collected through participant interviews provides some insight into these areas.

5.2.1 Judges valued the clinicians' specialist expertise

Judges considered AOD clinicians to be experts, and thought their presence in the court improved the chance of identifying offenders with AOD issues. All judges said the service was helpful and they placed great reliance[27] on the advice provided by clinicians.

One judge described the service as 'quite a good filtering mechanism', and said it would be rare to get a comprehensive AOD assessment that did not correlate with what the AOD clinician had said in their brief assessment. This was said to be across the board, including family violence cases.

One judge said the clinician could usually identify AOD dependency at first appearance, and could intervene at that point. It was generally agreed that AOD clinicians helped achieve economy in this respect. Several judges thought all courts should have access to an AOD clinician.

Several judges said that substance abuse issues were often obvious from the summary of facts so the AOD clinician was not needed to identify issues but rather to provide judges with direction regarding treatment.

[26] Refer to section 4.2.1.

[27] The importance placed on clinicians' expertise is discussed further in section 4.2.

Judges and other stakeholders also thought the AOD clinicians were especially skilled at providing information on tailoring treatment to the particular offender. Some judges thought AOD clinicians had the expertise to get the 'right' information; clinicians themselves felt they were able to get past offenders' denial to engage them in treatment.

5.2.2 Other key stakeholders also valued the service and expertise of AOD clinicians

Key stakeholders including defence lawyers, probation officers and police prosecutors attributed other important outcomes to AOD clinicians.

- Raised awareness of AOD issues in general.
- Helping offenders, reducing reoffending, and 'getting to the source of the issue'.
- Unpicking exactly how AOD issues related to offending.
- Motivating offenders along the path towards rehabilitation.
- Provision of expertise that could not be obtained from Probation Services. Several participants commented that Probation Services were 'not experts' and felt the AOD clinicians provided more valuable advice in this respect.

5.2.3 **Presence of clinician in court raises awareness of AOD issues**

AOD clinicians believed that their presence in the courts raised awareness among judges and lawyers, of offenders' AOD issues. One judge said it reinforced an existing view that 'AOD [addiction] plays a big part in crime'.

A lawyer explained that 'people are much more alive to the issues knowing the AOD clinician is there and how [they] work'. One clinician thought the raised awareness meant lawyers changed their perception of clients and may alter strategies for handling a case.

5.2.4 **Impact on the speed of court processes**

There was general agreement that having stand-down referrals to the AOD clinician only sped up court processes in comparison to adjourning the case (for a PAC report or comprehensive AOD assessment). Participants said stand-downs could be avoided if defence lawyers pre-emptively ordered the report before court started.

In this respect, there emerged a hierarchy of options.

1. Defence lawyers referring clients to the AOD clinician before court.
2. Judges ordering a stand-down for the AOD clinician to see someone on the same day.
3. Judges adjourning a case for approximately two weeks for PAC reports or comprehensive AOD reports to be ordered.

Nevertheless, in some courts, AOD clinicians mostly saw clients during stand-down periods (that is, option two). One judge described this as having a 'neutral effect' on efficiency of the court. However, stand-downs could inconvenience lawyers and offenders who would have to stay until their case was recalled. One judge described this is as 'a small price to pay'.

5.2.5 **The majority of all comprehensive AOD reports were ordered at eight[28] district courts**

Several of these courts were also part of the AOD comprehensive framework pilot (see Appendix 1) which may have encouraged the use of comprehensive reports, by introducing standard costs and quality criteria.

---

[28] Blenheim, Hutt Valley, Masterton, Nelson, Porirua and Wellington District Courts which had AOD clinicians, Christchurch and Dunedin which don't have an AOD clinician.

Comprehensive AOD reports were also ordered at other courts but the numbers were lower than ten annually and too small to interpret meaningfully. A factor that could influence the ordering of comprehensive AOD reports from other courts is judges' preference for PAC reports (as expressed by some comparison site judges) as they do not incur a cost.

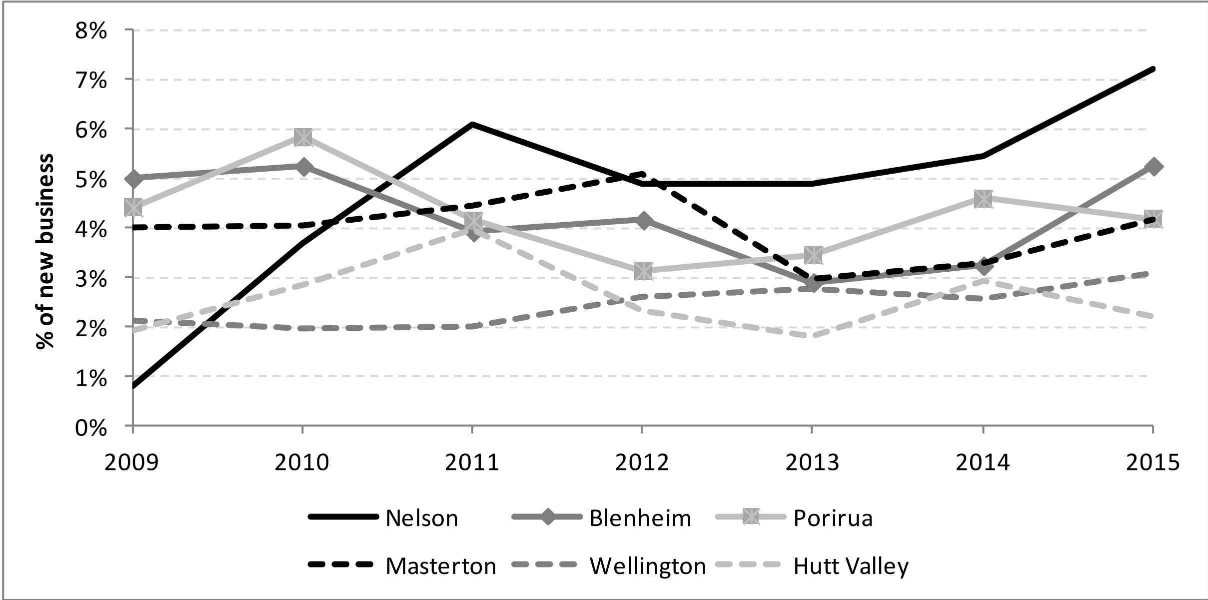
5.2.6 We were unable to confirm if the AOD clinician service in court influences the number of comprehensive AOD reports ordered

Judges, clinicians and defence lawyers generally indicated that it is possible more reports are ordered in those courts with AOD clinicians because they are identifying more offenders with AOD issues and recommending judges request more information.

We attempted to verify the impact of an AOD clinician service in court on the number of AOD comprehensive reports ordered in two ways. Firstly, in a time-series from 2009 to 2015 we compared comprehensive AOD reports ordered as a proportion of new business at courts with and without an AOD clinician. Secondly, in the same time-series we compared the six courts with an AOD clinician that have the option of ordering comprehensive AOD reports (See Figure 2): Blenheim, Nelson and Masterton (2001), Porirua and Wellington District Courts (2008) and Hutt Valley (2015). The year in brackets shows when the AOD clinician service was established in those courts[29].

Due to limitations in our data, in neither method were we able to determine conclusively the impact of the AOD clinician service on the ordering of comprehensive AOD reports.

Figure 2: Comprehensive AOD reports ordered, as a percentage of new business, for six district courts, 2009-2015



5.2.7 Some judges said there was duplication of reports

Judges had different views on which reports should be ordered in different situations. Some said there was duplication across reports available to the court. However, not all courts had all types of reports available to them.

The AOD clinician's assessment was described as a 'signpost' that could reveal AOD problems and trigger a PAC report to be ordered from Probation Services. A few judges indicated there were occasions where they ordered all three reports – an AOD clinician assessment, PAC report and comprehensive AOD report.

[29] See Appendix 1: History of AOD in court clinician initiatives.

One clinician thought their report sometimes influenced Probation Services as well as the judge. The clinician obtained signed consent from each offender to release the assessment information to Probation Services. This reportedly helped reduce timeframes and reduce duplication of services. A staff member from Probation Services thought reports from the AOD clinician were sometimes similar to those from Probation Services, but other times provided different information.

Some participants did not think the AOD assessment and the comprehensive AOD report overlapped because they provided different information; the comprehensive AOD reports were said to provide a treatment plan, give background context and explore mental health issues.

5.2.8 Several factors influence which reports are used

Several factors influenced judges when deciding which reports to use. This included the quality and type of reports available, which tended to vary by location. Most important was the severity of the crime and likely sentence, as indicated in the following comments.

- The AOD clinician's assessment was preferred for someone getting a sentence of community work or for first and second charges where the judges were not calling for a pre-sentence report.
- PAC reports were favoured if electronically monitoring was likely to be imposed; Probation Services would need to verify an address.
- PAC reports are required for potential sentences of imprisonment.
- For very complex cases, judges would call for a PAC report alongside a comprehensive AOD assessment.
- Two judges, plus one comparison site judge, said they would order comprehensive AOD reports because they were 'far more useful' and the PAC reports were 'not that great'.

The use of different types of reports was observed while court was in session, as the following example demonstrates:

> *Family violence case. Guilty plea. An AOD assessment report is presented by the lawyer. Lawyer requests AOD counselling and anger management within supervision sentence. The AOD assessment says the offender needs long term help for AOD problems. Judge stands the case down for a PAC report as well. Judge ask the probation officer if they received copies of the AOD clinician's reports. They say they didn't, so it is noted on the judgement that a copy of the report should go to Probation Services.*
> — Researcher's court observation notes

5.3 Sentencing decisions

Overall, judges used three key documents for decision-making: the summary of facts, criminal history and, where available, the AOD report from the clinician.

5.3.1 All the judges who had access to an AOD clinician said they took the clinician's recommendations into account most of the time and that it would be rare not to

This was borne out by the clinicians themselves and other participants. Judges frequently described AOD clinicians as being the professionals or experts. Judges considered the clinicians' advice to help remove guesswork.

One judge said he relied on the recommendations '100%of the time' because the clinician would be much more informed after sitting down one-on-one for half an hour with the offender. The judge would only speak to the offender briefly and did not feel this time was sufficient to accurately gauge the presence of AOD issues.

Without the clinicians, judges reported that they lacked the evidence to know the extent of offenders' AOD problems and did not know how to address such issues through sentencing. They reported not needing to rely exclusively on the PAC reports from Probation Services. One credited the clinician with helping them avoid a 'pot shot in the dark'. This judge said in the past they would base sentencing on the availability of treatment rather than knowing what would actually help the offender.

5.3.2 Judges reported that having the clinician's report could influence them

Judges reported that AOD clinicians' recommendations have changed the way they sentence offenders:

> *If the clinician wasn't there, the person would just be dealt with by the judge and go. There would be no intervention at all. They would just disappear.*
> — Judge

Judges indicated that the clinicians' reports influenced their decision-making in the following ways.

- The reports identified offenders who were in denial about their AOD issues.
- The report might also indicate offenders who wanted to address their problems, as well as those simply seeking to get the 'best deal' from the court.
- Judges would look favourably on people who accepted their problems and were genuinely committed to seeking help (particularly those requesting access to a residential programme).
- If the report concluded that no intervention was required, judges might change their view on whether or not to impose a supervision sentence with a drug and alcohol treatment component. However, one judge commented 'these [situations] are very much in the minority'.
- The report would inform judges' decision to act immediately or refer the offenders for further comprehensive assessment.
- One judge noted that when AOD issues were self-evident, the clinician's report would advise appropriate management of that problem rather than simply identifying it. This judge thought this added confidence in sentencing:

> *The key thing is tailoring a sentence that targets those issues and you're not flying blind. If you have a good understanding of what factors are motivating this person or causing them to commit offences you may get a better plan within Corrections to attack those issues.*
>
> *— Judge*

5.3.3 In some cases judges would defer sentencing to allow offenders to complete residential (or other) treatment programmes — sometimes bringing people back to check progress

These judges said they were more lenient in final sentencing towards someone who had successfully completed their treatment. Another judge indicated that in rare cases they might discharge without conviction if treatment was completed satisfactorily. For some offenders, completion of treatment meant the difference between a custodial sentence and community sentence. In such cases, judges would ask for a report from the service provider to verify (or not) the offender's completion of treatment.

One judge said that, while they might not suggest this course of action themselves, they would allow such a deferral if a lawyer requested it. However, not all judges used this approach. One judge explained that voluntary treatment would let offenders 'fall away' so they would end up imposing mandatory treatment anyway.

5.3.4 There were some situations where it was not feasible for AOD conditions to be imposed as part of the sentence

This was because the offender would not be able to meet the AOD conditions. One AOD clinician thought there needed to be more dialogue between lawyers, clients and Probation Services about whether particular types of sentence are suitable. Without this conversation, the clinician said in some cases it was 'setting them up to breach their conditions'.

As discussed earlier, some judges and clinicians placed importance on the offender maintaining employment. One judge said it was important not to jeopardise job prospects by imposing unrealistic treatment plans. Another judge commented that it was 'vital' to maintain employment 'if you can'. A third judge saw employment as one of the best protective factors a offender could have.

> *Many of the people who appear before me will have histories of unemployment and very bleak job prospects if they should lose their job. I don't want to jeopardise this.*
> — Judge

Nevertheless, not all judges held this view (and seriousness of the crime sometimes meant prison was the only option). A staff member from Probation Services also commented on the tension between employment and sentence obligations: 'if people are employed and housed they will get better outcomes from treatment…not all the judges seem to appreciate this'.

One judge identified access as a barrier to treatment success. They said their experience showed offenders had less successful treatment outcomes if they had to leave their support networks to attend programmes. A probation officer also commented on this, noting that access was a big problem for offenders who lived rurally and had to travel to treatment services. Such issues were compounded for those who had lost their driver licence as part of their sentence.

5.3.5 Data analysis was inconclusive about the impact of clinicians on convictions, sentencing and AOD condition stipulation

Court data was analysed to compare the proportion of cases in courts with the AOD clinician service and those without the service:

- on the most serious sentence received (eg imprisonment, community work, no sentence etc)
- where an AOD condition is stipulated at sentencing
- where an AOD condition is stipulated at sentencing where the most serious charge was a traffic and vehicle regulatory offence.

We are unable to draw conclusions about the impact of the AOD Clinician service from these comparisons for two reasons. Firstly, because the comparisons are unable to take account of any systemic pre-existing differences between the group of district courts with an AOD clinician and those without (eg type of cases and judge effects) that also influence the outcome variables. Secondly, the impact of AOD clinicians in court will be masked by the vast bulk of cases, on average about 94%, which are not referred to AOD clinicians.

The three comparison tables are set out in Appendix 11.

5.4 Treatment referral and completion

5.4.1 Some AOD clinicians said they would initiate treatment referral for motivated offenders before they appeared for sentencing

This was possible because sentencing can be delayed by as much as six to eight weeks. Figures from one court showed that in 2015 there were 30 referrals[30] to treatment made by one AOD clinician without judicial involvement. These referrals were mainly requested by private lawyers on behalf of offenders wanting to engage with AOD services while awaiting sentence.

Some AOD clinicians also said they personally followed up these types of referrals. One clinician said they would then provide feedback for use at sentencing. This feedback would explain how the client is benefitting from the treatment so far, and went beyond the 'confirmation of attendance' these agencies would normally provide to the judge.

[30] Source: DHB data.

As discussed previously, judges said they would look favourably on any offenders who showed commitment to addressing their AOD issues when sentencing them. The judges thought the prospect of leniency might encourage people to commit more fully to treatment.

Motivated offenders would also self-refer to treatment prior to sentencing, and others did so under pressure from their family. Several judges and AOD clinicians (plus one probation officer) thought it was better to get offenders engaged with AOD services before sentencing, when they were most motivated, rather than wait for sentencing to happen before initiating treatment. A probation officer said it was better if an offender was partway through treatment before their case was handed over to Probation Services.

5.4.2 There was a clear tension between mandating treatment and relying on initiative and motivation on the part of the client

This was alluded to in section 3.3.7. AOD treatment requires a lot of time and investment, and one clinician thought making a recommendation to an offender for self-referral could be risky in such circumstances because 'you are waiting for someone to take the initiative and they may just fall out of the system'.

Similarly, one judge reported a problem relying on offenders to follow through with voluntary counselling once they have been sentenced. In such cases, the offenders could not easily be brought back before the court unless they had breached a specific condition.

On the other hand, if supervision was imposed with a condition to undertake AOD treatment, Corrections would be able to bring the offender back before the court on a breach if they did not fulfil the obligations of the sentence. However, one judge noted this sometimes did not happen — 'sometimes people slip through the cracks' — because Corrections were overworked and understaffed.

Some participants identified issues that meant sentence obligations could not be completed within supervision periods. A probation officer said that supervision periods sometimes ended before initial appointments could even be secured with offenders, and that many remained on treatment waiting lists for too long. In addition, clients who missed a certain number of appointments with Probation Services would have to be stood down, which made it difficult for offenders to complete their treatment programmes within the supervision period.

5.4.3 Regions had variability in the availability of treatment services

Based on the comments of key stakeholders, regions had variability in the availability of services and the ability of services to meet demand. Some areas had to manage much longer waiting lists due to a lack of appropriate services; other areas 'generally' had enough treatment options to meet demand.

One participant said there were sometimes spikes in demand for AOD treatment following police 'crack downs' on certain offences. One AOD clinician claimed they were able to get people into treatment programmes more quickly than Probation Services. As a health provider, the AOD clinician was not hamstrung by delays to the court process and could initiate referrals 'straight away'.

For the most part, judges did not specify whether one-on-one or group counselling was preferred, but some AOD clinicians stated preferences. One clinician said group therapy was offered first in order to reduce pressure on waiting lists. However, they also said many clients received one-to-one counselling if the clinician thought they were not suited to the group setting.

However, a probation officer in another region said all AOD clinicians recommended one-to-one counselling. This probation officer also remarked on the lack of resources to provide one-to-one counselling for everyone.

5.5 Family violence cases

5.5.1 One judge commented on the importance of knowing mental health and AOD issues in order to manage risk and make safe decisions in family violence cases

Several judges and one clinician thought there was a correlation between AOD issues and family violence cases, with one noting 'it would be rare not to see this'.

One judge commented on the importance of knowing mental health and AOD issues in order to manage risk and make safe decisions in family violence cases. This judge said the AOD clinician's report could provide important context about these dynamics. The perception of another judge was that AOD issues increase the risk of reoffending. For example, under the influence of AOD the behaviour is more likely to be repeated and has more impact in the 'domestic arena'.

One AOD clinician considered it particularly important to look for co-existing problems among family violence cases, as they considered them more prevalent amongst family violence clients than in other (unspecified) criminal court cases. This view was also shared by a judge who thought it particularly important in family violence cases to 'know who we're dealing with'.

5.5.2 Although family violence cases were thought to have different and complex dynamics, there was very little difference in how AOD information is used in family violence cases

Several key participants, including judges, commented that family violence cases have very different and more complex dynamics than criminal cases. However, many of these same participants said there was generally no difference in how AOD information was used in family violence cases.
There were many reported factors contributing to the complexity of family violence cases.

- Offender and victim may have ongoing contact and may want to stay together.
- Both victim and offender may have been drinking or consuming drugs.
- The victim may have their own AOD treatment needs.
- Gang connections.
- Judges and lawyers seeing the same issues coming up for the same people.
- Victims saying they want the offender to get help, not go to prison.

Family violence victims were occasionally asked if they needed help managing their own AOD issues, but this did not appear to be standard practice. In such cases, one AOD clinician said it was important to manage the risk of having victims and perpetrators attend the same treatment group. In one location, the AOD clinician said a whānau group, available for offenders, would also offer victims support for dealing with their partner's AOD issues. The clinician reported this offer was sometimes accepted.

In two courts, probation officers thought family violence cases were approached differently from criminal cases because they needed to be 'unbundled' and breaches were taken more seriously.

5.5.3 Some comparison site judges also noted differences between family violence and criminal cases

One comparison site judge said they used comprehensive AOD reports more with family violence cases and explained they were more 'vigilant' for risk with family violence cases. Another comparison site judge perceived alcohol to be more of a factor in family violence cases.

5.5.4 It was unclear whether judges were deferring sentencing more often in family violence cases to allow offenders to undertake AOD and anger management treatment

One participant commented that judges were deferring sentencing in family violence cases for offenders to complete AOD treatment and anger management courses more often than in criminal cases. An example of this was observed:

> *Family violence case. Charges not stated. Lawyer is applying for discharge without conviction, and would like the case deferred so that the offender has time to complete AOD and anger management counselling. Police are opposing the discharge without conviction. Police also comment that previous counselling efforts have been 'heavy on intent and light on effort'. Case is deferred to [date] to give offender one more chance to do treatment (that might then be considered favourably in application for discharge).*
> — Researcher's court observation notes

However, there was no indication that this view was shared overall.

5.5.5 Some participants considered that it was better for family violence cases to be dealt with as efficiently as possible

There was a general perception that having an AOD clinician's reports meant the court could deal with a case that day rather than adjourning it, and that it was particularly important for family violence cases to be dealt with swiftly for the sake of the victim.

5.6 Comparison sites

This research also involved interviews with several judges presiding in courts without an AOD clinician service. These judges are referred to as comparison site judges, or simply 'judges' within the context of this section.

Comparison site judges approached decision-making in a similar way to that of judges who had access to an AOD clinician. However, they felt they were missing out — or 'flying blind' — because they lacked clinicians in their courts.

Note: comparison site judges' use of other reports is discussed in section 3.5.

5.6.1 The stated practice of judges in comparison sites did not differ significantly from judges in courts with clinicians

As with judges from courts with AOD clinicians, judges from comparison courts said they always looked for existing AOD issues. They also said that knowing someone had an AOD issue made a difference to their sentencing decisions.

If an AOD issue was identified, comparison site judges tended to impose supervision with treatment conditions. They would sometimes defer sentencing to allow offenders to complete treatment. They would then impose a more lenient sentence or discharge without conviction if the course had been completed successfully. This was similarly expressed by judges who had access to the AOD clinician.

One judge said they never knew how treatment had gone, only whether it was completed or not. This judge had 'no idea' whether they were imposing appropriate treatment because there was no evidence to know the extent of offenders' AOD problems. Ultimately, this judge based decisions on what services might be available, rather than what services would be best for the client.

Comparison site judges thought monitoring offenders through supervision would provide additional incentive for them to change. One judge would make decisions about including treatment as part of the sentence, but thought other judges automatically added a generic AOD clause into sentencing.

Comparison court judges based decisions on information provided in the summary of facts, criminal history, and information from the defence lawyer; some judges reported asking offenders directly

about AOD issues. One said ‘most people don’t deny they have a problem’. These judges would also sometimes seek information from comprehensive AOD reports (where available) and PAC reports.

Of interest, one judge expressed wanting to impose sentencing conditions for AOD treatment for non-family violence cases, but said the caseload pressure was ‘horrendous’. He said that the family violence and youth courts are the only ones you can really monitor people in. This put the judge in an unenviable position of deciding which cases needed the most help and which cases had the best prospects for change; these cases would then receive treatment-based sentences. This also implied that they were only using AOD conditions for family violence cases.

5.6.2 Comparison site judges knew little about the AOD clinician in court but perceived several benefits of the service

Most comparison site judges indicated a willingness to use the AOD service should it become available to them despite knowing little about it. One judge said ‘I guess I would use the AOD clinician’ service, but felt it hard to say for certain without seeing it operate.

Comparison site judges perceived several benefits of the AOD clinician service.

- It would help them help offenders.
- It would be useful to know the extent of an offender’s AOD issues, their current situation, and ‘where they’re at’.
- It would improve accuracy of risk assessment, particularly when there are children involved in family violence cases.
- It would tell if a offender was open to receiving help with their AOD issues.

Comparison site judges had experience working with forensic mental health nurses in their courts so they likened the AOD clinician service to that, with one judge noting lawyers were ‘very good’ at using the mental health nurses and pre-emptively requesting the nurse’s services.

Comparison site judges expressed some reservations about using the AOD clinician services, including:

- the impact of standing cases down when there is a full list
- whether the court would have adequate space to house an AOD clinician
- whether offenders’ self-report was accurate enough to inform decision-making.

With regard to the last point, one judge thought it would be helpful if AOD clinicians could verify what they are told, eg by accessing information about previous AOD treatment. Reportedly, the mental health nurses were able to access such information. Access to this type of information only existed for two of the AOD clinicians interviewed.

Overall, comparison site judges perceived the service positively. One said that having the AOD clinician service would be ‘absolutely magnificent…it seems like an obvious thing to do’.

5.7 Cost and efficiency

The lack of information on the effectiveness of the AOD clinician in court services means a cost benefit analysis could not be done as part of this research. Key stakeholders’ perceptions gave some indication about whether having an AOD clinician led to cost savings and efficiency gains.

5.7.1 Some efficiency gains were identified by key stakeholders

Overall, AOD clinicians were said to enable efficiencies in the following ways.

- Being able to deal with cases on the same day resulted in fewer adjournments. It was considered by some judges that a quick resolution was particularly important for family violence cases
- Surety provided by knowing there was no AOD problem, and saving what one judge termed ‘unnecessary referrals to Probation Services’.

Judges said the service had sped up some aspects of the court process enabling efficiency gains through fewer adjournments. According to some judges, the presence of the AOD clinician saved ‘churn’. If the judge got a report from the AOD clinician, they may not also need to order a stand-down report from Probation Services or a full PAC report. Ultimately, they saw the AOD clinicians as helping to reduce what they saw as unnecessary delays.

Judges who had presided in several courts said that when they presided in a court *without* an AOD clinician they tended to rely on Probation Services to identify AOD issues in PAC reports. Alternatively, the judge would order a comprehensive AOD report. These alternatives were viewed as less efficient and the PAC reports in particular were thought to lack the medical expertise of the brief assessment.

5.7.2 Participants claim more comprehensive AOD reports are ordered at courts with clinicians

Several judges referred to the cost of comprehensive AOD reports, with some expressing reluctance to incur the cost, while other respondents thought that providing information on offenders’ AOD issues meant there was no need to order comprehensive AOD reports. One judge thought fewer comprehensive reports were being ordered because of cases where the clinician found no alcohol issue or cases where an AOD issue was identified but sufficient information had already been provided in the clinician’s report. The judge explained: ‘it is a gatekeeper’s role, to make sure we’re not wasting resources and money’.

However, other judges reported ordering comprehensive AOD reports more frequently because the clinician was identifying a need for more in-depth information. The administrative data indicates more reports are ordered at courts that have an AOD clinician than at those that do not, but no regression analysis was possible to rule out other factors, therefore a direct correlation cannot be assumed.

5.7.3 Standing down cases does not adversely impact court time and processes

Judges described the standing down of cases for an AOD assessment during the court list as having minimal or ‘neutral’ impact on the efficiency of the court processes. If anything, it speeds up the processes by reducing the number of cases that would have adjourned for longer periods.

5.7.4 Unintended consequences

Probation officers cited two situations that could lead to unintended consequences. The first was if a judge has misunderstood the intention of an AOD clinician’s advice and imposed a sentence the AOD clinician did not intend.

The second situation was a judge ordering supervision based solely on the AOD clinician’s advice and without consulting Probation Services. One probation officer saw this as problematic because Probation Services may have held important information about the offender that would have influenced sentencing. The probation officer thought this happened because judges liked the idea of resolving matters on the day.

A further unintended consequence was the lack of facilities for the AOD clinician. A DHB provider explained that court funding for rooms was based on full time equivalent (FTE) staff numbers. However, because AOD clinicians are employed by the DHB, or are independently contracted by the DHB, they do not appear within FTE numbers for MOJ funding. Ultimately, it was said to fall on individual courts to provide a suitable space for AOD clinicians to work. Although MOH ultimately funds the AOD clinician service, there were said to be additional costs (aside from staffing) met by the court.

5.8 Views on expanding the service model

Currently the main focus of AOD clinicians is around providing information to judges to inform sentencing decisions. However, some other options for using their services at other stages of the criminal process were raised. Some clinicians were already doing this, eg at diversion.

5.8.1 Some participants considered whether the clinician should be available earlier in the process

One police prosecutor thought it would be helpful to have an AOD clinician available at time of arrest to conduct an assessment and brief intervention at the police station. This suggestion was also made in the 2014 evaluation of Tauranga's AOD clinician service (refer to Appendix 2). However, this evaluation noted the resource implication of having the clinician working at two locations.

5.8.2 Some judges wanted a clinician available at bail hearings

The Ministry of Justice has previously noted that, in isolation of other expert advice, obtaining information on AOD issues from an AOD clinician in court is unlikely to greatly improve judges' ability to assess risk at a bail hearing (Ministry of Justice, 2015). However, some judges have expressed a desire for AOD clinicians to be available at the bail stage of proceedings. Therefore, judges and AOD clinicians were asked whether they thought the service would provide helpful information for bail hearings.

One judge reported being happy with the current process for receiving AOD information and did not think it would be helpful to have the clinician involved at bail hearings. However, several other judges, including one from a comparison site, did think it would be helpful to have the AOD clinician involved at bail hearings. One AOD clinician was already being asked, mostly by the judge and occasionally by defence lawyers, to provide information at bail hearings, usually in cases where police were opposing bail.

Judges talked about the importance of assessing risk at bail, particularly for family violence cases. One judge said that, for example, a methamphetamine addiction would be a high-risk factor. This judge thought more information about family violence offenders was better because risk assessment was difficult; any assessment information from AOD clinicians would be helpful. Ultimately, though, information from AOD clinicians was deemed 'just one of a myriad of factors to take into account'.

It was not in the scope of this research to consider the practicalities of the AOD clinicians being involved earlier in the justice pipeline. However, several participants questioned how this might work in reality, and noted some possible areas to consider as follows.

- Bail decisions can be problematic because, prior to making a plea, offenders are reluctant to reveal too much information about themselves and their problems.
- Community magistrates and registrars, as well as judges, may preside at bail hearings.
- Police already provide information (AOD-related and otherwise) to judges in cases where they think bail should be denied.
- One judge was opposed to the idea of imposing treatment conditions at the bail stage. However, the AOD clinicians noted the value of starting treatment early in the process when the offender may be feeling more motivated to engage.

6 References

Bay of Plenty District Health Board (2014) *Court addiction service evaluation: Project report 2014*. Tauranga: Mental Health and Addiction Services.

Conner H and Walfisch K (2011) *Alcohol and other drug work: Overview*. Wellington: Ministry of Justice.

Family Violence Death Review Committee (2014) *Fourth annual report: January 2013 to December 2013*. Wellington: Author.

Ministry of Justice (2015) *Health information in courts: Briefing to the Minister*. CJS-29-12.

Sentencing Act (2002). Available from: http://www.legislation.govt.nz/act/public/2002/0009/latest/DLM135580.html (accessed 10 February 2016).

7 Appendices

7.1 Appendix 1: History of the service

This information was provided by staff at the respective district court.

2001 Nelson service pilot initiated by District Court Judge Walker. In this service, a clinician is present for the criminal lists each week and, when required, the judge can stand down cases for the offender and clinician to have a discussion. The judge also will ask questions of the offender. Once a comprehensive AOD report is called for, the clinician will make a date and time with the offender before they leave court, which saves time for the report to be done and received. The report is delivered 3 days prior to sentencing so takes around 3 weeks to complete. The service is provided by Marlborough District Health Board[31].

The service was extended to Blenheim District Court, funded by the DHB. Here, the AOD clinician sits in court for the criminal list on a Monday only, attending to morning list matters. Counsel or the judge will ask for a stand down and the clinician will report back to court with a brief written report. The clinician may also see an offender before court in the interview room at the court. A full comprehensive report may be requested which takes a few days and MOJ pays for. If a matter is adjourned, the clinician may return to court at another time for the offender's sentencing.

Masterton District Court introduced a similar service and still has an AOD clinician in court on occasion. This is usually one day a fortnight on a criminal list day[32].

2005 Tauranga in-court AOD clinician established, funded by National Drug Discretionary Fund[33].

2008 Northland, Kaikohe, Wellington and Porirua District Courts offered in-court AOD clinician service as joint venture between MOH and MOJ.

In mid 2008, the service commenced in several Youth Courts[34], but is no longer operating.

2009 Ministries of Health and Justice conduct review of pilots of mental health and AOD services in district and youth courts[35].

2014 Bay of Plenty DHB Court Addiction Service Evaluation.

2015 In-court AOD clinician service commenced at Hutt District Court.

The Comprehensive AOD Report Purchasing Framework

This was introduced in Wellington District Courts in 2008 and reviewed in 2010. It included:

- a standard number of hours and cost for each report, plus set claimable expenses
- a service brief to assessors outlining the key information required in the report.

---

[31] Nelson District Court Service Manager, Criminal, 21 /1/16.

[32] Criminal Case Officer, Masterton District Court.

[33] Specialist Courts and Court Based Initiatives, July 2011 extracted from the MOJ intranet 21/1/16.

[34] Criminal Jurisdiction Update, December 09 extracted from the MOJ intranet 21/1/16.

[35] Criminal Jurisdiction Update, December 09 extracted from the MOJ intranet 21/1/16 (refers to a Cabinet paper). The update states that Cabinet Agreed to report back to Ministers before 28 February 2010.

7.2 Appendix 2: Previous evaluation

In 2005, the AOD clinician in court service was launched at the Tauranga District Court[36] in collaboration with the Bay of Plenty (BOP) DHB Mental Health and Addiction Services. This pilot was then evaluated by MOH and MOJ in 2007. The pilot was deemed successful and transitioned to business as usual, with some recommendations for improvements.

The BOP DHB conducted a further evaluation[37] of their AOD clinician service in 2014 (referred to as the 2014 evaluation). This looked at whether recommendations from the earlier evaluation had been implemented, the efficiency of the service since 2007, whether clinicians were being fully utilised, and any further recommendations as needed.

A major point of difference between this research and the 2014 evaluation was offender participation. In the 2014 evaluation, the evaluator attended the AOD clinicians' assessments and asked offenders to complete a tick-box questionnaire with space for comments. The 2014 evaluation found that offenders appreciated feedback from the clinician on AOD consumption. They also found it useful to receive information, and some were open to treatment referral and follow up.

The 2014 evaluation included several recommendations that could be applied to how AOD clinicians operate at other courts. These included:

- encouraging more pre-emptive referrals from lawyers
- improving collaboration between Probation Services and AOD clinicians
- providing a suitably resourced office in a suitably accessible location within the court (eg a room, with a telephone and computer, which is conducive to private assessments)
- improving data collection and record-keeping systems
- undertaking a promotional campaign and facilitating regular meeting with stakeholders.

In March 2015, the BOP DHB implemented a plan based on these recommendations and others.

Although the 2014 evaluation differed from the current research in terms of scope, some findings were in keeping with this research.

- Pamphlets and resources about the service were available in court. Most judges were aware of the service, but did not necessarily know who the clinicians were, or the purpose of the service.
- Use of the service was low despite evidence of higher demand. Overall, the service was valued and seen as essential for assisting court processes.
- Most referrals came from magistrates and lawyers, with few referrals coming from judges. When judges did make referrals, it was because they were unsure whether the offender had AOD issues. When such issues were obvious, judges would refer offenders to Probation Services for a stand-down report.
- The AOD clinicians were sometimes asked — by both judges and Probation Services — for advice on the appropriateness of supervision.
- It was suggested that lawyers be more proactive referring offenders for assessments with the clinician. Earlier involvement with AOD clinicians was one factor deemed favourable for offenders at the time of sentencing.
- It was deemed a better use of clinicians' time to conduct assessments prior to court starting rather than leaving court during the day to carry out stand-down referrals.
- It was important for AOD clinicians to have a designated office space within the court.
- Police were not involved in making direct referrals to the AOD clinicians.

[36] The AOD clinician service here is known as the 'addiction assessment in court'. For consistency, the generic description is used throughout. However, the service in Tauranga operates slightly differently, with the clinician also attending the community magistrates' court and other types of list courts.

[37] Bay of Plenty District Health Board 2014, sourced with permission.

- Police favoured having an AOD clinician available to conduct a brief intervention at the police station, soon after arrest.

7.3 Appendix 3: Methodology

Parameters of this research were agreed as follows.

7.3.1 In scope

- Ad hoc advice provided by AOD clinicians in court
- Assessments provided by AOD clinicians in court
- Administrative court data, including bail and sentencing types
- Administrative data relating to AOD assessments (held by clinicians or providers)
- The role and influence of AOD clinicians

7.3.2 Out of scope

- Assessing the appropriateness of having AOD information used in court for decision-making
- Pilot AOD Treatment Court
- Forensic MH clinicians in court

7.3.3 Site selection

AOD clinicians are currently located in the following courts:

- Kaikohe
- Whangarei (operates family violence court)
- Tauranga
- Wellington
- Hutt Valley (operates family violence court)
- Porirua (operates family violence court)
- Masterton (operates family violence court)
- Nelson
- Blenheim

All other district courts were eligible for comparison. However, on the advice of MOJ policy advisors, certain district courts were excluded if they were involved in a pilot study during the same period, or if they operated the pilot AOD Treatment Court.

The selection of sites was based on a set of criteria taking into account the representation of both family violence and non-family violence courts, the number of comprehensive AOD assessments ordered by each court, and available budget.

With these considerations made, Whangarei, Wellington and Hutt Valley District Courts were selected for this research as the main sites offering the AOD clinician service (not including interviews conducted with two people from two other sites offering the service). Dunedin and Manukau District Courts were chosen as the comparison sites.

7.3.4 Ethical considerations

MOJ researchers follow the Association of Social Science Researchers' code of ethics. Tailored information sheets[38] were provided to potential participants that set out the purpose of the research, that participation is voluntary, what questions would be asked, and measures taken to ensure confidentiality.

Participants were asked to give their informed consent[39] to being interviewed and for the interview to be digitally recorded. All quotes in this research report are attributed to the role each participant performs. No individuals have been named. However, because of the small number of interviews

[38] A copy of the information sheet is in Appendix 6.

[39] A copy of the consent form is in Appendix 7.

conducted for each role, it may be possible to identify people; we have undertaken every effort to prevent this happening.

Electronic copies of the raw interview data are stored on a password protected computer and hard copies of this data are kept in a locked cupboard that only the research team can access. The raw data will be destroyed two years after this research report is circulated.

7.3.5 Assumptions

The design of this research makes several assumptions in identifying who key players might be, and which voices to privilege.

- Interviews are conducted with professional stakeholders rather than offenders or victims.
- AOD related treatment is assumed to be a positive outcome for offenders identified as having AOD issues.
- The provision of accurate AOD information is assumed to help judges make more informed decisions and increase the accuracy and rigour of such decisions.
- The use of administrative data assumes the data is suitable for the type of analysis undertaken.

7.3.6 Data collection

This research draws from three primary sources of data: semi-structured face-to-face and telephone interviews with key stakeholders, observations of court proceedings, and administrative data held by MOJ, DHBs and any other relevant service providers.

INTERVIEWS

A purposive sampling technique was used to identify and recruit participants from key stakeholder roles in the three main locations: AOD clinicians, judges, defence lawyers, Probation Services, DHB providers and police prosecutors. At each location, the court services manager, NZ Police and Probation Services provided a list of appropriate stakeholders who were then approached to participate in this research.

The plan was to interview, where possible, at least one person from each role at each of the three main AOD clinician sites. Key stakeholders from two additional locations[40] were also interviewed to understand the establishment of the service and build on existing information. This meant four AOD clinicians took part. In most locations, at least two judges were interviewed to assess consistency of practice and gather a broader range of views.

In total, 25 semi-structured interviews were conducted with:

- four AOD clinicians
- ten district court judges, including seven from courts with the AOD clinician service and three from comparison sites
- three probation officers and one probation manager
- three defence lawyers, including two public defenders and one in private practice
- two DHB managerial staff members
- two police prosecutors.

The ten judges came from a range of backgrounds. They had worked in a number of different courts over the past five to ten years. They all had some experience of working in criminal courts without AOD clinicians. Some had experience working in civil and family courts as well.

The following core topics were covered in all interviews:

- processes around AOD clinicians and their work
- judicial decision-making
- flow-on effect in terms of bail, sentencing and treatment outcomes

[40] Tauranga and Porirua District Courts.

- successes and challenges of AOD clinicians
- how family violence cases compare to non-family violence cases.

Interviews at the two comparison sites were conducted via telephone, covering the following topics:

- whether AOD information is considered in their judgements
- where they obtain this information (eg psychological reports) given that AOD clinicians are unavailable
- whether they would value the addition of AOD clinicians in their courtrooms (covering why and why not).

Copies of the interview guides are in Appendix 8.

ADMINISTRATIVE DATA

To triangulate interview data and to address particular objectives, administrative data from relevant providers was sought, along with data held by MOJ. However, health data was difficult to obtain because it either a) had not been recorded or b) could not be released due to privacy reasons. Because of the time pressure on this project, approval could not be sought from the Health and Disability Ethics Committee to access health data that may identify individuals.

The Ministry of Justice data was obtained for the most serious charge per person disposed in 2014/2015 (which started and finished in a district court), including sentencing information for that charge. In addition, MOJ data was obtained on the number of comprehensive AOD assessments being ordered at each court.

M`ore information about the administrative data is in Appendix 10.

RESEARCHERS COURT OBSERVATIONS

Court observations were conducted at all three main sites with AOD clinicians. This was to corroborate accounts of key stakeholders and witness how AOD clinicians interacted with the judiciary and other parts of the court system. A copy of the court observation template is in Appendix 9.

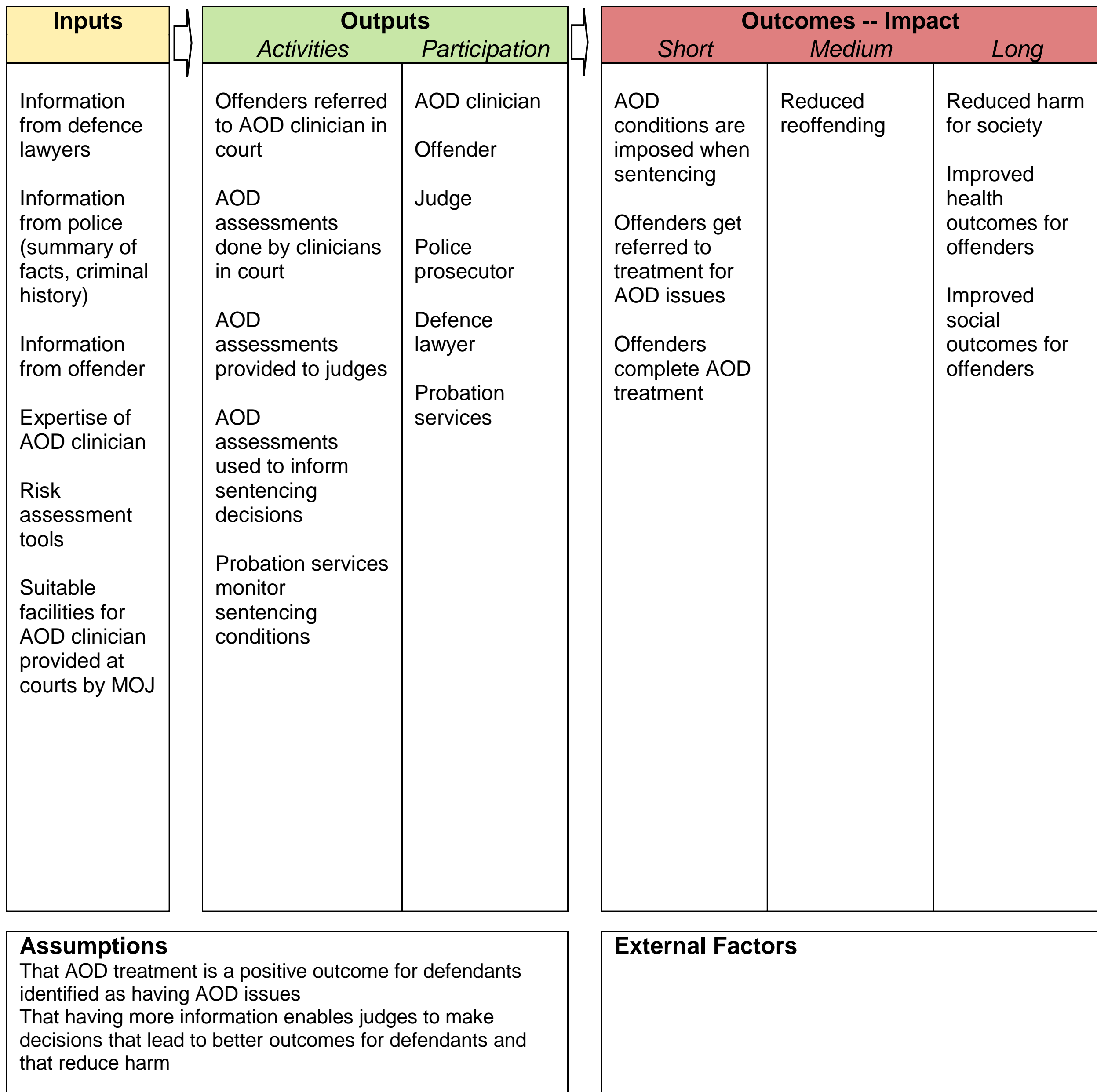
7.3.7 Analysis

Thematic analysis with NVivo software was used to interpret interview notes and observational data.

Administrative data was analysed to investigate any differences in sentencing outcomes or conditions imposed and numbers of comprehensive AOD reports ordered between courts with AOD clinicians and those without.

7.4 Appendix 4: Intervention logic model

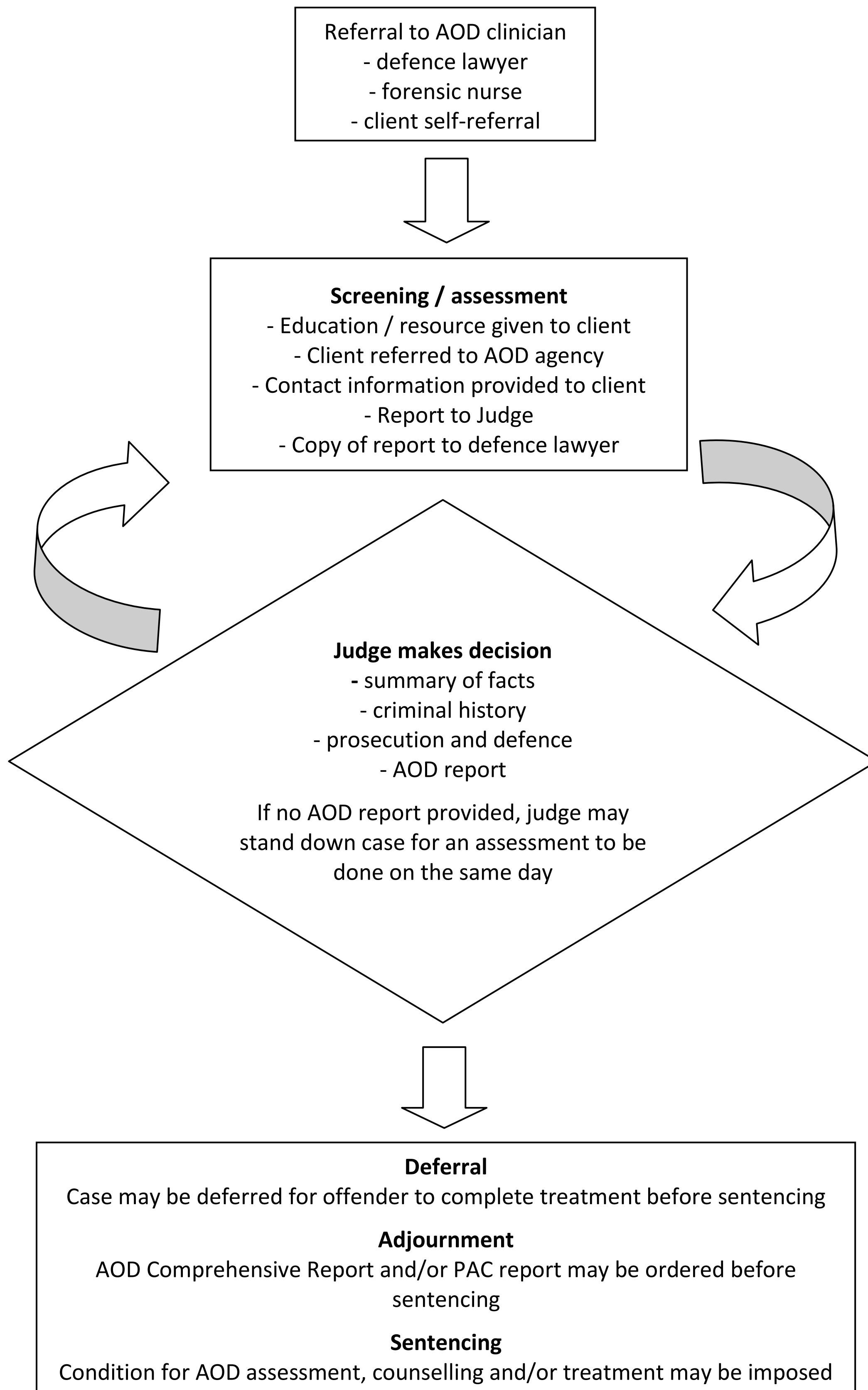
Program: **AOD clinician in-court service**
Situation: What are the expected outcomes from the service
Aim of the service: To provide offender health information to judges in courts to facilitate informed decision making



Inputs	Outputs		Outcomes -- Impact		
	Activities	*Participation*	*Short*	*Medium*	*Long*
Information from defence lawyers Information from police (summary of facts, criminal history) Information from offender Expertise of AOD clinician Risk assessment tools Suitable facilities for AOD clinician provided at courts by MOJ	Offenders referred to AOD clinician in court AOD assessments done by clinicians in court AOD assessments provided to judges AOD assessments used to inform sentencing decisions Probation services monitor sentencing conditions	AOD clinician Offender Judge Police prosecutor Defence lawyer Probation services	AOD conditions are imposed when sentencing Offenders get referred to treatment for AOD issues Offenders complete AOD treatment	Reduced reoffending	Reduced harm for society Improved health outcomes for offenders Improved social outcomes for offenders

Assumptions	External Factors
That AOD treatment is a positive outcome for defendants identified as having AOD issues That having more information enables judges to make decisions that lead to better outcomes for defendants and that reduce harm	

7.5 Appendix 5: Process chart



7.6 Appendix 6: Information sheet

AOD clinicians currently operate in several district courts around the country. The purpose of AOD clinicians in courts is to help judges make decisions on bail and sentencing by advising them of any alcohol or drug issues that an offender might have.

The Ministry of Justice is conducting exploratory research looking at the role of alcohol and other drug (AOD) clinicians in district courts. This research was proposed in the Stronger Response to Domestic Violence cabinet paper.

What is the evaluation about?

The purpose of this research is to better understand how the AOD clinician in court service is operating, how the advice given is used and the effect of having AOD clinicians in court on outcomes for offenders.

This research will explore topics including:

- The processes surrounding AOD clinicians and their work
- How AOD information influences judicial decision-making
- Any flow on effect in terms of bail, sentencing and treatment outcomes
- Any challenges facing AOD clinicians
- How family violence cases compare to non-family violence cases.

Why have I been selected?

We are inviting you to take part as you play a key role in district court processes and your thoughts and comments are important to help us understand how AOD clinicians currently operate in court and how the information they provide is used.

How will the evaluation happen?

Our fieldwork team consists of Brenda Crane (Senior Research Advisor and Project Lead) and Laura Ranger (Research Advisor). We will be observing court processes and interviewing key people such as judges, clinicians, prosecutors, and DHB staff.

What will my participation involve?

We are inviting you to participate in a face-to-face interview that will last approximately 30 to 60 minutes and will take place in November at your local district court or other suitable location. With your permission, the interview will be recorded for analysis purposes and may be transcribed.

What will happen to my information?

The information from the interviews will be summarised in an evaluation report for the Ministry of Justice. No data will be attributed to individual participants by name and your generic role description will be used to reference any direct quotes. Please note that because this research involves a small number of people in your role, your anonymity cannot be absolutely guaranteed. However, the researchers will strive to maintain confidentiality at all times. Audio files, research notes and summaries will be stored securely by the Ministry of Justice for two years and then destroyed.

What are the possible benefits and risks of this study?

Your participation will give us useful information that can be used to improve the justice system and the services it provides. We have not been able to identify any significant risks to participating.

What are my rights?

It is your choice whether you participate in this research, and you may withdraw at any point up until five days after the interview. During the interview, you do not have to answer all of the questions if you do not want.

You have the right to request a copy of your transcript and/or a summary of research findings. If you would like this, you will need to provide an address when you sign the consent form.

Are there any other ethical considerations?

All researchers working on this project will adhere to the Association of Social Science Researchers' code of ethics: assr.org.nz/ethics.html.

Whether or not you participate in this research will not affect any current or future relationship you have with the Ministry of Justice or other government agencies.

What if I have more questions?

If you have any questions about the interview or participating in this evaluation, please contact Brenda Crane, Senior Research Advisor, Ministry of Justice on 04 918 8546 or at Brenda.Crane@justice.govt.nz.

7.7 Appendix 7: Consent form

I agree to be interviewed about AOD clinicians in court, as outlined in the information provided to me by the Ministry of Justice. I understand that:

- My participation in this interview is voluntary and I can stop the interview at any stage
- I can withdraw my answers up to 5 days after my interview
- I have the right to request a copy of the transcript of my interview
- Findings from the interviews will be summarised together and published in a report
- Quotes from my interview may be used in this report but these will not use my real name
- The small number of key informants involved in the research means that my anonymity cannot be guaranteed absolutely
- Whether or not I participate in this research will not affect any current or future relationships with the Ministry of Justice or other government agencies
- With my permission, the interview will be audio recorded and transcribed.
- Audio files, transcripts and research notes will be stored securely at the Ministry of Justice and will not identify me. These files, transcripts and notes will be destroyed two years after the research report is finalised.

I have read the information sheet and this consent form. I have been given the opportunity to ask questions and have had those questions answered to my satisfaction. As a result:

I give my consent to participate in this interview	Yes	☐	No	☐
I agree to the interview being audio recorded	Yes	☐	No	☐
I agree to the audio recording being transcribed	Yes	☐	No	☐
I would like to receive a summary of the key findings	Yes	☐	No	☐

Name ____

Signature ____

Date ____

7.8 Appendix 8: Interview guide

This interview guide combines questions for different key stakeholders. Not all questions were asked of all participants.

Introduction

Explain purpose of the research. We are trying to find out how AOD clinicians work and to better understand the effect of this service. We are also looking at any flow-on effects this service has in terms of bail, sentencing and treatment outcomes.

This interview will take about 60 minutes. During this time I will ask questions about your role as [role], how you think the AOD clinician service has been operating, and discuss any opportunities for improvement in processes. We are interested in your thoughts and experiences. There are no right or wrong answers.

Go through information sheet, informed consent and audio recording. Sign consent form.

General introduction

- How long have you been in this role?
  - Pathway to this role
  - Training for this role
- What do you understand is the aim or purpose of having AOD clinicians in court?
- Who do you see as the target group you are expected to work with?
  - Is that the group they are working with?
  - Is anyone missing out? Who?

Questions for AOD clinicians

- How many days a week are you in court?
  - How many referrals received?
- Who refers offenders to you? How is contact initiated?
- What sort of information do you get asked for?
  - Assessment findings
  - Suggested sentencing options
  - Treatment options
- Does what you get asked for vary depending on who has referred the offender?
- Do processes differ when diversion is an option? How?
- What information do your record about your interactions with offenders?
  - Where is it recorded?
- Could you please talk us through the last referral you had from beginning to end?
  - How did you get introduced to the offender?
  - How did the offender react to being referred to you?
  - Were they cooperative?
  - What assessment tool did you use?
  - At what point in the court process did you meet with the offender?
  - How long did you spend with them?
  - What information did they give you?
- Was that a typical experience? If not, how did it differ from a typical experience?
- Are there key questions you ask of all offenders irrespective of the charge?
  - Do you use sources of information other than what the offenders tell you?
- How do you provide the information?
- How is the information you provide used in court?
  - By judges? What effect does it have on decisions?

- ~ By prosecutors?
  - ~ By defence counsel?
  - ~ By Probation Services?
- Do you get requests for other more general AOD information not specific to a case? Who from?
- Do you think the AOD information you provide makes a difference to the outcome for offenders? How?
- Are many offenders referred to AOD treatment services?
  - Who is responsible for making this happen?
  - Who is responsible for follow up to ensure they attended treatment?
  - How would you describe the availability of suitable AOD treatment services? Waiting times?
  - Are you ever required to follow up with treatment providers?
- What factors do you think influence whether a judge asks you for an assessment or opinion?
- In your view is your participation in the process having any impact on judge's levels of understanding about AOD issues?
- Are you aware of any unintended consequences resulting from an AOD clinician being involved in court cases?

Questions for judges (AOD clinician sites)

- What types of cases do you preside over?
- Overall, how useful do you think it is having AOD clinicians in court?
  - Has the advice provided by the clinicians increased your knowledge or awareness of offenders with AOD issues?
  - Has having an AOD clinician in your court influenced how you treat AOD issues?
  - [If relevant] In what ways is it different having an AOD clinician in court, compared with your earlier experience?
- Do you think having the clinicians in court increases the likelihood of you identifying offenders with AOD issues?
- Roughly how often do you refer an offender to the AOD clinician? Number of referrals per day/per week?
- Thinking about the most recent referral you made:
  - What grounds did you refer on? What signs/situation was there that made you think a referral was needed?
  - How and when was a referral made?
  - How was the referral recorded? Who by?
- Thinking about the most recent report you received from an AOD clinician:
  - What types of information or services did the clinician provide you with? Assessment findings? Suggested sentencing options? Treatment options?
  - How did the clinician feed information back to you?
  - What did you do with the information the clinician gave you?
  - What decision, if any, did the information contribute to eg bail decisions, sentencing decisions?
  - Do you think the AOD information provided by the clinician made a difference to your decisions? [If yes] In what way? Treatment for the offender or ordering a more comprehensive report? [If no] What was the reason for that?
- Was that a typical situation? If not, how would a typical situation differ?
- Can you think of an example where you changed your mind because of information provided by an AOD clinician?
- Can you think of an example where information provided by an AOD clinician *didn't* change your decision-making?
- Thinking about the information provided by the AOD clinicians in court, is there any difference in the way you use that for family violence cases versus non-family violence cases? If so, what is different?

- Does use of the AOD clinician service differ when diversion is an option? How so?
- What other sources of information do you take into account when making those decisions? Does this information come from the AOD clinicians or other sources? Eg comprehensive assessment?
- How does having the AOD clinicians on site impact referrals to other treatment and follow up services? Eg how or what influences any recommendations you make for offenders with AOD issues?
- What factors make you likely to refer offenders for comprehensive AOD assessments?
- Does having an AOD clinician increase or decrease your tendency to refer offenders for comprehensive assessments?
- Are there occasions where you would bypass the AOD clinician service and just order a comprehensive assessment?
- Do you think there is any overlap between the AOD clinician service and the comprehensive AOD report service? Are they fulfilling separate purposes?
- How does having the clinicians in court impact on other court processes? Eg stand down of offenders, does it speed up processes or, slow them down? What would be done differently if they weren't there?
- Are there any guidelines in place to ensure the AOD information court clinicians are giving to judges is being used in the same way by different judges?
  - If not, do you think there should be guidelines? What might these guidelines look like?
- In your view do other judges use the AOD clinician service in the same way you do? Why do you say that?

Questions for judges (comparison sites)

- Have you presided in a court where an AOD clinician is present?
- What information do you normally take into account when deciding about bail?
- What about sentencing? Would your process be the same?
- If an offender had an AOD issue, would you know about it? How?
- Would knowing about an offender's AOD issue make a difference to how you make bail/sentencing decisions?
- What do you know about the AOD clinicians in court service?
- What do you think is the aim or purpose of having AOD clinicians in some courts?
- Is this service something you would use if it was available in your court?
- What do you perceive to be its benefits? Disadvantages? Impact on identification of offenders with AOD issues?
- Do you have any reservations or worries about this type of service? What are these?
- Do you currently refer offenders for comprehensive AOD assessments? What factors influence you to do this?
- Do you think the comprehensive assessments are a sufficient tool for the court to manage offenders with AOD issues?

Questions for defence lawyers

- For what reasons do you refer a offender to an AOD clinician?
- What is the process for getting an AOD clinician to see a client of yours?
- Do processes differ when diversion is an option? How?
- What information do you receive from the clinicians? Verbal/written?
- How is the information used in court? By who?
- How is the information and/or your interactions recorded?
- Do you ever receive requests from police prosecutors to obtain an AOD assessment for your clients? Why?
- Do court processes differ for you when offenders have not received an assessment from an AOD clinician? How?

- Do you know how other lawyers use the AOD clinician service?
- Do they use it less frequently or more frequently or about the same as you? Why do you think this is?

Questions for Probation Services

- Thinking about the last case where you had input from a court-based AOD clinician, please talk us through the process.
  - Did having an AOD clinician in court influence Corrections' processes? If so, how?
  - Did you use information from AOD clinicians when making decisions? If so, how?
  - Did all this information come from the court-based AOD clinicians or other sources?
  - Did you think the information provided by AOD clinicians made a difference to the judges' sentencing decision? In what way?
- Was that a typical example of how you use the court based AOD clinician? If not, how does it differ from a typical case?
- How or what influences any recommendations you make for offenders with AOD issues?
- How do processes differ (eg writing PAC reports) when offenders have not received an assessment from an AOD clinician?

Questions for DHB providers

- What information does the DHB record about the AOD clinician service?
- Do you have any ongoing or regular contact with the clinicians? What form does this take?
- Do you think the AOD clinician service makes a difference to the outcome for offenders? How?
- Are many offenders referred to AOD treatment services?
- How would you describe the availability of AOD treatment services in the community?
  - Waiting times?
  - Does everyone who needs treatment receiving it?

Questions for police prosecutors

- Do you ever make requests for brief AOD assessments to be done? What reasons would you refer a offender to an AOD clinician for?
- What is the process for referring a offender to the AOD clinician?
- Do processes differ when diversion is an option? How?
- Does the AOD clinician ever provide you with information directly?
- How do you use the AOD information provided, either to your or generally in court?

General family violence questions

- Do you ever deal with family violence cases?
- How well do you feel you understand the dynamics of family violence?
- Have you had any training in family violence dynamics? If yes, was it to prepare you for this role or in general?
- Do you do anything differently for family violence cases versus non-family violence?
- Is there any difference in the way AOD information is used for family violence cases versus non-family violence cases? If so, what is different?

General diversity questions

- Does culture/ethnicity/gender of an offender influence how you interact with them?
- Do you feel the process is appropriate for all offenders, irrespective of their culture/ethnicity/gender? If not, why not? Does that affect outcomes for offenders?

General reflections

- How does having a clinician in court impact on other court processes?

- Stand down of offenders?
- Foes it speed up processes, slow them down?

- Is there continuity for repeat offenders?
- Do you see the same people coming back?
  - What does that mean?
  - How do you deal with it?
- I understand there are also more comprehensive assessments available to judges? Is there any link between what you do and those assessments?
- In your opinion, how could the AOD clinicians' service be improved?
- What does a successful AOD clinician service look like to you?
- What is currently working well with the service?
- Are there any unintended consequences (positive or negative) that have arisen from the use of AOD clinicians in court?
- What other comments do you want to make about the presence of AOD clinicians in courts?

7.9 Appendix 9: Court observation sheet

Type of case FV Non-FV
Charges ______________________________
Decision requested ______________________________
Outcome ______________________________
AOD clinician used? ______________________________

Type of case FV Non-FV
Charges ______________________________
Decision requested ______________________________
Outcome ______________________________
AOD clinician used ______________________________

Type of case FV Non-FV
Charges ______________________________
Decision requested ______________________________
Outcome ______________________________
AOD clinician used? ______________________________

Type of case FV Non-FV
Charges ______________________________
Decision requested ______________________________
Outcome ______________________________
AOD clinician used? ______________________________

Type of case FV Non-FV
Charges ______________________________
Decision requested ______________________________
Outcome ______________________________
AOD clinician used? ______________________________

Type of case FV Non-FV
Charges ______________________________
Decision requested ______________________________
Outcome ______________________________
AOD clinician used? ______________________________
Type of case FV Non-FV
Charges ______________________________
Decision requested ______________________________
Outcome ______________________________
AOD clinician used? ______________________________

Type of case FV Non-FV
Charges ______________________________
Decision requested ______________________________
Outcome ______________________________
AOD clinician used? ______________________________

7.10 Appendix 10: Administrative data

AOD CLINICIAN DATA

A monthly breakdown of the number of referrals to the AOD clinician was provided by:

- Capital and Coast District Health Board
- Northland District Health Board
- The Salvation Army.

SENTENCING DATA

Data was obtained for the most serious charge per person disposed in 2014/2015 (which started and finished in a district court). There were 79,581 people with charges disposed in 2014/2015. All offence and sentence information described in this report relates to a person's most serious charge in the year. Relevant variables included:

- Offender identification number
- Offence description and classification for the most serious charge
- Charge outcome of the most serious charge (eg convicted, discharged without conviction, diversion, not proved)
- Most serious sentence type for the most serious charge (eg imprisonment, home detention, community detention, intensive supervision, supervision, community work, fine, deferment, other)
- Location of district court for first appearance
- Location of district court for sentencing event
- Charge at family violence court indicator (yes, no)
- Police family violence flag (yes, no)
- AOD bail condition imposed (yes, no)[41,42]
- Anti-violence bail condition imposed (yes, no)
- AOD sentence condition imposed – including:[43]
  - To attend assessment, counselling and/or treatment (including inpatient treatment) for AOD abuse as directed by probation officer
  - To undertake AOD assessment, counselling or treatment as directed by probation officer
  - Relevant keyword in free-text field, including: alcohol, AOD, drug, CADS, substance abuse, drink + treat*, counse*, assess*, attend*, complet*, undert*, interven*
- Violence sentence condition imposed – including:
  - To undergo stopping violence programme as directed by probation officer
  - Relevant keyword in free-text field, including: violence, anger + treat*, counse*, assess*, attend*, complet*, undert*, interven*

COMPREHENSIVE AOD REPORT DATA

---

[41] Data for bail conditions is recorded in CMS via drop down menu options and free-text fields. Due to the large amount of information recorded in the free-text fields only information for the AOD and violence conditions could be systematically extracted.

[42] AOD bail conditions can include AOD-related conditions such as a ban on the consumption of alcohol or other drugs, or on being found intoxicated in a public place.

[43] As with bail conditions, data for sentence conditions is recorded via drop down menu options and free-text fields. Due to the large amount of information recorded only information for the AOD and violence sentence conditions could be systematically extracted.

Data was obtained for all comprehensive reports ordered and paid for by MOJ, from March 2009 through to December 2015. This included the number and cost of reports, as well as the filing date and location.

7.11 Appendix 11: Data comparison tables

The data covered the most serious charge per person disposed in the 2014/2015 financial year, which started and finished in a district court[44]. For 65,690 people their most serious charge was convicted.

Table 1 shows very little difference in the most serious sentence imposed when comparing courts with AOD clinicians to those without a clinician for all types of offence.

Table 1: Most serious sentence received by people convicted at district courts in 2014/2015, for courts with[45] and without AOD clinicians

	AOD clinician at court	No AOD clinician	Overall rate
Imprisonment	12%	10%	10%
Home detention	5%	4%	34%
Community detention	7%	7%	7%
Intensive supervision	2%	3%	2%
Community work	25%	25%	25%
Supervision	5%	4%	4%
Monetary	32%	36%	35%
Deferment	4%	3%	4%
Other	2%	1%	1%
No sentence recorded	5%	7%	7%
Total[46]	100%	100%	100%

Note: This data shows the most serious sentence for the most serious charge per person in 2014/2015. An individual may have had more than one charge disposed in the year. A person may also receive more than one sentence (eg community detention, community work, supervision, and disqualification from driving (categorised as other)) for a convicted charge, however, only the most serious sentence is shown here (eg community detention).

Table 2 shows the percentage of people convicted of their most serious charge, who had AOD conditions stipulated at sentencing, at courts with the AOD clinician service compared to courts without the service. This is for all types of offence and again, there is little difference evident.

[44] These results have not been tested for statistical significance so are indicative only.

[45] Courts with AOD clinicians: Kaikohe, Whangarei, Tauranga, Wellington, Hutt Valley, Porirua, Masterton, Nelson, Blenheim.

[46] Totals may not equate to 100% due to rounding.

Table 2: AOD treatment stipulated for sentences at courts with and without AOD clinicians

	AOD clinician at court	No AOD clinician	Overall
AOD condition stipulated	16%	14%	14%
No AOD condition stipulated	84%	86%	86%

Table 3 presents similar data to Table 2, but shows where the most serious charge per person was a traffic and vehicle regulatory offence. Looking at instances where a person's most serious charge in the year was a traffic and vehicle regulatory offence, there was also little difference. These offences were chosen because they constitute a significant amount of AOD clinicians' workload[47].

Table 3: AOD treatment stipulated for sentences where the most serious charge was a traffic and vehicle regulatory offence at courts with and without AOD clinicians

	AOD clinician at court	No AOD clinician	Overall
AOD condition stipulated	15%	12%	12%
No AOD condition stipulated	85%	88%	88%

[47] Only a small proportion of traffic offending will be represented, as traffic offences are low in seriousness compared to most other offences. People who had any other type of offending will have had their traffic offences trumped by other more serious offences.

MINISTRY OF
JUSTICE
Tāhū o te Ture

newzealand.govt.nz