Specialist Assessors’ Integration of Human Rights Perspectives within their Assessment of People Subject to New Zealand’s Intellectual Disability (Compulsory Care and Rehabilitation Act) 2003:

An Interpretive Descriptive Study

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2024

A thesis submitted to
Auckland University of Technology
in partial fulfilment of the requirements for the degree of
Doctor of Health Science

Abstract

In New Zealand, the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (provides a novel diversionary pathway, in the form of compulsory care orders, for people with intellectual disability who offend. A person subject to compulsory care is called a care recipient. Specialist assessors are clinical psychologists and psychiatrists who perform forensic assessments under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 and its companion legislation the Criminal Procedure (Mentally Impaired Persons) Act 2003. This doctoral research provides valuable insights into how 15 specialist assessors understand, interpret, and integrate human rights within their practice. How specialist assessors express and give effect to care recipients' liberty interests is also explored. Finally, the thesis probed the tensions or dilemmas that arise as specialist assessors contemplate human rights perspectives.

This research is undertaken in the context of international debates about psychologists' and psychiatrists' obligations to promote human rights in diverse practice contexts. New Zealand's ratification of the United Nations Convention for the Rights of Persons with Disabilities in 2006, and subsequent definition of care recipients' liberty interest by the Court of Appeal in 2011, changed the human rights landscape within which the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 operates. The challenges that specialist assessors face in promoting human rights was, therefore, ripe for exploration.

Through the methodology of interpretive description, using reflexive thematic analysis, the findings show that specialist assessors most often derive their understanding of care recipients' human rights from ethical principles or values. Rarely was their understanding drawn from international instruments like the United Nations Convention for the Rights of Persons with Disabilities. Three distinct perspectives regarding the integration of human rights into specialist assessor practice were revealed. These were located along the spectrum of "comfortable acceptance", "uncomfortable engagement", and "aware but not engaged". Themes of specialist assessor unease or uncertainty were prevalent. Uncertainty coalesced around the requirements of human rights law and the role it should play within specialist assessor practice. specialist assessors' unease was expressed as concerns about overstepping the boundaries of practice, the influence they could exert over decisions about liberty, and observations of varied practices. The study found that these factors were moderating how the specialist assessors integrated human rights perspectives.

Embedded in the data were specialist assessors’ critical observations about the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 framework. Three different perspectives emerged. These were “external scrutiny”, “specialist assessor self-scrutiny”, and “critique of the Act”. The multilayered critique provided by the specialist assessors added an unanticipated complexity to the analysis process that afforded a rich contextual analysis. It illustrated how specialist assessors were lifting their gaze to critically examine the surrounding socio-political climate and the associated human rights implications of their work. The specialist assessors raised important questions about the sufficiency of rights protections within the legislation. The findings indicate that the CRPD has low visibility within the IDCCRA framework relative to other areas of the disability sector.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

19 February 2024

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Signature	Date

Acknowledgements

Firstly, I would like to thank the 15 specialist assessors who participated in this study. I was humbled by your insights, candour, and the dedication to this work. You provided such rich material to work with. Each time I faltered during the many hours of coding and analysis, I held in mind the need to do justice to the perspectives you shared.

Secondly, this thesis would not have been possible without my wonderful supervisors Professor Kate Diesfeld, Professor Warren Brookbanks, and Associate Professor Brigit Mirfin-Veitch. I am deeply grateful for the enthusiasm, unstinting commitment and effort you gave to this project. It has been a privilege to share time and ideas with you. Your feedback has always been thought provoking, wise, and inspiring. The compassion and encouragement you extended to me during the tough times will never be forgotten.

To Associate Professor Armon Tamatea, I express my sincere gratitude for the time you gave to this project. Your insights and resources regarding the cultural aspects of the research process and analysis were invaluable. I would also like to make special mention of Dr Daniel Sutton who conducted the bracketing interview, Drew South for his expertise with Endnote and all things library related, Dr Shoba Nayar who proofread this thesis, Sue Knox for formatting the thesis, Adrian Higgins for helping me refine the interview schedule, and Rumen Rachev for his assistance with referencing.

I give special thanks to all those at Te Roopu Taurima O Manukau Trust who attended two hui that were undertaken to guide my research. To Raukura Hune, Justine Heihei, and Karen Smith, I would like to extend my gratitude for organising these hui. You enabled the care recipients and those who support them to have a strong voice in this study. The process held me true to the ‘why’ of this project and ensured I kept the perspectives and experiences of care recipients front and centre.

To all my friends and colleagues who have taken the road of doctoral or PhD study before me, I am grateful for the sense making and encouragement. I wish to make special mention to Tanya, Sarah, Anne, and Amanda. You were there when I needed you and provided wise counsel. To Olivia, Ingalise, Willem, Esther, Craig, Kirstyn, Katy, and Paul, thanks for knowing when to check in and urging me on. Chandresh, I am grateful for your flexibility in keeping all things practice related ticking over this past year. To Jo and Carole, your kindness and care was unparalleled.

My family have also walked with me on this journey. Mum, Dad, Jess, Allan, Soraya, Majid, Azi, and Johnny—I am grateful for your love and support. To Noah and Eli, you are the most affectionate, patient, and supportive children a mother could wish for. Noah, your notes of encouragement were treasured. Eli, your daily check-ins on progress in the last few months kept the finish line firmly in mind. I look forward to having our weekends back and spending more time with you both.

Finally, to Jay, you are my rock. This would not have been possible without you.

Ethics Approval

Ethics approval (20/263) was granted by Auckland University of Technology Ethics Committee (AUTEC) on 1 December 2020 for a term of 3-years, until 1 December 2023.

List of Abbreviations

BORA	New Zealand Bill of Rights Act 1990
CM	Care Manager
CPMIPA	Criminal Procedure (Mentally Impaired Persons) Act 2003
CR	Care Recipient
CRPD	United Nations Convention on the Rights of Persons with Disabilities
DI	District Inspector
DPO	Disabled People’s Organisation
FIDSS	Forensic Intellectual Disability Secure Service
GLM	Good Lives Model
HRA	Human Rights Act 1993
ICCPR	International Convention on Civil and Political Rights
ICESCR	International Convention on Economic Social and Cultural Rights
IDCCRA	Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
MHCATA	Mental Health (Compulsory Care and Treatment) Act 1992
MOH	Ministry of Health (New Zealand)
NIDCA	National Intellectual Disability Care Agency
RIDCA	Regional Intellectual Disability Care Agency
RIDSAS	Regional Intellectual Disability Supported Accommodation Service
RNR	Risk Needs Responsivity
SA	Specialist Assessor
TRT	Te Roopu Taurima o Manukau Trust
UDHR	Universal Declaration of Human Rights
UNCAT	United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Chapter 1 Introduction

1.1 The Research Context: A Precis

In the mid-1990s, New Zealand embarked on a novel approach to the management of intellectually disabled people who offend. The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCRA) (hereafter “the Act”) gestated over a 7-year period. It was precipitated by changes to mental health legislation that excluded intellectual disability as a ground for civil commitment. In addition, the development of the IDCCRA occurred against the backdrop of deinstitutionalisation and a broader governmental commitment to recognising the human rights of intellectually disabled people.

The IDCCRA, in concert with the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CPMIPA), provides a comprehensive and complex diversionary framework for people with intellectual disability who are charged with or convicted of an offence. These statutes aim to provide appropriate compulsory care and rehabilitation options that recognise and safeguard the special rights of people subject to the Act (IDCCRA, s3). People subject to the Act are called care recipients or special care recipients. These distinctions will be explained within the literature review.

Specialist assessors are psychologists and psychiatrists with expertise in the forensic disability sector. They undertake health assessments of people with intellectual disability who encounter the criminal justice system. These specialised health assessments focus on the diagnosis of intellectual disability, risk of reoffending, and rehabilitation needs. Once a person is subject to the Act, specialist assessors complete 6-monthly reviews and consider the need for orders to continue, change, or be extended. The specialist assessors’ statutory role has significant human rights implications because compulsory care orders significantly restrict the liberty of care recipients. Importantly, orders can be extended multiple times, lending the restrictions an indefinite quality.

The liberty implications of compulsory care under the IDCCRA are governed by three levels of care: hospital secure, community secure, and community supervised. The Act defines a secure facility and a facility setting out in broad terms the features of each

[IDCCRA, s 9]. Within each level of care, varied levels of control and restriction can occur over a care recipient's liberty. In addition, restrictions may be implemented in differing ways dependent on the policy or practice of specific service providers. Some care recipients are connected with mainstream residential disability providers; but many have no history of contact with disability services and do not identify as disabled. The following descriptions aim to provide an insight into the typical restrictions experienced by care recipients daily.

Care recipients subject to a hospital secure order are placed in locked inpatient units, located in psychiatric hospitals, that provide intensive and constant oversight. Locked in patient units are not mentioned in the Act, but this is how the term "secure facility" is interpreted in practice. All leave, on and off site, must be approved either by the care manager or by the Director General of Health. Specialist rehabilitation (e.g., therapeutic intervention) is typically delivered on site. Family contact is facilitated face to face or in other forms (e.g., phone, Zoom or letter) but is typically supervised.

Hospital secure care recipients experience the least degree of choice over their daily activities (e.g., who they live with, their diet, the staff who support them, and the activities available). However, efforts are made by the care teams to ensure good matching between care recipients and their key workers. Like prisons, paid jobs within the unit or hospital site can occur. However, no external employment occurs nor do care recipients in hospital settings attend community based vocational services.

In community settings, there is greater freedom of movement. However, all leave must be approved in advance by care managers. Care recipients on community supervised orders have the most freedom of movement. For example, with permission they may use public transport, go shopping or engage in unsupervised recreational activities, and stay with whānau or partners (or civil residential settings) overnight as they transition off orders. Community facilities may be locked, fitted with alarms, or have locked gates. Staff supervision ratios vary dependent on the level of care and estimated risk of each care recipient. For those on community secure orders leave is supervised by staff and is of more limited scope.

All care recipients, irrespective of their level of care exercise little choice of placement, house mates, and who supports them. All have their own room. Each care recipient has a weekly planner which sets out their vocational, rehabilitation, recreational, and daily living tasks. Access to devices (e.g., phones, tablets, or computers) may be dependent on the policy of the service provider. Access to money is usually supervised (e.g., debit cards are held by the care manager unless in use for a specific purpose), although arrangements may become more flexible as a care recipient enters the final stages of a community supervised order. Paid employment off premises is possible within a community supervised level of care and in some circumstances for those subject to community secure orders.

Sexual relationships between care recipients are typically prohibited at all levels of care. However, care recipients are supported to maintain pre-existing relationships and, in some cases, may develop new relationships with people in the community while they are subject to orders.

The prescription of medication occurs with the informed consent of care recipients (or their welfare guardian). There are provisions for enforced medical treatment in accordance with the Act (e.g., emergency treatment or managing a condition that gives rise to the reason for compulsory care) or the enactment of other law such as, the Mental Health (Compulsory Assessment and Treatment Act) 1992 (MHCATA). All care recipients' can be restrained (physically or mechanically), in specific circumstances (e.g., endangering the health or safety of self or others) subject to the provisions of the Act.

In summary, forensic practice within the IDCCRA brings a unique context and set of challenges for specialist assessors. There is a dual obligation for psychologists and psychiatrists in health assessor roles to consider risk and community safety while attending to an individual's welfare.

1.2 My Positioning within this Research

In 2004, I became a specialist assessor. I felt excited and proud to occupy a role that offered care recipients meaningful alternatives to prison. However, over time, I found myself wondering about the downstream consequences of the Act. Repeated extensions and the disruptive nature of orders due to facilities and services being located far from people's homes were areas of concern. In addition, some of the early resources available to care recipients to support effective rehabilitation (e.g., individualised therapy for specific offence-related issues) seemed increasingly harder to obtain.

As extensions were contested in the Courts and the complexity of the care recipient population increased, I found myself reflecting more deeply with colleagues on the consequences of orders. I observed risk aversion in the system and was not immune from a sense of pressure to 'make the right call'. I became attuned to the ways in which the Courts utilised the expert opinions of psychologists and psychiatrists when making decisions that have significant impacts on individual human rights. The decision to enrol in the Doctor of Health Science (DHSc) programme was underpinned by an aspiration to explore the intersection between psychology and the law from the perspective of an expert witness.

Six months into my doctoral journey and struggling for direction, I met with a colleague to brainstorm topics. This person had recently completed a DHSc, was an experienced forensic psychologist, and, like me, a specialist assessor since 2004. A discussion about therapeutic jurisprudence led to a focus on the IDCCRA and tensions experienced in the specialist assessor role. Several themes emerged. Firstly, we identified the presence of ambiguity and conflict in the specialist assessor's role. For example, psychologists and psychiatrists are trained to be therapeutic and benevolent; yet, within the IDCCRA framework, their work directly informs decisions about compulsory care and public protection. Secondly, my colleague wondered about the obligations of specialist assessors to comment on liberty interests as well as public protection, considering New Zealand's ratification of the United Nations Convention for the Rights of Persons with Disabilities (CRPD). At this point, my ears pricked up. This was the first time I had heard a specialist assessor talk about the CRPD. I knew very little about it and felt embarrassed. I wondered if other specialist assessors were aware of the Convention and contemplating its application to practice.

1.2.1 Guiding cases

The following analysis summarises and reflects upon two influential New Zealand cases that further inspired the thesis topic.

RIDCA Central (Regional Intellectual Disability Care Agency) v VM [2011] NZCA 659

VM was initially made a care recipient for 1-year, having been charged with carrying a knife in a public place. Had VM remained in the criminal justice system, her offence would have likely attracted a much lighter sentence. VM's initial order of 2-years was extended due to information indicating a higher level of risk and her poor engagement with rehabilitation and support. A second application to extend was granted (duration unpublished) and VM subsequently appealed to the High Court. The judgement found in VM's favour, and her order was quashed. The case eventually went to the Court of Appeal. The appeal's focus was not the reinstatement of VM's order; rather, the correct approach by the Courts to extension applications.

RIDCA Central v VM [2011] NZCA 659 is important because it highlighted the competing issues of liberty, proportionality, and risk that come into play within the IDCCRA regime. At the heart of the case was a debate about whether compulsory care orders should be extended if the extension period meant that detention under the Act was disproportionate to the gravity of the misconduct (or alleged offence) enacted by the care recipient. The Court of Appeal concluded that proportionality between the original offence and the length of a compulsory order was a factor to be considered, amongst other factors such as the community protection interest.

In considering the appropriate test for extensions, the Court of Appeal clarified the rights and freedoms of care recipients. The term "liberty interest" (para. 35) was adopted to describe the rights to freedom of movement, not to be arbitrarily arrested or detained, and to be free from discrimination on grounds of disability. In doing so, the Court of Appeal drew on the corresponding sections of the New Zealand Bill of Rights Act 1990 (BORA). The Court also referred to the case of *Pinet v St Thomas Psychiatric Hospital* [2004] noting that the Supreme Court of Canada used the term liberty interest to describe these rights, in a similar context.

The VM decision also set out the approach to applications for extension, specifically the factors to be considered by the Court when balancing a care recipient's liberty interest with the community protection interest. A key feature of this approach was the capacity of the Court to take account of a broad range of information[1] provided by specialist assessors to determine the weight to be given to the community protection interest.

Subsequently, guidance was issued to specialist assessors in the form of the *Legal Compendium: CCDHB Intellectual Disability Service* (Legal Compendium) (CCDHB & Luke Cunningham Clere, 2017) and other analysis undertaken by Dr Anthony Duncan, a Consultant Psychiatrist employed as the National Advisor for the National Intellectual Disability Care Agency (NIDCA). It was identified that the *VM* decision raised the question of whether specialist assessors were also required to balance the community protection interest against the care recipient's liberty interest when assessing the need for an extension to an order. The Compendium states that these matters are outside the scope of usual health practice and area of competence. The specialist assessor role was identified to be oriented towards risk assessment, rehabilitation needs and the community protection interest, not the liberty interest.

Post *VM*, I informally observed that specialist assessors engaged in a range of practices regarding the liberty interest. Some stated that they had considered the care recipients' liberty interest in their reports. Others indicated they had considered whether an extension to order was disproportionate when comparing an order length to sentences usually given in the criminal justice system. Some made no reference to the liberty interest and focused solely on eligibility, risk, and the need for compulsion. I began to wonder, "What is the correct approach? What is the legal authority for our assessment of potential or existing care recipients? Is the source the Legal Compendium, the Guidelines for Specialist Assessors (Ministry of Health, 2004) or the Court?"

J, Compulsory Care Recipient, By His Welfare Guardian, T v The Attorney General [2018] NZHC 1209

The second case that was instructive to this research was the more recent decision of *J, Compulsory Care Recipient, by his Welfare Guardian, T v The Attorney General* [2018] NZHC 1209, which combined four separate appeal proceedings, was complex, and examined J's human rights from multiple perspectives. J was a man with autism and

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[1] For example, the care recipient's overall profile risk to self and others, the risk of reoffence specific to the index offending or any other types of offending, responsivity to rehabilitation and ability to benefit from further rehabilitation. In addition, the SA must consider the least restrictive means of managing the risk or others (CCDHB & Luke Cunningham Clere, 2017).

intellectual disability who had been subject to compulsory care under the IDCCRA for 12-years. In 2004, he was charged with wilful damage, possession of offensive weapon, and unlawfully in an enclosed yard. He was found unfit to stand trial. At the time of the appeal hearing, J's order had been extended multiple times. Like *VM*, the offending that triggered his order was relatively minor. However, there was a large body of clinical data to indicate that J posed a high and imminent risk of sexual and violence harm to others.

J's lawyer argued that his detention under IDCCRA was arbitrary, discriminatory, and breached section 3(a) of BORA. Although J's detention was prolonged, the Court found it was not arbitrary (para 504). Further, the Court held that the IDCCRA Act was a protective scheme, not a punitive one, with effective and regular review processes (para 477). Having considered New Zealand's human rights obligations under the International Convention for Civil and Political Rights (ICCPR) and the CRPD, the Court noted that J's lawyer had argued the CRPD heralded a paradigm shift from a welfare approach to a rights-based approach. The Court acknowledged the concerns expressed by the Committee on the Rights of Persons with Disability[2] (the Committee) about New Zealand's continued use of fitness procedures and a diversionary scheme for care recipients (Committee on the Rights of Persons with Disabilities, 2014). However, the Court noted that the Committee's recommendation for legislative revision was rejected by the New Zealand Government (Office for Disability Issues, 2015). In assessing whether the IDCCRA framework was discriminatory according to international and domestic law, the Court stated:

> Despite the international discourse, the CPMIP Act and IDCCR Act schemes are express legislation in NZ… Even when determining whether the process is discriminatory under the appropriate NZBORA analysis, it is difficult to find that the CPMIP Act and IDCCR Act schemes produce a result which materially disadvantages those subject to it, or which cannot be demonstrably justified. (para 570-571)

Of particular significance, the Court appeared to welcome the specialist assessor addressing the liberty interest within her report:

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[2] The United Nations organisation charged with monitoring States Parties UNCRPD compliance.

> This issue was addressed head-on by Ms Torok, when she reported that issues related to proportionality were considered and it was concluded that due to J's high risk, the community protection interest outweighed the liberty rights of J, resulting in repeated extensions to the care order. (para. 411)

J's lawyer recently argued at the Court of Appeal that rather than safeguarding his rights, the Act and how it was applied undermined J's rights. The Court of Appeal maintained the position that the IDCCRA is protective and does not materially disadvantage care recipients due to the safeguards (*J v Attorney-General*, [2023] NZCA 660).

Reflections arising

These cases were informative but raised more questions than answers about the approach specialist assessors should be taking towards the human rights of care recipients. The correct approach for a specialist assessor to take to the liberty interest remained unclear. Further, the legal analysis undertaken in the *J* judgement illuminated the tensions precipitated by differing interpretations of domestic and international human rights law as they apply to the CPMIPA and IDCCRA frameworks.

Also, I reflected on the absence of discussion about the potential implications of the CRPD on the IDCCRA framework in previous specialist assessor training forums. For me, these factors signalled the need to understand more about the paradigm shift embodied in the CRPD approach to disability rights in the context of the IDCCRA.

1.2.2 Community consultation

A consultation hui held at Te Roopu Taurima O Manukau Trust (TRT) on July 20, 2020 provided the final puzzle piece in determining the focus of the research. TRT is a Regional Intellectual Disability Supported Accommodation Service (RIDSAS) providing supervised and secure care to care recipients in community facilities. It is the sole kaupapa Māori RIDSAS within the IDCCRA framework. The consultation aimed to ensure that the research was framed and conducted in a manner that was culturally sensitive and reflected the principles of Te Tiriti o Waitangi as articulated by the Courts and the Waitangi Tribunal (Waitangi Tribunal, 2019).

Te Tiriti o Waitangi, New Zealand’s founding document, establishes a special relationship between Māori and the Crown (Ministry of Health, 2020b). Academics and researchers in the field of psychology are ethically required to consider the principles of Te Tiriti o Waitangi (Macfarlane et al., 2011). In addition, recognition of Te Tiriti o Waitangi and human rights obligations are at the forefront of efforts by the Ministry of Health (2020b) to address the over-representation of Māori within the compulsory mental health regime. Similarly, the over-representation of Māori care recipients has been a consistent feature of the demographic data collected about care recipient (Ministry of Health, 2020a; Whaikaha Ministry of Disabled People, 2023).

This hui was attended by care recipients, support workers, care managers, service coordinators, and senior managers[3]. The participants perceived Te Tiriti o Waitangi as the foundation of human rights for care recipients and all tangata whenua in New Zealand. They also reflected on the influence held by specialist assessors over decisions about liberty. The idea that specialist assessors “hide behind their power” was shared. Care recipients expressed concern that a “one size fits all” approach constrained their ability to engage in rehabilitation that was personally meaningful and supported their goal to achieve liberty. An additional concern expressed by all attendees was that compulsory care orders sometimes displaced care recipients from their natural supports due to the location of RIDSAS.

1.2.3 The rationale becomes clear

In summary, the analysis of the legal decisions and the community consultation highlighted several important perspectives. Firstly, there was a lack of clarity about specialist assessors’ obligations to assess the liberty interest. However, equally, there were indications that the Court welcomed specialist assessor engagement with the liberty interest. Secondly, a debate about the compliance of the IDCCRA and CPMIPA with New Zealand’s CRPD obligations was illuminated, raising questions for specialist assessor practice. Thirdly, the cultural consultation provided an insight into how care recipients and other stakeholders perceived the specialist assessor’s role in relation to liberty interests, and the realisation of meaningful rehabilitation opportunities within the framework.

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[3] Approximately 40 people attended the hui.

While the rights implication for the IDCCRA and the impact of the CRPD on the legislative framework had been considered within some studies, no previous research had solely focused on human rights perspectives. Further, a preliminary review of the literature showed that no qualitative studies had focused exclusively on specialist assessor practice. Collectively, these factors provided the justification for research that explored the intersection between human rights and specialist assessor practice. From the outset, I was aware this would entail a shift into new and unfamiliar territory.

1.3 The Focus of the Thesis

The aim of this study was to examine the extent to which specialist assessors integrate human rights perspectives within their assessments under two statutes—the IDCCRA and CPMIPA. Summaries of the Acts are provided in the literature review. How specialist assessors understand and give effect to care recipients' human rights, specifically their liberty interests, is explored. The study recognises the close relationship between the liberty interest and proportionality but narrows its analytic scope to the liberty interest as defined within *RIDCA Central v VM* [2011].

The research examines specialist assessors' perspectives about their obligations to promote or protect the human rights of care recipients, and how they communicate about human rights to the Courts or other stakeholders. Finally, the thesis explores the presence of tensions or dilemmas that arise for specialist assessors as they contemplate human rights perspectives. The research is undertaken in the context of international debate regarding psychiatrists' and psychologists' obligations to promote human rights in diverse practice contexts.

The use of the word 'perspectives' is deliberate and influenced by several factors. Firstly, definitions of human rights can vary, dependent on the disciplinary context within which the inquiry is being undertaken (Nowak & Zenz, 2020). Secondly, several human rights instruments have application to the IDCCRA processes. In addition, the interpretations of some rights, such as the liberty interest, have evolved in accordance with the legal decisions. Lastly, the term 'human rights perspectives' has prominence within the literature on the integration of human rights into psychological practice (Hagenaars, 2016; Vess et al., 2017; Ward & Birgden, 2007).

A small body of literature and legal commentary has examined the IDCCRA, as summarised and critiqued in the literature review (Chapter 2). Some scholars have touched upon the human rights implications of the legislation by examining the experiences of care recipients or professionals involved in the framework (Prebble et al., 2013; Smith, 2015). However, no previous study has specifically explored how specialist assessors contemplate, communicate, or integrate human rights perspectives and the dilemmas arising.

Applying human rights-based approaches and perspectives to psychological and psychiatric practice is an emergent field. Early articles appeared in New Zealand and Europe in the 2000s. This thesis examines a specialist health practice through the methodology of interpretive description. The challenges that specialist assessors face in promoting human rights are ripe for exploration.

1.4 Terminology

The IDCCRA legislation caters for people who are charged with or convicted of offending. For those who are found unfit, the Court determines if they did the act or caused the omission which constitutes the basis for the offence charge. It is not a finding of criminal responsibility. Both groups are called care recipients or special care recipients. The term ‘special’ denotes a higher level of risk, more serious offending, and placement in a secure hospital setting. For ease of reference, care recipient will be used in sections of the thesis specific to the IDCCRA and New Zealand context.

Within the international literature, the term ‘intellectually disabled offenders’ is prevalent. This term may also be used where appropriate, for example, when citing international literature. It is recognised that the terms learning disability, intellectual impairment, or developmental disability are preferred or used synonymously with intellectual disability in New Zealand and internationally. Again, the term care recipient will be applied with reference to the IDCCRA.

In addition, within the New Zealand context, it is important to recognise the evolving use of language of cultural significance. The te ao Māori term ‘tangata whaikaha hinengaro’ translates to ‘people in pursuit of mental strength’. The variation of ‘tangata whaikaha’ also means ‘people determined to do well’ (Whaikaha Ministry of Disabled

People, 2024). Recent New Zealand publications have adopted these Māori terms in preference to disability, ID, and care recipient (Donald Beasley Institute, 2023; Duff et al., 2023) due to the strengths-based and inclusive nature of this language. The Pasifika term, 'tagata sa'ilimalo', is also growing in prominence. 'Tagata' means people or person. 'Sai'ilimalo' means the pursuit of success (Tōfā Mamao Collective, 2022).

1.5 Organisation of the Thesis

Chapter 2 (literature review) consists of three parts which, together, identify the gap filled by this study. The first section explores the theoretical framework for a human rights perspective within psychological practice. The international and domestic human rights law relevant to the IDCCRA is examined. The section ends with a focus on the CRPD. Issues specific to the principles and purpose of the CRPD, its grounding in a social model, New Zealand's ratification and implementation of the Convention, and the implications for the IDCCRA, and, in turn, specialist assessor practice, are explored. Section two briefly describes the historical context of the IDCCRA and the drafting process. Specific features of the Act are presented along with a review of the academic literature that has considered the realities of implementation as they pertain to a human rights perspective. The final section focuses on human rights and specialist assessor practice. The professional obligations of a specialist assessor are explored. The section then shifts to a review of the scholarship on the human rights implications of forensic practice. The section ends by traversing the emergent literature on human rights-based approaches in psychological practice.

The methodology and methods adopted for this study are comprehensively described in Chapter 3. A critique of the methodology is provided to explain the choice of interpretive description as an appropriate fit for this study. The construction of the study is described. An account of the community consultation process is provided. In accordance with reflexive thematic analysis, a detailed representation of the data analysis process is shared. The final section sets out the steps taken to ensure the integrity of the research processes.

Chapter 4 presents the findings of this study. Six themes were derived from the data. Themes one, five, and six focus on specialist assessor practice; specifically, how the specialist assessors understood, contemplated, or communicated a human rights perspective in relation to the role. The remaining themes looked beyond specialist assessor practice by highlighting factors specific to the legislation, service delivery, and cultural responsivity. Collectively, these contextual themes demonstrated how the specialist assessors were attuned to and reflected upon a diverse range of human rights perspectives within the IDCCRA framework.

Chapter 5 (Discussion) brings the findings into conversation with the wider field of study. How the findings speak to earlier research and make a novel contribution is explained. The chapter is divided into two parts. The first part sets out the diverse understandings of human rights expressed by specialist assessors. Variations in practice are described/portrayed as being on a spectrum, as a way of capturing how these understandings contributed to varied practices and attitudes toward the integration of human rights perspectives within the specialist assessor role. The discussion then turns to an analysis of factors that appeared to moderate specialist assessor practice. These factors were characterised by unease, uncertainty, or a lack of clarity about where human rights should feature in specialist assessor practice. The second part of the chapter turns to contextual factors. The specialist assessors' reflections on the human rights implications of the IDCCRA, the related infrastructure, and issues of service and cultural responsivity are discussed. After considering the strengths and limitations of the study, the implications for practice, further research, policy and legislative change are presented. Chapter 6 sets out the conclusions drawn from the study.

Chapter 2 Literature Review

2.1 Introduction

This thesis does not attempt an analysis of all human rights. Rather the focus is a subcategory of human rights perspectives and the liberty interest(s) of care recipients. In order to contextualise this study, important human rights and the underlying concepts are presented below.

As described in Chapter 1, this literature review is divided into three parts. The first part defines a human rights perspective and sets out the international and domestic human rights law relevant to the study. Considering the significance of the CRPD to disability rights, a more in-depth review examines the human rights implications of the Convention for the IDCCRA framework and specialist assessor practice. The CRPD is comprised of 50 articles that set out the entitlements of persons with disabilities and the related obligations of the signatories. Four CRPD articles with specific relevance to the research question(s) are identified.

Part two provides a historical context to the IDCCRA. The human rights considerations arising pre- and post-implementation are presented. The body of literature specific to the legislation, the related service framework, and statutory roles is canvassed. This survey highlights the lack of attention to human rights from the perspective of specialist assessors within existing scholarship.

Attention turns to the specialist assessor practice in the final part of the chapter. The specialist assessor's professional obligations are explored. A review of the literature on the human rights implications of forensic practice and related tensions is provided. The chapter ends with an examination of the burgeoning scholarship on psychological practice and human rights-based approaches.

2.2 Search Strategy

The first step of the research process undertaken in 2019/20 involved compiling and refining a list of initial search terms. The terms were clustered into the broader categories of intellectual disability, IDCCRA, coercive care, expert assessor/witness, human rights, care recipients/offenders, and forensic practice. Google Scholar, Web of

Science, Psych Info, OVID, Westlaw, and LexisNexis were identified as relevant databases. The initial search strategy involved terms from individual clusters to identify the most successful keywords.

At the next stage, combination searches were undertaken. The refined combination searches utilised the AND or OR commands. For example, “human rights” AND “ethics” AND “forensic practice” created smaller clusters of more specialised literature. As did “UNCRPD” AND “intellectual disability” AND “detention”. Or, “intellectual disability” AND “human rights” AND “forensic practice” AND “coercion”. The results from productive searches were cross-referenced. Approximately 100 articles were derived that covered the areas of human rights perspectives, expert assessor, IDCCRA, and the UNCRPD. Key citations were identified and followed to generate further material. Early in the process, it became evident that the large variance in keywords tagged to articles had limited the effectiveness of the initial searches. The automated search functions built into the Web of Science and OVID data bases were activated allowing newly published articles to be readily identified.

In March and April 2023, a second search was undertaken. The aim of this process was to generate alternate search strategies that might locate literature missed in the initial search, as well as newly published material. The original searches were also rerun on Google Scholar, with the addition of new term “the role of the assessor, human rights and the disability act in New Zealand”. Alternative searches added the suffixes “in arts” and “in education”. The first search generated the most results. As relevant papers were identified, the related citations were searched on Google Scholar. The derived papers were divided into two time periods, 2017-2023 (n=32) and pre-2017 (n=39). In addition, the search engines of AUT and University of Auckland library databases were searched for related theses (master’s and doctoral); 15 were identified. These results were cross-referenced against the original search undertaken in 2019/20.

Other professional resources and grey literature (e.g., media publications, policy, United Nations, government, non-governmental reports and documents) relevant to forensic practice, intellectual disability, the IDCCRA, or related legislation (mental health or capacity law) and human rights were identified from online searches.

2.3 Part I: The Foundations of Human Rights

2.3.1 International human rights frameworks

The atrocities of World War II forced the international community to confront fundamental questions of human rights. A shared acceptance of the need for action galvanised the development of the United Nations (Black & Cooper, 2020). A task force drafted the Universal Declaration of Human Rights (UDHR). This was a challenging and, at times, fraught process due to diverse understandings of philosophy, morality, religion, and the human experience (Nowak & Zenz, 2020).

The United Nations General Assembly adopted the UDHR on 10 December 1948. The preamble recognises that “the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world” (United Nations, 1948). Specific human rights are set out in 30 articles and include freedom from discrimination, freedom of speech, the right to own property, the right to marry, the right to a fair trial and religious freedom (United Nations, 1948).

The rights enshrined in the UHDR became international law by the ratification of two binding treaties—the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant of Economic Social and Cultural Rights (ICESCR). This triad is referred to as the International Bill of Human Rights and grounds the protection and promotion of human rights for all people, including those with disabilities (Hashimoto et al., 2020). In addition, the Convention Against Torture came into force in 1987, strengthening rights protection for persons deprived of their liberty. By ratifying these treaties (and others), New Zealand accepted an obligation to respect the rights by way of laws, policies, and practices (Gledhill, 2017). However, because New Zealand has a dualist system, the Articles set out in international treaties do not form part of New Zealand law unless they are specifically incorporated by parliament into domestic law. This thesis focuses on how specialist assessors might integrate these fundamental human rights treaties as part of a broader set of perspectives. Dignity and liberty: The basis for a human rights perspective

2.3.2 Dignity and liberty: The basis for a human rights perspective

Within the concepts and descriptions of human rights explored when devising this study, the values of dignity and liberty were recurring themes.

Recognition of human dignity has been described as the source of human rights because it provides "both a fundamental principle underlying human rights and a right in itself" (Basser, 2011, p. 21). A paramount characteristic of the concept of human dignity is said to be "its recognition of the inalienable intrinsic human worth of every person" (Wilson, 2021, p. 99). Accordingly, the preamble of the ICCPR recognises that human rights "derive from the inherent dignity of the human person"(United Nations, 1966). In addition to providing the source of human rights, the concept of human dignity also supplies "an interpretive lens to ascertain the content of specific rights" (Basser, 2011). Similarly, Wilson (2021) argued that a sound knowledge of the meaning of inherent dignity was a prerequisite to accurately interpreting human rights conventions like the CRPD; observing that the concept was under theorised within this convention.

Within professional disciplines like psychology and psychiatry, respect for dignity provides a fundamental ethical principle. The *Universal Declaration of Ethical Principles for Psychologists* (UDEPP) states:

> Respect for dignity recognizes the inherent worth of all human beings, regardless of perceived or real differences in social status, ethnic origin, gender, capacities, or other such characteristics. This inherent worth means that all human beings are worthy of equal moral consideration. (International Union of Psychological Science & International Association of Applied Psychology, 2008, p. 3).

The principle of liberty underpins core democratic principles and is a cornerstone of modern human rights frameworks (Feldman, 2009; McLean, 1996; Rodley, 2014). The Preamble of the ICCPR reinforced the relationship between inherent dignity and "free human beings enjoying civil and political freedom" (United Nations, 1966). Article 9 of the ICPPR sets out the right to liberty "Everyone has the right to liberty and security of person". The word liberty does not feature in the IDCCRA despite the restrictions on freedom provided by compulsory care orders. As described in Chapter 1 the liberty interest was subsequently defined by the Court of Appeal in the case of *RIDCA Central Regional Intellectual Disability Care Agency) v VM* [2011] NZCA 659 in response to a care recipient appealing an application to extend her order:

> The IDCCR Act sets out a number of rights applying to care recipients or proposed care recipients, such as the right to legal advice and the right to information. There are many others. However we think the focus of the principles set out in s 11(b) is on more fundamental rights, particularly rights ensuring basic freedoms of the kind described in the New Zealand Bill of Rights Act 1990 (the Bill of Rights) such as the right to freedom of movement, the right not to be arbitrarily arrested or detained and the right to be free from discrimination on the grounds of disability. In a similar context the Supreme Court of Canada used the phrase "liberty interest" to describe these rights and we will adopt the same term. [para 35]

In the broadest sense, human rights are likened to "protective capsules" (Freeden, 1991, p. 7) that preserve the conditions necessary for individuals to lead lives of dignity (Ward, 2008; Ward & Birgden, 2007). This description speaks to the function of human rights or, in other words, their application and purpose in a real-world context. The concept of dignity is regarded as being fundamental to ensuring that people who offend continue to be treated as human beings who have the capacity to make positive changes and enjoy worthwhile lives (Ward, 2011).

Specialist assessors working within the IDCCRA regime undertake forensic assessments that are used to inform judicial decision-making. Care recipients are compelled to engage in rehabilitation that aims to reduce the risk of reoffending with the dual purpose of public protection and restoration of liberty. It is argued that clinicians need to actively consider dignity and its constituent values of freedom and well-being when working in forensic settings like the IDCCRA framework (Ward, 2011). To better support forensic practice, Ward and Birgden (2007) designed a three tier theoretical model of human rights. Within the first tier of the model the authors accept Gewirth's (1981, 1998, 1996) premise that "freedom and wellbeing constitute the core values required for individuals to function as purposive agents and address human dignity" (Ward & Birgden, 2007, p. 633).

Within the second tier of their model Ward and Birgden illustrate how the core values of dignity, freedom and wellbeing can be unpacked according to the Orend's (2002) philosophical analysis of the five foundation human rights objects contained in the UDHR. The authors note that the rights contained in UDHR were expressed in greater detail within the articles of the ICCPR and ICESCR (Ward & Birgden, 2007). Thus, the authors' analysis encompasses this triad of human rights. Although Ward and Birgden acknowledged that the matching process is inexact, they argue that the value of freedom corresponds to the right to personal freedoms (e.g., movement, speech, association and religion) and the right to social recognition (e.g., the right to self-determination and autonomy). The value of wellbeing is said to correspond to the right to security (e.g., freedom from torture and due process rights in law), the right to subsistence (e.g., basic access to healthcare, education and primary needs such as food and water) and the right to equality before the law (e.g., freedom from discrimination on the ground of disability).

Using this arrangement, it is evident that the Court of Appeal's definition of the liberty interest spans both freedom and wellbeing rights, reflecting the interrelated nature of these rights. In the case of the IDCCRA, attending to care recipient's well-being needs (e.g., access to offence focused rehabilitation, freedom from discrimination and meeting health, social, or occupational needs), supports the restoration of liberty. The third tier of Ward and Birgden's model illustrates how the core abstract values of dignity, freedom, and well-being are expressed within foundational human rights frameworks, such as the Universal Declaration of Human Rights (UDHR), ethics, domestic law, governmental policies, legal documents and other rules.

Forensic scholars with an interest in human rights have utilised Ward and Birgden's model to examine aspects of forensic practice, including risk assessment, therapy, and monitoring within extended supervision and preventive detention regimes (Birgden, 2008; Vess et al., 2017).The model has also informed the development of ethical guides that integrate human rights perspectives (Barnao et al., 2012; Ward & Syversen, 2009). Within this scholarship, a human rights perspective is said to orient forensic practitioners to the quality of the assessment process and social or moral factors that may encroach on the process (Ward & Birgden, 2007). It requires forensic assessors to ensure that the rights of people entering the justice process are not automatically given less weight than the community members rights (Ward & Birgden, 2007).Further, a human rights perspective is said to provide "the ethical heart" (Ward & Birgden, 2007, p. 637) for the delivery of offence-focused rehabilitation programmes like the Good Lives Model (GLM) (Ward & Gannon, 2006) that meaningfully connect core values and skills. The relationship of this scholarship to the current study is examined in Part III of the literature review.

The relationship between dignity as a core value and taking a human rights perspective within psychological practice is also being explored in non-forensic settings. A human rights perspective is said to function as "a guiding principle for psychologists" (Hagenaars, 2016, p. 198) that facilitates the active promotion of human rights.

Within their legal analysis of New Zealand's compliance with seven major human rights treaties, McGregor et al. (2015) described human rights as internationally accepted values and normative standards that promote dignity, fairness, and equality for *all* people. Collectively, these theoretical and legal notions of human rights as values and normative standards that provide the conditions necessary for people to live with dignity framed the understanding of human rights used within the research process.

2.3.3 Rights and responsibilities in tension

In addition to being rights holders, humans are also duty bearers (Ward & Birgden, 2007). When a person breaks the law, the criminal justice system determines the appropriate consequence. This study is focused on the IDCCRA, which restricts care recipients' rights using compulsory care orders and other restrictive practices. The removal of liberty is a common feature of correctional and compulsory care regimes (Orend, 2002), as is the provision of rehabilitation, which aims to reduce the risk of further offending (Adshead, 2014; Ward, 2011). In this sense, the Act explicitly addresses the dual values of freedom and well-being, set out in the Ward and Birgden (2007) model. Specialist assessors are required attend to issues of risk that may curtail freedom and consider factors that may enhance the care recipient's well-being through the delivery of rehabilitation. Ideally, successful rehabilitation serves the human rights of the care recipient and their community.

How societies preserve the dignity of those who violate the rights of others is a question that has triggered considerable debate in the literature (McSherry & Freckelton, 2013; Vess, 2009) and media (Godfrey, 2023). One hotspot of this debate is whether offenders, by virtue of their criminal actions, forfeit their human rights. In her analysis of the various factors that fuel risk-averse communities and legal systems, McSherry (2013) stated:

> Human rights exist for the benefit of *all* individuals. Even those who have committed brutal crimes possess human rights and any curtailment of the right to liberty must be carefully justified because, ultimately the arbitrary denial of human rights for selected groups erodes the value of human rights for everyone. (p. 233)

Over the past 20-years, there has been a rise in community protection regimes implemented post-conviction in democratic societies, including in New Zealand (McSherry, 2014; Vess, 2009). The human rights implications of forensic practices occurring within these regimes are relevant to the current exploration of specialist assessor work within the IDCCRA. Before examining this literature, it is important to situate the study within the context of international and New Zealand human rights law. Special features of the New Zealand landscape are considered. The section will conclude with an examination of the CRPD and its relevance to this study.

2.3.4 New Zealand's primary human rights frameworks

There are three important documents to consider in New Zealand. Two are human rights statutes, the BORA and the Human Rights Act 1993 (HRA); the other is Te Tiriti o Waitangi.

BORA protects the civil and political rights of all New Zealanders in accordance with the International Covenant on Civil and Political Rights (Dawson, 2019; Human Rights Commission, 2010). The rights afforded by BORA are grouped together under four headings: life and security of the person; democratic and civil rights; non-discrimination and minority rights; and search, arrest, and detention rights. The right not to be discriminated against on the basis of disability is confirmed by s19 of BORA (Dawson, 2019) and the HRA which recognises intellectual disability as a protected class (section 21(1)(h)). Claims of discrimination by care recipients under the IDCCRA have been considered under NZBORA (see *J, Compulsory Care Recipient, By His Welfare Guardian, T v The Attorney General* [2018]).

Te Tiriti o Waitangi

Te Tiriti o Waitangi, New Zealand's founding document, establishes a special relationship between Māori and the Crown (Ministry of Health, 2020b). It is recognised as "New Zealand's own unique statement of human rights" (Human Rights Commission, 2010, p. 40), bringing together differing sets of worldviews and conceptions of self-determination (Baxter, 2020). Article 2 of Te Tiriti o Waitangi guarantees the protection of Māori authority (commonly referred to as rangatiratanga/self-determination), property, culture, language, and other essential interests (Dawson, 2019). Te Tiriti o Waitangi also guarantees citizen rights for all New Zealanders under one law (Article 3) and sets out the rights and obligations of the Crown to govern (Human Rights Commission, 2010).

There are two versions: the Māori version, Te Tiriti o Waitangi, and the English version, known as the Treaty of Waitangi. There are areas of agreement and disagreement between the two versions. A full discussion of these differences is beyond the scope of this study. However, the tensions arising from issues of interpretation within the modern context are important to acknowledge.

Psychologists, as a professional group, give priority to Te Tiriti o Waitangi as this was the text that was offered to and signed by many of the Māori signatories (New Zealand Psychological Society et al., 2002). A working knowledge of Te Tiriti o Waitangi is recognised as "a fundamental basis of cultural competent practice" (New Zealand Psychologists Board, 2018, p. 15). The principles of partnership, participation, and protection are drawn upon by psychologists to guide collaborative practices and develop constructive relationships (Tamatea & Waipara-Panapa, 2018).

As a living document, Te Tiriti o Waitangi is considered central to New Zealand's present and future (Human Rights Commission, 2010). The stated function of the Human Rights Commission in accordance with their obligations under the s5(2)(d) of the Human Rights

Act 1993 is to "create continuous meaningful improvement of the realisation of human rights for all people in Aotearoa New Zealand by being human rights and Tiriti based in our work" (Human Rights Commission, n.d.).

The IDCCRA does not explicitly recognise Te Tiriti o Waitangi obligations. However, section 13(2) specifies the powers to be exercised with proper respect for cultural identity and personal beliefs, including proper recognition of the importance and significance of the care recipient's ties to family, whānau, hapū, iwi, and family groups. Other disability specific legislation, such as the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHCATA) and the Protection of Personal and Property Rights Act 1994 (PPPRA), include reference to collective concepts such as whānau, hapū, and iwi. However, compliance with these cultural principles is not mandated (Elder, 2019). In her examination of how practitioners applied these principles to practice, Elder (2019) observed significant variance, leading her to observe that simply including important Māori concepts in law as guiding "principles" or factors to be "recognised… risks tokenism and inconsistent use" (p. 42). Others have observed a shift towards greater recognition of tikanga Māori in modern New Zealand law (Douglass, 2016; Ruru, 2020) in the wake of a Supreme Court decision that accepted the place of tikanga in New Zealand's common law (*Takamore v Clarke* [2011] NZCA 587). How tikanga principles could be translated into capacity assessments and wider health and disability policies is an evolving area of scholarship (Baxter, 2020; Ruru, 2020).

There is a recent impetus toward structuring and delivering health services and systems in a manner that reflects Māori knowledge systems and tikanga (Baxter, 2020; Ruru, 2020). For example, in the present review of the MHCATA, the preamble sets out the value placed upon the interconnected nature of all living and non-living things in accordance with a te ao Māori worldview (Ministry of Health, 2021). The Crown's Te Tiriti o Waitangi and human rights obligations are situated at the forefront of efforts to address the over-representation of Māori within the compulsory mental health law service regime (Ministry of Health, 2020b). Similarly, this over-representation of Māori care recipients has been a consistent feature of the demographic data collected about care recipients (Ministry of Health, 2020a). For example, ethnicity data published in 2023 by the Whaikaha Ministry of Disabled People showed that Māori accounted for 40% of the 232 care recipients subject to the Act that year (Whaikaha Ministry of

Disabled People, 2023). However, at this stage, there is no indication that a review of the IDCCRA, with attention to human rights issues and Te Tiriti o Waitangi obligations, is planned.

2.3.5 The CRPD: A new era

The CRPD consolidates all rights for disabled people and was created with disabled people. The CRPD is designed to protect and promote the rights of all people with disability. Article 1 states that “The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity” (United Nations, 2006a). New Zealand is a signatory to the CRPD. Its ratification marks a new era in disability rights. The implications of the CRPD on the IDCCRA and specialist assessors’ perspectives of care recipient human rights is a point of interest to this study.

Development, ratification, and implementation

The CRPD (United Nations, 2006b) and its Optional Protocol was adopted on December 13, 2006 at the United Nations Headquarters in New York and was opened for signature on March 30, 2007. A distinctive feature of the drafting process was the significant input of disability groups (Gledhill & Hickey, 2011). Described as “the most important development ever in institutional human rights law for persons with mental disabilities” (Perlin, 2011, p. 158), the CRPD introduced a disability narrative in the human rights framework that was welcomed by disability advocates (Lord, 2013). As of January 13, 2024, 188 countries have ratified the CRPD (United Nations Department of Economic and Social Inclusion, n.d).

Many of the Articles in the CRPD are reflected in New Zealand’s existing human right laws; namely, BORA and the HRA (Bell et al., 2015; Gledhill & Hickey, 2011). It is implemented by multiple cross-government work programmes coordinated by *The Disability Strategy 2016-2023* (Office for Disability Issues, 2016). In addition, CRPD compliance is a distinct feature of the present governmental reviews of mental health law (Ministry of Health, 2020b) and capacity law (New Zealand Law Commission IP49, 2022).

New Zealand's accession to the Optional Protocol to the CRPD (OP-CRPD) in 2016 provided the right of petition. This enabled individuals or groups to make claims of rights violations to the United Nations Committee on the Rights of Persons with Disabilities (the Committee), provided domestic options for redress were exhausted (Dawson, 2019; Richardson, 2012). As set out in the introduction, this pathway for complaint was acknowledged by the High Court in (*J, Compulsory Care Recipient by his Welfare Guardian, T v The Attorney General* [2018]). The view was taken by the High Court that New Zealand has its own framework for determining if discrimination based on intellectual disability has occurred. This decision signalled where the New Zealand Courts currently place emphasis when addressing rights-based claims.

Monitoring of the CRPD

Every 4-years, New Zealand's progress and compliance is scrutinised by the CPRD Committee (Office for Disability Issues & Ministry of Social Development, 2017). The last review was completed in September 2022 (Committee on the Rights of Persons with Disabilities, 2022). In total, New Zealand has participated in three reporting cycles. The monitoring and reporting requirements are fulfilled by the *New Zealand Disability Strategy 2016-2018*, the Office for Disability Issues, and the Independent Monitoring Mechanisms (IMM). The IMM is made up of the Disabled Peoples Coalition (DPO) Coalition, the Human Rights Commission, and the Ombudsman. Together, these entities independently promote, protect, and monitor disability rights in New Zealand (Minister for Disability Issues, 2011).

In addition, the National Protective Mechanisms (NPM), which includes the Office of the Ombudsman and the Human Rights Commission, amongst others, has the power to inspect places of detention. The CRPD, along with other relevant United Nations Covenants, provide terms of reference for NPM investigations. The *Oversight Investigation Report* (Boshier, 2021) investigated how the MOH had discharged its stewardship obligations towards care recipients in hospital secure facilities. The report concluded that due to capacity constraints and poor planning, the rights afforded to care recipients under the relevant legislation and CRPD were not always upheld. Reports by the Ombudsman are not disseminated to specialist assessors by the MOH. However, it is possible that individual specialist assessors do keep abreast of the outcomes of site visits. Given the Ombudsman's work examines whether care recipients' freedom and well-being rights are being upheld, the current research was alert to how informed specialist assessors were of these processes.

In April 2021, the Ombudsman undertook a further inspection of the Pohutukawa Unit, a FIDSS based at Mason Clinic, in accordance with NPM obligations under the Crimes of Torture Act 1988 (Office of the Ombudsman, 2022). The inspection found that there was no evidence that care recipients were subject to inhuman or degrading treatment or punishment, and many areas of improvement were noted (e.g., reduced use of seclusion, positive views expressed by care recipients, and good environmental conditions). However, several issues of concern were identified. Those relevant to specialist assessor practice and this thesis were the lack of step-down facilities and other transitional options along with long-term placement of care recipients in the Pohutukawa Unit due to a lack of accommodation. In addition, vacancies in the positions of clinical psychologist and cultural adviser limited the therapeutic programmes available to care recipients. The specialist assessors in this study expressed the impact of access to therapeutic interventions on liberty outcomes in themes three and four.

Purpose and principles

The CRPD was built on an international consensus that the rights of persons with disabilities were unrealised within existing human rights frameworks (Hashimoto et al., 2020; Quinn, 2009a). The preamble recalls and reaffirms the rights and principles contained in the UDHR, the ICCPR, and ICECR.

The values and principles that underpin the rights contained within the Convention are set out in Article 3 and are further discussed in the literature (Dawson, 2015; Quinn, 2009a). These include respect for inherent dignity, individual autonomy, non-discrimination, equality of opportunity and status, respect for difference, full and effective participation, and inclusion. These principles advocate for the right of persons with disabilities to be accommodated so they can benefit from the same rights as others (McGregor et al., 2015). The principles represent an explicit attempt to move away from social, health, and legal systems that are identified as paternalistic, coercive, or exclusionary (McSherry & Freckelton, 2013; Rioux et al., 2013).

The CRPD is grounded in the social model of disability, which attributes the cause of disability to social, political, physical, or cultural factors in the environment that disadvantage or exclude people (Oliver, 1983). Fifty articles prescribe the obligations placed on ratifying states to address discrimination and mistreatment of persons with disabilities (Bell et al., 2015; Kanter, 2019). The general obligations within Article 4 require states parties to "ensure and promote the full realisation of human rights and fundamental freedoms for all persons with disabilities" (United Nations, 2006a, p. 5).

Relatedly, States Parties are required to modify or abolish existing laws, measures, or practices that constitute discrimination against persons with disabilities (United Nations, 2006a). The IDCCRA has been identified as discriminatory in recent CRPD reporting cycles (Committee on the Rights of Persons with Disabilities, 2014, 2022). New Zealand's response to this finding is discussed later in this chapter.

The social model of disability and the IDCCRA

The social model of disability locates the responsibility for dismantling disabling barriers with society, not disabled individuals (Shakespeare, 2013; Stace, 2010). Proponents of the social model drew attention to how the medical model reinforced a paternalistic, oppressive and welfare-based approach to disability (The Union of the Physically Impaired Against Segregation & The Disability Alliance, 1975). By positioning disabled people as passive objects of care rather than active rights holders, it was argued that societies limited their realisation of fundamental human rights (Gledhill & Hickey, 2011; Rothman, 2010).

The specific obligations inherent to Article 5 of the CRPD, which guarantees equality and non-discrimination, were clarified by *General Comment No. 6 (2018) on equality and non-discrimination* (Committee on the Rights of Persons with Disabilities, 2018). Concern was expressed about the continued use of medical models by States Parties, despite incompatibility with the Convention:

> Individual or medical models of disability prevent the application of the equality principle to persons with disabilities… persons with disabilities are not recognized as rights holders but are instead "reduced" to their impairments. Under these models, discriminatory or differential treatment against and the exclusion of persons with disabilities is seen as the norm and is legitimized by a medically driven incapacity approach to disability. (p. 2)

In respect of each state’s obligations, the Committee asserted, “States parties shall modify or abolish existing laws, regulations and practices that constitute such discrimination… including: guardianship laws and other rules that infringe on the right to legal capacity” (p. 8).

This interpretation of Article 5 raises important questions about the IDCCRA. Specialist Assessors are gatekeepers for entry and exit from the IDCCRA regime. Their assessments, derived from medical and social science models, inform decisions about risk assessment and eligibility for compulsory care (which includes restriction on liberty and extensions to orders). On the one hand, the IDCCRA places responsibility on New Zealand to ensure that care recipients have access to an appropriate and protective rehabilitation regime. However, on the other hand, it has been observed that a care recipient must demonstrate that they no longer pose a significant risk to the safety of others for their order to end (Duncan, 2013), placing quite a high level of responsibility on the individual.

As highlighted by the recent Office of the Ombudsman’s reports, when the system does not provide appropriate or accessible rehabilitation options, this significantly impacts individual care recipients (Boshier, 2021), often in the form of inequity in relation to the length of time they experience a loss of liberty. How these challenges might impact a specialist assessor’s perceptions of a care recipient’s human rights is relevant to this study.

The human rights model: A way forward

The human rights model advanced by Quinn and Degener (2002) maintains elements of the social model and recognises the appropriateness of the medical model in some circumstances:

> The human rights model focuses on the inherent dignity of the human being and subsequently, but only, if necessary, on the person’s medical characteristics. It places the individual centrestage in all decisions affecting him/her and, most importantly, locates the main “problem” outside of the person and in society. (p. 14)

Some view this model as an improvement on the social model (Waddington & Priestley, 2021), while others see it as complementary (Lawson & Beckett, 2021). The term human rights model is not explicitly mentioned in the CRPD text. However, some have taken the view that the CRPD codifies the human rights model (Degener, 2016). There is an ongoing debate within the critical disability literature about the limitations of the social model; specifically, about whether it explains, embodies, and validates the real-world experience of disability (Arstein-Kerslake, 2017; Degener, 2016; Shakespeare, 2013). Nonetheless, international support for the CRPD illustrates acceptance of the need to challenge and deconstruct disabling social structures.

2.3.6 The CRPD articles relevant to this study

While it could be argued that all CRPD articles have salience within this research, at least six articles of the CRPD have direct relevance to this study. Each are reproduced in full in Appendix A.

As presented above, Article 5 guarantees equality and non-discrimination by recognising that all persons are equal before the law and entitled without discrimination to the equal protection and benefit of the law.

According to Article 12 persons with disability have equal recognition before the law and have the right to enjoy legal capacity on the same basis as other people in all aspects of life.

Article 13 guarantees access to justice. It includes an obligation on States Parties to promote appropriate training of health professionals to ensure effective access to justice for persons with disability.

The right of persons with disability to enjoy liberty and security of person on an equal basis with others is set out in Article 14. Specifically, persons with disabilities are not to be deprived of their liberty unlawfully or arbitrarily. In no case should disability justify the deprivations of liberty. The IDCCRA provides for compulsory care, which detains care recipients in designated facilities for the purposes of rehabilitation.

In addition, care recipients are ordered to engage in rehabilitation to reduce the risk of offending. Article 26 focuses on habilitation and rehabilitation. States parties should take effective and appropriate measures to enable people with disabilities to attain maximum independence, full inclusion, and participation in all aspects of life. Rehabilitation should be delivered as close as possible to their own communities, including in rural areas.

Finally, Article 30 recognises the right of persons with disabilities to take part in a cultural life on an equal basis to others.

Implications of the guidelines and comments issued by the Committee

Whether the CRPD created new rights or simply redefined and amplified existing human rights is an area of debate (French et al., 2010; Harnacke, 2013; Kayess & French, 2008). Accordingly, the CRPD has been followed by a series of General Comments and Guidelines. The *Guidelines on the right to liberty and security of persons with disabilities* (Committee on the Rights of Persons with Disabilities, 2015) is of direct relevance to this study because it deals directly with diversionary schemes, like the IDCCRA. These guidelines set out the close relationship between equality and non-discrimination (Article 5), equal recognition before the law (Article 12), liberty and security (Article 14). Points salient to the IDCCRA and CPMIPA are presented below.

The Committee confirms that Article 14 is a non-discrimination provision that does not allow for detention based on disability or perceived impairment. The Committee notes that several states had retained laws that allow for detention on the grounds of disability if “they are deemed dangerous to themselves or others” (Committee on the Rights of Persons with Disabilities, 2015, p. 17). The Committee said, “That practice is incompatible with article 14; it is discriminatory in nature and amounts to arbitrary deprivation of liberty” (p. 17). This interpretation would appear to cast doubt on the IDCCRA regime because intellectual disability and risk to others are central tenets of the legislation.

Accordingly, within the *Concluding Observations on the combined second and third periodic reports of New Zealand*, adopted in 2020, the Committee expressed concern about the IDCCRA’s compliance with Article 14, specifically because:

> The Intellectual Disability (Compulsory Care and Rehabilitation) Act of 2003, which includes extensions to compulsory care orders and which

> allows persons with intellectual disabilities to be detained for periods of time exceeding the maximum length of sentence they would be liable in the criminal justice system". (para 27(b) United Nations, 2022)

The Committee recommended repeal of these provisions.

To clarify how people with intellectual disability who offend should be treated within the criminal justice process, the Committee had earlier stated, "All persons, including those with disabilities, have a duty to do no harm. Legal systems based on the rule of law have criminal and other laws in place to deal with breaches of that obligation" (Committee on the Rights of Persons with Disabilities, 2015, p. 19). The Committee noted that people with disabilities are "…frequently denied equal protection under those laws by being diverted to a separate track of law, including through mental health laws" (Committee on the Rights of Persons with Disabilities, 2015, p. 19). The Committee considered these laws or procedures to offer a "lower standard when it comes to human rights protection, particularly the right to due process and fair trial" (p. 19). The Committee stated that diversionary practices are incompatible with the right to access justice (Article 14) and liberty and security. At ratification of the CRPD, and within subsequent reporting cycles to the Committee, the New Zealand Government has maintained the position that IDCCRA and CPMIPA comply with CRPD (New Zealand Government, 2018; Office for Disability Issues, 2015).

Preparatory work undertaken by the Government prior to ratifying the CRPD indicated that New Zealand's legislative framework was compliant, with only minor revisions required (Office for Disability Issues, 2009). Having reviewed the Office for Disability Issues analysis and cabinet papers, Bell et al. (2015) suggested that "there was no real attempt to address the more subtle implications of the Convention" (p. 282).

There appears to be a clear and obvious divide between the Committee's stance on Article 14 and the position taken by the New Zealand Government toward capacity regimes and diversionary systems for intellectually and mentally disordered offenders. It is important to recognise that the Committee's General Comments and Guidelines are not legally binding on States Parties, despite the fact they filter into the Concluding Observations on periodic reports. This tension was explored by Doyle Guilloud (2019) who observed that the radical reform required by States Parties to fully realise Article

14 rights was likely to remain a contentious issue within the UN rights infrastructure despite widespread ratification of the CRPD. This study was alert to the specialist assessors' understanding of a care recipient's CRPD rights, and their perceptions of the implications for practice within the IDCCRA regime.

Responses to the Committee's call for a disability neutral legal system

The requirement to introduce disability neutral law is a purported implication of Article 12, which guarantees the right to equal recognition before the law. In essence, this means that access to legal defences or diversionary schemes that take account of impairment would be removed (Appelbaum, 2016; Arstein-Kerslake et al., 2017; Peay, 2015; Richardson, 2012). Enactment of disability neutral law is said to entail a paradigm shift (Bell et al., 2015; Degener, 2016; Mirfin-Veitch, 2016) that, in the purest interpretation, would prohibit "any provisions that link legal and mental capacity" (Richardson, 2012, p. 348).

A critical review of fitness to plead proceedings/law and disability neutral legislation is somewhat beyond the remit of the thesis. However, the enactment of legislative changes of this nature would have significant implications for the CPMIPA and IDCCRA, and, therefore, specialist assessor practice. For this reason, the salient issues are briefly presented.

The IDCCRA's compliance with Article 12

An outcome of New Zealand's first CRPD reporting cycle was the Committee's recommendation that all people with disabilities detained in prisons or institutions be allowed to defend themselves against criminal charges; and be provided with the requisite accommodations to ensure effective participation in the legal process (Committee on the Rights of Persons with Disabilities, 2014). If implemented, this recommendation would have significant implications for the CPMIPA and IDCCRA regimes because dispositions preceded by an unfitness finding would appear non-compliant.

The New Zealand Government (2018) has subsequently maintained it would "not be appropriate to conduct a full trial for someone who is unable to properly conduct a defence" (p. 40). Calibration of current procedures was not discussed. In addition, the Government considered the CPMIPA and IDCCRA to contain appropriate safeguards and protections for care recipients. CRPD compliance would, therefore, require a radical departure from how legal capacity had been traditionally conceptualised in New Zealand (Mirfin-Veitch, 2016).

Concerns about the removal of protections

Scholars have voiced concern that the Committee's stance removes hard-won protections for people with disability (Dawson, 2015; Keene et al., 2023; Sabatello, 2015) and risks "discrimination" (Dawson, 2015, p. 71). Recently, the Victorian Branch of the Australian and New Zealand Association of Psychology Psychiatry and the Law (ANZAPPL) and the Victorian Forensic Branch of the Australian and New Zealand Royal College of Psychiatrists (RANZCP) debated the implications of abolishing of the defence of mental impairment in light of long-standing concepts of criminal responsibility (McSherry & Sullivan, 2023). One argument presented during the debate was that disability rights could be advanced without discarding the mental impairment defence, which was viewed as inherently protective and humane (McSherry & Sullivan, 2023). The opposing argument set out reasons for abolishing the defence on the basis that it was not fit for purpose, did not safeguard human rights or achieve adequate care and risk management for persons with mental impairment or cognitive disability facing criminal charges (Darjee & Marsh, 2023).

Although this debate was not specific to the CPMIPA or IDCCRA, this commentary demonstrates the important questions raised for professionals and Governments regarding the implementation of the CRPD. Whether specialist assessors were attuned to the debates generated by the CRPD and subsequence guidance issued by the Committee was a point of interest within the thesis.

The invisibility of care recipients and their international equivalents during CRPD drafting

The degree of consideration given to people with disability who are charged with or convicted of criminal offences during the drafting of the CRPD has been critiqued. For example, Sabatello (2015) observed that involuntary civil commitment and the needs of victims, not perpetrators of offending, was the focus of disability activists at the expense of "traditional forensic patients who had received little to no attention" (p. 79). An alternative view is that forensic clinicians were absent from the drafting process and, therefore, bear some responsibility for the invisibility of this group (Freeman et al., 2015; Szmukler, 2019). This critique echoes Perlin's (2010, 2018) observations of forensic psychology's silence on human rights issues. This issue is addressed in detail in the final section of this chapter.

In comparison, proponents of the CRPD have identified multiple positive outcomes and opportunities for care recipients and their equivalents. The CRPD has been described as a vehicle to empower people with disabilities by rejecting a social welfare approach and viewing disability as a matter of human rights (Harnacke, 2013). Others have characterised the CRPD as providing a "moral compass" (Quinn, 2009b, p. 34) in the way we think about and treat persons with disabilities. Exclusion from the criminal justice process is said to render people more vulnerable, "It does greater harm to exclude people with disabilities from recognition as moral subjects, than to pretend to excuse us from responsibility while in fact imposing even greater restrictions on our rights and freedoms" (Minkowitz, 2014, p. 3). This view was echoed by Arstein-Kerslake and colleagues (2017) who observed that people found unfit to plead or not guilty by way of insanity are often subject to far longer periods of detention than would have otherwise occurred if they remained in the criminal justice process. The subject of this thesis gives more visibility to people occupying the liminal space between civil containment and criminal detention.

The transformative potential of the CRPD

The transformative potential of the CRPD within a criminal justice context is recognised (Arstein-Kerslake et al., 2017; Gooding & O'Mahony, 2016; Minkowitz, 2010; Mirfin-Veitch, 2016). Along with the caution that enthusiasm needs to be moderated with realism (Appelbaum, 2019; Richardson, 2012; Szmukler, 2019). No countries have successfully implemented all aspects of Articles 12 or 14 (Mirfin-Veitch, 2016). Some countries (e.g., Australia and Canada) entered declarations of reservations at the time of ratification. Scholars have argued that the promise of the CRPD will not be realised should the requirements prove unworkable or are ignored (Appelbaum, 2019; Freeman et al., 2015; Szmukler, 2019).

Within the literature, alignment between the IDCCRA, the New Zealand Disability Strategy, and the CRPD was highlighted as an area requiring further attention. Whether the IDCCRA could conform to the requirements of the CRPD was an area identified as ready for debate (Prebble et al., 2013). Having considered the responsivity of the legal system to care recipients (and other people with disability), Mirfin-Veitch et al. (2014) identified that New Zealand was in a strong position to realise its CRPD obligations. This optimism was tempered by the observation that some New Zealanders with intellectual disability were not yet realising these rights. A useful and insightful discussion of the relevance of CRPD rights obligations within the IDCCRA framework was provided by Smith (2015). In her discussion of pending changes to the model of care and rehabilitation, Smith asserted:

> The provision of care and rehabilitation must include consideration of the UNCRPD, particularly in relation to Articles 12 (Equal recognition before the law) and 13 (Access to justice), which have particular relevance for care recipients. (Smith, 2015, p. 201)

This finding reinforced Smith's (2013) earlier assessment that "integration of a human rights framework within rehabilitation is necessary to provide real outcomes for people with intellectual disabilities who become subject to the IDCCRA" (p. 7).

The application and implications of the CRPD are areas of active debate and interest. The obligations imposed on New Zealand as a State Party to promote the training of professionals like specialist assessors in the CRPD so they can "better provide the assistance and services guaranteed by those rights" (Frawley & Naylor, 2014, p. 66) is of relevance to this study. specialist assessors' attunement to the tensions associated with the evolving human rights landscape, specifically implications for their practice within the IDCCRA framework, was explored in this study.

The next section of this review will focus on the development and implementation of IDCCRA. Special attention is given to commentary or applied studies that reference rights-based issues.

2.4 Part II: Safeguarding Care Recipient Rights

2.4.1 A historical context

Two decades ago, the IDCCRA passed into law. The drafting process is briefly described to provide a historical context and highlight the relevant rights considerations. The revision of New Zealand’s mental health legislation in the 1980s aimed to prevent the inappropriate use of compulsory treatment with intellectually disabled people (Duncan, 2013). Subsequently, a small group of people with complex needs or significant offence histories were released into the community with reduced support (Smith, 2015). Some of these individuals reoffended or were considered dangerous (Te HeuHeu, 1999). Considerable public pressure came to bear on the government of the time to develop an appropriate legislative solution (Brookbanks, 2003).

The Intellectual Disability (Compulsory Care) Bill in 1999 (IDCC) and the Criminal Procedure (Mentally Impaired Persons) Bill (CPMIP Bill) were drafted to fill the legislative gap (Duff & Sakdalan, 2007; Duncan, 2013). Project work by Brookbanks (1995) and Dawson (1997) informed the early development of these Bills. The goal was to craft appropriate disposition and care pathways for intellectually disabled people encountering the criminal justice system.

The discussion papers explored the potential structure of the proposed legislation, along with comparable international approaches, human rights implications, and the groups most likely to be captured by the legislation. A civil route allowing compulsory care for those who posed a danger to others but had not been charged with an offence was tabled (Brookbanks, 1995; Dawson, 1997; Ministry of Health, 1996). These provisions, however, were not supported by many stakeholders or members of the Parliamentary Select Committee (Cotter, 1996; Health Select Committee, 2001) and were abandoned (Brookbanks, 2003; Smith, 2015). Nonetheless, there was support for standalone provisions aimed at persons subject to the criminal justice system (Cotter, 1996; Health Select Committee, 2001).

Anticipated Care Recipients

A survey undertaken by Webb and Capie (1996) with service providers for the MOH indicated that around 200 people, mostly men aged between 25 and 40 years, were likely to qualify for the legislation. The realities of implementation are examined in a later section of this chapter. Of particular interest to the current research is Dawson's (1997) analysis of the anticipated care recipients. He suggested that three distinct groups could be captured by the law and considered the human rights implications for each. Subsequent research highlighted the relevance of Dawson's analysis, specifically for youth (Duncan, 2013) and those care recipients who had little ability to engage in rehabilitation (Smith, 2015).

Dawson (1997) anticipated that the first group was unlikely to identify as disabled or to have pre-existing relationships with disability services. Rather, they would be well known to the courts because of characteristics common to mainstream offenders. He characterised this group as:

> a group of low or borderline intelligence who are, in addition, seriously socially disabled, often due to deprivation in childhood. They are difficult to handle within the criminal and penal systems. They may be illiterate, impulsive, unreliable, in poor physical health and with further problems associated with substance abuse or institutionalisation. They frequently appear before the courts… The members of this group can usually enter consensual arrangements concerning their care. (Dawson, 1997, p. 8)

According to Dawson, the needs of this group were best met using a combination of voluntary and coercive non-custodial interventions delivered by probation services and other service providers. Although Dawson identified that this group would likely meet eligibility criteria, *he did not* view this group as an appropriate target for the IDCCRA or a civil commitment regime. There is considerable synergy between Dawson's analysis of this group and Duncan's (2013) description of the "New Care Recipients" (p. 362). Importantly, the scoping process highlighted that an influx of young people with complex psychosocial histories into the IDCCRA framework was forecast.

The second group described by Dawson consisted of a well-known cohort of people with mild or moderate intellectual disability, already known to, and likely living within, residential intellectual disability services, with established histories of challenging or harmful behaviour. This group was considered likely unfit to stand trial and already subject to restrictive practices (e.g., restraints, seclusion, and environmental restraints). Dawson expressed reservations about the appropriateness of rehabilitation, opining, “What the members of this group appear to need most from the law is protection from abuse” (p. 9). He *did not* view the IDCCRA as an appropriate mechanism for this group, proposing that alternative protections could be enacted within the justice and health frameworks.

Finally, Dawson (1997) identified a third small group with mild or moderate intellectual disability, engaging in serious criminal actions, for whom he believed the IDCCRA *would provide* an appropriate framework, “they should be cared for in intellectual disability services, and sometimes in secure care” (p. 10). He viewed this group as being appropriately held to account within a criminal process that allowed alternative disposition options in a non-custodial setting.

Importantly, Dawson (1997) cautioned against the assumption that only a small group of people would be captured by the legislation,

> Compulsory care will become a social institution, which may generate its own demand. Its existence may diminish the use of less restrictive means of delivering care, or prevent their development…Once under the regime a person may stay there for a long time. (p. 14)

Several inferences can be drawn from this statement. Firstly, pressure could come to bear on the IDCCRA framework due to inadequate resourcing of the mainstream disability services to deal with challenging behaviour. Secondly, should members of the second group become subject to orders, they may remain subject to compulsion for long periods of time, with significant human rights implications. Thirdly, introducing a compulsory care regime may have negative impacts on civil service provision. This research was alert to specialist assessors’ perceptions of the potential liberty implications for care recipients entering or remaining in compulsory care due to limited civil options.

More recently, the *Oversight Report* (Boshier, 2021) highlighted the resource constraints experienced within the IDCCRA framework from 2013 onwards, specifically provision of hospital-secure placements within disability-centric inpatient settings. Within a qualitative study conducted in 2013, professionals holding statutory roles within the IDCCRA expressed the view that the regime “should not be used as a backstop for community services that were inadequately resourced with behavioural programmes” (Prebble et al., 2013, p. 117).

Philosophical and rights issues

Diesfeld (2013) compared the strong rights orientation that had defined New Zealand’s earlier disability strategy with the legal coercion authorised by the IDCCRA. During the drafting process, it was anticipated tensions could arise from the development of a new law for people with intellectual disability “at a time when secure or locked services… are, for the most part being reduced in size or abandoned” (Dawson, 1997, p. 7). Several human rights and ethical “hotspots” emerged during the public and parliamentary debates (Brookbanks, 2003, p. 547). A notable ‘hotspot’ was the inclusion of an extension provision that could result in “indefinite preventative detention” (Ministry of Health, 2001, pp. 18-19). Advocacy groups foresaw this tension and requested the issue be addressed up front, “It is perhaps opportune time for legislation to direct this issue to a group who has or can develop expertise in weighing up conflicting public and personal interests in these situations” (Cotter, 1996, p. 14).

Concerns about extension provisions appeared to be overcome by the inclusion of safeguards, such as regular reviews and the ability for orders to be cancelled by the Family Court (Brookbanks, 2003). In addition, the Crown Law Office advised that the IDCCR was not in breach of BORA (Brookbanks, 2013; Smith, 2015). Nonetheless, just prior to the passing of the legislation, Brookbanks (2003) warned that care was required to ensure the IDCCRA was not used to achieve preventive detention.

The potential for the IDCCRA to be discriminatory was considered. Brookbanks (1995) recognised the importance of the normalisation principle in the disability sector but expressed reservations about the suitability of its application within the criminal justice system. The submissions received on the proposed legislation indicated there was support within the health and disability sector for a non-custodial alternative that could be more specifically tailored to the needs of people with intellectual disability (Cotter, 1996).

The important role that service providers would play in the success of the legislation and rights protections was spotlighted by Dawson (1997):

> The shape of the legislation depends to some extent on service development issues… Compulsory care of vulnerable people in secure conditions for long periods of time is contemplated. Adequate standards of care and protection of the basic human rights of detained people must be assured by the state. (p. 7)

Here, an explicit link is drawn between service provision and rights protections. In addition, legislative complexity was identified as a factor that might create challenges for service providers (Brookbanks, 2003).

The need for experts to inform, but not be responsible for, decisions about compulsory care was identified in the drafting process (Cotter, 1996). Civil libertarian groups observed that the degree of control over care recipients' liberty given to specialist assessors, coordinators, and care managers was a distinctive feature of the IDCC Bill (Bott, 2000 cited in Brookbanks, 2003). Decisions about disposition under the IDCCRA, variations to orders and extensions rest with the Court. However, aspects of the review process have been critiqued regarding the role of specialist assessor and coordinator decision-making (CCDHB & Luke Cunningham Clere, 2017). These issues are presented in a later section of the literature review and are a feature of themes two and five.

The lack of detail about the specialist assessor's role within early policy documents (Ministry of Health, 1996) could suggest that substantive planning occurred in the latter stages of the drafting process. Alternatively, it may indicate that scholars were less attuned to the role specialist assessors would play as gatekeepers to compulsory care. For example, specialist assessors play a pivotal role in determining whether people are eligible to become care recipients or whether existing orders should be cancelled or extended.

2.4.2 The final form of the Act

Purpose

The IDCCRA and the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHCATA) serve quite different purposes but have some elements in common. For example, they share a structured assessment and review process, a formulation of patients' rights, and a similar statutory structure. However, the differences outweigh the similarities. The IDCCRA's strong focus on public protection was observed as a profound difference (Brookbanks, 2003).

The purpose of the IDCCRA Act is set out in section 3:

(a) To provide the courts with appropriate care and rehabilitation options for persons who have an intellectual disability and who are charged with, or convicted of, an offence;
(b) To recognise and safeguard the special rights of individuals subject to this Act;
(c) To provide appropriate use of different levels of care for individuals who, while no longer subject to the criminal justice system remain subject to the Act.

Proposed care recipients, who are fit to stand trial and convicted, can be sentenced to prison if this is deemed most appropriate by the Court. Those who are unfit can be disposed of via the IDCCRA or MHCATA or immediately released. Two other entry points are transfer from prison or the MHCATA. During the scoping process, it was envisaged that the bulk of care recipients would come through transfer mechanisms, but this has not been the case (Duncan, 2013).

Compulsion is fundamental to the IDCCRA because of the requirement for all care recipients to accept care under a court order or a care and rehabilitation plan and to comply with all "lawful directions given by a care coordinator under sections 42(2) and 42(3)" (Diesfeld, 2013, p. 246). When compulsory care orders are made by the Court, the nature and the term of the care order is specified. Reports by specialist assessors typically provide an opinion on eligibility, the need for compulsion, the risk of reoffence, order length, and the least restrictive option available to address the proposed care recipient's risks and needs.

Eligibility criteria

The eligibility criteria are set out in section 7 IDCCRA:

1. A person has an **intellectual disability** if the person has a permanent impairment that-
    (a) Results in significantly sub-average general intelligence: and
    (b) Results in significant deficits in adaptive functioning as measured by tests generally used by clinicians, in at least 2 of the skills listed in subsection (4); and
    (c) Became apparent during the developmental period of the person.
2. Wherever practicable, a person's general intelligence must be assessed by applying standard psychometric tests generally used by clinicians.
3. For the purposes of subsection (1)(a), an assessment of a person's general intelligence is indicative of significantly subaverage general intelligence if it results in an intelligence quotient that is expressed–
    (a) As 70 or less; and
    (b) With a confidence level of not less than 95%
4. The skills referred to in subsection (1)(b) are–
    (a) Communication:
    (b) Self-care:
    (c) Home living:
    (d) Social Skills:
    (e) Use of community services:
    (f) Self-direction:
    (g) Health and safety:
    (h) Reading, writing, and arithmetic:
    (i) Leisure and work.
5. For the purposes of subsection (1)(c), the developmental period of a person generally finishes when the person turns 18 years.

The exclusion criteria described in section 8 of the IDCCRA clearly stipulate the requirement on specialist assessors to distinguish intellectual disability from mental health conditions, personality factors, acquired brain injury, and other antisocial characteristics. This provision is similar to the exclusion provision in section 4 of the MHCATA, where intellectual disability is an excluded condition.

The section 7 criteria are derived from the *Diagnostic Statistical Manual Fourth Edition Text Revision* (American Psychiatric Association, 2000). The subsequent *Diagnostic Statistical Manual Fifth Edition* (DSM-5) (American Psychiatric Association, 2013) places more emphasis on adaptive functioning relative to Full Scale IQ. A disparity between the legal and clinical criteria has been observed (Nuth, 2017). Arguably, the adoption of the DSM-5 criteria could result in a greater number of proposed care recipients becoming eligible for disposition under the IDCCRA. Notably, the eligibility for MOH funded intellectual disability support is also based on DSM-4TR criteria (Taikura Trust, 2023).

Categories of compulsory care

The Act created two new categories of compulsory care: secure and supervised. It also created two new terms: care recipient and SCR (IDCCRA, s 6). The complexity of the Act is reflected in the number of different classes of people who can sit within each category. For example, care recipients can be fit or unfit, disposed of and no longer subject to the criminal justice system, or subject to hybrid orders.

Special care recipients typically receive multidisciplinary care within Forensic Intellectual Disability Secure Services (FIDSS). The units are located within existing Regional Forensic Inpatient Services. Leave must be approved by the Minister of Health (IDCCRA, s 66) or the Director-General of Health (IDCCRA, s 67). The duration of the special care orders is half the term of the maximum prison sentence for their index offence (CP(MIP)A, s 30(1)(a) and (b)). When a SCR is unfit, their capacity to stand trial is reviewed 6-monthly by a specialist assessor (IDCCRA, s 89). If a SCR is determined to be fit to stand trial, there is a pathway for criminal justice proceedings to restart (CPMIPA, s 31). Once a SCR reaches the end of their order, their status automatically converts to care recipient (CPMIPA, s 30). Following a further review by a specialist assessor, an application can made by the coordinator to extend this order (IDCCRA, s 85).

More flexible care arrangements are available for care recipients. They may be placed in supervised or secure facilities in the community, or in hospital secure services (IDCCRA: subpart 3). Community-based facilities called Regional Intellectual Disability Supported Accommodation Service (RIDSAS) are homes situated in the community and operated by disability providers. They may have environmental restrictions, such as locked doors/gates, alarms or high fences. However, in most facilities, oversight is provided by 24/7 staffing. Order lengths vary from 6-months to 3-years (CPMIPA, ss 25(1)(b) and 34(1)(b)(ii); IDCCRA, s 45). Leave arrangements are approved by the care manager (IDCCRA, s 65). Most care recipients attend vocational services. Clinical input may be available within the RIDSAS but, in most circumstances, this is provided by external agencies such as Intellectual Disability Offender Liaison Services (IDOLS) or specialist sexual harm agencies like the SAFE Network.

Reviews and variations

Reviews are completed every 6-months by specialist assessors (IDCCRA, s 78). The specialist assessor’s report must be accompanied by the s79 certificate that confirms the legal status of the care recipient or SCR. The specialist assessor must state whether, in their opinion, the care recipient needs to be cared for as a care recipient (IDCCRA, s 82).

Orders may be extended (IDCCRA, s 85). The maximum extension is for 3-years, and the Family Court must consider and determine whether secure or supervised care is required. Applications to extend an order are made by the coordinator in consultation with a specialist assessor, who conducts the final review.

There are provisions for orders to be deferred, cancelled, or varied (IDCCRA, ss 85-87). Cancellations or variations typically occur within the review process at the recommendation of specialist assessors. Applications to defer the expiration of orders can be made by coordinators in the context of ensuring there is sufficient time to hear applications to extend orders. There are no published data on the number and length of extensions. This is of note given the relevant liberty concerns.

Rights protections

Compulsory care limits many of the liberties enjoyed by New Zealand citizens. The residual rights of care recipients are modelled on the MHCATA (Brookbanks, 2003). They include general rights to information, respect for cultural identity, and access to medical treatment, independent health and disability advice, legal advice, and company of others (IDCCRA, ss 47-59). Other checks and balances include opportunities for appeals, clarification and/or exercising of rights via District Inspectors and statutory reviews (Nuth, 2017)

care recipients are entitled to all the protections supplied within the Code of Health and Disability Services Consumer Rights (IDCCRA, s 48). Although not specified explicitly within the Act, care recipients are entitled to the fundamental human rights protections available under BORA 1990, the Human Rights Act 1993, and the UNCRPD (Brookbanks, 2013; Diesfeld, 2013). The Court of Appeal in *RIDCA Central v VM [2011*] interpreted section 11(b) of the IDCCRA as including the fundamental rights inherent to BORA. These specifically included the right to freedom of movement (s 18), the right not to be arbitrarily arrested or detained (s 22), and the right to be free from discrimination on the basis of disability (s 19). As discussed earlier in the thesis, these rights are now commonly referred to as the liberty interests [para.35 RIDCA Central v VM].

Other rights protections relevant to the Act include the principle of reciprocity, which Brookbanks (2005) defined as:

> If society is to impose a duty to comply with care on some of those who suffer from intellectual disability, it must impose a parallel duty on health and social care authorities to provide an appropriate standard of care… Accordingly, we would contend that where society compels an individual to accept compulsory care services those services must be available and of appropriate quality. (p. 74)

The analysis by Brookbanks identified service provision and accessibility of treatment as a human rights issue. The importance of robust service delivery to the success of the legislation was reiterated by several scholars (Bonardi, 2009; Diesfeld, 2013; Duff et al., 2023; Ngatai, 2013).

Multiple avenues of rights protection are therefore available to care recipients. Nonetheless, Brookbanks (2013) scrutinised the capacity of intellectually disabled offenders to effectively and meaningfully assess if the care received was properly and/or lawfully given. The need for an inbuilt advocacy framework, in the form of a responsible adult, to assist care recipients in their journey through the criminal justice and compulsory care process has been repeatedly raised (Brookbanks, 1995, 2003, 2019).

In 2013, the New Zealand Law Foundation commissioned qualitative research to examine the responsiveness of the legal system to people with intellectual disability (Mirfin-Veitch et al., 2014). The study found that it was common for care recipients (amongst other people with intellectual disability) to experience barriers to exercising their human rights within the justice system. The care recipients expressed to Mirfin-Veitch et al. (2014) the importance of feeling listened to and understood by lawyers and judges. This was equated with preserving dignity and respect within the justice process. The study recommended several areas of reform. Of relevance to this thesis was the call for increased specialisation within the legal and judicial fraternity. The quality of advocacy for care recipients was a strong subtheme of the current doctoral research (theme five).

Cultural assessments

Recognition of cultural identity is set out under Article 30 of the UNCRPD. The Act includes provisions for cultural assessments (IDCCRA, s 23). Also, *Guidelines for Cultural Assessment – Māori under the Intellectual Disability Compulsory (Care and Rehabilitation) Act 2003* were published by the MOH in 2004. The stated aim was to promote cultural assessments that facilitated effective, appropriate, and efficient care planning for Māori care recipients and their whānau (Ministry of Health, 2004). Guiding principles include ensuring assessment and care occur in the least restrictive environment, the right to receive a culturally appropriate assessment, and service delivery and involvement of Māori in the delivery of care and rehabilitation.

A primary reference point for the guideline was the Māori Health Strategy – He Korowai Oranga. According to the guideline, He Korowai Oranga set out the principles underpinning the relationship between Crown and Māori in a health context and the New Zealand Government's commitment, "to fulfilling the special relationship between iwi and the Crown under the Treaty of Waitangi" (p. 2). The guidelines identify that Māori cultural assessors are "responsible for conducting Māori cultural assessments in conjunction with the specialist assessors" (p. 1).

Definition of rehabilitation

New Zealand's CRPD obligations under Article 26 require the provision effective and appropriate rehabilitation measures to enable people with disabilities to attain maximum independence, full inclusion, and participation in all aspects of life. Rehabilitation should be delivered as close as possible to their own communities, including in rural areas.

Although rehabilitation is integral to the purpose of the IDCCRA, the term was not defined within the statute. Within the drafting process, there were concerns about how rehabilitation would be defined and operationalised (Brookbanks, 2003; Brookbanks, 2013; Diesfeld, 2013). In addition, there were recurring concerns about how rehabilitation would be balanced with risk management (Cotter, 1996; Health Select Committee, 2001; Smith, 2015). In *RIDCA Central v VM*, the Court of Appeal revisited the issue and adopted the Oxford Dictionary definition for rehabilitation, "3.a Improvement of the character, skills and behaviour of an offender through training counselling, education etc., in order to aid reintegration into society" (para. 73).

The appropriateness of rehabilitation as a philosophy for persons with intellectual disability was debated because rehabilitation traditionally refers to the restoration of previously acquired skills, knowledge, or abilities (Diesfeld, 2013). Others argued that 'habilitation' would have more accurately conveyed the process of helping care recipients, who are people with disabilities, to attain, keep, or improve skills for daily living ((Nuth, 2017).

The least restrictive alternative

The least restrictive alternative principle, sometimes referred to as the principle of parsimony, requires that "the state must pursue its interests in a manner that least intrudes upon (restricts) individuals' interests/rights" (Biklen, 1982, p. 124). This principle, while not explicitly stated in the final version of the Act, was nonetheless an important feature identified at inception (Ministry of Health, 2004; Scott, 2003, October 21) and reinforced by the Court in *RIDCA Central v VM* [2011].

The legal origins of the least restrictive option can be traced to the principles of due process, equal protection, and liberty (Biklen, 1982; Turnbull III et al., 2000). The principle formed the basis of a civil rights movement challenging the exclusion of children with disabilities from educational settings (Biklen, 1982; Hyatt & Filler, 2011) and was central to the deinstitutionalisation movement.

The concept of the least restrictive alternative is not without its problems. An early critique noted that the concept implies that “people with developmental disabilities must earn the right to move the least restrictive environment” (Taylor, 1988, p. 46). In practice, for care recipients to be granted more freedom they must show meaningful engagement with their care and rehabilitation plan. The capacity of a care recipient to engage with or meet these milestones may be limited by the degree and nature of their impairments or other external factors, such as limited resources or a lack of opportunity.

The role that professionals, like specialist assessors, play in determinations of the least restrictive option was also examined within the literature. Some scholars voiced concern that the least restrictive environment principle “supports the primacy of professional decision-making” (Taylor, 1988, p. 47), which, if misapplied, could result in rights violations (Hyatt & Filler, 2011). The tendency of courts to defer to professional judgment was also observed (Turnbull III et al., 2000). A prominent concern was the demand placed on clinicians’ decision-making as they balanced expectations of caution with the challenge of interpreting a legal concept in a clinical context and considering a client’s needs (Turnbull III et al., 2000).

The *Guidelines for the Role and Function of Specialist* Assessors (Ministry of Health, 2004) specify that in considering risk management, specialist assessors identify the “least restrictive manner whilst maintaining acceptable safety for others” (Ministry of Health, 2004, p. 1). This means that specialist assessors are required to identify care options that both reduce risk and provide rehabilitation in the *least restrictive environment.* The guidelines have not been updated.

The framing of the least restrictive option as a human rights issue is of particular relevance to this thesis, as is the influence of a specialist assessor’s opinions within the judicial decision-making process. Further, the potential for tensions to arise between legal concepts and clinical practice is signalled.

Comparable diversionary schemes

Despite New Zealand’s shift to standalone legislation, comparable jurisdictions such as Australia (Brookbanks & Freckelton, 2018; Mental Health Commission of NSW, 2017) and the United Kingdom (Jones & Talbot, 2010; Royal College of Psychiatrists, 2014) have continued to manage people with intellectual disability who offend using mental health, criminal justice, or guardianship provisions. More recently, Scotland has considered removing intellectual disability and autism from mental health legislation. Consequently, Scottish scholars have examined the legislative gap that precipitated New Zealand's decision to embark on the IDCCRA (Williams et al., 2020). Early diversion is described in some studies (Jones, 2007) as are hybrid health and justice orders (Chester, 2018).

Norway has dedicated legislation for the compulsory care of intellectually disabled offenders but, compared to the IDCCRA, it adopted narrower and more rigorous entry criteria (Sondena et al., 2009). Mandatory care can be imposed on people with an IQ below 55 (this score is at the upper level of the moderate ID range), who are absolved from criminal responsibility for the most serious forms of offending and considered at high risk of reoffence (Sondena, 2009). However, they may still receive custodial sentences. Care orders can be indefinite, although, like the IDCCRA, a minimum term and review periods must be set (Sondena et al., 2009). From the material reviewed, it was unclear how expert reports are procured. Evaluations of this regime indicated that a perceived benefit is that care recipient equivalents have greater access to staff with disability expertise, compared to their counterparts in prison. However, in the compulsory care facilities restrictive practices characterised by an "attitude of containment" were observed by the researchers (Sondena et al., 2009, p. 234). This finding suggests that people subject to the diversionary scheme continued to experience significant restrictions on liberty.

It is difficult to track the number of care recipient equivalents in international schemes. Methodological differences between studies and differing diagnostic thresholds limit the ability to draw ready comparisons (Baldry et al., 2013; Salekin et al., 2010). However, in the United Kingdom, there is consensus that people with intellectual disability are overrepresented in prisons (Hayes et al., 2007; Lindsay et al., 2018; Talbot, 2009, 2010) and vulnerable to long periods of detention in secure forensic facilities (Alexander et al., 2015; Chester et al., 2017; Douds et al., 2012). A similar pattern of overrepresentation at all stages of the legal process was observed in Australia (Hayes, 2018).

In other jurisdictions, many elements impact the journey people with intellectual disability take through the justice system. Moderating factors identified in the scholarship include discretion exercised by carers, the police, and judiciary (Chester, 2018; Jones & Talbot, 2010; McBrien & Murphy, 2006); access to specialist courts (Richardson, 2019); the nature of orders made (e.g., correctional, health, or a hybrid); or other sentencing provisions (Brookbanks & Freckelton, 2018; Hayes, 2005). In contrast, the IDCCRA purportedly provides consistent procedural, assessment, and disposition pathways (Brookbanks, 2019). However, the community sentencing options available to intellectually disabled offenders in England and Wales (Royal College of Psychiatrists, 2014) or in Victoria, Australia under the Sentencing Act 1991 (Vic) (Brookbanks & Freckelton, 2018) is arguably a strength. Expert reports are procured, but a role of comparable definition and scope to the specialist assessor could not be located in the literature.

2.4.3 The realities of implementation

Little is known about the effects of the IDCCRA on outcomes for care recipients. (McCarthy & Duff, 2019). Research comparing recidivism rates between care recipients and people receiving custodial sentences is now dated (O'Callaghan, 2012). Demographic information has been intermittently collected and are presented below.

The Care Recipients

People and places

Demographic data are published in ministerial reports and cited in several papers (Duncan, 2013; Ngatai, 2013; O'Callaghan, 2012), and are reported below. However, the reporting of demographic data between 2004 and 2024 about the care recipient population is inconsistent, which limited the depth of analysis that could be undertaken for the thesis.

Whaikaha Ministry of Disabled People published updated demographic data in April 2023. A total of 232 care recipients were recorded as being subject to the Act that year, of which 196 (85%) were male. Ethnicity data showed that 49% of care recipients were European/Other, 40% were Māori, 10% were Pasifika, and 1% were Asian.

The High and Complex Framework Strategic Statement did not detail how many care recipients were in receipt of supervised or secure level care. For the purposes of this study, inquiries were made directly with a senior advisor for the IDCCRA framework at

Whaikaha Ministry of Disability. As of April 2023, approximately 45-50 care recipients were placed in secure hospital beds (A Smith, personal communication, April 24, 2023). This hospital secure group is made up of SCR and care recipients (the specific ratios were not discussed). However, the High and Complex Framework Strategic Statement does show where care recipients are geographically located. The largest group were in Auckland (n=72), followed by Wellington (n=52), Midlands (n=45), Christchurch (n=42), and Dunedin (n=21). Northland, Auckland, and the lower North Island are identified as the most common regions from which care recipients originate.

In comparison, MOH data published in 2019 showed there were 304 care recipients in New Zealand (Ministry of Health, 2020a). The reduced number of compulsory orders in the most recent survey was attributed to COVID-related issues (e.g., court backlogs). It is anticipated numbers will rise as the system normalises (A Smith, personal communication, April 24, 2023).

Māori care recipients

The updated Whaikaha Ministry of Disability data are consistent with MOH data collected in 2013 and 2014 (Duncan, 2013). It also mirrors data gathered by the Department of Justice, which shows the over-representation of Māori at all stages of the criminal justice system. Māori represent 52% of people in prison despite being only 15% of the New Zealand population (justice.govt.nz, updated February 2, 2023). The disproportionate number of Māori in prisons was described as “sustained and embedded” (McIntosh & Workman, 2017, p. 725).

There are no studies specific to the IDCCRA regarding Māori care recipients, but other research has identified factors linked to the overrepresentation of Māori within the criminal justice system. Those relevant to the current study are briefly detailed. Scholars have linked early exposure to social and economic risk factors (Department of Corrections, 2007) and marginalisation secondary to colonisation and economic dislocation to overrepresentation (Brittain & Tuffin, 2017; Quince, 2007). Others have considered the cumulative effect of relational stressors, substance dependency, financial distress, and social isolation (Bevan & Wehipeihana, 2015). The work of Durie (2003) provided an important foundation for understanding the “trapped lifestyles” (p. 59) that create risk and lead to offending.

This thesis was alert to systemic and individual factors that could impact the liberty interests of Māori care recipients. Previous research has considered the impacts of structural or institutional racism (Brittain & Tuffin, 2017; Quince, 2007) as evidenced by police bias (Maxwell & Smith, 1998). In addition, poor legal representation was a factor linked to reduced bail opportunities and harsher sentences (Department of Corrections, 2007). Combined with the work of Mirfin-Veitch et al. (2014), this body of scholarship suggested that Māori care recipients may face a complex array of factors that increase their vulnerability to overrepresentation in the justice system. Further, the contribution that dominant Western epistemologies within psychological training and research have on equity and cultural competence with Indigenous and minority ethnic groups was recently explored using a content analysis of studies published in two New Zealand journals (Tan et al., 2023).

Efforts are currently underway to optimise the model of care for care recipients in hospital secure environments to better reflect cultural factors. The Mason FIDSS Approach, developed in Auckland, draws upon the views of care recipients, evidence-based approaches, and negotiated processes with Māori to develop a multifaceted model (Duff et al., 2023). The core components are positive behavioural approaches, a strengths-based model of offender rehabilitation, trauma-informed care, cultural responsivity, and interventions for Māori (Duff et al., 2023). The model explicitly addresses how colonisation and intergenerational trauma have shaped the social context in which offending behaviours evolve and the importance of providing a safe and values-driven care and rehabilitation environment (Duff et al., 2023).

The core values of the model (social connection, receiving compassion, having choices, being treated with respect and honesty) were derived from interviews with 12 care recipients who live at the unit. The interviews, conducted by way of group and individual sessions, explored how the care recipients wished to be treated and what was important in their care. The care recipients' stated values contributed to an evolving set of practice principles that express their human rights (Duff et al., 2023). The study is described as a service improvement initiative that attempted to integrate elements of research (e.g., literature review, input from care recipient and cultural advice). Despite the project's constraints, a negotiated consensus with Māori and the incorporation of the human rights values of care recipients provided an important first step toward implementing a different model of care.

Specialist assessors have the opportunity to closely examine a range of personal, environmental, and systemic factors that contribute to a care recipient's offending. Tamatea and Waipara-Panapa (2018) observed that "recognition of marginality in the course of encountering indigeneity and one's role in perpetrating that marginality – tacitly or otherwise – by virtue of representing a state institution can be aversive for psychologists" (p. 30). This study explores the dilemmas that might arise for specialist assessors when they contemplate human rights issues for care recipients. Issues specific to cultural factors are clustered in theme five.

Pasifika care recipients

No studies have focused exclusively on Pasifika care recipients. The updated Whaikaha Ministry of Disability data published in 2023 showed that 10% of care recipients (n=23 of 232) identified as Pasifika, which is broadly consistent with recent census data (www.stats.govt.nz updated January 1, 2023). The invisibility of Pasifika within mainstream disability services in New Zealand is a shared source of concern (Fuamatu, 2019; Tōfā Mamao Collective, 2022), underscoring the importance of efforts to make "hidden voices… visible" (Fuamatu, 2019, p. 140).

The *Tagata Sa'ilimalo Strategic Framework* (Tōfā Mamao Collective, 2022) sets out a vision to change practices in the disability sector for tagata sa'ilimalo (Pacific disabled people and their families/nofo-a-kainga and carers/supporters/tautua soifua in New Zealand). Tagata means people or person; sa'ilimalo means the pursuit of success (Tōfā Mamao Collective, 2022). A core part of this vision is to ensure that policy settings strongly reflect the centrality of collectivism to Pasifika people in their home and community settings. Tensions between the individualistic approaches typically embodied in existing disability service structures and international human rights frameworks are of interest to this study:

> For tangata sa'ilimalo, being Pacific is a primary source of identity – being disabled may only be a secondary consideration. In contrast, the disability system evolved with a more individualistic cultural frame, adopting a 'one size fits all' approach to policy and service design. This

> was further reinforced by the United Nations Convention on the Rights of Persons with Disabilities (2008) and its predominant focus on the individual, a situation that is being increasingly challenged by indigenous peoples. (Tōfā Mamao Collective, 2022, p. 7)

This thesis was alert to how specialist assessors contemplated the intersection between cultural factors and human rights within the practice context.

2.4.4 Rights-based issues

Papers addressing the IDCCRA published between 2003 and 2023 were reviewed. The majority provide legal or clinical analysis (Brookbanks, 2013; Diesfeld, 2013; Duff & Sakdalan, 2007; Duncan, 2013; Nuth & Thompson, 2018). Some examine policy issues (Bonardi, 2009; Ngatai, 2013). Qualitative studies have interviewed care recipients (Mirfin-Veitch et al., 2014) and professionals holding statutory or legal roles (Prebble et al., 2013; Smith, 2015). No studies focused exclusively on specialist assessor practice. The two studies with quantitative elements focused on recidivism rates (Duncan, 2013; O'Callaghan, 2012) or demographic characteristics of care recipients entering the framework during discreet periods (Duncan, 2013).

To date, no research or commentary conducted on the IDCCRA has focused exclusively on human rights issues. However, several authors have discussed the presence of ethical and rights-based tensions within the compulsory care framework. The primary themes are presented.

The impacts of an influx of young people

The paper by Duncan (2013) is distinctive for providing an examination of the characteristics of care recipients entering the framework. He identified increased referrals between 2005 and 2012 for defendants found unfit who were not previously known to intellectual disability services. He called this group the "New Care Recipients" (p. 362) and noted:

> Most have had disruptive and disorganised developmental experiences and their offending is emblematic of a problematic lifestyle. They have reasonably good basic self-care skills, and, but for their offending, would not be with an ID service provider. They would

> have been in prison or coping on the margins of society. (Duncan, 2013, p. 362)

Duncan expressed the view that this influx of youth was unanticipated. However, there is a high degree of correlation between the so-called new care recipients and Dawson's (1997) first group.

The evolution of the youth group was attributed to procedural changes in the CPMIPA combined with increased awareness of disability in the criminal justice system (Duncan, 2013). He contemplated how services could respond and adapt to the needs of a complex group of young people who did not identify as disabled. Hikitia Te Wairua, the Forensic Youth Inpatient Service located in Porirua, was established in 2011 to cater for this group (CCDHB & Luke Cunningham Clere, 2017).

Several papers have touched upon the challenges posed by new care recipients. Care managers reflected on the tensions arising from trying to strike the correct balance between managing risk, imposing restrictions, and building therapeutic rapport (Prebble et al., 2013). The notion of intellectual disability as a permanent impairment came under scrutiny because some youths who demonstrated improved cognitive functioning over the duration of their orders became ineligible for detention under the Act (Ngatai, 2013; Nuth, 2017; Nuth & Thompson, 2018). Given the Court is unable to revisit sentencing for care recipients disposed of under certain sections of the Act (e.g., IDCCRA, ss 24(1)(b) and 34(b)(ii)), the importance of robust eligibility assessment was highlighted (Ngatai, 2013).

Factors that could negatively impact the reliability of eligibility assessment for youth and adult care recipients were highlighted by Nuth (2017). These included poor effort, concurrent mental health issues, measurement error, or circumstantial factors. In addition, Nuth stated that dilemmas arose for specialist assessors who were constrained in their ability to voice concerns about the validity of eligibility data that had informed the Court's determination of intellectual disability during fitness inquiries. The fitness inquiries precede the inquiries about disposition options that are undertaken by specialist assessors. This procedural issue appears to have become an area of tension for specialist assessors who were alert to the liberty implications of inaccurate eligibility assessment.

Some authors identified positive benefits for the new care recipients within the IDCCRA framework, such as increased access to care and therapies (Diesfeld, 2013; Prebble et al., 2013; Smith, 2015). Equally, the potential for negative social and personal implications of being labelled with a disability was considered, particularly for those youth who rejected this status and had no previous contact with disability services (Diesfeld, 2013; Prebble et al., 2013; Smith, 2015). The situation precipitated critique about the sensitivity of IDCCRA entry criteria on the basis that the influx of new care recipients "revealed a problem of net widening" (Brookbanks, 2019, p. 12). Other scholars contemplated how limited options for the care or treatment of at-risk youth presenting with complex behaviour, personality, or social needs, in combination with systemic risk aversion, might have contributed to this outcome (Diesfeld, 2013; Duncan, 2013; Prebble et al., 2013).

The need to modify traditional disability approaches to better respond to the needs of the youth group triggered a comprehensive MOH review (Duncan, 2013; Ngatai, 2013; Prebble et al., 2013). Two of the primary adaptations were the inclusion of the Risk Need Responsivity (RNR) model of offender assessment and management (Andrews & Bonta, 2010) and aspects of the Good Lives Model (GLM) (Ward et al., 2007a; Ward & Stewart, 2003). There have been criticisms of the use of both the RNR model and the GLM in correctional and forensic settings. Underdevelopment of the responsivity principle, which focuses on designing interventions that foster a therapeutic alliance and humane engagement with a client, is an identified weakness of the RNR model (Polaschek, 2012; Ward et al., 2007b). However, this is balanced with the demonstrated empirical efficacy of the RNR model over the past 30 years (Mallion et al., 2020; Polaschek, 2012). In addition, Wormith and Zidenberg (2018) noted that many of the criticisms overlooked an expanded version of the RNR model, that emphasised practitioner sensitivity to the client's needs and strengths.

The focus on promoting an individual's goals, along with improved motivation and engagement, is an identified area of strength for the GLM (Mallion et al., 2020). However, Lutz et al. (2022) observed this was balanced with the need for the client to have "relatively good cognitive resources and a high ability for reflection" (p. 8). Additionally, the GLM has been criticised for a lack of empirical support for its key theoretical assumptions and intervention outcomes (Wormith et al., 2012). A systematic review conducted by Mallion et al. (2020) found mixed support for the the theoretical assumptions that underpin the GLM. However, the researchers concluded that, "GLM-consistent interventions were at least as effective as standard relapse prevention programs, whilst enhancing participants' motivation to change and engage in treatment" (Mallion et al., 2020, p. 2). Typically, relapse prevention programmes are underpinned by the RNR model (Barnett et al., 2014). Of relevance to this thesis, the GLM is underpinned by human rights theory (Ward et al., 2007a), which links reduced reoffending to the identification of strengths or goods that promote dignity, autonomy, and well-being (Orend, 2002).

Collectively, these critiques raise questions about the foreseen and unforeseen consequences of the IDCCRA. Considering the interest generated by the human rights implications for the youth group and the role specialist assessors play as gatekeepers to the Act, it was anticipated the specialist assessors in this study would be attuned to these issues.

Continued concerns about extensions

A strong theme within legal commentary on the Act is the lack of criteria to guide extensions. Although the Court of Appeal clarified the appropriate judicial approach in *RIDCA Central v VM [2011*], the potential for the Act to result in indefinite, arbitrary, or disproportionate or preventive detention has remained a source of debate and concern (Brookbanks, 2013; Diesfeld, 2013; Duncan, 2013). In addition, practitioners within the Act have referred to the indefinite nature of legislation as detention "by stealth" (Nuth, 2017, p. 110), particularly for those entering the framework as a transfer from prison.

The legislative challenge of meeting the dual goals of public safety and safeguarding care recipient rights was reflected upon by Brookbanks (2013):

> On the question of whether the treatment results in disadvantage, it is clear that despite the benevolent approach said to underlie the IDCCRA legislation, the absence of specific criteria limiting the ability repeatedly to extend CCOs [compulsory care orders] means that the IDCCRA regime is capable of significantly disadvantaging those who are subject to its provisions. (p. 238)

Ellis (2020) argued the IDCCRA is discriminatory against persons with intellectual disability because extension provisions permit arbitrary detention (Ellis, 2020). The position taken by the Courts to date does not support these assertions (see J*, Compulsory Care Recipient by his Welfare Guardian, T v The Attorney General* [2018]).

Internationally, long or indefinite periods of detention, particularly for those found unfit to stand trial, are also a source of concern (Brookbanks & Freckelton, 2018; Curtis et al., 2014). For example, in Victoria, Australia, the prospect of indefinite detention was identified to be a disincentive for disclosure of disability or advocates raising concerns about fitness to stand trial (Australian Law Reform Commission, 2014). More specifically, some care recipients in New Zealand have also articulated a preference for fixed prison sentences (Smith, 2015).

The potential for compulsory care to have counterproductive outcomes was explored by Duncan (2013). He expressed concern that the new care recipients faced a higher likelihood of extensions based on their risk of reoffence remaining stable in the face of poor responsivity to change (Duncan, 2013). In addition, Nuth and Thompson (2018) explored the potential for ineffective outcomes, describing the IDCCRA legislation as “a somewhat all or nothing mechanism” (p. 258) that could result in care recipients being dislocated from their communities while under orders due to the location of facilities. They hoped that the Act might evolve to provide more flexible care options so that the system issues underpinning care recipients offending could be better addressed. They further identified that appropriate funding of care recipients subject to repeated extensions may address issues of “perpetual extension” (Nuth & Thompson, 2018, p. 258). This analysis suggests specialist assessors are alert to the human rights implications of their practice. Findings specific to repeated extensions are presented in theme two.

Philosophical contradictions

Several problems arose in constructing this regime. In part, it was because of the path chosen to create the residential arrangements (Prebble et al., 2013). This hybrid civil/criminal scheme required a residential framework. Care recipients were placed in pre-existing disability residential services; however, it was all funded by the health sector which created tensions (Prebble et al., 2013) Predictably, it created a complex regime and residential framework for care recipients.

Care managers participating in the Prebble et al. (2013) study expressed the view that risk management had become the dominant imperative within service delivery, raising professional challenges:

> The care managers' statutory roles created a degree of tension at an individual and service level as they reconciled their philosophical beliefs with the coercive requirements of the Act… Finally, care managers face dilemmas over whether to apply for extension of the length of the care orders. (p. 122)

The authors concluded that a "philosophical contradiction" (Prebble et al., 2013, p. 122) had occurred by introducing statutory responsibilities for compulsory care into the disability sector which was not typically dedicated to compulsory care. A parallel could be drawn with the dual role literature (discussed in Part III of this chapter) where a specialist assessors' obligation to the justice system conflicts with the ethical principles of beneficence and non-maleficence

The study highlighted how the requirement to remain attuned to the liberty interests of the care recipients while also managing risk could create friction for practitioners. Specialist assessors are faced with the challenge of advising the Court about order length and the need for extension. This study explored how they approach this task and the tensions that arise. Nuth (2017) suggested that there were tensions embedded in the role due to the need for specialist assessors to make specific recommendations on the nature and duration of the compulsory care orders:

> This can be a challenging task because of competing issues like proportionality and what would constitute a reasonable time frame for effective rehabilitation to take place. Health Assessors, because of their clinical training, arguably err on the side of "rehabilitation" and clinical matters – whilst also considering the risk of reoffending. (p. 104)

He asserted that specialist assessors may be limited in their ability to appreciate proportionality and liberty interest considerations when formulating their recommendations for compulsory care (Nuth, 2017). For this reason, he advised that specialist assessors consult with “lawyers on both sides of the fence” (Nuth, 2017, p. 104) to ensure the reasons for their opinions are well understood. The current study extends existing research by focusing exclusively on how specialist assessors perceive the legislation and integrate human rights perspectives in their practice.

Summary

The IDCCRA is distinctive for its length, multiple points of entry, and statutory roles. The lack of definition of rehabilitation or the grounds for extension are noteworthy omissions. It has also attracted criticism for providing an overly complex and burdensome response to the challenges posed by a relatively small group of intellectually disabled people who were charged with, or convicted, of relevant crimes (Brookbanks, 2003; Duncan, 2013).

Although the numbers remain small relative to people incarcerated under the criminal justice system, this review highlighted that the number of care recipients entering the IDCCRA well exceeded the initial estimates (Webb & Capie, 1996). Further, as predicted, care recipients are a heterogeneous group with complex needs (Dawson, 1997). There is a need for workforce planning to ensure compulsory care services are sufficiently resourced to provide the clinical expertise care recipients require in the coming years (McCarthy & Duff, 2019).

Care recipients are one of the most vulnerable groups within justice and compulsory care settings due to their diverse and sometimes complex needs. The provision of a specialist care and rehabilitation regime over the past 2-decades has provided a disability-specific alternative to prison or detention under the mental health regime. Specialist assessors fulfil important functions within the disposition and review process. This leaves them well-placed to reflect on the human rights implications of the legislation.

2.5 Part III:Human Rights and Specialist Assessor Practice

This section describes the professional obligations held by specialist assessors. These obligations are then situated within the literature on forensic practice and human rights perspectives. Internationally, the role that psychologists could, or should, play in the promotion and protection of human rights is an evolving area of scholarship. The review also explores how psychologists outside of the forensic sphere reflect, communicate, and act upon human rights. This research provides an important context for exploring how specialist assessors integrate human rights perspectives within their practice.

2.5.1 Professional obligations

Specialist assessors must uphold the professional standards within their specific discipline while abiding by standards for expert witnesses and the statutory requirements of the IDCCRA.

Legal definition and designation

A specialist assessor must be a suitably qualified health and disability professional (IDCCRA, s 5). To date, clinical psychologists and consultant forensic psychiatrists have been appointed to the role by the Disability Directorate, formerly situated in the MOH but now located in Whaikaha Ministry of Disabled People. Specialist assessors are also health assessors for the purpose of inquiries ordered under the CPMIPA (CPMIPA, s4(1)c). The formal statutory designation is granted by the Director General of Health (IDCCRA, s 146).

Guidelines for assessors

The *Guidelines for the Role and Function of Specialist Assessors* (Ministry of Health, 2004, p. 42) aimed to provide a framework for specialist assessors that would create a consistent nationwide process. The guidelines prioritised three key values and/or clinical skills. The first being that specialist assessors would be alert to the characteristics, cultural, moral, and legal imperatives of the people of New Zealand and acknowledge the Te Tiriti o Waitangi. Secondly, specialist assessors would uphold practices and values held important regarding the rights and dignity of care recipients. Thirdly, specialist assessors would utilise best practices in risk assessment (Ministry of Health, 2004). The guideline provides detailed information about clinical issues, clinical judgment, and risk assessment. There is no guidance as to how the specialist assessors would uphold the rights and dignity of care recipients. These guidelines have not been updated since publication in 2004.

Legal compendium

The guidelines were supplemented by the *Legal Compendium* (CCDHB & Luke Cunningham Clere, 2017), which provides a detailed overview of the IDCCRA and CPMIPA with practice notes. In relation to extensions to compulsory care orders, specialist assessors are directed to "focus consideration of [sic] the risk the care recipient poses to the community" (para. 515). With respect to the human rights issues raised by extensions, it is stated:

> The case of *VM* requires the court to balance the community protection interest against the care recipient's liberty interest. One question that arises is whether a specialist assessor and care coordinator should also consider those factors when deciding whether to apply for an extension of a compulsory care order. However, these matters are well outside the scope of usual health and disability practice and including such matters within the scope of their report may be seen as operating outside their area of competence. (para. 508)

Intermittently, advisors from the RIDCA have provided analysis of topical legal decisions, which has included practice guidance for the personal use of specialist assessors.

Other professional resources

A chapter by Nuth and Thompson (2018) provided a comprehensive overview of the specialist assessor's role within the IDCCRA. Human rights issues are briefly considered through the lens of a specialist assessor's influence over the legal process: "In reality psychological assessments and opinions can strongly influence whether someone will come under the auspices of the IDCCR Act. This carries considerable responsibility regarding the liberty rights of potentially vulnerable individuals" (Nuth & Thompson, 2018, p. 258).

The authors touch upon ethical challenges arising from additional liberty considerations. For example, they observed that specialist assessors could face challenges as they navigate competing clinical needs (e.g., time required for effective rehabilitation) and legal considerations such as proportionality. This overview is helpful because the specific liberty implications of the specialist assessor role are articulated. Similar issues were raised by the specialist assessors interviewed for the current study and are presented in themes one and five. A specialist assessor's obligations under the CRPD was not traversed by Nuth and Thompson (2018). However, the authors observed that the IDCCRA "appears to be appropriately aligned" with New Zealand's CRPD obligations (Nuth & Thompson, 2018, p. 258). There are counterarguments to this claim which were raised in earlier sections of this chapter.

2.5.2 Legal obligations

Registration requirements

Specialist assessors are bound by rights and obligations set out under the Health Practitioner Competence Assurance Act 2003 (HPCAA). Since 2004, the practice of psychology has been regulated by this legislation. The New Zealand Psychological Board works to ensure that only practitioners who are registered use the term "Psychologist" (New Zealand Psychologist Board, 2024). Psychologists delivering assessments or interventions to individuals, whānau, organisations, and communities must be registered under this Act. Scopes of practice can only be obtained from the New Zealand Psychologist Board. Psychologists designated as specialist assessors usually hold the clinical and/or neuropsychology scopes of practice.

Forensic psychiatrists are similarly governed by the HPCCA and must be registered with the Medical Council. They complete the Advanced Certificate in Forensic Psychiatry, in addition to general medicine and specialist psychiatric training.

Code of conduct for expert witness

The term expert is defined within section 4 of the Evidence Act 2006 as:

> a person who has specialised knowledge or skill based on training, study or experience… expert evidence means the evidence of an expert based on the specialised knowledge or skill of that expert and includes evidence given in the form of an opinion.

specialist assessors, like all experts, are subject to the *High Court Rules Schedule 4 Code of Conduct for Expert Witnesses* (the Code) (Blackwell et al., 2018). They may be called to give evidence and have their opinions tested by way of cross-examination. Revised in 2016, the purpose of the Code is to orient the expert to their obligations to the Court; they have a duty to impartially assist the court on matters that are relevant and within their expertise. Additionally, an expert is not an advocate for any party, irrespective of the instructing party.

Subsections 3, 4, and 5 of the Code deal with the evidence provided. The experts must clearly state the facts and assumptions on which their opinion is based, along with the reasons and the materials relied upon. The expert must state any limitations, inaccuracies or areas where the opinion is incomplete. Sections 6 and 7 address the duty of an expert to comply with directions to confer independently and professionally with other experts). Typically, clinical psychology training programmes do not focus on the competencies required in the expert witness role (Blackwell et al., 2018).

The specialist assessor must confer with the care manager and coordinator as part of the assessment process (IDCCRA, ss 38 and 78). The review process requires specialist assessors to issue a certificate that provides an opinion on the care recipient's legal status (IDCCRA, s 79).

Ethical obligations

The relationship between ethics and human rights was a point of interest for this thesis:

> Ethical principles and human rights strengthen and complement each other. However, there are important differences… Each has its own language, history, culture, method, approach, and agenda. Despite those differences they can be good companions and work together in serving humankind. (Gauthier & Sinclair, 2020, p. 53)

Derived from moral philosophy and the Hippocratic Oath (Gauthier & Sinclair, 2020; Seymour, 2007), ethical codes involve the implementation of generalised norms and theories to practice (Beauchamp & Childress, 2020). Ethical principles are conceptualised as the bridge to human rights approaches (Plavsic et al., 2020). Ethical codes recognise a psychologist's obligations to individuals and society (Grisso, 2001).

The human rights model developed by Ward and Birgden (2007) for forensic and correctional practice, and expanded in Ward and Syversen (2009), illustrates the relationship between the values that underpin human rights and their expression in law and ethics. For example, the centrality of respect for dignity is evidenced by its positioning as principle one in both the *Code of Ethics for Psychologists Working in Aotearoa/ New Zealand* (New Zealand Code of Ethics) (New Zealand Psychological Society et al., 2002) and The Royal Australian and New Zealand College of Psychiatrists *Code of Ethics* (RANZCP Code of Ethics) (Royal Australian & New Zealand College of Psychiatrists, 2018); and its prominence within the Preamble and Article 3a of the CRPD (United Nations, 2006a).

Human rights law focuses on human entitlements that "are specific and prescriptive[4] in nature", while, ethical codes are considered "aspirational and inspirational in nature" (Gauthier, 2009, p. 26). Codes set out a psychologist's obligations towards other people, groups, and society (Seymour, 2007; Seymour & Nairn, 2012) and "their moral duty to respect human dignity in themselves and others" (Allan, 2013a, p. 18). Ethics and human rights hold the dual aims of protecting people from harm and enhancing their quality of life (Gauthier, 2009).

The four pillars of justice, autonomy, non-maleficence, and beneficence, advanced in Beauchamp and Childress's (1979) seminal text, *Principles of Biomedical Ethics,* significantly influenced the development of modern ethics (Beauchamp & Childress, 2020). The inclusion of justice and autonomy marked a shift in approach from traditional medical ethics (Beauchamp & Childress, 1979). The principle of justice seeks to ensure the fair and equal distribution of benefits, risks, and costs to all social groups. Respect for autonomy established the importance of self-determination. The principle of non-maleficence requires the avoidance of harm. Finally, beneficence relates to the obligation to act in a client's best interests. The principles are not rigid, and when they conflict, one may be justifiably prioritised over another (Beauchamp & Childress, 2020).

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[4] In referencing this point it is important to acknowledge that states parties may agree to be bound by UN Conventions, but there is no over-arching judicial system that can address breaches of the provisions set out in treaties or act to settle disputes. In addition, dualist systems like New Zealand require steps to be taken before treaty provisions become part of domestic law (B. McSherry, personal communication, n.d)

Depending on their disciplinary background, specialist assessors are guided by either the *Code of Ethics for Psychologists Working in Aotearoa/New Zealand* (New Zealand Code of Ethics) (New Zealand Psychological Society et al., 2002) or *The Royal Australian and New Zealand College of Psychiatrists Code of Ethics* (RANZCP Code of Ethics) (Royal Australian & New Zealand College of Psychiatrists, 2018). Each code provides a set of principles, which are clarified or expanded by values, annotations, or comments to support ready application to practice. The principles of justice, autonomy, beneficence, and non-maleficence are contained in the codes, although they may be expressed using different terminology. For example, within the New Zealand Code of Ethics, the promotion of well-being (value 2.1) aligns with beneficence, while active participation (value 2.3) corresponds to autonomy and self-determination. Central to each code is respect for dignity, reflecting the importance of this value in moral philosophy and human rights theory.

There are some noteworthy differences between the codes. For psychiatrists, the RANZCP Code of Ethics deals directly with compulsory care:

> Psychiatrists shall be especially mindful of respect for autonomy given their statutory role in treating a proportion of their patients compulsorily. Compulsory treatment may be justified where a less restrictive option cannot achieve safe and adequate care; its purpose is ultimately to promote and re-establish patients' autonomy and welfare. (Principle. 1.3)

For psychologists, there is no comparable statement in the New Zealand Code of Ethics. However, it is recognised that in certain settings, psychologists are "required to conduct assessments where consent may not be readily forthcoming" (Principle. 1.7.4) and that exceptions/limitations occur "where a psychologist's actions are mandated by law" (Principle. 1.7.9). In these circumstances, the psychologist must explain the limits to confidentiality and "seek to collect only that information that is germane to the purposes" (Principle. 1.6.4).

Internationally, psychological science is considered relevant to social justice (Patel, 2020; Vasquez, 2012). Relatedly, social justice and responsibility to society is the fourth principle of the New Zealand Code of Ethics:

> In New Zealand, the Treaty of Waitangi is a foundation document of social justice… The principle of social justice is about acknowledging psychologists' position of power and influence in relation both to individuals and groups within communities where the psychologist is involved, and in the broader context. It is about addressing and challenging unjust societal norms and behaviour that disempower people at all levels of interaction. (p. 25)

The RANZCP Code of Ethics makes no direct reference to *social* justice per se but emphasises the promotion of justice, fair allocation of resources, non-discrimination, and health promotion (Principle. 11).

There has been a trend towards greater sensitivity to Indigenous principles within ethical codes (Tassell et al., 2012). A distinctive feature of the New Zealand Code of Ethics is the explicit recognition of the rights and obligations conferred by Te Tiriti o Waitangi (Seymour & Nairn, 2012). The RANZCP Code of Ethics also explicitly recognises and values the status and knowledge of Aboriginal, Torres Straits Islander peoples and Māori. Nonetheless, it has been observed that most ethical guidelines continue to reflect the dominant academic culture (Tassell et al., 2012). Given ethics is about values, these scholars argued that ethical principles need to be informed by cultural differences (e.g., collectivist or kinship worldviews) to have utility in Indigenous contexts (Tassell et al., 2012). The importance of value systems was raised by the specialist assessors in the current study as they considered the human rights implications of their disciplinary training and the IDCCRA's grounding in a Western worldview. These findings are presented in theme four. The overlay between cultural bias and disability rights has been contemplated by others (Ruru, 2020).

In practice, ethical codes are used to help structure professional decision-making. They assist psychologists to identify and consider higher-order principles and values relevant to their situations, and then weigh the associated practice implications (Seymour, 2007; Seymour & Nairn, 2012). The RANZCP Code of Ethics states that the code is not designed to be used in isolation and should be considered amongst a suite of other relevant ethical and human rights instruments (which includes the CRPD and UNCAT) and professional guidelines. The New Zealand Code of Ethics recognises that psychologists may be subject to other workplace codes of conduct and practice. In the event the New Zealand Code of Ethics establishes a higher standard of conduct, it is *suggeste*d the psychologist adopt the higher standard (New Zealand Psychological Society et al., 2002). There are no further comments on how psychologists in forensic or legal roles should or could further navigate competing role conflicts.

Specialist assessors do not have a traditional client/clinician relationship with care recipients, characterised by the delivering of therapy. The specialist assessor is a purportedly neutral government expert. This form of relationship is not well defined in traditional ethical codes and is identified as an important gap for experts undertaking criminal justice and forensic work (Ward, 2013; Ward & Birgden, 2009). This is because experts can experience conflicts due to competing ethical or professional obligations, otherwise referred to as the dual role problem (Ward, 2013). These authors prefer an approach that enables the clinician to take into account the moral worth of all parties affected by the offending behaviour, including the community, the victim and the person who offended (Ward, 2013; Ward & Syversen, 2009). These issues are considered in more depth in a later section of this chapter.

Criminal justice and forensic practice and assessors

The HPCAA provides for standalone scopes of practice; for example, clinical, educational and neuropsychologists. However, there are no standalone scopes of practice for forensic or criminal justice psychology in New Zealand despite each being a thriving subspeciality (Polaschek, 2003). The specialist assessor’s role crosses the forensic and criminal justice system. Specialist assessors bring a diverse range of backgrounds and experience to the role, including expertise in general and forensic mental health and disability, criminal justice, and correctional settings. The American Psychological Association’s *Specialty Guidelines for Forensic Psychology* (American Psychological Association, 2013) defined forensic psychology as:

> professional practice by any psychologist working within any subdiscipline of psychology (e.g., clinical, developmental, social, cognitive) when applying the scientific, technical, or specialized knowledge of psychology to the law to assist in addressing legal, contractual and administrative matters. (p. 7)

Forensic practice includes scholarly and applied activities that focus on the intersection between psychology and the law (Heilbrun, 2006). Similarly, the American Academy of Psychiatry and the Law (2005) defined forensic psychiatry as:

> a subspecialty of psychiatry in which scientific and clinical expertise is applied in legal contexts involving civil, criminal, correctional, regulatory or legislative matters, and in specialized clinical consultations in areas such as risk assessment or employment. (p. 1)

The definitions, derived from the United States, have broad relevance to specialist assessor practice in New Zealand. They are supplemented by professional practice resources published by the New Zealand Psychological Society, such as *Psychology and the Law in Aotearoa New Zealand* (Seymour et al., 2018), that give advice about expert evidence, criminal justice proceedings, forensic practice, the CPMIPA and the IDCCRA.

2.5.3 The human rights implications of forensic practice

Forensic practice generates unique challenges for psychologists and psychiatrists working within the criminal justice system or compulsory care regimes. The client groups are typically vulnerable, and rehabilitation systems are characterised by coercive elements (McSherry & Freckelton, 2013). In addition, people's "legal rights are restricted by society's needs for safety and justice" (Allan, 2013b, p. 47). Clinicians undertaking assessments of risk may feel that the burden of community protection has been passed on to them (McSherry et al., 2007). Safeguarding care recipients' special rights is a core purpose of the IDCCRA, highlighting the value placed on the protection of human rights within the regime.

Potential sources of tension in assessor practice

A strength of the IDCCRA is the interdisciplinary/collaborative approach, which requires the specialist assessor, care coordinator, and care managers to work closely together. However, the specialist assessor is still expected to retain independence within the process and must act in accordance with the *Code of Conduct for Expert Witnesses* (High Court, 2016), the *Code of Ethics for Psychologists Working in Aotearoa/New Zealand* (New Zealand Code of Ethics) (New Zealand Psychological Society et al., 2002), competence guidelines (New Zealand Psychologists Board, 2018), and other health and disability frameworks.

Aspects of the specialist assessor's role draw upon therapeutic skills. Firstly, therapeutic skills are used to engage care recipients in the assessment process and to encourage self-disclosure. By virtue of their disability, some care recipients may be unable to provide informed consent. Also, some care recipients may not fully appreciate the repercussions of their statements (or confessions) to specialist assessors (Jones, 2019) despite being told about the limits to confidentiality and the purpose of the assessment.

Secondly, once a compulsory care order is in place, a specialist assessor may review a care recipient's progress multiple times. As a result, there is the potential for repeated contact to influence a specialist assessor's clinical decision-making processes because of deepened rapport and relationships with service providers, and engagement with the care recipient's whānau or primary support persons. These characteristics arguably place the specialist assessor in a unique space when compared to other expert roles.

The tension between the expert witness and therapeutic role is also illustrated around the issue of advocacy. Expert witnesses are required to be impartial, independent agents of the court (Blackwell & Seymour, 2011; Freckelton, 2019). The most recent professional guidance provided to specialist assessors in the *Legal Compendium* (CCDHB & Luke Cunningham Clere, 2017) appears to clearly orient them to risk assessment and community protection. Whereas a therapist has the scope to argue that compulsion is not therapeutically indicated for their client or that the release of health information shared in a therapeutic environment for use in a legal process is detrimental to therapeutic goal*s.* In comparison, the specialist assessor, as an expert, is expected to remain neutral. It is currently unclear how a consideration of the care recipient's liberty interests might be safely incorporated into the opinions they provide to the court. The first theme of the findings explores how specialist assessors were reflecting on human rights and communicating these issues to the Court.

Ethical Flashpoints

Role conflicts of this nature are variously referred to as the "dual role dilemma" (Robertson & Walter, 2008, p. 229), "double agency" (Appelbaum, 1997b, p. 233), and "dual loyalty" (Perlin, 1991, p. 111). Ward (2013) stated:

> The dual relationship problem emerges from the overlap, or if you like, clash between two (at least…) sets of ethical norms: those associated with community protection and justice versus norms related to individual well-being and autonomy. (p. 93).

Within their analysis of psychiatric practice in forensic and military settings, Robertson and Walter (2008) identified that the dual role dilemma was “characterised by the presence of a powerful third party to whom the psychiatrists has some perceived obligation” (p.228). Specialist assessors must navigate obligations to the Court as an expert witness, ethical obligations to care recipients and society, and manage their relationships with the various Ministries responsible for oversight of the IDCCRA infrastructure.

Role conflict is not unique to psychology or psychiatry. Forensic nurses in England (Simpson, 2005) and Ireland (Brennan, 2006) reported strain or ambiguity as they reconciled therapeutic aspects of the role with restrictions in the care context. More recently, role conflict was explored by Tarrant (2014) in a qualitative study with New Zealand court liaison nurses. The study found that a lack of certainty about role definition increased role conflict which manifested as stress.

Forensic psychiatry’s growing influence in the legal system spotlighted the dual role problem (Appelbaum, 1997a; Stone, 1984). To distinguish the purpose of forensic work from therapeutic work, Appelbaum (1997a) developed a theory of ethics that centred around truth-telling (e.g., clearly stating the limitations of scientific and professional knowledge) and respect for persons (e.g., transparency about the limitations to confidentiality and who is the client). A growing reliance on psychological risk assessment within preventive detention and extended supervision regimes renewed concerns (McSherry, 2013; Vess, 2009).

Scholars suggested that the dual role problem is amplified in forensic practice because of competing normative and value systems in combination with multiple stakeholders. Ward et al. (2014) contended:

> despite appearances, the dual role problem is actually tripartite in nature insofar as there are three relevant stakeholders with their

> corresponding relationships: (a) the practitioner and the offender, (b) the practitioner and the community/criminal justice system (including the victim), and (c) the offender and the criminal justice system, community and victim(s). (p. 46)

Individual practitioners face the task of reconciling the Code of Conduct for Expert Witnesses with their ethical code while attending to institutional norms and human rights frameworks at the same time (Candilis, 2009). Considering individual rights and society's interests is also a feature of ethical codes (New Zealand Psychological Society et al., 2002; Royal Australian & New Zealand College of Psychiatrists, 2018).

Dual relationships create "ethical flashpoints and a nagging concern" (Ward, 2013, p. 94) for practitioners as they anticipate the impacts of their recommendations on those they assess and/or members of the community. Further, compulsory care and treatment regimes are identified as incubators for ethical flashpoints by virtue of the focus on people with disabilities (Blackburn, 2004). A sense of dissonance may arise for practitioners faced with the task of resolving clashing interests or ethical obligations (Allan, 2013b; Barnao et al., 2012; Candilis & Neal, 2014a). In the absence of workable solutions, practitioners may present as disengaged or desensitised, resulting in drifted ethical or professional practices (Allan, 2013b). Some may choose to leave the practice setting (Clingempeel et al., 1980).

The term ethical blindness was used to explain the risk of failing to detect salient clinical matters because they cannot be seen (Ward & Syversen, 2009). Existing ethical codes have been criticised for being morally inadequate and failing to deeply engage practitioners on controversial issues (Lavin, 2004). Ethical blindness can cause inadequate self-reflection (e.g. appreciation of own biases) or tolerance of institutional or systemic practices that undermine the human rights of offenders (Barnao et al., 2012). In light of the high-stakes nature of IDCCRA assessments, the researcher was alert to ethical tensions or dilemma expressed by the specialist assessors as they contemplated human rights issues for care recipients.

The personal values or morals held by forensic practitioners may influence how competing interests of liberty and community safety are balanced (Grisso, 2001). The dual role problem can be heightened by the personal values practitioners bring to the work (Allan, 2013b; Candilis & Neal, 2014b). Further, when assessing for risk, clinicians need to consider the implications for members of the public (Barnao et al., 2012; Candilis, 2009). Clinicians may be sensitive to public morality (Allan, 2013b) and to societal risk aversion; both have provided fertile ground for the introduction of coercive regimes to prevent harm (McSherry, 2013).

Solutions to the Dual Role Problem

There appears to be some consensus that a lack of training on the ethical and human rights implications of forensic practice leaves psychologists and psychiatrists feeling poorly equipped to manage these competing demands (Allan, 2013b; Bush et al., 2006; Ward, 2013). Several solutions have been proposed to address the role conflicts experienced by forensic psychologists and psychiatrists.

Specialist Forensic Codes

The development of specialist forensic codes represents one approach. These codes build on earlier work by the American Psychological Association (1992) and Appelbaum (1997). Examples include the American Academy of Psychiatry (2005) *Ethics Guidelines for the Practice of Forensic Psychiatry* and the American Psychological Association's (2013) *Specialty Guidelines for Forensic Psychology*. Although the development of specialist guidelines was welcomed, concerns have remained about their power to resolve dual agency dilemmas. Criticisms include the lack of concrete guidance given to practitioners for navigating conflicts that might arise between their professional codes, the client, court, and service organisations (Ward, 2013); and their utility in multidisciplinary forensic settings (Barnao et al., 2012; Farrell & Drogin, 2016).

In Australia there was concern that the standards of the Australian Psychological Code of Ethics were insufficient to meet legal and ethical issues raised by forensic practice (Allan, 2013b). The generic references to human rights within many ethical codes were perceived as unhelpful for practitioners because of the absence of interpretive guidance. Instead, Allan (2013b) advocated that psychologists receive increased training in international and domestic human rights law to ensure they are well-informed about the entitlements and obligations relevant to their area of practice (Allan, 2015).

Of interest, The Australian Psychological Society (2014) developed *Ethical Guidelines for Psychological Practice in Forensic Contexts* (the Guidelines) which is to be used in conjunction with the Australian Psychological Society's (2007*)Code of Ethics* (the Code). The Guidelines are designed to assist the exercise of professional judgement by being "consistent with State and Commonwealth law" (Australian Psychological Society, 2014, p. 42). Some direction is provided about how psychologists should resolve a conflict between their legal and professional obligations. However, it is abstract rather than concrete, "Psychologists make known their commitment to the Code and the *Guidelines*, and take steps to achieve an appropriate resolution consistent with the *Code* and the *Guidelines*" (Australian Psychological Society, 2014, p. 42).

At an international level, the *Universal Declaration of Ethical Principles for Psychologists* (UDEPP) (International Union of Psychological Science & International Association of Applied Psychology, 2008) provides a contemporary ethical framework of global scope that encapsulates the core values of the UDHR (Gauthier, 2009; Hagenaars & Thompson, 2020). Primary objectives of the UDEPP are to develop a collective global voice on psychological ethics while also equipping individual organisations to ensure that their ethical codes that are sensitive and responsive to local needs and values. (International Union of Psychological Science & International Association of Applied Psychology, 2008). The UDEEP is made up of four principles. Principle I reinforces the overlap between human rights and ethical principles. Principle II, competent care for the wellbeing of persons and people, speaks directly to the need for psychologists to be aware of how their values, attitudes, experiences and social context influence their interpretations and actions. This aligns with the human rights perspective described by Ward and Birgden (2007). Principle III, integrity, speaks directly to the dual role problem and requires psychologists to monitor and manage personal biases along with "multiple relationships, and other conflicts of interest that could result in harm and exploitation of persons or peoples" (p.3). Accordingly, the UDEPP is considered fit for purpose in forensic settings (Allan, 2013). A further strength of the model is the inclusion of a broad range of cultural perspectives (Gauthier & Pettifor, 2012).

Human rights-informed approaches

Others have integrated Ward and Birgden's human rights model into ethical decision-making frameworks (Barnao et al., 2012; Ward & Syversen, 2009). The ethical evaluation guide developed by Barnao et al. (2012) in New Zealand aimed to combat ethical blindness in forensic practice. The authors argued that by applying a lens informed by the value of dignity and the associated values of freedom and well-being, clinicians are alerted to the wider range of ethical problems arising in forensic practice (Barnao et al., 2012). The guide was designed to be used in multidisciplinary settings. Strengths of this model are its simplicity, focus on multidisciplinary settings, and use of case studies to showcase application.

Making values explicit

Reconciling competing value systems is the focus of Candilis' (2009) "robust professionalism" model. The model seeks to make explicit the personal, professional, and community values that impact forensic practice. 'Robust professionalism' sets out seven ethical precepts, including sensitivity to vulnerable evaluees, sensitivity to role problems, self-reflection, integrity, honesty, and professionalism that are coupled with the skills of the forensic practitioner (Candilis, 2009). For example, sensitivity to a vulnerable evaluee is expressed by recognising sources of disadvantage, applying a cultural formulation, and recognising power dynamics. This approach would appear well suited to specialist assessments of care recipients by providing a model for considering the factors that contribute to the over-representation of Māori and other minority groups (e.g., the impact of colonisation or structural racism). In addition, there is a strong focus on practitioner behaviour and acknowledgement of the various value systems impacting practice. However, some have criticised the absence of a clear set of procedures for applying the model (Ward, 2013).

Existing codes are sufficient

Finally, other groups of psychologists take the position that existing ethical codes, if applied correctly, are sufficient to manage the demands of forensic practice (Wilson et al., 2007). Within the New Zealand correctional system, psychologists undertaking health assessments (e.g., risk assessments for parole or extended supervision orders) acknowledge the multiple roles inhabited by the psychologist. The traditional ethical principles (beneficence, non-maleficence, and justice) are employed during the assessment and reporting process (Wilson et al., 2007). These scholars argued that "There is no conflict as long as the clients are informed of the dual role, the limits to confidentiality, and the future use of information, especially as it relates to sentencing" (Wilson et al., 2007, p. 441).

Applied studies relevant to the Specialist Assessor role in New Zealand

Two recent New Zealand studies have explored dual role tensions arising for psychologists or psychiatrists in forensic assessment settings.

The impact of the three strikes legislation on fitness to stand trial assessments conducted under s38 of the CPMIPA, was examined by Huddleston (2020). The study found that health assessors were concerned about the liberty and well-being implications of the three strikes law for people with intellectual disability (and other vulnerable groups). The researcher concluded:

> Overall, the expressions of concern in regards to vulnerable groups exemplifies the caring and therapeutic nature of health assessors who seek to undertake FST (fitness to stand trial) assessments without disadvantaging the individuals or members of vulnerable groups. (Huddleston, 2020, p. 176)

Although health assessors were not in the therapeutic role, Huddleston's finding indicated they remained attuned to the therapeutic and rights implications of risk focused legislation. In contrast, this doctoral thesis has explored how the participants perceived the specialist assessor role and the related human rights obligations.

Ethical challenges arising in forensic practice was the focus of the second study. Sixteen forensic psychologists participated in qualitative research undertaken by Jones (2019). The study provided novel insights into ethical tensions experienced in the role. Included in the sample were specialist assessors, although the number is unspecified. The thematic analysis indicated that the participant's perceived forensic practice had changed from its traditional "helping role to one in which issues of risk have become predominant, and in which psychologists are increasingly required to consider the needs of multiple client parties" (p. 117). Other sources of tension were working in a system that "tended to err on the side of caution" and being "seen by clients as deciders of fate" (p. 118). Consistent with the work of Candilis (2009) and Ward et al. (2014), the participants described value conflicts that, in some cases, were resolved by leaving the practice setting or accepting/prioritising public interest concerns over offender welfare.

Like the Jones study, this thesis examines forensic practice and the tensions that might arise. However, rather than focusing on ethical tensions, the study explores the dilemmas arising for a highly specialised group of forensic practitioners as they contemplate *human rights* issues.

2.5.4 Ethics of risk assessment

Risk assessment constitutes a core aspect of the specialist assessor's role that has significant liberty implications. The use of risk assessment tools with vulnerable and marginalised groups raises important ethical and empirical questions for forensic practitioners (Day et al., 2018; Vess et al., 2017). Although this topic is not the focus of the thesis, the relevant literature is briefly described to reflects its broader salience.

Risk and civil detention regimes

Authors in New Zealand and Australia have explored the human rights and ethical implications of risk assessment within community protection legislation (Vess, 2009; Vess et al., 2017; Ward, 2011). The studies are not specific to the IDCCRA but do provide useful comparisons because of the focus on forensic or correctional practice within coercive regimes. It is strongly argued that forensic psychologists should pay close attention to the ethical issues posed by these legislative frameworks, recognise dual role problems, and "have a clearly articulated framework for understanding human rights" (Vess et al., 2017, p. 371). The key issues raised by this literature relevant to the current study can be distilled as follows.

Firstly, there may be issues of independence for psychologists undertaking risk assessment on behalf of government funded agencies (Vess, 2008). Secondly, the imposition of public protection measures in response to the potential to offend; for example, extended supervision orders or civil detention orders, is seen as ethically problematic (Janus & Prentky, 2003). That is, multiple extension orders may have the effect of detaining people for extensive periods (and longer than if they had been convicted of the relevant crime and sentenced to imprisonment). This concern was identified by Brookbanks (2003) prior to the enactment of the IDCCRA and has since been borne out (Ellis, 2020). Thirdly, boundary issues are raised when therapeutic skills are used to engage an offender in a risk assessment that has liberty implications (Vess et al., 2017). Fourthly, risk assessment brings the potential for false positive and false negative findings, resulting in an inaccurate assessment of risk (Vess, 2008).

Specialist assessors must make professional judgements about a care recipient's risk of reoffence. Within the literature it is identified that false negatives, that is, the underestimation of risk, can elicit significant personal and professional consequences for risk assessors, such as feelings of shame, guilt, burden, incompetence, or heightened public scrutiny (McSherry et al., 2007; Tamatea et al., 2018; Vess, 2009). In addition, underestimated risk causes harm to the future victim(s) and their community. In comparison, the ramifications of overestimations of risk may go unnoticed in a professional context but bring significant negative consequences for the affected person (e.g., a prolonged loss of liberty, distress) and their whānau (Tamatea et al., 2018; Vess, 2009).

Further, how practitioners conduct and report risk measures can have a significant influence on judicial decision-making (Hilton et al., 2015; Vess, 2008). Risk assessors should clearly and transparently explain the meaning and the limitations of the data they present (Tamatea et al., 2018; Vess et al., 2017). Equally, as observed by Justice Glazebrook (2018), judges have a responsibility to robustly scrutinise expert risk assessments. Also, McSherry (2014) analysed judicial decision-making within preventive detention regimes and expressed concern that expert testimony was being accepted without challenge. The process of translating psychological risk findings within the concepts and parameters defined in law poses challenges for all involved (Tamatea et al., 2018).

The IDCCRA was not designed to provide a preventive detention regime. The goal was to provide approach disposition and care pathways for intellectually disabled people entering the criminal justice system. However, the inclusion of the extension provision does require specialist assessors to be alert to the potential for indefinite detention. Vess and colleagues' (2017) analysis of role boundaries echoes Appelbaum's (1997a) emphasis on truth-telling and respect for the client within forensic practice because of the liberty implications arising from the assessment process. Given the presence of their intellectual disability, some care recipients are unable to provide informed consent or to discriminate between the different roles of helper, therapist, specialist assessor, and expert. This likely makes the role more complex. Adopting a human rights perspective to specialist assessor practice could make dual role problems more explicit, providing great impetus for a rights-focused assessor to seek solutions.

Running alongside these challenges is a robust debate about the efficacy of modern approaches to risk assessment (Nicholls et al., 2016; Tamatea et al., 2018).

Nature of risk measurement

Risk measures take various forms but broadly fall into two categories—actuarial or structured professional judgment. Actuarial tools provide predictive risk estimates based on group data derived from static risk factors (that are fixed and historical) or a combination of static and dynamic (changeable and current) risk factors (Grove & Meehl, 1996). Structured professional judgement tools consider a broad range of risk variables and provide descriptive risk estimates and case management plans (Douglas et al., 2014). A contested area is whether actuarial or structured professional judgement approaches render more reliable results (Falzer, 2013; Hanson & Howard, 2010; Hart & Cooke, 2013). In the domain of violence prediction, both methods have performed well (Heilbrun, 2009; Heilbrun et al., 2010; Singh et al., 2011). Practitioners are advised to tailor test choices to the specific needs of the assessment and client group (Skeem & Monahan, 2011).

Actuarial tools based on the risk/needs/responsivity model (Bonta & Andrews, 2016) are dominant in the New Zealand correctional context. In part, this reflects efficiencies associated with the measure, for example, the time taken to train assessors and test administration (Tamatea et al., 2016). In comparison, the use of structured professional judgement tools is widespread by experienced practitioners within private practice settings (W. Louw, personal communication, June 21, 2023).

There is limited discussion within the New Zealand literature about the use of risk assessment measures with care recipients (Duncan, 2013; Nuth & Thompson, 2018). Equally, there are a lack of data on recidivism rates for people with intellectually disability who offend (Lindsay et al., 2018). Specialist assessors have some discretion in their application of risk measures. However, for almost 10-years, the MOH has encouraged specialist assessors to use the Level of Service/Case Management Inventory. This is a structured professional judgment tool organised around the risk need responsivity principles (Andrews et al., 2004). It is designed for use with mainstream offenders to predict general offending and is normed on a large North American sample. The fairness of using a measure that includes factors such as educational attainment and employment with care recipients is identified as warranting exploration (Nuth & Thompson, 2018).

A nuanced, comprehensive, and critical approach to risk assessment is advocated within the international literature for people with intellectual disability who offend (Blasingame et al., 2014). Some actuarial and structured professional judgment measures have demonstrated reliability with this group (Fitzgerald et al., 2013; Gray et al., 2008; Lindsay et al., 2008). Also, intellectual disability-specific measures have been developed, such as the Assessment of Risk and Manageability of Individuals with Intellectual Disability who offend – Sexually (ARMIDILLO-S) (Boer et al., 2013). Following the trend in mainstream risk assessment, the identification of protective factors is of growing interest (Boer et al., 2004; Taylor & Lindsay, 2018). Contemporary structured professional judgment measures (like the HCR-20V3 and RSVP-2) provide scope for a detailed contextualisation of risk (Tamatea et al., 2018) and specific risk parameter statements (Allnut et al., 2010). Arguably, these features support their use with care recipients. It is beyond the scope of the current research to present this literature in further detail. However, it is important to note that specialist assessors need to navigate this landscape when contemplating their choice of risk measures with care recipients. This is because the risk assessment process has significant liberty implications.

Culture and risk assessment

The impact of cultural factors on risk assessment was a topic of interest and importance to the specialist assessors in this study. The landmark case of *Ewert v Canada* [2015] FC 1093 focused on the use of psychological risk assessment with Indigenous people who had offended. The court upheld Ewert's claim that the risk measures used were unreliable due to their susceptibility to bias and had negatively impacted his chances of parole. This outcome provides some support for those who have contested the cultural neutrality of risk measures (Gillies, 2013; Shepherd & Lewis-Fernandez, 2016). Actuarial measures have been critiqued for failing to consider the social and cultural circumstances in which risk arises (Day et al., 2018).

Further, culturally insensitive risk measures have been linked to poorly informed assessments, inappropriate interventions, and poor outcomes (Tamatea & Waipara-Panapa, 2018). Tamatea and Waipara-Panapa (2018) helpfully identified several international frameworks (Ridley et al., 1998; Suzuki et al., 2008) designed to specifically assist forensic and criminal justice practitioners in the process of integrating cultural material within criminal justice assessment. *To Tatou Waka* is a culturally inclusive framework developed by Macfarlane and Macfarlane (2008) and Macfarlane et al. (2011) in the New Zealand context to provide psychologists with a means to “listen to culture as well as disciplinary knowledge” (Macfarlane et al., 2011, p. 12). When assessments determine the life course of an individual, the authors stated, “there is more necessity to consider the cultural context and the relevance of cultural knowledge to the assessment process” (Macfarlane et al., 2011, p. 10). This model would appear to have applicability to specialist assessors given the liberty implications of their opinions on care recipients.

Summary

There are some supporters of the inclusion of human rights perspectives within forensic ethics and risk assessment frameworks, although others contest this approach. There is a paucity of empirical research conducted within the context of forensic practice, particularly with people with intellectual disability who have been charged with or convicted of offences (Ward & Syversen, 2009). The salient social and political factors identified in the literature will now be discussed.

2.5.5 Lifting the Gaze

A distinct theme within the literature reviewed is the need for psychologists and psychiatrists to lift their gaze and attend to a broader range of factors that impact the human rights of individuals, groups, and societies. Legal and clinical commentators appear to be exhorting forensic practitioners to critically examine the surrounding socio-political climate and the associated human rights implications of their work. This section will start with a brief description of the literature specific to forensic practice and then shift to the general psychology literature.

Tuning into justice, fear and power dynamics

Williams (2009) asserted that forensic psychologists should be cognisant of the “ways in which the legal system – and its participants and agents – perpetrate and reproduce injustices” (p. 327). This position is supported by others who have levelled criticism at forensic psychology for its failure to pay due attention to issues of justice (Adshead, 2014), risk aversion (McSherry, 2013), fairness (Allan, 2018), and offender welfare (Perlin, 2018; Ward et al., 2009).

Reflecting on the state of forensic psychiatry in the United Kingdom, Adshead (2014) poignantly stated:

> If we do not engage with the justice process that benefits us all, we are at risk of harming ourselves as well as others. If we treat vulnerable people merely as a means to security ends, we risk being unempathetic and derogate from human rights as the men and women we treat. It is our own moral identity as forensic practitioners that we need to continually explore and reflect upon; the story of our practice, that we tell trainees, colleagues and ourselves. (p. 10)

Preventive or civil detention schemes are a focal point for these concerns (Adshead, 2014; Thomas-Peter, 2006; Vess, 2009). Recent studies in the United Kingdom explored the power held by correctional psychologists when their risk assessments inform indeterminate sentencing (Shingler et al., 2019, 2020). This qualitative study utilised interviews with men sentenced to prison. The following insight reflects the impetus for this thesis:

> The final, and one of the most important, threads to prisoners' mistrust of psychologists was the view of psychologists as ‘the quiet ones with the power: what the psychologist says goes’. (Shingler et al., 2020, p. 14)

The treatment of detainees at Guantanamo Bay further galvanised public attention on psychology’s role within coercive environments, providing a timely reminder of the profession’s involvement in historical human rights violations (Candilis & Neal, 2014b; McSherry, 2013; Nowak & Zenz, 2020; Perlin, 2010). Similarly police brutality in the

United States has led communities of forensic psychiatrists to contemplate how their practices might combat structural racism (Candilis & Griffith, 2021).

In response to these concerns, recommendations were proposed by multiple international activist scholars and are analysed below. Perlin (2018) was openly critical of what he viewed as the silence and disconnection of forensic psychology on the human rights of people with disability in institutional settings. He challenged psychology to ameliorate the situation by engaging in a range of activities, including training in human rights, staying abreast of the judicial interpretation of international and domestic human rights norms, reporting the violation of rights, creating best practice guidelines for integrating human rights, advocating for development least restrictive environments, and paying close attention to the conditions within the institutions (Perlin, 2018). The importance of forensic professionals translating human rights into practice on the ground is viewed as pivotal to protecting care recipients (and their equivalents) within closed environments that deprive or limit liberty (Naylor et al., 2014).

In addition, McSherry (2013) identified that a "fear of violating the boundaries of their professions" (p. 211) may prevent practitioners from raising concerns about the human rights implications of risk-focused legislation. She advocated for the inclusion of justice ethics within ethical frameworks and concluded that psychologists should not blindly accept state policies that allow for the deprivation of liberty in forensic contexts.

Taking a more active role

Debate and reform

It is argued that forensic psychologists' knowledge of legal processes and expertise in criminal justice and coercive care policy leaves them well-placed to participate in public debate and policy reform about the moral dimensions of governmental and institutional policy (Allan, 2018; Nowak & Zenz, 2020; Williams, 2009). Relatedly, forensic practitioners are encouraged to come together as groups to discuss and reflect more broadly on issues of justice and the ethical and human rights challenges posed by forensic work (Adshead, 2014).

A further facet of this discussion is the collective responsibility and moral obligations held by forensic psychologists to make a meaningful contribution to the legal process (Allan, 2018; Allan, 2020; Williams, 2009). Most ethical codes, including the *Code of*

Ethics for Psychologists Working in Aotearoa/New Zealand (New Zealand Psychological Society et al., 2002), require practitioners to recognise the vulnerability of individuals, groups, or communities and take action. In New Zealand, there appears to be little dispute that psychologists should prioritise ethics over law when faced with conflicts (Billing et al., 2018). Reflecting on the obligations of the profession, Allan (2018) argued that psychologists could approach the challenges of protection and welfare within coercive regimes, provided they pay attention to ethical principles of justice and respect for humanity derived from the *Universal Declaration of Ethical Principles for Psychologists* (International Union of Psychological Science & International Association of Applied Psychology, 2008).

This view is supported by Perlin (2018), who called for forensic psychologists to take greater action against organisational or state practices that do not comply with their ethical obligations. Underpinning this discussion is the concern that if psychologists step away from forensic practice because of problems of dual agency, then less qualified or equipped practitioners from other disciplines may face pressure to step into this role (Allan, 2015). However, despite the commitment of psychologists to define and uphold ethics, some psychologists argue that the profession has failed to exert much influence over politics and, thus, “has yet to make a serious impression on injustices worldwide” (Tassell et al., 2012, p. 87).

International human rights law: Psychologists’ obligations are unclear

A lack of clarity about the obligations of individual forensic practitioners to uphold the international human rights frameworks ratified by their State may be a further barrier to greater action. European scholars have called for explicit references to human rights within ethical codes on the basis that psychologists do have professional and societal obligations to promote and uphold human rights (Hagenaars, 2016). Although most codes include generic statements about human rights, these are rarely defined (Gauthier & Sinclair, 2020).

The implications of explicitly defining human rights laws within ethical codes is a debated issue. The lack of a universal definition of human rights is seen as a barrier to inclusion (Allan, 2013a). In addition, Allan concluded that direct references to human rights were unhelpful because ethical codes and human rights serve different functions:

> Ethical codes stress psychologists' obligations towards other people, groups and society as a whole and their moral duty to respect human dignity in themselves and others. In contrast, human rights law is prescriptive, emphasises the individual and enforceable nature of rights and requires external compulsion". (Allan, 2013a, p. 18)

In making this observation Allan (2013a) noted that UN treaties were influential but not universal. Further, he observed that the enforceability of human rights is dependent on the extent to which governments had ratified a treaty or incorporated it into domestic law (Allan, 2013a).

Relatedly, some have asserted that traditionally, countries, not individuals, are bound by United Nations conventions (Allan, 2013a). Adding to this debate, Gauthier and Sinclair (2020) observed:

> it is not clear exactly what additional obligations this would place on psychologists, as psychologists are not bound by UN [United Nations] treaties, unless they form part of the domestic law of the jurisdiction (psychologists are expected to know and respect democratically established law, although if there is a conflict between such law and ethics, psychologists are expected to prioritize ethics). (p. 50)

However, others argue that a human rights framework imposes obligations on the state, organisations, and individual professions; that is, human rights norms strongly overlap with professional ethics (Ulrich & Wainwright, 2020). The obligations of individual psychologists are referred to as "horizontal obligations" (Ulrich & Wainwright, 2020, p. 82). The scholars explain these obligations as follows:

> Vertical obligations apply to states and are codified in the form of law. Horizontal obligations, by contrast, are predominantly ethical in nature and apply to both powerful corporate actors such as business enterprises and to private individuals (ordinary citizens). In our horizontal interaction with one another, we all become human rights duty bearers. (Ulrich & Wainwright, 2020, p. 83)

Regarding the current study, specialist assessors are governed and regulated by domestic law. They hold a statutory role within the CPMIPA and IDCCRA that impacts a care recipient's realisation of liberty and well-being rights. Therefore, it could be argued that they do have special or increased ethical and professional obligations to recognise the relevant human rights law. How the specialist assessors viewed this issue in relation to *their obligation* to address a care recipient's liberty right is the focus in this study.

Issues of domestic interpretation have been noted by international scholars exploring psychology and human rights (Sveaass & Wessells, 2020). Reporting on the findings of the American Psychological Society's human rights task force, Huminuik et al. (2022) stated that the legal responsibility to uphold rights is primarily borne by governments, but there are obligations on the psychological and professional associations to "promote and protect human rights and ensure accountability when human rights are violated" (p. 590).

Apparently in New Zealand there is some recognition of the Huminuik et al. (2022) argument because several bodies have made submissions regarding human rights. In recent years, the New Zealand College of Clinical Psychologists, the New Zealand Psychological Society, and the RANZCP made submissions on human rights issues regarding the proposed changes to mental health and capacity laws (see New Zealand College of Clinical Psychologists, 2023; New Zealand Psychological Society, 2022). Further, the RANZCP recently published a comment on human rights violations (Royal Australian & New Zealand College of Psychiatrists, 2022).

A point of consensus is the requirement for psychologists to be well informed about human rights law, particularly the United Nations treaties that directly apply to their practice area (Allan, 2013a). In the absence of clear legal obligations, specialist assessors may have a *moral* obligation to be informed about a care recipient's human rights entitlements within domestic and international legislation. Effective scrutiny of rights issues would, therefore, appear to be dependent on specialist assessors being well-informed about the relevant human rights laws. Coercive care triggers debate about ethical, moral, and rights-based issues. A lack of training in ethics and philosophy is linked to forensic psychologists feeling uncertain about how they can or should contribute to these debates (Allan, 2015). This study explores how specialist assessors derive their understanding of a care recipient’s human rights and their associated obligations.

2.5.6 Human rights-based approaches

How human rights feature in the practice of specialist assessors is explored in this study. The research question(s) reflects the researcher’s interest in the intersection between psychology and the law. Others have explored this relationship. It is observed that human rights analysis and discussion are often grounded in legal traditions (Hagenaars, 2016). However, others point out that:

> Psychology has always mattered in human rights, and human rights have always mattered in psychology, at least implicitly. Lately, however, the intersection of psychology and human rights has become more explicitly articulated. (Wainwright et al., 2022, p. 120)

This literature review has revealed an international, growing interest in how psychologists operationalise human rights (Huminuik et al., 2022; Kinderman, 2007). A theme within the literature was the gap between human rights law and its practical application in clinical practice. In the United Kingdom, it is recognised that the introduction of the Human Rights Act 1998 did not demonstrably improve patients’ or clinicians’ knowledge of human rights in healthcare settings (Curtice & Exworthy, 2010). This sparked interest in developing applied approaches that translated human rights law into a clear set of principles (Butchard & Greenhill, 2015). Accordingly, Curtice and Exworthy (2010) defined a human rights-based approach (HBRA) as:

> a bottom-up approach (as opposed to the top down variety requiring detailed knowledge of the Human Rights Act articles and associated case law) whereby the concepts which underpin all the articles of the Act are operationalised… In essence, the human rights-based approach is the process by which human rights can be protected in clinical and organisational practice by adherence to the core values of fairness, respect, equality, dignity and autonomy (FREDA). These principles are the basics of good clinical care sewn into what clinicians already do on a daily basis. (p. 151)

These authors illustrated the clinical implications of the FREDA principles in places of detention catering for care recipient equivalents. For example, fairness is equated with giving due consideration to a person's preference in compulsory care settings and paying due attention to fair trial rights (Curtice & Exworthy, 2010).

In mainstream learning disability services in the United Kingdom, the successful embedding of HRBAs has been dependent on several steps. The first step is the clear linking of law with ethical practice; secondly, the translation of FREDA values (or similar sets of principles) into practical decision-making strategies that can be readily applied by practitioners (Butchard & Greenhill, 2015). The goal is to move beyond aspiration and good intentions toward an active involvement in rights-based issues (Hagenaars, 2016).

Support for human rights-based approaches is premised on the argument that:

> psychology and human rights have a double relationship. The UDHR provides a normative framework for psychologists and is an inspiration for practice, research, education and conceptualisation. And, by virtue of their knowledge, practice and expertise, psychologists can and should contribute to human rights protection and promotion. (Wainwright et al., 2022, p. 122)

That is, there is a synergy between the ethos of human rights and ethical principles that guide psychological practice (Ulrich & Wainwright, 2020).

Psychologists are well placed to take more active steps towards integrating human rights-based approaches. Firstly, the science and practice of psychology are focused on the human experience and oriented towards identifying the conditions for dignity, belonging, change, and human flourishing (Hagenaars, 2016). In this respect, the profession's core values are congruent with human rights-based approaches (Butchard & Greenhill, 2015; Nowak & Zenz, 2020).

Secondly, psychologists are trained to think critically (Hagenaars & Thompson, 2020; Huminuik, 2023). They are subject to professional codes and have the skills to respond in robust, systematic ways to harmful practices, conditions, or rights violations (Kinderman, 2007). In addition, ethical codes, with their requirement to give regard to rights to privacy, autonomy, and dignity, communicate foundational human rights values (New Zealand Psychological Society et al., 2002). Recent efforts to explicitly link human rights principles to competent psychological practice reinforce the pivotal role of ethics (Plavsic et al., 2020; Ward & Syversen, 2009).

Thirdly, psychologists work in a diverse range of practice settings and organisations, including places of compulsory care (Kinderman, 2007) and detention (Nowak & Zenz, 2020). In addition, psychologists play a pivotal role in the treatment of trauma arising from human rights violations (Wainwright et al., 2022). As Butchard and Greenhill (2015) aptly observed, “For clinical psychologists, engaging with issues of human rights is a daily reality” (p. 20). Psychologists are also formally monitoring whether health or justice services are delivered in accordance with the human rights conventions ratified by their governments; either domestically within NPMs or internationally as United Nations rapporteurs (Nowak & Zenz, 2020).

Nurturing rights-focused psychologists and psychiatrists

Many scholars have strongly argued that professional and ethical practice would be enhanced by the inclusion of human rights perspectives (Bhugra et al., 2017; Gauthier, 2009; Hagenaars, 2016; Plavsic et al., 2020; Sveaass & Wessells, 2020). The more explicit connection of human rights to ethics is viewed as necessary to allow:

> more psychologists to employ their knowledge and skills for the promotion and defence of human rights, the prevention of human right violations, as well as alleviating the harmful consequences of those violations. This connection cannot be overemphasized. (Gauthier, 2020, p. 272)

Several options are available for psychologists who wish to take a human rights-based approach. At one end of the continuum is the improvement of human rights education and training opportunities for psychologists (Hagenaars & Thompson, 2020; Huminuik et al., 2022). On the other end is a “psychologist-activist” stance (Nadal, 2017, p. 942), which encourages psychologists (as scholars, educators, trainers, or practitioners) to explicitly and deliberately use their status and roles to challenge oppression. Specialist assessors who wish to assume a psychologist-activist stance may find themselves in new and unexplored territory. Initiatives aimed at embedding human rights-based approaches have been likened to “giving clinical psychology a backbone” (Butchard & Greenhill, 2015, p. 16).

The absence of human rights in professional training and continuing competency programmes is seen as a significant gap in the United Kingdom (Curtice & Exworthy, 2010), the United States (Huminuik, 2023), and Australia (Allan, 2013a; Gill, 2019). However, scholars are also reflecting on the gap from a global perspective (Bhugra et al., 2017; Hagenaars & Thompson, 2020). No New Zealand-specific literature on human rights and psychology or psychiatry training was identified within this review.

Human rights-based approaches: An evolving area

All the human rights-based approaches reviewed for this study share a focus on teaching and professional training to equip psychologists with a deeper knowledge of the relationship between human rights and practice (Butchard & Greenhill, 2015; Kinderman, 2007; Plavsic et al., 2020). These approaches complement the various domestic practice standards that exist for psychologists and psychiatrists in New Zealand. Consistent with Ward and Birgden (2007), scholars and practitioners advocating for human rights-based approaches identify the UDHR as the foundational instrument and primary source of primary human rights principles (Hagenaars & Thompson, 2020; Nowak & Zenz, 2020; Wainwright et al., 2022).

If psychologists are informed about human rights, they can contribute to the advancement of human rights by way of applied research and practice (Claude, 2002; Hagenaars & Thompson, 2020; Huminuik, 2023). The American Psychological Association Task Force on Human Rights recently reviewed the relationship between human rights and their guiding concepts of human welfare, public interest, and social justice (Huminuik et al., 2022). In doing so, the Task Force adapted Claude’s (2002) “Five Connections” between science and human rights to provide an organising framework for psychologists and organisations in their efforts to protect and promote human rights. The five components of the American Psychological Association’s “Five Connections Framework” are:

1. Psychologists *possess* human rights by virtue of being human, as well as specific rights essential to their profession and discipline;

> 2. Psychologists *apply* their knowledge and methods in the greater realization of human rights;
>
> 3. Psychologists *respect* human rights and oppose the misuse of psychological science, practice and application and the negative impact on human rights; and
>
> 4. Psychologists advance *equal access* to the benefits of psychological science and practice; and
>
> 5. Psychologists *advocate* for human rights. (Huminuik et al., 2022, p. 7)

A distinctive feature of this model is the acknowledgement of the specific rights and freedoms that support a psychologist's scientific endeavours (Huminuik & Wyndham, 2020) which provided another perspective on the dual roles that psychologists inhabit in a professional context. Here, the American Psychological Association focuses on the conditions necessary for psychologists to generate knowledge as a basis for human rights-focused practice. Of note, the Task Force recognised the special relevance of psychologists applying their knowledge and methods to ensure the rights of persons with *intellectual disability* are respected.

Other approaches attempt to bridge the gap between legalistic human rights statements and everyday practice by focusing on values that already resonate with clinicians (Butchard & Greenhill, 2015; Curtice & Exworthy, 2010; Nowak & Zenz, 2020). Butchard and Greenhill (2015) provided practical examples of how this could be achieved in dementia and learning disability services in the United Kingdom. Of interest to the current study were efforts to synthesise Kahneman's (2011) work on decision-making alongside training in human rights concepts to create a "counterbalancing framework, in this case human rights, to create a 'pull' away from fast risk-based and fearful decision making" (Butchard & Greenhill, 2015, p. 18)

Psychologists as human rights defenders and activists

Adopting a critical human rights-based perspective is seen as central to psychologists appraising how power dynamics negatively impact the realisation of human rights in practice settings (Patel, 2020). The term 'human rights defender' is derived from a United Nations resolution adopted in the United Nations General Assembly in 1998 (United Nations, 1998). It refers to individuals or groups who work to strengthen, protect, and improve the implementation of human rights as part of civil society movements or organisations (Plavsic et al., 2020; Sveaass & Wessells, 2020).

Critical human rights-based approaches (CHRBA) focus the practitioner's attention on the specific human rights, principles, and ethical and legal frameworks that are pertinent to practice settings with the goal of equipping psychologists with tools to take a more informed stance against oppressive or discriminatory practices, structural inequalities, and human rights abuses (Patel, 2020).

A recent study by Wainwright et al. (2022) indicated that professional psychology associations around the globe (including those in New Zealand) are involved in human rights advocacy. The Psychology Coalition at the United Nations (PCUN) seeks to promote human dignity, rights, well-being, and mental health through advocacy research, education, and related activities (Gauthier & Sinclair, 2020).

Barriers to assuming an activist stance

The barriers for psychologists who might wish to adopt an activist approach were explored by Nadal (2017), who identified five factors. Of relevance to the current study were, a) a desire to retain political neutrality, b) anxiety about crossing ethical boundaries, and c) the belief that social justice advocacy was not necessary to psychology coupled with limited advocacy training. There may be other reasons why psychologists feel hesitant to promote or advocate for human rights. Adopting a rights promotion approach may feel foreign (Plavsic et al., 2020). There may be increased self-care demands (Nadal, 2017; Plavsic et al., 2020). Colleagues may come into conflict with each other due to a clash of personal or political values (Vasquez, 2012). Psychologists may face negative professional consequences such as reprisals or marginalisation (Sveaass & Wessells, 2020). There may be negative public reactions when comments made by individual psychologists or professional organisations "go viral" (Vasquez, 2012, p. 344). Academics accused of a loss of political neutrality may also face economic consequences (Nadal, 2017). In addition, threats to personal safety or sense of betrayal have been reported in social justice scholarship (Vasquez, 2012). This thesis identified barriers to specialist assessors adopting a human rights-based approach. These are presented in Chapter 4, within themes one and five.

2.5.7 Summary

How psychologists might integrate human rights perspectives is a burgeoning area of interest within forensic and general psychological literature. This review has underscored the importance of specialist assessors being attuned to the human rights of care recipients. Role conflicts arising from competing ethical and professional obligations are well established in the literature. Several approaches are available for those clinicians interested in integrating human rights perspectives into their practice. There is a paucity of applied studies in forensic intellectual disability practice. Those available illustrate the ethical tensions arising for forensic psychologists when they contemplate the human rights implications of their practice.

Chapter 3 Methodology

The qualitative methodology of interpretive description, first developed by Thorne and colleagues in 1997, was used in this study. Reflexive thematic analysis, as described by Braun and Clarke (2022), and Terry et al. (2017), was the chosen method of analysis. The first part of this chapter describes interpretive description and provides a rationale for its use. The second part of the chapter gives a detailed account of the recruitment, data collection and data analysis phases, including the reasons for choosing reflexive thematic analysis. The chapter concludes with a description of the steps taken to ensure and maintain the integrity of the research.

3.1 Interpretive Description: A Distinct Qualitative Approach

Qualitative research as a field of inquiry can be understood as a complex interconnected family of terms, concepts, and assumptions (Denzin & Lincoln, 2011). Definitions of qualitative research are contested but despite differences in interpretation, there is general agreement that qualitative research locates the observer in their natural world by using a set of "interpretive material practices that make the world visible" (Denzin & Lincoln, 2011, p. 3). A wide range of methods may be used to capture practice and experience. Irrespective of specific methods, qualitative research has an explicit focus on making sense of the meaning people ascribe to their experience (Bryman, 2004). Aiming to provide a deeper understanding of human experience and behaviour, qualitative research enables the exploration of interactions between human beings and their environments (Munhall, 2007).

The current study gives expression to Lincoln and Guba's (1985b) interpretation of qualitative research by exploring aspects of specialist assessor practices as they naturally occur. Specifically, the thesis explored how specialist assessors integrate human rights perspectives into their assessments with care recipients. There is growing awareness of the human rights of persons with disability as a result of the ratification of the UNCRPD, and the emergence of legal cases (e.g., *J, Compulsory Care Recipient, By his Welfare Guardian. T v The Attorney-General* [2018]) and research activities that test these rights (Ellis, 2020) within the context of the IDCCRA. However, the practice of specialist assessors in New Zealand is not well attended to in the literature. The current study presents the evidence that is available in relation to this topic, and seeks to expand on this knowledge by questioning taken for granted influences or gaps within the existing dialogue (Thorne, 2020).

Interpretive description is a qualitative research methodology originating from the discipline of nursing (Thorne et al., 1997). It was designed to provide a meaningful and applied way to explore the daily realities of clinical practice (Hunt, 2009; Thorne, 2020). Interpretive description seeks to assist health practitioners by generating findings that “might steer them towards important and meaningful fine-tunings of awareness and insight in their actions” (Thorne, 2020, p. 159). Although designed for health practice, interpretive description is now utilised in diverse research contexts.

Interpretive description was designed to create knowledge for clinicians that is useful, readily applied, and advances clinical reasoning (Hunt, 2009; Thorne, 2016). These aims were strongly aligned with the researcher’s goal of illuminating a niche and understudied area of clinical forensic practice impacting a vulnerable population. The integrity of the research is derived from three facets: a real-world question; an understanding of what is known and unknown based on available literature; and a rich appreciation for the audience and context of the research (Thorne, 2016; Thorne et al., 1997).

The traditions of constructivism and naturalistic inquiry (Lincoln & Guba, 1985b) provided the epistemological foundation of interpretive description (Thorne, 2016). These philosophical underpinnings accept that there are multiple, co-constructed and subjective realities. Research findings are created within the process of interaction between the researcher and the participants (Guba, 1990). Specifically, the inquirer and the object of inquiry interact with each other, influence each other, and cannot be separated from each other (Thorne et al., 2004). Constructivism acknowledges the presence of implicit knowledge and influence.

An important aim of constructivist research is to uncover the taken-for-granted influences that are embedded in practice, situations, and relationships (Clarke, 2003). An inductive approach to data analysis is used, allowing the researcher to construct patterns and themes from the data. This differs from deductive analysis which focuses on using theoretical constructs or preset codes to analyse data. In summary, at the heart of the methodology is a fundamental recognition that human interpretation is a suitable starting point for a study of the social world (Pascale, 2011).

Interpretive description is related to qualitative description. The goal of qualitative description studies is to provide a “comprehensive summary of events in the everyday terms of those events” (Sandelowski, 2000, p. 334). The current study seeks to move beyond “straight description” (Sandelowski, 2000, p. 339) towards a more conceptual or abstract rendering of the data. The ability to take a deeper, more flexible and interpretive approach to the data was assessed by the researcher to be appropriate to the clinical, human rights, and legal tenets of the research questions. Interpretive description allows a flexible approach to data so long as there is methodological coherence (Thorne, 2020). The researcher is invited to draw on an assortment of research techniques and traditions, provided this can be done in a manner that is logical, systematic, and defensible (Oliver, 2011; Thorne, 2016).

In the current study, the researcher’s expert knowledge as a psychologist and specialist assessor provided the foundation for the necessary “theoretical scaffolding” (Hunt, 2009, p. 1288). Interpretive description recognises and values the theoretical and practical knowledge that clinicians as researchers bring to their projects (Thorne, 2016). In this study, the researcher’s familiarity with the subject matter was utilised to identify a gap in existing knowledge (Morse, 1994). Equally, the potential pitfalls of being both practitioner and researcher are recognised and addressed within this chapter. As a methodological framework, interpretive description sets out rigorous processes for understanding the potential biases arising from the researcher’s dual position as clinician and researcher (Thorne, 2016).

3.2 Critique of Interpretive Description

Critique of interpretive description as a methodology coalesces around three core issues, which are each discussed below.

3.2.1 Is interpretive description a distinctive approach?

Grounded theory, ethnography, and phenomenology are widely regarded as the foundational qualitative methodologies (Richards & Morse, 2013). The absence of an entirely distinctive or fresh methodological approach is, therefore, the primary criticism of interpretive description. Berterö (2015) pointed out interpretive description's strong links to grounded theory, naturalistic inquiry, and other methodologies asking, "What is the benefit… What is new?" (p. 2). Having considered Thorne and colleagues' acknowledgment of the subjective experience of participants and the verification methods used to ensure quality and rigour, Berterö (2015) labelled the method an extension of the grounded theory movement. Thorne (2014, 2016, 2020) has consistently acknowledged the formative connections with grounded theory and other qualitative methodologies while maintaining that interpretive description makes a unique contribution within the applied research context. She differentiated interpretive description as follows:

> I see interpretive description less as a discrete method per se and more as a means by which to name and clearly reference the well-founded organizing logic… Interpretive description articulates a raison d'etre for this kind of work and offers a nomenclature by which scholars working in this space might choose to distinguish their intentions from those of their methodological ancestors. (Thorne, 2016, p. 39)

Others have contemplated the issue of differentiation. An identified strength of interpretive description is its suitability for novel research questions derived from a researcher's field of practice, which do not complement traditional methodologies (Hunt, 2009; Pringle-Nelson, 2023). The flexible, applied, and so-called "generic" (Kahlke, 2018, p. 1) nature of the interpretive approach is said to provide a pathway for applied researchers to explore new questions that "lie in-between methodologies" (Kahlke, 2014, p. 48). In this regard, a generic approach offering methodological flexibility is viewed as a strength. Kahlke's critique drew on the earlier examinations of generic qualitative approaches (c.f. Caelli et al., 2003; Merriam, 2009).

In order to pre-emptively respond to critique, Hunt (2009) identified that researchers adopting interpretive description could be:

> more explicit in identifying what is borrowed from different methodologies…For instance, an ID [interpretive description] researcher might turn to grounded theory texts to better understand theoretical sampling. However, they might be less well served in

> seeking guidance in the literature of grounded theory for initiating coding. (p. 1290)

Further, Hunt noted that interpretive description offered a broader interpretive approach to coding relative to the detailed line-by-line approach employed in grounded theory. The goal of interpretive description is not to build a new theory; rather, it provides a foundation for understanding complex human problems in a practice context (Pringle-Nelson, 2023).

3.2.2 How much interpretation is enough?

A second and related area of criticism centres on how researchers find the correct level of interpretation and abstraction within the analytic process (Berterö, 2015; Hunt, 2009). This critique examines how the researcher defines the scope and limits of the interpretive process and navigates the flexibility of the approach (Hunt, 2009). Thorne has consistently asserted that the successful use of the methodology relies on the researcher's ability to engage in a rigorous, reflexive and iterative process of data analysis. Some researchers may embrace the flexibility of the approach as an opportunity for innovation, while others may grapple with the challenges of moving into a more creative and generative space (Kahlke, 2018; Thorne, 2016).

3.2.3 No clear rule rule-book

Finally, early adopters of interpretive description (Hunt, 2009) described difficulties in understanding the principles of constructivism and inductive analysis in the absence of a clear "rule book" (Kahlke, 2018, p. 1) to guide decision making. Others have expressed concern about an overreliance on manualised qualitative methodologies, warning that *methodolatry* could limit critical thinking and the development of heterogeneous approaches (Chamberlain, 2000; Janesick, 1994). Methodolatry describes a tendency to preference a specific method over other research considerations (Janesick, 1994). In summarising the debate on this topic, Willig (2008) noted:

> Research methods are not recipes but ways of approaching questions, and the value of our research depends on the skill with which we manage to match our methods to our questions in the pursuit of knowledge and understanding. The motivation required to sustain

> research involvement cannot come from an interest in methodology alone. (p. 514)

The relative obscurity of the interpretive description methodology both within and outside of qualitative research was seen as a further difficulty, leading to those using the approach having to explain and defend their choice (Hunt, 2009). However, over the past 15-years, a plethora of studies have been published using interpretive description as both a standalone or mixed methodology (e.g., Burgess et al., 2021; Dolan et al., 2022; Lapum et al., 2022). In addition, since 1997, the publication of a series of papers and texts has elucidated the approach and the associated conceptual principles that guide decision-making (Thorne, 2008; Thorne, 2016, 2020).

3.2.4 An appropriate fit

There were several reasons why interpretive description was identified as an appropriate approach for this study. Firstly, it was designed for health practice and supported an exploratory approach in an understudied area. The pragmatic contextualised and applied nature of the approach was assessed as being both appealing and suitable to the complex nature of the practice setting (Kahlke, 2014). In this case, the forensic assessment of intellectually disabled offenders within a unique legislative framework.

Secondly, it was determined that interpretive description provided the scaffold for designing a meaningful study of specialist assessors' perceptions of human rights within their practice environment. The ability to draw upon other influences, resources, and methods where they add value and are justified was viewed as a strength of the approach (Goodwin et al., 2023). The findings are located within a body of existing knowledge and the current practice, policy, legal, and human rights contexts. The methodological freedom to apply different lenses to the analysis, reflecting the various influences/contexts at play, was seen as a further area of strength.

Thirdly, the approach supported an interpretation of the current state practice; that is, how specialist assessors are 'doing business'. Interpretive description recognises and values individual and subjective experience while allowing for overarching themes and a complexity of views to be identified. It was anticipated that this approach would capture commonalities in experience and individual variation (Thorne, 2016). Knowledge is co-constructed by the researcher and the specialist assessors.

Fourthly, the clinical experience of the researcher is explicitly acknowledged and located. This knowledge is both a strength and a source of bias, which could be disadvantageous in the absence of rigorous reflexive processes. For this reason, the researcher engaged in several reflective activities, including a bracketing interview with an academic external to the supervisory team (D. Sutton, personal communication, February 3, 2020) that aimed to 'locate' or make explicit the factors that drew her to the study. The areas of focus were her personal experiences of the specialist assessor role, preconceived ideas, and motivations for engaging in doctoral study. The derived insights, along with the other processes that underpin the credibility and rigour of the study are discussed in more detail in the third section of this chapter.

Like other methodologies, interpretive description includes the moral dimension of clinical relevance (Morse, 2012; Thorne, 2016). This dimension is important to the current study for several reasons. Firstly, it demonstrates the researcher's awareness of the ways the study might have an immediate impact on practice by virtue of the participants engaging in a deep discussion of human rights perspectives. Second, it takes account of the potential for future use of the findings by the practice community or policymakers. Third, it recognises that while care recipients were not participants in this study, they are the group most directly affected by specialist assessor practices. Thus, two hui were undertaken to ensure care recipients had an opportunity to provide a perspective on the research questions and the analytic process.

3.3 Design

3.3.1 Sample description

Within an interpretive description study, the researcher must generate a coherent and defensible rationale about the number of participants required for the results to have meaning (Thorne, 2016). In the current study, potential participants were psychiatrists and psychologists holding the designation of specialist assessor under section 5 of the IDCCRA.

When the invitations were disseminated, there were 25 practising specialist assessors in New Zealand (including the researcher), comprising 6 psychiatrists and 19 psychologists. The researcher supervised three specialist assessors who were excluded from the research sample because this relationship was considered a conflict of interest. The thematic analysis literature recommended a sample size of 6-15 participants for doctoral projects or 15-20 for PhD studies using interviews as the primary data source (Terry et al., 2017). The rationale was that these numbers enabled intensive analysis of each interview. In consultation with the supervisory team, it was determined that all specialist assessors could be interviewed if they indicated an interest. Therefore, the remaining 21 specialist assessors were invited to participate in the study.

Once 12 interviews were completed, it was decided within the supervisory team that further participants would be accepted if they volunteered before 30 June 2021. The final sample consisted of 15 specialist assessors. Eleven were clinical psychologists, four were consultant psychiatrists. All identified as either male or female and the gender split was relatively even. The majority of the self-selected sample were located in the North Island. However, it is important to note that many specialist assessors work throughout New Zealand. The specialist assessors were not asked to disclose their ethnic identity. Where participants self-identified their ethnicity in relation to a specific theme this is illustrated by including an extract.

3.3.2 Other Forensic Roles

In addition to preparing specialist assessor reports, six of the participants held paid employment within forensic services operated by Te Whatu Ora Health New Zealand. The remainder were in full-time private practice.

The specialist assessors reported a range of forensic experience, including the preparation of reports for the Department of Corrections (e.g., parole board, extended supervision orders, or preventive detention); health assessments of fitness to plead, stand trial, or insanity; presentencing reports; and the provision of expert reports for other trial processes (e.g., defended hearings as instructed by the Crown or the defence). All of the psychiatrists disclosed significant experience working within the MHCATA. A smaller group (less than five) psychologists prepared reports within the wider forensic mental health or youth justice contexts.

In summary, in addition to their IDCCRA work, all specialist assessors had prepared reports with reference to other legislation that addressed issues of compulsory assessment and treatment or a loss of liberty.

3.3.3 Experience in the Specialist Assessor Role

The level of experience ranged from specialist assessors with less than 3-years' experience to those with more than 10-years, with over half of the participants falling in the more than 10-years' experience bracket.

3.3.4 Research preparation and recruitment

Ethical approval

Ethical approval (Reference Number 20/362) was granted by the Auckland University of Technology Ethics Committee (AUTEC) on January 20, 2021 for a term of 3-years (see Appendix I: Application for Ethics Approval). The final participant interview occurred in May 2021, and no contact with the participants occurred after this time. The key ethical considerations are detailed below.

Consultation with Māori stakeholders

Cultural consultation was undertaken with TRT, a local kaupapa Māori organisation that provides care and rehabilitation to care recipients. TRT is the sole kaupapa Māori provider in New Zealand. As discussed in Chapter 1, there is a disproportionate number of Māori care recipients, which required careful attention and consideration.

A powhiri and hui was held on July 23, 2020 at the TRT head office, which was attended by care recipients staff from across all levels of the organisation. The focus of the consultation was to share information with TRT about the research proposal, receive information, and answer questions. The consultation was designed to ensure that the research was framed and conducted in a manner that is culturally sensitive and reflects the principles of Te Tiriti o Waitangi as articulated by the Courts and the Waitangi Tribunal.

Specifically, the *Hauora: Report on Stage One of the Health Services Outcomes Kaupapa Inquiry* "Hauora Report" (Waitangi Tribunal, 2019) sets out five principles that apply to the health and disability system. These are tino rangatiratanga, equity, active protection, options, and partnership. The Te Tiriti o Waitangi Framework (Ministry of Health, 2020c) operationalised how Te Tiriti o Waitangi obligations can be met in day-to-day health practice, thereby providing a point of reference for the study. Feedback from the tangata (care recipients) expressed a sense of excitement and gratitude for being able to have a “voice that matters” (see Appendix C, email dated 29/7/20).

This consultation led the researcher to reflect on the emphasis that should be placed on Te Tiriti o Waitangi when exploring specialist assessors’ practice, in addition to other domestic and international rights instruments. The process also enabled the researcher to consider issues related to liberty interests and human rights that may be particular to Māori care recipients. Further, the consultation reinforced the central role tikanga plays in kaupapa Māori service delivery (e.g., powhiri, karakia, whānaungatanga); and identified areas of tension that can arise due to generic funding models used by the MOH (e.g., the lack of choice afforded to care recipients in vocational programmes). Subsequent amendments to the interview schedule reflected this consultation process.

A second hui was held during the data analysis phase to share findings and seek feedback. This process is detailed later in this chapter.

Recruitment

Participation was voluntary, and invitations were disseminated by a third party, namely the Project Administrator, Disability Directorate, MOH. The fact that the invitation came from the MOH could be perceived as problematic. However, this was carefully considered at the outset. Given specialist assessors consist of psychologists and psychiatrists there was no single professional organisation that could be utilised to share the invitation. Secondly, the researcher is a specialist assessor therefore attention was given to the ethical concerns associated with recruitment practices during insider research (Greene, 2014). The Project Administrator was provided with the invitation (Appendix D) and the list of specialist assessors who were excluded from the study due to a conflict of interest (e.g., specialist assessors who were in a supervisory relationship with the researcher). No additional communication from the MOH was provided to the specialist assessors about the research.

Specialist assessors could register their interest in participation with the researcher, by email. Upon submitting an expression of interest in the study, potential participants were given a Participant Information Sheet (PIS), which provided relevant information about the study (Appendix E) and the consent form (Appendix F). Fifteen specialist assessors expressed an interest and were accepted into the study.

The PIS included the project title, a description of the purpose of the study, and information about how the findings would be used. The selection criteria were outlined, and participants were informed of the interview procedure, how the information would be recorded, and their ability to withdraw from the study at any time. If participants chose to withdraw from the study, they would be offered the choice of having their data removed or allowing it to continue to be used.

The participants were all health professionals with experience in obtaining informed, voluntary consent. For this reason, the participants were asked to complete and return the consent form in advance of their interview (using regular post or emailing a scanned/photographed copy). When this did not occur in advance of the interview, the primary researcher completed face-to-face or oral consent protocols.

Participants had the option of face-to-face or Zoom interviews, either by preference or because their location was prohibitive to travel (e.g., outside the funding provisions of the study). The COVID-19 lockdowns created further constraints, making face-to-face interviews impossible during these periods.

It was made explicit to all participants that specific care recipients were not the focus of the research. A script was used at the outset of the interview process to remind participants not to identify specific care recipients (See Appendix G). The research was not inquiring into any specific care recipient’s offending behaviour, and the researcher did not request any health information specific to care recipients. Participants were also asked to de-identify care recipients when talking about any scenarios that they had encountered through their practice. If such information was volunteered, it was redacted from the transcripts and does not appear in the thesis or any other publication drawing on the research.

The participants could refer to third parties (e.g., lawyers, other professionals, services, Courts, or organisations like the police). However, identifying information was not solicited and, if given, was redacted prior to use in the final thesis.

For privacy, the participants were numbered from 1 to 15 based on the order interviews occurred. In addition, letters were used to signify the specialist assessor's geographical location. For example, A for Auckland and W for Wellington. This system enabled easy identification of any regional differences in practice. This system is used to attribute direct quotes in the thesis.

3.4 Data Collection

The goal of data collection was to gather plentiful and complex data to support a nuanced and detailed analysis (Terry et al., 2017). Data were collected by way of one-on-one interviews.

Most interviews were 60 to 90 minutes in duration. However, some were longer, with one taking 3-hours. All participants, except for two, opted to use Zoom. The interviews were recorded digitally by way of a recording device or using Zoom's built -in recording function. Handwritten fieldnotes were taken during the interviews to ensure that there was an additional brief record should technical difficulties arise.

A semi-structured interview schedule was devised to illuminate participants' perceptions of human rights. See Appendix G for the schedule of questions and accompanying vignettes. The schedule was derived from the literature review, along with supervisory input and cultural consultation. The vignettes reflected the research questions and were informed by issues that have been derived from issues published in legal decisions. It was anticipated that the vignettes would resonate with the specialist assessors' practice experiences and generate focused discussion about human rights perspectives.

The vignettes were provided to the specialist assessors 24-hours before the interview to orient them to the focus of the interview. All specialist assessors expressed that the vignettes were helpful. In response to vignette A (see Appendix B), several assessors disclosed that reference to the CRPD generated curiosity, and in some cases a level of discomfort about perceived gaps in knowledge. These discussions afforded opportunities to discuss how the specialist assessors managed these responses and other issues in relation to human rights education. If the issues contained in the vignettes did not naturally arise over the course of the interview, an open ended question was utilised at the end to canvas whether the specialist assessor wished to make any further comment on the vignettes.

The vignettes, therefore, framed the interviews, and are referred to, at specific points within the findings chapter. Together they aimed to mitigate the risk that specialist assessors may share confidential case information due to their familiarity with the researcher as an insider. A mock pilot interview was undertaken to test and refine the interview schedule with another researcher familiar with the area. The data were not included in the analysis.

The interview schedule and vignettes ensured a consistent approach to all interviews while allowing latitude for the exploration of emerging topics (Bryman, 2004). The use of open-ended questions is considered ideal for an exploratory study where little research has been previously conducted, as was the case for this research (Bryman, 2016).

Vignettes are commonly employed as an adjunct to interviews in qualitative research to allow actions in context to be explored (Barter & Renold, 1999; Hughes & Huby, 2002). The aim of the vignettes was to focus participants on a situation where human rights and liberty issues arise in ways that are relevant to the research questions. It was anticipated the vignette would provide an opportunity for differing interpretations to be elicited from a uniform situation (Barter & Renold, 1999; Hughes & Huby, 2002).

A potential disadvantage of using vignettes is the foreclosing of areas of responding (Barter & Renold, 1999). For this reason, open-ended questions were used to introduce the vignettes, followed by prompts aimed at encouraging the specialist assessors to expand further as required.

Specialist assessors were not interrogated on their understanding of the CRPD, the IDCCRA, other legislation, or professional codes. Rather, the interview questions explored commonly used terms such as the liberty interest, human rights, the least restrictive option, and proportionality. The questions aimed to explore why the specialist assessors do or do not practice in a particular way regarding human rights perspectives when writing reports; to identify areas where they feel enabled or constrained in respect of raising human rights; and to articulate any areas where dilemmas and tensions arise.

3.4.1 Method of data analysis

Reflexive thematic analysis

Interpretive description allows for a flexible approach to method choice (Thorne, 2016). Reflexive thematic analysis was viewed as a good fit because of the rigorous approach to theme development and the exploratory nature of the research question (Braun & Clarke, 2022).

Reflexive thematic analysis was used to analyse the interview transcripts and elucidate the main patterns and themes in the data (Braun & Clarke, 2022). Thematic analysis is a widely used tool for analysing qualitative data in psychology and other disciplines. The method acknowledges the subjectivity of the researcher as a primary tool in the analytic process, recognising that the resultant interpretation cannot be objective or accurate but can be underdeveloped or shallow in the absence of strong reflexive processes or sufficient immersion in the data (Braun & Clarke, 2022). Themes do not emerge from the data. Rather they are constructed by the researcher in the context of systematic engagement and a foundation of theoretical assumptions (Terry et al., 2017).

Reflexive thematic analysis takes the form of a six-phase approach as outlined by Braun and Clarke (2006; 2022) and described in other publications (Terry et al., 2017). The six phases of analysis were implemented in the current study as described below.

Familiarisation with the data. Following each interview, the recordings were professionally transcribed. The transcripts were then reviewed (by listening to the recordings) to check for accuracy and begin the familiarisation process (Braun & Clarke, 2022). The transcripts were anonymised, and redactions were made where necessary. A list of prompts was developed to give a consistent framework for reviewing the interviews. The researcher was interested in several factors: the way that participants oriented themselves to the questions; the assumptions and worldviews they drew from; the potential implications of their accounts for themselves and those around them; and any emotional responses to the questions.

The goal at this stage was to move systematically through the entire data set, keeping notes and making early analytic observations. The transcripts and memos were shared with the supervisory team to enable an audit trail for early analytic observations and feedback (Merriam & Tisdell, 2015). This process enabled familiarisation and discussion about the patterns observed within the data. An initial focus was the identification of novel or anticipated findings. In addition, it provided an opportunity for different lenses (e.g. legal and sociological) to be employed. A key observation made by the supervisory team was the degree of candour shown by the participants. This was attributed to both the researcher's interviewing style but also her credibility as an insider or bearer of shared knowledge and experience (Thorne, 2016).

The audit process facilitated an evaluation of the effectiveness of the interview schedule and the primary researcher's interviewing style. Where adaptations were required, they were made. For example, following a debrief of the initial interview, the interview schedule was amended to include an additional question that explored the factors that had shaped the participants' view of the specialist assessor role. This question derived data about specific training experiences as well as their disciplinary and employment histories.

The audit approach reflected the notion that best-laid plans and reality do not always align (Thorne, 2016). Additionally, this strategy supported reflexivity about the dual role the researcher brought to the research process as both a practising specialist assessor and a researcher (Braun & Clarke, 2022; Henwood & Pidgeon, 1992).

Throughout the data collection process, the researcher was mindful of ensuring she adopted a researcher's mindset and skills when interviewing, rather than defaulting to the specialist assessor role. Within each interview the meaning of jargon or other commonly known clinical/legal terms was checked by the researcher to minimise the assumptions of meaning or knowledge that could arise.

The second phase of reflexive thematic analysis involves the generation of initial codes. This phase was approached in two stages. Firstly, an initial precoding stage aimed to identify segments of interest and potential relevance, and then a second stage refined and synthesised these pre-codes (Braun & Clarke, 2022; Terry et al., 2017). Prior to embarking on the first phase of code development, the researcher reviewed the proposal to reorient herself to the literature review, the gaps identified, and the primary research questions. This information was compiled into a brief checklist.

Hyperresearch software (Hesser-Biber et al., 2015) was used to assist with the pre-coding process. Alongside this process, memoing was undertaken to record analytic reflections. Where these reflections felt important and related to areas covered in the literature review, the researcher took time to reread or search for articles, refer to legal judgements, or reread other texts like the *Code of Ethics for Psychologists Working in Aotearoa/New Zealand* (New Zealand Psychological Society et al., 2002). Detailed notes were made of these activities and reflections so that they could be drawn upon later in the writing process.

The initial focus was to systematically describe or label all segments of the transcript that seemed of interest or relevance to the research question. The goal was to remain broad, open and descriptive, resisting the urge to shift into a more analytic space (Braun & Clarke, 2022). Some codes were brief and pithy, while others were more detailed to ensure that the meaning and context were clear. Segments of text were frequently tagged with more than one description to capture nuance and detail, reflecting the notion that codes are the tools upon which analysis is built (Terry et al., 2017). Many codes were derived, mirroring the dense nature of the interviews.

Problems were encountered trying to refine the codes using the software. For this reason, the decision was made to return to working with hard copies of the transcripts. During this next stage, the transcripts were reviewed with a more critical and informed eye. Sections relevant to the research questions or other topics of interest were moved into a separate table. The pre-codes initially assigned were reviewed and refined by sorting them in a master list and then into a spreadsheet organised by categories of shared meaning and topic. This approach supported a process of immersion where deeper analytic insights developed (Braun & Clarke, 2022). From here, a process of collapsing the refined categories occurred by identifying like codes (Trainor & Bundon, 2021). By repeatedly revising the codes and interrogating the labels for shared meaning, a set of 120 codes with specific descriptions was developed.

<u>Searching for themes.</u> Braun and Clarke (2022) stated, “a theme has to capture a wide range of data that are united by, and evidence, a *shared* idea, sometimes quite

obviously, and sometimes far less obviously, and sometimes in different ways" (p. 77). They likened themes to a gem with many facets. This stage was approached in two ways that allowed visual mapping and sorting. The goal was to move beyond the topic summaries used during the coding stage towards more analytic conceptual patterns.

The first step was to brainstorm some early candidate themes using a series of mind maps. The list of initial candidate themes was: no clear mandate to address human rights; inconsistent approaches to human rights issues; unease; no monitoring or peer review of specialist assessors inhibits reflective human rights practice; and structural and systemic issues prevent a rights-based approach. The first thematic map was shared with the supervisory team and discussed. Two further thematic maps were developed. Each visual was dated and labelled first cut, second cut, and so on. To test the themes, the researcher attempted to write up one theme which quickly illustrated that the boundaries of the candidate themes were not clearly delineated.

To prepare for the second mapping process, primary texts were reread along with additional literature on thematic analysis. In addition, online lectures by Braun (2021) and Trainor (2021) were viewed. The goal was to identify problems commonly encountered in theme development and how to avoid or combat these. Consequently, the next visual stage involved printing the codes and cutting them into strips of paper to physically cluster codes into candidate themes. This approach provided the flexibility of easily trying new combinations. Each combination was photographed. Eventually, five candidate themes, with subthemes, were developed.

The information was translated into a word document that clustered themes and subthemes with supporting codes ready for the next stage of analysis. The content of this document was shared within a supervisory meeting for discussion.

Once five potential themes were developed Thorne's (2016) method of writing theme descriptions to test the strength of theme development was employed. This process involved asking reflective questions like:

- Is the theme viable?
- Are the boundaries clearly identified?
- Is there enough meaningful data to evidence the theme?

- Are the data contained in the theme too wide-ranging?

To provide the supervisory team with an in-depth view of the relationship between the themes and the data extracts, two themes were written up to test the structure of each theme. Feedback was incorporated into the next stage.

Reviewing themes. In this phase, the viability and scope of candidate themes were reviewed and refined by re-engaging with the transcripts (Braun & Clarke, 2022) and using a third visual mapping strategy. The strategy involved drawing a visual of a gem with facets to further refine themes and subthemes. This approach proved to be successful, allowing the research to move into a more creative, generative space (Thorne, 2016). As a result, some themes were entirely revised, and others were split into distinct themes. The focus of analysis then shifted to the themes and subthemes that were most relevant to the research question and could be evidenced in the dataset. Findings that were unexpected yet conveyed ideas that seemed of importance to the participants were an additional focus.

Defining and naming themes. According to Braun and Clarke (2022) this phase involves “further development around your themes, as well as more precise analytic work refining your analysis” (p. 108). This process was achieved by rewriting brief theme definitions that captured “the central organising concept or key take-away point” (Braun & Clarke, 2022, p. 108) of the theme. The research questions were front of mind. As each theme definition was completed, the same process was used for the subthemes. Each theme was colour coded. The final phase of this stage involved going back to transcripts and identifying extracts that best illustrated the themes and subthemes. The extracts were colour coded in readiness for the final stage of producing a written narrative.

Although the above stages are described in a linear way, an iterative process was utilised between stages three, four, and five to facilitate greater immersion in the data. The familiarisation notes were also revisited on several occasions, providing a helpful shorthand way of taking a ‘bird's eye view’ of the dataset.

As described above, multiple ways of ordering the data were trialled. The use of free writing techniques facilitated the theme definition process by forcing the researcher to reflect upon the boundaries of each theme and the relationships within and across themes. In this way, the process of thematic analysis aligned with interpretive description in that:

> the challenge becomes one of immersing oneself in the data, capitalizing on a strategic sequence of objective and subjective engagements with the data, and knowing the data well enough to be able to propose several options in ordering and organizing them such that the final presentation portrays the best possible representation of the important meanings they contain. (Thorne, 2020, p. 157)

The final phase of thematic analysis involved the telling of a story based on and about the data, making sense of patterns and diversity of meaning (Terry et al., 2017). Decisions were made about the optimal organising structure for communicating with the intended audience (Sandelowski, 1998; Thorne, 2020). Extracts were carefully chosen to illustrate the points made. The scholarship of qualitative research drawn upon for this thesis advises against the quantification of findings (Braun & Clarke, 2022; Thorne, 2016), which is reflected in the style of reporting. The exception to this rule is the reporting of an outlier, where is it acceptable to quantify. As the writing process unfolded, further refining of the analytic process occurred, shaping the final product.

3.5 Rigour and Trustworthiness

3.5.1 Considerations specific to the cultural data

As discussed above, five questions were added to the interview schedule to reflect the issues raised within the cultural consultation. The specialist assessors engaged deeply with these questions, and the researcher was concerned about treating these data in an appropriate and respectful way, believing the data to be instructive and informative. The researcher was conscious of her identity and the lens brought to the study as a clinical psychologist, specialist assessor, and researcher who is Pākehā. The researcher was also conscious that while specialist assessors were the focus of research, care recipients are both impacted by our practices and are important stakeholders.

The issues were reflected upon in supervision, and it was agreed that further input was required to identify the most suitable way to treat the data. Academics within the wider

AUT Health and Environmental Sciences faculty, the University of Otago, the University of Canterbury, and the University of Waikato were approached, and a range of scenarios explored, including cultural supervision and/or the incorporation of a te ao Māori world view by having an appropriate person comment on or respond to the analysis.

As part of this consultation process, Associate Professor Armon Tamatea, University of Waikato, provided a list of suggested readings, including Te Ara Tika (Hudson et al., 2010) and indigenous research practices (Smith, 2012), to guide analytic reflections and decision-making that could be incorporated into the methodology. The concept of relational accountability as a research ethic and how it considers broader notions of research, such as relevance, reciprocity, and responsibility for the relationship (Wilson, 2008) was discussed. In accordance with these principles, Associate Professor Tamatea suggested taking the findings back to the TRT (given the important role this initial hui had played in the research design) to share the themes arising from the research and capture the responses of an informed group.

It was identified that this approach would facilitate an opportunity for the views of care recipients and the RIDSAS staff to shape the analytic process and provide an alternative lens from a group that is affected by specialist assessor practice. It was envisaged this process would recognise that specialist assessor practice is embedded in a wider social context and shapes outcomes for both individuals and the collective. The naturalistic element of this approach and the inclusion of service users was viewed as a strength.

The second powhiri and hui was held on July 26, 2023 at the TRT head office, which was attended by care recipients and staff across multiple levels of the organisation. At this second hui a brief description of the research process was shared by the researcher, along with feedback about how the initial hui held in 2020 shaped the questions asked of the specialist assessors. A summary of the findings relating to themes of rehabilitation, liberty, cultural factors, and human rights were shared with the group. A member of the supervisory team attended the hui and made notes to honour the contribution of care recipients and staff members (see Appendix H). The researcher reflected on the feedback during the final stages of the analytic process and while constructing the discussion.

3.5.2 Quality of the research

Research projects should endeavour to ensure quality at all stages of the process (Bryman, 2016; Morse, 2002). Reliability and validity are the criteria traditionally used to evaluate the scientific value of quantitative research in the discipline of psychology. In contrast, within the qualitative field, researchers have assumed a range of positions in respect of the salience of these measures. In their seminal writings, Guba and Lincoln (1981) asserted that reliability and validity do not translate well onto qualitative research. In 1985, the authors further refined their work, proposing an alternative set of criteria to achieve credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985b). These ideas garnered widespread acceptance within the qualitative research community.

In the subsequent years, a range of alternative quality guidelines (Elliott et al., 1999; Henwood & Pidgeon, 1992; Merriam & Tisdell, 2015) have been developed. Most are rooted in Lincoln and Guba's (1985b) concepts. Running alongside these developments was debate within the literature about the universality and categorisation of quality criteria (Cho & Trent, 2006; Denzin & Lincoln, 2011; Willig, 2008). This debate has contributed to the evolution of methodologically specific approaches to quality. In addition, other scholars have argued that the concepts of reliability and validity remain of value and can be achieved by using verification strategies throughout the research process (Morse et al., 2002).

Insider research can generate specific ethical challenges due to the researcher's membership of the very groups they are examining (Corbin Dwyer & Buckle, 2009). Commonly recognised methodological safeguards fall into several categories including, explicit communication of positionality, disciplined bracketing processes to identify preexisting biases or assumptions, reflexive practices, and careful management of sample selection (Corbin Dwyer & Buckle, 2009; Greene, 2014). The credibility, transferability, and confirmability criteria devised by (Lincoln & Guba, 1985a) are viewed as having particular utility within insider research (Corbin Dwyer & Buckle, 2009). The following sections detail how these approaches were integrated in the study. However, the researcher's positioning was outlined in detail within Chapter 1 and issues specific to insider research were also addressed in earlier sections of this chapter.

3.5.3 Generic quality considerations

The following paragraphs describe how trustworthiness criteria proposed by Lincoln and Guba (1985b) were incorporated early on and throughout this study. Once a methodological approach was settled upon, the gaze was widened to include more specific approaches advocated by Thorne (1997, 2016). How these approaches were accommodated is discussed at the end of the section.

Credibility refers to the extent to which the researcher's accounts represent participants' descriptions and interpretations of the topic under study (Bryman, 2004). One strategy to achieve credibility is respondent validation or member checking. In the current study all participants were given an opportunity to review their transcripts, although none took up this invitation. Having considered the potential negative impacts on validity outlined within the literature, a decision was made not to utilise member checks throughout the analytic process, (Morse et al., 2002; Sandelowski, 1993). Participants were given the option to receive a summary of the findings at the completion of the research process. All took up this invitation.

Peer review is a strategy that can enhance credibility because it facilitates opportunities to receive feedback about the process of the study, congruence of the emerging findings with the raw data, and preliminary interpretations (Greene, 2014; Merriam & Tisdell, 2015). This was achieved through the presentation of the preliminary themes at the Australian and New Zealand Association of Psychiatry, Psychology and Law (ANZAPPL) annual congress held 23rd-25th November 2023 (McFadden, 2022) in Adelaide, Australia. It was also conducted by way of informal conversations with specialist assessors who did not participate in the study. Others in the sector (e.g., forensic practitioners, coordinators, and care managers) showed interest in the study, providing further opportunities for discussion and feedback.

Transferability reflects the degree to which the findings can be generalised to other relevant practice contexts (Lincoln & Guba, 1985b). In this case, the relevant practice context is specialist assessors or other clinicians working in forensic settings. The study tried to strike an appropriate balance between describing the participants' relevant disciplinary backgrounds and current work contexts while preserving their anonymity. Data analysis also sought to provide a rich account, in the tradition of thick description

(Ponterotto, 2006), supported by the appropriate and balanced use of extracts from the interviews (Braun & Clarke, 2022).

Dependability ensures transparency of research procedures so that others can replicate the approaches taken (Bryman, 2004; Merriam & Tisdell, 2015). A detailed description of the research procedures has been outlined in this methodology chapter. In addition, a range of audit procedures were employed, such as regular journaling of decision-making; the sharing of memos, codes, preliminary themes, and draft chapters with the supervisory team; and the dissemination of supervisory meeting minutes.

Finally, confirmability recognises the subjective nature of the research process by acknowledging the influence of the researcher on the outcome (Braun & Clarke, 2022; Bryman, 2004). To preserve integrity, the researcher must acknowledge their impact on the collection and interpretation of the data by utilising reflexive processes (Braun & Clarke, 2022; Bryman, 2004; Henwood & Pidgeon, 1992). As described earlier, the insider role of the researcher was acknowledged from the outset, and several steps were taken to identify the personal and professional values that could impact the research process.

Firstly, the researcher engaged with a bracketing interviewed conducted by an academic external to the supervisory team with knowledge of the practice context. A transcript was then shared with the supervisory team (D. Sutton, personal communication, February 3, 2020). This interview revealed that the values of justice, fairness, and pragmatism were important to researcher, as was taking an individualised approach to needs and risks of each care recipient. Further it was identified that the researcher held assumptions about how the specialist assessors' disciplinary backgrounds and work experience (e.g., correctional versus disability training) might impact their view of the role. The interviewer suggested that these assumptions were kept in mind during the analysis process and discussed with supervisors.

Secondly, a range of structured reflexive tasks were undertaken with the aim of making visible the assumptions, worldview, bias, and theoretical assumptions held by the researcher. These issues were revisited within the supervisory context and within ongoing reflexive journaling during the analysis and writing phases.

3.5.4 Methodologically specific considerations

In her discussions about devising a credible study, Thorne (1997, 2016) placed emphasis on the moral obligation held by a health researcher and epistemological integrity. Although these principles were touched on earlier in this chapter, they are discussed in more detail below.

Moral defensibility

Dealing first with moral defensibility, Thorne (2016) observed that health researchers needed to be cognisant that their work could be applied in clinical settings, even when analytic assumptions and limitations were clearly stated:

> the quality standards for health science research must therefore be somewhat different from standards in other theoretical fields... Health science disciplines exist because of a social mandate that entails a moral obligation towards benefiting individuals and the social collective. (p. 233)

Thorne goes on to state that careful consideration and self-critique of the following factors is required to ensure moral defensibility within an interpretive description study:

- the reasons for undertaking the research;
- the possible uses of the findings;
- how the research contributes to and fits within the development of disciplinary science; and
- recognition of contextual or tacit factors that influence the research process.

Each of these factors was considered from the outset of the study and were revisited using reflexive processes outlined earlier in this section and discussion within the supervisory team. In addition, the use of reflexive thematic analysis enforced a level of rigour to the research process because each phase required the researcher to clearly articulate and justify decision-making, keeping both the final product of the thesis and the audience in mind. The notion that care recipients are also recipients of specialist assessor practice was made explicit from the outset, recognising the moral obligation held by the researcher.

Epistemological integrity

Epistemological integrity requires the interpretive researcher to demonstrate a "defensible line of reasoning from the assumptions made about knowledge through to methodological rules by which decisions about the research process are explained" (Thorne, 2016, p. 233). In other words, the researcher must demonstrate congruence between the methodology, research question and method of data analysis.

As discussed in the first section of this chapter, work undertaken at the research development stage determined a strong fit between interpretive description and the exploratory nature of this study, which focused on a niche group of forensic practitioners working with a vulnerable population. There was also natural synergy between reflexive thematic analysis and interpretive description due to the emphasis on an iterative process of drawing rich, meaningful, and patterned insights from the data.

The method of analysis demanded prolonged engagement with the data (Thorne, 2016). Although the participants were interviewed only once, a large volume of dense and rich data were derived. The analysis sought to identify patterns within and across the dataset. Reflexive thematic analysis allowed for the facets of each theme to be explored and refined. The researcher recognised the possibility of constructing multiple meanings from the data, which helped her to avoid foreclosing on the coding and thematic structures too early (Terry et al., 2017; Thorne, 2016). The use of an inductive reasoning approach and the associated logic and audit trails are described in depth to enable the readers of the study to make an independent determination on credibility (Morse, 1994). Where metaphors are utilised, they were carefully chosen (and interrogated) to reflect the tone and intent of the data provided by the participants (Braun & Clarke, 2022; Janesick, 1994).

The current study does not claim to be seeking a single truth (Lincoln & Guba, 1985b). Rather, it seeks to illuminate an understudied area of specialist assessor practice within its natural context by eliciting the perceptions (Bryman, 2004) of the specialist assessors and considering the wider implications of their perceptions and experiences. Almost two-thirds of specialist assessors in the available national pool participated in the study, which provided an indication of the value and relevance placed on the research question as a professional group. The need to honour the data provided by the participants and produce a report of meaning was held in mind from the outset of the study. Thorne (2020) described this obligation as follows:

> In the applied research world, the “so what” is always a particularly important element of a qualitative report. This is the point when the investigator turns back to face the discipline to make explicit what can and cannot be taken from the findings to inform practice, as well as what requires further investigation. (p. 159)

In summary, the researcher’s clinical experience is explicitly acknowledged and positioned by interpretive description. Further, the method of thematic analysis provides a framework for a reflexive, systematic and rigorous approach to data analysis and the production of a meaningful thesis.

Chapter 4 Findings

4.1 Overarching Theme: The Implicit Nature of Human Rights

At first glance, human rights did not appear to be clearly or explicitly integrated within specialist assessor practice. Nor were human rights well-articulated in the form of a cohesive rights framework by the participants. Nonetheless, after closer examination the tacit relationship between human rights and professional clinical practice was an underlying and distinct theme within all interviews. This was well expressed by one specialist assessor: "*It's the subtext of the values that underlie the way in which the reports are being written*" (05.W).

Six themes were derived from the data analysis. All are linked to the superordinate theme. Theme one draws an obvious link to human rights by examining the knowledge and practices of the specialist assessors. The remaining themes illustrate the less obvious ways that the specialist assessors were contemplating or communicating about human rights or liberty interests of care recipients. The related tensions or dilemmas arising as the specialist assessors expressed human rights perspectives are described. These patterns of meaning are categorised as: the legislative framework; service delivery; cultural factors; the nature of the role; and the mechanisms for overseeing the integrity of specialist assessor practices.

4.2 Theme One: No Single Approach to Human Rights Knowledge and Practice

The interviews revealed a range of interest and experience in human rights matters. Some specialist assessors appeared to have had more exposure to, and knowledge of, human rights law than others. The absence of a 'one size fits all' approach was captured by one specialist assessor who described human rights as, "*A sticky topic, it's complex and depending on what your perspective is will affect your outcome or your answer*" (15.A).

A small group of specialist assessors appeared well versed in the relevant laws and expressed a strong interest in keeping abreast of the legal judgments relating to care recipients and issues of liberty and other human rights. However, most of the specialist assessors appeared to lack confidence or clarity when discussing the role that human rights have or could play within their practice. These specialist assessors were candid about their lack of exposure to, or knowledge of, international and domestic human rights instruments. Their descriptions of human rights indicated that their knowledge of human rights was most likely informed by personal and professional value systems, and some knowledge of key concepts, rather than specific human rights frameworks.

In essence this theme explores the foundational knowledge specialist assessors relied upon to define the human rights of care recipients, and their related professional obligations as specialist assessors.

4.2.1 Assessor knowledge of human rights

A whole range of human rights issues were raised by the specialist assessors. Human rights that protect a care recipient’s freedoms were a focus for some within the interviews:

> Well, I guess the basic level (of human rights) it is to have the same rights as we do within the criminal justice system… freedom from things and freedom to do things in life. (04.W)

Other common examples were: the right *to* freedom of movement, association, and speech; right to liberty; and the right to equity, choice, or self-determination. The specialist assessors appeared to use the terms self-determination and autonomy interchangeably. In addition, the specialist assessors who referred to tino rangatiratanga used it in relation to individual care recipients and their whanau or family. Several Specialist assessors understood the human rights of care recipients to mean freedom from discrimination and equal treatment. Fairness and principles of natural justice were emphasised:

> that means their right to be treated in the same way as anyone else and not to be arbitrarily detained or subject to processes merely because they happen to be less capable than the average person really, and so that they are being dealt with according to the proper statutes of law… So I guess that’s the thing I’d be thinking about most, there’s got to be a process which is completely fair. (02.W)

Others described the importance of dignity in relation to other rights:

> Well first of all that the care recipient has human rights including the right to be treated with respect and dignity and to be given information and not to be discriminated specifically because they have an intellectual disability. (12.W)

Finally, specialist assessors were also alert to the subtle ways in which clinicians could discriminate against persons with intellectual disabilities due to biases:

> It always seemed to me that people with intellectual disabilities were talked about in terms of their behaviour. And yet we describe motivation and emotional intent in other people. (05.W)

This extract could be interpreted in two ways. It suggests that assumptions about the internal world of people with disability run the risk of being othering and discriminatory. Alternately, good intentions in the form of paternalism could have the unintended effect of marginalising care recipients within decision making processes.

Rights to healthcare, rehabilitation, and well-being

The specialist assessors emphasised the right of care recipients to receive help and appropriate treatment while subject to compulsory care: “*That is a human right, everybody should have the right to have vocational and therapeutic and cultural (input)*” (03.A). Others provided concrete examples of being attuned to the quality of the care environment, and how the care recipient’s primary needs were being met:

> The review process is another mechanism in the system by which we make sure people are safe and well and that their well-being is taken care of and that the fundamental rights to care and support and warmth and accommodation and so on are attended to. (01.W)

Apparently, the specialist assessors were comfortable assessing whether service providers and/or coordinators were meeting their obligations around a care recipient’s rehabilitation entitlements.

Other specialist assessors placed more emphasis on ensuring there was sufficient detail in their reports to shape the therapeutic components of the care and rehabilitation plan. However, the degree to which a specialist assessor should involve themselves in the detail of therapeutic plans was contested:

> I think assessors are sometimes trying to take the perspective of some grand overseer who's going to make sure that everything in every domain is spot on. I don't believe that's our remit. I think that goes too far… I'm not a fan of the grand overseer and drawing up detailed treatment plans and so on, 'cause I don't think that's our role. (1.W)

Of note, some specialist assessors were actively considering the most *effective* rehabilitation option in addition to the least restrictive option. This was generally communicated to the court in the form of multiple options for disposition or placement, accompanied by a pros and cons analysis. Some specialist assessors provided examples of how the rights to liberty and rehabilitation could conflict:

> Sometimes I've had other staff who are involved in the assessment going for the least restrictive [option] and me going for a more restrictive because I know the person has had quite a long history of mild sexual offending and never had any rehabilitation …so it's just going to keep going. But they [the other staff] would rather not bring someone [in the IDCCRA]. Not address it [sexual risk]. I think [they] have the idea maybe it [the sexual risk] will just go away. (12.W)

This extract provided an insight to the practice challenges that occur when professional groups promote different rights at the same time. In addition, implicit to the specialist assessors' considerations was the idea that effective rehabilitation could promote the care recipient's liberty interest *and* the public protection interest in the longer term because the risk of reoffence was meaningfully reduced.

Ethical codes

Within their specific disciplines of psychology or psychiatry, specialist assessors are ethically obligated to be sensitive to the welfare and rights of the individuals they work with and all members of society. Over a third of the specialist assessors reported that their knowledge of human rights was derived from formal clinical training in ethical codes. For the psychologists, this was the *Code of Ethics for Psychologists Working in Aotearoa/New Zealand* (New Zealand Psychological Society et al., 2002). The four principles are: respect for the dignity of persons and people; responsible caring; integrity of relationships; social justice; and responsibility for society. The specialist assessors who were psychologists either referred to this ethical code directly, or by naming the individual principles.

For psychiatrists it is the Code of Ethics (Royal Australian & New Zealand College of Psychiatrists, 2018). Rather than referring directly to the Code of Ethics, psychiatrists described the principles of, "*beneficence and non-maleficence, justice, and autonomy*" (15.A), which are commonly known as the four pillars of medical ethics.

All specialist assessors appeared to view the relationship between ethics and human rights as being self-evident. "*We have our Code of Ethics that's always something that has to be considered*" (11.A). The implied or inherent nature of ethics in specialist assessor practice was a strong theme. Some drew explicit connections between their ethical obligations and the ways they considered human rights within the specialist assessor role. For example, the ethical codes were perceived to provide an "*ethical frame*" (13.W) to assist clinical decision-making when considering competing rights, interests, and perspectives. For others, the relationship between ethical and personal values was subtle and subtextual:

> Well naturally I have a responsibility as a psychologist and just as a decent person but mostly as a psychologist for issues of responsible caring and welfare for society and so on. Those things go unsaid and I suppose they are implicit in all my work, in the way I approach clients and people and responsibilities, wherever they lie. But I wouldn't talk about them. (01.W)

How the specialist assessors applied ethical principles to practice regarding liberty or other human rights considerations is explored later in this theme.

The liberty interest

All specialist assessors had heard of the liberty interest; however, confidence or familiarity with the term varied:

> The liberty interests? It's not a term I would normally use, so not one I automatically think about. But I guess it's about the individual's freedom to make mistakes and to do things without being unfairly disadvantaged. I guess… So they have a degree of freedom which shouldn't be removed without just cause. (2.W)

One specialist assessor referred obliquely to liberty interest when they described a care recipient as "*not a free agent*" (08.A). Some specialist assessors viewed the liberty interest as the "*core*" (14.N) or "*fundamental*" (11.A) human right.

A small group of specialist assessors referred to a New Zealand case when asked about their understanding of the liberty interest. They stated that the case of *RIDCA (Regional Intellectual Disability Care Agency) Central v VM* [2011] was their primary point of reference for this set of human rights, "*I do take that into account (liberty interest) because I think we've been briefed [on] the VM decision and that the significance of the original offence should be considered as well as the totality of their risk*" (08.A).

Others referred to the *VM* decision indirectly. Nonetheless it was clear that key aspects of the case were guiding this participant's approach:

> The longer someone experiences a period of incarceration in relation to a single offence, or a single set of offences the more there is an onus on them being released, them being able to realise their right to liberty... the emphasis on that grows (liberty) obviously the longer that (restriction) occurs for. (05.W)

Another discussed the *VM* decision but placed more emphasis on specific legal principles:

> I really understand that (the liberty interest) to be in two senses. The wider sense of jurisprudence where one of the principles is that the person should have the least amount of their liberty deprived as

> necessary in the circumstances or appropriate for the circumstances… And then another liberty right… is proportionality. (03.A)

There was consensus amongst specialist assessors that individual and collective rights were always in tension for care recipients: "*I think they're (risk and liberty) two sides of the same coin. You're looking at the risk assessment and you're balancing that against liberty interests*" (02.W). In addition, specialist assessors stated that the requirement to consider the least restrictive option, meant that specialist assessors had to consider the liberty interest:

> I'm always trying to keep in my mind least restrictive. I'm always trying to keep in mind two competing views. No order or an order, secure or community, and arguing, almost having a mental pros and cons list for each of those binary choices. (08.A)

The dialectic between risk and liberty was also expressed as *rights and responsibilities*. Some specialist assessors stated that having an intellectual disability did not absolve people from being accountable if their behaviour placed others at risk of harm:

> I think in terms of risk, it is very much linked to liberty and the person does have a responsibility to learn to manage that and I think that's why the risk assessments are so important because what specifically are you going to manage. In my sense you have to be a responsible person to enjoy liberty. (13.W)

The above extract raises the question of how issues of liberty and rehabilitation are best approached for care recipients who may be unable (by virtue of their disability or other behaviour and personality factors) to benefit from rehabilitation. The IDCCRA is not a regime of preventive detention. However, in the context of a care recipient presenting with high risk and poor responsivity to rehabilitation questions are raised about what constitutes a reasonable length of time for persons to be detained under protective IDCCRA legislation. This issue is explored in theme two.

Equally, other specialist assessors identified that compulsory care within the IDCCRA could lead to restrictions on liberty that exceeded a prison sentence:

> If someone were to not go through the IDCCR Act system and they went through the prison system and let's just say they got a year, well then if we're looking at someone under the IDCCR that already starts off at let's just say 2-years and then gets extended… looking at proportionality… that is a consideration or it's a factor. (03.A)

Running through the specialist assessors' discussion of liberty interests were underlying themes of equity and fairness.

Domestic or international human rights frameworks

Only a small number of specialist assessors referred to specific human rights frameworks. One specialist assessor's knowledge of domestic and international human rights frameworks was comprehensive, but this was the exception:

> First of all, there will be the human rights in whichever setting they're in. Obviously, they're entitled to the coverage of the human rights wherever they happen to be, so if they're already at one of the providers, they will have a detailed list. Usually I think it's about 10 human rights that they have to follow for all care recipients… moving more broadly there's the human rights associated with being, as far as I'm concerned, a New Zealand citizen… Then moving up there's rights when you're being assessed. You've got the right to not participate in an interview and to hear what the interview's about and get a full knowledge of what's going to happen and informed consent at interviews… moving up there's rights within the IDCCR and the CPMIP Act. I can't remember exactly how they're worded, but I'm fairly sure each of them sets out rights for the care recipient… And then moving up there's United Nations Convention on the Rights of Persons with Disabilities and there's a European Convention as well. (03.A)

Others referred to the relevant frameworks in more generic ways: "*various charters probably both in the UN and in New Zealand (apply). And of course, the rights of people with disabilities*" (05.W).

CRPD

On balance, the level of familiarity with the CRPD was inconsistent. Many specialist assessors were candid about their lack of knowledge: "*No, 'cause I don't know anything about that (UNCRPD)… I figured I'd be honest about the situation*" (01.W). Another specialist assessor reported, "*I couldn't tell you anything about it*" (05.W). One specialist assessor was embarrassed that their lack of knowledge of the CRPD had precipitated a recent change in behaviour:

> I was probably a specialist assessor for a good 18 months before even hearing about you know the United Nations Convention for the Rights and I was a bit perturbed and professionally embarrassed that I hadn't oriented myself to that legislation within the context of the work that we're doing. (14.N)

This specialist assessor's reflection strongly suggested that they now view knowledge of the CRPD as important to the specialist assessor role.

specialist assessors working within the mental health sector reported being exposed to the CRPD via formal training or peer discussion forums, but that they had not received it within their specialist assessor training:

> For me, that has been more in the mental health framework that it's happened… But there are a lot of legal frameworks that address it (CRPD). We have specialist assessor training days once in a blue moon, every now and again. That's the sort of things we could hear about and have some really good discussions about how much we would involve that in our assessment, whether we think about that (CRPD) or leave it to the Courts. (02.W)

Of interest, all specialist assessors were receptive to training on the CRPD being included in the training days coordinated by the MOH.

Te Tiriti o Waitangi

Two specialist assessors explicitly referred to Te Tiriti o Waitangi as a human rights framework. The following quote illustrates how one specialist assessor uses Te Tiriti o Waitangi as a starting point for thinking about their human rights obligations:

> The way I would see it within the Aotearoa context is quite broad. Like I'm thinking about starting with Te Tiriti in terms of our obligations under Te Tiriti and also thinking about as a country what we have signed up to in terms of international conventions. (11.A)

This same specialist assessor was attuned to the CRPD and the United Nations Declaration on the Rights of Indigenous Peoples, sharing that it was personal interest in the topic rather than a professional impetus that led them to seek this knowledge:

> So rights of Indigenous peoples and rights of people with disabilities and rights for children and young people as well. But I guess I mean it's an interesting topic that you have because I don't know sort of how it's sort of explicitly, we think about it you know in terms of rights as clinicians and as specialist assessors. So, I mean I find legislation and Conventions really interesting but in terms of how explicitly we address those in our assessments, I don't think we do that terribly well. (11.A)

A second specialist assessor referred to rights inherent in Te Tiriti o Waitangi, "*Having the Treaty of Waitangi as one of our founding documents, there's the rights associated there in the sense of principles of the treaty*" (03.A).

On balance most specialist assessors expressed that they lacked the confidence or expertise to assert how Te Tiriti O Waitangi might relate to the human rights of care recipients. The differing interpretations of the Te Tiriti O Waitangi related to the two versions (English and Te Reo Māori), as presented in the literature review, were identified as a further challenge. The potential Te Tiriti o Waitangi holds for specialist assessor practice and the delivery of effective rehabilitation to care recipients is explored later in this chapter within theme four.

4.2.2 A continuum of human rights practices

The subtheme, ‘a continuum of human rights practices’ traverses how the specialist assessors’ knowledge of human rights translates into specialist assessor practices. There was a collective lack of clarity about whether or how specialist assessors should balance notions of *entitlement*, *obligation*, or *responsibility* within their assessments. The absence of a standardised approach for resolving these tensions was highlighted: “*There’s no algorithm or matrix or whatever that any of us have come up with that helps us weight and balance this issue over that*” (05.W). The way specialist assessors decide whether to respond, or not, to the human rights issues they encounter was, therefore, seen as a point of tension for some of the participants.

The human rights practices reported by the specialist assessors spanned the continuum from those who emphatically stated it was not their role to address human rights or related matters of law, to those who felt comfortable advocating or promoting human rights in their reports. Between these two positions the remaining specialist assessors took a more nuanced or flexible position characterised by *attunement* and *contemplation* rather than *explicit communication* of human rights perspectives. While three categories of practice were detected, there was some blurring between these categories.

Indirectly expressing human rights perspectives

Some specialist assessors equated attunement or contemplation of human rights and the liberty interest as, *“[holding] those things in mind”* (08.A). The issue of attunement to, rather than communication of, rights issues was illustrated when specialist assessors talked about the role of the judge as the decision-maker and person best equipped to consider the bigger picture:

> I am looking to give the Court as much of my specialised and expert knowledge as I can to enable the Court to come to a decision which is the best one that they can in the circumstance. I’m very much aware that I’m not the one making decisions and that I’m really there as an expert witness to the Court, and it’s the Court's decision. (02.W)

While all specialist assessors viewed their work as important and influential at disposition, some did not see their reports as determining of the outcomes for care recipients, "*There's a bigger system behind this and I really do see myself as a cog in that machine*" (01.W). Relatedly, one specialist assessor did not see their recommendations about the need for compulsion or order type and length as being set in concrete:

> I think that's all the things that some people like us have to weigh up when we provide an opinion. Sometimes, I refrain from providing much of a clear view. I think if a judge was reading a report, they'd say, 'well, what exactly is this person recommending'. At least, in a report like that, I hope I've laid it all out so that they can see the competing issues. (08.A)

Other specialist assessors spoke of resisting perceived pressure to give the court a specific recommendation about the need for a compulsory care order because they do not believe it is the specialist assessor's role to tell judges what to do. A reluctance to make strong statements about the human rights implications of their opinions and recommendations was managed as follows, "*I sometimes like to set out two (options) in the sense of I feel I'm informing the court but that I'm not actually a judge to set that decision*" (03.A).

In contrast, other specialist assessors appeared comfortable with providing a firm opinion on the need for compulsory care, "*[The role of a specialist assessor is] to formulate everything there is and make recommendations, just to answer a, you know a simple question really, that one question of yay or nay [order or no order]*" (04.W).

Another specialist assessor described their approach to describing, *not solving*, the human rights dilemmas that could be posed when considering liberty and risk:

> Because these cases so often do sort of bring into focus these really difficult decisions and dilemmas, it also feels so important to remember that these issues of liberty, the human rights of you know a person's individuals rights versus community safety is really the purview of the Court. I think often we get into an individual wrangle about is it fair or isn't it fair. And I think it's really important from a

> values base that we're thinking like that. And at the same time, it is the Court's decision and I don't take that as something to hide behind. (05.W)

Collectively, these findings may indicate that the specialist assessors were less willing to make strong statements about human rights than they were to give a firm opinion about eligibility.

Communicating human rights issues directly

A small group of specialist assessors reported that they explicitly documented their consideration of human rights matters in their reports. For example, these specialist assessors might document that they had considered the care recipient's liberty interest, issues of proportionality, or other human rights norms, such as specific CPRD articles within the assessment process. However, amongst this small group, there were differences in thinking and approach.

Those comfortable in the role of human rights promotion asserted that specialist assessors are ethically obliged to act in this way. One person asserted, "*We can advocate for our clients without being their advocate…it's important to consider that where the Code [of Ethics] prescribes a higher standard of conduct […] the psychologist should adopt the higher ethical standard*" (11.A). Another specialist assessor viewed the IDCCRA's focus on rehabilitation as providing a platform for addressing care recipients' human rights:

> thinking about how can we promote all of those basic human rights functions of an individual longer term away from a punitive framework and more of a rehabilitative framework. So I would hope that's our main job unless I completely missed the brief. (14.N)

A third discussed how they included the CRPD within their assessment process:

> I'd obviously look at the convention, have it right in front of me, and I'd look at each of the areas. I'd look at them and I'd think of them in relation to the case and see what I thought about them to make sure that we weren't breaching them. (03.A)

A fourth specialist assessor reflected on the importance of communicating a care recipient's "*preference to go via the normal sentencing pathway*" (10.A) to the Court. While this specialist assessor did not identify the reporting of the care recipient's wishes as rights promotion, their actions could be viewed in this way. This is because taking a person's rights, will, and preferences into account promotes the UNCRPD right of equal recognition before the law (Article 12). Other specialist assessors reflected on the tension that arises when care recipients expressed a preference for prison over IDCCRA disposition. The reasons why a care recipient might prefer a finite sentence and the consequent human rights issues arising for specialist assessors is explored in theme two.

The group with misgivings had adopted the practice of explicitly referring to the liberty interest in their reports but were *unconvinced* this was good practice. Often this practice was precipitated because lawyers had cross-examined the specialist assessor about their consideration of the care recipient's liberty interest:

> I was in an extension hearing once and the lawyer asked me if I had considered the persons increasing liberty interest. And I said yes, I had and she said, 'well you haven't written that in your report'. And I said, 'well I want to be a bit cautious because that feels like a bit of legal terminology and I'm here to provide the clinical information'. But I bore it in mind and I do actually write now that I am thinking about this. (05.W)

However, some specialist assessors engaging in this practice expressed concern that they were overstepping the boundaries of clinical practice.

Human rights: "Not my lane"

A small group of participants did not think specialist assessors should write about the liberty interest or proportionality in their reports. In addition, they believed it was inappropriate for specialist assessors to weigh liberty interests or proportionality against risk factors when forming an opinion about compulsion. One specialist assessor used a metaphor to illustrate their view:

> I don't consider proportionality… I haven't been trained in understanding proportionality or… like, for me, that is very much a

> legal concept. Yeah, I don’t see that as my lane, with my current knowledge. (13.W)

This specialist assessor held a similar position about citing the CRPD within their reports. Other specialist assessors stated that commenting on legal matters, such as the liberty interest or proportionality, would result in them, “*stepping into someone else’s territory*" (15.A) and outside of their, “*sphere of expertise*” (09.A). Others referred to the Court having to weigh multiple variables within the decision-making process that were, “*matters of the law*” (14.N).

There was shared concern that straying into the advocacy role would distort or undermine the neutrality of the specialist assessor role; thereby lessening the value of the clinical material available to the Court:

> *I don’t see the specialist assessor’s role at all as being an advocate for the individual. Because that also distorts your neutrality. So, you’re not there for the service user. You’re meant to be in a neutral position providing information and advice to the Court. And as soon as you step into either for or against. You’re siding, and you’ve lost your neutrality*. (09.A)

This specialist assessor emphasised the importance of maintaining the position of impartiality as set out in the High Court Rules (Schedule Four) Code of Conduct for expert witnesses (2016). For these specialist assessors remaining within the boundaries of the specialist assessor role was critical.

Summary

Although all specialist assessors were *attuned* to human rights issues, a diverse range of *practices* were reported. Most specialist assessors expressed misgivings about including an analysis of human rights, the liberty interest, or proportionality within their reports. A minority of specialist assessors saw the promotion of human rights as part of their role. Despite these differences, most specialist assessors appeared to be thinking about rights issues when completing their assessments.

The specialist assessors were concerned that offering an opinion on human rights issues would overstep the boundary between expert and advocate. The following extract conveys the sense of unease that was apparent in many of the specialist assessor's interviews:

> I think I'd feel cautious about going too far in. And this is going to sound terrible. Sort of banging the drum of human rights in a report in that way for fear of sounding polemic. But I think human rights for me it would better to have human rights as the subtext driving the value of, the integrity of my assessment. (05.W)

This extract reiterates the theme of human rights being implied and values-based within specialist assessor practice. In addition, all specialist assessors agreed that the remit for including a rights-based approach to specialist assessor practice was unclear. All specialist assessors were aware that their reports could be used to assist judicial weighing of the liberty interest. In addition, there was a consensus that specialist assessors should identify the least restrictive option for the Court. A contested issue was whether or how specialist assessors should engage a clinical process of balancing human rights perspectives when they derive their opinions about the least restrictive option.

4.2.3 A convergence of views: Human rights obligations and practice

Although there was no single approach to human rights issues, specialist assessors were united in the view that they had an ethical duty to raise or act on breaches of human rights if observed. "*At the simplest level, it is all our jobs as well. So, nobody should walk past an obvious breach of rights full stop. Even if that's not your primary mandate, that doesn't mean that you ignore them, either*" (09.A).

The review process was seen as providing a safeguard for care recipients' rights. The process was an opportunity for specialist assessors, as professionals independent of the care team, to explore a range of issues relating to risk, continued detention, and the quality of care and rehabilitation:

> Probably I think a lot (about raising human rights) every time… I like the specialist assessor role because you come in as this outside person and you just look at the quality of the care, and you can give advice

> and then like... you can come from this really ethical viewpoint, and it’s interesting. (13.W)

Some specialist assessors indicated that they had communicated about human rights issues affecting care recipients within review processes.

Analysis of the interviews revealed that the human rights issues raised by the specialist assessors coalesced around quality-of-care or environment issues, overly restrictive care practices, or risks that might be posed to care recipients in care settings by fellow care recipients or staff. Initially, the specialist assessors denied that they felt constrained to raise these concerns. However, closer analysis showed that some specialist assessors were judicious about how these concerns were expressed. Further, their self-reports showed a tendency to use *indirect* methods of communicating rights issues. For example, this specialist assessor explained how they could use a range of forums to communicate their concerns:

> Yeah, that’s what I think about [how care recipients are treated, meeting of primary care needs]. I doubt I write about it. You know, you might go into a group home and you might see that it’s very dirty, the way in which the staff interact isn’t great. There’s mechanisms to bring that up. You probably wouldn’t put it in your report necessarily. You’d certainly address it… I’d probably document them in reports but not in specific terms… suggest the kind of things that are happening and what things could be worked on or changed. I think there’s mechanisms to speak to a care manager, to speak to the people in Wellington that are in charge of the quality of compulsory services […] I’d probably talk with family but I wouldn’t inform the family of specific concerns and stir that up but I would try and empower family to have more influence and a greater voice for their family member. (08.A)

The examples of rights concerns raised by this specialist assessor relate to welfare or well-being rights, not liberty rights. Further, this extract illustrated how the specialist assessor was considering the obligations held by service providers to meet these needs. A third specialist assessor shared their experience of infrequently raising human rights issues: "*It's rare when you bring up a really big example [human rights issue], but personally, I have done it. That's one of the roles*" (03.A). Overall, the specialist assessors described mixed approaches to advocating for a care recipient's rights.

4.2.4 Negative consequences for those who raise human rights concerns

A small number of specialist assessors disclosed that they had faced negative consequences after raising human rights issues. The consequences included complaints being made about them by care teams or falling out of favour with coordinators, resulting in reduced offers of work:

> You definitely notice that the phone would ring less for you know the next call up… I then fell out of favour because I was creating paperwork, so you just think you know I'm doing my best to promote dignity and respect and advocate for people's human rights and you think that there's something within the processes and procedures, they're limiting… that's important. (14.N)

Other specialist assessors touched on the financial implications of pursuing a course of action that was unpopular, with one noting that there were long periods when they were not given work, "*I think my last specialist assessor period I couldn't get three reports to send into the panel because I was basically not called for years. For about 4-years*" (15.A)

The possibility of being seen to inappropriately advocate for human rights was a source of additional pressure, especially for specialist assessors who were in full-time private practice:

> I am not there to advocate but, equally, I am there as a kind of expert assessor working out exactly what that means for me in the very early stages. I mean I guess from a more pragmatic view… will I get any more work if I do this? (07.W)

One participant perceived that the Courts and the MOH welcomed specialist assessors highlighting human rights concerns occurring within a single facility, but were less tolerant to specialist assessors drawing attention to systemic problems:

> So, I think you know ethically there's no question that if you see gross breaches of human rights it would be your role. And I don't think there's any barriers to kind of the bigger breaches. And I do think that then the system is very happy with you raising those issues. They're not very happy if you're raising issues about the breaches that are institutionalised within the whole system, or within the legal system or within the Ministry of Health system… So there's barriers to raising some ethical legal issues and there's not barriers to raising others. So if you want to whistle blow on bad practice in one particular house, they're very happy if you do that and not so happy if you raise a concern about more systemic things. (09.A)

This specialist assessor then stated that they had been reprimanded by both the Court and the MOH for raising systemic issues. Collectively, these findings indicate that some of the specialist assessors who had attempted to promote care recipient human rights had experienced a range of negative professional consequences for doing so. The above extract also suggests that the receptivity of other parties in the system may vary dependent on the nature of human rights issues being raised by the specialist assessor.

Those who had challenged the status quo for care recipients assessed to be at high risk (over the long term) or SCR found unfit felt an implicit pressure "*not to rock the boat*" (05.A). One specialist assessor referred to the process of being given "*covert messages*" (14.N) about levels of care from service providers or coordinators that, if incorporated, would have compromised their integrity. Another specialist assessor reflected on their experience of "*implicit pressure to go a certain way to suit the system*" (4.W) from care teams or ministerial staff.

A highly experienced specialist assessor described the need for a "*thick skin*" (02.W) when engaged in high-profile cases. This was echoed by others who had experienced professional challenges from peers or ministerial staff when providing an opinion that was at odds with the Court's or other parties' views.

In summary, a range of negative consequences were described by specialist assessors who had taken a rights-promoting approach to issues of care recipient well-being and liberty.

4.3 Theme Two: Features of the IDCCRA Raise Human Rights Concerns

The specialist assessors identified features of the IDCCRA that aroused human rights concerns. An underlying theme was the unintended or unforeseen consequences of the legislation. Disproportionate outcomes were linked to the limited options available under the Act. Concerns about fairness or equity also coalesced around the extension provision and the approach to risk assessment. In addition, some specialist assessors wondered if the Act was out of step with human rights advancements, such as the CRPD. The impact of risk aversion is considered, as are other critiques of the legislation with regards to liberty interests. Collectively, these issues raised questions about the inherent fairness of the IDCCRA itself, and the unforeseen impacts of different treatment based on intellectual disability.

4.3.1 Compulsory care: A narrow focus

Some specialist assessors were concerned that the inflexibility of IDCCRA service framework did not promote human rights. This was because rehabilitation must be provided within a facility (secure or supervised), but the needs of care recipients are heterogenous. These specialist assessors expressed concern about overreliance on a single criminal justice pathway to manage challenging or risky behaviour for such a diverse population. The specialist assessors appreciated that the IDCCRA was a gateway to a range of services; however, three concerns were raised.

Firstly, some specialist assessors were concerned that a narrow focus on criminal conduct could obscure other important causal factors within the care recipient's environment, "*That's [the offence] not actually the important thing going on here but, that's the thing that brought them in*" (02.A).

Secondly, the unintended consequences of the compulsory care regime were front of mind for some specialist assessors. For example, some specialist assessors highlighted that access to specialist disability intervention and support for complex individuals was often reliant on criminal charges. In this regard the IDCCRA was described as a blunt, all or nothing, tool:

> One of the problems with IDCCR as we've talked about it, is it seems an all or nothing sort of a device. There is no community treatment,

> compulsory community treatment option where things get bolted onto people’s care where they are. It involves either no order and it’s up to them what they do or it involves them being uplifted into mandated services that might be in a different town to where they are. (8.A)

Here, the specialist assessor is contemplating alternate approaches that could bring specialist services to the individual in a less restrictive and disruptive manner.

Finally, the binary nature of the options provided by the IDCCRA was expressed clearly as, “*Really, you’ve only got Sydney or the bush as the alternatives… there’s no in between outer suburbs you can hang out in. It’s detain or not detain*” (15.A). These specialist assessors were not suggesting that criminal behaviour should be ignored. Rather, they appeared to be reflecting on the importance of contextualising and responding to behaviour in appropriate ways so that less restrictive options could be identified. In this regard they were reflecting on their practice and how the design of the legislation and service infrastructure impacted on liberty and access to rehabilitation.

4.3.2 The human rights implications of relying on compulsory care

Some specialist assessors were concerned that relatively low-level misconduct, best characterised as challenging or nuisance behaviour, could lead to criminal charges (and compulsory care with deprivation of liberty). They viewed this issue as problematic when the primary causal factor was disability, not antisocial intent. Human rights issues were raised by several specialist assessors who drew a direct link between the criminalisation of disability needs and disproportionate outcomes:

> A lot of the reason that they’re going into [compulsory] care in the first place is not because they’re criminally inclined but …they’ve whacked the staff member so yeah… the assault’s been created by a system that’s not working for their needs, which is a huge human rights issue when you think about it. (04.W)

In addition, a few specialist assessors asserted that conceptualising behaviour as criminal versus challenging or nuisance had significant ramifications for the location of responsibility:

> With challenging behaviour, the onus probably, is accepted more from services to meet the challenges that person presents. Whereas offending is placing responsibility on that person for their offending or not offending. (08.A)

The nub of these critiques was that low level offending, better characterised as challenging or nuisance behaviour, could result in compulsory care. The specialist assessors queried whether better service delivery could avert compulsion under the IDCCRA. The specialist assessors suggested that community-based frameworks would better meet the needs of some care recipients. This was clearly articulated below:

> There is no equivalent of a community treatment order where support services visit them in the home and take them to where they need to go during the day and support family in the home. I mean, I can see why it's pretty hard to manage but that all or nothing thing hasn't really been looked into I don't think. (08.A)

The so called "all or nothing" nature of the Act was linked to counterproductive outcomes because, in some cases, the specialist assessors perceived that the negative outcomes of coming under an order outweighed the benefits. The liberty implications of this scenario are illustrated in the following extract:

> You don't necessarily need an order and if he was to go on an order, then that would've disrupted his whole life and it would've needed to come down to a RIDSAS to a different region… that would've increased risk paradoxically…every case is unique but you do come up against this. (13.W)

Others noted that during the review process it could become apparent risk was increasing by virtue of the person being placed in a compulsory environment that was not meeting their needs, be they social, cultural, or disability related:

> This is picking up a person’s entire life, what they choose to do for work, what they choose to do for leisure. Where they choose to live, who they’re going to associate with and plonking them in a situation where, and as you also point out in your vignettes, the situation doesn’t necessarily always resolve itself at the end of the care order. (15.A)

Alternatively, it was recognised that people might be better placed in prison: “*Sometimes, I might recommend that [the] person shouldn’t come under a care order because it’s never previously worked*” (08.A). Others reflected that a degree of realism was required when assessing whether orders would be productive:

> Quite often the restrictions can build up a level of resentment and frustration and that reduces compliance with them. I guess just on a very pragmatic note, actually restrictions don’t work if people don’t go along with them to a certain extent. (07.W)

Collectively, these extracts illustrate that specialist assessors were contemplating the long-term impacts of a loss of liberty on a care recipient’s risk and responsivity to care and rehabilitation. A clear conceptualisation of factors driving offending behaviour was linked to the promotion of liberty interests.

4.3.3 Orders do not provide certainty

Many specialist assessors were concerned about the potential for unfair and disproportionate outcomes for care recipients because of the lack of certainty surrounding term length. The following extract illustrates the human rights issues raised for a specialist assessor as they considered how order length was dealt with in the Act:

> Random numbers (order length) and you wonder why people end up completely over this… it’s a problem because 3-years is just a nonsensical number. So, we’re constrained by something that’s been written in law that actually makes absolutely zero clinical, ethical, moral, legal sense. And it’s not proportionate… you are infinitely better off if you get a sentence and at least you know where you stand

> … in lots of ways it’s easier for the specials (special care recipients) because they know well it’s the half max. And they’ve got kind of a number on it that kind of feels fair almost. (9.A)

The specificity of critique offered by this specialist assessor indicates a level of human rights awareness.

Other specialist assessors commented on the lack of certainty. For example, although prison was viewed as undesirable a specialist assessor observed, “*At least it will have a start date and end date*” (06.A). Other specialist assessors expressed that people who were fit to plead benefit from a determinate sentence because, if found guilty, they might have a shorter period of restrictions on their liberty, in comparison with an IDCCRA disposition.

As set out in in theme one, there were diverse views as to whether specialist assessors should be factoring considerations about proportionality into their opinions and recommendations. Regardless, the previous extract demonstrates that specialist assessors do think about whether IDCCRA orders are proportionate to mainstream sentencing provisions. One specialist assessor critiqued the consequences of being disposed of under the IDCCRA rather than being sentenced under criminal justice provisions:

> fundamentally there might be a different decision made for someone with a [intellectual] disability as opposed to someone who doesn’t… I think that’s an important human rights issue as well, particularly if you didn’t have that particular [intellectual] disability that you may have a different outcome, a different means, and if that comes down to impacting on your liberty and your right to freedom you know that’s a huge human rights issue. (11.A)

Others specialist assessors identified that care recipients who understood the distinction between being sentenced in the usual way and disposition under the IDCCRA might express a preference to “*do time*” (13.W).

Also, many people entering the IDCCRA are unknown to disability services and do not identify as disabled. One specialist assessor reported that in their experience this group were more likely to prefer prison because they did not want the stigma of being identified as disabled or wished to preserve social connections and "*mana*" (13.W). This preference could indicate the enduring nature of discrimination and stigma associated with individual and collective perceptions of disability.

4.3.4 Extensions have human rights implications

Some specialist assessors observed that most people in prison were released at the end of sentence irrespective of their engagement in rehabilitation. However, should a care recipient not engage with rehabilitation this could lead to an extension. The following extract spoke to the human rights concerns raised by this feature of the IDCCRA:

> Very dangerous people walk out of prisons every day and I think that's important. And the reason for that is we don't see it as fair to incarcerate people beyond their normal sentence. So that's different for people with intellectual disabilities [under the IDCCRA] and I think we should always bear that in mind. (05.W)

Another specialist assessor provided a more explicit example that expressed their concerns about extension provisions:

> There's certainly been cases where I've thought, 'crikey, this person's started off with a common assault charge back in 2007 and here I am reviewing them in 2020. That would never happen to a person who didn't have an intellectual disability. (01.W)

The potential for inequities arising from extensions to orders was echoed by other specialist assessors. In addition to the safeguards provided by the review process, specialist assessors expressed how they approached the liberty interest:

> As long as a default position when someone is coming up for the end of their order [is] that they are walking out that door unless there's information that strongly suggests otherwise. As long as that's the position that people hold in their mind, fine. (08.A).

This extract appears to be hinting that specialist assessors could become desensitised by perpetual extension. Alternately, it signals the importance of specialist assessors understanding that the intent of the legislation was not preventive detention.

4.3.5 People are getting stuck

The specialist assessors responses to a vignette offered further insights regarding the integration of human rights into their practices. Vignette A was about H, a man aged 45 years with a moderate intellectual disability and autism, who been a care recipient for 12-years. H's compulsory care order was extended four times. All specialist assessors identified with this vignette and reported it was a familiar or common scenario for care recipients. For some specialist assessors, the perpetual extension of a care recipient's compulsory care order brought human rights interests into sharp focus. They expressed that perpetual extensions marked a shift away from rehabilitation and liberty restoration to de facto indeterminate detention for community protection:

> Where the person has got stuck, doesn't seem to be benefitting in terms of moving towards freedom but the risks are still very, very, very high, then you're doing a slightly different balancing act… essentially it's a protection and detention rather than a rehabilitation, kind of role… I guess, yes, that's how it changes. I don't think otherwise I'd think explicitly about the liberty detention things outside of that. I tend to be fairly pragmatic I suppose in my approach. (02.W)

The prospect that some care recipients may never be rehabilitated was raised by other specialist assessors. If there was no rehabilitation then liberty might not be restored, which has human rights impacts. The specialist assessors agreed that a different approach was required for this group of care recipients. One specialist assessor observed that society accepted that some offenders will never be rehabilitated:

> This idea of somebody who is a lifer… so why couldn't it theoretically apply in an ID population?… and if there is such a person… I definitely see a lawyer's role in testing things out, pushing the envelope, seeing really what is the limit of non-compulsory services, what can they absorb. (08.A)

For other specialist assessors this scenario introduced a level of complexity to the work that was distinct to other forensic roles. The specialist assessors agreed this situation required careful consideration of how entrenched patterns of high-risk behaviour could be managed outside of the IDCCRA framework. A specialist assessor described their practice as follows:

> The approach that I would probably take in this situation would be to try and reduce the structure around the care, while monitoring his behaviour very carefully and you'd need to see an escalation of that behaviour to justify ongoing detention. (15.A)

Others agreed that there was an onus on services to ensure care recipients were provided with opportunities for positive risk taking. Positive behavioural support is defined as an evidence-based, person-centred approach that aims to enhance quality of life while managing the potential for harmful behaviours (Lynas, 2020).

Some saw the IDCCRA framework as providing a pragmatic response to a complex and risky group of individuals with "*problems for which there is no perfect solution*" (05.W). These extracts highlight disagreement as to whether the regime adequately protected care recipients' liberty interests.

Many specialist assessors reflected on the emotional consequences of encountering situations where a care recipient's assessed risk remained high over a lengthy period with little prospect of change:

> I have seen a similar scenario (to H), the risk was so significant and for those types of cases… I think it is a huge issue and it's really significant and I think I would come down on the side of risk more so than from a liberty, if I'm thinking of just that vignette example that you provided but yeah, I feel pretty helpless as well, hopeless. (11.A)

Here, the specialist assessor is candid about how they would prioritise public safety over the person's liberty interest but that this could engender a feeling of hopelessness. The specialist assessor also hints at the role risk aversion might play in specialist assessor decision-making, which will be explored later in this theme. How specialist assessors cope with the emotional consequences of difficult cases was, in part, linked to tenure in the role. The prospect of specialist assessors declining referrals for long term care recipients from coordinators was highlighted: "*I am sure some people refuse those kind of extension reviews if they know the person and they've known them forever*" (04.W). A relatively novice specialist assessor described their first experience of encountering a long-term care recipient within extension review: "*It felt like a real ethical dilemma around the direction to go in*" (10.A)

Some specialist assessors reflected that there are care recipients who will never be rehabilitated and for whom the community protection interest will always outweigh the liberty interest. Questions were raised by the specialist assessors about the Act being fit for purpose for this group. This issue is discussed later in the theme.

4.3.6 The special treatment of risk

Several specialist assessors commented on the unique way that risk was assessed within the IDCCRA. Those coming to the issue from a corrections or mental health framework referred to the need to recalibrate their approach, which involved a steep learning curve. For some this was positive. For example, a specialist assessor with a correctional background spoke of learning to become more comfortable with risk, having traditionally worked with high-risk offenders being considered for extended supervision or public protection. Conversely, a specialist assessor with mental health experience noted:

> It feels like a different kind of tension (IDCCRA versus MHCATA). I think because the risk that we tend to be working with in mental health is more sort of risk to self. It's not risk to others. It's not risk to the community so much. I feel like we can work in a… more risk tolerant way, or risk sort of flexible way. (10.A)

This extract suggests that the specialist assessor perceived that people subject to risk assessment under the mental health legislation might enjoy more liberty in comparison to care recipients under the IDCCRA. Other specialist assessors commented on contrasting approaches to risk taken by the MHCATA and IDCCRA. In part this was attributed to the focus of the MHCATA being imminent risk and treatable mental illness, versus the requirement to focus on nexus of risk between intellectual disability and offending. The need for a rehabilitation approach that could address the an individual care recipient's needs in a broad way was captured by one specialist assessor as, "*Essentially what you are trying to do with the IDCCRA is scaffold somebody's overall functioning*" (15.A). This same specialist assessor made an explicit connection between the future focused risk approach required within the IDCCRA and the human rights implications for care recipients:

> But of course when you talk about human rights its obviously there's concerns for our deprivation of liberty. And it's a very, very hairy situation when somebody hasn't committed an offence and yet they're having their liberty deprived on the basis that they might commit an offence. They're still individuals with individual rights under the Bill of Rights Act. (15.A)

The capacity to consider the totality of risk posed by a care recipient to the public, or a class of persons, was a further issue contributing to concerns about fairness and discrimination:

> You look at the totality of risk which I gather we are encouraged to do rather than just the risk of repeating the same offence… I am also mindful that perhaps this person became a care recipient for a relatively minor assault on a care worker, for which someone with an IQ above 70 would never have been in prison, let alone subject to additional care orders on the basis of totality of risk… you know it is not fair in some situations. It is not equitable, it's not the same for people with ID (intellectual disability). (05.W)

The liberty impacts of risk aversion by the Courts were raised by several specialist assessors. One experienced specialist assessor observed that the Courts seemed to tolerate residual levels of risk for mainstream offenders but held care recipients to a different standard, "*I think that the judges seem to have this bizarre expectation that we'll have zero recidivism [with care recipients]*" (09.A). Similarly, a relatively novice specialist assessor reported:

> As I'm figuring my way through this process, I can see that's a really primary issue that will come up for so many assessments. How do you balance that? Where in reality, so many of these care recipients are going to be carrying some degree of risk in a long standing kind of way. It will never be sort of zero for some of them. How do we sort of balance that? (10.A)

Others reflected on the risk aversion held by specialist assessors. There was a view that specialist assessors might feel more responsible for predicting or preventing future risk to the community than their counterparts working at the Department of Corrections:

> It's horrible when people who have met along the way then go on to do serious offences and we've been part of the system that's allowed them to be released back into the community… We can get very uncomfortable with that and some of us avoid that more than others… What is it about correctional psychologists and that system that just accepts that's the case? (05.W)

Other specialist assessors were focused on the factors that contributed to a risk averse approach. This situation was well encapsulated by the following extract:

> We like to believe that what we do is a really good thing, so we believe in our paradigms (actuarial risk assessment). And we're right to do that because we're right at a population level. The issue is we're not always right at an individual level. And it's very uncomfortable to say look I think this individual is different from the last individual I saw even though they look the same. It's pretty gutsy to do that and the Courts are similarly risk averse. And so you're writing something for the audience that you know they will be happy with. (15.A)

Several important points are revealed in this extract. Firstly, the merits and limitations of actuarial risk tools is touched upon. Secondly, the specialist assessor's use of the word "*gutsy*", indicates that they perceive some personal risk in taking a view that may not be popular to the audience, in this case the Courts. Finally, the specialist assessor gives us insight to the sense of pressure an specialist assessor might feel when they privilege a structured clinical judgment approach over actuarial risk prediction.

4.3.7 The adequacy of rights protections for care recipients

Approximately one third of the specialist assessors appeared to question whether the IDCCRA was out of step with human rights advancements like the CRPD. Specialist assessors were concerned about the implications of different treatment for care recipients relative to non-intellectually disabled offenders within the criminal justice process. Inherent to these concerns were issues of fairness, equal recognition before the law, justice, and liberty.

The importance of specialist assessors being cognisant of the different legislative frameworks was highlighted by one participant who was particularly concerned with the rights implications for special care recipients who were unfit to stand trial:

> [This situation is] extraordinarily paternalistic because the person is saying I understand this and I want it tested [the charges and evidence] and we say no you don't understand enough… You know the person has rights and these mechanisms can very easily degrade their access to those rights. (05.W)

This same specialist assessor referred to the totality risk approach, stating that this was a prime example of how intellectually disabled offenders were treated differently to their mainstream counterparts, "*They [people who do not have an intellectual disability] get sentenced largely on the discrete offence or offences they've committed. Not the kind of person they are*" (08.A). As noted earlier, comparisons between the IDCCRA and mainstream criminal justice provisions were a strong theme amongst the cohort of specialist assessors.

Another specialist assessor was categorical in their opinion that the IDCCRA required revision due to serious human rights implications:

> So it's desperately, desperately in need of fair overhaul so these are the inbuilt, serious abrogations of human rights that I'm more concerned about than the difference I make in my report on a one on

> one basis. So these are indeterminate sentences. Which is a fundamental breach. (09.A)

This specialist assessor queried whether it is possible for a specialist assessor to maintain an ethical practice within an inherently "*unethical system*". Human rights concerns were alluded to by others who noted the IDCCRA invited criticism for being discriminatory under CRPD, or counter to the spirit of the Convention, "*We are operating in that environment where we are dividing somebody off because they have a specific disability which is kind of against the spirit of the international declarations and conventions, I think*" (02.W).

In comparison, some specialist assessors who had professional experience in other jurisdictions viewed the Act as a protective and humane response to intellectually disabled offenders. Specialist assessors reflected on their own responses to the Act; for example, pride in the innovation it offered, privilege in the specialist assessor role, and a sense of being able to effect positive change for a vulnerable group of offenders. The extract below illustrates some of these factors:

> [I] worked in large institutions in the UK so I've seen the worst ways that people with an intellectual disability whose behaviour is just too challenging for everybody, I've seen the worst ways that they're managed… that stuff really hit me in terms of human rights stuff and just it being wrong and there needed to be another way but also the realisation that although you can integrate most people, there still are some people who are going to come up against the law and so I was right behind the development of a system to manage that better. (12.W)

Some viewed compulsory care as a more desirable alternative to prison, "*My clear opinion is it would be better to be under a hospital secure order than going to prison if you had the opportunity*" (03.A). This perspective can be critiqued in two ways. Firstly, the specialist assessor does not appear to be considering what a person with an intellectual disability facing these options might be weighing up in terms of what might be more desirable. Secondly, it communicates strong assumptions about what a 'good' decision is.

Specialist assessors believed the role required a degree of pragmatism. Some attributed this to the challenges of working with care recipients who struggled "*to make good decisions for themselves*" (2.W). For others it was about recognising the tensions between human rights and political imperatives:

> You want to promote the Bill of Rights but you know these Mental Health Act things, and IDCCR they haven't developed by accident. You know they've developed mostly as actually a budgetary solution. It maps out a pathway by which money can flow down to people so they can get services. That is a big part of legal stuff that people don't necessarily realise. (15.A)

However, others expressed disquiet about the unintended and problematic consequences of the alternative disposition pathway. These criticisms centred around the notion that, "*separate is never equal… in my view there needs to be one legislation covering everyone… inclusive enough to provide leeway, latitude, accommodation for different world view*" (06.A).

An experienced specialist assessor who participated in the drafting of the IDCCRA echoed this view:

> I remember those very early discussions and the options. But the politicians wanted a separate piece of legislation. That's what led to it happening. I think they didn't really think it through carefully. But we've got it and we've just got to live with it at the moment. (02.W)

Collectively, these findings illustrated the tensions arising for specialist assessors as they contemplated the intended and unforeseen human rights implications of the legislation.

4.3.8 Experience equips the assessor to think about liberty implications

The capacity to deeply reflect on the human rights and liberty implications of IDCCRA was linked to experience in the specialist assessor role and exposure to many different scenarios. One specialist assessor spoke candidly about this topic:

> It takes a good 50, 60 (assessments) or more to have any sense of what a special (care recipient) looks like compared to a care recipient… It's hard to appreciate in the early days and really know what that means. I'm up to 290 now. That's how many I've done and there's still new stuff to know… I think the more experienced people, when they start to worry less about the technical aspects of populating a report effectively and sending it off, they then start to think… well, many of them do, start to think more widely. (08.A)

This participant expressed that more experienced specialist assessors may be more inclined to survey the wider human rights issues. While this same specialist assessor expressed a reluctance to "*start lobbying*" for change they felt it was "*their job*" to "*point out the elephants in the room*" when asked to give presentations on the IDCCRA or the specialist assessor role. This specialist assessor expressed confidence in the capacity of the criminal justice system to be responsive and "*enlightened*" if provided with good information about the implications of the law for vulnerable groups.

Another experienced specialist assessor appeared less optimistic about the receptivity of the system to change:

> I have come to really hate some aspects of the law. The way it's been written actually produces bias as well and so there's an educational role for us [specialist assessors] to point those out… again it's really difficult because some of those things kind of feel like they're not really my role… these are things which the lawyer should be bringing up and the politicians should be bringing up. And they should have nothing to do with us as specialist assessors but they definitely impact on the specialist assessors. (09.A)

This extract illustrates the personal impacts and tensions arising from the role, as well as a lack of clarity about whose job it is to lobby for change. Together, these findings indicate that specialist assessors were reflecting on their scope to promote human rights within the IDCCRA framework.

4.4 Theme Three: Liberty Interests and Rehabilitation

This theme builds on the specialist assessors' critique of the legislation by focusing on the services that deliver rehabilitation to care recipients. The central idea is that service delivery issues can inhibit or enhance the restoration of a care recipient's liberty.

There are several facets to this theme. Firstly, the specialist assessors identified that when rehabilitation was not delivered in a timely or targeted way there could be consequences for a care recipient's liberty restoration. Secondly, how the geographic location of services could *dislocate* care recipients and work either towards or against the goal of rehabilitation is considered. Thirdly, the potential for compulsory care orders to be counterproductive and, therefore, in tension with the restoration of liberty is described.

4.4.1 Service delivery issues have consequences for a Care Recipient's liberty

Specialist assessors reported that service-related issues impact on the fundamental decision specialist assessors must make at review; that is, should the compulsory care continue or change? The human rights implications of extending compulsory care because of the inadequate delivery of rehabilitation are illuminated. Several specialist assessors observed that if no rehabilitation had occurred then orders were just restrictions.

The complexity of the care recipient group appeared to be front of mind for the specialist assessors as they contemplated access to rehabilitation within compulsory care framework. Some specialist assessors asserted the nature and intensity of therapeutic supports provided to care recipients was inadequate, raising questions about the Act's capacity to deliver on rehabilitation obligations:

> There's massive constraints in resourcing… For instance, you might have a person with very complex needs and there's this kind of nexus between personality functioning, intellectual disability, mental illness

> and they're getting 45 minutes of individual psychological intervention a week and then largely just going between various groups here and there and doing some music therapy and some animal therapy for instance. That's not to malign those things but… what are we expecting will be achieved… a reviewer like myself turns up and goes there's been no behavioural change as a consequence of a lack of resources… why would we expect there to be in that time? There's only been that very limited amount of time taken [to deliver rehabilitation] and that all reflects an absence of resources. (01.W)

This extract draws a clear link between service delivery and the liberty and rehabilitation decisions made by the specialist assessor at review. The reality of inadequate resourcing is clearly stated and identified as a significant constraint to effective rehabilitation delivery. Importantly, the specialist assessor is highlighting that a care recipient's capacity to address the risk factors that led to their offending is significantly constrained by the degree of access to rehabilitation.

Other specialist assessors expressed concern about the liberty implications for care recipients who had progressed to the end of the orders without accessing therapy:

> Because the environment isn't therapeutic and then it becomes really interesting for us if we've got the sense that the quality of service provision hasn't been particularly good. And then we've got to make a recommendation on the basis of risk. But we need to say you know in some way that that's probably because of the deficits in service delivery. So that gets really difficult then. So yeah, as I say, that's a way in which the constraints of service delivery impact on liberty interest. (05.W)

This extract illustrates tension arising for specialist assessors who are attuned to liberty interests within this scenario.

Disparate treatment and care approaches

Several specialist assessors commented on the presence of stark differences between the models of service delivery provided in hospital (FIDSS) and community facilities

(RIDSAS). There was consensus that hospital level services were richer in clinical resources compared to community services. The following extract speaks to the differences between models. By defining what community services would benefit from, the specialist assessor illustrates what is typical in a hospital level care environment:

> When I look at the difference, for example, between what happens in the hospital secure inpatient units where people have a very highly individualised, very professionally thought out and delivered programme compared to some of the things that they get once they move into the community-based facilities, it's chalk and cheese. So, I think it would be really nice if there were more resources to provide all of the clinical psychology, OT [occupational therapy], nursing, things that people need within those community-based facilities. (02.W)

This same specialist assessor went on to comment that there were very few clinicians employed in RIDSAS services. For another specialist assessor, the lack of financial resources to employ skilled personnel in RIDSAS was a source of tension that they had voiced in other contexts:

> I've had this discussion with other specialist assessors, where we've got this specialist legislation for people with intellectual disabilities which makes sense, and then the Forensic Coordination Service to coordinate and execute the Act. But of course where it all succeeds or fails is in the people, the daily interactions with the person in the services and if the services can't afford or can't find people who can behave usefully and therapeutically… then it doesn't work very well. (05.W)

Again, this extract draws an explicit link between the success of the IDCCRA framework, the quality of infrastructure underpinning the Act, and the lived experience of the care recipient.

Another specialist assessor had a differing view about resourcing issues, "*Of course, they're [RIDSAS services] constrained but there's a lot of creativity and a lot of amazing* *stuff that does go on providing for those basic needs and rights*" (04.W). In this instance the specialist assessor was referring to CRs in community facilities having the opportunity to engage in paid or voluntary employment while subject to orders.

Regional differences

Despite agreement that hospital services were multidisciplinary environments, other specialist assessors reported noticeable differences between the models of care being delivered across the hospital services, "*I think there's bigger differences between RIDDS around the country than there are between RIDSAS's around the country. That's my experience*" (08.A). There seemed to be a reticence by some specialist assessors to address this issue: "*I don't want to say anything too controversial but there seems to be quite stark differences in the models of care, or lack thereof in the different FIDDS around the country*" (05.W). The hesitation to be openly critical of services is interesting, particularly in light of the negative consequences disclosed by a specialist assessor who had promoted human rights (see theme one). These comments indicate care recipients in hospital level care may experience differing approaches to rehabilitation depending on where they live in New Zealand.

There were other instances of specialist assessors reporting regional variations in financial or operational resources. For example, in some regions care recipients could not access specialist psychological or occupational therapies due to an absence of skilled clinicians. One specialist assessor likened the situation to a "*postcode lottery*" (11.A). Other specialist assessors expressed frustration as they recounted their experience of workforce constraints. In the following extract the specialist assessor reflects on the capacity of services to follow through on the treatment and rehabilitation needs they identified in the risk assessment:

> here is the risk profile, here are the risk factors; therefore, this individual needs individualised psychological treatment, offence focussed work… you know core operational objectives that a service should be able to deliver, this is the whole reason for being, it's why we have the Act, let's rehabilitate. And then things to grind to a halt because they can't recruit staff because the service has a bad

> reputation or it doesn't pay enough money… you just think no, no. (14.N)

At the heart of the concerns raised by this specialist assessor was how services issues undermine the purpose of the IDCCRA, which is, "to provide the courts with appropriate compulsory care and rehabilitation options for persons who have an intellectual disability and who are charged with, or convicted of, and offence" (IDCCRA, s 3(a)).

By virtue of having an intellectual disability, care recipients will often require more intensive intervention from services. Some specialist assessors indicated that some care recipients could require more frequent sessions over the course of treatment or for therapy to be delivered over a longer period to scaffold change. As one specialist assessor reflected, "*This person's going to need at least 12-months of compulsory care to do anything meaningful with them*" (08.A). Again, this reflection reinforced that some specialist assessors consider the most effective care options in addition to the least restrictive alternative.

The tension arising from this situation was raised by the specialist assessors who compared the tariffs for minor offences under the criminal justice framework with the disposition options in the IDCCRA framework. The specialist assessors reiterated the importance of the anticipated time frames for rehabilitation being explicitly communicated to the Court for the resultant liberty issues to be considered.

In summary, the findings raised issues of fairness and equity for care recipients by placing a spotlight on the quality and consistency of the rehabilitation being delivered. Worryingly, specialist assessors reported that, in some instances, the staff delivering rehabilitation programmes may lack the appropriate skill sets or experience. At a broader level the findings indicated that specialist assessors viewed the IDCCRA framework as experiencing similar pressures to the rest of the health care sector. The liberty and well-being implications of lack of access to rehabilitation in combination with inconsistent models of care across New Zealand was a source of concern for all specialist assessors.

4.4.2 Diverse forms of dislocation have liberty implications

The intent of the IDCCRA is to deliver appropriate care and rehabilitation to care recipient that recognises and safeguards their special rights. Although the protective elements of the Act were acknowledged, there was consensus amongst the specialist assessors that becoming subject to a compulsory order also caused disruption to a care recipient's life and natural support systems that could undermine the effective delivery of rehabilitation.

Some specialist assessors saw IDCCRA facilities as providing temporary environments for care recipients that were protective, useful, and therapeutic, particularly if home was "*a place where dysfunction lies*" (05.W). While other specialist assessors observed that compulsory care could separate the care recipient from risky environments but did "*not necessary resolve*" (15.A) their issues long term. In many instances, compulsory care was viewed as necessary due to the nature of the index offending and level of ongoing risk posed to others. However, as discussed in theme two, there was disquiet about the liberty implications associated with the limited options available under the Act, and the potential for orders to become counterproductive.

The specialist assessors appeared to be weighing where IDCCRA facilities were geographically located when considering the least restrictive alternative. The word 'dislocate' was used by several specialist assessors in reference to the impact compulsory care orders could have on a care recipient, their whānau or family, and other natural support systems.

Importantly, a specialist assessor revealed the thought processes a specialist assessor might engage in but not necessarily write about in their report:

> I think it changes things enormously if you… dislocate people from the community they're used to and the services within that community… a common principle in behavioural psychology is generalisation and the whole purpose of the Act is to help a person be more effective in their context… This is psychology 101 for you and I but it's a principle that's been run roughshod over with the Act because it's an all or nothing tool. It doesn't bring services to them in their context. It

> actually uplifts them and places them in the place to receive input. (08.A)

The word rehabilitation is not used in this extract but, in essence, the specialist assessor is reflecting on factors that can undermine the delivery of effective rehabilitation. This specialist assessor highlighted that generalisation is a core psychological principle of rehabilitation and essential to a person sustaining positive behavioural or psychological change after the active therapy or rehabilitation is concluded. Similarly, other specialist assessors identified that for rehabilitation to be effective, care recipients needed support to generalise new skills learnt in the therapy setting to their natural environment. This process is commonly referred to as reintegration.

The challenges of supporting reintegration when services are located far from a care recipient's home was a concern for others, "*It's quite difficult to do a graduated process of return to your community when you're 5-hours drive away for instance*" (07.W). These comments indicated that specialist assessors viewed a meaningful connection between natural supports and the care and rehabilitation environment as a building block for a care recipient's successful generalisation and integration at the end of orders.

Threaded through the subthemes of dislocation and generalisation of rehabilitation was a parallel discussion about the optimal distribution of facilities. On one hand, specialist assessors reflected on the potential benefits of RIDSAS and FIDDS services being closer to peoples' homes:

> Having things that are closer to people's home area and whānau would be really, really important. I think dragging people to the other end of the country to try and do rehabilitation programmes… away from their family and their main supports is not good. So, it would be nice if we could afford to keep them locally where they are. (02.W)

On the other hand, specialist assessors recognised the challenges in developing a nation-wide network of accessible and high-quality of services. The dislocation of care recipients from communities caused by the centralisation of RIDSAS and RIDDS services was viewed by specialist assessors as problematic and, in one instance, "*tragic*" (09.A). However, so too was a situation where small regional specific services became isolated, thinly spread "*mini asylums*" (09.A) due to a lack of oversight, resourcing, or support. specialist assessors with experience working in the regions were mindful of the risk of human rights issues for care recipients within smaller regional facilities:

> I mean on the one hand you kind of get a one size fits all when you just have big centres, but on the other hand I have seen smaller places that have tried to do more individual things, providers really struggle and I can think of a situation where I just walked in and I said this can't continue like this. (12.W)

The lack of outcome data was seen as a barrier to identifying optimal service arrangements and assessing true impacts of dislocation:

> We don't have access to information about what the outcomes are for anybody. Much less broken down by geography or ethnicity. So, this is not a system that is in a position to learn or improve… My educated guess is that it probably does make enormous difference because there is clear you know geographical differences to the evolution of services. And again, services have not been supported to share best practice or learn from each other. (09.A)

Some specialist assessors described raising these issues for the Court within reports. However, they were not sure this had much of an impact on judicial decision making:

> Well I, I even probably use a line… that a care recipient order would mean taking this person away from their area to rehabilitate them… it is something I insert in all reports where relevant. Whether that gets any more weighting than someone who's in a convenient area for the RIDSAS it probably doesn't really. (04.W)

Another specialist assessor said that while it was unfortunate that care recipients could be separated by great distance from family it would not stop them from recommending an order if it was required.

4.5 Theme four: Cultural Factors and Human Rights

This theme focuses on how cultural factors impact care recipients’ human rights. All specialist assessors endorsed the importance of recognising the unique cultural identities of care recipients. The needs of Māori care recipients were a strong focus. Equally, the recognition of Māori worldviews, beliefs, and values was identified as the foundation for meaningful engagement. This mirrored the importance placed on Te Tiriti o Waitangi within New Zealand and the specialist assessors’ collective awareness of the disproportionate numbers of Māori care recipients.

The interface between culture and human rights perspectives is considered from several angles. First, factors the specialist assessors perceived to contribute to the high numbers of Māori entering the IDCCRA framework are identified. The second facet reflects on specialist assessors’ own cultural identities and the importance of culturally safe, competent, and informed practices. The third facet examines the expression of Te Tiriti of Waitangi and the poor utilisation of cultural assessments within the IDCCRA. Possible pathways for change identified by the specialist assessors are also explored.

4.5.1 Systemic factors

specialist assessors made links between the criminal justice system experiences of Māori care recipients and relatively more restrictive outcomes, both within the IDCCRA and the related legal processes:

> With regards to liberty interests. That’s a can of worms of course and rightly so, because I think Māori are probably unfairly treated at various stages from arrest to disposition, possibly as a cultural group… I think certainly the people I meet are willing to settle for substandard legal representation, are willing to accept responsibility and take the rap when they could argue it perhaps more rigorously and perhaps that’s a degree of helplessness thinking, what’s the point. (08.A)

This extract touches on the well-established overrepresentation of Māori in health and justice statistics. Of interest, the specialist assessor is reflecting upon how care recipients respond to systemic factors within the justice process that might promote unfair or inequitable outcomes. The issue of suboptimal legal representation is important considering the additional vulnerabilities that care recipients bring to the legal process.

Another specialist assessor reflected on the culminative effects of Māori-centric needs not being identified or met early enough. However, in this case, the specialist assessor puts a spotlight on issues of bias that heighten the risk of restrictive practices:

> I would want people to be receiving interventions a lot earlier so they're not at the stage where we have to come in and do an order…. I'd also worry about discriminatory practices as well decisions that we make as clinicians. We know that there is bias against Māori… not just at the stage where a recommendation for an order is being made but also throughout their care. (11.A)

The issue of inherent bias was raised by other others who stated that the IDCCRA was grounded in a Western worldview. specialist assessors provided specific examples of how the Western worldview played out during the assessment and rehabilitative process:

> The world view of DSM-4 & 5 and ICD-9 & 10, and what I would call like a western Pākehā view is different from te ao Māori and intrinsically so. But that's the lens that the Courts interested in. And that's the lens of potentially institutional racism, missing alternate ways of looking at… explaining the world… of designing rehabilitative interventions… There's a whole other issue of how I as a western Pākehā sees human rights in relation to individual identity. In the Pacific, not just Māori and in other cultures as well, identity is not strongly individually held. It's more of a collective. (06.A)

This specialist assessor identified that human rights tensions can arise from competing worldviews about disability and rehabilitation. This critique fed into observations by two specialist assessors about the challenges specialist assessors might face in making systemic changes, given that psychologists from Indigenous populations also undergo training in clinical programmes underpinned by Western models. A specialist assessor identifying as Māori reflected on their education within a Western system and of pivotal

Māori academics who subsequently influenced their view of the specialist assessor role and poor outcomes for Māori:

> so a lot of the beautiful talks and writing by Moana Jackson and Justice Joe Williams… it was a beautiful quote, something like …you can't use all the tools of the coloniser to decolonise or to make something right. The example given is you can't use a cheese grater to un-grate cheese. So if we're thinking about our practices [specialist assessor] what we've learnt, been trained in, and the tools that we use… how appropriate are they for Māori? And, should we be developing different tools? Or, are there blind spots in our clinical practice? So, ongoing important questions about cultural competency. (11.A)

The need to look below the surface to examine the deeper beliefs shaping practices was highlighted by another specialist assessor. "*So you can't just change the language or add in a few extra bits, and then say this is now appropriate for us with Māori… it's so systemically built in. It isn't a level playing field*" (09.A).

A novel observation by one specialist assessor was that Pasifika care recipients were particularly vulnerable within the IDCCRA framework, due to also being a group of care recipients who are over-represented and largely "*invisible*" (09.A) within the current care models. Others noted that informally some cultural needs were met (but not all) for Pasifika care recipients by carers or nursing staff who were fluent in their first language.

4.5.2 Colonisation, disenfranchisement, and trauma

specialist assessors were universally alert to the ongoing consequences of colonisation, including the intergenerational impacts of war, loss of land, loss of language, and disenfranchisement. They discussed how Māori care recipients and their whānau might view the compulsory care regime. Some specialist assessors held the view that Māori care recipients could find the system harsh or reflective of colonial systems. Another asserted:

> I think for those who are really into their culture, that separation is felt really acutely and for people who are disenfranchised, it's like further

> disenfranchisement and being away from the land and from their people. That's got implications for the rehabilitation aspect, because then you might get… even if it's with a Māori clinician or support worker, they might be from a different iwi. Just because they're Māori, it's not my people so to speak. (13.W)

Another specialist assessor reiterated the importance of being alert to the cumulative impacts of historical factors, such as disenfranchisement on Māori care recipients, their whānau, hapū, and iwi, past and present:

> I am not only just talking about what's happened in the life of that care recipient but also their tupuna, their preceding generations. I think there has always got to be that broader historical social legal context of why we have so many Māori care recipients and what we're doing about that… I mean being Māori, I'm also a professional… it's not a fair, equal distribution of power and as much as we [specialist assessors] have those caring intentions, the families will feel that, the care recipients will feel that. I think because we do have such a powerful voice that we do have obligations to raise these issues for the Court. I'm thinking of the enquiry into the abuse in State care… we are thinking about what's happened in previous generations, but it's also a whakapapa of trauma. (11.A)

This specialist assessor took the view that simply being alert to the issues of disenfranchisement is not enough. They perceived that specialist assessors have obligations as persons in positions of power within the system to influence the court process by spelling out the impacts of cumulative trauma on Māori as they relate to the realisation of health and cultural rights. Specifically, this specialist assessor highlighted how care recipients might be retraumatised by the experience of being institutionalised or other negative experiences within the justice system and related agencies. The power, influence, and privilege associated with the specialist assessor role is discussed in theme five.

4.5.3 Identity, cultural competence, and human rights

Building a meaningful rapport with care recipients was identified as an important component of the assessment process by specialist assessors. This was attributed to the high stakes nature of the assessments on a care recipient's liberty. Most specialist assessors identified as non-Māori, with several describing themselves as immigrants to New Zealand of European descent. specialist assessors were candid about how their personal identities and role may be perceived by Māori and other minority groups:

> a lot of cultural issues come up in general with care recipients you know. There is a whole range of different cultures that have become care recipients and there is always the language difficulties and general understanding. I've got basic Māori and I will ask people if they want to have a karakia when we meet, so that they have some choice but in the end you are still a white person, an old white person, at least I'm not male! (12.W)

specialist assessors were also forthcoming about their perceived levels of cultural competency and how these factors might collectively shape the assessment process:

> I guess we're always conscious of the specific cultural context, the whānau and the hapū and iwi ties and how they come in. I'm not sure in my experience it makes a huge deal of difference to the eventual outcome. I mean, particularly for somebody like me with an accent like mine, I've got to be particularly careful to make sure that I do that properly, and not only do it properly, but be seen to be doing it properly I think. (02.W)

Another specialist assessor reflected that despite efforts to be self-aware, competent, and safe, limitations remain:

> My continuing professional development last year was being very conscious about my knowledge of professional and cultural practice. And, I just think as immigrants you just have to hold your hand up and

> say no I'll keep reflecting… that's the limitation of my competence that I will always have to work on and reflect. (14.N)

All specialist assessors described a commitment to undertaking respectful, collaborative, and non-tokenistic assessments. Emphasis was placed on ensuring a meaningful experience and outcome for the care recipient and their whānau. Different strategies were described. A specialist assessor who self-identified as Māori spoke to the te ao principles they employed within their practice:

> what it comes back down to is tino rangatiratanga, yeah so that's about all liberty human rights the interest their right to care and to have their voices heard. An equitable service or ōritetanga and the same rights as you know the right to as good care as anyone else and not have these adverse issues. (11.A)

This participant felt encouraged by receptivity of Te Whatu Ora Health New Zealand and, in particular, their own place of employment to adopting these principles more widely. They noted that it was easier than people thought to bring these principles to life in an assessment and intervention context. Others were of the view that as a group specialist assessors had "*an empathy and interest for te ao Māori but can and should do better than that*" (06.A).

Other specialist assessors did not talk explicitly about te ao Māori concepts or principles; instead, referred to Te Tiriti o Waitangi principles of participation, partnership, and protection. Some gave concrete examples of how they incorporated these principles within their assessments:

> First of all, under New Zealand law we've got the Treaty of Waitangi principles… under participation… I feel it's extremely important to consult with whānau and to get what their genuine views are for the client, their family member, including where to from here and potential pathways even from when you're first doing the assessment. If I'm going, for example, to a family home, I would try and be culturally sensitive as best as I could. For example, I may in some circumstances talk to a cultural consultant to get some advice, but otherwise I'd try

> and follow what I would feel would be some respectful actions such as bring morning tea when I go and see a client at their home for everyone there and take off my shoes when I go in… basically just absolutely try and treat everyone with respect. I suppose you're trying to be aware that Māori are over-represented, and I don't in anyway want to contribute to that. (03.A)

Here the specialist assessor drew an explicit connection between their efforts to honour cultural factors which foster care recipient engagement and the liberty implications of the assessment process.

4.5.4 Giving expression to Te Tiriti o Waitangi

When asked a general question about their understanding of the human rights of care recipients, a few specialist assessors raised Te Tiriti o Waitangi. However, when Te Tiriti o Waitangi was introduced by the researcher in the context of rights issues specific to Māori care recipients, it was apparent that all specialist assessors were attuned to the potential for rights-based issues. For some, the differing interpretations of the Treaty was identified as an ongoing challenge:

> So I think juxtaposing all of those western concepts against a te ao Māori world view you know there are some parallels. The Treaty, I'm very pleased it exists but I struggle with it in abstract terms. And how to sort of translate that into practical terms. I hit up against the translational aspects of it. I'm unhappy about how it was translated; I think that has led to confusion. (06.A)

Another specialist assessor recognised the challenges caused by issues of interpretation for psychologists, specialist assessors, and other clinicians, but was clear and confident in their views about the way forward:

> I don't think that's terribly explicit but I think also maybe there is some anxiety about it or maybe some mis-understandings about it, and also I should probably make clear that I talk about Te Tiriti I don't talk about the Treaty, I only talk about the Māori version… I think we have

> probably done arguing about mis-interpretations, let’s just go with Te Tiriti and just get on with it. (11.A)

Others reflected that a lack of training about Treaty issues as they related to specialist assessor practice could have several implications, such as a lack of confidence or feelings of uncertainty, potentially leading to conflict or misunderstanding.

A range of views were offered by both Māori and non-Māori specialist assessors as to the potential Te Tiriti o Waitangi might hold in respect of meeting or enhancing the liberty interests of care recipients. Some framed the potential in respect of the development and delivery of meaningful cultural services:

> This is where cultural assessments would be helpful in terms of understanding individuals’ identities and their cultural belief systems, and translating that in to the risk framework. I keep going on about it, the context of risk in terms of what is that individual’s worldview and how have their experiences contributed to the origin of that behaviour. Let’s understand where that’s come from and lets not have our restrictive British-based system of law really focussing in a punitive manner and making sure that our rehabilitative programmes are actually culturally appropriate and in line with people’s belief systems. So that’s how I would see the basic level how do you make contribution to that. (14.N)

Of interest, there was consensus among the specialist assessors that cultural assessments were not well utilised within the IDCCRA framework (although required by section 23 of the Act). One specialist assessor viewed the rare use of cultural assessments as a failure which undermined the spirit of the IDCCRA:

> The law tried to make (cultural assessments) required rather than optional. I think there’s been a wholesale abrogation of the spirit of the Act in trying to achieve that. And there has been a wholesale abrogation then by the judiciary in complaining about that. All of the ones that I’ve seen have been helpful at some level. But again, I mean there’s an example of you know total failure to meet our obligations

> under the Treaty. Because you know how can you really say there's proper participation. If you've not got any specific cultural input. And again, because somebody is in a kaupapa service doesn't mean they've got cultural input or a cultural formulation or a cultural opinion being provided to the Court at all. (09.A)

Some specialist assessors had seen a handful of cultural assessments. "*I've only ever read about four cultural assessments in 5-years, that's all*" (14.N). Others reported that they had never seen a cultural assessment prepared within the IDCCRA process. Some observed that the quality of cultural assessments varied but, in general, there was consensus that consideration of cultural factors could enhance the specialist assessment process. One specialist assessor described how a cultural assessment enhanced their formulation of a care recipient's risk and rehabilitation needs:

> Personally, I found them fantastic, just invaluable and really critical to my risk decision making. So in the absence of them I may have come to possibly the same answer in terms of the risk summary judgement but my formulation was completely different and my recommendations to services completely different. (14.N)

Others noted the potential for cultural assessments to enhance the liberty interest for proposed care recipients by identifying alternatives for intervention that sat outside of the compulsory framework:

> It may be a marae, it could be a mentor looking within a marae, it could be marae-based programme, you really are trying to look more broadly to see if there are pathways or programmes that can mitigate the risk within the Māori cultural area, as well as others that aren't considered Māori cultural areas. (03.A)

The above extract focuses on the pathways that cultural assessments might illuminate for Māori care recipients. However, the importance of recognising and addressing the unique cultural needs for all care recipients was also reiterated, "*My own belief is that the more you can humanise the client or the care recipient the better, so that the courts* *can understand the person and where they're coming from. Obviously culture's a huge part of that*" (03.A).

Others reflected on the fairness of expecting meaningful change for Māori care recipients within a framework or services that were not meeting cultural needs. There was a concern that issues of poor cultural fit could lead to poor rehabilitation outcomes and extensions to orders, "*I'd say that's grossly unfair really*" (13.W). The extract below brings together many of the issues raised within this theme and asserts that effective identification of cultural needs with appropriate placement would reduce barriers to change. Recognition of cultural needs is seen as providing a solid foundation for the assessment of risk and responsivity to interventions:

> I mean it's an intersectionality deprived group of people really isn't it? I mean they're already deprived and then they're additionally deprived by other reasons. So the question is what are the additional liberty issues associated with this group of people… people also have a right to treatment as well. And I think that that needs to be considered. But in terms of the additional stuff for Māori, I suspect that the thing that would help me the most would be the knowledge of the individual services and whether they were able to deliver a culturally appropriate plan. That would result in the rehabilitation of that person and if you were putting someone who was highly sensitive to tikanga violations, into a service that didn't culturally suit them you're putting a square peg into a round hole… You're setting somebody up to fail if you're putting them in a service that doesn't suit them. (15.W)

In summary, most specialist assessors identified an approach to service delivery and rehabilitation planning responsive to Te Tiriti o Waitangi would result in "*genuine and meaningful partnership*" (13.W). In contrast, there were equivocal views on the role that cultural factors should play in the development or adaptation of actuarial risk assessment. Some specialist assessors expressed concern that adjusting actuarial risk measures based on cultural factors might diminish accuracy:

> I mean Te Tiriti is part of a cultural lens that you apply I guess. Or that you consider when you're coming up with care planning, but the risk

> assessments that you’re doing need to be unaffected or unaffected by potential sources of bias as much as possible. So the issue is the risk assessments aren’t normalised for Māori and Pasifika populations. And so that’s one way of looking at it. But… they are validated… around the world and internationally. And I have got a reasonable belief in how they work so I’d put a cultural tint to it or a cultural lens on it. But I would never adjust the risk assessment despite the fact that it hasn’t been properly validated with Māori. (15.W)

The applicability of actuarial risk assessment measures to Māori care recipients and other minority groups was contested. One specialist assessor expressed concern about the continued use of some risk assessment tools despite well documented concerns about issues of cultural and systemic bias, “*it [makes it] more likely that we’re going to criminalise any minority population, but particularly Indigenous populations*” (09.A). The importance of specialist assessors communicating the limitations of risk instruments to the Court was identified, “*I do worry about our risk assessment tools and our systems and processes in terms of all of us (specialist assessors) writing a disclaimer… they may not be appropriate and have to be interpreted within the light of norms of Canada*” (14.N). Many of the risk instruments used by specialist assessors and other forensic psychologists are developed and normed in North America.

These findings highlight the range of challenges faced by specialist assessors as they contemplate the use of risk assessment instruments within their practice. There appeared to be universal support for the inclusion of cultural factors in the risk assessment process to improve identification of less restrictive alternatives or more sensitive care and rehabilitation plans. However, whether actuarial risk assessments should be adjusted to account for cultural factors was a contested issue.

4.6 Theme five: “We Hold Tremendous Sway”

This theme explores how specialist assessors viewed their role in relation to legal decision-making about a care recipient’s liberty interest. Subthemes of influence, power, privilege, pressure, and responsibility characterised descriptions of the specialist assessor role. Diverse and contradictory perceptions of identity were exposed. The tensions arising as specialist assessors contemplated the liberty implications of their assessments is explored.

4.6.1 We feel influential

On one hand the specialist assessors agreed that ultimate decisions about liberty rest with the court. On the other hand they also perceived their reports be highly influential on judges, "*Although I'm not a decision-maker obviously, there's no getting away from the fact that we hold tremendous sway with the decision maker… telling that story of risk and rehabilitative need, is really fundamental to the work*" (01.W). As illustrated by this extract, specialist assessors perceived the role to have an enormous impact on judicial decision-making.

Another experienced participant agreed and said that specialist assessors were unwise to think they did not exert influence over the process:

> I think there's a huge amount of variability in the knowledge that the judges already have… our terminology and the way in which we provide information is incredibly influential to judges… I've been criticised within the system for being concerned about some of the outcomes that the judges reach on the basis that that's the judge's prerogative and it's hard luck if you don't like what the judge has decided. But actually, the judges reach those decisions heavily on the basis of the information they're provided with by experts in the field. And, if those experts are not providing objective and neutral fair expertise, then we cannot expect that judges will reach fair decisions either. And it's naïve to think that we don't have considerable influence in how we sway their opinions. (09.A)

This extract illuminates several important points. First, it suggests that how specialist assessors articulate their opinions could influence the court in different ways. Second, the emphasis placed on experts being neutral and objective is a direct reference to the Code of Conduct for expert witnesses and a warning against advocacy. Of further interest the specialist assessor is pointing out the relationship the between expert and judge, suggesting that some responsibility for poor judicial decision-making about liberty interests may lie with quality of evidence provided by experts.

This relationship between an specialist assessor's communication style and judicial decision-making about the liberty interest was highlighted by others. Concrete examples were provided:

> It's easy to write up five paragraphs about someone's assaultive behaviour. I see it in some people's reports where they'll list every single assault for instance, every single incident report. If you begin building a story like that, then I think the assessor can then really influence how that person is seen. The way we communicate with the decision-makers is fundamental to the outcome which in turn is fundamental to the liberty test and so on, isn't it? (01.W)

Others saw report writing an opportunity to put the care recipient's behaviour in context for the Court, "*The person is a person and therefore I think a critical part of our role is telling that person's story to the Court so that they can understand that*" (05.W). For another specialist assessor, report writing provided an opportunity to preserve humanity, by presenting information in a manner that, "*acknowledges the risks a person may pose but also their… humanness*" (13.W).

The issue of whether specialist assessors should specify term length was a contested issue. One specialist assessor stated, "*In what other clinical field do we make recommendations on the length? …So it does often feel like the judges are actually asking us to pass sentence on this person. And so actually it's not a clinician's role*" (09.A). This specialist assessor describes the unease generated by this situation, likening giving an opinion on term length to passing sentence. As discussed in the first theme, a group of specialist assessors avoid giving the Court a single recommendation, preferring to lay out various options.

In contrast, other specialist assessors appeared comfortable providing specific advice, seeing the purpose of the specialist assessor role as being "*to formulate everything there is and make recommendations, just to answer, you know a simple question really, that one question of yay or nay*" (04.W). This specialist assessor was left with the impression that judges readily accept their opinions and recommendations on term length, "*Well because, I think because we're kind of listened to aren't we, they (judges) listen to what we're saying, and they always do it don't they*" (04.W). This experience of being listened to was echoed by one of the most experienced specialist assessors, who reflected that in their 17-years of preparing specialist assessor roles, it was rare for their opinion to be challenged:

> I've only once had a judge not follow that recommendation so and I was wrong in that case. Yeah so you've got a big role to play in trying to get that balance right, you put the right information before the judge. (12.W)

One is left with the impression that this specialist assessor's experiences resulted in them feeling obliged to engage in their own balancing exercise. While it is not explicitly stated, the context of the discussion was striking a balance between risk and liberty. Another specialist assessor wondered whether judges accepted the opinions of specialist assessors because they were assumed to be "*humanitarian and fair*" (04.W) and, therefore, trustworthy.

Issues of transparency in the system were raised by some specialist assessors. There was a view that specialist assessors tried to downplay the level of influence they held within the process. "*We sometimes, sort of, hide behind by saying it's the judge's decision but you kind of know that the judge is probably going to listen to my recommendation*" (04.W). Another felt the degree of specialist assessors influence was masked by a "*system that's not transparent*" (09.A).

Further, specialist assessors were concerned with the role that they play in recommending whether an order should be extended or expire. There was agreement that the onus was often placed on the specialist assessor to determine whether an extension was indicated. In addition, some had been left with the impression that their findings could be determinative, "*I think the way the Act's designed is that we don't ask for hearings routinely. There's only a hearing if someone challenges a recommendation for extension… Although I'm saying it's the Courts decision there is no Courts decision*" (05.W).

Another specialist assessor observed that the ‘tick box’ structure of the report templates pushed specialist assessors to comment on the ultimate issues at disposition and review. For example, the specialist assessor is expected to sign a certificate at review that stipulates whether the care recipient’s status should continue or change. Only the first and last review report is submitted to the court. This was critiqued as conferring a level of influence and decision making on the specialist assessor that is uncommon within other areas of forensic practice.

All specialist assessors reflected on the large amounts of information gathered as part of the specialist assessment process. They believed the court utilised this information when making decisions about liberty. However, several specialist assessors reported that issues relevant to the liberty interest were not always raised with the court. The lack of clarity about whose responsibility it is to ensure this information is brought to the Court’s attention was raised by specialist assessors.

One specialist assessor reflected that it is not the role of the specialist assessor to take the perspective of the care recipient, but neither is it clearly the role of anyone else in the system:

> The specialist assessor’s role could have been more explicitly placed, as somebody essentially taking a perspective of the service user… And much more explicitly assess ways in which this person’s rights can be less restricted and less impacted. That’s not how it’s written as the role at all. But there’s nobody else who does that either so… You‘re being asked to assess the risk to other people. So in fact your responsibility is to society rather than to the individual that you’re seeing. So you’re very definitely not mandated to be in an advocacy role at all. But who is? Then so whose role is that within the IDCCR Act? (09.A)

This so-called gap in advocacy was a source of concern for other specialist assessors. One compared their experience of being cross-examined within IDCCRA proceedings to other criminal justice processes:

> There’s very limited testing going on. The lawyers that I have to deal with generally are pretty good but I’ve never had the kind of cross

> examination from a lawyer in this setting that I have in the District or High Court when I'm at Corrections… Sometimes the lawyers will stand up and have a generally weak approach… don't even know what to focus on…. They don't even ask fundamental questions… which means they rely on the specialist assessor outlining their own limitations. That's our professional obligation and of course, we always should. (01.W)

Others expressed surprise that orders were not "*challenged more often*" (11.A).

The risk of specialist assessors being pulled into an advocacy role because of a vacuum in robust representation of care recipient's human rights was reflected upon:

> So I do think it's a lawyers role to argue for the human rights of an individual. And I don't think that's a specialist assessor's role. And I think that we end up sort of crossing roles and therefore outside of probably our sphere of expertise as well. You know the codes of conduct for expert witnesses say actually you should only give expert evidence within your sphere of expertise. And so you know and I think that we are kind of pulled into doing some of the lawyer's jobs for them. (09.A)

The findings raised important questions about who is best placed and equipped to the advocate for a care recipient's human rights as the Court considers issues of risk and liberty.

4.6.2 Role tension

The specialist assessors expressed diverse perspectives about the function of the role in relation to issues of risk and liberty, which are described below.

Diverse role identities

The theme of influence was present in the way specialist assessors identified the role of a specialist assessor. The specialist assessors referred to the role in diverse ways. The expectation for specialist assessors to consider the risk a care recipient posed to the community was the most prevalent view of the role. "*You're being asked to assess the* *risk to other people. So in fact you're already being placed where your responsibility is to society rather than to the individual that you're seeing…. you are essentially a public protector*" (09.A). This view was echoed by others who identified risk assessment, not rights protection, as the core feature of the role. "*Assessing risk, that's by far the most important thing to do*" (01.W). Several specialist assessors spoke explicitly about considering victims, past and future, when considering public protection. "*Reducing risk to the community and potential victims in the future*" (13.W).

The assertion that specialist assessors act on behalf of the Crown or the state, was aligned with the public interest obligation. The following extract illustrates how one specialist assessor located themselves in relation to the Crown obligations:

> As assessors where we place ourselves assessing a Māori care recipient or potential care recipient, is that we are agents of the Crown. So we do have a responsibility as agents of the Crown to uphold Te Tiriti. (11.A)

The notion of being an agent of the state was tacit but nonetheless present in the mind of another specialist assessor, "*But the way I see it is that as a person who is an officer of the state… it's always in the background and needs to be carefully thought about*" (15.A).

Each of these descriptors raise the issue of specialist assessor bias. For example, the use of the term "*agent of the Crown*" (11.A) suggests an implicit adversarial bias, in that the specialist assessor feels instructed by or answerable to the Crown. Lastly, this language also infers a sense of power and status associated with the role that could be considered distinct from the usual therapeutic orientation of clinical psychologists or psychiatrists.

In contrast to the descriptions explored above, another specialist assessor viewed their role as, "*a friend of the Court. I think sometimes by laying it all out, you can really provide a good description of that person and what they are and what they contend with*" (08.A). This description is focused on specialist assessors providing detailed, objective information that assists the court to make sense of a care recipient's situation. In this regard, the account is aligned with the definition of an expert witness. However, the word "friend" is somewhat ambiguous, and is open to critique through the lens of bias.

Others described the specialist assessor role in more neutral ways; for example, "*investigator*" (14.N), "*formulator*" (04.W), or "*diplomat*" (13.W). The notion of being in service of the court was also expressed, "*My function? It's to serve and communicate to the courts*" (14.N).

Identity issues aside, all specialist assessors placed emphasis on the clinical skills that specialist assessors bring to the role and their capacity to inform the Court about salient issues. Further, there was consensus that specialist assessors assist and influence the Court by providing expert and robust knowledge.

Dual roles

The implication of identifying oneself as therapist and as gatekeeper to compulsory care was raised:

> It's that dual problem isn't it… because psychologists we are therapists but then we're sort of an agent of control aren't we in this… because I worked in the forensic system I was already very conscious of that duality in the yeah, a hard balance. (04.W)

Other specialist assessors identified a tension between the roles of clinician and specialist assessor. The need for support in resolving the related ethical dilemmas is alluded to below:

> I do kind of feel like there's so much grey in this. So I do, do a lot of talking about you know with peers about. And a lot I'd say the majority of the issues that come up there are the ethical and the kind of conflicts between the legal and the clinical roles. (09.A)

A second aspect to this tension was expressed. Here the specialist assessor is reflecting on how their use of therapeutic skills could mask the true function or orientation of the role:

> We use our clinical skills to be really nice and open and collaborative with the client but then we are going to make a decision about maybe taking their liberty away which maybe they don't want. It is a tension. (04.W)

Indirectly, this raised the question of how well-equipped care recipients, by virtue of their disability, are to distinguish the role of the specialist assessor from the therapist or clinician. This situation highlights the gaps between the ethical obligations guiding clinical therapeutic practices and the code of conduct which sets clear parameters for expert practice.

In summary, the subtheme of role conflict and competing obligations was woven through the diverse descriptions of the specialist assessor role. The conflicting ways specialist assessors described the role mirrored the lack of clarity about where human rights should feature in their practice. It was evident that tension arises for specialist assessors who wish to promote human rights but feel unsure how to express these interests.

4.6.3 Pressure to protect the community interest

The participants described emotional impacts arising from specialist assessor work due to the orientation to public protection. This was commonly expressed as a sense of burden, responsibility, or weight, "*I feel a lot of responsibility to especially with the seriousness of the offending… there is always that sort of a sense of anxiety around you know getting it wrong*" (11.A). Some felt that the pressure to make the right decision contributed to risk aversion:

> It takes a brave specialist assessor to say look I think you should prioritise this person's liberty interest over the possible risk to the community. Judges I suspect would fall in the same area. They don't want to be the last person to have done a report, or made a care order decision when somebody goes out and commits a serious sexual offence 6-weeks later. So I don't think anyone is going to overtly raise liberty interests in preference to risk. (15.A)

More than half of the specialist assessors commented on their tendency to take a risk-averse approach. The following extract highlights how risk aversion could manifest for specialist assessors:

> So the liberty interests are always in the background and you have to think very carefully before you are advising a court to deprive

> somebody of their liberty. So there is a tension, but it's not always spoken because a specialist assessor would probably not often go in H's case (vignette A) and say 'Hey this has gone on long enough!'… I mean we're going to err on the side of caution aren't we generally. Not going to want to stick our necks out and do something which other people wouldn't necessarily kind of support. And if you ask a psychiatrist or a psychologist to make a decision, they will tend to be defensive, or they'll tend to be on the side of trying to avoid the obvious harm. (15.A)

This extract illustrates the tension faced by specialist assessors who might wish to challenge the status quo by recommending a reduction in restrictions or the restoration of a care recipient's liberty. It is opined that specialist assessors are likely to take a cautious approach to risk assessment to avoid possible harm to the community. Other specialist assessors observed that the system might reinforce a bias towards extension. "*It's relatively straightforward to make an argument for most people for an extension of an order, or for an order in the first place if you're risk averse*" (05.W).

Feelings of burden and responsibility were attributed to specialist assessors internalising pressure to find "*the best way forward*" (04.W) in complex cases. One specialist assessor shared how they differentiate their job from the court's role in considering morality, deterrence, and public safety. Nonetheless the sense of pressure remained a strong subtheme:

> I used to work with a really great psychiatrist. He would always say when you have a dilemma don't feel under pressure to solve the dilemma, but describe the dilemma in the report… I think that's a more useful way of… not putting ourselves under personal pressure to try and answer these massively complex questions. (05.W)

The sense of burden is rarely shared:

> Again, it's the processes we don't talk about isn't it? One of the factors is the degree to which we feel like we could or couldn't live with

> ourselves if something happened... But we don’t really talk about that. (05.W)

Anticipatory anxiety about the possibility of wide-ranging negative consequences should a care recipient reoffend was linked to risk aversion. The consequences included intensive scrutiny by peers or the Court:

> I’ll talk about psychiatrists because they’re my tribe. To underestimate risk and to fear the criticism of colleagues in the coroner’s court. And the public should things go wrong. I’m not trying to be a martyr. I don’t think that will probably ever really be able to be taken out of the equation. Except maybe mitigated with our being able to articulate and put into words. (06.A)

This specialist assessor perceived that risk aversion could be mitigated, to some extent, but not eliminated. Another specialist assessor spoke of the relief they felt when positive progress had been made with a long-term care recipient:

> I’ve got someone at the moment who has been extended seven or eight times, I think. Yeah the burden is higher then. You have to justify it more [continued compulsion]. You breathe a sigh of relief when you go in to those reviews and you think phew we’ve had progress. (04.W)

This same specialist assessor contrasted the sense of relief with approaching a review where the outcome felt “*a fait accompli*” because the level of risk presented by the care recipient was consistently judged to be contrary to the public interest. Several participants agreed that there was little choice for specialist assessors faced with these scenarios, “*If the risks exceed a threshold for me then I cannot but recommend an extension*” (06.A).

These findings provide important insights to how specialist assessors perceive the tensions between risk and liberty interest arising in the role.

4.7 Theme six: A Non-reflexive System

A final and distinct theme was the importance of specialist assessors engaging in connected, informed, and reflexive practices that promote human rights. A source of concern was regional variations in specialist assessor practice. The causes were attributed to specialist assessor isolation, the absence of oversight or review processes, and varied training opportunities. The first subtheme discusses the autonomy afforded to specialist assessors, contributing factors, and the perceived human rights implications for care recipients. The second subtheme examines the ways reflexive practices protect against specialist assessor bias, drift, and isolation. The final subtheme identifies steps that could facilitate specialist assessors to further integrate rights-based based practice.

4.7.1 "The autonomy is wild"

Several specialist assessors reflected on the degree of self-determination in their role. In doing so, they drew comparisons to other forensic roles, "*When I compare our autonomy in this system with the Department of Corrections system, for instance, it's wild*" (01.W). This specialist assessor was frank about potential human rights implications of this situation for care recipients:

> I think about this system where I'm dealing with at the end of this is an intellectually disabled person who's usually vulnerable who cannot in any conceivable world advocate for themselves. There's no barriers between whatever the hell I think about today and what I tell the court. I could even do that without taking it to supervision. (01.W)

There was a view that specialist assessors could be "*leaned on more heavily*" (01.W) in comparison to current quality processes enacted by the MOH to demonstrate their practice was sound, including the domain of human rights.

Collectively, the specialist assessors acknowledged the specialist skills and professionalism held within the group. The diversity of specialist assessor backgrounds and disciplines was seen an area of strength:

> They're (specialist assessors) coming from different perspectives, different areas of expertise but generally I am really impressed with

> the standard of what comes through. When I see other people's reports I just think wow, we've got a lot of very, very clever and thoughtful people doing these things. (02.W)

Nonetheless the benefits of greater support and oversight were consistently highlighted in the interviews. The sense of isolation that some specialist assessors might feel is described below:

> The majority of us are very isolated in the roles… It's maybe a bit of a miracle that we're not all doing you know completely bizarre things because certainly there isn't anything built into the system for checks and balances, and feedback. We don't even have kind of a you know professional development performance review type system. (09.A)

Several issues are raised within this extract. Firstly, this specialist assessor appears concerned about the absence of review and quality processes that contribute to specialist assessors practicing in isolation. This perspective raised questions about the adequacy of processes to support and maintain the integrity of specialist assessor practices.

4.7.2 Variations in assessor practice give cause for concern

Variations is specialist assessor practice was a strong subtheme. Of interest several specialist assessors used the terms 'drift' or 'drifted' when reflecting on this issue.

Specialist assessors reported that they relied on personal supervision or other informal peer support processes to maintain good practices. "*I don't peer review all my specialist assessor reports but I will often talk to my peer supervisor about them just so you've got a bit of another set of eyes on it. I think that's good*" (13.W). Others spoke positively about support provided by clinicians appointed into dedicated IDCCRA advisory roles, and the accessibility of key people at the Disability Directorate, MOH. However, it was noted that this external support was typically sought for more complex cases rather than as a matter of course. The absence of a formalised feedback process was linked to variations in specialist assessor practice.

Regional variations in specialist assessor practice were discussed by others, "*I think there tends to be a drift in culture and so people might be doing it one way in Auckland and one way in the southern area*" (02.W). An explicit link between these variations in practice and the liberty outcomes for care recipients was drawn in the following extract:

> I've seen a couple of reports from a different region and have thought I would probably have recommended a longer order or recommended an order, which did make me talk to my peer supervisor. I thought [about] whether or not I might be landing [on] more the restrictive [option] or more likely to recommend an order for longer… I thought that was interesting to reflect upon, because if it comes down to who you get as your specialist assessor if you get an order… it's a bit uncomfortable, but yeah anyway that was an observation I had. (11.A)

This extract is noteworthy for several reasons. Firstly, the specialist assessor had observed that outcomes for care recipients may be dependent on which specialist assessor conducted the assessment. Secondly, the specialist assessor is candid about the discomfort this caused because of the related liberty implications. Thirdly, the specialist assessor appears to have used peer supervision to reflect on whether their own practice was biased in a particular direction; that is, towards more restrictive recommendations.

Another specialist assessor spoke of undertaking similar reflective processes as they read their colleagues reports:

> I see some really, really good reports and some really smart people doing some reports. But you know sometimes you also see bias creeping in… they don't have enough information to make the declarations or the recommendations that they're making and things like that. (15.A)

This specialist assessor then stated that a more structured, robust peer review process would serve the dual purpose of keeping "*people honest*" and enhancing professional practice, especially for newer specialist assessors. Others believed that setting benchmarks for practice would enable specialist assessors to learn from others' experiences. Mechanisms to improve practice and safeguard care recipients' human rights and liberty interests were suggested:

> There's an independence to the specialist assessors… that gives you a unique position of… being… independent to that particular person that you're seeing just now. But also to potentially use the specialist assessor group to… go round different organisations in different parts of the country, and ensure that there's better geographical similarities… It really helps with good practice as well as identifying... drifted practice… That would have been… a powerful… clinical community of practice. To build expertise and to make agreements about key performance indicators and about training. (09.A)

This specialist assessor then reflected on other barriers to a more connected community of practice:

> Specialist assessors have been kept very separate from each other. And in competition with each other and so there's been a sort of missed opportunity within the system to make much more of the specialist assessor role, and to… develop and help to contribute to an improvement in the whole system over time… People can't come together and say this isn't okay and how come we're not doing this. And I think that that's so short sighted because I just think it's such complicated work, you need many minds to try and make any improvements. (09.A)

This extract raises the question of whether the isolation is deliberate, unconscious, or a consequence of how the IDCCRA sector has been structured and resourced.

Other specialist assessors pondered the separation between assessors, viewing it as a missed opportunity for establishing shared "*boundaries*" (12.W) for practice. Some specialist assessors said they relied on reading colleagues reports to, "*see what people's opinions and attitudes are*" (12.W). Remarkably, this specialist assessor stated that the research interview was the longest conversation they had ever had about their IDCCRA role and work. They were firmly of the view that greater discussion amongst specialist assessors would not undermine independence or "*spoil the legal process*" (12.W).

Some had enjoyed targeted and intensive training about the IDCCRA, important case law (e.g., *VM*), and the specialist assessor role; while others "*learnt on the job*" (05.W). A novice specialist assessor reflected on their training experience:

> I'm coming more from the mental health field and I don't have any forensic experience or forensic background, I felt a little bit out of depth going into that training because it is so sort of forensic weighted. I felt like I had more questions maybe than the others and I still feel that that's something I'm sort of playing catch up with. Feels like quite a steep learning curve… The supervisors were helping me with it but ... I know that it's a bit of blind spot for me. (10.A)

This extract usefully illustrates how the specialist role is challenging compared to other areas of work. This specialist assessor described a relatively robust induction (three training days, several hours each day); however, the need for ongoing support was made clear.

Overall, training was described as infrequent. specialist assessors expressed gratitude for the training provided but noted that it was often heavily weighted towards "*imparting information*" (02.W) rather than providing opportunities for case discussion. A perceived gap in training and support was the sharing of relevant legal decisions and the linking of the law to relevant sections of the legislation. The tension between specialist assessors being well informed about the law but not overstepping the boundary into advocacy or judgement was touched upon by several specialist assessors:

> We are not expected to provide legal analysis but we are expected to be informed and have a reasonable understanding of case law. But where that sort of balance lies between what's a reasonable or adequate sort of understanding and at the same time not a lawyer, you know that's really tension. So I think it is something that we probably sort of need training in and supervision. (08.A)

This extract suggests that some specialist assessors believe targeted training would enhance their sense of efficacy, safety, and confidence in the role.

4.7.3 Reflexive practice protects against drift, bias, and isolation

The protective function of reflexive practice was referred to by a small number of specialist assessors, "*We all know practice can drift over time as well. That's why it's really important to maintain that reflective practice*" (11.A). There was a view that opportunities for collective reflection would foster the professional growth of specialist assessors:

> It's really hard to be self-reflective. There's no mirror that gives you any point of reference… so you need something out there that tells you, is this normal or this is not normal. And I absolutely struggle with the complete lack of any external way of knowing. Whether I'm good, bad or indifferent at what I do. I don't think there's anything in the system that tells me that in an unbiased way. (09.A)

According to one specialist assessor who is employed both within Te Whatu Ora Health New Zealand and in private practice, specialist assessors risked being professionally isolated due to the lack of a formal peer support system. Training days were seen as a means to develop or strengthen peer connections and to building the resilience to deal with wider systemic pressures:

> Well, it's been quite a while since we've had group training. They have been good without exception. And I think more should happen. Another positive thing is you know connection with other specialist assessors. And the sense of peer support in the context of a health system and mental health and disability system which is in frank disarray. (06.A)

Another specialist assessor linked the presence of a peer review system to learning and maintenance of rights-oriented ethical forensic practice:

> It's incredibly hard to do that [learn] in the darkness. Incredibly hard. I know plenty of totally fantastic, totally fantastic specialist assessors

> who despite all of these obstacles manage to navigate a pathway that is ethical. That is positive and hopeful. And rights oriented… but it is despite the system and the obstacles rather than because of the systems. (09.A)

The psychologist specialist assessors who work solely in private practice all discussed the importance of having good professional support systems (e.g., clinical supervision and collegial support) to support safe practice. Here the specialist assessor is talking about using the support of peers to work out if commenting on liberty issues oversteps the boundaries of clinical practice:

> Advice and collegiality… to say where the boundaries are and when we might be straying to slightly tricky territory but you can still navigate that tricky territory by being respectful to the court and acknowledging that you may be… reaching [at the bounds]. (08.A)

Irrespective of whether specialist assessors were in the public system, private practice, or a combination, all believed that there was great value in the MOH supporting specialist assessors to regularly meet to discuss case work and potentially engage in peer review and supervision.

4.7.4 Rights-based practice: A way forward

All specialist assessors were receptive to further training in human rights. Some identified that the study spotlighted the issue for specialist assessors:

> I'm really pleased to see some research done in this area… I think we could continue to be upskilled as a group. I think it should be better supported…. I think it would be okay if we were leaned on a bit more heavily in terms of making sure we were meeting our obligations. That should be informed by the kind of research that you're doing. (01.W)

A two-pronged approach was advocated. Access to rights-focused training by experienced academics or professionals was seen as the precursor to specialist assessors making informed decisions about how respond to the CRPD and other human rights instruments in their practice. The first stage involved the provision of training by experienced academics or professionals on the CRPD:

> That’s the sort of thing [CRPD] that we could hear about and have some really good discussions about how much that would involve our assessments and whether we think about that or whether we leave it to the courts. (02.W)

Others wanted more clarity about a specialist assessor’s scope to promote human rights in their reports, “*What are the limits of what clinical psychologists can say and refer to and when should we not?*” (3.A). The need for all specialist assessors to be equipped to engage in discussion about the interface between human rights instruments and clinical practice was emphasised, “*I think it’s important that we keep talking about those things and make sure at least we have some commonalities and understand where we’re all coming from because we can all learn from each other*” (02.W).

It was observed that facilitating training and discussions of this nature would require a different mindset from the MOH:

> The trainings are often focussed on quite concrete things and that are relatively basic around risk assessment. They’re aimed at upskilling everyone to make sure there’s a minimum standard of report. The idea of the training isn’t that we get together and think about our philosophies, and our approach, you know come up with imaginative approaches. (15.A)

One specialist assessor anticipated that introduction of an explicit human rights framework would be “*a bit of a paradigm shift in some ways*” (04.W). Others expressed a willingness to address human rights issues in their reports but saw the lack of practice guidelines as a barrier, “*What might be really helpful is to write some practice guidelines about how we might do that [address HR issues] I’d also want to be able to do that in a thoughtful and helpful way*” (11.A).

The challenges of facilitating training on human rights were reflected upon. One specialist assessor wondered if the MOH might view training of this nature as a responsibility for individual clinicians and/or their professional organisations:

> Look I think if you dumped this problem on my desk and said how are you going to manage this, your specialist assessors aren't human rights based enough, what I would do is put it back on the specialist assessors and say 'Hey look you've got the college and professional body obligations and stuff like that. What are you doing to, how are you going to prove to us that you're doing that kind of thing?' (15.A)

Other specialist assessors noted that the success of this kind of training or peer discussion would rest on the ability of specialist assessors to show vulnerability:

> So, those kinds of things can be good as long as people are prepared to be pretty honest and just sit in a room and have a good chat together and not be too intimidated by each other. Not in a sort of pulling each other apart, but just a constructive, critical look at things. There's a lot to be said for that. (02.W)

Although challenges were anticipated, there was consensus that training was necessary to better equip specialist assessors to understand the relevant human rights frameworks and more actively engage in discussion about their obligations.

In summary, the six themes derived from the findings demonstrate the explicit and implicit ways specialist assessors were contemplating human rights within their practices and the associated dilemmas arising.

Chapter 5 Discussion

5.1 Introduction

By way of background, together the IDCCRA and CPMIPA provide a comprehensive and complex framework for the management and disposition of people with intellectual disability who are charged with, or convicted of, an offence. The maximum term of a compulsory care order for a care recipient is 3-years. A SCR who is unfit to stand trial can face a maximum term of 10-years or an order equal to half the maximum term to which they could have been liable if convicted of the offence charged (CPMIPA, s30(1)(b)). The IDCCRA came into law in 2003. Specialist assessors are forensic practitioners who fulfil an important statutory role within the legislation (IDCCRA, s 5(1)). They assess proposed care recipients, and then undertake regular reviews of care recipients subject to compulsory care orders.

Specialist assessment reports inform judicial decisions about a care recipient's eligibility for a compulsory care order, the level of care, the term of an order (including the need for an extension), and rehabilitation needs. The specialist assessor is required to identify the least restrictive alternative (*RIDCA Central v VM* [2011]). The specialist assessor role is considered pivotal to the operation of the IDCCRA and CPMIPA (Nuth & Thompson, 2018).

The literature review presented in Chapter 1 established that forensic practice generates unique demands for psychologists and psychiatrists because of the human rights implications of this work (Allan, 2013a; McSherry, 2014; Ward & Birgden, 2009). Researchers have argued that adopting a human rights perspective orients forensic practitioners to the quality of the assessment process and social or moral factors that may intrude on the assessment process (Ward & Birgden, 2007). Additionally, a human rights perspective requires specialist assessors to ensure that the rights of people entering the justice process are not automatically given less weight than the public interest (Ward & Birgden, 2007). Arguably, all aspects of specialist assessments have significant liberty implications for care recipients, justifying the need for a human rights perspective (Perlin, 2018; Ward & Birgden, 2007).

This doctoral research was premised on several ideas. Firstly, it was unclear how specialist assessors derived their knowledge of human rights. Secondly, the researcher's personal practice experiences, preparatory research, and community consultations indicated that specialist assessors may be engaging in diverse practices regarding the liberty interest or discussion of relevant human rights law. Thirdly, it was anticipated that specialist assessors may be experiencing tensions because of the competing nature of a care recipient's liberty interests and the community's protection interest. Competing obligations of this nature within forensic practice are characterised as a dual role problem (Appelbaum, 1997a; Robertson & Walter, 2008; Ward, 2013).

Previous research has discussed rights-based issues arising from the IDCCRA (Brookbanks, 2003; Brookbanks, 2013; Diesfeld, 2013; Smith, 2015); or comparable coercive regimes (Adshead, 2014; McSherry, 2013; Vess, 2009). Much of this research focused on other statutory roles or considered the ethical issues arising from forensic practice in New Zealand and other international contexts. Few applied studies were located. No research had exclusively examined how specialist assessors working within the IDCCRA contemplated or addressed human rights within their practice.

This study has explored the extent to which specialist assessors integrate human rights perspectives within their assessments under two statutes—the IDCCRA and CPMIPA. More specifically, the study investigated how specialist assessors understand, express, and give effect to care recipients' liberty interests. Finally, the thesis probed the presence of any tensions or dilemmas that arise for special specialist assessors as they contemplate human rights perspectives. This research is undertaken in the context of international debates about the role of psychologists and psychiatrists concerning their obligations to promote human rights in diverse practice contexts.

Fifteen specialist assessors, who were either clinical psychologists or forensic psychiatrists, participated in the study. The author is a clinical psychologist; therefore, interpretation of the research findings is framed and underpinned by this disciplinary knowledge.

Six themes were derived from the findings. The themes demonstrate the explicit and implicit ways specialist assessors were contemplating human rights within their practices and the associated dilemmas arising. Themes one, five, and six outlined a range of issues directly related to specialist assessor practice. Theme one encompassed specialist assessor knowledge of human rights, and how they did or did not incorporate human rights within their practice. Areas of convergence and divergence were identified. Theme five examined the level of power and influence specialist assessors experience within the IDCCRA process. This was illustrated by the identities associated with the role and the tensions experienced as specialist assessors reflected on the human rights implications of their clinical opinions. In theme six, specialist assessors reflected on the independence afforded to the role compared to other forensic roles. They contemplated the human rights implications of limited oversight and variations in practice. Initiatives that could promote greater integration of human rights perspectives were identified. Creating opportunities for collective reflection and discussion about the place of human rights in specialist assessor practice was a strong subtheme. The findings specific to specialist assessor practice will form the first part of the discussion.

Themes two, three, and four look beyond specialist assessor practice. These themes highlight the ways specialist assessor were lifting their gaze to reflect upon the landscape within which specialist assessor practice exists. Factors specific to the legislation, service delivery, and cultural responsivity were examined. These themes show how specialist assessor were reflecting on issues of fairness, equity, and discrimination for care recipients. Factors specific to service delivery that have the potential to impact on the loss and restoration of the care recipient's liberty were identified. The cultural responsivity of the IDCCRA was a prominent theme for the specialist assessor. The findings indicate that specialist assessor derive a unique perspective of the human rights implications of each of these systemic factors as they undertake their role.

This study did not analyse the reports prepared by specialist assessor. Rather, the interviews revealed specialist assessors' integration of human rights and, specifically, care recipients' liberty interests, into practice. The results of this study show that all specialist assessors self-reported that they were attuned to human rights, in some way, shape, or form. Collectively, the findings suggest that human rights perspectives form part of a set of sub-textual values or considerations that drive the integrity of the specialist assessors' process. Although human rights may not be explicitly discussed within specialist assessor reports, based on the self-reported findings it is highly likely they were considered. This discussion is organised in three parts. Part I focuses on human rights knowledge and practices, and the tensions arising. Part II discusses factors within the practice context that were identified by specialist assessors to have human rights implications. Within each of the sections the implications of the findings are considered. Part III makes recommendations for practice, future research, policy and legislative reform. The discussion closes by reflecting on the strengths and limitations of the research.

5.2 Part I: Specialist Assessor Practice

5.2.1 Diverse understandings of human rights

The literature review examined human rights issues with application to care recipients and specialist assessor practice via several perspectives. These categories were: theoretical understandings of human rights; international and domestic human rights law; rights protections specific to care recipients; and how human rights feature in forensic and general psychological practice. This review was deliberately broad to reflect the exploratory nature of the study.

The findings from the interviews revealed that specialist assessors' understandings of human rights could not be characterised in a singular way. To some degree this finding was anticipated because the study included specialist assessors from two disciplines, bringing a range of professional experiences and backgrounds. This outcome is also consistent with the wide scope of rights issues with potential relevance to the IDCCRA framework. However, it also reflects the work of Nowak and Zenz (2020) who observed that rights cannot be viewed or understood in a singular way within psychological practice.

Referred to ethics or values, rather than human rights

The ethos and values of psychology is said to implicitly overlap with human rights (Kinderman, 2007). In addition, human rights are expressed as laws and as a set of values (Hagenaars & Thompson, 2020). The findings show that specialist assessors did not draw on any specific theoretical models of human rights when expressing their understanding of a care recipient's human rights. Nor did specialist assessors exclusively reference or privilege any single legislative or legalistic framework. Rather, specialist assessors tended to draw upon personally, socially, or professionally held values, morals, and ethical principles. Further, the findings highlighted that many specialist assessors viewed human rights as being implicit, rather than explicit, in their practice.

Paying attention to the values that underpin human rights is core to the social contract (framed within ethical principles) that psychology has with society (Allan, 2015). Individual specialist assessors in this study specifically referenced their ethical codes (e.g., Code of Ethics for Psychologists Working in Aotearoa/New Zealand or Royal Australian New Zealand College of Psychiatry (RANZCP) Code of Ethics). Some specialist assessors described the seminal bioethical principles of beneficence, justice, and non-maleficence advanced by Beauchamp and Childress (1979) or the principle of social justice.

The specialist assessors also referred to humanity and autonomy. Principle one of the RANZCP Code of Ethics requires psychiatrists to respect their patients' humanity, dignity, and autonomy. Arguably, a strength of this principle is the sensitivity to practice within compulsory care regimes, and the explicit directions for psychiatrists to pay attention to a suite of human rights instruments.

Regardless of whether the specialist assessor was a psychologist or a psychiatrist, access to education on human rights was key. Sometimes this was provided within their workplace, and sometimes it was derived from personal interest, study, or research. The specialist assessors did not report a focus on human rights education within their primary professional training.

These findings accord with several observations within the international research. Firstly, the role that values play within psychological and psychiatric practice are well-articulated (Candilis, 2009; Curtice & Exworthy, 2010; Hagenaars & Thompson, 2020). Secondly, most psychologists' (and psychiatrists') training on human rights perspectives is delivered via ethical or other professional practice codes (Allan, 2013a; Bush et al., 2006). Thirdly, a point of consensus in the literature is the need to improve human rights education and training opportunities (Hagenaars & Thompson, 2020; Huminuik et al., 2022; Plavsic et al., 2020).

The values of fairness, respect, equity, dignity, and autonomy), also referred to as FREDA values (Curtice & Exworthy, 2010), were emphasised by the specialist assessors. However, in order for FREDA values to have more potency in psychological or psychiatric practice, it is argued that they need to be explicitly framed through a human rights lens (Curtice & Exworthy, 2010). Human rights based approaches (HRBA) are designed to promote and protect human rights at a grass roots level of practice by bridging the gap between law and practice (Butchard & Greenhill, 2015; Curtice & Exworthy, 2010; Patel, 2020). The specialist assessors did not appear to be familiar with HRBA. However, given they were already conversant with FREDA values, specialist assessors may see merit in adopting explicit HBRA that are designed to support their decision making.

In this study the specialist assessors appeared to use the terms self-determination and tino rangatiratanga interchangeably in reference to individual care recipients and their whanau or family. Of interest, the human right to self-determination is generally used in relation to groups ("peoples") rather than individuals. For example, Article 3 of the United Nations Declaration on the Rights of Indigenous People (2007) states that "Indigenous people have the right to self-determination" (United Nations, 2007).

Whether ethical codes should be revised to include specific definitions of human rights or references to human rights law is a contested issue (Allan, 2013a; Hagenaars, 2016). The findings indicate that specialist assessors (some more than others) were using ethical principles to structure their thinking about human rights issues. However, the results clearly showed they would like human rights education and practice guidance from experts in human rights law. They identified that guidance about the relevance of obligations under international treaties like the CRPD to professional practice was a gap in training. This finding aligns with the view taken by the American Psychological Association human rights taskforce that psychology as a profession would benefit from a stand-alone definition of human rights, along with models and organising frameworks to guide HBRA within psychological practice (Huminuik, 2023; Huminuik et al., 2022).

Human rights expressed in generic ways

When the specialist assessors made specific human rights statements, these were characterised by generic descriptions. For example, some specialist assessors referred to, "*freedom from things and freedom to do things in life*" (04.W). Others emphasised the "*right to be treated in the same way*" (02.W). They *did not* specifically use the terms civil, political rights, economic, social, or cultural rights. Nor did they mention the foundational United Nations instruments like the UDHR, ICCPR, or ISESCR. Some referred to the CRPD, as discussed below.

The rights afforded to care recipients in IDCCRA, the CPMIPA, or under BORA, were either briefly touched upon or alluded to by specialist assessors, but were not a focus. Rather than referring to specific declarations or human rights instruments, specialist assessors broadly discussed how they addressed their obligations to care recipients.

The specialist assessor's portrayal of a care recipient's human rights could be described as two interrelated categories of rights. The first is freedom rights (e.g., freedom of choice, movement, association, speech and liberty). The second is well-being or welfare rights (e.g., treatment, quality of the care environment, and access to rehabilitation).

The two broad categories of freedom and well-being rights accord with Ward and Birgden's (2007) theoretical model of human rights. This model presents the core overlapping values of dignity, freedom, and well-being that manifest as specific human needs or objects, protected or enshrined in policy, ethics, or law.

Within scholarship that has examined what psychology as a discipline can bring to human rights work, an identified strength is the focus on lived experience and identification of the conditions required to support humans to thrive (Hagenaars, 2016). Psychologists, by virtue of their close engagement with vulnerable people in a range of contexts, are well placed to recognise rights issues as they manifest in real life (Nowak & Zenz, 2020; Sveaass & Wessells, 2020). Although the specialist assessors did not express specific legalistic definitions of a care recipient's human rights, the findings indicate they implicitly understood the core values or principles that underpin these entitlements.

Inconsistent knowledge of the CRPD

Overall, the study found that specialist assessors lacked knowledge about the CRPD. The small number who were informed had derived their knowledge from self-directed study or exposure in other practice settings (e.g., mental health). This finding strongly suggests that the CRPD lacked recognition by specialist assessors in the IDCCRA landscape.

Implementation of the CRPD by specialist assessors is likely further complicated by debate and tension generated by the Committee on the Rights of Persons with Disabilities' (2015, 2018) interpretation of Articles 5, 12, and 14 of the CRPD. For example, the Committee took the position that laws allowing the detention of people on the grounds of disability if "they are deemed dangerous to themselves or others" (Committee on the Rights of Persons with Disabilities, 2015, p. 17) are incompatible with liberty rights (Article 14). This interpretation would appear to capture extensions to orders.

Further, the Committee asserted that diversionary schemes such as the IDCCRA offer "a lower standard when it comes to human rights protection, particularly the right to due process and a fair trial" (Committee on the Rights of Persons with Disabilities, 2015, p. 19). If the New Zealand Government implemented the CRPD in accordance with the Committee's interpretation of these articles, (e.g., the repeal or revision of the CPMIPA and IDCCR and implementation of a disability neutral justice system), then related international scholarly analysis suggests significant implications for the IDCCRA framework and specialist assessor practices (Appelbaum, 2016; Arstein-Kerslake et al., 2017; Bhugra et al., 2017; Dawson, 2015; Peay, 2015; Richardson, 2012).

Specialist assessors were not attuned to these tensions or the potential practice implications of the Committee's interpretation of care recipients' rights specific to liberty and security (Article 14) or equal recognition before the law (Article 12). There could be several possible explanations for this result. Firstly, at ratification and within subsequent reporting cycles to the Committee, the New Zealand Government has maintained the position that IDCCRA and CPMIPA *do* comply with CRPD (New Zealand Government, 2018; Office for Disability Issues, 2009). Secondly, various policy documents developed by Whaikaiha Ministry of Disabled People, Office of Disability Issues and the Human Rights Commission, reviewed for this study, included relatively little discussion of how CRPD obligations apply to, or are met for, care recipients.

This situation is noteworthy when considering Smith's (2013) finding:

> Consideration of the outcomes provided for care recipients by the IDCCR must be made in the context of human rights and the development of the United Nation's Convention on the Rights of

> Persons with Disabilities… integration of a human rights framework within rehabilitation is necessary to provide real outcomes for people with intellectual disabilities who become subject to the IDCCR. (p. 7)

A primary function of the specialist assessor role is to evaluate the outcomes of compulsory care orders. Specialist assessors need to provide an opinion on whether orders should continue, change or be extended. Together, the low visibility of the CRPD within the framework and inconsistent knowledge expressed by specialist assessors in this study appear to function as important barriers to the integrated approach described by Smith (2013).

Specialist assessors are not unique in their lack of knowledge about their obligations to uphold United Nations treaties or conventions. The literature documents that a lack of clarity about health practitioners' obligations to uphold the international human rights frameworks is a barrier to understanding and action (Allan, 2013b; Gauthier & Sinclair, 2020; Huminuik et al., 2022). Certainly, within the current study specialist assessors indicated that the CRPD training had not been provided by the Disability Directorate. Nor had many of the specialist assessors been exposed to the CRPD in other practice domains. The current review of mental health and capacity legislation places CRPD and Te Tiriti o Waitangi in a central position (Law Commission, 2022; Ministry of Health, 2020b). Given the IDCCRA is New Zealand's only statute that specifically and solely refers to people with an intellectual disability and focuses on people in compulsory services (Diesfeld, 2013), one might expect a similar review will be undertaken at some point in the future.

Differing definitions of the liberty interest

A strong focus within the interviews was how specialist assessors conceptualised a care recipient's liberty interest. This concept was important because of the *RIDCA Central v VM* [2011] judgement which clarified the rights and freedoms encapsulated by the liberty interest. This case highlighted the competing issues of liberty, proportionality, and risk that specialist assessors face within the IDCCRA regime, and consequences for care recipients facing extensions.

Although some specialist assessors referred explicitly to the *VM* decision, others were unfamiliar with the judgment or the term liberty interest. Instead, this group described liberty in generic ways. This was an interesting finding given the status of *RIDCA Central v VM* [2011] as a legal precedent. This finding could suggest specialist assessors were not universally aware of the *VM* decision due to their diverse levels of training on relevant case law. Nonetheless, irrespective of how specialist assessors defined liberty interest, the findings show that all had contemplated liberty issues at some point within their assessments.

Furthermore, most specialist assessors considered liberty as the fundamental human right for care recipients, echoing the spirit of the VM decision. Specialist assessors viewed the liberty interest and proportionality as interrelated issues that had significant fairness implications. This was expected, considering the Court of Appeal's discussion of the proportionality in the context of liberty issues. However, the analysis undertaken for this study has focused exclusively on the liberty interest.

Least restrictive alternative not explicitly identified as a rights issue

One interesting finding was that the least restrictive alternative was not explicitly framed as a human rights issue by the specialist assessors. This finding contrasts with the pivotal role of the least restrictive environment within the disability civil rights movement (Chandler, 2020; Frawley & Naylor, 2014; Taylor, 1988). Nonetheless, many specialist assessors stated that they did contemplate the care recipients' liberty interests. Arguably, when specialist assessors took account of the least restrictive environment and liberty interests of care recipients, they were considering care recipients' human rights. However, the vast majority of specialist assessors did not claim to have knowledge of specific human rights, or specifically refer to human rights in their reports.

Te Tiriti o Waitangi

Two specialist assessors explicitly conceptualised Te Tiriti o Waitangi as a human rights framework. However, as set out in theme four, all specialist assessors were attuned to the importance of Te Tiriti o Waitangi in the health context. Although Te Tiriti o Waitangi was not explicitly identified as a rights framework by most specialist assessors, it was viewed as integral to issues of cultural responsivity within the wider IDCCRA framework and specialist assessment process. These issues will be discussed in more depth in later sections of this chapter.

Summary

The findings indicate specialist assessors most often derive their understanding of care recipients' human rights from ethical principles or values. Sometimes they rely upon ethical codes like the New Zealand Code of Ethics or the RANZCP Code of Ethics. Some specialist assessors refer to case law like *RIDCA Central v VM* [2011], statutes such as the IDCCRA or codes like the CHSCR. Rarely was their understanding drawn from international instruments like the CRPD.

While not a specific focus of this research, all specialist assessors described a clear obligation to consider the rights of *community members* to feel safe. They conceptualised the risk assessment process as being core to this aspect of the specialist assessor role. An orientation to community protection is consistent with the practice guidance available to specialist assessors (CCDHB & Luke Cunningham Clere, 2017). Nevertheless, the findings also demonstrate that specialist assessors viewed their role as gathering clinical information that is of potential relevance to the community protection interest *and* the liberty interest. In addition, the findings highlighted that specialist assessors are engaging in a variety of practices in relation to the human rights interests of care recipients. These practices are now discussed.

5.2.2 A spectrum of practices

The central question in this research is how specialist assessors integrate human rights perspectives, if at all, in their assessments. The study did not seek to answer the question of whether specialist assessors *should* integrate human rights in their practice. Nonetheless, upon reflection it could be argued that the research implicitly raised this issue.

The findings presented in theme one showed how specialist assessors contemplated and communicated a range of human rights perspectives. Initially, the findings were organised according to points of divergence and convergence; however, deeper reflection on the subthemes enabled the spectrum of practice to be conceptualised in a different way. Three distinct positions became apparent: comfortable acceptance, uncomfortable engagement, and aware but not engaged. Each of these positions are discussed below in relation to the findings.

Comfortable acceptance – 'We should'

At one end of the spectrum were specialist assessors who held the position of 'comfortable acceptance'. This is the perspective that the protection and promotion of a care recipient's human rights *is* the concern of specialist assessors. The specialist assessors described contemplating and reporting on liberty and well-being interests within their assessments. The findings indicate that comfort was derived from ability to draw upon clinical principles (e.g., formulation), ethical principles, or knowledge of human rights frameworks (international and domestic), including Te Tiriti o Waitangi.

specialist assessors within this group expressed the opinion that psychologists could advocate for the promotion and protection of human rights in a way that is distinct from legal advocacy. They viewed the IDCCRA as providing a foundation for thinking about freedom and well-being rights, because of the dual focus on compulsory care *and* rehabilitation. specialist assessors expressed that consideration of the least restrictive option, compulsion and rehabilitation, could not occur without contemplating liberty interests. While not seeking to formally quantify specialist assessors positioning on the continuum, it is interesting to note that just under a third of specialist assessors held this view.

Specialist assessors who undertook self-directed study of the CRPD and other human rights were comparatively more comfortable addressing human rights in their assessments. Further, the findings indicate that a personal interest, rather than a sense of professional obligation, was the impetus for adopting this stance. Importantly, although these specialist assessors were aware of the CRPD and had contemplated how it could be utilised in an assessment, the specialist assessors did not report that they always explicitly referred to human rights or liberty interests in their assessments.

These specialist assessors were also more likely to conceptualise Te Tiriti o Waitangi as a human rights framework that should be applied to practice in an explicit rights-focused way. The inclusion of Te Tiriti o Waitangi principles was viewed as a means to ensure a respectful and responsive assessment process.

Uncomfortable engagement – 'Should we?'

Along the spectrum, some specialist assessors had an uncomfortable engagement with human rights perspectives. The specialist assessors expressed apprehension that the explicit promotion of human rights was outside their scope of practice and expertise. A concern about overstepping boundaries was a recurrent theme. In essence, their unease was derived from a lack of clarity about where human rights should fit within their practice. The largest group of specialist assessors occupied this position.

The specialist assessors perceived a responsibility to prepare contextually rich risk assessments that took account of the wide context of the care recipient's circumstances. If this was done well, there was a view that human rights of care recipients could be "*gleaned*" (08.A) by advocates and judges, who were appropriately trained to do so. The focus on providing a rich description of the care recipient's context was also linked to preserving their humaneness within the process. This speaks to Nowak and Senz's (2020) observation that psychologists could readily adopt human rights-based approaches due to the overlap between the principles of freedom, dignity, inclusion, and the ethics of psychology.

Despite their apprehension, well captured by the following statement, "*I think I feel cautious about going too far in*" (05.W), the specialist assessors reported that liberty and well-being issues were contemplated or weighed within the assessment process. Consistent with the comfortable acceptance group, the *RIDCA Central v VM* [2011] decision was a common point of reference along with ethical principles and personal values.

Specialist assessors in this position also identified a link between considering the least restrictive option and/or compulsion with liberty considerations. In some cases, these issues were reportedly explicitly communicated in assessments, but not always. The results show that specialist assessors employed other communication techniques to implicitly communicate the presence of liberty or proportionality considerations. For example, they might set out multiple options for the Court; or, in finely balanced cases, refrain from giving a fixed opinion on term length or order.

A noteworthy finding was that experiences in Court had shaped specialist assessors' engagement with the liberty interest. Consequently, some specialist assessors adapted their practices to show they had explicitly considered the liberty interest. A common precipitant was cross-examination by a lawyer or questioning from a judge about how the liberty interest was factored into a specialist assessor's opinion, combined with critique about the absence of the topic within their reports. Alternatively, specialist assessors adopted the practice after reading legal judgments like the *VM* decision or engaging in discussions with peers or advisors about the liberty interest.

Like the liberty interest, specialist assessor engagement with the CRPD could occur in response to advocacy on specific cases. For example, a specialist assessor might have been alerted that they would be cross-examined on it. Specialist assessors said they would independently upskill themselves in the CRPD if they were aware this had been raised by a lawyer and was likely to be a focus of cross-examination. However, they remained unsure if this was within their remit and expressed concern about acting outside the scope of their practice.

Positively, specialist assessors appear to be alerted to the CRPD by these experiences, thereby increasing their knowledge. However, arguably, specialist assessors are professionally vulnerable due to the absence of relevant formal training on the CRPD and practice guidance. The results were mixed as to whether they would communicate specific articles of the CRPD in their reports. Excepting these circumstances, the findings indicate that specialist assessors were unlikely to routinely consider CRPD rights within their assessment.

This pattern of findings raised several important questions. Firstly, is it problematic that specialist assessors relied on their experiences within Court proceedings for their human rights education? Secondly, what is the impact for care recipients if specialist assessors' human rights practice continue to evolve in a piecemeal or uncoordinated way?

Dealing with the first question, decisions made by the Court rest in part on the nature of evidence put before it. The research question was shaped by analysis of how expert evidence from specialist assessors had informed case law dealing with liberty interests (*RIDCA Central v VM* [2011] and *J, Compulsory Care Recipient, By His Welfare Guardian, T v The Attorney General* [2018]). The evolving relationship between case law and health assessor practice in New Zealand was recently discussed by Brookbanks and Skipworth (2020) in the domain of unfitness to stand trial. This scholarship provides a useful example of how expert evidence shaped judicial decision making and vice versa:

> Many of the recent case law developments are suggesting a judicial approach to resolving the fitness questions which is more consistent with contemporary clinical practice… However, in shifting to this more clinically sympathetic approach, and including psychological (and even communication assistant) evidence, it appears there has been an adjustment to the fitness threshold. (Brookbanks & Skipworth, 2020, p. 86)

An important difference in this area is that health assessors undertaking fitness assessment can draw on "emerging best practice considerations" (Brookbanks & Skipworth, 2020, p. 119) based on recent case law which encourages a consistent approach. In contrast, the specialist assessors in this study identified the lack of practice guidelines to shape their approach to the liberty interest.

An alternative perspective on these findings is that specialist assessors are passive in their approach to human rights until probed by the Courts or others. This means that liberty or CRPD issues may be traversed in some cases, but not in others, with significant implications for the outcomes in individual cases. This passive stance could leave specialist assessors vulnerable to criticism from care recipients and their advocates. In other jurisdictions, research conducted with care recipient equivalents has criticised forensic psychologists for being silent with respect to human rights (Perlin, 2018). Equally, other scholarship calls upon forensic practitioners to take a more active and explicit approach to the rights interests of people they assess (Vess et al., 2017; Ward & Birgden, 2007).

The findings of the current study suggested that some specialist assessors perceived that care recipients are disadvantaged by inconsistent practices. These issues will be discussed later in this chapter. Further, by comparison, would the general public be comfortable with other professions with clear rights obligations (e.g., the police or Oranga Tamariki child protective services staff) relying on practice experience instead of having explicit rights standards and training to guide their practice? This is an issue that warrants further exploration, particularly in light of the lack of clarity reported by specialist assessors about their human rights obligations.

Aware but not engaged – ‘We shouldn’t’

At this end of the spectrum specialist assessors were firmly of the view that communication of care recipients’ liberty interests or reference to the CRPD within the assessment process was outside their scope of practice. With reference to integration of human rights into specialist assessor practice, one specialist assessor reported, “*I don’t see that as my lane*” (13.A).

The primary concern was that these issues were matters of law, not clinical practice. Some specialist assessors reported they were not knowledgeable about the CRPD or other human rights law. Furthermore, they did not believe it was their role to address human rights law. These specialist assessors believed they were knowledgeable about the liberty interest. However, careful analysis of the results indicates that although the specialist assessors were attuned to liberty issues, they made a conscious effort to exclude this information from their clinical decision-making processes. Consistent with the advice provided in the *Legal Compendium* (CCDHB & Luke Cunningham Clere, 2017) and the *Guidelines for the Role and Function of Specialist Assessors* (Ministry of Health, 2004) their assessments were oriented to risk, responsivity to rehabilitation, and public protection. They did not see it as their role to advocate for the care recipient’s liberty interest in their reports.

The specialist assessors expressed concern that addressing human rights distorted experts’ neutrality and strayed into advocacy, “*You’re meant to be in a neutral position providing information and advice to the Court. As soon as you step into either for or against, you’re siding, and you’ve lost your neutrality*” (09.A). The Code of Conduct for Expert Witnesses clearly stipulates that the expert is not to advocate for any party. This finding illustrated the importance accorded to the Code of Conduct by the specialist assessors.

Also, this finding broadly supports the findings of other studies that have explored the challenges Australasian forensic practitioners face as they try to maintain impartiality and safeguard human rights within civil commitment or extended supervision regimes (Vess, 2009; Vess et al., 2017). Core to these tensions are the multiple obligations faced by clinicians as they navigate the competing interests of the individual they are assessing and their affected community (Allan, 2013b; Ward, 2013).

This tension may account for some specialist assessors' views that 'we shouldn't' take a stance on human rights. For example, reporting on human rights issues would put specialist assessors in new, unfamiliar territory. specialist assessors may anticipate that taking a rights-focused approach will bring them into conflict or tension with others. Additionally, their perspective may disguise their unwillingness or resistance to engaging with the CRPD and the principles articulated in the *RIDCA Central v VM* [2011] judgment. These issues are explored in more detail in the following sections of this discussion.

Well-being rights distinguished by a more uniform approach: 'We should, but…'

The results suggest all specialist assessors felt ethically obliged to act on *graphic rights violations,* "*No one should walk past a breach of rights*" (09.A). The examples given included observations of unhygienic care environments, evidence of unmet physical or mental health needs, or abuse by staff in a residential setting.

Initially, the data were interpreted as meaning that specialist assessors comfortably accepted their obligations to uphold freedom and well-being rights. However, deeper analysis challenged this assumption, showing that specialist assessors were most likely referring to breaches of New Zealand's Code of Health and Disability Services Consumers' Rights, not liberty rights; or to ethical obligations under the Code of Ethics for Psychologists Working in New Zealand (2002). For example, principle 1.1 of the Code of Ethics for Psychologists Working in New Zealand defines the value general respect and its implications as:

> Psychologists respect the dignity of persons and peoples with whom they relate in their work and are sensitive to their welfare, and rights…. Psychologists recognise the basic rights of individuals to food, clothing, shelter and freedom from intentionally inflicted pain. (New Zealand Psychological Society et al., 2002, p. 4)

Further, and importantly, all specialist assessors stated that they did not feel prevented from raising well-being or welfare issues during a review. However, the more fine-grained analysis revealed that the specialist assessors exercised some hesitation in doing so. specialist assessors' comments about the need to act in a subtle or diplomatic manner signalled that uncomfortable engagement remained the dominant response (for most participants). The reasons for this caution were encapsulated by unease about overstepping boundaries and are explored later in the discussion.

5.2.3 Overarching tensions and practice challenges

The spectrum of practice highlighted several issues. Firstly, themes of unease or uncertainty were prevalent. Uncertainty coalesced around the requirements of human rights law and the role it should play within specialist assessor practice. A related lack of clarity was most pronounced regarding liberty interests and human rights laws. Specialist assessors' unease was expressed as concerns about overstepping the boundaries of practice, the influence they could exert over decisions about liberty, and their observations about varied practices in relation to the liberty interest. The study found that these factors were moderating how specialist assessors integrated human rights perspectives.

Uncertainty about where human rights should feature

Collectively, the findings show that specialist assessors' lack of knowledge about human rights law created uncertainty about their obligations to address human rights in their reports. Their uncertainty reflected a lack of clarity that has been described in international literature about the obligations on individual forensic practitioners to uphold human rights frameworks (Gauthier & Sinclair, 2020).

Some scholars have argued it is the *government's* responsibility to uphold human rights law (Allan, 2013a; Huminuik, 2023). Inherent to this debate is a subtle distinction between the psychologists' or psychiatrists' responsibility to understand and *promote* human rights values in practice versus being legally responsible for *upholding* rights. The challenge is articulated by Allan (2013a) in reference to how a psychologist might interpret the right to an adequate standard of living enshrined in the ICESCR:

> This provision clearly places an obligation on states to take steps to ensure their citizens have an adequate standard of living, but it does not tell psychologists, for instance in private practice, what exactly their obligations are and to whom they owe them. (p. 17)

The point being that individual psychologists may not have the means to uphold the civil, political, or economic rights entitlements contained in United Nations treaties (Allan, 2013a).

Some may argue that specialist assessors do have a special obligation to uphold human rights contained with the CRPD. This is because they hold a statutory role within the IDCCRA framework, a domestic law subject to oversight by the Committee on the Rights of Persons with Disabilities. International scholarship on comparable psycho-legal practice highlighted that specialist assessors directly participate in the administration of law (Allan, 2015).

Recent investigations by the Office of the Chief Ombudsman into the MOH stewardship obligations to care recipients under the IDCCRA reinforced the relevance of the CRPD (Boshier, 2021). The Chief Ombudsman's monitoring role and findings were neither raised with, or by, specialist assessors. However, the doctoral research was interested in the specialist assessors' level of exposure to the CRPD and their receptivity to the associated professional obligations.

Of relevance, the American Psychological Association Human Rights Task Force took the view that legal obligations are primarily borne by governments, *but* psychologists and their professional bodies should "promote and protect human rights and ensure accountability when human rights are violated" (Huminuik et al., 2022, p. 590). The position taken by the American Psychological Association Task Force is neither binding nor specific to the New Zealand context. However, in other activities New Zealand psychologists do look to the American Psychological Association for practice guidance. Further, the American Psychological Association asserted that psychologists:

> bear a heightened ethical obligation to respect, protect and promote human rights because they have specialized knowledge of human behavior, a unique societal role that confers a position of power in relation to vulnerable people, and because the discipline has been implicated in historical and contemporary injustices perpetrated against diverse populations. (Huminuik, 2023, p. 4)

This duty has resonance for specialist assessors in their work with care recipients within a compulsory care framework. The findings of this study revealed varying levels of comfort with the idea of specialist assessors promoting and protecting rights. There was more agreement about a specialist assessor's obligation to act in response to graphic violations of well-being rights. However, how specialist assessors should respond to liberty violations, such as the prolonged detention of care recipients, was less clear. The way the specialist assessors were positioned on the spectrum demonstrates that unclear human rights obligations is a source of tension.

This research with New Zealand specialist assessors confirmed that human rights are conceptualised in diverse ways (Allan, 2013a; Nowak & Zenz, 2020). The specialist assessors were aware of, and placed value on, human right laws. However, in the absence of clear direction about their legal obligations, specialist assessors were relying more on values and principles (e.g., FREDA) or ethical understandings. This finding was expressed as, "*For me it would be better to have human rights as the* <u>*subtext*</u> *driving the value of, the integrity of the assessment*" (05.W).

Is ethics training enough?

The results suggest that the specialist assessors viewed ethics training as their main source of human rights education. This raises the question of whether training in ethics does provide sufficient human rights education. The aim of this thesis was not to analyse how ethics features in human rights law, or vice versa. But the researcher felt compelled to probe specialist assessors' claims that their human rights activity was encompassed by their ethical practice.

Human rights and professional ethics are said to share the common goals of protecting people from harm and enhancing quality of life (Gauthier, 2009). In this regard they are complementary. However, equally, it is important that specialist assessors are equipped to recognise the similarities and differences between ethics and law. Ethical codes provide a moral, aspirational framework designed to address conflicts; while human rights represent legal entitlements that can be claimed within specific legislative parameters (Allan, 2013a; Gauthier & Sinclair, 2020). An emergent view within the scholarship is that human rights principles need to be better integrated within psychological ethical codes to strengthen protections against human rights violations

(Huminuik et al., 2022; Huminuik & Wyndham, 2020). Viewed through this lens, the ethical codes currently utilised by specialist assessors in this study may provide insufficient guidance or support for those wishing to take a more rights focused approach.

The low profile of human rights within psychological training has been critiqued by other scholars (Perlin, 2018; Ward & Birgden, 2007). The findings from the current study show that human rights law specific to care recipients was identified as a gap in specialist assessor training. This was a noteworthy, yet expected, finding based on the researcher's personal experience. This finding suggests the specialist assessors felt insufficiently equipped by ethics training to understand or address their human rights obligations to care recipients within the IDCCRA framework.

Benefits of human rights focused training

As demonstrated within the literature review there is growing consensus that greater discussion of human rights by psychologists is necessary to advance the disciplines (Wainwright et al., 2022). In addition, the potential for specialist assessors to contribute to a community of practice within the IDCCRA by benchmarking practice that improved safeguards for care recipients subject to compulsory care was signalled. This finding speaks to other scholarship that identified case discussion, (in combination with training on the theory and law of human rights), as an effective approach to enhancing practice (Stevens, 2014). Further, although none of the specialist assessors expressed familiarity with the definitions of a human rights perspectives offered by Ward and Birgden (2007) or Vess et al. (2017), they saw value in taking more explicit, collective, and structured approaches to identifying factors that could negatively impact on the assessment process.

Of note, the participants reported that historic specialist assessor trainings provided by the MOH focused on risk assessment rather than on liberty interests and human rights. It was suggested that discussion of relevant IDCCRA cases with human rights content would assist specialist assessors to better navigate their obligations and articulate dual role tensions. Opportunities to discuss cases, particularly those with finely balanced liberty issues, was seen as an important means to "*benchmark*" (09.A, 11.A) practices, thereby providing a valuable platform for exploring specialist assessor decision-making.

Notably, others viewed the independence of specialist assessors as a strength of the framework. Similarly, a cohort of New Zealand Court Liaison Nurses expressed unease about their competing obligations to society and client welfare (Tarrant, 2014). The study found that the nurses' eagerness to discuss these factors indicated the need for more structured, reflexive processes within the profession. In the current study, collective reflection was also linked to professional growth and innovation.

Who should educate specialist assessors regarding their human rights obligations?

There were differing perspectives as to who was responsible for delivering training about human rights law and related practice requirements. Guidance in the form of *Guidelines for the Role and Function of Assessors* (Ministry of Health, 2004) briefly touched on the importance of care recipients' rights and dignity but provides no specific advice as to how specialist assessors can uphold these rights. Some specialist assessors referred to this resource in general terms. However, it was not seen as a resource for rights-based issues. Additionally, this guidance predates the CRPD and is 20 years old. Updated guidelines would appear to be welcomed by specialist assessors. Relatedly, some specialist assessors explicitly questioned whether the Act was now "*out of step*" (0.2.W) with human rights advancements such as the CRPD. This issue will be discussed in a later section.

Some specialist assessors in this study identified human rights education as a philosophical issue best delivered by medical schools or psychology departments responsible for professional training. Others perceived that this training should be facilitated for specialist assessors by the MOH. The literature focused heavily on the need for universities and continuing education programmes to better equip psychologists and psychiatrists with human rights knowledge (Bhugra et al., 2017; Hagenaars & Thompson, 2020). Other scholars focused on the role of professional organisations in supporting their members to promote rights by way advocacy, research and continued competence programmes (Hagenaars, 2016; Plavsic et al., 2020; Wainwright et al., 2022).

Taking human rights-based approach would represent a paradigm shift

Some specialist assessors likened the introduction of an explicit rights-based approach to a paradigm shift; that is, a significant change in the status quo of practice. A paradigm shift implies a revolutionary change (Kuhn, 1966). The burgeoning scholarship on the need for human rights to have a more explicit presence in psychology (Huminuik et al., 2022; Wainwright et al., 2022) and psychiatry (Bhugra et al., 2017; Curtice & Exworthy, 2010; Gill, 2019) points to a growing appetite for change in New Zealand and internationally.

Importantly, none of the specialist assessors interviewed in this doctoral study identified their current level of knowledge of human rights as ideal. For many, their lack of knowledge and confidence in this area was a source of concern. There was a consensus that targeted training in relevant rights-based approaches and issues was a necessary foundation for specialist assessors deciding how to apply human rights in practice. Furthermore, the success of rights-based training, with the goal of exploring related practice, was perceived to hinge upon open and constructive discussion between the specialist assessors.

Understandably, specialist assessors may feel uncomfortable about stepping into new territory, particularly an area where, currently, there are no clear guidelines. However, arguably, it is important that clinicians take responsibility for setting the parameters of their practice regarding human rights perspectives. Although the specialist assessors voiced reservations about adopting a more explicit rights-based approach, the findings indicate many were already actively contemplating human rights implications of their practices. Being better informed was identified by all specialist assessors as a step towards identifying how practice might adapt or change. Increased educational opportunities were therefore seen as a prerequisite for making informed decisions about rights-based practice issues. In this regard, the findings suggest that some specialist assessors would like to take a more proactive role in setting the parameters for integrating human rights into practice.

Unease about overstepping practice boundaries

For most of the specialist assessors integrating human rights when forming a clinical opinion was a source of unease or discomfort. The results show that specialist assessors felt concern that practicing in this way overstepped the scope of their professional practice boundaries.

This phenomenon is not confined to New Zealand. Considering forensic practice within an international context, McSherry (2013) highlighted that a fear of violating the professional boundaries was a barrier to practitioners raising human rights concerns about compulsory care or preventative detention regimes. This hesitation is not specific to forensic practice (Nadal, 2017; Vasquez, 2012).

Scholars in the United States championing a "psychologist-activist" stance for psychologists who advocate for social justice (Nadal, 2017, p. 942) have examined the barriers commonly encountered. Some of the barriers within Nadal's (2017) critical review focused on anxiety about negative consequences. One example was a loss of professional standing because colleagues perceived psychologist-activists as biased or having crossed ethical and professional boundaries.

Returning to the current doctoral study, the findings echo and extend scholarship by providing insights from an applied forensic setting. The specialist assessors perceived there could be professional and personal costs for stepping outside of the boundaries of their role. Some specialist assessors likened reporting on human rights with lobbying or taking a social justice orientation. Implicitly this finding accords with Nadal's (2017) observation that psychologists may believe that taking a more active stance on human rights issues undermines the neutrality of psychology as a science.

There was also a prevailing view by the specialist assessors that commenting on human rights issues might diminish the neutrality of the expert role and breach specialist assessors obligations as experts under the Code of Conduct for Expert Witnesses. The prospect of other actors (e.g., judges, lawyers, colleagues, coordinators) perceiving they had overstepped into the role of a legal advocate was a related source of anxiety. Some specialist assessors perceived this could undermine the credibility accorded to their assessments—an outcome that is not in a care recipient's best interest.

Scholars have observed that psychologists who openly promote human rights could come into conflict with professional colleagues (Vasquez, 2012). Negative economic consequences are also implied in the literature. For example, Nadal (2017) observed that human rights focused academics worried about tenure or promotion. A small number of specialist assessors in this study disclosed negative economic consequences for raising human rights concerns, such as reduced offers of work. Others said they faced complaints by care teams or reprimand from the Court (e.g., judges) or the MOH. Others had not, but believed these were potential outcomes of being seen as an advocate.

Some specialist assessors perceived that the MOH welcomed them spotlighting human rights concerns about individual cases or facilities. However, interestingly, the specialist assessors considered the MOH was less receptive to them highlighting the more entrenched systemic issues that impacted care recipients' rights. According to one specialist assessor:

> So if you want to whistle blow on bad practice in one particular house… they're very happy if you do that and not so happy if you raise a concern about more systemic things. (09.A)

A small group of specialist assessors equated reporting on failures to provide rehabilitation in a targeted or timely way to raising human rights concerns. Scholars have observed that whether these issues are formulated as by-products of rigid and non-reflective systems, or intentional human rights violations, could depend on the insight and knowledge of individual psychologists (Sveaass & Wessells, 2020). However, there seems to be some consensus that openly defending human rights comes with costs and risks (Nadal, 2017; Plavsic et al., 2020; Sveaass & Wessells, 2020; Vasquez, 2012). Collectively, these results show that specialist assessors perceived that there could be a range of negative personal and professional consequences for overstepping professional boundaries by adopting an explicit human rights perspective.

Not therapists, but specialist assessors must attend to treatment and rehabilitation needs

The findings indicate that specialist assessors do not see themselves in a therapeutic role in the sense of delivering rehabilitation. However, assessing therapeutic needs and evaluating the benefits of psychological or psychiatric interventions, as well as other forms of rehabilitation related to risk reduction, was considered within their purview.

There were mixed views about how much influence a specialist assessor should exert over rehabilitation planning. For some, the ability to meaningfully engage with the development and oversight of rehabilitation plans was identified as a positive feature of the role. Others asserted that getting too heavily involved in treatment or rehabilitation issues overstepped the boundaries of the specialist assessor role.

Although not explicitly stated, the findings infer that role ambiguity is amplified when specialist assessors become aligned or associated with therapeutic goals or issues. Alternately, specialist assessors who become involved with therapeutic issues (e.g., by giving advice to therapeutic providers or other forms of consultation with care managers) may feel they compromise their independence and run the risk of overstepping the boundaries of the expert role.

New Zealand research explored the challenges faced by care managers within the IDCCRA as they navigated the conflicting roles of therapist and custodian (Prebble et al., 2013). The care managers likened the challenge to a "balancing act" (Prebble et al., 2013, p. 110). Similarly, specialist assessors are not in a therapeutic role; yet, the findings suggest they also face challenges as they formulate the need for compulsion and consider care recipients' well-being needs (e.g., capacity to engage in therapeutic rehabilitation or quality of life). This finding could be taken to mean that being in a well-defined assessment role with no expectation to deliver therapy does not render specialist assessors immune from the dual role tension or human rights obligations.

Unease about the human rights implications of variations in practice

Some specialist assessors had observed variations in specialist assessor practice which they perceived held liberty implications for care recipients. The self-reported variations were reflected by the spectrum of practice. This situation was a source of unease.

The term "*drifted practice*" (09.A, 11.A) was used to by some specialist assessors to describe variances between individual practitioners and regions. Previous research showed that drifted practice is associated with dual role problems in psycho-legal practice (Allan, 2013b). Drifted practice was defined as a shift away from ethics, characterised by practices that "erode the trust of the public in the profession and lead to division within the profession" (Allan, 2013b, p. 48). The behaviour of psychologists within military detention centres (e.g., Guantanamo Bay) is a commonly cited example (Perlin, 2018). Common precipitants are a lack of support or feeling disheartened about efforts to maintain ethical practice (Allan, 2013b; Allan, 2018). The acculturation or desensitisation by forensic psychologists to systems that repress ethical reflection is a further factor identified in the literature (Barnao et al., 2012)

The findings of this study show that specialist assessors perceived drifted practice to be underpinned by inadequate practice guidance, a lack quality procedures (such as regular peer review) and missed opportunities to benchmark practice as a group. specialist assessors with experience in other forensic settings reflected on the absence of a coordinated peer review process. They observed that responsibility was appropriately located with individual specialist assessors to use supervision. However, there was a view that specialist assessors could be "*leaned on more heavily*" (01.W) by the MOH to demonstrate they were meeting their professional obligations (e.g., expectations of formalised peer review processes or the introduction of external advisory review of specialist assessor reports).

The specialist assessors' unease speaks to the "nagging concerns" (p. 94) observed by Ward (2013) and others (Barnao et al., 2012) that arise in forensic practice. In other jurisdictions compulsory or treatment regimes are known to be a focus for 'ethical flashpoints' (Blackburn, 2004). The potential for ethical and human rights "hot spots" (Brookbanks, 2003, p. 547) was flagged during the drafting of the IDCCRA. These findings suggest that drifted practice presents the specialist assessors with ethical concerns, warranting further research due to the liberty implications for care recipients.

Relatedly, there was a theme of specialist assessors being relatively isolated from each other, limiting opportunities for case discussion. Drift might be prevented if MOH training provided benchmarking for human rights practice.

Unease about expert influence

All specialist assessors in the current study believed that ultimate decisions about liberty should rest with the Court. The scope to *assist* judicial decision-making and rehabilitation planning (by providing robust, specialised, and expert knowledge) was universally held to be a positive and essential aspect to the role. Nonetheless, findings demonstrated that specialist assessors still experience a weight of responsibility in the role. Further, they expressed unease about the degree of influence afforded to the role and how this could impact on liberty outcomes for care recipients. Their unease centred around features of the role in combination with varied experiences of external scrutiny.

Relationship with the state

Most participants viewed the specialist assessor role as explicitly oriented to public protection, not the rights protection of care recipients. In her analysis of risk assessment ethics, McSherry (2014) explored how mental health professionals could become “agents of state control”(p. 785) to the detriment of people captured by preventive detention or post sentence supervision regimes. In this doctoral study, the subtheme of ‘diverse role identities’ provided an important perspective on the specialist assessors’ relationship with the state.

Some specialist assessors identified themselves as “*officers of the state*” (15.A) or “*agents of the Crown*” (11.A) or “*agents of control*” (04.W). This finding has concerning implications from two perspectives. Firstly, should care recipients view specialist assessors in this way, it may foster mistrust or resentment, undermining the effectiveness of the assessment process. Secondly, it may signal the specialist assessors hold deeper ethical tensions or concerns about the IDCCRA framework that warrant further investigation. Similarly, other forensic psychologists in New Zealand felt like “deciders of fate” or “officers of the state” (Jones, 2019, p. 106). It is not possible to ascertain whether the psychologists who made these comments were specialist assessors. Nonetheless Jones’ (2019) findings echo the identity issues raised by some specialist assessors within the current study.

It is important to note that some specialist assessors defined their role in comparatively neutral and diverse terms (e.g., “investigator”, “storyteller”, or “friend of the court”). These contradictory role descriptions are interesting. The reasons for this may have something to do with the spectrum of practice identified in this study. Alternately, the role descriptions may reflect how the specialist assessors responded to, or resolved, the dual role conflicts encountered in their work. Although many specialist assessors expressed discomfort with the role of human rights advocate, they were more at ease with the role of storyteller:

> Well I guess it’s just telling the story of what they’re entitled to and what kind of life they should be living and could be living and you want them to live and how much that might be compromised by their care recipient status. (04.W)

Further research is required to illuminate and understand this issue.

Unofficial decision making

The official decision maker within the IDCCRA context is the judge. Nonetheless, some specialist assessors felt like their opinions were not only influential but also determinative of liberty outcomes for care recipients. The term unofficial decision-maker was adopted by the researcher within this study to encapsulate this idea. In other jurisdictions, for example in the United Kingdom, psychologists preparing parole board reports observed a reliance on their risk opinions by decision-makers (Shingler et al., 2020). This perception was matched by prisoners who perceived psychologists as the "quiet ones with the power" (Shingler et al., 2020, p. 14).

Within the current study, two primary issues regarding unofficial decision making were expressed. Firstly, specialist assessors noted that report templates and review certificates actively encouraged specialist assessors to make a finding on the ultimate issue (e.g., no change in status):

> The templates that I complete as a specialist assessor are obviously different from my free flow report, which I write probably more carefully in relation to ultimate issue question than in the tick boxes of the reviews for a specialist assessment. (06.A)

In addition, the specialist assessors reflected on the way that other aspects of clinical and legal decision making appeared blurred in the IDCCRA processes. Only the first and last review reports are submitted to the Family Court for judicial review, unless a variation in care is recommended by the specialist assessor. Therefore, specialist assessors perceived the review certificates, which specify whether compulsory care should continue, to confer a level of influence and decision-making that was distinct from other roles. This view accorded with legal analysis which noted, "It is somewhat paradoxical to note that although the review appears restricted to the clinical condition of the care recipient, the final opinion that the specialist assessor must provide is in relation to the legal status" (CCDHB & Luke Cunningham Clere, 2017, p. 97). A resolution is suggested in the Compendium (i.e., the specialist assessor including a reference in their report to the Court setting the duration and level of the order). However, of note, none of the specialist assessors referred to this analysis.

The requirement at final review for a specialist assessor to recommend the need for an extension appeared to heighten the sense of influence. This finding broadly supports other research in the area by highlighting the frictions that arise for practitioners in statutory roles (e.g., care managers and specialist assessors) who are faced with the decision to recommend extensions (Nuth, 2017; Prebble et al., 2013).

The current study provides a novel perspective because some specialist assessors observed that Court hearings only occurred if the application for extension was challenged. Consequently, this left some specialist assessors with the impression their opinions were conclusive or determinative.

Arguably extension assessments have commonalities with health assessments conducted by forensic psychologists or psychiatrists in other post sentence supervision regimes (e.g., extended supervision orders in New Zealand or post-sentence preventive detention in Australia). Similarly, McSherry (2014) made a connection between the stage at which risk assessment occurred and the increased ethical challenges posed for specialist assessors. She proposed the issue was more pronounced for risk assessments occurring in a civil context because the assessor's opinions informed decisions about detention orders outside of the criminal justice system. That is not because new offending had occurred, rather because it *might* occur (McSherry, 2014). This observation was echoed by some of the specialist assessors in the current doctoral research.

The perceived influence the specialist assessors reported within the legal process contrasts with the unease they expressed about expressing human rights concerns about service issues or a care recipient's access to rehabilitation during reviews. The presence of power imbalances when specialist assessors or other professionals working within the IDCCRA framework question the system is an area that warrants further examination.

Expectations of advocacy by lawyers, not specialist assessors

During disposition and extension hearings some specialist assessors thought the *lawyer,* rather than the specialist assessors, should champion human rights. But some specialist assessors also reported that the standard of lawyers' advocacy was not always high. Specialist assessors with experience preparing reports for extended supervision or public protection order and/or preventive detention applications appeared to have the highest expectation of advocacy. This accords with the increased judicial attention focused on correctional reports following the case of *R v Peta* [2007] 2 NZLR 627 (Glazebrook, 2018; McSherry, 2013). However, specialist assessors also perceived that some lawyers were poorly equipped to interpret and test risk assessment data.

Equally, others who did *not* have experience in the corrections arena also expressed concern about some lawyers' knowledge of the IDCCRA. Research conducted by the New Zealand Law Foundation a decade ago highlighted barriers to care recipients (and other people with intellectual disability) exercising their human rights in the legal system (Mirfin-Veitch et al., 2014). Lawyers participating in the study recommended "Mandatory training for lawyers wishing to work with clients with intellectual disability and in the area of the IDCCR Act" (Mirfin-Veitch et al., 2014, p. ix). This finding suggested that some lawyers perceived they did not have the requisite level of knowledge. As a result, increased specialisation within the legal profession was recommended to increase rights protection (responsivity) to care recipients (Mirfin-Veitch et al., 2014).

Nonetheless, others have noted that specialisation by lawyers could be hard to achieve given the relatively small number of care recipients coming before the Courts (Ngatai, 2013). A decade on, this concern regarding the need for upskilled, expert lawyers was echoed by specialist assessors.

The burden of influence and increased self-scrutiny

Within theme five, specialist assessors reflected on how their communication of risk information could influence judicial decision-making about a care recipient's liberty, "*The way we communicate with the decision-makers is fundamental to the outcome… fundamental to the liberty test*" (01.W). The tension between specialist assessors informing the process but not controlling the outcomes of liberty decisions was touched upon during the drafting phase of the IDCCRA (Cotter, 1996).

Comparable research with correctional psychologists in the United Kingdom reported a weight of personal responsibility associated with making recommendations that had significant implications for a prisoner's liberty (Shingler et al., 2019).

This doctoral study contributes to international scholarship because it demonstrates diverse responses by specialist assessors to the perceived burden of influence. One specialist assessor said the requirement to specify the term and nature of the order engendered a sense of burden, "*It does often feel like the judges are actually asking us to pass sentence on this person, actually it's not a clinician's role*" (09.A). Others were comfortable with this practice, yet mindful that their recommendations may go unchallenged, "*we're kind of listened to aren't we, they (judges) listen to what we're saying and they always do it don't they?*" (04.W).

An alternative response by specialist assessors was to set out options not a fixed opinion. The process of giving options echoed McSherry's (2014) analysis of a "middle ground" (p. 786) approach to risk assessment, because it seemed to alleviate the discomfort felt by specialist assessors who perceived they were unofficial decision-makers. The stated goal of this approach was to communicate complexity in finely balanced cases. This practice could be interpreted as both a method of moderating perceived influence and ensuring the court was well informed about the care recipient's risk and liberty interest. Irrespective of the approach described, all specialist assessors were mindful of need for forensic practitioners to carefully communicate actuarial risk findings (Hilton et al., 2015; Vess et al., 2017) and contextualise risk with clear parameter statements (Tamatea et al., 2018).

Perceptions of responsibility and risk aversion

Most specialist assessors felt an expectation to orient the assessment to public protection, not the liberty interests of care recipients. Consistent with other scholarship focused on forensic psychologists conducted in New Zealand and the United Kingdom, the orientation to public safety was associated with specialist assessors feeling personally responsible for future harm or offending (Jones, 2019; Shingler et al., 2019). In addition, specialist assessors reported internalising pressure to form the right opinion. These findings suggest that feelings of pressure, burden, or anticipatory anxiety could contribute to risk aversion, leading to community safety being given more weight than a care recipient's liberty. The specialist assessors were candid about a tendency to err on the side of caution. Further they perceived that the judiciary are similarly risk averse.

Taking a human rights perspective involves attunement to the social or moral values that intrude on the risk assessment process, and taking steps to ensure the rights of a care recipient are not automatically accorded less weight (Ward & Birgden, 2007). This scholarship could be interpreted to mean that specialist assessors should take steps to ensure a care recipient's liberty interests are given equal consideration to public safety concerns. Some clarity is provided by Ward and Birgden (2007):

> It is important to stress that this does not mean that whatever the offender wants automatically trumps the interests of others; human rights only entail obligations as long as the holder does not infringe on the rights of others. Thus, any intervention plan has to be consistent with the rights of other people without losing sight of the fact that it is the offender's life that is of concern. (p. 639)

Navigating the competing interests of the care recipient and the community is not without challenge for specialist assessors as they formulate opinions about the most suitable approach to address the care recipient's risk and rehabilitation needs.

Of interest, some specialist assessors were of the view that risk aversion was unavoidable within a forensic context because of the ever-present tensions between risk and liberty. Specialist assessors reflected that pressure to maintain the status quo for care recipients who were labelled high risk by others (e.g., care managers, coordinator, whānau or support staff) could contribute to a context where it was easy to argue for an extension. When care recipients had faced multiple extensions, specialist assessors reported a more acute awareness of liberty issues.

In addition to concerns for community safety, the specialist assessors identified various negative consequences for specialist assessors should their risk assessment prove inaccurate because a care recipient reoffended and caused serious harm. These consequences included scrutiny by media, agencies, the community or peers; as well as internalised feelings of responsibility for the harm caused.

Similar concerns were raised in a qualitative study conducted with psychologists, psychiatrists, and lawyers working within Australian preventive detention schemes (Keyzer & McSherry, 2013). Further, although not explicitly stated by the specialist assessors, these results accord with earlier scholarship that identified comparatively few negative consequences for professionals who incorrectly determine a person to pose a high risk of reoffence (Tamatea et al., 2018; Vess, 2009). In this scenario Vess (2009) noted "often the only source of consternation is from the offender or perhaps his family" (p. 271). In summary, the relationship between perceptions of specialist assessor influence and risk aversion identified by the specialist assessor were multifaceted in this study. The challenge of specialist assessors acknowledging a care recipient's rights interests within a system that may be implicitly risk averse was illuminated.

Downplaying influence

Some specialist assessors reported a tendency to downplay their level of influence when communicating with a care recipient or whānau about the potential outcomes of the assessment, "*We sometimes sort of, hide behind it by saying it's the judge's decision but you know that the judge is going to listen to you*" (04.W). It is possible that specialist assessors seek to diminish their perceptions of influence as a way to feel less burdened about the outcome. Alternatively, this approach could serve the function of externalising responsibility and blame to the Court which may be an attractive position for specialist assessors who are involved in contentious cases or assessing care recipients who have experienced multiple extensions. Further, it may provide a means of maintaining rapport with the care recipient, particularly in circumstances where specialist assessors undertake multiple reviews with the same care recipient over the course of a compulsory care order(s). This response would appear to run counter to the goal of transparency inherent to forensic ethics (Appelbaum, 1997a; Vess et al., 2017). This finding also highlights the moral challenges that can arise from forensic practice (Barnao et al., 2012; Ward, 2013; Ward et al., 2014) which, if unattended to, can result in feelings of dissonance or disconnection (Allan, 2013b; Candilis & Neal, 2014b)

Part 1: Concluding observations

This study explored how specialist assessors integrate human rights perspectives. The findings demonstrated that the specialist assessors expressed varying degrees of comfort in relation to their engagement with human rights. The spectrum of practice found in this study is most simply expressed by the sentiments, "We should", "Should we?", and "We shouldn't". The sources of unease and uncertainty that contribute to these positions were derived from the thematic analysis.

A spectrum of rights focused practices was also identified in the literature review. Psychologists and psychiatrists who wish to take a more rights focused approach would appear to have several options. At one end of this spectrum is improved access to education and training, led by universities, professional associations, or other organisations interested in developing competency (Hagenaars, 2016; Plavsic et al., 2020; Wainwright et al., 2022). Next, along this spectrum, is the promotion of human rights achieved by the implementation of principles or values into professional practice or policy (Butchard & Greenhill, 2015; Curtice & Exworthy, 2010; Patel, 2020). A further step would be practitioners more assertively protecting human rights interests by advocating for them in practice (Sveaass & Wessells, 2020), adopting explicit human rights perspectives or definitions (Huminuik et al., 2022; Ward & Birgden, 2007), and making submissions on policy or legal procedure (Birgden & Perlin, 2008; Wainwright et al., 2022). A step further may be psychologists taking up roles as human rights defenders within organisations tasked with monitoring the implementation of international human rights law obligations (Nowak & Zenz, 2020; Sveaass & Wessells, 2020). Finally, at the furthest end of the spectrum are those who embrace the role of psychologist-activist (Nadal, 2017; Vasquez, 2012), both at a practice and systemic level.

There seemed little appetite from the specialist assessors to step into the defender or activist roles. However, the findings strongly suggest that first steps for their human rights engagement includes human rights training on their obligations and application to practice.

5.3 Part II: The Bigger Picture

The aim of this study was to explore specialist assessor practice, specifically the integration of human rights perspectives. Practice exists within a context, and for specialist assessors the context includes health and service frameworks that underpin the IDCCRA. In accordance with the methodology of this thesis, establishing a deep and nuanced contextual understanding is fundamental to an interpretive description (Thorne, 2016).

In this study the specialist assessors did not perceive the legislation and its surrounding ecosystem in a singular way. Some specialist assessors viewed the IDCCRA as benevolent and protective, believing it inappropriate for care recipients to be incarcerated, unless all other options were exhausted. Some in this group viewed the Act as innovative and progressive in comparison to other jurisdictions in its approach to safeguarding care recipients' rights and focusing on rehabilitation. Other specialist assessors had a less complementary view conceptualising the Act as a pragmatic response to the challenges posed by a vulnerable group of people who had offended. The results suggested that the latitude to address the risk of reoffending and rehabilitative needs lends the specialist assessor role a sense of meaning and purpose.

Nonetheless, the findings reported in themes two, three, and four revealed that, in addition to the perceived benefits, specialist assessors were also thinking deeply and broadly about other aspects of the IDCCRA framework. This included the legal processes, the structure of the Act, and the delivery of services. The potential for a range of factors, (external to specialist assessor practice), to impact upon the loss and restoration of a care recipient's liberty were also identified. The degree of critique of the IDCCRA provided by the specialist assessors and discussed in the following sections exceeded the researcher's expectations. In support of other scholarship about the capacity of psychologists and psychiatrists to critically reflect on rights issues (Adshead, 2014; Bhugra et al., 2017; Hagenaars & Thompson, 2020; Nowak & Zenz, 2020) the findings demonstrated that specialist assessor were lifting their gaze, and tuning into a wide range of factors that have liberty and well-being implications. Additionally, it accorded with the emergent view that psychologists are well placed to apply a critical lens to the human rights implications of the practice context (Patel, 2020; Perlin, 2018; Vess et al., 2017).

5.3.1 Assessors' reflections on the human rights consequences of the IDCCRA

A strong theme within the findings was disquiet about the unintended or problematic outcomes of the IDCCRA. Most specialist assessors raised concerns about the adequacy of existing rights protections; they expressed this with reference to issues of fairness and equity. Collectively, albeit in varied ways, specialist assessors appeared to be contemplating the potential downsides of treating care recipients (who have intellectual disability) differently from other people (who do not have intellectual disability) by the justice system.

A dominant theme was the concern, in some cases, that features of the IDCCRA could contribute to unfair, discriminatory, or disproportionate outcomes. Specialist assessors compared IDCCRA orders with mainstream sentencing options. The benefits of being sentenced in the usual way were thus highlighted.

Extension provisions: A universal point of concern

Within New Zealand's CRPD periodic reporting cycles, concluded in 2014 and 2022, the Committee on the Rights of Persons with Disabilities (2014, 2022) raised concerns about features of the CPMIPA and IDCCRA. Of relevance to the current research, the human rights implications of the fitness provisions were focused on by the Committee during the first reporting cycle. Then, in 2022, the Committee turned its attention to the IDCCRA extension provisions.

The current findings suggest specialist assessors were also contemplating whether the existing safeguards are satisfactory, further supporting the previous concerns raised by advocacy groups, legal academics, and health practitioners (Brookbanks, 2013; Cotter, 1996; Duncan, 2013; Ministry of Health, 2001).The results indicated that limited knowledge of the CRPD was not a barrier to the specialist assessors critiquing of these provisions from a human rights perspective. However, the specialist assessors who were more informed about the CRPD tended to express stronger views about the need to revise the IDCCRA. The need for review has been raised by others (Brookbanks & Freckelton, 2018; Ngatai, 2013; Nuth & Thompson, 2018).

The need for rights protection was identified within the drafting process (Brookbanks, 1995; Dawson, 1997; Ministry of Health, 2001) with the goal of ensuring orders did not become preventive detention equivalents. In this study, specialist assessors observed that repeated extensions could result in care recipients becoming "*stuck*" (02.W, 09.A, 10A) under orders for lengthy periods. This feature of the Act was universally linked with the potential for disproportionate outcomes. Some specialist assessors raised the so-called special treatment of risk as a contributing factor that raised human rights concerns. The "totality of the risk approach" (p. 366) was described by Duncan (2013) in response to the *VM* decision. In effect, should the care recipient present with a level of risk at the end of their order, that is considered contrary to the community protection interests, an order can be extended.

Specialist assessors in this study pondered the fairness of subjecting people to protracted periods of compulsory care on the basis that they *might* commit any offence. Some specialist assessors observed that most individuals without disabilities (with the exclusion of those eligible for extended supervision orders or the like) were released from prison or community sentences at their end of sentence date, irrespective of their residual risk of reoffence or engagement with rehabilitation. These specialist assessors highlighted this outcome of the Act as a clear example of unfair or unequal treatment based on disability.

The specialist assessors also perceived a shift towards containment and protection in this scenario, as opposed to rehabilitation. This corresponded with earlier critiques regarding the appropriateness of the legislation for certain groups of care recipients with long term and/or complex needs (Dawson, 1997).

This study extends existing scholarship by offering an exploration of how repeated extensions can disadvantage care recipients from the perspective of specialist assessors. The human rights implications for “New Care Recipients’ facing extensions was a feature of earlier commentary (Duncan, 2013). However, the current study suggests that clients like H (from the vignette), who might better fit within Dawson’s (1997) second group, were a focal point for specialist assessors. Scholarship focused on the plight of care recipients facing perpetual detention has argued the Act is discriminatory and permits arbitrary detention (Ellis, 2020).

How best to manage care recipients who may never be rehabilitated was an area some specialist assessors believed required careful consideration by legislators. Although compulsory care was identified as a pragmatic response to this group, the results suggest there was disagreement between specialist assessors as to whether the current regime was suitable for this group. The benefits of a civil commitment regime were raised by some specialist assessors as an alternative to IDCCRA. This finding is noteworthy, considering the opposition to civil commitment pathways within the drafting process (Cotter, 1996).

Unlike a sentence, compulsory care orders do not have a guaranteed end date. This feature has attracted fairness and equity concerns (Brookbanks, 2013; Brookbanks & Freckelton, 2018; Diesfeld, 2013; Duncan, 2013; Nuth, 2017). In this study, specialist assessors identified that although a prison sentence was undesirable, comparatively, it offered people sentenced within the criminal justice system more certitude than care recipients. Previous research has identified that some care recipients would prefer fixed sentences (Smith, 2015). The issue of certitude is not well canvassed within the literature. However, the psychological impacts of indeterminate sentences have been recognised in the context of adolescents and emerging adults being sentenced to life imprisonment (see *Dickey v R* [2023] NZCA 2 [27 January 2023]).

The findings indicate that the human rights implications of extensions, in response to cases like H, had become clearer to specialist assessors over time. For this reason, some specialist assessors emphasised the importance of lawyers and services remaining focused on care recipients' liberty interests. In a *legal* context they envisaged this could be achieved by lawyers and/or judges robustly scrutinising specialist assessor reports.

In a *service* context the specialist assessors emphasised the importance of positive risk taking, and commitments to facilitating the least restrictive approaches. Both of these factors were referenced as best practice within the emergent model of care developed by a Forensic Intellectual Disability Secure Service (FIDSS) based in Auckland, New Zealand (Duff et al., 2023), alongside human rights considerations. The so-called "Mason FIDSS approach" incorporated the human rights perspectives of care recipients by giving expression to their stated values of autonomy, choice, and the *receiving* of care and compassion (Duff et al., 2023). The values expressed by the care recipients appear to align with Ward and Birgden's (2007) model of freedom and well-being rights. This development is important because it signals to specialist assessors that the IDCCRA system is gradually becoming more rights promoting.

The *most effective* option in tension with the *least restrictive* option

Additionally, some specialist assessors observed that rehabilitation needs and issues of proportionality could conflict. For example, a lengthy period of rehabilitation might be required to address a care recipient's risk of reoffending, that could exceed time served in the correctional system. This caused the specialist assessors to consider the *most effective option* in addition to the least restrictive option, an issue previously signalled by Nuth (2017). Other scholars have observed the importance of health assessors being aware that findings of unfitness can lead to lengthy periods of containment under the

IDCCRA (Huddleston, 2020). This scenario highlights the complexities that come with thinking about risk, rehabilitation, and proportionality for care recipients. However, equally, some specialist assessors felt it important to point out to the Court how a care recipient might be treated within a prison environment if they were sentenced in the usual way. To summarise, meaningful rehabilitation may mean more time in a coercive setting than people would face in prison. However, in line with previous studies, specialist assessors were equally mindful that people with intellectual disability could be very vulnerable in prison (Hayes et al., 2007; Talbot, 2010).

This finding suggested that some specialist assessors experienced a level of pressure in this role that was qualitatively distinct from other forensic roles. specialist assessors are not simply considering the issue of detention or no detention, like a psychiatrist's decision under the MHCATA. In this study, the specialist assessors were contemplating additional concerns such as the prospect of a potential imprisonment within the traditional criminal justice system or a lengthy IDCCRA detention based on rehabilitation requirements. According to specialist assessors, with this role comes the complexity of balancing freedom and well-being rights interests.

Special care recipients are especially at risk

Almost half of the specialist assessors had concerns that unfit special care recipients were at risk of lower levels of rights protections. A common concern was the highly restrictive nature of SCR orders. Another was the recognition that already lengthy orders could be extended at the end of the original term based on estimations of future risk. The third concern related to access to justice and equal recognition before the law (CRPD: Article 12). Equal access to justice is a core tenet of modern justice systems and human right laws protect equal access to all (McSherry et al., 2017). The IDCCRA provides 6-monthly reassessments of fitness as part of the review process. Nonetheless, the findings indicate that specialist assessors were concerned that the system could be more heavily weighted towards community protection interests in contrast to care recipients' liberty.

The adequacy of rights protections: A source of ethical tension

The inadequacy of rights protections for care recipients was found to be a source of ethical tension. Other research has explored how assessors respond to ethical flashpoints arising in forensic contexts (Ward et al., 2014). The causes of tension are well established and include the challenges associated with reconciling competing professional obligations (Candilis, 2009) or the competing interests of client, organisations, or the community (Allan, 2013b; Barnao et al., 2012). The findings of the doctoral study contribute to this body of research by demonstrating that concerns about the adequacy of rights protections for care recipients is a source of ethical tension for specialist assessors.

The current study did not explore how specialist assessors reconcile these tensions. However, the findings give some clues as to how some specialist assessors perceived and responded to ethical challenges. For example, in response to reflecting on the fairness concerns, participant 09.A raised the question of whether it is possible for specialist assessors to maintain ethical practice within an unethical framework. A pattern of forensic psychologists accepting, challenging, or leaving forensic or correctional settings in response to ethical tensions was identified more than 40 years ago in the United States, and was recently replicated in New Zealand research with a sample of forensic psychologists (Clingempeel et al., 1980; Jones, 2019). Specialist Assessor 09.A's perspective might be interpreted as increasing the chance that similarly minded specialist assessors could resolve the dilemma by leaving the practice setting (Clingempeel et al., 1980).

The findings did not suggest that the specialist assessors were desensitised or immune to ethical dilemmas. However, further research would be required to support this observation.

Other findings indicate that specialist assessors may challenge the fairness issues generated by human rights concerns indirectly. As previously discussed, there appeared to be little appetite for specialist assessors to take an activist approach or to lobby for care recipient's rights issues. This phenomena was analysed by Nadal (2017) in the United States. Instead, the specialist assessor were more likely to raise rights issues by naming or describing dilemmas in reports, or conducting thorough assessments with the hope that rights issues could be extracted by others.

5.3.2 Assessors' reflections on the IDCCRA infrastructure

Specialist assessors have limited influence over the way services are developed and resourced. However, at the broadest level, the findings of this study show specialist assessors were reflecting on the connections between the responsivity of the IDCCRA framework and clinical decisions they need to make about the loss or restoration of a care recipient's liberty.

Compulsory care: Not flexible enough to meet a diverse range of needs

An example of how some specialist assessors took account of care recipients' rights was their perception that the Act was lacking the requisite nuance to respond to the heterogenous needs of care recipients. In this regard it was described an "*all or nothing device*" (08.A) that could have counterproductive outcomes.

Some specialist assessors were concerned that an overreliance on the Act to address lower-level offending by care recipients limited access to care and/or specialist rehabilitation in less restrictive settings. The essence of these findings was that specialist assessors perceived that compulsory care could be avoided, in some circumstances, if there was a wider array of civil options to utilise. A potential implication of this finding is an over-reliance within the disability sector on the IDCCRA to meet the needs of people with high and complex needs. This finding accords with a study by Prebble et al. (2013) which explored care managers' perceptions of the IDCCRA.

This finding is also problematic when considering that the goal of deinstitutionalisation was to reduce the degree of restriction and coercion in the lives of people with disability (Frawley & Naylor, 2014; Stace, 2010). Further, it was predicted that the IDCCRA "may diminish the use of least restrictive means of delivering care, or prevent their development… Once under the regime a person may stay there for a long time" (Dawson, 1997, p. 14).

Consistent with earlier research, the specialist assessors were also contemplating how productive orders were in some circumstances (Duncan, 2013). The analysis provided by Duncan focused on new care recipients; however, the current study highlighted the limited alternatives to compulsory care and rehabilitation and how this could impact on the freedom and well-being of all care recipients. For example, the requirement for care and rehabilitation to be delivered in a facility was linked to the disruption of natural supports and protective factors.

Furthermore, when facilities were located far from a care recipient’s home, specialist assessors observed this could paradoxically increase the risk of reoffence or decrease responsivity due to feelings of dislocation or disconnection from whānau, employment, social networks, or whenua. As Duncan (2013) observed, release from the IDCCRA is dependent on successful rehabilitation. This finding accords with recent commentary by Nuth and Thompson (2018) concerning the benefits of building increased flexibility within the Act to improve outcomes. Finally, distance and disconnection from natural supports was identified as a factor that could negatively impact on reintegration at the end of the order, a factor that has implications for recidivism and thus a care recipient maintaining their liberty.

Within the community consultation process some care recipients expressed a disinterest in rehabilitation because they saw it as being a poor match for their needs, or as failing to equip them for life in the real world (e.g., being a parent, employee, securing housing). Their concerns were validated and potentially reinforced by the views of staff present at the hui. The perspective shared by the care recipients provided a valuable insight to their core rights concerns.

Service issues can inhibit/constrain or enhance the restoration of liberty

Specialist assessors’ practice is embedded in web of institutions (and law). Service delivery is one strand of that. To uphold rights, a robust service delivery system is required. The vital role that infrastructure would play in the success of the Act was identified during the drafting process (Brookbanks, 1995; Dawson, 1997).

Community consultation was completed for this research both in the proposal phase and during the analysis process. At both meetings the care recipients identified service delivery issues as areas of human rights concern. Specifically, the care recipients expressed that they faced limited choices which constrained their ability to achieve employment or engage in vocational tasks that were meaningful or maintain important social relationships. Specialist assessors were also contemplating the service delivery and related resourcing issues they encountered in their daily practice.

The specialist assessor participants discussed the rights implications of inadequate service delivery. Firstly, the specialist assessors reflected on the capacity of services to deliver rehabilitation in a timely manner. Secondly, they appeared to question whether or not rehabilitation is sufficiently specialised and targeted. Thirdly, the specialist assessors identified that compulsory care could result in significant disruption to natural supports due to the location of facilities. These findings, although not explicitly identified as such by specialist assessors, have relevance to New Zealand's UNCRPD obligations. Article 26(1) of the CRPD sets out the obligations held by States Parties to provide habilitation and rehabilitation as close as possible to a care recipients' communities, including in rural areas (United Nations, 2006b).

Other research has examined issues relating to the delivery of care and rehabilitation (Duncan, 2013; Ngatai, 2013; Prebble et al., 2013; Smith, 2015). The need for improvements to ensure the IDCCRA remains effective, flexible, and inclusive was identified (Nuth & Thompson, 2018; Smith, 2015). This thesis adds the specialist assessors' perspectives on how services impacted specialist assessors analysis of care recipients' progress, the risk of reoffence, and the need for an extension. Again, issues of fairness and equity were inferred when factors outside the direct control of care recipients resulted in extended periods of compulsory care.

Cultural responsivity

Theme four examined how specialist assessors perceived cultural factors to interface with the human rights within the IDCCRA framework and their clinical practice. Article 30(4) of the CRPD addresses the obligations on States Parties to ensure that the specific cultural and linguistic identities of care recipients are recognised and supported in an equal basis with others (United Nations, 2006b).

Cultural competency and human rights

Specialist assessors were candid about how their cultural identity might shape the assessment process. The specialist assessors described their commitment to undertaking assessments in a respectful, transparent, and non-tokenistic way. Nonetheless, they recognised that experiences of the care recipient and their whānau, both in the present sense and intergenerationally, could impact on the how the specialist assessor role and the IDCCRA process were perceived.

Cultural competence is a core component of psychological training in New Zealand. The findings indicate that consistent with the definition of cultural competence provided by the New Zealand Psychologists Board, specialist assessors were individually striving to demonstrate, “awareness, knowledge, and skill, necessary to perform a myriad of psychological tasks that recognises the diverse worldviews and practices of oneself and of clients from different ethnic/cultural backgrounds” (New Zealand Psychologists Board, 2018, p. 16). In addition, the findings show that specialist assessors were committed to improving their cultural competence.

A small group of Māori and non-Māori specialist assessors observed that translating Te Tiriti o Waitangi principles (i.e., ōretitanga, tino rangatiratanga, and partnership) into their practice in concrete ways enhanced the assessment process for two reasons. Firstly, it placed care recipients’ rights interests (liberty and self-determination) at the centre of the process and improved their experiences. Secondly, it improved the cultural competence of the specialist assessor and, in turn, the effectiveness of the process. The benefits of specialist assessors working within public services with the scope and resource to provide cultural supervision and support to develop these grass roots practices was identified. This finding illustrates Ward and Birgden’s (2007) human rights perspective in action; specialist assessors might ensure equal weight is accorded to the care recipient’s interest in the assessment process. Secondly, it highlights that the application of core human rights values implicitly resonates with clinicians, allowing them to be translated and embedded within psychological and psychiatric practice (Butchard & Greenhill, 2015). This finding suggests that a rights-promoting specialist assessor could be knowledgeable about, and a strong promoter of, Te Tiriti o Waitangi principles in their practices. This would accord with the focus given to the Crown’s human rights and Te Tiriti o Waitangi obligations in current revisions of other disability specific legislation (e.g., mental health and capacity law).

Some specialist assessors were less clear regarding Te Tiriti o Waitangi’s applications to their practices within the IDCCRA. As discussed in the literature review Te Tiriti o Waitangi is not explicitly referenced in the IDCCRA but references to cultural principles are contained in section 13(2). For some specialist assessors the challenges caused by differing interpretations of the Māori and English versions were identified as a barrier. Further, others have observed that health practitioners face challenges translating cultural principles in to practice in the absence of clear guidelines (Elder, 2019). Nonetheless, the findings suggest that many specialist assessor perceived that giving expression to Te Tiriti o Waitangi (e.g., by way of cultural assessment and more responsive rehabilitation practices or environments) would likely increase the likelihood of a care recipients needs being identified and met. Further, successful engagement in rehabilitation was linked to liberty restoration in the least restrictive, most effective, and most timely manner.

Cultural assessments and human rights

Overall, the results show that cultural assessments had little visibility within the IDCCRA process. Specialist assessors reflected that this limited their ability to take account of cultural factors within the specialist assessment process. There was consensus that consideration of cultural factors could enhance clinical formulations of risk and rehabilitation need by helping specialist assessors to identify less restrictive options and responsive plans.

This finding is consistent with the work of Macfarlane et al. (2011) in that specialist assessors reiterated the importance of being able to consider the cultural context when issues of liberty were at stake. In comparison, how cultural data should inform the scoring and interpretation of standardised risk assessment tools was an area where there were equivocal findings. Specialist assessors held differing perspectives about the suitability of adjusting or adapting risk measures to account for cultural factors. This finding is consistent with existing scholarship (Gillies, 2013; Shepherd & Lewis-Fernandez, 2016) and does not extend the literature. Nonetheless there was consensus that structured clinical judgement is improved when cultural data are available.

Feedback provided by TRT within the community consultations provided a further perspective on these findings. Those present at the second hui identified that cultural assessment enabled a process of whānaungatanga and connection which, in turn, provided the foundation for working towards successful reintegration at the end of an order. Although not specific to the IDCCRA framework, other disability scholars have emphasised the importance of tikanga practices, such as whānaungatanga, within a rights-focused approach that meets CRPD obligations in capacity assessments (Ruru, 2020). Furthermore, some specialist assessors in this study endorsed the view shared at the two hui that the identification of cultural factors at the disposition could enhance placement decisions (by coordinators) and reduce barriers to a care recipient's engagement. These specialist assessors identified that meaningful attention to cultural factors would enable greater collaboration and could reduce disconnection between a care recipient, their whānau, and services should disagreements about care or risk issues occur. These perspectives highlight the subtle nature of liberty issues within the IDCCRA framework.

Structural bias and human rights

In addition to the poor visibility of cultural assessments, consistent with other research (Brittain & Tuffin, 2017; Department of Corrections, 2007; Quince, 2007) specialist assessors perceived Māori care recipients were at greater risk of disproportionate outcomes due to a range of systemic factors. The specialist assessors observed that well established patterns of over-representation by Māori in the justice system were replicated within the care recipient population. Key issues arising in the findings speak to the work of other New Zealand scholars in the justice sector, which have discussed the long-term impacts of colonisation and disenfranchisement for Māori (Brittain & Tuffin, 2017) and the culminative impacts of lifestyle factors that serve to entrench cycles of risk and offending (Bevan & Wehipeihana, 2015; Durie, 2003).

The study also found specialist assessors were concerned about a structural bias towards a Western worldview within the legislation and related infrastructure (Brittain & Tuffin, 2017). Increased attention to Te Tiriti o Waitangi obligations within service development and rehabilitation planning was identified as a pathway to address these concerns.

Some specialist assessors reflected on the relationship between cultural factors and a care recipient's successful engagement in rehabilitation. The liberty implications of poor cultural fit contributing to a care recipient failing to benefit from rehabilitation and facing an extended order as a result were contemplated. One specialist assessor articulated this as a rights issue, "*I'd say that's grossly unfair really*" (13.W). The specialist assessors were in consensus that culturally responsive service delivery enhanced outcomes for care recipients.

The findings suggest some specialist assessors were reflecting on their role within the bigger systems or policies that sustain structural biases towards Māori care recipients and other minority groups (e.g., Pasifika care recipients). Other New Zealand scholars (Jones, 2019; Tamatea & Waipara-Panapa, 2018) have signalled that discomfort could arise for forensic practitioners when they reflect upon the power structures that entrench structural bias.

The findings also show that specialist assessors were attuned to structural bias inherent in disciplinary training of psychologists and psychiatrists (Herbert & Morrison, 2007; Tassell et al., 2012). Observations by Māori and non-Māori specialist assessors of the "*blindspots*" (11.A) that exist within disciplinary training in relation to embedded cultural bias were incisive. Further discussion of this issue is beyond the scope of this thesis but it does highlight the varied ways in which specialist assessors were reflecting upon their practice and drawing connections to human rights issues. Together, these findings reinforce the need for further research which focuses on the overrepresentation of Māori care recipients.

Pasifika care recipients

Finally, although Māori were a focus within the interviews, the importance of being responsive to the cultural needs of all care recipients was identified. Specific observations about the lack of attention given to the cultural needs of Pasifika care recipients by some specialist assessors accorded with advocacy in the wider disability sector (Tōfā Mamao Collective, 2022) and warrants further investigation. Research conducted by Fuamatu (2019) with a group of Samoan people with disability (and their primary supports) who lived in Auckland, New Zealand and the strategic framework developed by the Tofa Mamao Collective (2022), may provide useful resources for specialist assessors and other health professionals wishing to explore this area. The above authors' views regarding the importance of integrating collectivist worldviews are equally relevant for specialist assessors' practices. An improved focus on culturally responsive practices for Pasifika is a medium term goal (3-5 years) within the High and Complex Framework Strategic Statement 2023-2028 (Whaikaha Ministry of Disabled People, 2023).

5.4 Part III: Recommendations Arising from the Study

This research has resulted in 10 recommendations for practice, further research, policy, and legislative reform. Arguably there are more but, for the purposes of the thesis, the focus is deliberately narrowed to reflect core areas of insight and concern. Specific actions that could be taken by specialist assessors, or those who oversee and support specialist assessor practice, are highlighted. How the findings illuminate training needs for lawyers is briefly considered. Finally, areas service and legislative reform are presented. Together, these recommendations illustrate the connected nature of the IDCCRA framework. Taking actions in one area, for example, increasing opportunities for specialist assessor to collectively reflect on human rights, could have positive flow on effects to all other parts of the system.

5.4.1 Practice recommendations

Address gaps in human rights knowledge

By exploring how specialist assessors derived their knowledge of human rights, gaps were identified. Providing specialist assessors with further human rights training, particularly in relation to the CRPD, is a self-evident recommendation of this research. This study has found that ethics training alone appears insufficient to address the unique challenges arising within forensic practice. However, it does provide an existing and solid foundation from which to extend human rights training.

Specialist assessors are a small, highly specialised group of forensic practitioners. However, the findings may suggest gaps in human rights knowledge across other areas of psychological and psychiatric practice in New Zealand. Investigating the nature of human rights training in New Zealand’s medical and psychological training programmes would further illuminate this issue.

Further research would also reveal whether the burgeoning international interest in human rights-based approaches (Patel, 2020; Plavsic et al., 2020) and fit for purpose practice definitions of human rights (Huminuik et al., 2022) are reflected in the status/nature of psychological and psychiatry education provided in New Zealand.

Integrate a human rights model into specialist assessor training

The literature review undertaken for this thesis revealed human rights models with relevance to specialist assessor practice. For example, Ward and Birgden's (2007) model of human rights provides the theoretical and ethical heart for the GLM (Ward, 2010), that is already embedded in the IDCCRA care and rehabilitation framework. Although empirical support for the theory underpinning the GLM remains emergent, a recent systematic review showed that GLM and RNR interventions are equally effective (Mallion et al., 2020). In addition, researchers have argued that Ward and Birgden's human rights model provides a useful lens for the navigating the challenges of forensic practice (Barnao et al., 2012; Vess et al., 2017). Training in this human rights model could provide a useful starting point for specialist assessors to integrate an explicit human rights perspective. The model provides a mechanism for understanding the interrelated nature of the freedom and wellbeing rights underpinning care recipients' liberty interest(s) and may positively impact how specialist assessors conceptualise risk and rehabilitation issues.

Integrate an alternate ethical framework into specialist assessor training

The *Universal Declaration of Ethical Principles for Psychologists* (UDEEP) (International Union of Psychological Science & International Association of Applied Psychology, 2008) aimed to assist psychology organisations worldwide to evaluate the relevance, sensitivity and responsivity of their ethical codes to local issues. An identified strength of this ethical framework is the specific attention to the overlap between ethics and human rights, dual role issues and the personal or social biases that may encroach on the forensic practice. Therefore, application of the UDEEP into specialist assessor practice would foster a human rights perspective.

Additionally, there is merit in highlighting the differences between human rights and ethics. Specifically, where human rights go beyond ethics, have greater potency or generate alternate obligations for specialist assessors.

Promote human rights through a community of practice

Providing specialist assessors with increased opportunities for case discussion and peer review would enable them to develop benchmarks or thresholds for practice that enhance fairness and equity for care recipients within the IDCCRA framework. For this recommendation to be attained, the MOH and Whaikaha Ministry of Disability would need to take a lead in coordinating and resourcing meetings.

Promote human rights through enhanced peer review processes

The specialist assessors reported that formalised external monitoring of their practices was absent, limited, or inconsistent. They saw the value in external peer review, and this could be viewed as rights-promoting because better assessments mean better rights promotion.

Promote human rights at the service level

To date, the specialist assessor role has been focused on individual assessments of care recipients. However, specialist assessors' expertise could be harnessed to promote human rights at a systemic level. Given specialist assessors' knowledge, and movement across facilities in New Zealand, they are well positioned to evaluate services and models of care vis a vis care recipients' rights. This would reflect a critical human rights-based approach and one where the focus is on application and translation of human rights values into practice or service principles.

Use the least restrictive alternative as a platform for specialist assessors to address liberty interest

This thesis draws attention to the complementary nature of the least restrictive environment and the care recipient's liberty interest. Ensuring that least restrictive alternative analyses are integrated in all reports would enable specialist assessors address liberty issues explicitly and transparently.

Develop updated specialist assessor guidelines

The existing *Guidelines for the Role and Function of Specialist Assessors* (Ministry of Health, 2004) are overdue for review. This study could provide a launchpad for developing a guideline that encompasses a specialist assessor's human rights obligations, and better considers the human rights implications of the role.

Improve IDCCRA specialisation within the legal fraternity

The findings suggests that the influence of specialist assessors as experts is amplified by features of the IDCCRA in combination with other factors (e.g., limited testing of reports in a legal context). Given the age of the IDCCRA legislation, this troubling finding suggests that lawyers may require training on the IDCCRA, the liberty implications of compulsory care orders, and how to decode specialist assessor reports.

5.4.2 Recommendations for systemic and legislative reform

Although legislative and service issues were not the focus of this study, the specialist assessors raised the human rights impacts of wider systemic issues. The findings of this study reinforced earlier calls for legislative reform (Brookbanks, 2019; Committee on the Rights of Persons with Disabilities, 2022; Ngatai, 2013). Prevailing issues were the inflexibility of the IDCCRA framework, and its responsivity to a population of care recipients who have diverse needs.

Undertake research with care recipients

A natural progression from this study would be to give voice to the perspectives and priorities of care recipients. Future research co-constructed with care recipients could explore whether the IDCCRA regime is rights promoting; and, if not, what systemic and legislative reform is required.

Boost flexibility and responsivity within the IDCCRA framework

Findings illuminating the ‘all or nothing’ nature of the IDCCRA suggested that specialist assessors would welcome alternatives to compulsory care. These alternatives could draw upon principles of community sentencing, allowing oversight and rehabilitation to be delivered to care recipients within more naturalistic settings. This would have important implications for any reform process because it would require a rethink of the nature of compulsory care orders, including where or how orders are delivered. Any changes to how compulsory care is structured or implemented, would rely on building increased connectivity/capability between the intellectual disability, health, and corrections sectors.

Successful reintegration of care recipients to their communities of origin at the end of orders was at the forefront of the specialist assessors minds. This was also a strong theme in the community consultations. These issues are understudied and warrant further attention at a research and policy level.

Facilitate cultural assessments

Specialist assessors perceived that cultural assessments are an underutilised resource. Multiple benefits to routine cultural assessments were identified, including more nuanced formulation of risk, need and rehabilitation factors, and enhanced assessment of the least restrictive alternative, enhanced service delivery and reintegration planning.

Improve rights protections for Care Recipients

The adequacy of rights protections for care recipients who were subject to perpetual extension was a core issue that emerged in this study. It would seem that how the extension provision has operated in practice has exposed a weakness in the legislation. The need for review of this aspect of the legislation is underscored.

In addition, the three levels of care provided under the Act appear to result in diverse care and rehabilitation experiences for care recipients. The specialist assessors in this study reflected on the liberty implications of variations in service provision, across different facilities and geographic areas. It would be valuable for further research to explore the practical implementation of liberty interests within the three levels of care, specifically the presence of inconsistencies in restrictions sanctioned under the IDCCRA (e.g., access to employment, and technology).

Integrate the CRPD

Earlier calls to integrate a human rights framework within rehabilitation (Smith, 2013) seem to have gained limited traction. Within the High and Complex Framework Strategic Statement (Whaikaha Ministry of Disabled People, 2023) New Zealand's UNCRPD obligations are briefly mentioned in the foreword but there were no concrete references within the strategic plan itself. This absence is noteworthy given the integration of CRPD into other strategic policy objectives within the wider disability community and the current revisions of mental health and capacity law. Care recipients are arguably a vulnerable group due to their complex needs and the related restrictions placed around their liberty by justice process. This study spotlights the need for further exploration of the systemic and/or legislative barriers to CRPD implementation within the IDCCRA framework.

5.5 Part IV: Strengths and Limitations

5.5.1 Strengths

A large proportion (n=15/21) of the specialist assessors eligible for this study in 2020 participated. This demonstrates the value accorded to the research by the specialist assessor group. Further, it allowed the researcher to have confidence that the data gathered provide a robust representation of the perceptions held by specialist assessors about human rights.

The study provides valuable insights to how specialist assessors are ‘doing business’ in relation to various human rights considerations. The inclusion of two disciplines provided additional diversity and depth to the data. It allowed the researcher to reflect on the impact of differing disciplinary and training experiences.

Rich, complex, and nuanced data were derived from the interviews. The specialist assessors were candid and thoughtful. Their voices are clear and strong in the research. The specialist assessors welcomed the opportunity to reflect on how human rights feature in the specialist assessor role. They were also eager to reflect on issues specific to the service and legislative framework. This thesis tells two important yet inter-related stories from the perspectives of specialist assessors. One focuses on specialist assessor practice and construction of the role. The second speaks to the IDCCRA framework, its human rights implications, and factors that might enhance or inhibit a care recipients’ realisation of liberty and well-being rights. There are other stories to be told from the data gathered which will be developed in future articles and presentations.

The current study reflects the researcher’s interest, experience as a specialist assessor, and expertise. The potential for bias as an insider was recognised from the outset and addressed within a bracketing interview. This interview enabled the researcher to acknowledge and engage with her own positioning and subjectivities throughout all phases of the research and particularly during analysis. To counteract and strengthen the research process reflective practices were adopted by the researcher and shared with the supervisory team (e.g., journaling, recording supervisory insights, and memos). Clinical supervision was utilised to provide a forum to explore, reflect, and critique the interface between the researcher’s personal practice experiences and data gathered in the study. Reflexive thematic analysis was the method of choice because of the additional reflexive rigour it demanded of the researcher. During the final analysis and writing phase the researcher paused her specialist assessor work to ensure a separation of roles.

In addition, the researcher's insider knowledge as a specialist assessor may have contributed to an implicit sense of shared experience with the specialist assessors that facilitated open and rich discussion of during the interviews.

The study brought international perspectives on psychologists' and psychiatrists' human rights obligations to bear on this novel coercive care regime for people with intellectual disability. In doing so, the study situates the findings within burgeoning literature that has application for forensic practice and the fields of psychology and psychiatry more broadly.

The researcher's obligations to Te Tiriti o Waitangi as a health and disability practitioner, academic, and 'tangata Tiriti' were at the forefront of research design and implementation. It was reflected by the community consultations occurring during the proposal and analysis phases, and the inclusion of an expert advisor.

As the project progressed the researcher acquired a deeper understanding of forensic definitions of human rights perspectives. This inspired a brief critique of risk assessment that, although technically outside the scope of the thesis, arguably strengthened the thesis. Had the relationship between risk assessment and existing concepts of human rights perspectives been understood from the outset then additional, targeted questions could have been added. The findings support future research into optimal rights-promoting, culturally responsive risk assessment practices with care recipients and their international equivalents. The findings of this thesis speak to an emergent scholarship about the need for risk assessment practices to better account for cultural diversity (Day et al., 2018; Ward et al., 2022)

5.5.2 Limitations

This study represents the perspectives of one role, held by two professions within the IDCCRA. It important to recognise that specialist assessors are a select and educated group. Further, the 15 specialist assessors who participated in the study were selfselecting, which may indicate a greater interest or concern about human rights. As the findings are disseminated it will become apparent whether the specialist assessors who did not participate in the study (including those ineligible) identify with the derived themes.

The findings of this study may not represent the perspectives of other important groups in the IDCCRA framework, for example, care recipients, care managers, care coordinators, District Inspectors, lawyers, or judges. Nor does it claim to. However, the study has revealed elements about the specialist assessor role and the IDCCRA that are not reported elsewhere, and which warrant further investigation. In addition, the two hui undertaken at TRT provided an opportunity for care recipients, and those people working with them, to express their perspectives about human rights and engage with the findings. The interest expressed indicated that care recipients would welcome further opportunities to explore these issues.

The findings of this study are derived from the specialist assessors' self-reported practices regarding liberty interests and other human rights perspectives. It did not include a review of actual specialist assessor reports or an analysis of legal decisions. Other streams of data would have allowed a more comprehensive understanding of how liberty interests and human rights are integrated into the IDCCRA framework but would have required a much larger study. Reviewing specialist assessor reports would introduce additional ethical considerations.

The study does not claim to understand the entire specialist assessor role. Rather, the aim was to explore an understudied facet that had broader relevance to the practice of psychology and psychiatry. The insights derived from the study have identified areas for future inquiry. The study may assist specialist assessors in deepening their understanding of human rights or may motivate further steps towards a human rights-focused practice. For other specialist assessors, the thesis may reinforce their views that human rights are not within their role as an expert witness. The study may better inform these debates.

Chapter 6 Conclusion

6.1 Ethics and Values Underpin a Spectrum of Human Rights Practice

In New Zealand, several human rights frameworks are relevant to care recipients. They include CRPD, BORA, HRA, and the Code of Health and Disability Services Consumers' Rights. Yet, the findings of this study revealed that the majority of specialist assessors derived their understanding of human rights from ethical codes in combination with personal and professional values. Specialist assessors relied heavily on ethical principles and the values of freedom, respect, equality, dignity, and autonomy (Curtice & Exworthy, 2010) to guide their practice, and identified human rights as implicitly driving their practice. The absence of formal training in human rights, either within disciplinary or specialist assessor training, was noteworthy.

This doctoral research has provided valuable insights into how 15 specialist assessors interpreted and integrated human rights within their practice. Three distinct positions along a spectrum were revealed: comfortable acceptance, uncomfortable engagement, and aware but not engaged.

6.1.1 Three perspectives

'Comfortable acceptance' was the perspective that the protection and promotion of a care recipient's human rights *is* the concern of specialist assessors. Specialist assessors within this group expressed the opinion that psychologists could advocate for the promotion and protection of human rights in a way that is distinct from legal advocacy. They viewed the IDCCRA as providing a foundation for thinking about freedom and well-being rights because of the dual focus on compulsory care *and* rehabilitation. Specialist assessors in this group were generally (but not exclusively) well-informed about the United Nations treaties, domestic human rights law, and Te Tiriti o Waitangi. A minority referred to the specific rights contained with the IDCCRA. Importantly, their knowledge was self-directed, not derived from specific training on human rights.

'Uncomfortable engagement' was the perspective that explicit promotion of human rights was outside specialist assessors' scope practice and expertise. These specialist assessors were apprehensive that if they commented on care recipients' liberty interests or the CRPD they would overstep the boundaries of professional practice or other legal obligations (e.g., Code of Conduct for Expert Witness). Nonetheless, most actively considered liberty interests in their assessments. Some explicitly reported on the liberty interest but had misgivings about doing so. Importantly, explicit reporting on liberty interest often began in response to external scrutiny or critique (e.g., cross examination by a lawyer or questioning from a judge). To mitigate their unease, some Specialist assessors expressed their considerations of the liberty interest indirectly. For example, they avoided giving a fixed opinion on order type or duration by setting out multiple disposition options for the court.

‘Aware but not engaged’ was the perspective that communication of the liberty interests or the CRPD within the assessment process was outside the scope of specialist assessor practice. This was most simply expressed as “not my lane”. These Specialist assessors were concerned that comments on liberty interests or human rights distorted the neutrality of the expert role. Advocating for human rights was associated with a social justice stance which was perceived as being outside an expert specialist assessor’s scope of practice.

6.1.2 A distinct approach to well-being rights

One interesting aspect of the findings was the different perspectives specialist assessors held about well-being rights (e.g., entitlements to rehabilitation, health care, social, occupational, and cultural activities). The specialist assessors considered well-being and welfare rights as connected and interchangeable issues. The spectrum of practice showed that specialist assessors were more unified about their obligations to act on graphic breaches of well-being rights (e.g., abuse by staff members or neglect of primary needs), should these be encountered. Further, the review process was seen as providing an important safeguard of care recipients’ rights. The specialist assessors denied feeling constrained from raising well-being or welfare issues. Nonetheless, a more fine-grained analysis revealed they exercised some hesitation about promoting well-being rights. Comments about the need to act in a subtle or diplomatic manner signalled that uncomfortable engagement remained the dominant response.

6.2 Implicit Tensions Moderate Practice

This study did not seek to answer the question of whether specialist assessors should integrate human rights into their practice. Nonetheless, upon reflection, it could be argued that the research implicitly raised this issue. In doing so, several tensions were revealed as specialist assessors contemplated their obligations to understand, promote, protect, or advocate for the human rights of care recipients.

6.2.1 Unclear obligations

Firstly, the specialist assessors’ lack of clarity about human rights obligations reflected international scholarship (Nowak & Zenz, 2020). Whether obligations solely rest with governments or with forensic professionals *and* governments is a source of debate within the literature (Allan, 2013a; Huminuik et al., 2022) that was replicated in the current study. The specialist assessors were acutely aware of the influence accorded to the specialist assessor role. For this reason, the researcher anticipates that specialist assessors would be receptive to international scholarship which articulates how psychologists and psychiatrists could adopt a rights-aware or promoting stance.

There seemed to be little appetite from the specialist assessors to step into the defender or activist roles (Nadal, 2017; Sveaass & Wessells, 2020). Further, some likened the introduction of an explicit rights-based approach to a paradigm shift. However, the findings strongly suggested that the first step for specialist assessors to promote human rights is becoming better informed about human rights, the associated obligations, and the practice implications.

6.2.2 The sufficiency of ethical principles

Some specialist assessors perceived they were rights-compliant because of their application of ethical codes and personal ethics. The academic literature reviewed for this study illustrated the diverse views held about this topic (Allan, 2013a; Hagenaars & Thompson, 2020). Over the course of the research, it became apparent that ethics and human rights derive from the same values, are complementary but operate in different ways (Allan, 2013a; Gauthier & Sinclair, 2020; Ward, 2008).

The findings of this study, therefore, raise important questions of whether ethical codes have sufficient power to address the unique human rights implications of specialist assessor practice. Considering the uncertainty and unease reported by specialist assessors, one is left with the strong impression that the ethical codes currently utilised by specialist assessors provide insufficient guidance for those wishing to take a more rights-focused approach.

6.2.3 Unique role pressures

This research revealed that specialist assessors experienced a level of pressure in their role, which was qualitatively distinct from other forensic roles. The findings highlighted that specialist assessors are not simply considering the issue of detention or no detention, like a psychiatrist's decision under the MHCATA. In this study, the specialist assessors were contemplating additional concerns, such as the prospect of potential imprisonment within the traditional criminal justice system or a lengthy IDCCRA detention based on rehabilitation requirements.

Additionally, the findings contribute to scholarship about the unique ethical dilemmas that arise in forensic practice (Barnao et al., 2012; Candilis, 2009; Ward, 2013) by illustrating tensions within the specialist assessor identity. The self-applied and diverse role descriptions offered by the specialist assessors, which included officer of the state, agent of control, investigator, a friend of the court, and storyteller, may reflect how they responded to or resolved the dual role conflicts encountered in their work. Further research would be required to illuminate this issue.

6.3 A Multilayered Critical Examination of Systemic Factors

Embedded in the thesis were critical observations about the IDCCRA framework. Three different perspectives emerged. These were external scrutiny, specialist assessor self-scrutiny, and critique of the IDCCRA. The multilayered critique provided by the specialist assessors added an unanticipated complexity to the analysis process.

6.3.1 External monitoring

All specialist assessors reflected on the degree of self-determination afforded to the role. For some, this was a source of unease as they contemplated the specialist assessor's capacity to influence legal decisions about a care recipient's liberty and well-being. The specialist assessors reported that formalised external monitoring of their practices was absent, limited, or inconsistent. They saw the value in external peer review, and this could be viewed as rights-promoting because better assessments mean better rights promotion.

6.3.2 Self-scrutiny

This research highlighted how the specialist assessors reflected upon the human rights implications of their practice. They did this in the absence of external review and monitoring. It is possible that specialist assessors self-monitor and are accustomed to it as psychologists and psychiatrists (New Zealand Psychological Society et al., 2002; New Zealand Psychologists Board, 2018; Royal Australian & New Zealand College of Psychiatrists, 2018). However, the findings also suggested a link between the specialist assessor's self-critique and perception of inconsistent advocacy or limited testing evidence by lawyers or the Court. Alternately, heightened self-scrutiny may have evolved a response to features of the legislation or aspects of the role that have led some specialist assessors to feel like unofficial decision makers.

The specialist assessors would welcome opportunities to develop a community of practice. Opportunities to discuss casework were viewed as a valuable and untapped forum for collectively reflecting on the human rights implications of the work. The specialist assessors identified that increased case discussion and peer review would highlight variations in practice. They perceived this could combat drifted practice by enabling specialist assessors to set benchmarks or thresholds for practice that enhanced rights protections for care recipients (e.g., fairness and equity) within the IDCCRA framework. Specialist assessors want to take a more active and considered role in setting the parameters of their human rights practice. Importantly, the spectrum of practice revealed human rights-based approaches by specialist assessors have occurred in reaction to external critique or have evolved as a function of an individual specialist assessor's knowledge and interest.

An interesting alternative perspective on the community of practice was that specialist assessors were well placed to inform policy or service development aimed at safeguarding care recipients' human rights. With reference to international scholarship, utilising specialist assessor knowledge and experience in this manner this would reflect a critical human rights-based approach (Patel, 2020; Plavsic et al., 2020).

6.3.3 Lifting their gaze

In addition, the findings showed how specialist assessors were lifting their gaze to critically examine the surrounding socio-political climate and the associated human rights implications of their work. The specialist assessors raised important questions about the sufficiency of rights protections within the legislation. Their concerns about the extension provision under the IDCCRA added weight to calls for a review of the legislation (Brookbanks, 2019; Committee on the Rights of Persons with Disabilities, 2022).

Additionally, the specialist assessors discussed how issues of service and cultural responsivity impacted the delivery of rehabilitation. The specialist assessors' reflections on issues of cultural responsivity highlighted the untapped potential of cultural assessments within the process. Further, the findings are particularly relevant for considering how increased cultural responsivity could enhance the liberty and well-being interests of care recipients, along with their whānau, families, hapū, iwi, and communities.

6.4 Freedom and Well-being: Interrelated and Complementary Rights

The thesis provides a deeper insight into the interrelated nature of freedom and well-being rights. This is because the specialist assessors articulated how limited access to targeted or timely rehabilitation for care recipients could impact their evaluations of the need for an extension.

6.4.1 Barriers to rights-promotion

A valuable finding of this study was the insights provided into the structural factors that currently impact care recipients' realisation of their CRPD rights. Even if specialist assessors upskilled themselves regarding the CRPD (and relevant domestic law) and developed a clear, cohesive understanding of the obligations this brings to their practice, they may face other hurdles to effecting change. For example, specialist treatment for complex trauma or emotional dysregulation with a causative link to risk of reoffending may be unavailable in the care recipient's location, so they do not have an opportunity to reach the rehabilitation threshold for release.

In response, specialist assessors could continue with 'business as usual'. That is understandable because, at present, there is a lack of clarity about their human rights obligations. Further, the spectrum highlights that the specialist assessors held varied perspectives about the role that human rights should play in practice. Some take the view that if specialist assessors prepare contextually rich, risk-focused reports, then human rights can be extracted by others, like lawyers or judges, who are appropriately trained to do so. While others perceived that it was the specialist assessors responsibility to actively direct and pursue the delivery of necessary rehabilitation resources during the review process.

Further, it takes resources to become a rights champion. For example, time is needed to upskill on human rights and undertake the research needed to make robust submissions for IDCCRA reforms. In addition, a specialist assessor who wishes to engage in this form of advocacy would need self-belief, support from colleagues, and support from other influential stakeholders. Additionally, the system would need to be responsive to specialist assessors adopting a rights-focused stance; for example, judges willing to entertain any human rights factors that specialist assessors might include in future reports.

Concerningly, the findings indicate that some specialist assessors have experienced negative consequences for raising rights concerns, which created unease and led them to question the professional costs of coming into conflict with an unreceptive system. A rights-promoting specialist assessor might require assurance that they would not be shunned, criticised, or disadvantaged if they integrated human rights perspectives into their assessments.

This said, human rights defenders do not wait for permission or seek promises they will be safe from critique or resistance. If care recipients do not have the resources, skills, or power to secure they own human rights, then who will promote their human rights at the assessment stage? The findings show that some specialist assessors perceived there is a gap in advocacy of this nature for care recipients.

6.4.2 The low visibility of CRPD rights in the IDCCRA framework

Broader legislative questions were raised by this thesis. The literature review showed that the CRPD has low visibility within the IDCCRA framework relative to other areas of the disability sector. The lack of visibility is concerning, given the vulnerability of the care recipient population and the findings of earlier research that called for greater integration of human rights (Smith, 2013, 2015).

During CRPD monitoring, the Committee raised concerns about the unfitness and extension provisions embedded in the IDCCRA and CPMIPA (Committee on the Rights of Persons with Disabilities, 2014, 2015, 2022). In addition, the Committee's interpretation of Article 14 of the UNCRPD is that diversionary schemes like the IDCCRA provide a lower level of rights protections to care recipients and their international equivalents.

The stance so far taken by the New Zealand Government is that the IDCCRA complies with the CRPD (Office for Disability Issues, 2015). The call for disability-neutral legal systems and legislation such as the IDCCRA by the Committee is contentious and a source of ongoing international debate (Arstein-Kerslake et al., 2017; Bell et al., 2015; Dawson, 2015; Peay, 2015). Should the New Zealand government comply with the Committee's interpretation of Articles 5, 12, and 14, then, logically, this would mean repeal of the IDCCRA and CPMIPA.

6.4.3 Philosophical and legislative challenges

From the outset of this research, these bigger philosophical and legislative issues attracted the researcher's attention. There are impacts if the two Acts are repealed. A review of the IDCCRA is important and necessary. However, the benefits for care recipients should the legislation be repealed are, at this time, unclear. An important precipitant for the IDCCRA was consensus that people with intellectual disability were vulnerable in prison and unable to access the specialist rehabilitation required. Thus, the intent of the IDCCRA was to enhance not diminish rights protections. The Committee takes the view that care recipients and their equivalents would be better served by remaining in a criminal justice process that is disability neutral rather than being diverted into a separate stream of law (Committee on the Rights of Persons with Disabilities, 2015). Considering New Zealand's experience of implementing a novel diversionary regime, it would seem the country's disability sector is well placed to debate human rights implications this approach.

Further, within the *Guidelines on Article 14 of the Convention for the Rights of Persons with Disabilities,* the Committee lays out the components of humane care in prison or places of detention (Committee on the Rights of Persons with Disabilities, 2015). It could be argued many of these components exist in IDCCRA community facilities and the disability-centric hospital units (e.g., the Mason FIDDS). Perhaps a compromise would be the introduction of more checks and balances in the IDCCRA and a review of the disposition pathways available. This is touched upon within the recommendations outlined in Chapter 5 of this thesis.

Other jurisdictions are grappling with similar challenges (McSherry & Sullivan, 2023). The researcher also wondered about the role a specialist assessor might play in a disability-neutral legal system, or if there would be a role for specialist assessors at all. Given that the author is a specialist assessor, this aspect of the research journey has been challenging and unsettling. The insights gleaned during this thesis made the researcher sensitive to the barriers that other rights-promoting specialist assessors and psychologists face.

6.4.4 Lack of knowledge about human rights is not a barrier to critique

The specialist assessors were candid about their limited knowledge of the CRPD. However, this lack of knowledge did not prevent them from critically examining the implications of their role within a regime that has novel, therapeutic, protective, and coercive elements (Brookbanks, 2019; Diesfeld, 2013; Smith, 2015). As Wainwright et al. (2022) beautifully observed:

> Psychology has always mattered in human rights and human rights have always mattered in psychology, at least implicitly. Lately, however, the intersection of psychology and human rights has become more explicitly articulated. (p. 120)

This study represents an important first step toward the explicit expression of the intersection between human rights and specialist assessor practice.

6.4.5 Resources there to be utilised for specialist assessors with an appetite for change

This research has unearthed many resources that could be utilised by specialist assessors in their journey towards a human rights-focused stance. In particular, the human rights model and related perspective developed by Ward and Birgden (2007) could be readily applied to this area of practice. The core values of dignity, freedom, and well-being appear to have a natural synergy with the aims of the IDCCRA. The model was designed in New Zealand and Australia, is forensic-specific, and underpins the Good Lives Model (Ward et al., 2007a) already adopted within care and rehabilitation planning (Duff et al., 2023; Duncan, 2013). The model is likely to resonate with specialist assessors and the many other professionals working in this sector who are deeply committed to enabling care recipients to have good lives.

6.5 The Bigger Conversation

Finally, these findings reflect a larger debate about the role of human rights in psychology and psychiatry (Bhugra et al., 2017; Huminuik et al., 2022). The adequacy of professional and disciplinary training on human rights is being scrutinised globally (Hagenaars & Thompson, 2020; Plavsic et al., 2020). Further, the relationship between practice values, ethical codes, and legalistic human rights frameworks is robustly debated (Allan, 2013a; Hagenaars & Thompson, 2020; Nowak & Zenz, 2020). This study contributes to this burgeoning scholarship by expanding this discussion to a novel, applied forensic context.

Specialist assessors are well-placed to engage in this debate about the role of human rights in psychological and psychiatric practice. They are at the sharp end of forensic practice—assessing a complex group of people with intellectual disability who are in coercive care, in some cases, for many years. This research has highlighted the challenges that arise when care recipients have limited opportunities to engage in rehabilitation but continue to present with a high risk of reoffending.

Further, this thesis has revealed that in some cases, rehabilitation is under-resourced, poorly targeted, or lacking the cultural responsivity and competence required to support meaningful risk reduction. This study has highlighted features of the IDCCRA that may contribute to disproportionate outcomes for both Māori and non-Māori care recipients. This study has served to make the practice of specialist assessors more visible. Moreover, as the people most impacted by specialist assessor practice, importantly, it places the human rights of care recipients at the front and centre of this discussion.

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Glossary

Term	Definition
Care and rehabilitation plans	A plan prepared for the care recipient under section 24 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.
Care manager	Care managers are appointed by coordinators for each care recipient. They are employed by the Regional Intellectual Disability Supported Accommodation Service (RIDSAS) or the Forensic Intellectual Disability Secure Services (FIDDS) and are responsible for the day-to-day care and implementation of the care and rehabilitation plan. They approve leave and have powers to retake care recipients who are absent without authority.
Care recipient	A person who is a subject of compulsory care under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.
Coordinator	Coordinators are appointed by the Director General of Health. They are employed by the Forensic Coordination/Intellectual Disability Service (FCS/ID) and are responsible for administering the Act within set geographical areas. Their key tasks involve designating specialist assessors to undertake judicial orders for inquiries made under the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CPMIPA), undertaking needs assessments, making applications for care orders, designating where care recipients reside, approving care and rehabilitation plans, coordinating review processes, and making applications for extensions to orders.
District inspector	District inspectors are lawyers appointed by the Director General of Health. They are responsible for ensuring that care recipients' rights are upheld within the legislation. They take a lead role in investigating complaints by or on behalf of care recipients.
Hapū	Kinship group, clan, tribe or subtribe – section of a large kinship group and the primary and political unit in traditional Māori society (Te Aka Māori Dictionary, 2023).
Iwi	An extended kinship group, tribe, nation, people – often refers to a large group of people descended from a common ancestor and associated with a distinct territory (Te Aka Māori Dictionary, 2023).
Kaupapa	Principles and ideas that act as a base for foundation or action. A kaupapa is a set of values, principles, or plans which people have agreed on as a foundation for their actions (Te Ahukaramū Charles Royal, 2007).
Mana	Status or prestige.
Ōritetanga	Equity.
Pākehā	A Māori language term for New Zealanders primarily of European descent.
Specialist assessor or assessor	Means a suitably qualified and experienced health or disability professional who is designated by the Director-General of Health for the purposes of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

Term	Definition
Tangata whaikaiha	Disabled people (Te Aka Māori Dictionary, 2023).
Tikanga	The customary system of values and practices that have developed over time and are deeply embedded in the social context (Blackwell & Seymour, 2011)
Tino rangatiratanga	Self-determination, sovereignty, autonomy, self-government (Te Aka Māori Dictionary, 2023).
Whakapapa	In relation to a person, means the multi-generational kinship relationships that help to describe a person in terms of their matua (parents) and tupuna (ancestors), from whom they descend (Oranga Tamariki Act 1989 Children’s and Young People’s Well-Being Act 1989).
Whānau	Immediate and/or wider extended family (Walker, 2011).
Whānaungatanga	A relationship, kinship, sense of family connection – a relationship though shared experiences and working together which provides people with a sense of belonging. It develops as a result of kinship rights and obligations, which also serve to strengthen each member of the kin group (Te Aka Māori Dictionary, 2023).

Appendices

Appendix A: United Nations Convention on the Rights of Persons with Disabilities: Relevant Articles

Article 5
Equality and non-discrimination

1. States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to equal protection and equal benefit of the law.

2. States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.

3. In order to promote equality and eliminate discrimination, States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided.

4. Specific measures which are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention.

Article 12
Equal recognition before the law

1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.

2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.

3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.

4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person’s circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person’s rights and interests.

5. Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.

Article 13
Access to justice

1. States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.

2. In order to help to ensure effective access to justice for persons with disabilities, States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff.

Article 14
Liberty and Security

1. States parties shall ensure that persons with disabilities, on an equal basis with others:

    (a) Enjoy the right to liberty and security of the person;

    (b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

2. States parties should ensure that if persons with disability are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objective and principles of the present Convention, including the provision of reasonable accommodations.

Article 26
Habilitation and rehabilitation

1. States parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical mental social and vocational ability and full inclusion and participation in all aspects of life. To that end states parties shall organise, strengthen and extend comprehensive

habilitation and rehabilitation services aimed programmes, particularly in the areas of health employment education in social services, in such a way that these services and programmes:

(a) Begin at the earliest stage possible and based on multidisciplinary assessment of individual needs and strengths.

(b) Support participation and inclusion in the community and all aspects of society voluntary and available to persons with disabilities as close as possible to their own communities including in rural areas.

Article 30
Participation in cultural life, recreation, leisure and sport

1. States Parties recognize the right of persons with disabilities to take part on an equal basis with others in cultural life, and shall take all appropriate measures to ensure that persons with disabilities:

   (a) Enjoy access to cultural materials in accessible formats;

   (b) Enjoy access to television programmes, films, theatre and other cultural activities, in accessible formats;

   (c) Enjoy access to places for cultural performances or services, such as theatres, museums, cinemas, libraries and tourism services, and, as far as possible, enjoy access to monuments and sites of national cultural importance.

2. States Parties shall take appropriate measures to enable persons with disabilities to have the opportunity to develop and utilize their creative, artistic and intellectual potential, not only for their own benefit, but also for the enrichment of society.

3. States Parties shall take all appropriate steps, in accordance with international law, to ensure that laws protecting intellectual property rights do not constitute an unreasonable or discriminatory barrier to access by persons with disabilities to cultural materials.

4. Persons with disabilities shall be entitled, on an equal basis with others, to recognition and support of their specific cultural and linguistic identity, including sign languages and deaf culture.

Appendix B: Indicative Vignette and Interview Questions

The vignette and questions for the semi-structured questions are below. The vignette w informed by published legal judgments. After discussion with the advisory group, the questions will be finalised. The primary researcher will not solicit information about or re to specific care recipients. This will be explained to participants as part of the consent process within the participant information sheet and reiterated at the outset of the interview. See the script below:

> By way of reminder, I ask that you do not disclose the identities of the care recipients that you have worked with as we talk today. The focus of the research is specialist assessor practice in relation to human rights perspectives rather than specific clinical cases. Issues relating to risk issues/assessments or types of offending may be raised but not in a manner that will result in the identification of specific care recipients. As we progress through the interview questions, I will encourage you to use the vignettes I have provided to illustrate points or hypothetical scenarios. Should there be any details volunteered that could identify a care recipient, I will remind you not to discuss care recipients. These details will be redacted from the transcripts.

Vignette A

H is a 45 year-old old man with a moderate intellectual disability and autism. He has been a care recipient for 12 years. His compulsory care order was extended four times. He has received community-secure and hospital-secure care. High levels of resourcing were provided to support H's care and rehabilitation plan.

H has strong family support. His family wishes for H to return to their care. H expressed a desire and willingness to achieve this goal. However, significant challenges were posed in reducing his level of care and supervision due to his preoccupation with serious sexual harm and the high number of incidents in the care environment. H demonstrated an inability to understand the real-life consequences of enacting his violent sexual fantasies.

H appealed his placement under the (Intellectual Disability Compulsory Care and Rehabilitation) Act 2003 (IDCCRA). His lawyer had raised issues relating to H's liberty interests and his human rights. In particular, the lawyer raised the lengthy duration of H's status as a care recipient and the benefits of any further periods of care and rehabilitation, given the limited gains made over time. She also argued that further detention as a care recipient was discrimination under the United Nations Convention for the Rights of Persons with Disabilities (CRPD).

Imagine that you are the designated specialist assessor for the final review of H's order. You have been told you will be required to give evidence within the appeal process and that your assessment will be closely scrutinised.

Vignette B.

W is 21 years old. She has foetal alcohol spectrum disorder, and her intellectual disability is estimated to be at the upper limits of the mild range. W is known to have an extensive care and protection history, spending long periods of her adolescence transient and vulnerable. She has been imprisoned before.

W is fit to stand trial and convicted of serious violence offending at a defended hearing. The court has ordered inquiries under s35 Criminal Procedure (Mentally Impaired Persons) Act 2003 (CPMIPA).

Prior to being moved into an assessment bed at the Mason Clinic, W was remanded in prison for nine months. She has expressed a strong preference for a term of imprisonment. W feels more comfortable in prison because there are more people to socialise with. W has been told by her lawyer that the hybrid order could become a compulsory care order at the end of the sentence, which could be further extended. W prefers to, "do my time". The Crown Solicitor views a hybrid order as the most appropriate disposition.

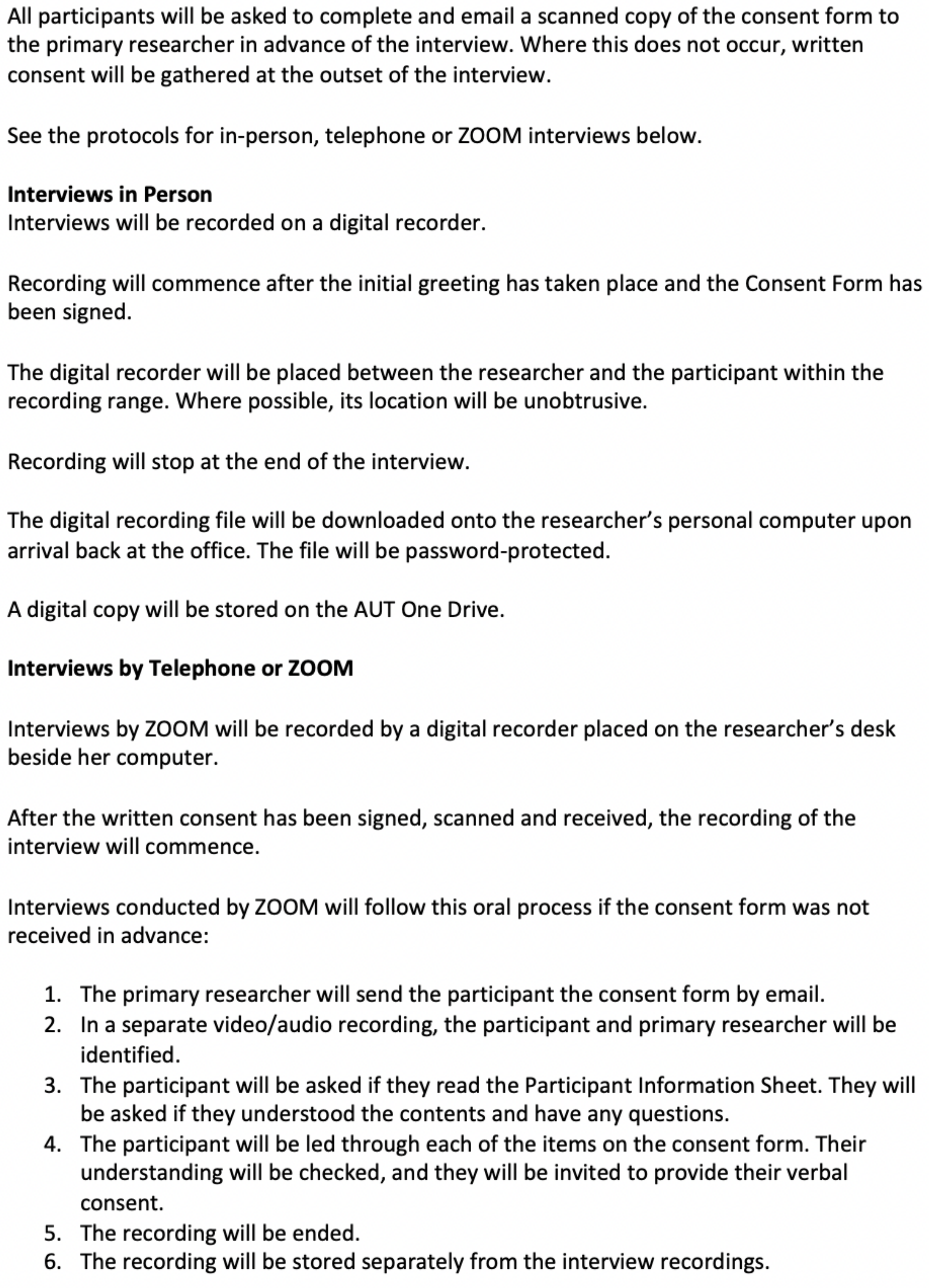
You have been designated to complete W's s35 CPMIPA inquiries. The findings of the inquiries are that W poses a high risk of violence. How would human rights weigh in for a specialist assessor?

Interview Questions

1. What do you understand the "human rights of the care recipient" to mean?
2. What do you understand the "liberty interests of the care recipient" to mean?
3. As a specialist assessor, how do you see your work contributing to the way the court balances the H's or W's liberty interest with community protection?
4. What sources of information would you rely on to inform your thinking about H's or W's liberty interests and human rights when you are making recommendations about the length of orders or extensions?
5. Are the considerations you make regarding a care recipient's liberty interest the same or different at the stages of disposition or extension?
6. To what extent, if at all, is there a tension between assessing for risk and raising a person's liberty interests?

7. To what extent have you felt that your role involved raising care recipients' human rights in assessments?
8. To what extent, if at all, did you feel constrained in your ability to do so?
9. In undertaking cultural consultation for this work, several issues specific to Māori care recipients were raised. The follow questions reflect these issues:
    9.1. We know that 41% of care recipients are Māori. What are the particular issues with liberty interests or human rights for this group?
    9.2. According to people at the hui, Te Tiriti o Waitangi is the foundational document regarding the liberty of Māori. What potential, in your view, if at all, does Te Tiriti O Waitangi hold for the discussion of liberty interests within the risk assessment of Māori care recipients?
    9.3. To what extent, if at all, do you consider the location of RIDSAS and RIDSS facilities to impact the outcomes for Māori care recipients?
    9.4. How might further assessment of cultural factors inform the consideration of liberty interests or human rights for the Court?
    9.5. To what extent, if at all, do current funding, legal or operational frameworks constrain the development of individualised care and rehabilitation programmes for Māori care recipients?
10. How, if at all, do you consider concepts such as less restrictive option and proportionality when you are formulating your opinions and recommendations?
11. In H's case, the UNCRPD was raised by the lawyer. Are there specific articles within the UNCRPD that you might refer to or are mindful of in your role as a specialist assessor?
12. How would you address the UNCRPD, if at all, in your assessment and report?
13. To what extent would you like more support, training or supervision in this area?

Appendix C: Protocol for Digital Recording of Interviews



All participants will be asked to complete and email a scanned copy of the consent form to the primary researcher in advance of the interview. Where this does not occur, written consent will be gathered at the outset of the interview.

See the protocols for in-person, telephone or ZOOM interviews below.

Interviews in Person

Interviews will be recorded on a digital recorder.

Recording will commence after the initial greeting has taken place and the Consent Form has been signed.

The digital recorder will be placed between the researcher and the participant within the recording range. Where possible, its location will be unobtrusive.

Recording will stop at the end of the interview.

The digital recording file will be downloaded onto the researcher's personal computer upon arrival back at the office. The file will be password-protected.

A digital copy will be stored on the AUT One Drive.

Interviews by Telephone or ZOOM

Interviews by ZOOM will be recorded by a digital recorder placed on the researcher's desk beside her computer.

After the written consent has been signed, scanned and received, the recording of the interview will commence.

Interviews conducted by ZOOM will follow this oral process if the consent form was not received in advance:

1. The primary researcher will send the participant the consent form by email.
2. In a separate video/audio recording, the participant and primary researcher will be identified.
3. The participant will be asked if they read the Participant Information Sheet. They will be asked if they understood the contents and have any questions.
4. The participant will be led through each of the items on the consent form. Their understanding will be checked, and they will be invited to provide their verbal consent.
5. The recording will be ended.
6. The recording will be stored separately from the interview recordings.

Interviews will then be recorded using the ZOOM recording function as a separate recording. As a backup, a digital recorder will be utilised

Recording will stop at the end of the interview.

The digital recording file will be downloaded onto the researcher's personal computer upon arrival back at the office. The file will be password-protected.

A digital copy will be stored on the AUT One Drive.

Interviews by Telephone

Interviews by telephone will be conducted with a microphone attached to the telephone receiver.

The rest of the procedure, as described above for ZOOM interviews will be followed.

Appendix D: Transcriber Confidentiality Agreement

Appendix D: Transcriber Confidentiality Agreement

Project Title: Specialist assessors' consideration of human rights in the assessment of intellectually disabled offenders: An interpretive descriptive study**.**

Project Supervisor: Professor Kate Diesfeld

Researcher: Amanda McFadden

☐ I understand that all material I will be asked to transcribe is confidential.

☐ I understand that the contents of the digital recordings can only be discussed with the researchers.

☐ I will not keep any copies of the digital recordings or transcripts, nor allow third parties to access them.

Transcriber's Name:

Telephone:

Mobile Phone:

E-mail :

Address:

Project Supervisor's Contact Details:
Professor Kate Diesfeld
Faculty of Health and Environmental Sciences
kdiesfel@aut.ac.nz
09 9219999 ext. 7837

Approved by the Auckland University of Technology Ethics Committee 20/1/21. AUTEC Reference 20/362. *Note: The Transcriber should retain a copy of this form.*

Transcriber Confidentiality Agreement

Project Title: Specialist assessors' consideration of human rights in the assessment of intellectually disabled offenders: An interpretive descriptive study.

Project Supervisor: Professor Kate Diesfeld

Researcher: Amanda McFadden

☑ I understand that all material I will be asked to transcribe is confidential.

☑ I understand that the contents of the digital recordings can only be discussed with the researchers.

☑ I will not keep any copies of the digital recordings or transcripts, nor allow third parties to access them.

Transcriber's Name: Elaine Phear Elaine Phear

Telephone:

Mobile Phone: 021 032 5794

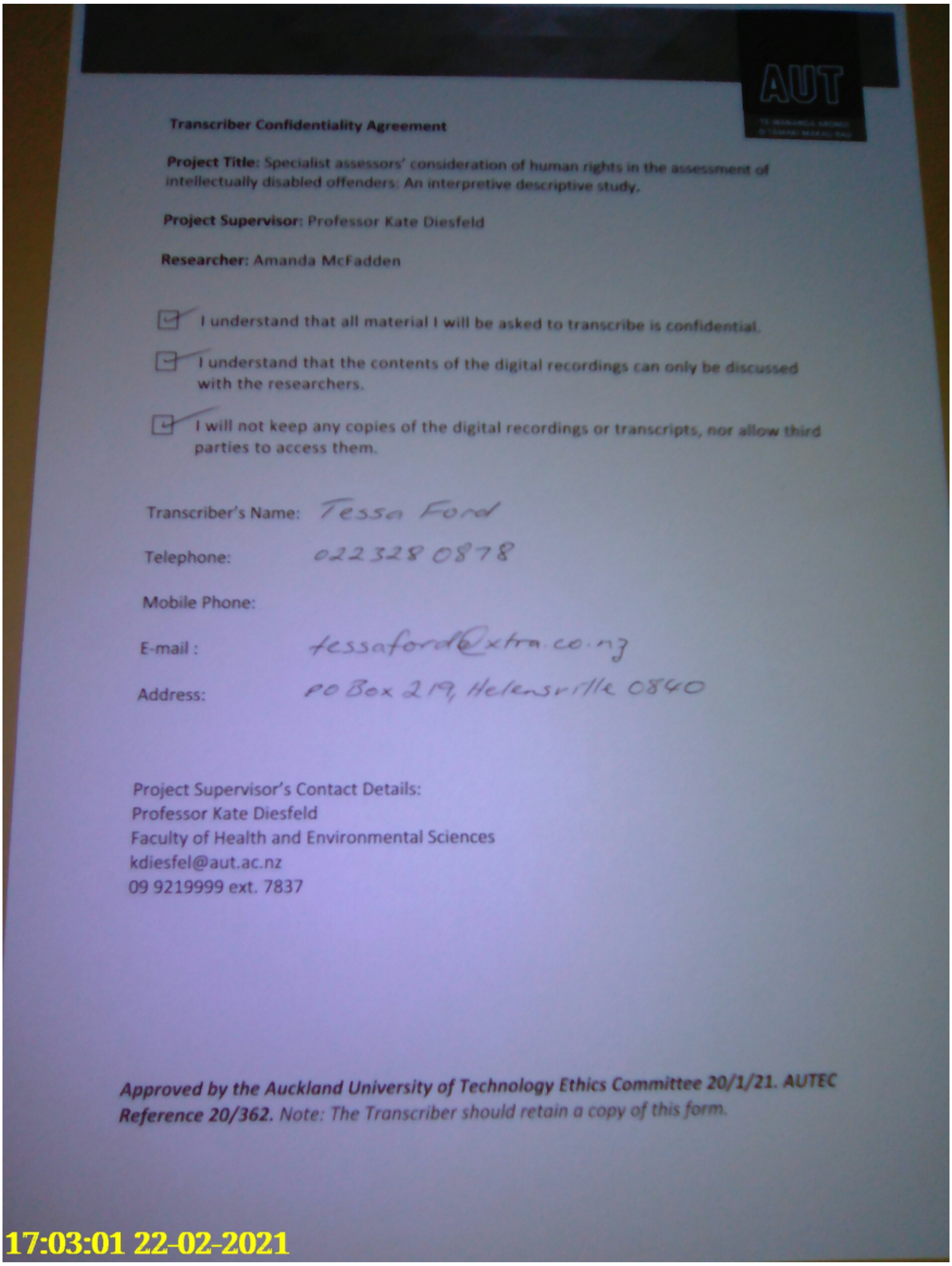
E-mail : elaineathome4@xtra.co.nz

Address: 57E Norwood Road, Bayswater, Auckland

22 February 2021

Project Supervisor's Contact Details:
Professor Kate Diesfeld
Faculty of Health and Environmental Sciences
kdiesfel@aut.ac.nz
09 9219999 ext. 7837

Approved by the Auckland University of Technology Ethics Committee 20/1/21. AUTEC Reference 20/362. *Note: The Transcriber should retain a copy of this form.*



Transcriber Confidentiality Agreement

Project Title: Specialist assessors' consideration of human rights in the assessment of intellectually disabled offenders: An interpretive descriptive study.

Project Supervisor: Professor Kate Diesfeld

Researcher: Amanda McFadden

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☑ I will not keep any copies of the digital recordings or transcripts, nor allow third parties to access them.

Transcriber's Name: Tessa Ford

Telephone: 022328 0878

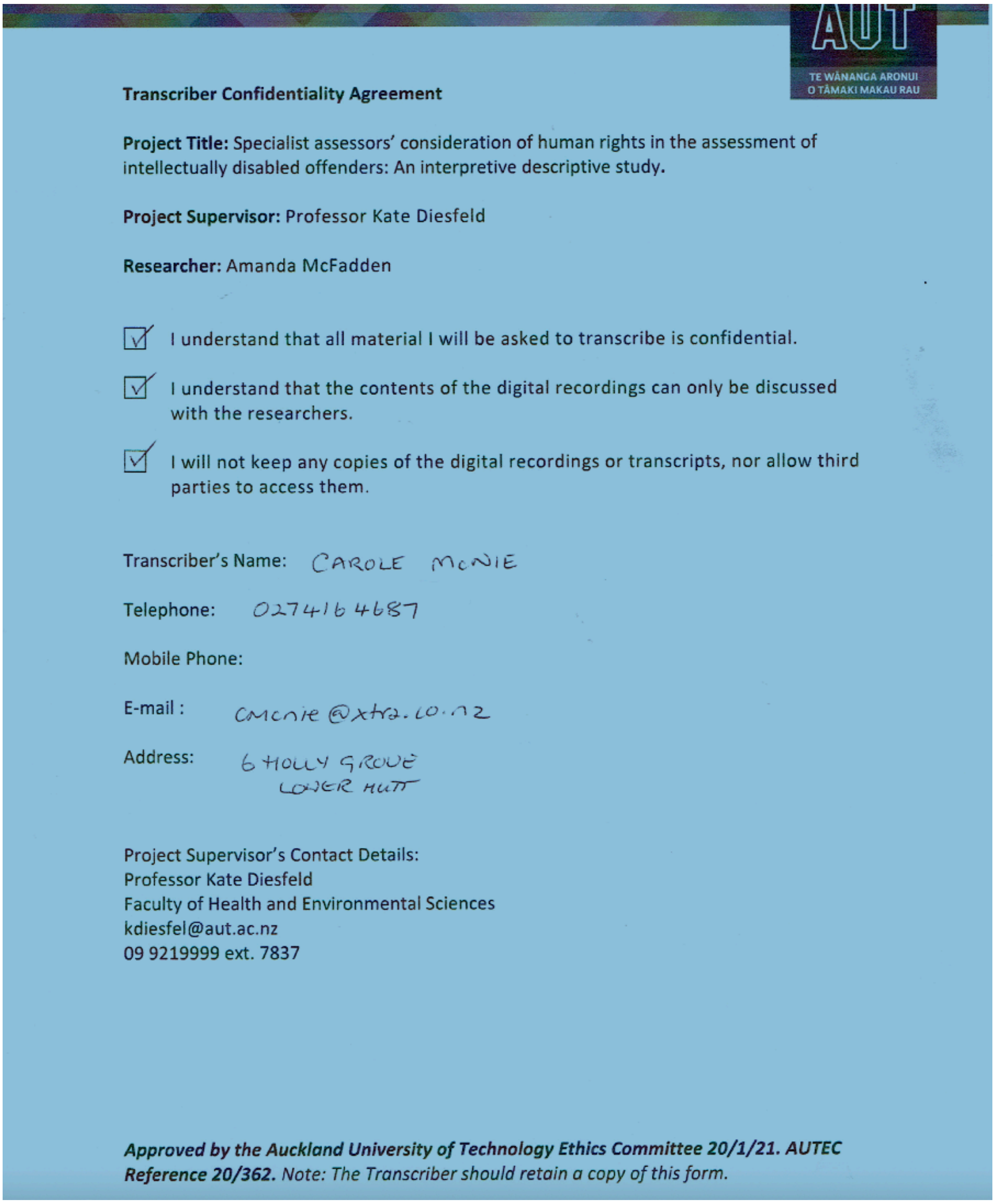
Mobile Phone:

E-mail : tessaford@xtra.co.nz

Address: PO Box 219, Helensville 0840

Project Supervisor's Contact Details:
Professor Kate Diesfeld
Faculty of Health and Environmental Sciences
kdiesfel@aut.ac.nz
09 9219999 ext. 7837

Approved by the Auckland University of Technology Ethics Committee 20/1/21. AUTEC Reference 20/362. *Note: The Transcriber should retain a copy of this form.*



Transcriber Confidentiality Agreement

Project Title: Specialist assessors' consideration of human rights in the assessment of intellectually disabled offenders: An interpretive descriptive study.

Project Supervisor: Professor Kate Diesfeld

Researcher: Amanda McFadden

☑ I understand that all material I will be asked to transcribe is confidential.

☑ I understand that the contents of the digital recordings can only be discussed with the researchers.

☑ I will not keep any copies of the digital recordings or transcripts, nor allow third parties to access them.

Transcriber's Name: CAROLE McNIE

Telephone: 0274164687

Mobile Phone:

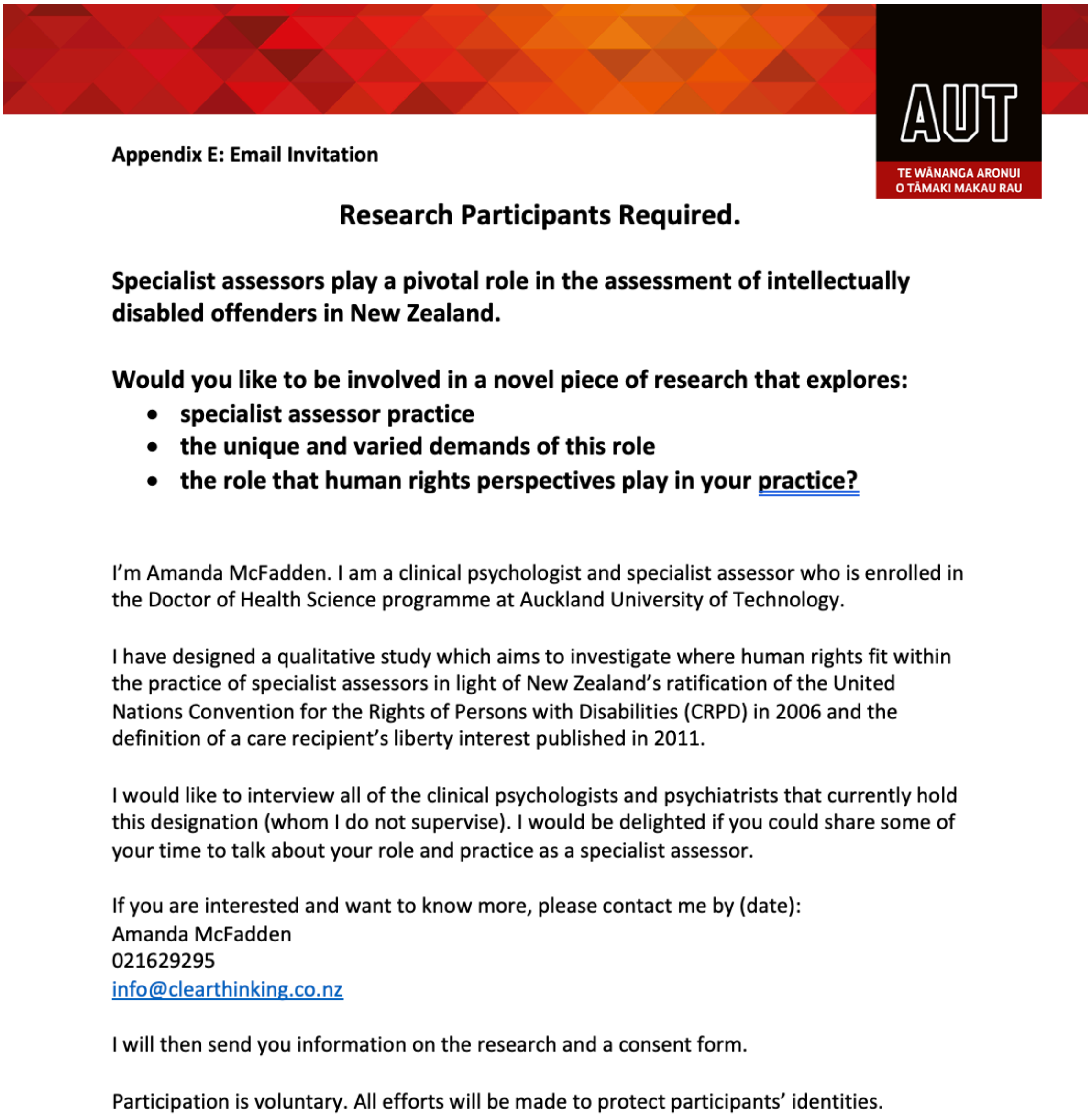
E-mail : cmcnie@xtra.co.nz

Address: 6 HOLLY GROVE
LOWER HUTT

Project Supervisor's Contact Details:
Professor Kate Diesfeld
Faculty of Health and Environmental Sciences
kdiesfel@aut.ac.nz
09 9219999 ext. 7837

Approved by the Auckland University of Technology Ethics Committee 20/1/21. AUTEC Reference 20/362. *Note: The Transcriber should retain a copy of this form.*

Appendix E: Email Invitation



Appendix E: Email Invitation

Research Participants Required.

Specialist assessors play a pivotal role in the assessment of intellectually disabled offenders in New Zealand.

Would you like to be involved in a novel piece of research that explores:

- **specialist assessor practice**
- **the unique and varied demands of this role**
- **the role that human rights perspectives play in your practice?**

I'm Amanda McFadden. I am a clinical psychologist and specialist assessor who is enrolled in the Doctor of Health Science programme at Auckland University of Technology.

I have designed a qualitative study which aims to investigate where human rights fit within the practice of specialist assessors in light of New Zealand's ratification of the United Nations Convention for the Rights of Persons with Disabilities (CRPD) in 2006 and the definition of a care recipient's liberty interest published in 2011.

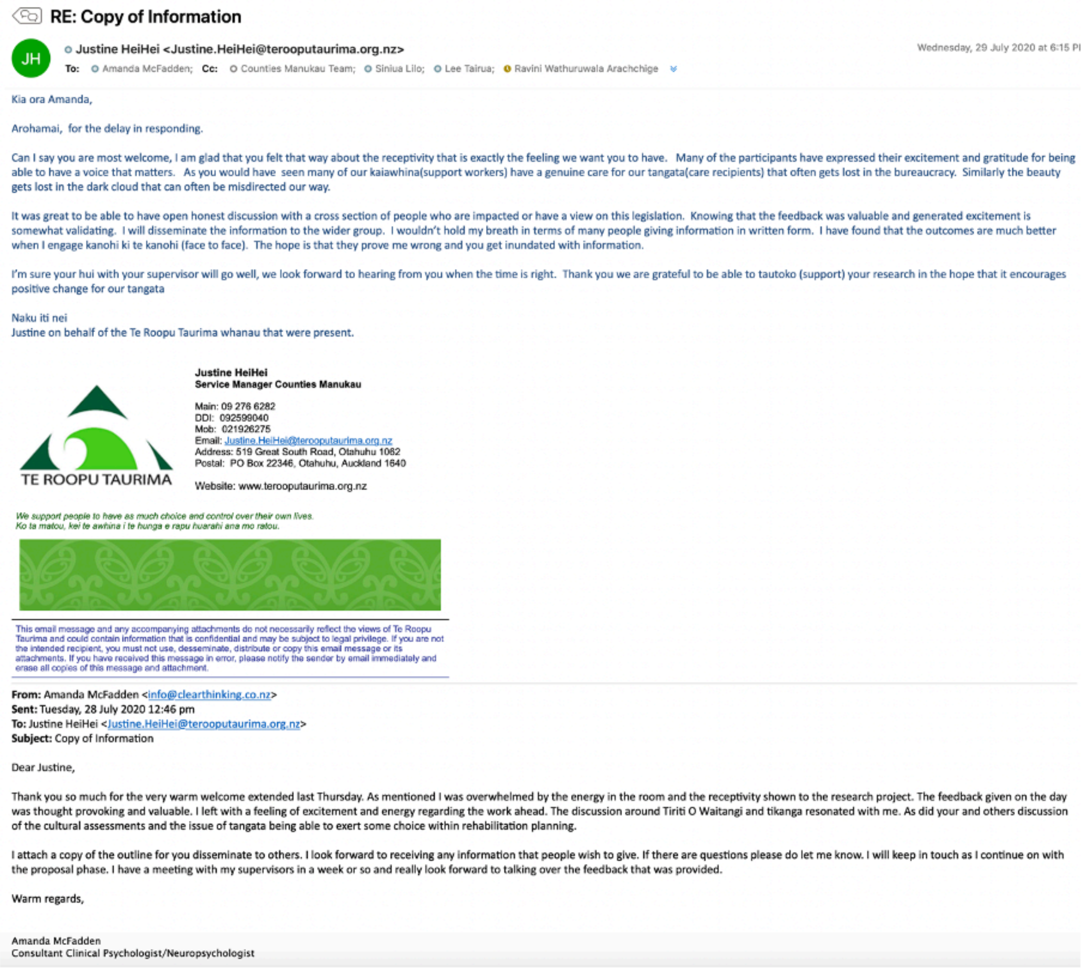
I would like to interview all of the clinical psychologists and psychiatrists that currently hold this designation (whom I do not supervise). I would be delighted if you could share some of your time to talk about your role and practice as a specialist assessor.

If you are interested and want to know more, please contact me by (date):
Amanda McFadden
021629295
info@clearthinking.co.nz

I will then send you information on the research and a consent form.

Participation is voluntary. All efforts will be made to protect participants' identities.

Appendix F: Email correspondence with Re Roopu Taurima O Manukau Trust and Disability Directorate



RE: Copy of Information

JH Justine HeiHei <Justine.HeiHei@terooputaurima.org.nz>
Wednesday, 29 July 2020 at 6:15 PI
To: Amanda McFadden; **Cc:** Counties Manukau Team; Siniua Lilo; Lee Tairua; Ravini Wathuruwala Arachchige

Kia ora Amanda,

Arohamai, for the delay in responding.

Can I say you are most welcome, I am glad that you felt that way about the receptivity that is exactly the feeling we want you to have. Many of the participants have expressed their excitement and gratitude for being able to have a voice that matters. As you would have seen many of our kaiawhina(support workers) have a genuine care for our tangata(care recipients) that often gets lost in the bureaucracy. Similarly the beauty gets lost in the dark cloud that can often be misdirected our way.

It was great to be able to have open honest discussion with a cross section of people who are impacted or have a view on this legislation. Knowing that the feedback was valuable and generated excitement is somewhat validating. I will disseminate the information to the wider group. I wouldn't hold my breath in terms of many people giving information in written form. I have found that the outcomes are much better when I engage kanohi ki te kanohi (face to face). The hope is that they prove me wrong and you get inundated with information.

I'm sure your hui with your supervisor will go well, we look forward to hearing from you when the time is right. Thank you we are grateful to be able to tautoko (support) your research in the hope that it encourages positive change for our tangata

Naku iti nei
Justine on behalf of the Te Roopu Taurima whanau that were present.

TE ROOPU TAURIMA

Justine HeiHei
Service Manager Counties Manukau

Main: 09 276 6282
DDI: 092599040
Mob: 021926275
Email: Justine.HeiHei@terooputaurima.org.nz
Address: 519 Great South Road, Otahuhu 1082
Postal: PO Box 22346, Otahuhu, Auckland 1640

Website: www.terooputaurima.org.nz

We support people to have as much choice and control over their own lives.
Ko ta matou, kei te awhina i te hunga e rapu huarahi ana mo ratou.

From: Amanda McFadden <info@clearthinking.co.nz>
Sent: Tuesday, 28 July 2020 12:46 pm
To: Justine HeiHei <Justine.HeiHei@terooputaurima.org.nz>
Subject: Copy of Information

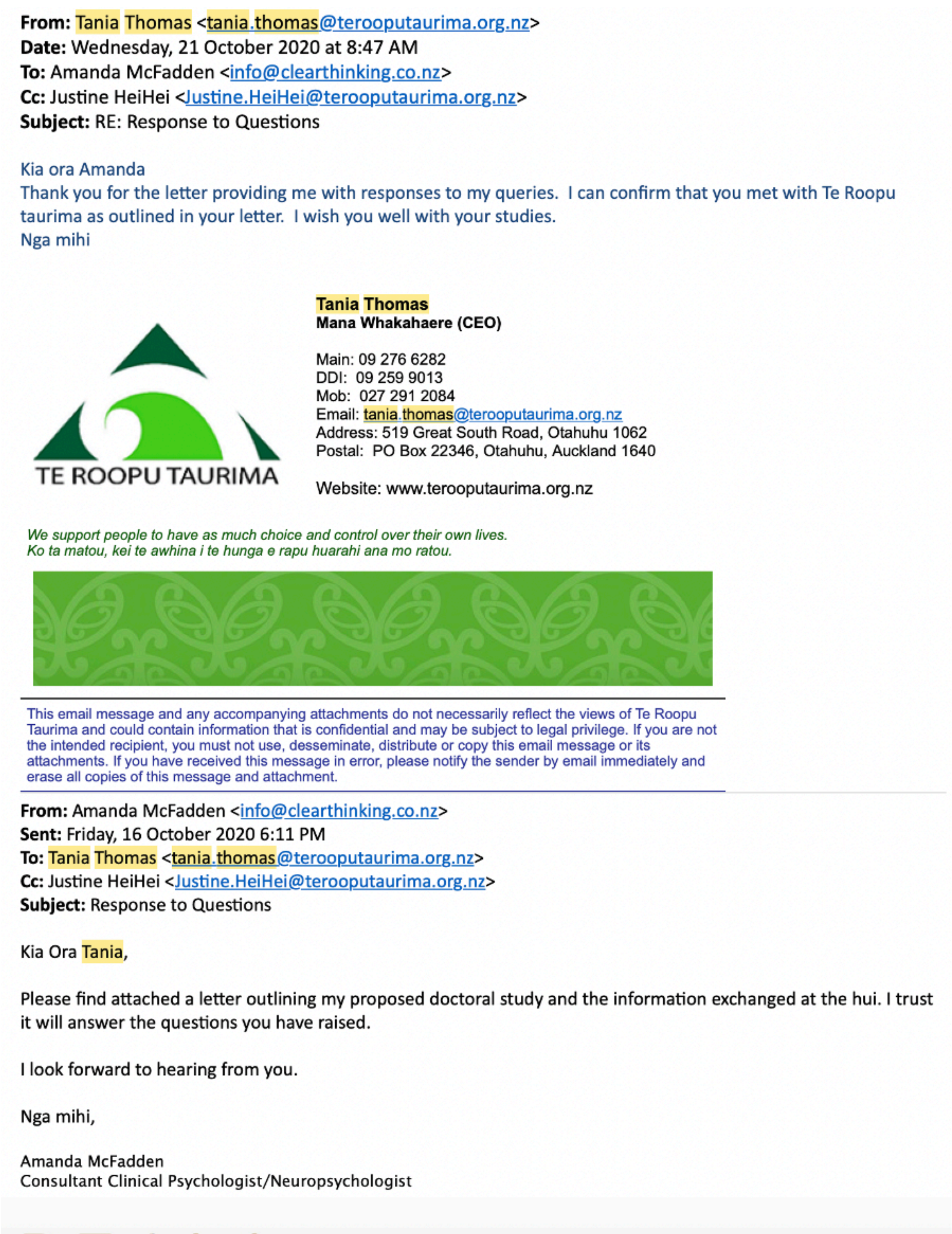
Dear Justine,

Thank you so much for the very warm welcome extended last Thursday. As mentioned I was overwhelmed by the energy in the room and the receptivity shown to the research project. The feedback given on the day was thought provoking and valuable. I left with a feeling of excitement and energy regarding the work ahead. The discussion around Tiriti O Waitangi and tikanga resonated with me. As did your and others discussion of the cultural assessments and the issue of tangata being able to exert some choice within rehabilitation planning.

I attach a copy of the outline for you disseminate to others. I look forward to receiving any information that people wish to give. If there are questions please do let me know. I will keep in touch as I continue on with the proposal phase. I have a meeting with my supervisors in a week or so and really look forward to talking over the feedback that was provided.

Warm regards,

Amanda McFadden
Consultant Clinical Psychologist/Neuropsychologist



From: Tania Thomas <tania.thomas@terooputaurima.org.nz>
Date: Wednesday, 21 October 2020 at 8:47 AM
To: Amanda McFadden <info@clearthinking.co.nz>
Cc: Justine HeiHei <Justine.HeiHei@terooputaurima.org.nz>
Subject: RE: Response to Questions

Kia ora Amanda
Thank you for the letter providing me with responses to my queries. I can confirm that you met with Te Roopu taurima as outlined in your letter. I wish you well with your studies.
Nga mihi

Tania Thomas
Mana Whakahaere (CEO)

Main: 09 276 6282
DDI: 09 259 9013
Mob: 027 291 2084
Email: tania.thomas@terooputaurima.org.nz
Address: 519 Great South Road, Otahuhu 1062
Postal: PO Box 22346, Otahuhu, Auckland 1640

Website: www.terooputaurima.org.nz

TE ROOPU TAURIMA

We support people to have as much choice and control over their own lives.
Ko ta matou, kei te awhina i te hunga e rapu huarahi ana mo ratou.

From: Amanda McFadden <info@clearthinking.co.nz>
Sent: Friday, 16 October 2020 6:11 PM
To: Tania Thomas <tania.thomas@terooputaurima.org.nz>
Cc: Justine HeiHei <Justine.HeiHei@terooputaurima.org.nz>
Subject: Response to Questions

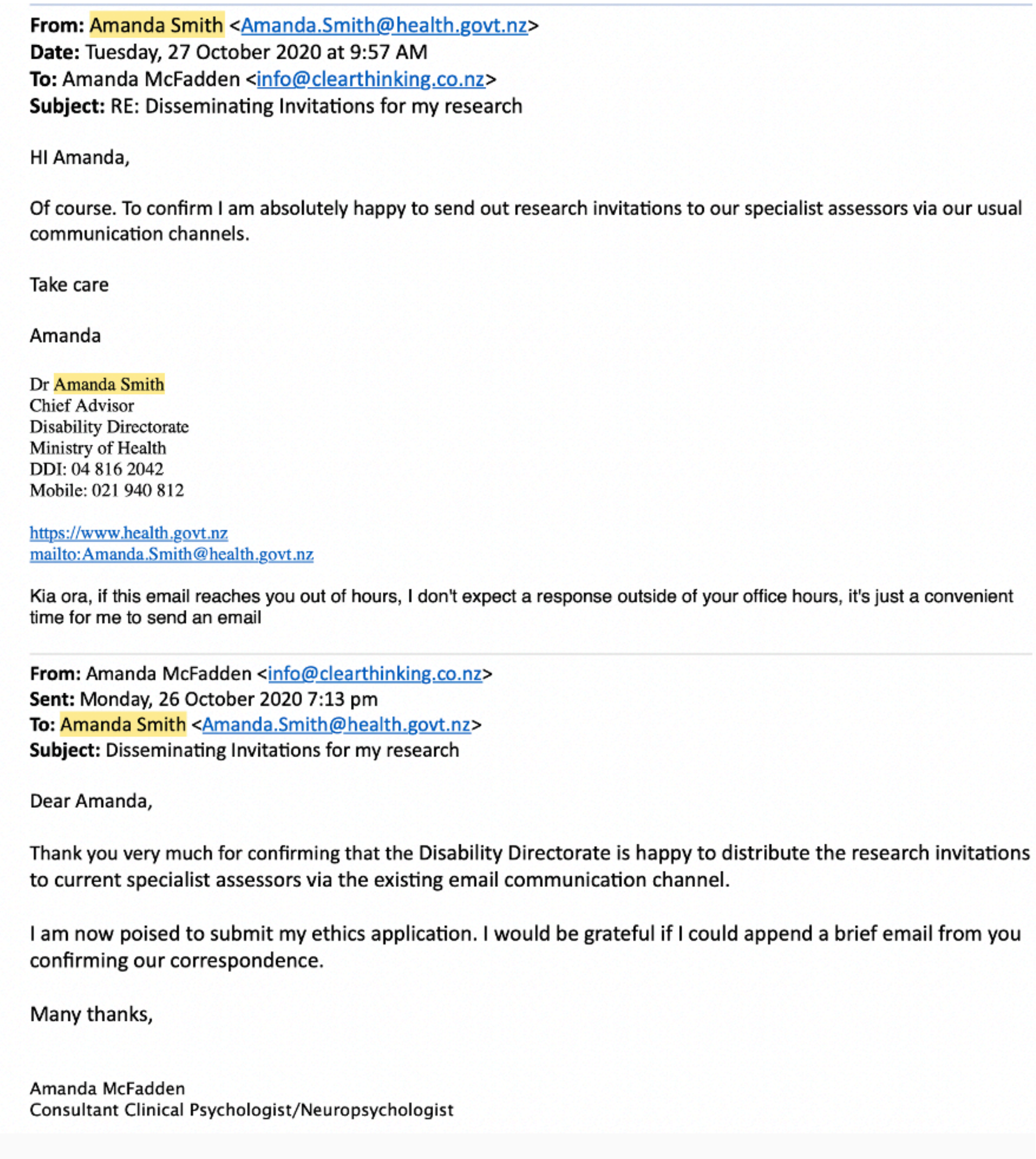
Kia Ora Tania,

Please find attached a letter outlining my proposed doctoral study and the information exchanged at the hui. I trust it will answer the questions you have raised.

I look forward to hearing from you.

Nga mihi,

Amanda McFadden
Consultant Clinical Psychologist/Neuropsychologist



From: Amanda Smith <Amanda.Smith@health.govt.nz>
Date: Tuesday, 27 October 2020 at 9:57 AM
To: Amanda McFadden <info@clearthinking.co.nz>
Subject: RE: Disseminating Invitations for my research

HI Amanda,

Of course. To confirm I am absolutely happy to send out research invitations to our specialist assessors via our usual communication channels.

Take care

Amanda

Dr Amanda Smith
Chief Advisor
Disability Directorate
Ministry of Health
DDI: 04 816 2042
Mobile: 021 940 812

https://www.health.govt.nz
mailto:Amanda.Smith@health.govt.nz

Kia ora, if this email reaches you out of hours, I don't expect a response outside of your office hours, it's just a convenient time for me to send an email

---

From: Amanda McFadden <info@clearthinking.co.nz>
Sent: Monday, 26 October 2020 7:13 pm
To: Amanda Smith <Amanda.Smith@health.govt.nz>
Subject: Disseminating Invitations for my research

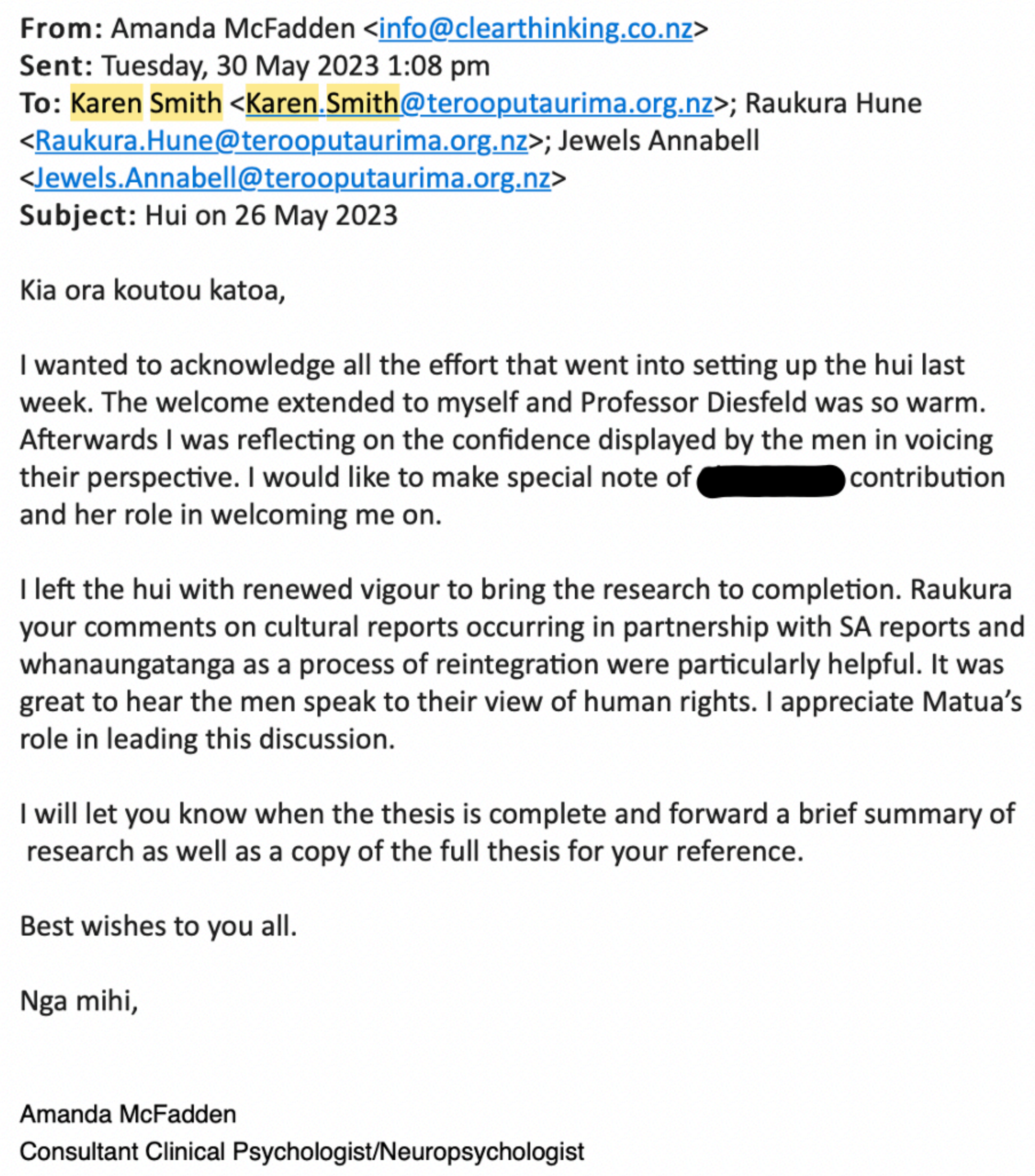
Dear Amanda,

Thank you very much for confirming that the Disability Directorate is happy to distribute the research invitations to current specialist assessors via the existing email communication channel.

I am now poised to submit my ethics application. I would be grateful if I could append a brief email from you confirming our correspondence.

Many thanks,

Amanda McFadden
Consultant Clinical Psychologist/Neuropsychologist



From: Amanda McFadden <info@clearthinking.co.nz>
Sent: Tuesday, 30 May 2023 1:08 pm
To: Karen Smith <Karen.Smith@terooputaurima.org.nz>; Raukura Hune <Raukura.Hune@terooputaurima.org.nz>; Jewels Annabell <Jewels.Annabell@terooputaurima.org.nz>
Subject: Hui on 26 May 2023

Kia ora koutou katoa,

I wanted to acknowledge all the effort that went into setting up the hui last week. The welcome extended to myself and Professor Diesfeld was so warm. Afterwards I was reflecting on the confidence displayed by the men in voicing their perspective. I would like to make special note of [redacted] contribution and her role in welcoming me on.

I left the hui with renewed vigour to bring the research to completion. Raukura your comments on cultural reports occurring in partnership with SA reports and whanaungatanga as a process of reintegration were particularly helpful. It was great to hear the men speak to their view of human rights. I appreciate Matua's role in leading this discussion.

I will let you know when the thesis is complete and forward a brief summary of research as well as a copy of the full thesis for your reference.

Best wishes to you all.

Nga mihi,

Amanda McFadden
Consultant Clinical Psychologist/Neuropsychologist

From: Jewels Annabell <Jewels.Annabell@terooputaurima.org.nz>
Sent: Monday, March 27, 2023 4:29:41 PM
To: Raukura Hune <Raukura.Hune@terooputaurima.org.nz>; Dr Hemant Thakkar <DrHemant.Thakkar@terooputaurima.org.nz>
Cc: Christine Henare <Christine.Henare@terooputaurima.org.nz>; Winiata Brown <Winiata.Brown@terooputaurima.org.nz>
Subject: FW: Follow up to letter

Hello everyone,

Amanda has contacted Karen as per the email trail below, and attached is a letter which outlines a bit about herself and the research she is completing towards a Doctorate of Health Science at AUT.

She met with the Te Roopu Taurima community in 2020 during the planning stages of the research and is now in a position to provide some feedback on the preliminary findings.

Raukura, I'm hoping that you were involved in the initial meeting, and would be able to organise a second hui to get the feedback from this research.

Hopefully it is okay to leave this in your capable hands!

I don't know a lot about this, but do please let me know if you have any questions, and I will find the answers for you 😊

Nga mihi,

Jewels

TE ROOPU TAURIMA

Jewels Annabell
Executive Assistant to CEO & NSM
Kaiawhina Rangapū ki te Manawhakahaere
DDI: 09 259 9012
Mob: 027 294 0018
Address: 519 Great South Road
Otahuhu, Auckland
Postal: PO Box 22346, Otahuhu 1640

Appendix G: Participant Information Sheet

AUT
TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

Appendix G: Participant Information Sheet

Date Information Sheet Produced: 26 October 2020

Project Title

Specialist assessors' consideration of human rights in the assessment of intellectually disabled offenders: An interpretive descriptive study.

An Invitation

Greetings,

I am Amanda McFadden. I am currently completing the Doctor of Health Science programme at Auckland University of Technology (AUT). As part of this qualification I am completing a research project. I am inviting you to participate in this research project, which is exploring how specialist assessors integrate human rights perspectives, if at all, within their assessments.

What is the purpose of this research?

The purpose of the research is to investigate where human rights fit within the practice of specialist assessors in light of New Zealand's ratification of the United Nations Convention for the Rights of Persons with Disabilities (CRPD) in 2006 and the definition of a care recipient's liberty interest in 2011. There is currently a lack of clarity about whether specialist assessors could, or should, be commenting on the human rights or liberty interests of care recipients within their reports.

In addition to the production of a doctoral thesis, the findings of this research may be used for academic publications and presentations. The research may contribute to the development of training materials.

How was I identified and why am I being invited to participate in this research?

You were contacted because you currently hold the designation of specialist assessor. The Disability Directorate sent out the invitation on my behalf. I would like to interview all of the clinical psychologist and psychiatrists that currently hold this designation (whom I do not supervise).

How do I agree to participate in this research?

If you are interested in participating in this study, please contact me by email or phone (details below). I am happy to answer questions about the research.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

We will talk about your practice as a specialist assessor, with a specific focus on human rights and liberty issues. We will talk and how you see your work contributing to the way the court balances a care recipient's liberty interest with community protection. I will ask you to reflect on two vignettes that detail common situations arising around the liberty interests of care recipients.

Interviews can be conducted during or after business hours, at my office or a location of your choice, in person or by ZOOM. During the preliminary telephone or email contact, you can decide what is the best option for you. I will then email you the consent form. Before the interview we will discuss the information sheet and I will answer any questions you have. If it is a zoom interview, you scan the signed consent form to me before the interview begins. If you agree, the interview will be audio-recorded, and later transcribed by a professional transcriber, who has signed a confidentiality agreement. If you do not agree to the recording, I will take notes. You have the option to review your transcript and return it with within one week, with any revisions.

The data collected will only be used for the purposes of this project and will be presented in the form of a thesis and articles, as well as presentations at professional forums and conferences.

What are the discomforts and risks?

While no major risks are anticipated, some people may feel discomfort when responding to the research questions. I will encourage you to use your personal clinical supervisory arrangements to reflect on any discomfort that arises. In addition, AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into AUT centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore Campus to make an appointment. Appointments for South Campus can be made by calling 921 9992
- let the receptionist know that you are a research participant, and provide the title of my research and my contact details as given in this Information Sheet.

You can find out more information about AUT counselling at http://www.aut.ac.nz/being-astudent/ current-postgraduates/your-health-and-wellbeing/counselling. For those based out of Auckland I will provide a lists of private practitioners held by the New Zealand College of Clinical Psychologists and a letter guaranteeing that I will cover the cost of up to three sessions. The letter is designed to be given the therapist of your choosing. The therapist can then contact Amanda, register the inquiry and confirm payment, while maintaining your anonymity.

What are the benefits?

The study recognises the pivotal role of specialist assessors in determinations regarding a care recipients' status. You may benefit through reflecting upon whether the integration of human rights perspectives is relevant to your assessments. Other professionals may contemplate whether human rights perspectives are incorporated within their own assessments. Ultimately, this may contribute to the content of care recipients' assessments.

The findings may inform future New Zealand policy and practice. I will benefit by obtaining a Doctor of Health Science degree. The research may be a platform for me to collaborate with other participants in the disability and law arena who have an interest in rights issues, and the role of expert witnesses.

How will my privacy be protected?

All information will be stored in a locked cabinet at North Campus AUT (office AR337). Only me, my supervisors and the professional transcriber will have access to the data. This information will be stored for six years, at which time it will be securely destroyed. Any information that may identify you will be removed from the data. However, given the relatively small number of specialist assessors, there may be a chance that future audiences could identify participants. All efforts will be made to protect participants' identities in publications and other fora.

How will the care recipients' privacy be protected?

You are asked not to disclose the identities of the care recipients that you have worked with. Should there be any details discussed that could identify care recipients, you will be reminded to not discuss care recipients and relevant content will not be included in the findings.

What are the costs of participating in this research?

Joining in the research is free. However, I request approximately 2 hours of your time (60-90 minutes for interview, 10-15 minutes consent, and 10-15 minutes follow-up discussion). You will be offered the opportunity to review your interview transcript. I will ask that they are returned within two weeks. Reviewing your transcript could take a further 60 minutes of your time.

What opportunity do I have to consider this invitation?

You will have one month to consider participating in this project. Please contact me directly if you would like to participate (see contact details below). I will arrange for the invitations to be resent on one further occasion at the end of the first month. Please ask me any questions you may have.

Data collection is expected to be completed by June 2021.

Even if you decide to participate, you may change your mind at any time, without adverse consequences of any kind.

Will I receive feedback on the results of this research?

You will be sent a brief summary of the findings following the completion of the data analysis.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Professor Kate Diesfeld, kdiesfel@aut.ac.nz, 099219999 ext. 7837.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, *ethics@aut.ac.nz*, (+649) 921 9999 ext. 6038.

Whom do I contact for further information about this research?

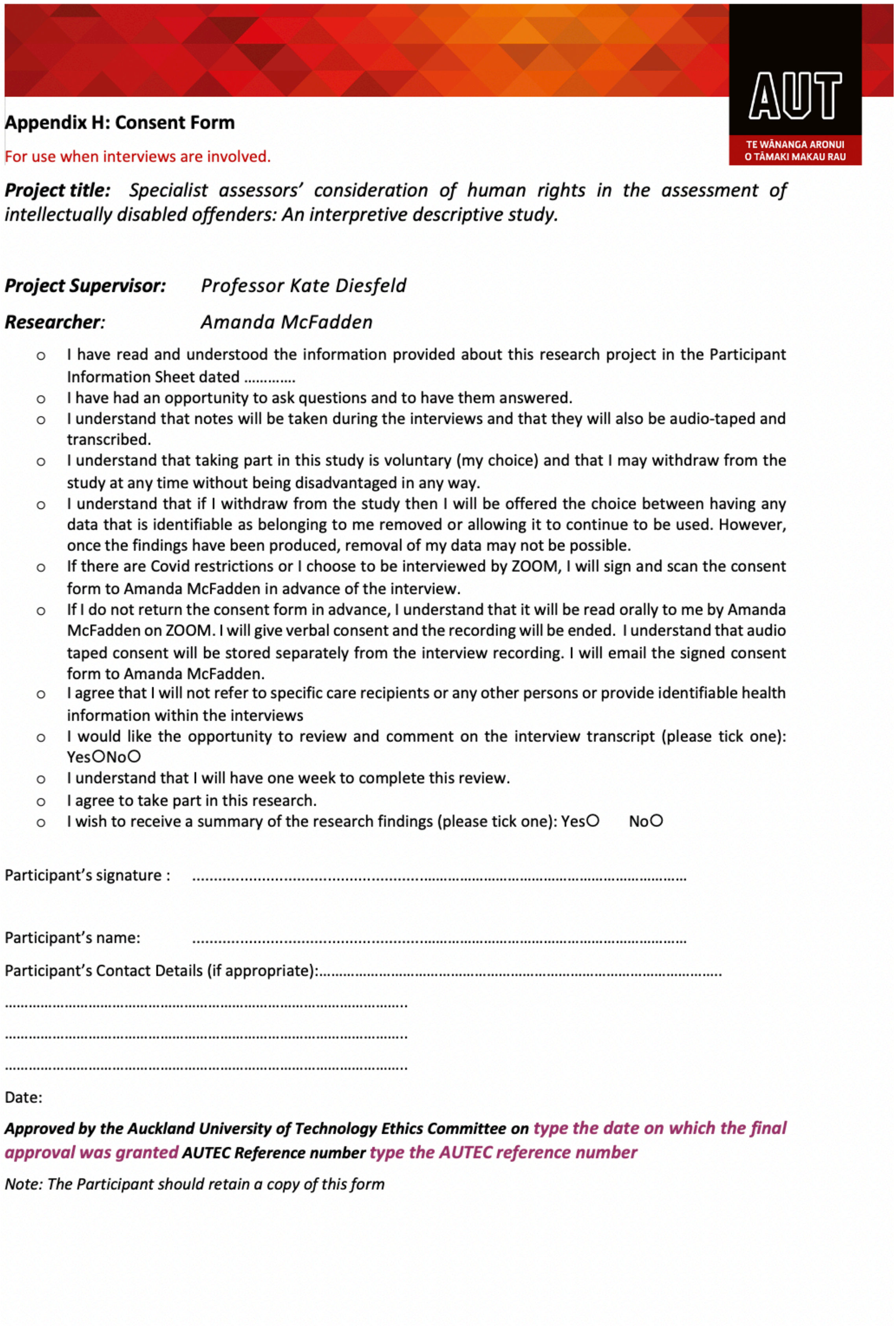
Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details: Amanda McFadden, ***info@clearthinking.co.nz***, 098351071, 021629295

Project Supervisor Contact Details: Professor Kate Diesfeld, kdiesfel@aut.ac.nz, 099219999 ext. 7837.

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, AUTEC Reference number *type the reference number*.

Appendix H: Consent Form



Appendix H: Consent Form

For use when interviews are involved.

Project title: *Specialist assessors' consideration of human rights in the assessment of intellectually disabled offenders: An interpretive descriptive study.*

Project Supervisor: *Professor Kate Diesfeld*

Researcher: *Amanda McFadden*

- I have read and understood the information provided about this research project in the Participant Information Sheet dated …………
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- If there are Covid restrictions or I choose to be interviewed by ZOOM, I will sign and scan the consent form to Amanda McFadden in advance of the interview.
- If I do not return the consent form in advance, I understand that it will be read orally to me by Amanda McFadden on ZOOM. I will give verbal consent and the recording will be ended. I understand that audio taped consent will be stored separately from the interview recording. I will email the signed consent form to Amanda McFadden.
- I agree that I will not refer to specific care recipients or any other persons or provide identifiable health information within the interviews
- I would like the opportunity to review and comment on the interview transcript (please tick one): Yes○No○
- I understand that I will have one week to complete this review.
- I agree to take part in this research.
- I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature : ……………………………………………………………………………………………

Participant's name: ……………………………………………………………………………………………

Participant's Contact Details (if appropriate):……………………………………………………………………………………………

……………………………………………………………………………………

……………………………………………………………………………………

……………………………………………………………………………………

Date:

Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEC Reference number type the AUTEC reference number

Note: The Participant should retain a copy of this form

Appendix I: Ethics Approval

TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

1 December 2020

Kate Diesfeld
Faculty of Health and Environmental Sciences

Dear Kate

Ethics Application: **20/362 Specialist assessors' consideration of human rights in the assessment of intellectually disabled offenders: An interpretive descriptive study.**

Thank you for submitting your application for ethical review. We are pleased to advise that the Auckland University of Technology Ethics Committee (AUTEC) approved your ethics application at their meeting on 23 November 2020, subject to the following conditions:

1. Provision in the Information Sheet of options for participants in other parts of New Zealand to access counselling free of charge given that AUT counselling is available only face-to-face for Auckland residents;
2. Provision of the indicative vignettes and questions to participants before the interview so that they can reflect on them;
3. Confirmation that the recommendations made through consultation with Māori (via Te Rōpu Taurima o Manukau Trust) have been incorporated into the interview questions;
4. Reconsideration of the possibility that organisational practices may be discussed during the interviews and clarification of how this will be managed;
5. Provision of a revised plan about how the data will be stored. The researcher is referred to AUTEC's revised guidelines for the storage of data and Consent Forms and the data storage matrix in section 18 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures*, which is available on the Research Ethics website at http://aut.ac.nz/researchethics;
6. Provision of more than a week for participants to consider their involvement in the research;
7. Amendment of the Information Sheet as follows:
    a. Inclusion of the time to review transcripts in the costs section;
    b. Inclusion of the possibility that the research may contribute to the development of training materials in the purpose section.

Please provide us with a response to the points raised in these conditions, indicating either how you have satisfied these points or proposing an alternative approach. AUTEC also requires copies of any altered documents, such as Information Sheets, surveys etc. You are not required to resubmit the application form again. Any changes to responses in the form required by the committee in their conditions may be included in a supporting memorandum.

Please note that the Committee is always willing to discuss with applicants the points that have been made. There may be information that has not been made available to the Committee, or aspects of the research may not have been fully understood.

Once your response is received and confirmed as satisfying the Committee's points, you will be notified of the full approval of your ethics application. Full approval is not effective until all the conditions have been met. Data collection may not commence until full approval has been confirmed. If these conditions are not met within six months, your application may be closed and a new application will be required if you wish to continue with this research.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

We look forward to hearing from you,

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: info@clearthinking.co.nz; Warren Brookbanks

Appendix J: Summary of Second Hui at Te Roopu Taurima O Manukau Trust 26 May 2023

Amanda McFadden and Professor Kate Diesfeld were formally called onto Te Roopu O Manukau Trust as part of the powhiri. Four male care recipients who live in a community secure facility were present, and one female (who was previously a care recipient) performed the karanga. Also present were a kaumatua, a care manager, a kaiwhakahaere (house leader), kaiawhina (support workers), and other members of the organisation. Approximately 14 people were present in total.

Amanda provided an overview of the study and the outcome of the first hui, for example, how this informed the research questions and interviews with SA. Amanda then shared a brief summary of two themes: service delivery and human rights, and cultural factors and human rights and shared some extracts from the findings.

The feedback provided had two key elements.

1. What human rights mean for care recipients.
   - The care recipients expressed human rights as the right to freedom, the right to independence, the right to choose, the right to work, and the right to have relationships.
   - They wanted rehabilitation that helped them achieve these goals.
   - A connection was expressed between accessing services and achieving freedom.
   - One care recipient expressed concern about being on a benefit; they preferred to be supported into employment to earn their own money.
   - Other care recipients wanted more choice over vocational options and rehabilitation services. They wanted rehabilitation to be more specific and personalised.
   - The care recipients expressed a desire to be closer to their homes, iwi and marae. There was a discussion by others at the hui about the impacts of closing RIDSAS facilities in Northland some time ago.
   - Some of the care recipients likened being under compulsory care to doing time: “I just want to do my time and get out”.

2. The importance of mandating cultural reports at the outset of the IDCCRA process was discussed.
   - The care manager and kaiawhina reflected on the ways cultural assessment strengthened the building of relationships with care recipients and their whanau from the outset of compulsory care.
   - In the absence of a formalised cultural report process that runs alongside SA reports and needs assessment, the responsibility falls to care managers at TRT.
   - It was reflected that the process of whanaungatanga is essential for the care and rehabilitation plans to be therapeutic.
   - Should cultural reports happen at the outset, then reintegration to whanau and whenua is born in mind from the outset, not something that is considered at the end.

- The need for support at the end of orders in the persons' location, was reflected upon by kaiawhina, kaiwhakahaere and others.
- Again, whanaungatanga and other tikanga practices were identified as factors that strengthened reintegration and prevented a cycle of compulsory care and reoffending.

The hui was closed after approximately 45 minutes, followed by a morning tea.