



LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON JUSTICE AND COMMUNITY SAFETY

Mr Jeremy Hanson MLA (Chair), Dr Marisa Paterson (Deputy Chair), Ms Jo Clay MLA

Submission Cover Sheet

Inquiry into Community Corrections

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Ms Brianna McGill, Secretary
Standing Committee on Justice and Community Safety
ACT Legislative Assembly
GPO Box 1020
Canberra ACT 2601
LACommitteeJCS@parliament.act.gov.au

Dear Ms McGill,

Re. ACT Inquiry into Community Corrections

Thank you for the opportunity to provide a submission to the above Inquiry.

The Foundation for Alcohol Research and Education (FARE) is the leading not-for-profit organisation working towards an Australia free from alcohol harms. We approach this through developing evidence-informed policy, enabling people-powered advocacy and delivering health promotion programs. FARE has been working with communities across the country to improve the health and wellbeing of Australians for 20 years.

This submission focuses on some of the challenges for Community Corrections within the ACT Criminal Justice System. These include the criminalisation and inadequate support for people with problematic Alcohol and Other Drug (AOD) use, Fetal Alcohol Spectrum Disorder (FASD), Raising the Minimum Age of Criminal Responsibility (MACR) and Electronic Monitoring (EM). In doing so, the submission briefly touches on some of the points in the Inquiry's Terms of Reference, namely the parole system, Intensive Correction Orders (ICOs), Drug and Alcohol Treatment Orders (DATOs) and recidivism outcomes.

ACT crime rates are going down, but incarceration levels continue to rise. The ACT criminal justice system has experienced an increase in prison population, costs and recidivism.¹ The criminalisation of AOD problems is a contributing factor in increasing incarceration.

Problematic AOD use has often been found to be strongly associated with contact with criminal justice systems, and a large proportion of crime in the ACT is associated with AOD use.² However, public health issues such as high risk AOD use, poor mental health and disabilities such as Fetal Alcohol Spectrum Disorder (FASD), must be treated as health and human rights issues, not stigmatised or criminalised.

Punitive responses to health and social issues are expensive and ineffective. Taking an evidence-informed, public health and human rights approach can both reduce the harm from alcohol and other drugs in the community, and reduce prison populations, costs and recidivism.

Evidence Briefs on FASD and Electronic Monitoring

The two evidence briefs attached along with this letter form part of this submission; they address:

- Fetal Alcohol Spectrum Disorder (FASD), criminal justice and government responses (Attachment 1)
- Electronic Monitoring (including for Alcohol-Related Offences) (Attachment 2)

Recommendations

FARE has made 8 recommendations to this Inquiry. These are outlined below and elaborated on further in this submission.

Recommendation 1. Implement evidence-based, public health and human rights approach to reducing alcohol harm, both in the criminal justice system and in the wider community. This is to reduce the risk of recidivism and of the risk of people coming into contact with the criminal justice system in the first place.

Recommendation 2. Implement Recommendation 4 of the 2019 ‘ACT Auditor-General’s Report ‘Recognition and Implementation of Obligations under the Human Rights Act 2004’. This requires explicit consideration and documentation of human rights in decisions by the ACT Justice and Community Safety Directorate.

Recommendation 3. Significantly increase investment in trauma-informed mental health and alcohol and other drug (AOD) treatment in the ACT criminal justice system and in the wider community.

Recommendation 4. Implement recommendations 12, 23, 24 and 27 of the Senate Inquiry into *Effective approaches to prevention, diagnosis and support for FASD*, that reported to Federal Parliament in March 2021.

Recommendation 5. Implement Fetal Alcohol Spectrum Disorder (FASD) screening, assessment and support in paediatric, youth justice and adult criminal justice.

Recommendation 6. Work with the federal government to address the gaps left by barriers to access and difficult eligibility with both the National Disability Insurance Scheme (NDIS) and Disability Support Pension (DSP). Address the gaps in service and support by the ineligibility of people in detention for NDIS, DSP, Pharmaceutical Benefits Scheme (PBS) and Medicare.

Recommendation 7. Develop FASD professional understanding and capacity. Educate relevant justice professionals about children with disabilities and cognitive impairment. Invest in professional workforce development to establish capacity for FASD screening, diagnosis and support.

Recommendation 8. Delay any plans for implementation of the electronic monitoring in community corrections. Re-assess the purpose, lived experience impact, human rights implications, costs and effectiveness of any trials and planned implementations of Electronic Monitoring (EM) programs including for alcohol-related offences.

Challenges for the ACT Criminal Justice System

The ACT Government’s ‘*Reducing Recidivism in the ACT by 25% by 2025*’ (RR25BY25) document, outlines some of the challenges facing the ACT Criminal Justice System:³

- **Increase in prison population.** There has been a significant growth in the number of people detained at the Alexander Maconochie Centre (AMC) in recent years. Numbers have risen from 268 detainees in 2012, to 429 detainees in 2019, an increase of 60 per cent.
- **Increase in recidivism.** Re-offending rates, (within two years of release), have increased in the ACT from 38.7 per cent in 2014–15 to 42.4 per cent in 2018–19. When including those returning to Community Corrections, the ACT has the highest recidivism rate of any Australian State or Territory of 71.3 per cent.⁴
- **Increase in costs.** The ACT justice system costs \$270 million annually, and is estimated to increase to \$337 million by 2025. In a significant Australian first, the ACT government is redirecting \$132 million over four years, that would have otherwise been spent expanding prisons, towards programs focused on rehabilitation and reintegration.

Legislative changes, problematic AOD use and other social determinants are significant contributors to increasing contact with the ACT criminal justice system.⁵

- **Changes in justice legislation and practices.** More awareness of domestic, family and sexual assault, more effective policing strategies, and the reduced rates of bail are contributing to higher rates of incarceration.
- **Social disadvantage.** Social issues like housing, unemployment, poverty and family trauma, particularly among young people, also have an impact on increasing risk of contact with the ACT criminal justice system. (Pillar 2, *'Responding to justice housing needs'* in the RR25BY25 plan addresses one of these aspects.⁶)
- **Alcohol harm.** In 2016, more than one third (36%) of people entering detention in ACT are reported as engaging in harmful or likely dependent alcohol use in the 12 months prior to their current incarceration.⁷ In 2018, almost one third (31%) were reported to be at high risk of alcohol harm.⁸

We know that alternative approaches are effective. Evaluations of preventative public health and diversion programs confirm their positive impact both on recidivism and on costs.⁹

Criminalisation and inadequate support for people with problematic AOD use

AOD problems are prevalent in prison populations and are often a direct cause of offending and recidivism, as well as the source of physical and mental health problems. People in contact with the criminal justice system are more likely to have experienced mental illness and problematic AOD use.¹⁰

There is a continued stigmatisation and criminalisation of people living with mental illness and problematic AOD use. They are already physically isolated by their sentences (even when not carceral), but ongoing stigmatisation further isolates them, inflicting further punishment beyond sentencing.¹¹ The National Alcohol Strategy (2019-2028)¹² and the ACT Auditor-General's report¹³ both call for a human rights approach. This means that reducing alcohol harm involves decreasing the stigmatisation and criminalisation of people with mental illness and problematic AOD use.

The provision of effective mental health and AOD programs is therefore a key component in criminal justice settings. However, there are long waiting lists for AOD programs and transitional support services for people in detention with substance abuse issues are inadequate and community-based support services for people who were formerly in detention, are limited.

In its submission to the current Inquiry into the *'Drugs of Dependence (Personal Use) Amendment Bill 2021'*, the Alcohol, Tobacco and Other Drug Association ACT (ATODA) says there is a AOD funding crisis in the ACT. ATODA says that the chronic underfunding of AOD services means that current capacity needs to at least double, so appropriate treatment is available to people who need it.

The ACT Government has implemented some significant AOD justice reforms that were recommended by the Standing Committee on Justice and Community Safety 2015 Inquiry into Sentencing.¹⁴ These reforms included the establishment of the drug and alcohol court with the *'Sentencing (Drug and Alcohol Treatment Orders) Legislation Amendment Bill'* in 2019¹⁵. It also involved the establishment of intensive corrections orders (ICOs), a drug diversion program, and an expanded community and work order programme. Unfortunately, the Drug and Alcohol Court is not currently accepting referrals during COVID-19, and the *'Disability Justice Strategy – ACT Corrections Disability Framework'* has also been delayed by COVID-19.¹⁶

The ACT Government is to be further congratulated in planning to significantly reduce recidivism by implementing the *'Reducing Recidivism in the ACT by 25% by 2025'*¹⁷ plan within the *'Build Communities Not Prisons'* initiative¹⁸. This plan includes:

- Pillar 3. Supporting people with substance use disorders in the justice system
- Pillar 4. Supporting people living with a mental illness or disability in the justice system

The ACT Government is taking a justice reinvestment approach to redirect funding away from building new prisons to invest in prevention and early intervention, and provide adequately funded supports and services. This approach is restorative, human rights-based and evidence-, culturally-, trauma- and gender-informed.

Each of the above reforms address issues after a person has already come into contact with the criminal justice system. Prevention also means addressing underlying social disadvantage (housing, unemployment, poverty and trauma).

Recommendation 1. Implement evidence-based, public health and human rights approach to reducing alcohol harm, both in the criminal justice system and in the wider community. This is to reduce the risk of recidivism and of the risk of people coming into contact with the criminal justice system in the first place.

Recommendation 2. Implement Recommendation 4 of the 2019 'ACT Auditor-General's Report 'Recognition and Implementation of Obligations under the Human Rights Act 2004'. This requires explicit consideration and documentation of human rights in decisions by the ACT Justice and Community Safety Directorate.

Recommendation 3. Significantly increase investment in trauma-informed mental health and alcohol and other drug (AOD) treatment in the ACT criminal justice system and in the wider community.

Fetal Alcohol Spectrum Disorder (FASD) and the Criminal Justice System

FASD is the leading preventable developmental disability in Australia and there is a high prevalence of FASD in people detained in the criminal justice system. Research at the Banksia Hill Youth Detention Centre in Western Australia identified that more than a third of the young people screened in detention were diagnosed with FASD. Researchers suggested this may be an under-estimate due to, for example, the lack of confirmation of prenatal alcohol exposure, suspecting that almost half of these young people may have FASD.¹⁹

The final report of the independent review into raising the Minimum Age of Criminal Responsibility (MACR) in the ACT noted that children in the justice system experience a range of disabilities, including FASD. It also noted that these issues often go unnoticed and unassessed or are inadequately responded or before entry into the youth justice system.²⁰

People in the criminal justice system are excluded from the National Disability Insurance Scheme (NDIS), Disability Support Pension (DSP), Pharmaceutical Benefits Scheme (PBS) and Medicare. The exclusion of people in prison who have a cognitive disability from the NDIS represents a substantial barrier to people with cognitive and mental health impairments getting adequate support, care and protection for their disability-related complex support needs. Screening, diagnosis and treatment should be targeted towards those in the criminal justice system.²¹

See the FARE evidence brief on FASD, criminal justice and government responses as Attachment 1. Also see FARE's submission to the ACT Review of ACT Health programs for children and young people.²²

Recommendation 4. Implement recommendations 12, 23, 24 and 27 of the Senate Inquiry into *Effective approaches to prevention, diagnosis and support for FASD*, that reported to Federal Parliament in March 2021.

Recommendation 5. Implement Fetal Alcohol Spectrum Disorder (FASD) screening, assessment and support in paediatric, youth justice and adult criminal justice.

Recommendation 6. Work with the federal government to address the gaps left by barriers to access and difficult eligibility with both the National Disability Insurance Scheme (NDIS) and Disability Support Pension (DSP). Address the gaps in service and support by the ineligibility of people in detention for NDIS, DSP, Pharmaceutical Benefits Scheme (PBS) and Medicare.

Recommendation 7. Develop FASD professional understanding and capacity. Educate relevant justice professionals about children with disabilities and cognitive impairment. Invest in professional workforce development to establish capacity for FASD screening, diagnosis and support.

Electronic Monitoring (including for Alcohol-Related Offences)

Current evidence suggests that Electronic Monitoring (including for Alcohol-Related Offences) in the criminal justice system is stigmatising, breaches human rights, is expensive and ineffective. The technology is unreliable, it does not reduce re-offending, does not reduce prison populations, it increases incarceration and does not treat problematic alcohol use. Electronic monitoring contributes to the criminalisation of children, First Nations peoples, people on low incomes and people with problematic alcohol and other drug use.

An ACT Auditor-General's report recommended that the ACT Justice and Community Safety Directorate include explicit consideration and documentation of human rights in decision-making.²³ This must include considering the serious human rights breaches regarding electronic monitoring outlined by the Queensland Human Rights Commission (QHRC).²⁴

See the FARE evidence brief on Electronic Monitoring as Attachment 3.

Recommendation 8. Delay any plans for implementation of the electronic monitoring in community corrections. Re-assess the purpose, lived experience impact, human rights implications, costs and effectiveness of any trials and planned implementations of Electronic Monitoring (EM) programs including for alcohol-related offences.

Thank you for the opportunity to provide a submission to this Inquiry.

Yours sincerely,



CATERINA GIORGI
CHIEF EXECUTIVE OFFICER

¹ ACT Government (2020) *Reducing Recidivism in the ACT by 25% by 2025*
https://justice.act.gov.au/sites/default/files/2020-08/Plan%20-%20RR25by25%20-%20Plan%20for%20printing%20-%20web-%20%20Final_0.PDF

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- ¹² Commonwealth of Australia Department of Health (2019) *National Alcohol Strategy 2019–2028*
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- ¹³ ACT Auditor-General (2019) *Recognition and Implementation of Obligations under The Human Rights Act 2004*
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Fetal Alcohol Spectrum Disorder (FASD), criminal justice and government responses: An evidence brief

The purpose of this brief is to outline evidence about Fetal Alcohol Spectrum Disorder (FASD), its prevalence in the criminal justice system, problems with screening, assessment, support and National Disability Insurance Scheme (NDIS) eligibility. It also focuses on actions that Australian Governments can take to address these issues.

Key points

- There is a high prevalence of FASD in the Criminal Justice System, with no routine screening.
- The Senate inquiry into *Effective approaches to prevention, diagnosis and support for FASD* (Senate FASD Inquiry) Inquiry made recommendations for State and Territory Governments to improve awareness, prevention and support for people with FASD, including screening young people in child protection and youth justice systems.
- FASD diagnosis is complex and expensive and there are limitations on screening and assessment. This leads to inadequate support and services for people with FASD.
- NDIS has gaps in access and eligibility for people with FASD.
- The Australian Government has funded a National Program on alcohol, pregnancy and breastfeeding.

1. Fetal Alcohol Spectrum Disorder (FASD)

Alcohol consumption in pregnancy increases the risk of children being born with FASD.¹ Alcohol passes across the placenta during pregnancy and the fetus has minimal ability to metabolise it due to its size and development. This is why the National Health and Medical Research Council recommends that 'women who are pregnant or planning a pregnancy should not drink alcohol'². Other risks of alcohol consumption in pregnancy include miscarriage, stillbirth, low birth weight and pre-term birth.^{3,4,5}

FASD is a diagnostic term describing a range of neurodevelopmental impairments⁶. It describes impacts on the brain and body of individuals prenatally exposed to alcohol. FASD is a lifelong disability. People with FASD experience challenges in their daily living and need support with motor skills, physical health, learning, memory, attention, communication, emotional regulation, and social skills to reach their full potential. Each person with FASD is unique and has areas of both strengths and challenges.⁷

FASD is the leading preventable developmental disability in Australia. Due to inadequate FASD screening and diagnosis, the prevalence of FASD is not known. However, estimates suggest that FASD affects between two to nine per cent of babies born each year.⁸ Aboriginal and Torres Strait Islander communities are disproportionately affected by FASD, with a rate of up to 12 per cent of births in some remote communities.⁹

Without diagnosis and appropriate intervention, people with FASD have a higher likelihood of secondary issues such as requiring greater education, health and mental health support, problems with parenting and employment, homelessness, and problematic alcohol and other drug use.¹⁰ With the many co-morbid conditions people with FASD experience,¹¹ the medical and social costs are great. In Australia, the annual cost of FASD in 2018 was estimated at \$1.18 billion.¹²

Australia has comparatively high rates of alcohol consumption during pregnancy.¹³ There are a range of factors contributing to this such as wider socio-cultural factors and the social environment around

women who are pregnant, including their own attitudes and beliefs.¹⁴ Research has also shown that levels of alcohol use prior to the pregnancy and experience of intimate partner violence increase the likelihood of women using alcohol during pregnancy.¹⁵¹⁶

Other factors include:

- lack of awareness of the National Alcohol Guidelines and lack of awareness of risk,
- just over half (51 percent) of all pregnancies are unplanned,¹⁷
- relatively high levels of alcohol use across the population,¹⁸
- inadequate support and services for people with problematic alcohol use, and
- limited use of screening and brief interventions in antenatal care.

The underlying causes of FASD, therefore, are complex and prevention initiatives require a range of efforts to inform and support women who are pregnant to stop or reduce their alcohol intake. The World Health Organization *Global Strategy to reduce the harmful use of alcohol* acknowledges that whole of population approaches to alcohol policy, targeting the price, promotion and physical availability of alcohol, are the most cost-effective policy approaches to reduce overall population use and alcohol harm, including FASD.¹⁹

2. FASD and the Criminal Justice System

There is a high prevalence of FASD in people detained in the criminal justice system. Research at the Banksia Hill Youth Detention Centre in Western Australia identified that more than a third of the young people screened in detention were diagnosed with FASD. Researchers suggested this may be an underestimate due to, for example, the lack of confirmation of prenatal alcohol exposure, suspecting that almost half of these young people may have FASD.²⁰

People in the criminal justice system are excluded from the National Disability Insurance Scheme (NDIS), Disability Support Pension (DSP), Pharmaceutical Benefits Scheme (PBS) and Medicare. The exclusion of people in prison who have a cognitive disability from essential health and social security supports represents a substantial barrier to people with cognitive and mental health impairments getting adequate support, care and protection for their disability-related complex support needs. Screening, diagnosis and support should be made available for people in the criminal justice system.²¹

3. The Senate FASD Inquiry

The Australian Senate held an inquiry into *Effective approaches to prevention, diagnosis and support for FASD* (Senate FASD Inquiry) from 2019 to 2021. The final report,²² released in March 2021, made 32 recommendations, some of which relate to areas where states and territories could make improvements. The relevant recommendations for State and Territory Governments are:

- **“Recommendation 12.** The committee recommends that the Australian Government fund a National Prevention Strategy to be developed and delivered in collaboration with State and Territory Governments.” (p. 64)
- **“Recommendation 23.** The committee recommends that the Australian Government work with State and Territory Governments to provide all educators with professional development training in the awareness, understanding and management of FASD.” (p. 111)
- **“Recommendation 24.** The committee recommends that the Australian Government work with State and Territory Governments to ensure all schools can deploy and resource FASD-specific strategies and assistance to support educators and to support students with FASD and suspected FASD, irrespective of IQ level.” (p. 111)
- **“Recommendation 27.** The committee recommends that the Australian Government, in partnership with State and Territory Governments, develop and trial protocols for screening

children and young people within child protection and youth justice systems for FASD.” (p. 112)

These recommendations demonstrate the need for action across the health, education and criminal justice sectors to better prevent FASD and ensure that people with FASD and their families are supported.

4. FASD screening, assessment and support.

FASD diagnosis is complex and expensive and can be difficult to access. This results in many people missing out on the support that a diagnosis facilitates. Receiving a diagnosis is essential for them to be supported appropriately and take steps to manage their disability to get the most from their lives. Additional resources are needed for screening, assessment, diagnosis and support.

Diagnosis requires a multidisciplinary team to do complex physical and neurodevelopmental assessments. Health professionals participating in a diagnostic assessment for a young person may include Paediatrician, Psychologist, Speech pathologist, Occupational therapist. For an adult, the health professionals involved in the diagnostic process are most likely to include Psychiatrist or physician, Neuro or clinical psychologist, and Mental health worker.

Screening provides an initial assessment that can facilitate referrals to supports and services. Screening pathways through General Practitioners, paediatricians, educators and social service providers should be promoted to ensure children who would benefit from a diagnosis and relevant support are identified as early as possible.

The Senate FASD Inquiry recommended that Governments should ensure all schools can deploy and resource FASD-specific strategies and assistance to support educators and students with FASD and suspected FASD, irrespective of IQ level.²³ There is also an urgent and critical need to educate health practitioners as many are not aware of the signs or dismiss FASD prior to proper assessments being undertaken. This can include being misdiagnosed with Attention Deficit Hyperactivity Disorder (ADHD) or other disorders.²⁴

Screening, diagnosis and support should especially include all those in the criminal justice system, but for both children and adults throughout the system. Given the high rates of FASD within youth justice settings, appropriate screening, diagnosis and ongoing support is critical to improving the lives of these children and establishing an ongoing pathway out of the criminal justice system.

5. National Disability Insurance Scheme access and eligibility

The Senate FASD Inquiry²⁵ noted that carers, families and individuals impacted by FASD face multiple barriers with the complex task of assessment, diagnosis and supports. People with FASD are further negatively impacted by issues within the National Disability Insurance Scheme (NDIS), such as gaps in funding and support options and a lack of coordination between the health system and the NDIS.

NDIS funding is available for people with FASD, but the process for accessing these supports is complex and fraught with barriers in relation to the burden of proof for functional impairments.²⁶ Due to this difficulty many people with FASD do not gain NDIS support or gain inadequate NDIS supports.

Another challenge with FASD and the NDIS is, as stated above, that people with FASD detained in the criminal justice system, including children, are excluded from the NDIS (and from DSP, PBS and Medicare). The exclusion of people in prison who have a cognitive disability from the NDIS represents a substantial barrier to people with cognitive and mental health impairments getting adequate support, care and protection for their disability-related complex support needs.²⁷

Government intervention in addressing these gaps is critical as screening and assessment may be the only pathway for some people towards gaining a FASD diagnosis and the needed supports.

6. National Program on alcohol, pregnancy and breastfeeding.

In December the National Health and Medical Research Council (NHMRC) released updated guidelines on alcohol. The *Australian guidelines to reduce health risks from drinking alcohol*²⁸ include “Guideline 3: To prevent harm from alcohol to their unborn child, women who are pregnant or planning a pregnancy should not drink alcohol”. However, there is low awareness of the Alcohol Guidelines:

- In a study of Australian women aged 18 to 45 years, the majority reported negative attitudes about alcohol in pregnancy, however one in three women did not know that alcohol use in pregnancy could cause adverse impacts²⁹.
- Research of Australian women who were pregnant, planning a pregnancy, or who had recently had a baby found that while women were aware that alcohol consumption during pregnancy was “probably unsafe,” they didn’t have information about the actual risks of alcohol consumption during pregnancy for the developing child^{30, 31} and did not view ‘moderate’ alcohol consumption or having an ‘occasional’ drink as being at odds with messages regarding alcohol abstinence³².

FARE has received funding from the Australian Government Department of Health to develop and deliver the National Program on alcohol, pregnancy and breastfeeding from July 2020 to September 2024. The National Program has four streams: targeting the general public, health professionals, women who are most at risk and Aboriginal and Torres Strait Islander peoples. FARE looks forward to engaging with all State and Territory Governments to support the implementation of the National Program.

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Electronic Monitoring (including for Alcohol-Related Offences): An evidence brief

The purpose of this brief is to provide an overview of the current policy and research evidence about electronic monitoring, (including for alcohol-related offences) and the broader implications of such a policy. It considers human rights, lived experience, cost, effectiveness and alternatives.

Key points

- Electronic monitoring (EM) is expensive and ineffective, (the technology is unreliable, and it does not reduce crime).
- EM does not reduce re-offending, does not reduce prison populations, it increases incarceration
- EM breaches human rights of privacy and freedom of movement, is stigmatising, coercive and ignores the increased impact on women.
- EM contributes to the criminalisation of First Nations peoples and people on low incomes.
- EM criminalises people with problematic alcohol use, instead of treating it.
- EM has limited usefulness in preventing Domestic and Family Violence (DFV).
- EM is not the only alternative to incarceration.

Australian State and Territory Governments are considering or already implementing electronic monitoring, including ankle bracelets with transdermal alcohol-testing for alcohol-related offences.

1. Overview

Current evidence suggests that Electronic Monitoring (EM) in the criminal justice system is stigmatising, breaches human rights, is expensive and ineffective. The technology is unreliable, it does not reduce re-offending, does not reduce prison populations, it increases incarceration and does not treat problematic alcohol use. Electronic monitoring also contributes to the criminalisation of First Nations peoples, people on low incomes and people with problematic alcohol use.

EM is widely advocated and implemented across Europe, North America and Australia. It is touted as a programme that can cut costs, reduce prison overcrowding and reduce recidivism. Despite the popularity of EM, primary studies and reviews of the effectiveness of EM have produced sobering findings. This is clearly observed in the systematic reviews [which] concluded that EM has been applied seemingly without adequate thought, producing little effect on recidivism rates and at times giving rise to unintended consequences.¹

EM is an important emerging issue with the Queensland and Northern Territory governments recently passing Youth Justice laws^{2,3} that ignored expert evidence and increased the use of ankle bracelet EM on children as young as ten years old. Other jurisdictions are also looking for technological solutions that may appear to address the spiralling criminal justice costs. However, EM does not reduce incarceration⁴ and instead increases and diverts Police resources into correctional surveillance.

Research appears to suggest a reduction in crime when EM is used in conjunction with other strategies, (for example, throughcare support, employment or training, regular AOD treatment). However, it is those other strategies that are attributed as the key factors in reducing reoffending.⁵ Likewise, research appearing to identify cost-benefit savings falsely presume an overall reduction in prison population.⁶

2. First Nations

Electronic Monitoring criminalises First Nations peoples. Aboriginal and Torres Strait Islander peak bodies have expressed their opposition to the use of electronic monitoring devices, saying they breach human rights, fail to improve community safety, and have a high risk of causing further harm.⁷ Academics have also indicated that EM widens the net of law enforcement that disproportionately targets Aboriginal and Torres Strait Islander peoples.⁸

Aboriginal and Torres Strait Islander peoples are overrepresented in Australia's criminal justice system. However, this growth in incarceration rates cannot be explained by changes in offending. The evidence does not suggest that offending rates amongst Aboriginal and Torres Strait Islander peoples have risen.⁹

The level of incarceration among Aboriginal and Torres Strait Islander peoples is likely caused by greater exposure to risk factors reflecting entrenched social and economic disadvantage caused by colonisation and dispossession. Such risk factors would include problematic alcohol use, along with unemployment, low levels of educational participation, mental health issues and disabilities including Fetal Alcohol Spectrum Disorder (FASD). However, given these do not reflect in increased levels of offending, this suggests that other factors, such as changes to criminal justice policies, (including EM), are driving the increased incarceration rates, and that these disproportionately affect Aboriginal and Torres Strait Islander peoples.¹⁰

In 2011, a 30-year-old Aboriginal man in South Australia, died after consuming lighter fluid, while subject to electronic monitoring with drug testing to identify alcohol or marijuana use that violated his bail restrictions. His partner gave evidence to the inquest into his death that he used lighter fluid while he was on bail as a substitute for alcohol and other drugs because of his bail conditions.¹¹

3. Voices of lived experience

The following stories are of people with lived experience of EM using ankle bracelets. They describe, in their own words, what it is like living with EM ankle bracelets.

“Living with an Ankle Bracelet”

The quotes below are from ‘M.M.’ in a ‘Marshall Project’ article.¹² He has been on parole for more than three years on multiple charges stemming from an altercation when he was 22 and his subsequent re-arrest for driving while intoxicated.

“I cannot sleep. There is a device on my leg. It requires that I wake up an hour early so I can plug it into a charger and stand next to the outlet, like a cell phone charging up for the day. Not the day, actually, but 12 hours. After that, the device runs out of juice. Wherever I am, I have to find an outlet to plug myself into. The device is my ankle bracelet. I wear it afraid that someone at work will notice the bulge. When I go to school, I worry my friends will spot it and leave me. I push it up into my jeans, hoping they won't see. But the higher up I push it, the more it starts to hurt; most days, my feet go numb. I try wearing bell-bottoms.

Throughout the day, the device becomes heavier and more painful, causing me to bleed. I push it down on my ankle to let my blood circulate — but then the pain becomes unbearable, and I can't plant my feet without crying out. The device is, both literally and metaphorically, my greatest source of pain. But every day I rise, stand by the socket, and charge my ankle to go to work.”

“‘Digital shackles’: the unexpected cruelty of ankle monitors”

These quotes are from a ‘Guardian’ article,¹³ which details some experiences of people subject to EM.

“It's like a rope around my neck, I can't get my feet back on the ground.” (Willard)

“It's horrible. A living nightmare.” (William)

"It's hard to imagine wearing it for 30 more years," she said. "It's depressing and upsetting to imagine having that much of my life monitored." (Sarah)

"Ankle Monitors Aren't Humane. They're Another Kind of Jail"

These quotes are from a 'Wired' article¹⁴ written by James and Emmet, who have lived under EM.

"To many, electronic monitoring is humane—one that allows people "on the bracelet" to live at home and move about more freely than they would behind bars. But those who have lived under this high-tech tether—including the two of us—see it differently. For many, electronic monitoring equals incarceration by another name. It is a shackle, rather than a bracelet. The rules for wearing a monitor are far more restrictive than most people realize. Most devices today have GPS tracking, recording every movement and potentially eroding rights in ways you can't imagine."

"There is no real proof that these devices make communities safer. Instead, the monitors function as an additional punishment, extending a person's sentence when they're placed on a monitor as part of parole. Or, they severely curtail the freedoms of those who are given a device before they've even been convicted. The money spent on this under-regulated and misunderstood technology would be better used to provide jobs or housing."

Poverty

Electronic Monitoring criminalises poverty. People on low incomes and people accessing income support, including people with problematic alcohol and other drug (AOD) use, often experience stigmatisation and discrimination.¹⁵ Governments have been increasingly automating systems that people in poverty access,¹⁶ often without adequate safeguards or justice, and with significant negative consequences, such as with robo-debt.¹⁷

The EM technology is expensive and, in some jurisdictions, people wearing the EM devices are charged a fee to help recover the costs. This places extra hardship on people on low incomes, and if they are not able to meet this requirement, may risk breaching their orders.¹⁸

Also, people released into the community with EM often have little access to paid employment so the family bear the cost of running the home prison¹⁹. This reinforces the 'double punishment' effect of imprisonment where a person is not only punished by have their liberty restricted, but also by receiving significant, and ongoing financial punishment beyond their term of incarceration.²⁰

4. Human rights

Privacy and freedom of movement

Electronic Monitoring breaches human rights of privacy and freedom of movement. The Queensland Human Rights Commission states that EM breaches the human rights of privacy (lack of controls in how information gathered is being used by governments) and freedom of movement.²¹ For breaches to be acceptable and tolerated, the specific activity must have both a legitimate purpose and a rational connection to that purpose. Community safety through reducing crime or alcohol harm is a legitimate purpose. However, as this evidence brief demonstrates, EM does not have a rational connection to this purpose.

Stigmatising

Electronic Monitoring is stigmatising. The ankle bracelets, including alcohol detection anklets, can be quite large and easily visible. The visibility of the device means wearers can be identified by members of the public. The Queensland Human Rights Commission, and other EM evaluations, warn that this impacts social interactions, leads to stigmatisation, serious mental health consequences and the possibility of vigilantism.^{22, 23, 24, 25, 26}

Lack of consent

Electronic Monitoring is coercive. Genuine consent involves free, informed and voluntary permission. People subject to criminal justice orders clearly often have no option to decline giving consent. However, even when offered the choice of EM over prison there is severely restricted options available, including limited options to the people sharing the person's home.

In Victoria, for a person to be granted EM at home, the entire family (including children) must be interviewed, assessed and provide consent for EM, including 24-hour phone calls, right of entry and search of the entire residence, and discussions about the detainee's progress. There is no real choice when the only other option is for their family member to stay in prison.

This situation also ignores the nature of consent and coercion in regards to gender and power relationships. There are concerns about women fearing the consequences of not giving consent to their homes becoming prisons for their partners, compared to them being on parole. This places a burden on them to consent to their male partner being restricted to the area for months.²⁷

Gender

Electronic Monitoring ignores the increased impact on women. As with many criminal justice programs, the focus of EM is largely on men as they comprise the overwhelming majority of offenders. The position of women who may offend is often assumed to be the same as males, ignored or marginalised. Yet there are structural biases which make it more difficult for women offenders, particularly single parents, to fulfil the eligibility requirements, particularly housing difficulties and poverty. As stated above, the impact on women sponsors within the home setting, is also as a concern. Home detention with EM creates risks for family violence.²⁸

5. Cost

Electronic Monitoring is expensive. All AOD testing is expensive,²⁹ and EM even more so as ankle bracelets with transdermal alcohol-testing can cost up to \$9,000 each.³⁰ Although some technologies are more expensive than others, EM is overall, a cheaper alternative to prison, (that is, if imprisonment numbers were declining). However, EM is more expensive than traditional parole or probation without EM. Research studies that appear to identify cost-benefit savings (compared with incarceration) falsely presume an overall reduction in prison population, which is not occurring.³¹

The cost of EM includes the individual's expense of recharging and internet access, (not always reliable in regional and remote areas). In some jurisdictions people are charged an amount to cover the cost of the monitoring.³² The average cost of imprisonment for keeping people who offend in prisons is nine times more than the average cost of a community order.³³ However, community-based programs without EM are even cheaper again than EM-based community orders.

6. Effectiveness

Technological capability

Electronic Monitoring technology is unreliable. Providers of EM, including ankle bracelets with transdermal alcohol testing, have been continuously upgrading the technology. However, the technology continues to have limitations in regard to effectiveness and accuracy.^{34, 35 36}

A study of the current technology published in 2021, indicates that wearable transdermal alcohol monitors are either unable to detect low-to-moderate drinking levels or they show a high failure rate.³⁷ Other technical problems arise due to the common limitations of correct set-up (including adequate information provided to the individual), reliable power supply, internet coverage and remote storage of data.³⁸

Crime

Electronic Monitoring does not reduce crime or reoffending. There is no statistically significant evidence that EM trackers have a positive effect on reducing crime or reoffending.^{39,40} The only exception may be when used for sex offenders placed on EM post-trial.

Governments continue to treat problematic alcohol and other drug (AOD) use as a criminal justice issue, instead of a public health issue, (see section below on problematic alcohol use). As a result, use of alcohol and other drugs remains more prevalent among people in contact with the criminal justice system than the general population.⁴¹ Yet prison AOD treatment programs, are rare, difficult to access, inadequate and ineffective.⁴²

Prison population

Electronic Monitoring does not reduce prison populations. Evidence indicates that both prison populations and alternatives (such as community sanctions and EM) have both increased despite the reduction in crime rates.⁴³ EM also facilitates people's homes being made into prisons, meaning the capacity for incarceration is virtually unlimited,^{44, 45} and reduces the imperative to address prison overcrowding or endless privatised expansions.⁴⁶

Net-widening

Electronic Monitoring increases incarceration. Net-widening is where criminal justice policies or practices are changed in a way that results in a greater number of individuals being incarcerated, regardless of changes in offending rates. When used pre-trial as part of bail conditions, EM increases the likelihood of a custodial sentence. This occurs for breach of bail conditions for minor offences that would not have otherwise attracted a custodial sentence, and thus increases the severity of the sentence.⁴⁷

This applies to other forms of AOD testing in the criminal justice system where probation officers have some discretion in their response to individuals testing positive for alcohol or other drugs. They are aware of the counter-productive nature of breaching people with problematic AOD use. Probation officers have observed that there is no point testing offenders with problematic AOD use who would not be able to stop regardless of the accountability or the punishments for continuing. This just sets them up to fail by providing a pathway for them to be breached and go back to prison, rather than a rehabilitative pathway.⁴⁸

Problematic alcohol use

Electronic Monitoring criminalises problematic alcohol use instead of treating it. Australia relies heavily on the criminal justice system to respond to problematic alcohol and other drug use despite clear evidence that it is better dealt with as a health issue.⁴⁹ Using EM (including ankle bracelets with transdermal alcohol testing) further criminalises problematic alcohol use. EM can monitor an individual's alcohol use but it cannot assess the reasons why the person uses alcohol, as it does not address recommended therapeutic principles. The focus is on compliance, not treatment.⁵⁰

EM (including ankle bracelets with transdermal alcohol testing) is not an indicated therapeutic treatment of problematic alcohol use, it is coercive not rehabilitative. Evidence-based behavioural therapies for problematic AOD use include Cognitive Behavioural Therapy, Contingency Management Interventions, Motivational Enhancement Therapy, Community Reinforcement Approach, and 12-Step Facilitation Therapy (such as Alcoholics Anonymous).⁵¹

The Australian National Drug Strategy (2017-2026)⁵² is based on demand reduction, supply reduction and harm reduction. However, the dominant strategy for dealing with problematic drug use is based on a policy of criminalisation. Criminalisation has been in place for many decades, but it has proven ineffective at significantly reducing the use of illicit drugs and has not achieved sustained reductions in supply. Criminalisation has created significant costs and unintended harms.⁵³

The Australian National Alcohol Strategy (2019-2028)⁵⁴ likewise is based on harm minimisation. The Strategy is structured around four priorities: improving community safety and amenity; managing availability, price and promotion; supporting individuals to obtain help and systems to respond; and promoting healthier communities. None of these evidence-based, public health responses involves the criminal justice system.

Domestic and family violence

Electronic Monitoring has limited usefulness in preventing DFV. EM is limited in preventing domestic and family violence (DFV) because of the nature of offenders and of DFV itself. It is also limited due to the capability of the technology itself; and the criminalising risks.

DFV includes coercive controlling abuse that may be perpetrated through various means beyond EM surveillance. These can include: threats, intimidation and harassment conveyed via mail, email, mobile phone or text message or via a third party acting for the offender. The intractable determination of some offenders to 'punish' their ex-partner means that they will stop at nothing, including EM, to attack the victim. These offenders find ways to manipulate the technology and are an unacceptable risk to the safety and wellbeing of their ex-partners.⁵⁵

Australia's National Research Organisation for Women's Safety (ANROWS) suggests that comprehensive best practice could incorporate EM, requiring the following five elements:

1. Comprehensive risk assessment and risk management
2. Evidence-based, reliable EM technology and responsive monitoring systems
3. Effective supervision of defendants/offenders and their participation in structured programs
4. Co-operation and information-sharing between technology providers and criminal justice and community agencies
5. Active inclusion in decision-making and information-sharing and safety planning with those who are at risk of further harm from the offender.⁵⁶

However, ANROWS also warns that these principles are inter-connected and cannot be applied in isolation. The consistent, adequately resourced application of all five principles is essential to the effective application of EM in the limited context of DFV.

7. Review of U.S. and New Zealand Programs

Criminal justice programs using EM with alcohol detection ankle bracelets have been trialled and evaluated in various international jurisdictions. The following is evidence from evaluations of EM for alcohol-related offences in programs in the U.S. and in New Zealand.

South Dakota 24/7 Sobriety program

The 24/7 Sobriety Project began in 2005 and is a court-based management program originally designed for repeat Driving Under the Influence (DUI) offenders. The program originated in South Dakota and is now being implemented in many other U.S. states. It uses a variety of mechanisms to ensure abstinence from alcohol and other drugs, including SCRAM ankle bracelets with alcohol-detection.

Evaluations of the 24/7 Sobriety Program do not address the concerns above regarding lived experience, human rights, stigma, net-widening or effective treatment of problematic alcohol use. However, they do provide some statistical measure of the immediate impact on crime and recidivism within the limited context of the criminal justice system.

Number of car crashes. With respect to traffic crashes, the evidence was not conclusive. 24/7 did not reduce overall traffic crashes, but there is suggestive evidence that crashes among males age 18–40 fell as a result of the program.⁵⁷

Probability of a DUI re-arrest. Results from statistical models provide *suggestive* evidence that 24/7 participation reduced the probability of DUI re-arrest (perhaps on the order of 45% to 70%), but missing criminal history information for approximately half of the sample prevents making stronger conclusions about causality.⁵⁸ Individual-level probability of rearrest is moderately (13.7 per cent) lower for 24/7 participants than non-participants 12 months after their DUI arrest.⁵⁹

Adult mortality. Randomised controlled trials and analyses of individual-level data, is needed to corroborate a finding of a drop in all-cause adult mortality, reassess the strength of the associations, and understand causal mechanisms.⁶⁰

The New Zealand AODT program

The New Zealand Alcohol and Other Drug Treatment (AODT) Court, was established in Auckland and Waitākere in 2012. In 2019, it was announced that the pilot courts would be made permanent. AODT incorporates multiple strategies, (including intensive monitoring with Alcohol Detection Anklets), where sentencing is deferred while participants work through the program. The program takes one to two years to complete. Following is evidence from multiple evaluations of the AODT program.

Alcohol Detection Anklets (ADAs) were ineffective in reducing recidivism. This was particularly evident with respect to reoffending rates, which were not lower than would be expected under normal conditions. Available evidence is unfavourable to continued investment in the relatively expensive ADA option.⁶¹

The program had no effect on the majority of offenders. The largest group of offenders explained that testing had no effect on their substance use as they already decided to abstain from AOD.⁶²

The program has no sustainable benefit. Over follow-up periods, the effectiveness of the AODT program in reducing reoffending and imprisonment declines markedly. The only significant difference for the reoffending rate and frequency of reoffending measures was within three years, and no significant differences in a four-year follow-up period.⁶³ Recidivism rates are found to be comparable with those who have not been subject to ADA.⁶⁴

Officers observed net-widening effects of enforcing of breaches. Probation officers observed that there was no point in testing offenders who had problematic AOD use and who were not able to stop regardless of accountability or punishments. The testing was setting offenders up to fail by providing a pathway for them to be breached and go back to prison rather than a rehabilitative pathway.⁶⁵

ADAs were stigmatising. Offenders with Alcohol Detection Anklets did not find them comfortable. The ADA device could be casually observed. Visibility of the device meant offenders could be identified as offenders by members of the public. That impacted social interactions and could result in the offender being exposed to questioning they would prefer to avoid about their offending and community sentence."⁶⁶

ADAs were expensive. The ADA element of the pilot has required the larger share of funding.⁶⁷

ADAs had technical problems. Staff thought many offenders had not received information about the ADA. They were concerned the offender may not have the required information around things like mouth wash, deodorants or creams that contain alcohol or how to look after the device.⁶⁸

8. Alternatives

Electronic Monitoring is not the only alternative to incarceration. EM (including Ankle Bracelets with transdermal alcohol testing) is framed as a cheaper alternative to incarceration. However, the evidence suggests that EM is stigmatising, unreliable, breaches human rights, doesn't treat problematic alcohol use, nor does it reduce crime, costs or prison populations. Treating public health issues such as problematic AOD use, and disabilities such as FASD, as health issues, not criminalising them, reduces harm in the community and reduces prison populations, costs and recidivism.

Even within the criminal justice system, there are many other sentencing alternatives to incarceration available, including other alternatives for prison sentences served in the community. These cheaper and more effective alternatives involve community work, rehabilitation programs, and intensive reporting to corrections officers. Yet, rates of community-based sentences have decreased whilst imprisonment rates have increased, due to poorly resourced programs and the media fuelled demands for 'harsher' sentences.⁶⁹

An example of a successful community-based program is the Work and Development Orders (WDOs) system first successfully implemented in NSW,⁷⁰ and now also being run in Queensland.⁷¹ These orders are an extension of previous community orders for people defaulting on state government fines. Activities that can be completed as part of a WDO are unpaid work; medical or mental health treatment by approved practitioners; educational, vocational or life skills courses; financial or other counselling and drug or alcohol treatment. Mentoring programs are included and culturally appropriate programs for Aboriginal or Torres Strait Islander peoples living in remote areas.⁷²

Other community-based programs that have been assessed include residential drug and alcohol treatment for Indigenous offenders, which have been found to have significant financial savings when compared with incarceration.⁷³

9. Conclusion

Evidence suggests that EM does not reduce crime, costs or prison populations. In addition, EM has been found to be unreliable, stigmatising, in breach of human rights, and unable to treat problematic alcohol use. There are effective, evidence-based, public health and community-based alternatives to Electronic Monitoring for responding to problematic alcohol use and alcohol-related offences.

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