Position Statement 95
Electronic monitoring of people utilising forensic mental health services
May 2018

Purpose

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is concerned about the coercive use of electronic monitoring on forensic patients. In the RANZCP’s view, electronic monitoring should only be applied on a case-by-case basis, taking into account the patient’s views and those of their treating clinical team. Electronic monitoring should not be used coercively, and should never be used as a substitute for proper risk assessment by a suitably trained health professional. While the RANZCP acknowledges that there is a range of community opinion on this issue, we have sought to detail our concerns and recommend ways of managing forensic patients that better reconcile community safety, effective treatment and human rights.

Key messages

- The RANZCP is concerned about the coercive use of electronic monitoring on forensic patients.
- Forensic inpatients are carefully assessed before they obtain community leave, and pose a low risk to the community, making electronic monitoring largely unnecessary.
- Electronic monitoring may be beneficial as part of an individualised risk management plan when implemented with the valid consent of the patient.
- The coercive use of electronic monitoring may seriously undermine therapy and violate a range of human rights, ultimately increasing risks to the community.
- The RANZCP instead advocates for greater investment in forensic mental health services, in order to ensure evidence-based treatment and risk management for all forensic patients.

Definitions

Electronic monitoring refers to the practice of attaching a tracking device to a person’s ankle. These devices use radio frequency or Global Positioning System (GPS) technology to monitor the location of the wearer. If the wearer fails to remain within designated boundaries, attend appointments or abide by curfews, those monitoring the signal can ensure that the wearer is returned to custody. Forensic patients can be subjected to electronic monitoring in South Australia and Queensland, but not elsewhere in Australia or New Zealand.

Forensic patient definitions vary across Australia and New Zealand. In South Australia, the term is not defined in legislation. In Queensland, the term applies to the following persons once they have been placed on a Forensic Order by the Mental Health Court:

- insanity acquittees (persons who have been found not guilty of an offence by reason of mental illness or cognitive disability)\(1\)
- persons found unfit to stand trial (either permanently or temporarily).

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\(1\) ‘Cognitive disability’ includes intellectual disability, acquired brain injury and other organic brain syndromes.
**Background**

Electronic monitoring of convicted offenders began in the USA during the 1980s and the practice spread to many countries in the following decades. In Australia and New Zealand, courts order electronic monitoring at various stages in the criminal justice process (such as bail, sentencing and parole) and in relation to various offenders (Smith and Gibbs, 2010).

Until recently in Queensland, high-risk convicted sex offenders were the only persons compelled to wear tracking devices (Office of the Public Advocate, 2013). In South Australia, a much wider range of persons can be ordered to wear the devices, although the devices are also strongly associated with sex offenders in that jurisdiction (South Australia Legislative Council, 2013).

Electronic monitoring of forensic patients is a relatively new practice. It was first applied in 2010, in pilot programs in the UK and later in the Netherlands, primarily on the basis of consent (Tully et al., 2014). Queensland and South Australia are currently the only jurisdictions to have legislation that can compel forensic patients to wear tracking devices.

To an extent, the practice is a response to media coverage promoting incorrect ideas about forensic patients: that they are prone to breaching the conditions of their community leave, and that, when they do, they pose a serious danger to the community (The Courier-Mail, 2013). However, the RANZCP considers that these ideas are not borne out by peer-reviewed studies on absconding behaviour. For example, over a 12-year period, forensic patients undertook leave from the Brisbane High Security Inpatients Service over 46,000 times. A total of 17 prisoners absconded while on leave, and none committed a serious violent offence (Scott, 2017). This result is consistent with findings in overseas jurisdictions (Wilkie et al., 2014).

The Canadian province of Nova Scotia recently considered adopting an electronic monitoring program that draws on the Queensland model (Gibson et al., 2014). After commissioning three reports into the clinical and legal issues, the provincial government banned the practice instead, citing likely harms to patients and breaches of Canadian human rights law. Each study confirmed that ‘there was no support or even speculative support that electronic monitoring would enhance public safety’ (Moulton, 2015).

**Forensic psychiatry and community leave**

Even if it could be shown that electronic monitoring does reduce the risk to the public, this would beg several questions: what happens when the tracking device is removed? Will electronic monitoring simply postpone the point of risk to the first instance of leave without the device (Alexander et al., 2014; Doley et al., 2013)? And how will the experience of electronic monitoring affect the forensic patient in the meantime?

To answer these questions, it is necessary to appreciate that forensic psychiatry reduces the risk of reoffending through addressing the factors that give rise to offending (Morgan et al., 2012). After careful assessment by the treating team, forensic inpatients can obtain leave in stages that gradually prepare them for discharge. These stages provide vital insights into the patient’s mental health, coping skills and risk levels – insights which inform further decision-making by the treating team. Graduated leave also helps patients to improve social, planning and other life skills, reconnect with their families, undergo drug and alcohol counselling and other psychological interventions, and pursue education and vocational training (Scott, 2017). Strong therapeutic alliances are at the heart of this process as they encourage honest engagement with the treating team and build a sense of hope. When used appropriately, electronic monitoring may help people progress through these stages quicker by mitigating perceived risks associated with their leave.

However, the use of electronic monitoring without consent can frustrate this graduated approach, inadvertently increasing risks instead of reducing them. The forensic patient may feel the device to be a physical manifestation of distrust by the treating team, an attitude that undermines the therapeutic relationship (Department of Health and Wellness and Department of Justice, 2012). This problem is compounded when the patient already suffers from a paranoid condition; some patients in this category also have an acute fear of electronic surveillance and their symptoms may be greatly exacerbated by wearing the devices (Reilly, 2013). By undermining the trust and rapport
between the forensic patient and the treating team, electronic monitoring may not only undermine treatment but, in doing so, may actually increase the risk posed to the community.

As many other parties such as the National Mental Health Commission have observed, tracking devices also associate the wearers with serious sex offenders, further stigmatising forensic patients and compounding their sense of anger, isolation and despair (The Australian, 2013; Australian Association of Social Workers, 2013). The Queensland Office of the Public Advocate made the following observation:

This stigma may hinder the [community leave] program which is designed to facilitate a gradual reintegration into the community. Successful reintegration is contingent not only on the activities of the person themselves but also on society’s acceptance of the person. The use of tracking devices may limit the effectiveness of the outcome it is purporting to support (Office of the Public Advocate, 2013).

It is therefore important that electronic monitoring only be used with the valid consent of the patient. While there may be an extent to which coercion in forensic settings is inevitable, the RANZCP believes that electronic monitoring should never be used where overt coercion is required to gain consent. Secondly, electronic monitoring should only be used when integrated into an individualised risk management plan implemented with the cooperation and participation of suitably qualified mental health professionals. The RANZCP does not support the application of electronic monitoring devices by corrective services without the cooperation of the individual’s treating clinical team.

**Breaching human rights**

In the RANZCP’s view, the coercive use of electronic monitoring on forensic patients may violate a number of human rights, in addition to being counter-therapeutic and counterproductive.

The *United Nations Convention on the Rights of Persons with Disabilities* prohibits discrimination on the basis of disability (Article 5) and specifically prohibits arbitrary deprivation of liberty on the basis of disability (Article 14). The RANZCP believes that electronic monitoring conditions discriminate when they are applied to forensic patients in circumstances where other individuals would not be subject to monitoring.

The *Principles for the Protection of People with Mental Illness* include a requirement to ensure the least restrictive treatment in the least restrictive environment (UN General Assembly, 1991). This principle underpins modern Mental Health Acts in Australia and New Zealand and it requires eliminating measures that are not necessary to protect the person’s safety and welfare or the safety of others. In some cases, electronic monitoring may constitute the least restrictive means of providing treatment. However, evidence shows that tracking devices are generally not necessary to provide this protection (Scott, 2014; 2017). In the opinion of the RANZCP, it therefore follows that electronic monitoring will often breach the least restrictive principle.

Australian governments have made commitments to reduce stigma and promote recovery in the *National Statement of Forensic Patient Principles* (Australian Health Ministers’ Advisory Council, 2002). However, the RANZCP believes that electronic monitoring risks stigmatising wearers (and people living with mental illness more broadly) and may thereby have potentially serious impacts on recovery.

The *National Statement of Forensic Patient Principles* also emphasises that forensic patients, like all other patients, have a right to privacy. For that reason, Principle 7 states that ‘sharing of information between correctional and health providers will only occur to the extent necessary for treatment and care or with the consent of the client’. In the RANZCP’s view, the right to privacy is breached when forensic patients are monitored by corrective services or private security companies without their consent.

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2 For example: *Mental Health Act 2016* (Qld) s3(3); *Mental Health Act 2007* (SA) s7(1)(b).
Recommendations

The RANZCP is deeply concerned about the coercive use of electronic monitoring on forensic patients considering the scant evidence to justify the practice and its potential to undermine the therapeutic relationship, increase risks to the community and violate human rights. The RANZCP supports the use of electronic monitoring only when:

- the individual concerned has provided valid consent to the wearing of a device
- the practice is integrated into an individualised risk management plan informed by the individual’s treating clinical team.

Where possible, the RANZCP favours alternative methods to support forensic patients on their journey of recovery. To achieve this, the RANZCP recommends:

- greater investment in forensic mental health services to ensure evidence-based treatment and risk management for all forensic patients
- pathways to release which are based on person-focused approaches to care
- further research into the use of tracking devices on forensic patients before wider implementation.

References


Mental Health Act 2009 (SA).

Mental Health Act 2016 (Qld).


Disclaimer

This information is intended to provide general guide to practitioners, and should not be relied on as a substitute for proper assessment with respect to the merits of each case and the needs of the patient. The RANZCP endeavours to ensure that information is accurate and current at the time of preparation, but takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.