OFFICE OF
THE CHILDREN'S
COMMISSIONER
NORTHERN TERRITORY

USE OF SPIT HOODS AND RESTRAINT CHAIRS ON CHILDREN

POSITION PAPER
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Protecting the best interests of Territory children

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Use of Spit Hoods and Restraint Chairs on Children

Purpose

This position paper seeks to provide an evidence base supporting the legislated prohibition of the use of spit hoods and restraint chairs on children in the Northern Territory.[i]

It seeks to demonstrate that the use of such devices on children involved in the justice system is not safe in any circumstance and is highly likely to cause further harm to the child.

OCC Position

The Office of the Children's Commissioner (OCC) **supports a legislated prohibition of the use of spit hoods and restraint chairs on all children in the Northern Territory.** Whilst this paper specifically explores the use of these devices on children involved in the justice system, the evidence presented regarding alternative practice options is applicable to all settings.

In May 2022, five years after the Royal Commission into the Protection and Detention of Children in the Northern Territory (the NT Royal Commission) recommended the use of spit hoods be prohibited, the Northern Territory Police Force (NT Police) confirmed the continued use of both spit hoods and emergency restraint chairs on children in police watch houses. NT Police stated that spit hoods had been used 27 times on children in police custody since 2018 (including on a 12-year-old child) and restraint chairs had been used six times.[1]

On 7 October 2022, during the drafting of this paper, the NT Police announced the discontinuation of the use of spit hoods on children in police custody, with alternative options such as "personal protective equipment (PPE)… and existing operational safety tactics [to] be utilised to reduce the risk of exposure".[2] This announcement came after public media scrutiny and it is understood to be an internal police policy. No public announcement has been made in relation to the continued use of restraint chairs by NT Police members.

[i] The OCC uses the term "child/children" to refer to people under the age of 18 as this aligns with the terminology used in the OCC's governing legislation, the *Children's Commissioner Act 2013* (NT). However, the OCC acknowledges and respects the diverse cultural perceptions of childhood, young people and adulthood that exist in the Northern Territory. In particular, the OCC acknowledges First Nations people under the age of 18 who have been through ceremony and are culturally accepted and acknowledged as adults.

While the OCC welcomes this announcement and commends NT Police for taking this action, it supports legislative amendments to ensure that spit hoods and restraint chairs are not used on children in any setting, including police and youth justice custody. This is in line with national best practice for youth justice, as well as Australia's international obligations to uphold human rights (most notably those enshrined in the Convention against Torture).[3]

Children who interact with the youth justice system in the Northern Territory are a vulnerable cohort. These vulnerabilities are often co-occurring, compounding in their effects, and beyond the control of children or their families. This paper will address:

- the underlying factors leading to contact with the justice system;
- why spit hoods and restraint chairs are unsafe and harmful to use on children, and especially vulnerable children; and
- alternative measures to the use of spit hoods and restraint chairs.

In this paper, Aboriginal and Torres Strait Islander children will respectfully be referred to further as Aboriginal children, acknowledging the cultural diversities within this cohort.

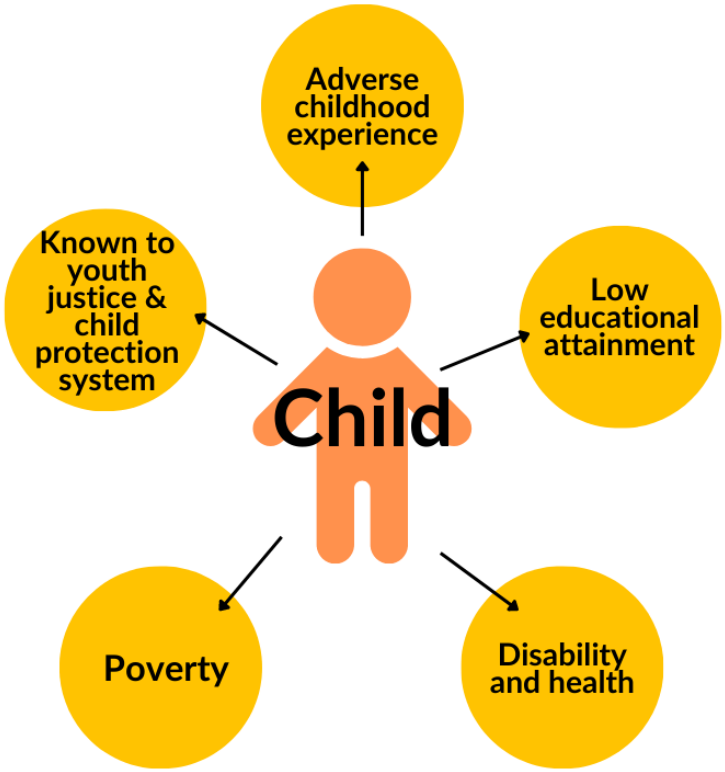
It is necessary to acknowledge that the significant majority of the children in the youth justice system in the Northern Territory are Aboriginal.[4] It is therefore also necessary to acknowledge the intergenerational trauma and political, racial and socio-economic factors that shape the lives of Aboriginal children subject to the Northern Territory justice and child protection systems. These systems should be safeguarding mechanisms for vulnerable children, promoting restorative and healthy child development practices as a priority. In reality, many Aboriginal children have been let down and indeed further traumatised by these systems, whose patriarchal and colonial foundations can elicit government responses that do not serve the best interests of Aboriginal children. Indeed they often further enforce discriminatory power dynamics between Aboriginal families and children and child protection, youth justice and police systems. To avoid continuing this discriminatory power dynamic and causing further damage, it is critical that any alternative measures to improve police and youth justice responses recognise this context and are led and informed by the Aboriginal community, including children with experience of the system, family, local Elders and Aboriginal community controlled organisations.

Much of this paper focuses on the vulnerabilities of children in this cohort and the prevalence of child maltreatment and/or exposure to child protection services, particularly amongst Aboriginal communities. This has been done to contextualise the circumstances of children who have been spit hooded or forced into restraint chairs while in police custody. It is not an implication of any inherent vulnerabilities of Aboriginal communities generally or their ability to care for each other. The impacts of colonisation, dispossession, structural violence and trauma resulting from government policy and decision making have been detrimental to Aboriginal people, and have disrupted the practices, traditions and ways Aboriginal people know how to care for their children which focus on culture, kinship, country and language. The OCC acknowledges the many strengths and abilities of these children, their families and communities, and that every day they celebrate and value their culture, express themselves in creative ways and display incredible resilience in the face of so many barriers. The OCC also acknowledges the similar strengths, abilities, creativity and resilience of all children in the Northern Territory and will continue to celebrate and promote them in our work.

Part 1: Who are the children we are talking about?

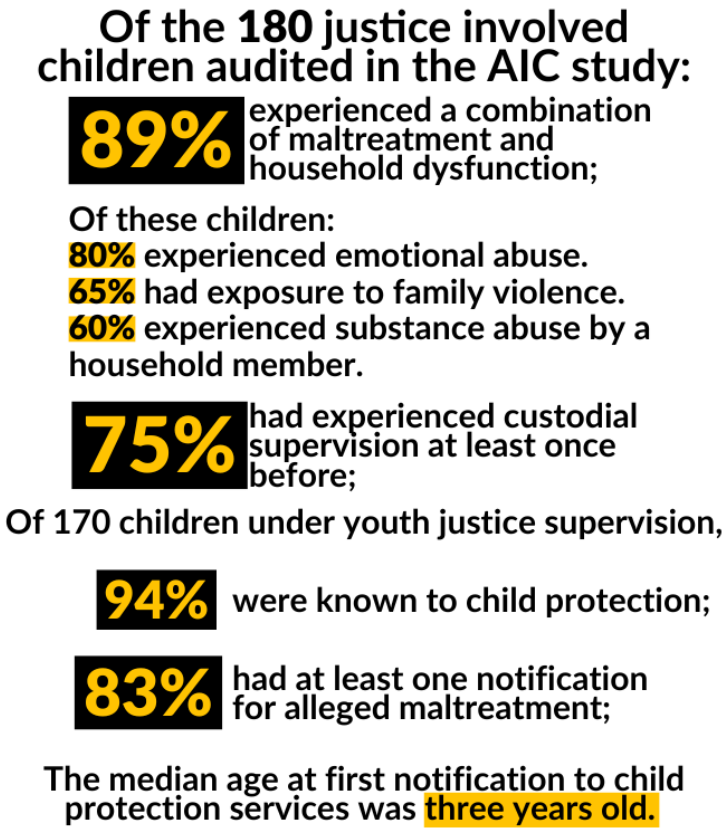
Background Characteristics

The underlying factors of how children end up involved in the criminal justice system are well documented, being reviewed in numerous Royal Commissions, parliamentary inquiries, coronial inquests, government and independent reports and research studies.[5] Children in the Northern Territory who find themselves either at risk of, or on the pathway into, the justice system are often subjected to cumulative vulnerabilities which they, and often their families, have little control or influence over. This includes histories of child removal, intergenerational trauma, low educational attainment or engagement, socio-economic disadvantage (including systemic racism and ongoing impacts of colonisation), disability, poor health and adverse childhood experiences.[6]



Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are events that are likely to detrimentally impact a child's future health and wellbeing. Maltreatment (physical, sexual, and emotional abuse, and physical and emotional neglect) and household dysfunction (parental separation, domestic violence, mental illness, substance abuse and incarceration) are just some examples of ACEs.[7] Recent studies by the Australian Institute of Criminology show that ACEs are highly prevalent among justice-involved children.[8]



[9]

These findings are supported by other recent research, including:

- The Northern Territory has the highest rates of child protection service contacts and youth offending in Australia.[10] Twenty-two percent of the Northern Territory child population have had a notification to child protection services; the national rate is 5%.[11] Eighty-one percent of children who came to the attention of child protection in

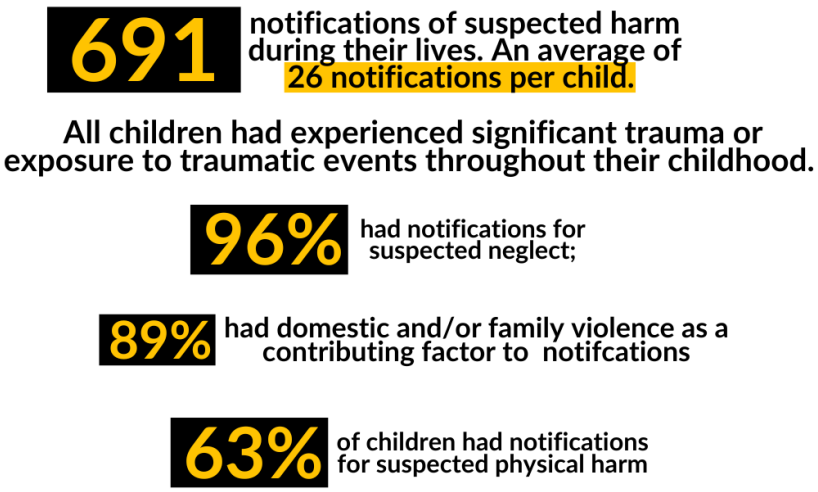
2021-22 were Aboriginal,[12] while 1 in 10 children in the Northern Territory has had multiple notifications of harm[ii] made to child protection authorities.[13]

- Orygen's 2018 report, '*Trauma and young people: moving toward trauma-informed services and systems'* (Orygen Report), reiterates that ACEs affect a child's physical and mental health, emotional responses, sense of self-worth, healthy wellbeing, behaviour and ability to develop healthy relationships.[14]

- There is a significant amount of literature identifying the links between child maltreatment and changes to brain structure (neuroplasticity) and function, stress-responsive neurobiological systems and health and emotional wellbeing[15]

- Menzies School of Health Research data-linkage study of Aboriginal children in the Northern Territory shows a strong link between chronic child maltreatment and subsequent youth offending.[16]

The research above also aligns with the OCC's recent sample audit of children under 14 held in NT youth detention centres. Of the 52 children aged 10-13 years admitted to youth detention in 2021-22, twenty-seven were the subject of the OCC audit. The audit found:[17]



[ii] Multiple notifications of harm – more than one formal report in the same year relating to a concern that a child has been, or may be at risk of being, abused, harmed or exploited.

The relationship between ACEs, poor educational attainment and health-damaging behaviours means that people who have these experience are more likely to suffer from poor health, low employment and social deprivation.[18] Addressing these fundamental issues will contribute to a better trajectory for children, especially when responded to early. Every child protection notification[iii] presents an opportunity to identify the child's care needs and support their family to address those needs in an appropriate, therapeutic manner.

> "Alcohol is a big problem – they hit children when they're not in their right mind. They kick them out when they're not in the right head space."
>
> Female, 13 years

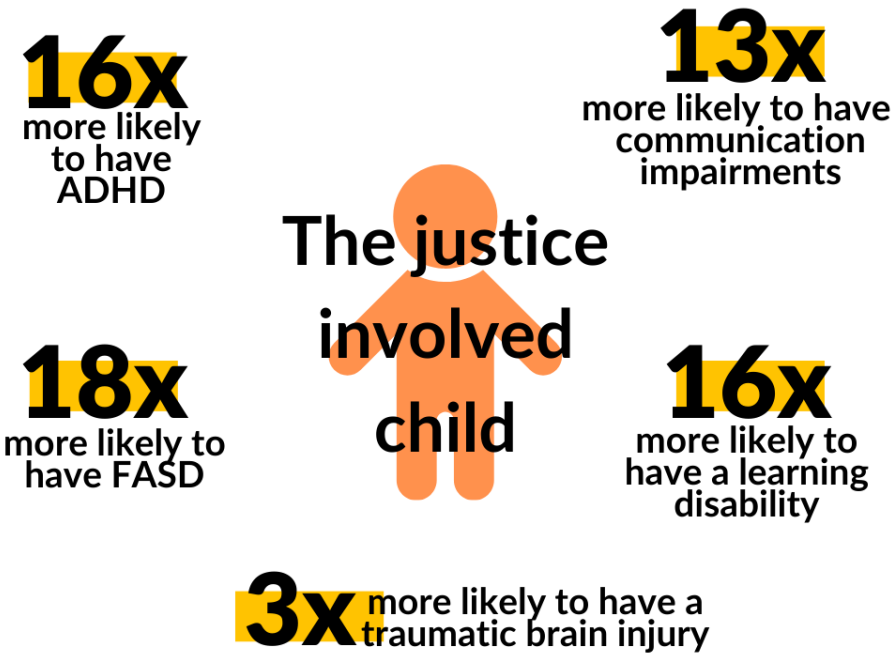
> "…kids can't sleep so they walk around all night coz parents are drinking coz they don't want to be home. My parents don't drink."
>
> Female, 15 years

Health and Disability

Physical Health

Living with a disability and/or poor health is another factor contributing to a child's involvement with the youth justice system. For example, when comparing justice-involved children with their community peers, a global study covering decades of primary sources on the health of adolescents in detention (including Australian children) found the justice involved cohort are: [19]

[iii] Child Protection Notification - formal report of concern that a child has been abused, harmed or exploited; or that a child may be at risk of being abused, harmed or exploited.



In many cases, these conditions affect the behaviours of children. Research examining the ways poor health and poverty often lead children into youth justice systems has found that many detained children have multiple, co-occurring health conditions, including mental disorders (e.g. self-harm, suicidal behaviour, and substance dependence), cognitive dysfunction and learning difficulties, non-communicable diseases (e.g. asthma), sexually transmitted infections and blood borne viral infections.[20] These conditions are further compounded by communication difficulties (such as hearing and speech impairments), experiences of trauma, and for children whose first language is not English.[21]

The use of restrictive practices (such as use of force, restraints and isolation) on children with disability can have multiple adverse effects, including physical harm, trauma and re-traumatisation, poor health, reduced lifespan, suicidal ideation and possibly death.[22] The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission) in their overview of responses to the criminal justice system issues paper found:[23]

> "...children with disability face a greater risk of being prosecuted by the criminal justice system, compared to children without disability. This is because multiple

service systems have failed to identify and respond appropriately to their needs, resulting in a prosecution".

This further emphasises the need for appropriate preventative and proactive supports tailored to the individual needs of children.

Psychological Impacts on Health

Children are an inherently vulnerable cohort due to their age and stage of development. Children's physical, emotional and cognitive maturity is different to adults. A human brain is not considered to be fully developed until the age of 25 years.[24] Complex behaviour, emotional regulation and sense of morality relies on the healthy development of the pre-frontal cortex from birth to age 25.[25]

As noted above, when a child's development is interrupted or impeded it can have significant, lifelong impacts. The relationship between children with ACEs and their subsequent involvement with the justice system is not unique to the Northern Territory. International studies demonstrate the psychobiology of violent and aggressive behaviours, including 'trauma triggers' and the connection between shame, guilt and displaced revenge.[26] In addition to this, many Aboriginal children bear intergenerational trauma stressors through physiological, genetic, behavioural and psychological factors,[27] as well as environmental factors such as overcrowded living arrangements and poverty.

The symptoms of developmental trauma[iv] can make it extremely difficult for a child to response calmly and coherently in a stressful environment. These symptoms include: emotional dysregulation, somatic dysregulation (e.g. aversion to touch, sounds, distress/illness that cannot be medically resolved), hyper- or hypo vigilance to actual or potential danger, extreme risk taking or recklessness, intentional provocation of conflict or violence, non-suicidal self-harm, impaired ability to initiate or sustain goal-directed behaviour, impaired interpersonal empathy and reactive verbal or physical aggression.[28]

In addition to this, a history of maltreatment or trauma can have a more pronounced and direct impact on a child's engagement with positions of authority, which often manifests in

[iv] Developmental trauma can be defined as s defined as a combination of traumatic interpersonal victimization and disruption in attachment bonds with a primary caregiver(s).

the education and justice systems. Research has shown that a diagnosis of oppositional defiance disorder is associated with an increased likelihood of prior trauma.[29] Oppositional defiance disorder is characterised by disruptive behaviour, a pattern of angry and irritable mood, and argumentative and vindictive behaviour. It also often leads to or occurs alongside conduct disorder, which is characterised by aggressive behaviour, defiance to authority figures and antisocial behaviour.[30] In a stressful police setting, such as an arrest, such disorders clearly limit a child's ability to regulate their emotions, communicate effectively and conduct simple problem solving.[31] This can cause anger and defiance, as a child may simply not know how to respond to a stressful situation. It is therefore crucial that front line services such as police have the training and resources to be able to safely engage with the child without causing further physical or psychological harm to them.

Alcohol and Other Drugs

Alcohol and other drug misuse can be both a coping tool to soothe the distress of past or present events as well as a contributing factor for adverse health outcomes.[32] This is particularly relevant to First Nations communities, who are twice as likely as non-Indigenous Australians to experience psychological distress and associated poorer health outcomes, violence and substance use.[33]

There is also a clear link between children involved in the justice system and use of alcohol and other drugs (AOD). In Australia, a study found that of children under youth justice supervision between 2012 and 2016, 1 in 3 also received treatment from an AOD service during that period.[34] Of that group, Aboriginal children were 14 times more likely to receive that treatment than non-Indigenous children.

Individuals who are subjected to ACEs are also more likely to develop addictions during their lifetime.[35] One UK study found that 60% of people who had experienced 4 or more ACEs were misusing substances. They were also twice as likely to binge drink and 11 times more likely to use heroine or cocaine. [36]

> "Big problem. Little kids smoke. They get into it by seeing all the big kids smoking."
>
> Female, 15 years

Neurodisability

Data on the prevalence of neurodisability[v] in youth detention populations in the Northern Territory is limited. However, a comprehensive two year study at the Banksia Hill Youth Detention Centre in Western Australia worked with 99 children to assess and diagnose neurodisabilities.[37] Of this cohort, one in three children had FASD and nine out of ten had at least one domain of neurodevelopmental impairment.

The demographics of the children in youth detention in Western Australia are very similar to that of the Northern Territory (where the vast majority are male and Aboriginal). Considering the information obtained by the OCC regarding the social, cognitive and behavioural complexities that children in detention in the Northern Territory face, the prevalence of neurodisability in the Northern Territory youth detention population is reasonably inferred to be similar to that of Western Australia.

Some common expressions of neurodisability and, in particular, FASD are:[38]

- Impulsivity/hyperactivity
- Difficulty with attention
- Poor memory and learning abilities
- Sensory difficulties
- Poor reasoning and judgment skills, including understanding of cause and effect
- Speech and language delays
- Vision or hearing impairments

Such impairments severely impact a child's ability to engage safely with police officers and the justice system more generally. For example, the abovementioned symptoms can be significantly compounded when a child is in a stressful environment, such as an arrest or being spit hooded. A child living with FASD in such a situation may:[39]

- become aggressive due to sensory overload from noise, flashing lights, being touched or lots of activity;

[v] Neurodisability describes a group of congenital or acquired long-term conditions that are attributed to disturbance of the brain and/or neuromuscular system and create functional limitations. The term includes attention-deficit/hyperactivity disorder (ADHD), foetal alcohol spectrum disorder (FASD), traumatic and/or acquired brain injury, intellectual disabilities, autism spectrum disorder and language disorders

- respond inappropriately to what is being asked because of a difficulty processing language or orders; or
- be unable to organise thoughts, process information or understand written language.

As a result, there is urgent need for adequately resourced services to complete multidisciplinary assessments of children at risk of entering, or already involved in, the justice system, so those children that require supports and therapeutic intervention receive it. Equally, there is an urgent need to provide adequate training and ongoing professional development for front line workers in all sectors, including police officers, to better understand and respond to people living with a neurodisability.

> "My mind's a riot – ADHD. I want to see myself as a role model for young people with ADHD. It's hard to focus and easy to be distracted and it goes too much over your head."
>
> Male, 16 years

Low Educational Attainment

Positive educational environments are a protective factor for children and encourage children's healthy wellbeing, development and skills needed to thrive in adulthood.[40] The Northern Territory Government use 80% school attendance from ages 6-17 as the threshold at which children will generally keep up with classroom learning.[41]

In 2020, just over half of the students in the NT (56.1%) attended school for 80% or more of the available time.

42

In 2018 the share of Indigenous students at or above national minimum standards was 14% for reading and 12% for numeracy, an increase from 3% and 4% respectively, but short of the target of halving the gap in this area.[43]

Children not engaged in or achieving positive results at school are at greater risk of a wide range of adverse outcomes, included poorer health and wellbeing, elevated risk of anxiety or depressive symptoms, and increased risk-taking behaviours such as substance use and violence.[44]

Providing trauma-informed education is imperative. Children with challenging behaviours, along with their families, need to be engaged to effectively identify their developmental stages and to address the child's learning needs in order to prevent education disengagement. Many studies highlight the link between children with trauma experience and poor academic outcomes.[45] In an education setting, expression of trauma can be characterised by:[46]

- increased anxiety, tension and irritability;
- aggressive or violent behaviour;
- limited ability to control emotions;
- difficulty forming positive relationships with peers;
- difficulty reacting to social cues and withdrawal from social situations;
- distrust of teacher's or positions of authority;
- perception of rules and consequences as undue punishment.
- disruptive classroom behaviour;
- concentration and time management issues; and
- absenteeism.

Such behaviours often increase the risk of these children disengaging with education and coming into contact with the police, the court system and ultimately youth detention.

> The teachers – if the teacher doesn't understand you it makes you not want to come. The workload is too much. When a teacher can't teach you to your learning style, it makes me not want to come cos I'm stuck, and like I can't do anything else.
>
> Male, 15 years

> How strict other schools were – I appreciate the timeline and having stuff I need to work with – but all the teachers stressing and principal on your back and it gets too stressful.
>
> Female, 21 years

Poverty and Social Disadvantage

Significant research has been undertaken which identifies the link between poverty, social disadvantage and criminalisation in relation to both adult and child populations.[47] While not necessarily a sole determining causal factor of criminalisation, evidence shows that poverty and social disadvantage significantly impact youth mental health and behaviour.[48] Exposure to poverty and associated social disadvantages have a cumulative effect on psychosocial development and poor behaviour, which can compound the challenges associated with pre-existing factors such as disability and child maltreatment.[49] The use of spit hoods on children in this cohort can further add to the cumulative effect on psychosocial development and can increase their likelihood of remaining in the justice system.

Rather than a direct link, poverty and associated social disadvantages (such as discrimination and stigmatisation, lack of social support or cohesion, and low educational attainment) are interconnected with other factors that can influence contact with youth justice and child protection. For example, while child maltreatment occurs in all sections of society, research has found that it is more likely to occur in families or communities subject to other types of adversity and stress.[50] The World Health Organisation's World Report on Violence and Health found that the potential for childhood maltreatment is increased when families are affected by low education, low income, or domestic violence; when communities have a high

concentration of poverty or unemployment; and when societies have weak social welfare systems.[51]

Early childhood health

In recent years there has been renewed focus on early childhood as the ideal time to shape a healthier future for that child.[52] Poor nutrition during early life is associated with long term deficits to a child's neurological, immune and physical development.[53] There is significant research showing that holistic, high quality early years education (0 to 5 years) for children and their families is a highly effective way to improve health and social outcomes across a person's lifespan. Some examples include:

- Head Start – an early education program established in the USA in 1965 focused on children at risk of poverty and social disadvantage.[54] The model adopts an ecological, holistic approach promoting family wellbeing, home visits, health screening and early care and education from birth to 5 years. Evaluations of the program have demonstrated improvements in language development, learning and social and emotional skills in children by the time they commence primary school.[55]
- Perry Preschool Study – this followed 123 African-American children at risk of social disadvantage for 40 years, who were engaged in a holistic, play based preschool program. While the model showed moderate short term improvements in cognitive skills (IQ), the most significant improvement was in long term improvements in character skills which saw reductions in aggressive, antisocial and rule-breaking behaviours.[56] As adults, the participants were more likely to be employed, own their own home, have higher educational attainment and less likely to have a criminal history or use tobacco. From a government economic perspective, it has been estimated that for every dollar invested into a child in high quality programs from birth to 5 years, there is 13% per year return on investment through increased school and career achievement and reduced costs in remedial education, health and criminal justice system expenditure.[57] The program continues in pre-schools across the USA and internationally.[58]
- The First 1000 Days Australia project is a First Nations designed and led model that broadens the international concept of early year's nutrition to include First Nations

methodologies, culture, family involvement and a holistic view of health and wellbeing that is beneficial for all children.[59]

It is the position of the OCC that greater focus and resourcing of preventive responses seeking to address underlying causes, such as holistic, high quality early years education for children and families at risk of social disadvantage, is critical to any efforts to limit the increasing numbers of children in the NT youth justice system.

In the Northern Territory, almost 45% of all Aboriginal households are living below the poverty line. In 2016, the median personal income for First Nations people was $281 per week, just 26% of the $1,072 received by other Territorians.

[60]

Housing

Poverty is multifaceted and its effects are felt through every aspect of a child's life. For example, this can include parent's needing to choose between school uniforms and food on the table, or medical appointments and fixing the car. It affects being able to purchase nutritional food, attend sporting or extra-curricular activities and regularly impacts people's ability to have healthy relationships.

Poverty is also strongly associated with homelessness, which includes overcrowding. The NT has 12 times the national rate of homelessness, with 20% of all Aboriginal people and one in six children experiencing homelessness.[61] In Australia, the highest levels of overcrowding occur in remote areas of the Northern Territory (NT). As at September 2021, 54 per cent of houses in remote Indigenous communities in the NT were considered overcrowded.[62] Research has shown that experience of emergency or transitional housing often proceeds or occurs concurrently with child protection involvement,[63] and that child or family homelessness is often present alongside other co-presenting factors (such as domestic and

family violence, financial disadvantage, incarcerated parents and teenage parents).[64] If children feel stressed, unsafe or uncomfortable in their home they are often forced to seek out safety and connection in public spaces, where they are more likely to come into contact with police, child protection or youth justice services.

> "We were homeless for 11 months….we were kids…If I look back now I can see my parents found it hard to deal with, but we were there for each other. Some nights were tough."
>
> Female, 15 years

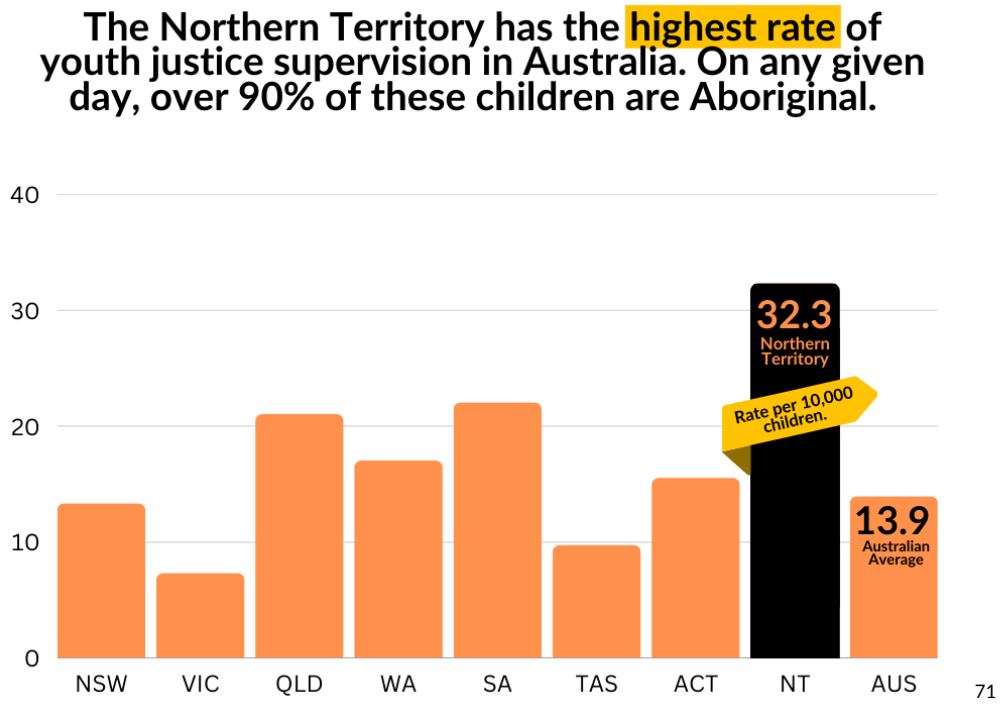
Known to police, youth justice and child protection systems

Children with attachment disorders, emotional dysregulation and aggressive impulsive behaviour often want the people around them to become part of what they're experiencing.[65] In order to ease this experience, adults must provide these children with safety, continuity and stability in order to help regulate their emotions.[66]

When such stability is not able to be provided, children and members of their households often come to the attention of statutory child protection services. As noted earlier, the Northern Territory has over four times the national rate of child protection notifications, with the significant majority of notifications (81%) being made in relation to Aboriginal children.[67] Neglect is the most prevalent harm type that is notified (43%), while emotional harm (49%) and neglect (26%) are the most prevalent types of harm that are substantiated by child protection services.[68] Domestic and family violence safety concerns are captured as either neglect or emotional abuse.

In the Northern Territory, police are the most prominent reporters to the statutory child protection agency, making 35% of all child protection reports.[69] This proportion increases for children who are in contact with both the youth justice system and child protection services (sometimes referred to as the 'crossover group'): by age 17, 89% of reports to child protection for children in the 'crossover group' are made by police.[70] This means that children who come into contact with police are often already known to police due to a variety of reasons, including police attendance to domestic violence incidents at the child's home. As a

result, police are likely to have relevant information about the child's background available to them through their intelligence gathering systems.[vi]



The Northern Territory has the highest rate of youth justice supervision in Australia. This demands better practice to prevent children from being exposed to known criminogenic risks such as further ACE's and traumatic incidents, which we know increases the likelihood of further justice involvement. The high levels of justice involved children, and the awareness of their circumstances, also creates ample opportunity for police to identify and appropriately respond to children expressing signs of trauma and/or health issues, rather than allowing situations to escalate to the point where a spit hood is deemed necessary. For example, frequent interactions with a child increases the opportunities for police to record expressions

[vi] NT Police Force uses PROMIS and IJIS data systems for their engagements with members of the public. The PROMIS system can be accessed remotely (i.e. while on patrol) and stores information about people who have previously had contact with police. This system has the capability to include information such as prior experiences with a young person, family issues relating to that young person (such as existing or expired DVOs), potential physical or cognitive impairments and exposure to trauma. The OCC understands the NT Police Force is also rolling out an improved data system, SerPro, which will improve data linkage, access to information in the field, and reduced manual data input (Digital Territory, *Implementing SerPro, a modern, proven and integrated digital policing system in the NT* (Web Page, accessed 24 May 2023) <https://digitalterritory.nt.gov.au/digital-government/action-plans/action-items/implementing-serpro-a-modern-proven-and-integrated-digital-policing-system-in-the-nt>).

of trauma in their data systems, allowing them to pro-actively employ de-escalation measures for children who have previously experienced trauma responses. Such approaches are safer for both children and police officers, and further discussion of alternative engagement methods and de-escalation practice is provided in the following section.

It is noted that the Northern Territory Government (NTG) ceased the use of restraint chairs and spit hoods in youth detention centres after the Four Corners investigation 'Australia's Shame' was aired in 2016, pending the Royal Commission into the Detention and Protection of Children in the Northern Territory (**Royal Commission**). The NTG subsequently confirmed these changes through legislative amendments which omitted these devices from the list of approved restraints permitted to be used in youth detention centres.[72] The NTG also committed to a restorative practice approach to trauma and full care training for those working in the youth justice system.[73]

Part 2 - Why are spit hoods and restraint chairs unsafe and harmful?

A spit hood is a device which is made of fabric and is used to prevent the transfer of diseases through human fluids (e.g. from vomiting, spitting or biting). There are various forms of spit hood. The type of spit hood used by the Northern Territory Police Force until recently had white mesh designed to sit over the upper half of the head, a piece of elastic designed to sit on the nose and a loose fitting section of thicker, black material to cover the mouth. The black fabric is intended to allow the person to discharge fluid form their mouth (such as vomit) without blocking their airways, and to block that discharge from contacting other people.

[74]

If a spit hood is improperly used, the risk of inadequate ventilation or asphyxiation is increased.[75] For example, the photo above shows an incorrect application of a similar design of spit hood as that was previously used by NT Police, whereby the elastic is placed around

the throat rather than nose. If the person were to vomit whilst having the spit hood applied in this manner it could be caught inside the mesh section, increasing the risk of choking or suffocation. The OCC understands that, at approximately the same time as announcing the prohibition on use of spit hoods on children, the NT Police Force adopted a new design for use on adults in its custody, known as the Spit Guard Pro.[76] While it is advertised as having "no known health or safety risks", the OCC has serious concerns for any use of this or any design of spit hood on children for the reasons set out in this paper.

A restraint chair (also called an emergency restraint chair or "ERC") is a device in which a person can be seated and their arms, torso, legs and head/neck (depending on design) can be strapped down to prevent movement.

Spit hoods are no longer used in any youth detention centre in Australia, while the Northern Territory and Western Australia are the only police forces that continue to use them on adults.[77] The characteristics and lived experiences of children in detention centres match that of the children police interact with in the community, as police are the first point of contact for these justice involved children. Indeed, virtually all children in detention have had to come through police custody. It logically follows that the evidence to ban spit hood use on children in detention is also highly relevant to children across the entire youth justice continuum, including those in police custody.

Dangers of Using Spit Hoods and Restraint Chairs

Spit hoods

There is no safe way to use a spit hood on a child. Spit hoods are used along with other restraints in order to prevent the person from removing the device.[vii] An investigation by the Ombudsman of South Australia found that the use of spit hoods and the force used to apply them was at times disproportionate, served to escalated situations and was not used as a last resort.[78]

[vii] Spit hoods are commonly used in conjunction with handcuffs, as otherwise the detainee can take the spit hood off. Prior to banning spit hood use on young people, NT Police confirmed its internal policy was that at no time were young people or adults placed in an ERC also subjected to having a spit hood applied (Letter from Northern Territory Commissioner for Police to the Northern Territory Acting Children's Commissioner, 19 November 2021).

Use of spit hoods and restraints can pose a risk of asphyxiation and death, particularly when coupled with forcing the person into the prone position.[viii] Unsafe restraint and/or the application of spit hoods in order to prevent spitting have resulted in numerous injuries and deaths of people in custody throughout Australia and the world. For example, in its submission to NSW's Select Committee on the High Level of First Nations People in Custody, Justice Action stated:[79]

> *"Coroners' inquests into Robert Plasto Lehner's death (Northern Territory 2009), Carl Antony Grillo (Queensland 2011), Bradley Karl Coolwell (Queensland 2017), and Pasquale Giorgio (Queensland 2018) reveal that in each of these cases, the causes of death were the result of being restrained in the prone position. This led to eventual suffocation from positional asphyxia. Further deaths in similar circumstances could have been avoided had the information, and possible strategies for reform, been implemented across jurisdictions."*

The NT Royal Commission found the use of spit hoods and restraint chairs (as well as other forms of restraint) exacerbate discomfort and distress of children with potential to cause harm and recommended that the use of both be prohibited.[80]

In its investigation, the South Australian Ombudsman found that the use and application of spit hoods was inconsistent with international laws and introduces the risk of potentially fatal asphyxiation, in part because multiple adults were needed to force the spit hood over the child's head.[81] In the 12 cases reviewed, in every case but one the affected child was forced to the floor during the interaction. Some examples of children being forced into the prone position and spit hooded are shown below:[82]

[viii] The prone position is a body position in which the person lies flat on the ground with their chest in contact with the ground and their back facing upwards. The supine position is the opposite, with the back in contact with the ground and the chest facing upwards.

More recently:

- In South Australia in 2016, Wayne Fella Morrison died after being restrained at the wrists and ankles, placed in a spit hood and positioned face down in the back of a prison van. A pathologist who gave evidence in the coronial inquest included a "potential positional element" as a factor contributing to his death.[83]

- In Rochester, New York in 2020, Daniel Prude was handcuffed, hooded and forced to the ground before an office put his knee to his back for approximately two minutes. Video shows him falling silent and going limp. He was taken to hospital and removed from life support a week later.[84]

- In a youth detention centre in South Australia in 2019, a 13 year old girl was pinned to the floor by five staff members, spit hooded and handcuffed with her hands behind her back after she refused to go to bed.[85]

- In Sussex in 2012, an 11 year old girl with a neurological disability was detained for over 60 hours, arrested 3 times, held twice in a police watch house and subjected to leg restraints and spit hoods on 4 occasions.[86]

It is noted that attempts to ensure detainee safety while using spit hoods are often flawed, as noted above in relation to the improper placement of elastic around the throat rather than the nose. As a further example, most spit hoods are designed to be somewhat transparent so the pallor of the detainee's skin can be monitored for signs of asphyxia. However, many medical guidelines note that visual assessment for signs of asphyxia alone is particularly unreliable for darker skin tones.[87] Appropriate assessment includes use of natural light or a

halogen lamp. The availability and effectiveness of doing this in the context of a person with a spit on their head is severely limited.

It is the OCC's position that there is no safe way to use a spit hood on a child. The continued use of spit hoods by police has been globally criticised.[88] The purported 'reasonable and justified'[89] act of using a spit hood is outweighed by the risks of re-traumatisation, harm, breathing difficulties (e.g. gagging and vomit) and death. It is unacceptable that this restraint is employed when there are known, more effective alternatives available.

Restraint chairs

Similarly, the UN Committee Against Torture has recommended that the use of restraint chairs as a method of restraining people in custody be abolished, as their use "almost invariably [leads] to breaches of article 16 of the Convention".[90] Article 16(1) states that "each State Party shall undertake to prevent… acts of cruel, inhuman or degrading treatment or punishment".[91]

In an independent review of seclusion and restraint practices in New Zealand, Dr Sharon Shalev found that the use of restraint chairs in police custody was "particularly concerning, and I was not convinced that these extreme forms of restraint were reserved as a last resort when all else had been tried and failed".[92]

> **"…I was not convinced that these extreme forms of restrain were reserved as a last resort when all else had been tried and failed."**

Dr Shalev also states that the use of restraint chairs, either in isolation or conjunction with spit hoods, is known to have significant adverse physical and psychological effects on an individual.[93] These risks are elevated where the detainee is a child or adolescent, if there are

medical or situational conditions (such as asthma or intoxication) and for people who have a history of abuse, as they can experience restraint as a re-enactment of their original trauma.[94]

While national data on the prevalence of restraint chair use in Australia is not available, as noted above the NT Police have confirmed that since 2018 restraint chairs have been used on children at least 6 times. Former National Children's Commissioner Megan Mitchell has stated that 'tying a child to a chair and putting a hood over their head teaches children in juvenile detention that abusing people who were powerless is "normal"'.[95]

In respect of their prevalence internationally, in the US a review of lawsuits found that restraint chairs were linked to 20 deaths in custody between 2014 and 2020.[96] A separate review found the device was connected to 36 deaths in custody between the late 1990s and 2014.[97] Between 2015 and 2020 New Zealand, police strapped 38 children into restraint chairs, some on more than one occasion.[98]

Immediate and Long-Term Impacts on children

Spitting is a behaviour that can result from the experience and expression of trauma symptoms (inclusive of other aggressive behaviours like verbal abuse, punching, kicking, biting, and self-harm).[99] Tools such as spit hoods and restraints can be re-traumatising, as observed by other co-occurring trauma presentations such as dissociation, sobbing and outbursts of rage.[100]

In the NT Royal Commission it was submitted that spit hoods and restraint chairs have been employed in the past to give children 'a chance to calm down'.[101] There is no evidence to show their use is therapeutic or causes a calming effect. Hooding of any child can be panic-inducing. As noted above, a child who is in the situation where police deem it necessary to use a spit hood are also likely to have experienced trauma or ACE in their childhood and/or to have a physical or mental impairment. To use a spit hood on a child in this context is dehumanising and dangerous. There are very few clinical studies on the use of spit hoods - none on their safe use on children. Evidence from one trial suggests that spit hoods did not result in clinically significant changes in breathing when trialled on healthy, adult subjects who were seated and monitored for vitals in short time periods.[102] These do not reflect the circumstances in which spit hoods are used on children in the NT.

Traumatic engagement with police, like being hooded or restrained, constitutes an adverse childhood experience which can have adverse disruptive effects on the trajectories of a child's life. Persistent and repeated exposure to such harms have the very real potential to contribute to a vicious cycle of consequences that in turn lead to further adverse experiences and outcomes (e.g. compromising development and core neural networks, substance abuse, limited ability to engage in healthy relationships, repeated justice involvement, poor economic outcomes). All practice with vulnerable children, including the practice of police officers, should aim to disengage the conflict cycle – not perpetuate it. Approaches that shift the power dynamic from authority figures dealing with as "delinquents", to restorative practices working towards a common, positive goal for children with complex needs are necessary and safer for all involved. Some alternatives in this regard are set out below.

In addition to the directly traumatising effects of spit hooding and mechanical restraints, the 'normalisation' of trauma - the cyclical intergenerational adversity experienced by some Aboriginal families - can be perceived as 'an inevitable and accepted part of life' by the services, societies and systems which govern the lives of children.[103] Responses that operate with intended or unintended discriminatory bias towards Aboriginal children reduce the likelihood of safe interactions. In order for youth justice responses to be non-discriminatory, effective and safe, the 'responders' must recognise the lived experience and related behaviours of the child with whom they are interacting.

Part 3 - Worker Safety: Risks and Evidence

A common justification for applying a spit hood is to prevent the transmission of communicable disease by way of infected body fluids (i.e. blood or saliva).[104] Such diseases include Hepatitis A and B, Tuberculosis and HIV. However, the facts do not support this justification and evidence proves this risk is overstated.[105] In its investigation into the use of spit hoods in youth detention, the South Australian Ombudsman stated:[106]

> *There is a relatively high rate of blood-borne illnesses within Australia's adult custodial population, although the risk of transmission from bloody saliva or bites to the skin ranges from very low to non-existent, depending on the illness.*

In Canada, the 2012 determination in *R v Ratt* established that there is no evidence of any documented verifiable transmission of any disease to a police officer in a spitting incident.

[107]

Further, there has been no incident of HIV being passed on through spitting, even when the spitting contains blood, in the entire history of the disease.[108]

In a recent systematic review of HIV transmission, it was concluded that there was **no risk of transmission through spitting**.[109]

It has also been recently established that there is a **lack of evidence to support that Hepatitis B or Hepatitis C can be transmitted through spitting or biting**.[110]

Similarly, spit hoods are understood to be ineffective in preventing the transmission of infections, such as COVID-19.[111]

Significant public research outlines surgical masks are a far more practical and effective measure of infection control regarding respiratory viruses.

[112]

Furthermore, Australian and international medical associations recommend full vaccination against diseases such as Hepatitis A, Hepatitis B and COVID-19 as preventative measures to increase safety from contracting the illness.[113]

Existing recommendations call for specific education and training for police, delivered by medical professionals, incorporating comprehensive information on the real versus perceived risks associated with diseases such as Hepatitis A and B, Tuberculosis and HIV. [114] This would also improve the ability of officers to ensure those who do suffer from such illnesses are engaged with dignity, professionalism and compliance with recognised healthcare standards, rather than "prejudice and fear".[115]

Part 4 - Australia's International Obligations

The use of spit hoods and emergency restraint chairs on children is a blatant violation of children's rights under various international treaties to which Australia is party.

As part of its investigation into the use of spit hoods in the Adelaide Youth Training Centre, the South Australian Ombudsman succinctly summarises the international treaties and provisions that are breached when spit hoods and restraint chairs are used on children.[116] Briefly, the relevant treaties and provisions are:

- The Convention on the Rights of the Child (articles 3; 37(b))
- Convention against torture and other cruel, inhuman or degrading treatment or punishment (including the optional protocol to this convention) (articles 2(1); 16(1))
- Standard minimum rules for treatment of prisoners ("Mandela Rules") (rules 1; 36; 47(1)-(2))
- Rules for the protection of juveniles deprived of their liberty ("Havana Rules") (rules 64; 87)
- Standard minimum rules for the administration of juvenile justice ("Beijing Rules)" (rules 5.1; 26.2)
- Guidelines for the prevention of juvenile delinquency ("Riyadh Guidelines") (guideline 54)

However, international treaties create no practical obligations for compliant practice by Australian governments if they are not given effect through domestic legislation. By previously allowing the use of spit hoods and continuing the use of restraints on children, state and territory governments have violated Australia's international commitments regarding the treatment and torture of children.

Part 5 - Alternative Measures

Spit hoods are no longer used in any youth detention centre in Australia, while Northern Territory and Western Australia are the only police forces that retain their use on adults.[117] The availability and use of restraint chairs by WA, SA and QLD police forces remains unclear, while NSW, ACT, Victoria and Tasmanian police forces have stated they do not use either spit hoods or restraint chairs on children.[118] As no statement has been made regarding their prohibition, it is understood that restraint chairs currently remain available for use on children in police custody in the Northern Territory.

While it is welcome to see jurisdictions taking steps to discontinue use of punitive and harmful restraints, this only goes part way to providing a comprehensive response.

NT Police often respond to children in extremely difficult situations and their options to deal with children demonstrating self-harming behaviours can be limited. NT Police acknowledge they respond to children in heightened emotional states, under the influence of drugs and alcohol, and with poor mental health or disability.[119]

It is the position of the OCC that, in order to improve the experience of both detainees and officers in custody settings, police officers need to be provided with sufficient education and training focused on de-escalation and alternative, health focused approaches to children in custody. Investment in changing culture away from punitive, operational responses to understanding the triggers and causes of high stress situations will allow for safer resolutions and outcomes for both the child and police officer. It is also the best practice approach for dealing with young people in crisis given that other restraint options, such as padded cells, sedation and hand/leg cuffing all have significant concerns of their own.

Collaborative problem solving

Psychosocial interventions that are systematic, equitable and culturally competent are increasingly recognised as a crucial element to behavioural management in youth justice services.[120] Further, there is a large body of research identifying effective de-escalation techniques to reduce aggressive incidents without the use of force.[121] Much of this research has been conducted in nursing, psychiatry and psychology. However, it is relevant and indeed

important to extend the evidence based practices in psychology to the work of police officers so they can adopt strategies that have been shown to reduce the use of force on children.[122]

One such approach is collaborative and proactive solutions (CPS), which is a form of cognitive-behavioural therapy, developmental psychology and neuropsychology. It is based on the premise that challenging behaviour occurs when the demands and expectations being placed on a child exceed their capacity to respond adaptively, which can then lead to negative responses.[123] Rather than focusing on the child's behaviour, the model focuses on identifying the expectations the child is having difficulty meeting and helping them to solve the problems instead of modifying behaviour through other systems (e.g. reward and punishment) or by force. This approach shifts the idea that a child is simply a 'bad kid' to understanding that some children have difficulties meeting adult expectations in the moment due to their development.[124] While no identified research has reviewed the success of CPS in the work of police officers, studies have shown it has been effective in reducing restraints in adolescent inpatient psychiatric units and reducing youth injury, confinement, restraint and isolation in youth detention facilities.[125]

A recent study partnered with a police department to run a police training workshop designed to promote officer's knowledge of trauma behaviour in adolescents and use of CPS. It found the workshop has potential to positively impact officer's understanding of trauma affected adolescents, however more practice and coaching was required for their de-escalation abilities to significantly improve. Research and programs involving other police departments has similarly shown promise in changing police officers' attitudes about complex children and increasing knowledge of conflict de-escalation.[126]

De-escalation

Frequent, mandatory training in de-escalation techniques must be a major part of all ongoing training requirements for officers in custodial settings. The Australian Institute of Criminology has articulated that given police are a key justice interface, they should receive specific support and training in how to interact with children if they are to serve as role models for self-regulation.[127] Research supports this, and in 2017 the Child Study Centre at Yale University published a comprehensive toolkit for law enforcement departments to adopt to assist their officers in responding to children exposed to violence.[128] It highlights that with

proper training and resources, police can be instrumental in creating a safe environment that will help children and to have a sense of security and stability.

It is important that communication training teaches police to employ effective, calming and stabilising approaches to an individual before attempting to solve any problems (this should include techniques to avoid antagonistic, discriminatory or dismissive behaviour or language).[129] Basic forms of de-escalation include:[130]

- Clear verbal (in first language as often as possible) and non-verbal communication
- Engagement and establishment of connection (this is especially important for children, i.e. child friendly language)
- Communicate with a goal of negotiation rather than the employment of force
- Taking steps to put the person at ease (e.g. calming, reassuring, positive behaviour)
- Training for Police that prioritises de-escalation methods over 'minimum use of force' to safely resolve an incident[131]
- Involvement of Aboriginal adults, family and peers to mitigate feelings of cultural isolation

Health responses

Related to increased focuses on de-escalation tactics, police models in Australia and internationally have increased focus on providing mental health responses to crisis incidents. This includes extensive training for police officers in identifying and responding to mental health crises in individuals, as well as employing mental health practitioners as part of the police force to accompany officers on particular callouts.[132]

In 2016 the Western Australia Police Force implemented a pilot program adopting this approach. The Mental Health Co-Response Trial (**MHCR**) involved mental health practitioners co-located with police at the Police Operations Centre in Perth and two mobile teams operating in the field and Perth Watch House.[133] Mental health practitioners were involve at each stage of a police response to and management of people experiencing a mental health crisis. An independent evaluation of the trial found that it had improved the safety and

wellbeing of police and mental health service consumers, improved resources allocation and increased collaboration between the relevant services at each stage of the model. It also found that there was absolutely a need to address community demand for mental health based responses to many police call-outs.[134] Based on the success of the trial, the model has since been expanded cover the entire Perth metropolitan area, the Midwest (incorporating Geraldton and surrounds) and the South West (incorporating Margaret River and surrounds) regions of Western Australia.[135] It has also expanded to include Aboriginal mental health workers as part of the call-out team.

In October 2020, the NTG announced the Mental Health Co-Responder Project trial between the Department of Health, St John's Ambulance and NT Police Force to provide a new, collaborative approach to mental health emergencies.[136] Under the trial, a mental health clinician responds to mental health callouts with a police officer or a paramedic to provide specialised care. The team operates five days a week in the evenings and is based at the Casuarina Police Station. Early indications show the program had positive benefits, with 70% of calls directed to the team not requiring hospital admission.[137] The OCC is not aware if the program has been comprehensively evaluated or if there are plans to expand the model more broadly in the NT.

It is the position of the OCC that, in the NT context, access to appropriate and timely mental health services in police custody could have significant impacts in de-escalating high intensity situations involving children (especially in police vehicles and in watch houses) and avoid officers feeling the need to resort to using mechanical restraints. It is acknowledged that under the current system, not all NT police stations may have custody nurses at all times. As a result, many police officers may be expected to conduct medical assessments of people in crisis or respond to underlying medical impairments when they are not specifically trained in these areas. Based on the evaluation noted above, adopting the MHCR model would see both police and mental health services more effectively utilised, relieving the stress and workload on police officers who are called out to such situations. It is the OCC's position that the NTG conduct a comprehensive evaluation of the Mental Health Co-Responder Project and, pending the outcome and recommendations of that evaluation, consider both the expansion of the initiative across the Territory and the inclusion of local Aboriginal staff as part of this team. More generally, it is the OCC's position that the NTG, NT Police and the

Department of Health review current practices and consider increasing the involvement of health professionals and Aboriginal staff in all police settings.

Independent review mechanisms

Government inquiries and Royal Commission recommendations (including the Royal Commission into Deaths in Custody) highlight the need for accountability in custodial settings, including robust complaint mechanisms wholly independent of police services.[138] It is the OCC's position that not only should strong internal police policies exist in relation to independent review mechanisms (e.g. identification and referral of incidents), these policies must be strongly adhered to with a commitment to continual quality practice improvement. Where incidents have led to use of force, external independent review is necessary to ensure meaningful action and learning is undertaken to avoid repeated incidences of any conduct deemed inappropriate or unnecessary.

International Examples

Characteristics and lived experience of Australian children with justice involvement align with their international counterparts.[139] Evidence-based practices in the USA, UK, Canada and NZ emphasise the same concerns about vulnerable children who have justice and child protection involvement, limited early intervention or support, increased risk of targeted discrimination due to their age and race, and poorer life outcomes.

New Zealand – Police Youth Aid

In 1989, New Zealand passed the *Children's and Young People's Well-being Act 1989* (NZ), also known as the *Oranga Tamariki Act*.[140] This represented a fundamental shift in youth justice, from a retributive to a restorative approach.[141]

Among various reforms, the Oranga Tamariki Act creates limitations on arrests and charging for children and directs police away from instituting formal proceedings where allegations are made.[142] Children are instead referred to the highly trained and specialised Police Youth Aid division who are focused on "alternative action". This takes the form of a warning or, where police determine that a warning is an insufficient response, Youth Aid officers create an "Alternative Action Plan" with the offender. [143] If the agreed-upon alternative action is

completed, the police will not lay charges. Alternative Action Plans include activities focused on restorative justice, such as victim-offender conferences, return of stolen property, payment for damage, community service work, counselling, writing an apology letter, attending school every day, or doing an assignment on the effects of their actions. If the child does not complete the diversion plan, then the Youth Aid offers may send the case to Youth Court.

Youth Aid officers are considered to be more senior within the New Zealand police force structure and receive a higher pay scale.[144] They undertake a 2-3 year course with significant focus on trauma and cognitive and intellectual disability, after which they receive a Diploma in Youth Services. Youth Aid officers have national standards, training and a handbook to develop consistency.

These reforms, among others, have significantly decreased the amount of children going through New Zealand's youth justice system. The number of children charged in Youth Court decreased from approximately 6,000 in 1989 to 1,884 in 2017.[145] Importantly, this is coupled with a decrease in police apprehensions and custodial sentences. Between 1996 and 2008, the child (10-14 years) apprehension rate decreased by 38% and the young person (14-17 years) rate fell by approximately 20%.[146] This has trend continued, with a decrease of 40% of apprehensions of 10-16 years between 2011 and 2016.[147] In 1989, 300 young people were given custodial sentences; in 2013 it was approximately 30, which was less than 0.5% of young people appearing in Youth Court.[148]

The NT Royal Commission recommended the NTG establish a specialist, highly trained Youth Division similar to the New Zealand Youth Aid team.[149] In response, the NTG and NT Police have established the Youth Diversion team within NT Police. While its aims are similar and it is a positive step towards a restorative justice approach, the level of resourcing – in particular the adequate resourcing of specialist qualifications and increased remuneration for police officers involved – does not match New Zealand's Police Youth Aid model. Furthermore, there has not been comprehensive, ongoing monitoring and evaluation of the effectiveness of the current NT diversion system.

It is the position of the OCC that the NTG fully implement all aspects of Recommendation 25.1 of the NT Royal Commission. Such resourcing must include increased involvement of

Aboriginal Community Police Officers and the broader Aboriginal community and be part of a broader restorative youth justice system that includes diversion and support services provided by Aboriginal Community Controlled Organisations. This approach has shown to decrease the overall amount of apprehensions of children as well increase the capacity of police officers to identify and understand children with complex needs. It is the OCC's position that these reforms would put in place systems and provide police officers with the skills which would decrease the situations where police feel they need to put a child in a restraint chair or spit hood.

De-Escalation Techniques

Evidence based monitoring and evaluation of de-escalation techniques demonstrate how police can successfully use tactics to minimise the need for physical confrontation. For example, in 2010 the Dallas Police Department changed its training practices to focus on de-escalation and community policing. Within 3 years, arrests were down by 17% and within 5 years excessive force complaints were down by 63% (from 147 to 53). This was accompanied by a decline in the city's murder rate, reaching its lowest point in 80 years in 2015.[150]

Mental Health Responses

The Crisis Intervention Team (**CIT**) model was developed by the Memphis Police Department in the late 1980s with the core aim of reducing fatal police shootings involving people with mental illness.[151] The Memphis CIT model has three components: a) intensive (40 hours) specialised training in responding to mental health crisis incidents for police officers applying to be part of the CIT; b) training for dispatch officers to recognise community reports with a high probability of a person with mental health issues being involved; and c) a centralized drop-off mental health facility with an automatic acceptance policy to minimise police officer transfer time.

The effectiveness of CIT in its fundamental goal of reducing fatal police shootings has proven difficult to measure. This is due to various issues, including varied applications of the model across a highly diverse US police jurisdiction landscape.[152] However, evidence from evaluations have found:[153]

- Improvement in attitudes and reduction of stigma in police officers who receive mental health training
- Referral to mental health units more likely and arrests less likely
- Benefits in officer-level outcomes (such as officer satisfaction)
- Increased self-perception of a reduction in use of force

In a separate model focusing on mental health, the Birmingham Police Department's (US) model builds on the Memphis model by employing "community service officers" (CSOs) who have professional training or qualifications in social work or related fields and are used to de-escalate situations involving complex mental health crisis.[154] CSOs also assist in other appropriate callouts such as family violence, transportation or shelter needs. In addition to the support of trained CSOs, regular police officers receive training by mental health professionals through a multi-agency training initiative, including restraint of people.

Community Engagement

In 2013, the New Zealand Government commenced its ten year Youth Crime Action Plan (**YCAP**), in which government partnered with communities to successfully reduce youth offending.[155] This Plan acknowledged that while the volumes of youth crime had reduced as a result of existing reforms (such as the Youth Aid program noted above) the disparities in youth justice outcomes for Māori children had increased, with apprehension rates for Māori children five times higher than non-Māori. As a result, a key part of the YCAP is aimed at improving the outcomes for Māori children by working with Māori communities and frontline services, including police, across 20 communities in New Zealand to develop their local solutions to youth offending. The YCAP acknowledges that local communities and professionals are often best placed to respond to offending that help children develop in positive ways government should see ways to allow for flexible local solutions to address youth crime.[156] While a publicly available review of this plan is not available, as part of its broader youth justice reforms New Zealand has seen a long term decline in charges finalised against children in court, with a peak of 5,000 in 2007 continuously declining to 1,500 in the year to June 2022.[157]

An evaluation of community oriented policing models in the UK found that while the reduction in overall crimes rates was limited, there was:[158]

- improved police/community relationships;
- improved police legitimacy and perceptions of satisfaction;
- a reduction of citizen's perceptions of social and physical disorder in their neighbourhood; and
- statistically positive effects on crime and anti-social behaviour, with reductions in 5 out of 8 categories.

It was noted that it is difficult to conduct a general analysis of community policing as programs are often quite different and operate in different contexts and demographic environments. It also noted that poor or inconsistent results in evaluations of this type of policing have been attributed by some to implementation failure[159]. In the Northern Territory context, implementation of any community approaches can be strengthened through a commitment to community control and self-determination as set out under National Closing the Gap Priority Reforms.

While there are often difficulties comparing models across different jurisdictions, the examples above show how other communities are using health, de-escalation and community engagement focused responses to interactions between police and complex individuals in high stress situations. Using a spit hood or a restraint chair as a method of 'safe restraint' in a pre-emptive manner undermines principles of de-escalation or preserving health.[160] A further breakdown of national and international practices regarding spit hoods, restraint use and de-escalation techniques is set out in Annexure A.

Conclusion

Spit hoods and restraint chairs are archaic and the case for their use on children is unjustifiable, especially where such devices are used on children who are likely to be victims of trauma, have significant health or disability impairments, or both.

This circumstance is clearly the case in the Northern Territory, where research shows a strong link between chronic child maltreatment, child protection notifications and subsequent youth offending in the Northern Territory.[161] These findings and recommendations are based on similar cohort studies where the presence of neurodevelopmental impairments in justice involved children in the NT is expected to be extremely high.[162]

Circumstances that exacerbate feelings of fear, distress, helplessness, shame, panic and anger in children at any point along the justice continuum – such as use of a spit hood or restraint chair - are likely to contribute adversely to their life outcomes. Understanding behaviours through a lens that is cognisant of the role and impacts of possible trauma, poverty, disability and other contributors to justice involvement is a key component to effective and safe youth justice service provision.

The cohort in discussion are primarily Aboriginal children. Aboriginal children, their families and communities are impacted by centuries of colonisation, dispossession, structural violence and trauma that have disrupted existing systems of care based on culture, kinship, country and language. It is critical that any alternative measures (such as de-escalation training, mental health responses or community policing) to improve police and youth justice responses are culturally responsive, and led and informed by the Aboriginal community. This includes children involved in the system, family, Elders and Aboriginal community controlled organisations. People from the same communities as children in the justice system are best placed to understand and engage with those children, as they are able to draw on similar lived experience and cultural authority. They are also the best placed to recognise and celebrate the many strengths and abilities of these young people, which is often overlooked when implementing policies to support and empower vulnerable cohorts.

The purpose of the justice system is to facilitate a safer society. The harm to vulnerable children through the use of spit hoods and restraint chairs does the opposite. It impairs a

child's healthy development, which includes their ability to work their way out of the justice system.

Police officers also have the right to be safe in their workplace. The overwhelming medical evidence shows that spit hoods are not effective at preventing communicable disease transmission. More importantly, initiatives employing de-escalation tactics and health focused responses have shown to be safer for both individuals in contact with police and officers. Community safety, including the safety of police and children, increases when fewer children are exposed to traumatising experiences.

Ultimately, these restraints are ineffective and inhumane. A better system for all, including the broader community, must be based on the best available evidence. Spit hoods do not meet the asserted needs of police or increase the safety of community; our children deserve better.

ANNEXURE A

Australian practises

New South Wales

Spit hoods and restraint chairs are not used on children in New South Wales. New South Wales police complete training on:

- Identifying behaviours that indicate mental illness
- Communication strategies
- Risk assessment
- De-escalation and crisis intervention techniques when communicating with vulnerable people[163]

Victoria

Spit hoods and restraint chairs are not used on children in Victoria. Alternative practices employed by Victoria police include:

- Personal provisional protection equipment
- In emergencies, police officers wear a helmet with a clear visor
- Extensive training to provide them with the capability to manage such situations

Tasmania

Spit hoods and restraint chairs are not used on children in Tasmania. Tasmanian police use alternative mechanisms such as:

- physical distancing,
- minimising face-to-face contact by placing in secure area,
- using divisional vans for transport,
- provisional protection equipment such as eye wear, face shields, masks and gloves.[164]

- If a person is at risk of self-harm, protocol requires monitoring of the individual every 15 minutes and removing items that could cause harm.

South Australia

South Australia is the first jurisdiction in Australia to legally ban use of spit hoods by police or in youth justice centres. In passing this legislation, South Australia agreed that putting a spit hood over a head of a detained person, or asking them to do it themselves, amounts to torture. The South Australian Ombudsman concluded the use of spit hoods and mechanical restraints breach international treaty obligations to which Australia is a signatory, including OPCAT.[165]

Use of spit hoods in Norway

The Norwegian Parliamentary Ombudsman is the body tasked with overseeing Norway's implementation of the Convention against Torture. In its 2019 annual report it found:

- On the use of spit hoods:
    - the risk of asphyxiation they pose, noting cases in other countries where people have died while wearing spit hoods, and where disproportionate use of spit hoods appears to have contributed to or caused the death;[166]
    - the risk of high levels of fear, stress, loss of control and choking sensation, particularly for people with serious mental health issues and noting the high proportion of inmates in Norwegian prisons with such issues;[167] and
    - in response to a suggestion from government that a spit hood could be used to allow an inmate to socialize with others as an alternative to solitary confinement for spitting, the Ombudsman found that 'it is unlikely that more meaningful human contact can take place if inmates are wearing a spit hood in addition to mechanical restraints such as handcuffs or body cuffs …this can have a humiliating and dehumanising effect… and constitutes a clear risk of inhuman and degrading treatment.'[168]
- International law is moving towards a more critical stance on the use of restraints, in particular against people with mental health issues. The UN Special Rapporteur on

Torture has recommended that the Member States discontinue the use of restraints entirely for people in that situation. The same applies to the UN Convention on the Rights of Persons with Disabilities.[169]

- The European Court of Human Rights appears to be applying a stricter review of cases concerning the use of restraints.[170]
- The health risks posed by being placed in restraints means that a qualified and accessible health service with solid procedures for follow-up during and after the use of restraints is essential.[171]
- The use of restraints involves a risk of both somatic injuries, including fatal injuries, as well as a risk of trauma and serious psychological distress.[172]

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