Handle with Care

Office of the Child and Youth Advocate
Newfoundland and Labrador

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Message from the Child and Youth Advocate

When children grow up in violent homes, they experience trauma. Their homes lack safety and security. Their family is not a place of refuge or sanctuary. Their world is an unsafe and unpredictable place. Right and wrong is turned upside down. The impact of such trauma can be expected to be seen behaviourally and emotionally in these children, and it undermines their mental well-being.

For these children, it is important that responses are trauma-informed and child-centered. It is vitally important for children to feel safe and to receive compassionate responses. Every contact and intervention provides an opportunity for building trust. Children's behavior must be understood to be a form of communication and to have meaning.

This investigation looked at a case involving a seven year old child who experienced a mental health or behavioural episode while residing with her mother at a shelter for victims of family violence. Paramedics, uniformed police, and then the mobile crisis response team responded in that order. The end result saw the child handcuffed, in the absence of the mental health clinician. Our communities may have many pressing needs for police enforcement services. However a misbehaving or mentally unwell young child should not be one of them.

Mobile crisis response teams involving police and mental health clinicians are expanding in Newfoundland and Labrador. Overall, this approach is welcome and recognizes that people in such crisis are experiencing primarily a health issue, not a criminal justice issue. The timing is opportune to incorporate the recommendations from this investigation into new and existing teams in order to strengthen evolving mental health services and responses.

When a child has experienced trauma, everyone in the child's life has a role to play and can be part of the child's path to healing. There are clear and compelling lessons in this investigation for law enforcement and health care to do better for traumatized children. This is both achievable and necessary. Young children need help, not handcuffs.

Finally, but importantly, this report has not identified this child or family. I ask that all readers respect this child's privacy and that of the family.

Jacqueline Lake Kavanagh
Child and Youth Advocate

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"… often people who are said to have a history of mental health issues, and whose behavior is such that people in the vicinity feel concerned for their safety or for the safety of the individual. These had, in the past, been sent through 911 to local law enforcement…But over the years you have seen very high profile cases that have not gone the way everyone wanted and we know that was, just in a sense, the tip of the iceberg. People in a mental health crisis do not need to be hand-cuffed and jailed, they need to be treated. And this is where the mental health counsellor or social worker with the skills in de-escalation and the deep understanding of mental health issues can then provide that."

Hon. John Haggie
Minister of Health and Community Services
Government of Newfoundland and Labrador

Introduction

The Office of the Child and Youth Advocate

Newfoundland and Labrador's Child and Youth Advocate is an independent Statutory Officer of the House of Assembly. She derives authority from the **Child and Youth Advocate Act**. The role of the Advocate is to protect and represent the rights, interests, and viewpoints of children and youth in Newfoundland and Labrador. This is accomplished through individual advocacy, investigations and reviews, systemic advocacy, and children's rights education.

United Nations Convention on the Rights of the Child

The Office of the Child and Youth Advocate operates from a children's rights framework. Children's universal human rights are articulated in the **United Nations Convention on the Rights of the Child**. Canada ratified this Convention in 1991 with written endorsement and support from all provinces and territories. The Convention is the most universally accepted human rights framework in the world today. It speaks to the social, cultural, economic, civil, and political rights of children. Children's rights are real and meaningful. When these rights are protected and respected, they help children live better lives and have improved opportunities.

Within the context of this investigation, several **United Nations Convention on the Rights of the Child** articles were identified for concern. Article 3 requires decisions to be made in the best interests of the child and with consideration for how decisions will impact the child. Article 24 references children's right to quality health care services and this includes mental health services. Appropriate and responsive criminal justice and legal services are identified in Article 40. Articles 19 and 39 speak to the importance of a child's right to help and protection if hurt or mistreated.

Investigative Reviews

Section 15(1)(a) of the **Child and Youth Advocate Act** provides the Advocate with authority to receive, review, and investigate a matter relating to a child or youth or a group of them, whether or not a request or complaint is made to the Advocate. The Advocate may release a public report upon completion of an investigation. The purpose of the report is to present findings regarding the services provided to young people and to make recommendations that will help prevent similar incidents from occurring in the future.

The investigative report does not assign legal responsibilities or draw legal conclusions, nor does it replace other processes that may occur, such as investigations or prosecutions under the **Criminal Code** of Canada. It is intended to identify and advocate for systemic improvements and meaningful changes that will result in better responses, and enhance the overall safety and well-being of young people who are receiving designated services. It is not about finding fault with specific individuals.

About this Investigation

The Office of the Child and Youth Advocate received a complaint that a seven year old child had been handcuffed by the police after she experienced a behavioral or mental health episode. The child had been residing with her mother at a crisis shelter for family violence victims. The Advocate called this investigation surrounding the events and response after receiving the Royal Newfoundland Constabulary's official position that the action of handcuffing the child was justified. The investigation involved sworn witness interviews, a review of case file documents, an examination of relevant policy and legislation, research on trauma in children, mental health crisis intervention services to children, and police use of force.

It is important to note that the purpose of this investigation was not to assign blame to the individual first responders. They acted pursuant to their training. Rather, the focus of this investigation is on the systemic issue of training in the context of mental health and trauma response to children. This is a systemic gap that needs to be addressed to respect the rights of all children, in particular those with mental health issues.

Trauma in Children

When children grow up in violent homes, they experience trauma. Their homes lack safety and security. Their family is not a place of refuge or sanctuary. Trusting relationships have been breached. Their world is fundamentally an unsafe and unpredictable place. All of this runs counter to what a child needs in order to grow and develop and to begin to find their place in a world of potential and opportunity. Instead they live in fear and survival mode. This is the lens through which they see the world.

There is a vast body of research about the impacts of trauma on children. While each child experiences an individual response, there are widely recognized impacts of trauma on children. It is important to recognize the signs of trauma, incorporate knowledge about trauma into responses and guiding policies, and mandate appropriate training to those who respond to traumatized children. These impacts must be often understood as normal responses to abnormal events. It is critically important not to re-traumatize a child in any efforts to help.

The American Psychological Association (2008) identifies trauma impacts in children as including development of new fears, anger, irritability, sadness, depression, separation anxiety, and somatic complaints. Other expected signs include hypervigilance, challenging authority, and hyper-activity (Georgetown University, 2017; IACP, 2017). There is often a hyper-responsiveness to frightening situations and difficulty assessing threat (Dudley, 2015). The National Child Traumatic Stress Network (n.d.) explains "Children who have experienced complex trauma often have difficulty identifying, expressing, and managing emotions, and may have limited language for feeling states". A child in crisis cannot always communicate their thoughts, feelings or emotions clearly or understand what others are saying to them during the crisis event (NAMI, n.d.). Furthermore, the National Child Traumatic Stress Network (n.d.)

discusses how traumatized children may lack impulse control, become oppositional, react unpredictably and then become overwhelmed and have difficulty calming themselves. Dudley (2015) reinforces that children who have experienced trauma have difficulty calming down once hyper-reactivity has been triggered.

The evolving field of brain research on traumatized children helps in understanding these impacts. Exposure to trauma has been shown to alter changes in the interrelated brain circuits and hormonal systems that regulate stress. The brain structures responsible for regulating intense emotions are deactivated (Dye, 2018). The “fight or flight response” can become a constant with these children, and issue warnings and alerts even when none are present (Dudley, 2015). Toxic stress associated with a child’s trauma is real and has real impacts on a child’s developing brain, and in how they perceive information in their environment and react to it.

Once again, it is important to understand that behaviours can be normal responses to abnormal events in a child’s life. Some experts have stated that extreme behaviors and distress can be viewed as coping adaptations to past or current traumas rather than symptoms of a mental health disorder. Some responses to people in extreme distress can be unhelpful and (re)traumatizing. Re-traumatization occurs when a current situation provides powerful reminders of past trauma, such as the inability to stop or escape a perceived or actual personal threat. One noted form of re-traumatization is restraint (Sweeney, 2018).

Children who are exposed to family violence are at increased risk of school absenteeism, physical and mental health problems, suicide attempts, emotional distress, criminal behavior, substance abuse, and intergenerational violence (Webb, 2016). This demonstrates the wide-reaching and potential long-term and serious impacts on these children.

Case Summary

The Office of the Child and Youth Advocate received a complaint that a seven year old child had been handcuffed by the police after she experienced a behavioral or mental health episode. The child had been residing with her mother at a crisis shelter for family violence victims. The Advocate called this investigation into the events and response after receiving the police force’s official position that the action of handcuffing the child was justified.

On the day of the incident the young child was experiencing a mental health crisis or behavioral episode and was displaying aggressive behaviors toward her mother and staff at the shelter. Staff described the child as “angry, upset, agitated and unresponsive”. The child was confined to the shelter’s main office, a large space with doors closed and staff blocking the exit. The child became frantic and began pacing back and forth the office. The mother and the shelter staff members agreed that the child needed a hospital assessment, especially in light of the child’s recent hospitalization for mental health issues. Fearing for the child’s safety in a personal vehicle, staff members called an ambulance for hospital transport.

Before paramedics arrived, the child's behavior was described as having escalated. The paramedics called for police assistance to transport the child to hospital. First responders acknowledged that there had been previous calls for service related to this child who had presented with complex and aggressive behaviors. Records indicated the paramedics called the dispatch center a second time and reported that things were getting worse and they needed police immediately.

A uniformed officer arrived and spoke to the mother and staff. The officer subsequently requested the assistance of the mobile crisis response team after hearing the mother's account of her child's history and possible diagnosis.

Shortly after the mobile crisis response team arrived and assessed the situation, the mental health clinician left the room to make a telephone call to obtain the child's medical record. The child threw a small object which struck the officer. The response team officer engaged the uniformed officer and they placed the child in handcuffs for the stated purpose of the protection of persons in the room and for the protection of the shelter property. The child was described as compliant when being handcuffed. The child then sat next to her mother until transported to hospital. The child remained in the handcuffs for a period of time before being placed into the waiting ambulance. The handcuffs were removed and the child was transported to the hospital accompanied by the uniformed police officer at the request of the paramedics. Shelter staff notified the Department of Children, Seniors and Social Development.

Mobile Crisis Response Teams

Mobile mental health crisis response teams offer a specialized response involving mental health and law enforcement professionals. This specialized response recognizes that historically police services often responded to calls for service that were not fundamentally about criminal behavior but rather a person's mental health. With this understanding, these teams offer a response that is primarily oriented towards the person's mental health needs. The focus is on de-escalating the crisis, and engaging the appropriate health services. A traditional law enforcement presence and approach can escalate the situation depending on the person's condition, and leave the person who is experiencing a mental health episode feeling like a criminal and in a heightened state of response and distress. The traditional approach is what happened in this case and is contrary to the focus and approach of the specialized mental health response.

In 2018, the Newfoundland and Labrador Provincial Government, including its Regional Health Authorities and the Royal Newfoundland Constabulary, introduced new crisis intervention teams in St. John's, Labrador West, and Corner Brook. These teams included both a mental health worker (registered nurse or social worker) and a plainclothes police officer working together in the community (Executive Council, 2018). In late 2020, government announced that mobile crisis response teams would be expanded to Gander, Grand Falls-Windsor, and Happy Valley-Goose Bay, in partnership with the Royal Canadian Mounted Police.

The mental health clinician communicates with the person in crisis to de-escalate the situation, offer supportive counselling, help navigate the mental health system, and determine whether the person meets the criteria for detention under the **Mental Health Care and Treatment Act**. The police officer's role is also to de-escalate, and has been described as primarily ensuring the safety and protection of the clinician. The officer can access the police database to determine if the person has a history of violence, and can detain a person when necessary. Police training is described as providing specialized training in crisis intervention and better enabling officers to respond to help de-escalate a mental health crisis (CBC News, 2019). Team officers also receive training in topics such as recognizing mental health diagnoses, psychiatric medications, drug abuse and dependence, and mental health law. One of the core elements of the model is collaboration with community partners, including mental health providers. This collaboration involves the joint crisis intervention of police officers, and mental health responders (clinicians) (RNC, n.d.). Clinicians on the response team are hired based on previous mental health experience and seniority in their respective fields. Clinicians must have Applied Suicide Intervention Skills Training (ASIST) prior to commencement with the response team. Neither the clinician nor police officer in this case had received training in de-escalation techniques or trauma-informed responses with a focus on children.

The rationale for these teams was captured well by Dr. John Haggie, Newfoundland and Labrador's Minister of Health and Community Services when the recent expansion was announced. He stated that calls to the Newfoundland and Labrador crisis intervention teams are:

> "… often people who are said to have a history of mental health issues, and whose behavior is such that people in the vicinity feel concerned for their safety or for the safety of the individual. These had, in the past, been sent through 911 to local law enforcement…But over the years you have seen very high profile cases that have not gone the way everyone wanted and we know that was, just in a sense, the tip of the iceberg. People in a mental health crisis do not need to be hand-cuffed and jailed, they need to be treated. And this is where the mental health counsellor or social worker with the skills in de-escalation and the deep understanding of mental health issues can then provide that." (Hillier, 2020)

Findings

The findings in this investigation point to a joint law enforcement and health care response that was neither proportional nor responsive to the particular needs and rights of this young child. Specifically, a seven year old child victim of violence who was experiencing a mental health or behavioural episode was handcuffed in the context of a mental health response, and accompanied to the hospital by an armed uniformed officer.

In the course of the response, there were shelter staff, the child's mother, paramedics, a uniformed police officer, and the mental health crisis team responders (clinician and plainclothes officer) present. This was likely overwhelming for a child in crisis and distress. This response was not conducive to creating calm and effective connection with a distressed young child in a way that is appropriate for her age, developmental level, and trauma history. There was a lack of understanding about the impact of trauma in a young child's life and in the potential associated manifestations. For example, an appreciation of hyper-reactivity to perceived threats, fear, anger, behavioral extremes, wariness of physical contact with adults, separation anxiety, and regressive behaviors would have pointed to a different response. Furthermore, understanding the importance of not re-traumatizing the child would have informed an alternate intervention.

The information and policies reviewed in this investigation do not provide evidence of a capacity for specialized mental health crisis team responses for children. While the mobile crisis response team can respond to calls for mental health crisis intervention for people of all ages including children and youth, the reality was described as infrequently involving calls for children. Without training specific to children, clinicians and officers must rely on their adult-based training techniques to respond to a child experiencing a mental health crisis. This is neither effective nor appropriate and was not in the best interest of the child. Services to children, and especially traumatized children, must be specifically responsive to their age, cognitive, social and emotional development, and be informed by best practices in child development and child rights. A young child who is acting out or who is experiencing a mental health episode requires a helpful response. It should not involve handcuffing the child.

United Nations Resolution 69/194 speaks to the importance of appropriate criminal justice responses to children. In this Resolution, Member States are urged to design and implement training programs for criminal justice professionals on the rights of the child, in particular on the Convention on the Rights of the Child and international human rights laws, and to provide information on appropriate ways to deal with all children, in particular those who might be subject to discrimination. Member states are also urged to educate criminal justice professionals about the stages of child development, the process of cognitive development, and the dynamics and nature of violence against children (UNGA, 2015).

Recommendations

There are readily available lessons resulting from this investigation and they help provide guidance in how to better respond to vulnerable children with a history of trauma. These insights inform the following recommendations:

Recommendation 1:

Regional Health Authorities, Royal Newfoundland Constabulary, and Royal Canadian Mounted Police collectively review and revise the training program for Mobile Crisis Response Teams to include the following criteria:

a. **Trauma-informed approach for children and youth;**
b. **Strategies and interventions reflective of best practices for intervening with children and youth in crisis;**
c. **Professional development for team members about the cognitive, emotional and social development of children and youth; and,**
d. **Guidance and education on children's rights.**

Recommendation 2:

The Department of Justice and Public Safety and the Department of Health and Community Services engage Regional Health Authorities and both provincial police forces to determine scope and intent of Mental Health Crisis Response Teams in responding to young children, and to determine if alternate responses and resources are necessary.

Conclusion

Many young people in the child welfare, justice, and health care systems have histories of violence and trauma. It is vital to understand this and to recognize the various signs and widespread impacts. Compassionate and trauma-informed responses can be part of these vulnerable children's path to recovery and future well-being. All adults who respond to children and youth have a role to play here, regardless of their point of intervention and level of contact. First responders have a very important role to play in enhancing a child's safety and sense of control in a crisis situation, and to support coping and resilience. Every effort must be made to avoid re-traumatizing the child. This is where trust in the system's helping responses can begin for a young child. It can be a pivotal contact for a young person and can be life-altering. Trauma-informed responses to a child experiencing a crisis must include a shift in thinking from "what is wrong with this person" to "what happened to this person" (BCCEWH, 2013).

First response organizations are responsible for ensuring their members are well-positioned to competently meet a variety of complex and challenging situations in the community. This points to the significance of sound policy, effective training plans, and solid guidance, direction and supervision in the context of responses to vulnerable children.

The recommendations in this report identify changes that will guide improvements and enable first responders to better respond to children and youth, particularly those with a history of trauma. They should be considered minimum requirements. Children can survive trauma, and future well-being is possible. This requires understanding, compassion, and trauma-appropriate responses from the adults in children's lives. It requires all who intervene to handle with care.

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Appendix II: Investigative Process

Documents Reviewed

Department of Justice and Public Safety
Police records
Police policies
Police training materials

Department of Health and Community Services
Regional Health Authority policies
Regional Health Authority records/files

Investigative Interviews

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