Title: A qualitative analysis of physicians’ perspectives on university student mental health transfers in Ontario, Canada

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Conflict of Interest Disclosures: None reported.

Funding/ Support: CAMH Foundation

Role of the Funder/ Sponsor: An unrestricted grant awarded to Dr. Zaheer supported the cost of interview transcription.

Author Statements:
AC is a family physician in Guelph, Ontario. Between 2012 and 2020, the bulk of her clinical work focussed on the provision of primary health care to university students.

GN is an undergraduate student and research assistant in Toronto, Ontario. She has lived experience of mental illness and mental health transfers between community sites and hospitals.

SN is a disabled neurodivergent physician and scholar of Canadian literature. He works in a student health clinic where the bulk of his practise concerns the mental health of adolescents and young adults.

JZ is an emergency department psychiatrist and researcher, with qualitative research expertise. She often works with patients who have been sent to hospital from university health clinics on a Form 1.
Abstract

Background
When a student presenting at a university health clinic is assessed to pose a risk of harm to self or others, Ontario’s Mental Health Act can be invoked. A Form 1 can be completed, mandating emergency psychiatric assessment in hospital. Qualitative interviews with clinic physicians were undertaken and analyzed to understand the variability in mental health transfer processes. In particular, researchers were interested in police-involved transfers, the use of physical restraints, understanding physician concerns about policies, and conceptualizing policy and process evolution, including barriers and facilitators to change.

Methods
Eleven physicians from 9 university health clinics in Ontario, Canada participated in semi-structured in-depth qualitative interviews between July 2018 and January 2019. Thematic analysis of interview transcripts was supported by NVivo 12. Ten physicians completed short questionnaires. Policy documents were obtained from 5 clinics.

Results
Mental health transfer processes are not uniform. Some university clinics use strategies to minimize police involvement in mental health transfers, with restraints used rarely. Some university clinics involve police for all transfers. Three major themes were identified through interview analysis: 1) police involvement and restraint use can cause harm; 2) restraints should be utilized in rare circumstances, where potential benefits are assessed to outweigh known and potential harms; and 3) transfer policies are often informed by pragmatic, non-clinical factors.

Interpretation
While respondents agree that involvement of police and restraint use are rarely warranted, mental health transfer processes vary significantly. Alternatives exist, and there are opportunities to move towards standardizing less invasive and traumatizing transfer practices.
Introduction

Canadian university students are increasingly experiencing mental health crises, and often seek care at institutionally-operated student health clinics (1–5). When assessed to pose an imminent risk to self or others, legislative tools like Ontario’s Mental Health Act (MHA) (6) give physicians the authority to mandate emergent psychiatric assessment. In Ontario, students can be placed on a “Form 1” and transferred to a Schedule 1 hospital. Processes for such transfers are an under-researched topic, part of a larger gap in research surrounding the conveyance of people experiencing mental health crises to hospital from community-based points of care (7–11). There is significant heterogeneity in transfer processes when students presenting at university health clinics in Ontario, Canada are placed on a Form 1. In particular, the involvement of police and use of physical restraints for transfers vary between institutions (3,11).

The role of police and indications for the use of physical restraints are important questions confronting health professionals (3). Police involvement and use of restraints are argued for on the basis that they provide a type of safety to patients themselves, to health professionals, and to the individuals transporting patients to hospital (12). Opponents of routine police involvement and restraint use contend that such practices are traumatizing, stigmatizing, and perpetuate the criminalization of people with mental illness (10,11,13–17). Given historical and ongoing police violence against systemically marginalized groups, particularly racialized groups, the actual and potential harms of engaging police in the provision of mental health care must be acknowledged (18–20).

Our team of researchers is comprised of two physicians who have worked at university health clinics, an emergency room psychiatrist and researcher, and an undergraduate university student. We conducted semi-structured qualitative interviews with 11 physicians from 9 university health clinics in Ontario, Canada, and completed a thematic qualitative analysis (21) of interview transcripts. Responses to a questionnaire exploring participants’ beliefs about mental health transfer processes, and available institutional policy documents were additionally reviewed. We sought to better understand: variability in mental health transfer processes, particularly with regards to involvement of police and use of physical restraints; clinicians’ experiences engaging with these processes; and clinicians’ concerns about policies and processes. We hoped to learn of the existence of dignified and humane transfer processes in order to identify a path towards less traumatizing mental health transfer processes province-wide.

The study design was approved by the Hamilton Integrated Research Ethics Board (HiREB).

Methods

Study Design
To understand the variability in transfer processes, and physicians’ experiences with Form 1 student transfers, semi-structured qualitative interviews were conducted with practicing physicians working at Student Health Clinics across Ontario. Interview transcripts were subsequently analyzed. Our interview analysis was situated within an interpretivist paradigm. A relativist ontology, which holds that reality is socially, intersubjectively and experientially created, was applied (22). This ontology informs the subjectivist epistemology which holds that
we cannot separate ourselves from what we know (22). In this paradigm, investigator and
participant are connected: each individual’s understanding of the world is central to their
understanding of themselves and others, and influences, in turn, their understanding of the world
(22). As the inquiry proceeds, through dialogue, investigators and participants co-create findings
and knowledge. We have adopted the social interactionist orientation, exploring collective
behaviours, beliefs, and experiences to understand how social interactions and behaviours evolve
policies and processes (23). The Standards for Reporting Qualitative Research reporting
guidelines have been utilized (24).

**Study Sampling**

Seventeen Ontario university clinic facilities were identified as recruitment sites. We sought to
complete semi-structured, one-on-one, telephone or in-person interviews with an English-
speaking primary care physician or psychiatrist working in each of these clinics. A preliminary
target of 20 respondents was established. Non-physicians were excluded, as these individuals do
not have the authority to invoke the *Mental Health Act* (6).

Our professional networks were utilized to distribute recruitment materials electronically, via
personal emails and the Ontario University and College Health Association (OUCHA) Listserv. AC
contacted clinics directly by phone and email per a formalized protocol to request the contact
information of physicians identified as Medical Lead. Recruitment materials were additionally
posted to social media. Snowball sampling was employed. AC was able to obtain contact
information for 28 physicians working at 16 of 17 eligible clinics. Eleven interviews were
conducted with physicians from 9 facilities. This represents 29.3% of physicians contacted, and
56.3% of facilities contacted.

AC contacted administrative personnel and requested policy documents from clinics not
represented by interview participants. Information was gathered about the practices of two
additional clinics. The policy summary includes 11 of 17 (64.7%) eligible university clinics.

Written and verbal informed consent was obtained from all participants. No incentives were
provided for study participation.

**Data Collection**

One-on-one telephone and in-person semi-structured interviews were conducted by AC
according to the study interview guide (Appendix). Interviews were digitally recorded and
transcribed verbatim by investigators or a professional transcription service. Person and place
identifiers were removed prior to analysis. Interviews were between 27 and 50 minutes long;
they were concluded when the question list was exhausted and no themes required further
development.

**Data Analysis**

Memos were written after interviews were completed by AC and after reviewing the transcripts
by GN, SN and JZ. Interview transcripts were thematically analyzed and coded manually from
both a procedural and substantive perspective using NVivo 12 by AC and JZ. Coding overlapped
with data collection, with analysis of interviews informing later interviews. Transcripts were read, coded, reread and re-coded as necessary. Following coding, the text subsumed under each code was reviewed, summarized, and an analytic memo written to capture code content. AC and JZ met periodically to ensure consistency in coding, and to collaborate on data analysis. Data saturation was defined as the point at which no new data was judged to support identified themes (18). Investigators met to explore themes and construct larger theories.

Results

Table 1 summarizes characteristics of the 11 physician respondents working at 9 university-affiliated medical clinics in Ontario, Canada. Table 2 summarizes the variability in transfer processes between the 11 clinics included. Police are involved in the majority of transfers from 7 of the 11 clinics, and in all mental health transfers from 5 of the 11 clinics. Alternatives include accompaniment by clinic staff or non-clinical support persons on foot or by vehicle, and transfer by ambulance.

Three major themes were identified: 1) police involvement is potentially harmful for students experiencing mental health crises; 2) restraints should be utilized in rare circumstances; and 3) transfer policies are often informed by non-clinical factors (speed of transfer, police policy, workflow issues).

I. Police and restraints cause harm to students experiencing mental health crisis

Each physician respondent identified harms of police involvement, expressing a common understanding that mode of transfer should be dictated by clinical factors, with restraints used rarely.

i. Police involvement is problematic generally

Police and the use of handcuffs were described as traumatic and criminalizing. “A lot of people have had some very negative interactions with the mental health care system and the justice system, that’s for sure”, one physician noted (Respondent C).

Negative associations with and consequence of police involvement are amplified when restraints are used. As one respondent highlighted:

“people already have enough trouble being in hospital, but to have to be taken in handcuffs, you know, out of the building and loaded up in a police cruiser and taken half a block, it seems brutal and traumatic for the patient, and sends all the wrong messages about a caring, supportive environment” (Respondent C).

ii. Interference with future treatment

Respondents shared concerns that police involvement and use of restraints could “have negative impacts on their help-seeking and everything else” (Respondent C). Engaging police could fracture the therapeutic relationship: “The idea that you’re breaking trust with a vulnerable person can have huge impacts on care down the road” (Respondent D).
Such feared outcomes are not merely hypothetical:

“...We have run into people who have either come back for another reason and are clearly unwell, or who have come back with significant reluctance saying, you know, ‘I am only here for X, Y, Z; I am not going to tell you all this because of what happened last time.’ [...] Having been placed on the Form 1 and transferred sometimes will, I think, prevent people from coming back” (Respondent D).

2. Justifying police involvement and restraint use: clinical considerations

Despite the attendant harms of police and restraints, respondents believed that there are circumstances when transfer by police and, in rare cases, use of restraints, are necessary. Notions of patient safety informed decision-making about mode-of-transfer:

“(We are) balancing the safety of the student with what’s going to be most comfortable for them and finding the right balance there. And I know it is potentially not a great experience to be escorted by police, but definitely when it’s really necessary for their safety, then it really does make sense” (Respondent G).

Clinical factors were also weighed, with risk of violence, probability of clinical deterioration, and potential of patient elopement highlighted by respondents. Regarding safety and risk of violence, a respondent told AC:

“...if we have any indication that someone may be violent toward other people or is actively psychotic...we engage the police at all times” (Respondent E).

For patients assessed to be at risk of fleeing during transfer, police were identified as the most suitable personnel to conduct transfers:

“Paramedics aren’t really trained to go after a patient and chase them down. Not that that is something that happens frequently, but it’s still something I think you have to be concerned about, is potential worst-case scenarios, and how that could turn out” (Respondent B).

3. Transfer policies are influenced by extra-medical factors

i. Rationale for police

Form 1 transfer policies and processes vary and may constrain decision-making. At some university health clinics, formally codified or otherwise well-understood processes dictate that campus or municipal police be contacted for all transfers under the Mental Health Act. At other facilities, the province-wide emergency telephone number (9-1-1) is activated when a Form 1 is completed, with either police or emergency medical services (ambulance) responding to calls.
some settings, clinic staff, or support persons selected by the student may accompany students to hospital.

Clinic policies and practices can be dynamic. Two respondents had experienced shifts from flexible to more constrained practices. One respondent mused that: “I think that probably there are still staff who would feel like walking them over themselves would be more humane” (Respondent K).

Barriers to the adoption of flexible transfer practices were identified. In considering job descriptions and workplace protections, one respondent was concerned about: “union responsibilities and roles for the staff that were involved, that it was outside of their roles” (Respondent E). One physician worried about staff liability:

“I think the main risk is if the student decides to flee the situation and our staff wouldn’t really be able to make them go to emerg. And then…if something went wrong and the student ended up hurting themselves, how would that affect the staff that was unable to really do that job properly?” (Respondent G).

Workflow and wait time considerations were cited as reasons for discontinuing staff involvement in student transfers:

“In the past, we used to send a counsellor or a nurse with them in a taxi, and we found that to be too time-consuming because they might end up in the emergency room for five hours waiting to be seen. So, they changed that policy to us calling 9-1-1” (Respondent D).

Where physicians were able to exercise discretion about mode-of-transfer, workflow concerns and wait times were identified as reasons for involving police over transfer by mobile crisis units, ambulance, or accompanied by staff: “we’re quite busy in our clinic…so I guess one part of it is do we have staff that can leave, and usually they’ll wait with the students until the students get seen” (Respondent G).

One respondent posited that expeditious care might be beneficial for patients, even if it entailed police involvement: “the reason I think police [is] just because I think it’s faster and sometimes that’s important because it’s not a pleasant experience often for patients to be sent to a hospital on a Form 1” (Respondent I).

**ii. Extra-medical rationale for restraint use**

Four respondents at three universities shared their experiences with routine handcuffing for Form 1 patient transfers. Where constitutive handcuffing occurs, physicians understand this to be a consequence of police policies, “and the rationale was because of …safety” (Respondent F).
Another respondent expanded on their understanding of the justification for such policies, saying:

“Again, it was really just concerns from the police standpoint of their liability, and that was the main issue” (Respondent K).

Strict police policies and practices “cater to the highest potential risk” (Respondent D). Deviation from policies and practices by individual officers can create professional risk:

“the campus police say that they are following the guidelines of [municipality name] Police Service which says, use restraints every time. And my impression — this has not been said to me, but my impression is that they are always supposed to use restraints, but there are a few officers who go against, you know, the commanding officer’s request. They make a decision in the moment, and, you know, I am not sure that that would be supported by their organization” (Respondent D).

Discussion

Our exploration of physicians’ experiences with transfer processes at Ontario university clinics highlights existing variability, underscores the harms of police involvement and use of restraints, and clarifies factors influencing police involvement and handcuff use.

Respondents were generally not aware of the existence of formal institutional policies governing mental health transfers. In most settings, informal processes dictate how transfers occur. Police involvement, and use of handcuffs, while understood by physicians to be harmful, are normative in some clinics. At others, students are routinely transported to hospital by ambulance. At yet others, clinic staff generally convey students to hospital, with police involvement rare.

Respondents articulated the adverse effects of police involvement and of handcuff use, effects that have been substantiated by research and summarized in prior published work by members of our group (11). Police involvement and use of handcuffs criminalize and stigmatize individuals, and can serve to breach the therapeutic relationship, deterring people from engaging in future care.

Some physicians believed that police involvement and restraint use may be conditionally necessary to prevent or manage elopement, violence, or clinical deterioration. In reality, these risks may be magnified when police are engaged, particularly for patients with intersecting and systemically marginalized identities (18-20). Pragmatic concerns related to workflow and human resources capacity underpin the continued reliance on police. Notions of risk – inextricably linked to stigmatization of mental illness – and of liability are layered upon inflexible policies to make police and restraints normative in some settings.

Within contemporary care paradigms, individual health clinics can look to existing alternatives to improve their processes. Dignified and less-stigmatizing processes permit clinical factors to
inform decisions about mode-of-transfer. Most often, clinical staff accompany students requiring emergency mental health assessment to hospital. In rare instances, in the context of safety or elopement concerns, police are contacted. When police are involved, discretion is exercised about the need for restraint use. In some settings, mobile crisis teams exist, and a mental health worker and police officer are involved in transporting patients. Such teams vary, with some utilizing plain-clothed officers and unmarked vehicles, measures that may further de-stigmatize police involvement.

To avoid piecemeal policy implementation, and to develop and implement coherent and consistent best practices for mental health transfers province-wide, collaboration is necessary between municipal and provincial governments, university administration and university bodies, non-governmental organizations, hospitals and hospital associations, medical bodies, police departments and organizations, and emergency response units and organizations. People with lived experience must be meaningfully engaged. A fulsome understanding of risk/ liability must consider the harms of police involvement to people experiencing crisis.

We hope that our examination of this under-studied area of mental health care will inspire further inquiry. In particular, exploration of the intersection between mental health care provision and policing must explicitly examine the forms of power underpinning health care and policing, and which health care and policing, as social structures, work to uphold (18-20).

Limitations

We interviewed physicians at just over half (52.9%) of eligible university clinics. We obtained some information about transfer practices from administrative staff at 2 additional clinics. Inclusion of more respondents might have permitted a richer analysis of more varied experiences. It is possible that concerns about existing processes motivated some physicians to participate, and that some positive perspectives about mental health transfers have thus not been included. Physician perspectives may diverge in important ways from the perspectives of other clinical team members. The transfer experiences of students, who can best speak to the traumatic impact of different practices, remains unstudied. In designing our study, we failed to explicitly consider how intersecting contextual factors, like race and racism, influence individuals’ experiences of police and handcuffs. We acknowledge that this represents a substantial omission, and that it should be addressed in future work.
Table 1. Demographic Characteristics of 11 Participating Student Health Physicians

| Demographic       | No. (%) |
|-------------------|---------|
| Identified Female | 7 (63.6)|
| Identified Male   | 4 (36.4)|
| Speciality        |         |
| Family Practice   | 10 (90.9)|
| Psychiatry        | 1 (9.1) |
| Years in practice |         |
| 0-5               | 1       |
| 6-10              | 3       |
| 10+               | 7       |
| Years in student health |       |
| 0-5               | 3       |
| 6-10              | 2       |
| 11+               | 6       |
## Table 2. Description of Transfer Procedures

| Description of transfer process when F1 is issued | Police or Campus Police involved? | Handcuffs used? | Representative quotes |
|--------------------------------------------------|----------------------------------|----------------|-----------------------|
| Fixed processes – Emergency response is activated, with police transporting most students to hospital |                                   |                |                       |
| 1 Campus police (Special Constables of municipal police) are contacted to transport students. In rare cases, 9-1-1* is called and municipal police convey students. | Always                           | Formerly always; now discretionary use | “They don’t use any restraint procedures unless the situation indicates that, and it is done in as low-key and as kind of student-friendly and gentle a way as possible.” |
| 2 Campus Police (Special Constables of municipal police) are called to transport students. | Always                           | Almost always  | “but it has come to my attention over the last few years that they mostly, you know, nine times out of ten, will apply handcuffs to a patient, which can be a very traumatic experience.” |
| 3 Campus Police (Special Constables of municipal police) are called to transport students. | Always                           | Always         | “The policy at [university name] is that then they call Campus Police and then Campus Police comes to escort them. And every time that I’ve called, they have handcuffed the patient. And zero times did I think it was necessary um I asked them I remember having a conversation with them with the police officers to maybe consider not handcuffing, ‘cause the patient was totally willing to go, but that they said “no” in each circumstance” |
| 4 9-1-1* is called and police and/or paramedics convey students. | Almost always                    | Never          | “The nurse arranges (for) the police to come.” “That horrified me…Handcuffs? I hadn’t even thought of handcuffs” |
| 5 9-1-1* is called and a mobile crisis team (police and mental health worker) and/or paramedics responds to convey students. | Majority                         | Rarely         | “The time there was (handcuffs) it was…I think it was out of necessity like the person was verbally resistant before…police arrived but then when police arrived, they were a little more physically resistant so it was out of necessity they used restraints…but otherwise it’s never it’s never been discussed because I think it was just clear it wasn’t needed” |
| 6 9-1-1* is called and police or paramedics respond to convey students. | Almost always                    | Rarely         | “We started specifically requesting for police instead of paramedics … and then our experience has been if that’s available, they do send a mental health officer, or an officer with some mental health training. And we have usually had pretty good success” “I can’t ever remember handcuffs being used” |
### Fixed processes – Emergency response is activated, with ambulance conveying most students to hospital

| 7 | 9-1-1* is called, and students are most often transported by paramedics. In rare instances, where safety concerns are identified, police become involved in transfers. | Rarely | Rarely | “(We) would call an ambulance and usually, they will come to the university and then they would take them from there. If we have any concerns about them wanting to leave, or feeling unsafe, we call security which is on campus. That has happened quite a few times where we have just had security waiting until the ambulance comes and takes the person to the hospital.” “Definitely no, nothing really that we have seen in terms of (handcuffs) or anything like that.” |
|---|---|---|---|---|
| 8 | Campus police (Special Constables of municipal police) are called. Campus police call 9-1-1* and wait in clinic until paramedics arrive. Paramedics conveys student to hospital. | Not specified in protocol | Not specified in protocol | N/A - Clinic process document obtained from supervisor via email. |

### Flexible processes – students are accompanied by clinic staff in most cases, with discretionary involvement of police or paramedics

| 9 | Students are accompanied to hospital by clinic staff in the majority of cases. Occasionally, students are accompanied to hospital by friends/family. In rare cases, on the basis of safety concerns, 9-1-1* is called and police and/or paramedics convey students. | Rarely | Rarely | “Usually what will happen if someone is really, really distressed, whether they’re certified or not, (clinic staff) will escort them over to the emergency room” “The options can be the patient going with one of our nursing staff, walking them over; the patient being escorted by the police, and the patient being escorted by a family member or friend. Those would be really the three. Or when I say one of our nurses, also some other non-nursing staff, like a clinic manager will sometimes take students to the hospital on a Form 1.” |
| 10 | Students are accompanied to hospital by clinic staff in the majority of cases. Occasionally, students are accompanied to hospital by friends/family. In rare cases, on the basis of safety concerns, 9-1-1* is called and police and/or paramedics convey students. | About 50% of the time | Rarely | “For those patients who are seeking help and recognize that they need help and who accept our assessment that they should be Form One’d, because they are a risk to themself or to others, we offer them actually transportation that we arrange, and an accompaniment with one of our staff people. We’ll actually send a nurse with a patient to the emerge, and hand over the patient at the emerge to a nurse and triage at the emerge.” |
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|    | N/A | N/A | N/A | No physician respondent.  
|----|-----|-----|-----|Clinic Director reported Form 1 use to be rare. |

* 9-1-1 is the emergency telephone contact number in Ontario, Canada*
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Appendix

**Qualitative Interview Guide – Student Health Physicians**

**Title of Study:** Patient Transfers Under the Mental Health Act: A Qualitative Survey of University Campus Health Facilities in Ontario  
**Principal Investigator:** Dr. Andrea Chittle  
**Co-investigators:** Drs. Shane Neilson and Juveria Zaheer, Gina Nicholls  
**Sponsor** N/A  
**Contact** Dr. Andrea Chittle  
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This interview guide was adapted from a template created by Dr. A. Ka Tat Tsang (Tsang, 2008).

1. **Venue:** Wherever it is convenient for the participant, and allows sufficient privacy. Interviews will be conducted by telephone.

2. **Duration:** As long as it takes for the participants to complete their stories, anticipated to take between thirty and ninety minutes.

3. **Procedures:**

   A. **SET UP**

   i. Introduce yourself and the purpose of the interview, e.g., “I am a member of the Best Practices for Mental Health Transfers Working Group, formed by family physicians at the University of Guelph. We are conducting a research project looking at policies and processes for patient transfers to hospital when patients are placed on a Form 1. We are hoping to gain an understanding of what policies and processes exist at different University health clinics in Ontario, and we would like to know more about your experiences transferring certified patients to hospital.”

   ii. Review the key content in the consent form (e.g., confidentiality and anonymity, the participant’s right to withdraw and to review interview transcripts and delete
data).

iii. Explain the need for audio-recording and obtain approval from the participant. [Remember to have a recorder available and to check it for proper functioning, including sufficient battery life, memory space for recording]

iv. Ensure that written consent has been received electronically.
B. OPEN EXPLORATION

i. Start the conversation with a brief prompt, e.g., you may repeat the purpose of the research and invite the participant to share his/her experience, the following are examples of what you may want to say to the participant:

Thank you for agreeing to be interviewed. Your time and expertise are very much appreciated. The main purpose of this interview is to understand the policies and processes for mental health transfers are the university health clinic where you work, and you experiences, thoughts, and feelings engaging with these policies and processes. We are very interested in your personal experience. I’m wondering if you’d be willing to share a little bit about yourself, your background, and how you came to work in student health care?

ii. The main purpose of this part of the interview is to allow the participants to express themselves as freely as possible, this can be achieved by keeping in mind that:

1) The participant decides what is important to him/her, so let them talk about whatever they want to as much as possible. That means we DO NOT control the agenda rigidly, but try to allow maximum narrative space. You may also want to make sure that you do not interrupt the participant or cut her/him off.

2) Each individual has his/her own idea of what is relevant to the research question. You should let them talk even though you may find what he/she says is irrelevant, unless the speech is obviously cyclical or incoherent. You may, however, repeat the research question at times to remind.

3) Respect the participant’s language by using their expression and their wordings as closely as possible, this will avoid unnecessary (mis)interpretation and narrative conditioning on our part.

4) Use more prompts and invitations, and use less questions; e.g. invite them to elaborate on or explain about, or give examples for a topic or an experience that they have mentioned. A question-and-answer format tends to put the participant in a passive mode, and severely compromises the opportunity for the participant to volunteer
information which is not on your list of questions, therefore defeating
the very purpose of ethnographic or discovery-oriented interviewing.
If you need to ask questions, ask open-ended and not close-ended
questions. Ask specific questions only when you have collected
enough information from a topic and need to know the specific details.

5) Summarize what the participant has said, this will let the participant know
that you've been listening, and help to build a good rapport. This is also
helpful when you want to shift the conversation to another topic - make a
summary first and smoothly change the topic. Try to be brief with
summaries, for long summaries might turn people off.

6) The purpose of this interview is to explore and discover, NOT to
solve problems or comment on practice.

7) Pay attention to “free information” (content not required by your question or
request, given to you freely): The participant offers as he/she responds to
your prompts and questions, these are often things that the participant want
to talk more about

iii. Please try to jot detail notes during the interview, this will help you to keep track
of what has been said and to make summary. Please also note down your
impressions. These notes can be especially valuable in the unlikely event of
recording failure.

iv. When you think the open exploration part has been completed, try to summarize
the main points of the conversation and ask the participant if he/she has anything
more to add. If not, thank him/her for the sharing. Then prepare them for the
structured exploration part by saying something like, “In the remaining time, I am
going to ask you some further questions.”

C. STRUCTURED INQUIRY

i. The purpose of structured inquiry is to focus on specific areas or issues we are
interested in, but have not been addressed by the participant in the Open
Exploration section. It is hoped that by this time, you would have established a
good relationship with the participant and he/she might be more ready to talk about these topic

ii. Before we ask the questions, note if any of them had already been answered during the Open Exploration. Ask only those that have not been addressed. Asking the question again will make the participant feel that we have not been paying attention and listening carefully.

Topics for exploration

1. Can you tell me a little bit about yourself? Your background? How you came to work in student health?

2. Tell me about your experiences caring for individuals with mental illness? What proportion of your clinical work is occupied with caring for individuals with mental illness?

3. In your clinical work, have you “certified” an individual with mental illness, placing that patient on a Form 1 for transfer to hospital for psychiatric assessment? Can you share an experience that sticks out in your mind related to “forming” a patient? What is the usual process for transferring a Formed patient to hospital at your clinic? Is there an explicit written policy (if a written policy or procedure document exists, request a copy)?

4. Who usually conveys patients to hospital? If police/security, what is their usual process? Are restraints (handcuffs) used? Routinely, or at the discretion of the transporting officer? How often are restraints used? What factors are considered in deciding whether restraints are used?

5. Have there been circumstances when you deviated from the usual policy/process for transferring Formed individuals? What were the circumstances, and how was the patient transferred?

6. How long has the current policy/process been in force? Prior to the current policy, how were students transferred? What factors or events resulted in the creation of the current policy? What factors or events have resulted in changes to the policy?

7. What is working well with the current policy/process?
8. Do you have any concerns about the current policy/process?
9. What would you change about the current policy/process?

Sensitizing concepts

1. Safety/ minimizing harms
2. Dignity/ respect of persons
3. Stigmatization of mental illness
4. Criminalization of mental illness
5. Clinician autonomy vs bureaucracy

Ways in which to ask follow up questions about sensitizing topics (probes and clarification)

1. Can you tell me more about that (process, event)?
2. Can you give me a specific example?
3. Can you explain your answer?
4. In what way?
5. How did you understand that?
6. What does that mean to you?

Wrap up questions

6. Do you have anything to add?
7. Is there anything I should have asked?
8. How did the interview feel for you?
9. Is there anything that surprised you?
10. How are you feeling now?
11. Are there any other physicians at your clinical facility who you think I should speak to about this issue (psychiatrists, other family physicians)?