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Title: Physicians' perspectives on crisis mental health transfer processes from university health clinics to hospitals in Ontario, Canada: a qualitative analysis

Authors: Andrea Chittle MD, Shane Neilson MD, Gina Nicoll, Juveria Zaheer MD

Reviewer 1: Dr. Martina Kelly

Institution: University of Calgary, Calgary, Alta.

General comments (author response in bold)

Thank you for the opportunity to read this interesting article. I provide my review as an academic family physician with an interest in mental health and experience with qualitative methodologies.

This paper addresses an important topic, particularly pertinent in context of contemporary conversations of equity and experiences of minority groups with police. The findings show wide variation in an important area of clinical care, with vulnerable people, and I believe the findings warrant wider attention in Canadian healthcare.

I have a few suggestions, which authors might consider.

General comments:

1. The text could be tighter – there are a few places of redundancy/ repetition. Tenses change throughout the text and might benefit from review, and possible use of active voice to tighten text?

Efforts have been made to limit redundancies and keep tenses consistent, modelled after other published qualitative papers from CMAJ Open.

2. While recognising the passion behind this research topic, there are times when I just wondered if /how that was managed to give a balanced reporting of findings.

Author reflexivity statements have been incorporated into the body of the Methods section. This subsection reads:

“Author Reflexivity

AC has worked as a primary care physician at a student health clinic for nearly a decade. She has been involved in the care of many students experiencing mental illness. 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. GN is an undergraduate student and research assistant. She has lived experience of mental illness and mental health transfers between community sites and hospitals. 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.

AC and SN co-founded the informal “Best Practices for Mental Health Transfers Working Group” in the spring of 2019. This group advocated for the adoption of flexible crisis mental health transfer processes at the University of Guelph, authored a Commentary in Canadian Family Physician challenging constitutive use of restraints for such transfers, undertook a literature review and policy survey of transfer policies, and conducted this qualitative study.”

In undertaking this study, we sought to explore and understand variabilities in practices and processes for crisis mental health transfers. Our research cannot be separated from

the investigators' worldviews, which are the product of our perspectives and experiences. The qualitative paradigm in which our research is situated acknowledges that this work cannot be unbiased. AC shared her perspectives and experiences as relevant during the interviews. Thematic analysis was coloured by JZ's and AC's understanding of reality.

Title:

1. although recognising the title is informative, I had to read it twice to understand what the paper was about. I am unsure (apologies) if the term 'mental health transfers' is an accepted term in Canada or if another phrase might better represent the issue at stake?

The title has been changed to: *"Physicians' perspectives on crisis mental health transfer processes from university health clinics to hospitals in Ontario, Canada: A qualitative analysis"*

Introduction:

1. some of the third paragraph (L55-60) and ethics statement might fit better in the methods section. This might allow the research question to be more clearly stated.

The third paragraph has been shortened, and now reads:

"Through qualitative analysis of interviews with university health clinics in Ontario, Canada, we sought to explore and better understand existing emergency mental health transfer processes, their evolution, and barriers and facilitators to change. We were particularly interested in the role of police and use of physical restraints. We hoped to learn of the existence of dignified and humane transfer processes in order to identify a path towards universalizing less traumatizing emergency mental health transfer processes."

The ethics statement has been moved to a new sub-section called "Ethics" in the Methods section:

"Ethics

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

2. From the research question as stated that the author group have a specific perspective, which is also noted in the interview guide – where there is mention of a 'Best practice for Mental Health Transfers group'. I wondered if that should be mentioned in the body of the text, perhaps under methods in a section on team reflexivity as this likely impacted the analysis and readers need to be aware of that. I also thought the research question in the interview guide was nice and clear and could, perhaps be used in the text.

In the Methods section, under Study Design, a new subheading titled: "Author Reflexivity" has been added, and reads:

"Author Reflexivity

AC has worked as a primary care physician at a student health clinic for nearly a decade. She has been involved in the care of many students experiencing mental illness. 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. GN is an undergraduate student and research assistant. She has lived experience of mental illness and mental health transfers between community sites and hospitals. 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.

AC and SN co-founded the informal “Best Practices for Mental Health Transfers Working Group” in the spring of 2019. This group advocated for the adoption of flexible crisis mental health transfer processes at the University of Guelph, authored a Commentary in Canadian Family Physician challenging constitutive use of restraints for such transfers, undertook a literature review and policy survey of transfer policies, and conducted this qualitative study.”

The research question has been re-phrased in the Introduction section to be clearer. It now reads:

“Through qualitative analysis of interviews with university health clinics in Ontario, Canada, we sought to explore and better understand existing emergency mental health transfer processes, their evolution, and barriers and facilitators to change. We were particularly interested in the role of police and use of physical restraints. We hoped to learn of the existence of dignified and humane transfer processes in order to identify a path towards universalizing less traumatizing emergency mental health transfer processes.”

3. I wondered, but am not sure if justification for looking at university students would help set the topic up more e.g. to mention age of these students and emergence of significant mental illness at this time in life. This experience is likely to have life-long ramifications and implications for future care.

Thank you for this suggestion. The first paragraph of the introduction has been modified to further contextualize our research endeavour. It now reads:

“Post-secondary students confront myriad stressors that may contribute to the emergence of mental illness (1). Among Canadian post-secondary students, longitudinal data suggests that rates of mental illnesses are increasing, with more students reporting self-harm, suicidal ideation, and suicide attempts over time (1).”

4. Is there any data on the number of these transfers to get an idea of the scale of the issue? Is there any data on the actual risk people pose – or does it not exist because police transfer is part of accepted practice??

Robust data is lacking. Our group reported on the rate of police-involved transfers at the University of Guelph in our cited Canadian Family Physician commentary. On September 7, 2021, a media report was published that exposes a dramatic increase over time in the absolute number of mental health apprehensions in a number of Canadian jurisdictions. We have added wording to the first paragraph of the Introduction to provide additional details about this:

“While robust data is lacking, the number of annual student mental health apprehensions on some Ontario university campuses has increased dramatically since 2014.(3) However, 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 (4–8). 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 (8,9). The engagement of police and use of restraints for transfers from some clinics has been the subject of media scrutiny (10–12)."

Methods:

1. Some redundancy in the opening paragraph (L72-76), I might suggest simply starting with theoretical perspective. I am unsure if all readers will understand ontology and wonder if some simpler sentences might help a reader in this section.

This text of the opening paragraph has been amended in an effort to clarify meanings and reduce redundancies. It now reads:

"Interviews: To understand the variability in transfer processes, and physicians' experiences with crisis mental health student transfers, semi-structured qualitative interviews were conducted with practicing physicians working at Student Health Clinics across Ontario. Interview transcripts were subsequently analyzed thematically (21). Theoretical perspectives informed interview analysis. These included: the interpretivist paradigm; relativist ontology; subjectivist epistemology; and social interactionist orientation (22,23). Reality is complex and experienced uniquely ("interpretivist paradigm". This reality is socially, intersubjectively, and experientially created ("relativist ontology") (22). Each individual's understanding of the world is central to and influenced by their understanding of themselves and others ("subjectivist epistemology") (22). Investigators and participants are connected: as the inquiry proceeded, investigators and participants co-created findings and knowledge through dialogue (22). Collective behaviours, beliefs and experiences were explored to understand how social interactions and behaviours contribute to the evolution of policies and processes ("social interactionist orientation") (23). The Standards for Reporting Qualitative Research reporting guidelines have been utilized (24)."

2. Study sampling: consider moving the sentence on interviews to data collection and just focusing on sampling here. I'm unclear why a target of 20 was established and how this sentence helps?

The sentence describing the interviews was removed. The description of the interviews was retained in the Data Collection section as follows:

"Interviews: One in-person and 10 telephone semi-structured interviews were conducted by AC between July 2018 and January 2019. A study interview guide was used (see Appendix)."

In this section, wording was amended to reflect the rationale for the sample size. It now reads:

"A preliminary target of 10 - 20 respondents was established to optimize the representativeness of the sample and to achieve concept saturation. In thematic qualitative analysis, between 10 and 20 respondents are typically required to achieve concept saturation, which was defined as the point at which neither coders (AC,JZ) generated new codes during transcript analysis. Saturation was achieved with the study sample of 11 interview participants."

3. Data collection: consider adding when data was collected (its in the abstract) and how many interviews were in person and phone (did that impact the quality of the data collected?). The mention of themes here feels a bit out of place. Suggest a sentence earlier stating that data collection and analysis were iterative or address in the analysis section.

This wording has been amended.

“Interviews: One in-person and 10 telephone semi-structured interviews were conducted by AC between July 2018 and January 2019. A study interview guide was used (see Appendix).”

The reference to “themes” has been removed, and wording about cessation of interviews revised:

“Interviews ended when the question list and topic discussion concluded.”

4. Data analysis:

a. I wasn't entirely clear...did the group read a subsection of transcripts to start with and conduct some early open coding as a team and then AC, JZ coded independently, meeting regularly to review codes, refine etc. Team met periodically to review, refine the themes?

Thank you for this feedback; we have elaborated on the Data Analysis section.

Inserted into manuscript:

“Interviews: This study used a thematic analysis methodology (21) within an interpretivist paradigm. Data collection and analysis occurred simultaneously in keeping with interpretive qualitative research practice.(26,27) In the first step, transcripts were read and re-read to obtain a broad understanding of physician perspectives about transfer policies and processes. The first 3 transcripts were read by all study team members and ideas noted through a memoing process. Memos were completed individually by AC after each interview and by SN, JZ and GN after reading the transcripts. Memos about team discussions were also created. Transcripts were then examined closely and initial codes inserted. AC and JZ open-coded each of the 3 transcripts independently, and then met to review the coding and begin consolidating the coding tree. AC and JZ then coded the next 3 transcripts and met to discuss the codes and make connections between them. Each transcript was read, coded, re-read and re-coded as necessary by both AC and JZ. SN and GN offered feedback to the analytic process. Following coding, the text subsumed under each code was reviewed, summarized and an analytic memo was created to capture code content. AC and JZ, with input from SN and GN, grouped codes into potential themes and created a thematic map. Themes were refined and organized.”

b. Some reflections on researcher reflexivity might help given author perspectives stated in the research question.

A section has been added to the Methods titled “Author Reflexivity”:

“Author Reflexivity

AC has worked as a primary care physician at a student health clinic for nearly a decade. She has been involved in the care of many students experiencing mental illness. 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. GN is an undergraduate student and research assistant. She has lived experience of mental illness and mental health transfers between community sites and hospitals. 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.

7AC and SN co-founded the informal “Best Practices for Mental Health Transfers Working Group” in the spring of 2019. This group advocated for the adoption of flexible crisis mental health transfer processes at the University of Guelph, authored a Commentary in Canadian Family Physician challenging constitutive use of restraints for such transfers, undertook a literature review and policy survey of transfer policies, and conducted this qualitative study.”

c. I don't think the team developed any theories, so might remove that? This was thematic analysis rather than grounded theory, I think?

Yes, we used thematic analysis informed by an interpretivist paradigm, with a goal of creating themes and subthemes, rather than theory. We have clarified this in the manuscript.

5. There is no mention of what happened to the policy documents. Also in the abstract there is mention of brief questionnaires but these are not mentioned in the methods section, so unclear what was asked and how that informed analysis?

This study was a qualitative study. Primarily, we undertook thematic analysis of interview transcripts. We asked participants to complete a survey in order to gather some broad information about the characteristics, experiences and ideas of participants.

Demographic data about participants is included in the manuscript as “Table 1: Demographic Characteristics of Physician Respondents (N=11)”.

“Table 1. Demographic Characteristics of Physician Respondents (N=11¹)

Demographic	No. (%)
Identified Female	7 (63.6)
Identified Male	4 (36.4)
Speciality	
Family Practice	9 (90.9)
Psychiatry	2 (9.1)
Years in practice	
0-5	1 (9.1)
6-10	3 (27.3)
11 +	7 (63.6)
Years in student health	
0-5	3 (27.3)
6-10	2 (18.2)
11 +	6 (54.5)

¹ Data was drawn from questionnaire responses for 10 participants, and from the interview transcript for 1 participant who did not submit a questionnaire.”

Participant responses regarding their experiences with crisis mental health transfers were integrated into “Table 3. Description of Transfer Procedures (N=11)” (pasted below). We endeavoured to gather institutional documents from participants, and from institutions we were not able to recruit participants from. The documents were not themselves analyzed. Ultimately, we were most interested in ascertaining whether formalized processes existed, and whether processes were flexible or fixed. The

presence or absence of formalized processes, and the nature of these processes was explored in our interviews. The presence or absence of policies, and their general content, have been summarized in “Table 3. Description of Transfer Procedures (N=11)”.

Table 3. Description of Transfer Procedures (N=11¹)

			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	<p>“The usual process now is that a clinician will decide somebody needs to be Formed. We will contact our campus police service; they will come, and again, there will be, I guess, a joint assessment of the situation and typically students are not needing to be handcuffed anymore.” (Respondent E1)</p> <p>“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.” (Respondent E2)</p>
2	Campus Police (Special Constables of municipal police) are called to transport students.	Always	Almost always	<p>“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.” (Respondent D)</p>
3	Campus Police (Special Constables of municipal police) are called to transport students.	Always	Always	<p>“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” (Respondent K)</p>
4	9-1-1* is called and police and/or paramedics convey students.	Almost always	Never	<p>“The nurse arranges (for) the police to come.” (Respondent B)</p> <p>“That horrified me...Handcuffs? ...I hadn’t even thought of handcuffs” (Respondent B)</p>
5	9-1-1* is called and a mobile crisis team (police	Majority	Rarely	<p>“The time there was (handcuffs) it was...I think it was out of necessity like the person was verbally resistant</p>

	and mental health worker) and/or paramedics responds to convey students.			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" (Respondent I)
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" (Respondent A) "I can't ever remember handcuffs being used" (Respondent A)
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." (Respondent H) "Definitely no, nothing really that we have seen in terms of restraints or anything like that." (Respondent H)
8	Campus police (Special Constables of municipal police) are called. Campus police call 9-1-1* and wait in clinic until paramedics arrive. Paramedics convey student to hospital.	Not specified in protocol	Not specified in protocol	No physician respondent. Clinic process document obtained from supervisor via email.
Flexible processes – students are often accompanied by clinic staff, with discretionary involvement of police or				
9	Students are accompanied to hospital by clinic staff in the majority of cases.	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"

	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.			(Respondent C1) “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.” (Respondent C2)
10	Students are accompanied to hospital by clinic staff in the majority of cases. Occasionally, students are accompanied to hospital by friends/family. In some 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 themselves 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.” (Respondent J)
N/A – Form 1 not utilized				
11	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

¹ Information about transfer processes and policies was drawn from interview transcripts for 9 institutions. This was corroborated by review of policy documents from 4 of these institutions. Information about 1 institution was drawn solely from review of policy documents. Information about the final institution was derived solely from email communication with administrative staff.

² Participants coded with the same letter represent the same clinic.

Results

1. Might a table overviewing the themes and subthemes guide a reader, or signposting sentences e.g. theme one consisted of 3 subthemes etc. Consistency in the wording used to report the themes would help too (e.g. theme 2).

The quotes have been extracted to “Table 4: Quotes supporting primary themes.” This table has been modelled after previous published qualitative work in CMAJ Open. Subthemes are noted in the table.

Table 4: Quotes supporting primary themes

Theme; subtheme	Representative Quotes
1. Police and restraints cause harm to students experiencing mental health crisis	
i. Police involvement is problematic generally	<p><i>“A lot of people have had some very negative interactions with the mental health care system and the justice system, that’s for sure” (C1¹)</i></p> <p><i>“...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” (C1¹).</i></p>
ii. Police involvement interferes with future treatment	<p><i>“...they’re very suspicious and hard to engage” (C1¹).</i></p> <p><i>“The idea that you’re breaking trust with a vulnerable person can have huge impacts on care down the road” (D).</i></p> <p><i>“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.’ [... H]aving been placed on the Form 1 and transferred sometimes will, I think, prevent people from coming back” (D).</i></p>
2. Justifying police involvement and restraint use: patient considerations	
	<p><i>“(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” (C2¹).</i></p> <p><i>“...if we have any indication that someone may be violent toward other people or is actively psychotic...we engage the police at all times” (J).</i></p> <p><i>“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</i></p>

	<i>how that could turn out” (B).</i>
<i>Transfer policies are influenced by extra-medical factors</i>	
<i>i. Rationale for police</i>	<p><i>“I think there may have been some concern based on, you know, union responsibilities and roles for the staff that were involved, that it was outside of their roles” (E1’)</i></p> <p><i>“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?” (C2’).</i></p> <p><i>“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” (H).</i></p> <p><i>“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” (C2’).</i></p> <p><i>“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).</i></p>
<i>ii. Extra-medical rationale for restraint use</i>	<p><i>“Again, it was really just concerns from the police standpoint of their liability, and that was the main issue” (Respondent J).</i></p> <p><i>“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. And so discussions that we have had with the constables about whether or not that should be done are typically met with, you know what, we have to cater to the highest potential risk.” (D)</i></p> <p><i>“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</i></p>

	<i>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" (D).</i>
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¹ *Participants coded with the same letter represent the same clinic.*

2. In the section on use of restraints I wondered if an additional sentence or two is required to balance as from the table it would look like restraints are rarely used at a number of institutions, or if that should be commented on in relation to that table in the opening paragraph.

In the opening paragraph, additional wording has been added, which reads:

The final paragraph has been modified to incorporate this feedback.

“ii. Extra-medical rationale for restraint use

The routine use of physical restraints during crisis mental health transfers appears uncommon, occurring at only 2 of the 11 university clinics included. Where constitutive handcuffing was practiced, physicians understood this to be a consequence of police policies aimed at avoiding liability and assuring student safety. Strict adherence to police policies was rationalized on the basis that restraints ensure a secure transfer. Respondents hypothesized that policy compliance reduced professional risk to police officers.”

Discussion

1. Either in the introduction or in the discussion, I wondered if some contextualisation of the issue e.g. in relation to international practice, or even practice in other provinces could help broaden the implications of this work? I see the authors self-cite previous work, but some of it may help in the introduction or discussion section. Coming from a country where this group of patients are accompanied to hospital by mental health staff, and police are involved only at a distance, I have been surprised by involvement of police with mental healthcare here. This suggestion may however, be beyond the scope of this article.

Some additional context has been added in the Interpretation section. Scholarship on this issue is sparse. We have referenced our group’s published review (Policies and procedures for patient transfers from community clinics to emergency departments under the mental health act: Review and policy scan. Int J Law Psychiatry [Internet]. 2020;71(October 2019):101576).

“There is a dearth of information about processes for transferring patients requiring emergent psychiatric assessment from community-based points of care to hospital.(8)Police involvement and the use of restraints in the provision of crisis mental health care relate to: limited system resources; gaps in comfort and training; notions of risk and safety, and concerns about liability. (8) Police involvement and restraint use can be traumatic, with the death of people in crisis occurring in the worst-case scenarios. (5–8,14–18) People can experience fear and stigmatization when police are involved and handcuffs applied, which can engender mistrust and deter future help-seeking. (5–8) Alternatives to police exist in the form of mobile crisis teams or paramedic services in some provincial, national and international jurisdictions. (6,8) Mental health advocates in Canada and elsewhere are advancing visions of crisis care service and supports that do not involve police at all. (3,10,11,16,18–20) Our exploration of physicians’ experiences with transfer processes at Ontario university clinics highlights existing variability, affirms the known 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.

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.”

2. I think for me, the most disturbing part of the results was how health system issues e.g. convenience, wait times trumped good patient care – particularly young people, at a very vulnerable time, without parent support. I wondered if some additional references on alternative models could be provided, to help a motivated reader.

We are in agreement. Scholarship on this issue is sparse. We have referenced our group’s published review (Policies and procedures for patient transfers from community clinics to emergency departments under the mental health act: Review and policy scan. Int J Law Psychiatry [Internet]. 2020;71(October 2019):101576), which may offer some additional context.

3. The authors indicate a number of limitations, which suggest the need for further research in this area and I wondered if they had any planned?

We do not have any other research planned at this time. We do hope that we can apply for funding to better understand the perspectives of the University students involved; especially with a focus on intersectionality.

Reviewer 2: Dr. Pauline Pariser

Institution: University Health Network, Toronto, Ont.

General comments (author response in bold)

Timely, informative article that lays the groundwork for quality improvement in addressing youth mental health; in particular university students at risk for suicide. The role of police intervention has become a clarion cry in the community so documenting the barriers is a worthwhile addition to our knowledge base.

1. My suggested revision focuses on your discussion where you suggest that alternatives could be considered:

"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."

It would be a stronger contribution if you surveyed the literature for evidenced-based examples of alternative interventions and added these references to your discussion.

Thank you for this feedback. We have added some additional context in the Interpretation section:

“There is a dearth of information about processes for transferring patients requiring emergent psychiatric assessment from community-based points of care to hospital.(8)Police involvement and the use of restraints in the provision of crisis mental health care relate to: limited system resources; gaps in comfort and training; notions of risk and safety, and concerns about liability. (8) Police involvement and restraint use can be traumatic, with the death of people in crisis occurring in the worst-case scenarios. (5–8,14–18) People can experience fear and stigmatization when police are involved and handcuffs applied, which can engender mistrust and deter future help-seeking. (5–8) Alternatives to police exist in the form of mobile crisis teams or paramedic services in some provincial, national and international jurisdictions. (6,8) Mental health advocates in Canada and elsewhere are advancing visions of crisis care service and supports that do not involve police at all. (3,10,11,16,18–20) Our exploration of physicians’ experiences with transfer processes at Ontario university clinics highlights existing variability, affirms the known harms of police involvement and use of restraints, and clarifies factors influencing police involvement and handcuff use.” Scholarship on this issue is sparse, which is partly what motivated us to conduct this research. We have referenced our group’s published review (Policies and procedures for patient transfers from community clinics to emergency departments under the mental health act: Review and policy scan. *Int J Law Psychiatry* [Internet]. 2020;71(October 2019):101576), which may offer some additional context.