Handcuffed

Rethinking physical restraints for mental health transfers in university settings

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When students presenting to university health service facilities in Ontario pose a likely and imminent risk of harm to self or others because of underlying mental health concerns, assessing physicians can invoke the *Mental Health Act*[1] and place students on a Form 1 (an application for emergent psychiatric assessment). Students are subsequently transferred to a psychiatric facility and can be held involuntarily for up to 72 hours pending specialist evaluation. There are numerous options for conveying students to hospital in these circumstances. At the University of Guelph in Ontario, campus community police are routinely involved in acute mental health transfers, and physical restraints are used in by far most cases. Clinicians at the university have increasingly expressed discomfort with the constitutive practice of involving law enforcement personnel in mental health patient transfers, as well as the near-universal application of handcuffs.* This commentary is a component of our advocacy efforts aimed at raising awareness and expanding the relevant evidence base in order to create the impetus for change. At issue is striking a balance between respecting the dignity of ill persons and concerns for safety.

Mental health on campus

Postsecondary students are reporting rising rates of serious mental illness and suicidality. The 2016 National College Health Assessment found that nearly half of students admitted to "feeling so depressed in the previous year it was difficult to function."[2] Fourteen percent of student respondents "had seriously considered suicide in the previous year," and "2.2% of students reported a suicide attempt within the previous year."[2] To assist such students as part of their mandate, many postsecondary institutions in Ontario have health service facilities affiliated with their campuses. At Student Health Services at the University of Guelph, a substantial proportion of our clinical work involves primary mental health care. The severity of mental health struggles among students was tragically revealed by an unprecedented cluster of suicides in student residence at the University of Guelph during the 2016-2017 academic year. The care provided to mentally ill students at the university faced local and national scrutiny.[3] We continue to frequently encounter students who are acutely distressed: in 2017, 15 students were sent to hospital for urgent psychiatric assessment, 14 of whom were placed on a Form 1 (A. Chittle, chart audit, April 16, 2018).

There is broad consensus that providing high-quality mental health care in increasingly constrained health resource environments is challenging.[4] While the discussion that follows focuses on the role and policies of law enforcement participating in acute mental health transfers, we acknowledge that health care professionals and organizations have critical roles to play in improving competency and enhancing interprofessional and cross-sectoral collaborations with the aims of better managing mental health crises in outpatient settings and implementing alternative pathways to the emergency department when patient transfers are necessary. Where policies and practices compromise dignity and perpetuate stigma within health care settings, we ought to address these shortcomings.

Use of restraints for transfers

At Student Health Services at the University of Guelph, campus community police have long been involved in acute mental health transfers to hospital by default. Historically, discretionary handcuffing was practised. A strict directive was issued mandating the use of physical restraints for all Form 1 patient transfers after a patient attempted to elope more than 10 years ago (L. Davenport, personal communication, May 10, 2018). In our experience, our patients at Student Health Services pose negligible risks to others. They usually are young, identify as female, are not agitated, are not intoxicated, are not holding weapons, and are cooperative. We believe that the routine use of handcuffs for transfer of such patients not only negatively affects health in the present, but also reduces the likelihood that patients will seek medical attention in the future when they are in distress. Patients have articulated that the involvement of police, and the use of handcuffs specifically, causes embarrassment and shame, making them feel as if they are perceived as being violent, dangerous, or criminal. Emergency department physicians report that some patients arriving in handcuffs are angry and defensive as a result of their treatment during transfer, to the detriment of efforts by the receiving clinician to establish a therapeutic relationship and provide optimal care (I. Digby, personal communication, February 15, 2018).

*Since this article was submitted in the summer of 2018, substantial positive developments have occurred in our institution. There is organizational willingness to support physician clinical judgment, and restraints are less frequently used when police are involved in transfers.

Our desire to change the practice of routine handcuff use for Form 1 transfers motivated us to mobilize and engage community partners. Dr Juveria Zaheer, a knowledgeable researcher and psychiatrist at the University of Toronto in Ontario, offered key procedural help and encouragement. Clinic physicians met with Campus Community Police leadership. We learned that the Campus Community Police, as Special Constables of the Guelph Police Service, are compelled to follow the policies of the municipal force. We were advised that the municipal police policy has been interpreted to mandate the use of handcuffs in all situations where police take an individual into custody (including all criminal arrests and all apprehensions under the Ontario *Mental Health Act*).[1,5] We spoke with Guelph police officers, as well as with officers working in other regional municipalities (Hamilton, London, Chatham-Kent, and Toronto). We filed access-to-information requests to obtain policy documents. We conducted a literature review on the use of restraints for mental health transfers of community-sourced patients. We spoke with clinicians and clinical leaders in other local settings and at other university-affiliated health clinics in Ontario. Finally, we are in the process of conducting a qualitative study that will examine the mental health transfer policies at university-affiliated health clinics in Ontario in greater detail.

Our efforts to bring about changes have, unsurprisingly, come up against the sort of institutional inertia that often sustains long-held practices. On the whole, however, what we have learned has been unexpected. While we—and many of the other health care professionals we networked with—believe that there is no justification for the practice of handcuffing our patients routinely, especially considering widespread calls in the medical literature for judicious use of physical restraints,[6] we discovered a normative police practice of handcuffing patients in several jurisdictions. We were heartened to learn of some notable exceptions. Law enforcement personnel rationalize handcuff use as necessary for the protection of the patient and officers. This practice is underwritten by a metaphor of safety generated by each individual officer's personal n-of-1 case (and we have learned of tragic cases) in which things went awry because a patient was not restrained. This is analogous to the n-of-1 case that prompted enactment of our own campus security's universal restraint policy. This metaphor is deeply rooted in police officer training that, at its essence, is "overly focused on police officer safety as opposed to training on the nature of mental disorders and de-escalation techniques."[7]

We appreciate the challenging nature of modern policing and allow that there is no tool that can be employed to perfectly predict risk.[8] Yet we object to allowing n-of-1 anecdotes to justify the harm done to each and every compliant, low-risk patient being conveyed to hospital. The number needed to harm here is, quite possibly, 1. Our discussions with law enforcement officers highlight the complexity of the situation police find themselves in when interacting with individuals with mental illness. Sympathetic officers believe that they will not benefit from institutional support if they do not physically restrain patients during transfer and a negative outcome occurs. They are concerned about exposing themselves to personal and professional liability, even in jurisdictions where policies explicitly allow for discretionary handcuff use. Ironically, the reality that our discussions have revealed, of persistent stigma, criminalization, and perceived lack of institutional police support for more dignified treatment of the mentally ill, coexists with a robust literature that catalogs the stigma-reducing effects of mobile crisis intervention teams.[9,10]

Police policy documents that fail to differentiate between "arrest" and "apprehension," and that justify the continued universal use of handcuffs for all individuals in police custody, are at odds with recommendations from landmark inquests and reviews that aim to improve police interactions with mentally ill individuals. In his review of Toronto Police Service (TPS) policies and practices that was prompted by the fatal shooting of 18-year-old Sammy Yatim by an officer of the TPS in 2013, Justice Frank Iacobucci encouraged the TPS to

> identify exceptions to TPS requirements such as handcuffing, the use of in-car cameras, and other measures, in recognition that the apprehension of a person in crisis under the *Mental Health Act* differs from other types of police apprehensions.[11]

Ontario's Independent Police Review Director, Gerry McNeilly, suggested that the TPS

> amend TPS procedure documents to ensure it is clear that officers should not adopt a practice of handcuffing emotionally disturbed persons being apprehended under the *Mental Health Act* unless those individuals exhibit behaviour that warrants the use of handcuffs.[12]

Our review of the literature provided insight into the evolution of ideas around the use of force by police over the past 20 years in order to shed light on our current predicament. Explicit recommendations for policy change and calls for modernized police training[13] have yet to be taken up in all jurisdictions. It is clear that our patients continue to encounter stigma in their interactions with police. We hope that an exceptionally tragic outcome for someone with mental illness at the hands of police is not required in every community in Ontario in order for local police services to be receptive to change.

Improving outpatient crisis care

In our setting, we continue to work actively to expand our clinical skills and capacity, and to enhance

collaborations with community agencies with the aims of reducing the number of patients sent to hospital on a Form 1 and enhancing community-based acute mental health care. In parallel, we are advocating for the creation of alternative pathways to the emergency department for patients placed on a Form 1. The legislation is not proscriptive; clinical judgment is expected to guide decisions about mode of transport. Options for transport might include the following: by private vehicle; by taxi, either alone or accompanied by a support person or health professional; by emergency medical services; or by security or law enforcement, either alone or accompanied by a health professional.[1,14] We concur with local clinical leaders that police involvement in the care of individuals with mental illness is stigmatizing and ought to be avoided where possible. Achieving policy change requires considerable administrative support in settings like ours, where physicians do not employ other registered professionals directly. Connecting with local stakeholders created an opportunity for us to attend and present at a meeting of our regional Human Services and Justice Coordinating Committee.[15] We accepted an invitation to delegate at a Guelph Police Service Board meeting in October of 2018 to highlight our experiences and advocate for expedited policy updates. We understand that revisions are ongoing.

Conclusion

The use of physical restraints in mental health transfers is a systemic problem that causes harm and will require broad-based change at provincial and national levels. Enforcement agencies, hospitals, ministries of health, and the provincial bodies of registered health professionals should collaborate to ensure that a framework for the safe and dignified transport of low-risk involuntary patients to hospital exists. Such cooperation is necessary not in theory but according to existing evidence.[16] We hope that our ongoing qualitative study examining the existing transfer practices at Ontario's many university-affiliated health clinics will inform these efforts.

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Competing interests
None declared

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This article has been peer reviewed. *Can Fam Physician* 2019;65:460-2

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