Problematizing The British Columbia Mental Health Act: Past, present and solutions for the future

Christopher Gast

ABSTRACT

The British Columbia Mental Health Act provides a framework for the treatment of individuals in mental health crises. However, in doing so the Mental Health Act also allows for sweeping police powers for the ability to detain individuals during mental health crises. Further, the Mental Health Act also allows for those who administer psychiatric treatments to do so under a regime of deemed consent with little oversight into their means and methods.

This paper seeks to provide a historical context to the Mental Health Act, alongside contemporary criticism of the Act, characterizing its overreaches as Charter violations, particularly in the context of ongoing Supreme Court challenges. In framing this discussion, the aim of this paper is to provide a lens through which people can consider the real-world impact of this legislation on affected British Columbians.

Finally, this paper looks towards the future of mental health care in British Columbia in order to provide thoughtful, actionable paths towards mental health services under principles of informed consent and community-oriented wellbeing.

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INTRODUCTION

Urbanized Western societies have a long history of the involuntary admittance of people suffering from mental illness into medical institutions. In most cases, it is popularly believed that these individuals pose some kind of a danger to themselves and others, and removing them from society is the safest option. Notably, this is the same approach taken with punitive prison systems. In the criminal justice system, however, there are several important oversights and significant judicial decisions that guarantee the protection of Charter rights.[1] Under the Mental Health Act, these constitutionally enshrined personal freedoms are seriously undermined.

This paper will outline the history of the Mental Health Act and its predecessors, examine the ways in which the Act runs contrary to an individual's Charter rights and the Supreme Court decisions articulating those rights. It will also discuss obstacles respecting intersectionality of mental health crises such as drug addiction and homelessness. Finally, this paper will propose certain changes to the Act which may do away with some of the more egregious issues.

The storied history of incarceration is a controversial one in a modern era. Despite significant advances in medicine, psychology and sociology, the means by which people are detained in accordance with the Mental Health Act remain as primitive as those employed over a hundred years ago. Further, the Mental Health Act strips those

[1] *R v Oakes*, 1986 CanLII 46 (SCC) 1 SCR 103 at para 70. There are many more decisions that illustrate the issue in greater depth, but the important through-line established in Oakes is that any infringement of rights must be reasonable and demonstrably justified on a form of proportionality. [*Oakes*]

individuals of both their rights to personal freedom, bodily autonomy and medical consent.[2] Per sections 22-24 of the MHA, there is no language about the information a patient admitted under these sections is entitled to. Not only is this highly morally problematic, but it runs directly contrary to rights guaranteed in the Charter of Rights and Freedoms.[3] As such, this paper seeks to critically analyze the functions and implementation of the Mental Health Act in British Columbia against its relative benefits, discuss its history and propose alternatives for the future.

HISTORY

Prior to substantial American populations migrating North out of the Oregon territory, following the gold rush in the latter half of the 19th century, almost all instances of mental illness diagnoses were simply "insanity", and those individuals tended to be cared for by family or simply sent back to their nation of origin.[4] In 1872, not long after British Columbia officially joined Canada, in response to increased occurrences of mental illness in new urban centers as well as public outcry, the first asylum, the Victoria Lunatic Asylum was established[5]. It is also worth noting that this first asylum was established on the Songhees First Nations Reserve on Vancouver Island.[6] The opening of this asylum was followed closely by the implementation of the *Insane Asylum*

[2] *Mental Health Act* RSBC, 1996, c 228 at ss 22-24 [*Mental Health Act]*
[3] Canadian Charter of Rights and Freedoms, at s 7, Part 1 of the Constitution Act, 1982 being Schedule B to the Canada Act, 1982, 1982 c 11 (UK) [*Charter*]
[4] E. Yearwood-Lee, *"Mental Health Policies: Historical Overview"* (January 2008) https://multiculturalmentalhealth.ca/wp-content/uploads/2019/07/legislative-library-_mental_health-policies1.pdf at p 3
[5] R. G. Foulkes, "*British Columbia Mental Health Services: Historical Perspective to 1961*" (1961) 85:11 Canadian Medical Association Journal, at pp 649-650 [*BCMHS:HS]*
[6] Ibid

Act in 1873[7], formally establishing the Supreme Court's jurisdiction over the persons, personal wealth, and estates of "idiots and lunatics" in British Columbia.[8]

In the early years of the 20th century, several more institutions were established, mostly in the lower mainland of BC.[9] The function of these asylums was a combination of treatment via outdoor farming labour, rigid routine, and supervised medical attention. Abuse and mistreatment, particularly towards women, was common at these institutions. From 1933 until 1973 sexual sterilization was legal in British Columbia under the Sexual Sterilization Act and was specifically empowered to function towards individuals detained under mental health laws.[10] To this date, there has been no formal apology for the government's involvement in eugenic sterilization programs for those deemed "unfit" for reproduction. Patients were subjected to poor treatment in overcrowded facilities, including long detentions, sedation, "dip torture" or otherwise forcibly medicated without their full knowledge about the effects of these drugs, nor their consent.[11]

After the second World War, however, advances in medicine and psychology granted more options for accommodating and treating individuals with mental illness while reducing strain on the prison system or the very limited number of provincial asylums.[12]

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[7] *An Act respecting Asylums for the Insane*, LABC 1873, c 90
[8] Ibid, at ss 19-22
[9] *Supra*, *BCMHS:HS* at pp 650-651
[10] *An Act respecting Sexual Sterilization*, LABC (1933) c 59
[11] Supra, *BCMHS:HS* at pp 650-651
[12] S. Davis., "*Community Mental Health in Canada: Theory, Policy and Practice*", Revised and Expanded Edition (Vancouver, BC, UBC Press, 2014) at p 196 [*Community Mental Health*]

This process of moving from fewer, massive facilities to smaller, community-oriented units would come to be known as ‘Deinstitutionalizing’. During this time, several regional health authorities cared for a large variety of patients and disorders, thereby “taking the problem away from citizens in the community and relieving a major burden for family members”[13]

The Mental Health Act in British Columbia was initially implemented in 1965, consolidating several acts relating to hospitals, child care and mental illness.[14][15] This act was created with the good intention of using smaller, community-oriented mental health services, instead of large asylums in or near urban centers. While there have been many amendments to the Mental Health act in the last sixty years, some of the most questionable components, detailed in the sections below, core to its functioning remain untouched.

ISSUES WITH MODERN MENTAL HEALTH ACT

This section addresses several of the major problems associated with the Mental Health Act. These problems include the powers it grants to police and health care providers and the lack of oversight therein. Furthermore, a history of racial discrimination, particularly towards Indigenous communities and a lack of informed consent in patients makes for a system which disproportionately punishes and detains those already

[13] Ibid, at pp 194-195
[14] Supra, *Mental Health Act*
[15] Those acts being the: *Clinics of Psychology and Medicine Act, Mental Hospitals Act, Schools for Mental Defectives Act, Provincial Child Guidance Clinics Act*, and *Provincial Mental Health Centres Act.*

vulnerable populations, namely Indigenous people and those struggling with addiction, particularly in major urban centers in the lower mainland of British Columbia and on Vancouver Island.

The Mental Health Act grants a great level of autonomy to the directors of mental health facilities while also providing very little oversight for their decisions and actions.[16] Per section 31 of the Act, a patient is not innately entitled to a second opinion on their treatment. In the circumstances where a patient actually is entitled to a second opinion there is a very restrictive time period for when "…a person may request a second medical opinion on the appropriateness of the treatment that has been authorized"[17] It is important to note that this is not a review of the treatment itself, nor of the admittance process, only a review of the "appropriateness" of the treatment. There is also no formal review process for the actual detention of patients.[18]

POLICING

From reading the Emergency Procedures section of the Act, a police officer can apprehend and take a person to a physician if they "are acting in a manner likely to endanger that person's own safety or the safety of others, and is apparently a person with a mental disorder."[19] There is no further definition about what constitutes "being apparently a person with a mental disorder" in the text of the Act. There is also no

[16] Supra*, Mental Health Act,* at p2 s 8
[17] Supra*, Mental Health Act,* at p3 s 31
[18] Supra*, Mental Health Act*
[19] Supra*, Mental Health Act,* at p3 s 28

specified requirement or threshold for an individual to have done anything violent, disruptive, disturbing or otherwise, rather, it is completely up to the discretion of the officer at the scene. This is a stark departure from the requirements for detention in a criminal context, which requires having actually violated the law in such a way that is deemed serious enough to be an offence worth depriving an individual's personal freedom. This is in accordance with the principles of fundamental justice.[20]

In the 2016-2017 year, approximately 15,000 individuals were involuntarily detained by police officers in British Columbia under the Mental Health Act.[21] This is also approximately how many people were arrested for drug charges in BC that same year.[22] Further, one in four of those people who are involuntarily admitted experience physical restraint and isolation.[23] Statistics can be somewhat rote when dealing with numbers of this scale, but it is important to bear in mind that every single one of those people represents a vulnerable British Columbian, often in crisis whose life has been significantly upended and who is having physical violence inflicted on them by the state.

As we continue this discussion it must be stated that British Columbian courts have ruled a number of times in such a way that legitimizes this use of force by police

[20] Supra, [*Charter*] at s 7
[21] R. Diab & J. Sanderson, "*Reasonable Apprehension Under Mental Health Law*" 48:2 Queen's Law Journal 83
[22] S. Boyd, "*Drug Arrests in Canada, 2017*" Vancouver Area Network of Drug Users (15 September 2018) at p 4
[23] "*Health Justice report - Seclusion and Restraints in BC: What we know and what we don't*" (9 April 2025) https://disabilityalliancebc.org/health-justice-report-seclusion-and-restraints-in-bc-what-we-know-and-what-we-dont/

officers, including entering homes without permission.[2425] This represents a profound failure of not only the courts in British Columbia, but also of the state of crisis intervention service. Threats of self harm and suicidal idiation ought to be taken seriously, but addressing those concerns by way of the forceful entry of armed police officers into an individual's home is troubling on its face. The Mental Health Act provides far too much latitude to police officers to use force to "resolve" mental health crises.

After an involuntary detention like this, any treatment that the director or supervising physician, with no requirement of a second opinion, decides to administer, is deemed to have been given with consent.[26] There is also no requirement for contact to be made with any other parties, nor is there any specified limits for what treatment, including physical restraint, jail-like holding cells or the administration of electro-convulsive therapy.[27]

STRAIN ON THE HEALTH CARE SYSTEM

The above potential for mistreatment is also only before taking an analysis of the actual volume of admissions under the Mental Health Act for voluntary versus involuntary patients. Based on research from The Canadian Journal of Psychiatry, during the years 2008 to 2018, voluntary admissions have remained nearly unchanged, despite the population of British Columbia increasing from 4,319,000 to over 5,000,000 in that same

[24] *R v Milino* 2009 BCSC 1802 (CanLII) pp 52-62
[25] *Foley v Abbotsford Police Department*, 2020 BCHRT 137 (CanLII) at pp 33-36
[26] R. Dhand, & I. Grant, *"Opinion: Charter challenge to B.C. Mental Health Act Long overdue"* (23 September 2016) Vancouver Sun [*Charter challenge*] https://vancouversun.com/opinion/opinion-charter-challenge-to-b-c-mental-health-act-long-overdue
[27] Ibid

period of time.[28] With respect to involuntary admissions, however, the rate has increased substantially from 10,263 to 17,120 in that same timeframe.[29] Represented as percentages, this represents a change from 52% of admissions to 61% percent of admissions.[30] These numbers mean that almost all growth in terms of ballooning admissions numbers come from those involuntary admissions. From the perspective of a province and government constantly concerned with the overcrowding of hospitals[31] and the overwork of physicians and nurses, addressing this enormous swelling of numbers related to involuntary admissions could seriously lessen that strain.

In considering all of the above, it is important to frame all further discussion of the Mental Health Act that the means by which individuals are institutionalized against their will. These detainments can easily be (and in many cases have been) characterized as section 7 Charter rights violations, as it concerns the right to refuse treatment.[32] As will be discussed below, admittance to psychiatric institutions under the Mental Health Act is often used as an alternative to jails. It is a coercive and short-term solution to get people out of their homes and communities rather than the actual appropriate locations for an individual in crisis.

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[28] Loyal, J.P. et al, "*Trends in Involuntary Psychiatric Hospitalization in British Columbia: Descriptive Analysis of Population-Based Linked Administrative Data from 2008 to 2018"* (2023) 68:4 The Canadian Journal of Psychiatry [*Involuntary Psychiatric Hospitalization*]

[29] Ibid

[30] Ibid

[31] B. Ferradini, *"Crisis at Surrey Memorial Hospital ER worsening, doctors say."* (17 September 2024), CBC https://www.cbc.ca/news/canada/british-columbia/surrey-memorial-hospital-emergency-department-crisis-doctors-letter-1.7325687

[32] S. N. Verdun-Jones & M. S. Lawrence, "*The Charter Right to Refuse Psychiatric Treatment: A Comparative Analysis of the Laws of Ontario and British Columbia concerning the Right of Mental-Health Patients to Refuse Psychiatric Treatment*" (2013) 46:2 article 9 UBC Law Review [*Charter Right to Refuse]* at pp 490-494

Further problematizing the Mental Health Act is the nature by which second opinions and other recourse must be sought.[33] Almost all of the onus for seeking a second opinion is on the institutionalized individual, many of whom are not actually aware of their rights, as there is no formal, standardized process by which they, or someone close to them are made aware of the recourse available to them.[34] This, even before considering the state in which many individuals are involuntarily detained, is in violation of the standards surrounding and respecting informed consent for medical treatment in Canada.[35]

CASE LAW PRECEDENT

A large body of case laws across Canada sets important and unambiguous precedents for how the rights of individuals and the obligations of the state are to function in the context of the medical system. Eldridge v BC[36] establishes that hospitals are arms of the government because they carry out the critical governmental function of administering health care. As such, these institutions are bound to deliver this service in a constitutionally compliant way. Hospitals are not private institutions, and must be held to an especially high standard of quality, safety and Charter compliance in their operations.

[33] Supra*, Mental Health Act*
[34] Supra*, Mental Health Act*
[35] *Starson v Swayze*, 2003 SCC 32 [*Starson*]
[36] *Eldridge v British Columbia (Attorney General)*, [1997] 3 SCR 624 [*Eldridge*]

An important Ontario Court of Appeal decision, *Malette v Shulman*[37] addresses consent as it relates to health care. In this case, Dr. Shulman was aware both that the unconscious Georgette Malette was a Jehovah's Witness, and that the Jehovah's Witness faith disallows blood transfusions. Regardless, Dr. Shulman performed a blood transfusion, a decision which likely saved Malette's life. Malette then sued for assault and battery, winning. Highly relevant to the question of consent and bodily autonomy with respect to mental health is Donnelly J on this decision; "The right to refuse treatment is an inherent component of the supremacy of the patient's right over his own body. That right to refuse treatment is not premised on an understanding on the risks of refusal."[38] In the appeal decision, then, Robins, J.A. writes "... a medical intervention in which a doctor touches the body of a patient would constitute a battery if the patient did not consent to the intervention…"[39]

A decision which is more specific to Mental Health (though also in an Ontarian context) is *Fleming v Reid*.[40] In Fleming, the Ontario Mental Health Act violated the rights of bodily autonomy as they related to administration of antipsychotic drugs without their consent. The right was established that patients (or, in certain emergency situations, their appointed decision-maker), have a right to decline to consent for treatment based on their own judgement. Once again, per Robins J.A., "Few medical procedures can be

[37] *Malette v Shulman*, 1990 CanLII 6868 (ON CA) [*Malette*]
[38] Ibid
[39] Ibid
[40] *Fleming v Reid*, 1991 CanLII 2728 (ON CA) [*Fleming*]

more intrusive than the forcible injection of powerful mind-altering drugs which are often accompanied by severe and sometimes irreversible adverse side effects."[41]

While this right is not absolute, and there may be circumstances where psychiatric treatment without consent may be necessary, there must be a very compelling reason to infringe on one's right to self-determination of their body, and by extension infringe upon their rights.[42] As such, the default stance to be adopted based on the above decisions is that a person is assumed to be able to consent. This also means that a person or their loved ones or caregivers have the right to refuse consent, rather than be subjected to a regime of deemed consent as discussed in the following section.

DEEMED CONSENT

The BC Mental Health Act operates with the assumption of deemed consent. Generally, health care in Canada operates under the principles of informed consent for an individual making their own choices with respect to their care. However, in the context of somebody who is incapable of making their own medical decisions, doctors must find approval from other sources, most commonly a friend, family member or other representative of the patient.[43] Under a regime of deemed consent, however, a health care provider does not need to seek consent from another source.[44] Those who are

[41] Ibid at part 5
[42] Supra, *Oakes*
[43] "*Chater challenge to deemed consent in BC: What does this mean?",* Health Justice (27 May, 2025) [*Deemed Consent*] https://www.healthjustice.ca/blog/deemedconsentcase
[44] Ibid

close to a patient have no say in the treatment of their loved ones once they have been admitted to a psychiatric facility under the Mental Health Act.[45]

Jonny Morris, the CEO of the Canadian Mental Health Association BC writes that, “We hope that there’s a world in which the Mental Health Act is modernized so that deemed consent is replaced with evidence-based safeguards.”[46] As the act functions now, once an individual has been detained they all but lose all of their rights to medical autonomy. This runs contrary to a fundamental right to medical autonomy and self-determination of one’s own body.

Further enshrining the to self-determination is the watershed 2003 Supreme Court of Canada decision in *Starson v Swayze*.[47] The question at the heart of this discussion was whether an individual is able to refuse treatment, even if a doctor (or, as would likely be the case under the British Columbian Mental Health Act, the director of a psychiatric institution) does not believe this is the best course of action.[48] To quote Weisstub as mentioned in Starson,

> “The tendency to conflate mental illness with lack of capacity, which occurs to an even greater extent when involuntary commitment is involved, has deep historical roots, and even though changes have occurred in the law over the past twenty years, attitudes and beliefs have been slow to change. For this reason, it is particularly important that

[45] Ibid
[46] A. Kulkarni, “*Charter challenge to B.C.’s Mental Health Act being heard in court*” CBC (31 May, 2025) [*Heard in cour*t] https://www.cbc.ca/news/canada/british-columbia/charter-challenge-bc-mental-health-act-deemed-consent-1.7549197
[47] Supra*, Starson*
[48] Ibid

autonomy and self determination be given priority when assessing individuals in this group."[49]

This is to say, a patient is not required to agree with any given doctors' assessment of their mental health and with the treatments thereof. There are two criteria to determine this consent: ability to understand the information relevant to a decision, and an ability to understand the consequences of a decision, or a lack of one.[50] Once again, except in extreme, emergency cases[51], a person has a right to informed consent, and to have that consent honoured and respected. The deemed consent regime flagrantly fails by this metric.

Per the Human Rights Commissioner of BC, compulsory treatment under a regime of deemed consent should be used only as a last resort.[52] As the Mental Health Act functions now, it is allowed to be the first recourse for officers on the scene to apprehend an individual, without engaging in principles of community wellbeing or proper deferral to experts or deescalation.

[49] Ibid
[50] Supra*, Starson* at para 78
[51] Supra*, Charter Right to Refuse* at p 519
[52] K. Govender, "*A human rights-based approach to the toxic drug crisis*" British Columbia's Officer of the Human Rights Commissioner (November 2025) at p 19 [*Human rights-based approach*]

CHARTER CHALLENGES

Recently in British Columbia, efforts to challenge the most problematic provisions of the Mental Health Act as they violate section 7 Charter rights have failed under *British Columbia (Attorney General) v Council of Canadians with Disabilities*.[53] While the Council of Canadians with Disabilities (CCD) did succeed as a group with a public interest standing, their challenge was not able to alter the text nor the functioning of the Mental Health Act. As of May 2025, Health Justice has begun a Charter challenge on the federal level to the deemed consent regime of the BC Mental Health Act.[54] This challenge argues that the position that the deemed consent provisions of the Mental Health Act are Charter violations. British Columbia is the only jurisdiction in Canada that uses a deemed consent regime. This kind of challenge which argues that these provisions of deemed consent violate Charter rights may prove to be invaluable in order to safeguard vulnerable British Columbians.[55]

INDIGENOUS RIGHTS TO HEALTH

It is important to bear in mind as well, admissions to psychiatric facilities which are justified under the Mental Health Act are asymmetrical across different populations. In 2021, the Representative for Children and Youth published their report, which found that involuntary detentions for youth under the Mental Health Act rose 162% over a nine-

[53] *British Columbia (Attorney General) v Council of Canadians with Disabilities*, 2022 SCC 27 [*CCD*]
[54] Supra, *Deemed Consent*
[55] Supra, *CCD*

year period[56] It merits acknowledging the way that this mirrors indigenous overrepresentation in the prison system, where the Indigenous incarceration rate is nearly nine times the rate of the non-Indigenous population.[57] Unfortunately, there is little comprehensive data about the numbers of indigenous adults admitted under the Mental Health Act, but given the frequency of adversarial interactions with the police and health care systems[58], it is Indigenous people are detained at considerably higher rates than the general population.

On the other side of the coin, those Indigenous communities in the rural Northern areas of the province often struggle to have access to any kind of mental health services, particularly when living in remote communities where there are no hospitals. This is a contributing factor to rates of suicide among Indigenous people in British Columbia being significantly higher than the averages of the general population.[59] Herein lies the intersection with the over policing and over representation of Indigenous populations when considering an individual police officer's authority to deem who is and is not suitable to be admitted under to a psychiatric institution.

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[56] C. Casimer, *"Treatment Over Detention: Immediate Changes Requiring Regarding the Use of Involuntary Detentions for Youth under the Mental Health Act"* (19 January 2021) /https://www.bcafn.ca/sites/default/files/docs/news/2021JAN19_FNLC%20NR_RCY%20Mental%20Health%20Report.pdf

[57] P. Robins, et al, *"Over-representation of Indigenous persons in adult provincial custody, 2019/2020 and 2020/2021"* (12 July 2023) Statistics Canada https://www150.statcan.gc.ca/n1/pub/85-002-x/2023001/article/00004-eng.htm

[58] N. A. Jones, et al, *"First Nations Policing: A Review of the Literature" (2014)* Collaborative Centre for Justice and Safety

[59] M. B. Kumar, & M. Tjepkema, *"Suicide among First Nations people, Metis and Inuit (2011-2016): Findings from the 2011 Canadian Census Health and Environment Cohort (CanCHEC)* (2019) Statistics Canada https://www150.statcan.gc.ca/n1/pub/99-011-x/99-011-x2019001-eng.htm

BC Human Rights Commissioner Kasari Govender says that the addictions and mental health crisis in British Columbia is rooted “in colonial approaches [to health] that prioritize individualism over community and wealth over health.”[60]

Indigenous rights to health are codified in the UN Declaration of the Rights of Indigenous People and make up seven of ninety-four of the Truth and Reconciliation Calls to Action.[61][62] As of this writing, none of those calls have been answered. A failure to address the systemic violence and discrimination within the health care system represents an ongoing failure of the colonial state and this failing continues to deal harm to racialized communities.

MENTAL HEALTH AND DRUG ADDICTION

In this section of the analysis of the Mental Health Act’s implementation, focus is given to the intersection between drug addiction, mental illness and homelessness in British Columbia. It is common knowledge that dangerous drug addictions represent a serious harm for users, and that the rates of dangerous drug use and overdose are at historically high levels in British Columbia.[63] This has become a serious public health crisis for the province in ways which feed negatively into the public’s relationship with mental health.

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[60] Supra, Human rights-based approach
[61] *“United Nations Declaration on the Rights of Indigenous Peoples Act”* SC 2021, c 14 [UNDRIP]
[62] “*Truth and Reconciliation Commission of Canada: Calls to Action”* Truth and Reconciliation Commission of Canada (2015)
[63] F. Ali, et al, *“‘2.5 g, I could do that before noon’ a qualitative study on people who use drugs’ perspectives on the impacts of British Columbia’s decriminalization of illegal drugs threshold limit”* (2023) 18:32 Substance Abuse Treatment, Prevention and Policy

Individuals struggling with drug addiction and mental health suffer from a negative public perception, which can harm efforts related to rehabilitation.[64] Those same individuals dealing with mental health disorders, who have been failed or alienated by the medical system are much more likely than the general populace to be struggling with addiction.[65] Because of this, these people are even more likely to come into conflict with the police, and in doing so, are often characterized as "... a person with a medical disorder",[66] may be detained by police officers.

In continuing with this discussion, it must also be stated that addiction is both a mental and a physical disability in the context of the Human Rights Act.[6768] There is a significant amount of jurisprudence to this point, but for the purposes of this discussion it needs to be recognized that the Human Rights Act is both quasi-constitutional and to be read as broadly as possible.[69] In doing so, the function of the Human Rights Act is clear, in that it is meant to ensure that already vulnerable people do not suffer further discrimination. The means by which the Mental Health Act continues to inflict harm on drug users runs directly contrary to this act.[70]

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[64] Supra*, Mental Health Act* at s 3 part 22
[65] B Rush, et al, *"Prevalence of Co-Occurring Substance Use and other Mental Disorders in the Canadian Population"* (2008) The Canadian Journal of Psychiatry
[66] Supra*, Mental Health Act* at s 3 part 28
[67] *Human Rights Code* RSBC 1996 c 210 [*HRC*]
[68] *British Columbia (Public Service Agency) v British Columbia Government and Service Employees Union,* 2008 BCCA 357 (CanLII) at pp 35-36
[69] *Gonzalez v Ministry of Attorney General*, 2009 BCSC 639 (CanLII) at para 49
[70] Supra, *HRC* at s 8

Further, the criminalization of drugs, and by extension the criminalization of individuals with substance abuse problems provides a pipeline into the prison system.[71] The incarceration of those involved with drugs means that people who are entangled in the spaces of addictive substances are likely to be exposed to violence, discrimination, and generally further degrees of trauma.[72] The Canadian prison system does a poor job with efforts of rehabilitation, and instead of setting up those inside for success, health, resources or employment, they are simply let back out onto the streets, but often worse off than position they came in for the pain, trauma and isolation frequently suffered even in short stints in jail.[73]

The above is of course, only keeping in mind illegal drugs. There is an enormous industry of drugs and pharmaceutical companies in Canada. While the drugs used in psychiatric medications are useful in many contexts, they are still very potent (and often addictive) drugs, regardless of their legality. This includes antipsychotic medications like Risperidone, Aripiprazole and Quetiapine[74] that can, and have been administered to patients with the approval of directors of psychiatric institutions or individual physicians.[75] These medications can cause physical pain, heart complications, and in

[71] *"Approaches to Decriminalizing Drug Use & Possession"* UN Drug Policy Alliance (Febuary 2015) https://www.unodc.org/documents/ungass2016/Contributions/Civil/DrugPolicyAlliance/DPA_Fact_Sheet_Approaches_to_Decriminalization_Feb2015_1.pdf
[72] K. R. Quandt, & A. Jones, "*Research Roundup, Incarceration can cause lasting damage to mental health"* (2021) Prison Policy Initiate https://www.prisonpolicy.org/blog/2021/05/13/mentalhealthimpacts/#:~:text=Lasting%20effects&text=A%202013%20study%20of%2025,someone%20leaves%20the%20prison%20gates.
[73] Ibid
[74] "*Antipsychotic Medications*", CAMH https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/antipsychotic-medication [*Antipsychotic Medications]*
[75] Supra*, Charter Right to Refuse* at p 491

some extreme cases, even affect women' s fertility.[76] After their prescription and administration, there is often little accountability for the directors, nurses or physicians who administered or prescribed those drugs, as those decisions are both protected, and have been deemed to be performed with consent, per the Mental Health Act.[77]

OBSTACLES TO BETTERING THE MHA

In no small part because of the above associations with drugs and the prison system, there is also an association of violence with mental illness that permeates the public consciousness. This preconception limits the kind of public outreach that can be done, as well as the construction and staffing of new mental health facilities.[78] Though this is far from the only obstacle affecting the betterment of mental health services in British Columbia, the social pressure, influence, and voting patterns of community members who would rather the problem be out of their line of sight remains a substantial obstacle for means of change which could better their communities. As such, those community members who are the most vulnerable and those whose lived experiences should be consulted, and have those perspectives seriously considered for community betterment projects.[79]

[76] Supra, *Antipsychotic Medications*
[77] Supra*, Mental Health Act*
[78] S. Arlt, *"Navigating Conservative Drug Policy in Ontario's Safe Consumption Sites: A Critical Investigation of Harm Reduction Policy and Practice"* at p 60-62
[79] Ibid at p 59

Because of the above, much of public consciousness prefers that community members suffering from mental illness simply be removed from the public eye. This is also reflected in British Columbia's police responses to unhoused populations and "tent cities". A substantial portion of the unhoused population of British Columbia are suffering from untreated mental illness or other disadvantageous forms of neurodivergence. A survey from 2021 from BC Housing finds respondents citing mental health and addictions issues as the primary reason for losing their home at a rate of over 30%. Further, over 50% of those respondents reported rates of mental health issues in general.[80] As such, conversations surrounding mental health ought to include acknowledgement of the state of drug decriminalization as well as rates of homelessness and incarceration.

Homeless shelters in British Columbia can be both inadequate and oppressive.[81] While many of them may have beds available, the personal cost to stay at one may not be a trade-off individuals are willing to make. Being forced to stay in an environment where theft, physical violence, and sexual assaults are commonplace can be unsafe and deeply stressful[82], forcing one into either a state of vulnerability or exhausting hyper-vigilance. Further, many of these institutions place uncomfortable restrictions on people

[80] D. Lupick, "*Homelessness Services Association of BC*" (2021). 2020/2021 Report on Homeless Counts in B.C. Prepared for BC Housing, Burnaby, BC. at p 20-21 https://www.bchousing.org/publications/2020-21-BC-Homeless-Counts.pdf

[81] R. Hurtubise, P-O. Babin, C. Grimard "*Finding Home: Policy Options for Addressing Homelessness in Canada*" (e-book) (Toronto: Cities Centre, University of Toronto 2009) at c 1.2 "*Shelters for the Homeless: Learning from Research*" [*Finding Home]* https://www.homelesshub.ca/sites/default/files/1.2%20Hurtubise%20et%20al%20-%20Shelters%20for%20the%20Homeless.pdf

[82] K. A. Rudolph, *"'Shelter is Stressing Me Out': Challenges Meeting Health Care Needs of Older Adults in Congregate Shelters"* (2023) 34:3 Journal of Health Care for the Poor and Underserved pp 1003-1020

who may want to use their facilities. For example, no pets, no visitors and no drugs (even if prescribed by a doctor).[83] Because of this structural failure, many individuals, particularly in the warmer summer months, prefer to spend their days and nights in environments where they are not subject to these restrictions and scrutiny, naturally choosing to set up a tent somewhere that feels safer and more peaceful.[84] This logical choice can then put them in conflict with municipal governments and police departments. As mentioned above, the authority granted to police departments to forcibly move and destroy the shelters, temporary or otherwise of unhoused populations is both profoundly unjust and a violation of Charter rights. British Columbian jurisprudence has comprehensively proven that tent is a dwelling-house[85], and any environment that is a dwelling-house carries along with it certain legal protections, including expectation of safety and privacy.

All in all with respect to Indigenous rights to health care, intersections with drug addictions and homelessness, and coupled with the criminalization of mental illness, these actions by the state represent a profound failure of both the medical system and the criminal justice system. British Columbia has proven time and time again that its first recourse to mentally ill individuals is to quasi-legally detain them under the health care system rather than meaningfully allocate resources to community wellbeing projects.

[83] Supra*, Finding Home*
[84] Supra*, Finding Home* at p 5
[85] *R v Picard, 2018 BCPC 344* at para 29

As the Mental Health Act currently operates, it does serve its primary function of removing these individuals from the public sphere and providing practitioners with means to treat them. However, the means by which it harms individuals and disrupts their core rights is disproportionate with the purpose it serves to either the medical system or society at large.

Discourse around the Mental Health Act continues to evolve and is a major factor in the contemporary political landscape. As recently as October 29 2024, a newly re-elected Premier David Eby promised expanded use of the Mental Health Act for the involuntary detention of persons suffering from mental illness and drug addiction as part of his party's election platform in 2024.[86] Despite the criticism from legal scholars on this issue,[87] the fact that a majority government made of a (nominally) socially progressive party continues to take this stance illustrates how complicated and divisive conversations surrounding mental health, addiction and medical incarceration continue to be in British Columbia.

As of 2025, David Eby has announced a review of the Mental Health Act, following the attack at the Lapu-Lapu Day Block Party in Vancouver.[88] However, in April 2025, British Columbia opened a first-of-its-kind correctional unit, specifically to provide involuntary care for those who are "...in a mental health crisis with overlapping brain injuries and

[86] C. Dickson, *"What to expect from a new BC NDP government"* (29 October 2024) CBC https://www.cbc.ca/news/canada/british-columbia/b-c-ndp-government-accountability-1.7357437
[87] Supra*, Charter Challenge*
[88] A. Joannou, N. Shen, "*New B.C. corrections unit offers involuntary care for mental health, addictions*" CBC News (25 April, 2025) https://www.cbc.ca/news/canada/british-columbia/bc-involuntary-care-mental-health-addictions-1.7518511

addiction concerns."[89] This facility, the Surrey Pretrial Services Centre, was opened in the Surrey-Panorama riding, notable for being one of the six ridings in Surrey that the NDP lost to the new Conservative opposition in the 2024 election.[9091] The explicit purpose of this correctional facility is to provide space and beds for those who are undergoing involuntary treatment after having been detained under the above-mentioned provisions of the Mental Health Act. Eby's NDP choosing to allocate provincial resources towards a facility like this reflects a government which places a greater emphasis on politicking and placating an electorate than it does on actually reevaluating harmful legislation.

However, some health care workers have begun to push back against this expansion of involuntary care. In December 2025, a small coalition of addiction care workers in Victoria organized a "refusal campaign", rejecting their obligation to provide involuntary treatment under a deemed consent regime.[92] This group argues that they have a moral obligation to refuse violent and unsafe practices like involuntary care. This is not a stance that is predicated on legal liability, but rather one of citizens who see that institutions acting improperly should be held to higher standards.

[89] Ibid
[90] "*New Beds improve care for incarcerated people with mental-health, addiction issues*" BC Mental Health & Substance Use Services (24 April, 2025) https://www.bcmhsus.ca/about-us/news-features/new-beds-improve-care-incarcerated-people-mental-health-addiction-issues
[91] "*Provincial Voting Results*" Elections BC (17 April 2025)
[92] L. Leyne, "*Addictions workers push back against involuntary care*" Times Colonist (2 December 2025) https://www.timescolonist.com/opinion/les-leyne-addictions-workers-push-back-against-involuntary-care-11563730

THE FUTURE

Looking to the future, even without completely repealing it, there are many avenues that British Columbia could take to lessen the aspects of the Mental Health Act that are breaches of charter rights. Overseas, the British Parliament itself passed their own Mental Health Act in 1959. Even in this Act, the terms of admittance, this act required the recommendation of two doctors, one of whom was required to have special psychiatric experience. Further, the application to admit this person must be made by a family member.[93] This 1959 Mental Health Act also contains language about the patient's right to a second opinion, and that if an individual is admitted with the recommendation of only a single physician, then they can be held for a maximum of 72 hours.[94] It is worth bearing in mind that this act, while very flawed in its own right, came into effect five full years before the British Columbian Mental Health Act.

Other options require only looking domestically for appropriate solutions. In Ontario, the Ontario Mental Health Act has several provisions that explicitly call for second opinions,[95] and provide means by which power of care can be more appropriately allocated.[96] Additionally, simple language that properly defines harms, rather than appearances of dangerousness can significantly reduce unnecessary detention.[97] Implementing similar tools to these would reduce some of the most egregious oversights of the Act, and offer some much-needed recourse for patients.

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[93] *Mental Health Act*, 1959, HMSO, c 72, 7 and 8 Eliz 2
[94] Ibid at ss 25-29
[95] *Mental Health Act* RSO 1990 c M.7
[96] Ibid
[97] J. E. Gray, *"Clinically Significant Differences among Canadian Mental Health Acts: 2016"* (2016) 61:4 The Canadian Journal of Psychiatry [*Differences among Canadian Mental Health Acts]*

Another area that the province could improve is the way that the doctors present are able to authorize treatment for a patient who may refuse. While British Columbia uses the director of the psychiatric unit alone,[98] New Brunswick has a tribunal that authorizes treatment.[99] Quebec goes a step further and uses the court to authorize treatment for involuntary patients.[100],[101] Obviously, this would not remove the central issues that come from the involuntary treatment of patients in the first place, and it could also slow the processing of patients. However, distributing this medical authority into multiple hands, as well as requiring debate and consensus makes a difference towards the level of authority any individual actor can wield under these systems. This change would make it somewhat more likely that those core principles of personal autonomy will be acknowledged and respected.

Crucially, however, the most important way to reduce harm from involuntary detention and treatment is to expand the scope and scale of voluntary treatment in British Columbia.[102] Mental health services are an essential component of health care and those who are struggling deserve to have access to services that are administered in ways that respect the autonomy of individuals struggling with mental health crises and addiction. As of 2023, more British Columbians are receiving treatment for mental

[98] *Mental Health Act* RSNB 1973 c M-10
[99] *Act respecting the protection of person whose mental state presents a danger to themselves or others*, CQLR c P-38.001
[100] Supra*, Differences among Canadian Mental Health Acts*
[101] Supra*, Differences among Canadian Mental Health Acts*
[102] Supra, *Human rights-based approach*, at p 17

health issues involuntarily rather than voluntarily.[103] Reframing the way that these services are administered and delivered requires a fundamental reframing of the function of health care into one that emphasizes community wellbeing and safety.

NOTHING ABOUT US WITHOUT US

The phrase, “nothing about us without us” is a common rallying cry for the disabled and drug policy advocacy communities. In essence, it espouses that no policy decisions about a given group of people should ever be made without the explicit consultation of individuals who are a member of those groups. As such, before any movement or changes to legislation like the Mental Health Act, proper consultation should happen with people who have experienced addiction, mental health crises or other disabilities.[104] Doing so would not innately guarantee that there would be no infringements on the rights of those individuals, but it could go a long way to ensuring that the voices of those most specifically affected by legislation would not be unduly and unfairly affected by it.

The Disability Alliance BC, in addition to supporting the CCD’s position and their ongoing Charter challenges, also argues that any care which does not properly consult disability advocates is innately ableist in its implementation and function.[105] Once again it is important to remember that the people who are affected by involuntary care are not

[103] Supra, H*uman rights-based approach*, at p 19
[104] Supra, *Heard in court*
[105] K. Milne, “*Human Rights vs. BC’s Mental Health Act*” Transition, (Fall/Winter 2022) at p 14

numbers or statistics - they are people with inalienable rights. Somebody should not need to suffer or fight before they are able to safely and effectively receive the treatment that they need.

SAFE CONSUMPTION SITES

Investments in safe consumption sites, as well as reassessing the way that shelters for the unhoused are used is the final essential step. This goes hand in hand with the above-mentioned necessity of investing in voluntary care, including meeting people struggling with addiction where they are. From a community welfare perspective, measures which keep vulnerable people off of the streets and with access to crisis centers, safe supplies of drugs and accessible sources of mental health care are both morally positive, as well as considerably less expensive for the public than jails.[106] Additionally, access to safe consumption sites means that people do not have to engage with organized crime in order to have access to drugs.[107]

In Canada at large, safe consumption sites are politically controversial, particularly in the context of misinformation being spread about their function in a community.[108] However, educating the public about them can be difficult when there are deeply-seeded doubts about these programs and commonplace discrimination towards drug

[106] A. Piquero, *"Cost-benefit analysis for jail alternatives and jail"* (2010) https://criminology.fsu.edu/sites/g/files/upcbnu3076/files/2021-03/Cost-Benefit-Analysis-for-Jail-Alternatives-and-Jail.pdf
[107] Supra, *Human rights-based approach* at p 14
[108] S. Arld, "*Navigating Conservative Drug Policy in Ontario's Safe Consumption Sites: A Critical Investigation of Harm Reduction by Policy and Practice"* (2022) University of Victoria

users in a given community.[109] Because of this, it is important that education is made an essential component of this expansion of voluntary care. Ensuring that the people who access safe consumption sites are not othered or pathologized in their communities but are allowed to talk about their stories and struggles openly and honestly is an essential part of moving the needle as far as public perception is concerned.[110]

CRISIS OFFICERS

Even outside of the scope of reforming the Mental Health Act, there are measures that could be taken by municipalities and the provincial government to reduce admissions and undue harm. As discussed above, there is a strong connection between police contact and involuntary admittance.[111] Police officers are frequently put in positions where they are the only front-line mental health agents for a given community, and their training leaves them poorly equipped for these encounters. Having police departments require mandatory mental health crisis response training could go a very long way towards both minimizing the dangers for both parties in these encounters and dissuading individual officers from detaining people via de-escalation training, when it is not absolutely necessary.

In the same vein, municipal police departments investing in or partnering with mental health crisis services and empowering specifically trained experts to be the first point of contact for individuals suffering through difficult or frightening circumstances has been

[109] Ibid at pp 86-88
[110] Ibid, at pp 22-28
[111] Supra*, Involuntary Psychiatric Hospitalization*

proven to be a considerably safer alternative to police officers alone[112]. These supports are expanding in British Columbia, but the scope of these services are limited, and at present are still the exception, not the rule.[113] Guaranteeing the presence of crisis intervention officers could ensure that people in crisis would not be subject to the trauma that can come from hostile interactions with the police. Instead, those interactions could be handled by or filtered through someone who is specifically trained in the relevant kind of psychology, medicine and principles of de-escalation.

CONCLUSION

Medicine and psychological services can, and ought to be delivered to vulnerable individuals as a fundamental right. Canada's legally enshrined access to publicly funded health care is one of the cornerstones of Canadian society, both socially and legally.[114] Further, individuals suffering from the most acute effects of mental illness can pose a serious danger to themselves and others. The role of involuntary detention and occasional police involvement are necessary evils to ensure the safety of vulnerable people in the public. However, regardless of what structures may be in place, those individuals dealing with mental illness or mental health crises are still human beings whose rights ought to be protected, no matter their circumstances or dispositions may be. As such, it is the obligation of governments, police officers, medical practitioners,

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[112] R. E. Flannery, & G. S. Everly, *"Crisis Intervention: A Review"* (2000) 2:2 International Journal of emergency mental health

[113] *"Supports expanding for people in mental-health, substance-use crisis"* BC Gov News (17 July 2023) https://news.gov.bc.ca/releases/2023MMHA0043-001148. Only one year later the expanded ministry that is the subject of the article no longer exists.

[114] *Canada Health Act*, RSC 1985 c C-6

and those in the legal profession to establish means by which the rights of patients can be protected as they seek treatment.

Any society can only be as great as its least well-off members. To this point, the Mental Health Act has served a purpose for British Columbia, but the negative effect that it has had on some of the most vulnerable people is too great to ignore. In this author's opinion, the most effective and ethical solution would be to start from the ground up, creating a new act that places a greater emphasis on public health, rehabilitation, education and community responsibility, rather than simple detention and removal from communities.

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