HEALTH JUSTICE

A Path Forward: Human rights-based guiding principles for BC's mental health law and services

Guiding Principles Publication | Health Justice

December 2022

Publishing Notes

Contributors: Health Justice staff, Lived Experience Experts, Indigenous Leadership Group, Family/Personal Supporter Advisory members, Clinician Advisory members, and many other community stakeholders.

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This publication is the first in a series of publications launched by Health Justice that will set out a path for BC to improve its mental health and substance health law and policy to better support human rights. Sign up for updates on the Health Justice website to receive notification of other publications as we develop them.

This publication does not provide legal advice. It describes the law at its date of publication but may not reflect changes made after its publication.

Funding for the research and development of this publication was generously provided by the Law Foundation of British Columbia.

THE LAW FOUNDATION OF BRITISH COLUMBIA

ISBN 978-1-7389565-0-0

Interactive Menu

If you're not a fan of standard table of contents try out the menu below. If you are, there is one on the next page. Click the names of what you would like to know about.

NOTE: This menu will not be clickable on mobile due to pdf limitations.

Contents

Introduction

In this section, we describe some information about Health Justice and our process:

- Health Justice uses research, education, and advocacy to improve the laws and policies that govern coercive mental health and substance use treatment in BC.
- Health Justice uses a participatory engagement governance model that centres those most impacted by our work.
- This publication has been developed using an iterative process rooted in the foundational knowledge and analysis of the Lived Experience Experts Group, the Indigenous Leadership Group, other people with lived and living experience of involuntary treatment, clinicians, and family/personal supporters of people with lived experience.

"In addition to our board of directors, Health Justice is governed by the Lived Experience Experts Group and the Indigenous Leadership Group."

Introduction to this document, Health Justice and our process

The delivery of mental health services, and particularly the use of detention and involuntary treatment, have deep implications for a person's human rights, including the right to equal protection before the law, the right to bodily autonomy, and the right to liberty. Many places outside of BC have recognized these impacts in their mental health laws and incorporate legal guiding principles to clarify and embed values, principles or objectives for the statutes that address the most crucial human rights issues that arise.

Much of BC's Mental Health Act has remained essentially the same since the 1960s. It has not been updated to fully reflect human rights or emerging practice, and it does not contain any provisions to clarify its purpose or underlying values. As a result, the practical application of the Act and the way it impacts a person's life is largely up to the individual service provider's understanding and approach. The lack of core guiding principles or clarity of purpose leaves open the possibility for systemic bias to influence decision-making under the Act.

In the face of well documented human rights violations occurring under BC's current Mental Health Act and an urgent need to modernize BC's approach to mental health law and involuntary treatment, this publication sets out eight core guiding principles that should be incorporated in a new mental health law in order to shift BC's mental health and substance use health system towards a human rights-based approach.

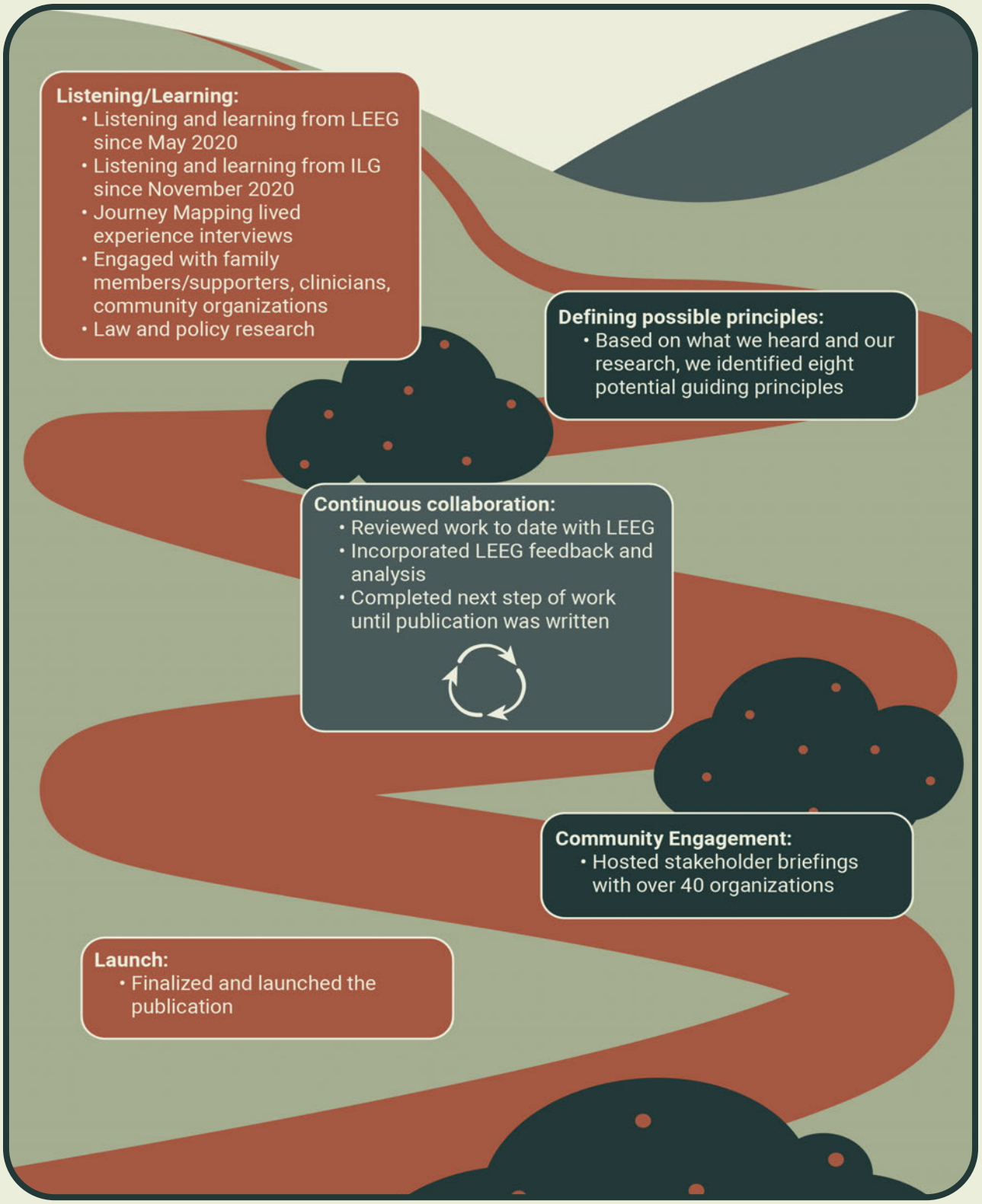
The documented issues with BC's mental health system are complex and deeply entrenched. Incorporating guiding principles into the law alone will not create the necessary systems change in BC. However, a values-based foundation that is rooted in core human rights principles is needed to ensure that every person has an equal chance to be well. They provide important guidance on BC's approach to mental health and substance use health law and services that have the potential to guide systems change.

Each of the eight guiding principles identified in this publication can be incorporated into BC's mental health law and provide a path for change towards a person-centred system that respects human rights. In future publications, Health Justice will provide further analysis on how the eight principles can be further implemented in the law.

About Health Justice

Health Justice was established in 2020 to undertake research, education, and advocacy to improve the laws and policies that govern coercive mental health and substance use health treatment in BC. We work using a participatory engagement governance model that centres those most impacted by our work. In addition to our Board of Directors, our work is governed by the Lived Experience Experts Group (LEEG), made up of individuals with lived experience of involuntary mental health or substance use treatment, and the Indigenous Leadership Group (ILG), made up of individuals with expertise in the impacts of our work on First Nations, Métis, and Inuit people. Health Justice brings together human rights, lived experience, cultural, clinical, family, and community-based expertise to inform our work.

Our process


Listening/Learning:
• Listening and learning from LEEG since May 2020
• Listening and learning from ILG since November 2020
• Journey Mapping lived experience interviews
• Engaged with family members/supporters, clinicians, community organizations
• Law and policy research
Defining possible principles:
• Based on what we heard and our research, we identified eight potential guiding principles
Continuous collaboration:
• Reviewed work to date with LEEG
• Incorporated LEEG feedback and analysis
• Completed next step of work until publication was written
Community Engagement:
• Hosted stakeholder briefings with over 40 organizations
Launch:
• Finalized and launched the publication

To develop this publication, we have been listening and learning from the Lived Experience Experts Group since May 2020 and the Indigenous Leadership Group since November 2020. We have also heard from clinicians, family members/personal supporters, and other organizations and service providers. In spring 2022, Health Justice hosted Journey Mapping sessions where people with lived and living experience of detention and involuntary treatment under BC's Mental Health Act shared their experiences in one-on-one interviews. Participants were diverse in terms of their geographic location in BC, community size, Indigeneity, race, gender, age, family status, and many other factors. All of this expertise has informed this publication, and we have sought feedback in an iterative way as the document was developed.

Throughout the publication, you will see quotes and analysis from Lived Experience Experts, which were provided through Lived Experience Expert Group meetings or through Journey Mapping interviews. Quotes and analysis from the Indigenous Leadership Group are also featured, which were provided during the Group's meeting process. Authors of quotes and analysis have consented to the inclusion of their thoughts and words in this publication.

Health Justice has also carried out a large amount of legal and policy research since early 2020. Staff and volunteer law students have analyzed BC's Mental Health Act against constitutional and human rights requirements and international human rights agreements. We have also researched the ways that over 22 other jurisdictions in the world frame their mental health laws and incorporate human rights. Finally, Health Justice has filed several Freedom of Information requests to try to learn more about how the Mental Health Act is being used and to ensure that information is accessible to the public.

In an effort to grow a movement rooted in relationship, in the fall of 2022 Health Justice commenced a community stakeholder briefing process by inviting individuals and organizations to attend briefing sessions to learn about our work and the publication. We invited interested stakeholders into this work and asked them if they would like to express support for it in some way. We are very grateful for the support and interest we received in this process.

The following organizations opted to express that they support, see value, or see a need for the recommendations contained in this publication:

Acknowledgment

In this section Health Justice acknowledges that:

- Our registered office is located on the traditional, ancestral, and unceded territory of the xʷməθkʷəy̓ əm, Sḵwx̱ wú7mesh, and səl̓ ílwətaɬ Nations.
- Colonization has disrupted distinct First Nations, Inuit and Métis legal and health systems. Colonial dynamics continue today, including through the health and legal systems.
- All of the thoughts, ideas, and analysis in this publication have been built upon expertise and analysis shared with us by experts with direct lived and living experience and Indigenous leaders.

"Involuntary treatment can be experienced as yet another source of control over Indigenous people that pathologizes the impacts of colonialism."

Acknowledgment of territories, Indigenous legal orders, and the impacts of colonization

Health Justice's work focuses on provincial laws that apply throughout the area that is colonially named British Columbia. These colonial laws impact Indigenous people living on the traditional, ancestral, and unceded First Nation territories as well as land that is governed by treaties. Currently in BC, over 200 distinct First Nations, 39 chartered Métis communities, and many First Nations, Métis, and Inuit people living away from home in communities across British Columbia hold their own unique ancestral legal orders, justice systems, well-established health practices, concepts of health, and traditional healers.

Colonization, including land theft and the application of colonial laws, have disrupted these sovereign legal and health care systems in numerous ways. The ongoing intentional displacement of communities from their traditional territories and the separation of children from their families and communities undermine protective factors and interrupt ways of sharing knowledge, families, communities, cultural land-based practices, and languages. The colonial dynamics continue today in many public systems, including the health and legal systems. Involuntary mental health and substance use treatment, enforced by the colonial health and legal systems, can be experience as yet another source of control over Indigenous people that pathologizes and criminalizes the impacts of colonialism. Recognizing this systemic context is foundational to understanding the impacts of genocide, colonization, and racism in colonial health and legal systems on First Nations, Métis, and Inuit people, as well as their resilience and resistance to those systems.

Health Justice is a virtual organization with a registered office address located on the traditional, ancestral, and unceded territory of the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), and səl̓ílwətaɬ (Tsleil-Waututh) Nations. Staff, board members, Lived Experience Experts Group members, and Indigenous Leadership Group members live and work on the lands of many different First Nations. Health Justice staff live, work and have ties to the traditional, ancestral, and unceded territories of the xʷməθkʷəy̓ əm (Musqueam), Sḵwx̱ wú7mesh (Squamish), səl̓ílwətaɬ (Tsleil-Waututh), Lək̓ ʷəŋən (Lekwungen) peoples (including the Songhees and Esquimalt), kʷikʷəƛəm (Kwikwetlem), QayQayt, Sinixt, Syilx, and Ktunaxa Nations.

Acknowledgment of foundational expertise

All of the thoughts, ideas, and analysis in this publication have been built upon expertise and analysis that has been shared with us by experts with direct lived and living experience and Indigenous leaders. It has helped us understand how the system is or isn't working, recognize how people are impacted, and identify avenues for positive change. This work would not exist without that expertise.

The work is also building on a long history of advocacy and organizing related to mental health detention, diagnosis, labels, and services, often carried out by people with lived or living experience. We want to acknowledge that Health Justice did not start this work and have had the privilege of learning from and building upon hard work already done by others who are often unacknowledged.

It is impossible to adequately make the depth of this leadership visible with citations and individual acknowledgments. Communities and individuals sharing their wisdom and insight have deeply shaped the ideas throughout this publication, and throughout all of Health Justice's work.

Section Summary

Why does BC need a human rights-based approach?

BC needs a human rights-based approach in its mental health law and system because:

- Mental health has a deep and reciprocal connection to our human rights.
- Human rights under international agreements, the Canadian Charter of Rights and Freedoms, and Human Rights Codes intersect with mental health law.
- BC's Mental Health Act grants extraordinary power that impacts an increasing number of people, and not all people are impacted in the same way.
- There are well documented accountability and human rights problems related to BC's Mental Health Act.

"People have this perception of all consuming, omnipotent power... in the end, what they [professionals] want is what defines what your rights are."

- Lived Experience Expert

Why does BC need a human rights-based approach?

Mental health has a deep and reciprocal connection to our human rights. A failure to respect basic rights has a negative impact on our overall health, including mental health. A failure to implement adequate safe, accessible mental health services, law, and policy results in human rights violations for someone with a mental health-related disability.

For example, communities that experience racism, colonization, or other forms of discrimination suffer negative mental and physical health impacts because of those experiences. In addition, we know that these people face immense barriers to finding affordable, adequate, safe, and accessible services that support their needs, which creates further inequities.

> **"Behind every issue, whatever your issue is, there is an entire person. There is a human being and they have human rights."**
>
> **- Lived Experience Expert[1]**

This quote describes an experience that many people with lived experience of involuntary treatment describe in similar terms: detention and involuntary treatment under the Mental Health Act makes them feel less than human. They are forced to continually reassert their humanity, including that they are credible experts about their own bodies, minds, lives and needs.

In addition, a human rights-based framework ensures that law and policy address the root causes of mental distress at a systemic level instead of at the individual level. For example,

human rights require we look at interdependent needs like adequate housing, adequate income, and freedom from discrimination, which all impact mental health and wellbeing. This framing is helpful to move away from our current approach, which focuses on responding once someone is already unwell, and focuses on reducing their individual symptoms, but not at systemic policy change that would prevent a crisis and support their overall health.

Human rights and how they apply to health services

Our human rights stem from international agreements that flow from the Universal Declaration of Human Rights. The Declaration was adopted in 1948 in the aftermath of the human rights atrocities of World War II with the goal of creating a common standard for basic rights throughout the world.[2]

The rights contained in the Declaration are expanded upon in the International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights. The rights are further expanded upon in several additional agreements to reflect the needs and past human rights violations experienced by specific communities of people, including racialized people via the UN Convention to End Racial Discrimination; women via the UN Convention to Eliminate all forms of Discrimination Against Women; people with disabilities via the UN Convention on the Rights of Persons with Disabilities; Indigenous peoples via the UN Declaration on the Rights of Indigenous Peoples; and children via the UN Convention on the Rights of Children. Compliance with these agreements is required for a state to uphold human rights.

Most of these human rights agreements create obligations for countries that sign them, with compliance monitored via periodic review and complaint protocols. They require that countries commit to ensuring that laws, policy, and government actions respect and uphold human rights, prevent human rights violations, and continually work toward the **progressive realization** of the commitments contained in the agreements.[3] Progressive realization means that countries must take steps and use the maximum of their available resources to continue working towards fulfilling the rights. This recognizes that it may not be possible to fulfill all rights-based obligations immediately, but it does not mean that countries can wait to take action. Instead, countries must continually show they are making every effort to comply with the obligations set out in human rights agreements.[4]

Canada has ratified or adopted all of these agreements.[5] The rights contained in these international documents also form the basis for Canada's own human rights tools: the Canadian Charter of Rights and Freedoms (Charter), contained in the constitution, and human rights statutes like BC's Human Rights Code, which hold a quasi-constitutional status.

All the rights contained in the Charter must be respected in legislation and state action, but the following Charter rights are particularly relevant in the context of health care and social services:

- The section 2 right to freedom of conscience, religion, thought, belief, opinion, and expression.
- The section 7 right to life, liberty and security of the person and the right not to have those rights violated unless the violation complies with the principles of fundamental justice.
- The section 9 right not to be arbitrarily detained.
- The section 10 rights on detention to be informed promptly of the reasons, to retain and instruct counsel without delay and to be informed of that right, and to have the validity of the detention determined through a habeas corpus application and to be released if the detention is not lawful. (Habeas corpus is a way for a person to apply to a court and ask them to review any state detention to determine if it complies with the law.)
- The section 12 right not to be subjected to any cruel and unusual treatment or punishment.
- The section 15 right equal protection and equal benefit of the law without discrimination on the basis of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.[6]

Involuntary treatment has immense impacts on human rights

BC's Mental Health Act authorizes the detention and involuntary treatment of people who have a "mental disorder" (the term used in the Act).

The powers authorized by the Act are extraordinary[7] and affect some of our most fundamental human rights, including the right to an equal chance at health; the right to autonomy over our body and make our own health care decisions (security of the person); the right to be free from detention (liberty); and the right to be treated equally (with respect to disability, but also other protected identity factors).

Mental Health Act Overview

The Mental Health Act is one of the main laws in BC that authorizes detention in health settings and coercive health care. It sets out when you can be detained and involuntarily treated for a "mental disorder". People with a range of disabilities, health conditions, and diagnoses are being detained under the Mental Health Act, including people with psychiatric diagnoses, brain injuries, dementia, Fetal Alcohol Spectrum Disorder, and substance use related health issues.

It is a common misconception that people must be considered at risk of harm to themselves or others to be detained under the Mental Health Act. While historically the threshold in the law was only to detain people at risk of harm to themselves or others, the law was expanded in 1998. Since then, physicians involuntarily admit and detain people in a Mental Health Act facility on the basis of four criteria:

1. You have a mental disorder that requires psychiatric treatment and seriously impairs your ability to react to your environment or associate with others;
2. You require psychiatric treatment in a facility or on extended leave;
3. You require care, supervision and control in a facility or on extended leave to protect you or other people OR to prevent your mental or physical health from substantial deterioration; and
4. You are not suitable as a voluntary patient.

The Mental Health Act also authorizes police to apprehend and detain people based either on personal observations or information that was provided to police by third parties. While this apprehension is civil (i.e. there is no requirement that there be a suspicion of criminal activity), individuals apprehended by police are frequently placed in handcuffs and otherwise restrained during transportation to a Mental Health Act facility.

Once you are made an involuntary patient, staff working at designated facilities and mental health teams have significant legal powers to make decisions impacting your rights. Three key powers grant authority to make decisions impacting involuntary patients:

- **Section 31 of the Mental Health Act** states that involuntary patients are "deemed" to have consented to any form of psychiatric treatment staff at detaining facilities or mental health teams choose. Since the law creates a fiction that consent already exists, that means the law doesn't require involuntary patients to be assessed to see whether they are capable of making treatment decisions. Involuntary patients who are capable of making their own treatment decisions are not permitted to make their own decisions and families and personal supporters are excluded from decision-making on behalf of

their loved ones. This does not happen for other forms of health care in BC. If someone is assessed as mentally incapable of making a treatment decision, the people they trust and know them best act as supported or substitute decision-makers.

- **Section 32 of the Mental Health Act** states that every patient is "during detention, subject to the direction and discipline" of the facility staff. This means that patients can be solitarily confined in seclusion rooms, mechanically restrained with straps that tie them to their beds, or otherwise punished during their time in hospital. There are no limits on when, how, or why someone can be subject to these restraints and no review. Other conditions involuntary patients experience in detention, such as access to visitors, access to methods of communication like a phone, and access to the outdoors is determined by staff with this broad grant of discretion.
- **Section 37 of the Mental Health Act** provides authority for staff at detaining facilities to release involuntary patients on leave in the community under conditions. In community involuntary patients on leave are generally under the supervision of a mental health team and still subject to the "deemed consent" model, therefore this amounts to a de facto sort of compulsory community treatment regime. There are no criteria or limitations on the conditions that can be imposed on involuntary patients and someone suspected of violating their conditions of leave can be recalled back to detaining facilities.

The Act is specifically intended to impact the human rights of people with mental health-related disabilities, a community that faces historic discrimination, deeply held stereotypes,[8] stigma,[9] and significant access to justice barriers.[10] The Convention on the Rights of Persons with Disabilities affirms that people with mental disabilities have a right to not be discriminated against and to equally enjoy freedom from arbitrary detention, health care autonomy, and an equal chance to achieve their best health.[11] A human rights-based framework can assist in ensuring these rights are respected and that patterns of discriminatory beliefs are not further entrenched through the powers authorized in the law.

In addition, there are emerging arguments to critically analyze whether we should have separate mental health laws at all instead of incorporating rights and obligations related to mental health services into broader health care-related legislation. For example, the World Health Organization (WHO) and the UN High Commissioner on Human Rights (OHCHR) recently issued guidance on this point and noted that stand alone mental health laws reinforce historic and ongoing discrimination that mental health needs are different than other health needs and need to be managed with special legal authority for coercion and force.[12]

Involuntary treatment impacts communities differently

BC collects only minimal demographic data related to involuntary treatment under the Mental Health Act, including age, location, and sex. It is unclear whether the Ministry of Health collects data to monitor how the Mental Health Act impacts people on the basis of race, Indigeneity, gender, sexual orientation, or income level.

Data can be a powerful tool to help understand how government powers like those authorized under the Act are being used, and it can help maintain safeguards to ensure powers are being used fairly and in ways that do not reflect systemic discrimination. Data can also be harmful when it is collected and used without the consent and governance of communities impacted. BC's Office of the Human Rights Commissioner issued a report on the importance of disaggregated data to understand and address inequities, and on the importance of data sovereignty for communities whose data is being collected.[13]

While there is little disaggregated data available on the use of the statutory powers and safeguards related to BC's Mental Health Act, the information that is available indicates that the impacts of detention and involuntary treatment may be disproportionate based on factors such as age, sex, Indigeneity, and race. The data provides a useful lens into these disproportionate impacts in some ways, but also often fails to reflect the experiences of people with intersecting aspects of their identities that result in impacts that cannot be understood through any one category.

Age

Rates of detention and involuntary treatment are growing at faster rates for certain populations in BC. The Representative for Children and Youth documented that detentions of children and youth under the Mental Health Act increased "alarmingly" by 162% between 2008/09 and 2017/18.[14] Access to justice metrics also demonstrate that children and youth access hearings to review their detention at substantially lower rates than the overall population.[15]

Gender and sex

There is also reason to believe that the impacts of the Mental Health Act may be gendered. A deeper look at the increase in detention and involuntary treatment of children and youth reveals that there are vastly disproportionate impacts on girls and young women between the ages of 10 and 19. The rate of detention and involuntary treatment for that population has increased by approximately 222% between 2008/09 and 2017/2018.[16] In contrast, the rates of detention and involuntary treatment of boys and young men increased by approximately 81% over the same period.

These statistics are based on Ministry of Health records that state: "Cases with gender other than male or female are only counted in total only[sic]," but the records use binary sex categories.

As a result, it is unclear if and how these numbers reflect gender identity.

Additionally, there is some evidence that among all involuntary patients in BC, female patients have been administered electroconvulsive therapy at rates that are approximately two to three times higher than male patients.[17]

Race and Indigeneity

BC does not track disaggregated race-based data with respect to mental health detention and involuntary treatment, however, disproportionate impacts documented in other jurisdictions indicate there are significant reasons to monitor this data. BC's Human Rights Commissioner has called for this data to be prioritized in BC's work to improve data collection and monitoring to support equity.[18]

Mental wellbeing and the use of state powers like those authorized under the Mental Health Act are deeply influenced by racism, colonialism, systemic discrimination, and inequity. Jurisdictions that do track impacts based on race, ethnicity, and Indigeneity have shown that Indigenous, Black, and other racialized communities experience detention and involuntary treatment at disproportionately higher rates and are subject to higher levels of coercion while detained.[19]

The 2020 report on anti-Indigenous racism in BC's health care system titled *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care*, was based on engagement with thousands of Indigenous people and clinicians and documents a number of discriminatory stereotypes that are applied to Indigenous people in the health care system.[20] Many of these racist stereotypes, including that Indigenous people are less capable and less likely to be compliant,[21] may directly impact how health care staff assess the appropriateness or necessity of detention and involuntary treatment for an Indigenous person. The report profiles two examples of stories from Indigenous people who went to hospital seeking physical health care who were detained under the Mental Health Act, with police and security involvement.[22]The Ministry of Health has stated that it believes Indigenous children and youth are detained at higher rates in BC under the Mental Health Act, despite the absence of data on that question.[23]

Further, understanding disproportionate experiences of involuntary mental health treatment as an indicator of systemic racism aligns with the analysis of Dr. Kwame McKenzie, CEO of the Wellesley Institute and Director of Health Equity at the Centre for Addiction and Mental Health. Dr. McKenzie has noted that Black and other racialized people are less likely to be offered mental health supports, such as counseling or psychotherapy, and are more likely to be offered prescription drugs and subjected to coercive health care.[24]

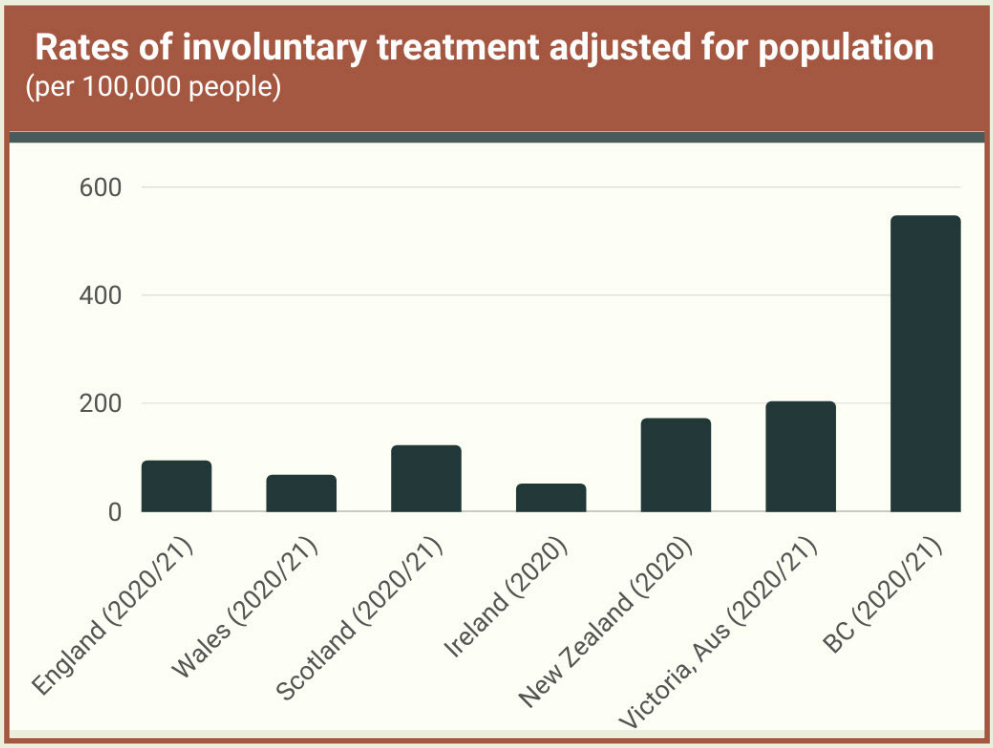
Substance use

There is ongoing confusion and lack of consensus in BC about the use of involuntary treatment under the Mental Health Act for substance use.[25] Regardless of this lack of clarity, the Mental

Health Act is currently being used for people whose primary health issue is a substance use disorder.[26] According to a report by SFU's Centre for Applied Research in Mental Health and Addictions, in 2016/17 over 22% of involuntary admissions under the Mental Health Act were people diagnosed with a primary substance use disorder. Further, the report documents significant growth in the use of the Act to authorize detention and involuntary treatment in relation to substance use. Between 2008/09 and 2016/17, involuntary admissions for a primary substance use disorder increased by 140%.[27]

BC's escalating reliance on involuntary treatment

It is clear that BC's Mental Health Act has significant impacts on human rights. In addition, the number of people it impacts continues to increase rapidly. In comparison to other jurisdictions with available data, BC's use of involuntary treatment is high:[28]



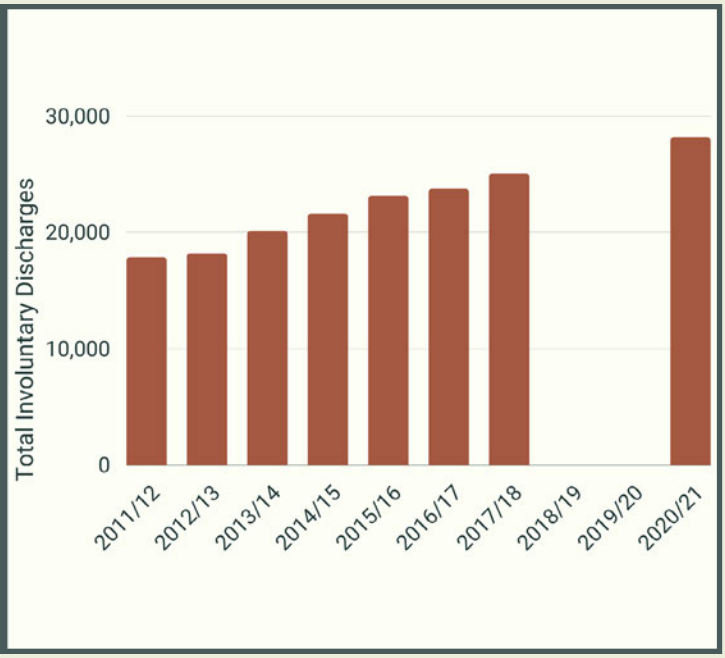
Note: It is challenging to compare data across different legal jurisdictions because different laws create different triggers and processes for involuntary treatment. This graphic illustrates the overall detentions by population available in public data.

The use of the detention and involuntary treatment powers granted in the Mental Health Act has been increasing in recent years while the use of voluntary treatment under the Act has remained largely stagnant. In other words, BC is increasing its reliance on involuntary approaches to mental health services while failing to expand access to voluntary services at comparable rates.

Increasing rate of involuntary hospitalizations

This data is from the Ombudsperson's 2022 Systemic Investigation Update (Fig 2b at page 31). It reflects all discharges from Schedule B and C facilities designated under the Mental Health Act by fiscal year, all diagnoses combined

Data for 2018/19 and 2019/20 is not available due to changes in data reporting made by the Ministry of Health.



Increasing reliance on involuntary treatment

This data is from the Ombudsperson's 2022 Systemic Investigation Update. It reflects all discharges of unique patients from Schedule B and C facilities designated under the Mental Health Act by fiscal year, main diagnosis category.

Data for 2018/19 and 2019/20 is not available due to changes in data reporting made by the Ministry of Health.

There is a well-documented lack of accountability in BC's involuntary treatment system

Detention and involuntary treatment pursuant to the Mental Health Act has become the primary way acute mental health and substance use health care is provided in BC. At the same time, there is mounting evidence that BC's health system is violating the human rights of people experiencing detention and involuntary treatment.

Community

In 2017 the community-based research report *Operating in Darkness: BC's Mental Health Act Detention System* found widespread issues of non-compliance with basic human rights, such as practices among detaining facility staff of discouraging detainees from exercising their right to seek review of their detention by offering inducements, making threats, exerting pressure, and actively interfering with access to hearings.[29] The report concluded that the Mental Health Act is insufficient to fulfill the human rights of detainees even if complete compliance was achieved. It made over 50 recommendations for reform.

In 2018, the Carnegie Community Action Project released *No Pill for This Ill: Our Community Vision for Mental Health*.[30] The report documents the experiences of people living in Vancouver's Downtown Eastside (DTES), including the ways that BC's current approach to mental health services creates harm and undermines wellbeing. It made a number of recommendations, including ending the policing of mental health, ensuring people are respected as experts in their own mental health needs, increasing peer-based services, and ending the war on drugs.

In 2019, the Downtown East Side Women's Centre released *Red Women Rising: Indigenous Women Survivors in Vancouver's Downtown Eastside* based on the leadership and input of 113 Indigenous women living in the DTES. Recommendations included non-police mental health and wellbeing responses, increased cultural safety in the health system, reforms to the Mental Health Act to ensure it complies with the Charter, and many others.[31]

Ombudsperson

In 2019 the Ombudsperson's Office published *Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act*, which found that only 28% of files audited across BC had the legally required documentation to detain and involuntarily treat patients under the Mental Health Act. The Ombudsperson made 24 recommendations centred on improving compliance and echoed community recommendations for the Ministry of Attorney General to establish a legal aid funded service to provide independent rights advice to involuntary patients upon detention.

In that 2019 investigation report, the Ombudsperson stated:

> …the health care system, specifically the health authorities and the Ministries of Health and Mental Health and Addictions, have not taken sufficient steps to uphold patient rights by implementing external oversight and internal management practices sufficient to ensure statutory compliance. Moreover, they have not developed a culture within the mental health care system that places sufficient emphasis on the importance of an involuntary patient's legal rights.[32]

In 2022, the Ombudsperson's Office released an investigative update documenting the progress to implement these 24 recommendations. That report found that despite three years of dedicated work, only one third of the 2019 recommendations had been implemented.[33] In addition, 42% of files had the legally required documentation to detain and involuntarily treat patients under the Mental Health Act, only a 14% increase in compliance with basic mandatory legal procedures.

Representative for Children and Youth

In 2021 the Representative for Children and Youth released *Detained: Rights of Children and Youth under the Mental Health Act*, documenting an alarming increase of detention and involuntary treatment with children and youth.[34] The report found that there was a lack of opportunity for detainees to have a say in treatment options that are more trauma-informed, relational, diverse, and connected with family and culture[35] and that unregulated use of restraint and confinement was "unacceptable".[36] The report summarized the experience of children and youth as follows:

> Most of the young people who participated in this report were surprised to learn that they had rights; they did not remember hearing about, or seeing forms explaining their rights. Young people weren't aware they could request second medical opinions or access a lawyer for support to review their detention. They recalled forced medication, not being involved in treatment decisions and a lack of attention to the underlying reasons for their pain. They recalled scary periods of isolation and restraint. Indigenous young people recalled racism and an absence of culturally relevant treatment.[37]

Mental Health Review Board

In its 2019/20 annual report, the Mental Health Review Board documented that while detention rates have risen, the number of people accessing review panels, the most accessible way for a person to have their detention and involuntary status reviewed, has not been rising to keep pace. The Board concluded that the Act has "systemic issues that undermine the ability of patients to receive fair, timely, and independent reviews of their loss of liberty."[38]

United Nations Special Rapporteur

BC's Mental Health Act was singled out for criticism by the United Nations Special Rapporteur on the Rights of Persons with Disabilities following an inspection of Canada in 2019. The Special Rapporteur observed that "the Mental Health Act of British Columbia contains very broad criteria for involuntary admissions and, once detained, a person can be forcibly treated without their free and informed consent, including forced medication and electroconvulsive therapy" in contradiction to Articles 14 and 25 of the United Nations Convention on the Rights of Persons with Disabilities.[39]

Pandemic Impacts on Human Rights

The COVID-19 pandemic has only exacerbated the existing human rights impacts set out in this report. The mental health impacts of the pandemic were not experienced equally. People with existing mental health concerns, Indigenous people, people with disabilities, LGBTQ2SI+ people, and people living in poverty experienced more negative impacts.[40]

Human rights concerns about mental health detention were also heightened during the pandemic. For example, the Office of the United Nations High Commissioner for Human Rights expressed concerns that people confined to institutional settings face greater risks of human rights violations in times of pandemic, such as being subject to restraints or isolation.[41]

A human rights-based approach aligns with evidence-based practice

A human rights-based approach aligns with a recovery oriented model for mental health services[42] and with public health practices that prioritize the social determinants of health and root causes of illness.[43] In addition, a human rights-based approach is required to meet emerging recommendations established by the World Health Organization (WHO) in its comprehensive guidance on promoting person-centred and rights-based approaches to mental health services,[44] and the recent draft *Guidance on Mental Health, Human Rights and Legislation* created in partnership with the Office of the United Nations High Commissioner for Human Rights.[45]

Further, incorporating human rights is about creating enforceable human rights protections, but it also provides a foundation for systems change throughout BC's mental health law, policy,

and services. Using human rights as a framework to develop, evaluate, and apply BC's mental health law will improve mental health services in practical and tangible ways throughout the province. While the legal enforceability of human rights is crucial, their ability to impact everyone's experiences in accessing service is also important:

> Human rights have all too often been associated with courts, lawyers and retrospective legal action. It is also not unusual to hear people express the fear that introducing a human rights-based approach will mean people demand entitlements that simply cannot be delivered in a difficult financial climate. Used effectively, however, rights have the potential to offer us a set of standards that shape policies, programmes and practical interventions, i.e. something that concerns us all in our everyday lives.[46]

Mental health law and services that prioritize, incorporate, and respect human rights will support the mental health and wellbeing of people across BC.

Section Summary

Why does BC need guiding principles for mental health law and services?

BC needs guiding principles for its mental health law and services because:

- Without a purpose or clear principles in the law, the use of the law will depend largely on individual interpretation.
- BC's current Mental Health Act has no express purposes or guiding principles, which results in conflicting understanding and confusion.
- There is currently a global movement to rethink the purposes of mental health laws, so developing principles for BC is timely.
- Guiding principles can help ensure we do not repeat historic human rights violations.

"It feels like it's a crime to be mentally ill in BC – detention and involuntary treatment feel like punishment."

- Lived Experience Expert

Why does BC need guiding principles for mental health law and services?

Knowing the purpose and the guiding principles of a law can assist any person who is tasked with interpreting the law, whether it be a health care worker or a judge in a legal decision. Guiding principles provide an indication of the purpose of a statute and what it is intended to achieve. They can also be a powerful tool for culture and systems change.

The benefits of guiding principles

Without a purpose or clear principles articulated in the law, the use and application of the law will depend largely on individual interpretation. This leads to inconsistent application of the law in practice, with experiences of BC's Mental Health Act varying greatly depending on how individual facility staff or physicians interpret the scope of the Act and their authority. For example, there is significant confusion and lack of consensus among physicians on whether the Act permits the detention and involuntary treatment of people for substance use health issues.[47]

The greater the scope of individual interpretation, the greater the chance that unconscious bias plays a part in decision-making. For example, stereotypes based on Indigeneity or race are more likely to be relied on in subjective decision-making, which may be contributing towards the disproportionate use of Mental Health Act detention with Indigenous and racialized people.

In addition, without guiding principles that set out the values we want to achieve in our mental health and substance use health system, administrative and financial pressure, or the daily

stress of working in an under resourced system can quickly become priority considerations that take precedence over the needs of the individual involved. For example, without a foundational value establishing the power and necessity of procedural safeguards, which can then be prioritized across the system in training, evaluation, and service design, filling out legally required forms can be viewed as an unimportant administrative task, instead of a crucial safeguard and opportunity to involve a patient in decisions that impact them.

The BC Ombudsperson has recognized that BC's mental health system has a cultural problem in that it does not place enough priority on respecting patient rights.[48] Guiding principles in the law can help to shift the culture of the system if they are actioned in a way that ensures the principles result in meaningful change at an individual level.

BC's Mental Health Act has no guiding principles or clear purpose

BC's current Mental Health Act does not include any purposes or principles that guide interpretation and application of the Act. In the absence of clear principles, we are left to look to other interpretations to understand what the Act is trying to achieve, many of which are either outdated or occurred in another context. Those interpretations vary.

Many people with lived and living experience of involuntary treatment, as well as family members and personal supporters, understand the purpose of the Mental Health Act as a tool of control, compliance, or punishment. A Lived Experience Expert observed,

> **"It feels like it's a crime to be mentally ill in BC – detention and involuntary treatment feel like punishment."**
>
> **- Lived Experience Expert[49]**

In contrast to this visceral understanding, courts and the government have also tried to determine the purpose of the Act with very different conclusions:

- In 1993 in the *McCorkell v Riverview Hospital* decision, the BC Supreme Court concluded based on the statutory framework of the time, which has since been amended, that the purpose of the Act is "the treatment of the mentally disordered who need protection and care in a provincial psychiatric hospital".[50]
- In 2003 in the *EME v DAW* decision, the BC Supreme Court, while deciding whether to appoint a litigation guardian for the plaintiff in a motor vehicle action, the Court stated that "[a]n object of the Mental Health Act is to ensure appropriate care is available to persons who are unable, due to a disorder of the mind, to function at a minimally effective level in the community".[51]
- The BC government often describes the Act being used to promote safety. For example,

> in the *Pathway to Hope* the Ministry of Mental Health and Addictions stated, "The safe practice of involuntary admissions under the B.C. Mental Health Act balances the rights of the individual with the obligation to help and protect people living with mental illness."[52]

The Guide to the Mental Health Act, first published in 1997 and last revised in 2005, relies on the interpretation the BC Supreme Court made in the *McCorkell* case. It also states the "Mental Health Act helps provide people with mental disorders the treatment and care they need when they are not willing to accept it" and that the "main purpose of the Mental Health Act is to provide authority, criteria and procedures for involuntary admission and treatment."

None of the existing sources recognize the role of the Mental Health Act with respect to voluntary mental health services or the fact that many people with mental disorders are subject to the Mental Health Act when they are willing to engage with treatment and care. This may be because laws like the Mental Health Act also impact legal liability through legitimizing activities that would otherwise be unlawful. For example, detaining and providing treatment without consent would otherwise be considered battery, assault, and/or false imprisonment.[53]

The tendency to focus primarily on detention and involuntary treatment as the purpose of mental health law has been criticized as a reflection of long held discriminatory stereotypes about people with mental health-related disabilities, including that they are incapable, dangerous, or flawed.[54] It has also been noted to reflect a prioritization of medication-based approaches and crisis-based responses.[55]

Despite the immense state powers authorized under the Mental Health Act, there is no acknowledgement of the fact that involuntary treatment comes with a high risk of causing harm. Some people with lived experience of involuntary treatment report great benefit from their involuntary treatment. Others report being deeply harmed and traumatized. Many report experiencing both benefits and harm from their experiences. However, it is clear that involuntary treatment carries the potential for harm and trauma. There is also little focus on other aspects of the statute that impact rights: for example, ensuring access to quality services, requiring safeguards related to uses of force, coercion, "disciplinary" powers like the use of seclusion and restraint, or establishing oversight over the role of police in apprehensions.[56]

BC is an outlier in its lack of guiding principles in the Mental Health Act. Mental health laws from New Brunswick, Newfoundland and Labrador, Nova Scotia, Ontario, Yukon, Northwest Territories, and Nunavut have express purposes or principles embedded in some way.[57] Many of these examples contain commitments to human rights, cultural safety, respect for language, prioritization of self-determination, non-discrimination, and a commitment that involuntary intervention will be a last resort.[58]

In addition, other statues in BC use guiding principles or values as a foundation.[59] Federally, the Accessible Canada Act also sets out a strong set of principles to guide its interpretation:

> 6. This Act is to be carried out in recognition of, and in accordance with, the following principles:
>
> a. all persons must be treated with dignity regardless of their disabilities;
>
> b. all persons must have the same opportunity to make for themselves the lives that they are able and wish to have regardless of their disabilities;
>
> c. all persons must have barrier-free access to full and equal participation in society, regardless of their disabilities;
>
> d. all persons must have meaningful options and be free to make their own choices, with support if they desire, regardless of their disabilities;
>
> e. laws, policies, programs, services and structures must take into account the disabilities of persons, the different ways that persons interact with their environments and the multiple and intersecting forms of marginalization and discrimination faced by persons;
>
> f. persons with disabilities must be involved in the development and design of laws, policies, programs, services and structures; and
>
> g. the development and revision of accessibility standards and the making of regulations must be done with the objective of achieving the highest level of accessibility for persons with disabilities.[60]

Other places in the world also place a strong emphasis on enshrining guiding principles and values in their mental health laws that reflect basic human rights principles and ensure those principles inform the way the law is applied in practice.

There is a global movement to rethink the role and purpose of mental health laws

It is also useful for BC to revisit the purposes and guiding principles in its mental health law in order to align with international recommendations to rethink the current approach to mental health law globally. For example, the World Health Organization in partnership with the UN Office of the High Commissioner for [61]Human Rights is developing global guidance on mental health, human rights, and legislation. The draft guidance circulated in summer 2022 recommends against standalone mental health legislation. It points out the various ways that legislation specifically targeting people with mental health-related needs can entrench and reinforce stigma and stereotypes:

> Legislation on mental health often singles out mental health as a separate regime, either through stand-alone laws or separate 'mental health' sections in general health laws. Experience shows that this approach emphasises segregation of mental health, which potentially reinforces mental health-related stigma and a siloed approach. Furthermore, these separate regimes reinforce the idea that mental health is a specialized practice that requires exceptions to the equal exercise of rights, enabling arbitrary restrictions to generally accepted principles of the right to health, such as on the right to free and informed consent.[62]

The draft guidance goes on to recommend that countries undertake a "mainstreaming" of mental health law in collaboration with peope with lived and living experience and using a human rights-based approach.[63] This mainstreaming means intregrating the legal issues that impact people with mental health-related needs into general laws that apply to health care, health care consent, patient rights, social care, capacity laws, and anti-discrimination laws. The underlying idea is that all of these laws should encompass the legal issues that apply across disability and health-related needs, so there is no need to segregate legal issues on the basis of disability, health issue, or diagnosis.

A recent Royal Commission on the mental health system in Victoria, Australia also questions the status quo approach to mental health laws.[64] The Royal Commssion found that the primary purpose of mental health laws is often to authorize coercion and involuntary treament, which fails to prioritize and address other crucial purposes like promoting mental wellness, ensuring person-centred care, establishing strong governance for the mental health system, and protecting and promoting human rights.

BC has the opportunity to revisit the purposes of its mental health law in the context of these emerging global conversations. Guiding principles have the potential to ensure that BC's law reflects these recommendations and reflections.

Guiding principles can help ensure we do not repeat human rights attrocities

People with mental health-related disabilities or those who have been labeled with them have experienced a history of discrimination, prejudice, and rights violations.[65] In *Ontario v G*, the majority of the Supreme Court of Canada wrote:

> In our society, persons with disabilities regrettably "face recurring coercion, marginalization, and social exclusion". As this Court has recognized, "[t]his historical disadvantage has to a great extent been shaped and perpetuated by the notion that disability is an abnormality or flaw". In reality, persons with disabilities are not flawed, nor can they all be painted with the same brush. While they may share experiences of "[s]tigma, discrimination, and imputations of difference and inferiority", diversity within those labelled disabled is not the exception but the rule. Section 15's promise of respect for "the equal worth and human dignity of all persons" requires that those with disabilities be considered and treated as worthy and afforded dignity in their plurality. And s. 15's guarantee that discrimination not be given the force of law requires careful attention to the diverse impacts that government action will have on those with disabilities.
>
> The stereotyping, exclusion, and marginalization experienced by persons with disabilities is also visited on those with mental illnesses. The prejudicial idea that those with mental illnesses are inherently and perpetually dangerous, along with other stigmatizing, prejudicial notions, has led to profound disadvantage for individuals living with mental illnesses. This disadvantage has deep historical roots:
>
> > Mental illnesses are not like other illnesses, because they regularly cause people to lose their rights and freedoms in ways that are unimaginable in other health conditions…
> >
> > Historically, the care of the mentally ill has been deplorable. During the great confinement in the early part of the 1800s, hospital officials in Europe had the authority to round up and imprison people who were mentally ill (termed then madmen and idiots), along with beggars, vagabonds, criminals, the unemployed, and other undesirables. The characterization of the mentally ill as wild beasts justified their forcible confinement and social banishment.
>
> Though the early 19th century's most abhorrent treatment of those with

> mental illnesses has been left behind, stigmatizing attitudes persist in Canadian society to this day. As Stuart, Arboleda-Flórez, and Sartorius observe, "perceptions of violence and risk of violence are central to . . . support for coercive treatments, legislative solutions, and justifications for social inequities and injustices". While discriminatory attitudes and impacts against those with mental illnesses regrettably persist, they must not be given the force of law.[66] [citations omitted]

Canada and BC have a well documented history that legitimized and entrenched deeply harmful treatment of people with mental health-related disabilities. These include using the law to remove human rights and inflict discrimination. For example, the 1873 Insane Asylum Act removed legal rights with no review process and the Sexual Sterilization Act in place in BC from 1933 to 1973 violated reproductive rights and was rooted in eugenics.[67]

We still have not adequately acknowledged the human rights atrocities that were committed against people detained at institutions like Essondale/Riverview. The BC health care system still describes the treatment of patients at Riverview as "a legacy of care and compassion", ignoring human rights infringements and harm that occurred via experimental treatment, including insulin shock coma treatment and lobotomy surgeries, as well as mandatory labour and unacceptable institutional living conditions that led to tuberculosis outbreaks.[68] A 1994 report of the Ombudsperson of BC documented concerns about legal issues, quality of life, treatment and discharge.[69]

These harms have been and continue to be heightened for people with intersecting identities that trigger racism, colonialism, ableism, and gender-based inequities, in addition to other systemic oppression. The disproportionate impacts on different communities can also be seen in the way different populations are impacted differently (for example, Indigenous and racialized people, children and youth, girls and young women, and people who use substances).

Human rights laws and agreements were developed in the aftermath of acknowledged human rights violations and provide a framework for ensuring we learn from past and current mistakes in order to move forward in careful and reflective ways.

The following eight core guiding principles form a strong foundation for mental health and substance use health law and services in BC. While the law does not hold all the answers for needed systems change in BC, "legislation can bring out a cultural change and social transformation agenda in relation to mental health" because it "plays a fundamental role in framing attitudes and behavior towards people with mental health conditions and psychosocial disability."[70]

The principles were developed relying on lived experience and Indigenous expertise, international human rights research related to the right to health, and research on mental health laws in over 22 other provinces and countries. These principles can be expressly incorporated into BC's mental health law to form a foundation that will guide the application of the law and necessary systemic change throughout BC's mental health system. The rationale for each principle is set out, followed by examples from other places in Canada and the world that support the principle, and show how it can be incorporated into mental health law in BC.

Eight guiding principles for a human rights-based mental health system

1. Recognition of human rights
2. A holistic approach to mental wellness
3. Access to quality health services
4. Nothing about us without us - participation in law, policy, and services
5. Compliance with the UN Declaration on the Rights of Indigenous Peoples
6. Prioritize intersectional equity
7. Promote self-determination at every opportunity
8. Accountability and oversight strengthens services

Principle 1: Recognition of human rights

BC should recognize human rights as a guiding principle in its mental health law because:

- Recognition of humanity and the common protections and freedoms that all people need to live with dignity is the core foundation of human rights law.
- Our history is full of examples of people who intended to help others, but who nevertheless caused significant harm to the very people they were trying to help.
- A human rights framework supports us to focus on the impact of actions rather the intentions.

"Behind every issue, whatever your issue is, there is an entire person. There is a human being and they have human rights."

- Lived Experience Expert

Principle 1: Recognition of human rights

Independent legislative offices have documented an ongoing systemic problem with a failure to prioritize the human rights of people who experience detention and involuntary treatment in BC,[71] a conclusion also reached by people with lived and living experience:

> **"[C]learly, people have this perception of just totally, like, all consuming, omnipotent power... So total, when you're in it, it feels like they can do anything, they can do absolutely whatever they want. And there's nothing you can do at all. It really does feel like rights are just such an absurd concept. Because, if you have a right, it's just like this thing that like, you have rights, but in the end, what they want is what defines what your rights are."**
>
> **- Lived Experience Expert[72]**

This quote lays bare the power wielded under the authority of the Mental Health Act. Recognition of humanity and the common protections and freedoms that all people need to live with dignity is the core foundation of human rights law. Including the recognition of human rights explicitly in BC's mental health law would ensure that the rights of people accessing services remain at the centre of the statute's purpose and the ways in which services are designed, delivered, and evaluated. The inclusion of a commitment to human rights is the first step towards fulfilling obligations under international human rights agreements.[73]

This is particularly important when it comes to detention and involuntary treatment given its immense impacts on human rights and dignity. The Act grants extraordinary power over the bodies, choices and lives of people, and expressly acknowledging the necessity of human rights in helping safeguard that authority is part of creating healthy law and policy.

Given that services are intended to help and the role of service providers is to provide that help, it can be hard to recognize how genuine attempts to help can cause real harm. Even with the best of intentions, making assumptions about what is best for another person can be impacted by unconscious bias and deeply entrenched stereotypes about people with mental health-related disabilities. Our history is full of examples of people who intended to help others, but who nevertheless caused significant harm to the very people they were trying to help. A human rights framework supports us to focus on the impact of actions rather than intentions. Explicit acknowledgment of the role and importance of human rights set out in the Charter, the Human Rights Code, and international human rights agreements can help create a constant reminder that human rights exist, create obligations, and are very relevant in a health care context.

An explicit acknowledgement of human rights can also ensure that rights to equal recognition

before the law and non-discrimination are respected.[74] These are core to the enjoyment of all human rights, including the right to health. Protecting non-discrimination can ensure that no one is denied a right, privilege, or service solely because of past or present voluntary/involuntary status, receipt of mental health services more generally, or because of specific aspects of their identity.

Further, the importance of expressly acknowledging and protecting human rights is evident in the recently issued Draft Guidance on Mental Health, Human Rights, and Legislation created by the World Health Organization and the United Nations High Commissioner on Human Rights.[75] The guidance offers concrete ways that law makers can provide evidence-based services rooted in human rights as part of a transition to a rights-based approach to mental health law and services.

An express commitment to the role and importance of human rights through a legislated guiding principle would signal a profoundly meaningful cultural shift in BC.

Learning from outside BC

Other places in the world have already begun to ensure that human rights are explicitly mentioned and embedded in mental health legislation. For example, Victoria, Australia recently passed a new mental health law that has an entire section on protecting rights. The law also contains robust objectives for the statute that center human rights, including:

> In pursuit of the highest attainable standard of mental health and wellbeing for the people of Victoria, this Act has the following objectives —
>
> [...]
>
> to protect and promote the human rights and dignity of people living with mental illness by providing them with assessment and treatment in the least restrictive way possible in the circumstances;[76]

Victoria's law goes on to include a specific "dignity and autonomy principle":

> The rights, dignity and autonomy of a person living with mental illness or psychological distress is to be promoted and protected and the person is to be supported to exercise those rights.[77]

Ireland has included the following in their mental health law:

> In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person) due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy.[78]

In 2018, the *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* recommended that New Zealand repeal and replace its current law because it is outdated and it does not align with international human rights agreements.[79] Specifically, the Inquiry recommended that the new law "reflect a human rights-based approach, align with modern models for mental health care and minimise the use of compulsion, seclusion and restraint."[80] The New Zealand government accepted this recommendation and is currently in the midst of a process to create a new mental health law.[81]

Finally, Western Australia enshrined strong protections of human rights in its mental health law:

> The objects of this Act are as follows —
>
> a) to ensure people who have a mental illness are provided the best possible treatment and care —
>
> i) with the least possible restriction of their freedom; and
>
> ii) with the least possible interference with their rights; and
>
> iii) with respect for their dignity.[82]

Other jurisdictions in the world like Norway, Portugal, and Washington state also incorporate an acknowledgement of human rights and dignity into their mental health laws.[83]

Specific ways this guiding principle could be incorporated into BC's mental health law:

- Any person who has or is perceived to have a mental health-related disability has the same rights as all other people and those rights must be taken into account in exercising powers under the act and in the provision of services.
- A person's right to respect for their dignity, bodily autonomy, and liberty will be recognised and taken into account in exercising powers under the Act and in the provision of services.
- BC's mental health law will protect and promote the human rights and dignity of people with mental health-related disabilities and all people subject to the law.

Principle 2: A holistic approach to mental wellness

BC should recognize a holistic approach to mental wellness as a guiding principle in its mental health law because:

- People with lived and living experience often experience involuntary treatment as almost entirely focused on medication compliance.
- BC's current Mental Health Act does not incorporate broader understandings of health and wellness and it does not protect a right to or establish any services outside of hospitalization and involuntary treatment.
- A human rights framework recognizes the broad and intersecting things we all need to be well.

"My recovery journey involved a lot of rebuilding. I did the rebuilding mostly through volunteering... I had to do my rebuilding in the community, not in an institution."

- Lived Experience Expert

Principle 2: A holistic approach to mental wellness

> **"Hospitalization and medication didn't bring back the friends I had lost. It didn't fill the gaps that were in my resume. It didn't repair my confidence which had been shattered. It didn't instantly make me feel comfortable being around other people. I had lost my comfort with others because I had been paranoid for a long time (but never violent). So, my recovery journey involved a lot of rebuilding. I did the rebuilding mostly through volunteering. Medication was not the whole answer. As for the hospital, I had to do my rebuilding in the community, not in an institution."**
>
> **- Lived Experience Expert[84]**

As this quote from a person with lived experience clearly illustrates, mental wellness requires more than hospitalization, and mental health is more than the absence of symptoms. However, mental health laws like BC's Mental Health Act are understood almost entirely through the lens of authorizing detention and involuntary treatment in or through designated facilities. People with lived and living experience often experience the Act and involuntary treatment as almost entirely focused on medication compliance.[85]

The Act does not incorporate broader understandings of health and wellness and it does not protect a right to or establish any services outside of hospitalization and involuntary treatment. It doesn't recognize the key role of housing, income, community inclusion, and freedom from discrimination in supporting mental health and recovery from illness. It doesn't recognize the importance of family and kinship connections, culturally based services, psychosocial services, or counselling. As a result, these aspects of what we all need to be well are missing from BC's legal scheme related to mental wellness, and are often missing from mental health services as a result.

A recent review of Victoria, Australia's mental health system noted that focusing mental health laws so narrowly on involuntary treatment leads to a focus on only a subset of the interventions or services that might support wellness:

> Moreover, the narrow focus of the Mental Health Act on compulsory assessment and treatment reinforces a focus on pharmacological interventions, the treatment of symptoms, and clinical recovery from symptoms, without taking into account social factors, such as housing, cultural background or socioeconomic factors.[86]

In addition, the overly narrow focus on involuntary treatment can further entrench discriminatory stereotypes about people with mental health-related disabilities:

> [T]he focus of provisions in mental health legislation on preventing serious harm to the person or another person can fuel stigmatising views that people living with mental illness or psychological distress are dangerous, or a risk to themselves or society."[87]

A human rights framework recognizes the broad and intersecting things we all need to be well, from health care services to housing, to a standard of living that allows us to live with health and dignity, to freedom from violence and discrimination, to access to culturally based practices, to participation in our communities, to self-determination for Indigenous communities.[88] These rights align and in many ways mirror the social determinants of health.[89] They also align with a recovery oriented approach to mental health, which recognizes wellness occurs in the context of a person's life –relationships, community membership, standard of living, and experiences of discrimination all deeply shape our ability to recover or be well.[90]

In 2017, the UN Special Rapporteur issued a report on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health that focused on the right to mental health. The Special Rapporteur noted that in order to comply with human rights law, governments must adopt an approach to mental health services that "looks beyond (without excluding) biological factors, understanding psychological and social experiences as risk factors contributing to poor mental health and as positive contributors to well-being" while "avoiding the arbitrary assumption that biomedical interventions are more effective."[91]

Learning from outside BC

Jurisdictions outside of BC have recognized the importance of more broad and holistic understandings of mental wellness that go beyond the absence of symptoms in their mental health laws. For example, Tasmania, Australia's mental health law has a schedule setting out principles for delivering mental health services that include commitments to:

- provide a service that is comprehensive, accessible, inclusive, equitable and free from stigma;
- emphasise and value promotion, prevention and early detection and intervention;
- promote and enable persons with mental illness to live, work and participate in their own community;
- operate so as to raise community awareness and understanding of mental illness and to foster community-wide respect for the inherent rights, liberty, dignity, autonomy and self-respect of persons with mental illness;[92]

Victoria, Australia placed strong emphasis on the need to take a broader and more cross-sectoral approach to its mental health law in its *Royal Commission Report*, finding that "a workable legal framework that promotes good mental health and wellbeing needs to go beyond permitting compulsory treatment." While its new mental health law is still largely focused on involuntary treatment, Victoria has explicitly included principles to support mental health and wellbeing. These include that a goal of the law is to promote conditions so that people can experience good mental health and wellbeing, as well as recover from mental illness or psychological distress, and so they can connect and coordinate with other support services to respond to the broad range of circumstances that influence mental health and wellbeing.[93] The law also states:

> A person living with mental illness or psychological distress is to be provided with access to a diverse mix of care and support services. This is to be determined, as much as possible, by the needs and preferences of the person living with mental illness or psychological distress including their accessibility requirements, relationships, living situation, any experience of trauma, level of education, financial circumstances and employment status.[94]

In addition, some laws protect the role of non-biomedical supports in a person's wellness. For example, New Zealand's current mental health law expressly requires that the powers in the law must be exercised in a way that recognizes the role of family and community (whanau, hapu, and iwi reflect relationships and community relationships in Māori culture):

> The power must be exercised, or the proceedings conducted,—
>
> a) with proper recognition of the importance and significance to the person of the person's ties with his or her family, whanau, hapu, iwi, and family group; and
>
> b) with proper recognition of the contribution those ties make to the person's wellbeing.[95]

Nunavut's mental health law uses a very similar approach to New Zealand by also requiring that its law be carried out with respect for a person's ties to their chosen family and the contributions those relationships make to their health.[96]

Specific ways this guiding principle could be incorporated into BC's mental health law:

- Mental health services and treatment will be comprehensive, accessible, inclusive, equitable, and free from stigma.
- A person living with mental illness or psychological distress will be provided with access to a diverse mix of care and support services.
- BC's mental health law will promote conditions so that people can experience good mental health and wellbeing, as well as recover from mental illness or psychological distress, and so they can connect and coordinate with other support services to respond to the broad range of circumstances that influence mental health and wellbeing.
- BC's mental health law and services will recognize the importance and contributions to wellbeing of a person's chosen connections with family, friends, kin, and community.

Principle 3: Access to quality health services

BC should recognize access to quality services as a guiding principle in its mental health law because:

- The right to mental health includes the right to equitable access to mental health services, and those services must meet core human rights quality standards to support the dignity of the individual accessing them.
- Quality health services must be timely, adequate, affordable, equitable, accessible, person-centred, and ethical.
- When there is a failure to provide access to quality voluntary mental health services, the perceived need for involuntary services increases.

"I don't actually ever remember getting treatment. I got medicated against my will... I didn't get any therapy, just medication and being held."

- Lived Experience Expert

Principle 3: Access to quality health services

> **"But they didn't like let me stabilize or anything. They just put me on the injection. The first time I got it, I walked from my place. And then, in order to walk back, I literally had to stop in the back alley and lay down for two hours in the pissing rain on the concrete. I was so fucking tired. I could not physically go on and my eyes lay down for two and a half hours and had a nap in the pouring rain."**
>
> **- Lived Experience Expert[97]**

This quote illustrates the lived experience of accessing mental health services that do not offer person-centred support. The result of an experience could easily lead to distrust of service providers and treatment options; by failing to take basic steps to monitor the impacts of a new medication, the service providers and treatment put the individual in a situation that undermined their safety and dignity.

The right to mental health includes the right to equitable access to mental health services, and those services must meet core human rights standards in order to support the dignity of the individual accessing them. The UN Committee on Social, Economic and Cultural Rights has interpreted this to mean they must be:

- **Available:** services must be timely and adequate in quantity to meet community needs, including related to determinants of health.
- **Accessible:** services must be affordable, equitable, geographically and physically accessible.
- **Acceptable:** services must be person-centred, respectful of the individual, culturally safe and responsive to different identity factors like Indigeneity, race, culture, language, gender, sex, and (dis)ability; they must also benefit the wellbeing of the individual (not just avoid harm).
- **Quality:** services must be provided in accordance with evidence and professional ethics.[98]

There are well documented issues with inadequate mental health and substance use services in BC, with some key services not covered by the public health care system and publicly funded services subject to long waitlists.[99] People in many parts of the province are forced to travel long distances and leave their home communities, families, traditional territories, and support networks in order to access services.[100] In addition, when people do get access to mental health service in BC, there are well documented issues with systemic racism throughout the health system[101] and publicly reported concerns about inhumane and uncoordinated treatment.[102]

When there is a failure to provide access to quality voluntary mental health services, the perceived need for involuntary services increases: "The lack of services means that people must be in significant crisis before they can get access."[103] Further, as a Lived Experience Expert described, detention in hospital does not necessarily result in access to a range of treatment options:

> **"I don't actually ever remember getting treatment. I got medicated against my will… I didn't get any therapy, just medication and being held."**
>
> **- Lived Experience Expert[104]**

This over reliance on involuntary treatment, combined with the documented human rights violations occurring in BC's involuntary treatment system, also undermines the quality of mental health services in BC because mental health professionals are unable to provide services in accordance with their professional ethical requirements. For example, in 2021 the Nurse and Nurse Practitioners of BC issued a position statement documenting how the Mental Health Act and BC's current approach to involuntary treatment undermines the ability of nurses to provide patient-centred care.[105]

Incorporating an express commitment to quality mental health services, including the specific components of quality services, as a guiding principle in the law would create a foundation for system transformation focused on ensuring people have access to evidence-based, ethical, and safe services when they need them.

Learning from outside BC

Like the other guiding principles, jurisdictions outside of BC provide examples for the ways in which quality services could be expressly incorporated in BC's mental health law. For example, Nunavut's new Mental Health Act states that:

> The purpose of this Act is to improve the mental wellness of Nunavummiut and address Inuit-specific needs related to mental wellness by
>
> […]
>
> d) facilitating the provision of necessary care to Nunavummiut with serious mental disorders in a way that
>
> i) is clinically safe and effective,
>
> ii) is culturally safe,
>
> iii) is compassionate and minimizes traumatization,
>
> […]

viii) helps individuals being provided care to navigate the mental health care system,

ix) reduces the need for Nunavummiut to be away from their home communities,[106]

[...]

Nova Scotia also has principles related to geographic accessibility and a commitment to evidence-based practice in its mental health law:

a) persons with mental disorders should have access to mental health services as close to the person's home as practicable;

[...]

f) the person has the right to a treatment plan that maximizes the person's potential and is based on the principles of evidence-based best practice;[107]

Finally, the new mental health law in Victoria, Australia provides guiding principles related to quality of mental health services:

12. In pursuit of the highest attainable standard of mental health and wellbeing for the people of Victoria, this Act has the following objectives

[...]

c) to provide for comprehensive, compassionate, safe and high-quality mental health and wellbeing services that promote the health and wellbeing of people living with mental illness or psychological distress and that—

i) are accessible; and

ii) respond in a timely way to people's needs and recognise that these needs may vary over time; and

iii) are consistent with a person's treatment, care, support and recovery preferences wherever possible; and

iv) are available early in life, early in onset and early in episode; and

v) recognise and respond to the diverse backgrounds and needs of the people who use them; and

vi) provide culturally safe and responsive services to Aboriginal and

Torres Strait Islander people in order to support and strengthen connection to culture, family, community and Country; and

vii) connect and coordinate with other support services to respond to the broad range of circumstances that influence mental health and wellbeing;[108]

There are several other jurisdictions around the world that commit to quality services in their mental health laws that BC could learn from, including Denmark, Washington state, and Alaska.[109]

Specific ways this guiding principle could be incorporated into BC's mental health law:

Mental health services and treatment will be:

- Comprehensive and high quality;
- Clinically safe and evidence-based;
- Accessible;
- Respond in a timely way to people's needs;
- Person-centred and consistent with a person's values and wishes;
- Provided as close to a person's home community as possible;
- Culturally safe and recognize a distinctions-based approach to cultural safety for First Nations, Inuit and Metis people; and
- Recognize the wishes and needs of people from diverse backgrounds.

Principle 4: Nothing about us without us - participation in law, policy and services

BC should recognize the expertise of people with lived and living experience as a guiding principle in its mental health law because:

- A core aspect of international human rights agreements is the idea that communities impacted by a law, policy, or service should have a role in decision-making related to those matters.
- Human rights require that people with lived and living experience should have a meaningful role in decision-making that impacts them on both a personal and a systemic level.
- The expertise of people with direct lived experience or organizations made up of and controlled by people with lived and living experience should be centred; indirect experience is not a replacement.

"The involvement of the patient, like, since it's your mental wellness plan, you should probably be involved in it. But they don't involve you at all. Like, they don't ask you."

- Lived Experience Expert

Principle 4: Nothing about us without us - participation in law, policy, and services

A core aspect of international human rights agreements is the idea that communities impacted by a law, policy, or service should have a role in decision-making related to those matters; this is a requirement of international human rights agreements in order to provide effective health services.[110] In other words, people with lived and living experience should have a meaningful role in decision-making that impacts them on both a personal and a systemic level.

This is especially important for people with mental health-related disabilities because they have historically been treated as incapable and decisions about them have been and continue to be made on their behalf without their participation or consent. A person with lived experience questioned existing treatment planning processes, stating:

> **"The involvement of the patient, like, since it's your mental wellness plan, you should probably be involved in it. But they don't involve you at all. Like, they don't ask you."**
>
> **- Lived Experience Expert[111]**

On an individual level, the right to health under the Convention on the Rights of Persons with Disabilities has been interpreted to mean that governments have an obligation to take progressive steps to eliminate the exclusion of people from decisions about their own health care and bodily autonomy.[112]

On a systemic level, the Convention on the Rights of Persons with Disabilities states:

> In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, State Parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations.[113]

The UN Committee on the Rights of Persons with Disabilities has provided additional guidance on what is required to fulfill this collective right. It has clarified that there is a difference between disability organizations for people with disabilities versus respective organizations *made up of and controlled by* people with disabilities.[114] In particular, the Committee has made it clear that organizations that provide services for people with disabilities, research organizations, and family member-based organizations do not fulfill the role of disability organizations for the purpose of consultations and participation. A Lived Experience Expert made the necessity of direct lived experience knowledge clear:

> **"…this work depends upon not only the meaningful inclusion, but the leadership of people with lived and living experience because this is ultimately about our wellbeing. How can we feel supported and heal if we're not even involved in our own treatment."**
>
> **- Lived Experience Expert[115]**

This is important because, due to stereotypes and misplaced assumptions about the abilities of people diagnosed with "serious mental illness," the perspectives of family members or others often supplant direct lived experience voices regardless of whether or not they share the same opinions and views of people with lived and living experience. Family member and research organizations hold great expertise, but their participation should be at the invitation of (and in addition to, not instead of) people with direct experience of disability.[116]

In addition, the Committee has made clear the extent and scope of consultations that will meet the requirements for participation in order to adhere to human rights:

> [It is an] obligation to closely consult and actively involve persons with disabilities, through their own organizations, in legal and regulatory frameworks and procedures across all levels and branches of Government. States parties should also consider consultations with and the involvement of persons with disabilities as a mandatory step prior to the approval of laws, regulations and policies, whether mainstream or disability specific. Therefore, consultations should begin in the early stages and provide an input to the final product in all decision-making processes. Consultations should include organizations representing the wide diversity of persons with disabilities, at the local, national, regional and international levels.[117]

The Convention also requires that governments provide financial support to disability organizations in order to facilitate their participation.[118]

A guiding principle reflecting both the individual and systemic participatory principles would enshrine a commitment to prioritizing and mandating the participation of people experiencing detention and involuntary treatment in decisions about their own lives and health. In addition, it would ensure that people with mental health-related disabilities have a role in systemic law and policy decisions that impact them. One cannot be achieved without the other.

Learning from outside BC

The importance of the participation of people with mental disabilities in decision-making about their own lives was highlighted in the UK review of the Mental Health Act:

> The Convention on the Rights of Persons with Disabilities (CRPD) requires that no decisions about disabled persons should take place without them, so those with relevant lived experience should be involved in decision making across the system, including co-design and production with patients at ward level. Patients should be treated in a way that respects them in the context of their own lives, recognises their strengths, needs, values and experiences and provides equality of outcome regardless of any disabilities or protected characteristics. It is not enough to merely ask that people detained under the Act are listened too, nor can we achieve our goals, of fair treatment for all, if detained patients continue to have so little say in their care and treatment.[119]

Many other jurisdictions have incorporated the principle of participation into their laws. Nunavut's mental health law "supports the engagement of individuals being provided care in their treatment."[120] Queensland, Australia's mental health law requires that a person be encouraged to take part in decisions that effect their life to the greatest extent possible."[121]

Scotland's mental health law requires that the powers under it be carried out with regard for:

- the importance of the patient participating as fully as possible in the discharge of the function; and
- the importance of providing such information and support to the patient as is necessary to enable the patient to participate in accordance with the paragraph above.[122]

Victoria, Australia's new mental health law has as an objective to guide its Act that reflects the need for participation at a systemic level as well, noting a goal of its law is: "to recognise and respect the right of people with mental illness or psychological distress to speak and be heard in their own voices, from their own experiences and from within their own communities and cultures." The law goes on to include a specific "lived experience principle":

> The lived experience of a person with mental illness or psychological distress

and their carers, families and supporters is to be recognised and valued as experience that makes them valuable leaders and active partners in the mental health and wellbeing service system.[123]

Denmark and the Netherlands also incorporate principles about lived experience participation in services in their mental health laws.[124]

Specific ways this guiding principle could be incorporated into BC's mental health law:

- A person accessing mental health services or treatment will be encouraged and supported to take part in decisions that impact their life and their views should be centred in decision-making.
- A goal of BC's mental health law will be to recognise and respect the right of people with mental health-related disabilities or psychological distress to speak and be heard in their own voices, from their own experiences, and from within their own communities and cultures.
- The lived experience of people with mental heath-related disabilities or psychological distress will be recognised and respected as expertise that makes them valuable leaders and active partners in the mental health and substance use health service system, including in the design, delivery and evaluation of services.
- The lived experience of people with mental health-related disabilities or psychological distress will be recognized as necessary expertise in any design or amendments to provincial mental health law and policy in BC.

Section Summary

Principle 5: Compliance with the UN Declaration on the Rights of Indigenous Peoples

BC should include compliance with UNDRIP as a guiding principle in its mental health law because:

- First Nations, Inuit, and Métis people and communities have diverse, strong and sustaining health practices. However, Indigenous people in BC experience immense health inequities due to the historic and ongoing impacts of colonization and discrimination.
- Mental health detention and involuntary treatment can be experienced as an ongoing form of control, coercion, and loss of self-determination.
- BC has committed to implement UNDRIP.

"What is cultural safety in this context?... [T]he systems in place that have inflicted trauma are still in active existence – one of the ways that this system exists is through the Mental Health Act."

- Indigenous Leadership Group Member

Principle 5: Compliance with the UN Declaration on the Rights of Indigenous Peoples

> **"What is cultural safety in this context? It means being cognizant of historical and intergenerational trauma, and the impacts of colonization while recognizing that, the systems in place that have inflicted trauma are still in active existence – one of the ways that this system exists is through the Mental Health Act."**
>
> **- Indigenous Leadership Group Member[125]**

This quote from a member of the Indigenous Leadership Group makes clear that an understanding of the historic and ongoing role of colonization is crucial context to create culturally safe services. Cultural safety and humility have quickly become buzz words in the health care system in an effort to address systemic racism and improve accessibility for Indigenous people accessing services. However, defining what cultural safety looks like and taking practical steps to ensure it is a challenging path, as the quote above illustrates.

There is immense diversity in approaches to wellness among different Indigenous communities in BC, but a core concept is that people, earth, and everything around us are deeply interconnected and that wellness comes from internal and external balance that goes beyond the absence of illness. These continue to be strong and sustaining wellness practices today.[126]

Despite this strong foundation, First Nations, Inuit, and Métis people in BC experience disturbing and immense health inequities due to the historic and ongoing impacts of colonization and discrimination. BC's history of and continued genocide, colonization and racism against Indigenous people was rooted in the intentional eradicating, limiting, or supressing of Indigenous rights, relationship with the land, cultural and familial practices, and systems of health and wellness.

Many specific colonial tools have had and continue to have direct impacts on Indigenous wellness systems by undermining traditional ways of staying well and access to health knowledge and treatments. These include the historical and ongoing separations and interruption of families, communities, and knowledge sharing structures through residential schools, discriminatory Indian Act policies, child apprehension, and criminalization.[127] The forced displacement of communities from traditional territories interrupted the ability of Indigenous people to maintain balance with the environment and culturally based health practices.[128] BC also has a legacy of racist and discriminatory health services, from Indian Hospitals and segregated services to violations of bodily autonomy to entrenched systemic racism that continues today.[129]

First Nations, Métis and Inuit people have continually resisted that systemic suppression to continue these foundational wellness practices. They continue to be sustaining practices today despite ongoing colonial interference. However, this ongoing racism, colonialism, and genocide has had and continues to have detrimental impacts on the health and wellbeing of Indigenous people, creating significant health inequities.

Indigenous communities face an ongoing lack of safe and accessible services, which forces many into crisis-based responses, including reliance on police to address community mental health needs. The colonial mental health system, and especially detention, involuntary treatment, and police involvement, can be experienced as an ongoing form of control, coercion, and loss of self-determination for Indigenous people.

It is crucial that the self-determination of First Nations, Métis, and Inuit communities be at the centre of any mental health law in BC, and given BC's commitment to implement the UN Declaration on the Rights of Indigenous Peoples (UNDRIP) via the Declaration on the Rights of Indigenous Peoples Act, compliance with and principles from UNDRIP should be included as guiding principles. The *In Plain Sight* report documented that, legislation has been underutilized as the foundational mechanism to systemically address issues of Indigenous-specific racism in health care.[130]

Guiding principles could give meaningful effect to several interrelated aspects of UNDRIP, including:

- Article 4: the right to self determination and participation in mainstream services;
- Article 18: the right to participate in decision-making that impacts rights;
- Article 19: the right to free, prior, informed consent to decisions that impact Indigenous communities;
- Article 24: the right to practice and access to traditional medicines
- Articles 2, 21: the right to equitable access to health services without discrimination (e.g. anti-racist and culturally safe services); and
- Article 22: ensuring particular attention is paid to the needs of youth and people with disabilities.

Learning from outside BC

While work to implement the obligations set out in UNDRIP into domestic laws is an emerging process, other jurisdictions have already taken steps to enshrine the rights of Indigenous people in mental health laws. For example, Queensland, Australia's mental health law incorporates specific guiding principles related to Aboriginal People and Torres Strait Islanders. These principles confirm that the law should be applied with respect for the following:

- the unique cultural, communication and other needs of Aboriginal people and Torres Strait Islanders must be recognised and taken into account;
- Aboriginal people and Torres Strait Islanders should be provided with treatment, care and support in a way that recognises and is consistent with Aboriginal tradition or Island custom, mental health and social and emotional wellbeing, and is culturally appropriate and respectful;
- to the extent practicable and appropriate in the circumstances, communication with Aboriginal people and Torres Strait Islanders is to be assisted by an interpreter.[131]

Nunavut's new mental health law specifically requires consideration of cultural safety in its implementation. In addition, the Act recognizes the role of tikkuaqtaujuit (selected representatives with a broader definition than legal guardian or parent).[132] It also requires at least three Inuit cultural advisors be appointment to the Mental Health Review Board, based on their knowledge of Inuit societal values, the Inuit language, and Nunavut.[133]

New Zealand's mental health law expressly recognizes the importance of Māori community ties and relationships (whanau, hapu, and iwi) and the role they play in wellbeing. It requires these be reflected in the way the law is applied.

Finally, Victoria, Australia's new mental health law includes a guiding principle that prioritizes cultural safety and connections to culture and community specifically for Aboriginal and Torres Strait Islanders.[134] It goes on to include specific principles committed to cultural safety, recognition of community and cultural ties, and access to traditional medicines (full excerpt is included below).[135]

Victoria's mental health law also sets out a detailed and nuanced recognition of the role of colonization in the mental wellness of Aboriginal and Torres Strait Islanders, respect for self-determination, and the importance of respecting culturally based approaches to wellness:

1. The Parliament recognises that Aboriginal people in Victoria are First Nations people of Australia and acknowledges their enduring connection to Country, kin, land and culture.
2. The Parliament acknowledges the following—

a) that Aboriginal self-determination serves as a foundational principle to improve mental health and wellbeing outcomes of Aboriginal people in Victoria;

b) the lasting impact of laws, practices and policies on the mental health and wellbeing outcomes of Aboriginal and Torres Strait Islander people since colonisation and enduring to this day;

c) cultural dislocation, oppression, intergenerational trauma, lack of healing, systemic racism, institutionalised inequality and the loss of land, lore and language continue to harm the mental health and wellbeing of Aboriginal people in Victoria today;

d) the strength of Aboriginal people, culture, kinship and communities in the face of historical and ongoing injustices;

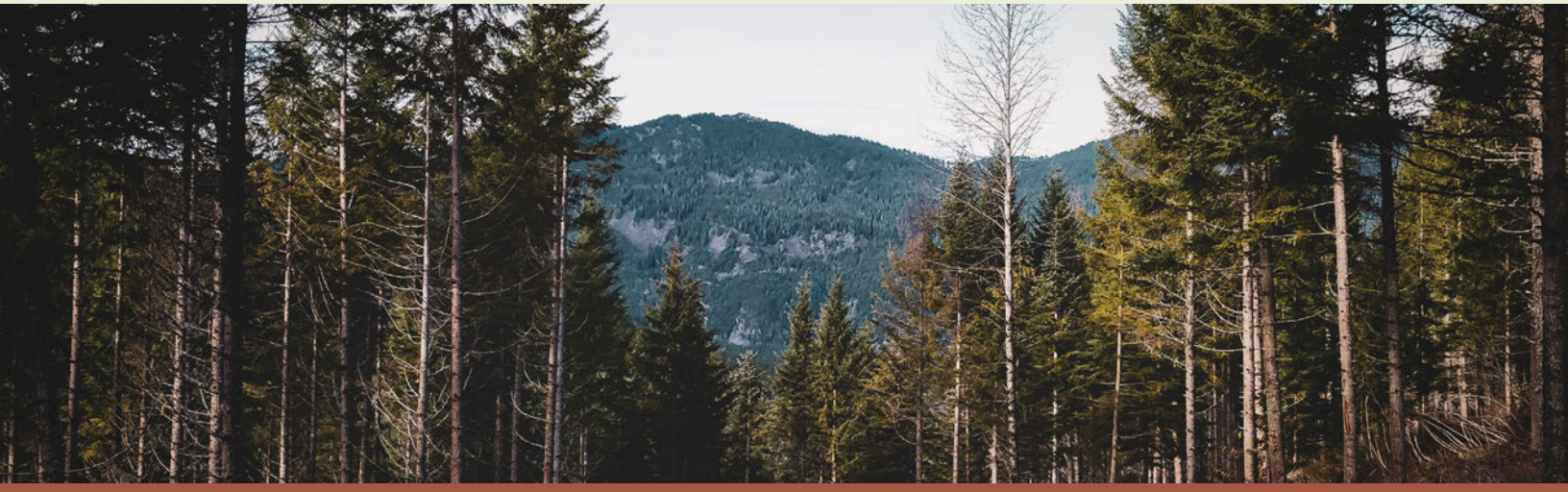
e) Aboriginal people's ongoing connection to culture, community and Country and the importance of this connection for the mental health and wellbeing of Aboriginal people in Victoria.

3. It is the intention of Parliament that the mental health system recognises, respects and supports the distinct cultural rights of Aboriginal people and their right to receive culturally safe holistic mental health and wellbeing services throughout Victoria.

4. The Parliament supports initiatives which address the ongoing mental health inequalities experienced by Aboriginal people in Victoria.

5. The Parliament recognises the essential role of Aboriginal community controlled health organisations in meeting the mental health and wellbeing and care needs of Aboriginal people in Victoria.

6. The Parliament supports the development of future reforms which further Aboriginal self-determination within mental health and wellbeing services in Victoria.[136]



Specific ways this guiding principle could be incorporated into BC's mental health law:

- BC's mental health law and services will be created, delivered, and evaluated in compliance with the United Nations Declaration on the Rights of Indigenous Peoples.
- Community-specific self-determination is a foundational principle to improve mental health and wellbeing outcomes of Indigenous people in BC.
- Indigenous communities will be supported to develop their own self-determined wellness supports.
- Mental health and substance use health services will recognize Indigenous people's ongoing connection to culture, community, and territory and the importance of this connection for their mental health and wellbeing.
- Mental health and substance use health services will recognise, respect and support the distinct cultural rights of First Nations, Inuit, and Métis people and their right to receive culturally safe, holistic services throughout BC.
- First Nations, Inuit, and Métis people will be provided with mental health and substance use health services in a way that recognises, is consistent with, and supports access to their distinct traditions or customs.

Principle 6: Prioritize intersectional equity

BC should prioritize intersectional equity as a guiding principle in its mental health law because:

- Mental health laws do not impact all people in the same way. When a person accesses mental health services, they are a full person with many intersecting aspects to their identity.
- The right to the highest attainable standard of health requires equal access to services, and especially for communities that experience the biggest health inequalities or intersecting barriers.
- Equitable access requires ensuring that services are safe for everyone and do not create unintended impacts or barriers due to personal identity factors.

"Like, we're not necessarily all equal. We don't all have the same past, or the same experiences and it should come into play."

- Lived Experience Expert

Principle 6: Prioritize intersectional equity

> **"[A] lot of women coming home from Hastings may or may not have had sexual trauma in their past. So when you take them to a hospital and six security guards who are all men, strap them to a bed, rip their clothes off them. And this is done repeatedly. This might cause some long-term mental unrest for those women. And there's never any counseling given about that, or any, like, nobody even acknowledges that or talks to you about it, or you know what I mean? And I think in that, like regard, gender should come into play… Like, we're not necessarily all equal. We don't all have the same past, or the same, like experiences and it should come into play. Like why? Why does there need to be six men security guards in the room when you're getting changed."**
>
> **- Lived Experience Expert[137]**

This quote illustrates the ways in which gender and previous experiences of gender-based violence deeply impacted this individual's lived experiences under the Mental Health Act. It also highlights one of the many ways in which the use of force, coercion, and restriction on freedoms does not impact all people in the same way. When a person accesses mental health services, they are more than their mental health issue. They are a full and complex person with many aspects to their identity outside of their current mental health needs.[138]

Prioritizing equity can include addressing accessibility issues like ensuring different cultural, religious, or spiritual practices are respected in the provision of mental health services. It includes respecting gendered caregiving roles and family status, the needs of dependents, experiences of gender-based violence, and reproductive rights. It includes respecting gender identity and expression. It includes consideration of age and disability-related needs. One Lived Experience Expert described the ways in which their role as a new mother and caregiver was not respected during their detention, and when they tried to advocate for options that might better meet their intersecting needs, they were dismissed:

> **"In other countries, they have mother baby units for people that are experiencing that mental health crisis. Where I could have kept [my baby with me]. Maybe not in the initial stages when I was really unwell, but 3-4 days later, I was doing so much better. I could have been spending so much more time bonding, soaking up those moments that you're supposed to be soaking up."**
>
> **- Lived Experience Expert[139]**

The international human right to mental health requires equal access to services, including ensuring they are respectful and appropriate for the communities that experience the biggest gaps in health outcomes or barriers to access.[140] Equitable access means more than just physical access or availability; it also requires ensuring that services are safe for everyone and do not create unintended impacts or barriers due to personal identity factors like race, Indigeneity, gender, sex, (dis)ability, spirituality, or place of origin/migration status.

Intersectional equity requires that mental health law and services also respect and ensure accessibility for people who may have multiple aspects of their identity that overlap or intersect to shape their experiences.[141] It is an acknowledgement that different and overlapping experiences of inequity can operate together and exacerbate each other. It means, for example, that the experiences of an Indigenous transgender person will be different than the experiences of an Indigenous cisgender person or the experiences of a non-Indigenous transgender person because their gender identity and Indigeneity intersect and inform each other to shape their experience.

In addition, international human rights treaties set out further specifics related to the right to non-discrimination and the right to mental health for communities that have historically experienced and currently experience discrimination in the health system. For example:

- The Convention on the Rights of Persons with Disabilities recognizes that people with disabilities have been discriminated against in the health care system and there needs to be investment in efforts to redress these harms, respect differences, and accept

persons with disabilities as a welcome part of human diversity and humanity.[142]

- The Convention to End All Racial Discrimination recognizes that racialized people have been discriminated against in the health care system and that there needs to be investment in anti-racism measures and cultural safety.[143]
- The Convention to Eliminate All Forms of Discrimination Against Women recognizes that women and gender diverse people have been discriminated against in the health care system and that there needs to be investment in gender equity and safety, protection of reproductive rights, and respect for caregiving roles.[144]
- The Convention on the Rights of Children recognizes that children have evolving capacity and may face more barriers than adults in speaking up for themselves and exercising their rights. Additional safeguards and procedural protections may help ensure that children's voices are heard.[145]

Including a guiding principle in BC's mental health law and commitments to prioritizing equity is a crucial step towards closing the gaps in health and wellbeing experienced by many communities.

Learning from outside BC

Many places outside of BC have already taken significant steps to name and prioritize equity in the principles that guide the application of their mental health laws. For example:

- Northwest Territories' mental health law states that "decisions that affect a person who is subject to this Act should respect the person's cultural, linguistic and spiritual or religious ties."[146]
- Tasmania's mental health law requires services "to be sensitive and responsive to individual needs (whether as to culture, language, age, religion, gender or other factors)."[147]
- Scotland's mental health law requires that power under the act will be carried out in a way that respects "the patient's abilities, background and characteristics, including, without prejudice to that generality, the patient's age, sex, sexual orientation, religious persuasion, racial origin, cultural and linguistic background and membership of any ethnic group."[148]

Queensland, Australia's mental health law requires that "a person's age-related, gender-related, religious, communication and other special needs must be recognised and taken into account" and "a person's hearing, visual or speech impairment must be recognised and taken into account."[149] Among other principles, the law also sets out that services provided to persons from culturally and linguistically diverse backgrounds must have regard to the person's cultural,

religious and spiritual beliefs and practices.[150]

Finally, Victoria, Australia's mental health law sets out a number of specific principles that illustrate a robust commitment to prioritizing equity. They include:

> **Wellbeing of young people principle:** The health, wellbeing and autonomy of children and young people receiving mental health and wellbeing services are to be promoted and supported, including by providing treatment and support in age and developmentally appropriate settings and ways. It is recognised that their lived experience makes them valuable leaders and active partners in the mental health and wellbeing service system.[151]
>
> **Diversity principle:** The diverse needs and experiences of a person receiving mental health and wellbeing services are to be actively considered noting that such diversity may be due to a variety of attributes including any of the following—
>
> - gender identity;
> - sexual orientation;
> - sex;
> - ethnicity;
> - language;
> - race;
> - religion, faith or spirituality;
> - class;
> - socioeconomic status;
> - age;
> - disability;
> - neurodiversity;
> - culture;
> - residency status;
> - geographic disadvantage.
>
> Mental health and wellbeing services are to be provided in a manner that—
>
> a) is safe, sensitive and responsive to the diverse abilities, needs and experiences of the person including any experience of trauma; and
>
> b) considers how those needs and experiences intersect with each other and with the person's mental health.[152]
>
> **Gender safety principle:** People receiving mental health and wellbeing services may have specific safety needs or concerns based on their gender. Consideration is

therefore to be given to these needs and concerns and access is to be provided to services that—

- are safe; and
- are responsive to any current experience of family violence and trauma or any history of family violence and trauma; and
- recognise and respond to the ways gender dynamics may affect service delivery, treatment and recovery; and
- recognise and respond to the ways in which gender intersects with other types of discrimination and disadvantage.

Cultural safety principle:

- Mental health and wellbeing services are to be culturally safe and responsive to people of all racial, ethnic, faith-based and cultural backgrounds.
- Treatment and care is to be appropriate for, and consistent with, the cultural and spiritual beliefs and practices of a person living with mental illness or psychological distress. Regard is to be given to the views of the person's family and, to the extent that it is practicable and appropriate to do so, the views of significant members of the person's community. Regard is to be given to Aboriginal and Torres Strait Islander people's unique culture and identity, including connections to family and kinship, community, Country and waters.
- Treatment and care for Aboriginal and Torres Strait Islander peoples is, to the extent that it is practicable and appropriate to do so, to be decided and given having regard to the views of elders, traditional healers and Aboriginal and Torres Strait Islander mental health workers.[153]

Wellbeing of dependents principle: The needs, wellbeing and safety of children, young people and other dependents of people receiving mental health and wellbeing services are to be protected.[154]

Specific ways this guiding principle could be incorporated into BC's mental health law:

- Decisions that affect a person who is subject to BC's mental health law will respect the person's cultural, linguistic, and spiritual or religious ties, as well as their gender, sex, (dis)ability, race, ethnicity, Indigeneity, age, family status, and social condition.
- Mental health services and substance use health services will respect the wholeness of a person and their identities beyond their mental health needs.
- Mental health services and substance use health services will be responsive and accessible to any needs related to personal identity, including:
    - Race or ethnicity;
    - Indigeneity;
    - Experiences of trauma or violence, including experiences of gender-based violence;
    - Sex, including reproductive health needs;
    - Gender identity and expression, including gender-affirming health needs;
    - Family status, including caregiving responsibilities;
    - Age, including the needs of children and youth;
    - Religion, faith, or spirituality;
    - Geographic location;
    - Language or communication needs;
    - Culture; and
    - Social condition.

Section Summary

Principle 7: Promote self-determination at every opportunity

BC should promote self-determination at every opportunity as a guiding principle in its mental health law because:

- People with mental health and substance use-related disabilities have been subject to deeply entrenched discriminatory stereotypes about their capacity to make decisions in their own lives.
- BC's current Mental Health Act is outdated in its treatment of the legal capacity of people who experience detention and involuntary treatment.
- The use of coercion can cause harm that should be avoided whenever possible. Supporting self-determination benefits wellbeing.

"When someone is unwell and perhaps not able to make the same decisions they would normally make in some areas..., it doesn't mean that they can't make decisions in every area."

- Lived Experience Expert

Principle 7: Promote self-determination at every opportunity

> **"We're defaulting to involuntary treatment as opposed to using it as a last resort. You go to the hospital and it's a pre-determined outcome rather than what needs to happen. It feels like a box being ticked."**
>
> **- Lived Experience Expert[155]**

The quote above from a Lived Experience Expert expresses how the health care system can default to certification under the Mental Health Act without meaningfully providing access to voluntary services and options.

As referenced above, people with mental health substance use-related disabilities have been subject to deeply entrenched discriminatory stereotypes about their capacity to make decisions in their own lives. Historically, these assumptions have been legitimized through laws that deny them fundamental rights, including removing the ability to marry, forced sterilization, and limitations on the right to control or own property. They continue today through laws that interfere with parenting rights, the denial of the right to control your own body, and the right to liberty.[156]

These stereotypical assumptions and denials of legal capacity are rooted in ableism, which Talila "TL" Lewis defines as:

> [A] system that places value on people's bodies and minds based on societally constructed ideas of normality, intelligence, excellence, desirability, and productivity. These constructed ideas are deeply rooted in anti-Blackness, eugenics, misogyny, colonialism, imperialism and capitalism.[157]

BC's Mental Health Act is outdated in its treatment of the legal capacity of people who experience detention and involuntary treatment. For example, despite other laws in BC that centre a presumption that a person is capable of making their own decisions until an assessment establishes otherwise, including the Adult Guardianship Act[158] and the Health Care (Consent) and Care Facility (Admission) Act,[159] BC's Mental Health Act does not include this presumption. In other words, people with any other kind of health issue or disability in BC are assumed to be able to make their own decisions unless they are assessed otherwise in accordance with legal requirements. People experiencing detention and involuntary treatment under the Mental Health Act do not get the benefit of this assumption; instead, the deemed consent model sends a message that there is assumption that they are incapable or that their capacity to make decision doesn't matter.

Other laws in BC also expressly state that any services offered should be the least restrictive as possible.[160] In other words, any use of coercion should only be a last resort and if a less restrictive option is available, it should be the priority. People detained and experiencing involuntary treatment under the Mental Health Act do not get to benefit of these protections.

All of these existing laws that expressly assume a person is capable and require services to be the least restrictive as possible appear to be based on an understanding that treating a person as incapable, using coercion, and applying force come with harms that should be avoided whenever possible. One of the challenges with the Mental Health Act and BC's mental health system is that it fails to acknowledge, make visible, and consider the harm that can be caused by the use of coercion related to liberty and health care consent rights, which can cause overt trauma. However, even smaller exercises of coercion that occur during detention can contribute to an experience where almost every aspect of a person's life feels controlled and all choice is constrained.[161]

> **"When we are treated involuntarily, choice is often taken away from us at many levels and about many things. It's important to remember that even when someone is unwell and perhaps not able to make the same decisions they would normally make in some areas because their perception of reality is different, it doesn't mean that they can't make decisions in every area. People can still have opportunities to exercise choice. Many of the choices I would have liked to make when I was hospitalized were the same then as they would be now, when I am well."**
>
> **- Lived Experience Expert[162]**

While there is significant debate about the legal path for ensuring respect for the legal capacity of people with mental health and substance use-related disabilities, human rights require the progressive realization of laws and services that recognize people as experts in their own lives. This means BC must be taking constant steps towards supporting the legal capacity and self-determination of all people with disabilities in every way possible – self-determination supports wellbeing and coercion can cause harm. It is necessary to expressly recognize these impacts in the law because of the historic and ongoing power imbalances in the mental health and substance use health system.[163] It will also help us build effective services that meet people's needs in a more meaningful way.

In addition, BC relies heavily on the use of police to respond to actual or perceived mental health needs in the community. People identified as having a mental health condition or concern are grossly overrepresented in police-related fatalities.[164] This disproportionately high level of police fatalities show how dangerous an overreliance on the use of force through police responses are

for people with mental health and substance use-related health issues. There are clear calls to detask police as primary mental health crisis responders and develop human rights-based, peer led, civilian support services to eliminate this unnecessary reliance on coercion and force.[165]

When a person needs mental health support, and especially when they are in crisis, they need access to services that they perceive as, and that actually are, safe and inclusive for them. They need services that will treat them as full humans and center them in decision-making. This is a core aspect of trauma-informed practice, and for Indigenous people, it can help prevent the perpetuation of state control that is ever present in colonialism. People with lived and living experience describe it in simple and effective terms:

> **"If you make a person feel like they have no control, no agency, you're making it more traumatic and setting them up for dependence, resentment, hostility towards the system."**
>
> **- Lived Experience Expert[166]**

In the context of BC's rapidly increasing use of detention and involuntary treatment, and the reduced use of voluntary approaches, it is crucial that BC include a commitment to autonomy and restrictions on the use of coercion in the guiding principles of its mental health law.

Learning from outside BC

There is no shortage of examples of mental health laws from outside of BC that incorporate these principles. For example, Nunavut's Mental Health Act states the purposes of the statute include facilitating the provision of necessary care to Nunavummiut with serious mental disorders in a way that "is compassionate and minimizes traumatization," "is the least restrictive possible," and "encourages the use of voluntary services."[167] Further, a person exercising power under the statute "shall not place an individual in involuntary status if the individual consents, and is capable of consenting, to undergo any assessment, treatment, transport or admission considered necessary" and must exercise the powers in a way that is "no more restrictive on individual rights than is necessary."[168]

Portugal's mental health law contains guiding principles of mental health policy that requires "mental health care… be provided in the least restrictive way possible."[169] New South Wales, Australia's mental health law includes a guiding principle for treatment that states "any restriction on the liberty of patients and other people with a mental illness or mental disorder and any interference with their rights, dignity and self-respect is to be kept to the minimum necessary in the circumstances."[170]

Nova Scotia's mental health law sets out the following guiding principles:

- treatment and related services are to be offered in the least-restrictive manner and environment with the goal of having the person continue to live in the community or return to the person's home surroundings at the earliest possible time;
- the primary mode of admission to a psychiatric facility shall be as a voluntary patient wherever possible; and
- treatment and related services, where possible, should promote the person's self-determination and self-reliance.[171]

Victoria, Australia's new mental health law shows a strong and detailed commitment to these principles. The objectives of the law include "to protect and promote the human rights and dignity of people living with mental illness by providing them with assessment and treatment in the least restrictive way possible in the circumstances."[172] The law then goes on to set out a number of specific guiding principles related to supporting autonomy and self-determination:

- **Least restrictive principle:** Mental health and wellbeing services are to be provided to a person living with mental illness or psychological distress with the least possible restriction of their rights, dignity and autonomy with the aim of promoting their recovery and full participation in community life. The views and preferences of the person should be key determinants of the nature of this recovery and participation.[173]
- **Supported decision making principle:** Supported decision making practices are to be promoted. Persons receiving mental health and wellbeing services are to be supported to make decisions and to be involved in decisions about their assessment, treatment and recovery including when they are receiving compulsory treatment. The views and preferences of the person receiving mental health and wellbeing services are to be given priority.[174]
- **Dignity of risk principle:** A person receiving mental health and wellbeing services has the right to take reasonable risks in order to achieve personal growth, self-esteem and overall quality of life. Respecting this right in providing mental health and wellbeing services involves balancing the duty of care owed to all people experiencing mental illness or psychological distress with actions to afford each person the dignity of risk.[175]

Ireland's mental health law states that:

- A person shall not be considered as unable to make a decision in respect of the matter concerned unless all practicable steps have been taken, without success, to help him or her to do so.

- A person shall not be considered as unable to make a decision in respect of the matter concerned merely by reason of making, having made, or being likely to make, an unwise decision.
- There shall be no decision taken in respect of a person unless it is necessary to do so having regard to the individual circumstances of that person.
- A decision taken in respect of a person shall—
    - be made in a manner that minimises—
    - the restriction of the person's rights, and
        - the restriction of the person's rights, and
        - the restriction of the person's freedom of action,
    - have due regard to the need to respect the right of the person to dignity, bodily integrity, privacy, autonomy,
    - be proportionate to the significance and urgency of the matter the subject of the decision, and
    - have due regard to the need to have access to health services that have as the aim of those services the delivery of the highest attainable standard of mental health as well as the person's right to his or her own understanding of his or her mental health.[176]

There are so many other examples of jurisdictions that have made an express commitment to self determination in their mental health laws that could be explored, including: the Northwest Territories; Denmark; the Netherlands; Norway; Northern Ireland; Queensland, Australia; Tasmania, Australia; South Australia; Hawaii; Alaska; North Rhine Westfalia, Germany; and Berlin, Germany.[177] It is clear that BC is a sharp outlier in our failure to recognize the value of promoting self determination and minimizing the potential harms inherent in coercion.

Specific ways this guiding principle could be incorporated into BC's mental health law:

- Unless the contrary is demonstrated, every adult is presumed to be capable of making decisions about their health care. A person's way of communicating with others is not, by itself, grounds for deciding that they are incapable.
- The primary mode of providing mental health and substance use health services, including admission to hospital, will be through voluntary means.
- Mental health and substance use health services will be offered in a way that maximizes the self-determination of the person receiving service or treatment regardless of their legal status as a voluntary or involuntary patient.
- People receiving mental health and substance use health services will be supported to make decisions and to be involved in decisions about their assessment, treatment, and recovery, including when they are receiving involuntary treatment. Their views will be prioritized.
- Any restriction on liberty or autonomy, and any interference with rights, dignity, and self-respect, will be kept to the minimum necessary in the circumstances.
- Coercion and force will be used only as a last resort.
- Mental health and substance use health services will recognize and consider that the use of coercion can cause harm even when it is intended to help.

Principle 8: Accountability and oversight strengthens services

BC should include accountability and oversight as guiding principles in its mental health law because:

- When extraordinary power over a person's human rights is granted in law, adequate transparency and oversight are important safeguards.
- Accountability includes data collection, transparency, independent systemic monitoring, effective complaint mechanisms, and access to justice for those whose rights are impacted.
- BC has a documented lack of accountability, systemic oversight, and safeguards in the face of the powers granted in the Mental Health Act.

"They don't explain that you don't have anybody to complain to that's independent... why complain to the people that already hurt you about the people that hurt you?"

- Lived Experience Expert

Principle 8: Accountability and oversight strengthens services

When the law grants extraordinary power over a person's human rights, it is necessary that adequate transparency, oversight, and accountability mechanisms are in place to monitor how the power is being used and guard against abuses and unfair uses of power. People with lived and living experience are clear about the need to ensure accountability as part of BC's legal approach:

> **"It should have to be justified each time they override a person's choice. Not just making them involuntary, but all the little choices too. It would be onerous, but that's transparency."**
>
> **- Lived Experience Expert[178]**

The WHO and OHCHR have noted:

> Accountability is an important component of the human rights framework. Without accountability, human rights lack enforcement and are rendered meaningless. Governments and other actors are accountable to rights holders, and mechanisms need to be established to define clear responsibilities, to measure and monitor progress, and to engage with rights-holders to improve policy-making.[179]

These measures include ethical data collection to understand how the powers authorized under a mental health law are being used; transparency about the results; and systemic monitoring and oversight that is independent from the system authorized to exercise power. They also includes effective independent individual and systemic complaints mechanisms and access to justice for people whose rights are impacted.[180]

Lived experience of the existing accountability mechanisms in place in BC often reveal they lack independence and can feel ineffective to the people using them. A Lived Experience Expert critiqued the lack of transparency and objectivity present in existing mechanisms, stating:

> **"Well, I guess we'll fast forward to the end of the story, because they don't explain that you don't have anybody to complain to that's independent. Not in the beginning of the process anyway. Because the people you're complaining to is the quality office they are the hospital and so it was the patient quality care review [office], they're the health authority. So why complain to the people that already hurt you about the people that hurt you…"**
>
> **- Lived Experience Expert[181]**

BC has a glaring lack of transparency, systemic oversight, and safeguards in the face of the powers granted in the Mental Health Act. This deficiency has been documented as illustrating a cultural problem in BC's mental health system that does not place adequate importance on the rights of patients.[182] Despite a systemic investigation documenting these issues, the last three years have seen only minimal improvement on basic compliance issues, with the majority of detentions still violating the basic legal requirements in the Act.[183] Issues with transparency, data collection, and basic legal compliance remain in BC's current system; a shift to a rights-based approach will only underscore the importance of remedying these problems.

There is often an assumption that the purpose of safeguards is limited to addressing wrongful detention and involuntary treatment. A Lived Experience Expert analyzed the universal importance of safeguards, noting they must go beyond protecting against bad actors or mistakes:

> **"When talking about safeguards, the conversation often shifts to detaining the wrong people or people who aren't crazy or people who don't deserve it. The person who is as crazy as you can imagine still deserves to be treated well, still retains all these rights, it's not about 'these rights are important for people who actually deserve rights'. The rights are important for everyone, not just the wrong people being detained."**
>
> **- Lived Experience Expert[184]**

Safeguards can certainly help avoid a situation of wrongful detention, but they also benefit every person who is subject to the legal power of the Mental Health Act.

In response to a 1994 investigation by the BC Ombudsperson relating to the conditions, treatment, and accountability at Riverview, BC created the role of Provincial Mental Health Advocate. The goal of that role was to monitor and report to the public on the state of mental health services and the mental health system in BC.[185] The role was established in 1998 only to be eliminated in 2001 after a change in government. Since then, there as been no coherent, dedicated system of accountability and oversight in BC's involuntary treatment system or mental health and substance use health system more broadly.

Significant work is needed to make systemic and meaningful shifts in BC's mental health and substance use health system so that the individuals accessing services see those shifts in their experiences. A guiding principle acknowledging the role and importance of accountability and oversight, and mandating that BC's mental health law and its application be rooted in these principles, would be a strong foundation to start cultural change.

Learning from outside BC

Jurisdictions outside of BC illustrate how principles related to transparency, accountability, and oversight can be included in mental health laws to support human rights.

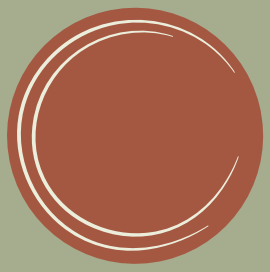
For example, the purposes of Nunavut's mental health law include a commitment to data transparency, stating the statute is intended in part to facilitate "tracking the needs related to mental health and addictions in Nunavut and the delivery of involuntary care."[186] Included in the objectives for Tasmania's mental health law is "to provide for appropriate oversight and safeguards in relation to such assessment and treatment."[187]

Several other jurisdictions create robust accountability and oversight mechanisms in their laws. For example, Ireland's mental health law creates an Independent Mental Health Commission "to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centers under this Act."[188] Further, Ireland's law mandates the appointment of an Independent Mental Health Inspector that visits and inspects every approved detaining facility at least once a year and reports on the level of compliance.[189]

Other jurisdictions include mandatory reviews of the use of and efficacy of their mental health laws. Ontario's mental health law mandates automatic reviews of the use and effectiveness of community treatment orders at specific periodic intervals, with a public report of the results.[190] Nova Scotia's law mandates its Mental Health Review Board to review the file of every involuntary patient 60 days after admission and then on mandated intervals after that, essentially ensuring that detentions are subject to independent review regardless of whether a person applies for a review.[191] Ontario's law also mandates automatic review on every second renewal of community treatment orders if the individual has not applied for a review.[192]

Victoria, Australia's 2014 mental health law included the creation of a specialized Mental Health Complaints Commission. The independent body is responsible for safeguarding rights, resolving complaints, and recommending improvements to Victorian public mental health services. It works to address individual complaints and help improve policies and procedures to resolve complaints, identify, analyze, and review quality, safety, and other issues arising out of complaints, and make recommendations for service improvements to a number of relevant government bodies.[193] Victoria's newly passed mental health law goes further to establish a Mental Health and Wellbeing Commission.[194] The Commission is specifically tasked with ensuring government accountability with a long list of specific functions that include monitoring, complaints resolution, ensuring quality and safety of services, and promoting rights.[195]

Finally, Scotland's mental health law creates a Mental Welfare Commission with oversight powers to visit people detained under the law, including through unannounced visits; monitor how the law is being used, including legal compliance through the inspection of records; investigate individual and systemic concerns, including through inquiries; and offer advice and information.[196]



Specific ways this guiding principle could be incorporated into BC's mental health law:

- BC's mental health law and services will promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the rights of people subject to the law.
- A goal of BC's mental health law will be to provide for independent oversight and safeguards in relation to powers exercised under the law.
- BC's mental health law and services will facilitate tracking data related to mental health and substance use-related health issues of people in BC, including but not limited to the use of involuntary treatment and the use of force.

Conclusion

Incorporating guiding principles in BC's mental health law, both to clearly establish the objectives of the law and to mandate a vision for mental health services throughout the province, is the first step in creating a foundation for change. The eight guiding principles set out in this publication reflect a commitment to a human rights-based approach to the provision of mental health and substance use health services that respect and promote dignity, autonomy, and wellbeing.

Guiding principles alone will not create wide-spread systemic change. However, they do illuminate the pathway for change. In Health Justice's future publications, we will be expanding on the practical implementation of these guiding principles and ways they can be meaningfully incorporated in a new, modern, human rights-based mental health law for BC.

Endnotes

1 Lived Experience Expert, Focus Group.

2 See for example, Canadian Museum for Human Rights, https://humanrights.ca/story/the-universal-declaration-of-human-rights.

3 Office of the United Nations High Commissioner for Human Rights, "Fact Sheet 33: Frequently Asked Questions on Economic, Social ad Cultural Rights" (undated) [UN Fact Sheet] at pages 13-17.

4 UN Fact Sheet, see note 3, at pages 13-17.

5 International Covenant on Economic, Social and Cultural Rights, 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) [CESCR]. Canada acceded to the ICESCR on 19 May 1976 and it took effect on 19 August 1976; International Covenant on Civil and Political Rights, 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976) [CCPR]. Canada acceded to the ICCPR on 19 May 1976 and it took effect on 19 May 1976; International Convention on the Elimination of All Forms of Racial Discrimination, 07 March 1966, 660 UNTS 1 (entered into force on 4 January 1969) [CERD]. Canada signed CERD on 24 August 1966 and ratified it on 14 October 1970; Convention on the Elimination of All Forms of Discrimination against Women, 18 December 1979, 1249 UNTS 1 (entered into force on 3 September 1981) [CEDAW]. Canada signed CEDAW on 17 July 1980 and ratified it on 10 December 1981; Convention on the Rights of the Child, 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990) [CRC]. Canada signed the CRC on 28 May 1990 and ratified it on 13 December 1991; Convention on the Rights of Persons with Disabilities, 13 December 2006, 2515 UNTS 3 (entered into force 3 May 2008). Canada signed the CRPD on 30 March 2007 and ratified it on 11 March 2010; UN General Assembly, United Nations Declaration on the Rights of Indigenous Peoples, 13 September 2007, UN Doc. A/RES/61/295 [UNDRIP] (Canada voted against UNDRIP, but removed its permanent objector status and adopted the Declaration in 2016).

6 The terminology related to equity and equality can be confusing. Increasingly, the term "equality" is being used to describe applying the same system or approach to everyone regardless of their needs, while "equity" is used to refer to creating systems or approaches that recognize specific needs and barriers of traditionally marginalized groups and respond to those needs. The legal and human rights systems use the term "equality" to cover both concepts, but distinguishes between formal equality (treating everyone the same regardless of differing needs or barriers) and substantive equality (recognizing that systems may need to treat people differently based on their different needs or barriers in order to level the playing field). In this publication, we will use the term equity to refer to the latter concept.

7 Office of the Ombudsperson, "Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act", Special Report No. 42 (March 2019) [Committed to Change].

8 *Battlefords and District Co-operative Ltd. v. Gibbs*, 1996 CanLII 187 (SCC), [1996] 3 SCR 566 [Battlefords] at para 31.

9 *British Columbia (Attorney General) v Council of Canadians with Disabilities*, 2022 SCC 27 [CCD] at para 115.

10 CCD, see note 9, at para 115.

11 Committee on the Rights of Persons with Disabilities, "Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities" (2015).

12 World Health Organization and Office of the High Commissioner for Human Rights, "Draft Guidance on Mental health, Human Rights, and Legislation" (2022) [WHO & OHCHR Guidance] at s1.3.

13 British Columbia's Office of the Human Rights Commissioner, "Disaggregated demographic data collection in BC: The Grandmother perspective" (2020) [The Grandmother Perspective].

14 Office of the Representative for Children and Youth, "Detained: Rights of Children and Youth under the Mental Health Act" (January 2021) [Detained].

15 Detained, see note 14, at page 65.

16 Based on data from British Columbia, Ministry of Health Integrated Analytics, "Hospital Discharges with MH Diagnosis by Involuntary and Other," FOI Request HTH-2020-07130 (2021) at page 7.

17 British Columbia, Ministry of Health Consolidated Analytics Services, "Electroconvulsive Therapy among Mental Health Patients with an Involuntary Hospitalization," FOI Request HTH-2017-73370 (2017).

18 The Grandmother Perspective, see note 13, at page 82.

19 For example:

- See Australia research showing that involuntary assessments, the procedural pathway to authorize involuntary treatment, as well as seclusion and restraint, are disproportionally used on Aboriginal and Torres Strait Islanders: Queensland Health, "Queensland Health Aboriginal and Torres Strait Island Mental Health Strategy 2016-2021" (September 2016) at page 11.
- See UK report documenting that members of Black African and Caribbean communities, in addition to other racialized communities, experience higher rates of involuntary mental health detention: United Kingdom, "Final Report of the Independent Review of the Mental Health Act 1983" (December 2018) [UK Final Report] at page 59.
- See New Zealand research documenting that Māori people are grossly overrepresented in those who experience the use of seclusion rooms in health and disability settings: Dr

Sharon Shalev, "Time for a Paradigm Shift: A Follow Up Review of Seclusion and Restraint Practices in New Zealand" New Zealand Human Rights Commission (December 2020) at pages 41-42.

- See US research documenting that detained Black/African American and Hispanic patients experience higher rates of physical restraint in the emergency department: K Schnitzer at al, "Disparities in Care: The Role of Race on the Utilization of Physical Restraints in the Emergency Setting" (2020) Official Journal of the Society for Academic Emergency Medicine, 28:9 957.

20 Dr. Mary Ellen Turpel-Lafond (Aki-Kwe), "In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care, Addressing Racism Review Full Report to British Columbia Ministry of Health" (2020) [In Plain Sight].

21 In Plain Sight, see note 20, at pages 36-42.

22 In Plain Sight, see note 20, at pages 49, 54.

23 Detained, see note 14, at page 5.

24 Kwame McKenzie & Kamaldeep Bhui, "Institutional racism in mental health care: Services have some way to go before they meet the challenges of a multicultural society" (2007) 334:7595 *BMJ* 649.

25 Daniel Vigo et al, "Exploring Care Options for Individuals with Severe Substance Use Disorders in British Columbia: Final Report" (SFU Centre for Applied Research in Mental Health and Addictions, 2019) [CARMHA Final Report] at page 22.

26 CARMHA Final Report, see note 25, at page 8.

27 CARMHA Final Report, see note 25, at page 8.

28 Note that it is very challenging to compare data across legal jurisdictions because involuntary treatment schemes vary in their design and in how data is recorded. Sources for the data presented:

- NHS Digital, "Mental Health Act Statistics, Annual Figures – 2022-21" states at page 2 there were 53,239 new detentions in 2020/21. 2020 population estimated at 56,550,000.
- Stats Wales, "Admissions to mental health facilities by local health board" states in 2020/21 there were 2,157 formal (involuntary) admissions; 2020 population estimated at 3,170,000.
- Ministry of Health, "Office of the Director of Metal Health and Addiction Services 2020 Regulatory Report" (New Zealand Ministry of Health, 2021) states at page 10 that in 2020, 8,755 people were subject to a community or inpatient compulsory treatment orders; 2020 population estimated at 5,084,000.
- Mental Welfare Commission for Scotland, "Mental Health Act Monitoring Report 2020-21: Statistical Monitoring" (2021) states at page 52 that in 2020/21, there 6,699 new

compulsory treatment orders; 2020 population estimated at 5,466,000.

- Antionette Daly & Sarah Craig, "National Psychiatric Inpatient Reporting System (NPIRS) Annual Report on the Activities of Irish Psychiatric Units and Hospitals 2020" (Ireland Health Research Board, 2021) states at page 6 that the 2020 rate of involuntary admissions was 51.7/100,000 people, with involuntary admissions representing 16% of all admissions.
- Victoria State Government, Department of Health "Victoria's mental health services annual report 2020-21" (2021) states at page 36 that in 2020/21, 50.2% of the admissions are compulsory treatment admissions; there were 26,884 acute separations so approximately 13,496 compulsory separations (see page 50; overall admission data is not included in the report, so we have used separation as a best estimate). 2021 population estimated at 6,649,000.
- BC 2020/21 data taken from Office of the Ombudsperson, "Systemic Investigation update: Report on the Implementation of the Recommendations from Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act" (July 2022) [Committed to Change Update] at page 31; 2020 population estimated at 5,147,712.

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33 Committed to Change Update, see note 28.

34 Detained, see note 14, at page 5.

35 Detained, see note 14, at page 6.

36 Detained, see note 14, at page 59.

37 Detained, see note 14, at page 5.

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39 United Nations, "End of Mission Statement by the United Nations Special Rapporteur on the rights of persons with disabilities, Ms. Catalina Devandas-Aguilar, on her visit to Canada" (12 April 2019).

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42 Mental Health Commission of Canada, "Guidelines for Recovery-Oriented Practice" (2015) [MHCC Recovery Guidelines].

43 See for example, Canadian Public Health Association, "What are the social determinants of health?" online: https://www.cpha.ca/what-are-social-determinants-health.

44 World Health Organization, "Guidance on community mental health services: Promoting person-centred and rights-based approached" (2021).

45 WHO & OHCHR Guidance, see note 12.

46 Health and Social Care Alliance Scotland, "Being Human: A human rights based approach to health and social care in Scotland" (2013) at pages 8-9.

47 CARMHA Final Report, see note 25, at page 22.

48 Committed to Change, see note 7, at page 3.

49 Lived Experience Expert.

50 *McCorkell v Riverview Hospital*, [1993] 8 WWR 169, 104 DLR (4th) 391 (BCSC) at para 53.

51 *EME v DAW*, 2003 BCSC 1878 at para 27.

52 British Columbia, "A Pathway to Hope: A roadmap for making mental health and addictions care better for people in British Columbia" (2019) at page 28.

53 Royal Commission info Victoria's Mental Health System, "Final Report Volume 4: The fundamentals of enduring reform," (2012) [Victoria Royal Commission] at page 13.

54 Victoria Royal Commission, see note 53, at page 21; WHO & OHCHR Guidance, see note 12, at page 19.

55 Victoria Royal Commission, see note 53, at pages 15, 21, 22; WHO & OHCHR Guidance, see note 12, at page 19.

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58 See for example, Nova Scotia MHA, see note 57; Nunavut MHA, see note 57; Northwest Territories MHA, see note 57.

59 See for example, Adult Guardianship Act, RSBC 1996, c6 [AGA], s2; Representation Agreement Act, RSBC 1996, c405, s2; Child, Family and Community Services Act, RSBC 1996, s46, ss2-3.

60 Accessible Canada Act, SC 2019, c10, s6.

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62 WHO & OHCHR Guidance, see note 12, at page 28.

63 WHO & OHCHR Guidance, see note 12, at page 28 and 29.

64 Victoria Royal Commission, see note 53, at pages 13-15.

65 *Battlefords*, see note 8, at para 31.

66 *Ontario (Attorney General) v G*, 2020 SCC 38 at para 61-63.

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110 The principle of participation in public life is well established in article 21 of the Universal Declaration of Human Rights and reaffirmed in article 25 of the International Covenant on Civil and Political Rights. Participation, as a principle and a human right, is also recognized in other human rights instruments, such as under article 5(c) of the International Convention on the Elimination of All Forms of Racial Discrimination, article 7 of the Convention on the Elimination of All Forms of Discrimination against Women, and articles 12 and 23(1) of the Convention on the Rights of the Child. The Convention on the Rights of Persons with Disabilities recognizes participation as both a general obligation and a cross-cutting issue. In fact, it enshrines the obligation of States parties to closely consult and actively involve persons with disabilities (article 4(3)) and the participation of persons with disabilities in the monitoring process (article 33(3)) as part of a wider concept of participation in public life.

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