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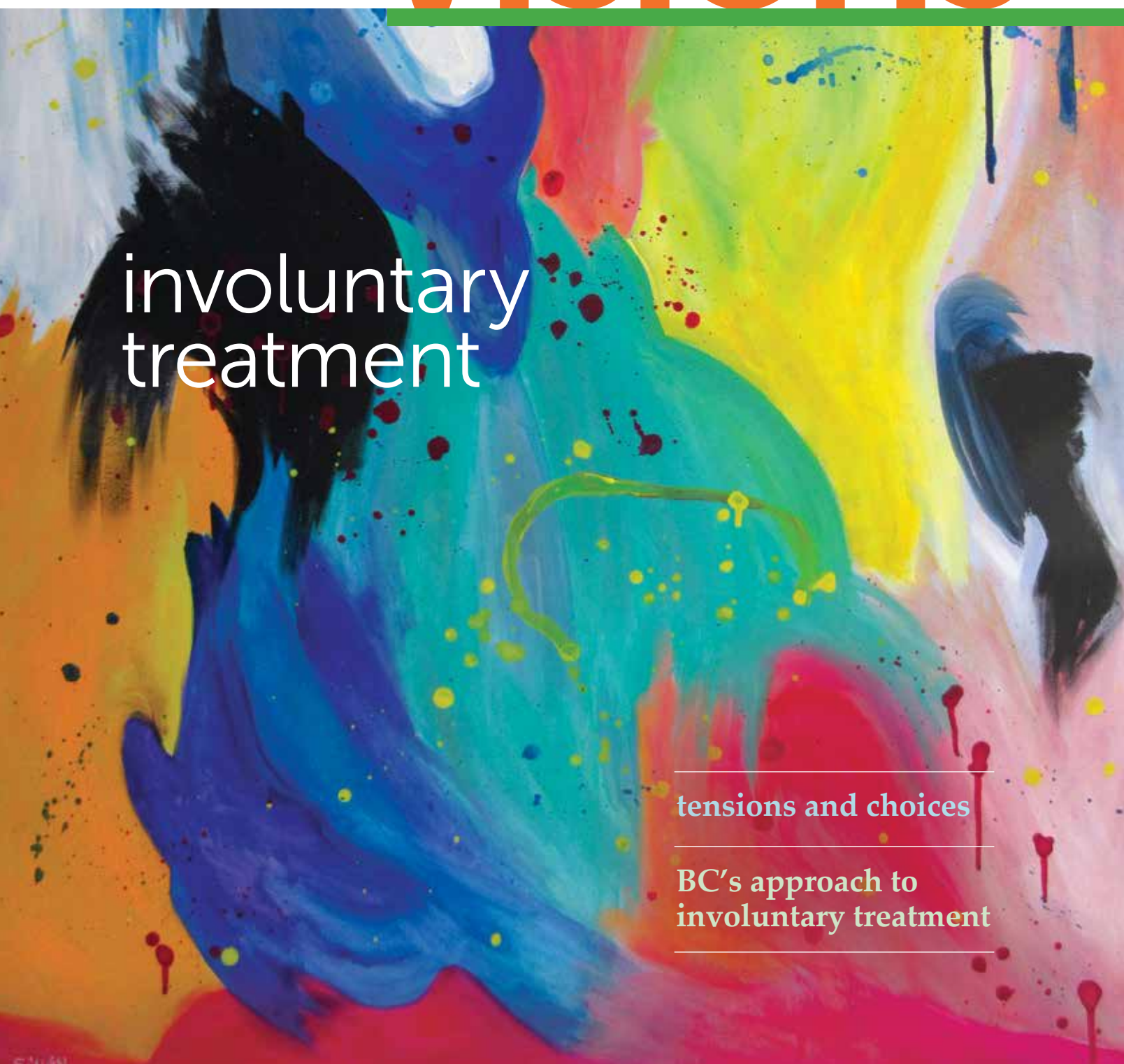
BC'S MENTAL HEALTH AND SUBSTANCE USE JOURNAL | Vol. 21 No. 2 **2025**

visions



involuntary treatment

tensions and choices

BC's approach to involuntary treatment

visions

Published triannually, *Visions* is a national award-winning journal that provides a forum for the voices of people experiencing a mental health or substance use problem, their family and friends, and service providers in BC. It creates a place where many perspectives on mental health and substance use issues can be heard. *Visions* is produced by the BC Partners for Mental Health and Substance Use Information and funded by BC Mental Health and Substance Use Services, a program of the Provincial Health Services Authority.

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bc partners and heretohelp

HeretoHelp is a project of the BC Partners for Mental Health and Substance Use Information. The BC Partners are a group of non-profit agencies working together to help people improve their quality of life by providing high-quality information on mental health, mental illness and substance use. We represent the BC Schizophrenia Society, Canadian Mental Health Association's BC Division, Canadian Institute for Substance Use Research, FamilySmart, EmbodyBC (a Family Services of the North Shore program), and the Mood Disorders Association of BC (a branch of Lookout Housing and Health Society). BC Partners work is funded by BC Mental Health and Substance Use Services, a program of the Provincial Health Services Authority. Visit us at www.heretohelp.bc.ca.

We would like to acknowledge that the coordination and production of this issue of Visions *Journal took place on traditional, ancestral, unceded xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish) and Sḵwx̱wú7mesh (Squamish) territories.*

The opinions expressed in this journal are those of the writers and do not necessarily reflect the views of the member agencies of the BC Partners for Mental Health and Substance Use Information or any of their branch offices.

Cover art: "Beauty and the Beast" by Sandra Yuen, a visual artist, published author, drummer for Beautiful Lizards and a public speaker on recovery. She received the Courage to Come Back Award and the Diamond Jubilee Medal for overcoming severe adversity to give back to society. **Artist Statement:** Initially, I had paranoid schizophrenia and was unable to have insight or believe I was ill. Without involuntary hospital treatment, I may not have had the care, support and expertise to recover. As I travelled the long road to recovery, art became a necessary part of my therapy. It allowed me to look inward and grow into who I am today. "Beauty and the Beast" represents two sides of a person, synthesized in this painting. syuenartist.com

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footnotes reminder

If you see a superscripted number in an article, that means there is a footnote attached to that point. In most cases, this is a bibliographic reference. For complete footnotes, see the online version of each article at www.heretohelp.bc.ca/visions.

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we want your feedback!

If you have a comment about something you've read in *Visions* or would like to write a letter to the editor for publication, please fill out our feedback form at **heretohelp.bc.ca/visions-feedback**. Please include your name and city of residence. All letters are read. Your likelihood of being published will depend on the number of submissions we receive. For full guidelines, please visit .

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visions






the big picture

stories + strategies

looking ahead: don't erase me—why culture matters in mental health

about this issue

Dear *Visions* Readers,

You may find the articles in this issue of *Visions* challenging no matter where you stand on involuntary treatment. To give more space to process the content we have slightly reordered the sections. We begin with commentaries from our two guest advisors and a Big Picture piece to set up the topic, followed by the Independent Rights Advice Service (IRAS), personal stories of lived experience, and Big Picture items to help contextualize the various perspectives. Looking ahead introduces our next issue, Don't Erase Me: Why Culture Matters in Mental Health. If you prefer to read articles on their own, you can find this issue at heretohelp.bc.ca/visions.

Language evolves and changes over time. Many people with lived and living experience prefer the term "involuntary treatment" to describe detention under the *Mental Health Act*, rather than "involuntary care." Treatment highlights the legal and medical aspects of the intervention. It may also more accurately reflect a person's experience, rather than 'care,' a softer term which can be viewed as reducing the impact of loss of autonomy and the compelled aspects of treatment. Others, including professionals, may have these or more reasons for using one term or another. The language we use is a part of our story; thus, we have printed the words chosen by the author.

We would love to hear your reaction to this issue and important community topic. Please contact us at heretohelp.bc.ca/visions-feedback.

Visions Editorial Board

editor's message

Involuntary psychiatric treatment is a controversial topic in health care. In BC, the numbers of those over age 15 detained rose 66% between 2008 and 2018. The largest increase was for people experiencing substance use disorders (139%), reflecting an overall rise from 14,195 in 2008 to 23,531 in 2018.[i]

What might this rise in numbers mean? Is involuntary treatment helpful? And what of substance use disorders? What are the experiences of people who have received involuntary treatment? What do we need to change within our care systems to ensure people get mental health, substance use, and other supports they need? These are some of the questions explored herein.

For many years I was an outreach worker serving people experiencing homelessness in a mid-sized city. A number had serious mental health and substance use concerns. I got to know Shay through regular encounters in a soup kitchen.

Shay mostly talked to himself. Often, when I spoke to him, he ran away. He was very malnourished. He would neither apply for income assistance nor see a doctor. After months of observation, contact attempts and worker input, a psychiatrist with the downtown health centre decided to certify Shay and hospitalize him. After several weeks Shay's overall health significantly improved and he was lucid. He spoke with the doctor.

Shay was angry. He understood people worried about him. He admitted he felt better physically than he had for some time. He also said the medications slowed his mind and made it cloudy, dulled his creativity, and made him feel less like a person. When asked what he would do upon discharge, Shay said he would stop taking psychiatric medication. When the doctor pointed out that this may well result in him returning to his previous fearful and unhealthy state, Shay noted that yes, that may happen and, that was his choice to make. The doctor felt Shay understood the potential consequences of his behaviour and released him from hospital. Upon release, Shay stopped taking medication and returned to his previous psychotic state. He disappeared a few months later. I eventually heard that he had passed away.

I often thought of Shay while working on this issue of *Visions*. For me, his story highlights the complex and nuanced intersections between a person who needs medical assistance, their human rights, life needs, and the health care system. How do we best address these needs within our current social, cultural, and political contexts? This *Visions* issue is meant to add to this important conversation as it relates to involuntary treatment. I encourage you to think about the question and draw your own conclusions.

Trudy Norman, PhD
Managing Editor

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"She Would Not Be Alive"

A CRITICAL LIFELINE FOR PEOPLE LIVING WITH SEVERE MENTAL ILLNESS

FAYDRA ALDRIDGE

Erin Hawkes-Emiru, a neuroscientist and published author, believed she had to die for a greater cause. She thought tiny rats were eating her brain, which was also capable of regeneration. If she died, neuroscientists could research her incredible brain and learn how to cure diseases.

Faydra Aldridge

Faydra's career spans over 20 years in corporate communications and project management. She is the CEO of the BC Schizophrenia Society. Faydra previously held a leadership role with the Vancouver Coastal Health Research Institute, has experience as a CBC Morning Show Producer and has held executive roles with national and international community organizations

When Erin became suicidal due to these beliefs, she was admitted to hospital and prescribed antipsychotic medications. But Erin did not want to take the pills because she believed they had rats in them.[1]

This experience is not unique. In hospitals, schizophrenia has the highest involuntary admission rate of any diagnosis.[2] This is because core features of the illness—delusions, hallucinations and disordered thoughts—can prevent people from seeking or accepting treatment for their illness. Another common symptom is anosognosia, a neurological inability to recognize one's illness. If a person does not believe they are ill, why would they ask for help or want treatment?

Untreated mental illness can result in many challenges, among them:

- disrupted family relationships
- school failure
- unemployment
- substance use
- homelessness
- suicide

Prolonged untreated psychosis also negatively affects the brain, causing:

- decreased cognitive functioning
- neurological damage
- increased risk of developing other conditions, including substance use disorders

Thankfully, under the *BC Mental Health Act*, clinicians were allowed to hospitalize and medicate Erin. In her memoir, she declared: "forced treatment saved my life."

At the BC Schizophrenia Society, we've heard from many others with similar experiences—like Vanessa, mother of a daughter living with schizophrenia. "She would not be alive," Vanessa told us. "Flat out without the involuntary treatment... she simply wouldn't be alive."

Protection from harm

While it is always preferable for people with severe mental illnesses to be admitted and treated with their consent, this is not always possible due to the nature of these illnesses.

The *BC Mental Health Act* permits clinicians to involuntarily treat those in need, protecting them from the harms of treatment refusal. This legislation provides important benefits to patients, their families and communities:

Better outcomes: Starting treatment for psychosis as soon as possible, even when treatment is refused, minimizes damage to the brain.[3] Early treatment avoids greater impairment and higher relapse and readmission rates.[4]

Decreased suffering: The delusions and hallucinations experienced by people living with schizophrenia are often terrifying. We hear this regularly from those who have been through it, and their families. Leaving people in this state prolongs fear and distress and can make symptoms harder to treat.

Decreased detention: Treatment refusal results in longer hospitalizations. People may need to be detained despite their refusal—often for months or years—which deprives them of their rights.[5]

Decreased seclusion and restraint: People who pose a threat to themselves and/or others because of their illness but refuse treatment often need to be placed in seclusion or restraints. This could be prevented with earlier treatment with safe, effective medications.

Hospital use and costs: Patients who refuse treatment but still need hospitalization may take up hospital

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beds for longer. This creates the need for extra funding for detention beds (beds taken up by those who must be detained for safety reasons but refuse treatment).

Early discharge: People who refuse treatment may be discharged before they are well. This often results in high relapse and readmission rates.

Patient and staff impacts: Patients who refuse treatment are more likely to engage in disruptive behaviours, including threats to, and assaults on, staff and other patients.[6] This can interfere with treatment and quality of life for other patients.

Family impacts: Families often provide critical care for people living with a severe mental illness. Appropriate treatment lessens the caregiving burden and distress for families.

Decreased violence and stigma: People receiving treatment for their mental illness are much less likely to be involved in violent incidents than those with untreated psychosis.[7]

Even though involuntary treatment often saves lives and protects health rights, there are concerns that it violates other individual rights. The *BC Mental Health Act* includes specific admission criteria and several safeguards to ensure involuntary treatment is applied responsibly.

To be admitted under the *BC Mental Health Act*, a physician or nurse practitioner must assess a person and determine that they have a severe mental disorder that requires psychiatric treatment in a designated facility to protect the person, or others, from harms. This admission needs to be confirmed by an independent physician for any admission beyond 48 hours.

If a person is admitted, they must be notified of their rights under the *BC Mental Health Act*. The Independent Rights Advice Service has also been established to provide information and support to people admitted for involuntary treatment. A near relative of the patient must also be notified immediately after admission.

Patients can only be treated with safe, effective psychiatric treatments, and a physician must provide them with a description of their treatment plan, the reasons for the plan and its benefits and risks. Patients can also request a second opinion.

Finally, patients who believe they don't meet the criteria for involuntary admission can appeal to a review panel to be discharged. Patients can appeal panel decisions to the Supreme Court of BC.

In the name of safety

The use of involuntary treatment should be minimized as much as possible and does not exist in isolation from our mental health system. There is a greater likelihood of better outcomes with early diagnosis and intervention, more voluntary hospital beds and effective community support.

To anyone who does not understand the complexities and challenges of severe mental illnesses, involuntary treatment can seem like an extreme measure. However, involuntary treatment provides a critical safety net when people are at their most vulnerable.

For Erin, Vanessa's daughter and others living with a severe mental illness, involuntary treatment makes life-saving treatment possible, even when their illness prevents them from seeking that treatment on their own. V

related resources

Learn more about the Independent Rights Advice Service at: irasbc.ca

For a patient Q&A about review panels, visit: bcmhrb.ca/app/uploads/sites/431/2023/08/Information-for-Patients-Plain-Language-August-2021.pdf

For a complete guide to BC's *Mental Health Act*, see: bcmhrb.ca/app/uploads/sites/431/2018/11/Mental-Health-Guide-by-Ministry-of-Health-2005.pdf

At a Crossroads

BC'S APPROACH TO INVOLUNTARY TREATMENT

HEALTH JUSTICE

It's no secret that involuntary mental health and substance use treatment is a hot-button issue in BC. Rhetoric related to expanding involuntary treatment is highly politicized. Often, the talk is more rooted in point-scoring than evidence-based policy or long-term solutions. People with lived and living experience of involuntary treatment feel their lives are being used in a game of political football.[1]

Health Justice is a non-profit organization that uses research, education and advocacy to transform the systems that shape mental health and substance use treatment in BC. Learn more at: healthjustice.ca/about

Photo credit: PamelaJoeMcFarlane for ©iStockphoto.com

Discussions about involuntary treatment are often steeped in fear, misinformation and an oversimplified focus on whether involuntary treatment is "good" or "bad." What's missing from these debates is nuance, humility, evidence-based policy and the voices of people with lived and living experience.

Instead, involuntary treatment is presented as a quick fix to deeply entrenched, systemic issues related to challenges affecting BC and beyond. These include:

- an inadequate mental health and substance use system
- lack of affordable housing
- Canada's outdated drug policy
- unaffordability
- social exclusion

These problems were created by decades of policy decisions by various levels of government, and quick, politically-motivated announcements are not going to solve them.

Reality check

It might be worth talking about what

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involuntary treatment is, what it is not, and why that matters. In BC, involuntary treatment in the health system is governed by the *Mental Health Act*, a provincial law that authorizes the detention of a person in a designated facility. Many people don't know that the province already has over 70 of these facilities, many of which have been operating for decades.[2]

Once detained, the law authorizes involuntary psychiatric treatment, which includes:

- forcibly administering medication[3]
- regular use of seclusion rooms
- physical, mechanical and chemical restraints[4]

Involuntary treatment usually does not involve:

- more holistic approaches to wellness
- access to safe housing
- adequate income supports
- long-term talk therapy
- a focus on the individual's wishes and goals for their lives[5]

Fundamentals of health care consent

Our ability to control what happens to our own bodies is one of our most fundamental human rights and is protected in the *Canadian Charter of Rights and Freedoms*. The *Charter* is the basis for sexual consent laws, reproductive rights and health care consent laws.

In the relationship between doctors and patients, doctors hold a lot of power and knowledge. This power imbalance is why health care consent ensures doctors must share information about proposed treatment options. Health care consent includes sharing:

- the condition being treated
- information about the proposed treatment
- risks and benefits of that treatment[6]

We have the right to decide whether to consent or refuse treatment based on the information provided. If we are unable to consent or refuse health care because of our health issues, BC has a system where, based on our previously expressed wishes, the people we choose or the people who know us best step in to consent or refuse. The goal underpinning this whole system is ensuring that our personal wishes, values and views are the focal point of any decisions.

Disregard for consent

Under BC's *Mental Health Act*, none of those rights apply to people experiencing involuntary psychiatric treatment. Instead, they are deemed to consent to any psychiatric treatment their team sees as appropriate.[7] This happens regardless of:

- their ability to make a particular decision
- any wishes previously expressed about what they would like to happen if they become unwell
- whether the people close to them, who know their views and wishes, are willing and available to make decisions for, or with, them

> **People with lived and living experience of detention and involuntary treatment regularly leave feeling fearful of engaging with the health system again, ashamed and mistrustful, and carrying trauma, including PTSD.**

There is currently a case before the BC Supreme Court challenging whether BC's law violates the *Charter*. The BC government has been fighting this case since 2016.[8]

This means people who experience involuntary mental health or substance use treatment under BC's *Mental Health Act* lose the ability to control what happens to their bodies in extreme ways. Regardless of good intentions, the effectiveness of the treatment administered or why we think involuntary treatment is necessary, this loss of control has the potential to create serious and lasting harm.

Real people

Health Justice has undertaken hundreds of hours of engagement with people who've experienced involuntary treatment through our governance groups, interviews, focus groups, surveys and more. The harm of involuntary treatment is reflected in how they tell us they feel about their experience. Some find the experience positive in that it kept them safe. Some find it harmful, with no benefits. Many have a less binary

view: some parts were helpful, but some parts caused significant harm. That harm can have a lasting impact.

People with lived and living experience of detention and involuntary treatment regularly leave feeling fearful of engaging with the health system again, ashamed and mistrustful, and carrying trauma, including PTSD.[9] These effects are the opposite of what people need to feel safe accessing health care services in the future.

As well, involuntary treatment does not impact people equally. Children and youth, Indigenous, racialized and gender-diverse people may experience the loss of control over their own bodies in different or heightened ways.[10-13]

A time for choice

The question, then, is how we can address the complex and entrenched social issues we see in our communities while also minimizing harm and supporting the dignity and humanity of the people who are suffering the most due to these issues? In April 2025, Premier Eby announced that the Minister of Health will undertake a review of the BC's *Mental Health Act*.[14] At the time of writing, BC has not announced its plans for the review.

In our view, BC is at a crossroads. We can continue on our current path of quick fixes and oversimplified solutions, assuming involuntary treatment is inherently "good" and ignoring the harm created and lack of change in our communities that results.

Or, we can take the admittedly harder path: review the law and the mental health and substance use systems with intention and care.[15] We can decide we want to take time to understand the complexity of the issues raised by involuntary treatment, including colonialism, ableism, power and the role of doctors, and create an independent process, removed from political dynamics.

We can centre the voices of people with lived and living experience to learn what works for them and what harms them. We can learn from places around the world grappling with similar issues, like Scotland, which is now reviewing its mental health law. This option requires significant bravery and, more importantly, humility.

However, walking this more difficult path alongside those most directly affected by the legislation will support wellness and safety for all members of our communities. V

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Time for change

REFORM BRITISH COLUMBIA'S *MENTAL HEALTH ACT*

MARINA MORROW, PHD

British Columbia stands at the point of an important historical moment with respect to supporting people in our communities with mental health and substance use problems. The province can choose to implement measures that will increase institutionalization and coercive practices, like involuntary treatment, restraints and seclusion. Or it can choose to follow international best practices.

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Marina is a Professor in the School of Health Policy and Management at York University and Director of the Mad Studies Hub (yorku.ca/research/madstudieshub). Starting with her work on the Riverview Hospital redevelopment process in the early 2000s, she has studied mental health reforms, equity and human rights in the BC context

These call for increased community-based care and supported decision-making that aligns with equity and human rights. Politicians and policy-makers must let their decisions be guided by sound evidence, which includes evidence based on people's lived experiences of mental health and substance use care.

A controversial law

Historically there has been much debate within the province about the role of BC's *Mental Health Act*. This debate has intensified based on growing concerns about community safety, harms from toxic drug supplies and increased homelessness and poverty. The *Mental Health Act* is a legal mechanism that allows the state to suspend a person's rights and involuntarily detain and treat them if certain criteria are met.

The criteria typically include:

- concerns about the person's dangerousness to themselves or others, or
- evidence that their mental health is deteriorating

The *Act* is not meant to be used punitively, or as a substitute for

criminal justice. In Canada, all provinces and territories have mental health acts, but they don't all have the same criteria with respect to the involuntary committal and treatment process.

In fact, BC is an outlier. It has the only mental health act that allows for deemed consent. This concept means that when people are detained under the *Act*, they're considered to have "deemed" to consent to all treatment that follows. In practice, this means the *Act* creates:

- **centralized power:** the director of the admitting facility and the treating psychiatrist decide on treatment
- **little recourse for patients:** there is no option for the person to refuse that treatment
- **a closed process:** unlike other jurisdictions, there is no separate legal process to determine capacity and consent
- **lack of independence:** there is no meaningful access to an independent decision-maker and recourse to challenge treatment decisions[1]

Negative outcomes

A wide body of research evidence points to the harms that people experience when receiving involuntary psychiatric treatment. These harms include:

- undermining the person's self-determination
- a feeling of loss of humanity
- disrupted communication with family and friends
- disruption of any existing therapeutic relationships[2]

Recent qualitative studies in BC show that some people are physically and mentally harmed in the context of involuntary treatment.[3] Importantly, involuntary treatment has not been shown consistently to improve clinical outcomes.[4] Black, Indigenous and migrant populations are more likely to be involuntarily detained, treated and experience restraints.[5] In BC, youth appear to be a growing population being involuntarily detained and treated, and the gendered impact of involuntary treatment has been explored.[6]

Photo credit: SBSArtDept for ©iStockphoto.com

The problems we see today on our streets and in our communities are the result of many decades of neglect in funding community-based, voluntary care options in mental health, and in decision making at federal and provincial levels.

Rising admissions

BC has one of the highest rates of hospitalization and readmission for mental health and substance use issues, and involuntary treatment has been on the rise, year over year, since 2008.[7] The *BC Mental Health Act* has come under repeated scrutiny for concerns that it overrides human rights. For example, the *Act* is now subject to a Charter challenge by the Council of Canadians with Disabilities.

Most recently, the Committee on the Rights of Persons with Disabilities, which reviews Canada's compliance with the UN Convention on the Rights of People with Disabilities, singled out the *Act*—twice. First, they found that BC's use of deemed consent over-

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rides mental health care consent and supported decision-making rights.

Second, they noted concerns that facility staff in BC have been disciplining involuntary patients, rather than working towards elimination of seclusion and restraints. Indeed, available BC data shows that one in every four people who are involuntarily committed experience seclusion and restraint.[8]

The evidence is clear that the *Act* does not sufficiently protect the rights of people who are subjected to it. Yet politicians, under pressure to solve the complex problems of mental health and substance use and, increasingly, to address community safety concerns, are repeatedly calling for greater use of the *Mental Health Act* and more institutional forms of care.

A plan for change

The problems we see today on our streets and in our communities are the result of many decades of neglect in funding community-based, voluntary care options in mental health, and in decision making at federal and provincial levels. This neglect has undermined harm reduction models in substance use care and increased homelessness and poverty. These problems can't be resolved with a single legal mechanism—the *Mental Health Act*.

Rather, they must be addressed by developing a comprehensive plan. This plan should involve thoughtful consultation with multiple and diverse lived-experience experts, community-based organizations, advocacy groups and mental health and substance use practitioners.

Nationally and internationally, excellent models of mental health care and support exist that are non-coercive, consensual and in line with human rights. Premier Eby has committed to reviewing BC's mental health legislation. He must do so to align the *Act* with best practices internationally and ensure that the human rights and dignity of British Columbians suffering from mental health and substance use issues are upheld. V

related resources

For an update on the ongoing Charter challenge of BC's *Mental Health Act* by the Council of Canadians with Disabilities, see cbc.ca/news/canada/british-columbia/charter-challenge-bc-mental-health-act-deemed-consent-1.7549197

To read critiques and observations about the *Mental Health Act* by the UN Committee on the Rights of Persons with Disabilities, visit: tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRPD%2FC%2FCAN%2FCO%2F2-3&Lang=en

To learn more about the Gerstein Crisis Centre, a Toronto program noted by Human Rights Watch as a leader in addressing mental health issues humanely, visit: hrw.org/news/2021/12/02/canada-program-leads-way-addressing-mental-health-crises

Safeguard Your Rights

BC'S INDEPENDENT RIGHTS ADVICE SERVICE FOR PEOPLE IN INVOLUNTARY TREATMENT

SOPHIA CIAVARELLA

Naomi was waiting alone in a dark hospital room. It felt late, but there was no clock, and someone had taken her phone. She didn't know where she was. The last few days had been such a blur, she didn't remember what happened. She felt confused and scared.

Sophia is Provincial Manager of the Independent Rights Advice Service. She comes to this position with a background in community-led care. Sophia is passionate about providing safe, relevant and effective care that reflects the priorities and needs of the communities in which she works

Photo credit: tomazl for ©iStockphoto.com

She heard someone yelling at a woman in the room beside her for "drinking too much water." Naomi was afraid of getting yelled at too. She wasn't going to ask any questions.

*Two days later, she was out of the hospital. No one had ever told her where she was or why she was there. No one explained to her that she had rights; she assumed she had none. For years, she hid her mental health problems because going back there felt scarier than anything in her head.**

* Story shared with consent; Naomi is a pseudonym

Unfortunately, stories like the one above are all too common in BC. A 2019 Ombudsperson Office report[1] revealed that less than half of people in involuntary treatment were being notified of their legal rights—including their right to know where they were, why they were there, their right to a lawyer and even their right to challenge their detention. It's a long road towards change—but change has started.

As of December 3, 2025, after years of determined advocacy and documentation of rights violations, people in BC who are receiving involuntary

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treatment have the legal right to access free rights advice at specific moments during the treatment process. To protect this right, a new service has launched to provide this vital rights information. The service, called the Independent Rights Advice Service, or IRAS, exists to educate people in involuntary treatment on their legal rights and how to act on them.

Ask questions, get answers

If you are a person receiving involuntary treatment for mental health or substance use, you are now legally in your rights to get help from an advisor with the rights service. The job of an IRAS rights advisor is to educate you on your rights under the *Mental Health Act*. But it's so much more than that.

Rights advisors are independent from mental health facilities and hospitals, their staff or care teams. This means that as an IRAS service user, you can:

- ask advisors questions
- request support to exercise your rights without fear of influence or reprisal
- sit down with an advisor and have a dedicated, person-centred conversation that recognizes how stressful and confusing your experience is
- find out what decision-making power you do still have

Above all, a rights advisor can remind you that, no matter how you feel, you are not alone.

Although IRAS is relatively new (it launched in early 2024) and rights advisors can't provide legal advice, it is a major step forward. Studies of similar services across Canada show that independent rights advice services have broader impacts. They:

- improve quality of life for people in involuntary treatment
- assist health care systems in addressing anti-racism
- provide more equitable services[2, 3, 4]

Strengthening rights

Several official *Mental Health Act* forms are changing to reflect patients' new right to advice from IRAS (one of the new forms is printed after this article). The changes mean if you are receiving involuntary treatment, you will be informed of your right to meet with an advisor whenever:

- you are admitted to the facility
- you are transferred to a different facility
- your medical certificate is renewed
- you are placed on "extended leave" living in community

At each of these points, care teams who are involuntarily detaining a person are legally required to connect them with IRAS if the person chooses. While IRAS is primarily a virtual service for now, we do some in-person meetings and are working on having a greater in-person presence as our numbers and meeting requests grow.

Advice from people who've been there

Many advisors have lived experience of mental health care and detention themselves, making them the perfect people to understand what other people in involuntary treatment are going through. They can ensure service users have their rights respected and no one is silenced or left hidden in the cracks.

Currently 10 rights advisors work across the province. At IRAS, we have carefully chosen and rigorously trained these advisors to do their work in a culturally safe, trauma-informed way.

IRAS is also designed and delivered using a partnership model. This model brings together multiple organizations and stakeholders, including the expertise of people with lived and living experience of involuntary treatment.

To ensure IRAS remains informed by, and accountable to, the lived experience of detention, IRAS is governed by two committees:

- a Lived and Living Experience Leadership Committee, made up of people with experiential expertise of the mental health care system and involuntary treatment

get access to rights advice

IRAS is free and available province-wide. Visit irasbc.ca

- If you are currently detained in a mental health facility: Ask your nurse, social worker or doctor for access to a rights advisor. They will fill out a form. You are allowed to bring a friend, family member or other supporter with you if you'd like.
- If you are on extended leave from a mental health facility in the community: You can book a rights-advice meeting yourself at irasbc.ca
- If you need help navigating the IRAS website: You can leave a voicemail at 604-681-4070.

- a Governance Committee, composed of Indigenous-led organizations and legal partners

Developed from the ground up

The idea for the rights service is not new. Most provinces have a similar service. In BC, community organizations, especially Indigenous-led and peer-led organizations, have been documenting human rights abuses in the mental health care system for decades while advocating for an independent rights advice service.[5, 6, 7]

There was even a previous independent rights advice service, but there was no law to ensure people got access to the advice.[8] While it was a 2022 follow-up[9] to the original 2019 BC Ombudsperson report[1] that finally pushed the government into action, IRAS wouldn't have been possible without the long history of people with lived and living experience of involuntary treatment who laid the path forward.

IRAS is now delivered by three affiliates of the Canadian Mental Health Association in close collaboration with Health Justice, which leads training, education and engagement, and the service is funded by BC's Ministry of the Attorney General. IRAS works in tandem with the new legal right to advice, which has been enshrined by an amendment to BC's *Mental Health Act*.

Photo credit: SDI Productions for ©iStockphoto.com

Many advisors have lived experience of mental health care and detention themselves, making them the perfect people to understand what other people in involuntary treatment are going through.

What's next for rights advice

BC and Canada as a whole have a long way to go when it comes to respecting the rights of people navigating health care systems, addressing the impact of colonization and promoting anti-racism and equitable access to health care. IRAS also has a lot of work to do. We are currently working on ensuring greater access to culturally specific services and resources, and focusing on evaluation to measure our impact on service users and systems. We want to learn and improve.

As we continue to educate and support people in involuntary treatment, we will celebrate the work we've done and use it to motivate future work with passion, reflection and a commitment to ensuring that our service users feel connected, respected and empowered as decision makers in their own health care. As the new provincial manager of IRAS, it is my goal for our service to be a source of hope and security for people at a time in their lives when they rarely feel either. V

for footnotes go to www.heretohelp.bc.ca/visions

BRITISH COLUMBIA | Ministry of Health

FORM 13.1 - MENTAL HEALTH ACT
YOUR RIGHTS UNDER THE *MENTAL HEALTH ACT* AS AN INVOLUNTARY PATIENT

(Sections 34 and 34.3, R.S.B.C. 1996, c. 288) HLTH 3513.1 2025/07/30

You are here as an involuntary patient. This means your doctor or nurse practitioner assessed you. Their opinion is you are experiencing a serious mental health issue and you need psychiatric treatment in or through a mental health facility. The facility must provide you with appropriate care, treatment, and support.

You have rights under the *Mental Health Act*. Page 1 of this form is a summary of your rights. These will be reviewed and discussed with you. More details about these rights are on page 2. You can ask questions or for more information at any time. You will get a copy of this form.

You must be informed where you are getting mental health treatment.

You are being treated in or through: _____ in _____
Designated Facility Name *City or Town*

You must be informed why you are an involuntary patient.
The doctor or nurse practitioner must write the reasons on a certificate. You can ask to see this certificate.

A doctor must assess you regularly to check if you should still be an involuntary patient.

You can meet with a Rights Advisor.
Rights Advisors explain your rights, answer questions, and provide options. They do not work for the government, facility or treatment team. Rights Advisors meet with you in private and do not share what you talk about. Their help is free.

You can ask for a second medical opinion on your treatment.
If you do not agree with your mental health treatment, you can ask for another doctor to give a second opinion on your treatment.

You can apply for a hearing with a review panel if you do not agree that you should be an involuntary patient.
The people on the panel do not work for the government, facility, or treatment team. They are not involved in decisions about your treatment. They hear your case and decide if you should still be an involuntary patient. The hearing is free.

You can speak to a lawyer.
A Rights Advisor can help you with finding a lawyer or other legal help.

You can apply to the court for a judge to review your case.
The judge can see if:
1. There is evidence that proper procedures were followed and there is legal authority to keep you as an involuntary patient.
2. There is enough reason or legal authority to keep you as an involuntary patient.

You may sign this form if you wish. (check all that apply)

☐ **I confirm that my rights under the *Mental Health Act* have been reviewed and discussed with me.**

☐ **I do want to meet with a Rights Advisor. I understand I can ask to meet with a Rights Advisor whether I sign this or not.**
I understand my name, personal health number, and contact information will be shared with the Rights Advisor.

First and Last Name of Person (please print)	*Signature of Person*	*Date (DD / MM / YYYY)*

TO BE COMPLETED BY THE TREATMENT TEAM MEMBER PROVIDING RIGHTS NOTIFICATION (check all that apply)

☐ This form has been reviewed and discussed with the person.
☐ The person declined to complete the form.
☐ The person is not able to review and discuss this form at this time. They will be reassessed regularly and the rights notification will be attempted again.

Name (please print)	Role	Date (DD / MM / YYYY)	Time (24HR HH:MM)

One of the new *Mental Health Act* forms that detained individuals will see after December 3rd, 2025, in British Columbia. It describes the rights all detained patients have and the new legal right to access a rights advisor with the Independent Rights Advice Service. Only the form is printed here. The back of the form is not; it describes the rights a detained person has and answers to common questions. All of the new forms are available on the Ministry of Health website.

Involuntary Treatment

A SYSTEM IN NEED OF TRANSFORMATION

TRACY WINDSOR, RSW

I want to preface this article with an acknowledgement of my social location, which influences every interaction I have.

Tracy (she/they) is a Registered Social Worker, Certified Peer Supporter and Volunteer Executive Director of Kaleidoscope Mental Health Support Society in Vancouver. Writing from personal and professional experience, they bring lived expertise and front-line insight to conversations about involuntary psychiatric treatment, peer support and system transformation

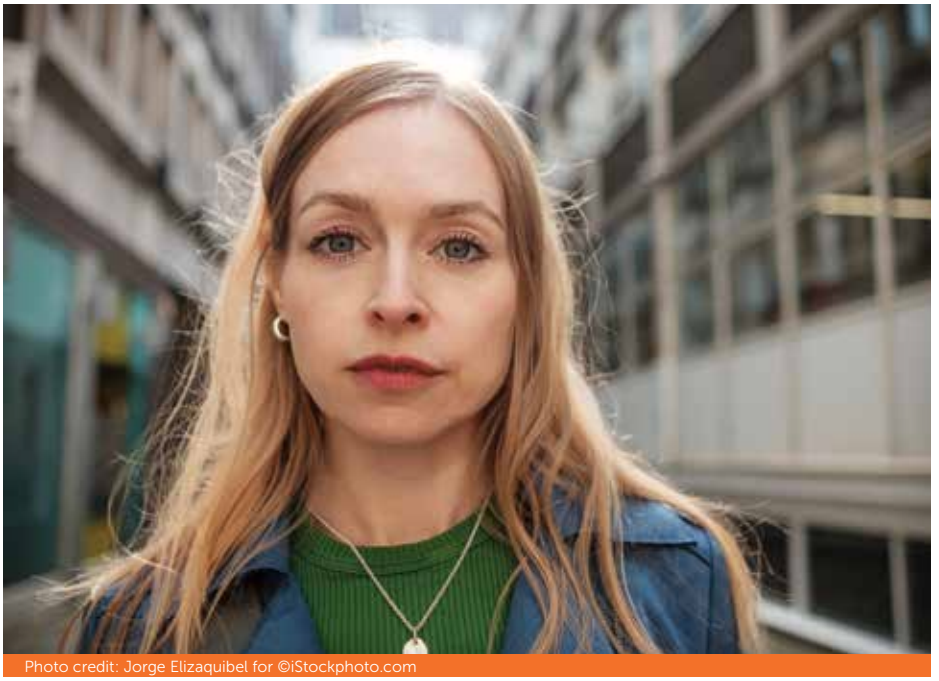

Photo credit: Jorge Elizaquibel for ©iStockphoto.com

I am a white settler on the shared, unceded, ancestral territories of the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish) and səlilwətaɬ (Tsleil-Waututh) Nations. I'm in my late 30s. I have a bachelor of social work, a master of social work, and I'm developing a PhD proposal. I'm the volunteer executive director of a small—but growing—non-profit organization.

I have a diagnosis of bipolar disorder (type I) with psychotic features. I identify with this diagnosis. For me, it explains the phenomena I experience, including mood fluctuations and changes in my perceptions of the shared reality. I use this term with my friends to describe the way the world is interpreted by most people, especially those not impacted by the experience of psychosis.

A full life

Despite limitations related to my bipolar disorder, I am normally gainfully employed. My recent experience of mania and psychosis and a subsequent crash into depression have severely limited my ability to be in a workplace setting outside my home or the hospital. Thankfully, I'm able to do paid and unpaid work—which I love and gives my life so much meaning—while I'm in hospital. I have a place to

for footnotes go to www.heretohelp.bc.ca/visions

In moments where I've felt disconnected from the system, it's often been peers who've helped me feel seen, supported and hopeful again. Their presence reminds me that recovery is possible and I'm not alone. Peer workers don't just support individuals; they help transform systems, making them more compassionate, human and trauma-informed.

call home, which I visit on passes away from hospital and will return to when I'm discharged.

I am cognizant of the privilege I have and the respect I receive during my interactions with mental health professionals and police, which happen rarely, when I experience symptoms of bipolar disorder that are distressing to myself and those around me. Other people facing marginalization might not get that respect. My symptoms landed me in the situation I'm in now—as an involuntary patient detained under the *Mental Health Act of British Columbia*. I'm writing from here today.

Of note: this is my second time detained under the *Mental Health Act* in as many months. I first went in May 2025 for a manic and psychotic episode and stayed four weeks. I then had about a month outside of hospital, during which I spent time connecting with family. But I didn't have adequate care to keep me feeling well.

I was detained again in June 2025, when my mood crashed into depression—likely, fallout from the manic and psychotic episode I had in the spring.

Before these recent admissions, I was in hospital at the end of 2022, when I went in voluntarily for a brief depressive episode. The time before that was an involuntary stay in 2011 for depression, so it's fair to say I had a pretty good run of stability going on 14 years.

My first big psychotic episode was in 2008, which is when I was connected with the Early Psychosis Intervention program. I trusted the team there with my life. They told me the research says people with my diagnosis do best when they stay on medication for life. I believed them, taking my medications as prescribed every day, rarely questioning whether I needed them.

I hadn't had another episode of psychosis (that wasn't cannabis-induced) until this spring. I think it followed my choice to reduce my dose of medication. I was influenced by the idea circulating online, now proven wrong for me, that people might not face repeat psychosis.

The problems with involuntary treatment

Going into the hospital this time hit a little different. I knew that once I was admitted, I would be entering a setting where I'd be contained, sedated and subjected to a process of trial-and-error with medications meant to return me to my "usual" self.

When I arrived, there were few—if any—genuine efforts from care providers to build a meaningful relationship with me. Most interactions were limited to a quick checklist: questions like whether I was having thoughts of suicide or hearing voices. (Even though I've never heard voices, I'm still asked that question twice a day.) I also didn't want to go to the hospital because I know so much more about how psychosis and depression can be treated, and I knew I wouldn't necessarily get cutting-edge treatments.

That's part of what made this hospitalization so difficult: the awareness that care can look different—more relational, more attuned to the complexity of what I go through. I've experienced the difference it makes when someone actually sees you, not just your symptoms. This is where peer support matters so deeply.

Peer support: The unsung hero

Peer support is a huge part of my life. Peer supporters can connect with people with lived experience in ways that feel more human, more grounded and less like the interaction is just going through a checklist. Because they've been there themselves, peer supporters offer understanding rooted in empathy, shared struggle and mutual respect—something that's hard to teach and impossible to fake.

In moments where I've felt disconnected from the system, it's often been

peers who've helped me feel seen, supported and hopeful again. Their presence reminds me that recovery is possible and I'm not alone. Peer workers don't just support individuals; they help transform systems, making them more compassionate, human and trauma-informed.[1]

In the end, the issue isn't involuntary treatment itself, but the quality, culture and context in which it's delivered. When hospitalization becomes little more than sedation, containment and perfunctory questionnaires, it fails to offer the kind of care people need and deserve, especially in moments of deep vulnerability.

If we're going to use involuntary treatment—and without meaningful alternatives, it seems we have little choice—we must also commit to transforming it to invest in relationships, centre peer support and ensure the care is real, not just routine. V

related resources

Learn more about the Early Psychosis Intervention program for BC residents at earlypsychosis.ca

for footnotes go to www.heretohelp.bc.ca/visions

Advocate, Advocate, Advocate

A FAMILY'S JOURNEY THROUGH THE MENTAL HEALTH SYSTEM

CAROLINE AND ROY

When our son Robert was in his third year of university, he called us to say he'd been hospitalized. He was certified, admitted to a mental health ward involuntarily. Robert soon requested a review of that involuntary status and won.

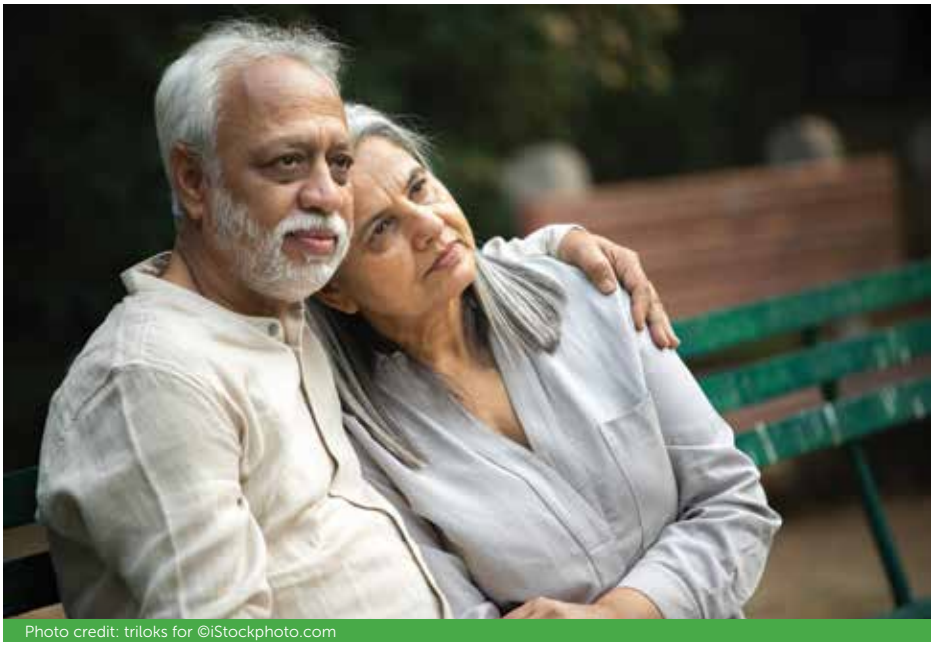

Photo credit: triloks for ©iStockphoto.com

Caroline and Roy are parents and business owners. They live in rural BC

He returned to his classes, but he still wasn't doing well, so we took him to a different hospital. Even though there was no diagnosis yet, they kept him in seclusion. He stayed in seclusion until we got him transferred to yet another facility—in his fourth week. He was just 23.

That was just the start of Robert's story. He has a schizophrenic disorder, with a bipolar affective disorder. He has lived with quality of life and worked for years. But probably every four or five years, Robert will alter his meds and end up getting sick.

Since that first treatment, it's hard to get him to go to hospital. He's afraid he'll be put into seclusion, which definitely does harm. Too often, isolation has been used not just for safety, but as a form of punishment—and Robert has experienced this many times, even until recently.

Robert is now 48. Over the years, we've seen the system change. As a family, we used to have supports and a treatment plan. Now, much less.

Shorter stays

The system seems more focused on numbers. During involuntary stays, once they get our son to a certain level with medication, he's discharged. It feels like they care more about moving patients out quickly than supporting

long-term recovery. That can be very risky when you're dealing with people who are still ill. You're playing with their lives.

Robert was eventually placed on extended leave provision. That's a clause under the *Mental Health Act* that's supposed to allow re-entry into the community while still getting care. We were told Robert could be re-admitted easily. But when he relapsed within days, the hospital said they no longer had his records. We had to go through the ER and triage to get him help. It felt like they wanted us to do their job.

We've also seen lost referrals, bad communication and lack of continuity in care. At one facility, Robert had five different psychiatrists in three weeks. In another, a doctor pushed for electroconvulsive therapy (ECT) even though Robert refused and the diagnosis didn't fit with that treatment.

Family input

Involuntary treatment is difficult to deal with. The power is in the hands of a doctor—one who might not be connected to the family. Families are often ignored. You can feel like a nobody, or get attitude from caregivers even when it isn't warranted. There've been lots of tears over the years.

That's not to say we haven't had some fantastic people. But, for involuntary treatment, Robert has had to go to different places several times—to bigger centres. We have to travel five, six hours. They used to have no problem with us staying as visitors the whole day. Recently, we're only allowed one-hour visits, and occasionally we've been denied that time outright. We couldn't believe it.

At one meeting, Robert's psychiatrist flat out asked us, with our son present, if Robert could return home. That's an enormous amount of responsibility to put on a family. We're not trained. But how do you look your son in the eye and say, "you're not welcome home?" We felt pressured to accept him back, even though he wasn't well enough for that. Where else was he to go? Why weren't we asked what we thought would be helpful?

Stigma

The media's portrayal of mental illness also reinforces harmful stereotypes. When something bad happens, why do the media always say "a person with mental illness" was involved. They don't say "a person with diabetes" or "a person with cancer." It makes people think that people with mental illness are dangerous—they're not.

A stable place

Robert now has a spot in a duplex through a housing program that helps people become more independent. A case worker comes in to make sure Robert is taking his meds and there's counselling if he needs help. He can stay up to two years. He moved in voluntarily to get the help. We think he should be commended for that.

We visit every few weeks, talk on the phone, but we try not to dote. We always try to treat him like an adult who can make his own choices. We're also aging, and we've told him he needs to work on his own health because we're not going to be around forever.

Changing involuntary treatment

The system is far from perfect. But if it weren't for involuntary treatment, Robert may not have had any care at all. We don't know where he would be, or if he would still be alive. There's a tension between Robert having his rights removed for periods with mandated treatment, in the hope of healing, and a better life. That's the reality we'll live with for the rest of our days.

We do want to see improvements. When patients consent, families should be included in care planning and communication. Especially when families are already involved in the person's circle of care. As well, complaints by patients should be reviewed by panels independent of the health system—people without ties to the hospitals or health authorities.

We also think patients need consistent providers and follow-up, especially after discharge. And there should be support in smaller rural communities. More resources are needed outside major urban centres.

We can only capture so much of our decades of experience with the mental health system in this article. The journey has been long, complicated and often painful, but also filled with moments of resilience and hard-won stability.

Our advice to other families is simple: advocate, advocate, advocate. You have the right to ask about the policies, and you have to speak up to get your loved one proper care. V

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Help When All Else Fails

JEN

I was mixing lots of booze with weed, not eating and not sleeping. After a few tormented weeks of no sleep, with delusions in full effect, I saw things and heard things that were not there. I became suicidal and too sensitive for anything. I was also homeless, with delusions that people were out to get me.

Photo credit: Drazen Zigic for ©iStockphoto.com

Jen enjoys photography, writing and travel. She lives in the Lower Mainland

It was confusing as to how I got under involuntary treatment in the first place. I was making a complaint when the police politely escorted me to the hospital. Somehow, it seemed they played along with my delusions enough that I trusted them and went into that hospital.

I think from there I felt paranoid and out of control when they said I was being admitted. I felt betrayed. Deep down I knew something was wrong though, and that I probably needed the help, as my thinking was very off.

A mixed experience

Things were explained clearly to me. But the admission still played on some of the delusions I was having, so I was probably acting suspicious.

I always felt treated with respect at this hospital. I did feel heard by staff and medical staff, too.

I tend to keep to myself and sketch or do some kind of art, so the art room helped me distract myself. Slowly the cloud of delusions started to lift after some time at the hospital, and I began to realize how much I had needed to be there. I think for me, my doctor made a big impact with how I looked at my own mental health, encouraging me to try not to be so hard on myself, and to not stigmatize.

The only thing I would say that was difficult about this whole stay at the hospital was that there were actual mice there! It felt very dingy, unkempt

and institutionalized. These are not great conditions in which to better yourself.

But I think the stay helped me tremendously. I had become very suicidal in my thinking. I wanted to die and had attempted at one point. I really don't think I would be alive if I had not been admitted involuntarily.

Next steps

The discharge was pretty easy from what I remember. The doctor found the right medicine and dose that effectively lifted all the delusions. I wouldn't say I was thinking completely clearly, but clear enough that I knew what I needed to do to take care of myself. I was given a plan when I left and had some supports in place. The hospital made sure I had a place to go to. I did feel ready to leave, as most suspicious behaviour had left as well.

I think what helped the most in my recovery was knowing nothing was permanent, that I would continually be improving as my brain adjusted to the medicine. It's a weird feeling that's hard to describe, but at that point with the medicine, you're in between, and you just need to keep going until you're totally well. I'd experienced getting well before.

After leaving, I got an alcohol and drug counsellor through a clinic with Vancouver Coastal Health, and we still talk about how it's going. The clinic sorted me out with what I want to do afterwards, including employment, and offers help with my overall health. It's been a good support.

I would change the system by making the facilities more welcoming and less institutionalized! The mice, where I was, were a little traumatizing.

I would say to the workers: keep treating us with kindness and respect. It goes a long ways.

I would say to someone going through what I went through: don't fight the system, but let them help you. My hospital stay saved my life. V

Photo credit:Meeko Media for ©iStockphoto.com

I would say to the workers: keep treating us with kindness and respect. It goes a long ways.

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A Sister's Struggle

A STORY OF LOSS AND SYSTEMIC FAILURE

MACKENZIE

My oldest sister Belinda was always an independent, resourceful and tough human, by necessity. I looked up to her. She always tried to be there for me through our toughest times. But beneath this exterior was a soul that harboured deep trauma, pain and devastating loss.

Photo credit: Juanmonino for ©iStockphoto.com

Mackenzie is a therapist, nutritionist and personal trainer with over 25 years' experience in eating disorder and substance use prevention and treatment. She integrates clinical expertise and lived experience to empower youth and families. Mackenzie leads province-wide awareness campaigns to promote early intervention in hopes of reducing long-term chronic illness

Growing up, our shared experience was marked by mental illness, poverty, neglect, substance abuse, sexual abuse, violence, incarceration and other traumas that go hand in hand with the transient lifestyle we endured. There was one big difference between us that I believe caused my sister to have grave challenges and a lack of opportunities—things I never fully understood and had the privilege of never having to. You see, my sister was half Indigenous.

We grew up on the Blood Indian Reservation (now Kainaiwa/Blood Tribe). Our parents struggled with their own issues and were unsupported in caring for us. We were bounced from foster home to foster home. The care that could have made a difference was not made available, or the system just didn't understand how to intervene with such complex and transgenerational issues.

A sudden apprehension

Belinda was forced into involuntary care for "troubled youth," even though she was the most stable and nurturing care my siblings and I had ever received growing up. It was very confusing to all of us. Belinda had not broken any laws. Nor was there any other reason for her to be removed from us siblings except that she was a minor herself. We were allowed to visit her early on, but our visits were

terminated because she repeatedly tried to run away.

Belinda had no one to advocate for her. Our mother was detained at the time in Ponoka Hospital, Alberta's first psychiatric hospital. Her father was also dealing with mental health issues and was basically unknown to her. The only reason I can make sense of for why such a decision was made was the colour of my sister's skin. None of us non-Indigenous siblings endured such unfair and biased treatment.

The "home for troubled youth" is where Belinda's biggest problems began. Being separated from the siblings she loved and cared for caused extreme distress, which was never honoured. Each time she ran away to be reunited with us, she was taken back—with more security forced on her. This "care home" was her undoing.

It's where she met other "troubled" youth who were apparently held in detention due to law-breaking behaviours such as drug use, breaking and entering and violence. I think it's important to note that all the youth I saw there were Indigenous. I don't fully know or understand the extent of the harm that came to my sister there, but I do know this is when she began restricting her food intake—starving herself—and using alcohol and other substances that were readily available to her.

Fragile coping

Belinda was never supported or able to finish school while in care and instead had to take an unskilled job in the community. This left her at a massive disadvantage and negatively impacted her life. At 18 she was left to her own devices despite her ill health and addiction.

Her traumatic history also affected her ability to maintain healthy relationships. Over the years, family and friends turned against her or lost touch due to her transience, leaving her even more isolated. Without therapeutic support, Belinda gained limited insight into her mental illness, substance use and behaviour patterns. This put her at further risk of victimization. The relationships and abuse she endured maintained her downward spiral, even as they helped her cope. She had no alternative.

One day, Belinda decided she was ready to accept help. I believe she'd fought hard for years to get to that place of acceptance, especially considering her earlier experience with enforced care. I was able to help her find substance use treatment, where she remained for six weeks. When she asked for more time, she was denied. Despite her physical and mental challenges, the facility had no space.

They assured us that homecare would be in place upon her discharge that Thursday evening. Support did not show up until the following Monday, when I learned my sister had a critical medical emergency resulting from an undertreated infection and was in hospital on life support fighting for her life.

Belinda was released into a single room occupancy (SRO), a dangerous and unsupportive environment. Her health was extremely fragile, and the lack of immediate aid left her vulnerable. One week later, we faced the heartbreaking decision to remove life support, as her brain was no longer responding. She left behind two children who suffer their own substance use and mental health challenges. Her daughter was in custody the day of her death, and the police refused to allow her to say goodbye. We can see the transgenerational pattern forming before our eyes.

Help when it's needed

Belinda's death is a tragic reminder of the systemic failures in our justice and health care systems. Even when people like my sister are ready to ask for help, the system often fails due to resource constraints and errors made by overwhelmed staff.

Considering the lack of care Belinda received in involuntary care as a youth, I was very hesitant and unsure about requesting residential treatment. But after unnecessarily losing my sister to death, I can see its potential to save lives. Yet, the lack of resources is a systemic issue that needs to be tackled before we can effectively address the debate between involuntary and voluntary care. My sister's story is a call to action for a more compassionate, trauma-informed and responsive health care system—one that ensures no one is left without the support they need when they ask for or need it most.

May you finally be at peace. I pray you could know the gratitude I hold in my heart for your every sacrifice. I miss you, my dear sister. V

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When Help Harms

MARIANNA

I have the unique perspective of being involuntarily treated and then working with people who are going through the same thing. For me, I will never be the same person I was before being committed. Each time it happened I felt pieces of me break off, and what was left for me to put together again was in shambles.

Marianna

Marianna (she/her) has been deeply impacted by her lived experience as an involuntary psychiatric patient. Raised on Treaty 6 territory and living her adult life on 'Namgis and Snuneymuxw land, she has recently returned home. She brings empathy to her work as a mental health advocate working with people navigating detainment. Marianna holds a dual degree in Indigenous studies and psychology

The last time I was certified, I spent the first month so severely sedated I have zero recollection of that time. I have no memories about what I did to fill my day. I don't remember anyone telling me to shower or to brush my teeth. After six weeks, I was discharged and taken off all but one medication that my brain had become dependent on.

For me, that is when things got serious. I'll never forget the withdrawals I went through, thinking that I absolutely could not make it through another day feeling how I did. The injustice I felt and witnessed lit a fire within me. I said that I would be back on the units one day, but not as a patient. And I was, returning to provide a service on the unit. It wasn't easy. I often reflect on how hard it's been to be triggered and professional at the same time.

Unheard

The experience of involuntary psychiatric treatment can be described as terrifying and unjust. It can be particularly frightening for those who have interactions with the police. I was kicked into a car by one officer, and another one made callous comments about needing to "pull out a cage for this one." Both times, the police refused to disclose where they were taking me, and I was not aware of the destination.

Once inside the system, the trauma continues. Many patients comment that they feel animals are treated better. A power imbalance is reinforced. Once admitted, medication is weaponized. I was told by a nurse, "If you keep talking, they will put you on more pills." This leaves a person unheard and harmed.

The environment within involuntary psychiatric treatment facilities is often anything but healing. People often describe the spaces as cold, sterile and distinctly non-therapeutic. They lack the warmth and human connection necessary for recovery. The primary function of the medical staff appears to be ensuring medication compliance, rather than providing the emotional support or guidance needed to navigate a crisis.

Patients are left to use their own resources and expected to process the profound trauma of being certified and institutionalized, with little to no help. There is a lack of support on the unit. Racism and discrimination are very real there, making the ward an even more hostile and isolating place for some. Patients feel deeply the institutional focus on control, rather than care. Ultimately, prioritizing containment leaves patients to suffer in an environment that reinforces their trauma instead of alleviating it.

Old ideas

Involuntary psychiatric treatment is governed by outdated laws. The *Mental Health Act* remains largely unchanged since the 1960s. This legal void, coupled with a lack of regulation on practices like solitary confinement and use of restraints, allows for immense unchecked power. The very language used to define the criteria for the need of involuntary status, such as "control" and "supervision," reflects a system more focused on containment and institutionalization, rather than healing and patient dignity.

This power imbalance often leads to an environment where patient rights are not upheld, and where patients are often punished for exercising them. For instance, individuals applying for a review panel (an option to reassess their detainment) are sometimes pressured to cancel it based on false promises of an earlier discharge. While the *Canadian Charter of Rights and Freedoms* guarantees the right to know the reasons for detention, this is often ignored in practice. Compounding these issues is the fact that directives for care, created by a person prior to hospitalization to describe how to handle their crises, are not legally binding.

Unique distress

The lived experience of those who have been subjected to the mental health system reveals a reality that is often more terrifying and dehumanizing than clinical frameworks suggest. Involuntary treatment is designed to stabilize the individual, prevent irreversible harm and restore them to a state where they can once again make rational choices.

Yet, personal accounts often challenge this ideal. Some patients find themselves in a worse condition after being discharged than when they were first admitted—that was my experience. Detainment is distressing, both for the person experiencing it and for those who love them. However, it is one of those things that is hard to fully understand unless you have gone through it. It doesn't mean someone can't understand parts of it. But to know it wholly is to go through it yourself.

To people who are living this reality, I want to validate your feelings of injustice. I hear you. I see you. We will see systemic change. Keep speaking your truth. V

The environment within involuntary psychiatric treatment facilities is often anything but healing. People often describe the spaces as cold, sterile and distinctly non-therapeutic. They lack the warmth and human connection necessary for recovery.

for footnotes go to www.heretohelp.bc.ca/visions

On the Front Lines

A FIRST RESPONDER'S PLEA FOR CHANGE

PATRICK W.

I never imagined that helping people could feel this heavy.

Photo credit: SDI Productions for ©iStockphoto.com

Patrick is a firefighter in a major Canadian city. Drawing on his own lived experience of trauma, Pat was compelled to pursue a career as a first responder, where he brings empathy to all his work. He has over 35 years' experience responding to medical emergencies and advocating for systemic change in front-line care

When I became a first responder, I knew I'd see pain. I knew I'd witness trauma. But I didn't expect the sheer depth and volume of suffering, or how powerless I'd feel in the face of it. Every shift now feels like a slow-motion disaster—one that never ends.

Most of the people I respond to are living in conditions no one should have to endure. They're experiencing homelessness, poverty, violence, addiction, untreated mental illness—and often all of the above. I've watched people overdose in alleyways, in tents, in public bathrooms. I've revived the same person multiple times in a week. I've seen people become angry and cry when they wake up because they didn't want to be saved.

And I've seen what happens when we try to help. Increasingly, we're met with violence. I've had colleagues punched, bitten, threatened with weapons. Some have been seriously injured. A few have been killed. We're trained in naloxone administration, in de-escalation techniques. But nothing prepares you for the moment someone you're trying to save turns on you.

It's not just the danger. It's the futility. Our work in the past 10–20 years has changed dramatically, with tenfold calls related to substance use. We bring people back from the brink, only to release them into the same unsafe, unsanitary conditions. There's no follow-up. No treatment plan. No place for them to go. We're not solving anything—we're just delaying the inevitable.

The toll of toxic drugs

I've lost count of how many people

We need to offer real trauma-informed treatment. Real housing. Real mental health care. Sometimes, that means making hard decisions about when someone needs help, even if they can't ask for it themselves.

I've watched die. Some from overdose. Some from violence. Others from neglect and untreated medical conditions. I've seen people grieving friends who died beside them in a tent. I've seen people so deep in psychosis they don't know where they are. And I've seen the toll it takes on my co-workers: burnout, PTSD, depression, addictions and, increasingly, suicide. We're all running on empty.

What's hardest is the silence. The lack of acknowledgment and support from leadership. The public doesn't see what we see. Management doesn't ask how we're coping. There's no expectation or encouragement to talk about the trauma, no real mental health support or resources offered. We're expected to keep showing up, shift after shift, like it's normal.

But it's not normal and it's not OK.

One tool to break the cycle

We need to talk about involuntary treatment. I know it's controversial. I know it raises ethical questions. But right now, we're watching people die in slow motion because we're too afraid to intervene. We need a system that allows us to step in when someone is clearly unable to care for themselves or is a danger to others. Not to punish them, but to protect them and others. To give them a fighting chance at recovery.

Because the truth is, many of the people we see don't want to live like this. They're not choosing addiction. They're not choosing homelessness. They're trapped in a cycle of trauma, victimization, mental illness and substance use, and there's no way out. We need to offer real trauma-informed treatment. Real housing. Real mental health care. Sometimes, that means making hard decisions about when someone needs help, even if they can't ask for it themselves.

Right now, the system is failing everyone. It's failing the people we're trying to help. It's failing the communities we serve. And it's failing us—the first responders who are expected to carry the weight of it all.

I'm tired. I'm angry. I'm scared. I'm disillusioned. And I know I'm not alone.

We need leadership that listens and protects us. We need policies that reflect the reality on the ground.

On paper, measures for debriefing (discussions after difficult events) and support for first responders look strong; however, in reality, management often puts the responsibility to initiate or participate in these measures on the traumatized crew, rather than ensuring they're meaningfully supported.

We also need the public to understand that this crisis isn't just about addiction or homelessness. It's about a broken system that's left too many people behind. Many times, we don't even know if the person we respond to lives or dies. There's no follow-up unless we see that same person on the street again, which happens frequently. It's a revolving door.

To other first responders, I say, don't be ashamed to seek out support before the problems begin. Find people in your field who understand the challenges you face, and a safe place to debrief and be supported. Know the resources that are available and how to access them. I think it's important not to use family, as this can only serve to traumatize them, as well and increase stresses in the home. Many of us end up divorced due to this fact. Addictions, divorce and suicide are all quite high in this field. Learning to cope in a positive way is key.

I still believe in this work. I still believe in helping people. But we can't continue to do what we are doing. It is futile. And we can't keep pretending that what's happening out here is acceptable.

Because it's not.

We need change. We need compassion—not just for the people on the street, but for the people trying to help them.V

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No Home, No Hope?

INVOLUNTARY TREATMENT STOPS SHORT OF ADDRESSING THE HOMELESSNESS CRISIS

TREVOR GOODYEAR, PHD, RN AND ANGELA RUSSOLILLO, PHD, RPN

Homelessness is a pressing issue in BC. Every day, the housing crisis is pushing more people onto the streets. At the same time, the public is sounding the alarm about rising and unmet mental health and substance use needs, which are intensified by the toxic drug crisis. For some people in our communities, these health and social issues go hand in hand.

Photo credit: Nikola Stojadinovic for ©iStockphoto.com

Trevor is an Assistant Professor of Nursing at UBC. His research focuses on drug policy and substance use, especially among youth and equity-owed groups. Trevor's work is informed by his past clinical nursing experiences, including in youth mental health and community health

Angela is an Assistant Professor at the UBC School of Nursing. Her research focuses on stigma, mental health services and policy solutions. She aims to reduce disparities in treatment through health services reform, advocacy and the integration of evidence-based practices

Many are calling for involuntary treatment, which forces people with a mental disorder into treatment without consent, as a solution to these issues. But is this really the best option?

We've seen these issues first-hand

As nursing researchers, we've worked clinically with people receiving involuntary treatment. We've also studied how homelessness, mental health and substance use overlap, increasing the risk for negative health and social outcomes. And we can tell you: forcing people into treatment doesn't solve these complex issues. There are better ways.

The rise of involuntary treatment

Involuntary treatment under BC's *Mental Health Act* isn't new. This legislation has been in place for decades despite persistent human rights concerns. In 2024, the BC government announced plans to amend the *Act* to allow for involuntary treatment of people with substance use disorders, not just mental disorders.[1]

Each year in BC, there are approximately 30,000 involuntary admissions.[2] From what we can tell, we are now seeing the highest rates of involuntary treatment in our province's history.

Meanwhile, rates of voluntary treatment have plateaued. People aren't choosing to enter treatment because good, accessible options just aren't available. Instead, more people are reaching crisis points where forced treatment is seen as the only option.

The use of involuntary treatment is rising in parallel with the toxic drug crisis—now the top cause of death for people ages 19 to 59 in BC. There's also public campaigning to create safer streets amid high-profile violent incidents involving people who are homeless and experiencing mental health and substance use crises. In the face of these issues, communities are desperate to act.

Involuntary treatment might seem like a tangible solution. But it's not the right choice. Many groups, including government and health leaders, are drawn to involuntary treatment as a means of doing something to help. However, quick fixes do very little to address the issues that land people on the streets or in crisis in the first place.

More harm than help

There's little evidence that forced treatment helps people who are struggling with homelessness and mental health and substance use challenges.[3] In fact, it risks doing more harm than good.

Involuntary treatment can be destabilizing and often perpetuates the instability it aims to resolve. There are clear links between involuntary treatment and trauma, health care avoidance and fatal overdose after relapse, as forced abstinence can reduce a person's tolerance to opioids.[1] In our clinical work, we've also seen people become displaced through involuntary treatment. They can lose their personal belongings, tents and social housing. This takes a heavy emotional toll and can feel like an assault on human dignity.

For people who have histories of trauma or exposure to child welfare, jail, shelters and social housing, being forced into psychiatric or substance use treatment can feel like yet another system taking control and limiting choices. Involuntary treatment can even signal danger, leading to people avoiding services. This makes people more likely to remain homeless and experience worse mental and physical health.

Policy changes that expand involuntary treatment have unintended and unevenly distributed consequences. While anyone can end up homeless, it's not random. Indigenous and racialized people, 2SLGBTQIA+

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> **While there are no simple solutions, the direction is clear: less coercion, more care.**

people, youth and others facing inequality are hit the hardest. These groups also experience inequities in mental health and substance use challenges, and when it comes to forced treatment.[2]

Focus on the real issues

The push for involuntary treatment ignores the real reasons people end up on the street or in crisis. These issues come from:

- underfunding for, and lack of, affordable housing
- poverty and inadequate income supports
- poor availability of community-based and voluntary mental health and substance use treatment
- intergenerational trauma and structural inequalities, including systemic racism and colonialism[1,2]

These gaps lead people to receive care only when they are in crisis, at which point involuntary treatment becomes a last resort and a first-line support. We can do better than the current system, which is marked by fragmentation, long wait times and under-resourced capacity to provide compassionate and voluntary supports.

Towards meaningful solutions

There's an uncomfortable truth we as a society must confront: involuntary treatment serves to make the public more comfortable rather than to genuinely help people in crisis. The issues we're seeing in BC can't be solved by clinging to unproven policy solutions.

The path forward requires collective commitment from all groups—public, policy-makers and people with lived and living experience—and the courage to confront complex issues. While there are no simple solutions, the direction is clear: less coercion, more care. The question is not whether we can afford to make meaningful changes, but whether we can afford to continue without them. V

pathways to more voluntary care

Research shows that social determinants (root causes) such as housing access, economic conditions and our early childhood upbringing shape people's risk for homelessness and mental health and substance use challenges.[4] To address these determinants, international guidance tells us we must invest in:

- a living wage
- a safe place to call home
- giving people a sense that they belong and are valued in society

Bold actions can also improve access to mental health and substance use care in our communities, including:

- sponsoring more team-based care to address the shortage of primary care providers
- enhancing public health insurance (i.e., MSP) coverage of psychiatric and psychological services
- building cross-sector capacity for schools and health and social services to support substance use education, harm reduction and treatment

Not the Answer Many Hope For

INVOLUNTARY ADDICTION TREATMENT FOR DRUG DEPENDENCE

KORA DEBECK, PHD AND PERRY KENDALL, CM, OBC, MBBS, FRCPC, MHSC LLD(HON)

As BC contends with the tenth year of a toxic drug public health emergency, policy makers, alongside community and the public, continue to search for solutions.

Kora DeBeck is a Distinguished Professor in SFU's School of Public Policy. She is a Dorothy Killam Fellow, CIHR Applied Public Health Chair and member elect of the Royal Society of Canada College. Kora has been conducting research for more than 15 years involving people who use drugs, publishing over 200 studies in this area

Perry Kendall is the former Provincial Health Officer for BC, a recipient of the Order of Canada, the Order of BC and the Legacy Premier's Award, and an inductee into the BC Public Service Hall of Excellence. Perry is a clinical professor at the UBC School of Population and Public Health and adjunct faculty at the University of Victoria

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Rates of death have dropped slightly, but in 2024 they were still twice as high as when the public health emergency was declared in 2016.[1] Throughout the crisis, many policy ideas have been brought forward to prevent fatal drug poisonings. Compulsory addiction treatment is one policy idea that various segments of society have advocated for as a way to separate people from toxic street drugs.[2]

In the fall of 2024, the Government of BC announced plans to expand involuntary treatment through the *Mental Health Act* for individuals struggling with mental health disorders, addictions, and brain injuries.[3] This announcement sparked more debate about the risks and benefits of using involuntary addiction treatment for substance dependence.

The stated reason for expanding involuntary addiction treatment is that it could safeguard vulnerable individuals struggling with substance use. Yet some media largely characterized the announcement as a "public safety pitch."[4] This suggests that street disorder and random violence are driving political support for this intervention, especially concerns about the trio of acquired brain injury, serious untreated mental illness, and substance use.

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Unclear evidence

Regardless of why people support more involuntary treatment, we have significant concerns with implementing this approach in BC. A primary concern, based on our decades of research and public health experience, is the lack of evidence supporting the effectiveness of involuntary addiction treatment, particularly among structurally marginalized populations (people disadvantaged by social structures of power, like racial categories and poverty).[5] This is particularly troubling given the large increase, over the past two decades, in use of BC's *Mental Health Act* on youth with problematic substance use.[6]

Vulnerability for people who use drugs

Involuntary treatment forces people to restrict their drug intake. This poses risks of serious unintended consequences. That's because a period of drug abstinence lowers people's drug tolerance. When individuals leave addiction treatment, or other locations like hospitals and jails, they face significantly increased risk of fatal overdose.[7]

Despite noble intentions, involuntary treatment forcibly induces a state of low drug tolerance (where people cannot take the amount they might have been used to before without overdosing). This is a highly vulnerable and potentially life-threatening position, given the frequency of drug relapse.

Historically, what many consider to be the best way to support abstinence from street opioids has been opioid agonist therapy, like methadone and suboxone. To be effective, individuals must take their medications consistently. Yet evidence across multiple settings is showing that people are not keeping up with methadone and suboxone treatment in the era of fentanyl.[8] When individuals do not stay on opioid agonist therapy, the risk of drug relapse and subsequent fatal overdose increases even more.[9] This underscores the very real dangers of forcing drug abstinence on people who are not ready or willing to stop using drugs altogether.

Another concern with involuntary addiction treatment is that many people who are dependent on substances have histories of trauma and institutionalization. Being forced into a treatment setting can be traumatic.

Lack of trauma-informed support

Another concern with involuntary addiction treatment is that many people who are dependent on substances have histories of trauma and institutionalization.[10] Being forced into a treatment setting can be traumatic. It also risks undermining connection and trust in therapeutic systems, the very factors known to be important for long-term recovery.[6]

This may not only undermine the success of initial treatment but may also inadvertently deter people from voluntarily seeking help in the future. A related worry with involuntary addiction treatment is that the voluntary addiction treatment system is under-resourced and inadequate. In our view, there is a fundamental flaw with forcing some people into addiction treatment when many others who want and need treatment can't access it because there aren't enough treatment beds and other services.

Potential misuse

We are encouraged to see that, despite pressure from some advocates to implement involuntary addiction treatment for drug dependence, the BC government appears to have listened to public health advice. In March 2025, they issued guidance to clarify that substance dependence itself should not be treated on an involuntary basis.[11]

The document, called General Guidance for Physicians on the Use of the *Mental Health Act* when Treating Substance Use Disorders, says: "the *Act* should not be invoked or relied upon for the purpose of treating substance abuse or addiction in and of itself."[11]

While this is good news, substance use disorders continue to be classified as a subtype of mental health disorders by government advisors.[11] This creates the possibility of confusion and potential misuse of the *Mental Health Act*. Close monitoring and regular reporting are critical to ensure the *Act* is not extended to involuntary addiction treatment.

Sadly, we believe there's a high threat of scope creep with the *Mental Health*

Related resources

Previous publications by the co-authors describe their concerns with the expansion of involuntary treatment for people who use drugs in BC. See:

"Secure Care: More Harm than Good," co-authored with Andreas Pilarinos and Dania Fast, published in the *Canadian Medical Association Journal* (2018), 190(41), E1219-e1220, see: cmaj.ca/content/190/41/E1219

"B.C.'s plan for involuntary addiction treatment is a step back in our response to the overdose crisis," published in The Conversation (2024, September 25), see: theconversation.com/b-c-s-plan-for-involuntary-addiction-treatment-is-a-step-back-in-our-response-to-the-overdose-crisis-239367

Act, meaning using the legislation to cover more people, for more reasons. We observe a growing movement of magical thinking in the public and among some political actors about addiction treatment and its potential to meaningfully address the overdose crisis and reduce public street disorder.[12]

Improvements to the addiction treatment system are urgently needed, and we welcome initiatives that bring much needed additional funding and support for the voluntary addiction treatment system. However, given that substance dependence is a chronic relapsing condition, ongoing substance use is inevitable in society. Thinking that we can "treat" our way out of this crisis is not only misguided, it risks issuing a literal death warrant for many people struggling with substance dependence. People who use drugs and all British Columbians deserve more than wishful thinking and politically convenient actions that are not suited to the complex problems of substance use. V

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Involuntary Care is a Symptom, Not a Solution

KIFFER G. CARD, PHD

Involuntary psychiatric and substance use care is increasingly framed as a necessary response to urgent public health crises.[1] I would argue that, in some cases, it can be lifesaving, especially when individuals no longer have the decision-making capacity to act in their own best interest. Many people even say involuntary care helped them.[2] So it's reasonable to believe there are situations where involuntary care is ethically justifiable.[3]

Kiffer G. Card

Kiffer is an Assistant Professor in the Faculty of Health Sciences at SFU, where he holds the Michael Smith Health Research Scholar Award and the Blanche and Charlie Beckerman Fellowship in Public Health Innovation

Still, we must consider the lack of strong evidence for involuntary care's benefit[4] alongside the recent rise in its use.[5] This is especially true in the current political context, where trends toward authoritarianism pose an increasing threat to all our liberty.

Rather than passing judgment on the ethics or effectiveness of involuntary care, I think we need to focus on what involuntary care represents: not a solution, but a symptom of problems facing our health systems. We need to understand why involuntary care has evolved from a rarely used tool to a central policy response to overdose deaths, homelessness and public disorder.

I argue that the rising use of involuntary care is driven and sustained by four interrelated forces:

1. A framework too focused on individual-level problems and solutions

First, at the heart of this issue is a pathologizing framework that narrowly frames problems at the individual level. This framework casts human distress as an individual failing, which obscures the systemic conditions that generate personal and collective crises. I believe most of us cling to the myth that the mind is separate from the body, and that individuals are separable from their social

environments. We operate as though mental illness and substance use are the result of chemical imbalances. Instead, they are functional responses to our environment.[6]

Mental health problems are best understood in the context of:

- lack of safety
- absence of belonging
- patterns of living that deny our purposes and needs

Indeed, scientific studies show distress is the normal response when we live in environments that go against our basic human needs and interests.[7] Yet, this reality is essentially ignored. In its place, a biomedical, individualistic system presents a distorted view of the problem.

2. Metrics-driven bureaucracy

Second, our system focuses on small, countable successes rather than measuring real change. Government reports tout more treatment beds and overdose reversals as markers of success. These numbers mask the absence of adequate, sustained care in communities of mutual support. For example, a bed in a facility means little if the provider is underfunded and understaffed. Politicians and bureaucrats are rewarded not for fixing the problem, but for managing its visibility.

3. Political incentives for easy, immediate wins

Third, governments choose what's expedient rather than engaging in serious discussions about equity, justice and well-being. The result is simplistic, data-driven decision-making that manages harm rather than preventing it. Distress becomes a compliance issue, rather than a collective concern.

I conducted an experiment among Canadian residents. Even when programs offered greater population health benefits, the public tended to reject prevention-oriented interventions in favour of treatment-oriented ones. They prefer mental health programs in favour of ones targeting physical health, and they opt to allocate resources to interventions that support the general population at the expense of those supporting marginalized people.[8]

These preferences matter because they shape what is politically feasible. Governments often respond to the will of the majority, rather than to the actual needs of people who are struggling with substance use and mental health challenges.

4. Fear of change

Finally, we are biased to justify systems. People tend to favour the status quo by rationalizing the way things are as inevitable or even preferable, even when the status quo poses very real problems.[9] Instead of change, we (and our policy-makers) favour incremental actions that have little potential to actually solve the problem.

Involuntary care is one such favoured approach. It already exists as a policy response, its use matches our stigmas and biases, and if there isn't enough support for people who are involuntarily treated, it will hardly be of public concern (except to those unfortunate enough to be exposed to it either professionally or as a patient). As a "solution" it seems effective: demonstrating its success is as easy as listing the number of care beds alongside the other countable metrics used to define care in our health system.

A better way forward

These four forces act to reinforce one another, contributing to a complex system in which involuntary care is held up as an acceptable practice. However, our research among mental health experts suggests there is an alternative path. We must overcome our fear and imagine a care system that strengthens the social fabric of society. This would involve:

- building a system of community-based social supports
- expanding timely access to voluntary and culturally safe care
- supporting pathways for people to re-enter their communities
- resourcing other well-supported evidence-based practices

Admittedly, these strategies are expensive and politically risky. They shift responsibility away from people with little political power and onto governments and the populations they represent. In other words, the interventions we need are transformative, and transformation is hard. So, if we want a better system, we need to stop acting as if distress is only an individual problem and start responding to it. That means acknowledging what our systems are doing and failing to do, and not relying on hollow metrics to create this understanding.

We need to be honest about trade-offs and have the courage to take transformative action. Without this, involuntary care will remain not a solution, but a symptom of a system disengaged from the project of human flourishing. V

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Going Beyond Prescription and Pills

HASSAN NAWAZ

The following is a conversation between CMHA BC's Bakht Anwar (BA) and Hassan Nawaz (HN) on his experiences with involuntary treatment. Hassan explores what's known as culturally competent care and its vital role to BC's mental health system.

Hassan Nawaz

Hassan, from Surrey, BC, is self-taught and explores neuroscience and spirituality. Outside of daily life he focuses on bridging the gap between faith and science in today's age, with a deep interest in how people perceive themselves and their environment

BA: Tell me a bit about yourself.

HN: My family migrated from Pakistan to Canada about 20 years ago. Like many South Asian families, we were led by the idea of a "better life" in the West. But I quickly discovered that this promise was empty.

Growing up, I lived in two worlds at once. One, my Eastern heritage, with its depth, continuity and spiritual anchoring. The other, Western society—materially advanced, but spiritually numb. That duality fractured my sense of self-identity. I was torn between preserving what was timeless within me and conforming to a system that assimilates people. This internal struggle was the root of many mental health challenges later in life

BA: As you reflect on your 20 years of experience in Canada, can you share what led up to your involuntary admission?

HN: My admission can't be separated from post-colonial trauma in South Asian societies. Colonization stripped my people of resources, dignity and sovereignty. Later generations got stuck in survival mode. Families who migrate in search of "opportunity," often dislocated, cut off from community, are forced to adapt to an environment that overlooks their history.

For younger people, Canada offers material advantages, yes—but at the cost of disconnection. We are neurobiologically obligated to inherit a fractured world view from our parents, while being pressured to mould ourselves into the Western stencil, which cannot speak to the depth of our identity. I was caught between two anchors: the East, which I felt strongly

about but could not fully live, and the West, pressuring me to assimilate into its hyperreal stencil for life.

This tension led to confusion, loneliness and, eventually, depression. But instead of recognizing the wounds I was grappling with, the Western system reduced my struggle to a "disorder," something to be managed chemically.

BA: What was it like when you were first brought into involuntary treatment? How did you feel?

HN: My treatment was shallow and incomplete. Psychiatrists approached me with their charts and diagnoses. Yes, on a factual level, they were not wrong. But their Western framework is empty. It reduces the human being to brain chemistry and behavioural patterns, but no category for the soul.

In Islamic and eastern epistemology, the human being is not fragmented. We are whole: body, mind and spirit. Our suffering is not a mechanical error. It's a misalignment between our inner reality and the divine order of life. What I received in the hospital was not healing, but management. The prescriptions were a Band-Aid on a spiritual wound.

BA: Was there anyone on your care team you could resonate with or who worked to build in your spirituality or culture?

HN: There was a psychiatrist who shared my heritage and identity. Though trained in the same Western institutions, he carried an understanding of my cultural and spiritual foundations. When I spoke with him, he did not dismiss my philosophy as irrelevant—he engaged. That was the first moment I felt I could resonate with a health care provider. But it was telling that it took someone who shared my heritage and background to see me as whole.

BA: What could have made your care more culturally competent?

HN: If it had expanded beyond the individual, the care would have been transformative. In our tradition, healing is never isolated—it's relational, familial and societal. For South Asians, you can't separate mental health from the intergenerational trauma of colonization. Western psychiatry dressed up with "cultural sensitivity" won't work. We need to reconnect with our philosophical and spiritual foundations. We must decolonize and reconstruct our mind and soul.

BA: What was the discharge process like? Did you feel ready to leave?

HN: The psychiatrist discharged me when they believed my perception of reality had stabilized and the medication had taken effect. I was given a year of treatment and psychological follow-up. On the surface, this seems responsible. But it was superficial. The root causes of my crisis—intergenerational trauma, migration and the war on my identity—were untouched.

I left the hospital outwardly stable, but inwardly unchanged. The Western system made me functional again for society, without addressing that it broke me. I had to rediscover through my own searching how colonization and separation from my heritage had shaped my pain.

BA: What can make the mental health system more holistic?

HN: We need what I call pre-emptive recovery. That means rebuilding safeguards rooted in culture, tradition and community. The East has always understood that healing is not about numbing symptoms with pills, but about restoring inner balance guided by insight. Our ancestors preserved wellness by seeing us as whole—physical, emotional and spiritual.

Western medicine may have its uses, but it's also narrow, and it's mostly focused on our biochemical makeup. Real healing is based on trust, belonging and meaning. It means drawing on traditions the West dismisses as "primitive."

BA: What would you want health care providers or policy-makers to know about your experience? How could the mental health system provide better culturally competent care?

HN: I would say the Western model of care is incomplete. It views human beings as machines to be managed, rather than souls to be nourished.

If we're serious about culturally competent care, it must include genuine humility—recognition that Eastern traditions offer holistic insights into the human condition. Our heritage includes timeless healing principles that address not only the mind, but the heart and soul. True healing lies not in more pills, prescriptions and protocols, but in reconnecting with the wisdom the East has safeguarded for centuries.V

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Vicious Cycle

FAILED BY INVOLUNTARY AND VOLUNTARY MENTAL HEALTH CARE

ZAINAB

Our journey began in 2009 when my daughter was 13. Since then, she has revolved in and out of psychiatric care under BC's *Mental Health Act*. The care she's received, forced and voluntary, can at best be described as inaccessible, incompetent, indifferent and cruel.

Photo credit: klebercordeiro for ©iStockphoto.com

Zainab is a mental health advocate and family member of a loved one with severe and persistent mental illness. She firmly believes the failure of the BC mental health system to provide adequate care has resulted in untreated mental illness that has worsened and led to self-medication with narcotics

Accessing care has been fraught with challenges and barriers. These include waiting in the ER for seven excruciating hours with her in full blown psychosis, and being turned away because of lack of beds and her denial of symptoms, only to go through the whole admissions process again the next day

Getting access to treatment was just the first barrier we encountered along the way. Other challenges include utter exhaustion from having to repeat our story with every new professional we encountered, and receiving no explanation for why doctors prescribe medications in the first place or the consequences for refusing to take them (solitary confinement in a straitjacket).

We've also wrestled with cultural and religious ignorance, stereotyping and condescending attitudes, including comments like, "how come your English is so good" and "this is how we do things in Canada." We've been greeted in Punjabi just because we're South Asian, and using prayer beads for comfort has been laughed at and equated with fundamentalist Muslim customs. I've had case managers blame me, a single mother, for being a "tiger mom," and accuse me, in my daughter's presence, of having my own mental issues.

Photo credit: Image Source for ©iStockphoto.com

When an individual is in recovery, their families are also in recovery. Yet the family is mostly excluded from care, and there's little respect for their perspective and role as first responders and caregivers, with absolutely no therapeutic services offered to the family unit.

A recovery that keeps slipping away

My daughter is now an adult—still not receiving the care she needs—and also struggling with a substance use disorder. Our experiences have led to my family's complete mistrust of mental health services in BC. We're lucky if we come across individual professionals who take the time to listen and treat us with respect.

For those who suggest that forced treatment is not an effective approach, my own experience as a caregiver who's had to make that crucial call under duress says otherwise. If my daughter hadn't been hospitalized involuntarily on numerous occasions, she would have been at grave risk of deteriorating to death by suicide or fatal overdose.

Tough choices

According to BC's *Mental Health Act*, people can be involuntarily admitted for treatment when their mental health is at risk of deterioration, or if they or others need protection. This is a last resort. And it is traumatic for everyone involved. A brutal and callous police force makes things worse—one time, the police threw down my daughter hard on the concrete pavement, causing a concussion and subsequent fear of treatment and authority.

Conversely, while yes, choice is important, it must be a capable choice. The person must understand the symptoms of their illness and consequences of rejecting treatment. In the throes of addiction and delusional thinking, my daughter has neither, so is incapable of making rational decisions. Also, the tendency to deny one's symptoms and illness is common.

Willingness to change is equally important. Treatment doesn't stick unless a person meets a provider halfway. We therefore find ourselves entrenched in this vicious cycle: the revolving door of treatment.

Families shut out

When an individual is in recovery, their families are also in recovery. Yet the family is mostly excluded from care, and there's little respect for their perspective and role as first responders and caregivers, with absolutely no therapeutic services offered to the family unit.

Every time my daughter interacts with the system, the family's input is completely ignored, despite the fact that she turns to us for constant support and we are an official part of her advocacy team, with all the appropriate sharing consents in place. We have to keep reminding the psychiatric team of this, as well as advocate for them to fully review her file and history for consistency of treatment.

Not once have we had the function of BC's *Mental Health Act* or details

for footnotes go to www.heretohelp.bc.ca/visions

of her diagnosis explained to us. Nor have we been informed when she's been admitted or released after several overdoses or suicide attempts. Sometimes, we've had to search for her frantically for 24 hours before finding her.

We recently had to plead for a meeting with her psychiatrist and case manager after an overdose attempt. In the 15 minutes granted to us, they were so disorganized they couldn't find the relevant paperwork, including Form 16 (Notification to a Near Relative) and Form 20 (Extended Leave, which allows a patient to reside in the community under specific conditions).

When I asked about what supports were offered to her to thrive in the community, they said categorically that the extended leave is only for the purposes of administering medication; they simply didn't have the capacity to extend any other help. But my daughter doesn't possess any life skills or insight to follow through! Similarly, the psychiatrist refused to discuss opioid agonist therapy, saying it does not compete with the high produced by narcotics.

We later got a letter from the case manager informing us of the date of a review panel hearing. To our surprise, our daughter had challenged her extended leave authorization. The case manager simply refused to explain the family's role, or what happens at a hearing like this, citing confidentiality. Thankfully, our daughter didn't show up. Had her challenge been successful, we would have had to face our gut-wrenching fear of her symptoms worsening without access to proper medical care.

One-way confidentiality

We fully understand that the psychiatric team must respect confidentiality. But sometimes, the family can provide crucial information to help them protect a patient's well-being. Likewise, the family's confidentiality must also be respected. Unfiltered information shared by case managers with my daughter has often been taken out of context and contributed to her paranoia and mistrust of us, creating damage to an already fragile relationship with the family. We are her saviours, but also the enemy, depending on her wellness.

Where to go from here

There's a dire need for investment in more sensitive, empathetic, wrap-around social supports and services. I also think BC's current *Mental Health Act* is outdated and needs a thorough review, especially regarding concurrent disorders and family involvement.

After 16 years of the revolving door, and despite having the voice to advocate for better treatment, I've lost faith in what the system has to offer. That said, I will continue to be the squeaky wheel. I won't give up hope that someone out there will take the time to listen and ensure my daughter doesn't continue to fall through the cracks. V

resources

Independent Rights Advice Service
irasbc.ca

Independent Rights Advice Service (IRAS) provides information and help to people receiving involuntary care under the *Mental Health Act*. Rights advisors explain your rights as a patient and explain the Review Board process, help you request a review of your involuntary status and detention or a second medical opinion, and help you access a lawyer or other legal support (including legal aid, if you need it). IRAS is available to patients detained in a facility as well as patients on extended leave. Patients may have a friend or family member with them during the rights advice meeting if they wish to do so.

To learn more about accessing IRAS for yourself, a loved one, or a patient:

- Visit **irasbc.ca**
- Print information about IRAS and legal rights (available in several languages) at **irasbc.ca/printable-materials**

To learn more about your rights under the *Mental Health Act*, see Your Rights under BC's *Mental Health Act*: What you can do if you're certified as an involuntary patient from IRAS: **heretohelp.bc.ca/infosheet/your-rights-under-bcs-mental-health-act**

LEGAL REPRESENTATION AND ADVICE

Community Legal Assistance Society
clasbc.net

Representation for people who have an upcoming Mental Health Review Board hearing under the *Mental Health Act* or Criminal Code Review Board hearing. Visit **clasbc.net/get-legal-help/mental-health-law** or call 604-685-3425 (1-888-685-6222 toll-free) to learn more.

Legal Aid Mental Health Assistance Line
legalaid.bc.ca

Information about legal matters related to mental health law and representation for those who qualify. Find your local legal aid location at **legalaid.bc.ca/contact/locations** or call 604-235-1338 in Greater Vancouver or 1-844-235-1338 in the rest of BC (Monday, Tuesday, Thursday, and Friday from 9:00 am to 3:30 pm and Wednesday from 9:00 am to 2:30 pm).

BC First Nations Justice Council
bcfnjc.com

Culturally appropriate information, advice, support, and representation for Indigenous people. Find an Indigenous Justice Centre in your area at **bcfnjc.com/resource-map** or call 1-877-602-4858 (toll-free).

Child and Youth Legal Centre
scyofbc.org/child-youth-legal-centre

Free legal support for young people to age 19 dealing with a legal matter. Call 778-657-5544 or 1-877-462-0037 (toll-free) or email **cylc@scyofbc.org**.

Health Justice
www.healthjustice.ca

Find information about seeking legal advice or representation for people currently detained under the *Mental Health Act* and information for people or supporters who have had a negative experience with the *Mental Health Act* at **healthjustice.ca/legal-and-complaint-resources**.

LEGAL REPRESENTATION AND ADVICE

- Representative for Children and Youth | Detained: Rights of children and youth under the *Mental Health Act*: **rcybc.ca/reports-and-publications/detained**.
- Office of the Ombudsperson | 2022 Investigative Update: Committed to Change: **bcombudsperson.ca/investigative_report/2022-investigative-update-committed-to-change**.

This list is not comprehensive and does not necessarily imply endorsement of all the content available in these resources.

heretohelp
Mental health and substance use information you can trust

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