

# Involuntary Treatment: Criminalization by another name

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# ACKNOWLEDGMENTS

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## Territories

This position paper is a response to calls for involuntary treatment in the colonial province of British Columbia. What is currently known as BC is made up of unceded, unsurrendered territories of distinct Indigenous Nations, whose inherent Rights and Title have never been extinguished.

Pivot Legal Society is located on stolen lands of the unceded territories of the xʷməθkʷəy̓əm (Musqueam Nation), Skwxwú7mesh (Squamish Nation), and səliłwətał (Tsleil-Waututh Nation). We are grateful to Indigenous Peoples for their continuous relationship with their lands and are committed to learning to work in solidarity as accomplices in shifting the colonial default.

**Endorsed by:*****Organizations***

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BC Association of People on Opioid Maintenance (BCAPOM)  
BC Poverty Reduction Coalition  
Canadian Drug Policy Coalition  
Canadian Students for Sensible Drug Police (CSSDP) Vancouver  
Care Not Cops  
Coalition of Peers Dismantling the Drug War  
DUDES Club Society  
EACH+EVERY: Businesses for Harm Reduction  
Feminists Deliver  
Hamilton Social Medicine Response Team (HAMSMaRT)  
HIV Legal Network  
Vancouver Area Network of Drug Users (VANDU)  
West Coast LEAF  
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# INTRODUCTION

This position paper is endorsed by organizations and individuals who call for the abolition of involuntary treatment, including opposition to the passage of any policy or legislation that expands, sanctions, or encourages the practice.

Rather than supporting expanded involuntary or carceral treatment, we endorse supports and services that directly meet people's material needs, built on a framework of consent, capacity, cultural safety, and peer leadership.

We call on all levels of government to invest in robust access to voluntary treatment options, including primary care, detox, treatment programs, publicly funded counselling services, residential mental health services, harm reduction programming, safe supply, family programming, culturally affirming options, and treatment modalities that reflect the intersecting identities of all those who seek and/or desire mental health and substance use support and care.

# RECOMMENDATIONS

1. Invest in robust access to voluntary treatment options, including primary care, detox, treatment programs that have strict regulatory oversight, harm reduction programming, safe supply, family programming, culturally affirming options, and treatment modalities that reflect the intersecting identities of people who use drugs. All voluntary options should be available immediately upon request and accessible across inner-city, rural, and remote areas.
2. Immediately fund and scale up safe supply programs to ensure a regulated and predictable supply of drugs is accessible to all.
3. Immediately eliminate all police involvement and power under the provincial *Mental Health Act*, particularly the ability to apprehend someone using an officer-based assessment; as well as repeal any potentially intersecting provisions, regulations and legislation that grants law enforcement a healthcare scope, including the warning and referrals subsection of federal Bill C-5, and the 'alternative measures' embedded into BC's decriminalization framework.
4. Prevent the expansion of legislation that broadens apprehension criteria to include overdose.
5. Eliminate any form of involuntary and/or coercive treatment, including BC legislation, as well as any umbrella agency-level policy (i.e., employer or union policies that mandate employees into involuntary treatment programs).
6. Repeal all legislation and regulations that are used to disproportionately target Black, Indigenous, and racialized communities.
7. Repeal all legislation and regulations that are used to target people who use drugs and disabled people. There is already existing legislation that permits forced treatment against these groups. It is violent and unjust and must be eliminated.

## THE POLITICAL CONTEXT

Currently, numerous law- and policymakers across BC are advocating for the expansion of involuntary treatment, suggesting that admission criteria should be expanded to include people who experience non-fatal overdoses.

Despite the broad, expansive, human rights, and evidence-based critiques of involuntary treatment, BC Premier David Eby began advocating in August 2022 for an expansion of the provincial criteria for involuntary treatment to include residents who experience multiple overdoses. In November, Premier Eby said he would expand involuntary treatment to the corrections system and develop an app to streamline mental health commitments by police.<sup>i</sup> The provincial government has shifted its failed attempt to target youth who use drugs with involuntary treatment, and potential expansion has resurrected in recent months, through public statements by the Premier and in the recommendations of the provincially commissioned Rapid Investigation into Repeat Offending and Random Stranger Violence in British Columbia (2022).<sup>ii</sup> The mandate letter issued to Minister of Mental Health and Addictions Jennifer Whiteside calls on the Minister to “Assess and expand supports for people who are causing detrimental harm to themselves and others as a result of mental health or substance use, to increase safety and improve health outcomes while upholding the rights of all British Columbians.”<sup>iii</sup>

This framework, expanding carceral care, is being promoted while access to voluntary care remains inaccessible, high-barrier, strict and shifting in eligibility, and austere and punitive in practice. The existing framework for involuntary care is already deeply fraught and we demand urgent action that addresses the harms that are a direct function of any form of involuntary or mandated care.

After decades of advocacy led by drug users, international, national, and regional governments have been forced to confront the failures of the drug war. Alongside growing awareness of the harms caused by prohibition, language and frameworks associated with public health have gained prominence. Public health approaches are the standard method used across Canada in attempting to control drug use and people who use drugs, with all levels of government at least purport to use this lens.

People who use criminalized drugs (PWUD) demanded action prior to the declaration of a provincial public health emergency in 2016. While PWUD and their supporters used the language of public health to redirect focus away from the risks associated with drug use to risks embedded in punitive drug policy environments, public health discourse has led to PWUD-led movements to be co-opted and depoliticized by governments, police, and some academics and researchers.<sup>iv</sup> Though public health approaches are championed as a more progressive approach to drug use, their attendant policies and practices are frequently rooted in the same institutionalized stigma, racism, and anti-drug sentiment as drug prohibition and the overall Medical Industrial Complex<sup>v</sup> to justify similar ends. Alongside a deeper history of disability justice movements, we contend that drug use is not a criminal justice issue, nor is drug use inherently related to healthcare—but that drug policy is an issue of justice and liberation.

## BC'S INVOLUNTARY CARE FRAMEWORK: MISGUIDED & MISUSED

The history of mental health treatment in BC is rife with human rights abuses, including sterilization, segregation, eugenics, confinement, abuse, experimentation, overcrowding, and unsanitary conditions within institutions.<sup>vi</sup> BC's current mental health legislation—the *Mental Health Act*<sup>vii</sup> (MHA) – continues this harmful legacy, both in terms of the Act itself and its application by individuals of the health professions.

In recent years, involuntary treatment has been promoted by governments as a viable solution to drug toxicity deaths, but also a myriad of systemic issues ranging from a housing shortage, food insecurity, and inadequate income security in addition to workload pressures on direct care workers. All forms of involuntary treatment ignore the harms caused by colonialism and capitalism, which themselves focus heavily on control of racialized and poor populations, which is replicated through forced hospitalizations—particularly when police are involved. This exemplifies how coercion is justified through a lens of public health, neglecting the autonomy and dignity of those struggling with their mental health and PWUD. Public health terminology has become the latest tool to maintain control over PWUD yet replacing formal incarceration with so-called treatment in name only still relies on the same regimes of surveillance and control that founded drug prohibition.

### Legal Analysis

Under colonial provincial law, all adults have the right to consent or refuse health care treatment—unless they have been involuntarily detained by the 'mental health care' system. Involuntarily detained people are also deprived of the right to appoint a representative decision-maker (for example a trusted friend or family member) to make decisions in the event they lose the capacity to decide for themselves.

BC's legal regime is constitutionally suspect because it deprives people of the right to control what is done to their mind and body, exposes people to physical and mental harm, and discriminates against people on the basis of mental "disability," a protected ground under the BC Human Rights Code. In Ontario, parts of a similar regime were successfully challenged in court and struck down as unconstitutional.<sup>viii</sup> In BC, there is an ongoing court challenge to the law.<sup>ix</sup>

### The current legal system

Initially, people are transported to the Emergency Department of a Designated Facility. Many people, however, are often assessed and then released without receiving treatment. If admitted to the Designated Facility, an involuntarily detained patient is "deemed" to give consent to any treatment authorized by the institution.<sup>x</sup>

The *Mental Health Act* allows a person to be admitted to a mental health facility without their consent: first for up to 48 hours with a medical certificate,<sup>xi</sup> then for longer periods of time with additional medical certificates.<sup>xii</sup>

Generally, all adults have the power to give or refuse consent to treatment,<sup>xiii</sup> or appoint a "representative" for making decisions on their behalf if they do not have the capacity to make choices for themselves.<sup>xiv</sup> However, people detained under the *Mental Health Act*, whether in hospital or in community, are explicitly removed from these protections requiring consent<sup>xv</sup> and allowing a person to appoint a representative.<sup>xvi</sup>

A person can challenge their detention, but the process is difficult and legalistic. There are two routes, both high-barrier, to challenge detention:

- If a person was detained inappropriately (for example, the medical certificate wasn't properly completed, or the person wasn't given the procedural protections guaranteed by the *Mental Health Act*, such as notification to their family or an explanation of their rights), then they must file a "habeas corpus" application to the court system.
- If a person is challenging their current detention as inappropriate because they can consent to or refuse treatment on their own, then (within a limited period of time), they can file an application to the Mental Health Review Board.

Section 12 of the *Health Care (Consent) and Care Facility (Admission) Act* (HCCCFAA) also allows for the provision of health care in urgent, emergent cases in order to save a person's life, to prevent serious physical or mental harm, to alleviate severe pain *and* the patient is incapable of giving or refusing consent. People may in fact decline the proposed treatment yet receive it involuntarily/against their will if, in the health care provider's opinion, they are incapable of giving or refusing consent (and a representative decision-maker isn't available). People do however continue to have rights in this process.<sup>xvii</sup> There is a noted gap in data-collection and auditing regarding the use of the HCCCFAA for this purpose, nor information on how clinicians attend to the rights of their patients during this process.

## How the current regime is arguably unconstitutional

The *Charter of Rights and Freedoms*, part of the colonial constitution, guarantees everyone the right to "life, liberty and security of the person"; these rights can only be limited by the "principles of fundamental justice."<sup>xviii</sup> The government is also constitutionally prevented from arbitrarily detaining people.<sup>xix</sup> Every detained person has the right: to be informed of the reason for their detention; to retain and instruct a lawyer; and have the validity of their detention determined by a court.<sup>xx</sup> These rights protect a person's bodily and mental integrity and freedom and prohibit arbitrary detention and unjustified medical treatment.

The *Charter* also prohibits the government from discriminating on the basis of "mental disability." By treating people in a mental health crisis in harmful ways, very different than the way others needing care are treated, the government discriminates against them.

Of course, rights are only as good as the systems and resources dedicated to ensuring them. Even the current system, which is woefully inadequate, is not functioning in accordance with the MHA itself.

The BC Ombudsperson investigated the system's compliance with the (constitutionally inadequate) protections of the MHA and identified a shocking lack of compliance even with the meagre required procedures, concluding that "all of the health authorities were non-compliant in *well over half the files* that we reviewed. Across the province, a review of paperwork determined that the health authorities only completed all required forms 28% of the time."<sup>xxi</sup> A follow-up report found "some improvement" but "continued gaps" with procedural protections completed less than half of the time.

## INVOLUNTARY TREATMENT IS A PUNITIVE APPROACH

As the Representative for Children and Youth in BC highlights in a 2021 report, the harms of the current mental health treatment regime are intrinsic to the *MHA* but can be exacerbated because directors, facilities, and staff who interact with people who are subject to forced treatment are afforded significant room for discretionary decision-making:

*Patients, including children and youth, who are detained under the Mental Health Act may be subject to the 'direction and discipline of the director and members of the staff of the designated facility.' While discipline is authorized under the Mental Health Act, the Act does not define what constitutes discipline, does not restrict or include parameters to govern its use, and does not provide the ability for an individual to formally challenge the use of discipline.*

The MHA outlines the involuntary admissions process in designated facilities.<sup>xxii</sup> Broadly speaking, the Act allows police to apprehend people who are “apparently suffering from [a] mental disorder” and transport them to the emergency department of a designated facility for assessment, and if they are determined to meet criteria, they would typically be admitted to a locked psychiatric unit in the facility.

After discharge, people may continue to be surveilled and, if a physician deems them at risk of self-harm or harm to others, administered involuntary medication and intervention under “Extended Leave” in community. Forced drugging in the community has been called a “tranquil prison.”<sup>xxiii</sup> Client/patient input is not a consideration of the assessment required under the Act.

The potential for the MHA to punish people who are involuntarily admitted for treatment is intrinsic to the Act. Community Legal Assistance Society (CLAS) BC explains that it “grants sweeping powers to the director and the facility staff to direct and discipline detainees.” CLAS further reports that restraint and seclusion of detainees have been utilized as a coercive tactic and a disciplinary measure, including solitary confinement, restraining patients to beds, restricting movement within a facility, physical force, forcible removal of clothing, and chemical restraints.<sup>xxiv</sup> There is no legal requirement to document or justify these so-called treatments. In addition to the obvious infringements on personal and bodily autonomy, use of the MHA actively deters those who may otherwise want or need to access support from the healthcare system distrustful of, avoidant of, or even traumatized by healthcare providers and facilities.

## RISING RATES OF FORCED TREATMENT

In 2020/21 there were 17,677 instances of involuntary admission to BC healthcare facilities.<sup>xxv</sup> Between 2005 and 2016, detention under the *Mental Health Act* application in BC nearly doubled, resulting in 20,000+ apprehensions.<sup>xxvi</sup> While these rates are already alarming, there is also a significant gap in data, because involuntary admissions that last less than 24 hours, and use of the HCCFAA, are not consistently documented or recorded.

In 2019, BC’s Ombudsperson put forth 24 recommendations for change, and noted “significant levels of non-compliance” regarding documentation required to authorize involuntary admission.<sup>xxvii</sup> While apprehended people have rights under the Act, the Ombudsperson found that only 28% of involuntary admissions were done in compliance with the forms required by the MHA<sup>xxviii</sup>. The Ombudsperson further found “failure of psychiatric facilities, health authorities, and the provincial government to ensure compliance with the *Mental Health Act*’s procedural safeguards.”<sup>xxix</sup> While provincial government ministries and all health authorities accepted and agreed to implement the Ombudsperson’s recommendations, a 2022 Investigative Update found that only one-third of the recommendations had been fully implemented.<sup>xxx</sup>

As BC's involuntary care framework is applied more frequently, recent statistics suggest that the MHA is being used as a catch-all response to various behaviours and scenarios that are not indicative of a mental health crisis. In the absence of fostering voluntary, community-driven approaches to care and crisis intervention, the Act has become a standalone instrument.<sup>xxx</sup>

## INVOLUNTARY TREATMENT INTERSECTS WITH OTHER OPPRESSIVE SYSTEMS

As rates of involuntary admission have risen, apprehensions involving police have also increased rapidly. The use of public funds and police resources to position officers as frontline responders raises serious concerns: police are not only ill-equipped and untrained to deal with mental health events (especially when compared to the skills of experiential and healthcare workers), but also have a demonstrated history of escalating mental health events, sometimes with fatal consequences. For example, civilian deaths and injuries during police-based wellness checks are all too common. The final report of the Special Committee on Reforming the Police Act (2022) includes a brief analysis of police-involved deaths:

*The BC Coroners Service completed a review of 127 police involved deaths among persons during or within 24 hours following contact with police between January 1, 2013, and December 31, 2017. Of the 127 deaths, 21 were attributed to police use of force. They noted that 29 percent of those whose deaths were associated with police use of force were Indigenous, and two-thirds exhibited mental health symptoms at the time of the event.*<sup>xxxii</sup>

In 2020, the death of Tla-o-qui-aht woman Chantel Moore prompted national calls to end the practice of police conducting wellness checks. The practice remains. In April 2022, Surrey RCMP killed Haida Elder Jimmie Johannesson during a "wellness check." In November 2022, queer activist Dani Cooper was killed by the North Vancouver RCMP during a "wellness check." Given this pattern, any reliance on police in mental health care and treatment, including partnerships regarding involuntary treatment, should be suspended in favour of retaining health professionals working in tandem with experiential workers who are skilled in responding to complex events involving mental health.

### Racism & Institutionalization

When considering the broader impacts of involuntary care and forced treatment, policymakers, healthcare workers, direct service workers, and human rights advocates must recognize that the interlocking systems of settler colonialism and white supremacy continuously produce rules and regulations that are designed to regulate Black, Indigenous, and racialized peoples.

Across Canada, there has been very little information collected to develop an understanding of the involuntary admissions of Indigenous, Black, and other racialized peoples. Forced treatment, however, is best understood within a long history of forced interventions that have led to individual and community harm and intergenerational trauma. Violence has historically been enacted toward Indigenous peoples through a combination of terror and brute force, targeted legislation, and social policies, often under the guise of benevolence. Canada's cultural genocide of Indigenous people in the form of residential schools was also said to be in the best interests of Indigenous people.<sup>xxxiii</sup> Black people were violently dispossessed of their homes and enslaved in Canada – subjected to profound horrors, also often narrated as being "for their own good."

Selective record-keeping at every level of government means there is limited formal data on how state violence, including involuntary institutionalization, disproportionately impacts Indigenous, Black, and racialized populations. Currently, the province does not track disaggregated race-based data to understand the impact of involuntary admission on racialized and minoritized communities, but it states that "work is underway to collect this data."<sup>xxxiv</sup> Analyses that have been collaboratively produced with these communities offer some

information about the current paradigm of mental health and substance use care. For example, *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care* (2020) found that 23% of Indigenous people who responded to the review's survey said they were "not at all safe" when accessing mental health or substance use services.<sup>xxxv</sup> *In Plain Sight* also profiles several Indigenous patients' experiences with mental health care, revealing the way systemic racism impacts an individual's health care experience.

Anti-Black racism also shapes the mental health and interventions available to Black community members, often intersecting with social and structural determinants of health, such as income, education, social exclusion, food security, and direct experiences of harm and trauma.<sup>xxxvi</sup> A retrospective data analysis from patient referrals in Canada also revealed that Black Canadians who experience first-episode psychosis were more likely to experience coercive treatment and intervention, and researchers concluded further work was needed to understand the role of racial prejudices in the experience of Black patients.<sup>xxxvii</sup> In addition to Black patients' direct experiences, there has been significant scholarship regarding the processes that encode racism through discriminatory patterns of psychiatric diagnoses.<sup>xxxviii</sup> Forced psychiatric treatment, within the broader institutions of psychiatric and the overall medical system, will likely target Black, Indigenous and racialized community PWUD specifically.

## Gender & Institutionalization

Gender presentation informs processes of mental health evaluation, diagnosis, and involuntary confinement. The perception of girls, women, and trans and non-binary people as mentally unstable originates in structures of sex- and gender-based violence. It can be traced to the proliferation of early psychiatric diagnoses such as "hysteria" and its Greek cognate, "wandering womb," that were routinely been affixed to victims of sexual assault. The legacy of patriarchal diagnostic criteria is expressed today in diagnoses such as "borderline personality disorder," which is predominantly labeled in girls and women, and in the pathologizing of feminized behaviours as "irrational" or "troublesome."<sup>xxxix</sup> Once institutionalized, Health Justice BC notes that "girls, women, non-binary people, Two-Spirit people, and others with marginalized genders may experience disproportionate challenges and harms while detained...such as facing the risk of sexual violence, having aspects of their gender pathologized or being separated from newborn infants."<sup>xl</sup>

More concretely, the forced sterilization of people considered "mentally defective" was a eugenicist practice that was codified in BC law until 1973, and sterilization practices continued after this law was repealed.<sup>xli</sup> BC's practices of forced sterilization were also part of eugenicist, genocidal practices that targeted women, particularly those who were Indigenous and marginalized on the bases of race and class. In BC, sterilization was practiced at multiple provincial facilities, including the now-defunct Essondale and Provincial Mental Hospital.<sup>xlii</sup> Even though sterilization is no longer legally sanctioned, psychiatric diagnoses are still leveraged to target mothers and disassemble family systems. Specifically, private medical records that detail involuntary treatment could be used to justify interventions of the family policing system.

The gendered psychiatric treatment and pathologizing of women, girls, and people of marginalized genders intersects with reproductive justice and systems of family policing. Currently, Ministry of Children and Family Development social workers can access the medical records of parents without notifying the parent or obtaining their consent, based on BC's child welfare legislation.<sup>xliii</sup> This provision of the *Child, Family and Community Service Act* is currently being challenged at the BC Court of appeal.<sup>xliv</sup> Private medical records that detail involuntary treatment could be used to justify interventions of the family policing system. As West Coast LEAF has highlighted in their response *T.L. v the Attorney General of British Columbia*, BC's family policing system disproportionately affects Indigenous families and parents who experience overlapping inequalities. Indigenous mothers, in particular, are targeted by the family policing system, and the expansion of involuntary treatment could lead to broader use of the "colonial, apprehension-based approach" as medical records are used to justify the ongoing removal of children from their families.<sup>xlv</sup> Proposals for advancing the use of involuntary treatment must be considered within this broader milieu.

## Youth & Institutionalization

The rates of involuntary admissions of children and youth into mental health facilities have also increased in recent years.<sup>xlvi</sup> This has coincided with the release of several reports and investigations by BC's Representative for Children & Youth (RCY) that focus on the child and youth mental health care system.<sup>xlvii</sup> The RCY report concluded that the demand for community mental health services for children and youth continues to exceed available resources and that programs that do exist are not developed collaboratively with impacted communities.<sup>xlviii</sup> The provision of these resources is a shared responsibility of the Ministry of Children & Family Development and provincial health authorities.

Youth who use drugs have already been targeted; in July 2020, the provincial government unsuccessfully attempted to garner support for an involuntary treatment proposal directed at youth, Bill 22: *Mental Health Amendment Act*. The controversial Bill, which allowed for the involuntary hospitalization of youth who experience an overdose, was retracted by Mental Health and Addictions Minister Sheila Malcolmson following immense public outcry.<sup>xlix</sup> PWUD, health professionals, policy groups, researchers, and legal organizations all pointed to the Bill's lack of evidence and its likelihood to violate the health, safety, and rights of PWUD. This event points to a lack of meaningful engagement with youth who use drugs in drug policy model development, a dearth of fact-based drug education for young people, and the consistent refusal by all levels of government to recognize that youth deserve to contribute to the policies and practices that shape their lives.

## PWUD & Institutionalization

Despite the myriad problems associated with BC's involuntary care framework, and the consistent failure of government and health authorities to implement recommendations that protect people detained under the MHA, involuntary treatment is seen by some members of government and the public as an appropriate response to drug use and affiliated drug toxicity deaths. The history of PWUD interactions with the healthcare system is riddled with barriers and discrimination. Involuntary treatment has been discredited as an effective or public health-aligned course and has actually been identified as an overdose risk unto itself.<sup>l</sup>

The inefficacy of involuntary treatment is well-established, and emerging evidence shows risks are much more acute in the context of the drug toxicity crisis.<sup>li</sup> In a 2022 interview, Dr. Paxton Bach co-medical director of the BC Centre on Substance Use confirmed that compulsory treatment is largely ineffective: stating "forcing somebody into detoxification results in loss of drug-related tolerance, potentially increasing the risk of overdose upon leaving treatment."<sup>lii</sup> These interventions are profoundly dehumanizing. This approach to treatment negates the importance of personal will (in deciding one's own drug use or abstinence), the medical reality of withdrawal, which can be debilitating, and the systemic underpinnings of struggling to manage drug use (i.e., pain, poverty and other inequities, trauma, recreation). BC researchers have already identified high rates of fatal overdoses upon release from correctional facilities.<sup>liii</sup> Recent international research indicates that the fear of post-treatment death is well-founded, and Vancouver-based research found that individuals' substance use patterns were unchanged after coerced treatment.

PWUD already face numerous barriers while attempting to access voluntary public healthcare, whether drug-related or not. Some medical professionals express overt hostility toward PWUD, while discrimination and stigma may be compounded by intersecting identity markers such as living in poverty, being racialized, or engaging in survival sex work. This leads to the medical mismanagement of withdrawal symptoms and misdiagnoses attributed to substance use, leading many PWUD to avoid medical care entirely. Coercive "treatment" cannot be seriously considered when the healthcare system is already so inhospitable for PWUD. Involuntary institutionalization damages what minimal work has been done to invite PWUD back into the system, particularly if healthcare workers remain limited in terms of the options available to them for responding to addiction and/or overdose appropriately. Not only will coercive measures exacerbate tensions

between PWUD and the health system but, given the failed track record of involuntary treatment, harm against PWUD will continue to be perpetuated.

## **Ableism & Institutionalization**

Disability justice and psychiatric consumer/survivor/ex-patient/mad (“C/S/X/M”) movements.<sup>liv</sup> have been instrumental in de-pathologizing the symptoms of mental illness and situating them within their social determinants. Their advocacy has led to the creation of social justice and rights-based alternatives to involuntary confinement in local, national, and international contexts, accompanied by legislation and policies that enshrine and protect human rights. This dually includes fighting to advance access to voluntary care located in their communities, especially for those with histories of being arbitrarily and/or involuntarily detained in hospitals or treatment facilities.

Activists and organizations in BC have fought to deinstitutionalize people locked in psychiatric facilities under the guise of safety and protection since the 1950s.<sup>lv</sup> Advocacy for deinstitutionalization contributed to the end of *some* forms of medical incarceration, namely for groups holding other forms of social power, whose identities otherwise aligned with the status quo. These shifts also occurred in tandem with rising neoliberalism within healthcare, wherein government prioritized cost-efficiency measures whether or not they further disenfranchised disabled people.<sup>lvi</sup> The dominance of white disabled people with economic resources within these movements has profoundly influenced the scope of rights-based legislation, regulation, enforcement, and control within disability rights and inclusion organizing. As Patty Berne,<sup>lvii</sup> of Sins Invalid, explains:

*The disability rights movement simultaneously invisibilized the lives of peoples who lived at intersecting junctures of oppression – disabled people of color, immigrants with disabilities, queers with disabilities, trans and gender non-conforming people with disabilities, people with disabilities who are houseless, people with disabilities who are incarcerated, people with disabilities who have had their ancestral lands stolen, amongst others.*

The current push for involuntary treatment exemplifies the invisibility and exclusion of poor, Black, Indigenous, racialized, gendered, and queer lived and living experiences of disability.

Government, healthcare workers, researchers, law, and policymakers must stop treating marginalized community members as inherently dangerous, deficient, broken, or deserving of violence. This violence includes involuntary treatment.

## SHIFTING TOWARDS DISABILITY JUSTICE & HEALTH JUSTICE

In contrast to harmful, genocidal, and coercive models of so-called care described above,<sup>lviii</sup> frameworks for treating distress have been envisioned by queer and racialized disabled communities, offering new ways of imagining and applying care, value, belonging, community, and justice. For example, the Disability Justice Network of Ontario's "Disability, Health, and Transformative Justice" disrupts the violence inherent to the medical system, including policies and practices that entrench medical racism, ableism, and anti-drug user stigma. As the Disability Justice Network of Ontario states:

*We believe that institutionalization is a result of the same systems of incarceration that removes, isolates and confines community members in psychiatric institutions, emergency shelters, and prisons. We believe in an end to the warehousing, caging, and incarcerating of people instead of providing care and justice.<sup>lix</sup>*

Embedded in the framework for disability justice is intersectionality. This framework of understanding recognizes that socially constructed identities are defined in relation to their perceived un(der)productivity in capitalist economies. Disability is a political identity, defined by the state and its processes and systems that view and assess human life through the lens of production and capital.<sup>lx</sup>

Rather than shifting funding and political support towards involuntary models of incarceration disguised as care, we endorse the principles of disability justice, a movement to counter the violence of an ableist, cisheteropatriarchal, colonial, heteropatriarchal capitalist society and to resist the destabilizing violence of white supremacy.

## BC MUST INVEST IN CARE AND CONSENT, NOT INVOLUNTARY TREATMENT

Multiple social issues are shaping the conditions of people experiencing mental health issues in BC, including a housing crisis and rising levels of homelessness, the fatal and increasingly contaminated illicit drug supply, and the COVID-19 pandemic.<sup>lxi</sup> As the Nurses and Nurse Practitioners of British Columbia outline in their 2021 position statement, "Increased reliance on involuntary and coercive psychiatric treatment practices is in part due to a lack of adequate early intervention and prevention-based community services."<sup>lxii</sup>

Involuntary treatment creates the illusion of a quick fix; however, more than 6 years into the public health emergency created by the contaminated illicit supply, illusions are insufficient. There are serious implications for both the current use of involuntary treatment in BC, as well as any potential expansion, as detailed in the impacts of such interventions on Black, Indigenous, racialized, women, folks of marginalized genders (including Two-Spirit, queer and trans people), young people, PWUD, and disabled people.

Expansion of involuntary treatment both exacerbates existing harms and fails to address the underlying systemic issues. Forced treatment is part of a broader spectrum of violent, colonial, racist medical treatment that is historically and contemporarily deployed against people who do not conform to white supremacist, settler logic, and should not be seen as a substitute for meaningful policy interventions to structural and systemic inequalities.

## RECOMMENDATIONS

1. Invest in robust access to voluntary treatment options, including primary care, detox, treatment programs that have strict regulatory oversight, harm reduction programming, safe supply, family programming, culturally affirming options, and treatment modalities that reflect the intersecting identities of people who use drugs. All voluntary options should be available immediately upon request and accessible across inner-city, rural, and remote areas.
2. Immediately fund and scale up safe supply programs to ensure a regulated and predictable supply of drugs is accessible to all.
3. Immediately eliminate all police involvement and power under the provincial *Mental Health Act*, particularly the ability to apprehend someone using an officer-based assessment; as well as repeal any potentially intersecting provisions, regulations and legislation that grants law enforcement a healthcare scope, including the warning and referrals subsection of federal Bill C-5, and the 'alternative measures' embedded into BC's decriminalization framework.
4. Prevent the expansion of legislation that broadens apprehension criteria to include overdose.
5. Eliminate any form of involuntary and/or coercive treatment, including BC legislation, as well as any umbrella agency-level policy (i.e., employer or union policies that mandate employees into involuntary treatment programs).
6. Repeal all legislation and regulations that are used to disproportionately target Black, Indigenous, and racialized communities.
7. Repeal all legislation and regulations that are used to target people who use drugs and disabled people. There is already existing legislation that permits forced treatment against these groups. It is violent and unjust and must be eliminated.

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<sup>i</sup> Akshay Kulkarni, “B.C. Premier’s Expansion of Involuntary Medical Treatment Infringes on Human Rights: Advocates” online: (27 November 2022) CBC News <<https://www.cbc.ca/news/canada/british-columbia/david-eby-involuntary-treatment-criticism-1.6664848>>.

<sup>ii</sup> Amanda Butler & Doug Lepard, *A Rapid Investigation into Repeat Offending and Random Stranger Violence in British Columbia*, online: (September 2022) <[https://news.gov.bc.ca/files/Prolific\\_Offender\\_Report\\_BCFNJC\\_submission.pdf](https://news.gov.bc.ca/files/Prolific_Offender_Report_BCFNJC_submission.pdf)>.

<sup>iii</sup> Office of the Premier, “Minister Letter”, online: (07 December 2022) <[https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/premier-cabinet/mlas/minister-letter/mmha\\_-\\_whiteside.pdf](https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/premier-cabinet/mlas/minister-letter/mmha_-_whiteside.pdf)>.

<sup>iv</sup> Katie deRosa, “B.C. NDP leadership race: Eby pitches involuntary care for severe overdose cases”, online: (18 August 2022) Vancouver Sun <<https://vancouversun.com/news/bc-ndp-leadership-race-eby-pitches-involuntary-care-for-severe-overdose-cases>>; Public Safety and Solicitor General, “B.C. releases expert recommendations on repeat offending”, online: (21 September 2022) BC Gov News; Alana Klein, “Criminal Law and the Counter-Hegemonic Potential of Harm Reduction” (2015) 38:2 Dal LJ 447. <<https://news.gov.bc.ca/releases/2022PSSG0059-001422>>.

<sup>v</sup> Mia Mingus, “Medical Industrial Complex Visual”, online: (6 February 2015) Leaving Evidence <<https://leavingevidence.wordpress.com/2015/02/06/medical-industrial-complex-visual/>>.

<sup>vi</sup> Emily Yearwood Lee, “Mental health policies: Historical overview”, online: (January 2008) Multicultural Mental Health <<https://multiculturalmentalhealth.ca/wp-content/uploads/2019/07/legislative-library-mental-health-policies1.pdf>>.

<sup>vii</sup> *Mental Health Act*, RSBC 1996, c 3, s 22.

<sup>viii</sup> *PS v. Ontario*, 2014 ONCA 900

<sup>ix</sup> In 2016, the Council of Canadians with Disabilities (“CCD”) and two individuals filed a *Charter* challenge to three parts of the law: (i) *Mental Health Act*, s. 31(1); (ii) *Health Care (Consent) and Care Facility (Admission) Act*, s. 2(b) and (c); and (iii) and *Representation Agreement Act*, s. 11(1)(b) and (c) [BCSC File No S168364]. After the two individual plaintiffs withdrew from the case, the province challenged CCD’s “standing” to bring the case on others’ behalf. After fighting CCD all the way to the Supreme Court of Canada, in 2022 CCD was allowed to proceed with the case. See: *British Columbia (Attorney General) v. Council of Canadians with Disabilities*, 2022 SCC 27

<sup>x</sup> MHA, *supra* note 7, at c. 288, section 31(1): “If a patient is detained in a designated facility under section 22, 28, 29, 30 or 42 or is released on leave or is transferred to an approved home under section 27 or 28, treatment authorized by the director is deemed to be given with the consent of the patient.”

<sup>xi</sup> *Ibid* at section 22(1). A person can also be admitted in an “emergency”, under s. 24 of the *Health Care (Consent) and Care Facility (Admission) Act*. Instead of admission to a facility, emergency treatment can also be imposed under sections 12 of the *Health Care (Consent) and Care Facility (Admission) Act*.

<sup>xii</sup> *Ibid* at c. 288, sections 22(2) and 24.

<sup>xiii</sup> *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c. 181, section 4(a).

<sup>xiv</sup> *Representation Agreement Act*, RSBC 1996, c. 405.

<sup>xv</sup> HCCCFAA, *supra* note 13, section 2(b) and (c): “This Act does not apply to... (b) the provision of psychiatric care or treatment to a person detained in or through a designated facility under section 22, 28, 29, 30, or 42 of the *Mental Health Act*, (c) the provision of psychiatric care or treatment under the *Mental Health Act* to a person released on leave or transferred to an approved home under section 37 or 38 of the *Mental Health Act*”.

<sup>xvi</sup> *Representation Agreement Act*, *supra* note 14, s. 11(1)(b): “Despite sections 7(1)(c) and 9, an adult may not authorize a representative to refuse consent to... (b) the provision of professional services, care or treatment under the *Mental Health Act* if the adult is detained in a designated facility under section 22, 28, 29, 30 or 42 of that Act, or (c) the provision of professional services, care or treatment under the *Mental Health Act* if the adult is released on leave or transferred to an approved home under section 37 or 38 of that Act.”

<sup>xvii</sup> Seniors First BC, *Legal Issues in Residential Care: An Advocate’s Manual* (Vancouver: Seniors First BC, 2021) at 129.

<sup>xviii</sup> Section 7 of the Charter: “Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.”

<sup>xix</sup> Section 9 of the Charter: “Everyone has the right not to be arbitrarily detained or imprisoned.”

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<sup>xx</sup> Section 10 of the Charter: “Everyone has the right on arrest or detention (a) to be informed promptly of the reasons therefor; (b) to retain and instruct counsel without delay and to be informed of that right; and (c) to have the validity of the detention determined by way of habeas corpus and to be released if the detention is not lawful.”

<sup>xxi</sup> Office of the Ombudsperson, *Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act*, online: (Victoria: BC Ombudsperson, 2019) <<https://bcombudsperson.ca/assets/media/OMB-Committed-to-Change-FINAL-web.pdf>> at page 7, emphasis added.

<sup>xxii</sup> Designations Under The *Mental Health Act* [S 3(1),(2)] Made by Ministerial Order M 393/2016 unless otherwise stated, online: (1 January 2022) <<https://www2.gov.bc.ca/assets/gov/health/managing-your-health/mental-health-substance-use/facilities-designated-mental-health-act.pdf>>.

<sup>xxiii</sup> Erick Fabris, *Tranquil Prisons: Chemical Incarceration Under Community Treatment Orders* (Toronto: University of Toronto Press, 2011).

<sup>xxiv</sup> Laura Johnston, *Operating in Darkness: BC’s Mental Health Act Detention System* (Vancouver: CLAS BC, 2017) <<https://clasbc.net/wp-content/uploads/2019/06/CLAS-Operating-in-Darkness-November-2017.pdf>> at page 41.

<sup>xxv</sup> Office of the Ombudsperson, *Systemic Investigation Update: Report on the Implementation of Recommendations from COMMITTED TO CHANGE: Protecting the Rights of Involuntary Patients under the Mental Health Act*, online: (Victoria: BC Ombudsperson, 2022) <<https://bcombudsperson.ca/assets/media/Committed-to-Change-Report-Update-July21-2022.pdf>> at page 8.

<sup>xxvi</sup> Johnstone, *supra* note 25, at page 13.

<sup>xxvii</sup> Committed to Change, *supra* note 21, at page 6.

<sup>xxviii</sup> *Ibid* at page 7.

<sup>xxix</sup> *Ibid*.

<sup>xxx</sup> *Ibid* at page 11.

<sup>xxxi</sup> Canadian Mental Health Association – BC Division, “Policy Perspective: Charter Challenge of the BC Mental Health Act – Involuntary Treatment (Section 31)”, online (April 2017) CMHA BC <<https://cmha.bc.ca/documents/policy-perspective-charter-challenge-of-the-bc-mental-health-act-involuntary-treatment-section-31/>>.

<sup>xxxii</sup> Legislative Assembly of British Columbia, *Transforming Policing and Community Safety in British Columbia*, (Victoria: Legislative Assembly of BC, 2022) at page 27.

<sup>xxxiii</sup> Roland Chrisjohn and Sherri Young, *The Circle Game: Shadows and Substance in the Residential School Experience in Canada* (Penticton: Theytus Books, 2006); Chris Chapman and A.J. Withers, *A Violent History of Benevolence: Interlocking Oppression in the Moral Economies of Social Working* (Toronto: University of Toronto Press, 2019); Robyn Maynard, *Policing Black Lives: State Violence in Canada from Slavery to the Present* (Halifax & Winnipeg: Fernwood, 2017).

<sup>xxxiv</sup> Moira Wyton, “Forced Mental Health Treatment Spikes in BC”, online (23 November 2021) The Tyee <<https://thetyee.ca/News/2021/11/23/BC-Forced-Mental-Health-Treatment-Spikes/>>.

<sup>xxxv</sup> Mary Ellen Turpel-Lafond, *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care*, online: (Victoria: BC Government, 2020) <<https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf>> at page 23.

<sup>xxxvi</sup> Office of Health Equity and the Anti-Black Racism and Mental health Advisory Committee, *Dismantling Anti-Black Racism: A Strategy of Fair & Just CAMH*, online (Toronto: CAMH, 2021) <<https://www.camh.ca/-/media/files/camh-dismantling-anti-black-racism-pdf>>.

<sup>xxxvii</sup> Sommer Knight, G. Eric Jarvis, Andrew G. Ryder, Myrna Lashley, Cécile Rousseau, “Ethnoracial Differences in Coercive Referral and Intervention Among Patients with First-Episode Psychosis”, online: (2021) 73:1 Psychiatric Services 2 <<https://doi.org/10.1176/appi.ps.202000715>>.

<sup>xxxviii</sup> Jonathan M. Metz, *The Protest Psychosis: How Schizophrenia Became a Black Disease* (Boston: Beacon Press, 2009); OmiSoore Dryden and Onye Nnorom, “Time to dismantle systemic anti-Black racism in medicine in Canada”, online: (2021) 193:2 Canadian Medical Association Journal <<https://www.cmaj.ca/content/cmaj/193/2/E55.full.pdf>>.

<sup>xxxix</sup> Pamela Bjorklund, “No Man’s Land: Gender bias and social constructivism in the diagnosis of Borderline Personality Disorder” (2006) 27:1 Issues in Mental Health Nursing 3 <<https://doi.org/10.1080/01612840500312753>>.

<sup>xl</sup> Health Justice, “Gender Equity”, online (n.d.), Health Justice <<https://www.healthjustice.ca/gender-equity>>.

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- <sup>xli</sup> Native Women's Association of Canada, "Forced Sterilization of Indigenous Women Expert Meeting", online: (25 March 2019) <<https://nwac.ca/assets-knowledge-centre/NWAC-Expert-Forum-Forced-Sterilization-Summary-Report-March-25-2019-FINAL.pdf>>.
- <sup>xlii</sup> Karen Stote, "The Coercive Sterilization of Aboriginal Women in Canada", online: (2012) 36:3 American Indian Culture and Research Journal <[https://api.fqpn.staging.molotov.ca/wp-content/uploads/2021/02/AICRJ\\_STOTE-STERILIZATION.pdf](https://api.fqpn.staging.molotov.ca/wp-content/uploads/2021/02/AICRJ_STOTE-STERILIZATION.pdf)>.
- <sup>xliii</sup> *Child, Family and Community Service Act*, RSBC 1996, s 96.
- <sup>xliv</sup> *T.L. v the Attorney General of British Columbia*.
- <sup>xlv</sup> West Coast LEAF, "Release: Case to determine parents' right to privacy at BC Court of Appeal", online (16 January 2023), West Coast Leaf <<https://www.westcoastleaf.org/our-publications/release-case-to-determine-parents-right-to-privacy-at-bc-court-of-appeal/>>
- <sup>xlvi</sup> Representative for Children and Youth, *Detained: Rights of children and youth under the Mental Health Act* (RCYBC, 2021) <[https://rcybc.ca/wp-content/uploads/2021/01/RCY\\_Detained-Jan2021.FINAL\\_.pdf](https://rcybc.ca/wp-content/uploads/2021/01/RCY_Detained-Jan2021.FINAL_.pdf)>.
- <sup>xlvii</sup> *Ibid* at page 15.
- <sup>xlviii</sup> *Ibid*.
- <sup>xlix</sup> Marilou Gagnon et al "Why NDP Should Drop Its Youth Overdose Bill", online (9 November 2020) The Tyee <<https://thetyee.ca/Opinion/2020/11/09/NDP-Bill-Youth-Detention-Overdose/>>.
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- <sup>lxi</sup> Maja Kolar, Colleen Varcoe & Rochelle Einboden, "Involuntary psychiatric treatment and the erosion of consent: A critical discourse analysis of mental health legislation in British Columbia, Canada", online (2022) *health* <<https://doi.org/10.1177/13634593221096241>>.
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