Detained:

Rights of children and youth under the *Mental Health Act*

JANUARY 2021

REPRESENTATIVE FOR
CHILDREN AND YOUTH

Jan. 19, 2021

The Honourable Raj Chouhan
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, B.C., V8V 1X4

Dear Mr. Speaker,

I have the honour of submitting the report *Detained: Rights of children and youth under the Mental Health Act* to the Legislative Assembly of British Columbia.

This report is prepared in accordance with Section 20 of the *Representative for Children and Youth Act* which gives the Representative authority to make special reports to the Legislative Assembly if the Representative considers it necessary.

Sincerely,

Dr. Jennifer Charlesworth
Representative for Children and Youth

pc: Ms. Kate Ryan-Lloyd
Clerk of the Legislative Assembly

Susan Sourial
Committee Clerk, Legislative Assembly

Contributors

The Representative would like to acknowledge with gratitude the young people who shared their experiences and insights for this report.

The Representative would also like to thank mental health law expert Laura Johnston for her time and attention, and the following current and former RCY staff who contributed to this report:

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Contents

Executive Summary 3

Scope and Methodology 9
- Engagement with Young People 9
- Data Collection 11

Background 12
- Mental Health Services for Children and Youth in B.C. 13
- Previous RCY Reports on the Mental Health System 14
- The *Mental Health Act* and its Safeguards 17
- Critical Injuries Reported to the Representative 27

Youth Experience Under the *Mental Health Act*: Listening to Young People 38
- Uncovering Themes within Young Peoples' Experience 42
- Procedural Safeguards and Child Participation 45

Opportunities for Change – Other Approaches to Treatment Under the *Mental Health Act* *68*
- Social Ecological Model of Mental Wellness 68
- Youth-Centred Care 69
- Family-Centred Care 69
- Culturally Connected Care 70
- Youth Perspectives: Thinking Outside the Box 73

Recommendations 76

Glossary of Terms 80

Appendices 82
- Appendix 1: International Human Rights Treaties 82
- Appendix 2: Youth Profiles 84
- Appendix 3: InWithForward 98
- Appendix 4: Project Participants 100
- Appendix 5: RCY Data Collection 101
- Appendix 6: Legislative Frameworks 112
- Appendix 7: *Mental Health Act* Forms 116
- Appendix 8: MCFD Designated Psychiatric Facility Inpatient Admissions 117

References 119

The Representative and staff, who do their work throughout the province, would like to acknowledge that we are living and working with gratitude and respect on the traditional territories of the First Nation peoples of British Columbia. We specifically acknowledge and express our gratitude to the keepers of the lands on the traditional territories of the Lheidli T'enneh peoples (Prince George), the Songhees and Esquimalt Nations (Victoria), and the Musqueam, Skwxwu'7mesh, Tsleil-Waututh and Kwikwetlem Nations (Burnaby) where our offices are located.

We would also like to acknowledge our Métis and Inuit partners and friends living in these beautiful territories.

Emotional Trigger Warning

This report explores topics related to mental health treatment and detentions that may be upsetting for some people. For those who have experienced treatment in the mental health system, and First Nations, Métis, Inuit and urban Indigenous peoples, the content may trigger memories of distressing personal experiences. While the report is intended to examine the administration of the system of involuntary detention under the *Mental Health Act*, it also examines the subjective experiences of young people in the involuntary child and youth mental health system and the content may trigger feelings or thoughts of past events.

If you require emotional support, you can contact:

- BC Crisis Centre: phone 1-800-784-2433 or online chat: https://www.crisislines.bc.ca/
- the First Nations and Inuit Hope for Wellness Help Line and On-line Counselling Service, available toll-free at 1-855-242-3310 or through hopeforwellness.ca
- the KUU-US Crisis line, available 24/7 toll-free at 1-800-588-8717 to provide support to Indigenous people in B.C. For more information, visit: kuu-uscrisisline.com
- the Métis Crisis Line, available 24 hours a day toll-free at 1-833-MétisBC (1-833-638-4722).

Executive Summary

In the course of the Representative for Children and Youth's daily work, it is apparent that many young people in this province struggle with mental health issues, in some cases severe, and that their needs are often not being met by the system of mental health supports and services available for children and youth.

The Representative (RCY) has issued numerous reports that have raised concerns about the inadequacies of mental health services for young people, including a lack of prevention and early intervention as well as service navigation and availability issues, and has called more than once for the creation of a comprehensive and responsive voluntary system of mental health services for children and youth.

The provincial government has recognized these concerns, including the 2017 creation of the Ministry of Mental Health and Addictions (MMHA) and the 2019 strategic document, *A Pathway to Hope: A roadmap for making mental health and addictions care better for people in British Columbia.*[1] The Roadmap describes the current mental health service system as *"service delivery defined by waitlists and crises"* and includes a 10-year plan with an initial three-year implementation phase. While there are some welcome steps here, crucial gaps in the system remain today.

Why this report?

This report had its beginnings in a review initiated by then-Representative Bernard Richard in the fall of 2018. After a broad review of RCY's advocacy files and critical injury and death reports, Richard wanted to examine how children could better participate or have a voice in important decisions that impact them, looking specifically at legal proceedings under the *Child, Family and Community Service Act (CFCS Act)*, the *Mental Health Act* and the *Family Law Act*. Richard was also concerned about the disproportionate number of Indigenous children impacted. The current Representative decided to continue with this review and to also write a report focusing on the rights of children detained under the *Mental Health Act* and centering the experiences of young people with lived experience.

When children and youth require treatment and cannot be treated voluntarily, B.C.'s *Mental Health Act* allows for involuntary mental health treatment. The Act recognizes that for some people, involuntary care is necessary to keep them, or others, safe.

Mental health detentions are among the most intrusive measures that a state can impose on people. Like imprisonment, these detentions result in the deprivation of liberty. Under the *Mental Health Act,* a child can be admitted and detained against their will, have treatment imposed on them and be subject to discipline, restraint or periods of isolation. In fact, B.C. is the only province in Canada where a capable, involuntary patient has no right to make psychiatric treatment decisions.

This report is the first from this Office to explore the system for involuntary detention under the *Mental Health Act.* The purpose of exploring the *Mental Health Act* and youths' lived experience within this

[1] Ministry of Mental Health and Addictions, *A Pathway to Hope: A roadmap for making mental health and addictions care better for people in British Columbia* (Victoria, 2019).

framework is to highlight ways to strengthen safeguards, enhance opportunities for young people to have a say in their treatment and improve the experience and outcomes for children and youth.

This report amplifies the voices of youth with lived experience of involuntary detention and starts from the premise that young people have the right to participate in making decisions about their care, to the extent that they are able. The fear and confusion expressed by youth when they describe their experiences in involuntary detention is troubling; their perspectives provide insight into a world governed by the *Mental Health Act.*

The Representative believes in the importance of voice and self-determination grounded in the *Canadian Charter of Rights and Freedoms* and international human rights instruments such as the *United Nations Convention on the Rights of the Child,* the *United Nations Convention on the Rights of Persons with Disabilities* and the *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP).* This report seeks to highlight where children and youth detained under the *Mental Health Act* may be supported to exercise their rights.

The unique significance of how First Nations, Métis, Inuit and urban Indigenous people experience mental health detentions is also considered in this report, given the multitude of ways in which the rights and freedoms of Indigenous peoples have been limited and interfered with throughout colonization, residential schools and the child welfare system.[2] Although the involuntary detention of First Nations, Métis, Inuit and urban Indigenous children and youth under the *Mental Health Act* may be intended for their safety and protection, it can be seen and experienced as another link in a long chain of oppression imposed by the state on Indigenous peoples. Of concern to the Representative is the racism experienced by First Nations, Métis, Inuit and urban Indigenous children and youth in hospitals, as documented in the recent report *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care,* and the absence of culturally safe and relevant services and supports.[3]

While the intention of mental health detentions is to keep young people safe, involuntary admission is a powerful tool that can be misused and generate harm. Sometimes it is used well and contributes to well-being and other times that is not the case, as was clear in stories from young people who participated in this report that the experience of involuntary admission is not always protective or therapeutic.

Although the *Mental Health Act* features protective safeguards – including requiring the provision of information about rights, notification of a near relative, second medical opinions, re-assessments, Mental Health Review Board hearings and access to legal counsel for Review Board hearings – this report finds that young people are apparently not being informed of and certainly not being supported to exercise their rights under the Act.[4] Given their immaturity and state of dependency, children and youth should

[2] As a result of colonization and the disruption and extinguishment of Indigenous peoples' connection to family, community and culture, there are people who identify as Indigenous who have been disconnected from their cultural roots and are not yet able to identify themselves as being of a particular First Nation, or Métis or Inuit community, or who choose to identify as having multiple ties and identities or as urban-residing Indigenous peoples. In recognition of the wishes expressed by people from whom RCY has learned, RCY includes urban Indigenous as a group to whom we are also accountable.

[3] Addressing Racism Review, *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care* (Victoria, 2020)

[4] The Mental Health Review Board is an independent tribunal that conducts review hearings on the involuntary admission of patients under the *Mental Health Act.*

have enhanced protections of their rights when they are facing deprivation of liberty, as is the case in the youth criminal justice system. This need for increased protections is important in the mental health context as children and youth's capacity to understand and exercise their rights may be diminished by their mental state at the time of admission.

To understand how the *Mental Health Act* functions and how to improve the experiences of children and youth in crisis, this report draws on a number of information sources including: RCY and external data; a review of current legislation, regulations and guidelines; interviews with key stakeholders; and engagement with young people who have been detained under the *Mental Health Act.*

This report found that the number of children and youth who are receiving involuntary mental health services has increased alarmingly. In the 10 years between 2008/09 and 2017/18, these admissions rose from 973 to 2,545 – or 162 per cent. This raises troubling questions about the adequacy of the voluntary, community based system of care and treatment and its ability to avoid unnecessary involuntary detention. Clearly, the time has come for government to devote special attention to how the *Mental Health Act* can be improved in its operation and administration to better protect and respect the voice and the interests of children and youth it affects in such profound ways.

Most of the young people who participated in this report were surprised to learn that they had rights; they did not remember hearing about, or seeing forms explaining their rights. Young people weren't aware they could request second medical opinions or access a lawyer for support to review their detention. They recalled forced medication, not being involved in treatment decisions and a lack of attention to the underlying reasons for their pain. They recalled scary periods of isolation and restraint. Indigenous young people recalled racism and an absence of culturally relevant treatment. Data reviewed for this report supports the young peoples' memories, and reveals that children and youth are not exercising their rights under the Act. It is not clear to the Representative that children's voices are routinely considered with regard to certification, treatment and discharge under the *Mental Health Act,* all of which are decisions that intimately impact their lives.

Data tracking and monitoring was found to be insufficient in a number of areas that the Representative had hoped to analyze for this report as it was either not collected or varied greatly from one health authority to the next. For example, although the Ministry of Health informed RCY it believes Indigenous children and youth are disproportionately hospitalized involuntarily, there is no data available on the number of Indigenous children – or specifically the number of First Nations, Métis and Inuit children – who are admitted under the *Mental Health Act.* The Representative was unable to use data received from the Ministry of Health regarding length of time that children and youth are detained under the *Mental Health Act* out of concerns raised by the health authorities about its accuracy. In addition, the number of children under age 16 who are hospitalized at the request of their parents and without their consent is unknown and health authorities were not able to provide data on the frequency of second medical opinion requests. Similarly, it was impossible to assess compliance and effectiveness of the use of secure rooms and seclusion without reviewing individual patient files.

This lack of data on vulnerable young people leaves a gap in understanding the full effect of B.C.'s *Mental Health Act.* Data assists in finding patterns, in identifying population impacts, in ensuring rights are upheld and in recognizing areas for improvement – all vitally important issues, and even more so where the deprivation of liberty is involved.

The report also finds that oversight of restraint and confinement measures – which may be experienced as traumatizing – is inadequate. Use of these practices demands rigorous oversight and accountability. It is concerning that legislation and regulation to guide the use of these measures does not exist – although there is legislation and regulation to govern the use of restraints in residential care facilities licensed under the *Community Care and Assisted Living Act* and the use of restraints and confinement in youth custody centres.

Other important findings in the report include the lack of opportunity for young people detained under the *Mental Health Act* to have a say in treatment options that are more trauma-informed, relational and diverse rather than exclusively medical, and to stay connected with family and culture to help deal with underlying causes of their symptoms. RCY heard that what the young people most yearned for while experiencing detention was connections with family, friends and community to support healing, instead of the loneliness and separation felt in the hospital setting.

This report includes 14 recommendations to a number of public bodies. The recommendations are presented in five themes and include, in summary:

Overarching:

1. Identify why involuntary mental health detention for children and youth is increasing and opportunities to reduce these admissions
2. Standardize the collection and reporting of key data pertaining to children and youth admitted under the *Mental Health Act.*

Admission:

1. Review and reconcile the section of the *Mental Health Act* that allows a child under 16 to be admitted on a voluntary basis at the request of their parent or guardian
2. Develop a process to enable a First Nations, Métis or Inuit child or youth to notify their community or Nation of their involuntary admission.

Rights:

1. Notify an independent body every time a child or youth is detained under the *Mental Health Act* and mandate this body to provide rights advice and advocacy
2. Develop new informational materials provided to children and youth detained under the *Mental Health Act* that explain what is happening, their rights and options
3. Ensure First Nations, Métis or Inuit children and youth who are detained under the *Mental Health Act* are offered services by staff who assist Indigenous patients
4. Allow children and youth detained under the *Mental Health Act* to retain personal items that do not pose a risk to their safety or the safety of others.

Treatment:

1. Ensure First Nations, Métis, Inuit and urban Indigenous children and youth detained under the *Mental Health Act* receive trauma-informed, culturally safe and attuned mental health services

2. Review practices for: a) children under 16 who have been voluntarily admitted and ensure "mature minor" capacity assessments are carried out prior to treatment; and b) children assessed as mature minors who have been involuntarily admitted
3. Amend the *Mental Health Act* to ensure isolation and restraint are only used as a last resort and only in accordance with legislative or regulatory criteria
4. Conduct a review of extended leave to assess its effectiveness, review the need for oversight mechanisms and whether children and youth are aware of their rights on extended leave.

Reviews:

1. Create mandatory periodic Mental Health Review Board reviews for involuntarily detained children and youth and children under 16 who are admitted at the request of their parents
2. Pilot a new Review Board hearing process for children and youth that is trauma-informed and culturally attuned.

Many opportunities exist to improve the experience of children and youth involuntarily detained under the *Mental Health Act.* Research for this report calls into question – again – whether B.C.'s voluntary system of mental health and concurrent mental health substance use services is able to meet the needs of children and youth. Given the stakes associated with involuntary admission – liberty and security of the person – it is imperative that there is a robust system of voluntary mental health care services in place as well as strong procedural safeguards to ensure that, when this extraordinary power is applied, it is done so appropriately and only to the extent necessary.

A Note on Terminology

Mental health detentions are commonly referred to as "certifications," as "being sectioned," or as "involuntary admissions." Children and youth who come into contact with the mental health system may identify themselves in different ways. This report uses the term mental health "detentions" to describe the involuntary admissions of children and youth in designated hospitals under the *Mental Health Act*. The Representative has chosen to use the term "detention" as it is the statutory language used in the *Mental Health Act*.

In addition to the use of the word "detentions," there are a number of references in this report to "residential" services. The Representative acknowledges that the term "residential" has specific meaning to Indigenous people and acknowledges the harm done to Indigenous children, families and communities from residential schools in British Columbia and across Canada.

Currently, the Ministry of Children and Family Development and the Ministry of Health use the term "residential" when referring to residential services provided to children in care who live in staffed residential resources and to residential mental health services. The Representative encourages the systems to change the way they reference these types of services. In the meantime, for the purposes of this report, the Representative has had to use the term "residential" as it is the term used to refer to those services.

Addressing Racism Review – The *In Plain Sight* report

Indigenous young people engaged for this report relayed experiences of racism and the lack of culturally safe and relevant treatment while they were involuntarily detained under the *Mental Health Act*. In addition, during the course of research for this report, Indigenous service providers and leaders expressed serious concern to RCY about the absence of culturally relevant mental health supports for First Nations, Métis and Inuit children and youth, and non-existent funding to provide these services.

The Representative finds it troubling that, considering these issues, no data is monitored on the number of Indigenous young people impacted by involuntary detention, particularly in light of the racism experienced by First Nations, Métis, Inuit and urban Indigenous children and youth in hospitals, as documented in the recent report, *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care*.[5]

In June 2020, former Representative for Children and Youth Mary Ellen Turpel-Lafond was appointed by B.C. Health Minister Adrian Dix to lead an independent Review into allegations of Indigenous-specific racism and discrimination in the provincial health care system.

The Review released *In Plain Sight* on Nov. 30, 2020, which found that *"Indigenous people in B.C. are exposed to widespread racism that often results in negative experiences at the point of care, inequitable medical treatment, physical harm and even death."* The Review found *"clear evidence of pervasive interpersonal and systemic racism that adversely affects not only patient and family experiences but also long-term health outcomes for Indigenous peoples."*

Racism in health care is grounded in the ongoing effects of colonialism and, unfortunately, it is common. Nearly 60 per cent of Indigenous health care workers surveyed by the Review said they had personally witnessed interpersonal racism or discrimination directed toward Indigenous patients, while more than one-third of non-Indigenous health care workers said that they had witnessed such occurrences.

More than one in five respondents to the Review's Indigenous Peoples' Survey (IPS) seeking patient experiences reported that they were likely to feel *"not at all safe"* while accessing health care. They were most likely to feel *"not at all safe"* in institution-like settings, including hospitals.

The Review found that experiencing racism can often lead to mistrust or avoidance of the health care system, an over-reliance on emergency care and poorer health outcomes.

With regard specifically to mental health services, 23 per cent of respondents to the IPS reported feeling *"not at all safe"* when accessing mental health and substance use services. Recommendation 17 of the Review called on the B.C. government and the First Nations Health Authority to *"demonstrate progress on commitments to increasing access to culturally safe mental health and wellness and substance use services."*

The Review reports also examined the context of health services through a rights lens. *"The Indigenous right to health means that Indigenous peoples should have full access to health care services in ways that reflect and are responsive to Indigenous worldviews and conceptions of health, without discrimination ... . In November 2019, the B.C. government passed the* Declaration on the Rights of Indigenous Peoples Act (DRIPA). *The federal government has also committed to pass legislation to implement the UN Declaration. Upholding the Indigenous right to health, including as reflected in the UN Declaration, is now firmly established as the foundation for addressing discrimination and racism against Indigenous peoples in B.C.'s health care system. This means identifying the work that must be done to implement Indigenous understandings of health, full access to culturally-appropriate health care services for Indigenous individuals, and Indigenous self-determination in health care – including through changes in laws, policies and practices, as well as roles for Indigenous institutions."*

Echoing the findings of *In Plain Sight, Detained: Rights of children and youth under the Mental Health Act* specifically addresses the mental health system experiences of First Nations, Métis, Inuit and urban Indigenous children and youth in Recommendations 4, 7 and 9.

[5] Addressing Racism Review, *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care* (Victoria, 2020)

Scope and Methodology

This report focuses on the application of involuntary provisions of the *Mental Health Act* to children and youth, and is informed by young people with lived expertise. It explores the administration of the system for involuntary detention under the *Mental Health Act* and examines the subjective experiences of children in the involuntary youth mental health system. The report builds on previous reports from the Ombudsperson and the Community Legal Assistance Society (CLAS) by examining the perspective of children and youth admitted under the *Mental Health Act*.[6, 7]

Drawing on multiple sources of information, this report seeks to understand how B.C.'s *Mental Health Act* functions, how it is meant to function and what might be done to better hear the voices of children and youth who are experiencing a mental health crisis. Information sources include RCY and external data, a review of legislation, regulations and guidelines, interviews with key stakeholders and in-depth engagement of young people who have experienced detention under the *Mental Health Act*. This report does not review practice nor reflect the experience or perspectives of service providers, but rather centres the experiences of youth.

Engagement with Young People

To learn more about how young people experience involuntary detention under the *Mental Health Act*, the Representative partnered with InWithForward, a B.C. organization that specializes in social research. During August and September 2019, InWithForward met with 14 young people who were detained under the *Mental Health Act* during their adolescence. InWithForward's ethnographic approach strives to dive deeply into the experiences of a small number of youth purposefully chosen, and is not necessarily a representative sample. Through InWithForward, these young people shared with RCY their understanding of the *Mental Health Act* and their experience within hospitals and with medical professionals as they grappled with what it meant to be assessed, certified, treated and discharged as many as 21 times.

Some of the young people felt strongly about using their own names in this report, however, s.20 of the *Representative for Children and Youth Act (RCY Act)* does not authorize the Representative to disclose personal information in a special report necessitating the Representative to use psuedonyms. To learn more about these young people, see Appendix 2.

[6] The Office of the Ombudsperson, *Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act* (Victoria, 2019)

[7] Community Legal Assistance Society, *Operating in Darkness: BC's Mental Health Act Detention System* (Vancouver, 2017)

YOUTH VOICES

"I felt like they took away a piece of me that's unique and just wanted me to match everyone else."

JOHN

"I would wanna be painting while I was crying … they treated it like a hobby instead of a coping mechanism."

STEVE

"I just felt so written off like just another Aboriginal youth. … Now I'm in my 20s I'm like 'Wow! I have a voice! I'm powerful!'"

ADRIANNA

"I've been dealing with mental health since I could remember. It's a really big weight on your shoulders."

RAI

"What people see me as isn't the same as how I see me as, and I don't even know what I am."

LILY

"I'd wake up … and either be calm and go back to sleep or freak out and get sedated again … . It was like that for about three months. It's just a big blur."

SEAN

"They said I could call a lawyer. I don't have one and I hate court. I just waited it out. I was an eagle trapped in a cage. I can't fly or enjoy things. They took that away from me."

CHARLIE

"Having an adult taking interest in me and actually caring about my mental health … I didn't really exactly have much of that other than my grandfather."

SAMUEL

The young people who are brave enough to speak in this report were detained at different ages, with different diagnoses, gender and cultural identities. The young people come from Prince George, Vancouver, New Westminster, Abbotsford and Victoria. They range in age from 16 to 29, and their age at the time of first admission ranged from 10 to 18. The length of admissions varied, with 10 of the young people experiencing detentions of one month or longer; six were detained three or more months; and two were detained for six months.

Three of these young people identified as female, six as male, two as transgender male, two as transgender female and one as two spirited. Four of the young people self-identified as Indigenous and one described their identity as Cree, Mohawk, Aboriginal and First Nations. Ten youth identified as white or Caucasian. Eight were in the care system around the time of their certification, describing removal, placement, broken placements and the ongoing search for belonging as significant contributing factors to their mental wellness.

For more information on InWithForward's process, see Appendix 3.

Data Collection

RCY drew from a variety of external and internal data sources for this report. Consultations were conducted with 19 key stakeholders between August 2018 and November 2019 and during the project completion phase between August and September 2020 including child advocacy organizations, First Nations and Métis leadership, experts in the mental health field, health care professionals, lawyers and government bodies. Particular attention was paid to consulting with Indigenous stakeholders in order to understand the unique implications of detentions under the *Mental Health Act* for Indigenous children and youth. A list of project participants is presented in Appendix 4.

Information that was provided by six of the province's health authorities, the Ministry of Health, Ministry of Children and Family Development (MCFD), the Mental Health Review Board and the Legal Services Society was analyzed. Internal data included critical injury and death reports that RCY receives for children and youth receiving a reviewable service at the time of or within the year prior to their injury or death.[8] The analysis of these injury and death reports for children and youth who had experienced a mental health hospitalization in their lifetime is in Appendix 5.

Mental Health Review Board

The Mental Health Review Board is an independent tribunal established under the *Mental Health Act*. The Review Board conducts review hearings on the involuntary admission of patients under the *Mental Health Act*.

In addition, the Representative reviewed relevant legislation, regulations and guidelines pertaining to B.C.'s *Mental Health Act*, *Infants Act* and *Administrative Tribunals Act*, along with legislation and practices in other jurisdictions and international rights conventions. A scan of relevant literature was conducted with a focus on youth experience of involuntary mental health treatment and detentions.

For more information on RCY's methods, see Appendix 5.

[8] Reviewable services are outlined in the *RCY Act* and include services or programs under the *Child, Family and Community Service Act* and the *Youth Justice Act*; mental health services for children; and addiction services for children.

Background

B.C.'s *Mental Health Act* was first enacted in 1964 and the legislation has been updated many times since then. For the most part, the provisions of the *Mental Health Act* apply to children and youth in the same way they apply to adults. As a piece of legislation, it recognizes that for some people, involuntary care is necessary to keep them, or others, safe. This legislation raises issues in two key areas: society's concern for the treatment of persons suffering from mental disorders, given the impacts of some disorders on a person's life and health, on loved ones and sometimes on the public; and the infringement of personal liberty and autonomy that is involved when people are committed to a hospital against their will, and then administered medications or other invasive treatments also without their consent. While historically autonomy and protection have been viewed as being in opposition to each other, a more modern human rights understanding sees that supporting participation and autonomy can also enhance support, treatment and recovery. This interpretation underscores why voice and autonomy are key themes in this report.

In 1982, the *Canadian Charter of Rights and Freedoms* came into effect, guaranteeing many rights and freedoms to Canadians, including the rights in Section 7:

> 7. *Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with principles of fundamental justice.*

There have been a number of *Charter* challenges to mental health legislation across Canada. It is now well accepted that involuntary admission and forced treatment violate a person's liberty and security of the person. However, this by itself does not determine whether there has been a *Charter* breach. Infringements of liberty and security of the person will still comply with the *Charter* if they take place "in accordance with the principles of fundamental justice" or are "reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."[9, 10]

Child Participation or Voice of the Child

Child participation is about children having the ability to express their views and their views being taken seriously in accordance with their age and maturity. The importance of the voice of the child is reflected in domestic law and international human rights conventions, including the *UN Convention on the Rights of the Child*, the *UN Declaration on the Rights of Indigenous Peoples* and the *UN Convention on the Rights of Persons with Disabilities*. (See Appendix 1 for a summary of the relevant human rights Conventions.)

B.C.'s *Mental Health Act* criteria for involuntary admission has been upheld by the courts as being compliant with the *Charter*.[11] However, there are aspects of the Act that have not yet been subject to *Charter* scrutiny. One example is the section of the Act that allows an involuntary patient to be

[9] *Charter of Rights and Freedoms*, Part 1 of the *Constitution Act*, 1982, being Schedule B to *Canada Act* 1982 (UK), 1982, s.7.

[10] *Charter of Rights and Freedoms*, Part 1 of the *Constitution Act*, 1982, being Schedule B to *Canada Act* 1982 (UK), 1982, s.1.

[11] In *McCorkell v. Riverview Hospital (Director)*, [1993] B.C.J. No. 1518 (S.C.), the Supreme Court of British Columbia held that an earlier version of the Act (pre 1998) struck a "fair balance" between individual rights and individual protection and did not use criteria that were too vague to apply. In *Mullins v. Levy*, 2009 BCCA 6, the B.C. Court of Appeal examined the 1998 amendments and found that even though the criteria had changed, they also struck a fair balance and were not too vague to apply.

administered treatment against their will.[12] Other potential *Charter* issues arise from the section of the Act that appears to allow children under 16-years-old to be admitted and treated against their will at the request of their parents, even if the child is a mature minor and even if they don't otherwise meet all the criteria for admission that are required for persons 16 or older.

It is not the Representative's role to make findings about whether the *Mental Health Act* or its administration violates the *Charter* rights of children. However, a review of *Charter* cases is valuable for many reasons, not least because the cases reveal the differing approaches that different provinces take to mental health regulation generally. The cases point to the great importance of careful policy analysis when governments strive to strike a fair balance between competing interests in this sensitive and difficult area.[13]

Mental Health Services for Children and Youth in B.C.

Mental health services for children and youth may be delivered in community, in residential settings or in hospital. Oversight, funding and delivery of services is the shared responsibility of MCFD and the province's health authorities. MCFD is responsible for the delivery of community-based services and forensic psychiatric services for children and youth, as well as the Maples Adolescent Treatment Centre, while health authorities are responsible for the delivery of hospital-based services for individuals across their lifespan, including several specialized mental health facilities for children and youth.[14, 15] Health authorities also deliver community-based programs including outpatient programs, specialized outreach teams, collaborative psychiatric care for underserved and remote populations and, in some health authorities (e.g., Island Health and Fraser), Early Psychosis Intervention (EPI).

Through its Child and Youth Mental Health (CYMH) services, MCFD provides or funds community-based mental health services across the province for children and youth with mental health issues from birth to 18-years-old. CYMH teams operate approximately 100 walk-in intake clinics throughout B.C. which offer voluntary services and supports including mental health promotion and prevention, early intervention, treatment and support services and specialized programs for children, youth and their families. Many locations offer therapeutic groups and parenting skills sessions and can provide children

[12] Section 31(1) of the *Mental Health Act* states that *"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 37 or 38, treatment authorized by the director is deemed to be given with the consent of the patient."* In *MacLaren v. British Columbia (Attorney General)*, 2018 BCSC 1753, the plaintiffs asked the court to strike down this provision. The Court decided that the case could not be heard because the two individual plaintiffs had discontinued and the Council of Canadians with Disabilities did not meet the test for "public interest" standing. The Supreme Court of British Columbia's decision that the Council of Canadians with Disabilities did not have public interest standing was overturned on appeal in *Council of Canadians with Disabilities v. British Columbia (Attorney General)*, 2020 BCCA 241. The constitutional validity of the "deemed consent" provisions therefore remains outstanding.

[13] This can be seen in cases from other jurisdictions, including: *P.S. v. Ontario*, 2014 ONCA 900, which found that civil mental health tribunals were constitutionally required to have jurisdiction to supervise the conditions of long-term detainees; *Zaugg v. Ontario (A.G.)*, 2019 ONSC 2483, which struck a claim challenging the Ontario *Mental Health Act* before it was adjudicated at trial; and *JH v Alberta (Minister of Justice and Solicitor General)*, 2020 ABCA 317, which struck down several provisions of the Alberta *Mental Health Act* for providing insufficient protections against unreviewed detention.

[14] Hospitals designated as psychiatric units under the *Mental Health Act* with specialized facilities for children and youth include: BC Children's Hospital's child and adolescent psychiatric units and in-patient eating disorder unit; Lionsgate Hospital Carlisle Youth Concurrent Disorder Centre; and adolescent psychiatric units at Surrey Memorial Hospital, Kelowna General Hospital and University Hospital of Northern British Columbia.

[15] Admission data for MCFD-delivered inpatient mental health programs is summarized in Appendix 8.

and youth direct access to psychological or psychiatric services or arrange these services through a referral.

MCFD also delivers or funds distinct Indigenous-focused mental health services for children – called Aboriginal Child and Youth Mental Health (ACYMH) teams – in some areas of the province. ACYMH teams deliver core CYMH service functions as well as services designed to respond specifically to First Nations, Métis, Inuit and urban Indigenous children and youth. Indigenous children and youth may be able to access other mental health services through their nations, chartered communities or local Aboriginal Friendship Centres, however due to limited funding, not all are able to provide mental health services and there is wide range among those that do. Overall, there is a widely acknowledged need for more community based mental health services for Indigenous children, including those living in urban areas.

Regional Health Authorities:

- Fraser Health Authority
- Interior Health Authority
- Northern Health Authority
- Vancouver Island Health Authority
- Vancouver Coastal Health Authority.

Province-Wide Health Authorities:

- Provincial Health Services Authority
- First Nations Health Authority.

Friendship Centres

Friendship Centres are non-profit community hubs that provide services to Indigenous peoples living in 25 urban communities in B.C. They provide a welcoming space for all members of the community to share knowledge and connect with others to support wellness, and offer a range of culturally safe programs and services. Depending upon funding, some Friendship Centres are able to provide child, youth and family mental health supports.

Previous RCY Reports on the Mental Health System

RCY has produced multiple reports and investigations that address aspects of the child and youth mental health care system. These reports include:

1. *Still Waiting: First-Hand Experiences with Youth Mental Health Services in B.C.* (2013)
2. *Paige's Story: Abuse, Indifference and a Young Life Discarded* (2015)
3. *A Tragedy in Waiting: How B.C.'s mental health system failed one First Nations youth* (2016)
4. *Missing Pieces: Joshua's Story* (2017)
5. *Broken Promises: Alex's Story* (2017)
6. *Time to Listen: Youth Voices on Substance Use* (2018).

Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C. reviewed mental health services available to youth ages 16 to 18 in order to determine how responsive the system is to the needs of these youth and their families. While other RCY reports focused on the voluntary system of care, the *Still Waiting* report made several observations that are relevant to the exploration of involuntary mental health treatment in this report:

- Youth and their families experience too many barriers to mental health services, including a lack of understanding of mental health problems, long wait times and services that are not designed for youth
- Mental health services are fragmented and difficult for families to navigate.[16]

RCY has further raised concerns about the inadequacies of mental health services for children and youth, including a lack of promotion, prevention and early intervention, as well as service navigation and availability issues. RCY has called for the creation of a comprehensive and responsive system of mental health services for children and youth.[17] The then-newly formed Ministry of Mental Health and Addictions (MMHA) recognized these concerns in its 2019 strategic document, *A Pathway to Hope: A roadmap for making mental health and addictions care better for people in British Columbia* (the Roadmap), a new vision for B.C.'s mental health and addictions care. The Roadmap noted that the B.C. mental health system is "fragmented" and lacks consistency in delivery and oversight.[18]

In the Roadmap, MMHA sets out actions to be taken over the next three years, including improving wellness for children, youth and young adults. Key pillars in working toward this goal are prevention, early intervention and wellness promotion and the seamless and integrated care of children and youth.[19] The Roadmap calls for the expansion of Foundry centres and strengthening partnerships with Indigenous communities to build capacity to deliver culturally appropriate services.[20, 21] These commitments are in the early design and implementation phases. The province announced funding for 123 new youth substance-use treatment and withdrawal-management beds in August 2020 with locations to be determined in consultation with health authorities.[22] However, the demand for community mental health services for children and youth continues to exceed their availability. As of May 1, 2020, 2,531 children and youth were waitlisted for CYMH services and the average wait time was 53.9 days.[23]

[16] Representative for Children and Youth, *Still Waiting: First-hand Experiences with Youth Mental Heath Services in B.C.* (Victoria, 2013).
[17] RCY, *Missing Pieces: Joshua's Story*, 2017
[18] Ministry of Mental Health and Addictions, *A Pathway to Hope: A roadmap for making mental health and addictions care better for people in British Columbia* (Victoria, 2019), 3.
[19] Ministry of Mental Health and Addictions, *A Pathway to Hope: A roadmap for making mental health and addictions care better for people in British Columbia* (Victoria, 2019), 17.
[20] Foundry is a province-wide network of integrated health and social service centres for young people ages 12 to 24. Foundry centres provide a one-stop-shop for young people to access mental health care, substance use services, primary care, social services and youth and family peer supports.
[21] Ministry of Mental Health and Addictions, *A Pathway to Hope: A roadmap for making mental health and addictions care better for people in British Columbia* (Victoria, 2019), 19.
[22] Ministry of Mental Health and Addictions. News Release. https://news.gov.bc.ca/22859.
[23] Data provided to RCY staff at briefing by MCFD staff, May 2, 2020.

Despite the creation of MMHA and the work it is undertaking, the Ministry of Health continues to be responsible for the *Mental Health Act*.[24] The Ministry of Health has established provincial standards to improve compliance with the *Mental Health Act* in response to the Ombudsperson's recommendations and has collaborated with MMHA on the establishment of a quality improvement framework to improve compliance with the Act and supporting the safety of patient care under the involuntary admission process. However, the Ministry of Health has not committed to reviewing the *Mental Health Act* to bring it in line with evidence-based best practices.[25]

While several reports issued by the Representative over the years point to problematic aspects of mental health services, the use of involuntary detention and young people's experience of detention has yet to be explored. Many reports received by RCY about the use and impact of involuntary detentions for youth, as well as reports detailing injuries and deaths of children who have experienced involuntary detention under the *Mental Health Act*, have raised questions about children's experiences throughout the process of detention. One such report was for a young person named Christina.[26]

Christina's Story[27]

Christina is a First Nations girl from a small B.C. community. Her parents both experienced abuse as children and grew up in the child welfare system. When Christina was born, her parents were actively using substances. Before she turned one, Christina and her older sibling were removed from their parents' care due to concerns of neglect.

While in care, Christina was moved outside of her home community and through 13 different placements including a failed adoption attempt and an adoption that eventually broke down. As Christina got older, she and her sibling were separated, despite their wishes to remain together.

As a teenager, Christina was diagnosed with multiple mental health and behavioural challenges. She began to misuse substances and overdosed multiple times. Her caregivers were concerned that she was being sexually exploited. Christina and a much older boyfriend often lived in "tent cities" or camped in the bush.

In her mid-teens, Christina was involuntarily detained under the *Mental Health Act* for the first time, due to concerns that she may have been experiencing psychosis and that she was at risk of self-harm. It is unclear whether Christina was aware of and understood her rights under the *Mental Health Act*. Christina was released the next day without any community plan or safety plan. Despite Christina's often expressed wish to be placed with her older sibling, she was moved to a home without her sibling and her situation continued to worsen.

[24] The Ministry of Health is responsible for the *Mental Health Act* with the exception of Sections 24.1 and 24.2, which are the responsibility of the Attorney General and Minister Responsible for Housing.

[25] The Office of the Ombudsperson, *Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act* (Victoria, 2019).

[26] This story has been anonymized to protect the identify and privacy of the individual involved. The name "Christina" is a pseudonym.

[27] Christina's story is gleaned from a review conducted by RCY staff using documentation produced by the Ministry of Children and Family Development.

After numerous hospital admissions for substance use and mental health concerns over the following two months, Christina was admitted for the second time as an involuntary patient under the *Mental Health Act* and placed on "extended leave" from the hospital approximately two weeks later. Extended leave for Christina meant she could live in a resource outside of the hospital but was required to be at the resource at all times, attend all medical appointments and adhere to all medication and counselling requirements. If Christina violated these conditions, she could be recalled to the hospital. One of her conditions included receiving involuntary injections of medication. It is unclear how Christina understood her extended leave, or if she understood her rights while on extended leave.

The resource Christina was placed in raised alarms to MCFD and hospital staff a number of times about its inability to meet the stringent conditions of her extended leave, but no alternative measures or supports were identified. Instead, it seems the threat of being recalled to hospital was used to try to ensure Christina complied with her treatment plan. Christina's substance misuse worsened and she continued to overdose, experience mental health crises and be readmitted to hospital for failing to adhere to the conditions of her extended leave.

When Christina was finally given the opportunity to live with her older sibling, her situation improved. Although her extended leave under the *Mental Health Act* continued, the requirements were amended and she had fewer conditions and less medication. Christina and her older sibling were able to return to their home community to visit and connect with family. Christina was an involuntary patient on extended leave for more than a year.

Eventually, Christina was discharged from extended leave after a Mental Health Review Board panel hearing. Today, Christina receives community-based mental health and substance use services and lives in a specialized placement that offers outreach support.

Christina's experience raises a number of important questions. How do youth experience involuntary detention? How aware are young people of their rights under the *Mental Health Act*? What voice do young people have when they are involuntarily admitted? What supports do youth have to exercise their rights? How does the experience of involuntary admission impact them in both the short and long term and what can be done to help such a person connect, or reconnect, with their family or other supports?

The *Mental Health Act* and its Safeguards

B.C.'s *Mental Health Act* sets out criteria for both voluntary and involuntary admission of those with mental disorders to designated facilities.[28, 29]

For involuntary patients, certification under the *Mental Health Act* requires one physician to complete a certificate for the designated director to detain a patient for up to 48 hours and a second physician to complete a certificate for the designated director to continue detention beyond 48 hours.[30] After the second certificate is signed, a patient can be detained for up to one month. After the first month, certification must

[28] "Person with a mental disorder" is defined as "a person who has a disorder of the mind that requires treatment, and seriously impairs the person's ability to (a) react appropriately to the person's environment or (b) associate with others."
[29] A "designated facility" is a provincial mental health facility, a psychiatric unit or an observation unit.
[30] "Designated director" means a person appointed under the regulations to be in charge of a designated facility.

be renewed for further detention. The first renewal certificate can extend the detention for an additional one-month period. The completion of a subsequent renewal certificate extends the detention for a further three-month period. All renewal certificates that follow would extend the detention for six-month periods. If at any time during a detention period the patient no longer meets the criteria for involuntary admission, the patient must be discharged. The detention periods are illustrated in Figure 1.

Figure 1: B.C.'s *Mental Health Act* Detention Periods

Certification Period	Certificate Required	Length of Detention Permitted
First period	First Admission Certificate (Form 4)	48 hours
Second period	Second Admission Certificate (Form 4)	1 month
Third period	Renewal Certificate (Form 6)	1 month
Fourth period	Renewal Certificate (Form 6)	3 months
Fifth period	Renewal Certificate (Form 6)	6 months
All subsequent periods	Renewal Certificate (Form 6)	6 months

Source: Adapted from Community Legal Assistance Society, *Operating in Darkness: BC's Mental Health Act Detention System, 2017*.

Insofar as the Act applies to children,[31] the Act operates differently depending on whether the person being admitted is over or under age 16.

Children ages 16 or older

For children 16 or older, the rules for voluntary and involuntary admission are the same as they are for adults:

> ***Voluntary admission:*** A person age 16 or older may be voluntarily admitted to a mental health facility if they request admission and the *Mental Health Act* designated director is satisfied that the person has been examined by a physician who believes that the person has a mental disorder. A "voluntary" patient who is 16 or older must be discharged at the patient's request.[32]
>
> ***Involuntary admission:*** A person age 16 or older may be involuntarily admitted to a mental health facility if a physician who has examined the person issues a medical certificate certifying that all four criteria for certification are met:
>
> - the person has a mental disorder for specified reasons
> - requires treatment by a designated facility
> - requires care to prevent the person's mental or physical deterioration or for the protection of the person or others, and
> - cannot suitably be admitted as a voluntary patient.[33]

[31] The *Representative for Children and Youth Act* defines "child" as a person under 19 years of age.
[32] *Mental Health Act*, s. 20(6)(b).
[33] *Mental Health Act*, s. 22.

Involuntarily admission triggers several important safeguards set out in the *Canadian Charter of Rights and Freedoms*, the *Mental Health Act* and Mental Health Regulation. These include:

(1) In addition to restrictions built into the detention periods noted above, when someone is involuntarily admitted, they are entitled to (a) written and oral notice of the name and location of the facility where they are detained, (b) notification of their circumstance to near relatives,[34] (c) notification of their right to talk to a lawyer under s. 10 of the *Charter*, (d) the right to be promptly provided with reasons for the detention, (e) the right to have the detention reviewed by an independent review panel or court, and (f) the right to request a second medical opinion on the appropriateness of the treatment authorized by the designated director.[35]

(2) The requirement for facilities to complete specific forms to explain their actions and protect the rights of patients. For example, "Form 4" explains the reason a patient has been detained and explains the patient's rights to contact a lawyer and to challenge the detention.[36]

Children under 16

While the *Mental Health Act* allows a child under 16 to be admitted on an involuntary basis using the "adult" pathway described above, it also creates a special "voluntary" admission pathway for the admission of a child under 16 at the request of a parent or guardian.

A child under 16 is considered a voluntary admission if their parent or guardian requests that they be admitted and the facility director is satisfied that the examining physician believes that the person has a mental disorder.[37]

The Act describes this path of admission as "voluntary" because it recognizes the legal rights of parents to make decisions on behalf of their children. However, from the perspective of the child under 16, the admission may not be perceived as voluntary. Moreover, if the child is a mature minor – a child with the legal capacity to make decisions despite their age and any mental health issues – these admissions are involuntary in every sense of the word.[38] The mature minor principle allows a child who has been assessed as being a mature minor to consent to treatment where, as would be the case for an adult, all the risks and options are provided so that the consent given is a truly informed consent.[39]

The Act appears to recognize that these voluntary admissions are not necessarily "voluntary" and sets out several safeguards for these admissions:

1. On admission, the child must be informed of the reason for their admissions and notified of their right set out in Section 10 of the Charter to talk to a lawyer and their right to an independent hearing by the Mental Health Review Board or court to challenge their detention.[40]

[34] "Near relative" includes a grandparent, parent, child, spouse, sibling, half sibling, friend, caregiver or companion designated by a patient.
[35] *Mental Health Act*, ss. 34, 34.2
[36] Mental Health Regulation
[37] *Mental Health Act*, s. 20
[38] "Mature minor" is the term that courts use to describe the concept that even though children are not given exactly the same decision-making rights as adults, they "are entitled to a degree of decision-making autonomy that is reflective of their evolving intelligence and understanding." *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30 (AC).
[39] *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30 (AC)
[40] *Mental Health Act*, s. 34.1

2. The child must be examined within each of the first two months after the date of admission, within three months of the second examination and, after that, within six-month periods. If the physician concludes at any of these examinations that the child does not have a mental disorder, the child must be discharged.[41]
3. The child must be discharged at the request of the parent or guardian, unless the facility director is satisfied that the child would meet all the conditions for certifying a patient over 16.[42]

Children under 16 and consent to treatment

Importantly, children under 16 who are voluntarily admitted at the request of a parent or guardian are not subject to the controversial "deemed consent to treatment" provisions of the *Mental Health Act*.[43] This raises the question of how physicians obtain legal authority to treat such children when the physician believes that psychiatric treatment is required.

A physician has no legal right to treat a child merely because they are a physician or because they believe the treatment is in the child's best interests. A physician must have legal authority to provide treatment. Since the deemed consent provisions of the Act do not apply to "voluntary" admissions of children under 16, the physician will ordinarily seek parental consent to treat the child. However, as discussed below, if the child is a mature minor, the parents cannot override the views of the child, and only a court order could authorize treatment against the child's will.[44]

Deemed Consent

If a patient is involuntarily detained in a designated facility or is released on leave, treatment authorized by the designated director is deemed to be given with the consent of the patient. This means that the facility director may authorize the treatment recommended by treating physicians without assessing a patient's capacity to make their own treatment decisions and without consulting a substitute decision-maker.

Mature minors

The Supreme Court of Canada has stated that, while a mature minor does not automatically have the same rights to consent to treatment as a competent adult, the mature minor principle "addresses the concern that young people should not automatically be deprived of the right to make decisions affecting their medical treatment."[45] It provides instead that the right to make those decisions varies in accordance with the young person's level of maturity."[46]

If a child is assessed to be a mature minor, the doctor must respect the child's views and wishes even if they are different from the parents' views. The only way in which a child's views could be overridden in that situation would be by court order based on what is best for the child.[47]

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[41] *Mental Health Act*, s. 20
[42] *Mental Health Act*, s. 20
[43] *Mental Health Act*, s.31
[44] *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30 (AC)
[45] AC, para. 58.
[46] AC, para. 46.
[47] In *A.C.*, at para. 56, the Court stated: *"…mature minor status at common law will not necessarily prevent the court from overriding that child's wishes in situations where the child's life is threatened. In such cases, the court may exercise its parens patriae jurisdiction to authorize treatment based on an assessment of what would be most conducive to the child's welfare, with the child's views carrying increasing weight in the analysis as his or her maturity increases."* Such a power is also set out in s. 29 of the *Child, Family and Community Service Act*: *"If a child or a parent of a child refuses to give consent to health care that, in the opinion of two medical practitioners, is necessary to preserve the child's life or to prevent serious or permanent impairment of the child's health, a director may apply to the court for an order under this section."*

The *Infants Act* allows a child who has been assessed as being a mature minor (a child or youth capable of making their own decisions) to consent to treatment when: a health care provider has explained the nature, consequences, benefits and risks of the treatment; the health care provider is satisfied that the child understands; and the health care provider has concluded that the treatment is in the child's best interests. Section 17 of the *Infants Act* allows for a mature minor to accept treatment but does not all allow them to refuse.

While the mature minor principle is easy to state, it is not always easy to apply – especially within a mental health institution following an admission requested by a child's parents, and where a mental health issue can in some cases affect a child's ability to provide consent to treatment.

A physician is not legally required to make or record an assessment about whether a child is a mature minor and thus capable of making decisions. Without this requirement, a child's voice could be lost or improperly disregarded when it comes to mental health treatment decisions.

Steve's Story[48]

Steve is a 21-year-old who describes himself as a helper, outgoing and a self-advocate. He is thought of as a kind and earnest urban Indigenous man who has been healing from traumatic childhood experiences, family breakdown and mental health hospitalizations that he didn't find to be particularly helpful or supportive. Steve's first hospitalization was a voluntary admission for suicidal ideation at the age of 14. At the time, he wanted to work through the trauma of his failed adoption and subsequent return to the foster system. Instead, he felt isolated and not listened to when he asked for alternatives to medication during his hospitalization.

Steve experienced two more mental health hospitalizations after turning 19, including one in which he was detained under the *Mental Health Act*. He did not know about his rights, the Mental Health Review Board process or the option of receiving a second medical opinion about his treatment plan. Reflecting on his detention, Steve describes feeling shame and isolation, being restricted, being under constant surveillance, not being listened to and feeling like nobody cared. Steve was eventually diagnosed with PTSD and depression and wishes that he had been given space and support to deal with it earlier in his experiences with the mental health system.

The road map in Figure 2 shows the various pathways someone can take on a journey through involuntary detention as well as the various safeguards that exist along the way.

[48] Steve related his story to InWithForward as part of the ethnographic research conducted for this report.

Figure 2: Roadmap and Safeguards

YOUTH PATHWAYS IN AND OUT OF THE MENTAL HEALTH SYSTEM

IN

TO THE HOSPITAL

Go on your own.

Friend or family member takes you.

Police apprehend and take you.

Judge orders a warrant for your apprehension and assessment.

RIGHTS NOTIFICATION

Immediately upon admission, a young person must be notified of their rights.

Notification must also go to a near relative.

ONGOING DETENTION

A patient's admission may be renewed.

SAFEGUARD

At each renewal, the patient must be reassessed.

ADMISSIONS

May be admitted:

- Involuntary
- Voluntary:
  - by self, if *over 16*
  - by parent or guardian if *under 16*

INVOLUNTARY TREATMENT

Involuntary patients are deemed to consent to any treatment authorized by the designated director.

Treatment decisions for voluntarily admitted youth under 16 are made by their parents or guardians.

SAFEGUARDS

Treatment provided should be documented and discussed with the patient.

Involuntarily admitted patients may request a second medical opinion. (Voluntarily admitted patients – of any age – cannot request a second medical opinion.)

EXTENDED LEAVE

A patient may be authorized to continue compulsory treatment in the community

SAFEGUARD

The Mental Health Review Board is required to annually review a youth's "treatment record."

OUT

CHALLENGING A DETENTION

Young people may:

- apply to the court for an order to be discharged
- make a *habeas corpus* application for release
- apply to the Mental Health Review Board.

DISCHARGE

A youth may be discharged if a doctor, the Mental Health Review Board, or a court finds they no longer meet admission criteria.

WHAT'S NEXT...?

Critiques of the *Mental Health Act*

While the presence of specific safeguards within the *Mental Health Act* provide an important counterbalance to the extensive powers in the Act, recent reports raise significant concerns about compliance with, and oversight of, these safeguards.

The CLAS 2017 report, *Operating in Darkness: BC's Mental Health Act Detention System*, asserted that *"B.C. is considered the most regressive jurisdiction in Canada for mental health detention and involuntary psychiatric treatment."*[49] The report points to the lack of attention paid to the protections enshrined in the *Mental Health Act*, noting the lack of information gathering on involuntary admissions and compliance tracking and no effort to assess the effectiveness of the safeguards in place.[50] CLAS called for a complete overhaul of the *Mental Health Act* by an independent law reform commission.

The concerns articulated in the CLAS report were echoed and expanded upon in the B.C. Ombudsperson's 2019 report, *Committed to Change: Protecting the Rights of Involuntary Patients Under the Mental Health Act*. This report investigated how and to what extent legal safeguards were followed upon admissions under the *Mental Health Act*. The report found *"pockets of good practice,"* but overall it found a culture of practice within the health care system that minimizes or ignores the legal rights of involuntary patients, concluding that B.C.'s *"health authorities and the Ministries of Health and Mental Health and Addictions have not taken sufficient steps to uphold patient rights by implementing external oversight and internal management practices sufficient to ensure statutory compliance."*[51, 52]

While both the B.C. Ombudsperson and CLAS reports present evidence that the safeguards embedded in the *Mental Health Act* are not being observed, absent from those conversations is the impact of this piece of legislation on children and youth. A review of the available literature shows that little attention is paid to children and youth's interaction with this system of detention.

The observance of these safeguards is of equal importance for all children and youth, but the question of how they are best operationalized in practice raises the issue of who precisely these children are. Anecdotally, the Ministry of Health informed RCY that Indigenous children and youth are disproportionately represented in involuntary detentions under the *Mental Health Act*. However, this information is not collected by health authorities or by those tasked with the administration of the *Mental Health Act*. The failure to collect this information is depriving the system of information that is essential to ensuring that the rights and safeguards set out in the Act are given to the vulnerable children and youth who are actually impacted, and by means that reflect their actual backgrounds, cultures and ways of understanding.

This report builds on the reports from the Ombudsperson and CLAS by examining the perspective of children and youth admitted under the *Mental Health Act*.

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[49] Community Legal Assistance Society, *Operating in Darkness: BC's Mental Health Act Detention System* (Vancouver, 2017), 6.

[50] Community Legal Assistance Society, *Operating in Darkness: BC's Mental Health Act Detention System* (Vancouver, 2017), 165.

[51] The Office of the Ombudsperson, *Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act* (Victoria, 2019), 2-3.

[52] The Office of the Ombudsperson, *Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act* (Victoria, 2019), 3.

Pathways In

As seen in Figure 2, there are differing pathways that a child may take to be admitted to a designated facility for treatment under the *Mental Health Act*. Police can be involved in involuntary admissions through exercising their powers under the Act. Approximately 20 per cent of initial detentions of youth participating in this report involved the police.[53]

If a police officer apprehends the young person, they must be taken immediately to a physician for examination. A physician will then assess whether the young person meets the criteria for involuntary detention and signs a medical certificate for the designated director. Another pathway is a transfer from youth custody to a designated psychiatric facility. This, too, would require assessment by a physician.

Typically, when a young person requires assessment under the *Mental Health Act*, the young person is taken to the hospital. When RCY met with officers from the Victoria Police Department, the police questioned whether the hospital was the best place to assess children as it can be an overly stimulating environment geared toward physical health problems and not necessarily mental health problems. The Canadian Mental Health Association BC Branch shared with RCY its belief that, when necessary, children should be brought to the hospital by ambulance not by police.

Each of the 14 youth heard from for this report charted a unique course to detention. Figure 3 captures the pathways taken by these young people for their first involuntary admission.

"The majority of times, I've been handcuffed. If it was a nice officer, they would handcuff me in the front. If it was a dickhead, they'd handcuff me in the back. You're kind of treated like you're a criminal. They pat you down. They search you. You take off your shoes, empty your pockets. Sitting in the waiting room with a cop beside you, you think: I hope no one sees me … It's just embarrassing more than anything."

ALAN

The first time was when I was younger, 13, when they [family] read my texts. I had sprinted to my safe space. My mom's boyfriend had called the cops. I was in the river. They said if I ran, they would taser me. They cuffed me … it was so threatening as a kid."

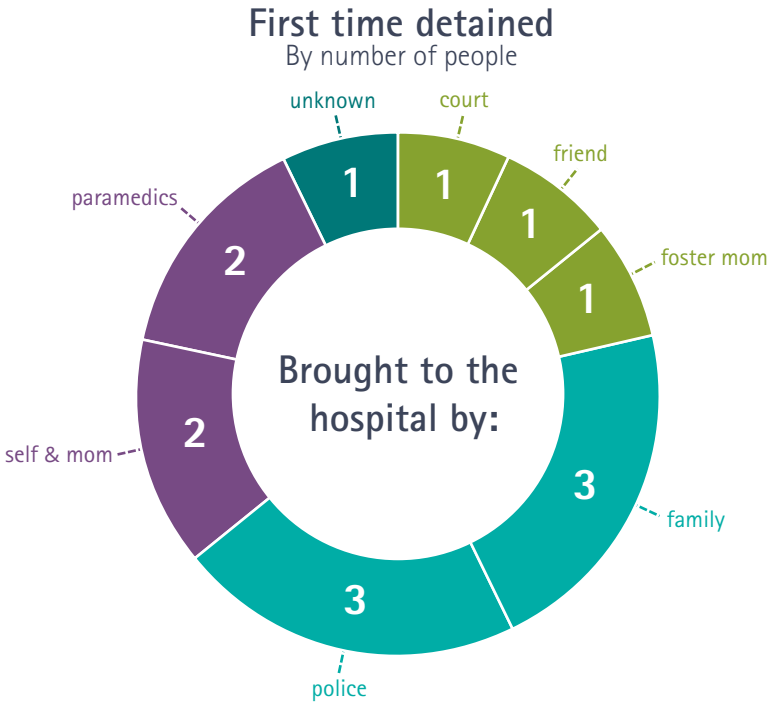
CHARLIE

"That day. I was really missing my mom … I went to the bathroom, I self-harmed really bad … I posted an alarming status on Facebook … got on Skytrain. As I was walking down the street, two police officers asked for my ID. They get into my bag. They arrest me, throw me into the back of the cop car. The cops didn't understand. The nurses didn't … One paramedic helped me; he just sat with me, but then he left."

ADRIANNA

[53] Section 28(1) states that *"a police officer or constable may apprehend and immediately take a person to a physician for examination if satisfied from personal observations, or information received, that the person (a) is acting in a manner likely to endanger that person's own safety or the safety of others, and (b) is apparently a person with a mental disorder."* Section 28(2) states that a person apprehended under this power *"must be released if a physician does not complete a medical certificate in accordance with section 22 (3) and (4)."*

Figure 3: First pathway to hospital for the young people engaged for this project[54]



Source: InWithForward

Reasons for Admission

As noted earlier, in order to admit a patient on an involuntary basis, a doctor must examine a patient and reach specific conclusions, including that the patient cannot suitably be admitted as a voluntary patient.

Mental Disorder

"Person with a mental disorder" means a person who has a disorder of the mind that requires treatment and seriously impairs the person's ability to (a) react appropriately to the person's environment or (b) associate with others.

Ministry of Health data on involuntary mental health hospitalizations of children and youth show that, over a five-year period 2013/14 to 2017/18, most stays were for primary diagnoses of mood or "neurotic disorders" (62 per cent) followed by schizophrenia and delusional disorders and substance use disorders (see Figure 4).[55, 56] In this period of time, the number of children and youth with substance use disorders as the diagnosis increased from 184 to 252 annually, representing 10 per cent of the total mental health diagnoses for involuntary hospitalizations of children and youth over the five-year period.[57]

[54] For the young people who reported their detention was a result of a court decision, it is unclear whether this was the result of an application under the *Mental Health Act* s.28(3) or as a diversion or referral through another court process.

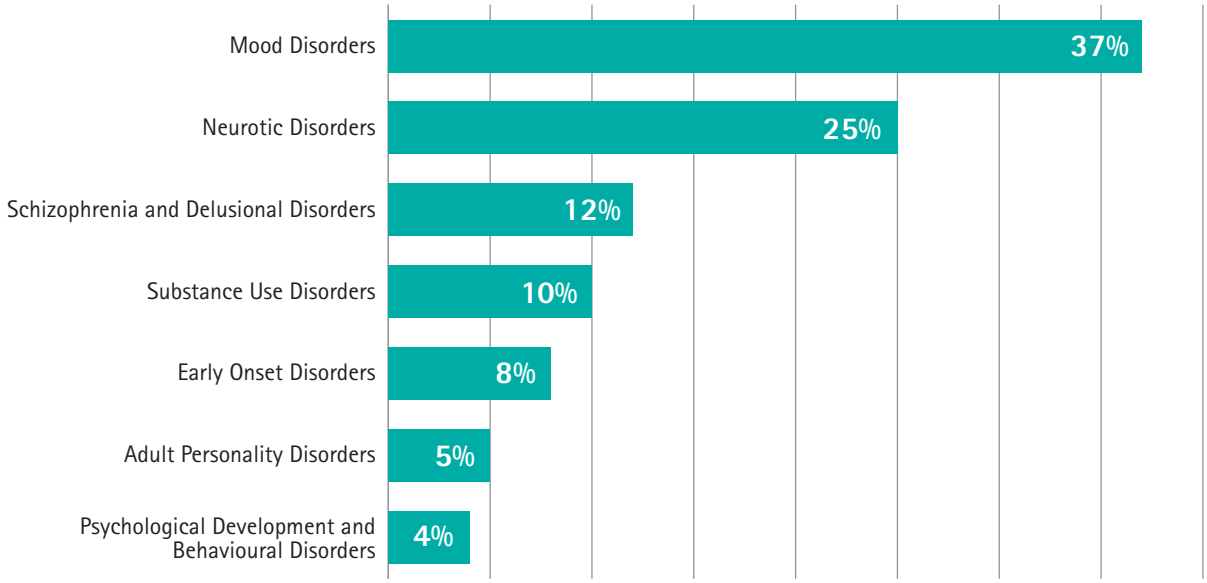
[55] Neurotic disorders category includes neurotic, stress related and somatoform disorders including anxiety disorders, obsessive compulsive disorders, reaction to severe stress, adjustment disorders, and dissociative disorders.

[56] The term "neurotic disorders" is no longer in common use. It was eliminated from the DSM in 1980. It is still used in Ministry of Health's database, but is not used outside of hospitals.

[57] Since patients are counted as involuntary if any portion of their hospitalization was involuntary, the primary diagnosis is not necessarily the reason child or youth was held under the *Mental Health Act* during the period of detention.

The *Mental Health Act* does not expressly authorize treatment for substance use disorder alone in the absence of a co-occurring mental health disorder. It is unclear if the data reported in Figure 4 giving substance use as a primary diagnosis relates to substance use disorder alone, to concurrent substance use and mental health disorders, or to a combination of both. The Representative is aware that some youth with problematic substance use have been detained for stabilization care in different parts of the province.

Figure 4: Category of diagnosis for children and youth with involuntary mental health hospitalizations (2013/14 to 2017/18)

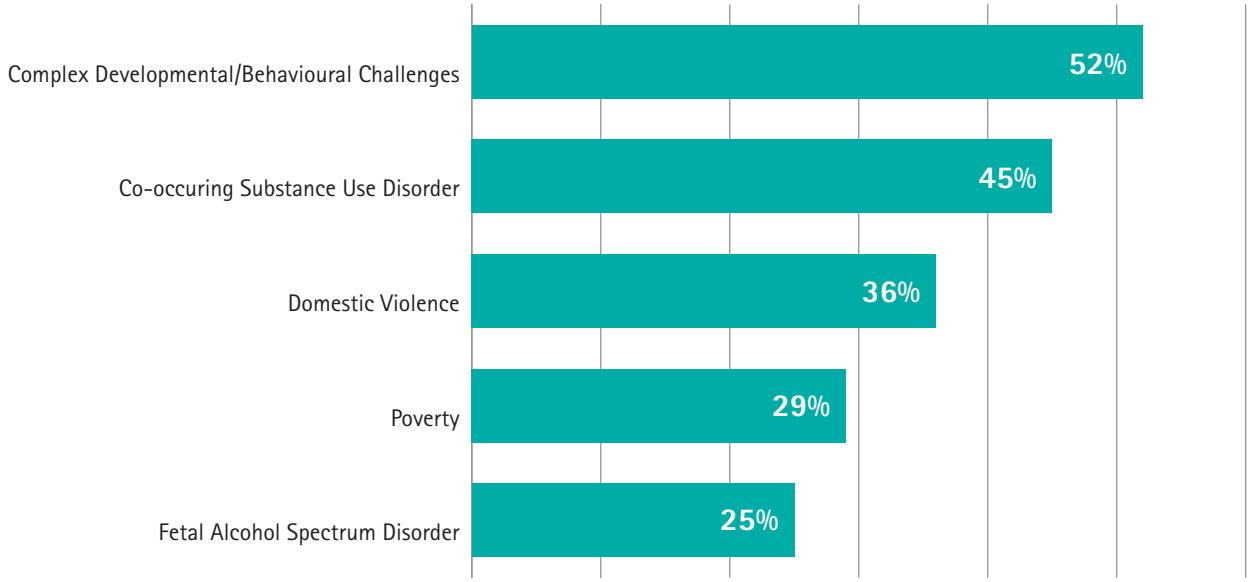


Source: Ministry of Health, extract of category of diagnosis by International Classification of Disease codes

Critical Injuries Reported to the Representative

RCY reviews critical injuries and deaths of children and youth who received reviewable services at the time of or within the year prior to their injury or death.[58] Staff analyzed injury reports from April 1, 2018 to Oct. 31, 2019 for the cohort of children and youth who had ever experienced a mental health hospitalization. The results highlight the complexities and adversities faced by this cohort, in addition to a mental health diagnosis (See Figure 5). There were 107 children and youth with injuries reported to RCY during this 18-month period who also had a mental health hospitalization. In this group, 45 per cent were noted to have co-occurring mental health and substance use challenges, 52 per cent had evidence of complex developmental/behavioural challenges and 25 per cent had suspected or confirmed fetal alcohol spectrum disorder. More than one-third had lived with domestic violence in their family and at least one-quarter had experienced poverty.

Figure 5: Additional issues faced by children and youth with mental health hospitalization and a critical injury reported to RCY from April 2018 to October 2019, 0 to 18-years-old (n = 101)



Source: Critical Injury and Death Reports received by RCY

[58] Reviewable services are defined in the *RCY Act* as those provided under the *Child, Family and Community Service Act* and the *Youth Justice Act*, mental health services for children, addiction services for children, or another government service, as designated by the Lieutenant Governor in Council.

Sammy's Story[59]

Described as friendly and kind, Sammy is a young woman whose story reflects many intersecting challenges. Like many children who experience detentions under the *Mental Health Act*, Sammy's life experiences have been complex. Sammy is a 19-year-old First Nations youth who spent most of her own childhood in the care of child services. Many of Sammy's family members are survivors of residential schools and her early life experiences included poverty, family member substance use challenges and exposure to domestic violence.

Shortly after Sammy was born, her mother moved to B.C. and, with MCFD's approval, placed Sammy in the care of family members. The ministry was aware that someone in the home had been convicted of violence against children. Two years later, Sammy's sibling disclosed ongoing abuse by this person to a community professional. Sammy and her siblings came into MCFD care and were placed together in a foster home. Pre-school-aged Sammy began receiving ongoing, long-term mental health counselling.

At 10-years-old, Sammy was adopted by her foster family with the consent of her mother and her band. She remained in contact with her biological family and visited her home community.

When Sammy was a young teen, she experienced anxiety, was using substances and was self-harming. She went to an Indigenous wellness program but was discharged after getting into a fight with another resident. By age 14, Sammy was experiencing considerable conflict with her adoptive mother, who reached out to MCFD for support services and planning. A year later, Sammy was once again brought into MCFD care. Over a period of five months, she was moved to multiple communities and foster homes and experienced sexualized violence. Sammy attempted suicide and was admitted involuntarily to hospital under the *Mental Health Act*. It is unclear whether Sammy was aware of her rights or how Sammy's voice was heard during this period of detention.

Upon discharge, Sammy was moved to a group home in another community. She was using substances and experiencing sexual exploitation. After multiple incidents with her group home staff, Sammy was moved to a foster home and then a shelter before ending up in a supported, semi-independent living suite. She went to substance treatment but chose to leave the program. Due to concerns for Sammy's safety, she was moved from her suite into a foster home. Sammy was offered life skills programs and had a large care team involved in supporting her, including youth workers, mental health workers, substance use workers and a social worker.

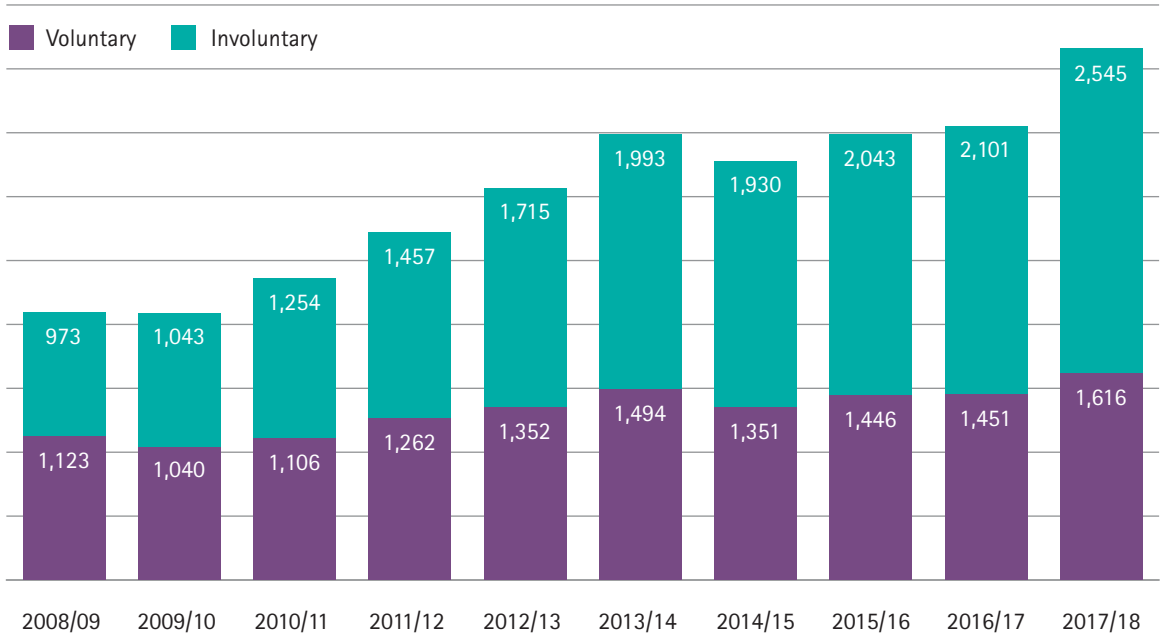
At age 17, Sammy experienced a near-fatal overdose. She informed her care team that she was finished with drugs and alcohol and she stopped using substances shortly after. Sammy worked with her care team to plan for her transition out of care at 19, which included moving her back into a semi-independent living suite and connecting her with adult support workers. Sammy is noted to be making incredible strides in her healing. She is recognized as a mature, independent and organized young woman who has been doing well and continues to benefit from support services.

[59] Sammy's story is gleaned from a review conducted by RCY staff using documentation produced by the Ministry of Children and Family Development.

A Growing Phenomena

In the decade between 2008/09 and 2017/18, involuntary hospitalizations under the *Mental Health Act*, as reflected in the number of discharges for all ages (children and adults), increased from 13,005 to 21,377.[60, 61] For children and youth admitted involuntarily, the increase over the same period of time was 162 per cent, from 973 to 2,545 annual discharges, while the increase for adults over this same period was 57 per cent, from 12,032 to 18,832 annual discharges. Voluntary admissions for children and youth in this period increased by 44 per cent from 1,123 to 1,616. In addition, the proportion of children and youth who were receiving mental health treatment in the hospital with involuntary status compared to voluntary also increased over this 10-year period, with those on involuntary status increasing from 46 per cent of these cases to 61 per cent (see Figure 6).

Figure 6: Voluntary and involuntary mental health hospital discharges for children and youth (0 to 18-years-old)



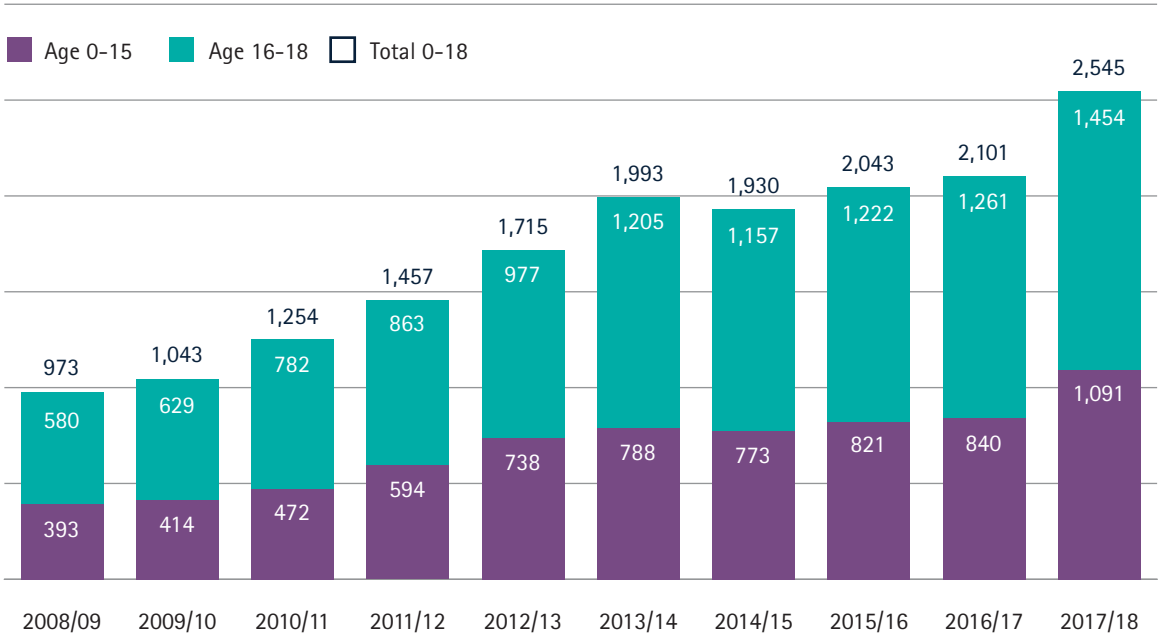
Source: Ministry of Health

[60] Ministry of Health – Admission under *Mental Health Act* data request.

[61] Since aggregate data is gathered after discharge, the fiscal year discharge data is not necessarily equivalent to the number of admissions in that same fiscal year. Some patients who were discharged would have been admitted during an earlier fiscal year. Involuntary status is assigned when a patient is detained under the *Mental Health Act* at any point during the duration of hospitalization.

In 2017/18, 4,161 discharges were reported for both involuntary and voluntary child and youth mental health hospitalizations. As seen above in Figure 6, 2,545 (61 per cent) of these had an involuntary status, and 1,616 (39 per cent) were voluntary. For the 16- to 18-year-olds in this cohort, two-thirds were involuntary hospitalizations. For their younger counterparts, just over half were involuntary (see Figure 7).[62] The count of discharges includes multiple discharges for patients who had more than one hospitalization within a single year.

Figure 7: Mental health hospital discharges with involuntary status, by age group[63]



Source: Ministry of Health

Fraser Health Authority accounted for the highest number of involuntary mental health hospitalizations for children and youth, with 963 discharges in 2017/18, which is 38 per cent of the provincial total. For the same period, Interior Health Authority reported 20 per cent of mental health detentions for children and youth, and the other four health authorities reported between nine per cent and 13 per cent (see Table 1).

[62] The number of under 16-year-olds that are detained involuntarily may be higher than the statistics reported because children under age 16 may be admitted on a "voluntary" basis by parents or guardians if the admitting doctor agrees. This may or may not be with the consent of the child and hence may in fact be a de facto involuntary admission.

[63] This data reflects total number of involuntary admissions by health authority and does not take into account population of each health authority.

Table 1: Mental health hospitalization discharges with involuntary status, by heath authority, 0 to 18-years-old

	Count of Involuntary Discharges			Proportion of Total Involuntary Discharges by Health Authority			Proportion of Population by Health Authority
	2015/ 2016	2016/ 2017	2017/ 2018	2015/ 2016	2016/ 2017	2017/ 2018	2017
Fraser	679	741	963	33%	35%	38%	42%
Interior	424	436	521	21%	21%	20%	15%
Northern	208	208	257	10%	10%	10%	7%
Vancouver Coastal	222	212	223	11%	10%	9%	21%
Vancouver Island	276	271	326	14%	13%	13%	15%
PHSA	234	233	255	11%	11%	10%	-
Total	**2043**	**2101**	**2545**	**100%**	**100%**	**100%**	

Source: Ministry of Health

Although as previously noted the Ministry of Health told RCY that it believes Indigenous children and youth are disproportionately hospitalized involuntarily, there is no data available on the number of Indigenous children, or specifically the number of First Nations, Métis and Inuit children, who are admitted under the *Mental Health Act*. This is because health authorities do not ask children and youth to self-identify on admission, and when Indigeneity is known, there are no systems in place to track, report and monitor this data.

Similarly, the true number of children under age 16 who are hospitalized without their consent is unknown. These children may not have consented to their admission and experience their hospitalization and treatment as involuntary. This is not captured in the data because mandatory hospital reporting to the Ministry of Health does not include Form 3 (Medical Report [Examination of a Person under 16 Years of Age Admitted at Request of their Parent or Guardian]). This lack of data on vulnerable young people leaves a gap in understanding how many children and youth under 16 are admitted by their parents or guardians for treatment in hospital and whether they have been admitted with or without their consent.

Designated facilities

When children and youth are admitted to hospital as inpatients, they may be admitted to general, pediatric, adult psychiatric or adolescent psychiatric units, depending on their age and which units are available at a given hospital. The extent to which assessment and treatment services address the specific mental health concerns of a child or youth in that setting depends upon the individual staffing complement and resources available at each hospital. Hospitals with psychiatric units and specialized residential mental health resources are designated as mental health facilities under the *Mental Health Act*.

Designated Facility

A designated facility is defined under the *Mental Health Act* as a provincial mental health facility, psychiatric unit or observation unit.

Short stays in non-designated hospitals are permitted for stabilization. However, patients admitted to an observation unit must be transferred to a designated facility within five days once a second Medical Certificate is received by the designated director of the observation unit. There are 76 designated provincial mental health facilities and hospital psychiatric and observation units across the province.[64] Only seven hospital facilities and two MCFD-operated facilities have an inpatient adolescent psychiatric unit or specialized bed-based treatment unit, providing 124 specialized in-patient beds for B.C. children and youth (see Table 2).[65]

Table 2: Child and adolescent designated facilities in British Columbia

Health Authority/ Ministry	Facility Name	Ages Served	# of beds
Interior	Kelowna General Hospital Adolescent Psychiatric Unit	12 to 18	8
Fraser	Surrey Memorial Hospital Adolescent Psychiatric Unit	12 to 17	10
	Surrey Memorial Hospital Child and Adolescent Psychiatric Stabilization Unit	6 to 17	10
Vancouver Island	Queen Alexandra Hospital (Ledger House) Child and Adolescent Stabilization Unit Child Psychiatric Unit Adolescent Psychiatric Unit	 6 to 16 6 to 12 13 to 16	 3 5 6
Northern	University Hospital of Northern B.C. Adolescent Psychiatric Unit	12 to 18	6
Provincial	BC Children's Hospital Child and Adolescent Psychiatric Units	18 and under	6
		11 and under	10
		12 to 18	10
	BC Children's Hospital Eating Disorder Program	12 to 18	14
Vancouver Coastal	Lions Gate Hospital Carlisle Youth Concurrent Disorder Centre	13 to 18	10
MCFD	Maples Adolescent Treatment Centre	12 to 18	22
	Youth Forensic Psychiatric Services	12 to 17	4
		Total Beds	124

Source: Ministry of Health and MCFD

[64] There are 25 facilities designated as provincial mental health facilities, 37 hospital psychiatric units and 14 hospital observation units. https://www.health.gov.bc.ca/library/publications/year/2020/facilities-designated-mental-health-act.pdf.
[65] Ministry of Health, Child and Youth Mental Health Beds by Hospital – MHSU bed survey September 2019.

A growing disparity exists between the number of children and youth being hospitalized and the number of specialized beds available in the province. A significant gap in capacity is seen, with more than 4,100 voluntary and involuntary mental health hospitalizations for children and youth in 2017/18 and only 124 specialized beds to meet their needs in a psychiatric crisis and for longer term treatment. When increasing demand is not met with additional capacity, a bed shortage translates into shorter hospital stays, patients not being admitted or patients being admitted to other units. The Representative heard that generally youth who are 17 or 18-years-old are admitted to adult psychiatric units.

As noted in previous RCY reports, this means that many young people admitted under the *Mental Health Act* do not have access to adolescent psychiatric units within their community and, as such, they may be placed in general, pediatric or adult psychiatric units. These units are likely not appropriate settings for young people experiencing mental illness, and the care provided may not be suitable for their needs. As noted in RCY's 2013 report *Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.*, pediatric units may be experienced as degrading for young people and their families, and adult-psychiatric units may expose young people to adults with chronic and severe mental illness, which may erode the young person's hope for their own future well-being.[66]

Young people in rural and remote areas have further challenges in accessing adolescent psychiatric units as most adolescent units are located in urban centres. Young people from rural communities may be more likely to be placed in alternative placements or be transferred out of their community and away from their family to access treatment.

[66] Representative for Children and Youth, *Still Waiting: First-hand Experiences with Youth Mental Heath Services in B.C.* (Victoria, 2013), 61.

Pathways Out

When a young person is discharged from hospital as a result of a parental request for discharge, a Mental Health Review Board decision, or discharged by medical staff because they no longer meet the criteria for involuntary admission, the young person and their caregivers will normally need ongoing mental health care support.

Unfortunately, there is a disconnect between the intended goal of involuntary care – which would be to stabilize and then connect individuals to therapeutic voluntary services – and the fact that robust voluntary services do not currently exist in B.C.[67] Indeed, multiple stakeholders have suggested that sometimes detention – or extended detention – under the *Mental Health Act* is being used because of a lack of adolescent child and youth psychiatric services as well as lack of available community resources more generally.

"Where to discharge them to is always the question."

"There is not enough psychiatry in the community. There is no real step-down program."

"Not every youth gets access to our psychologist... he is only here every other week."

"A lot of people get lost from hospital to community."

– Service Providers to InWithForward

[67] RCY, *Who Cares? B.C. Children with Complex Medical, Psychological and Developmental Needs and their Families Deserve Better*, 2014; RCY, *Time to Listen: Youth Voices on Substance Use*, 2018; BC Auditor General, *Oversight of Contracted Residential Services for Children and Youth in Care*, 2019; and Canadian Mental Health Association, *We Don't Know What to do with You: Changing the Way we Support the Mental Health of Youth in and from Care*, 2019; RCY, *Missing Pieces: Joshua's Story*, 2017; The Federation of Community Social Services of BC and the Ministry of Children and Family Development, *Residential Review Project: Final Report*, 2012.

Government bodies RCY consulted for this report acknowledged that there is a serious shortage of child and adolescent psychiatrists in B.C. Depending on their training and comfort level, other physicians will sometimes provide services for youth with mild to moderate mental health disorders. The Ministry of Health and MMHA noted that this issue is particularly apparent in rural communities, where children and youth are forced to travel considerable distances to get the services they need or rely on telehealth psychiatric services. Those with access to safe housing and appropriate supports are more likely to be discharged, suggesting that some individuals may remain detained under the *Mental Health Act* when they no longer meet the detention criteria because there is no suitable housing, community or family resources and supports.[68] One young person interviewed for this report exemplified why such family involvement can be crucial to ensuring that adequate supports are in place once a child or youth is no longer certified, remembering, *"My mom had to force the ladies at the hospital to get me a counsellor before I left. That time after hospital went from mediocre to good to bad to rocky."*

Telehealth Outreach Psychiatric Services

Telehealth offers real-time patient care through secure videoconferencing, providing assessment, treatment and follow-up services to young people in remote and rural locations. Telehealth provides remote communities access to psychiatrists, nurses and a social worker from BC Children's Hospital. Learn more about this service here: http://www.phsa.ca/Documents/Telehealth/TOPS_Telehealth_Oct2014.pdf.

For children and youth in care, this presents special challenges. There are limited placement options for children and youth with complex care needs under MCFD's current service delivery system.[69] One health care professional RCY staff spoke to referenced a youth whose detention was being prolonged because MCFD could not find this youth an adequate placement.

This challenge is compounded by the fact that many children and youth in care do not have family members who can act as advocates for them post-discharge.

Step Up/Step Down Care

Step up/step down services are intensive intermediate mental health treatment options that are less intensive than hospital care and more supportive than many types of community mental health care. When these services are available, an individual with declining mental health can 'step up' into a highly supportive environment in the community to prevent their mental health from deteriorating further and prevent the need for hospitalization. People who have received and no longer require hospitalization can 'step down' into this form of intermediate care to enable a gradual and supported return to the community, reducing the likelihood of readmission to hospital.

The lack of step up and down resources has been a significant issue raised by the Representative in previous reports.

[68] Community Legal Assistance Society, *Operating in Darkness: BC's Mental Health Act Detention System* (Vancouver, 2017), 39.

[69] RCY, *Who Cares? B.C. Children with Complex Medical, Psychological and Developmental Needs and their Families Deserve Better,* 2014; RCY, *Missing Pieces: Joshua's Story*, 2017; RCY, *Time to Listen: Youth Voices on Substances Use*, 2018; B.C. Auditor General, *Oversight of Contracted Residential Services for Children and Youth in Care*, 2019; and Canadian Mental Health Association, *We Don't Know What to do with You: Changing the Way we Support the Mental Health of Youth in and from Care*, 2019.

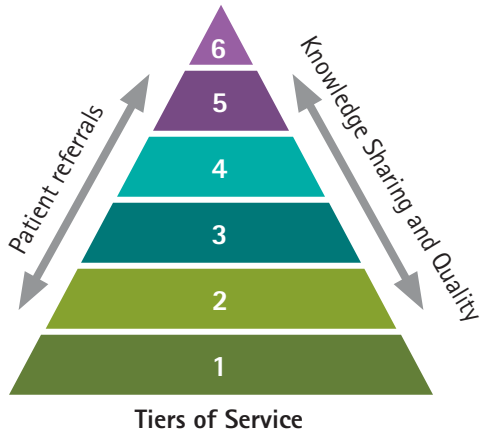
Child Health BC is leading the development of the Tiers of Service Framework and Approach for system planning and coordination for children's health in the province.[70, 71] This new framework has been supported by B.C. health authorities, ministries, school boards and non-profit organizations. Tiers of Service modules have been completed or are in development for 11 clinical service, diagnostic and therapeutic child and youth health services, including the clinical service module for Mental Health Services for Children and Youth (completed – see Figure 8) and the module for Substance Use Services for Children and Youth (in development).

"I didn't have a psychiatrist before … so that was a little better, but then a lot of crap happened."

RAI

The Tiers of Service Framework maps clinical services along the continuum of service to meet different levels of mental health needs with corresponding levels of service. Services under the model are divided into categories of community-based, residential and hospital inpatient services and take into consideration that remote and rural communities need to provide child and youth mental health services through emergency rooms and general inpatient beds, rather than through specialized beds and units available for similar needs in larger communities.

Figure 8: British Columbia child and youth Mental Health Tiers of Service Model



Mental Health Services for Children and Youth

Tier 6: Children's Provincial Subspecialty Mental Health

Tier 5: Children's Regional Subspecialty Mental Health

Tier 4: Children's Comprehensive Mental Health

Tier 3: Child Focused Mental Health

Tier 2: General Health

Tier 1: Health Promotion and Prevention

Source: Child Health BC

[70] Child Health BC is a provincial health network whose Steering Committee brings together health care providers, child health leaders and leading physicians across B.C. to ensure collaboration when serving children and their families, to enable the most innovative, novel and sustainable services for children's health in B.C.

[71] Child Health BC, *Tiers in Full, Mental Heath Services for Children and Youth* (July 2019), retrieved March 5, 2020. https://childhealthbc.ca/sites/default/files/19_07_17_mh_tiers_in_full.pdf.

Michael's Story[72]

Michael was placed in the care of grandparents by MCFD when he was one, due to concerns about his parents' substance misuse and domestic violence. When Michael was three, MCFD took on his permanent care via a Continuing Custody Order. When Michael was five, his grandparents could no longer care for him as he was having violent outbursts they did not know how to manage. He then spent four years with other family members. This placement ended after reports that he was physically abused by his caregivers.

Nine-year-old Michael was moved to a staffed residential resource. He had ongoing contact with his mother, siblings and maternal grandparents. He remained in this resource for approximately three years. Michael was diagnosed as having attention deficit hyperactivity disorder, oppositional defiant disorder, impulse control disorder, probable bipolar affective disorder, intermittent explosive disorder, neurodevelopmental disorder, anxiety, various learning disabilities, unspecified mood disorder and physical development problems. A CYMH psychiatrist in his community managed his medications.

During Michael's time in this resource, staff had challenges managing his behaviours. They used medications as a form of crisis control and repeatedly called the police when they could not de-escalate Michael. Michael was involuntarily hospitalized under the *Mental Health Act* many times following suicide attempts and violent incidents in the community and in his resource. It is unclear if and how Michael's voice was heard throughout these involuntary admissions and whether he felt his periods of involuntary admission were therapeutic and protective.

By the end of his third year at this resource, Michael's family had a meeting with his MCFD team and the resource staff. Michael was admitted involuntarily to hospital and, upon his release, was placed in a highly specialized staffed resource. With ongoing support from a care team, Michael moved back in with his mother last year. Michael enjoys spending time with his younger siblings, playing video games and learning about his First Nations ancestry.

[72] Michael's story is gleaned from a review conducted by RCY staff using documentation produced by the Ministry of Children and Family Development.

Youth Experience Under the *Mental Health Act*: Listening to Young People

Recognizing that there is often a gap between how systems are designed and the ways that they are implemented and experienced by the people engaging with them, RCY partnered with InWithForward to engage young people with lived expertise with involuntary mental health detentions. This allowed the Office to learn about young peoples' understanding of the *Mental Health Act* and their experience within hospitals and with medical professionals as they grappled with what it meant to be assessed, certified, treated and discharged.

Adrianna's Story[73]

Adrianna is a courageous, confident young woman finding her voice and power, learning about her Indigenous culture and, at 21, planning to be the first in her family to attend university. She is finding her way through years of painful family separation and a revolving door of involuntary mental health hospitalizations. Adrianna and her siblings grew up as a tight knit family under the care of their grandmother. Her parents struggled with addiction and, at 15, Adrianna's world was turned upside down. Removed from her grandmother's care, Adrianna bounced from group home to group home, to the streets, and eventually to a Youth Agreement.[74]

Her journey in and out of mental health hospitalizations began at age 14, when she was first certified under the *Mental Health Act* for depression and suicidality – and another 20 certifications followed during her adolescence. Adrianna didn't understand why she was being held at the hospital in her early hospitalizations; it was a friend who later explained the basics of what being "certified" meant and that they were doing it to keep her safe.

During her repeat mental health hospitalizations, where the main treatment was medication, Adrianna felt as though nurses and doctors had very little time or empathy for her. She recalls as a young teenager that she just wanted somebody to give her a hug, to sit with her, to talk with her, to care about what was going on for her. Adrianna's hospital and MCFD interactions did not work to support and reinforce her relationships with existing family members or her Indigenous culture. In fact, she often felt her identity was disrespected and that she was dismissed or maligned as *"that Native girl."*

It wasn't until she was 19 that Adrianna was finally referred to treatment that began to shape her healing. She attended a substance use disorder treatment program for young adults (17 to 24) that included therapeutic recreational activities, life skills, therapy and access to Elders. It was through this program that Adrianna began to reconnect with her culture, understand more about herself and her family and start to pursue healing with her voice and on her own terms.

[73] Adrianna related her story to InWithForward as part of the ethnographic research conducted for this report.

[74] A Youth Agrement (YAG) provides assistance to youth ages 16- to 18-years-old when a youth cannot remain in their family home. The youth is not in the care of MCFD but MCFD provides financial assistance and works with the youth to create a plan for independence.

Sean, Luna, Steve, Samuel, Alan, Liam, Rai, Koral, Wolf Moone, Adrianna, Tony, Charlie, John and Lily – the youth who worked with InWithForward – have each been deprived of freedom of movement and choice, temporarily, because doctors determined they *"needed care, management and control in a designated facility to keep them from putting at risk their well-being or the well-being of someone else or to keep their mental or physical condition from getting worse."*[75, 76] Although 14 young people is a small group, the depth of their engagement in the process enabled InWithForward and RCY to gain valuable insights. This section gives voice to their experiences. Their memories may not fit neatly within our understanding of the *Mental Health Act*, but their experiences are their reality.

Overall, the young people whose experiences are reflected in this report recounted negative impressions of their involuntary *Mental Health Act* admissions. One young person remarked, *"They treat you so much better when you go into the hospital for a physical thing than a mental thing."* The stigma of mental illness combined with the lack of control and privacy inherent in the involuntary admission process is evident in how the young people spoke about their experiences.

[75] The young people represented in this report had the opportunity to provide various levels of consent. The young people were given the opportunity to specify which details they wanted included or omitted from sharing. After InWithFoward had written their stories, they were returned to the young people for review and confirmation. For more information on InWithForward's process, see Appendix 3.

[76] BC Division of the Canadian Mental Health Association, *BC's Mental Health Act in Plain Language* (Vancouver, 2004), 12.

WHAT IT FELT LIKE TO BE DETAINED

When it comes to the experience of detention, the issues of medication and isolation are the stand outs for the young people heard here. One young person recounted forced psychiatric treatment, restraint and seclusion on the day they were admitted to hospital under the *Mental Health Act*:

> *"Then I get to the hospital, still don't know what's going on, still don't know a thing, and then I was freaking out so bad that they had to … put me in one of those rooms … but, first, they had me restrained to the bed and I was … screaming, I was like, 'Let me go!' I was … freaking out and then they … injected me with something – I don't even know what it was to this day, I think it was Ativan or something. They injected me with it. I'm still screaming and so then they like pushed the bed I was on into like this white room. And then they left me there! And I don't even know how long I was there! Like, so messed up! And then they checked on me once, and I was freaking out, just … 'I want my mom! I want to leave now! I'm not supposed to be here.' Then I think I fell asleep for a day."*

Of the young people RCY heard from, more than half disagreed with the treatment they received. One of the young people expressed frustration at the response they received from their treating physician when they requested an alternative to their prescribed medication: *"[The doctor] will always fight me … not listening to the why or anything … and constantly lord over the fact that it was his decision to make."* They discovered that painting calmed them down, but painting was restricted: *"I would want to be painting while I was crying … they treated it like a hobby instead of a coping mechanism."*

The young people were left wrestling with how to reconcile their image of care (which was to receive therapeutic support) with what they viewed as the reality of treatment (which was to receive medication). They expressed that their pain was not so much reduced as sedated.

"[The meds] could make me calm down, but it won't get to the root of the problem."

ADRIANNA

"Sure the [medication] worked, they did what they were supposed to do, but they didn't work on any of the emotional issues. The doctors turned me into a zombie."

LIAM

"I'd wake up … and either be calm and go back to sleep or freak out and get sedated again … it was like that for about three months. It's just a big blur."

SEAN

"The pills didn't work at first. They switched me … They were like, 'Are they working?' And I was like, 'No, they are not working because I don't need meds.' I wasn't depressed. I had trauma. I didn't want to be on medication and that was a non-negotiable."

STEVE

Uncovering Themes within Young Peoples' Experience

InWithForward's conversations with the young people concerning their involuntary admissions to hospital under the *Mental Health Act* brought five key themes to the surface:

- purpose
- relationships
- power
- memory
- identity.

What follows is InWithForward's exploration of these themes.

1. Purpose

Most young people attributed their mental health challenges to the absence of attention and love, to abuse, divorce, abandonment, removal, neglect and loss. Young people expected their hospital stay would address the reasons for their pain, not just treat the symptoms of their pain – and were disappointed to find medication as the focal point of detention. Young people expected hospitals to help them heal to move beyond their symptoms to the roots of their anguish. And yet, young people found their pain wasn't so much attenuated as sedated. Every young person with whom InWithForward spoke wrestled with how to reconcile their image of care with the reality of their hospitalization. From their perspective, to be *cared for* is to receive attention and love. To be *treated* is to receive pills and injections.

The young people desperately wanted to feel whole again. The *Mental Health Act* focuses on stabilization. Therein lies a tension where healing is the process of making or becoming whole or healthy again, whereas stabilization is about reducing the severity of a person's distress and restoring some equilibrium, so the person is more amenable to treatment.

Young people wondered, if stabilization is the purpose of hospitalization, then when and where does the healing begin?

"I'm just like, 'Are they actually fixing me or is this making it worse?' ... In other words, I don't know if the ways we deal with mental illness are the best. We could definitely think of better ways to do that. Like especially with the medication."

LILY

"We did nothing, basically, every day that you're in the hospital. You meet with a psychiatrist for five minutes."

JOHN

2. Relationships

Young people situated their emotional well-being within families and relationships. Mental health challenges are not personal, so much as interpersonal, reflecting shifting relational dynamics such as abuse, divorce, abandonment and death. And yet young people described their admission and treatment as a solitary and lonely experience. Some young people reported that psychiatric units went beyond medication, providing counselling or therapeutic groups, but that these offers were typically time-limited and non-relational, and – at least in their recounting – focused on the individual outside of their connections to family, friends and other supportive relationships.

"There was a practicum student who sat down with me with a picture of the brain and explained dopamine, etc. And that was the first person in the hospital who talked to me who treated me as normal, on the same level."

JOHN

"The doctor was really intimidating. I'm anxious, like even if I had known about some of these things [rights], I still don't think I would have ever asked him."

SAMUEL

"I needed something to grasp onto. I needed hope."

ADRIANNA

"There was a nice lady and she would bring me chips and talk to me. She would laugh. Everybody else would treat me like I was crazy. They would just look at me and write me off."

STEVE

3. Power

For the young people, the *Mental Health Act* creates an adversarial dynamic between safety and control. This approach to keeping people out of harm's way involves taking away their autonomy, sense of self and independence, and any semblance of control that they might have felt they had over their lives. The young people who were brought to the hospital by the police came to see the *Mental Health Act* as punitive rather than restorative. Alan, who was transferred to a psychiatric unit from a youth justice custody centre, felt as though hospital was only marginally better than prison.

Young people recounted ways they tried to maintain some semblance of independence and control. These acts of defiance could feel like small wins – though, over time, young people with repeated admissions described falling into submission. As Samuel said, *"At one point, I kind of just tried to make it seem like I was getting better with the process so I could get out."*

"I thought I had no power, I just had to follow orders and they'll let you go … ."

ADRIANNA

"I had control over whether or not I wanted to eat until they forced me to eat, but then I would just go puke because 'How dare you force me to eat, you just wasted your time cuz look it's in the toilet.' But, then they started feeding me through a fucking tube at one point."

SEAN

4. Memory

Medication and isolation were distinct memories for the young people. Some details really stood out such as a kind nurse, a soothing cup of tea, a therapy dog or, alternatively, a brusque doctor, a stay in the isolation room, a forced injection.

Most fuzzy was young people's recollection about rights. Most of the young people InWithForward met with were surprised to learn that they had rights; they did not remember hearing about or seeing forms explaining their rights about second opinions, access to legal counsel or the Mental Health Review Board. John said in disbelief, *"So, they're supposed to actually read you the rights? I hope I'm the first person who is surprised by that, but I don't think I am."*

"Yeah, there were some good people in there that were friends, they were helpful, supportive, genuinely concerned for us ... Instead of making me feel like I was their patient, they made it feel like it was teamwork, working together to get out of this problem situation. I wish that doctors and nurses would treat more of their patients like that."

LILY

Asked to describe their stay in hospital, young people trended toward darker, impressionistic words – feelings, rather than facts, lodged in their memories. Medication and not being permitted to participate in treatment decisions left young people feeling most disempowered. As involuntary patients, young people have no way to contest the treatment being administered to them under the *Mental Health Act*. Discharge planning was looked back on as cursory; young people felt little had changed for them upon exit; life circumstances often remained the same.

"The adolescent psych unit was really different than the peds unit. The peds unit was lonely. In the adolescent unit, you can talk with other kids, sit on couches, watch movies, read. I liked how they did snacks and tea with honey."

LUNA

"I have a voice and I can use it. Being sectioned, I never felt I was heard... . All of the things I went through, I learned a lot. I am genuinely happier. I thought I needed a mom or dad or boyfriend to feel happier. I can be happy myself."

ADRIANNA

5. Identity

Detention was largely experienced as one more trauma on a trail of traumas. None of the young people recall having an opportunity to debrief their hospital experience and incorporate it within their longer-term recovery process. None of the Indigenous young people recalled being introduced to culturally specific recovery frameworks, strategies or supports. Instead, young people remembered being left to try and reconcile the experience(s) on their own.

> "I've seen so much that I know the changes that are needed. I've been brave for myself … . This year, I'm positioning myself to be in a place where I can have a little bit of authority in other peoples' lives and help guide the way."
>
> STEVE

> "I'm trying to figure out who I am, where I belong, who I'm going to be around. When my environment around me is too structured, it throws me off too much … . Not enough structure means too much is changing. There has to be a balance."
>
> LILY

The two young people who were transitioning genders remembered certification experiences as especially disorienting. While medical professionals mostly respected their pronouns, Koral and Lily didn't feel their transition journey garnered similar respect. For Lily, that meant not having access to hormone therapies while in hospital and literally feeling stripped of her identity.

> "I see myself as transitioning. I have a picture of what that might look like, but I can't draw it right now."
>
> "I went in there for a few times in the mental ward. For whatever reason, I was taking hormones, I'm a strong believer that that was not the case of why I freaked out in the first place, but the doctors weren't convinced. So they took it away and put me on something else, which I found was very dangerous … . And nobody believes me when I say that. It really sucks."
>
> LILY

> "I've wanted to transition since I was 12-years-old … The only reason I ever have any anxiety in the first place is … the all-the-time stress of being in the wrong body without any means of conquering it … . If my doctors had listened, I would have moved on with my life a lot sooner."
>
> KORAL

Procedural Safeguards and Child Participation

As described in the Background section of this report, procedural safeguards exist in the *Mental Health Act* that are meant to ensure an individual has some level of voice or autonomy while detained under the Act and to prevent the unchecked exercise and abuse of state power. An exploration of the extent to which children and youth are exercising their rights under the Act or utilizing these safeguards reveals instances where there are either no formal mechanisms for review, voice or independence or where the mechanisms available in the Act are not being used.

Rights Notification

Hospitals are required to provide information to patients about their rights under the *Charter* and the *Mental Health Act* upon admission, any time they are transferred, whenever a renewal certificate is issued and when the physician changes their status from a voluntary to an involuntary patient. Specifically, in addition to the hospital's name and location, patients must be informed of their right to:

- be informed of the reasons for the admission
- contact, retain and instruct a lawyer or advocate without delay
- be examined regularly by a doctor to see if you still need to be an involuntary patient
- apply to the Mental Health Review Board for a hearing to decide if you should be discharged
- have the legality of the detention determined by the court through a habeas corpus application[77]
- appeal the doctor's decision to detain you in hospital, and
- request a second medical opinion on the appropriateness of treatment.

Children under age 16 admitted by a parent or guardian as a voluntary patient must also be provided with rights information.

In addition, if a patient *"does not, or appears not to, understand the rights information upon admission, it must be repeated as soon as the person is capable of understanding the content therein and another copy of Form 13"* provided.[78]

Rights information is typically provided to patients in person by hospital staff – doctors, nurses, case managers and social workers – in writing, using Form 13 (Notification to Involuntary Patient Rights under the *Mental Health Act*) and Form 14 (Notification to Patient Under Age 16, Admitted by a Parent or Guardian, of Rights Under the *Mental Health Act*). It is unclear if health care professionals are provided any specific training in order to inform patients – let alone children or youth – of their rights under the *Mental Health Act*. Indeed, the CLAS report concluded that health care providers lack the necessary training, education and time to provide rights advice.[79]

Further, hospital staff are not independent from the overall process, and the quality or meaning of the rights information they provide may be impacted by their positions of authority, especially so in the eyes of children and youth. Anything a child or youth asks or says when being informed of their rights can be documented in records by hospital staff, which may be relied on to support further detention or involuntary treatment. Neither Form 13 or Form 14 – nor any of the other 19 *Mental Health Act* forms — is child-friendly in their design.

When a young person is admitted to hospital involuntarily or by their parent or guardian, the *Mental Health Act* requires the designated director to send notice to a near relative immediately after the patient's admission, discharge or an application to the Mental Health Review Board.[80] The young person may

[77] Every detainee has the right pursuant to s. 10(c) of the *Charter* to make a habeas corpus application to determine whether the detention is valid.
[78] Ministry of Health, *Guide to the Mental Health Act* (Victoria, 2005), 41.
[79] Community Legal Assistance Society, *Operating in Darkness: BC's Mental Health Act Detention System* (Vancouver, 2017), 67.
[80] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 34.2.

also nominate a near relative.[81] If the young person does not nominate anyone, the facility is supposed to notify *"any near relative"* it deems appropriate.[82]

The near relative notification explains the patient's rights and explains the rights that may be exercised by the patient, a relative or another person on the patient's behalf. As the B.C. Ombudsperson emphasized in his 2019 report:

> *"A properly completed and sent Form 16 allows the families of people with mental disorders to be allies in ensuring that the system of involuntary admissions is credible and effective and protects their loved ones in times of crisis."* [83]

It is difficult to assess how effective near relative notification is as the Ministry of Health only recently started tracking this data.

> "My friend explained to me what the *Mental Health Act* was and why they took me in. I think she had been there before. She explained everything the nurses hadn't."
>
> ADRIANNA

The Ombudsperson's office reviewed 1,468 patient files for its 2019 report. According to this review, just 49 per cent of the patient files they reviewed in 2017 contained any Form 13 that would indicate a patient was notified of their rights, and only 32 per cent of files that should have contained a Form 16 to indicate that a near relative had been notified of a patient's rights actually included this form.[84] Of particular alarm for the rights of children and youth, the Ombudsperson found that BC Children's Hospital had a Form 13 compliance rate of just 10 per cent.[85, 86] These low compliance rates reflect what RCY heard from the young people spoken to for this report, who indicated a lack of understanding of their rights. Of the young people heard from, only a small minority of them recalled being informed of and aware of their rights at any point while detained. The Ombudperson's investigation lead BC Children's hospital to address issues of low compliance.

The data shows that the majority of children and youth are admitted for sufficiently long periods of time that they should have rights information provided to them more than once, as shown in Figure 9.

Rights notification is one of the most important safeguards in the *Mental Health Act*. The legislature has imposed solemn legal duties on designated directors to provide specific rights notifications to involuntary patients and persons under 16 years of age who are admitted "voluntarily."[87]

These rights notification provisions reflect that, beyond its essential functional value, rights notification reflects respect for basic human dignity that remains even when a person is detained. It is no accident that Section 10 of the *Charter* gives every detained person the right to be informed promptly of the

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[81] Near relative means a grandfather, grandmother, father, mother, son, daughter, husband, wife, brother, sister, half-brother or half-sister, friend, caregiver or companion designated by the patient and includes the legal guardian of a minor and a committee having custody of the person of a patient under the *Patients Property Act*.

[82] Ministry of Health, *Guide to the Mental Health Act* (Victoria, 2005), 42.

[83] The Office of the Ombudsperson, *Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act* (Victoria, 2019), 64.

[84] The Office of the Ombudsperson, *Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act* (Victoria, 2019), 7.

[85] The Office of the Ombudsperson, *Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act* (Victoria, 2019), 62.

[86] All designated mental health facilities are now audited quarterly for completion of forms.

[87] *Mental Health Act*, ss. 34 and 34.1).

reasons for the detention, the right to retain and instruct counsel without delay and to be informed of that right, and the right to have the validity of the detention determined by way of habeas corpus and to be released if the detention is not lawful. The systemic failures regarding rights notification identified by the Ombudsperson are cause for significant alarm both in general and in relation to detained children and youth.

Figure 9: Renewal points when children should be provided rights information

Considering the distinct vulnerabilities faced by children and youth, there is a need for rights advice to be provided in an accessible and developmentally appropriate manner. The Ombudsperson's 2019 report recommended that the province create an independent rights advisory service to provide advice and support to patients around their detention. The Ombudsperson emphasized his concern about rights information being provided by health care professionals, which is deeply problematic for a number of reasons. Health care professionals:

- lack independence
- may not have received training or have sufficient knowledge about the law and cannot provide rights advice

In addition, the Representative is concerned that health care professionals:

- hold significant control and power over patients' care, liberty and person, and
- can be intimidating to vulnerable minors who lack experience and maturity and who would see these professional adults as authority figures.

Knowing what their rights are and how they apply is an important step toward a young person's participation in the important decisions made about them, particularly decisions that affect their bodily integrity and personal autonomy. In order to access their rights, young people must be able to contact legal counsel or another advocate, requiring access to a telephone or computer and the privacy to use them.

"[If I'd known my rights] I most likely would have tried to get out … I probably would have the first time I was there. I wanted to do anything to get out … 'cuz you are so young they don't think you know anything."

JOHN

"I don't remember hearing anything about rights."

TONY

"I remember being read my rights once, on the day I was admitted, when you're in your worst mental space. It would be nice if you were reminded of these rights."

LIAM

"We're allowed to have second opinions. And we're allowed to get legal aid if necessary. These were all things I didn't know before … wasn't until my first time getting out of there that I figured all that out, and it wasn't easy."

LILY

Wolf Moone's Story[88]

Wolf Moone is a 17-year-old Indigenous transgender youth who writes poetry and short-stories and is currently working on a memoir. In the absence of treatment and care that may have helped him make sense of his experiences, he finds writing is a way to try to make sense of it all. Wolf Moone struggles with making connections and remembers when he was younger, *"I was always with my mom, my mom was constantly there. But eventually she stopped being around as often … I had never really had a connection to another human being."* Wolf Moone was removed from his family's care when his mom stopped being around and has been in care for more than seven years. He is currently on a Youth Agreement, homeless and couch-surfing.

Wolf Moone's first hospitalization for mental health was at age 10, when he spent six months in treatment related to his eating disorder and mood disorder. As a young teen, he returned to in-patient care for three months at an adolescent treatment centre. Wolf Moone accepts that he needed help and hospitalization but didn't like the feeling of *"being in the dark"* that came along with it. He felt like he was never properly informed about his treatment plan, the types of medication he was being given, or how any of it was supposed to help him. *"I would have liked to know what they were doing and why."*

Wolf Moone remembers being told that his stay at the adolescent treatment centre was voluntary, but was later surprised to learn that he couldn't leave the program after a month. He did not know about his rights under the *Mental Health Act* or have knowledge about his right to ask for a second medical opinion.

After discharge, Wolf Moone was told to connect with a psychiatrist and counsellor but was not supported in making those connections and continues to have difficulties finding community mental health services that are helpful. He describes the impact of his in-patient interventions as increasing his anxiety, depression and PTSD symptoms, and recalls his detention experiences as traumatic, harsh and unfair. In his words, he found hospitalization *"almost impossible to the point where it was almost as if I wasn't even in my body anymore. And like, I was just kind of watching what it was doing. But I couldn't do anything."*

[88] Wolf Moon related his story to InWithForward as part of the ethnographic research conducted for this report.

Access to Legal Representation

While patients have a right to contact, retain and instruct a lawyer, there are barriers that make this difficult. Individuals detained under the *Mental Health Act* do not have access to information and legal advice about their rights through Legal Aid BC duty counsel, advice counsel or a 24-hour telephone line.

Legal Aid BC (formerly known as Legal Services Society) provides funding to the Community Legal Assistance Society (CLAS) to represent patients at Mental Health Review Board hearings through a service called the Mental Health Law Program. However, Mental Health Law Program staff only represent patients at Review Board hearings; they do not provide assistance in applying for a Review Board hearing, nor do they provide patients with information, advice or assistance on their rights under the *Mental Health Act*. Legal Aid BC does not fund CLAS to provide rights advice to patients when they are admitted to hospital under the *Mental Health Act*.

To help address this concerning gap in access to information about rights and process, the non-profit organization Access Pro-Bono has initiated a telephone advice program for patients detained under the *Mental Health Act* to set up appointments to talk to a lawyer.[89] Lawyers volunteering under the Access Pro-Bono Mental Health Program offer advice on the Act, right to second opinion, how to apply for a Review Board hearing, legal test and procedure at the panel hearing, and consequences of cancelling/postponing hearings and how to prepare.[90] However, since this is a service that involuntary patients have to learn about and access on their own, it is reasonable to conclude that only a small number of involuntarily detained children are likely to access this service.[91]

Access to legal representation is also dependent upon access to a phone or other means to connect with legal services. Some of the young people heard from for this report said that lack of access to a private phone was a significant barrier to reaching out for legal help. In order to access this right, young people need access to a private room with a telephone and support to understand who they can ask for legal representation. While safety is always the primary consideration, the Representative believes that young people can be observed and kept safe without having their calls monitored – as evidenced by the practices in B.C.'s youth custody facilities.

Treatment

The *Mental Health Act* defines treatment as *"safe and effective psychiatric treatment and includes any procedure necessarily related to the provision of psychiatric treatment."*[92] As noted earlier, the Act says that any treatment authorized by the designated director for an involuntarily detained patient is deemed to be given with the consent of the patient, meaning that the Act authorizes psychiatric treatment to be administered to patients without their consent or the consent of a parent or other family member acting as a substitute decision-maker.[93] A treatment authorization form found in the regulations made under the *Mental Health Act* states that an individual who agrees with a proposed treatment and is considered capable of making that decision by the treating physician, may sign the treatment consent form.[94] This applies to any involuntary patient.

Where an involuntarily detained individual is considered capable of making treatment decisions but disagrees with the proposed treatment, or where the individual is considered incapable of making treatment decisions, the form is signed by the director or a designate, such as a physician or a nurse on the treatment team. The Ombudsperson's 2019 report found that nearly all treatment descriptions in the Forms 5s they reviewed either were so vague as to be meaningless or consisted of an exhaustive list of all treatments available at the facility. The Ombudsperson found that at least 16 facilities regularly completed the Form 5s by using a rubber stamp, pre-filled form or boilerplate language that provided a standard description of treatment. The Ombudsperson reviewed a Form 5 for a 15-year-old youth who

[89] Community Legal Assistance Society, *Operating in Darkness: BC's Mental Health Act Detention System* (Vancouver, 2017), 61.
[90] "Mental Health Program," Access Pro-Bono, http://accessprobono.ca/mental-health-program.
[91] Less than one-percent of cases are reviewed. In 2017/18, there were 21 Mental Helath Review Board hearings and 2,545 discharges for children with involuntary status. Data: Ministry of Health and Mental Health Review Board.
[92] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 1.
[93] Section 31(1) of the *Mental Health Act* states that *"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 37 or 38, treatment authorized by the director is deemed to be given with the consent of the patient."*
[94] *Mental Health Regulation*, B.C. Reg. 233/99, s. 11.

was admitted on an involuntary basis. Rather than providing a description of the treatment proposed for the youth, a stamp was used that basically described all psychiatric and medical treatment available at the facility. Despite the form being so broad that it did not enable informed consent, the form was signed by the youth.[95]

B.C. is the only province in Canada where capable, involuntary patients might not be provided with an opportunity to make psychiatric treatment decisions. The only option in B.C. to challenge one's treatment under the *Mental Health Act* is to request a second medical opinion. Unlike other jurisdictions, treatment decisions are not reviewable by the Mental Health Review Board. If patients in B.C. are aware of the option to request a second medical opinion, they may do so once in every certification period. In other words, Form 11 – to request a second medical opinion – can be submitted upon certification one month after admission, after a further period of one month, again after three months and again six months after that.

The *Infants Act* and Involuntary Admission

Through consultations, the Representative has heard of instances of health authorities citing the *Infants Act* as the authority to admit a child for mental health treatment on an involuntary basis. This practice is concerning to the Representative as there is no authority under the *Infants Act* to admit a child to hospital. The *Infants Act* provides mature minors the ability to consent to treatment. Nowhere in the Act does it set out the authority to detain a child in hospital. To use the *Infants Act* in that fashion undermines the specific legislated processes and protections that are set out in the *Mental Health Act*.

In other jurisdictions, treatment decisions may also be reviewed by independent tribunals or the courts.[96] For example, in Alberta, a capable, involuntary patient may retain their right to refuse treatment. However, the treating physician may apply to the Review Board to obtain an order for the administration of treatment.[97]

As also noted above, the "deemed consent" provision in the *Mental Health Act* does not apply to children under 16 who are voluntarily admitted under the *Mental Health Act* at the request of their parents. Authority to treat these children depends on whether they are a mature minor for the purposes of the treatment decision. If not, the parents must consent to treatment or, failing that, a court order must be obtained.

It is important to note that Section 17 of the *Infants Act* does not give physicians the ability to treat a mature minor who refuses consent. Instead, Section 17 of this Act gives physicians the ability to obtain consent to treatment from a minor who understands the nature and consequences and the reasonably foreseeable benefits and risks of the health care. However, that section does not give either the physician, the designated director, or the child's parent or guardian, without a court order, the right to override a mature minor's refusal of treatment.

[95] The Office of the Ombudsperson, *Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act* (Victoria, 2019), 53.
[96] For example, Alberta, Manitoba, Ontario, Quebec, New Brunswick and Nova Scotia all have independent tribunal or court oversight of psychiatric treatment.
[97] *Mental Health Act*, R.S.A. 2000, c. M-13, s. 29.

Liam's Story[98]

When Liam imagines health and healing, he's on a mountain top, not medicated in a psychiatric unit with white walls, LED lights and no access to the outdoors and fresh air.

Liam's first mental health detention was at age 13, after being brought to the hospital by his family because of psychosis. His childhood experiences included emotional abuse, disconnection from family members and removal from his family. Liam recalls being hospitalized four times for mental health treatment. Now, at age 22, it's still hard for him to reconcile the Liam *"in a shitty state of mind"* with a version of himself that he can embrace. He is able to project ease and charm, but it belies a mental state that's *"definitely up and down right now,"* fueled by ever-present stress. He is experiencing homelessness and self-medicates with cannabis to help cope with his mental health challenges and stressors.

Liam's longest hospitalization was four months. He says he learned to *"play the game"* to please doctors and achieve discharge as soon as possible. His treatment plan in the hospital was medication rather than working on his underlying emotional issues.

His need for some sense of self-determination created friction with his care providers, and he didn't feel comfortable talking to physicians and counsellors he didn't know. *"[Counselling] was offered but who's going to open up to someone they don't know? I won't."* Liam would open up to *"family members or a good friend,"* but these natural support networks were not available or encouraged.

Liam describes his mental health detention as being medicated into submission and feeling stress and anxiety that was exacerbated by his circumstances which he described as white walls, bright lights and a lack of fresh air. He is still working on reconciling his family and hospitalization experiences, recognizing his self-worth and dealing with his ongoing stress and mental health challenges – and dealing with all of this without the stability of housing.

Like Liam, many of the young people involved in this report disagreed with their treatment and felt like they had no say in their treatment plan. Most of them also didn't understand that they could request a second medical opinion.

It is concerning that capable children may not be afforded the opportunity to consent to their own treatment. For children admitted on an involuntary basis, the fact that consent is "deemed" to be given should not render the child's views irrelevant. In some cases, the child may be able to provide the clinician with information that changes the treatment plan and, even if the treatment plan does not change, taking the child's views and concerns seriously may be an important part of building trust and encouraging healing.

[98] Liam related his story to InWithForward as part of the ethnographic research conducted for this report.

For children under 16 admitted at the request of their parents, the importance of the child's views is even more important where the child is a mature minor, as the child's refusal of treatment must be obeyed by the physician unless the designated director or parents obtain a court order. The Representative has serious concerns as to whether and to what extent assessments of children and youth's decision making capacity (mature minor assessments) are being undertaken for this growing cohort of hospitalized children, and whether their views are being sought and respected, as required by law. Further, children under age 16 admitted by their parents, who disagree with psychiatric treatment being provided with the consent of their parent or guardian, do not have access to the safeguard of requesting a second medical opinion such as involuntary patients have.[99]

"None of the times there [in the hospital] worked; they made me more unstable ... the hospital ... just ... wanted me out of there."

TONY

"The art therapist came on Tuesdays and Thursdays. It felt way too young [for me]."

LUNA

Second Medical Opinions

Patients of any age who are detained under the *Mental Health Act* can request a second medical opinion on the appropriateness of the treatment that is authorized by the designated director. Patients can request a second medical opinion once in each of the following periods:

- the one month period after admission
- the following three-month period
- the following six-month period.

When a patient requests a second medical opinion, the designated director has to consider whether changes should be made to the patient's treatment.

A second medical opinion does not decide whether a person detained should remain certified; it only considers whether the treatment is appropriate. There are several limitations to second medical opinions, including: no timeline to establish how long a facility has to arrange a second medical opinion other than "as soon as possible"; the challenged treatment can continue while the second opinion is being arranged; no requirement that the second medical opinion be completed by someone independent of the treatment team; and no requirement for the treatment team to change the course of treatment if the second medical opinion differs. In fact, the 2017 CLAS report *Operating in Darkness* found that a second medical opinion almost never results in changes to a patient's course of treatment. Rather, CLAS concluded that second medical opinions are almost always completed by physicians who are colleagues of the treating physician at the detaining facility, are sometimes conducted without an in-person examination and rarely differ from the original treatment plan. In its report, CLAS also noted that there is no legal obligation for a treating physician to change a treatment plan even if the second opinion provides a different view.

The Representative hoped to analyze data on the use of second medical opinions for children but was unable to do so as this information is not collected, and the only option for this analysis would have required a review of individual patient files.

[99] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 31(2).

The young people interviewed for this report repeatedly said they felt as though they had no independence in their treatment. The young people overwhelmingly felt as though there was a disconnect between what they expected from their periods of hospitalization (meaningful treatment for their underlying issues) and what they actually experienced (periods of stabilization and forced medication). While most of the young people RCY heard from agreed with their diagnosis, the majority disagreed with their treatment. This indicates that young people do not reject the conclusions of mental health professionals, but rather want to have agency in determining how they will be treated and what actions will be taken to support them. Most of the young people involved in this report did not understand that requesting a second medical opinion was an option. Requesting a second medical opinion is not an option for children under 16 who are admitted by their parents, despite the fact that their treatment decisions may be made by their parents. The Representative believes that there should also be a process to enable this group of young people to have their treatment decisions reviewed.

Discipline and Control of Patients

Discipline

Discipline is the practice of making people obey rules or standards of behaviour and punishing them when they do not.

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."*[100] 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 *Guide to the Mental Health Act* is silent on the use of discipline for involuntary patients.[101] Discipline is commonly understood as the practice of making people obey rules and punishing them when they do not obey. The Representative questions whether it would ever be appropriate to discipline or punish a child, who is detained in the hospital, for not following rules.

Practically speaking, "discipline" may be operationalized in hospitals through the use of isolation or secure rooms, restraints and denial or removal of privileges. The *Mental Health Act* is silent on the use of isolation and restraint and does not limit their use to situations where a patient poses a risk to themselves or others. More than half of the young people heard from for this report recalled the use of restraints and isolation and, for many of them, these experiences were terrifying.

"There were times I freaked out. And I yelled at people, and they put me in there [isolation room] for like three days out of the three weeks. It's terrifying, man. I don't care who you are: no one deserves to be locked in a small room because they are upset … ."

SAMUEL

"I was freaking out. They restrained me to the bed and injected me with something and left me in there. It was so messed up. I wanted my mom … It looks like exactly a jail cell. No handle. 'Holy fuck,' I was thinking. 'I got to keep my cool.' "

ADRIANNA

"It's teasing on torture to have to be in the rubber room for longer than four hours."

JOHN

[100] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 32.
[101] Ministry of Health, *Guide to the Mental Health Act* (Victoria, 2005).

After apparently being ignored repeatedly, one young person recalled that they had no choice other than to urinate in their room and reflected, *"That feels like shit. It's unfair. I'm a nice guy."*

Through these experiences with discipline during their involuntary admissions, young people may come to see the *Mental Health Act* in punitive rather than restorative terms. This may create distress in young people to the extent that they may come to distrust the health care system and be less inclined to seek support when it is needed.

Jurisdiction Example: Alberta

In Alberta, although patients have the right to refuse treatment, they do not have the right to refuse control.* However, the authority to use control requires minimal use of force, either by physically laying hands on a patient, using devices, jackets or straps to restrict movement, or using medication to control a patient's movement. Control is different from treatment. It must be used only to the extent necessary to prevent serious bodily harm to a patient or another person. If interventions or medications are used to control behaviour, staff must document the behaviour that required control and detail the measures used.

*The Alberta Mental Health Act: A Guide for Mental Health Service Users and Caregivers, 2nd edition. Canadian Mental Health Association, Calgary Region. https://alberta.cmha.ca/wp-content/uploads/2019/02/TheAlbertaMentalHealthAct.pdf

B.C.'s Ministry of Health has developed provincial standards and guidelines for secure rooms, including their design and construction, and the practice of seclusion in designated mental health facilities.[102] The *Provincial Quality, Health & Safety Standards and Guidelines for Secure Rooms* is intended to define parameters for the safest possible delivery of seclusion and recognizes that the safety of the patient and staff ultimately depends on the knowledge, skill and judgment of the clinicians responsible for service delivery. The *Standards and Guidelines* specify that seclusion should be a last resort and intended as a short-term emergency containment measure only, when no other method of preventing an individual from harming themselves or others has succeeded.

The guiding principles of the *Standards and Guidelines* are prevention and minimization of seclusion, and delivery of person-centred and trauma-informed care. The guidelines state that seclusion does not contribute to healing or recovery and may be harmful, particularly for those with a history of trauma. The provincial seclusion standards apply uniformly to both children and adults. The definition of "person-centred treatment" recognizes that services need to consider the developmental needs and age of a patient, but that is the only recognition of the unique circumstances of children.

The standards for initiating seclusion stipulate that, except in exceptional circumstances, each and every seclusion intervention requires a seclusion order by a physician or registered nurse, and that the order be reviewed by a psychiatrist or director appointed under the *Mental Health Act*, as soon as possible. There is no time limit on the duration of seclusion, but standards specify that seclusion must be terminated as quickly as possible, face-to-face monitoring must occur at least every 15 minutes and that for seclusion to continue, it must be reviewed throughout the intervention at 30 minutes, two hours and every four hours for the duration of seclusion. Standards for post-seclusion require review and debriefing of the incident with the patient and family/caregivers where appropriate. While seclusion standards are province-wide, policies that address the practice of restraint (physical, mechanical and chemical) are instead governed by individual health authorities and facilities.

[102]Ministry of Health, Provincial Quality, Health & Safety Standards and Guidelines for Secure Rooms in Designated Mental Health Facilities under the B.C. *Mental Health Act* (Victoria, 2014).

One of the young people described being *"locked"* in a padded isolation room at times, not dissimilar to their previous experiences of separate confinement in a youth justice custody centre.[103] Another young person found that the use of secure rooms was often preceded by force: *"They dealt with anger with seclusion and aggression with medication … I remember thinking is it even legal? Is it legal for three big dudes to hold a 120-pound girl down?"*

While the *Standards and Guidelines for Secure Rooms* should provide some protection to patients admitted to hospital under the *Mental Health Act*, it is not known how fully these guidelines are implemented. Records on the use of secure rooms and seclusion are not maintained by health authorities in a manner that enables assessment of compliance and effectiveness without having to review individual patient files. The standards include both the requirement to document the use of seclusion interventions and to review the incident with the patient and guardians, as well as the requirement for designated facilities to collect data on the frequency of seclusion interventions, and that each health authority track and report this data to the Ministry of Health.[104]

Seclusion room use was reported for 194 children and youth with a mental health hospitalization in 2018/19, and 38 per cent of the patients who experienced the use of seclusion rooms were age 15 or under. Some children and youth experienced seclusion interventions more than once, as there were 289 seclusion room incidents reported for the 194 patients.[105] The use of seclusion varies by facility and health authority, with the Interior Health Authority and Fraser Health Authority reporting the highest count of seclusion room interventions.

Table 3: Use of seclusion rooms by hospital health authority, 2018/19

	Age 0 -15		Age 16 -18		Age 0 -18	
Hospital Health Authority	Incidents	Unique patients	Incidents	Unique patients	Total Incidents	Total Unique Patients
Interior	26	17	61	38	87	55
Fraser	22	15	48	33	70	48
Vancouver Coastal	1	1	14	7	15	8
Vancouver Island	19	15	26	19	45	34
Northern*	21	16	37	23	58	39
Provincial Health Services Authority	12	9	2	1	14	10
Total	**101**	**73**	**188**	**121**	**289**	**194**

Source: Ministry of Health

* Data provided by Ministry of Health may be unreliable. For fiscal 2018/19, Northern Health Authority recorded 65 total incidents and 56 unique patients.

[103] Separate confinement is colloquially referred to as *"solitary confinement."*

[104] Ministry of Health, *Provincial Quality, Health & Safety Standards and Guidelines for Secure Rooms in Designated Mental Health Facilities under the B.C. Mental Health Act* (Victoria, 2014), 43.

[105] Ministry of Health. Use of Seclusion(safe) rooms: case count and unique patient counts with and without an Involuntary Status under the *Mental Health Act*.

The two provincially designated mental health facilities operated by MCFD also utilize seclusion rooms.[106] In 2018/19, there were 50 incidents of seclusion room use for 11 patients in Maples Adolescent Treatment Centre and Youth Forensic Psychiatric Services (see Table 4). MCFD issued a practice directive in 2013 discontinuing the use of safe rooms in all residential resources, but this policy has not been extended to MCFD-operated mental health facilities.[107, 108]

Table 4: Use of seclusion rooms by MCFD operated Designated Mental Health Facility, ages 12 to 18 years

	Youth Forensic Psychiatric Services		Maples Adolescent Treatment Centre		Total of MCFD Operated Designated Facilities	
	Incidents	Unique Patients	Incidents	Unique Patients	Incidents	Unique Patients
2014/15	19	11	17	6	36	17
2015/16	117	18	77	7	194	25
2016/17	76	11	70	7	146	18
2017/18	53	10	34	5	87	15
2018/19	11	8	39	3	50	11

Source: MCFD

Youth interviewed for this report spoke of the emotional harm and disempowering impact of their seclusion and restraint. Isolation poses both medical and psychological risk to mental health patients, and increased potential of harm to children and adolescents.[109] Mental health patients with a history of trauma are more likely to experience seclusion and which causes further trauma and harm and may escalate challenging behaviour. The provision of trauma-aware and trauma-informed care and treatment should be provided to address underlying needs and concerns and reduce the likelihood of behaviours that typically lead to the use of restraint and seclusion and further traumatization.[110]

[106] The Maples Adolescent Treatment Centre policy manual has material on the use of seclusion rooms and restraints.
[107] Ministry of Children and Family Development Practice Directive 2013-01: Use of Safe Rooms in Residential resources.
[108] Maples Adolescent Treatment Centre Policy Manual has criteria for the use of seclusion rooms and restraints. The criteria establish acceptable types of seclusion and restraints and the procedures to follow to ensure the use is necessary and appropriate based on an immediate risk of harm to the young person or another individual, and includes procedures that are to be followed after seclusion or restraints are used including debriefing with the young person and staff, reporting requirements such as a critical incident report, and administrative review for restraints that last longer than three minutes.
[109] British Columbia Ministry of Health: Secure Rooms and Seclusion Standards and Guidelines: A Literature and Evidence Review, September 2012.
[110] British Columbia Ministry of Health: Provincial Quality, Health & Safety Standards and Guidelines for Secure Rooms in Designated Mental Health Facilities under the B.C. *Mental Health Act*.

While there is an absence of B.C. data on mental health seclusion by race, gender and Indigeneity, in New Zealand it is known that there is disproportionate use of seclusion on Indigenous populations in inpatient settings, with Indigenous adults 3.7 times more likely to be secluded than non-Indigenous patients.[111]

It is critically important that seclusion and restraint measures are used appropriately and as a last resort. As a matter of principle, the use of these extraordinarily intrusive measures demands rigorous monitoring and accountability, especially with vulnerable children and youth. Unlike other provinces, in B.C. there are no legislative criteria that define, govern or establish oversight of such disciplinary measures. There is also no statutory right for a patient to request a review of the use of seclusion, although a review may be requested as a matter of policy.

BC Supreme Court 2018 Decision on Solitary Confinement

In January 2018, the B.C. Supreme Court declared that indefinite solitary confinement as practised in federal prisons violated Sections 7 and 15 of the *Canadian Charter of Rights and Freedoms*. After hearing expert testimony from both sides, the Court accepted the expert opinions from the BC Civil Liberties Association and John Howard Society of Canada ("the Plaintiffs) as fact. The Court accepted that the laws permitted prolonged, indefinite confinement, placing inmates at a *"significant risk of serious psychological harm, including mental pain and suffering, and increased incidence of self-harm and suicide"* (para 247). Further, the indeterminacy of confinement was problematic because it exacerbated the risks of harm and impacts of past trauma.

The BC Civil Liberties Association has called for the province to completely prohibit the use of restraints and seclusion for all children under the age of 16 admitted under the *Mental Health Act*, or at minimum to restrict it except to prevent serious or imminent harm, with amendments to the *Mental Health Act* to include restrictions on seclusion.[112] There is a call to protect other populations from isolation as treatment or discipline. The Manitoba Child Advocate recommended the end of solitary confinement for youth, and the College of Family Physicians of Canada has called for the abolishment of solitary confinement for youth on ethical, moral and medical grounds.[113, 114] B.C.'s *Health Care (Consent) and Care Facility (Admission) Act* prohibits restraint for the purpose of punishment or discipline, or for the convenience of care facility staff, however this legislation does not apply to involuntary psychiatric treatment in a designated facility under the *Mental Health Act* (s.26.1).

The Representative is concerned that there may not be sufficient oversight of this extraordinary power to discipline young people who are being treated under the *Mental Health Act*. The fact that these measures are coercive and may be experienced as traumatizing underlines the need for rigorous oversight and accountability. The absence of legislation and regulation to guide the use of this extraordinary power is

[111] Royal Australian and New Zealand College of Psychiatrists. Position Statement 61: Minimizing the use of seclusion and restraint on people with mental illness. February 2016. https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/minimising-the-use-of-seclusion-and-restraint-in-p.

[112] BC Civil Liberties Association. https://bccla.org/wp-content/uploads/2020/08/letter-to-MMHA-and-MH-Bill-22-August-7-2020.pdf.

[113] College of Physicians of Canada. Position Statement on Solitary Confinement. Aug. 7, 2016. https://portal.cfpc.ca/resourcesdocs/uploadedFiles/Directories/Committees_List/Solitary%20Confinement_EN_Prison%20Health.pdf.

[114] Manitoba Advocate for Children and Youth. Learning from Nelson Mandela. A Report on the Use of Solitary Confinement and Pepper Spray in Manitoba Youth Custody Facilities. 2019. https://manitobaadvocate.ca/wp-content/uploads/MACY-2019-Learning-from-Nelson-Mandela-FINAL.pdf.

concerning, although such legislation and regulation exists to govern the use of restraints in residential care facilities and the use of restraints and confinement in youth custody centres. To permit the unregulated use of restraint and confinement of patients, and specifically of children, is unacceptable.

Jurisdiction Example: Ontario

In Ontario, the *Mental Health Act* Criteria for Restraint: Section 14 states that nothing in Ontario's Act authorizes a psychiatric facility to detain or to restrain an informal or voluntary patient.

Section 53(1) notes that where restraint is used on an involuntary patient, the use of restraint on a patient shall be clearly documented in the patient's record of personal health information by the entry of a statement that the patient was restrained, a description of the means of restraint and a description of the behaviour that required restraint or continued restraint. Section 53(2) clarifies that, where a chemical (medication) restraint is used, the entry documentation shall include a statement of the chemical employed, the method of administration and the dosage.

Independence and Identity

> "The biggest thing that honestly made me feel a sense of control was having my things. Now these are mine. The ability to choose what should I put on. A shirt and pants, not those stupid hospital gowns."
>
> SAMUEL

Several young people who participated in this report said the lack of control over their own belongings was a big part of what made their experience of detention feel like a punishment and a loss of individuality and independence. In B.C., the *Mental Health Act* is silent on the issue of the right to clothing and belongings, although there are examples of very different approaches in other jurisdictions. For example, Yukon's *Mental Health Act* includes patient rights related to the protection and preservation of human and civil rights. This includes the right to receive and wear clothing of the person's choice unless it is likely to endanger the person or offend others, and the right to access visitors and to make/receive phone calls.[115] The protection of these rights can be particularly important for young people to maintain and express a sense of independence and identity.

In its 2017 report *Operating in Darkness,* CLAS notes:

> *"Left to the discretion of detaining facilities, detainees are generally required to remove their clothes and wear a hospital gown/pyjamas on admission. Detaining facilities treat clothing not as a right, but as a privilege, and often use access to clothing as a behaviour modification method. Representatives reported that some detaining facilities even prevent detainees from wearing clothes in review panel hearings of the Mental Health Review Board."* [116, 117]

This raises significant concerns around the ways young people may experience a sense of powerlessness and a loss of dignity in addition to the loss of liberty and freedoms inherent in a mental health detention.

[115] *Mental Health Act*, R.S.Y. 2002, c. 150, s. 40.
[116] Community Legal Assistance Society, *Operating in Darkness: BC's Mental Health Act Detention System* (Vancouver, 2017), 14.
[117] This may not be standard practice in all child and youth psychiatric units.

The CLAS report also raises the concern that while other detained populations in Canada, including B.C. youth in youth custody, have a right to someone of the same sex removing their clothing, people detained under the *Mental Health Act* have no right to same sex clothing removal. Indeed, CLAS reports that detainees routinely experience having their clothing forcibly removed by health care providers and security guards of a different gender.[118] Children and youth of all genders, especially those who have experienced sexualized violence, may experience this as deeply traumatizing.

Extended Leave

A patient admitted involuntarily to the hospital under the *Mental Health Act*, including a child or youth, may be placed on "extended leave" if the designated director considers that leave would benefit a patient detained in the designated facility.[119] Extended leave is intended to ensure *"the earliest possible release of an involuntary patient from hospital"* and *"optimize an involuntary patient's potential for community living through the provision of support for treatment compliance once out of hospital."*[120]

When a patient is on extended leave the conditions of their involuntary admission remain, but they live in the community rather than in the hospital.[121] A patient who does not comply with the conditions of their leave can be recalled to the hospital at any time.

Over the 10 years between 2008 and 2018, there has been an increase in the use of extended leave for young people, rising from 27 cases per year to 77 cases per year.[122] The proportion of children and youth certified under the *Mental Health Act* who are on extended leave has remained fairly constant, varying from three to five per cent of the total annual count of hospitalizations of children and youth with at least one involuntary period during the length of stay, as illustrated in Table 5.

[118] Community Legal Assistance Society, *Operating in Darkness: BC's Mental Health Act Detention System* (Vancouver, 2017), 15.
[119] *Mental Health Act*, R.S.Y. 2002, c. 150, s. 37
[120] Ministry of Health (2005) p. 29
[121] For the purpose of this report, extended leave is defined as leave of more than 14 days that occurs while the child or youth is still certified under the *Mental Health Act*.
[122] Some children may have been certified and discharged more than once during this time period, therefore this number represents cases, rather than unique patients.

Table 5: Extended leave for children and youth (0 to 18-years-old) certified under the *Mental Health Act*.

Fiscal Year	Extended Leave	Total Involuntary Discharges	Extended Leave as a Percentage of Discharges
2008/09	27	973	3%
2009/10	52	1,043	5%
2010/11	43	1,254	3%
2011/12	55	1,457	4%
2012/13	51	1,715	3%
2013/14	73	1,993	4%
2014/15	73	1,930	4%
2015/16	85	2,043	4%
2016/17	99	2,101	5%
2017/18	77	2,545	3%

Source: Ministry of Health

The use of hospital extended leave varies by health authority. The Fraser Health Authority and Vancouver Island Health Authority accounted for the largest number of cases of extended leave in the most recent three years of data available (2015/16 to 2017/18).[123] (See Table 6)

Table 6: Count of extended leaves by hospital health authority, ages 0 to 18-years-old

	2015/16	2016/17	2017/18	3 Year Total
Fraser	31	32	25	88
Vancouver Island	18	40	28	86
Vancouver Coastal	16	6	8	30
Northern	10	11	6	27
Interior	3	6	8	17
PHSA	7	4	2	13
Total	85	99	77	261

Source: Ministry of Health

[123] Ministry of Health. Case counts of patients on extended leave with an Involuntary Status under the *Mental Health Act* by hospital health authority. Both Fraser Health and Island Health have Early Psychosis Intervention (EPI) programs which provide ongoing psychiatric supports to enrolled youth that support extended leaves.

Table 7: Percentage of total extended leave cases by hospital health authority, ages 0 to 18-years-old

	2015/16	2016/17	2017/18	3 Year Total
Fraser	36%	32%	32%	34%
Vancouver Island	21%	40%	36%	33%
Vancouver Coastal	19%	6%	10%	11%
Northern	12%	11%	8%	10%
Interior	4%	6%	10%	7%
PHSA	8%	4%	3%	5%

Source: Ministry of Health
Note: May not add up to exactly 100% because of rounding

While it may often be preferable for children to be treated in the community rather than in the hospital, during this review the Representative heard a number of concerns about the use of extended leave for children and youth including:

- the threat of recall to hospital being used to coerce compliance
- situations where young people were placed on extended leave in resources that were not equipped to meet their needs or to support compliance with their leave
- lack of evidence to support that placing children on extended leave leads to better outcomes and no studies or evaluations completed on the effectiveness of extended leave for children in B.C.
- while the intention of extended leave is to provide *"a client-centred therapeutic intervention,"* there is no requirement for patient engagement during the process
- a concerning lack of safeguards for extended leave to ensure that young people's rights are respected.[124]

Unlike other Canadian jurisdictions, in B.C. the only statutory condition to place a patient on extended leave is for the designated director to believe that extended leave would benefit the patient.[125] Before placing a patient on extended leave, the director is advised by treating physicians about the stability of the patient, treatment plan, and other conditions of release. There are no limitations on the conditions of extended leave and very limited opportunity for review.

[124]Community Legal Assistance Society, *Operating in Darkness: BC's Mental Health Act Detention System* (Vancouver, 2017), 22.
[125]Details regarding the conditions of extended leave are available in the provincial *Guide to the Mental Health Act*.

Jurisdiction Examples: Extended Leave

Other jurisdictions have more specific legislated criteria that articulate when extended leave can be used. For example, in Alberta a patient may only be placed on extended leave if two doctors, including one psychiatrist, examine the patient separately within three days and all of the following criteria are met:

(1) The patient is suffering from a mental disorder

(2) One or more of these conditions apply:

a. In the past three years, the individual was a formal patient in a designated facility at least two times or for at least 30 days; and/or was in a facility, hospital or correctional institution where they were eligible to be a formal patient

b. And/or, in the past three years the individual has been on a Community Treatment Order (CTO) at least once; and/or

c. Both doctors believe the individual to show a pattern of repetitive or recurring behaviour while living in the community that shows they are likely to cause harm to themselves or others or become significantly more ill mentally or physically, or become physically impaired if they don't get continuing treatment or care in the community.

(3) Both doctors believe the individual is likely to harm themselves or others or to become significantly more mentally or physically ill or become seriously physically impaired if they don't get continuous treatment and support in the community

(4) The doctors believe the individual is able to follow the treatment and care plan the CTO describes.

Extended leave *"may continue as long as the involuntary status of the patient is maintained through correct renewal procedures, or until the patient is recalled to hospital, or discharged."* [126] This is concerning as patients on extended leave in the community may be more likely than inpatient detainees to remain certified when they no longer meet the criteria.[127]

In the absence of more diverse voluntary therapeutic options that provide young people and their care teams options for treatment, community-based involuntary treatment via extended leave might be a more humane option than institutionalization. However, significant concerns remain around how extended leave is used and whether it is effective, and for whom it could be effective or beneficial.

[126] Ministry of Health, *Guide to the Mental Health Act* (Victoria, 2005), 33.
[127] Community Legal Assistance Society, *Operating in Darkness: BC's Mental Health Act Detention System* (Vancouver, 2017).

Mental Health Review Board

In B.C., an involuntary hospital admission will only be reviewed at the request of a patient or a person acting on the patient's behalf.[128] This involves completing Form 7: Application for Review Panel Hearing. The process is the same for young people under age 16 voluntarily admitted by their parent or guardian who disagree with their admission.[129] Involuntary patients may request a review once per detention period (which is one, three or six months long). Once a patient's application for review is received, the review hearing must be scheduled within 14 or 28 days, depending on where the involuntary patient is within the cycle for certification renewal, and provided that 90 days have passed since the conclusion of any previous hearing.[130]

The review panel hearing is conducted by the Mental Health Review Board. The panel's only function is to decide whether an involuntary patient meets the four criteria for certification (see page 14). If a review panel decides a patient detained under the *Mental Health Act* does not meet the four criteria for certification, the patient is decertified and must be discharged from hospital unless they are admitted on a voluntary basis. If a review panel decides a patient does meet the four criteria, their certification continues.

After applying for a Review Board hearing, patients, including children and youth, can request to have a legal advocate or lawyer appointed to represent them at the hearing. If a young person is found not to have capacity to instruct counsel, the young person may represent themselves or have a family member or friend represent them.

Table 8: Mental Health Review Board hearings involving children and youth (0 to 18-years-old) with legal representation

Year	Annual Involuntary Mental Health Hospitalizations by discharge	Requests for Review Board Hearings	Requests as percentage of discharges	Review Board Hearings	Hearings as percentage of discharges	Number of Hearings with Legal Representation by CLAS
2008/09	973	33	3%	8	0.8%	6
2009/10	1,043	45	4%	12	1.2%	9
2010/11	1,254	52	4%	9	0.7%	5
2011/12	1,457	68	5%	16	1.1%	9
2012/13	1,715	63	4%	15	0.9%	9
2013/14	1,993	55	3%	12	0.6%	3
2014/15	1,930	58	3%	15	0.8%	7
2015/16	2,043	70	3%	17	0.8%	12
2016/17	2,101	66	3%	20	1.0%	12
2017/18	2,545	59	2%	21	0.8%	14
Ten-year Total	**17,054**	**569**	**3%**	**145**	**0.9%**	**72**

Source: Mental Health Review Board, Ministry of Health and CLAS

[128] Excluding persons on extended leave for a consecutive period of a year.
[129] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 21.
[130] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 25(1).

As of Jan. 31, 2020, the Mental Health Review Board could also appoint a Discharge Advocate to assist the panel in reaching a fair, timely and just decision, although this step has not yet been taken due to a lack of funding. The Mental Health Review Board defines the role of Discharge Advocates on a case-by-case basis, which may include participating in cross-examination, drawing the panel's attention to evidence in favour of discharge (decertification) from the records and presenting legal submissions in support of discharge, where appropriate.[131, 132] Table 9 above describes the number of Mental Health Review Board hearings for children and youth with legal representation.

Very few children and youth admitted under the *Mental Health Act* are exercising their rights to have their detention reviewed by the Mental Health Review Board. The number of review hearings requested represents, on average, three per cent of total involuntary hospitalizations (see Table 9). In 2017/18, there were 2,545 discharges of previously detained children and youth and just 59 review board requests.[133, 134] Twenty-one requests for review proceeded to a hearing and only 14 of these had legal representation from CLAS at the hearing, the agency contracted by Legal Aid BC to provide representation at all Mental Health Review Board hearings.

Children and youth detained under the *Mental Health Act* are less likely than adult patients to request a review by the Mental Health Review Board. Reviews were conducted for approximately four per cent of all involuntary cases in 2016/17, compared to only one per cent for children and youth.[135]

While there is no "right" number of reviews that would be expected, it is concerning that so few children and youth are accessing the review process and legal representation, raising the question whether this is, in part, due to lack of information about rights or the absence of child-friendly materials and process, and lack of access to independent legal advice and assistance in exercising those rights.

Access to legal representation from CLAS is not available until after a child or youth requests a review, putting the onus of applying for a review on the detainee, who may already be overwhelmed by their hospitalization, loss of liberties and, as some youth expressed, interruption of their natural supports and community. The time delay between applying for a review hearing and the actual review panel hearing taking place may also impact the numbers requesting a hearing. The hearing is required to be held 14 days after application if a patient requests it during the first two months of involuntary admission, and within 28 days of the request after the third month of detention. Given one-third of detentions of children and youth (2017/18) were for a duration of less than one month, waiting up to 14 days for a hearing makes the process to challenge certification inaccessible for many children and youth.

The written reasons for Mental Health Review Board decisions are a critically important component of procedural fairness for children and youth. The reasons explain how board members applied the legislative criteria to the facts of the child or youth's situation and adjudicated the careful balance of fundamental *Charter* rights. However, in reviewing a sample of 38 decisions (or 26 per cent of the

[131] British Columbia Mental Health Review Board, *Practice Direction – Patient Representatives and Discharge Advocates* (Vancouver, 2020).

[132] Discharge Advocates are not instructed by patients to represent them at the hearing. Rather, Discharge Advocates attend the hearing at the request of the Mental Health Review Board to test the facility's case for continued detention and assist the panel in reaching a fair and just resolution of the proceeding.

[133] Ministry of Health, annual mental health hospitalizations by discharge, administrative data.

[134] Community Legal Service Society administrative data

[135] Community Legal Assistance Society, *Operating in Darkness: BC's Mental Health Act Detention System* (Vancouver, 2017), 98.

145 decisions) spanning the 10-year period between 2008 and 2018, RCY noticed that many of the decisions reviewed did not adequately explain how the decisions were reached. It was also evident that in recent years there has been an improvement in the sufficiency of the information recorded. In 2020, the Mental Health Review Board published its first set of anonymized reasons for decisions – a positive step toward greater accountability.

Jurisdiction Examples: Mandatory Review Mechanisms

Other Canadian jurisdictions have mandatory review mechanisms in place to prevent indefinite periods of detention without review. For example, in Manitoba, involuntary patients are deemed to have applied to the Review Board on the filing of a third renewal certificate. In Alberta, involuntary patients who have been detained for a period of six months or have had an application for a review withdrawn or cancelled will have a mandatory review of their detention by a review panel. In *JH v Alberta (Minister of Justice and Solicitor General)*, 2020 ABCA 317, the Alberta Court of Appeal found that the guarantee in the *Alberta Mental Health Act* of a hearing every six months was an insufficient safeguard to fulfill the Charter rights of involuntary patients because there was still a clear risk of unnecessary detention.

Revolving Doors

All stakeholders interviewed for this report recognized that involuntary hospitalization ends up being a revolving door for some children and youth. Indeed, the young people heard from for this report – especially those who felt they had fragile support systems – expressed that they often felt they were unable to access the help they needed, both inside and outside of the hospital.

"The discharge plan was for them to call me in two weeks, but they didn't."

ADRIANNA

One young person interviewed for this report attributed their repeated certifications under the *Mental Health Act* to the inadequate support they received post-discharge, stating:

> *"I feel like it became such a vicious cycle in my life … the hospital definitely played a big part in me becoming a psycho because you go in there, maybe you don't like it, you don't get the answers you feel like you need, like it's almost certain that it's going to happen again. You never found the solution to your problem. They just gave you medication and told you to see a therapist."*

First Nation and Métis stakeholders lamented the lack of care in community to support children and youth in healthy and healing ways. Long wait lists for services and a lack of appropriate supports often leads to a *"revolving door"* of involuntary hospitalizations that traumatize youth over and over. This trauma is particularly acute for First Nations, Métis, Inuit and urban Indigenous children and youth who carry with them the repeated intergenerational traumas of residential schools and child welfare apprehensions.

"Psychiatrists made me take meds. They wanted me out. They let me go … no appointments after."

TONY

An independent rights advocate would be an important service for children and youth, having someone be 'on their side' ensuring they aren't being kept in acute, restrictive

"I was told to connect to a psychiatrist and counsellor, but I never was connected to those supports."

WOLF MOONE

settings longer than necessary, to advocate for discharge planning, or to facilitate connection to community supports.

Without meaningful supports post-discharge, children and youth may be forced back into the conditions that contributed to their deteriorating mental health in the first place. All of the young people InWithForward spoke to remembered being admitted more than once, with the majority of these youth being admitted three times. One young person recalled being admitted 21 times in their life.

Frustratingly, this is an issue that RCY has spoken out about for years. In RCY's 2013 report, *Still Waiting: First-Hand Experiences with Youth Mental Health Services in B.C.*, youth who received hospital inpatient or bed-based treatment for mental health problems and their families indicated that they were not properly supported in the youths' return to home and community. Said one parent, *"As for family support, there was not enough. It's been exhausting. The hospital Emergency ward sent her home to a traumatized family. There really needs to be more continuity of support."* In RCY's 2017 investigative report *Missing Pieces: Joshua's Story*, the need for a clear and comprehensive youth mental health system was brought into clear focus against the backdrop of Joshua's suicide.

Unfortunately, it does not appear that there have been significant improvements in post-discharge supports for children and youth in the years since the release of *Still Waiting* and *Missing Pieces*.

In *Pathway to Hope*, MMHA announced plans to improve mental health wellness for children, youth and young adults. The Roadmap identified priority actions, with a plan of expanding step-up and step-down services, including two intensive day programs and 20 family care home step up/step down spaces with clinical care, yet 18 months after funding was allocated in Budget 2019/20 for these new community placements, they are still not in place.[136] Further, in September 2020 the MCFD advised the Representative of its plans to create high intensity outreach teams in a small number of communities instead of creating the step up and step down beds identified as priority in the Roadmap.

[136]Ministry of Mental Health and Addictions, *A Pathway to Hope: A roadmap for making mental health and addictions care better for people in British Columbia* (Victoria, 2019), 20.

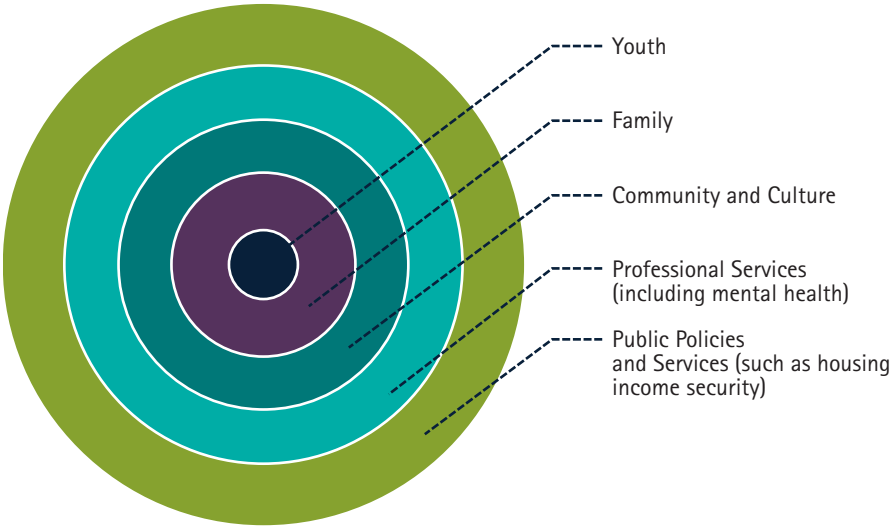
Opportunities for Change – Other Approaches to Treatment Under the *Mental Health Act*

Social Ecological Model of Mental Wellness

The treatment of young people under the *Mental Health Act* reflects a biomedical approach that focuses on the individual to the exclusion of other factors, countering many young peoples' expectations that their hospitalization would help them move beyond the symptoms to address the roots of their anguish.[137] "*If my doctors had listened, I would have moved on with my life a lot sooner,"* said one youth.

There are many opportunities to improve the experience of children and youth involuntarily detained under the *Mental Health Act*. The social ecological framework puts children at the centre with family and culture as the first protective factors wrapped around them. Mental health services and policy embrace not just the child, but the community and family, too.

Figure 10: Social Ecological Model of Mental Wellness



Ensuring that all children and youth who are admitted for treatment under the *Mental Health Act* are supported in building, maintaining and strengthening their connections to their loved ones and to their culture and community will help mitigate the isolation and loneliness young people experience while detained, may improve their ability to participate in decision-making around their treatment and support their ability to continue healing upon discharge.

[137] British Psychological Society, 2011

Youth-Centred Care

In order for children and youth to be active participants under the *Mental Health Act*, they need to have access to information and advice about their rights, support to exercise their rights and information about their diagnosis and treatment.

Family-Centred Care

Detention under the *Mental Health Act* is an individual experience, premised on separating the person from the risks of their environment. And yet, loneliness and separation seem to be the feelings the young people heard from for this report most wish would subside – both during and after hospitalization. What was heard from the young people is that they want to experience safe, warm, supportive connection that will help them deal with the underlying causes of their symptoms.

Young people situate their emotional well-being within their relationships. Mental health challenges are interpersonal, reflecting shifting relational dynamics that include abuse, abandonment, death and divorce. While some young people reported that some psychiatric units went beyond medication, providing counselling or therapeutic groups, they recounted that these offers were time-limited and non-relational, still premised on individual over family and community well-being.

As evidenced above, many of the ideas the young people brought forward for improving the experience of children and youth before, during and after detention centre on connections to other people in the same way that they contextualize their experience of mental health crisis through their relationships. It's noteworthy that, within minutes of meeting with InWithForward, Charlie talked about his parents' divorce and the impact of family breakdown on his sense of self.

While the *Mental Health Act* requires notification of a near relative when a child or youth is detained involuntarily, this is not the same as inviting in and engaging family, friends and community in order to support collective healing. Indeed, the deemed consent model in the *Mental Health Act* may exclude family members such as parents from participating in treatment decisions when a child or youth is involuntarily admitted. Embracing family-level and community interventions for children and youth experiencing mental health crises may help divert young people from involuntary admission, improve their experience while admitted and improve their outcomes once they are discharged.

> "The main reason that I was depressed was like, moving into a foster home from being adopted. That was really hard."
>
> STEVE

> "My life was different variations on low. My dad was a user – alcoholic and abusive – so the feeling stretches back a long way."
>
> RAI

> "I was always with my mom. My mom was constantly there. But eventually she stopped being around as often. And other than her and my twin brother, I had never really had a connection to another human being."
>
> WOLF MOONE

Culturally Connected Care

None of the Indigenous young people spoken to for this report were introduced to culturally specific recovery frameworks, strategies or supports: *"Honestly? I didn't really get anything out of it … I just felt so written off like just another troubled Aboriginal youth."*

Cultural Safety

An approach that considers how social and historical contexts, as well as structural and interpersonal power imbalances, shape health and health care experiences. "Safety" is defined by those who receive the service, not those who provide it.

For one First Nations youth, the system response during their detention turned out to be one-dimensional: *"There was one way in their head to calm me down and that was medication … I don't think distractions are a plausible approach. I feel like if we're there, we're trying to work through something much deeper."* Forced psychiatric treatment under the *Mental Health Act* runs the risk of medicalizing Indigenous responses to historical and contemporary traumas, making the individual detained responsible for overcoming their pain while the conditions for that pain continue.

Young people expressed that there were limited and infrequently available alternatives or complementary interventions or resources, and this observation was echoed by other stakeholders.[138] Integration of Indigenous and Western approaches to treatment would allow for patients to experience increased autonomy and control and would also support their healing in culturally appropriate ways. A more holistic approach to treatment would view cultural perspectives and practices as inherently connected to other traditional treatment modalities.

"I felt categorized because of my age and race … One time, they [staff] wouldn't call me by my name, they called me 'the native girl.' Or they'd ask a question like, 'Do you have any stability?' and then ask about my race. They thought it was subtle. I don't think it has anything to do with my race."

ADRIANNA

Maples Adolescent Treatment Centre

The Maples Adolescent Treatment Centre offers specialized assessment and treatment programs for youth aged 12 to 18 who face significant psychiatric and behavioural difficulties. All programs and services utilize a holistic approach and include participation by the family as well as professionals in their home community. In most programs, there are both residential and non-residential options.

Maples houses the Tlatsini Indigenous program, a direct service to youth admitted to Maples or to Maples' staff providing culturally safe services to Indigenous and non-Indigenous youth, families, caregivers and communities. All youth who stay at Maples, both Indigenous and non-Indigenous, have access to an Indigenous Cultural Coordinator, an Indigenous Awareness Worker and a Knowledge Keeper to work with and support them. The Representative sees the culturally safe services provided at the Maples Adolescent Treatment Centre as a "bright spot."

[138] Centre for Applied Research in Mental Health and Addictions, Exploring Care Options for Individuals with Severe Substance Use Disorders in British Columbia (Vancouver, 2019).

Promising Practices

L, KI, L (L,TH,KEEL) Child and Youth Mental Health Program

The L,KI,L program offered by Hulitan Family and Community Services Society located in Victoria, B.C. provides support to Indigenous children and youth and their families, helping improve their mental health and overall well-being. The program is holistic in its approach, incorporating both cultural and mainstream interventions. The program embraces teachings of the medicine wheel in addressing the mental, emotional, physical and spiritual needs of children, youth and their families.

Okichitaw Indigenous Martial Arts Program

The Okichitaw program, located in the Greater Toronto Area, is a culturally based and developed program offered to urban Indigenous peoples. The program empowers individuals and promotes mental health by delivering a martial arts program that is grounded in Indigenous culture and values.

Tlatsini Indigenous program

All youth who stay at the Maples Adolescent Treatment Centre have access to an Indigenous Cultural Coordinator, an Indigenous Awareness Worker and a Knowledge Keeper to work with and support them. Tlatsini is a Tlingit word pronounced "Klatseenee" gifted to the Maples for Indigenous programming and means "The Place We Gather Strength."

Promising Practices

Respect for Cultural Identity Under New Zealand's *Mental Health Act*

New Zealand's *Mental Health Act* acknowledges that different cultures have different needs and beliefs and these must be considered when you are being assessed or treated under that country's Act.

New Zealand's Act holds that patients must be treated with proper respect for their cultural and ethnic identity, language and religious or ethical beliefs and the importance of a patient's ties to their family, community and culture must be properly recognized. These rights could include:

- the opportunity to speak your own language
- having your *"whanau"* (Māori word for extended family) and/or culture involved in your care and treatment
- health professionals understanding and considering cultural beliefs when looking at diagnosis and treatment options.

Aboriginal Patient Navigators

The Ministry of Health *2019/20 – 2020/21 Service Plan* includes the objective of effective population health, health promotion and illness and injury prevention services.[139] One of the Ministry of Health's strategies to achieve this objective is to *"continue working with health authorities, First Nations Health Authority, Métis Nation BC and other health system partners to support the commitment to culturally safe health services across the health care system."* [140]

One approach currently being used by all health authorities in B.C. to provide more culturally appropriate and safe services is the use of Indigenous patient navigators, nurses or liaisons.[141] Depending on the region, these positions provide services that include: helping Indigenous patients access health services, helping them understand the hospital care system, helping with discharge planning, supporting patients with accessing community services and supporting patients' families.

The Indigenous patient liaison program dates back to the 1980s. As the program evolved over time, the positions and how they function look different across and within health authorities.[142] The Representative sees this program as a "bright spot" in the B.C. health care system that deserves ongoing support and that could potentially bolster Indigenous youth voice and feelings of cultural safety when they are experiencing detentions under the *Mental Health Act*.

Land-Based Healing Programs

Detention under the *Mental Health Act*, with the exception of extended leave, commonly means long stretches of time spent indoors, which is a hardship for many patients. Stakeholders emphasized the need to improve access to land-based healing programs in which young people are able to connect with the land and their culture.

[139] Ministry of Health, *2019/20 – 2010/22 Service Plan* (Victoria, 2019).
[140] Ministry of Health, *Guide to the Mental Health Act* (Victoria, 2005), 6.
[141] Provincial Health Services Authority, *Dancing in Both Worlds: A Review of the Aboriginal Patient Liaison/Navigation Program in British Columbia* (Vancouver, 2015).
[142] Provincial Health Services Authority, *Dancing in Both Worlds: A Review of the Aboriginal Patient Liaison/Navigation Program in British Columbia* (Vancouver, 2015), 6.

Promising Practices

Nutshimit Program, Charles J. Andrew Youth & Family Treatment Centre in Newfoundland and Labrador

Nutshimit is a land-based healing program that provides Indigenous youth a safe, caring and comfortable environment to heal. Nutshimit draws on traditional healing and connection with the land and sea, by teaching youth skills that include: hunting, fishing, berry-picking, preparing traditional and healthy foods and traditional crafts.

Kwanlin Dün Jackson Lake Healing Camp in Yukon

Jackson Lake provides various land-based healing camps for children and their families. Children and their families share in cultural activities, traditional foods, Elders' teachings and time on the land. The camps provide a supportive, holistic and compassionate environment based on the integration of traditional and modern knowledge.

Youth Perspectives: Thinking Outside the Box

Youth-centred care must take the perspectives of youth into consideration. The young people interviewed for this report through InWithForward shared their stories as an act of catharsis and change. Each of the youth expressed real hope that their experiences could spark meaningful reform in practice and in systems.

These youth want to be part of the solutions. Together with InWithForward, they brainstormed a range of ideas, not simply as recommendations but as starting points for further collaboration and co-creation. InWithForward organized the young peoples' ideas into three categories: before detention, during detention and after detention.

Before Detention

What if events such as divorce, death, and removal from family triggered automatic offers of care and support? What if we didn't wait for young people and their families to reach out when in crisis, but recognized anguish and distress as normal responses to traumatic situations?

This could look like:

- Retreats and camps held year-round for young people to release their feelings and try new coping strategies
- Peer guides for young people who have come out the other side of tough events who can provide honest guidance and camaraderie.

During Detention

What if the detention experience afforded more choice – about when and how information was delivered, healing frameworks and strategies and types of supports at discharge? What if medical professionals weren't the only ones responsible for providing information and support, but young people, Elders, artists and naturalists also had a role to play?

This could look like:

- Video channels with content made for and by young people explaining certification and the *Mental Health Act* that could be watched on demand throughout a hospital stay
- Exposure to a range of spiritual and cultural practices could be provided to set young people up with healing practices and communities beyond medication
- Family dinners that are facilitated sessions with family members that recognize that young peoples' mental health challenges are connected to their relationships
- Free phone line provided inside psychiatric units that offers youth unlimited and private access to phones to connect with a lawyer or other advocate.

After detention

What if we recognized that detention is itself a distressing experience and provided opportunities for young people to debrief, offer feedback and share their perspectives as part of staff and family training?

This could look like:

- Debrief sessions offered to every young person who has been certified
- A ratings and reviews system for youth to provide feedback on their hospital experience, nominate helpful staff for awards and offer suggestions
- Rent-a-grandparent programs where retired community members offer a cup of tea, a listening ear and some grounding post-hospital stay
- Youth-delivered training, including workshops provided to health professionals by young people with real tactics and strategies for communicating with youth certified under the *Mental Health Act*.

Recent Development – Bill 22, Mental Health Amendment Act, 2020

Bill 22 was introduced in the B.C. Legislature on June 23, 2020. The proposed amendments to the *Mental Health Act* would allow designated hospitals in B.C. to establish 'stabilization units' and legally authorize short term involuntary stabilization care for youth with severe problematic substance use, who present in an emergency room, in the aftermath of a substance overdose.[143]

In response to Bill 22, the Representative and a number of her colleagues – including the Ombudsperson, the Coroner, the British Columbia Centre on Substance Use, Health Justice, the BC Civil Liberties Association, the Union of BC Indian Chiefs, the BC Association of Aboriginal Friendship Centres and the Delegated Aboriginal Agencies Directors forum and the Human Rights Commissioner – raised significant concerns about the proposed amendments.

The concerns raised centre upon the government's decision to introduce a new form of involuntary care for children and youth, absent adequate investments in a robust suite of voluntary substance use services and supports for young people in the province. Further concerns include:

- Bill 22's proposed stabilization units could add new layers of shame, stigma and fear as many young people experience involuntary stabilization as punitive

[143] The intent of Bill 22 is to provide youth stabilization care in part of a public hospital that has an emergency department and a psychiatric unit or observation unit within the meaning of the *Mental Health Act* and is suitable to provide the youth stabilization care.

- The proposed stabilization units may also result in a reluctance to call for medical help if that call might result in detention
- If young people fear calling for help after an overdose, the result could be an increase in fatal overdoses
- Short-term involuntary care may further alienate young people from their families, care providers and community supports
- Bill 22's proposal may create another system of detention that could be experienced by First Nations, Métis, Inuit and urban Indigenous youth as a continuation of colonial oppressive policies
- Increase of Indigenous youth coming into care through the application of discriminatory practices that see Indigenous parents as unable to care for their children, and
- Bill 22 lacks necessary procedural safeguards including a right to an independent review.

In response to the concerns expressed, the Minister of Mental Health and Addictions said the government will take some time to engage on the issue before moving forward with the Bill. On August 13, 2020 the government announced funding to double the number of youth substance use treatment and withdrawal management beds (123 new beds) with a $36-million investment through 2022/23.

Recommendations

Overarching

RECOMMENDATION 1

That the Ministry of Mental Health and Addictions work with the Ministry of Health and the Ministry of Children and Family Development to conduct a review, after consulting with health authorities, First Nations, Métis Nation and urban Indigenous communities and leadership and other appropriate bodies, into the use of involuntary mental health care for children and youth to identify the conditions that are contributing to its increased use, and identify immediate opportunities to provide voluntary interventions or improve practices that would reduce involuntary admissions.

Review to be complete by Jan. 1, 2022.

RECOMMENDATION 2

That the Ministry of Health require health authorities to collect and report key information pertaining to children and youth admitted under the *Mental Health Act* in a way that is standardized across the province and reported regularly, including but not limited to:

- identity factors (ethnicity, gender identity)
- Indigeneity – First Nations, Métis and Inuit identity
- standardized length of stay data across all hospital settings
- admissions of children on a voluntary basis at the request of their parents
- requests for, and outcomes of, second medical opinions
- detailed seclusion and restraint data
- data related to extended leave
- outcomes related to quality of care, effectiveness and patient satisfaction.

This work to be completed by June 1, 2022.

Admission

RECOMMENDATION 3

That the Ministry of Health, in partnership with the Ministry of Mental Health and Addictions and the health authorities, review and reconcile s.20(a)(ii) of the *Mental Health Act* that permits the designated director to admit a child under 16 on a voluntary basis at the request of their parent or guardian with the mature minor doctrine.

Review to be complete by Jan. 1, 2022.

RECOMMENDATION 4

That the Ministry of Health, and the Ministry of Mental Health and Addictions actively engage and consult with First Nations, Métis Nation and urban Indigenous health bodies and leadership to develop a process to enable a child or youth to notify their community or Nation of their involuntary admission.

To be complete by Sept. 1, 2021.

Rights

RECOMMENDATION 5

That the Attorney General in partnership with the Ministries of Health and Mental Health and Addictions, ensure that an independent body is notified every time a child or youth is detained under the *Mental Health Act* and that this body is mandated to provide rights advice and advocacy to children and youth.[144]

Independent body to be in place by Dec. 1, 2021.

RECOMMENDATION 6

That the Ministry of Health in co-operation with the Ministry of Mental Health and Addictions and the health authorities assess the appropriateness and accessibility of the information currently provided to children and youth and develop new information using multiple formats and media to better support young people to understand what's happening to them and what their rights and options are when detained under the *Mental Health Act*. Youth with lived expertise to be engaged to advise on the information that is most helpful and how best to make information available to children and youth.

Information to be developed by Dec. 1, 2021.

RECOMMENDATION 7

That the Ministry of Health work with the health authorities to develop a process to ensure that First Nations, Métis or Inuit children or youth who are either detained under the *Mental Health Act* or are under 16 and admitted by their parent/legal guardian are offered services by hospital staff who assist Indigenous patients such as navigators, liaison nurses, nurse practitioners and Elders in residence.

Process to be developed and operational by Jan. 1, 2022.

[144] BC Ombudsperson's recommendations 21 to 23 from March 2019 report *Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act* are applicable, have yet to be achieved and are now overdue. Recommendation 5 in this RCY report adds to the *Committed to Change* recommendations to bring specific focus to children and youth.

RECOMMENDATION 8

That the Ministry of Health and the Ministry of Mental Health and Addictions put forward amendments to the *Mental Health Act* after actively engaging and consulting with health authorities, First Nations, Métis Nation and urban Indigenous communities and leadership and other appropriate bodies, that will ensure children and youth who are detained under the *Mental Health Act* have the right to retain personal items that do not pose a risk to their safety or the safety of others and continue practices that support their physical, emotional, mental, spiritual and relational well-being and their sense of identity.

Amendments to be put forward by May 1, 2022.

Treatment

RECOMMENDATION 9

That the Ministry of Health, the Ministry of Mental Health and Addictions and the First Nations Health Authority actively engage and consult with First Nations, Métis Nation and urban Indigenous leadership and communities to identify changes needed in order to ensure that First Nations, Métis, Inuit and urban Indigenous children and youth are provided with trauma-informed, culturally safe and attuned mental health services, including a diversity of treatment modalities specific to their unique culture, when detained under the *Mental Health Act*.

Changes to be identified by Sept. 1, 2021 and implemented in full by Sept. 1, 2022.

RECOMMENDATION 10

That the Ministry of Health, in partnership with the Ministry of Mental Health and Addictions and the health authorities, undertake a comprehensive review of practices for:

a) children under 16 who have been "voluntarily" admitted, and take all necessary legal and administrative measures to ensure that "mature minor" capacity assessments are carried out where treatment is proposed, that the results of those assessments are recorded, and that physicians understand their duty to comply with the views of a mature minor regarding treatment, subject only to the order of a court

b) children assessed as mature minors who have been involuntarily admitted, and take all necessary legal and administrative measures to ensure that (i) despite the deemed consent provisions, the views of the young person are obtained, recorded and carefully considered before treatment decisions are made, and (ii) treatment information is conveyed in a manner that children and youth may understand.

Review to be complete by March 1, 2022.

RECOMMENDATION 11

That the Ministry of Health and the Ministry of Mental Health and Addictions put forward amendments to the *Mental Health Act* after actively engaging and consulting with health authorities, First Nations, Métis Nation and urban Indigenous communities and leadership and other appropriate bodies to ensure that, for children and youth who are detained under the *Mental Health Act*, isolation and restraint are:

- only used as a last resort when all other interventions have been exhausted, and
- only used in accordance with specific legislative or regulatory criteria including assessment, time limits, reviews, documentation and reporting requirements.

Amendments to be put forward by May 1, 2022.

RECOMMENDATION 12

That the Ministry of Health and the Ministry of Mental Health and Addictions conduct an evidence-informed and outcomes-based review of extended leave for children and youth who are detained under the *Mental Health Act* to:

- assess the effectiveness of extended leave as a mental health intervention for children and youth, and
- if extended leave is determined to be effective, review the need for additional legislative or regulatory criteria and oversight mechanisms, and review the extent to which children and youth are aware of and exercise their rights on extended leave.

Review to be complete by Jan. 1, 2022.

Reviews

RECOMMENDATION 13

That the Ministry of Health and the Ministry of Mental Health and Addictions put forward amendments to the *Mental Health Act* after actively engaging and consulting with health authorities, First Nations, Métis Nation and urban Indigenous communities and leadership and other appropriate bodies to create mandatory periodic Mental Health Review Board reviews for (i) involuntarily detained children and youth, and (ii) children under 16 who are admitted at the request of their parents, to ensure that such reviews do not depend on the child's knowledge or ability to make such a request. Mandatory reviews should only be conducted with the consent of the child or youth or their representative.

Amendments to be put forward by May 1, 2022.

RECOMMENDATION 14

That the Mental Health Review Board pilot a new Review Board hearing process for children and youth that centres the young person and is trauma-informed and culturally attuned after actively engaging and consulting with health authorities, First Nations, Métis Nation and urban Indigenous communities and leadership and other appropriate bodies.

Pilot to be operational by Oct. 1, 2022.

Glossary of Terms

Aboriginal Child and Youth Mental Health (ACYMH) services: CYMH services for First Nations and Aboriginal children, youth and their families that are delivered or funded by Ministry of Children and Family Development (MCFD). These services include core CYMH service functions as well as approaches designed to respond specifically to First Nations and Aboriginal communities

Child and Youth Mental Health (CYMH) services: an MCFD program of mental health services for children and youth with mental health problems from birth to 18 years of age and their families. CYMH services include triage, resource and support services upon referral, mental health assessment, treatment planning, therapeutic interventions, and mental health consultation.

Child and youth mental health practitioners: professionals who provide or manage mental health services for children and youth through a variety of agencies. These practitioners include mental health clinicians who provide assessment and treatment, and outreach and support workers who provide other mental health services to children and youth with mental health problems.

Certification: where a physician fills out a certificate under Section 22 of the *Mental Health Act* that allows for an individual to be involuntarily admitted and detained.

Crisis stabilization: support that prevents a mental health crisis from getting worse and/or reduces immediate risk of harm to self or others.

Cultural Safety: an approach that considers how social and historical contexts, as well as structural and interpersonal power imbalances, shape health and health care experiences. "Safety" is defined by those who receive the service, not those who provide it.

Deemed Consent: when a patient is involuntarily detained in a designated facility or is released on leave, the treatment authorized by the designated director is deemed to be given with the consent of the patient.

Mature Minor: a child who is assessed by a health care provider as having the necessary understanding to be capable to give consent. A child who is a mature minor may make their own health care decisions independent of their parents' or guardians' wishes. In B.C. there is no set age when a child is considered capable to give consent.

Mental health: a state of well-being in which the individual realizes his or her own abilities, copes with the normal stresses of life, works productively and contributes to his or her community. Good mental health is much more than the absence of mental illness – it enables people to experience life as meaningful and to be creative, productive members of society.

Mental health challenge: a cluster of symptoms that causes distress and disrupts one's ability to function in important aspects of life. Mental health problems include those that may not meet the criteria for diagnosis as mental illnesses as well as those that do.

Mental illness/disorder: a mental health problem that meets the criteria for one of the mental disorders in the current Diagnostic and Statistical Manual of Mental Disorders (DSM).

Outpatient services: traditionally, services delivered by hospitals where patients visit without receiving acute care from an Emergency Room or being admitted to in-patient services. Some acute hospital-based levels of care, such as acute home-based treatment, are now delivered through outreach to youth in home and community settings.

Protocol: a formal agreement or understanding that guides how two or more organizations will work together when delivering services.

Step up/step down care: a form of intensive intermediate mental health care that is less intensive than hospital care but more supportive than many types of community mental health care. When these services are available, an individual with declining mental health can 'step-up' into a highly supportive environment in the community to prevent their mental health from deteriorating further and prevent the need for hospitalization. People who have received and no longer require hospitalization can 'step down' into this form of intermediate care to enable a gradual and supported return to the community, reducing the likelihood of readmission to hospital.

Stigma: beliefs and attitudes that lead to the negative stereotyping of people with certain attributes, circumstances or experiences and to prejudice against them and their families.

Appendices

Appendix 1: International Human Rights Treaties

The issues of voice and self-determination are key elements of three specific International human rights treaties to which Canada is a signatory: the *United Nations Convention on the Rights of the Child*; the *United Nations Declaration on the Rights of Indigenous Peoples*; and the *United Nations Convention on the Rights of Persons with Disabilities*, as noted in these specific sections:

- ***United Nations Convention on the Rights of the Child***

  Article 12:

  1. State Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.
  2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

  Article 25:

  State Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.

  Article 37: State Parties shall ensure that:

  a) No child shall be subjected to torture or other cruel, inhuman, or degrading treatment or punishment.

  b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time.

  c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances;

  d) Every child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority and to a prompt decision on any such action.

- *United Nations Declaration on the Rights of Indigenous Peoples*

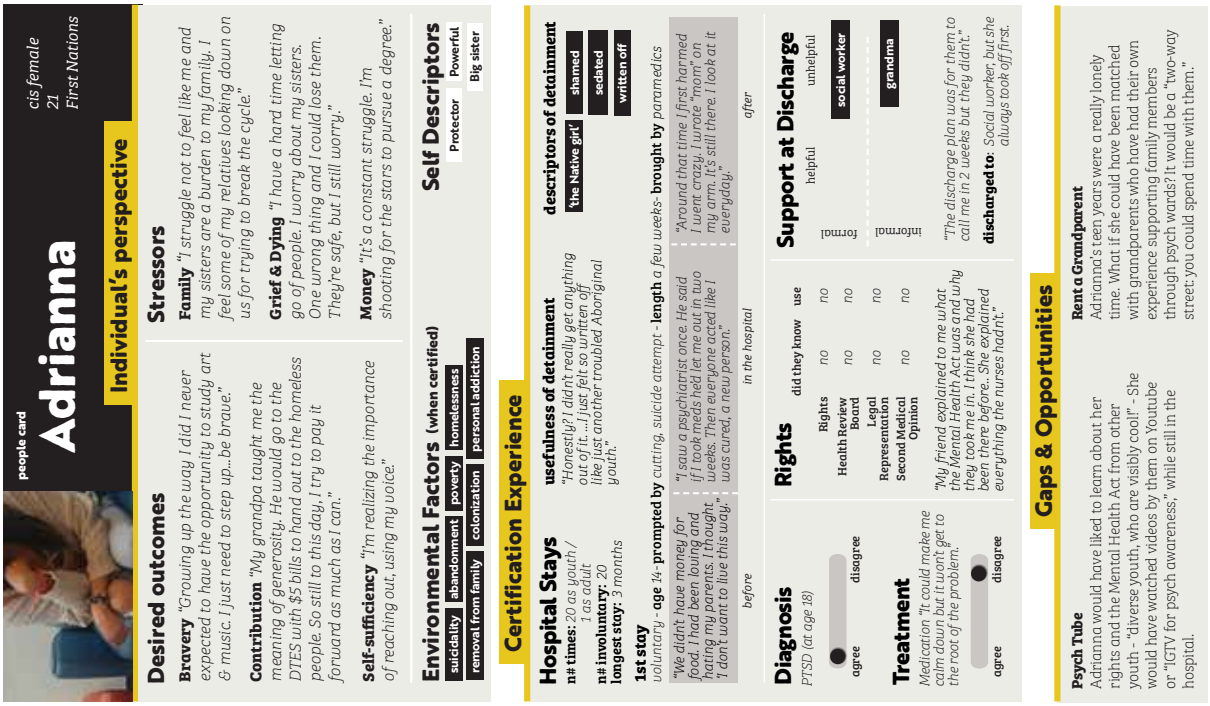
  Article 24 (1): Indigenous peoples have the right to their traditional medicines and to maintain their health practices including the conservation of their vital medicinal plants, animals and minerals.

  Article 29: States shall also take effective measures to ensure, as needed, that programmes for monitoring, maintaining and restoring the health of indigenous peoples, as developed and implemented by the peoples affected by such materials, are duly implemented.

- *United Nations Convention on the Rights of Persons with Disabilities*
  - **Article 12:**
    1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
    2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
    3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.
    4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.
    5. Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.
  - **Article 14:** The involuntary detention of persons with disabilities based on risk or dangerousness, alleged need of care or treatment or other reasons tied to impairment or health diagnosis is contrary to the right to liberty and amounts to arbitrary deprivation of liberty.

While it is not the Representative's role to monitor compliance with the international treaties, she considers these treaties guiding principles for the work she undertakes.

Appendix 2: Youth Profiles



"Now I'm in my twenties I'm like 'Wow! I have a voice! I'm powerful!"

How many psych ward visits does it take for a traumatized teen to receive a hug? For Adrianna, it was 18. "As a young teenager," she reflects, "I would just want someone to sit with me and talk with me, and show empathy." Instead, the system response turned out to be a bit of a one trick pony: "There was one way in their head to calm me down and that was medication." She was certified 21 times, without a diagnosis. "I don't think distractions are a plausible approach. I feel like if we're there, we're trying to work through something much deeper."

Looking back, Adrianna sees her years of depression and suicidality as situational: "I probably never would've ended up in the psych ward if it weren't for a chain of events." The eldest of five girls, Adrianna and her sisters lost their dad, and then their mom to the Downtown East Side. Their grieving grandmother provided a home for them, but couldn't help with the intense longing. "If there's a reoccurring theme in all this it's my mom. I missed her so much and I always thought she might help." After several incidents, she was deemed too high-need for her grandmother's care, and moved into a group home. "Grandma speaks her Native language but wasn't good at English...so I feel like people didn't want to deal with her: easier to deal with the ministry, to put me in care." Her depression deepened.

It wasn't until her last visit, age 19, that she was referred to a concurrent treatment program and finally got an opportunity to work through trauma while reconnecting to nature and culture. "I'm sober now, and I'm properly medicated now," but more importantly, "I'm getting to know myself and love myself. I'm finally finding myself."

story returned

John

#Youth Mental Health Act #NewWestminster

"It felt like they took away the piece of me that's unique & just wanted me to match everyone else."

Before turning seventeen, John describes himself as "colorful" and "outgoing." That was before four involuntary admissions to the psych ward at age 17. And before the padded room. Far from being safe in hospital, John sees his time as punishment. Once, after flipping a table, guards said: "you either go in willingly or not!" He was locked in a room with a bed and small window for hours. "It's teasing on torture to have to be in the rubber room for longer than four hours." After being ignored repeatedly, John had no choice other than to pee in the room. "That feels like shit. It's unfair. I'm a nice guy." The punishment John remembers wasn't just physical. He overheard doctors ridiculing him. Professionals tell him that the mockery never happened. That leaves John conflicted: he's not sure he can trust himself, but what if it's true? Doubt can gnaw at you and that's hard because John believes only you can be the expert in you. Now, at 29, John feels he's on an upward swing. His last hospital stay was four months ago, and for the past three months, his meds have been stable. He's making progress with his daughter, working at being more independent, and feeling supported by New Leaf, a mental health service. "I like the routine I have (now): eat breakfast, shower, clean clothes, hang out with friends, go to my parents house for dinner." Despite feeling good about himself, he still feels dismissed by lots of professionals (EPI groups were an exception). The last time he shared "very very" negative thoughts with his doctor, they admitted him, rather than talking it through. "They don't want to listen to me, obviously." Even at 29, doctors prefer to communicate with his mom. Still, he's a burgeoning self-advocate: "My dad taught me not to stop until I get what I want."

people card

John

cis male
29
Caucasian

Individual's perspective

Desired outcomes

Independence *"My goal is always to be more independent in life. I am currently in a little set back."*

Self-sufficiency *"One day, I want to just be able to take care of her [daughter] and me at the same time. And I think that's huge."*

Bravery *"It sucks to wake up and have voices and all that stuff, but you have to be brave and take it on the chin and be like I'm gonna go for it, I'm going to nail today."*

Stressors

Friends *"They'll just not understand it." (the effects of meds or the hallucinations)*

Grief *"I'm having a streak of bad luck with my family members being sick. I lost my dad two months ago."*

Money *"Money's always tight. Especially on PWD. After rent, after food [and bills]... you're left with nothing."*

Environmental Factors (when certified)

drug use | lack of sleep

Self Descriptors

Nerdy | Client | Friend

Certification Experience

Hospital Stays

n# times: *4 as youth / at least 6 as adult* ?
n# involuntary: *at least 7* ?
longest stay: *3 weeks / age 17*

usefulness of detainment

"I really wish there was a positive spin on it, but it sucked every single time."

"I most likely would have tried to get out... the first time I was in there, I wanted to do anything to get out."

descriptors of detainment

no choice | no options | isolated | it sucked | unfair | foggy | trapped | crummy | terrible

1st stay

involuntary - **age** *17* - **prompted by** *hallucinations* - **length** *3 weeks* - **brought by** *parents*

before	*in the hospital*	*after*
"I was very colorful. I was very outgoing.... I had so much energy pouring through my body and adrenaline..."	*"I was really depressed... I'll never forget being 21 days in the psych ward. Like that was so long, that was so long. And a lot of being like in the rubber room."*	*"I felt I was boring. I left the hospital with medications to take and it really changed who I was as a person."*

Diagnosis

changes depending on the doctor: Borderline personality psychosis NOS, NVLD non-verbal learning disorder

agree — disagree

Treatment

Medication & seeing a psychiatrist

agree — disagree

Rights

	did they know	use
Rights	*no*	*no*
Health Review Board	*yes*	*no*
Legal Representation	*no*	*no*
Second Medical Opinion	*no*	*no*

"So you can be like, I'm good. I don't need to be here. But like, it didn't matter. It was the doctor's opinion versus your opinion. And you're crazy. So what can you do?"

Support at Discharge

	helpful	unhelpful
formal	Epi groups, Epi psychiatrist	kids help line
informal	friend that understands, parents, friends group	

"Hospital. Well, no good. Epi, superior. Cuz they actually gave a shit. Yeah, at hospital... I just don't remember them giving a shit."

discharged to: *home with parents*

Gaps & Opportunities

Life After
What if people like John could see how it's possible to have a life after detention and living with a mental health diagnosis? What if there was an online platform John got access to in hospital, and after, with stories and chats from other people who have been in his shoes?

Automatic Comment
What if all youth who were certified got an invitation after they left hospital to comment on their experience, and debrief with someone about any trauma they experienced while there?

Conversations took place August 23rd 2019 - 10am - 12:45pm | Researcher: Valentina Brancato

(?) *unclear or didn't remember* (?) *we didn't ask*

story returned

Liam

#Youth Mental Health Act #Abbotsford #foster care

"I need to get into a place where I feel like I can care, and not have this unbearable weight."

When Liam imagines health and healing, he's on a mountain top, not in a psych ward with white walls and LED lights, not medicated into submission.

It's still hard to reconcile the Liam "in a shitty state of mind" with a version of himself that he can embrace. He's able to project ease and charm, but it belies a mental state that's "definitely up and down right now," fueled by ever present stress. After all, he's homeless, and can't imagine balancing the hours of work he'd need to pay for housing with "the rest of life."

The doctors who dope him up and "turn me into a zombie" don't inspire his trust. "Lived experience is very important to counsel and advice." Book learning doesn't qualify someone to help Liam pursue a good life. Instead, Liam talks about what he thinks matters: his parents' divorce, his father's refusal to accept him, being put in care. And the missed opportunities - "hiking, camping, intro to a different lifestyle."

Instead, doctors pepper him with awkward questions like, "how do you feel in your home setting?" "[Counselling] was offered but who's going to open up to someone they don't know? I won't." Liam would open up to "family members, or a good friend." Often, his way of negotiating his options creates friction, but he feels professionals need to accept his need for some self-determination. "I would, when in care, decide 'I'm not going to take my meds anymore.' Everyone around me would [grimace], but I feel it's a valid position." His mom supports his choices, to self-medicate with cannabis, for example, "kinda sorta." "She sees that it benefits me and it doesn't benefit me. I have trouble admitting that cannabis can be misused by me, and it not being the only option."

He's willing to be challenged, but not by people who are just "doing their job."

people card

Liam

male
22
Caucasian

Individual's perspective

Desired outcomes

Self worth *"It's an ambition. There's not much point in beating myself down."*

Safety & Security *"Growing up that was a huge value because I didn't always have it. There was usually an argument in the house."*

Bravery *"My mom has said more recently that I've been a strength for her, which adds to my self worth."*

Stressors

Housing *"I don't have a house. Things are expensive...It's a definite stress in my life, finding stability."*

Family *"Marijuana is something I enjoy doing...my family has a conflict with that, especially my dad's side. It's turned into a physical confrontation with cops called."*

Mental Health *"For the most part, I'm just stressed, I can't think straight, I forget to prioritize, forget things in general."*

Environmental Factors (when certified)

divorce · personal addiction · removal from family · emotional abuse

Self Descriptors

trust issues · spiritual · outdoorsy · brave

Certification Experience

Hospital Stays

n# times: *4* ?
n# involuntary: *0*
longest stay: *4 months* ?

usefulness of detainment

"I was playing the game to be able to please doctors and get discharged."

descriptors of detainment

plain white walls · LED lights · regulated · canned air · caged · stressful environment

1st stay

voluntary - **age** *13* - **prompted by** *psychosis* - **length** ? - **brought by** *family*

before	*in the hospital*	*after*
	"My grandpa was dying but the doctor denied me a pass to go see him before he died. I hold on to that to this day."	

Diagnosis

Severe anxiety

agree — disagree

Treatment

Medication: "Sure they worked, they did what they were supposed to do, but they didn't work on any of the emotional issues."

agree — disagree

Rights

	did they know	use
Rights	*yes*	*no*
Health Review Board	*no*	*no*
Legal Representation	*no*	*no*
Second Medical Opinion	*no*	*no*

"I remember being read my rights once, on the day I was admitted, when you're in your worst mental space. It would be nice if you were reminded of these rights."

Support at Discharge

	helpful	unhelpful
formal		psychiatrist, counselor
informal	dad, mom	

discharged to: *mom; Group home*

Gaps & Opportunities

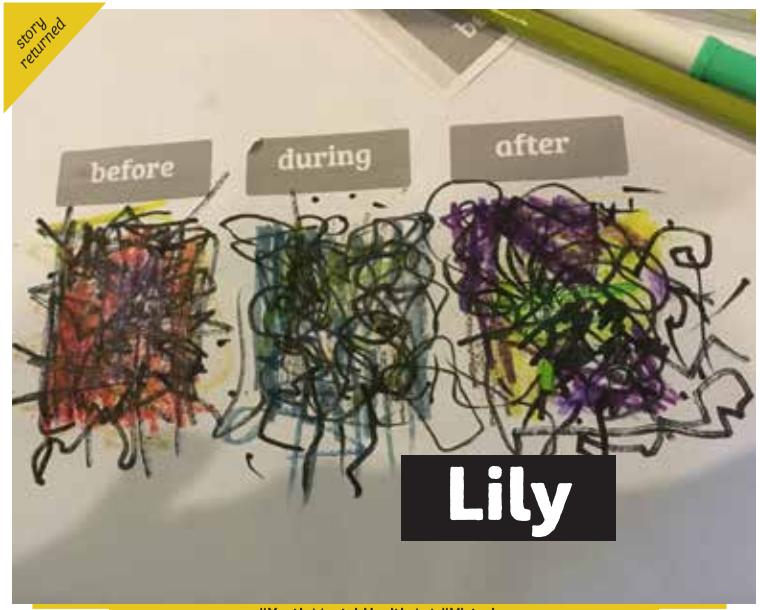
Draw Change
Liam is "a visual learner." What if he could have worked with an artist, guardians, and medical professionals to create a visual plan for when he was leaving the hospital?

Youth Know Best
Liam could "help professionals understand how to be with somebody, not just ask questions from a book, but, to 'get on my level.'" What if he were part of a crew of youth who train professionals in how to explain the Mental Health Act from a youth perspective?

Conversations took place August 15th 2019 - 5 - 8:30pm | Researcher: Natalie Napier & Valentina Brancda

? *unclear or didn't remember* ? *we didn't ask*

story returned



#Youth Mental Health Act #Victoria

"What people see me as isn't the same as how I see me as, and I don't even know what I am."

Lily informs me that her transition is more than just a gender transition: "I am trying to figure out who I am right now." She dissociates a lot, and has what she calls an abstract mind. "Since the beginning of time people haven't understood me properly, no one took the time to show me properly." She would like to learn how to socialize better because as she puts it: "It's a confusing topic. We all live in different realities." Another confusing topic is hospital. "I had a bad experience with the hospital. So anything hospital related makse me nervous." Taken off the hormones prescribed for her gender transition, she felt her identity was negated, not supported. Since the end of high school, Lily estimates she has been hospitalized four or five times and "maybe more, it's hard to say." She found it all very confusing. Lily sifts through the markers, choosing specific colours, using them to share: "That's what it felt like, I'm like, are they actually fixing me or is this making it worse?"

Colours hold significance to Lily. She wears mostly blacks and whites, but is considering adding more purple. "I do like art, visual and audio art, I think it's beautiful." She's also thinking about getting into poetry. Lily uses the metaphor of a soft violin, played on a loop, along with emotional lyrics, to describe what her life looks like now. She spends her days going "nowhere in particular" -- running errands and going home. She is well known at the Foundry and Island Central Health, and has been coming to the Sanctuary drop-in consistently for 5+ years. Still she says, "I have no one to talk to." She is trying to find her purpose in life: "One that's not soul crushing. You know?" I have a picture of what that might look like, but I can't draw it right now."

people card

Lily

trans female
23
Caucasian

Individual's perspective

Desired outcomes

Transitioning *"I wish I had the picture. Well I'm transitioning right now, so I am trying to figure out who I am right now. You know?"*

Respect *"I want to live a creative abstract lifestyle with other people that are like me."*

Connection *"And how to socialize better. Confusing topic. We all live in different realities."*

Stressors

Purpose *"Not knowing where I'm going with my life at all."*

Thoughts & Feelings *"Not understanding who I am, how my thoughts and feelings work, or how like, other people work. You know?"*

Routine *"I just don't want to be stuck in a stagnant kind of lifestyle. Just doing the same thing all my life."*

Environmental Factors (when certified)

Did not share

Self Descriptors

Transitioning | Artistic | Creative

"I have an abstract mind"

Certification Experience

Hospital Stays

n# times: *1 as youth* ?
4+ as adult ?
n# involuntary: ?
longest stay: ?

1st stay - details unclear
involuntary - **age** *17* ? - **prompted by** ? - **length** ? - **brought by** ?

usefulness of detainment

"Are they actually fixing me or is this making it worse?"

descriptors of detainment

"Anger and sadness and fear represented in different colours. It's a mix of all three."

unheard | bad | confusing | old system

before	*in the hospital*	*after*
"Since the beginning of time people haven't understood me properly... no one took the time to show me properly."	*"The whole experience was really confusing. I think there should be more communication in there."*	*"Making sure I'm taking care of myself... making sure that my mind doesn't slip into a grey place, you know."*

Diagnosis

depression, anorexia, schizophrenia, PTSD, depression, bipolar disorder

agree — disagree

Treatment

"I don't believe in old systems, they don't work."

agree — disagree

Rights

	did they know	use
Rights	no	no
Health Review Board	no	no
Legal Representation	no	no
Second Medical Opinion	no	no

"Not really, no. At least I don't think they did." "Back when I had a voice, back then no one listened to me. I think everybody has the right to say something."

Support at discharge

	helpful	unhelpful
formal	Sanctuary ?	Foundry ?
	Island Central Health ?	
informal	people that care ?	

"I don't know if the current ways we deal with mental illness are the best. We could definitely think of better ways to do that. Especially with the medication."

discharged to: *unsure*

Gaps & Opportunities

Trans Rights
Lily was taken off her hormones by the doctors during her time in the hospital, which she found traumatizing. How else could her trans identity have been recognized and celebrated in hospital, rather than negated?

Therapeutic Menu
Lily has found it hard to connect with other creative people like her. What if mental health services offered more creative outlets and multiple therapeutic approaches to try? What if young people had access to a menu of therapeutic outlets to try?

Conversations took place August 24th 2019 - 4:14 - 5:30 pm | Researcher: Melanie

? *unclear or didn't remember* ? *we didn't ask*

story returned

Alan

#Youth Mental Health Act #New Westminster

"Growing up it was basically monkey see, monkey do kind of thing."

Alan reflects back about his mom's heavy drinking. "She was a horrible liar, and she was really manipulative. So basically, I developed a habit of lying when I was very young." He describes fabricating stories to make friends. "Eventually I grew out of it and I realized I didn't have to lie to be around people." Alan talks now about how honesty leads to more opportunities, and closer friends that trust and believe in you. His aspiration? "I want to live a happier life and be more positive." Alan hopes to find work, and go to college to become a psychiatric nurse so he can help people facing mental health challenges. He has plenty of life experience to share. After moving to Prince George to live with his dad and step mom, he became entangled in the criminal justice system. Drug addiction, poor peer choices and lots of drinking saw him kicked out of school and home. He was selling drugs and met some "violent and shady individuals." Alan and his friends were asked to prove themselves: a couple individuals got hurt in the act, leading Alan to spend 4 years in custody. Compared to jail, the psych ward was "smooth sailing." There was only one incident when he first arrived. He thought the staff were treating the patients unfairly, and became belligerent, yelling for individuals to take action. The nurses rushed over to say, "Take your medication... otherwise we're calling staff to forcefully subdue you so we can administer the injection." He could see the nurse prepping the needle so he barricaded himself in a room. Five more staff arrived; one said, "Alan I don't want to apply force...I will give you 3 min to comply or we're coming in." After 2 min, Alan took the medication. Because of his time in jail, Alan says he was aware of his rights, but considered them futile.

people card

Alan

cis male
23
Caucasian

Individual's perspective

Desired outcomes

Respect *"Growing up my parents basically embedded into my mind. And they told me respect goes a long way."*

Balance with Nature *"It's so peaceful, and really grounds the soul to speak. I just appreciate what the world has to offer.."*

Honesty *"I found that it was a lot easier to get along with people and easier to make close friends that actually have trust in you and believe in you."*

Stressors

Loneliness *"The rest of my family lives in Ontario. The only family I have out here is my uncle, but he's like a workaholic."*

Isolation *"So basically I have a bad habit of just like sitting at home, not getting out as often as I should."*

Purpose *"I'm going to eventually...make things happen in my life and be actually grateful, and happy and less lonely and less isolated, and have more routine."*

Environmental Factors (when certified)

parental addiction | divorce | homelessness | emotional abuse | abandonment | transience | criminality | personal addiction

Self Descriptors

Writer/Lyricist · Creative · Outgoing

"[being] more creative with the way I write, it gives me confidence to be more outgoing."

Certification Experience

Hospital Stays

n# times: *1 youth / 3 adult*
n# involuntary: *1*
longest stay: *1 month*

Usefulness of Detainment

"I had no choice, the lawyers on the board of directors side gave me this huge, huge form to read over, and i was like yeah, I'm not having that, and I just decided to go through with it... It wasn't as bad as i thought it was going to be."

descriptors of detainment

"It was like a hotel compared to the jail system."

lots of rules | safe | professional | smooth sailing | better food

1st stay

court ordered - **age** *17* - **prompted by** *judge* - **length** *1 month* - **brought by** *guard*

before	in the hospital	after
"That's basically how I got involved into the legal system. A couple individuals got hurt, and 7 of us got locked up."	*"They basically explained that the facility is very safe, there's no worries you should have, there's lots of rules in place to make sure that nothing bad happened."*	*"I don't budget my money as well as I should, So im just sitting around, lots."*

Diagnosis

Bipolar, Mania, ADHD, Anxiety

agree ● disagree

Treatment

On medication: "there's this negative energy that's emulating on the inside of my body, and I could explode at any minute, it's horrible."

agree ● disagree

Rights

	did they know	use
Rights	*yes*	*no*
Health Review Board	*yes*	*no*
Legal Representation	*no*	*no*
Second Medical Opinion	*no*	*no*

"I didn't even consult my lawyer, I was like, this isn't even worth my time... They said I could put a review to the switchboard, and take them to court, but you know."

Support at Discharge

	helpful	unhelpful
formal	New Leaf, 1:1 worker, support worker, psychiatrist, parole officer	
informal	uncle, family in Ontario	

"The only family I have out here is my uncle... so I don't have a key, I have to wait for him till like 10:30 at night. So I'm just sitting around, lots."

discharged to: *detention centre*

Gaps & Opportunities

The Creatives
Alan uses rhyme as one way to express himself. What if youth were supported to create a piece of art or music video to describe their time in the hospital as both a feedback tool and therapeutic tool?

Inside-Outside
One of the hardest things about hospital is feeling trapped "inside" without access to nature. What if elements of nature were brought into psych wards and there was more of an emphasis on the healing powers of nature?

Conversations took place August 19th 2019 - 3:19 - 5:09 pm | Researcher: Melanie Common

(?) *unclear or didn't remember* (?) *we didn't ask*

story returned

#Youth Mental Health Act #Prince George

"If you don't know about your rights, what are you going to do? Does it mess with your opportunities?"

Change is in the air. Some of it is good: Luna just graduated high school, and plans to study psychology in college. Some of it is sad: Four deaths in the family this year. And plenty is uncertain: Her parents are divorcing; her mom is moving to Nainamo, and she's likely to follow. "I don't want to fall down the rabbit hole again." Earlier this year, Luna took a month-long mental health break from school & work (a job she hated at an auto store). Despite some tough moments, she's stayed out of the psych ward for four years. After 2 admissions to hospital, 3 wrong diagnoses, and a couple of bad counselors (they talked too much!), Luna feels pretty good with her diagnosis and treatment. "I am open about having bipolar type II, and can learn to live with it...With my psychiatrist, he sees me as an adult, and gives me some choice." But, the right support came only after "falling through the cracks." At age 8, Luna started seeing counselors to address emotional abuse: "My dad was being a dick then." But she only got 5 sessions at a time, and it wasn't enough. By 13, Luna was cutting. Her GP said it was just hormones. One day, she cut so deep, she scared herself and headed to the hospital. Stuck in the pediatric ward until a bed in the adolescent unit opened up, there was nothing to do and few supports. Once transferred to the psych unit, school, social workers, pet and art therapy kept her busy. Reading with a cup of tea & honey was a highlight. Discharge was a lowlight. Without her mom's advocacy, she wouldn't have been set up with a counselor. The period after was "mediocre, good, bad, and rocky." A second two-week admission stabilized things, but she wonders what her medical files say. Will her time under the Act stay on her file forever? Update: Luna's added a third stay under the Act to her file; this time in the adult unit, a few weeks after our first chat. "It was more anxiety driven, but they did tell me about my rights." With a shift in diagnosis, meds and counseling, plus a pause in college & work, Luna adjusting to what it all means: "it's scary but good."

people card

Luna

cis Female
18
Caucasian

Individual's perspective

Desired outcomes

Fitting-in *"I've always wanted to fit in with peers and family. I need to, but never do."*

Love and connection *"I value when people show compassion, empathy and love cuz I always had an issue with trusting."*

Wisdom *"I value being very smart. It's something I need more."*

Independence *"I really like independence, I don't have much of it ... making my own rules and appointments."*

Stressors

Family and relationships *"My family is falling apart under me. They are dying off. My parents are getting a divorce. My relationship with my mom is rocky and she is usually my rock."*

Friends *"They always stress me out. I get worried about their stuff instead of my stuff."*

Grief and Loss *"I wonder who is going to be next?"*

Environmental Factors (when certified)

emotional abuse

Self Descriptors

follower | a patient | shy | alien | bookworm

Certification Experience

Hospital Stays

n# times: *2 as youth / 1 as adult*
n# involuntary: *1 (as adult)*
longest stay: *1 month*

usefulness of detainment

"I scared myself. I went to the ER to be safe. I was admitted for a month: when they told me I was discharged, I lost it."

descriptors of detainment

confusing | lonely | scary | tea & honey | cozy

1st stay

voluntary - **age** *13* - **prompted by** *cutting & suicidal ideation* - **length** *1 month* - **brought by** *self & mom*

before	*in the hospital*	*after*
"Before, there were holes and it was rough. I was falling through the cracks for a while."	*"It's scary to ask for anything. I am so shy. You don't know the rules...The art therapy felt too young but I liked the snacks and tea, you got some choice."*	*"I didn't feel right enough to be discharged. My mom had to force them to get me a counselor before I left."*

Diagnosis

Bipolar Type II until 2 wks ago when re-diagnosed with Borderline Personality

agree — disagree

Treatment

Lithium + Counseling until 2 wks ago: re-evaluating meds

agree — disagree

Rights *(as young person)*

	did they know	use
Rights	no	no
Health Review Board	no	no
Legal Representation	no	no
Second Medical Opinion	no	no

"I agreed with the admission; they didn't tell me about the MHA. Still don't know what it means on your record. I don't know if I am under the Act. Is there a pink dot on my file?"

Support at Discharge

	helpful	unhelpful
formal	school counselor	counselor
	psychiatrist	John, counselor
informal	mom	dad

"My psychiatrist won't put me on things without me. It's a partnership."

discharged to: *family*

Gaps & Opportunities

Psych Tube

What if Luna had access to video content made by for youth in psych wards? Luna thinks it would have been helpful if she watched at different points during her admission, and could have understood the rules and known what to ask for.

Youth know best

Luna really knows what makes for a good doctor-patient relationship. She knows how to separate the useful from the useless counselors. Now, she'd like to share her know-how with medical professionals. What if hospital staff were trained by youth with lived experience?

Conversations took place August 13th 2019 - 11am-4pm | Researchers: Sarah Schulman and Natalie Napier

(?) *unclear or didn't remember* (?) *we didn't ask*

#Youth Mental Health Act #Abbotsford #foster care

"I had eight years of stuff to unpack and they didn't give me any space or time to do that."

The first time Steve was in the psych ward, he was hoping to work through the trauma of an adoption that fell through, and his return to the foster care system. Instead, he found the hospital to be combative and a poor listener. He desperately wanted therapeutic work alongside his adoptive family. Instead, the hospital called his adoptive family to take Steve out on a fun day. He recounts: "They weren't safe people to send me with (alone). They didn't want to help me.. my mom said to me, 'why did you even call us? like F.U. So, that was a little bit traumatic."

Steve didn't think meds helped either. He asked for alternatives, but recalls the doctor would "always fight me... not listening to the why or anything... and constantly lord over the fact that it was his decision to make." At the hospital he discovered painting calmed him, but it was restricted, "I would wanna be painting while I was crying... they treated it like a hobby instead of a coping mechanism." These past dissapointments haven't taken away Steve's kindness and earnestness. With smiley eyes he says, "I'm happier now than I have been in a long time."

Steve is learning to take time for himself. He is proud of having an extra room he can rent to someone in need, and is looking for jobs where he feels respected. His favorite place is Shanty Town -- a homeless camp -- where people help each other out, unencumbered by formal systems that don't work. Steve says "It's magical... it's fun to get to know peoples' stories... they're not just fakeass happy."

people card

Steve

cis male
21
Mohawk

Individual's perspective

Desired outcomes

Inner harmony *"Inner harmony is the result of that faith [in God], like a balance inside from having a strong faith outside."*

Kindness *"It can be a catalyst of change. It's kind of like the key to happiness; it's the key to love and connection."*

Meaningful work *"I don't want to work like at Walmart... I get bored so fast and I feel disrespected... I like the law because it makes it okay if people rub me wrong or they insult you in an intellectual way."*

Stressors

Grief & Loss *"It's the end of relationships and times of life that seemed fulfilling, or there's a lot of happy moments that are not accessible anymore... Some people died."*

Status *"I turned status upside down to me, because I've been making a lot of money and I wasn't happy... but I've gotta handle my mental health, I intent to take a break."*

Addiction *"I've developed a really unhealthy addiction to marijuana... it's something that I've been battling with for a long time"*

Environmental Factors (when certified)

emotional abuse | abandonment | removal from family

Self Descriptors

helper | outgoing | self advocate

Certification Experience

Hospital Stays

n# times: *1 as youth / 2 as adult*
n# involuntary: *1*
longest stay: *3.5 weeks*

usefulness of detainment

"It was just kind of continuing a normal life inside of like a bubble. It just didn't seem helpful... I don't think I would have gone to the hospital now"

descriptors of detainment

combative | isolating | weird | crazy | physical restrictions | under watch | they don't care | not listening | shamed

1st stay

voluntary - **age** *14 or 15* - **prompted by** *suicidal thoughts* - **length** *3.5 months* - **brought by** *friend*

before	*in the hospital*	*after*
"That whole time was very isolating. I was at a foster home, they just treated me the same that my other family."	*"It's like you are crazy & we have to watch you be crazy... that drives you more crazy cuz no one is treating you seriously... I didn't really feel connected to anybody at all"*	*"You leave without answers and no one tells you what's going on" referring to his friend's experience*

Diagnosis

Depression & anxiety, PTSD

agree — disagree

"They diagnosed me with PTSD, and they should have worked on it back then."

Treatment

Medication & therapy

agree — disagree

Rights

	did they know	use
Rights	no	no
Health Review Board	no	no
Legal Representation	no	no
Second Medical Opinion	no	no

"I didn't know about things like second opinion... Back then I was intimidated by the doctor"

Support at Discharge

	helpful	unhelpful
formal	home school	
formal	EMDR trauma therapy	
formal	case worker	
informal	friends	
informal	supportive foster mom	

"I think there was a wait-list or something for therapy, and then once it started it was like a few years later."

discharged to: *group home*

Gaps & Opportunities

Mediation Team
What if there was a mediator between youth and doctors that was external to the hospital? Their role? To listen to youth's needs and hopes, translate that into a language clinicians might better understand, hear doctor's points of view, and translate options & opinions back to youth.

Talk-to-your-doc
What if there was a phone line inside of hospitals to connect young people with therapists in the community -- so they could be introduced and start building relationships during their hospital stay and be better connected to support post discharge?

Conversations took place August 14th 2019 - 7-9pm | Researchers: Valentina Brandão & Melanie Common

(?) *unclear or didn't remember* (?) *we didn't ask*

story returned

Wolf Moone

#Youth Mental Health Act #Vancouver #foster care

"Nobody's ever really asked me about my experience with my mental health."

Wolf Moone is working on a memoir. He's already written short stories and poetry on wattpad and quotev, which are self-publishing platforms. In his 17 years, he's gathered a lot of material but few opportunities to make sense of it beyond his own writing. Currently in provincial care, and on a youth agreement, he's homeless and couch surfing.

Hospital traumas started early; at first, for a sleep audit at age eight, which isolated him for 72 hours. He remembers being so scared to be away from his mom: "I couldn't be alone at night after that."

Before mental health issues arose, his mom "stopped being around as often," and he was removed from her care. At age ten, he was rushed to the hospital after passing out at school from severe Anorexia and Bulemia. Diagnosed with bipolar and "showing signs of dissociative disorder" he was sent to an adolescent treatment centre for three months at age 14. The impact of these interventions has been "worse anxiety, worse depression, worse PTSD than before."

He accepts that he needed help, but not the feeling of being kept in the dark that came with it. "I would have liked to know what they were doing and why. Like at this point in life, I don't even care if I had a choice on whether or not I took those pills."

He remembers being told the last stay was voluntary, but then was surprised to find he couldn't leave after a month. He found treatment "almost impossible to the point where it was almost as if I wasn't even in my body anymore. And like, I was just kind of watching what it was doing. But I couldn't do anything."

people card

Wolf Moone

trans male
17
Aboriginal

Individual's perspective

Desired outcomes

Independence *"My entire life I have always wanted to do things for myself."*

Adventure *"[I've] kind of wandered around, looking for beautiful things and I stumbled upon some really cool adventures that are going on."*

Love & Connection *"[Before] I was always with my mom. So [it's] having that connection to others and the love that's shared through my friend group... we're basically a family.*

Stressors

Services *"Finding mental health help that actually helps me."*

Housing *"No one will rent to a sixteen year old."*

Connection *"Staying connected to people is stressful because of my tendency to dissociate. It makes it hard to maintain steady and healthy connections to people."*

Environmental Factors (when certified)

bulemia | anorexia | gender dysphoria | homelessness | removal from family

Self Descriptors

Adventurer | Independent | writer

Certification Experience

Hospital Stays

n# times: *2 as youth*
n# involuntary: *at least 1* ?
longest stay: *6 months*

usefulness of detainment

"I definitely have worse anxiety, worse depression, worse PTSD than I did before."

descriptors of detainment

uninformed | harsh | hazy | unfair | terrible | youngest | testing

1st stay

voluntary - **age** *10* - **prompted by** *passing out* - **length** *6 months*- **brought by** *paramedics*

before	*in the hospital*	*after*
"I was always with my mom, my mom was constantly there. But eventually she stopped being around as often...I had never really had a connection to another human being."	*"I was never told what the medications were for, what they were even called, what they were doing to me."*	*"I was told to connect to a psychiatrist and counselor but I never was connected to those supports."*

Diagnosis

Bulemia, Bipolar
Signs of Dissociative Disorder

agree — disagree

Treatment

Medication & counseling
"It was almost impossible to the point where it was as if I wasn't even in my body."

agree — disagree

Rights

	did they know	use
Rights	no	no
Health Review Board	no	no
Legal Representation	no	no
Second Medical Opinion	no	no

"They said it was a completely voluntary thing to go. But they never told me that I was not allowed to leave until they found the treatment was over."

Support at Discharge

	helpful	unhelpful
formal		
informal		

discharged to: *Adoptive parents*

Gaps & Opportunities

Youth Know Best
The trauma of hospitalization at ages 8, 10, and 12 has stuck with Wolf Moone. What if he could be part of a crew of youth who train medical professionals, social workers and counsellors in how to understand and explain the Mental Health Act from a youth perspective?

Draw Change
In Wolf Moone's memory, there was little to no follow up after discahrge from a 6 month hospital stay. What if he and his guardians could have worked with an artist and medical professionals to create a visual plan for what would happen upon leaving the hospital?

Conversations took place August 17th 2019 - 5 - 7pm | Researcher: Natalie Napier

(?) *unclear or didn't remember* (?) *we didn't ask*

#Youth Mental Health Act #Manitoba #foster care

"Nobody was ever like, 'you're a product of your crazy family.' Everyone was always like, 'you're just crazy.' "

Despite two detentions, Sean doesn't attribute his healing to hospitals: "I got better on my own, without the help of the hospital or my dad." Instead, healing came from spirituality and his discovery of white magic. "I felt like I had opened a book full of secrets... I had all these new things opening ahead for me." Throughout our conversation, he gives us a masterclass on the mystic/occult, describing white magic as "ancient techniques of energy manipulation, Kundalini, Reiki."

When he was young, he was into dark magic because he "wanted to be as powerful as possible to control everyone around me... I grew up helpless and powerless."

Sean's two experiences in the hospital, six months apart, were radically different because he showed up differently. The more violent he was, the less care he felt he got. The first time he was brought by the cops after threatening people. In the hospital he says, "I was angry and violent... a lot more authentic. Like, I don't want to fucking be here." In the three months detained - mostly sedated and chained - he never felt heard. "I felt like I was just another number... invisible... nobody would talk to me, when they'd bring me my food no one would ever look at me." Sean thinks he was labeled "crazy" by doctors because of his belief in angels and demons. The second time he was admitted, he was compliant or in his words "manipulative." Staff were nicer. He was out in a week and without the same Schizophrenia diagnosis as before. This second time, his dad coerced him to go to hospital. He felt Sean was attracting unwanted attention to the family's "gangster" lifestyle. Sean never thought he would make it past 19. Now he's mostly clean of drugs, wants to garden like he used to with his grandma, and is applying to disability due to his chronic eczema. He raps some songs for us: it's his way to protest for social justice.

people card

Sean

two spirited
23
Cree

Individual's perspective

Desired outcomes

Social Justice *"I've always been very passionate about injustices against people and violations of human rights.... making music that's where I channel that now"*

Respect *"I give respects even to people who don't give it back because I'm better than they are."*

Being a rapper *"I've been rapping since I was like 14... I'm working on an album right now. I have 12 songs finished and polished"*

Stressors

Death *"People are walking, talking libraries... when a person dies without passing on all of that knowledge... it dies with it."*

Money *"I'm really fucking poor. I can do what I used to do, and have nobody respect me, and have all the money I need. But I don't want people to see me like that.*

Physical health *"I have chronic painful eczema, so I break out really bad and my skin burns."*

Environmental Factors (when certified)

personal addiction | physical abuse | homelessness | transience | criminality | divorce | emotional abuse

Self Descriptors

rapper | eccentric | spiritual | dungeon & dragons master

Certification Experience

Hospital Stays

n# times: *2 as youth*
n# involuntary: *1, & 1 coerced by dad but voluntary on paper*
longest stay: *3 months*

1st stay

involuntary - **age** *16* - **prompted by** *violence, death threats to others* - **length** *3 months* - **brought by** *cops*

usefulness of detainment

"I feel like the hospital failed miserably... As much as I hated being in this fucking hospital, I think it saved me from killing someone." About his psychiatrist/counselor: "They wouldn't give a fuck: they'd say you are wrong, you are wrong."

descriptors of detainment

felt invisible | not heard | not paid attention to | cold | impartial | terrified

before	*in the hospital*	*after*
"I felt like I was falling apart... like I couldn't hold on to anything."	*"I'd wake up...and either be calm and go back to sleep or freak out and get sedated again... it was like that for about 3 months. It's just a big blur."*	*"I went right back to what I was doing: selling drugs and doing drugs, being violent and everything"*

Diagnosis

Schizophrenia and Psychosis

agree — disagree

Treatment

Medication

agree — disagree

Rights

	did they know	use
Rights	*no*	*no*
Health Review Board	*no*	*no*
Legal Representation	*no*	*no*
Second Medical Opinion	*no*	*no*

"I was told that if I tried to leave, I would be arrested. I would be detained and taken brought back. That if I were to leave, I would be considered a missing person."

Support at Discharge

	helpful	unhelpful
formal		
informal	dad, mom	

"We can refer you to this and that... I threw it [paper with instructions]in the fucking garbage when I walked out... I was with my big fucking gangster dad. He was like: "You don't need to fucking do that shit..."

discharged to: *his dad*

Gaps & Opportunities

Coping catalogue
For Sean, gardening with his grandma is a good memory and coping strategy. What if when young people were admitted, they could pick from a catalogue of coping strategies, and these were made available during their stay?

Do it right
What if youth with experience under the Mental Health Act come to hospitals to explain rights to young people and describe what is happening. They leave a survival kit, which includes ways to research and understand the Act.

Conversations took place August 13th 2019 - 4:30 - 8pm | Researcher: Valentina Brunoda & Elizabeth Boyd

(?) *unclear or didn't remember* (?) *we didn't ask*

#Youth Mental Health Act #Abbotsford #foster care

"They didn't explain anything. I said why the fuck am I in here, and they literally ignored me."

For $137, Tony can be himself: a ballsy survivor, recovering alcoholic, artist, and musician with a streak of malevolence. "I see myself as evil. Minecraft is leaking into the world," he says. Born as Sunny, that name no longer captures who they are. For a fee, government will recognize his identity. "My baby daddy was named Tony, I know its weird, but that's my other personality." Not everyone is so accepting, yet. When we meet, Tony is looking for a place to sleep. They ask to crash at a friend's campsite. "No, I'm sorry," the friend replies, calling him "It." At 19, Tony has aged out of the youth shelter and been kicked out of the adult shelter. Staying at their mom's house is not an option: "She's a bitch. She can fuck off." With only their longboard, a blanket that doubles as a "cool cape" during the day, and a backpack stuffed with meds and a speaker for EDM music, Tony travels light. They are used to bouncing around: foster care, group homes, hospitals. "They treat psych patients differently than regular patients." Neglect and apathy are reoccurring themes of their stays in the psych ward. Age 16 was their first involuntary admission. They were "homicidal" after a miscarriage. The cops brought them in, after pinning them to the ground. A year later, they returned to the psych ward — voluntarily. "I barely remember it. I was admitted, but no one paid any attention to me." The highlight? A friend who came to visit. The lowlight? Waiting for their mom to visit. She never did. Tony doesn't think these stays worked: "They just wanted me out and discharged me. I went back to the group home. There were no follow-ups." While all the meds have left Tony feeling foggy, they are certain they've never heard of their rights. Rights are good, Tony says, because "some people don't need to be in there." Tony knows what they need: friends, family and love.

people card

Tony

trans Male
19
Caucasian

Individual's perspective

Desired outcomes

Fitting-in *"Definitely important to me because I never fit in, I was always the outcast, picked last, left out, bullied in school, in family."*

Love and connection *I never had that. I had it with one guy, then he decided to do drugs."*

Health & wellbeing *"I want to lose weight."*

Independence *"I don't want to live with a roommate and get my shit stolen."*

Stressors

Housing *"I'm homeless. I was forced to be. My mom is a bitch."*

Loneliness *"No one wants to come to my camp and visit; that's the loneliness."*

Mental Health *"I just feel like my mental state is slipping away and I have a constant headache."*

Environmental Factors (when certified)

bullying | removal from family | personal addiction | homelessness | miscarriage | death & grief

Self Descriptors

artist | survivor | victim | helper | musician

Certification Experience

Hospital Stays

n# times: *3 as youth*
n# involuntary: *2*
longest stay: *3 months*

usefulness of detainment

"I feel like the meds didn't work. Still feel that...The hospital is fully retarded."

descriptors of detainment

retarded | neglected | lonely | sucks | locked up | useless

1st stay

involuntary - **age** *16* - **prompted by** *"homicidal" thoughts* - **length** *unsure* - **brought by** *cops*

before	*in the hospital*	*after*
"It was after a miscarriage. I was nice to the cops; when they said they would take me to psych, I said fuck you."	*"I barely remember it. You don't have to do things. I chose not to do anything."*	*"Psychiatrists made me take meds. They wanted me out. They let me go...No appointments after."*

Diagnosis

Bipolar

agree — disagree

Treatment

Prescription drugs

agree — disagree

Rights

	did they know	use
Rights	*no*	*no*
Health Review Board	*no*	*no*
Legal Representation	*no*	*no*
Second Medical Opinion	*no*	*no*

"No, I don't remember my rights. Actually, I think that's important because there are people that don't need to be in the psych ward."

Support at Discharge

	helpful	unhelpful
formal		
informal		

"No one was helpful. Right now, I have a youth worker helping me find housing who is kinda helpful."

discharged to: *group home*

Gaps & Opportunities

Psych Tube
What if Tony had access to video content made by for youth in psych wards? Video content that not only explained rights, but offered perspectives? And what if, after discharge, Tony was invited to share their experience with others to process the experience? Tony was interested.

Peer Visitors
Tony doesn't remember a lot about their admissions, but they do recall waiting for visitors. They didn't always come. What if there were teams of visitors, with the same diagnoses, who could drop by, bring snacks, and share some of their healing journey?

Conversations took place August 12th 2019 6-8pm; August 12th 2019 12-2pm | Researchers: Sarah Schulman

(?) *unclear or didn't remember* (?) *we didn't ask*

Charlie

#Youth Mental Health Act #Prince George

"I'm looked at as a different citizen... like you can't interact with him, but I can be interacted with."

If Charlie's life were a movie, it would be an action-packed drama. Within a minute of saying hello, Charlie shares what he sees as the most significant plot lines: "At five, my parents split up. We moved all the time, going house to house, borrowing money." He was misdiagnosed with ADHD, and the meds worsened his agitation. By middle school, suicidal thoughts were normal. One day, he sent a text to his mom and retreated to his calm place by the river. The cops were called. They threatened to taser him, and brought him to the hospital against his will. He remembers little about this time other than "meds are just a band-aide." The police are reoccurring characters in Charlie's screenplay: dispensing judgment, not kindness, one of Charlie's core values. After that first hospital stay, many followed. "I was tired of being in hospital and started jumping out of cars." Somewhere along the way, friends introduced him to chemicals.

"I got addicted to molly," Charlie recounts. "I was losing my mind." Little helped except the alternative high school, where teachers offered more support. By December 2017, things heated up. While having a bonfire beneath a bridge, an (ex) friend sprayed him with mace. A fight ensued. The cops didn't believe his story. "Doctors thought I was even more insane." The only way Charlie knew to keep his sanity was to exercise in his room. "I was bored, I needed to do something." He remembers hearing about his rights, but deemed his opinion useless. Eventually his dad secured his release, but relocating to Campbell River with him turned out to be a mistake. "I told him thanks for trying to be a father, but it's not working." Returning to Prince George, homeless, Charlie is ready for his screenplay to turn from drama to comedy. He's an avid freestyler. "I want to make people laugh at the rough sides."

people card

Charlie

cis Male
19
Caucasian

Individual's perspective

Desired outcomes

Connection *"Having a better life means finding the right people to be around, having a home, with love."*

Wisdom *"I like to have knowledge and be smart in my own ways. People say I'm dumb but I'm smart in my own way."*

Kidness *"I've always learned to be kind with friends, family and even strangers. I always say hi to people I walk by on the street."*

Stressors

Money *"I know life's not all about money, but damn money bothers people like me."*

Relationships *"I'd like to have my family around and friends that are real with me."*

Work *"When I work, I work and give it 100%. Mental health makes it seem that I can't work with people and I am considered dangerous."*

Environmental Factors (when certified)

divorce | poverty | homelessness | parental addiction | transience | grief & loss | personal addiction

Self Descriptors

gamer | comedian | kind | hard worker

Certification Experience

Hospital Stays

n# times: *3+* ?
n# involuntary: *At least 3* ?
longest stay: *1.5 months* ?

usefulness of detainment

"I was getting more depressed, I wasn't getting better... I was going insane, being in hospital for so long."

descriptors of detainment

bullshit | hospitable, at points | invasive | no privacy | against will | trapped

1st stay

involuntary - **age** *13* - **prompted by** *suicide attempt* - **length** ? - **brought by** *police*

before	*in the hospital*	*after*
"I ran away to my safe place... My mom's bf called the cops. They said they would handcuff me, or taser if I run."	*"I counted days on a chalkboard. They said I was here for 2 wks, I think it was 1.5 months... I was bored: I wanted to get healthy & work out, rap, draw."*	*"Just caught in the cycle...My mom and I never got along, I moved out...I got addicted ... I lost my mental state..."*

Diagnosis

Schitzphrenia & Bipolar Type I

agree — disagree

Treatment

Medication: "I'm about to refuse taking meds if they don't get the right ones."

agree — disagree

Rights

	did they know	use
Rights	*yes*	*no*
Health Review Board	*unsure*	*no*
Legal Representation	*yes*	*no*
Second Medical Opinion	*unsure*	*no*

"They said I could call a lawyer. I don't have one and I hate court. I just waited it out. I was an eagle trapped in a cage. I can't fly or enjoy things. They took that away from me."

Support at Discharge

	helpful	unhelpful
formal	youth care worker	psychiatrist
informal	dad, mom	

discharged to: *dad (on last visit)*

Gaps & Opportunities

Psych Tube
As Charlie transitions into the adult world, he'd like to learn more about what laws apply. He wants to be prepared for what lies ahead, and find out how to stand up for himself. What if there was a youtube channel with content (poetry, raps, etc.) produced by & for young adults?

Natural Paths
Charlie is curious about natural remedies and how indigeneous culture might address mental health challenges. What if there was a network of natural healers who offered a range of more organic supports, alongside medical treatment?

Conversations took place August 13th 2019 - 6:30-8:15pm | Researcher: Sarah Schulman and Natalie Napier

(?) *unclear or didn't remember* (?) *we didn't ask*

#Youth Mental Health Act #Abbotsford #foster care

"The clothes I wore, they just made me feel like more me-ish."

Samuel never had a lot of personal belongings. He was raised by his grandfather "because my parents couldn't" and living in a foster home when he had his first experience in the psych ward. "The few bits of clothing I did have, taking that away, it was just a slap in the face to me." While he understands the risk of someone hanging themselves, at age 17, he was struggling with his self-image. Being forced to wear a hospital gown was awful, "like, of course, I'd get panicky and freak out about it, and their first reaction is 'ah, he's going crazy, call security!'"

Samuel cut himself the night he was admitted. Growing up in "such a weird lifestyle, I didn't learn proper coping mechanisms." That was the day he broke up with a girlfriend and found out his grandfather had died. "There were a couple [of cuts] that night that just got really deep." His foster mom took him to the ER for stitches and to talk to a doctor. "My foster mom cared, but she didn't care-care." He begged and pleaded not to go. Still, he held some hope that the doctors could help. "Not so much on that aspect anymore," he says. These days, the hospital feels like part of a vicious cycle. "You never found the solution to your problem. They just gave you medication and told you to see a therapist." According to Samuel: "It's never really the professionals that help you." The nurses "shove medication down your throat. They literally are there to do what doctors told them to do." He found one exception: a "genuine" outreach worker who brought him chips & outside food and introduced the program MindShift. "Having an adult taking interest in me and actually caring about my mental health... I didn't really exactly have much of that other than my grandfather."

people card

Samuel

cis male
22
Caucasian

Individual's perspective

Desired outcomes

Respect *"I've had to do that a lot with my job [as a pressure washer], because I guess technically, I'm the youngest one there."*

Honesty *"Being a human being is being able to be honest with each other."*

Faith *"It's definitely one of the reasons why I'm still here today, because I'm able to look at something and just be like, you know what, it's bad now, but it's not forever."*

Stressors

Mental Health *"Just my whole friggin life. Oh, my goodness. My upbringing was not good. My childhood was not good."*

Loneliness *"I had like, a lot of pretty bad relationships... only now I'm kind of starting to realize like it's possible to be content in the presence of friends."*

Not enough time *"I get up at like 5am go to work at 7, get back home at like 6 o'clock at night. Like every single day."*

Environmental Factors (when certified)

removal from family | death & grief | break-up | abandonment | poverty

Self Descriptors

Caregiver | Victim | Provider

"I'm that guy. I'm constantly cleaning the house and cooking food for people."

Certification Experience

Hospital Stays

n# times: *1 youth/multiple adult*
n# involuntary: *1-2* ?
longest stay: *3 weeks*

Usefulness of Detainment

"It really did not help. It was just a constant trying to make myself look better than I actually was... at some point, I realized how much I needed the outside world too. To keep me whole."

descriptors of detainment

"They're like 'oh, I'm the doctor, you're the patient, I know what you need, blah blah blah...'"

terrified | cried a lot | pleaded | panicky | freaked-out | alone

1st stay

voluntary ? - **age** *17* - **prompted by** *cutting / suicidality* - **length** *3 weeks* - **brought by** *foster mom*

before	*in the hospital*	*after*
"I felt an emptiness that I really should not have had to experience at an age like that."	*"Suddenly you're having all these rules and all these things shoved in your face." "They don't really handle your freak-outs that well."*	*"My friends, the park, my music, bike rides, hiking. Everything, not in the hospital. Literally every single thing."*

Diagnosis

ADHD, Anxiety, Depression

agree — disagree

Treatment

"They fed me a lot of drugs, and I just pretended like they were working."

agree — disagree

Rights

	did they know	use
Rights	*no*	*no*
Health Review Board	*no*	*no*
Legal Representation	*no*	*no*
Second Medical Opinion	*no*	*no*

"The doctor was really intimidating... I still don't think I would have asked him... the moment I find someone kind of intimidating--I shut down with that person."

Support at Discharge

	helpful	unhelpful
formal	MindShift	
informal	my best friend	a friggin' girl

"It helped me, but it kind of screwed me over. I met a friggin' girl at [mind shift], from that point I was fairly distracted with the program. I don't feel like I took full advantage of it."

discharged to: *foster family* ?

Gaps & Opportunities

Youth Certified & Awarded

Samuel would like medical staff to know that 1) not every kid is the same; 2) just because you have power doesn't mean you can solve anything, and 3) kids are the future: the way we treat them has a huge effect on their lives and others down the line. What if staff in psych wards had to go through a training delivered by young people and get certified by them? And what if young people could nominate the 'positive staff' they encountered and there was a yearly youth-run awards ceremony celebrating good practice?

Conversations took place August 14th 2019 - 12:23 - 3:47 pm | Researcher: Melanie Cammon & Valentina Brenada

? *unclear or didn't remember* ? *we didn't ask*

#Youth Mental Health Act #Abbotsford #foster care

"I just don't think I'm going anywhere in my life because I haven't started."

Koral pauses mid-sentence. She's forgotten what she was saying again, and looks around for a reminder. Her anxiety, and the drugs she's on for epilepsy, have a lot of side effects including quite profound short-term memory loss. "The doctors are still wondering what causes my [seizures] and the only explanation they have is that I cause them myself." Koral's doctors suspect that she has schizophrenia "like my mother," whose care she was removed from at age 16. But Koral sees her symptoms in a different light. "I've wanted to transition since I was 12 years old." The seizures and "mental health stuff" started at 13. Sitting in a pair of grey sweats with an unshaven beard, Koral reflects that in the 14 years since, she's felt stuck, and never genuinely supported. "The only reason I ever have any anxiety in the first place is ...the all the time stress of being in the wrong body without any means of conquering it."

Koral started staying at a friend's last week but is thinking of moving back to the shelter. The friend calls and texts to remind her to take her medication. She knows it's important not to move out without saying anything but as usual, she is finding it difficult to accept help. "I get stressed out when other people try to help me."
At the shelter, she's "more comfortable: there's people just as crazy as I am there." Her ten plus visits to the psych ward are judged as good or bad depending on her ability to socialize and make friends there. Mostly she recalls being isolated from other patients. "I was actually afraid in the psych ward, which isn't normal for me."
She would like to feel she is actively becoming her own person, a real challenge when she is so heavily medicated. "If my doctors had listened, I would have moved on with my life a lot sooner."

people card

Koral

trans female
26
Caucasian

Individual's perspective

Desired outcomes

Fitting in *"I don't know how to do that, so, that's important."*

Self sufficiency *"That's why I don't like people helping me."*

Stressors

Memory *"I have short term memory loss...in conversation I can forget what I'm saying or that I'm talking. It's caused by anxiety and meds."*

Family *"I don't know where half my family is. My mom is....on drugs. She isn't answering her buzzer."*

Friends *"I don't know how to make friends. I forgot how. It's my own isolation [but,] I don't really like being alone."*

Environmental Factors (when certified)

poverty | parental mental health | removal from family | homelessness | gender dysphoria | suicidality | parental addiction

Self Descriptors

caregiver | citizen | nerdy | empath

Certification Experience

Hospital Stays

n# times: *10 - 20*
n# involuntary: ?
longest stay: *6 months (her sense of time)*

usefulness of detainment

"[The last time I went there] was the most helpful because I made friends. It was not about the staff."

descriptors of detainment

isolated | uncaring | unsupportive

1st stay

voluntary - **age** *13-14* - **prompted by** *seizures*- **length** *unsure* - **brought by** *mom*

before	*in the hospital*	*after*
"Sometimes it's about other people telling me I need to go there and I've gone there myself. But usually I'm in disarray."	*"In there, our individuality is replaced with a diagnosis that's supposed to define us... Keeping quiet is like self defense."*	*"I don't think I was really helped a lot."*

Diagnosis

Schizophrenia "I don't think I'm schizophrenic. I think I get anxious a lot."

agree — disagree

Treatment

Medication & counselling: "Same psychologist for a long time. He's not doing anything."

agree — disagree

Rights

	did they know	use
Rights	*no*	*no*
Health Review Board	*no*	*no*
Legal Representation	*yes*	*no*
Second Medical Opinion	*no*	*no*

"I signed a contract [at Surrey Memorial] but I never read it."

Re: Health Review Board "Yeah, I would have done that."

Support at Discharge

	helpful	unhelpful
formal	shelter	psychiatrist, psychologist
informal		mom

discharged to: *mom; group home; Salvation Army*

Gaps & Opportunities

The Committeds
Koral would have liked some more help preparing for and just after leaving the hospital. What if there were people who have come through the other side of certification/detention, to come and share their experience while you're in hospital or right after?

Psychtube
Koral would have liked to learn more about her situation, but not through a clinician. What if there were a Youtube channel created by youth for youth, explaining the Mental Health Act and your rights. Watch in the hospital to understand what's happening.

Conversations took place August 17 13:30-16:15 | Researchers: Natalie Napier & Elizabeth Boyd

(?) *unclear or didn't remember* (?) *we didn't ask*

story returned

Rai

#Youth Mental Health Act #Abbotsford #foster care

"Because I was always bullied throughout school, I'm always feeling like I'm doing something wrong."

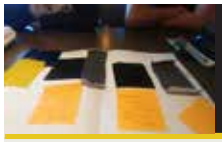
Rai dumped her boyfriend the day after our discussion about values, ambitions, and how the past has shaped them. For Rai, it was a bold move. Feeling abandoned by friends and family has been a recurring motif in her story, so "having people stick with me" remains a constant concern. And given her agoraphobia, she wasn't likely to leave the house without him.

Still, these fears sat uncomfortably beside her bubbling ambition: "I want to be a writer, photographer, work with animals, do music...What am I supposed to do with my life?" She is enrolled at a learning centre this fall in order to get her high school diploma. Dreaming about the future is an act of bravery. "My whole life, nothing really good happens to me. Last year, I ended up homeless!" Her career ideas reflect her recent understanding that art has been "a coping strategy" all along. It's something she only noticed when she stopped last year.

Recognizing that mental health will always take up space in her life, Rai wishes that other people had more exposure and understanding, maybe through a course in school. "I've been dealing with mental health since I could remember. It's a really big weight on your shoulders. I've tried so many doctors and medications..." With fibromyalgia and kidney disease, Rai has found physical ailments garner a different kind of attention. At the last visit to emerg to adress suicidal thoughts, the nurses were so "mean" she left without treatment.

Rai grew up with an abusive dad. The dad is finally out of the picture, but the impact remains. "I'm constantly stressed, feeling that things can fall apart any time."

At this point, Rai has boldly decided her trajectory is upward. "I'm a survivor of more than just one thing. I'm a survivor of rape two years ago. And I'm a survivor of depression and a suicide attempt."



people card

Rai

cis female
19
Caucasian

Individual's perspective

Desired outcomes

Inner harmony *"Everything peaceful: I'm just a really nice person - I think I am."*

Adventure *"Because, when I was good [health-wise] I loved the outdoors, and now I've grown up, I hate leaving the house."*

Safety & Security *"I need security, mainly financial, because I've grown up having nothing. With people, [it's about] having people stick with me. So many people have walked out of my life."*

Stressors

Housing *"I've never been in one place for a long time, and I have now been homeless....Am I going to be able to stay? Can I afford this?"*

Mental Health *"I've been dealing with mental health since I could remember...If I'm alone, I won't go anywhere."*

Relationships *"I guess because I was bullied throughout school, [I'm always] feeling like I'm doing something wrong."*

Environmental Factors (when certified)

sexual abuse | emotional abuse | suicidality | parental addiction | homelessness | removal from family | poverty

Self Descriptors

survivor | writer | artist | shy

Certification Experience

Hospital Stays

n# times: *2*
n# involuntary: *0*
longest stay: *1 week*

usefulness of detainment

"I didn't have a psychiatrist before...so it was a little better, but then a lot of crap happened."

descriptors of detainment

1st stay	2nd stay
pretty good	neglected
nice	bullied
	starvation

1st stay

voluntary - **age** *16* - **prompted by** *suicidal thoughts* - **length** *1 week* - **brought by** *self + mom*

before	in the hospital	after
"Different variations on 'low.' My dad was a user - alcoholic, and abusive, so the feeling stretches back a long way."	*"The first time, people were kinder. A volunteer taught me how to use a loom. I still do... No one else stands out particularly."*	*"I don't really know how I felt: happy but scared at the same time."*

Diagnosis

Anxiety - agoraphobia, panic disorder, Chronic depression

agree — disagree

Treatment

Medication & counselling: "Finally found [medication] that works, and I can't have it."

agree — disagree

Rights

	did they know	use
Rights	*yes*	*no*
Health Review Board	*no*	*no*
Legal Representation	*no*	*no*
Second Medical Opinion	*no*	*no*

Support at Discharge

	helpful	unhelpful
formal	psychiatrist, counsellor	
informal		dad, mom

discharged to: *mom* ?

Gaps & Opportunities

Draw Change
Rai didn't realize that arts were a coping mechanism until she stopped. What if she could have worked with an artist and medical professionals to create a visual plan when she was leaving the hospital?

Youth know best
Rai has had a good experience and a bad experience being hospitalized. What if she could be part of a crew of youth who train medical professionals, social workers and counsellors in how to understand and explain the Mental Health Act from a youth perspective.

Conversations took place August 15th 2019 - 12:30 - 4:15pm | Researcher: Natalie Napier

? *unclear or didn't remember*

? *we didn't ask*

Appendix 3: InWithForward

The Indigenous researcher Leanne Betasamosake Simpson, asks: *"What does it mean to 'prioritize being with each other, being with the work, being with the possibilities more than they prioritize the gymnastics of trying to get it right in a structure built on wrongness."*[145] Her answer is to pay attention to whose voices are prioritized and whose voices are marginalized, and to pursue ways of knowing rooted in first-hand experience and relationship. This is the spirit with which InWithForward approached being with young people.

The key questions that guided InWithForward's time with the young people:

- What is the experience of certification for young people? What colours, textures, sounds and words are they left with?
- What do rights mean to young people who have been certified under the *Mental Health Act*? How do they understand their rights, and what role (if any) do rights play?
- What do agency and control look like in the context of certification under the *Mental Health Act*?
- What were the expectations versus realities of involuntary admission to hospital? What (and who) helps versus hinders healing?
- Where might points along the certification journey be for greater agency and healing?
- How does certification under the *Mental Health Act* shape young people's trajectories?

After each conversation, InWithForward wrote a short profile of the young person. Profile cards are designed to engender empathy and understanding, as well as to serve as a tool for brainstorming ways to improve services and shift systems.

Importantly, effort was made to return each profile card to the young person in a process known as *"Story Return"* so that the youth were provided the opportunity to review, check assumptions and rewrite story elements on the profiles. This process ensures the integrity of the deep data derived from the participants. Moreover, several young people expressed how reading their own story engendered pride. One young person commented after reading their profile, *"I feel kind of proud that I am still here."* The profile cards of the eight youth who participated in the Story Return process are presented in Appendix 2.

Throughout their work with the Representative, InWithForward drew upon Indigenous methodologies for story gathering described by Betasamosake Simpson as *"doing or making, relationship, visiting, singing, dancing, storytelling, experimenting, observing, reflecting, mentoring, ceremony, dreaming and visioning as ways of generating knowledge."*[146] Their analytic approach is further rooted in ethnography, phenomenology and constructivist worldview.

Using a process called segmentation, they group individuals into clusters based on similar life experiences, expressed needs, motivations and environmental factors. Rather than look at young people under the *Mental Health Act* as one homogeneous group, InWithForward seeks to identify the most important points of difference, in order to come up with more actionable insights and generate ideas and information about supports and interventions that might be more attractive, relevant and impactful for young people held under the *Mental Health Act*.

[145] Leanne Betasamosake Simpson, *As we have always done: Indigenous freedom through radical resistance* (Minneapolis; London: University of Minnesota Press, 2017).

[146] Leanne Betasamosake Simpson, *As we have always done: Indigenous freedom through radical resistance* (Minneapolis; London: University of Minnesota Press, 2017).

In seeking to understand the young people's ability to participate in the decisions that impact their lives, sociologist Roger Hart's Ladder of Participation functions as a guiding concept.[147] Accordingly, child participation can be conceptualized as a ladder with eight rungs: (1) manipulation, (2) decoration, (3) tokenism, (4) assigned but informed, (5) consulted and informed, (6) adult-initiated but shared with youth, (7) youth-initiated and directed; and (8) youth-adult partnership.

InWithForward helped the young people use a timeline and post-it notes to reconstruct their journey into and out of hospital and key events along the way. While most young people described functioning under a haze of medication, particular moments stuck out, and those were explored further. Using Hart's Ladder of Participation, recollected events were organized by ladder rung, opening up a dialogue about power, control and authority, and focusing in on when the young people had felt heard and by whom.

[147] Roger A. Hart, "Children's Participation from Tokenism to Citizenship," *Innocenti Essays*, no. 4 (1992).

Appendix 4: Project Participants

British Columbia Association of Aboriginal Friendship Centers

British Columbia Children's Hospital

British Columbia Civil Liberties Association

British Columbia Law Foundation

British Columbia's Office of the Human Rights Commissioner

Canadian Mental Health Association

Child and Youth Legal Centre

Community Legal Assistance Society

First Nations Health Authority

First Nations Leadership Council

Legal Services Society

Mental Health Review Board, Province of British Columbia

Métis Nation British Columbia

Native Courtworker and Counselling Association of British Columbia

Office of the Children's Lawyer, Province of Ontario

Office of the Ombudsperson, Province of British Columbia

Office of the Provincial Advocate for Children and Youth, Province of Ontario

Office of the Provincial Health Officer, Province of British Columbia

Victoria Police Department

Appendix 5: RCY Data Collection

Background

As already noted, the Representative has drawn on several sources of data for this special report. One of those sources is information in respect of deaths and critical injuries reported to the Representative under s. 11(1) of the Act.[148, 149]

Internal data collection

The Representative receives reports for critical injuries and deaths of children and youth who are receiving or have received a reviewable service within the year prior to their injury or death. These reports provide valuable information about the potential connection between services and a child's well-being.

For this report, RCY undertook a descriptive analysis of all critical injuries and deaths of children and youth reported to the Representative from April 1, 2018 to October 31, 2019. During that time, 1,361 critical injuries and deaths of children and youth met the Representative's criteria for review as set out in the *RCY Act*. Of the reports reviewed, 116 met the inclusion criterion for this project, such that:

- the child or youth, or their family received a reviewable service within the year previous to the critical injury or death
- the policies or practices of a public body or director may have contributed to the critical injury or death
- the child or youth's critical injury or death referenced admission under the *Mental Health Act* in the child or youth's lifetime.

The critical injuries and deaths were analyzed to indicate trends amongst children and youth who are detained under the *Mental Health Act.*

Several of the reportable circumstances were selected to be reviewed more comprehensively at the initial screening stage. This comprehensive screening included examining documents such as medical records, MCFD case files and relevant policies and standards. Excerpts from some of these comprehensive reviews are included in this report to illustrate overall findings. Pseudonyms are used for the case examples in this report in order to protect the privacy and identities of the youth.

Descriptive analysis of critical injuries and deaths

The sample of critical injuries and deaths reviewed included children and youth receiving reviewable services and with mandate injuries or deaths reported to the Representative for the 18-month period of April 2018 to October 2019. Injuries and deaths were reported for 1,361 children and youth during this timeframe: 1,194 children and youth were reported to experience critical injuries and 167 children and youth died. Word searches were conducted with this sample to identify those children and youth noted

[148] In *Representative for Children and Youth v. Attorney General of British Columbia*, 2019 BCSC 1888, the British Columbia Supreme Court held that the Representative is entitled to issue a special report to the Legislative Assembly that is informed by internal aggregate data that was collected in the exercise of her critical injury and death review function under Part 4 of the Act.

[149] A critical injury is an injury to a child that may result in a child's death or that may cause serious or long-term impairment of the child's health. For a more detailed discussion of what is a serious injury, see the Representative's Special Report *"Reporting of Critical Injuries and Deaths to the Representative for Children and Youth," December 2010.*

in the CITAR-II record to have had a mental health admission in their lifetime. Files were examined at the participant level for inclusion or exclusion, and 116 youth met the criteria.

Inclusion criteria included:

- One or more reported mandate critical incidents (injury or death) reported, and
- Inpatient stay for 24 hours or longer due to:
  - Certification under the *Mental Health Act* (involuntary admission)
  - Voluntary admission for assessment, stabilization and/or medication management in a hospital, APAU, CAPSU, CAPE unit, Ledger, Maples or CCU
  - On a short or extended leave from an inpatient unit.

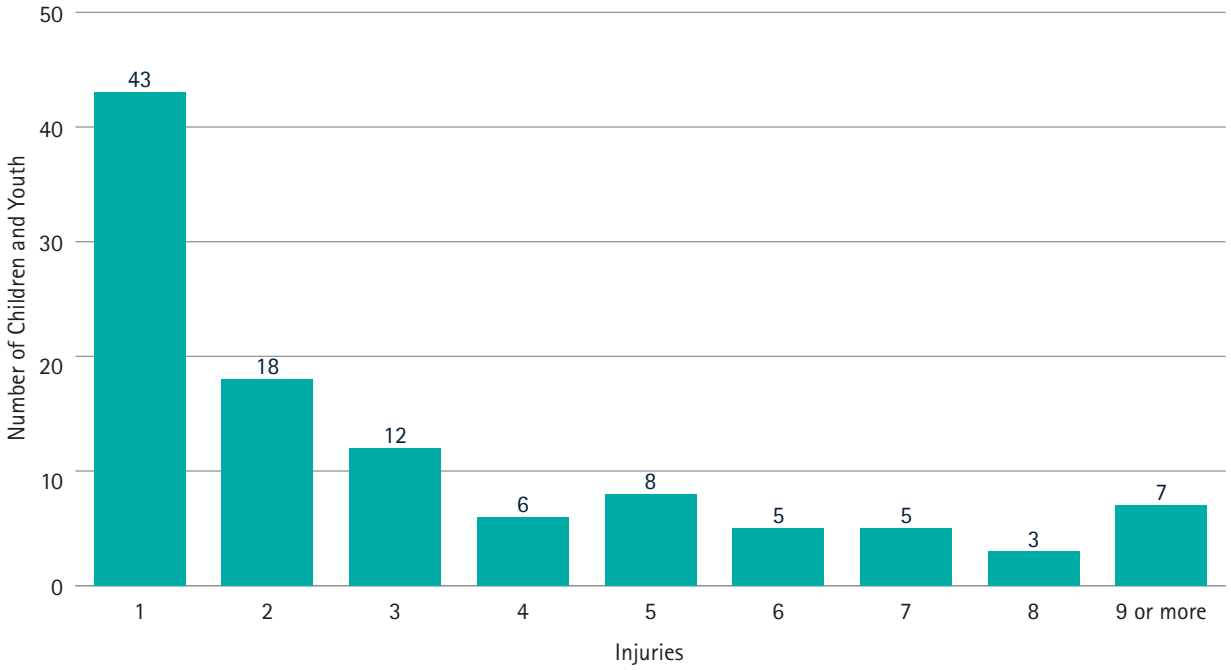
Exclusion criteria included:

- Apprehension by police under the *Mental Health Act*, but not admitted to the hospital voluntarily or involuntarily,
- Admitted to a hospital for mental health reasons for less than 24 hours, or
- Admitted to a hospital for non-mental health reasons (e.g., stabilization after an accidental overdose).

Results

There were 116 youth that met inclusion criteria: 107 youth experienced critical injuries and nine youth died while receiving a reviewable service or in the twelve months prior and had a mental health admission during their lifetime. These youth had a total of 402 injuries reported during the 18 months. More than half of youth (57%) experienced more than one critical injury during this period (see Figure 1).

Figure 1: Number of reported injuries per individual with history of mental health hospitalization (April 2018 to October 2019)



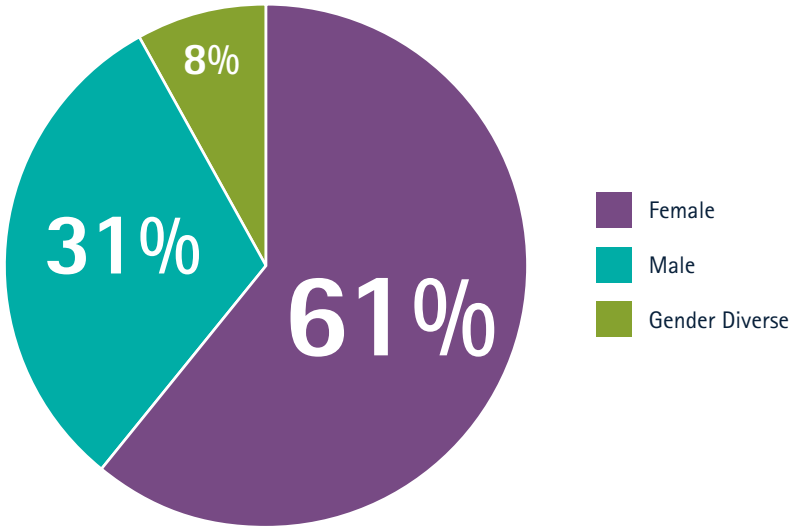
Injury data

There were 107 youth with reported injuries and a mental health admission in their lifetime. Themes for youth with critical injuries and mental health admissions are explored using descriptive statistics.

Youth characteristics

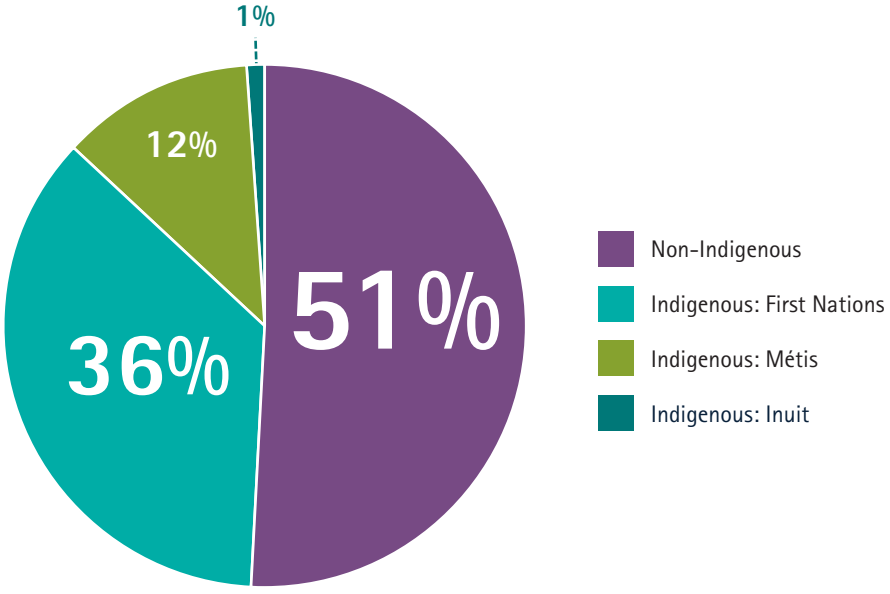
More than half of this sample were reported to be female (61%) and almost one-third were male (31%). Eight per cent of the youth identified as gender diverse (8%).

Figure 2: Gender of youth with critical injuries and mental health admissions (April 2018 to October 2019)



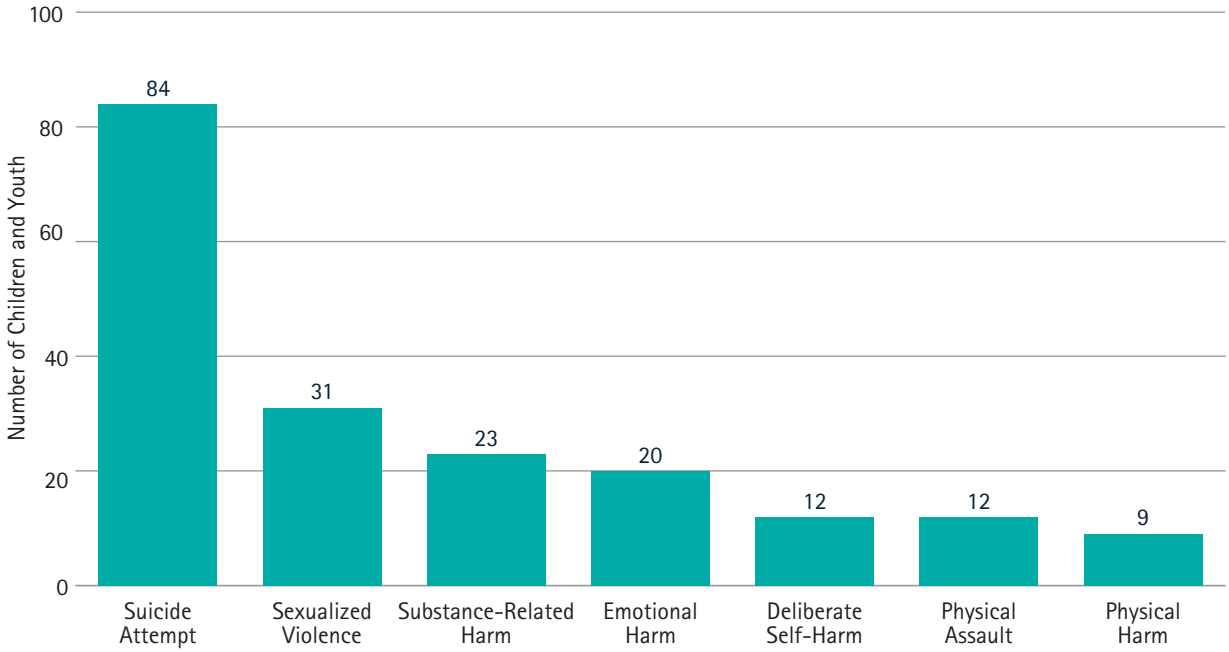
Half the sample was identified as non-Indigenous (51%) and just over one-third were identified as First Nations (36%). There were 13 youth in this sample identified as Métis (12%) and one youth was identified as Inuit (1%).

Figure 3: Indigeneity of youth with critical injuries and mental health admissions (April 2018 – October 2019)



Seven types of injuries were coded based on descriptions provided by service providers (see Figure 4).

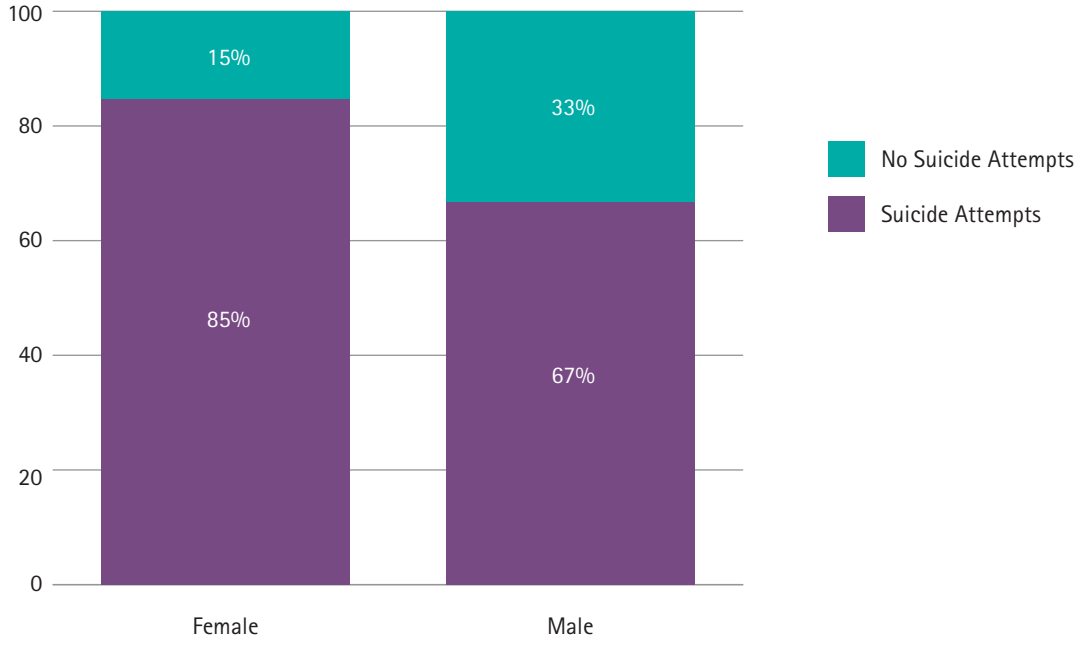
Figure 4: Injury types reported for those with mental health admissions (April 2018 to October 2019)



The most commonly reported injury was suicide attempt (79%). Most of these youth (61%) had one mandate suicide attempt reported, with a range up to 16 suicide attempts reported for one youth in the sample. There was a significant relationship between gender and suicide attempts. Analyses[150] revealed that female youth were more likely than expected, given the distribution of the data, to have reported suicide attempts. Alternately, male youth were less likely than expected to have reported suicide attempts. More than three-quarters of female youth (85%) in this cohort had at least one reported suicide attempt, whereas approximately two-thirds of male youth (67%) had at least one reported suicide attempt (see Figure 5).

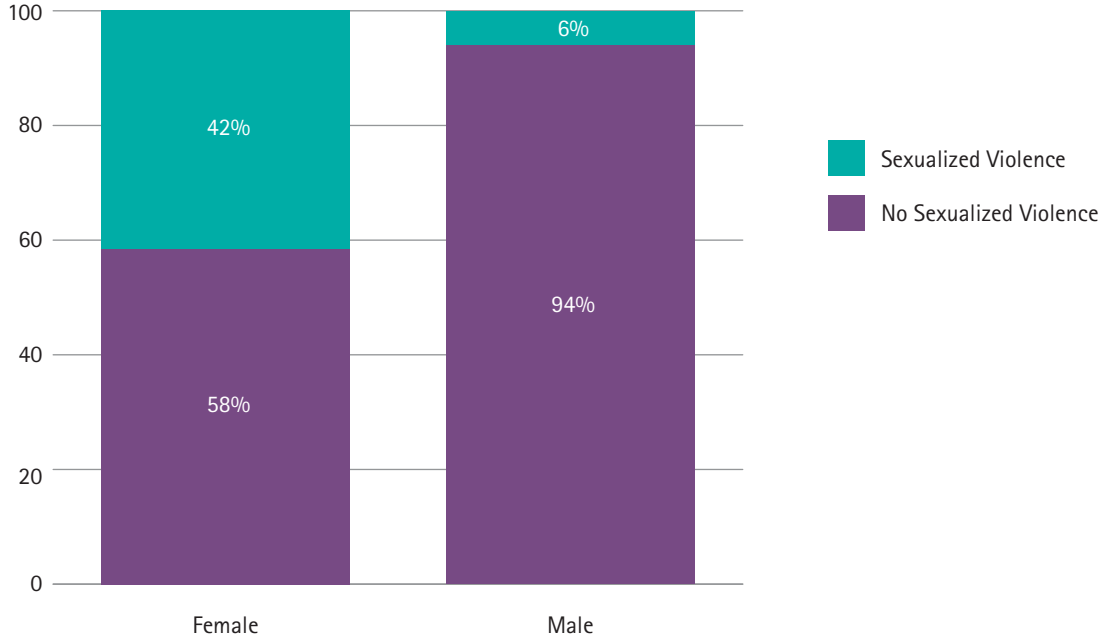
[150]Chi-square analysis evaluates group differences for dichotomous variables. Chi-square evaluates observed values against values that are "expected," based on the distribution of the data. Expected values are those that would occur if there is no relationship between variables. Chi-square is a descriptive statistic; that is, it describes a relationship between two variables but does not explain the cause of any difference (Mary L. McHugh, "The Chi-square test of independence," *Biochemica Medica*, 23, 2 (May 2013): 143-149.

Figure 5: Comparison of suicide attempts by gender (April 2018 to October 2019)



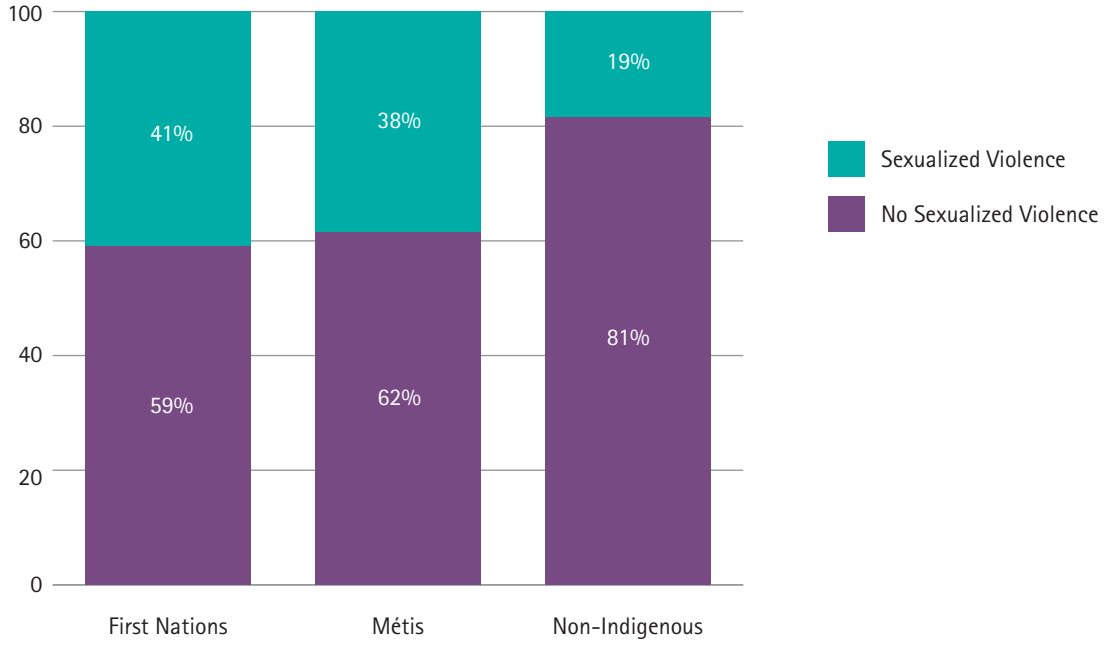
More than one-quarter of youth (29%) experienced a reported sexualized violence injury. Approximately half of these youth (48%) had one reported sexual violence injury, with a range up to nine. As with suicide attempts, there was a significant relationship between gender and reported sexualized violence injuries. Analysis revealed that significantly more female youth than expected had at least one reported sexualized violence injury (see Figure 6).

Figure 6: Comparison of sexualized violence injuries by gender (April 2018 to October 2019)



There was also a significant relationship between indigeneity and sexualized violence. First Nations youth were significantly more likely than expected to have at least one reported sexualized violence injury. Conversely, non-Indigenous youth were significantly less likely than expected to have a reported sexualized violence injury. There were five Métis youth (39%) with a reported sexualized violence injury.

Figure 7: Comparison of sexualized violence injuries by Indigeneity (April 2018 to October 2019)

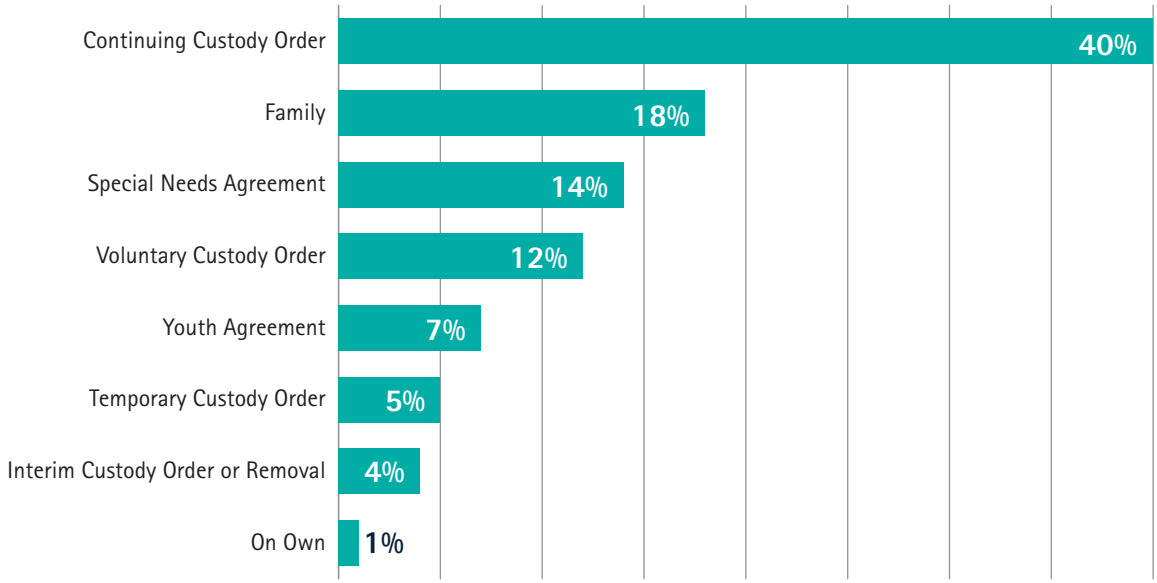


Additionally, one-fifth (22%) of the sample had a reported substance-related injury. More than half of these youth (61%) had one reported substance-related injury, with a range up to 4. There was no relationship between gender and substance-related harm. Deliberate self-harm was reported for 12 youth (11%). One youth had 25 reported deliberate self-harm injuries. Only three of these youth with deliberate self-harm injuries were male and all youth with more than one reported deliberate self-harm injury were female. Physical assaults were also reported for 12 youth (11%). All but one youth with reported physical assault injuries had one reported injury.

Systems characteristics

The majority of youth in this sample had been in government care (76%) and the rest had never been in care (24%).[151] Between April 2018 and October 2019, almost half of youth in the sample were permanently in care via Continuing Custody Order (40%). See Figure 8 for the summary placement types at time of injury for this cohort.[152]

Figure 8: Legal status of youth with critical injuries and mental health admissions (April 2018 to October 2019)



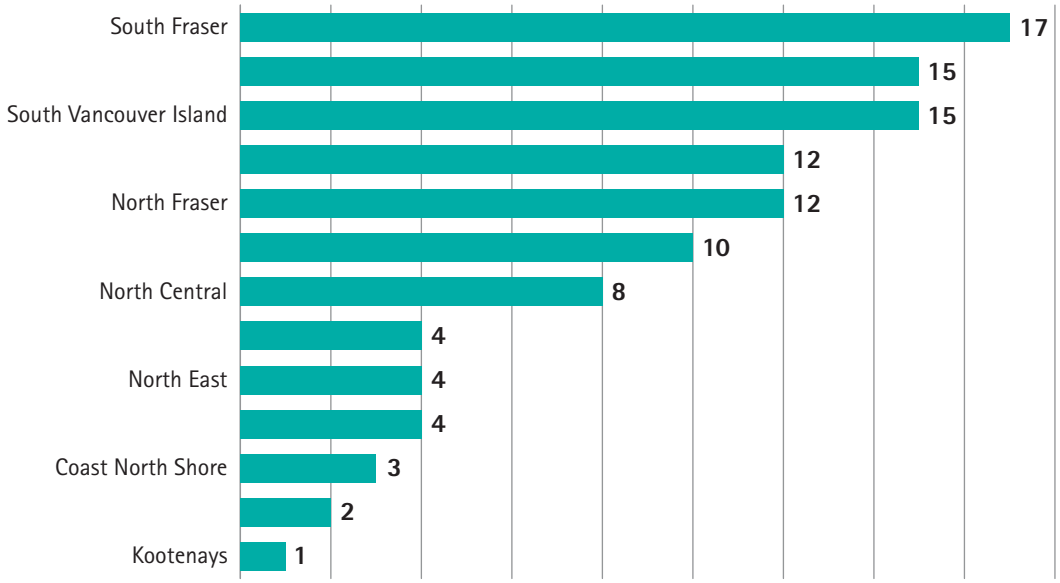
Children and youth in this sample were spread across B.C. Figure 9 depicts the Service Delivery Areas in which children and youth lived.[153] Children and youth living in the Lower Mainland (South Fraser, East Fraser, North Fraser and Vancouver Richmond) made up half the sample (51%) and those living on Vancouver Island made up another quarter of the sample (25%).

[151] Children and youth were coded as "in care" if they had ever been in MCFD care and "not in care" if they had always lived with family.

[152] Legal status was determined by the youth's most recent legal status (e.g., if the child had initially been brought into care via VCA, then was removed, and was most recently CCO, the child was coded as CCO).

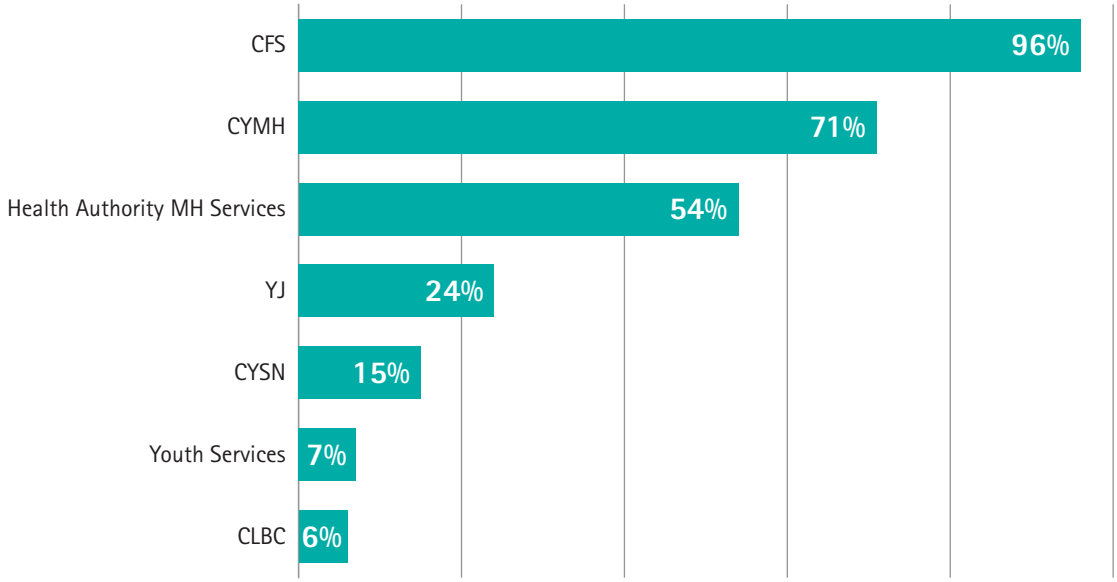
[153] If a child moved between Service Delivery Areas, the SDA in which the child spent the most time was coded as their SDA.

Figure 9: Children and youth with critical injuries and mental health admissions by Service Delivery Area (April 2018 to October 2019)



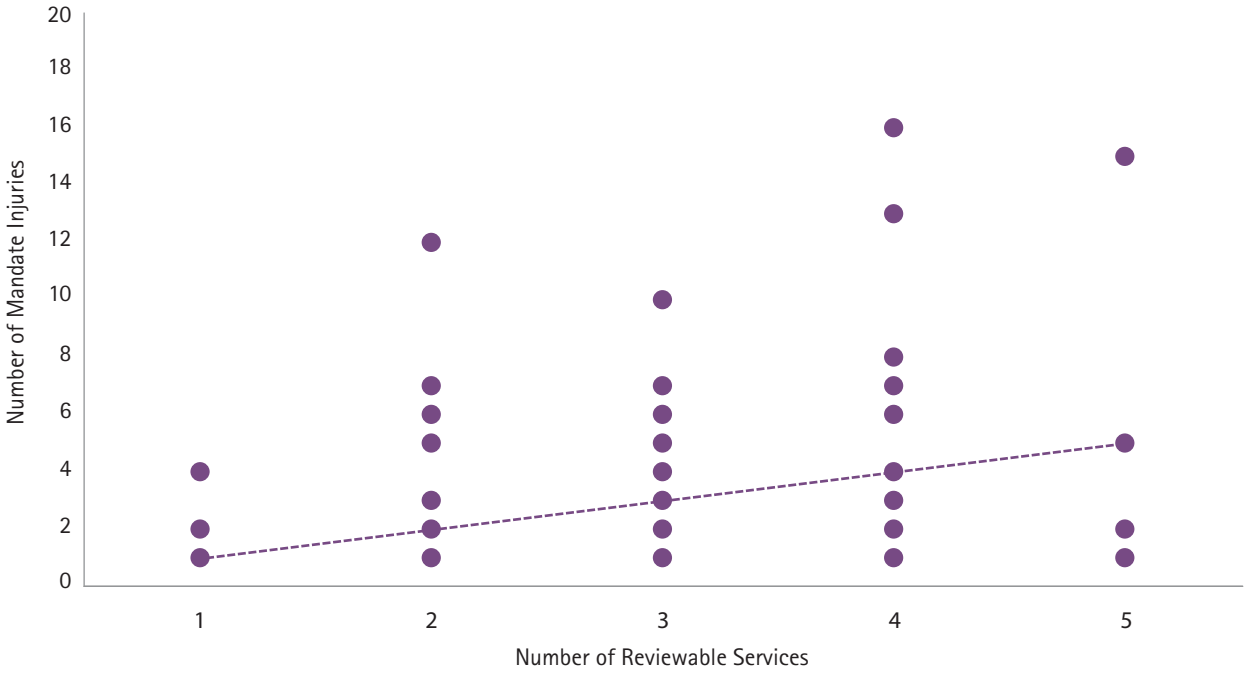
On average, children and youth in the sample were served by three reviewable service areas, with a maximum of six reviewable service areas. Almost all children and youth (96%) were served by child and family services (CFS). Almost three-quarters of children and youth (71%) received services through CYMH and more than half (54%) received mental health services through their health authority. Forty children and youth received services through CYMH and health authority mental health programs. Almost one-quarter of children and youth (24%) had youth justice involvement. Fewer than one-quarter of children and youth (23%) were receiving addictions services (see Figure 10).

Figure 10. Reviewable services involved with children and youth with critical injuries and mental health admissions (April 2018 to October 2019)



The number of mandate injuries reported for youth with mental health admissions had a significant and positive relationship with the number of reviewable services involved with youth (see Figure 11).[154] This means that, overall, as the number of reported injuries increases for youth, so does the number of involved reviewable services. Visual inspection of the data reveals that youth with one reported injury were more likely to be served by CFS, CYMH or both. On the other hand, youth with 10 or more mandate injuries were often served by CFS, CYMH, other MH service, YJ and addictions services. While this statistic is not causal (i.e., it is impossible to determine why this relationship exists), it does raise interesting questions. Is it the case that, as youth engage in more serious injuries, practitioners recruit more services for a youth in order to prevent further injuries? Or is it the case that the number of injuries and the number of reviewable services are both an indicator of the complex situations experienced by youth in this cohort?

Figure 11. Relationship between number of mandate injuries and number of reviewable services for youth with mental health admissions (April 2018 to October 2019)



There were 17 issues of interest coded for youth with critical injuries and mental health admissions. An average of six issues coded per youth, with a maximum of 11. All youth had a reported mental health diagnosis and 48 children and youth (45%) were noted to have co-occurring mental health and substance use challenges. More than half of youth (52%) had evidence of a complex developmental/behavioural challenge and one-quarter of youth (25%) had suspected or confirmed Fetal Alcohol Spectrum Disorder (FASD). Slightly more than one-fifth of youth (22%) had both Complex Developmental Behavioural Conditions and FASD. A number of youth experienced adversity in their lives. For instance, more than one-third of youth (36%) had lived with parents who had substance use challenges and another third (36%) had lived with domestic violence. Further, at least one-quarter of youth (29%) had experienced poverty.

[154]Since these are two continuous variables, the presence and strength of the relationship was determined through Pearson correlation [David C. Howell, *Fundamental Statistics for the Behavioural Sciences, 6th Ed.*, (Belmont, CA: Thomson Wadsworth, 2008), 170-181].

External Data Collection

To understand the prevalence and experiences of children and youth detained under the *Mental Health Act,* data was requested from the province's six health authorities, the Ministry of Health and the Ministry of Children and Family Development. Information requested for children under 19 years of age included data on:

- voluntary and involuntary admissions
- consent to treatment
- admissions duration
- extended leave
- use of seclusion and safe rooms
- Indigenous self-reported identity
- the prevalence of second opinion requests.

Ministry of Health provided 10 years of annual data on mental health hospitalizations in B.C. for children and youth ages 18 and under through the Discharge Abstract Database (DAD).[155, 156] The DAD does not include historical data for all inpatient tertiary mental health facilities, and those under Schedule A of the *Mental Health Act* Designated Facilities are not included in hospitalization data.[157] The data summarizes the number of cases of mental health hospitalizations with and without an Involuntary Status under the *Mental Health Act*, length of stay, category of mental health diagnosis and number of cases of extended leave.

Due to a lack of data collection, health authorities were not able to provide RCY with data on the prevalence of second opinion requests or information specific to Indigenous self-reported identity. Length of stay data provided by Ministry of Health was not consistent with data provided by some health authorities and was omitted from the report due to concerns with reliability.

The Mental Health Review Board – an independent administrative tribunal panel comprised of a physician, a legal member and a community member – provided the Representative with data on review panel hearings and decisions. The Community Legal Assistance Society (CLAS) provided the Representative with data on the legal representation of patients at Mental Health Review Board hearings.[158]

Relevant Legislation, Regulations and Guidelines

Relevant legislation, regulations and guidelines pertaining to B.C.'s *Mental Health Act*, *Infants Act* and *Administrative Tribunals Act* were reviewed, along with legislation and practices in other jurisdictions and international rights conventions. The information was analyzed to indicate potential limitations in B.C.'s mental health system and to inform interviews with key informants. Details of the legislation reviewed can be found in Appendix 6.

[155] Ministry of Health data on mental health data is reported by number of discharges and by discharge date.
[151] Standards on abstracting patient charts into the Discharge Abstract Database (DAD) are set by the Canadian Institute for Health Information, and these standards determine which data elements are available.
[157] Schedule A Designated Mental Health Facilities for Children and Youth include Jack Ledger House, Maples Adolescent Treatment Centre and Youth Forensic Psychiatric Inpatient Assessment Unit.
[158] The Legal Service Society provides funding to CLAS, who provides legal representation for patients under the Mental Health Review Board.

Literature Scan

A scan of relevant literature was undertaken with a focus on youth experiences with involuntary mental health treatment and detentions, as well as secure care. While there appears to be a movement toward seeking youth participation in developing broader mental health strategies, increasing access to mental health services and reducing stigma, there appears to be very little research and evaluation specific to mental health detention.[159, 160] As a result, the literature scan was necessarily limited.

Consult with Key Informants

Consultations were conducted with 17 key informants between August 2018 and November 2019.

The Representative met with key stakeholders including child advocacy organizations, experts in the mental health field, health care professionals, lawyers and government bodies. Particular attention was paid to consulting with Indigenous stakeholders in order to understand the unique implications of the detentions under the *Mental Health Act* for Indigenous children and youth. A thematic analysis of the consultations was conducted to develop the key issues for this report.

[159] Mental Health Commission of Canada, *The Mental Health Strategy for Canada: A Youth Perspective* (2016), retrieved from https://www.mentalhealthcommission.ca/sites/default/files/2016-07/Youth_Strategy_Eng_2016.pdf.

[160] Jack.org, Youth Voice Report (2019), retrieved from https://jack.org/getattachment/Youth-Voice-Report-2019/2019-YVR-Website.pdf.aspx?lang=en-CA.

Appendix 6: Legislative Frameworks

According to the World Health Organization (WHO), mental health is *"not just the absence of mental disorder,"* but rather *"a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."*[161] Unfortunately mental health can be illusive. According to the Mental Health Commission of Canada, 1.2 million children and youth in Canada are affected by mental illness, and the majority (80%) struggle to find appropriate treatment services.[162]

B.C.'s *Mental Health Act*

The *Mental Health Act* is legislation that sets out the criteria for both voluntary and involuntary admissions of persons with mental disorders to designated facilities. The *Mental Health Act* applies to all people and, for the most part, does not distinguish between children and adults. The procedural rules governing involuntary admission are the same for adults as they are for children.

The specific circumstances that may lead care providers or family members to consider involuntary admission under the *Mental Health Act* vary greatly, but for a person to be involuntarily admitted, three conditions must be met. The person must:

1. have a mental disorder that seriously impairs the person's ability to react appropriately to the environment or to associate with others
2. require safe and effective psychiatric treatment in or through a designated facility
3. require care, supervision and control in or through a designated facility to prevent substantial mental or physical deterioration or for the protection of the person or the protection of others, and
4. not be suitable for admission as a voluntary patient.

The *Mental Health Act* sets out detailed procedural rules governing involuntary admissions, including rules regarding certification, ongoing admission, rights during certification and discharge. These include the right to written and oral notice of the name and location of the facility where they are detained, the right to be provided with reasons for the detention, the right to counsel, the right to have an independent review panel or court review their detention and the option to request a second medical opinion when treatment is imposed.

The *Mental Health Act* sets out various forms that facilities must comply with while exercising power, one of which informs patients of their rights. The *Mental Health Act* also requires that a near relative be informed of the admission and of the patient's rights.

For children under the age of 16 who may be admitted to a facility at the request of their parent or guardian, procedural protections generally apply as if the child is involuntarily detained. The child is entitled to examination by a physician on the same schedule as all involuntary patients, and the child has a right to request a review of their detention, even if their parents do not agree. The only substantive difference between a child's rights under 16 who is admitted by a parent or guardian and all

[161] World Health Organization, *Promoting mental health: concepts, emerging evidence, practice (Summary Report)* (Geneva, 2004).

[162] Mental Health Commission of Canada, "Children and Youth," Mental Health Commission of Canada, https://www.mentalhealthcommission.ca/English/what-we-do/children-and-youth.

other involuntary patients, is that the child has no option to request a second medical opinion of their treatment. According to the Ministry of Health, the reason for this is because children under 16 are voluntarily admitted and therefore voluntarily consent to treatment.

Rights and Freedoms

While safeguards exist within *Mental Health Act*, there are also National and International conventions that set out the rights for individuals and groups. In considering the ways in which detentions under the *Mental Health Act* are experienced by youth, it is important to do so in the context of the broader protections that apply to these young people.

Canadian Charter of Rights and Freedoms

The *Canadian Charter of Rights and Freedoms* (the *Charter*) protects individual rights and freedoms that are essential to keeping Canada a free and democratic society.[163] It ensures that the government does not interfere with these rights or freedoms by allowing individuals to challenge government actions that violate their rights and freedoms.

When an individual is detained under the *Mental Health Act*, they are denied their liberty and security of the person as guaranteed under the *Charter*. Upon admission, the designated facility *"has absolute control over virtually every aspect of their life and body,"* and individuals lose their right to liberty, personal autonomy and security of the person.[164] The *Charter* guarantees that when these rights are impacted, there must be fair procedures and safeguards in place.

Canadian Charter of Rights and Freedoms

Section 7: 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.

Section 9: Everyone has the right not to be arbitrarily detained or imprisoned.

Section 10: 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.

Section 15: Everyone is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination.

[163] *Charter of Rights and Freedoms*, Part 1 of the *Constitution Act*, 1982, being Schedule B to *Canada Act* 1982 (UK), 1982, c 11 [*Charter*].

[164] Community Legal Assistance Society, *Operating in Darkness: BC's Mental Health Act Detention System* (Vancouver, 2017), 15.

United Nations Convention on the Rights of Persons with Disabilities

Additionally, Canada is party to the *United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)*, which sets out key rights that people with disabilities should enjoy in a fair society. It is accepted by the Committee on the Rights of Persons with Disabilities that people with a mental illness fall under the Convention and thus have the right to liberty and the right to equal recognition under law.[165, 166, 167, 168] The United Nations Special Rapporteur on the Rights of Persons with Disabilities has expressed concern that the B.C. *Mental Health Act* "contains very broad criteria for involuntary admissions and, once detained, a person can be forcibly treated without their free and informed consent, including forced medication and electroconvulsive therapy." Article 12 is of importance, outlining the right to enjoy legal capacity on an equal basis with others and the right to the support needed to exercise legal capacity.

United Nations Convention on the Rights of Persons with Disabilities

Article 14: The involuntary detention of persons with disabilities based on risk or dangerousness, alleged need of care or treatment or other reasons tied to impairment or health diagnosis is contrary to the right to liberty and amounts to arbitrary deprivation of liberty.

United Nations Convention on the Rights of the Child

Children are afforded the right to have their views be given due weight in all matters that affect them and to be provided with age-appropriate assistance to realize this right, which is a right also recognized in the *United Nations Convention on the Rights of the Child (UNCRC)*.[169]

One of the fundamental purposes of the *UNCRC* is to recognize and enforce that a child is an individual with fundamental human rights and views of their own. While the *UNCRC* does not set out an absolute ban on depriving liberty for mental health reasons, it holds that the detention of a child in a mental health facility is only valid to the extent that conditions set out in Article 37 are met (see text box).

The *UNCRC* further recognizes the assessment and realization of a child's best interests as a primary consideration in all actions or decisions concerning them. Moreover, the assessment and determination of a child's best interests must uphold the child's right to express their own views freely and give due weight to these views.[170]

According to the *UNCRC*, any legislation, policy, or procedure involving decision-making processes regarding young people must include procedural guarantees that consider the child's best interest, as well as the child's views within decisions that affect their lives, including a child's right to challenge the legality of a deprivation of their liberty.

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[165] The Committee on the Rights of Persons with Disabilities is a body of independent experts which monitors implementation of the Convention by the States Parties. It is hosted by the United Nations Office of the High Commissioner on Human Rights (OHCHR).

[166] Referred to as having a "psychosocial disability".

[167] Office of the United Nations High Commissioner for Human Rights. *Committee on the Rights of Persons with Disabilities: Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities* (2015).

[168] Office of the United Nations High Commissioner for Human Rights. *Committee on the Rights of Persons with Disabilities: Guidelines on Article 12 of the Convention on the Rights of Persons with Disabilities* (2015).

[169] *United Nations Convention on the Rights of the Child*, (Treaty Series 1577, 1989).

[170] *United Nations Convention on the Rights of the Child*, (Treaty Series 1577, 1989), Article 12.

Convention on the Rights of the Child

Article 37: State Parties shall ensure that:

a) No child shall be subjected to torture or other cruel, inhuman, or degrading treatment or punishment.

b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time.

(c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances.

d) Every child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority and to a prompt decision on any such action.

United Nations Declaration on the Rights of Indigenous Peoples

For Indigenous children and youth, their right to participate in decision-making in all matters which would affect their rights, is additionally set out in the *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)*. *UNDRIP* was held up by the Truth and Reconciliation Commission's report as the framework for reconciliation.

UNDRIP emphasizes the rights of Indigenous people to maintain and strengthen their cultural traditions and practices, including those related to health.[171] Further, *UNDRIP* provides Indigenous peoples the right to participate in decision-making in all matters which would affect their rights, through representatives chosen by them with their own procedures, as well as to maintain and develop their own Indigenous decision-making institutions.[172] In November 2019, B.C. became the first province in Canada to formally recognize *UNDRIP* in legislation and begin to work toward implementation by working with the First Nations Leadership Council to develop the legislation. It is unclear how this will be implemented with respect to detentions under the *Mental Health Act*.

Declaration on the Rights of Indigenous Peoples

Article 24 (1): Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals.

Article 29: States shall also take effective measures to ensure, as needed, that programmes for monitoring, maintaining and restoring the health of Indigenous peoples, as developed and implemented by the peoples affected by such materials, are duly implemented.

[171] *United Nations Declaration on the Rights of Indigenous Peoples*, Articles 7, 23, 24, and 29.
[172] *United Nations Declaration on the Rights of Indigenous Peoples*, Article 18.

Appendix 7: *Mental Health Act* Forms

Forms are available to review online HERE.

Form 1	Request for Admission (Voluntary Patient)
Form 2	Consent for Treatment (Voluntary Patient)
Form 3	Medical Report (Examination of a Person Under 16 Years of Age, Admitted at Request of Parent or Guardian) (Renewal Certificate)
Form 4	Medical Certificate (Involuntary Admission)
Form 5	Consent for Treatment (Involuntary Patient)
Form 6	Medical Report on Examining of Involuntary Patient (Renewal Certificate)
Form 7	Application for Review Panel Hearing
Form 8	Review Panel Determination
Form 9	Application for Warrant
Form 10	Warrant (Apprehension of Person with Apparent Mental Disorder)
Form 11	Request for Second Medical Opinion
Form 12	Medical Report (Second Medical Opinion)
Form 13	Notification to Involuntary Patient of Rights under the *Mental Health Act*
Form 14	Notification to Patient under age 16, Admitted by Parent or Guardian, of Rights under the *Mental Heath Act*
Form 15	Nomination of Near Relative
Form 16	Notification to Near Relative (Admission of Involuntary Patient or Patient under Age 16)
Form 17	Notification to Near Relative (Discharge of Involuntary patient)
Form 18	Notification to Near Relative (Request for a Review Panel Hearing)
Form 18.1	Notification to Near Relative (Order for a Review Panel Hearing)
Form 19	Certificate of Discharge
Form 20	Leave Authorization
Form 21	Director's Warrant (Apprehension of Patient)

Appendix 8: MCFD Designated Psychiatric Facility Inpatient Admissions

Voluntary and Involuntary Admission Data for MCFD Maples Adolescent Treatment Centre and Youth Forensic Psychiatric Services

Table 1: Maples Adolescent Treatment Centre, Total Annual Admissions, Voluntary and Involuntary under the *Mental Health Act*

	Total Involuntary and Voluntary Admissions				Indigeneity of Total Admissions				Gender	
	Voluntary	Involuntary	% Involuntary	In-Care	First Nation	Métis	Inuit	% Indigenous	Male	Female
2009/10	112	8	7%	29	24	3	0	23%	82	38
2010/11	91	6	6%	34	26	2	0	29%	61	36
2011/12	114	6	5%	35	28	2	0	25%	70	50
2012/13	108	5	4%	23	17	2	0	17%	58	56
2013/14	111	0	0%	20	15	6	0	19%	61	50
2014/15	130	1	1%	25	25	2	0	21%	67	64
2015/16	139	6	4%	39	32	8	0	28%	67	79
2016/17	135	5	4%	38	18	6	0	17%	54	86
2017/18	147	3	2%	24	36	7	1	29%	72	78
2018/19	126	4	3%	19	39	2	1	32%	53	77

Table 2: Youth Forensic Psychiatric Services, Total Annual Admissions, Voluntary and Involuntary under the *Mental Health Act*

	Total Involuntary and Voluntary Admissions				Indigeneity of Total Admissions				Gender	
	Voluntary	Involuntary	% Involuntary	# Child in care	First Nation	Métis	Inuit	% Indigenous	Male	Female
2009/10	0	0	–	0	0	0	0	–	0	0
2010/11	0	3	100%	1	1	0	0	33%	3	0
2011/12	0	3	100%	0	1	0	0	33%	3	0
2012/13	0	8	100%	4	1	0	0	13%	6	2
2013/14	0	5	100%	2	4	0	0	80%	5	0
2014/15	0	4	100%	2	2	0	0	50%	4	0
2015/16	0	13	100%	8	8	2	0	77%	9	4
2016/17	0	3	100%	2	2	0	0	67%	3	0
2017/18	0	8	100%	5	6	0	0	75%	3	5
2018/19	0	11	100%	5	2	0	0	18%	6	5

Table 3: Average Duration of Stay for Voluntary and Involuntary Admissions under the *Mental Health Act*

	Maples Adolescent Treatment Centre		Youth Forensic Psychiatric Services
	Voluntary	Involuntary	Involuntary[1]
2009/10	58 days	302 days	–
2010/11	44 days	153 days	6 days
2011/12	43 days	213 days	5 days
2012/13	45 days	301 days	14 days
2013/14	32 days	–	5 days
2014/15	42 days	819 days	6 days
2015/16	36 days	165 days	16 days
2016/17	40 days	426 days	5 days
2017/18	34 days	305 days	20 days
2018/19	30 days	167 days	28 days

[1] All admissions at Youth Forensic Psychiatric were involuntary

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