STUDIES IN SOCIAL JUSTICE
Volume 18, Issue 3, 440-460, 2024

British Columbia's Mental Health System: Addressing Systemic Human Rights Issues

VIVIANE JOSEWSKI
University of Northern British Columbia, Canada

MARINA MORROW
York University, Canada

RIANNA WARKENTIN
University of British Columbia, Canada

MOHAMED IBRAHIM
University of British Columbia, Canada

ABRAHAM J. COHEN
York University, Canada

ABSTRACT *In British Columbia (BC), Canada, mental health reforms over the last decade have moved back and forth between calls for practices that restrict human rights and those that are rooted in equity and social justice. In this article, we explore some of these tensions and their implications for human rights and equity in mental health care by critically analyzing three policies guiding mental health reform in BC using an intersectionality-based policy framework. Specifically, we interrogate the effects of a biomedical and individualized framing of mental health and substance use. We argue that such a framing is buttressed by neoliberal ideology and lays the groundwork for public and professional acceptance of coercive practices with particular consequences for Indigenous and racialized populations. This framing is juxtaposed with a holistic wellness and trauma-informed policy framework anchored by an understanding of the impact of colonization. However, what is missing in both policy framings is a full account of the documented ongoing human rights violations experienced by many people accessing BC's mental health system. Our analysis shows how applying an intersectionality-based policy framework allows for a deeper exploration of the complex, interlocking systems of power and oppression that give rise to these human rights violations. We conclude with a discussion of the important role that decolonizing and intersectional approaches play for capturing the complexities of systemic inequities and advancing mental healthcare that protects and promotes mental wellbeing and human rights.*

Correspondence Address: Viviane Josewski, School of Nursing, University of Northern British Columbia, Prince George, BC V2N 4Z9; email: viviane.josewski@unbc.ca

ISSN: 1911-4788

KEYWORDS mental health reform; human rights; intersectionality; Canada; critical discourse analysis

Introduction

Public, activist and professional discourse in British Columbia (BC) surrounding mental health reforms over the last decade has moved between calls for practices that restrict human rights (British Columbia Schizophrenia Society & British Columbia Psychiatric Association, 2019; Falcon, 2021; Ormand, 2017) and for practices rooted in equity and social justice (Boyd et al., 2017; Josewski, 2020; Milne & Hamfelt, 2019; Morrow & Malcoe, 2017; Morrow & Weisser, 2012; Van Veen, 2021; Van Veen et al., 2018; Van Veen et al., 2019). On one hand, BC has the highest rate of psychiatric hospitalizations in Canada (PIVOT Legal Society, 2023) with many politicians and mental health practitioners calling for even more tools to forcibly detain and treat people, especially those with substance use problems (e.g., Canadian Drug Policy Coalition, 2022; Falcon, 2021). A recent BC study (Loyal et al., 2023) showed that between 2008 and 2018, the number of involuntary psychiatric hospitalizations in those aged 15 years and older rose by more than 65%, which includes a 128% increase in forced hospitalization via police apprehensions (p. 257). On the other hand, BC is home to progressive advocates who have called for decriminalization and safe distribution of illicit opioids and the abolishment of any policy, legislation and practice that permits or encourages involuntary treatment (PIVOT Legal Society, 2023). It is also the only province in Canada that has a First Nations Health Authority (FNHA), which is working to systematically transform mental health service delivery for First Nations in BC, using Indigenous ways of knowing and healing (FNHA et al., 2013).

In this paper, we explore this tension and its implications for human rights and equity in mental healthcare especially as they relate to Indigenous Peoples by applying an Intersectional Based Policy Analysis (IBPA) (Hankivsky, 2012) to three policies guiding mental health reform in BC. The terms Indigenous and Aboriginal are used throughout this paper to refer to the original inhabitants of Canada and their descendants, including First Nations (referred to as Indians in the *Canadian Constitution*), Inuit, and Métis peoples, as defined by Section 35 of the *Canadian Constitution* of 1982. We first discuss how IBPA allows for a critical exploration of interlocking systems of power and oppression, such as biomedicalism, neoliberalism and colonialism, which give rise to the systemic inequities shaping people's experiences of and access to mental healthcare (Cook et al., 2017; Hankivsky & Jordan-Zachery, 2019). Following a brief historical overview of mental health policy in BC, including the ongoing legacy of colonization and its links to psychiatric practice, we analyze BC's 10-year mental health plan, *A Pathway to Hope: A Roadmap for Making Mental Health and Addictions Care Better for People in British*

Columbia (British Columbia MMHA, 2019) (hereafter called, *A Pathway to Hope)*. We interrogate the effects of biomedicalism and neoliberalism on equity and human rights in mental health, arguing that this framing serves to promote individualized and market solutions to complex social problems and lays the groundwork for public and professional acceptance of coercive practices (Morrow, 2022). This is evidenced in the current provincial government's commitment to enacting legislative amendments and introducing policies to involuntarily admit and detain people who use substances under BC's *Mental Health Act* as part of its response to the opioid crisis (Clarkson, 2023). Examples include a recent amendment to the *BC Mental Health Act* authorizing nurse practitioners to certify patients for involuntary admission and detention under the Act (British Columbia MMHA, 2023), and the ongoing political support for *Bill 22, The Mental Health Amendment Act* (2020), which would, if introduced, make it easier for physicians to forcibly detain and treat youth who are deemed to have severe problematic substance use. This Act would, Alongside other medically coercive practices, the Act would impact Indigenous youth and communities who disproportionately experience substance use and mental distress among other intersections of disadvantage (British Columbia Legislative Assembly, 2022; Johnston, 2017). Although mental health advocates managed to convince the BC government to take *Bill 22* off the table in 2021, the Act stands as an example of the kind of polarization on mental health policy and human rights that exists in BC.

The second part of the paper shifts the focus of discussion to two further documents: *A Path Forward: BC's First Nations and Aboriginal People's Mental Wellness and Substance Use 10-Year Plan* (FNHA et al., 2013) and *FNHA's Policy on Mental Health and Wellness* (FNHA, 2019) (hereafter called, *A Path Forward*, and *FNHA's Mental Wellness Policy,* respectively). Our analysis juxtaposes the predominantly biomedical and individualized framing of mental health in *A Pathway to Hope* and the holistic wellness and trauma-informed framework anchored by an understanding of the impact of colonization used in *A Path Forward* and *FNHA's Mental Wellness Policy*. We argue, however, that what is missing in both policy framings is a full account of the documented ongoing human rights violations experienced by many people accessing BC's mental health system.

Intersectionality and Intersectionality Based Policy Analysis (IBPA)

Intersectionality provides our conceptual framework for analyzing BC's mental health reform and its current iterations. Intersectionality is a critical approach to research, policy and practice that reveals the complex interactions among social categories of difference (e.g., race, class, gender, ability, and sexual orientation) and the systems and processes of domination and oppression that produce experiences of privilege and discrimination

(Crenshaw, 1992; Hankivsky & Jordan-Zachery, 2019). Intersectional approaches value people's own descriptions and understandings of their lives. In intersectional paradigms, the emphasis is on centering the margins, and privileging the voices of those whose lives are impacted by poverty, sexism, racism, colonialism, sanism, transphobia, heterosexism, and other systems of power. The analytic potential of intersectionality comes from its ability to uncover complex power dynamics experienced through various oppressive systems (Hill-Collins & Bilge, 2016).

In the context of policy, intersectionality is a powerful analytical and social justice-oriented tool for exploring and addressing how systemic inequities manifest (Cook et al., 2017). Intersectionality based policy analysis (IBPA) is therefore particularly well suited for exploring questions related to equity in mental health and human rights because of the ways in which it reveals underlying social and structural causes (Morrow & Malcoe, 2017; Morrow & Weisser, 2012).

In the forthcoming analysis we employ IBPA by asking a set of guiding questions (Hankivsky, 2012) specifically designed to get at the values and assumptions underlying a policy approach to a particular problem, and how the subsequent representations of the problem impact different populations in unique ways. Specifically, we focus on four questions found in IBPA: (1) What is the policy "problem" under consideration?; (2) How have representations of the problem come about?; (3) How are groups differentially affected by this representation of the problem?; and (4) What are the current policy responses to the problem? (Hankivsky, 2012). We begin by discussing some of the present-day effects of colonialism on mental health care in BC more broadly before shifting the focus of discussion towards an examination of BC's recent mental health policy history, and the *BC Mental Health Act* (1996) (IBPA questions one and four).

Colonialism is increasingly recognized as a distal determinant of Indigenous mental health and wellbeing (Allan & Smylie, 2015; Greenwood et al., 2022). In keeping with this understanding, in this paper colonialism refers to the social, political, economic, cultural, and geographical processes (historical and present-day) by which Indigenous Peoples were and are dispossessed of and disconnected from their ancestral and traditional lands, ways of life, cultural identities, language(s), communities, and nations. Through the recounting of colonial histories, we can explore questions two and three of the four IBPA questions.

Colonialism and the Legacy of Psychiatry and Western Medicine

The persistent effects of settler colonialism, racism and ongoing erosion of human rights on the mental health of Indigenous peoples in Canada are evident in the disproportionate rates of post-traumatic stress disorder, suicide (particularly in youth), substance use, violence and other mental health

concerns prevalent in many Indigenous communities (Barker et al., 2017; Kirmayer et al., 2014; National Inquiry on Missing and Murdered Indigenous Women and Girls, 2019; Truth and Reconciliation Commission of Canada, 2015; Turpel-Lafond et al., 2021). Particularly devastating has been the intergenerational trauma stemming from the forceful removal of Indigenous children into Canada's Indian Residential School system where neglect and abuse were commonplace (Bombay et al. 2014; Kirmayer et al., 2014; Truth and Reconciliation Commission of Canada, 2015).

Western medicine, and especially psychiatry, has been integral to colonial projects by perpetuating racist discourses of Indigeneity used to justify paternalistic and oppressive modes of settler colonial governance and approaches to mental health (de Leeuw et al., 2010; Josewski, 2020; Wyndham-West, 2009). For example, medicalized constructions of the mentally "disordered," "traumatized" or "alcoholic Aboriginal" (Waldram, 2004) have been recurring themes in Indigenous policy and media accounts that all serve to construct Indigenous peoples as "mentally inferior" and therefore, in need of "care by the state" (Wyndham-West, 2009, p. 145). Historically, this paternalism is codified in the *Indian Act* (1985), Canada's key federal legislative framework governing matters pertaining to registered Indians (First Nations) and reserve communities. The *Indian Act* remains an active piece of federal legislation that continues to govern Indigenous peoples' access to health services and benefits today. Non-status and off-reserve Indigenous peoples are typically excluded from federally funded on-reserve mental health programs and services, leading to reduced access to Indigenous-specific mental health services for urban Indigenous peoples − a term that collectively describes First Nations (status or non-status), Métis, and Inuit peoples who reside in off-reserve population centres outside of Métis settlements, First Nations, or Inuit communities (Allan & Smylie, 2015; British Columbia Association of Aboriginal Friendship Centres, 2020).

Indigenous-specific racism and discrimination remain deeply entrenched within the Western mental healthcare system (Allan & Smylie, 2015; Browne, 2017; Browne et al., 2021; Turpel-Lafond et al., 2021). The extent to which discriminatory perceptions of Indigenous people, including the myth of the alcoholic Aboriginal, continue to operate across BC's health care services is detailed in a recent report which summarizes the findings of a government-issued independent investigation into accusations of anti-Indigenous racism within BC's hospitals (Turpel-Lafond, 2020). The investigators found that 84% of all Indigenous respondents reported experiencing discriminatory treatment when accessing care based in racist assumptions or cultural disrespect (Turpel-Lafond, 2020). Thus, throughout colonial history discrimination and racism have been codified into BC's mental health policies and practices through the dominance of biomedical traditions and the marginalization of Indigenous experiences, understandings, and responses to mental health (Josewski, 2020).

Mental Health Reform and the BC Mental Health Act

Mental health reforms in BC over the past number of decades have focused on the downsizing of its provincial psychiatric hospital, Riverview, the regionalization of mental health and substance use services and the establishment of community-based supports (Morrow et al., 2010). In this context human rights abuses such as involuntary detainment and treatment continue to be sanctioned under BC's mental health laws (Johnston, 2017). The *BC Mental Health Act* (1996) established in 1964, is considered the most restrictive in Canada because persons held under the *Mental Health Act* are deemed to have consented to any form of psychiatric treatment once they have been admitted to hospital and this treatment can be forcibly administered This practice is in violation with the rights guaranteed by the *Canadian Charter of Rights and Freedoms* (1982), and the *United Nations Convention on the Rights of People with Disabilities (UNCRPD)* (UN General Assembly, 2007a) and *Declaration Act on the Rights of Indigenous Peoples (UNDRIP)* (UN General Assembly, 2007b) (British Columbia Representative for Children and Youth, 2021; Johnston, 2017). Thus, BC's health authorities exercise "an extraordinary and intrusive exercise of state power" using detention, which marks "only the beginning of rights deprivation [and] the loss of liberty" experienced by people, including children and youth, with mental health and substance use issues in BC (Johnston, 2017, p. 5). Compared to other jurisdictions, BC's *Mental Health Act* and *Mental Health Regulation* "are outdated, deeply flawed, and inadequate to fulfill the rights guaranteed by the Charter and the UN CRPD" (Johnston, 2017, p. 6) causing some individuals to move to other jurisdictions simply to avoid BC's deemed consent model (p. 15).[1] Concerns regarding the lack of consideration of the ways in which race, class and gender inform people's experiences of detainment under the Act have also been raised leading Johnston (2017) to advocate for a comprehensive revamp of BC's *Mental Health Act*.

Despite the comprehensive evidence that has been amassed on the inequitable impacts of BC's *Mental Health Law* and detainment system, public and professional opinion continues to be swayed towards calls for reinstitutionalization, and more and broader uses of the Act (British Columbia Representative for Children & Youth, 2021; Falcon, 2021; Ormand, 2017), most notably in the aforementioned introduction of *Bill 22* to the Legislative Assembly in 2020 – a proposed amendment to the *BC Mental Health Act* to detain youth with severe problematic substance use for up to one week in designated hospitals in the aftermath of an overdose (British Columbia Representative for Children & Youth, 2021). Advocates have noted that the number of children and youth receiving involuntary mental health services had

[1] In 2016 the Act became the subject of a Charter challenge against deemed consent, which allows for involuntary treatment without the consent of a patient or their trusted friend or family member (for details see https://clasbc.net/our-work/cases/deemed-consent-law-under-the-mental-health-act/).

already increased by a startling 162% from 2008 to 2018, and raised concerns that Indigenous children and youth are disproportionately impacted (British Columbia Representative for Children & Youth, 2021, p. 3).

Ongoing impacts of historic and intergenerational trauma mean that Indigenous youth experience higher rates of substance use at earlier ages compared to their non-Indigenous counterparts (Dell & Hopkins, 2011). The widespread anti-Indigenous racism within BC's health care system (Turpel-Lafond, 2020), and the lack of access to culturally safe and relevant mental health and substance use services, further compound concerns about the disproportionate risks and harms associated with the perspectives contained in *Bill 22* for Indigenous youth (British Columbia Representative for Children & Youth, 2021; First Nations Leadership Council, 2020). As noted in a press release by the BC First Nations Leadership Council (2020), the coercive detention and treatment regime proposed under *Bill 22* is "inconsistent with current evidence regarding substance use" (para. 4), and the principles of culturally safe and trauma-informed care. Culturally safe care seeks to create safety and respectful relationships as defined by the people receiving services through addressing power imbalances inherent within the healthcare system (Browne, et al., 2021; FNHA, 2022). Trauma-informed care recognizes and seeks to mediate the effects of trauma(s) on people's healthcare experiences through empowerment practices (Browne et al., 2021; Raja et al., 2015).

After strong opposition from diverse fronts (British Columbia Representative for Children and Youth, 2021; First Nations Leadership Council, 2020), *Bill 22* was paused to allow for more public consultation, especially with Indigenous peoples, and youth whose voices have largely remained unheard. The lack of consultation with BC's Indigenous communities contradicts BC's own Declaration Act on the Rights of Indigenous Peoples (DRIPA) passed in 2019. DRIPA is meant to support the alignment of BC's institutions, laws, policies and practices with human rights. Despite this, the BC government has at times signaled a commitment to return *Bill 22* to legislature (British Columbia MMHA, 2020; Harnett, 2021). Strong lobby groups representing parents of people with mental illness diagnoses, alongside prominent psychiatrists and political leaders, argue that involuntary committal is necessary to ensure the treatment and safety of people with serious or chronic mental health conditions (British Columbia Schizophrenia Society & British Columbia Psychiatric Association, 2019; Harnett, 2021). This argument relies on assumptions that people with mental illness are unable to make decisions in their own best interests (Van Veen et al., 2018; Woo, 2016) and that they are prone to irrational acts of violence against themselves and others if denied inpatient psychiatric care (British Columbia Schizophrenia Society & British Columbia Psychiatric Association, 2019; DeAngelis, 2021; Labrum et al. 2021; Swanson, 2021).

Such false representations of mental illness are problematic because they fail to recognize the use of coercion in mental health as human rights violations and to advance a structural analysis of violence. For example, research shows

that only a relatively small number of people with serious mental illness commit violence and if violent behaviour is displayed, other contextual factors besides the mental illness itself tend to be involved (DeAngelis, 2021; Labrum et al. 2021; Swanson, 2021). What remains unexamined in the master "narrative of disorder-driven violence" (Swanson, 2021) is the role of gender, race, class, disability, and other social determinants of health (Van Veen et al., 2018). For example, there is strong evidence demonstrating women with serious or chronic mental illness are at heightened risk of experiencing violence, including intimate partner violence, compared to women in the general population (Du Mont & Forte, 2014). Increasingly, intersectional analyses are revealing the complex ways in which colonial, racialized and gendered discourses are enacted in mental health and disability policies and practices (Daley et al., 2019; Ibrahim & Morrow, 2015; Van Veen et al., 2018; Van Veen et al., 2019). As Fernando (2010) notes there is a "racist tendency to designate black people as schizophrenic" because of racist assumptions about Black and other racialized men who are seen as particularly violent, suspicious, and dangerous (cited in Pilling, 2019, p. 101). Van Veen et al. (2018, 2021) describe how such discourses have been evoked within BC and used to provide the justification for increasingly coercive mental health practices under the guise of benevolent paternalism and concerns for public safety.

Public sympathy for involuntary committal as necessary to ensure adequate treatment of people with long-term, chronic mental health conditions, and increasing involvement of police in mental health care have also grown in light of the extreme poverty and homelessness that is concentrated in Vancouver's Downtown Eastside where Indigenous people are over-represented and many people also struggle with mental health and substance use issues (British Columbia Legislative Assembly, 2022; British Columbia Schizophrenia Society & British Columbia Psychiatric Association, 2019; Falcon, 2021; Griffiths, 2020). As a result, community mental health teams embedded with armed police officers are becoming more frequent. Critics of this police embedded model point to the disproportionate use of coercive measures against poor, racialized and Indigenous populations (Van Veen et al., 2018; Van Veen et al., 2019).

Despite these problems, BC has a strong history of resistance to psychiatric discourses and is a leader in some innovative peer support and harm reduction approaches. Organizations like the West Coast Mental Health Network and Unity Housing, which are rooted in the activism and leadership of psychiatrized people (Van Veen et al. 2018), continue to thrive alongside of low barrier housing (e.g., the Portland Hotel), safe injection sites (Insite), Indigenous centred health collectives (e.g., Vancouver Aboriginal Health Society), peer advocacy groups like the Vancouver Area Network of Drug Users and the Drug Users Liberation Front, and by progressive community/academic partnerships (e.g., the establishment of Health Justice in Vancouver) building evidence for system changes that respect equity and human rights (Boyd et al., 2017; Morrow & Malcoe, 2017). The city of

Vancouver has also been at the forefront in getting the Federal government to allow an exemption to decriminalize possession of opioids to help ameliorate the opioid death crisis (Grochowski, 2021). As of January 2023, BC residents are allowed to possess up to 2.5 grams of opioids, cocaine, methamphetamine and MDMA, thus becoming the first province in Canada to get a decriminalization exemption; this exemption is in place until January 2026 (British Columbia MMHA, 2022). BC was also the first Canadian province to get a legal exemption to operate safe injection sites in March 2015 (CBC News, 2015). While these expressions of resistance are important steps toward building an equity-oriented mental health system that upholds the rights of people experiencing mental distress, state sanctioned acts of violence and psychiatric control through the Mental Health Act continue to be normalized.

A Pathway to Hope: Reinforcing Biomedical and Individualistic Understandings of Mental Distress

As the first plan to be initiated by BC's NDP government in 2019, *A Pathway to Hope* is meant to provide a roadmap for "transforming mental health and substance use care" in BC over the next 10 years (British Columbia MMHA, 2019). The plan's vision lays out four overarching pillars of transformation: (1) wellness promotion and prevention, (2) seamless and integrated care, (3) equitable access to culturally safe and effective care, and (4) Indigenous health and wellness.

As emphasized in the Minister's Message, the plan was developed in a collaborative fashion with input from "a wide range of organizations, agencies and individuals" and responds to "what British Columbians have passionately argued for" (British Columbia MMHA, 2019, p.12). However, not all voices, experiences and arguments have been equally listened to and heard. For example, rather than giving primacy to voices of people with lived experiences of mental illness or substance use, the plan begins with first acknowledging the significant contributions made by the "insight and expertise" of "front-line workers, First Nations and other Indigenous communities, caregivers, professionals, researchers, civic leaders, law enforcement officials and more," and only then moves on to acknowledge the "stories and words" of people with lived experiences of mental illness or substance use (British Columbia MMHA, 2019, p. 1). This inadvertently reinforces existing power imbalances that marginalize and diminish the voices and expertise of individuals with lived experiences of mental illness and substance use, and is in direct contradiction to the plan's espoused commitment to promote cultural safety in the mental health care system (Cultural Safety Attribute Working Group, 2019).

While the voices and experiences of family members and providers are important, they cannot be assumed to speak for those who live with mental illness and substance use; in fact, their views and needs are often at odds with many family members passionately arguing for a stronger role for

institutionalized models of care (British Columbia Schizophrenia Society & British Columbia Psychiatric Association, 2019; Harnett, 2021). In contrast, many psychiatric survivors advocate for "exploring means of addressing distress outside of medical systems and addressing the social factors that can cause or exacerbate mental distress, including the effects of psychiatrization" (Pilling, 2019, p. 99). This message is lost, however, within the plan, which primarily focuses on mental health service accessibility and availability. By only addressing *gaps* between users and the system, it minimizes systemic inequities and silences survivors' voices. This silence perpetuates structural violence and human rights abuses,[2] rather than prompting transformative change as the plan suggests.

While the plan acknowledges the ongoing impacts of colonialism, racism, and trauma on Indigenous communities and youth, it falls short in fully addressing the role of race and racism in shaping mental health experiences and needs among other racialized, non-Indigenous populations. It also overlooks intersections of factors including race, racism, gender, sexuality, class, and disability in shaping individual experiences. For instance, the document contains minimal reference to gender and sexual orientation, despite the higher rates of mental health issues among LGBTQ2S+ youth (British Columbia MMHA, 2019). The priority focus on Indigeneity in this way reinforces stigmatizing constructions of Indigenous Peoples as inherently at risk while overlooking the mental health challenges faced by other marginalized groups (Shelton & Abramovich, 2019).

Even when acknowledging social factors and structural conditions, *A Pathway to Hope* misses opportunities for broader structural analyses of how gender, sexuality, class, and other factors shape experiences of mental health, substance use, and care. Instead, the plan individualizes the problem by keeping the focus on "individuals who face barriers related to race, ethnicity, religion, gender, age, social class, and/or sexual orientation" (British Columbia MMHA, 2019, p. 27). Furthermore, no mention is made of the ways in which mental health services (including crisis responses) can be experienced as violent and coercive. Theorizing gender, age, class, etc., as individualistic and separate risk factors that create access barriers to mental health and substance use care problematizes the vulnerability of certain groups rather than the structural violence and oppression creating this vulnerability.

Consistent with the guiding questions of IBPA, the section below takes a closer look at the implications of such a problem framing in terms of what changes are envisioned and where responsibility for change is perceived to lie. *A Pathway to Hope* outlines "three-year priority actions" within each of its four identified areas of urgent need: (1) Improved wellness for children, youth, and young adults; (2) supporting Indigenous-led solutions; (3) substance use, and

[2] Structural violence refers to the structural injustices embedded with social, political, and economic systems (including the healthcare system) that place some groups at increased risk for social suffering and poor health, producing and perpetuating health and social inequities (Farmer, 2003; Farmer et al., 2006)

(4) improved access, better quality (British Columbia MMHA, 2019). These actions are, with few exceptions, focused on improving timely and equitable access to mental health and substance use programs and services by removing systematic barriers to care, and promoting prevention – as expanding treatment services "alone cannot meet the mental health and substance use needs of children and youth" (British Columbia MMHA, 2019, p. 18). While a focus on systematic barriers to accessing care and prevention is crucial, within the plan's individualizing framework, prevention is for the most part narrowly conceptualized through the lens of early intervention; the underlying assumption being that early access to treatment services prevents further mental distress and promotes wellness and resilience across the life span. It follows that screening for mental health-related risk factors rather than actions to address the wider social determinants of mental health, such as ameliorating homelessness and poverty, become the focus of attention. Indeed, it is only within the context of improving Indigenous peoples' wellness that addressing the social determinants of health is prioritized in the plan.

It is therefore important to ask: What is missed by focusing on improving accessibility to care alone? As supported by a large body of literature (e.g., Allan & Smylie, 2015; British Columbia Schizophrenia Society & British Columbia Psychiatric Association, 2019; Milne & Hamfelt, 2019) addressing systematic barriers to mental health and substance use care is without doubt important ,and it is positive to see the Ministry commit to improve access to affordable community counselling and address stigma within the mental health care system. Yet, increasing accessibility and reducing stigma without acknowledging discrimination or changing the ways in which the mental health system and the biomedical model of treatment can be violent and exacerbate trauma and mental distress should be viewed with scepticism.

Indigenous-led Approaches to Transforming BC's Mental Health and Addictions Care: A Path Forward and FNHA's Mental Wellness Policy

With the creation of the First Nations Health Authority (FNHA) in 2013,[3] and the transfer of control over First Nations health programs and services from Health Canada to FNHA, several significant transformational changes have taken place. The most fundamental level of transformation concerns the framing of mental health and the integration of First Nations perspectives into the design and delivery of mental health services. Both A *Path Forward*

[3] The FNHA's mission is to support BC First Nations to implement the Transformative Change Accord and Tripartite First Nations Health Plans (First Nations Leadership Council et al., 2006; 2007), which outline a shared commitment between the federal and provincial governments and BC First Nations to work together to "close jurisdictional and health gaps" between First Nations and other British Columbians (First Nations Leadership Council et al., 2007, p. 5). Together the First Nations Health Plans identify disparities in mental wellness, substance use and youth suicide as key areas for priority action.

(FNHA et al., 2013) and *FNHA's Mental Wellness Policy* (FNHA, 2019) incorporate a First Nations wellness perspective, which conceives of mental wellness holistically and calls for "changing the status quo medical model to a wellness model" (FNHA et al., 2013, p. 6). Both policy documents position Indigenous "self-determination … [as] the foundation of all work" done by FNHA and its partners (FNHA, 2019, p. 3). The outcome of a strategic partnership between tripartite partners, health authorities, Métis and urban Indigenous community partners, a province-wide consultation and community engagement sessions, *A Path Forward* (FNHA et al., 2013) indicates a departure from the "colonial mentality that saw First Nations people as unable to take care of themselves" (O'Neil et al. 2016, p. 235).[4]

In keeping with an understanding of colonialism and racism as root determinants of Indigenous mental health (Greenwood et al., 2022), *A Path Forward* (FNHA et al., 2013) and *FNHA's Policy on Mental Wellness* (FNHA, 2019) clearly endorse a view that "mental health and wellness approaches must be designed based on an understanding of the deep and ongoing impacts of colonialism, including experiences of intergenerational trauma and racism" (FNHA, 2019, p. 3). This is evident in the recommendations within the two FNHA policies, which call for actions that build community and health system capacity for supporting and delivering "culturally-safe, comprehensive, and coordinated continuum of mental health and wellness approaches" (FNHA, 2019, p. 2), and "bring together the best of traditional and cultural approaches with western approaches" (FNHA, 2019, p. 4).

In keeping with this, *A Path Forward* underscores the need for strategic actions in four areas, "Holistic Wellness, Community Care, Integrated Care, and Specialized Care" (FNHA et al., 2013, p. 16). Compared to *A Pathway to Hope* (British Columbia MMHA, 2019), which emphasizes early detection and intervention – secondary prevention measures usually undertaken by health professionals (Donovan & McDowell, 2018) – *A Path Forward's* (FNHA et al., 2013) broader determinants of heath framework promotes strategies that are more reflective of primordial and primary models of prevention. For example, a key strategic direction for improving the holistic wellness of First Nations and Aboriginal peoples outlined in *A Path Forward* is to ensure that,

> All British Columbians understand and collaboratively address the intergenerational impacts of colonization and residential schools and the persistent effects of racism on mental wellness and/or substance use for First Nations and Aboriginal people. (FNHA et al., 2013, p. 25)

[4] In 2011, a BC First Nations and Aboriginal Mental Wellness and Substance Use Strategy Council was created to oversee the development of *A Path Forward*. The Strategy Council included representatives from the Tripartite signatories to the First Nations Health Plan, as well as health authority and the BC Association of Aboriginal Friendship Centres (BCAAFC) and the Métis Nation British Columbia (MNBC).

To achieve this vision, the plan calls for implementing actions to increase awareness of cultural safety and humility among health and human service providers, as well as within the public through "education and awareness, including training within schools, post-secondary institutions, and workplaces" (FNHA et al., 2013, p. 25). This broadening of the scope to address anti-Indigenous racism beyond the healthcare system reflects how Indigenous peoples articulate and experience colonialism and racism as a structural determinant of Indigenous mental health (Allan & Smylie, 2015; Greenwood et al., 2022).

Despite evidence of significant transformational changes within the framing and approaches to Indigenous mental health and substance use care outlined within *A Path Forward* (FNHA et al., 2013) and FNHA's *Mental Wellness Policy* (2019), some spaces of omission and contradictions are evident. The first is that although *A Path Forward* recognizes that Indigenous peoples have collective and individual rights, and articulates an expectation "that the implementation of these strategies and actions will be conducted with respect for the human dignity and human rights of those impacted by the Plan" (FNHA et al., 2013, p. 3), neither *A Path Forward* nor FNHA's *Mental Wellness Policy* (2019) clearly articulate the interconnections between Indigenous peoples' human rights as outlined by Canadian, constitutional and international law and their mental health. This omission points to a disconnect between BC's espoused commitment to align all laws and policies in BC with the principles of *UNDRIP* (UN General Assembly, 2007b) in consistency with BC's *Declaration on the Rights of Indigenous Peoples Act* (2019), and the ways in which Indigenous mental health policy is currently articulated.

Particularly noteworthy is the omission of discussion about BC's *Mental Health Act*, and the implications of an Indigenous reframing of mental health and wellness for the Act. This omission stands in stark contrast with a body of evidence demonstrating race-based and ethnic disparities in hospitalization rates for mental illness (Carriere et al., 2018), including compulsory detention and re-admission to psychiatric care (Barnett et al., 2019). While community-identified needs and priorities are clearly at the centre of both *A Path Forward* (FNHA et al., 2013) and FNHA's *Mental Wellness Policy* (2019), the voices and perspectives of Indigenous peoples, and specifically children and youth, with lived experiences of detention under the *BC Mental Health Act* (1996) are absent from either document; this is despite the fact that Indigenous children and youth are disproportionately represented among the growing number of youth in BC who are subjected to involuntary detainment under the Act and its "blatant human rights violations" (First Nations Leadership Council, 2021, p. 1). This omission demonstrates a misalignment between the explicit focus on Indigenous children and youth, and the trauma-informed and responsive principles that are meant to guide the implementation of actions to increase cultural safety in BC's mental health care system. As the British Columbia Association of Aboriginal Friendship Centres (2020) asserts, the use of involuntary care under the Mental Health Act is a blatant example of culturally

unsafe care underscoring the need for improved "legislative standards to regulate the use of isolation and restraints against mental health patients to ensure compliance with Charter rights" (p. 42).

Finally, neither policy fully accounts for and attends to the multiple intersecting social positions that create and sustain the inequities in mental health and health care among Indigenous peoples. For example, while *A Path Forward* notes that mental health and substance use services must be provided on an equitable and inclusive basis "to all First Nations, Métis and Inuit people (urban, rural and remote) in British Columbia regardless of where they live" or their status under the *Indian Act* (FNHA et al., 2013, p. iii), there is little discussion within the plan of the distinct experiences and needs of Indigenous peoples living in urban centers, Indigenous women, girls and 2SLGBTQQIA+ people as emphasized in the TRC's (2015) final report and recommendations and of the National Inquiry on Missing and Murdered Indigenous Women and Girls (2019). According to National Association of Friendship Centres (2021), Canada's "distinctions-based approach has allowed urban Indigenous people to become 'unseen' by current government policy approaches" and resulted "in inadequate resourcing for urban Indigenous services" (p. 7). Still, *A Path Forward's* (FNHA et al., 2013) inclusion of urban Indigenous partners (i.e., British Columbia Association of Aboriginal Friendship Centres and the Metis Nation BC) and the explicit acknowledgment of both First Nations *and* Aboriginal people within the plan's title and throughout the document suggest a desire for an approach that recognizes both the cultural distinctiveness of First Nations, Métis and Inuit (which aligns with the *Canadian Constitution Act* of 1982) as well as the importance of being inclusive of urban Indigenous voices for advancing equity in mental health for all Indigenous peoples.

A recognition of the diversity of Indigenous peoples seems to be missing from FNHA's 2019 *Mental Wellness Policy*, however, which focuses exclusively on First Nations. While the policy emphasizes the importance of attending to the unique needs of First Nations *individuals* in urban areas, *collectively* there is no acknowledgment of urban Indigenous communities and organizational partners. Furthermore, there is not a single reference made to non-status First Nations, Inuit and Métis people. Whether policy implementation will involve urban Indigenous-led health partnerships and ensure access to mental health services for non-status First Nations and other Indigenous groups remains unclear.

Overall, our application of IBPA to BC mental health policy highlights complex tensions. Individualistic frameworks dominate the representation and problematization of mental health within mental health policy and silence the diverse voices of people with lived experiences reinforcing biomedical and neoliberal influences within health care, which translate equity and social justice concerns into risk factors and a narrow focus on access. Ultimately, this reinforces biomedical and institutional responses under mental health legislation that legitimize psychiatric and colonial forms of structural violence, and human rights violations.

Decolonizing Mental Health Care, Intersectional Approaches and Human Rights: Towards Transformative Change

Human rights for people with disabilities, including for those with psychosocial disabilities are enshrined in the *Convention on the Rights of People with Disabilities (UNCRPD)* (UN General Assembly, 2007a) and those of Indigenous peoples in the *Declaration on the Rights of Indigenous Peoples (UNDRIP)* (UN General Assembly, 2007b). Both are conventions that Canada has ratified,[5] and therefore publicly made commitments to these human rights declarations which must be respected and applied in the context of mental health laws and mental health care. Human-rights approaches mean that peoples' individual and collective rights to autonomous decision making must be upheld when they are capable of making decisions and supported decision making must be instituted when they are not. Respect for autonomy and dignity in mental health care services is suggested best practice by the World Health Organization (2021). Self-determination is also an important part of culturally safe and trauma-informed models of care, which emphasize the deconstruction of power imbalances within health care encounters, strengths-based and collaborative approaches to treatment (Browne et al., 2021; Yeung, 2016). Moreover, as Pictou (2020) points out, "collective self-determination cannot be achieved without individual self-determination or without sovereignty over our own bodies" (p. 386). Self-determination at the individual level needs to be supported by simultaneous actions across systemic and structural levels. This includes, among other things, policies and legislation that enable the development of self-determined solutions that work for those affected based on their own experiences of mental health and wellbeing (Jacklin & Warry, 2011; National Inquiry on Missing and Murdered Indigenous Women and Girls, 2019).

Decolonizing and intersectional approaches are powerful tools for realizing human rights by helping reveal and transform the inner workings of power and oppression through actualizing change at structural, systemic, and service delivery levels (Greenwood, 2019; National Inquiry on Missing and Murdered Indigenous Women and Girls, 2019; Pictou, 2020). Intersectionality can help advance anti-colonial human rights agendas by drawing attention to the overlooked complexities of social identities and locations and making connections between different hegemonic forms of power that co-produce simultaneous experiences of privilege and oppression according to people's various social identities, and social locations (Dhamoon, 2015). By starting from the lived experiences of people, intersectionality can produce practices and policies that attend to these complexities and address the root causes of mental health inequities and human rights abuses. We contend as others have (National Inquiry on Missing and Murdered Indigenous Women and Girls,

[5] Although Canada ratified the *UNCRPD* in 2010 it did so with a reservation on Article 12 which allows for Canada to continue to use substitute decision making.

2019; Pictou, 2020) that a decolonizing, intersectional approach with attention to human rights is an important tool for understanding and addressing the needs, priorities, and contexts of people in the pursuit of equity and social justice.

Applying an intersectional human rights-based framework underscores the need for transformative change. Such change results from dismantling institutionally embedded power relations and manifestations of settler-colonialism by interrogating and disrupting what is often taken for granted to uphold and advance both individual and collective human rights. That is, although reforms to the *Mental Health Act* in BC are welcome, especially if they come with more mechanisms to protect the rights of people held under the Act, real change will only come when human rights violations and coercion in the mental health care system are understood as forms of structural violence that systematically undermine mental wellbeing both individually and collectively.

Acknowledgements

The authors would like to acknowledge the Social Sciences and Humanities Research Council (SSHRC) for supporting the research on which this paper is based.

References

Allan, B., & Smylie, D. (2015). *First Peoples, second class treatment: The role of racism in the health and well-being of Indigenous peoples in Canada*. Wellesley Institute. https://www.wellesleyinstitute.com/wp-content/uploads/2015/02/Summary-First-Peoples-Second-Class-Treatment-Final.pdf

Barker, B., Goodman, A., & DeBeck, K. (2017). Reclaiming Indigenous identities: Culture as strength against suicide among Indigenous youth in Canada. *Canadian Journal of Public Health, 108*(2), e208-e210. https://doi.org/10.17269/CJPH.108.5754

Barnett, P., Mackay, E., Matthews, H., Gate, R., Greenwood, H., Ariyo, K., Bhui, K., Halvorsrud, K., Pilling, S., & Smith, S. (2019). Ethnic variations in compulsory detention under the Mental Health Act: A systematic review and meta-analysis of international data. *The Lancet Psychiatry, 6*(4), 305-317. http://dx.doi.org/10.1016/S2215-0366(19)30027-6

Bill 22 – 2020: Mental health amendment act, 2020. https://www.leg.bc.ca/parliamentary-business/legislation-debates-proceedings/41st-parliament/5th-session/bills/first-reading/gov22-1

Bombay, A., Matheson, K., & Anisman, H. (2014). The intergenerational effects of Indian residential schools: Implications for the concept of historical trauma. *Transcultural Psychiatry, 51*(3), 320-338. https://doi.org/10.1177/1363461513503380

Boyd, S., Murray, D., & NAOMI Patients Association. (2017). Ethics, research and advocacy: The experiences of the NAOMI Patients Association in Vancouver's Downtown Eastside. In M. Morrow & L. H. Malcoe (Eds.), *Critical inquiries for social justice in mental health* (pp. 365-385). University of Toronto Press.

British Columbia Association of Aboriginal Friendship Centres. (2020). *Urban Indigenous wellness report: A BC Friendship Centre perspective.* https://bcaafc.com/wp-content/uploads/2020/11/BCAAFC-Urban-Indigenous-Wellness-Report.pdf

British Columbia Legislative Assembly. (2022). *Transforming policing and community safety in British Columbia.* https://www.leg.bc.ca/content/CommitteeDocuments/42nd-parliament/3rd-session/rpa/SC-RPA-Report_42-3_2022-04-28.pdf

British Columbia MMHA (Ministry of Mental Health and Addictions). (2019). *A pathway to hope: A roadmap for making mental health and addictions care better for people in British Columbia*. https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/initiatives-plans-strategies/mental-health-and-addictions-strategy/bcmentalhealthroadmap_2019web-5.pdf

British Columbia MMHA (Ministry of Mental Health and Addictions). (2020, June 23). *Stabilization care proposed for youth following an overdose*. Government News. https://news.gov.bc.ca/releases/2020MMHA0032-001139

British Columbia MMHA (Ministry of Mental Health and Addictions). (2022, May 31). *BC receives exemption to decriminalize possession of some illegal drugs for personal use*. Government News. https://news.gov.bc.ca/releases/2022MMHA0029-000850

British Columbia MMHA (Ministry of Mental Health and Addictions). (2023, February 23). B*.C. takes action to reduce ER wait times for people in mental-health crisis*. Government News. https://news.gov.bc.ca/releases/2023MMHA0012-000225

British Columbia Representative for Children and Youth. (2021). *Detained: Rights of children and youth under the Mental Health Act*. https://rcybc.ca/wp-content/uploads/2021/01/RCY_Detained-Jan2021.FINAL_.pdf

British Columbia Schizophrenia Society, & British Columbia Psychiatric Association. (2019). *Inadequate access to acute psychiatric beds in British Columbia: Is anybody listening?* https://www.bcss.org/wp-content/uploads/2019/10/Beds-Report-Oct-14-2019.pdf

Browne, A. J. (2017). Moving beyond description: Closing the health equity gap by redressing racism impacting Indigenous populations. *Social Science & Medicine, 184*, 23-26. https://doi.org/10.1016/j.socscimed.2017.04.045

Browne, A. J., Lavoie, J. G., McCallum, M. J. L., & Big Canoe, C. (2021). Addressing anti-Indigenous racism in Canadian health systems: Multi-tiered approaches are required. *Canadian Journal of Public Health, 113*(2), 222-226. https://doi.org/10.17269/s41997-021-00598-1

Canadian Charter of Rights and Freedoms, s 15, Part 1 of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (UK), 1982, c 1.1.

Canadian Constitution Act,1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11.

Canadian Drug Policy Coalition. (2022). *Drug decriminalization in Canada.* https://drugpolicy.ca/

Carriere, G., Bougie, E., & Kohene, D. (2018). Acute care hospitalizations for mental and behavioural disorders among First Nations people. *Statistics Canada, 29*(6), 11-19. https://www150.statcan.gc.ca/n1/en/pub/82-003-x/2018006/article/54971-eng.pdf?st=HDITIgvJ

CBC News. (2015, March 25). *Insite supervised injection site receives Health Canada exemption*. https://www.cbc.ca/news/canada/british-columbia/insite-supervised-injection-site-receives-health-canada-exemption-1.3009454

Clarkson, B. (2023, March 24). *Involuntary treatment of drug users under B.C.'s Mental Health Act could be deadly, legal group warns.* CTV News Vancouver. *https://bc.ctvnews.ca/involuntary-treatment-of-drug-users-under-b-c-s-mental-health-act-could-be-deadly-legal-group-warns-1.6328154*

Cook, J. A., Morrow, M., & Battersby, L. (2017). Intersectional policy analysis of self-directed mental health care in Canada. *Psychiatric Rehabilitation Journal, 40*(2), 244-251. https://doi.org/10.1037/prj0000266

Crenshaw, K. (1992). Race, gender, and sexual harassment. *Southern California Law Review*, *65*(3), 1467-1476.

Cultural Safety Attribute Working Group. (2019). *Indigenous engagement and cultural safety guidebook: A resource for primary care networks*.

Daley, A., Costa, L., & Beresford, P. (Eds.). (2019). *Madness, violence, and power: A critical collection.* University of Toronto Press.

de Leeuw, S., Greenwood, M., & Cameron, E. (2010). Deviant constructions: How governments preserve colonial narratives of addictions and poor mental health to intervene into the lives of Indigenous children and families in Canada. *International Journal of Mental Health and Addiction*, *8*(2), 282-295. https://doi.org/10.1007/s11469-009-9225-1

DeAngelis, T. (2021). Mental illness and violence: Debunking myths, addressing realities. *Monitor on Psychology, 52*(3). https://www.apa.org/monitor/2021/04/ce-mental-illness

Declaration on the Rights of Indigenous Peoples Act, SBC 2019, c. 44. https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/19044

Dell, D., & Hopkins, C. (2011). Residential volatile substance misuse treatment for indigenous youth in Canada. *Substance Use & Misuse*, *46*(sup1), 107-113. https://doi.org/10.3109/10826084.2011.580225

Dhamoon, R. (2015). A feminist approach to decolonizing anti-racism: Rethinking transnationalism, intersectionality, and settler colonialism. *Feral Feminisms, 1*(4), 22-37.

Donovan, D., & McDowell, I. (Eds.) (2018). *AFMC primer on population health: A virtual textbook on public health concepts for clinicians.* Association of Faculties of Medicine of Canada.

Du Mont, J., & Forte, T. (2014) Intimate partner violence among women with mental health-related activity limitations: A Canadian population-based study. *BMC Public Health 14*(51). https://doi.org/10.1186/1471-2458-14-51

Falcon, K. (2021, January 17). Misguided policies are undermining the quality of life in urban centres. *Vancouver Sun*. https://vancouversun.com/opinion/kevin-falcon-misguided-policies-are-undermining-the-quality-of-life-in-urban-centres

Farmer, P. E. (2003). *Pathologies of power: Health, human rights, and the new war on the poor.* University of California Press.

Farmer, P. E., Nizeye, B., Stulac, S., & Keshavjee, S. (2006). Structural violence and clinical medicine. *PLOS Medicine, 3*(10), e449. https://doi.org/10.1371/journal.pmed.0030449

FNHA (First Nations Health Authority). (2019). *Policy on mental health and wellness. https://www.fnha.ca/WellnessSite/WellnessDocuments/FNHA-Policy-on-Mental-Health-and-Wellness.pdf*

FNHA (First Nations Health Authority). (2022). *Cultural safety and humility.* https://www.fnha.ca/wellness/wellness-and-the-first-nations-health-authority/cultural-safety-and-humility

FNHA (First Nations Health Authority), British Columbia Ministry of Health, & Health Canada. (2013). *A path forward: BC First Nations and Aboriginal People's mental wellness and substance use 10 year plan*. https://www.fnha.ca/Documents/FNHA_MWSU.pdf

First Nations Leadership Council. (2020, July 9). *RE: Bill 22 proposed amendments to the mental health act.* British Columbia Assembly of First Nations. https://d3n8a8pro7vhmx.cloudfront.net/ubcic/pages/4265/attachments/original/1601245022/Bill_22_2020July09_FNLCtoBC_Bill_22.pdf

First Nations Leadership Council. (2021, January 19). *Treatment over detention: Immediate changes required regarding the use of involuntary detentions for youth under the mental health act.* British Columbia Assembly of First Nations. https://www.bcafn.ca/sites/default/files/docs/news/2021JAN19_FNLC%20NR_RCY%20Mental%20Health%20Report.pdf

First Nations Leadership Council, Government of Canada, & Government of British Columbia. (2006). *Transformative change accord: First Nations health plan - supporting the health and wellness of First Nations in British Columbia*. https://www.health.gov.bc.ca/library/publications/year/2006/first_nations_health_implementation_plan.pdf

First Nations Leadership Council, Government of Canada, & Government of British Columbia. (2007). *Tripartite First Nations health plan.* https://www.fnha.ca/Documents/TripartiteFNHealthPlan.pdf

Greenwood, M. (2019). Modelling change and cultural safety: A case study in northern British Columbia health system transformation. *In Healthcare Management Forum, 32*(1), 11-14. https://doi.org/10.1177/0840470418807948

Greenwood, M., de Leeuw, S., Stout, R., Larstone, R., & Sutherland, J. (Eds.). (2022). *Introduction to determinants of First Nations, Inuit, and Métis Peoples' Health in Canada.* Canadian Scholars' Press.

Griffiths, N. (2020, June 26). Mental health calls to Vancouver police have doubled in past decade. *Vancouver Sun*. https://vancouversun.com/news/crime/mental-health-calls-to-vancouver-police-have-doubled-in-past-decade

Grochowski, S. (2021, October 7). Cocaine, heroin and meth buyers' club gets Vancouver's approval to secure a safe supply. *Vancouver Sun*. https://vancouversun.com/news/local-news/cocaine-heroin-and-meth-buyers-club-seeking-vancouvers-approval-to-secure-a-safe-supply

Hankivsky, O. (Ed.). (2012). *An intersectionality-based policy analysis framework.* Institute for Intersectionality Research and Policy.

Hankivsky, O., & Jordan-Zachery, J. S. (Eds.). (2019). *The Palgrave handbook of intersectionality in public policy*. Palgrave Macmillan.

Harnett, C. E. (2021, May 21). Premier says legislation to keep youth who overdose in care will return after consultation. *Times Colonist*. https://www.timescolonist.com/local-news/premier-says-legislation-to-keep-youth-who-overdose-in-care-will-return-after-consultation-4689325

Hill-Collins, P., & Bilge, S. (2016). *Intersectionality*. Policy Press.

Ibrahim, M., & Morrow, M. (2015). Weaning off colonial psychiatry in Kenya. *Journal of Ethics and Mental Health, 9*. https://jemh.ca/issues/v9/documents/JEMH_Open-Volume_Article_Theme_Colonization_Weaning_June2015.pdf

Indian Act, RS 1985, c. I-5. https://laws-lois.justice.gc.ca/eng/acts/i-5/

Jacklin, K., & Warry, W. (2011). Decolonizing First Nations health. In J. C. Kulig & A. M. Williams (Eds.), *Health in rural Canada* (pp. 373-389). UBC Press.

Johnston, L. (2017). *Operating in darkness: BC's Mental Health Act detention system*. Community Legal Assistance Society. https://d3n8a8pro7vhmx.cloudfront.net/clastest/pages/1794/attachments/original/1527278723/CLAS_Operating_in_Darkness_November_2017.pdf?1527278723

Josewski, V. (2020). *Moving towards cultural safety in mental health and addictions contracting for urban Indigenous Peoples: Lessons from British Columbia* [Unpublished doctoral dissertation]. Simon Fraser University. https://summit.sfu.ca/item/19947

Kirmayer, L. J., Gone, J. P., & Moses, J. (2014). Rethinking historical trauma. *Transcultural Psychiatry, 51*(3), 299-319. https://doi.org/10.1177/1363461514536358

Labrum, T., Zingman, M. A., Nossel, I., & Dixon, L. (2021). Violence by persons with serious mental illness toward family caregivers and other relatives: A review. *Harvard Review of Psychiatry, 29*(1), 10-19.

Loyal, J. P., Lavergne, M. R., Shirmaleki, M., Fischer, B., Kaoser, R., Makolewksi, J., & Small, W. (2023). Trends in involuntary psychiatric hospitalization in British Columbia: Descriptive analysis of population-based linked administrative data from 2008 to 2018. *The Canadian Journal of Psychiatry, 68*(4), 257-268. https://doi.org/10.1177/07067437221128477

Mental Health Act, RSBC, 1996, c. 288.

Milne, K., & Hamfelt, A. (2019). *Building an equitable foundation: Removing barriers to access for people with mental health and substance-use related disabilities*. Canadian Mental Health Association. https://bc.cmha.ca/wp-content/uploads/2019/09/POL_BuildingEquitableFoundation_Report_8.5x11_2019_10_09.pdf

Morrow, M. (2022). "Women and madness" revisited: The promise of intersectional and mad studies frameworks. In M. Morrow, O. Hankivsky, & C. Varcoe. (Eds), *Women's health in Canada: Challenges of intersectionality* (pp. 311-330). University of Toronto Press.

Morrow, M., & Malcoe, L. H. (Eds.). (2017). *Critical inquiries for social justice in mental health*. University of Toronto Press.

Morrow, M., Pederson, A., Smith, J., Josewski, V., Jamer, B., & Battersby, L. (2010). *Relocating mental health care in British Columbia: Riverview hospital redevelopment, regionalization*

and gender in psychiatric and social care. Center for the Study of Gender, Social Inequities and Mental Health.

Morrow, M., & Weisser, J. (2012). Towards a social justice framework of mental health recovery. *Studies in Social Justice, 6*(1), 27-43. https://doi.org/10.26522/ssj.v6i1.1067

National Association of Friendship Centres. (2021). *Canada: Submission to the United Nations Human Rights Committee on the International Covenant on Civil and Political Rights (ICCPR).* https://nafc.ca/downloads/iccpr-submission-2021.pdf

National Inquiry on Missing and Murdered Indigenous Women and Girls. (2019). *Reclaiming power and place: The final report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*. https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Final_Report_Vol_1a-1.pdf

O'Neil, J., Gallagher, J., Wylie, L., Bingham, B., Lavoie, J., Alcock, D., & Johnson, H. (2016). Transforming First Nations' health governance in British Columbia. *International Journal of Health Governance, 21*(4), 229-244. https://doi.org/10.1108/IJHG-08-2016-0042

Ormand, G. (2017, December 10). *Advocates, families speak out in defence of B.C.'s Mental Health Act*. CTV News. https://www.ctvnews.ca/health/advocates-families-speak-out-in-defence-of-b-c-s-mental-health-act-1.3729323

Parliament of Canada. (2021). C-15: An Act respecting the United Nations Declaration on the Rights of Indigenous Peoples. https://www.parl.ca/LegisInfo/en/bill/43-2/c-15

Pictou, S. (2020). Decolonizing decolonization: an indigenous feminist perspective on the recognition and rights framework. *South Atlantic Quarterly, 119*(2), 371-391. https://doi.org/10.1215/00382876-8177809

Pilling, M. (2019). Changing directions or staying the course? In A. Daley, L. Costa, & P. Beresford (Eds.), *Madness, violence and power: A critical collection* (pp. 97-114). University of Toronto Press.

PIVOT Legal Society. (2023). *Involuntary treatment: Criminalization by another name*. https://assets.nationbuilder.com/pivotlegal/pages/3690/attachments/original/1679547073/Involuntary_Treatment_-_Criminalization_by_another_name_-_Finalized_2.pdf?1679547073

Raja, S., Hasnain, M., Hoersch, M, Gove-Yin, S., & Rajagopalan, C. (2015). Trauma informed care in medicine: Current knowledge and future research directions. *Fam Community Health 38*(3), 216-26. https://doi.org/10.1097/FCH.0000000000000071

Shelton, J., & Abramovich, A. (2019). LGBTQ2S youth homelessness: A call for structural intervention. *Parity, 32*(8), 24-25.

Swanson, J. W. (2021). Introduction: Violence and mental illness. *Harvard Review of Psychiatry 29*(1),1-5. https://doi.org/10.1097/HRP.0000000000000281

Truth and Reconciliation Commission of Canada. (2015). *Honouring the truth, reconciling for the future: Summary of the final report of the Truth and Reconciliation Commission of Canada*. https://irsi.ubc.ca/sites/default/files/inline-files/Executive_Summary_English_Web.pdf

Turpel-Lafond, M. E. (2020). *In plain sight: Addressing Indigenous-specific racism and discrimination in B.C. health care*. https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Full-Report-2020.pdf

Turpel-Lafond, M., Lemchuk-Favel, L., & Johnson, H. (2021). In plain sight: Elaboration on the review. *BC Medical Journal, 63*(2), 83-88.

United Nations General Assembly. (2007a). *Convention on the Rights of People with Disabilities*. https://www.refworld.org/docid/45f973632.html

United Nations General Assembly. (2007b). *United Nations Declaration on the Rights of Indigenous Peoples*. https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html

Van Veen, C. (2021). *Between care and control: A discourse analysis of Vancouver's "mental health crisis"* [Unpublished doctoral dissertation]. Simon Fraser University.

Van Veen, C., Ibrahim, M., & Morrow, M. (2018). Dangerous discourses: Masculinity, coercion and psychiatry. In J. Kilty & E. Dej (Eds.), *Containing madness: Gender and 'psy' in institutional contexts* (pp. 241-265). Palgrave MacMillan.

Van Veen, C., Teghtsoonian, K., & Morrow, M. (2019). Enacting violence and care: Neoliberalism, knowledge claims and resistance. In A. Daley, L. Costa, & P. Beresford (Eds.), *Madness, violence and power: A critical collection* (pp. 59-63). University of Toronto Press.

Waldram, J. (2004). *Revenge of the Windigo: The construction of the mind and mental health of North American Aboriginal peoples*. University of Toronto Press.

Woo, A. (2016, September 13). B.C. patients launch court challenge over forced psychiatric treatments. *The Globe and Mail*. https://www.theglobeandmail.com/news/british-columbia/bc-patients-launch-court-challenge-over-forced-psychiatric-treatments/article31846031/

World Health Organization. (2021). *Guidance on community mental health services: Promoting person centred and rights-based approaches*. https://www.who.int/publications/i/item/9789240025707

Wyndham-West, M. (2009). Phenomenologically productive "creation" stories: Aboriginal health discourse and mass media coverage of the Kashechewan "crisis." *vis-à-vis: Explorations in Anthropology, 9*(1), 143-157.

Yeung, S. (2016). Conceptualizing cultural safety: Definitions and applications of safety in health care for Indigenous mothers in Canada. *Journal for Social Thought*, *1*(1), 1-13.