

Rethinking Mental Health in British Columbia: A Trauma-Informed Critique of the *Mental Health Act* and Western Counselling Education

by

Satina Rai

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APPROVED BY Laurel Tien, PhD, RCC, RCC-ACS, Capstone Supervisor,

Master of Counselling Faculty

Abstract

This capstone critically examines British Columbia's *Mental Health Act* (MHA) through a trauma-informed framework with specific focus on the deemed consent provision and its impact on Indigenous Peoples and other marginalized groups. Drawing from abolitionist worldview, decolonial and anti-oppressive perspectives, and lived experience, this paper explores how the MHA positions mental health as an individualized biomedical issue rather than recognizing and addressing the oppressive social systems that contribute to collective mental illness. In doing so, it grants excessive, unchecked authority to healthcare professionals and police officers, perpetuating systems of control and surveillance rather than community-based, culturally sensitive care. It also critiques the capitalistic and colonial nature of Western-centric counselling education, arguing counsellors must question curriculum and challenge these structures to create cultural safety, autonomy, and community care. By re-evaluating legislation and curriculum through trauma-informed frameworks, we can equip counsellors to disrupt harmful systems and advocate for transformation that address root causes of mental illness rather than pathologizing—and punishing—individuals impacted by systemic harm.

Key words: Mental Health Act of British Columbia, impacts of police on mental health, deemed consent, impacts of settler colonialism on mental health, efficacy of involuntary treatment, mental health industrial complex, role of physicians under the MHA.

Table of Contents

Chapter 1: Introduction4

Introduction4

 Background the Issue/Problem 5

 Purpose of the Capstone 8

 Research Question(s)..... 8

 Significance of the Capstone..... 9

 Contributions to the Field..... 10

 Theoretical Orientation 10

 Positionality Statement 12

 Definition of Terms 13

 Overview of the Paper 14

Chapter 2: Literature Review16

Introduction16

 The History of B.C.'s *Mental Health Act*..... 17

 Issues with the Application of the Legislation 21

 The Biomedical Model and the Discourse it Creates 24

 Policing and the Mental Health Act: Legislation and Critiques..... 26

 The Criminalization of Mental Health..... 29

Summary30

Chapter 3: Application.....32

Summary of Findings32

Discussion/Implications32

Recommendations.....35

Limitations in Capstone37

Intersections in Literature.....37

Conclusions.....38

References40

Work Cited40

Rethinking Mental Health in British Columbia: A Trauma-Informed Critique of the *Mental Health Act* and Western Counselling Education

Chapter 1: Introduction

In British Columbia (B.C.), Western-based counselling education—rooted in the biomedical model and Diagnostic and Statistical Manual of Mental Disorders (DSM)—and the *Mental Health Act* (MHA) are shaped by white, patriarchal, capitalistic ideologies (Gorritz, 2024; Wahbi & Beletsky, 2022). As a result, the mental health needs of marginalized individuals most impacted by systemic colonial harm are not being met (Decolonize Mental Health, 2023). To address the root cause of mental health issues and support meaningful solutions, the approach to understanding and treating mental health requires a trauma-informed, abolitionist perspective that prioritizes safety, equity, and community-based care over carceral control and weaponized treatment and therapy (Wahbi & Beletsky, 2022).

In Chapter One of this paper, I explore the literature around fundamental issues with B.C.'s mental health legislation, including a current legal challenge before the courts. I also highlight how the literature discusses legislation itself and enforcement of the legislation may be unjust, with a disproportionately negative impact on Canada's Indigenous population. Further, I frame my critique of the MHA, Western views, the biomedical model, and the DSM through my own lived-experience and identity as a Punjabi Sikh, first generation settler living on stolen lands.

In Chapter Two, I present a review of literature detailing the history of B.C.'s mental health legislation from inception to present-day. This review includes a critical analysis of the

biomedical model that underpins the legislation, its application (in particular its impact on Indigenous Peoples and people living in poverty), and the influence the Act has on the criminalization of mental health. In Chapter Three, I present my summary of findings, recommendations, and conclusion that counselling education must integrate anti-oppressive, decolonial perspectives to support a new paradigm of mental health advocacy and practice.

Background the Issue/Problem

In May 2025, the Supreme Court of British Columbia (the Supreme Court) began hearing a Charter challenge to determine whether the ‘deemed consent’ provision in British Columbia’s *Mental Health Act* violates the Canadian Charter of Rights and Freedoms (the Charter). This case, filed nearly a decade ago by the Council of Canadians with Disabilities (CCD), argues that the MHA violates the Charter by permitting involuntary detention and psychiatric treatment without consent, undermining bodily autonomy, equality rights, and protections guaranteed to persons with disabilities (Community Legal Assistance Society [CLAS], 2016). Under the current MHA, individuals certified as involuntary patients are treated as though they have consented to any treatment their healthcare provider deems appropriate—including forced administration of psychotropic medication and in some cases, electroconvulsive therapy (Fraser, 2015). This provision is the primary reason why B.C.’s mental health legislation is widely regarded as highly regressive (CLAS, 2017), and is notably the only mental health legislation in Canada to include a deemed consent clause.

I argue that at the core of the legislation and the way in which people with mental health disorders are treated in B.C. is the dominant belief that Western views of psychiatry, and

Western ways of “healing” (i.e. medication) are the most—if not only—valid approaches. This Western approach is rooted in the biomedical model that emphasizes science, diagnosis, and treatment of disease instead of addressing root cause, the human being involved, and their experience as a whole (Fraser, 2015). Further, the biomedical model informs the Diagnostic and Statistical Manual of Mental Disorders (DSM) used by mental health professionals in North America to diagnose mental health conditions.

Since its initial publication in 1952, the DSM has been used as a tool to define what is normal and what is abnormal. However this continues to shift over time. For example, homosexuality was classified as a mental illness until the 1970s. Although newer versions of the DSM attempt to integrate cultural considerations, systemic perspectives such as impacts of racism, settler colonialism, or capitalism on mental health are lacking (Bredstrom, 2017; Wada & Fellner, 2024). New studies have shown that many individuals who were on the task force for creating the DSM-5 have ties with pharmaceutical companies—receiving payments from pharmaceutical companies that total fourteen million U.S. dollars—and therefore profit off of the medicalization of mental health (Davis et al., 2024). Due to these ties with pharmaceutical companies, the objectivity of diagnostic criteria is deeply compromised, reinforcing a system that pathologizes human experience to drive profits rather than promoting mental well-being through holistic, culturally informed understanding (Davis et al., 2024). Further, I argue that when mental health issues are primarily framed as biological issues, the significant impact of systemic issues like poverty, housing insecurity, racism, settler colonialism, homophobia, sexism, transphobia, and capitalism on human behaviour are ignored.

While the deemed consent provision is highly problematic for the reasons stated above, it is not the only issue within the legislation or its enforcement. From a legislation perspective, both police officers and physicians are granted significant authority over individuals experiencing mental health crises, and I believe it is questionable whether either group has the necessary training to manage mental health situations effectively. With respect to enforcement, the growing involvement of police in mental health emergency responses has contributed to the criminalization of mental health—particularly affecting First Nations peoples—and has reinforced carceral approaches at the expense of community-based, culturally specific resources (Grand Chief Stewart Philip, 2023). Other members of marginalized communities are also targeted by racialized enforcement. In an article published by the Capital Daily, Victoria B.C. resident Michael Belfon shares that he has been recovering from physical and mental trauma after having a “near death experience” when police used an armored truck, K-9 unit, and irritant gas to break into his home to conduct a “wellness check.” (Basu, 2022). The sixty-four year old black man, who was tasered during the incident, spent a month and a half in the hospital and lost his home as a result of the event. Residents witnessing the “wellness check” are quoted in the article for naming the Victoria Police Department’s actions as “a clear display of racism, police brutality, and complete abuse of power.” (Basu, 2022).

At a fundamental level, I argue that if the regressive nature of the Act—with its deemed consent provision—is not addressed, the colonial biomedical approach to mental health will continue to harm individuals in crisis. Carceral responses from medical professionals and police officers will continue to perpetuate cycles of trauma, discrimination, and criminalization instead of honouring the Hippocratic Oath and the Oath of Office to do no harm and act with integrity

and fairness, respectively. And, counsellors registered under the B.C. Association of Clinical Counsellors (BCACC) who fail to question the legislation and the impact of its enforcement on their clients will be complicit in perpetuating violations against the Charter of Human Rights instead of providing ethical, culturally informed care.

Purpose of the Capstone

This capstone examines literature on how British Columbia's *Mental Health Act* frames mental health as a biological issue as opposed to an outcome of socially oppressive systems, giving unjustly vested authority to police offices and healthcare professionals that deepens the oppression of marginalized members of society and individuals detained under the Act.

Through a trauma-informed, anti-oppressive framework, I explore the ways in which counsellors can help prevent harm and advocate for change using culturally sensitive approaches that prioritize safety, choice, and empowerment over power structures, police interventions, and social hierarchies. The ultimate aim of this capstone is to argue that counselling education—much like the MHA—needs to be questioned and addressed, and that in order to fulfill our professional obligations, we must view curriculum—along with mental health legislation and its enforcement—through an anti-oppressive, abolitionist lens.

Research Question(s)

The research questions this paper address are:

1. What is the history, efficacy, and issues/critiques of mental health legislation and enforcement of involuntary treatment in B.C.?

2. What is the impact of B.C.'s mental health legislation and enforcement on Indigenous Peoples and other marginalized groups?
3. What alternative approaches/models/frameworks could more effectively address the root cause of mental health issues?

Significance of the Capstone

In B.C., our government has declared that we are in a mental health crisis and is insisting that involuntary treatment is the best path forward along with bolstering police budgets (Carnegie Community Action Project, 2018; Boyd & Kerr 2015). When legislation is not clearly understood, it is possible that people can be misled about its efficacy and overlook the impacts that it has on people's lives. For counsellors, who are stakeholders in this legislation—as there are many counsellors who have called the police on clients or have had clients admitted under the MHA—there is a high level of complicity in the harm that people experience under the Act and through the continued reliance on police as front-line responders to mental health crisis. If there is an understanding of the issues that this legislation and police response to mental health creates, then opportunities are opened up for alternative approaches to mental health to be considered, created, and advocated for. Counsellors hold significant power in a therapeutic relationship, therefore it is essential that there is an understanding of how this power can affect a client's wellbeing. The literature notes that those who have experienced mental health crises have expressed a desire for alternatives, the details of which this capstone will explore.

Contributions to the Field

Given the many issues with the MHA and police being at the forefront of mental health emergency response, I believe that it is important for counsellors to have an in-depth understanding of the problems that stem from the legislation and its enforcement so that they may advocate more effectively for their clients and help to prevent harm. The alternatives to the MHA and police interventions that people with lived experience are asking for—such as affordable and livable housing, low-barrier access to mental health care, and community-based resources—are viable solutions counsellors can support and promote if they are aware of these needs. Addressing the root causes of people’s suffering helps create pathways for healing and repair, rather than simply managing symptoms as they arise. By confronting the issues within current practices, opportunity for new approaches to be imagined and developed is created. I argue that this process encourages counsellors to recognize and champion alternatives that may already exist, particularly the work led by Black, Indigenous, and People of Color (BIPOC) individuals and communities. As counsellors, engaging in a continuous journey of unlearning and relearning is essential, and questioning existing systems and policies is a critical part of this process.

Theoretical Orientation

When it comes to my research and analysis, I acknowledge some biases based on my experience. Academically, I have been learning about viewing the world through an abolitionist perspective, and am exploring concepts that support the complete dismantling of unjust systems as opposed to reforming them. The term abolitionist originates from the historical movement to abolish slavery but has since been expanded and adapted to other contexts

(Merriam-Webster, 2025). Ultimately, an abolitionist worldview and anti-oppression, trauma-informed theoretical frameworks inform my critique of the MHA, the DSM, and the way in which counsellors currently train and practice within the broader health system.

Applying the above referenced worldview and frameworks, I argue that counsellors can approach mental health from a perspective that extends beyond Western views, the biomedical model, and the DSM to acknowledge the impact of systemic social issues on a person's mental health. To do so, counsellors must first be aware of the origin and evolution of the MHA, critiques of how the Act is presently implemented in our society, and the ways in which the legislation empowers police officers and physicians to detain or harm individuals as a result.

In addition to abolitionist worldview and anti-oppression, trauma-informed theoretical frameworks, I have been guided in my analysis by many different teachers including Dr. Jennifer Mullan (2023) who, in her book as well as her broader work, discusses how we must decolonize therapy. Decolonization begins with acknowledging the deep harm that settler colonialism and imperialism have caused in people's lives in many ways to uncover the real roots of suffering . An exploration of decolonization requires an anti-oppressive, trauma-informed framework as each are rooted in challenging systemic power imbalances and centering marginalized voices. Recognizing how systems of oppression—such as racism, settler colonialism, ableism, sexism, classism, homophobia, and transphobia—affect people's lives is paramount to my work and the work of counsellors at large. The personal is political, and we must acknowledge how therapy is political (Mullan, 2023). As eurocentric ways of understanding and providing therapy tend to

pathologize the individual, we must move towards ways of being and knowing that have been purposefully forgotten (Mullan, 2023).

Positionality Statement

Personally, I am a first generation settler born on the unceded traditional territory of the Lheidli T'enneh First Nation, part of the Dakelh (Carrier) peoples' territory. I am now an uninvited settler currently residing on the unceded territory of the W̱SÁNEĆ peoples and the lək̓ʷəŋən speaking people known today as the Esquimalt and Songhees. I am of Punjabi Sikh heritage and am currently exploring what my sexual and gender identity mean to me and how I identify. I am currently enrolled in a Master's program to become a licensed counsellor. The intersection of all the aspects of my identity have influenced my beliefs and perceptions, including how I approach my education and professional aspirations.

As someone who has worked in frontline crisis response for several years, I have seen firsthand how various oppressive systems in place have deeply harmed the individuals I've worked with. Additionally, I have seen how many of these individuals have internalized these systems and believe that the harm that has come to them is somehow a fault of their own—which then deeply impacts their mental well-being. Through my counselling education, I have been taught various modalities that aim to help the individual process what is happening for them, but oftentimes what is missing is an acknowledgement of how systems such as racial capitalism, white supremacy, and colonization, create and perpetuate the harm. The topic for this capstone came to me through the desire to better understand the policies and legislation

that we as counsellors help enforce and the systems that are at play below the surface of the legislation.

Definition of Terms

Abolitionist Lens: “a political vision, a structural analysis of oppression, and a practical organizing strategy. While some people might think of abolition as primarily a negative project — “let’s tear everything down tomorrow and hope for the best” ... abolition is a vision of a restructured society in a world where we have everything we need... that are foundation to our personal and community safety ... abolition is a positive project that focuses, in part, on building a society where it is possible to address harm without relying on structural forms of oppression or the violent systems that increase it.” (Wahbi & Beletsky, 2022)

Carceral: “Carceral at its most basic definition is related to the word incarceration and means to confine in a jail or a prison. Scholars have expanded this definition to refer to the systems, forces, and logics that create and reproduce carcerality and which go beyond the institutions of jail and prison and include punishment, policing, and surveillance” (Rasmussen & Suslovic, 2025).

Settler Colonialism: “focuses on the *permanent* occupation of a territory and removal of Indigenous Peoples with the express purpose of building an ethnically distinct national community... [that] requir[es] constant maintenance in an effort to disappear Indigenous populations... [It is] therefore premised on ‘logics of extermination’ as the building of new settlements necessitates the eradication of Indigenous populations, the seizure and privatization of their lands, and the exploitation of marginalized peoples in a system of capitalism established by and reinforced through racism.” (Bonds & Inwood, 2015)

Deinstitutionalization: “The process of replacing long-stay psychiatric hospitals with less isolated community-based mental health services, reducing institutionalization in favour of community care.” (Merriam-Webster, 2025).

Medicalization: “To view or treat something as a medical concern, problem, or disorder.” (Merriam-Webster, 2025).

Neoliberalism: “A person or policy that promotes free market competition and sustained economic growth through capitalism as a means for achieving progress.” (Merriam-Webster, 2025).

Power Structures. “The hierarchical interrelationships existing within a controlling group.” (Merriam-Webster, 2025).

Social Hierarchies: “The internal institutionalized relationships built up by persons living within a group ... especially with regard to the hierarchical organization of status and to the rules and principles regulating behavior.” (Merriam-Webster, 2025).

Overview of the Paper

To validate my position that a trauma-informed, anti-oppressive approach to counselling is vital for creating meaningful change in the field of mental health, I review literature tracing the history of B.C.’s mental health legislation from its origins to the present. Chapter Two is organized into five sections: The History of B.C.’s *Mental Health Act*, Issues with the Application of the Legislation, The Biomedical Model and the Discourse it Creates, Policing and the Mental Health Act: Legislation and Critiques, and The Criminalization of Mental Health. Together, these sections demonstrate a comprehensive and critical understanding of how B.C.’s

Mental Health Act functions not as a mechanism to ensure safety in society, but rather as a tool for enforcing social control.

Chapter 2: Literature Review

In Chapter One, I provided an overview of B.C.'s mental health legislation—in particular the deemed consent provision—framing my analysis through a legal, decolonial, and personal perspective. In this Chapter, I will explore various themes that have emerged from the existing, available research relevant to the following research questions: What is the history, efficacy, and issues/critiques of mental health legislation and enforcement of involuntary treatment in B.C.? What is the impact of B.C.'s mental health legislation and enforcement on Indigenous Peoples and other marginalized groups? What alternative approaches/models/frameworks could more effectively address the root cause of mental health issues?

The research for this literature review has been completed using the City University of Seattle library online database, as well as the online search engines Google Scholar and ResearchGate. Key words used in this search included: “*Mental Health Act of British Columbia*,” “impacts of police on mental health,” “deemed consent,” “impacts of colonialism on mental health,” “efficacy of involuntary treatment,” “mental health industrial complex,” and “role of physicians under the MHA.” Articles included in this literature review were also selected from the references cited in articles found from this search. The inclusion criteria for literature included in this study are peer reviewed articles or studies conducted from relevant organizations that have been published between 2015 to present. Literature that is not considered a peer reviewed article was included based on applicability and relevance of the research. These criteria inform the research themes of: the history of B.C.'s *Mental Health Act*; issues with applications of the legislation; the biomedical model and the discourse it creates;

policing and the *Mental Health Act*—legislation and critiques; and the criminalization of mental health.

The History of B.C.'s *Mental Health Act*

It is important to set out the historical context under which B.C.'s *Mental Health Act* came into existence. British Columbia, being an English colony, initially adopted British laws regarding the treatment of those who were labelled “lunatics.” The *Insane Asylum Act* and the *Lunacy Act* of 1872 gave Supreme Court of B.C. judges the final say over who could be involuntarily committed as well as the ability to appoint others to be guardians over the person and their estate. These were among the first pieces of legislation to intertwine legal and health systems when pertaining to mental health specifically (Fraser, 2015). Neither of the Acts referenced above provided clear definitions of what “lunatic” or “insane” meant, nor did they provide any way for anyone to appeal the subsequent orders.

The Victoria Lunatic Asylum, B.C.'s first asylum, opened in 1872 and closed in 1878 due to overcrowding and poor treatment of patients. This led to the opening of a second facility, the Provincial Asylum for the Insane, in New Westminster in 1878 (Fraser, 2015). In 1897, the *Hospitals for the Insane Act* and the *Lunacy Act* were enacted (Fraser, 2015). Under the *Hospitals for the Insane Act*, two doctors were required to complete paperwork in order to “commit” or involuntarily admit and detain an individual in a psychiatric facility for treatment, however a judge still had final say. The *Lunacy Act* gave full power to judges to decide whether someone was a lunatic and equally to decide what would happen to their property and estate (Fraser, 2015). There remained no clear definitions around what a lunatic was, and no options

to appeal. Essondale, which would become known as Riverview Hospital, was then opened in 1904 to absorb patient overflow from the Provincial Asylum for the Insane (Fraser, 2015).

The *Hospitals for the Insane Act* was updated to the *Mental Hospitals Act* in 1912, however no substantial change to the legislation was made (Fraser, 2015). It was not until 1940 when the *Mental Hospitals Act* was enacted that committal orders could be reviewed. This updated legislation stated that committal orders must be reviewed by two independent doctors, but the review couldn't happen until three months after initial detention (Fraser, 2015). In 1948, the *Clinics of Psychological Medicine Act* was enacted, allowing mental health clinics to be opened where adults could be assessed to see if they should be certified (requiring involuntary admission to a psychiatric institution), fundamentally increasing the number of pathways to potentially being certified (Fraser, 2015). Further pathways were established in 1955, under the creation of the *Provincial Child Guidance Clinics Act*, which authorized clinics to assess children to determine if they should be certified.

During this time, patients who were detained in psychiatric facilities were subjected to abuse including electroconvulsive therapy (which is still administered in B.C. today), forced sterilization, "work therapy" (forced labour), psychosurgeries, and lobotomies (Fraser, 2015). In 1953, the *Schools for Mental Defectives Act* was passed, allowing for the involuntary commitment of children to the Woodlands School (Woodlands) – formally known as the Provincial Asylum for the Insane (Fraser, 2015). At Woodlands, there were horrible instances of overcrowding, physical, and sexual abuse. It took until 2018 for some survivors to receive compensation for their experiences (Fraser, 2015).

In 1964, B.C.'s *Mental Health Act* was enacted as a consolidation of the *Clinics of Psychological Medicine Act*, *Schools for Mental Defectives Act*, *Mental Hospitals Act*, *Provincial Mental Health Centres Act*, and the *Provincial Child Guidance Clinics Act*. The consolidated Act marked the first time legal and medical powers were explicitly combined in one piece of legislation, centralizing control under the medical profession while still embedding legal authority (Fraser, 2015). The *Mental Health Act* put significant power back in physicians' hands to make unilateral decisions about who is deemed mentally ill and what treatment they should receive. This coincided with the increasing popularity of the DSM for mental health diagnosis and the increased use of psychiatric medications as treatment. The MHA also granted police power to apprehend and commit individuals that they think are mentally ill or a harm to themselves or others (Fraser, 2015). In 1998, the MHA was amended to give psychiatrists the ability to impose involuntary treatment on patients they deem at risk of deteriorating without medication – even if the patient is capable of making medical decisions and is not a harm to themselves or others (Fraser, 2015).

In 2019, a report from the Office of the Ombudsperson British Columbia (OMB) titled *Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act (Committed to Change)* was issued, publishing 20 findings highlighting the lack of compliance with the legal documentation required for involuntary admission to designated psychiatric facilities in the province. The OMB found that there was “extraordinary state power with little oversight or accountability.” (*Operating in Darkness: B.C.'s Mental Health Act Detention System*, 2017). Additionally, they found that the forms that are required to be filled out by an institution when detaining someone were oftentimes unintelligible or not filled out at

all. In fact, the five forms required to be filled out when someone is detained were properly filled out only 28% of the time. This report highlights that in B.C., under the Act, the legal rights of mentally ill patients involuntarily detained in psychiatric facilities are being denied.

From an international perspective, the United Nations (UN) Special Rapporteur on the Rights of Persons with Disabilities, an independent expert appointed by the UN Human Rights Council to promote and protect human rights and dignity of individuals with disabilities worldwide, has stated that B.C.'s *Mental Health Act* is not in compliance with the UN Convention on the Rights of Persons with Disabilities (UN CRPD) (Fraser, 2015). This is a significant statement as Canada ratified the UN CRPD in 2010 (Arch Disability Law, 2025), obligating Canada as a whole to uphold the treaty under international law even if international treaties don't automatically become Canadian domestic law. Based on the UN CRPD requirements, B.C. must remove deemed consent from the legislation, embrace trauma-informed care, and increase legal capacity and representation to be compliant with international human rights standards.

More recently, in 2020, Bill 22, known as the *Mental Health Amendment Act*, was introduced to the legislative assembly. The Bill did not pass, but if it had it would have given health care professionals the power to detain youth for up to seven days following a drug overdose ("stabilization care"), authorized the use of restraints (chemical or physical), and enabled detainment reviews without independent professional opinions (*Decolonizing the Mental Health Act | Health Justice [Decolonizing Mental Health] 2023*). Physicians would also have been able to administer different forms of health care to youth without their consent or the consent of their parents/guardians. Bill 23 then passed in 2022, providing a framework for

an independent rights advice service to be established, but does not provide details about what this will look like (*Decolonizing the Mental Health Act | Health Justice [Decolonizing Mental Health] 2023*). Otherwise, B.C.'s *Mental Health Act* remains virtually unchanged in over 60 years.

Issues with the Application of the Legislation

Under the *Mental Health Act* in British Columbia, physicians and nurse practitioners are given huge amounts of power over patients that have been detained. As referenced earlier, once a person has been detained under the MHA, medical professionals operate from a lens of deemed consent. This means that there is an assumption that the patient is consenting to any and every form of treatment that the physician decides, even if they are capable of withholding consent. This includes forced psychiatric medication, electroconvulsive therapy, restraints, and isolation. Additionally, detainees are not allowed to make a Representation Agreement (or it is not honored) which would allow them to designate someone to make decisions on their behalf if they are deemed incapable (*Operating in Darkness: B.C.'s Mental Health Act Detention System, 2017*).

As there are no legal criteria governing the use of seclusion or restraints in the MHA, hospital staff can make decisions for patients as they see fit. This includes the use of physical restraints (being strapped down to a bed or physically restrained by staff/security guards), solitary confinement, and chemical restraints (psychotropic medication to control behavior). Further, there are no legal requirements to document the use of any of these methods of restraint, and no administrative body that detainees can issue complaints to about the use of

such restraints. This is in direct violation of various Charter rights, specifically Section 7 (Life, Liberty, and Security of the Person), Section 12 (Cruel or Unusual Treatment or Punishment), and Section 15 (Equality Rights) (CLAS, 2017). In their 2016 position statement on solitary confinement, the College of Family Physicians of Canada (CFPC) flags this violation by advocating for the abolition of solitary confinement, particularly for individuals with medical conditions or mental illness, and opposing its use as a form of discipline due to detrimental effects on health.

From a lived-experience perspective, many detainees who have been confined or restrained in psychiatric institutions have expressed feeling, “desperation, helplessness, abandonment, humiliation, and claustrophobia,” and individuals who have had the dual experience of being detained in jail and under the MHA have expressed they had more rights as prisoners and would prefer detention in jail over a psychiatric facility (*Operating in Darkness*, 2017).

In addition to the use of solitary confinement or restraints, there is also no legal criteria in the MHA when it comes to governing clothing of those who are detained. Therefore, it is left up to individual hospitals, and their staff, to determine procedure. Patients are often forced to give up all of their personal items and clothing (even if it is not a safety risk) to wear hospital gowns. Some hospitals forcibly strip the patients who have been detained and there is no criteria to ensure that the procedure is conducted by someone of the same sex. Sometimes “earning back” clothing and personal items are used as a behavioural incentive, encouraging compliance with the orders of the doctor/nurse. Further, when detainees are not given their clothes back for review hearings, this can create a specific perception in the eyes of the review

board that the individual “belongs in the hospital” when they show up in hospital issued garments (*Operating in Darkness*, 2017).

In their publication *Operating in Darkness*, the CLAS specifically highlights legal issues that lawyers have seen when working alongside detainees. Not only do physicians have immense power over their patients while they are detained, they play a huge role in the review panel process. As mentioned earlier, detainees are entitled to apply for a review of their detention by the Mental Health Review Board (MHRV), an independent tribunal made up of a physician, a lawyer, and a community member who is not a medical practitioner or lawyer. These review panels are not automatic, and a detainee must request one themselves. The CLAS points to evidence that oftentimes, detainees are not informed of their right to request a review panel, and if one is requested, they can be pressured into cancelling the panel by hospital staff. The physician that sits on the MHRV is paid by the province to prepare expert medical evidence and present the case for detention at the hearing, but there isn't funding available for any of the expenses the detainee could incur (including lawyer fees and fees to have professionals testify on their behalf) (*Operating in Darkness*, 2017). There are also situations in which the community member on the board is actually a physician who is no longer practicing, which contradicts the purpose of community representation.

The CLAS further notes in their publication that beyond the review process, there is a lack of consistency across following proper release criteria. Some physicians will refuse to release detainees until they have had a review panel, whereas other physicians will release detainees immediately before a review panel so that the review doesn't happen. When interviewing physicians, CLAS found that a clear understanding of the criteria or the legal aspect

around detention was lacking (*Operating in Darkness*, 2017). In their review of the detention paperwork, the CLAS also discovered there was no way to tell if the doctor who had completed the documentation was a physician with psychiatric training, or a regular physician. This is concerning as, according to the study conducted by AlSalem et al. (2020) on accuracy around initial diagnosis, non-psychiatric physicians are more likely to misdiagnose patients with over half of referrals given by non-psychiatric physicians to psychiatric physicians containing misdiagnosis – particularly when it comes to depression, bipolar, personality disorders, or psychosis. Per the study, these disorders tend to be the most likely diagnoses of those who are detained under the MHA, and therefore suggests that a significant percentage of detainees may be misdiagnosed.

The Biomedical Model and the Discourse it Creates

Western hegemony in psychology is the basis for the mental health legislation and discourse we see today. The *Mental Health Act* is rooted in the Western view of psychiatry which is rooted in a biomedical model (Fraser, 2015). A biomedical model of health frames mental illness as a disease of the brain, placing the root cause and treatment site within the individual (Fraser, 2015). The MHA draws from the DSM's definition of a mental disorder, and the discourse around psychopathology underpins this legislation. Standardized diagnosis allows shared understanding amongst health care professionals and promotes uniform treatment approaches. Since diagnosis is required for provincial funding, it incentivizes practitioners to diagnose and individuals to seek out diagnosis (Kolar et al., 2023).

Although the biomedical model states that psychopathology is rooted in neurological deficits or genetic abnormalities that require pharmaceutical interventions, diagnoses are underpinned by behavior evaluated against socially accepted norms (Kolar et al., 2023). Outside of “normal” becomes pathological, but who decides what normal is? Mental health, under a biomedical model, is framed as the absence of disease or illness, so an individual “cure” continues to be the marker of successful treatment. A focus on the individual as opposed to the structures that are in place that profoundly impact their mental health (e.g. colonization, racism, ableism, poverty, transphobia, homophobia) creates treatment plans that target symptoms as opposed to root causes. This also puts the blame and onus of recovery on the individual while these systems continue to operate with no accountability and therefore no pressure to change. This leads to the medicalization of social behaviors that were not previously seen as medical concerns, and equally, the demarcation of what is deemed normal vs. abnormal (Kolar et al., 2023).

When the biomedical model shapes thought around mental illness, social issues such as poverty risk becoming treated as an individual psychological problem rather than the broader systemic concern—stemming from systemic inequality—that it actually is. This psychologization of social issues such as poverty is deeply problematic considering the fact that the World Health Organization (WHO) has described extreme poverty as, “...the world’s biggest killer and the greatest cause of ill-health and suffering across the globe.” (Greene, 2019). Multiple studies have shown that poverty increases the risk of having poor mental health outcomes. They also show that children who are impoverished end up having more behavioural issues, and are at an increased risk for depression, schizophrenia, and anxiety (Greene, 2019). Racialized individuals,

those who identify as trans, people with disabilities, and those living in single parent households are at higher risk to experience poverty (Nations, 2022). The psychologization and medicalization of social issues then puts the blame on individuals for having chemical imbalances—or in the case of poverty, not working hard enough—which furthers the stigma and marginalization of these individuals and ultimately worsens mental health outcomes (Greene, 2019).

Policing and the Mental Health Act: Legislation and Critiques

British Columbia's *Mental Health Act* affords powers to police officers to detain individuals based on their own determination of the individual's mental status. According to the MHA:

Section 28 (1) A police officer or constable may apprehend and immediately take a person to a physician or nurse practitioner 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.

There are various issues with placing police officers at the forefront of Mental Health Emergency Response (MHER) (Hey et al., 2025). The first being how broad the legislation is when it comes to the police's ability to apprehend someone. Under *B.C.'s Provincial Policing Standards*, police receive training in de-escalation, risk assessment, and co-response models

(collaborative approaches to emergency mental health involving mental health professionals and first responders) to identify and respond to mental health crises. However, they do not receive any training on how to diagnose formal disorders, and therefore are wrongly empowered to determine if an individual requires detainment based on their own ethics and judgement. Considering the lack of training, it is easy to extrapolate that police officers making detainment decisions are not taking into account the influence of systemic issues like racism, settler colonialism, sexism, classism, and ableism on their decision making processes.

The idea of safety and protection that is mentioned throughout the Act is also vague. A Supreme Court ruling in 1993 justified the need for protection that goes beyond physical dangerousness and includes, ‘threats, violence, paranoid delusions, command hallucinations, irrational wasting of money, deteriorating physical condition, likelihood of or losing a job, dropping out of school, grossly unsanitary living conditions, and suicidal ideas or behaviors’ (Hey et al., 2023). As many of these criteria are subjective, they ultimately frame people with mental illness as incapable and incompetent, therefore providing unsubstantiated justification for involuntary treatment—and the overriding of consent “for their own good” (Hey et al., 2023).

In Canada, the Royal Canadian Mounted Police (RCMP) was created to enforce colonization by forcibly removing Indigenous Peoples from their lands, and enforcing attendance at residential schools and Indian hospitals. They have also played, and continue to play a significant role in the overcriminalization and incarceration of Indigenous Peoples (*Decolonizing the Mental Health Act | Health Justice [Decolonizing Mental Health]* 2023). To this day, the RCMP—a national police service—actively contributes to the apprehension of

Indigenous children in conjunction with B.C.'s Ministry of Children and Family Development (MCFD). The RCMP also upholds injunctions and violently suppresses land and water defenders, and fails to address and are often complicit in violence against Indigenous women, girls, 2-Spirit and gender diverse people (Decolonize Mental Health, 2023).

Not only can interactions with the RCMP and local police forces exacerbate mental health issues, they can create mental health issues that were previously not there. According to research conducted by Hey et al., in 2025, police violence creates a four to eleven times higher likelihood of suicide. This research also suggests that interactions with police creates a false perception that a person has committed a crime, when in reality they are in need of support. This perception of criminal activity can then cause individuals to experience greater surveillance from police or the MCFD, creating a cycle for people that is difficult to get out of (Hey et al., 2025).

Interacting with police is not only entirely unhelpful for some people, but it can be very traumatizing and in some cases, lethal. In Canada, people with mental illness and Indigenous Peoples are overrepresented when it comes to 'law enforcement interventions' and police-related fatalities. Persons with mental illness are seven times more likely to experience police-involved fatalities than those without (Hey et al., 2025). Indigenous Peoples account for 33% of all fatal police involved shootings, while only making up 4% of Canada's population (Hey et al., 2025). People with mental illness are over two times more likely to be criminally charged than those without, and are two times more likely to be tasered (administered an electroshock by a weapon used by police officers) than persons experiencing criminal arrests (Hey et al., 2025). In response to these statistics, the Centre for Addiction and Mental Health (CAMH) and the

Canadian Mental Health Association (CMHA) released statements in 2020 calling for the removal of police from mental health emergency response, and the creation of a more culturally safe and trauma-informed approach to crisis intervention.

The Criminalization of Mental Health

In a 2016 paper by Boyd & Kerr, they argue that over the years, there has been a marked increase of interactions between the police and people with mental illness that correlates with the implementation of neoliberal policies and resulting cutbacks in social supports such as accessible healthcare and housing. They also note that around the same time the *Mental Health Act* was enacted, there was a movement for de-institutionalization and the creation of community-based resources as a response to reports of gross human rights violations (Boyd & Kerr, 2016). In B.C., despite this movement, the reality is that while the Vancouver Police Department (VPD) budget continues to rise each year, there has been little funding for community services and resources – leaving those who need it most, most vulnerable (Boyd & Kerr, 2016).

Boyd and Kerr (2016) also highlight the stigmatized link between mental health and addictions to homelessness and poverty. This correlation influences the perception of low-income people as unstable, incapable, and mentally ill, therefore turning economic hardship and disparity into a mental health problem as opposed to the social problem it actually is. Of course, the impacts of poverty on mental well-being are immense, and given the compounding traumas that homelessness creates, those that experience poverty are at an elevated risk of hardship – including premature death. Boyd and Kerr (2016) conclude that by shifting the focus from health, community and social support, livable housing, and peer-run organizations to

increased surveillance, social control is widened without improvements to the lives of people living with mental illness.

In British Columbia, the VPD has played a significant role in creating discourse around mental health, specifically tying it to dangerousness and criminality. According to Boyd and Kerr (2016), the Downtown East Side (DTES) of Vancouver is a socially produced space weaponized by the VPD and the government to continue the discourse that criminalizes those who are experiencing mental health and addictions. It is consistently targeted in the media as an epicenter of crime and violence which is possible when the biggest claims makers about the neighborhood are not those that live there, but rather the VDP and the City of Vancouver. This neighborhood is being highlighted in this capstone as it is a clear example of how those who are in need of support consistently go unheard because they are silenced and spoken over. The way that the DTES is portrayed in the media directly impacts policy, budget, and resource allocation, as well as public opinion and more broadly, how people think about mental illness (Boyd & Kerr, 2016).

Summary

In summary, this research examines the history and critical issues surrounding the *Mental Health Act*, with specific emphasis on the deemed consent provision in B.C.. By tracing the origins of mental health law in B.C., it is clear that legislation has historically lacked—and continues to lack—proper definitions, appeals processes, and protection for people labeled with mental illness. Since its inception, the MHA has given over-reaching and unchecked authority to medical professionals, grossly expanded involuntary treatment pathways, and

reinforced the biomedical model that frames mental health as an individual pathology requiring medical intervention without taking into account the impact of oppressive systems such as poverty, racism, and settler colonialism on human behaviour. Collectively, the research above reveals widespread, and disproportionate harm of marginalized groups—particularly Canada’s Indigenous Peoples and those living in poverty. My review also critiques the role of the RCMP and municipal police under the MHA, where subjective detainment criteria and limited mental health training enable harmful and discriminatory detentions and potentially lethal outcomes. Rooted in a colonial and carceral worldview, the MHA criminalizes mental health struggles and amplifies stigma, especially through its enforcement in places like Vancouver’s Downtown Eastside. This literature demonstrates that B.C.’s mental health legislation is oppressive, and in violation of the UN CRPD and the Canadian Charter of Rights and Freedoms.

Chapter 3: Application

Summary of Findings

My research presented in Chapter Two critically examines B.C.'s *Mental Health Act* with a focus on the colonial, carceral foundations of the legislation and specific analysis of the deemed consent provision. It highlights the Act's lack of clear definitions, appeals processes, and protections, while exposing how the legislation enables involuntary treatment, police abuse, and systemic discrimination—particularly against Indigenous Peoples and those living in poverty. The Act reinforces a Western-based biomedical model, and violates both the UN CRPD and the Canadian Charter of Rights and Freedoms. My research also reveals how B.C.'s mental health legislation reinforces neoliberal agendas that dismantle social supports while bolstering police power. These outcomes contribute to the criminalization of mental illness by framing poverty, addiction, and collective responses to structural oppressions as individual pathologies rather than social issues. As such, surveillance intensifies while those most in need of support are increasingly marginalized.

Discussion/Implications

I, like many counsellors, entered this profession with a genuine desire to support people who need it, and to make a positive impact on people's lives. However, to become a licensed therapist and actually get to do the work, aspiring counsellors like myself must first comply with a series of educational requirements set by colonial institutions. The content we as counsellors learn or don't learn within these institutions is not just coincidence; it is specifically chosen and reviewed to maintain existing power structures. Educational institutions are increasingly

functioning as corporate entities accountable to shareholders and funding bodies, which frequently prioritize existing capitalist (and white supremacist) structures over promoting critical thinking, challenging systemic injustices, and enabling social change.

I argue that the majority of institutions within which counselling operates—including the educational institutions that certify counsellors—are inherently colonial, racist, and capitalist. At large, universities tend to maintain superficial liberal values but avoid the deeper critiques of capitalism and settler colonialism necessary to foster genuine social change. For example, land acknowledgments have become commonly accepted in universities—though more performative than meaningful—whereas the genocides actively occurring in our world (Palestine, Sudan, Congo) are always avoided. From a counselling perspective, instead of learning from those who have lived experience with incarceration based on mental health status, we learn from police officers who share stories from their perspectives.

The history and power of B.C.'s *Mental Health Act* has deep and damaging implications when applied to clinical practice, however in the current education paradigm I argue that counsellors are not taught to critically examine or question the legislation. Therefore, we lack understanding of the major issues with this legislation as well as the major issues around its real-world application. For example, we are not taught about the legal or human rights violations that the deemed consent provision enables within the Act, as discussed in the chapters above. We are also not taught to consider systemic issues like racial bias when making the decision to engage police if we suspect someone is at risk of harming themselves or others, and equally, the way in which police involvement with marginalized individuals suffering from

mental illness can result in inequitable treatment and further stigmatization. Instead, we are taught that the police are our allies, and only the basic, practical aspects of the legislation.

These examples reinforce collective harm rather than fostering truth, equity, and a justice-oriented approach to addressing society's challenges. I argue that if we as counsellors continue to accept harmful legislation without questioning its impact—or the colonial foundations of what we are being taught—we become complicit in the suffering of the individuals we are trained to support. We cannot continue to ignore the uncomfortable realities of the institutions and structures we exist in while claiming to help. Ethical, client-centered mental health support requires critical examination and challenging of the structures that contribute to their distress.

By applying this research to clinical practice, perhaps we can begin to move away from practice that revolves around the DSM and diagnostic criteria. As one learns more about the roots of modern, Western psychology the more it becomes apparent that its foundation is based on the knowledge, norms, values, views and items constructed by predominantly white men. I argue that this white male worldview has a tremendous impact on what is perceived as “normal,” often devaluing anything that falls outside of their standards. This is particularly relevant with respect to Indigenous ways of being and knowing as their general emphasis on holistic interconnectedness and balance do not align with Western diagnostic categories or frameworks.

When counsellors accept the Western/white patriarchal perspective as the foundation for therapy, we marginalize BIPOC perspectives, the perspectives of women and gender non-conforming folks, and any other perspectives that fall outside of the established norm. Further,

Western psychology and the DSM impact what is “normal” across many different aspects of life, such as gender identity, sexuality and how we relate to one another and the world around us. Deeply questioning these norms, turning towards these people, and truly listening to—and amplifying—their marginalized voices is a necessary step towards creating safer, more equitable counselling spaces.

Recommendations

To integrate abolitionist, anti-oppressive, decolonized, trauma-informed frameworks into counselling education and practice, guidance on how the Act reinforces colonial control, limits client autonomy, and perpetuates discriminatory outcomes in clinical practice is required. As counsellors, we have huge amounts of influence over our clients and often surveil their behaviour to determine if the behaviour is within limits of “safety” for the client’s protection. For this reason, I argue that it is imperative that counsellors receive comprehensive education and training on the Act through a trauma-informed framework that emphasizes learning from people with lived experience being detained under the MHA.

Moving beyond colonial education systems, trauma-informed counsellors centre and amplify the voices of individuals with lived experience of harm caused by oppressive systems by prioritizing the creation of safe, collaborative, and culturally aware spaces. We as counsellors must continue to listen to our clients and advocate for what they are saying that they need. I believe that one cannot Cognitive Behavioural Therapy (CBT) one’s way out of crushing poverty, and one cannot use Eye-Movement Desensitization and Reprogramming (EMDR) therapy to

eliminate the realities of racial capitalism. Self-care, while a useful tool, will not change the material realities of those suffering under oppressive systems.

In this Capstone, I argue that If we don't advocate for systemic change and continue to simply treat individuals through biomedically-influenced models, we are replicating what is happening at a macro level. We become the buffer between the oppressed and the oppressor, removing the teeth from the anger and rage of those who are suffering under the material realities created by the conditions of racial capitalism, settler colonialism, ableism, transphobia, xenophobia, homophobia, etc.. Counsellors must look beyond the controlled education system and seek out alternative voices in the therapy profession that speak about abolition, anti-racism, anti-capitalism and experiences in the mental health industrial complex.

Advocating for education that provides an honest view of the realities of the people who are experiencing mental health crises, and the root causes of the "mental health crisis," is an important step. Often, when we read or write in academia, it is done from an ivory tower—positioned above those we are learning about. This makes information inaccessible through the complex language we use and the databases that gate keep actual knowledge.

Beyond theory, understanding that by implementing affordable and livable housing, a livable minimum wage, accessible community-based mental health supports, and culturally appropriate resources, we can significantly improve people's mental health is foundational to providing effective counselling services. As the research in Chapter Two demonstrates, addressing the social conditions people live within is far more beneficial for mental health than applying band-aid individual fixes.

Limitations in Capstone

One of the goals of this capstone was to highlight the issues with the *Mental Health Act* and to provide alternatives. Much of the existing literature focuses on specific issues within the MHA (e.g., the deemed consent provision or the legal concerns surrounding the legislation). I believe more research that centers and amplifies the voices of those most impacted by this legislation is necessary. Some references I included were not traditional peer-reviewed articles but rather reports by various community-based organizations, or testimonials from individuals that have experienced harm related to the Act and its enforcement—published in traditional media. While this may be seen as a limitation within the norms of traditional Western academia, I believe these reports and accounts of lived experience provide valuable insights from practitioners, community members, and individuals experiencing mental health issues.

Intersections in Literature

In addition to the lack of literature that centers and amplifies the voices of those most impacted by B.C.'s regressive mental health legislation, my review of the existing literature also reveals significant gaps in how mental health legislation is examined through an abolitionist or decolonial lens. Similarly, there is a lack of exploration around models of healing in mental health outside of Western frameworks. In both contexts, Indigenous, community-based, and culturally grounded approaches to mental wellness are overlooked. Instead, the dominant narrative in the research reinforces the biomedical models, and the structures that contribute to harm. The focus on reforming within existing systems prevails, highlighting the critical need for alternative paradigms built on foundations of equality, autonomy, and decolonized wisdom.

Conclusions

A trauma-informed, anti-oppressive, decolonized approach to counselling offers a desperately needed alternative to the dominant Western model rooted in the DSM and shaped by a white male, capitalistic worldview. We are participating in a carceral system that, instead of investing in mental health resources, continues to increase police budgets and relies on law enforcement as the first responders to mental health crises—despite their lack of specialized training and a history of causing harm or even death to many individuals in crisis.

As Audre Lorde famously said, *“the master’s tools will never dismantle the master’s house,”* (Lorde, 1984, p. 112) reminding us that transformative work requires drawing on voices and knowledge outside these entrenched systems. Counsellors committed to helping people achieve greater emotional well-being, resilience, and improved quality of life must actively seek out abolitionist, anti-racist, anti-capitalist, and decolonial scholars and perspectives, centering the lived experiences of those most impacted by systemic harm. Alternative models like Victoria’s Community Led Community Response Team—an emergency response system without police involvement—demonstrate practical, community-driven ways to address crises without relying on carceral systems that often exacerbate trauma.

To move toward meaningful change, we must begin by influencing counselling education, ensuring that the curriculum we learn incorporates these critical perspectives as a foundation for broader changes in law and policy. Ways in which this can take place include, but are not limited to: integrating books such as *Decolonize Therapy* by Dr. Jennifer Mullan (2023) into counselling education curriculum; encouraging counsellors to participate in workshops to attend lectures by BIPOC counsellors and professors; and promoting exposure to

and engagement with collectives of therapists who have anti-oppressive views, such as www.inclusivetherapists.com. Spreading awareness of, and learning from these innovative approaches—while deepening our understanding of B.C.’s mental health legislation and its implications—is essential to rethinking, reimagining, and building mental health support systems that prioritize safety, equity, and liberation over control and pathologization.

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