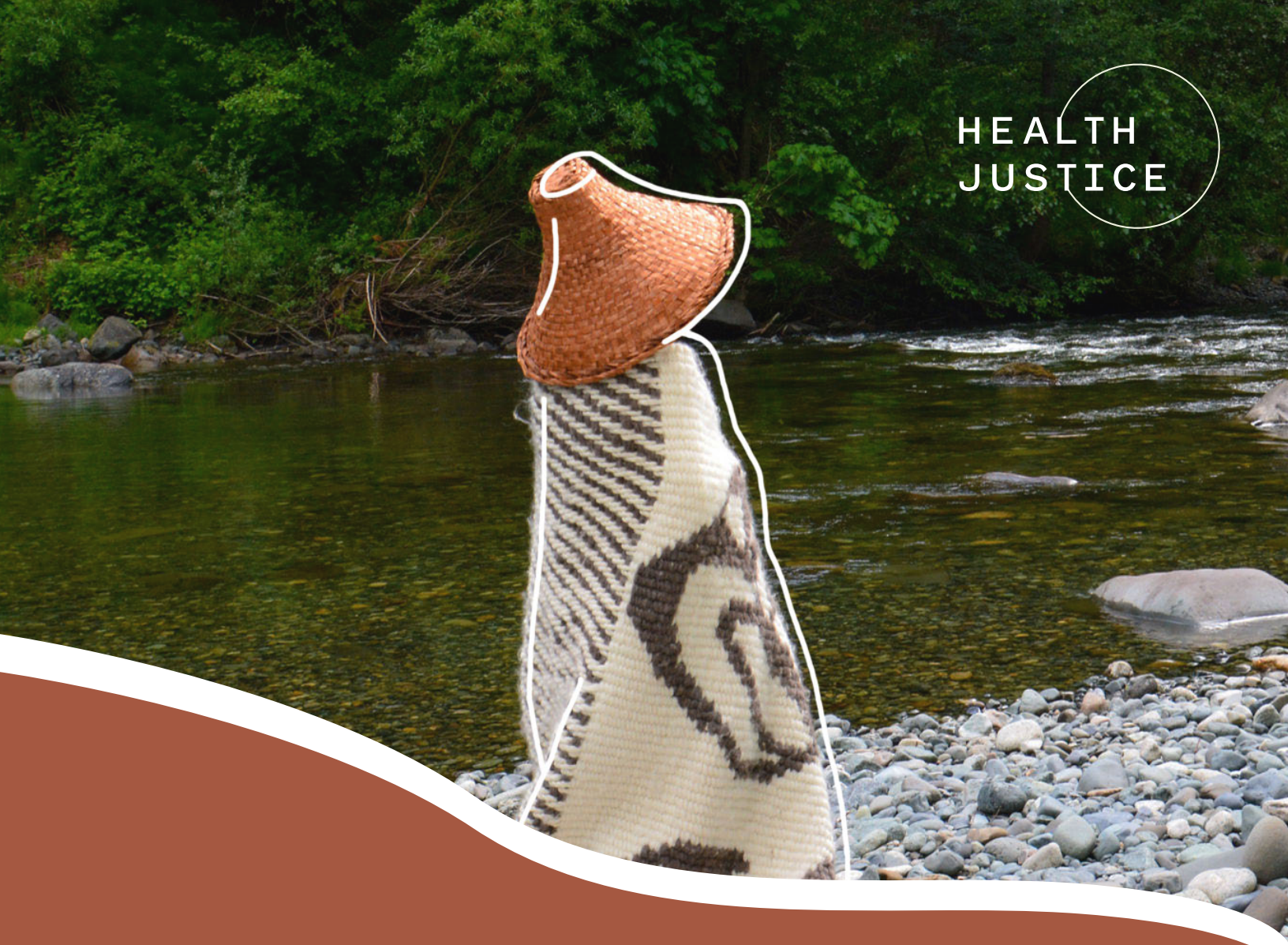

HEALTH JUSTICE

“Pathologize the systems and not the people:”[1]

Decolonizing BC’s mental health law

[1]Dr. Natalie Clark

Photo by Tricia Thomas, Salish Eye Productions

Community reflection

Union of British Columbia Indian Chiefs

"This publication magnifies and exposes the truths that Indigenous people have long articulated – mental health law in BC is based on colonial concepts and perpetuates immense trauma for First Nations people and communities. In accordance with Bill 41, the Province has an obligation to align this law with the United Nations Declaration on the Rights of Indigenous Peoples and cease this centuries long cycle of carceral approaches to health and wellbeing that weaponizes racist, discriminatory, colonial beliefs and systems against Indigenous people. I call on Premier Eby and the government of BC to genuinely consider this timely publication as a guide to urgently reforming mental health law, in alignment with the UN Declaration."

— Grand Chief Stewart Phillip

Bizaan Bimose (Tonya Robitaille)

Content note

This publication and Health Justice's work engages with many topics that can be difficult to read or hear about, including colonization, residential schools, Indian hospitals, racism, mental health distress, mental health treatment, detention, violence, policing, and discrimination. These may bring up past negative experiences or memories with the health care system, police, or experiences of violence or oppression.

We encourage you to take care of yourself and your needs as you read our content. If you require any support, you can find a list of available resources on our website: https://www.healthjustice.ca/content-warning.

If you are an Indigenous person in urgent need of support, you can call the KUU-US Crisis Line, available 24/7 toll-free at 1-800-588-8717 to provide support to Indigenous people in BC. For more information, visit https://www.kuu-uscrisisline.com/.

Publishing notes

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Union of BC Indian Chiefs

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Photography: Tricia Thomas (Salish Eye Productions), Bizaan Bimose (Tonya Robitaille)

This publication is the second in a series of publications launched by Health Justice that will set out a path for BC to improve its mental health and substance use law and policy to better support human rights. Sign up for updates on the Health Justice website to receive notification of other publications as we develop them.

This publication does not provide legal advice. It describes the law at its date of publication but may not reflect changes made after its publication.

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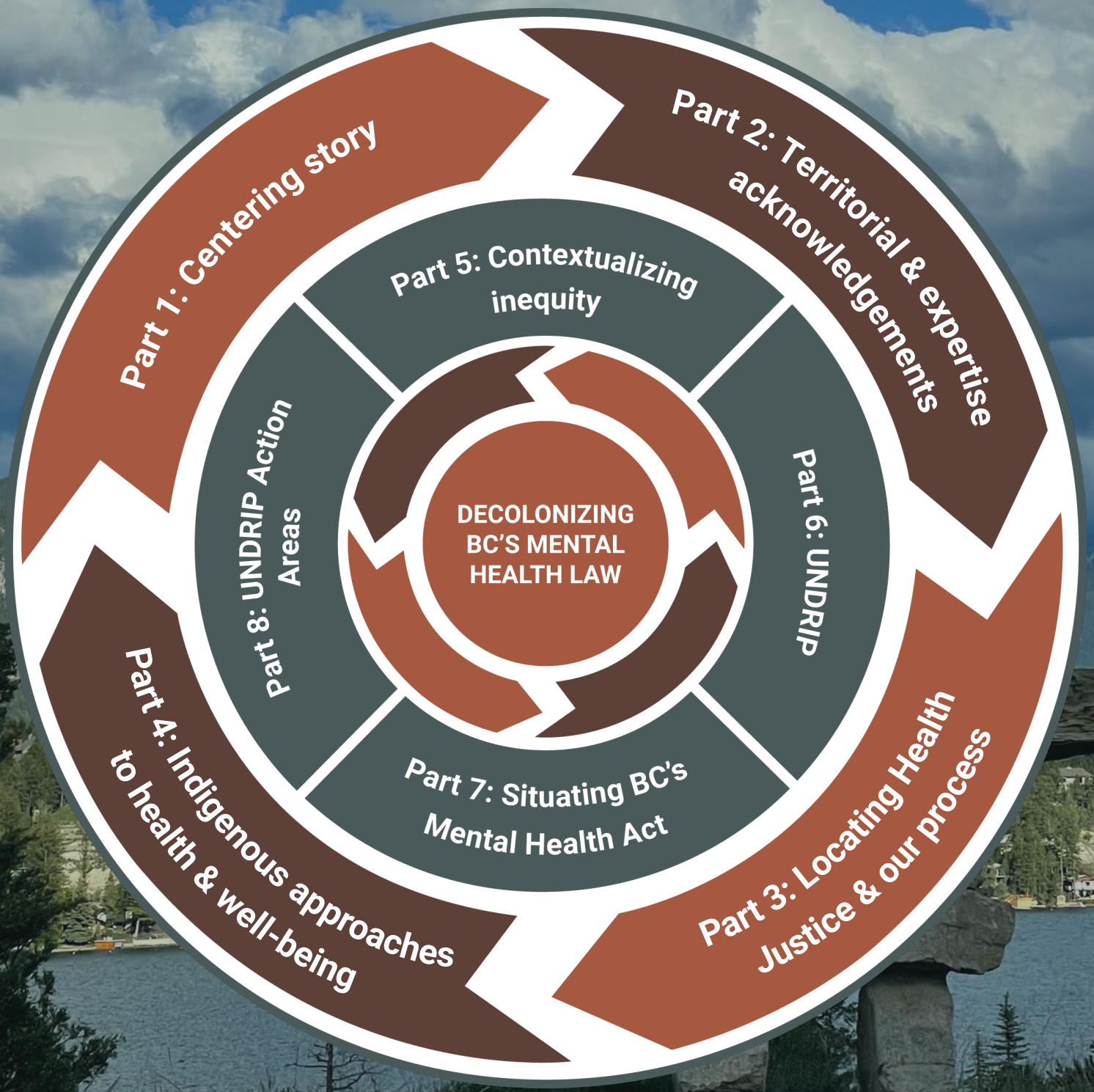

Photo by Bizaan Bimose (Tonya Robitaille)

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DECOLONIZING MENTAL HEALTH LAW

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Indigenous Leadership Group members

In addition to the members below, we would like to acknowledge the contributions of the members of the Indigenous Leadership Group who are no longer involved on an ongoing basis. Their expertise and knowledge have shaped this publication and Health Justice's work.

Chris Tait (He/Him)

Hello! My name is Christopher Tait and I am originally from Wet'suwet'en Territory. I am 31 years old. I began my advocacy work in the child welfare system looking at redoing policy that affected youth who were aging out of foster care in BC. I helped create the Youth Engagement Toolkit and consulted on various projects with MCFD and other non-profits. As a former youth in care myself, I had both good and bad experiences within the system. I began public speaking at 16 and sharing how my story was mostly a success but still had many hurdles. What excited me most about being involved with this project was being able to create more changes towards a lacking mental health system. I believe the best changes come from those with experience and look forward to sharing my insight and learning from others as well.

Goodingaay Guud Jaad / Stephanie Watkins

Goodingaay Guud Jaad is from the Xaayda (Haida) Nation; however, she was born in, and currently works, lives, and plays on the unceded territory of the Tsimshian Nation on Kxeen (Prince Rupert). Her colonized name is Stephanie Watkins. Goodingaay Guud Jaad is a registered clinical counsellor with the British Columbia Association of Clinical Counsellors and she holds a Bachelor's degree in Indigenous Studies and a Masters of Education Counselling, with a specialization in trauma and counselling within rural and remote communities. Currently, Goodingaay Guud Jaad works for Northwest Inter-Nation Family and Community Services Society (NIFCS) as a counsellor that travels to Indigenous communities on the Northwest Coast providing services to people of all ages.

Iain Thomas

Iain is an Indigenous lawyer with a J.D. from the University of Victoria Faculty of Law. He is also a member of Health Justice's Board of Directors. Iain is from Wolfville, Nova Scotia, and is a proud member of Snuneymuxw First Nation in British Columbia. Prior to law school, he completed a Bachelor of Arts in Economics at St. Francis Xavier University in Antigonish, Nova Scotia. Iain is particularly interested in Indigenous laws and governance and was a member of UVIC's Indigenous Law Student Association. Outside of law, Iain enjoys various sports and is an active long-distance runner. Additionally, Iain enjoys backcountry camping and playing the piano.

Jacki McPherson

Jacki is from the Okanagan Nation. She has worked in Aboriginal health for approximately 30 years. Jacki currently manages all health programs for the Penticton Indian Band, and is part of the Okanagan Nation Alliance Wellness Committee. In her previous role as President of the First Nations Health Directors Association of BC, Jacki was involved with the transfer of health services from Health Canada to the First Nations Health Authority. She has also worked closely with Interior Health Authority in all areas of health.

Jillian Jones

Jillian is the Director of Mental Health and Harm Reduction for Métis Nation BC's Ministry of Mental Health and Harm Reduction. She is located on the land of the lək̓ʷəŋən People, known today as the Esquimalt and Songhees Nations in what is colonially referred to as Victoria, BC; recognizing additionally that Victoria is the chosen home of the Métis Nation of Greater Victoria Association. Jillian walks alongside this work as a third-generation settler, with Italian and Russian ancestry. Graduating with a degree in education, she has worked in the mental health field for the past eleven years. As part of her role with MNBC, Jillian advocates for culturally appropriate mental health and addictions programs and services at the national, provincial, and regional levels – working alongside MNBC'S mental health and harm reduction team to provide support, education and advocacy for Métis individuals and communities on mental health and wellness related and harm reduction initiatives in BC.

Kim Haxton (Potowatomi), Facilitator

Kim Haxton (Potowatomi) is from the Wasauksing First Nation in Ontario. She has worked across Turtle Island and abroad in various capacities but always with a focus on local leadership.

Her deep understanding of the need for genuine restoration has far-reaching implications as leaders seek vision and all people seek direction to address the mounting pressure of a system incongruous with the values of the natural world. Kim has developed and facilitated programs in land-based education and leadership for the past 30 years, including as co-founder of Indigeneyez.

She takes her place among thought leaders in the area of decolonization, particularly as it applies to language, art, economics and gender. She encourages the "lateral liberation" of consciousness by drawing from the embodied knowledge of Indigenous peoples. In multi-day workshops, she moves people through a personal process of questioning what is the truth and what is simply constructed – effectively rupturing what we "know." True expression of respect, harmony, inclusion, equity can come from this place.

Dr. Natalie Clark, PhD, MSW, BSW, RSW

Natalie's work is informed and mobilized through her interconnected identities including as a parent and grandparent of Secwepemc children and youth, and part of the Secwepemc community through kinship ties; an academic; activist and sexual abuse counsellor. This work is also grounded in her intersecting kinship relationships to Indigenous communities (Secwepemc, Métis), Settler ancestry (Welsh, Irish, English) and the systems in which our lives are shaped. In addition to her role as a Professor at Thompson Rivers University in the School of Social Work, Natalie continues to practice as a clinical supervisor, educator and counsellor specializing in violence and trauma as well as a grrlz group facilitator for Indigenous girls and non-binary youth. Natalie has 25 years of experience in the area of trauma and violence with a focus on healing and resistance, and the coping responses to trauma/violence including the impact of colonial and gendered policies on Indigenous children, youth, families and communities.

Terri Gillis

Terri is a project manager for the toxic drug response team with First Nations Health Authority (FNHA). She was formerly with Métis Nation BC's Ministry of Mental Health and Harm Reduction, working as the Provincial Harm Reduction Coordinator. Terri lives and works on the stolen lands of the Squamish, Musqueam, and Tsleil-Waututh Nations in what is colonially referred to as Vancouver, BC; recognizing that Vancouver is also the chosen home of the North Fraser Métis Association. Terri has a degree in Justice Studies and additional education in Addictions, Mental Health, and FASD. She recently became a Gladue Report Writer and commits her time to assisting people through self-empowerment.

Dr. Sarah Hunt / Tłaliłila'ogwa

Sarah Hunt / Tłaliłila'ogwa is a queer scholar-activist who has spent more than two decades engaged in collaborative work in pursuit of justice for Indigenous people and communities. As Canada Research Chair in Indigenous Political Ecology at the University of Victoria, Sarah's research asks what justice feels like across the nested scales of our bodies, homes and waters/lands. She has published upwards of 40 journal articles, book chapters and reports, with emphasis on centering Indigenous knowledge, laws and norms, particularly through the perspectives of 2SQ gender diverse people, women, and youth. Sarah seeks to align her anti-violence work with diverse feminist, queer and anti-racist movements, including in her role as a board member of the Urgent Action Fund. Sarah/Tłaliłila'ogwa is Kwakwaka'wakw, from the Kwagu'ł and Dzawada'enuxw Nations, and is also of Ukrainian and English settler ancestry.

Bizaan Bimose (Tonya Robitaille)

Bizaan Bimose (Tonya Robitaille) is an Anishinaabe Métis woman with kinship ties to Ktunaxa and Secwépemc First Nations. She currently lives as a guest on the unceded territories of the Syilx people of the Okanagan.

Tonya draws on her training from a range of modalities in her work with community, including herbal and traditional medicines, and land based healing. She has worked extensively with day school survivors, street outreach with unhoused relatives, and with people healing from addictions and trauma. This work has been foundational to the trauma informed, heart centered workshops and healing sessions she creates and facilitates for individuals and community to honour peoples' healing journeys.

As an educator, she creates experiential and embodied learning opportunities, inviting people to actively participate and to apply their understandings to create transformative change in their personal lives, communities, and workplaces. Deeply committed to empowered Indigenous community capacity building, decolonizing harm reduction and mental health, wellness, and substance use, she shares a wealth of lived experience in her work with organizations like Foundry, First Nations Health Authority, Canadian Mental Health Association, Health Justice, and BC Mental Health and Substance Use Services.

She is a proud mother and titi (grandmother), a gentle friend to all animals, and spends her free time on the land gathering medicines and making new friends.

Stephen Cain

Stephen recently started working with Mission Possible doing clean-up in the Downtown Eastside of Vancouver. He is a former youth in care and has overcome addictions issues related to alcohol. Stephen has a diploma in Child and Youth Care Counselling from Douglas College, an Associate of Arts Degree from the Nicola Valley Institute of Technology (NVIT), and he is just finishing up an Associate of Arts Degree in Criminology. He has also worked with the Burnaby Neighbourhood House and the Squamish Lil'wat Cultural Centre's Indigenous Youth Ambassador Program. Stephen also enjoys working out, hanging out with friends, and prepping food – especially barbecuing in the summer.

Bizaan Bimose (Tonya Robitaille)

Section Summary

Part 1: Centering story

In this section, we begin with a story:

- The following story was shared by a person with lived experience during a Journey Mapping interview, a process during which people with lived and living experience of involuntary treatment shared their experiences, expertise, and analysis in a one-on-one interview.
- A pseudonym has been used to protect the individual's anonymity, and they have reviewed and consented to the story's presentation in this publication.

If Ash could create an effective mental health system, it would be Indigenous led so that communities can use their own medicines, their own definitions of health, and their own ideas of risk.

Photo by Bizaan Bimose (Tonya Robitaille)

Centering story

Ash and her kids continue to work through the complex guilt and trauma of what they experienced, with ongoing collateral effects.

Ash suffered abuse from her Indigenous but white-passing mother from a very young age as a result of the impacts of colonialism and intergenerational trauma. Ash's mom started taking her to clinicians as a young child and saying she had an altered understanding of reality, likely to prevent reports of abuse from being believed. When Ash disclosed the abuse to family members, Ash's mom had her detained under the Mental Health Act saying that Ash was imagining things and disconnected from reality. Ash was 14 at the time and was held in an adult psychiatric ward for 9 months. The experience was deeply traumatic, with forced medication, forced clothing removal, and periods of time spent naked in seclusion rooms. Ash's acts of resistance, like refusing to speak, were punished until she complied. Her father, who "looks Indigenous," was not allowed to see her and was unable to resist what was happening.

The experience of being detained at age 14 changed Ash's life and resulted in exploitative relationships, substance use, and eventually homelessness. It also created an avenue for Ash's abusers to weaponize the Mental Health Act repeatedly. Based on reports from her abusive parent and an abusive ex-partner, Ash has been detained multiple times under the Act. These detentions have resulted in violent, public apprehensions by police and the devastating forced removal of her children, who were then abused in the foster system. On one occasion, Ash was forced to stand handcuffed with a police officer in the waiting room of the hospital in her small community, feeling humiliated and traumatized, while people who knew her walked past. After her children had been forcibly removed, no one told Ash where they were or what was happening to them, and she was not allowed to speak with them. As a result, Ash has been separated from her children for years at a time. With a documented history of involuntary detention and treatment, a number of misdiagnoses, and experiences of homelessness, drug use, and sex work, Ash's knowledge and views about her own health were repeatedly disbelieved or dismissed. Instead, the system believed the reports of her abusers.

Ash's mom was also detained in the colonial mental health system. Ash was not told why at the time, but she remembers

Photo by Bizaan Bimose (Tonya Robitaille)

Centering story

her mom being gone for a year when she was a child. Her grandparents looked after her and her siblings. Ash later learned that her mom had been detained after a suicide attempt, and her mom was detained again when Ash was an adult. Ash is aware that her mom lived in deep poverty her entire life, a symptom of entrenched colonization. In retrospect, Ash now wonders if her mom was motivated to have Ash detained so she could get custody of Ash's children and the accompanying financial support. Ash's children quite literally helped pay her mom's rent.

None of Ash's detentions occurred when she was at risk to herself or others and she does not believe she got treatment during any of them. Ash experienced involuntary treatment as violence and being medicated, with the same colonial impacts as the prison system, but under the label of "health." Ash learned to comply and say what they wanted her to say to get out and have her kids returned, but she did not get effective health treatment. Submission and compliance to try to get her children back, and avoiding giving the child welfare system any more reasons to keep them from her, became her primary focus.

At other times in her life, Ash's mental health has been a concern and her safety has been at risk, but she has not been supported by the health system. Because of involuntary detentions and the forced separation from her children, Ash attempted suicide twice. In both situations, she was treated in an emergency department and then quickly discharged from the hospital within a few hours to a day with no follow-up care. At one point Ash was experiencing severe suicidal ideation and she went to an emergency department multiple times asking for help, but she was turned away.

After her experiences with involuntary treatment and having her children taken, now Ash will never ask for mental health help because the risk is too great. She has been at risk of suicide more recently and she did not seek mental health supports because of fear of being detained or being separated from her child, who she fought to get back into her custody. This fear has been passed to her children, who also will not seek mental health support, or who carefully control and limit what they tell mental health service providers. They fear repeating Ash's experiences of being detained or separated from their own children.

During her most recent detention, Ash sought help from an Indigenous-led wellness and family support organization. They were allowed to visit her once and

Photo by Tricia Thomas, Salish Eye Productions

Centering story

Ash was not allowed to smudge, but they brought her medicines she could touch, which Ash found very helpful. Ash also knew they were on her side. She was relieved to have them, as independent eyes, see her and witness what was happening to her. Ash experienced this as a measure of accountability that would help protect her. She continued to speak with the service providers by phone and they helped her create a plan to access transition housing, which she did after leaving detention on a day pass and not returning.

Ash was eventually diagnosed with complex PTSD and neurodivergence, neither of which were identified or treated by the involuntary mental health system. She completed treatment for substance use and is pursuing post-secondary education. She regained custody of her youngest child. Ash and her kids continue to work through the complex guilt and trauma of what they experienced, with ongoing collateral effects. Ash is now a knowledge keeper in her community.

If Ash could create an effective mental health system, it would be Indigenous led so that communities can use their own medicines, their own definitions of health, and their own ideas of risk. People would be supported to ask for help before they are in crisis and without experiencing significant risk. If a person is unable to make decisions because of illness, this community-led system would offer a circle of support to come around them, instead of using punishment, violence, and force.

Photo by Bizaan Bimose (Tonya Robitaille)

Part 2: Territorial and expertise acknowledgements

Health Justice acknowledges that:

- Our registered office is located on the traditional, ancestral, and unceded territory of the xʷməθkʷəy̓əm, Sḵwx̱wú7mesh, and səlílwətaɬ Nations.
- Colonization has disrupted distinct First Nations, Inuit, and Métis legal and health systems. Colonial dynamics continue today, including in the health and legal systems.
- All of the thoughts, ideas, and analysis in this publication have been built upon expertise and analysis shared with us by experts with direct lived and living experience and Indigenous leaders.

This work is building on a long history of advocacy and organizing related to decolonization, reconciliation, and the health system.

Photo by Bizaan Bimose (Tonya Robitaille)

Part 2: Territorial and expertise acknowledgements

Acknowledgement of territories

Health Justice is a virtual organization with a central office address located on the traditional, ancestral, and unceded territory of the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), and səl̓ílwətaɬ (Tsleil-Waututh) Nations. Staff, board members, Lived Experience Experts Group members, and Indigenous Leadership Group members live and have ties to the lands of many different First Nations. Contributors to this publication live, work, or have ties to the traditional, ancestral, and unceded territories of the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), səlilwətaɬ (Tsleil-Waututh), Lək̓ʷəŋən (Lekwungen) Peoples (including the Songhees and Esquimalt), kʷikʷəƛəm (Kwikwetlem), QayQayt, Sinixt, Syilx, Ktunaxa, Secwépemc, Okanagan, Snuneymuxw, Kwagu'ɬ, Dzawada'enuxw, and Wasauksing Nations, as well as Gaw Tlagée (Old Massett) Haida Gwaii.

Acknowledgement of foundational expertise

All of the thoughts and ideas in this publication have been built upon expertise and analysis that has been shared with us by experts with direct lived and living experience and Indigenous leaders. It has helped us understand how the system is or isn't working, recognize how people are impacted, and identify avenues for positive change. This work would not exist without that expertise.

Circular chapter photo by Bizaan Bimose (Tonya Robitaille)

The work is also building on a long history of advocacy and organizing related to decolonization, reconciliation, and the health system. We want to acknowledge that Health Justice did not start this work and we have had the privilege of learning from and building upon hard work already done by others who are often unacknowledged.

It is impossible to adequately make the depth of this leadership visible with citations and individual acknowledgements, although we have tried. Communities and individuals sharing their wisdom and insight have deeply shaped the ideas throughout this publication, and throughout all of Health Justice's work.

Section Summary

Part 3: Locating Health Justice and our process

In this section, we describe some information about Health Justice and our process:

- Health Justice staff have been meeting with the Indigenous Leadership Group since November 2020.
- This publication puts into action the Indigenous Leadership Group's advice. We hope to provide the context necessary to begin to understand the impacts of the Mental Health Act and its role in the mainstream health system on First Nations, Métis, and Inuit people in BC.
- As a non-Indigenous organization, we strive to avoid repeating the pattern of non-Indigenous organizations co-opting reconciliation work in ways that reinforce patterns of colonialism and paternalism.

"If people don't know, if they don't receive the education, they won't change."

— Jacki McPherson

Photo by Bizaan Bimose (Tonya Robitaille)

Bizaan Bimose (Tonya Robitaille)

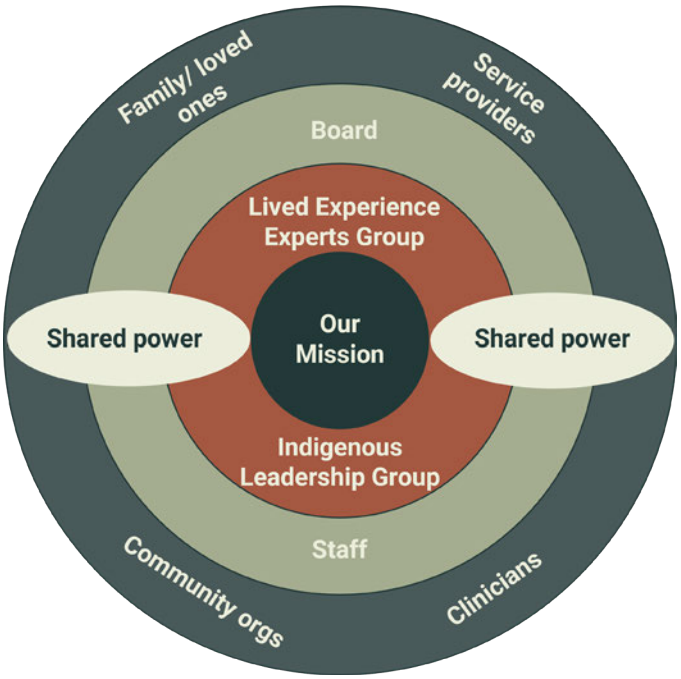
Part 3: Locating Health Justice and our process

About Health Justice

Health Justice's current work focuses on research, education, and advocacy in support of reforming the laws that govern coercive mental health and substance use treatment to better support human rights and dignity. As a non-Indigenous organization, we strive to be responsible allies and work in support of First Nations, Métis, and Inuit people and communities.

Health Justice uses a participatory engagement governance model that centres those most impacted by our work. In addition to our Board of Directors, our work is governed by the Lived Experience Experts Group, made up of individuals with lived experience of involuntary mental health or substance use treatment, and the Indigenous Leadership Group, made up of individuals with expertise in the impacts of our work on First Nations, Métis, and Inuit people. Health Justice brings together human rights, lived experience, cultural, clinical, family, and community-based expertise to inform our work.

Circular chapter photo by Bizaan Bimose (Tonya Robitaille)



Health Justice centres the Indigenous Leadership Group as part of its governance structure to ensure that those most impacted by our work have the power to shape it. This model does not attempt to fulfill obligations regarding consultation with or consent from First Nations or Indigenous leadership organizations, including those exercising self-determination in relation to health and social services. Colonization, including land theft and the application of colonial laws, have disrupted sovereign Indigenous legal and health care systems and practices in numerous ways. These colonial dynamics continue today in many public systems, including the health and legal systems. Involuntary mental health and substance use treatment, enforced by the colonial health and legal systems, can be experienced as yet another source of control over Indigenous people that pathologizes and criminalizes the impacts of colonialism. Recognizing this systemic context is foundational to understanding the impacts of genocide, colonization, and racism in colonial health and legal systems on First Nations, Métis, and Inuit people, as well as their resistance and resilience to those systems.

Health Justice's work focuses on provincial laws that apply throughout the area that is colonially named British Columbia. These colonial laws impact Indigenous people living on the traditional, ancestral, and unceded First Nation territories including land that is governed by treaties. Currently in BC, there are over 200 distinct First Nations who hold inherent title to their ancestral lands. Further, there are 39 chartered Métis communities, and many First Nations, Métis, and Inuit people living away from home in communities across British Columbia. These communities and individuals hold their own unique legal orders, justice systems, well-established health practices, and concepts of health. Within each of those groups, there exists immense diversity in terms of culture, language, histories, interests, and priorities. By adopting

a distinctions-based approach, we hope to avoid a pan-Indigenous approach that assumes that laws, policies, histories, and decisions impact all Indigenous people and communities in the same way.

Our process

One of Health Justice's primary focus points is improving BC's mental health law, the Mental Health Act. On this path, Health Justice staff have been meeting with the Indigenous Leadership Group since November 2020, with facilitation guidance and support from Kim Haxton (Potowatomi). We have been able to listen to and learn from the Group, and this document is intended to support Health Justice to act on the Group's leadership and direction.

Since May 2020, Health Justice staff have also been meeting with the Lived Experience Experts Group, and in 2022, we carried out a series of Journey Mapping one-on-one interviews with people with lived and living experience of detention and involuntary treatment under BC's Mental Health Act. The opening story in this publication is a summary of one of those interviews.

One of the requests to Health Justice made by the Indigenous Leadership Group is that we use our organizational resources to share the burden of educating non-Indigenous people, organizations, and institutions about the causes of health inequity by naming colonization and systemic racism and reiterating that the violence, intergenerational trauma, and resulting health impacts of colonialism have impacted and continue to impact the well-being of First Nations, Métis, and Inuit people in BC. Colonization and systemic racism also impact the safety, effectiveness, and accessibility of the mainstream mental health system on an ongoing basis.

One member of the Indigenous Leadership Group noted the importance of educating people in colonial systems and institutions:

> **"If people don't know, if they don't receive the education, they won't change."**
>
> **— Jacki McPherson**

This request from the Indigenous Leadership Group that Health Justice share this burden reflects the need to ensure that the health of Indigenous people in BC is understood in its full historical and present systemic context and through the voices of Indigenous people.[2] Failing to include broad systemic context when talking about health equity or health disparities, as often occurs, results in locating risk in First Nations, Métis, and Inuit people by erasing the impacts of genocide, colonization, and racism as well as their resistance and resilience to those systems.[3]

Dr. Billie Allan and Dr. Janet Smylie have described how this failure to include systemic context reinforces entrenched racism:

> While stories about Indigenous health are frequently marked by an absence of context, they can also be characterized by the presence of racist stereotypes and inaccuracies pervasive in mainstream Canadian narratives. These include the idea that genetic predeterminations — as opposed to factors like access to the social determinants of health — are responsible for the health inequities experienced by Indigenous peoples and other racialized groups.[4]

The *In Plain Sight* report documented deeply entrenched systemic anti-Indigenous racism in BC's health care system. While there has been controversy related to its author's claims of community membership, it is not appropriate for Health Justice to hold opinions on Indigenous identity. We have included the report here because its contents are based on contributions from thousands of Indigenous people whose experiences are real. The report's analysis notes that racist stereotypes reflected in these experiences are an active continuation of the same racist stereotypes that have underpinned Canada's colonial history since contact:

> Imposition of colonial systems such as the Indian Act were intent on eradicating Indigenous peoples to make way for the priorities of settlers and settler governments, including expropriation and domination of lands and resources. Fulfilling this desire requires the oppression of Indigenous peoples and was premised on powerful assumptions about the inferiority of Indigenous peoples and the natural superiority of settlers and colonial governments. These assumptions centred around the genetic, cultural and intellectual inferiority of Indigenous peoples, thus enabling the state to enact policies to segregate, assimilate and govern all aspects of the lives of Indigenous peoples. Indigenous peoples were deemed to be weak and dying off, incapable and primitive, poor users of land without a proper land tenure system or social organization, thus requiring "civilization."[5]

The report goes on to document how these racist stereotypes about Indigenous people continue to be woven throughout our health system. They remain deeply entrenched in the very foundations of our current colonial systems, and the ongoing systemic inequities experienced by Indigenous people are the result of this past and ongoing discrimination. As a result, any discussion of First Nations, Métis, and Inuit health, and particularly those written by a non-Indigenous organization, comes with a responsibility to actively combat these deeply entrenched inaccurate and racist stereotypes by centering Indigenous voices and by focusing on the systemic roots of health inequities.

This publication puts into action the Indigenous Leadership Group's advice. We hope to provide the context necessary to begin to understand the impacts of the Mental Health Act and its role in the mainstream health system on First Nations, Métis, and Inuit people in BC. In undertaking this work as a non-Indigenous organization, we are aware of the harmful pattern of predatory, non-Indigenous non-profit organizations co-opting reconciliation work in ways that reinforce patterns of colonialism and paternalism.[6] We have done our best to avoid repeating this pattern by working in partnership with the Indigenous Leadership Group and by learning from Indigenous writers and experts, prioritizing their direct words and analysis whenever possible.

We developed this publication in an iterative process with the Indigenous Leadership Group, reflecting the themes we heard from the expertise they shared with us. We drafted the publication in sections, seeking input and feedback from the Group on each section along the way. Quotes from the Group are included throughout to share their own words in conveying their thoughts and expertise.

We are grateful for the expertise and leadership shared with us to shape this work.

Section Summary

Part 4: Indigenous approaches to health and well-being

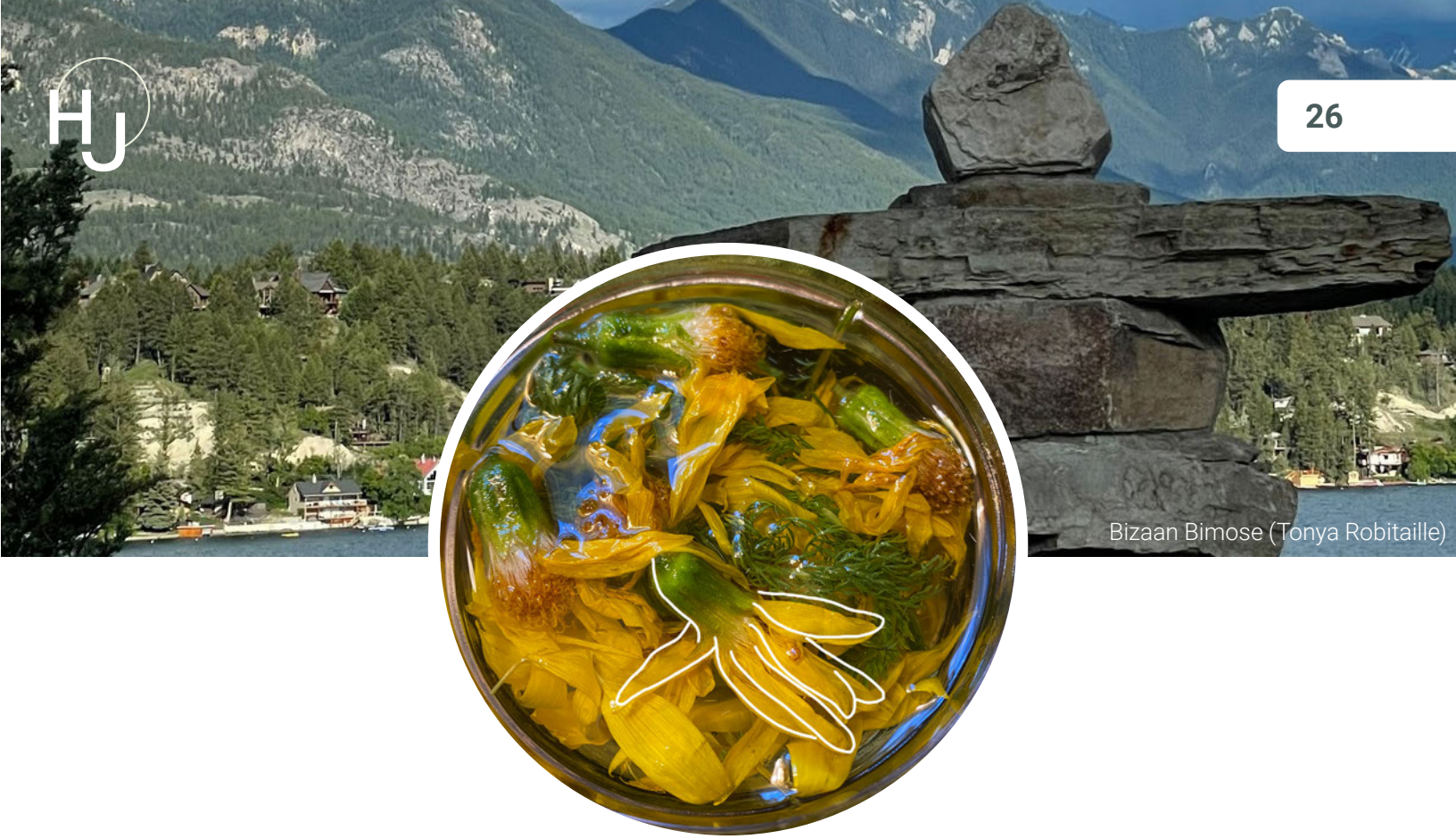
In this section:

- There is immense diversity in approaches to wellness among different Indigenous communities, but a common core concept is that wellness comes from holistic internal and external balance that goes beyond the absence of illness.
- Current mainstream conceptions of "mental health" and mental health treatment have roots in colonialism, and those roots shape the way mental health services are conceptualized today.
- To support the health equity of Indigenous people in BC, we need to build upon existing ideas of the social determinants of health with Indigenous-led understandings of the determinants of Indigenous health and well-being.

"We rely on a colonial model, entrenched in western diagnosis."

— Indigenous Leadership Group member

Photo by Bizaan Bimose (Tonya Robitaille)



Part 4: Indigenous approaches to health and well-being

> **"What does an Indigenous model look like? Heterarchy. Person to person."**
>
> **— Kim Haxton (Potowatomi)**

There is immense diversity in approaches to wellness among different Indigenous communities, but a core concept of health and wellness common to First Nations, Métis, and Inuit people is that people, earth, and everything around us are deeply interconnected and that wellness comes from holistic internal and external balance that goes beyond the absence of illness.[7]

For tens of thousands of years, First Nations people in what is now called BC have had well-established approaches to supporting individual and community wellness.[8] While there is immense diversity among First Nations in BC, a core understanding of wellness often reflects a holistic approach that strives for balance between the mental, emotional, spiritual, and physical.[9]

Circular chapter photo by Bizaan Bimose (Tonya Robitaille)

In addition, First Nations people understand that wellness reflects relationships and interconnection with the land, family, community, and nations.[10] One member of the Indigenous Leadership Group spoke about the need to bring a more holistic approach to health services for Indigenous people:

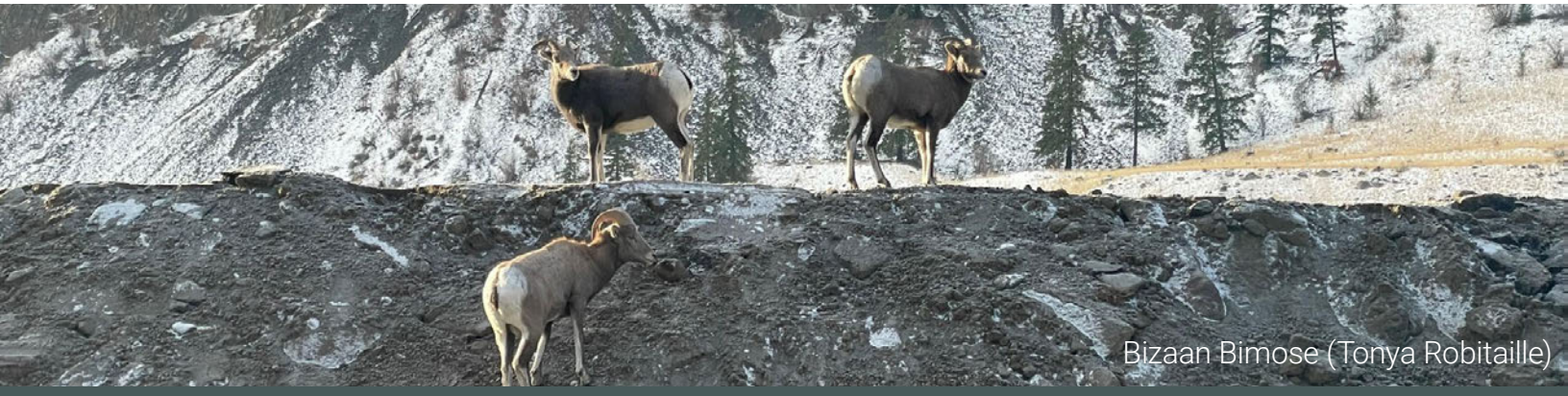
> **"A wrap-around approach, where they are helped to get out of the system. It will be costly to organize it, but in the end, it will save money, it will save people, it will save families, it would save so much time, and hurt."**
>
> **— Jacki McPherson**

Métis people hold distinct approaches to wellness, but they also reflect a holistic understanding:

> In describing what mental wellness and health meant to them, many people spoke about the concept of holism, where mental health cannot be understood in isolation. In this way, wellness was understood as a whole, where mental, emotional, spiritual and physical health were interconnected.[11]

Inuit worldview is guided by Inuit *Qaujimajatuqangit*, described by Joe Karetak and Frank Tester as "a set of values and practices… ways of being and looking at things," that hold timeless relevance and importance.[12] They are an "ethical framework and a detailed plan for a good life" and rooted in four cultural *maligarjuat* ("big things that must be followed"),[13] which make holistic respect for all things and living in balance core priorities.[14] Shirley Tagalik explains the role of Inuit *Qaujimajatuqangit* in Inuit understandings of health:

> *Inuit Qaujimajatuqangit* is the foundation upon which social/emotional, spiritual, cognitive and physical wellbeing is built. It also sets the strength-based context for the wellbeing of all future generations. Cultural health is the basis for every other kind of health because in it resides the sense of identity, the collective social supports for the individual, and the sense of belonging grounded in loving, healthy and supportive relationships. These are the requirements that nurture healthy individuals.[15]



Bizaan Bimose (Tonya Robitaille)

While the practice of longstanding, holistic understandings of wellness have been attacked and suppressed by genocide, colonization, and racism, First Nations, Métis, and Inuit people have continually resisted that systemic suppression to maintain these foundational wellness practices. These practices continue to be strong and sustaining today despite ongoing colonial interference. One member of the Indigenous Leadership Group spoke about the need to bring these practices into health services to create change:

> **"What are our stories? We have stories with practices in use for a long time. Bring them in to change the narrative."**
>
> **— Indigenous Leadership Group member**

Current mainstream conceptions of "mental health" and mental health treatment have roots in colonialism, and those roots shape the way mental health services are conceptualized today.[16] These conceptions include the medicalization of difference, which can lead to differing conceptions of "normal" between different cultures. For example, what might be framed as abnormal in a Eurocentric culture may not be viewed in the same way by a particular First Nations community.[17] Sarah Nelson points out a specific example of this: historically, colonial conceptions of gender and sexuality have focused on binary, heterosexual categorizations that reinforce strict norms, with identities outside of those norms pathologized as a medical problem.[18] In contrast, many Indigenous communities in Canada have recognized and respected diverse and nuanced understandings of Two-Spirit identities for centuries.[19]

On the topic of mainstream conceptions of mental health, one member of the Indigenous Leadership Group had this to say:

> **"We rely on a colonial model, entrenched in western diagnosis."**
>
> **— Indigenous Leadership Group member**

In recent decades, there has been growing acceptance of the idea that our health and wellness is shaped by more than just our individual behaviours and biology. Instead, the health of all people and communities is shaped by the social context in which they live; to reduce health inequities and support more preventative and holistic approaches to health, we must address the social determinants of health.

Importantly, the understanding that our health and well-being is shaped by the holistic context of our lives has always been included in Indigenous ideas of health.[20] The concept is only beginning to be seen in the colonial, medicalized health system. Despite this fact, research on social determinants of health is often written by non-Indigenous people, and the social determinants of the health of Indigenous people is often a subset of that work.[21] In the second edition of *Determinants of Indigenous Peoples' Health in Canada: Beyond the Social*, the editors note that:

> … within social and political domains, colonialism has yet to be fully and consistently accounted for as a significant determinant of health. This is despite the fact that Indigenous peoples—who globally experience the greatest disparities in health—identify colonialism as perhaps the most important determinant of their (ill) health (Loppie Reading & Wien, 2009; Richmond & Ross, 2009; Bourassa, McKay-McNabb, & Hampton, 2004; de Leeuw, Greenwood, & Cameron, 2010).[22]

To understand in full context what systemic changes will support the equitable health and well-being of Indigenous people in BC, we need to build upon existing ideas of the social determinants of health. This must include an Indigenous-led understanding of the determinants of Indigenous health and well-being.[23] A member of the Indigenous Leadership Group spoke about the need to think more broadly about what is needed to support mental wellness:

> **"We need to support determinants of health – increases in robust supports, a prevention focus. We can't wait until we're in crisis. We don't need cops, maybe we need an Elder and some tea, a smudge. It can sometimes be that simple (and sometimes not)."**
>
> **— Bizaan Bimose (Tonya Robitaille)**

These determinants connect to self-determination, land and resources, culture, language, spirituality, and more, and come together to form a holistic understanding of health and well-being that reflects the worldview and practices of Indigenous people. Eurocentric, medicalized approaches to health and health care do not, on their own, adequately support the health and wellness of Indigenous people and communities because they do not reflect a holistic and relational understanding of well-being. They also often reflect colonially rooted ideas about health and health care.

Section Summary

Part 5: Contextualizing inequity: Impacts of genocide, colonialism, and racism

In this section:

- Colonial tools, including the Indian Act, residential and day schools, and Indian hospitals, were all fundamentally designed to erode and remove self-determination. They were about breaking down systems of government and community, breaking kinship, and removing identity and community membership from community control.
- Many specific colonial tools have had and continue to have direct impacts on Indigenous wellness systems by undermining traditional ways of staying well and access to health knowledge and practices.

"Avoid pathologizing being Indigenous and understand how colonial trauma shows up in mental health."

— Dr. Sarah Hunt / Tłaliłila'ogwa

Photo by Tricia Thomas, Salish Eye Productions

Bizaan Bimose (Tonya Robitaille)

Part 5: Contextualizing inequity: Impacts of genocide, colonialism, and racism

It is well documented that First Nations, Métis, and Inuit people in Canada experience significant health disparities compared with the non-Indigenous population, including related to mental health. There is no shortage of statistics and sources that illustrate these inequities, and we will not repeat them here.

Instead, we will focus on the source of these inequities. To put it simply, the effects of genocide, colonialism, and racism have undermined – and continue to actively undermine -- the fundamental human rights of Indigenous people to maintain access to traditional approaches to wellness and to enjoy an equal opportunity to be healthy.[24] A member of the Indigenous Leadership Group noted:

> **"Understand that colonial systems are sources of vulnerability, vulnerability is not inherent in being Indigenous. Avoid pathologizing being Indigenous and understand how colonial trauma shows up in mental health."**
>
> **— Dr. Sarah Hunt / Tłaliłila'ogwa**

Colonial tools, including the Indian Act, residential and day schools, and Indian hospitals, were all fundamentally designed to erode and remove self-determination. They were about breaking down systems of government and community, breaking kinship, and removing identity and

Circular chapter photo by Tricia Thomas

community membership from community control.[25] BC's history of genocide, colonization, and racism against Indigenous people is rooted in this intentional eradicating, limiting, or suppressing of Indigenous rights, relationship with the land, cultural and familial practices, and systems of health and wellness. Many specific colonial tools have had and continue to have direct impacts on Indigenous wellness systems by undermining traditional ways of staying well and access to health knowledge and practices. The following are some examples.

Land theft and forced displacement

The systematic, forced displacement of First Nations and Métis people from their traditional territories, and attempts to extinguish land rights, were foundational to building Canada as a nation because it was required to gain access to land and resources that enabled white settlement to flourish. Relocation of Inuit communities in the 1950s and '60s was an attempt to reduce colonially enforced dependency and Canadian sovereignty to areas where white settlers did not want to live.[26] This dispossession undermined the culture, ways of life, self-determination, and social structures of Indigenous people, including their ability to maintain a balanced relationship with the environment, which supports wellness.

By literally and figuratively separating Indigenous people from their territories, colonial policies also interrupted traditional wellness practices that had been functioning for thousands of years.[27] Communities could no longer access land-based medicines that had been effective for centuries; land-based knowledge sharing of wellness practices was no longer possible. These and many other aspects of wellness, including language, culture, oral traditions, and governance systems, were disrupted, undermining wellness in foundational ways.[28] Forced displacement from traditional territories and ongoing colonial policies also led to people no longer knowing or being in relationship with their territories even if they could physically access them. In addition to wellness practices, one member of the Indigenous Leadership Group described how displacement from territory also interrupted the organization of communities, including the sacred responsibilities of Indigenous people because it undermined the sense of purpose that comes from every person having a responsibility to the land.[29]

In addition, many Indigenous communities were and are relegated to reserves. Often that reserve land is of poor quality and is too small to sustain existing community resource management. During the Cold War, Inuit communities were moved to the far north to face extreme hardship and starvation; they also faced horrific living conditions if they moved to more hospitable coastal settlement areas to follow children in residential schools or for food and resources.[30] They were also relocated for health reasons because it was too costly to provide health services in the remote north.[31] The free mobility of First Nations and Métis people was controlled through tools like the pass system. This resulted in communities being forced into poverty and inequality because they were prohibited from maintaining their economic and governance structures, while also being prohibited from participating in the colonial capitalistic model.

This process is not relegated to history in Canada. As the Yellowhead Institute has noted,

> … First Nations are caught between a rock and a hard place. Assimilation has long been the goalpost of Canadian policy, but it moves constantly depending on the danger to state sovereignty. When First Nations demand access to the Canadian economy — e.g. seeking to remove barriers erected in the *Indian Act* — they are granted piecemeal progress, so long as the balance of power remains intact. But when they refuse to grant access to corporations and governments to their territories — in order to protect their own economies — First Nations are no longer wanted in the franchise. They are perceived as threats that must be contained and constrained.[32]

In BC, the prioritization of resource extraction, commodification of land, and failure to meaningfully recognize First Nations rights to land-based self-determination continue today. BC continues to use colonial policing and legal/regulatory processes to interrupt First Nations stewardship of their traditional territories. This can be seen in recent examples like the Unist'ot'en camp in defence of Wet'suwet'en lands, the Ktunaxa Nation's defence of Qat'muk,[33] or the recent opposition to the approval of the Trans Mountain Pipeline expansion brought by the Coldwater Indian Band, Squamish Nation, Tsleil-Waututh Nation, and the Ts'elxwéyeqw villages of Aitchelitz, Skowkale, Shxwhá:y Village, Soowahlie, Squiala First Nation, Tzeachten, and Yakweakwioose.[34]

Further, colonial displacement onto substandard reserve lands or economically marginalized areas means that many Indigenous people and communities in BC have been forced to live in locations that are disproportionately unsafe in the face of climate crisis-related events.[35]

Assault on children and families

The residential and day school systems across Canada subjected First Nations, Métis, and Inuit children to genocidal abuse, malnourishment, unsafe conditions, insufficient health care, rampant disease, and human rights violations that resulted in intergenerational health impacts that continue today. They were an intentional and strategic means of separating children from their families and communities for the purposes of assimilation.

Attendance at residential or day school was enforced by police and economic coercion. For example, after being made economically dependent on the government through forced relocation and loss of traditional resources, land-based Inuit families were granted a Family Allowance, but only if they sent their children to colonial schools.[36] Children who attended the schools were forced to cease the culture and ways of life of their family and community and instead assimilate to colonial religion, food, culture, language, and dress.[37]

Residential schools also enforced colonial binary, racialized, and patriarchal gender categories that erased diverse community understandings of gender and power.[38] This erased the visibility of Two-Spirit people and relegated Indigenous women and girls to simplistic gender categories based in Eurocentric worldviews that fail to encapsulate the diversity and nuance of Indigenous conceptions of gender.[39] The Indian Act's patrilineal mandate for Indian status resulted in Indigenous women and their children being disenfranchised from their community governance structures, services, and land.[40]

In addition, many Indigenous people reject the label of "schools" with respect to residential and day schools because of their complete failures related to education. Children who were forced to attend received substandard education and often left inadequately prepared for working in the colonial economy, pursuing further education, or sharing traditional knowledge. This led to poverty and insecurity that undermined health and well-being.[41] The entrenched nature of these patterns was described by a member of the Indigenous Leadership Group:

> **"There's a national narrative baked in the systems, it hasn't stopped."**
>
> **— Terri Gillis**

All of these cumulative acts of erasure, separation, and suppression of culture and knowledge undermined protective factors foundational to First Nations, Métis, and Inuit approaches to wellness. They also interrupted ways of teaching health knowledge: kinship structures, families, communities, cultural practice, and language.[42]

These impacts did not end with the closure of residential and day schools. They continued through the "Sixties Scoop," a core expansion of the child welfare system and social work profession based on racist assumptions that white professionals were needed to assimilate Indigenous people from their inferior ways of living.[43] This resulted in the mass apprehension of First Nations, Métis, and Inuit children from their families and communities to be adopted, often to white, middle-class families throughout Canada and the US.[44] The impacts were much the same as residential schools: children were dislocated from their culture and identity, sometimes abused, and experienced ongoing economic, education, and health inequities.[45]

These dynamics continue today through the grossly disproportionate policing of Indigenous families and the apprehension of Indigenous children through BC's child welfare system. As of 2021/22, Indigenous children are almost 18 times more likely to be in care than non-Indigenous children in BC.[46] They are more likely than non-Indigenous children to be apprehended for neglect,[47] which is a result of the long-term economic and social inequity experienced due to colonization.[48] These obviously inequitable rates of child apprehension have serious and harmful impacts on the mental wellness of Indigenous children who are apprehended, but services

continue to be inadequate.[49] In addition, Indigenous mothers who fear the removal of their children and those whose children are removed experience devastating and disproportionate health impacts, including increased rates of drug poisoning/overdose and avoidance of harm-reduction services.[50]

Further, Indigenous women experience vastly disproportionate health inequities as a result of factors including their frequent experiences of family, sexual, and physical violence; lack of safe, secure housing on and off reserve; and poverty.[51] The health inequities experienced by Two-Spirit, transgender, and gender-diverse Indigenous people continue to be omitted from health research, only reinforcing the erasure of their identities and experiences and further undermining their well-being.[52]

Segregated, low-quality, racist health services

The creation of separate, low-quality health services for Indigenous people reflected racist beliefs about them by subjugating their health and wellness to inferior, underfunded health systems that framed them as a health risk to settlers. Further, the systems undermined autonomy as well as mental, emotional, spiritual, and physical wellness.[53]

Informal segregation occurred through separated buildings or wards in community hospitals. When health services were provided through the same facility as settler services, access and quality were often inequitable because the federal government underfunded the facilities for services provided to Indigenous patients.[54]

Segregation was further entrenched via separate Indian hospitals, a tool of colonial assimilation with the goal of undermining traditional health practices originally created to address racist fears that Indigenous people would endanger the health of settlers.[55] While experiences varied, many Indigenous people in Indian hospitals were subjected to detention in overcrowded conditions, isolation, confinement, invasive treatment, abuse, and experimentation.[56] Many people reported the experience as similar to or a continuation of their experiences at residential schools.[57] They also often forced people to leave their communities, culture, and territory for long periods of time to access substandard health services for health issues that were generated by colonial systems in the first place.[58] For example, in the north Inuit were moved from their communities to more southern hospitals to reduce the costs of providing health services in the north.[59] Inuit women were often separated from their children for extended periods of time, with devastating effects.[60] When being returned to their communities, children were often offloaded at the wrong location or community.[61]

These systems also entrenched biomedical approaches as the predominant colonial model of publicly funded health in BC, relegating First Nation, Métis, and Inuit approaches to wellness to inferior status, a dynamic that continues today.[62] *In Plain Sight* documented widespread

systemic anti-Indigenous racism in BC's health care system, including racist stereotypes that reflect and reinforce the same colonial dynamics.[63] Further, the segregation of services due to provincial/federal jurisdictional disputes continues to result in inequities. Under the Constitution Act, 1867, the federal government purported to have jurisdiction over Indigenous people and reserve lands while provincial governments were granted jurisdiction over health and social services.[64] This division has led to jurisdictional disputes about responsibility to provide crucial services to Indigenous people. For Indigenous children specifically, infighting between different levels of government has created discriminatory barriers to health services as a result of these segregated funding models.[65]

Violations of autonomy

Colonialism was and is a project rooted in control and coercion. The Canadian state sought to control the family, cultural, community, governance, health, resource, and education structures of First Nations, Métis, and Inuit people in Canada. The agency and bodily autonomy of Indigenous people were repeatedly violated through unethical and non-consensual experimentation and medical procedures, often to control or contain them or to test health treatments for settlers.[66] From nutritional experiments in residential schools to interference with reproductive rights, total disregard for personal agency reflected the same racist beliefs about Indigenous people at the root of colonial genocide.[67] Coercion and assimilation were also hallmarks of the colonial agenda with respect to health services. Multiple forms of coercion were used widely, including practices like withholding treaty payments until entire families consented to health examinations and procedures,[68] and were a foundational aspect of Indian hospitals and colonial health services. In 1914, the Indian Act was amended to allow for regulations that authorized the forcible removal of tuberculous patients from their homes.[69] In 1951, broader legal authority for coercion was formalized in federal law via amendments to the Indian Act, which expressly authorized regulations that enabled compulsory detention and health treatment of Indigenous people.[70] The accompanying regulations that created specific authority for detention purported to "protect and promote the health of all Indians."[71]

Indian hospitals typically had locked wards, and patients who left without permission were fined and/or arrested.[72] These hospitals were also a documented pathway to other forms of institutionalization; for example, Indigenous people were admitted to the Coqualeetza Indian Hospital for assessment, and then transferred to mental institutions like Essondale/Riverview or Woodlands.[73]

Gross human rights violations and infringements on bodily autonomy also included the forced or coerced sterilizations of Indigenous women and other Indigenous people with uteruses under provincial eugenics legislation. While there are few records of the race or Indigeneity of the people subjected to BC's Sexual Sterilization Act, court records show that Indigenous women and girls were among those sterilized in relation to detentions at Essondale/Riverview.[74] The

reproductive choices of Indigenous women were also controlled via widespread prescription of birth control in response to racist concerns about the size of Indigenous families.[75]

The lack of respect for bodily autonomy continues today when Indigenous people are subject to racist and paternalistic stereotypes that they are less capable than non-Indigenous people.[76] Indigenous women and girls in particular are often subject to racist and paternalistic assumptions that they are inherently "at risk" and in need of saving,[77] or that they are not experts on their own health and well-being.[78] A 2021 report of the Senate Committee on Human Rights found coerced or forced sterilizations have been reported in Canada as recently as 2018.[79] Further, the disproportionate criminalization and incarceration of Indigenous people in Canada additionally controls their freedom and autonomy through the use of state force.[80]

In 2012, the Truth and Reconciliation Commission of Canada issued 94 Calls to Action to support reconciliation. Seven of those Calls to Action addressed health. To date, zero of those seven recommendations have been fully implemented.[81]

Section Summary

Part 6: UN Declaration on the Rights of Indigenous Peoples and health

In this section:

- There is no shortage of reports and studies with recommendations to improve the lives and well-being of Indigenous people in Canada.
- Meaningful change to address the health inequities experienced by Indigenous people and communities can seem difficult in the face of decades of inaction.
- UNDRIP sets out interconnected and interdependent human rights that provide a pathway to self-determination, wellness, and equity for Indigenous people. In this way, UNDRIP can be a powerful tool to help frame the existing Indigenous-led literature on Indigenous determinants of health.

"We need to be looking at the work as obligations, not recommendations."

— Goodingaay Guud Jaad / Stephanie Watkins

Photo by Tricia Thomas, Salish Eye Productions

Bizaan Bimose (Tonya Robitaille)

Part 6: UN Declaration on the Rights of Indigenous Peoples and health

Meaningful change to address the health inequities experienced by Indigenous people and communities can seem difficult in the face of decades of inaction. BC's mental health law and policy, like all law and policy, are rooted in foundations of colonialism and continue the cycle of health inequities.

There is no shortage of reports and studies with recommendations to improve the lives and well-being of Indigenous people in Canada. As of December 2022, Eva Jewell and Ian Mosby documented that seven years after the release of the Truth and Reconciliation Commission's Calls to Action, Canada has fully implemented only 13 of the 94 calls, with none of the health-specific calls completed.[82] The former Chief Commissioner of the National Inquiry on Missing and Murdered Indigenous Women and Girls (MMIWG) has stated that the Inquiry was never taken seriously and that, as far as she knows, there is no implementation plan for the Inquiry's recommendations.[83]

One member of the Indigenous Leadership Group stated:

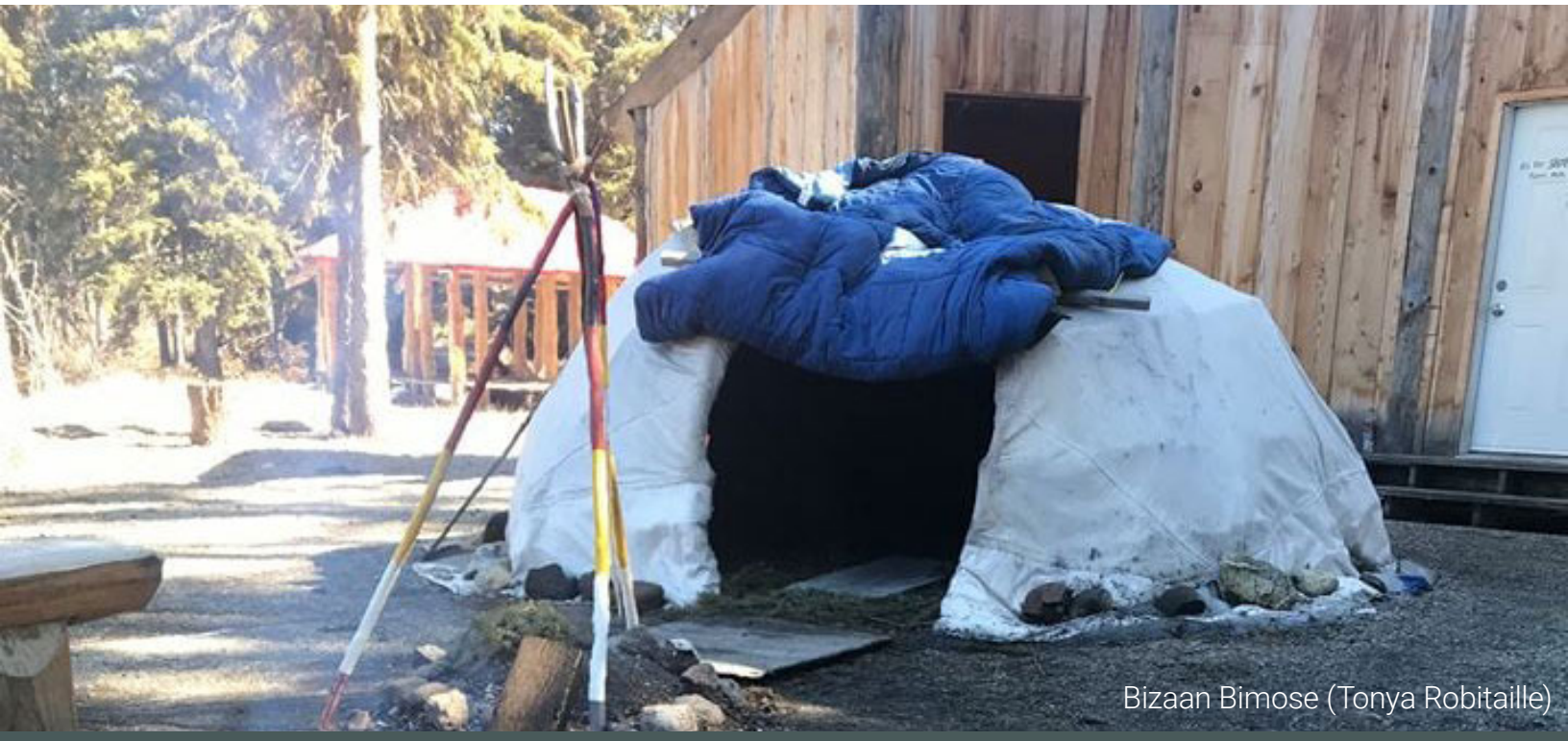
> **"We need to be looking at the work as obligations, not recommendations."**
>
> **— Goodingaay Guud Jaad / Stephanie Watkins**

Circular chapter photo by Tricia Thomas

Some Indigenous leaders in Canada have expressed some optimism at recent developments regarding the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). BC passed the Declaration on the Rights of Indigenous Peoples Act[84] in BC (DRIPA BC), and Canada passed the United Nations Declaration on the Rights of Indigenous Peoples Act[85] federally (DRIPA Fed) – both essentially commit to take all necessary measures to ensure provincial and federal laws are consistent with UNDRIP. In 2022, BC released an Action Plan for DRIPA BC covering 2022-2027.[86] In reference to BC's enactment of DRIPA BC and then-pending federal DRIPA Fed, Hayden King, Executive Director of the Yellowhead Institute, wrote:

> While it may be some time before UNDRIP is realized in this country legally, the legislation in B.C. and in Canada is a helpful tool for Indigenous communities to hold governments accountable politically.
>
> In an atmosphere where justice is seemingly and perhaps ironically only won by Indigenous communities through conflict in the public square, in the courts, and on the ground, the Declaration offers an opportunity.[87]

The Declaration does not create new rights[88] and, on their own, DRIPA BC and DRIPA Fed do not create enforceable rights, but both statutes acknowledge that UNDRIP has application in BC and Canadian law[89] and propose to contribute to or provide a framework for the implementation of UNDRIP.[90] The formal inclusion of UNDRIP in DRIPA BC and DRIPA Fed is cause for some hope because it provides some form of commitment to the individual and collective human rights for Indigenous people set out in UNDRIP.



Bizaan Bimose (Tonya Robitaille)

UNDRIP sets out interconnected and interdependent human rights that provide a pathway to self-determination, wellness, and equity for Indigenous people. In this way, UNDRIP can be a powerful tool to help frame the existing Indigenous-led literature on Indigenous determinants of health. It is artificial to separate out the health-specific rights in UNDRIP for this reason given the holistic nature of health and well-being. For example, the following sections have clear connection to the health and well-being of Indigenous people and communities:

- **Equality and freedom from discrimination:** Articles 1 and 2 affirm that Indigenous people have, as individuals and collectively, all of the fundamental human rights and freedoms guaranteed in international human rights law, including the right to live free from discrimination. Article 15 requires Canada to take effective steps to combat and eliminate discrimination and prejudice against Indigenous people. Racism has well-documented negative impacts on health and well-being and, in relation to health services, can be a reinforcing cycle where racism harms health, and health services perpetuate racism.[91] Being treated equitably, respectfully, and with dignity is a core foundation for health and well-being.
- **Community self-determination:** Article 3 affirms the self-determination of Indigenous peoples. This includes self-determination over their community membership and internal political, legal, economic, social, and cultural affairs (Articles 4, 5, 14, 20, 23, 31, 33, 34, 35) using a distinctions-based approach that recognizes diversity. Further, Articles 18 and 19 affirm that Indigenous peoples have the right to participate in decisions that impact them, and that Canada has an obligation to consult and cooperate in good faith to obtain their free, prior, and informed consent before adopting any law or policy that may affect them.

  Warner Adam writes about the foundational role of self-determination in First Nations health and wellness:

  > In taking on the responsibility for our own lives, we have to recognize the voices of our ancestors and Elders. Their voices echo in my mind: to be respectful of this land, to be mindful of the temptations of the world, to be smart enough to use systems to rebuild our nations with pride and dignity, and to become self-sufficient. We need to change our socio-economic conditions in order to improve health conditions in our communities. We need autonomous First Nations systems and governance. We cannot let ignorance interfere with the health and well-being of present or future generations.[92]

  Métis self-determination is a fundamental determinant of Métis health; upholding inherent Métis rights has been prioritized as a foundation for health and wellness.[93] Community or Nation-specific self-determination has been highlighted as especially

important to move away from pan-Indigenous approaches,[94] as has the need to support self-determination and decision-making participation of urban Indigenous people.[95]

- **Health practices:** Article 24 states that Indigenous people have the right to their diverse traditional medicines, to maintain their health practices, and to an equal right to the enjoyment of the highest attainable standard of physical and mental health. Community self-determination broadly, including over conceptions of health and health supports, is a necessary foundation to holistic wellness.[96] Community-specific traditional health practices, deeply connected to cultural and spiritual practices, can help Indigenous people avoid the ways in which the western medical system can further colonial dynamics.[97]
- **Cultural, spirituality, and language practices:** Articles 11, 12, 13, 31 affirm the rights of Indigenous people to practise and develop their own cultural practices, histories, traditional knowledge, languages, spiritual and religious traditions, customs, ceremonies, and cultural expressions. In addition, Article 15 affirms rights to the "dignity and diversity" of cultures, traditions, histories, and aspirations to be presented in education and public messages. Diana Steinhauer and James Lamouche write about the role of cultural continuity and identity as key determinants of the health of Indigenous people:

  > It is becoming increasingly clear that culture is vital to healthy individuals and communities, and that recognition and utilization of traditional cultural structures and practices are better determinants of good health than the utilization of external—and in many ways deviant—structures of mainstream society.[98]

- **Land:** UNDRIP affirms the right of Indigenous people to their traditional lands, territories, and resources (Article 26), including the right to use and develop their lands or territories; to determine priorities and strategies for their development or use (Article 32), and to maintain and strengthen their distinctive spiritual relationship with the land (Article 25). Article 10 sets out that First Nations in BC will not be forcibly removed from their lands or territories without free, prior, and informed consent, and with compensation. Article 32 affirms that in advance of any project impacting their traditional lands, territories, and resources, BC must act in good faith to get the free, prior, informed consent of First Nations people. Articles 8 and 28 affirm that First Nations in BC have a right to redress for lands that have been stolen, occupied, damaged, or used without their free, prior, and informed consent.

  Rights and autonomy with respect to community-specific traditional lands and territories are inextricably intertwined with many of the determinants of health of Indigenous people.[99] Relationship and connection with traditional lands and territories is often foundational to embodied and experiential education and knowledge sharing,

they may be the place of or feature in stories key to cultural and spiritual traditions, and land-based resources may be sources of traditional medicines and health practices.[100] Further, being in good relationship with the land and stewarding the land and resources are key to holistic health and well-being.[101] Responsible and sustainable access to land-based resources can support economic security.

- **Economic security:** Articles 5 and 20 affirm that Indigenous communities have the right to maintain and strengthen their own economic systems. Article 21 affirms that Indigenous people have the right to improve their own economic and social conditions without discrimination, and that countries should take effective steps to ensure this with particular attention paid to the rights and special needs of Indigenous elders, women, youth, children, and persons with disabilities.

Finally, Article 43 affirms that the rights set out in UNDRIP "constitute the minimum standards for the survival, dignity and well-being of the indigenous peoples of the world."

Section Summary

Part 7: Situating BC's Mental Health Act

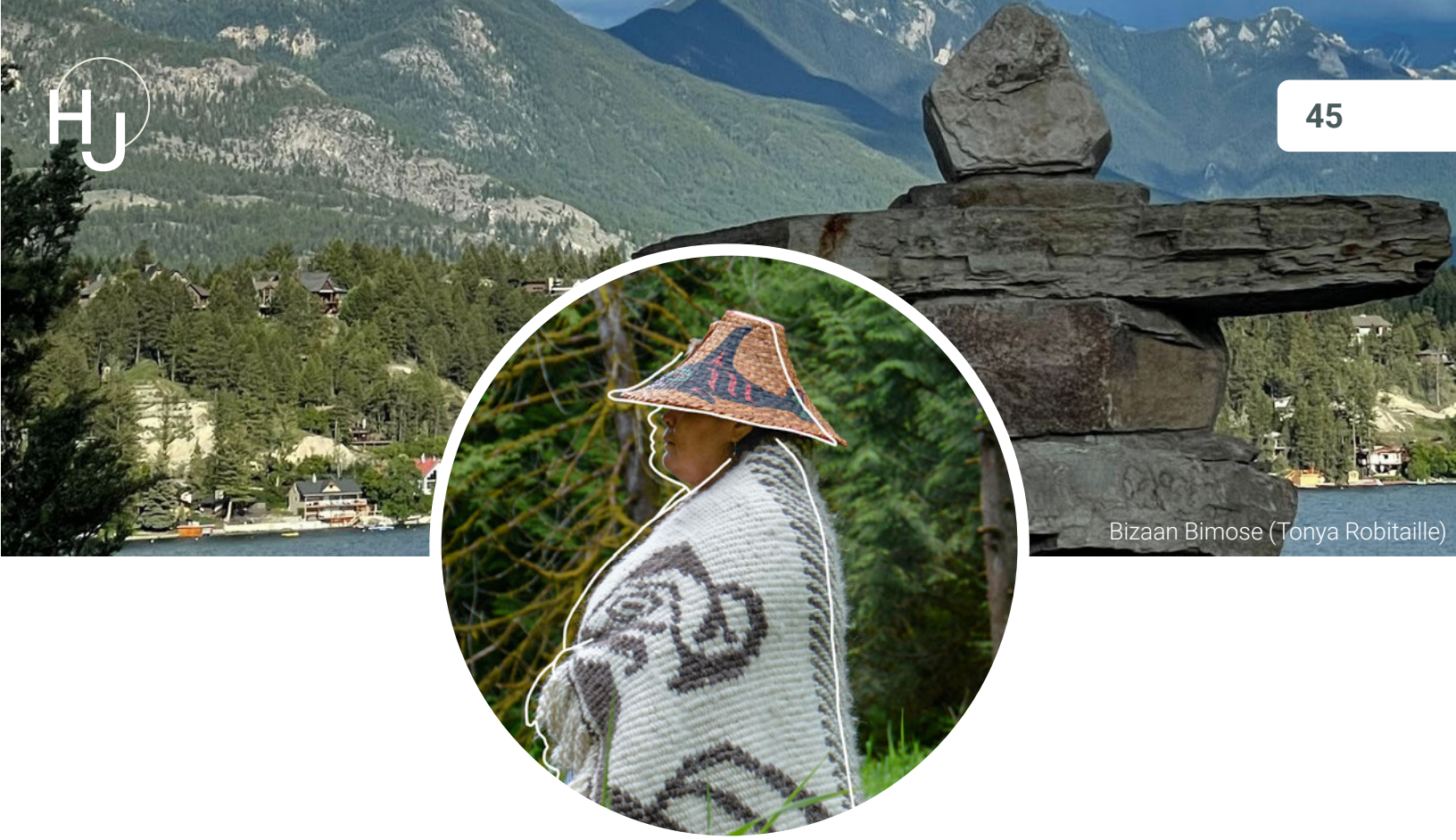
In this section:

- Particularly in rural and remote communities where safe, local, community-based mental health and wellness services are wholly inadequate, the Mental Health Act can be one of the only tools currently available for someone who might benefit from psychiatric treatment to avoid criminalization.
- For some First Nations, Métis, and Inuit people in BC, detention and involuntary psychiatric treatment under the Mental Health Act are a continuation of the control and repression of community self-determination and traditional health practices, replacing them with government control and colonial understandings of risk and wellness.

"Colonized systems define risk and safety for us. They don't align with Indigenous community and culture."

— Dr. Sarah Hunt / Tłaliłila'ogwa

Photo by Tricia Thomas, Salish Eye Productions



Bizaan Bimose (Tonya Robitaille)

Part 7: Situating BC's Mental Health Act

The Mental Health Act authorizes the detention and involuntary psychiatric treatment of people who are assessed as having a "mental disorder." The Act operates within the institutional, mainstream health system and the documented racism deeply entrenched in that system. A member of the Indigenous Leadership Group commented on cultural safety in the context of mental health services in the mainstream health system:

> **"What is cultural safety in this context? It means being cognizant of historical and intergenerational trauma, and the impacts of colonization while recognizing that the systems in place that have inflicted trauma are still in active existence – one of the ways that this system exists is through the Mental Health Act."**
>
> **— Goodingaay Guud Jaad / Stephanie Watkins**

For many people, at first glance BC's Mental Health Act is a tool intended to help people in need of intensive psychiatric supports. Particularly for rural and remote communities where safe, local, community-based mental health and wellness services are wholly inadequate, the Act can be one of the only tools currently available for someone who might benefit from psychiatric treatment.[102]

The Act can also be viewed as an important diversion tool to get someone health supports instead of being criminalized for health-related needs.[103] In the context of the ongoing

Circular chapter photo by Tricia Thomas

over-policing, criminalizing, and incarceration of Indigenous people, this is important. BC's First Nations Justice Council includes as part of its foundational philosophies the need to "be proactive in creating conditions where First Nations people are no longer disproportionately interacting with, nor being impacted by, the justice system."[104]

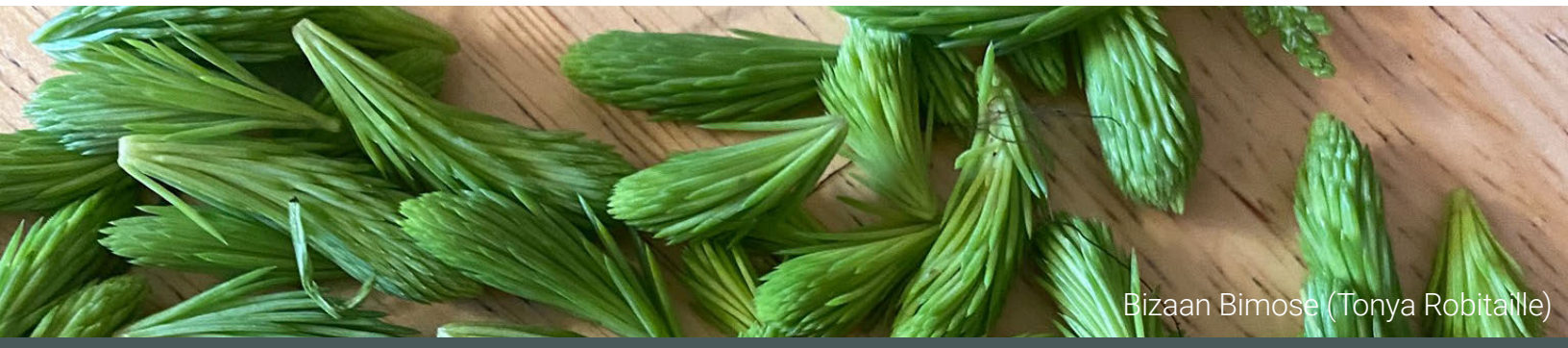
These needs are important for First Nations, Métis, and Inuit communities in BC, given the intentional undermining of their self-determination, the mental health and wellness impacts of ongoing colonial racism, unequal access to culturally safe mental health and substance use services, and well-documented harm from disproportionate rates of criminalization and incarceration.

> **"We need more support, more voluntary treatment, better options – that's when people succeed."**
>
> **— Bizaan Bimose (Tonya Robitaille)**

However, this quote from an Indigenous Leadership Group member illustrates the importance of recognizing that there is also an immense need to increase access to voluntary, community-led, self-determination-based services. In the face of systemic underfunding, BC has relied heavily on involuntary treatment. There are many other ways to provide access to wellness supports, or psychiatric services, to avoid the harm of the criminal justice system.

This is especially important because for some First Nations, Métis, and Inuit people in BC, detention and involuntary psychiatric treatment under the Mental Health Act are a continuation of the control and repression of community self-determination and traditional health practices, replacing them with government control and colonial understandings of risk and wellness. Involuntary treatment can be experienced as yet another institutional means of suppressing the autonomy of First Nations, Métis, and Inuit people and pathologizing the impacts of and resistance to colonialism.

BC does not collect disaggregated data to support an analysis of who is detained and how powers are exercised under the Act. This means that there is no proactive monitoring of how many First Nations, Métis, Inuit, and urban Indigenous people are detained under the Act and what kind of conditions or treatment they experience. This prevents analysis and accountability of ways the powers in the Act may be influenced by anti-Indigenous racism or other biases.



Bizaan Bimose (Tonya Robitaille)

Despite this, the BC government has acknowledged that it assumes that Indigenous people, and specifically children and youth, are disproportionately impacted by the Act.[105]

Other jurisdictions that have a similar colonial history that do track disaggregated data related to involuntary treatment find that the immense power granted via involuntary treatment legislation is not used equally across communities. Specifically, they have found:

- Indigenous people are disproportionately subject to assessments that can lead to detention and involuntary treatment;[106]
- Indigenous people are far more likely to experience more extreme uses of coercion and force such as seclusion (solitary confinement) and restraints (physical and mechanical) when compared with non-Indigenous people;[107]
- Indigenous people are disproportionately subject to indefinite involuntary treatment orders;[108]
- Indigenous people are disproportionately subject to community treatment, where they continue to be subject to involuntary treatment while living in community.[109]

With that in mind, it is important to reflect on the ways in which the current Act may create further inequity for Indigenous people and reflect entrenched colonial approaches.

Colonial conceptions of risk and racist stereotypes

Exercises of power under the Mental Health Act are fundamentally about risk, whether it is risk to the safety of the person involved, risk to the safety of others, or risk that the individual's health may deteriorate substantially.[110] The Act empowers police to make assessments of safety when determining whether to apprehend someone who appears to have a mental disorder in order to transport them to a physician to nurse practitioner for a medical examination.[111] A member of the Indigenous Leadership Group noted:

> **"Colonized systems define risk and safety for us. They don't align with Indigenous community and culture."**
>
> **— Dr. Sarah Hunt / Tłaliłila'ogwa**

First Nations, Métis, and Inuit people who experience being assessed for safety and risk may be subject to colonial understandings of risk that do not align with their community's understanding. There are well-documented concerns about the appropriateness of colonial methods for psychological risk assessment in other contexts due to cultural bias against Indigenous people.[112] Indigenous youth have been active in resisting the harmful narratives that being Indigenous creates inherent risk, instead advocating for strength-based approaches rooted in acceptance, respect, and inclusivity.[113]

Given the colonial pattern of locating risk and inherent vulnerability within Indigenous people instead of within the systems of genocide, colonialism, and racism, it is easy to see how mainstream conceptions of risk might influence the experiences of First Nations, Métis, and Inuit people in relation to the exercise of power authorized by the Mental Health Act.

This is especially true because, in deciding whether or not to exercise power to detain and involuntarily treat someone under the Act, considerations may include an assessment of or assumptions about the person's capacity and belief about whether they can make decisions in their own best interests and in the interests of their families and communities. Further, determinations about whether someone might be a safety risk or whether their health might deteriorate without involuntary intervention will necessarily involve an assessment of the likelihood someone will voluntarily comply with recommended treatment that might support their health. The Act requires that specific requirements be met to authorize detention and involuntary treatment. One of those requirements is that a person "cannot suitably be admitted as a voluntary patient."[114] These kinds of determinations can easily be influenced by racist stereotypes commonly applied to Indigenous people in BC's health system identified in the *In Plain Sight* report: that they are less capable and less compliant that non-Indigenous people.[115]

Given that these stereotypes continue throughout BC's health care system, it is difficult to imagine how they would not be reflected in any decisions to detain First Nations, Métis, and Inuit people under the Mental Health Act or the way they are treated while they are detained.

Barriers to community, family, and personal autonomy

The Mental Health Act creates barriers to autonomy and self-determination in a number of ways. First, it authorizes detention and involuntary treatment that may be described in the health system as "high acuity," or high intensity. This means that treatment under the Act often occurs through hospitals and specialist facilities and not through primary care or community-led services. The First Nations Health Authority Policy on Mental Health and Wellness contemplates that "high acuity" services will be under the control of the mainstream health system with far less personal, familial, and community agency and self-determination.[116] This means that the Indigenous-led FNHA service system and Nation-based health care services and staff will be less involved and have less influence over the treatment and conditions. The mainstream, colonial health care system has nearly total control over someone detained under the Mental Health Act.

Second, a core purpose of the Act is to control the bodily autonomy of a person experiencing involuntary treatment. The Mental Health Act removes the power of involuntary patients to make their own psychiatric health care treatment decisions. Instead, the Act empowers the facility staff to make treatment decisions on a person's behalf through the "deemed consent" model,[117] typically using a biomedical approach. The Act also grants extraordinary power to

facility staff to "discipline" involuntary patients, which can include the use of restraints and seclusion or solitary rooms. As stated by a member of the Indigenous Leadership Group, these powers reinforce inequity and can further undermine self-determination of Indigenous people:

> **"I have seen the inequities in the [Mental Health] Act and how it strips the vulnerable of self-determination, humanity and disproportionately affects Indigenous peoples and youth."**
>
> **— Goodingaay Guud Jaad / Stephanie Watkins**

Finally, in addition to removing the power of an individual to make their own psychiatric health care decisions, the Mental Health Act also excludes families and loved ones from involuntary psychiatric health care decisions.[118] This is in stark contrast to all other health care decisions in BC, which empower the people we appoint or those who know us best to help make decisions if we are incapable of making them ourselves.[119]

For First Nations, Métis, and Inuit people who experience involuntary treatment under the Act, this means that the people who may have most familiarity with their cultural practices, and who may be able to help support access to culturally based health supports, are excluded from their care. In the context of parents and children, autonomy to make the decision to choose culturally based health care instead of mainstream biomedical health treatment has been found to be a protected Aboriginal right under section 35 of the Constitution,[120] but the Act ignores this constitutional right and fails to create any legal requirement to acknowledge or respect it.

One member of the Indigenous Leadership Group spoke about the realities of systems and institutions with colonial roots:

> **"Some people say systems are broken, but these systems are not broken. They were designed and work today to meet their purposes. That's still happening. Tearing families and communities apart, segregating and isolating."**
>
> **— Stephen Cain**

Family connections can also be undermined by the involuntary treatment process because while detained, Indigenous parents may be forcibly separated from their children, and the detaining facility may control visits or phone access. In addition, a detention under the Mental Health Act may result in increased surveillance from the child welfare system or the apprehension of children. As outlined in the story at the beginning of this publication, fear of child welfare involvement can become a significant barrier to accessing services.

Barriers to cultural practices

When a person is detained as an involuntary patient under the Mental Health Act, the detaining facility and staff have nearly total control over not just their treatment but also their movement, activities, and daily life during detention. This includes whether a person can go outside, whether they can leave a particular hospital unit, and whether they can access any health and wellness supports outside of the treatment administered by the detaining facility staff. They may have their clothing and jewelry removed, sometimes by force, which can be items of personal, cultural, or spiritual significance.

First Nations, Métis, and Inuit people detained in hospital might not be able to access existing services designed to improve cultural safety in the health system, like Aboriginal patient navigators or Indigenous health liaisons. They also might not be able to access outdoors for land-based health practices because they cannot go outside, or cultural practices like smudging because it might not be permitted on locked psychiatric units. In addition, if a First Nations, Métis, or Inuit person is being held in a seclusion room, they are very unlikely to have access to any cultural supports or even visitors that can support cultural affinity or companionship.

Police and criminal justice involvement

> **"Rural communities have very limited mental health services – police have to choose between the Mental Health Act or jail, and the Mental Health Act takes time and they have to leave community – it's unsafe."**
>
> **— Jacki McPherson**

BC's Mental Health Act authorizes police to apprehend and transport a person who appears to have a mental disorder and who is acting in an unsafe manner. In rural and remote areas with inadequate community-led services, police may be relied upon as the only emergency responders available. The Act authorizes police to transport the individual to a hospital or another facility for an examination when conditions are met;[121] in other words, the police can remove a person from their community. This apprehension and transport power is in addition to the power to enter private residences without a warrant as well as a warrantless apprehension stemming from the common law police power to protect life.[122]

One member of the Indigenous Leadership Group spoke about the harms of relying on police in mental health crises:

> **"The history of the RCMP was to steal and police land for settlers and remove First Nations people from their land. For us to call police into our communities, we are giving them permission to police people's bodies. It's not a coincidence."**
>
> **— Goodingaay Guud Jaad / Stephanie Watkins**

When police arrive at a mental health call, they bring immense state power, a deep colonial history, an ongoing role in enforcing colonial compliance, and the ability to use state-sanctioned lethal force and violence.[123] The documented systemic anti-Indigenous racism in policing in Canada is overwhelming.[124] The RCMP was created to enforce Canada's colonial agenda by forcibly displacing Indigenous people from traditional lands and played a key role in enforcing mandatory attendance at residential schools and Indian hospitals. That history, on its own, means that the presence of police does not signify safety for many First Nations, Métis, and Inuit people and communities who are all too aware of the role police have played and continue to play in colonial policies of overcriminalization and systemic racism. Further, police continue to play a role in apprehending Indigenous children. They are implicated in the failure to address violence against Indigenous women, girls, Two-Spirit, transgender, and gender-diverse people. They continue to enforce injunctions against Indigenous communities defending land, water, and natural resources. For many, the presence of police does not support well-being; instead, it raises legitimate fear, anger, and distrust.

Relying on police as part of the first-line mental health response reinforces stereotypes that Indigenous people who need mental health support are dangerous or threaten public safety. The presence of police can reinforce the racist stereotype that Indigenous people are a safety risk when they need health support.

Section Summary

Part 8: Action areas to consider in BC's implementation of UNDRIP and beyond in mental health law

In this section:

- UNDRIP is not a magic bullet that will dismantle centuries of colonization, but it is an important tool for the implementation of Indigenous rights in a meaningful way.
- When combined with the implementation of other human rights-based principles, UNDRIP can create a foundation for a mental health law that supports the rights and wellness for Indigenous people.
- Based on the expertise and analysis shared with Health Justice by the Indigenous Leadership Group and people with lived experience, we have developed areas for consideration in the implementation of UNDRIP in BC's mental health law.

"We don't belong in institutions. They have never worked for us as Indigenous people."

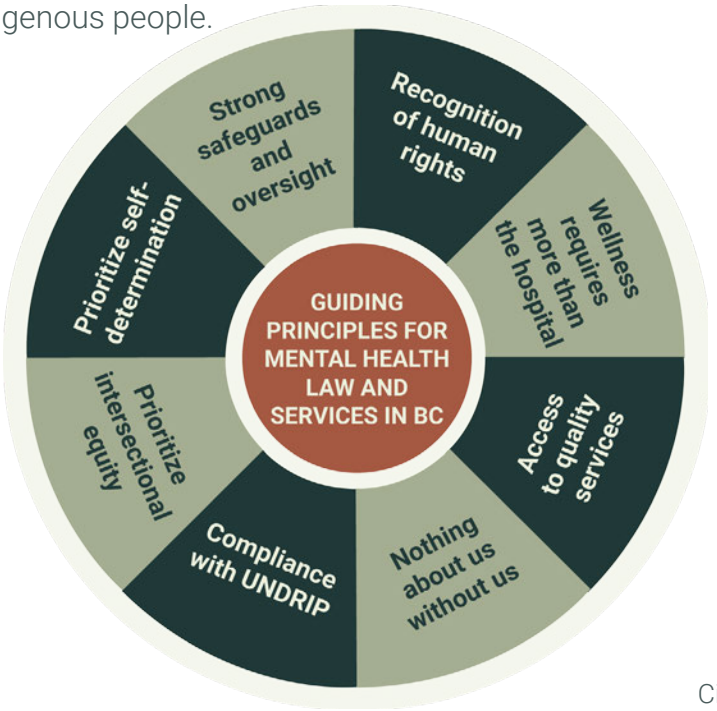
— Bizaan Bimose (Tonya Robitaille)

Photo by Tricia Thomas, Salish Eye Productions

Bizaan Bimose (Tonya Robitaille)

Part 8: Action areas to consider in BC's implementation of UNDRIP and beyond in mental health law

UNDRIP is not a magic bullet that will dismantle centuries of colonization and genocide, but it is an important tool that helps provide a baseline for the implementation of Indigenous rights in a meaningful way. When combined with the implementation of other human rights-based principles, UNDRIP can create a baseline for a mental health law that protects human rights and wellness for Indigenous people.



Circular chapter photo by Tricia Thomas

Because Health Justice is a non-Indigenous organization, it is inappropriate for us to make law reform recommendations on the specific ways BC's mental health law could incorporate UNDRIP. That process must involve a good-faith government-to-government consultation with self-determined First Nations, Inuit, and Métis leadership bodies to achieve free, prior, and informed consent about any changes to the law that will impact Indigenous communities in BC.

Based on the expertise and analysis shared with Health Justice from the Indigenous Leadership Group and Indigenous people with lived and living experience, we have developed areas for consideration in the implementation of UNDRIP in BC's mental health law. Many of these action areas align with the provincial government's DRIPA Action Plan, released in 2022, and its commitments to uphold the human rights contained in UNDRIP in its institutions, laws, polices, and practices.[125]

Acknowledge colonial harms and resistance to those harms

UNDRIP requires that states take action to address many of the historic and ongoing harms of colonialism, including combating prejudice and discrimination and promoting tolerance and understanding between Indigenous and non-Indigenous people.[126] The BC government has confirmed that DRIPA BC is, in part, an acknowledgement of the colonization and attempted genocide of Indigenous Peoples and the resulting fractures to "the self-determined lives, cultures and well-being of Indigenous Peoples across Canada."[127]

In the absence of knowledge and understanding of the context about the role of colonization and systemic racism in the health of First Nations, Inuit, and Métis people, health inequities are often understood through racist stereotypes. Given how entrenched systemic anti-Indigenous racism is in BC's health system, one way that UNDRIP could be recognized in BC's mental health law is through an express acknowledgement of the historic and ongoing harms of colonization and racism. This should include acknowledgement of the role of colonization in creating mental health inequities, and acknowledgement that the use of coercion and force in the mental health system may have disproportionate impacts on Indigenous people in the context of historic and ongoing control under colonialism. In addition, acknowledging UNDRIP in BC's mental health law could include the express acknowledgement of the ways in which Indigenous people have resisted colonial oppression and maintained strong community, cultures, and practices that support their wellness today.

For an example of this approach, see Victoria, Australia's mental health law, which includes a Statement of Recognition that acknowledges colonial harms and the strength of Indigenous communities.[128]

Victoria, Australia's Mental Health and Wellbeing Act

13 Statement of Recognition

(1) The Parliament recognises that Aboriginal people in Victoria are First Nations people of Australia and acknowledges their enduring connection to Country, kin, land and culture.

(2) The Parliament acknowledges the following—

a) that Aboriginal self-determination serves as a foundational principle to improve mental health and wellbeing outcomes of Aboriginal people in Victoria;

b) the lasting impact of laws, practices and policies on the mental health and wellbeing outcomes of Aboriginal and Torres Strait Islander people since colonisation and enduring to this day;

c) cultural dislocation, oppression, intergenerational trauma, lack of healing, systemic racism, institutionalised inequality and the loss of land, lore and language continue to harm the mental health and wellbeing of Aboriginal people in Victoria today;

d) the strength of Aboriginal people, culture, kinship and communities in the face of historical and ongoing injustices;

e) Aboriginal people's ongoing connection to culture, community and Country and the importance of this connection for the mental health and wellbeing of Aboriginal people in Victoria.

(3) It is the intention of Parliament that the mental health system recognises, respects and supports the distinct cultural rights of Aboriginal people and their right to receive culturally safe holistic mental health and wellbeing services throughout Victoria.

(4) The Parliament supports initiatives which address the ongoing mental health inequalities experienced by Aboriginal people in Victoria.

(5) The Parliament recognises the essential role of Aboriginal community controlled health organisations in meeting the mental health and wellbeing and care needs of Aboriginal people in Victoria.

(6) The Parliament supports the development of future reforms which further Aboriginal self-determination within mental health and wellbeing services in Victoria.

Recognize community-specific self-determination

> **"Who is setting the standards of what is helpful to our people? Not us."**
>
> **— Jacki McPherson**

This quote from a member of the Indigenous Leadership Group highlights the current lack of self-determination in BC's health system. Community self-determination is the foundation of health and well-being for Indigenous people and communities. The erosion, erasure, and prohibition of self-determination has been and is at the core of the colonial project. First Nations, Inuit, and Métis people and communities have maintained strong health and well-being, cultural, and spiritual practices in the face of this onslaught, but they continue to be suppressed today.

Self-determination is at the heart of UNDRIP and all the rights it affirms. Achieving a reality where "Indigenous Peoples exercise and have full enjoyment of the right to self-determination and self-governance" is a core goal of the BC government's DRIPA Action Plan.[129]

Adhering to UNDRIP in BC's mental health law could include an express acknowledgement of the role of distinctions-based self-determination as a foundation to Indigenous health and well-being. It could also include acknowledging that communities should self-determine their own health and social needs, and that free, prior, and informed consent of First Nations, Inuit, and Métis communities must be foundational to the creation, implementation, and evaluation of law, policy, and services that impact those communities. As noted by a member of the Indigenous Leadership Group, this must be done in a distinctions-based way that reflects the diversity of Indigenous communities:

> **"Solutions, laws, and services can't be one size fits all. They need to connect to the people and those most impacted to design the most effective response. That will create social change."**
>
> **— Stephen Cain**

For an example of this approach see Victoria, Australia's mental health law's Statement of Recognition.[130] That statement is an express acknowledgement of the role of self-determination in wellness and the importance of community self-determination in service delivery.

In addition, the exercise of self-determination may be shaped by the intersecting rights and identities of Indigenous people who may be impacted by the Mental Health Act. For example, the Convention on the Rights of Persons with Disabilities mandates the direct participation of people with disabilities in the law, policy, and services that impact them, which may be useful in shaping self-determination related to issues that Impact Indigenous people with disabilities.[131]

Restoring gender roles and conceptions of gender that disrupt the gender and racial hierarchy rooted in colonialism, which is harming Indigenous women, girls, Two-Spirit and gender-diverse people, can also play a role in self-determination.[132]

Rapidly expand funding for community-led services

> **"We need our people healing our people."**
>
> **— Jacki McPherson**

There is a well-documented, clear need to fund expanded mental health and wellness services that are developed by and for specific First Nations, Inuit, and Métis communities. This is especially true for rural and remote communities. Those services should be preventative and support people before they are in crisis, they should be free from state control and coercion, and they should be community specific. One member of the Indigenous Leadership Group noted the systematic nature of under-resourcing of services to meet community needs:

> **"There's an acceptance of there being a lack of resources, especially in isolated communities. When it comes to a crisis, there are hardly any options. There is often only one option: the police."**
>
> **— Goodingaay Guud Jaad / Stephanie Watkins**

Communities must be supported to identify their own needs and develop supports to address those needs that align with their own distinct culture, traditions, and health practices:

> **"We need the core principle that health is held by community, not box-ticking, external consultants, or limited funding opportunities. They have held the wisdom and knowledge for Indigenous communities."**
>
> **— Terri Gillis**

BC's DRIPA Action Plan commits to increasing the availability, accessibility, and continuum of Indigenous-led and community-based services and supports that are trauma-informed, are culturally safe, and address a range of holistic wellness needs or people in crisis.[133] BC can adhere to UNDRIP in its mental health law by acknowledging the need for and commitment to supporting community-led services. An example of this approach can be found in Victoria, Australia's Statement of Recognition.[134]

Eliminate racism in the mainstream mental health system

> **Cultural safety includes "ongoing commitment and work to engage in cultural safety, anti-racism, unlearning as a process that does not end with one course, one reading, etc."**
>
> **— Goodingaay Guud Jaad / Stephanie Watkins**

The entrenched systemic anti-Indigenous racism in BC's health system is well documented. The provincial government has acknowledged the need to address Indigenous-specific racism in BC, including in government systems, practices, and policies, as a fundamental goal to achieving the objectives set out in UNDRIP and DRIPA BC.[135] There is an urgent need for BC to continue its work to eliminate racism in the mental health system and shift away from a culture based on deeply rooted discrimination. Part of that work includes taking practical and meaningful steps to ensure cultural safety throughout the system, and go beyond metaphorical ideas and buzzwords:

> **"We have to be specific about cultural safety. What is it in practice."**
>
> **— Jacki McPherson**

In addition to ongoing work like the BC Cultural Safety and Humility Standard, cultural change and implementation of UNDRIP in BC's mental health law can be realized through legislated commitments to cultural safety, including a legal framework to define cultural safety in practice.[136] For example, New Zealand's mental health law must be used with recognition of the importance and significance of cultural community ties, recognition for how those ties support well-being, and respect for a person's cultural identity, language, and religious beliefs.[137] Victoria, Australia, and Nunavut's mental health law go beyond naming cultural safety to include specific ways mental health services can incorporate cultural practices and safety.[138]

New Zealand's Mental Health Act

5 Powers to be exercised with proper respect for cultural identity and personal beliefs

(1) This section applies to—

- (a) a court, tribunal, or person exercising a power under this Act in respect of a person; and
- (b) a court or tribunal conducting proceedings under this Act in respect of a person.

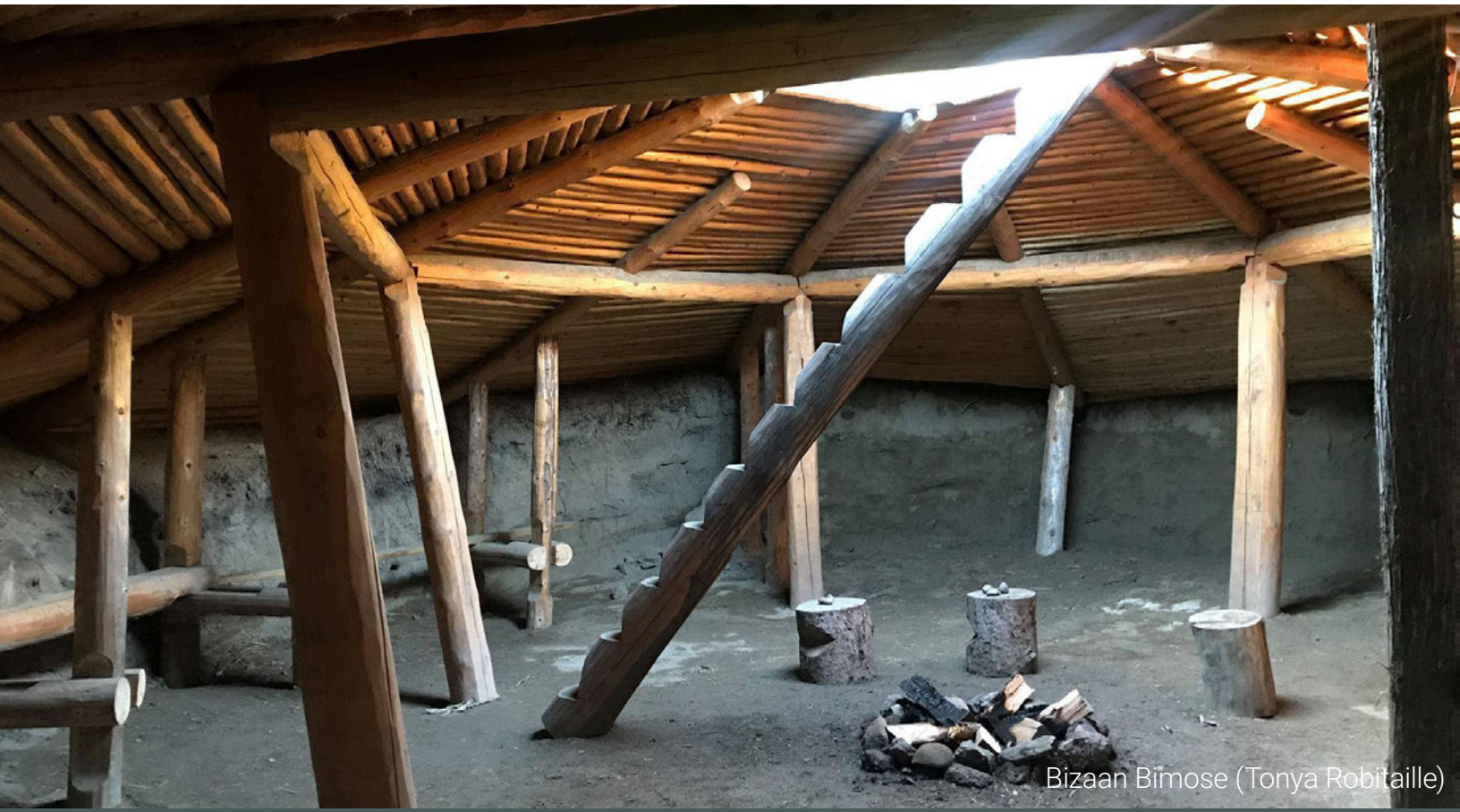
(2) The power must be exercised, or the proceedings conducted,—

- (a) with proper recognition of the importance and significance to the person of the person's ties with his or her family, whanau, hapu, iwi, and family group; and
- (b) with proper recognition of the contribution those ties make to the person's wellbeing; and
- (c) with proper respect for the person's cultural and ethnic identity, language, and religious or ethical beliefs.

Reduce or eliminate approaches that rely on use of force and control

> **"We don't belong in institutions. They have never worked for us as Indigenous people."**
>
> **— Bizaan Bimose (Tonya Robitaille)**

A hallmark of settler colonialism has been the physical control of Indigenous people and communities, through forced displacement from land, involuntary removal of children, forced segregation, and overcriminalization and incarceration. Many of the systems of colonialism were and are enforced by police and other uses of force. BC's current approach to mental health law is almost entirely focused on authorizing various forms of coercion and use of force. From police apprehension powers, the use of private security, seclusion rooms, and physical and mechanical restraint, tools of physical control and force are used throughout the involuntary mental health system. This is reflected in the fact that BC's DRIPA Action Plan commits to address systemic bias and racism in policing and address the roles of police in complex social issues related to mental health, substance use, and homelessness.[139]



Bizaan Bimose (Tonya Robitaille)

One way that BC can implement UNDRIP in its mental health law is to expressly acknowledge these impacts and commit to reducing or eliminating tools of force and control in the mental health system. That could include commitments to reduce or eliminate the use of tools like seclusion and restraints, like Victoria, Australia's mental health law.[140] It could also include ensuring that most mental health services are voluntary and that involuntary approaches are only a last resort when all other options have been exhausted, like Nunavut's mental health law and many other places in the world.[141] Finally, BC's mental health law could limit the role of police in responding to community mental health needs by including non-police, peer-led crisis service models in its mental health law.

Nunavut's Mental Health Act

1. The purpose of this Act is to improve the mental wellness of Nunavummiut and address Inuit-specific needs related to mental wellness by

…

(d) facilitating the provision of necessary care to Nunavummiut with serious mental disorders in a way that

…

(iii) is compassionate and minimizes traumatization,

(iv) is the least restrictive possible,

…

(vi) respects the rights of individuals being provided care,

…

(xi) encourages the use of voluntary services and programs that complement compulsory services

Ensure mainstream mental health law and services strengthen Indigenous determinants of health

A member of the Indigenous Leadership Group told us that mental health law and services should help strengthen an Indigenous person's connection to their community, territory, and culture instead of further breaking those connections. This aligns with the BC's government's commitment in the BC's DRIPA Action Plan to achieve a reality where "Indigenous Peoples feel safe accessing the health-care system, knowing that they will receive high quality care, be treated with respect and receive culturally safe and appropriate services."[142] To meaningfully support the mental well-being of First Nations, Inuit, and Métis people, rights set out in UNDRIP should be included in BC's mental health law. The following are some examples based on the way that Indigenous authors have framed the determinants of health for Indigenous people.

Land

Connection to the land and traditional, ancestral territory is a key determinant of well-being for Indigenous people, and a core aspect of colonization has been the forced dislocation from land. In addition, traditional health practices are often deeply connected to land. All Indigenous people may benefit from connection to the land or land-based therapies, and First Nations people in BC may benefit from health practices or connection to their ancestral territories specifically. As a result, BC's mental health law can take steps to implement UNDRIP by including provisions that support connections to territory. Increasing the availability of culturally safe, traditional, and land-based healing for substance use is expressly named in BC's DRIPA Action Plan.[143]

For example, BC could include provisions to expressly acknowledge the importance and validity of land-based healing models, like Nunavut's mental health law.[144] In addition, Nunavut's law expressly includes land-based therapies in its list of mental health services.

Nunavut's Mental Health Act

4. (1) The Minister may provide the following mental health and addictions services:

…

(g) land-based healing;

(h) Inuit counselling;

…

(j) trauma treatment, including for historical and intergenerational trauma;

…

(m) programming for the development of healthy attachment, self-esteem, coping skills and relationships, including with family;

(n) cultural programming to support mental wellness and healing;

…

Finally, Nunavut's law includes the right to return home for people who are removed from their home communities or territories during involuntary treatment.[145] As expressed by a member of the Indigenous Leadership Group, this is especially important for people living in rural areas:

> **"There is huge value in a requirement to transport someone home on discharge. In rural and remote communities, people leave as hopeless as when they came in."**
>
> **— Goodingaay Guud Jaad / Stephanie Watkins**

Connection to culture, identity, spirituality, language, and traditional health practices

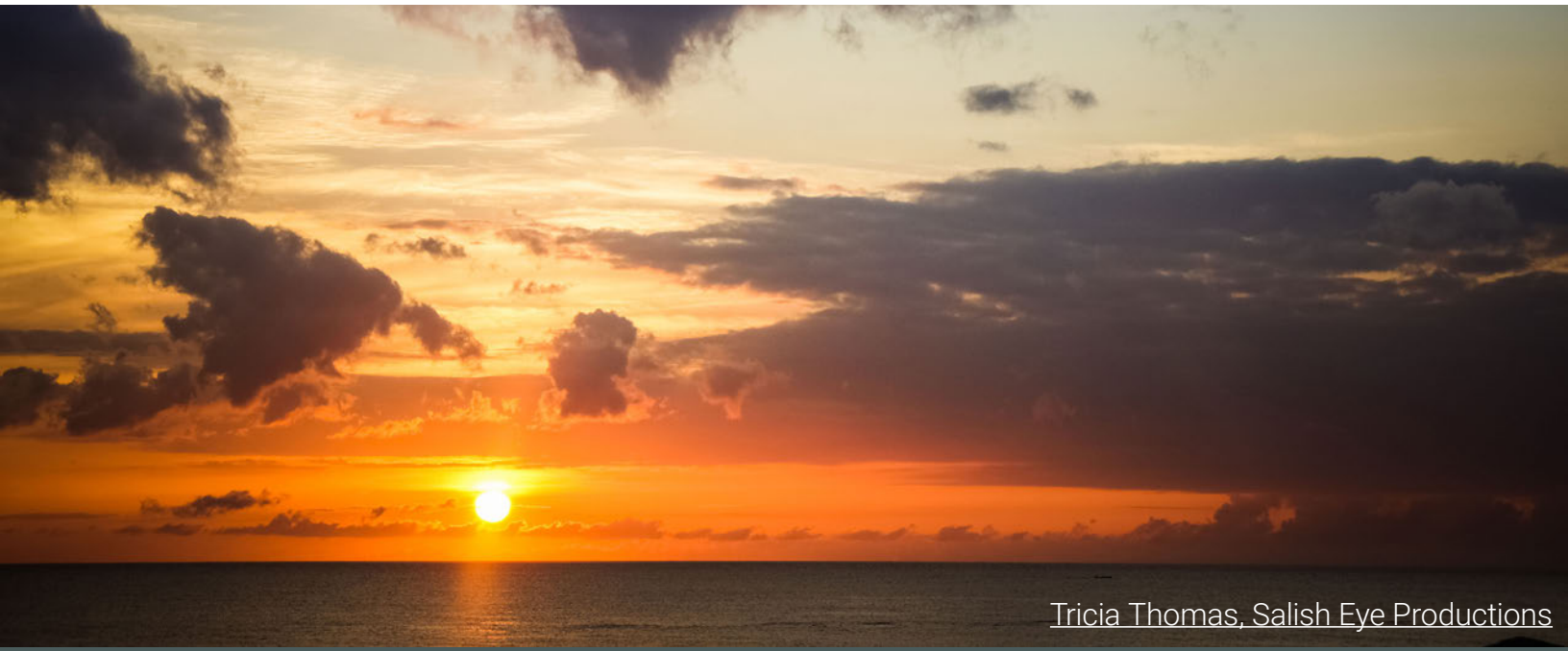
> **"We need to take into account culture, geography, availability of services. Well-being is tied to people, language, culture."**
>
> **— Indigenous Leadership Group member**

There is no doubt that access to supports that affirm their identity or that strengthen connection to their specific culture, spirituality, or language benefits the health of Indigenous people. BC's current approach to involuntary treatment removes people from their community, creates barriers to connecting with cultural supports, and excludes the participation of family, community, and supporters. This means that in a time of significant health need, Indigenous people are unable to access some of the very supports that will benefit their well-being.

Culturally safe health care also requires actively displacing colonial categorizations that have been used to control Indigenous people and to attempt to eradicate diverse community understandings of intersecting identity factors like gender, sex, and sexuality.[146] In this way, cultural safety can also be supported through prioritizing equity and ensuring that services respect and acknowledge self-determined understandings of intersectional equity.[147]

As noted by a member of the Indigenous Leadership Group, strengthening these connections must be considered as a necessity in the health of Indigenous people:

> **"Indigenous ways of being/doing/knowing aren't an 'add on'."**
>
> **— Terri Gillis**



Tricia Thomas, Salish Eye Productions

To take legislative steps to strengthen connections instead of undermining them, BC's mental health law could include specific protections related to involuntary treatment such as:

- Ensuring cultural supports are available within every detaining facility. For example, Nunavut's mental health law includes culturally based services and Inuit-specific counselling in the services offered (see section 4 excerpted on page 61).[148]
- Protecting the right to access distinction-based cultural supports, whether they be provided within the health system or externally, regardless of legal status as an involuntary or voluntary patient.
- Acknowledging the value of and protecting the right to access traditional, culturally based health practices, as Victoria, Australia, does in its mental health law.[149]

Victoria, Australia's Mental Health and Wellbeing Act

27 Cultural safety principle

(1) Mental health and wellbeing services are to be culturally safe and responsive to people of all racial, ethnic, faith-based and cultural backgrounds.

(2) Treatment and care is to be appropriate for, and consistent with, the cultural and spiritual beliefs and practices of a person living with mental illness or psychological distress. Regard is to be given to the views of the person's family and, to the extent that it is practicable and appropriate to do so, the views of significant members of the person's community. Regard is to be given to Aboriginal and Torres Strait Islander people's unique culture and identity, including connections to family and kinship, community, Country and waters.

(3) Treatment and care for Aboriginal and Torres Strait Islander peoples is, to the extent that it is practicable and appropriate to do so, to be decided and given having regard to the views of elders, traditional healers and Aboriginal and Torres Strait Islander mental health workers.

- Recognizing the importance of and protecting access to chosen family, personal supporters, Elders, and community members, as is done in New Zealand's mental health law (see section 5 excerpted on page 58).[150]
- With the consent of the individual, involving chosen family, personal supporters, Elders, or community members in decision-making, as is done in Nunavut and Victoria, Australia's mental health laws (see section 27 excerpted above).[151]

Nunavut's Mental Health Act

Nunavut's law uses the term "tikkuaqtaujuq" (selected representative) to reflect Inuit cultural and societal values. A patient's tikkuaqtaujuq has rights under the law to be informed about and involved in the individual's care.

- With the consent of the individual, considering a process to notify their First Nation or community representative so they are aware a member of their community is being detained and experiencing involuntary treatment.
- Appointing cultural advisors to be able to help inquire and identify what, if any, cultural supports an individual may choose. For example, Nunavut's mental health review board has three Inuit cultural advisors who help ensure the review board process is culturally safe and offers culturally based practices.[152]

> **Nunavut's Mental Health Act**
>
> **64 Composition of Mental Health Review Board**
>
> ...
>
> **Inuit cultural advisors**
>
> (4) The Minister shall appoint at least three individuals who are Nunavut Inuit residing in Nunavut as Inuit cultural advisors.

Take meaningful action to ensure accountability and oversight

> **"Words are nice, but where is the action? Where are the consequences? People have to see it to trust it."**
>
> **— Jacki McPherson**

This quote from a member of the Indigenous Leadership Group highlights the frustration from ongoing lack of meaningful action to address the inequities experienced by Indigenous people. In the face of these longstanding inequities and the continued colonial impacts experienced by First Nations, Inuit, and Métis people, transparency and accountability are crucial aspects to BC's decolonizing work and mental health systems change. While work to implement the Anti-Racism Data Act continues, BC currently does not collect disaggregated data to understand how Indigenous people are impacted in the mental health system, or by involuntary treatment specifically. There is a well-documented lack of systemic oversight and accountability, identified in many reports and investigations.

BC can begin to protect rights set out in UNDRIP and address these gaps by incorporating accountability and oversight measures in its mental health law. This could include:

- Committing to work with Indigenous communities to develop a self-determined process for tracking data to better understand how First Nations, Inuit, and Métis people are impacted by barriers to mental health services; the use of involuntary treatment; use of force like police apprehension, seclusion, and restraints; systemic and individual complaints processes; and legal compliance with procedural safeguards. See, for example, the recommendations of the BC Office of the Human Rights Commissioner.[153]

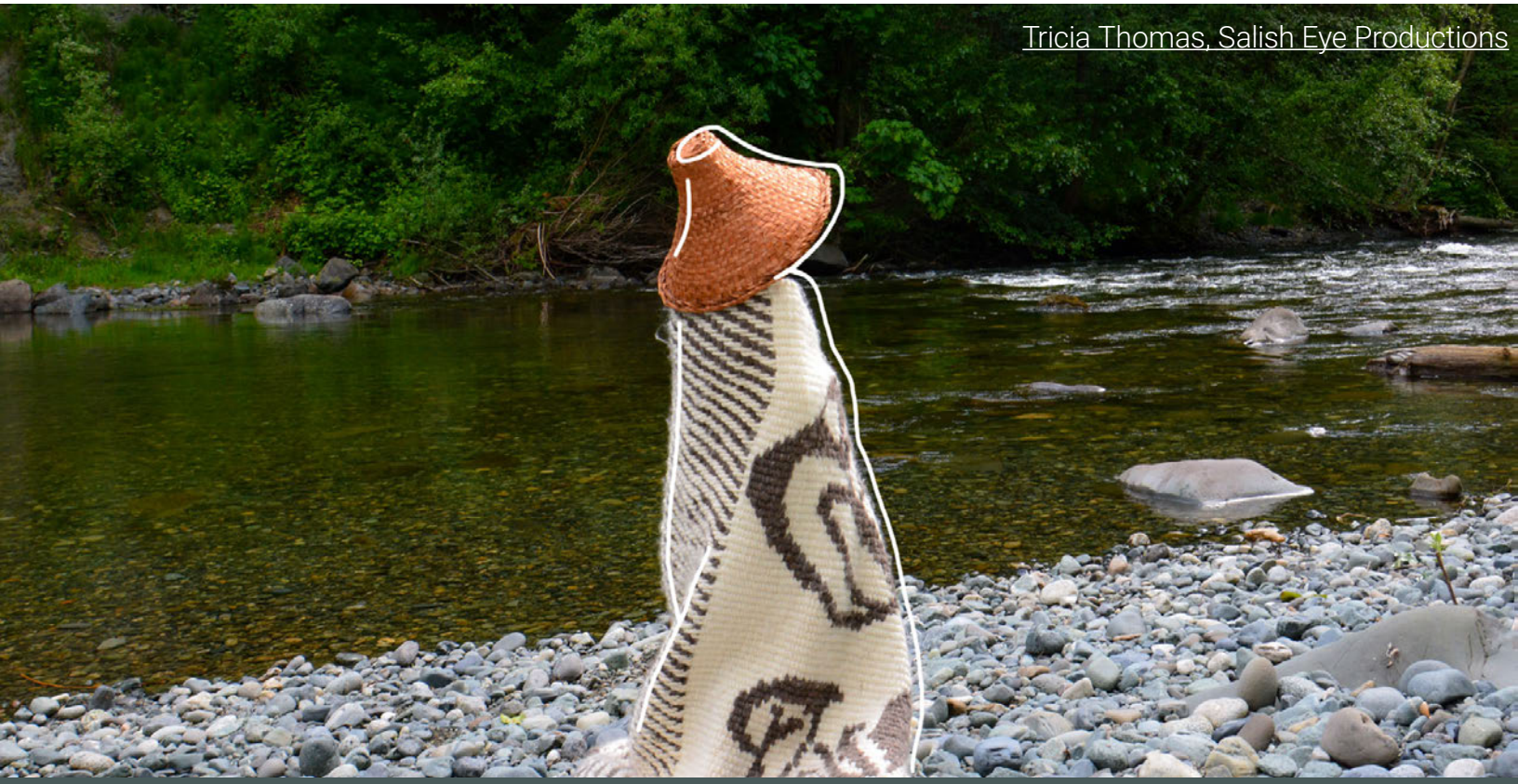
- Establishing individual and systemic complaints processes independent of detaining facilities, health authorities, and the provincial health ministries to ensure accountability and monitor progress in combatting racism, ensuring cultural safety, and understanding the systemic role of detention, involuntary treatment, and force against Indigenous people in BC. This aligns with Recommendation 12 in the *In Plain Sight* report, which called for the Ombudsperson to consider focusing on anti-Indigenous racism in the health system.
- In line with Recommendation 17 in the *In Plain Sight* report, establishing clear accountability mechanisms to monitor and evaluate the impact of commitments to increase access to culturally safe mental health and wellness and substance use services.
- Improving access to justice for First Nations, Inuit, and Métis who experience involuntary treatment, including ensuring access to culturally safe and self-determination-based legal services, complaint mechanisms, and remedies to provide redress for experiences of racism.

Finally, truly taking steps towards decolonizing approaches to mental wellness and addressing the impacts of colonization requires moving beyond reforming BC's colonial mental health law. It requires acknowledging and implementing the thousands of well-established recommendations and calls to action that have been previously developed by Indigenous communities, Indigenous activists, and allies. In addition to formal recommendations, Indigenous communities themselves, including Elders, families, children, and youth, hold the knowledge and answers about what their communities need to be well. Their thousands of years of strength and resistance light up the pathway to eliminating health inequities for Indigenous people and communities, but we must choose to listen and take action.

Conclusion

BC's current approach to mental health law disproportionately impacts First Nations, Inuit, and Métis communities. For some people, it is a continuation of an entrenched pattern of colonial systems that undermine Indigenous self-determination, agency, and well-being. In this way, the Mental Health Act forms part of an entrenched institutional approach in the health system and beyond that continues to control and define the lives of Indigenous people. While the UN Declaration on the Rights of Indigenous Peoples does not provide a complete and comprehensive solution to these longstanding impacts, it does provide a useful framework to imagine how Indigenous rights can be incorporated in the law in BC alongside other human rights-based guiding principles.

There are many practical ways that BC can action UNDRIP in BC's mental health law to meaningfully support the rights and well-being of First Nations, Inuit, and Métis people in BC, and to minimize the colonial harms inflicted by the involuntary treatment system. These areas for consideration also have the potential to create a framework in BC's mental health law that will support the holistic well-being of Indigenous people and a means to evaluate success. Many of these action areas align directly with the provincial government's stated commitments to implementing UNDRIP in BC, as set out in the DRIPA Action Plan. We hope that this publication offers helpful research and analysis to support conversation around ways to decolonize BC's mental health laws and services.



Tricia Thomas, Salish Eye Productions

Endnotes

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Appendix: Examples from outside BC

Nunavut

Mental Health Act, SNu 2021, c19 (excerpts only)

Purpose

1. The purpose of this Act is to improve the mental wellness of Nunavummiut and address Inuit-specific needs related to mental wellness by

(a) improving mental health care and addictions services;

(b) assisting with suicide intervention, prevention and postvention;

(c) facilitating the involvement of *tikkuaqtaujuit* (selected representatives) and family;

(d) facilitating the provision of necessary care to Nunavummiut with serious mental disorders in a way that

(i) is clinically safe and effective,

(ii) is culturally safe,

(iii) is compassionate and minimizes traumatization,

(iv) is the least restrictive possible,

(v) is centred on the best interests of individuals being provided care,

(vi) respects the rights of individuals being provided care,

(vii) supports the engagement of individuals being provided care in their treatment,

(viii) helps individuals being provided care to navigate the mental health care system,

(ix) reduces the need for Nunavummiut to be away from their home communities,

(x) supports early intervention,

(xi) encourages the use of voluntary services and programs that complement compulsory services, and

(xii) reduces re-hospitalizations;

(e) facilitating tracking the needs related to mental health and addictions in Nunavut and the delivery of involuntary care; and

(f) being flexible and adapting to Nunavut's evolving mental health care and addictions system.

2. …

"*tikkuaqtaujuq* (selected representative)" means the *tikkuaqtaujuq* (selected representative) determined in accordance with section 3;

...

Adult's or mature minor's *tikkuaqtaujuq* (selected representative)

3. (1) The *tikkuaqtaujuq* (selected representative) of an adult or mature minor is

(a) if they have a guardian named under the *Guardianship and Trusteeship Act*, the guardian;

(b) otherwise, if they designated an individual to act as *tikkuaqtaujuq* (selected representative) while capable of doing so, that individual; or

(c) otherwise, the member of their family or the friend that is

(i) most evidently and directly concerned with the oversight of their care and welfare, as determined in accordance with the regulations; and

(ii) able and willing to act in accordance with section 3.1.

Only one *tikkuaqtaujuq* (selected representative)

(2) For the purposes of this Act, an adult or mature minor may only have one *tikkuaqtaujuq* (selected representative) at any one time.

...

Identifying *tikkuaqtaujuq* (selected representative)

(3) If, under this Act, a health professional is required to identify the *tikkuaqtaujuq* (selected representative) of an adult or mature minor, the health professional shall, in accordance with subsection (1),

(a) select the individual that, in the circumstances, appears to be the *tikkuaqtaujuq* (selected representative); and

(b) if, following a selection under paragraph (a), the health professional identifies another individual who is more appropriate as the *tikkuaqtaujuq* (selected representative), select that individual as the *tikkuaqtaujuq* (selected representative).

...

Role of *tikkuaqtaujuq* (selected representative)

(10) Subject to this Act, the role of a *tikkuaqtaujuq* (selected representative) of an individual is to

(a) be consulted by health professionals during assessment and treatment of the individual;

(b) be consulted and informed about the decisions made respecting the individual under this Act;

(c) in the case of an individual who is an adult or a mature minor, provide consent when the individual does not have the capacity to consent to the matter for which the consent is sought; and

(d) in the case of an individual who is a non-mature minor, provide consent.

Right to information

(11) When the *tikkuaqtaujuq* (selected representative) of an individual is requested to provide consent under this Act, they are entitled to receive all information concerning the individual and the proposed treatment that is necessary for informed consent.

…

General

4. (1) The Minister may provide the following mental health and addictions services:

(a) clinical services, including examinations, diagnostic services, medication management and psychiatry;

(b) therapy;

(c) prevention;

(d) substance use treatment;

(e) advocacy on behalf on individuals receiving mental health and addictions services;

(f) inpatient services;

(g) land-based healing;

(h) Inuit counselling;

(i) support groups;

(j) trauma treatment, including for historical and intergenerational trauma;

(k) postvention services;

(l) respite care and other supports for those experiencing mental health challenges;

(m) programming for the development of healthy attachment, self-esteem, coping skills and relationships, including with family;

(n) cultural programming to support mental wellness and healing;

(n.1) mental health services in schools;

(o) recovery services;

(o.1) outreach services;

(p) interprofessional consultation services;

(q) public education and communications campaigns;

(r) training;

(s) any other services the Minister considers appropriate for

(i) preventing circumstances that lead to mental disorder or distress, or

(ii) promoting and restoring the mental health and wellness of people in Nunavut.

Research

(2) The Minister may conduct research on

(a) mental health and wellness;

(b) methods of providing mental health and wellness services, particularly their effectiveness; and

(c) Inuit-specific approaches to mental health, wellness and services related to mental health and wellness.

...

Right to return

27. (1) An individual transported under the authority of this Act has the right, in accordance with the regulations and the policies of the Government of Nunavut, to be returned to the place where they were originally apprehended, or to another appropriate place, when

(a) they exit involuntary status; or

(b) having been transported outside Nunavut under the authority of this Act,

(i) they are discharged from a health facility outside Nunavut, and

(ii) arrangements have not been made for them to continue involuntary status in Nunavut.

Right to remain pending return

(2) An individual who is awaiting transport under paragraph (1)(a) has the right to remain in the health facility where they were located upon exiting involuntary status until the departure of the transport, but the right to remain ceases if they refuse the transport.

Minister ensures right

(3) The Minister shall ensure that transportation arrangements are made in accordance with the right in subsection (1).

Freedom to leave

(4) For greater certainty, an individual has no obligation to avail themselves to the rights provided under this section.

...

64 Composition of Mental Health Review Board

...

Inuit cultural advisors

(4) The Minister shall appoint at least three individuals who are Nunavut Inuit residing in Nunavut as Inuit cultural advisors.

Victoria, Australia

Mental Health and Wellbeing Act, 2022 (excerpts only)

12 Objectives

In pursuit of the highest attainable standard of mental health and wellbeing for the people of Victoria, this Act has the following objectives—

…

(b) to reduce inequities in access to, and the delivery of, mental health and wellbeing services;

(c) to provide for comprehensive, compassionate, safe and high-quality mental health and wellbeing services that promote the health and wellbeing of people living with mental illness or psychological distress and that—

(i) are accessible; and

(ii) respond in a timely way to people's needs and recognise that these needs may vary over time; and

(iii) are consistent with a person's treatment, care, support and recovery preferences wherever possible; and

(iv) are available early in life, early in onset and early in episode; and

(v) recognise and respond to the diverse backgrounds and needs of the people who use them; and

(vi) provide culturally safe and responsive services to Aboriginal and Torres Strait Islander people in order to support and strengthen connection to culture, family, community and Country; and

(vii) connect and coordinate with other support services to respond to the broad range of circumstances that influence mental health and wellbeing; and

(viii) include a broad range of treatment options with the aim of providing access to the same treatment and support irrespective of whether a person is receiving voluntary or compulsory treatment; and

(ix) include a broad and accessible range of voluntary treatment and support options—

(A) to enable a reduction in the use of compulsory assessment and treatment; and

(B) to enable a reduction in the use of seclusion and restraint with the aim of eliminating its use within 10 years;…

13 Statement of Recognition

(1) The Parliament recognises that Aboriginal people in Victoria are First Nations people of Australia and acknowledges their enduring connection to Country, kin, land and culture

(2) The Parliament acknowledges the following—

(a) that Aboriginal self-determination serves as a foundational principle to improve mental health and wellbeing outcomes of Aboriginal people in Victoria;

(b) the lasting impact of laws, practices and policies on the mental health and wellbeing outcomes of Aboriginal and Torres Strait Islander people since colonisation and enduring to this day;

(c) cultural dislocation, oppression, intergenerational trauma, lack of healing, systemic racism, institutionalised inequality and the loss of land, lore and language continue to harm the mental health and wellbeing of Aboriginal people in Victoria today;

(d) the strength of Aboriginal people, culture, kinship and communities in the face of historical and ongoing injustices;

(e) Aboriginal people's ongoing connection to culture, community and Country and the importance of this connection for the mental health and wellbeing of Aboriginal people in Victoria.

(3) It is the intention of Parliament that the mental health system recognises, respects and supports the distinct cultural rights of Aboriginal people and their right to receive culturally safe holistic mental health and wellbeing services throughout Victoria.

(4) The Parliament supports initiatives which address the ongoing mental health inequalities experienced by Aboriginal people in Victoria.

(5) The Parliament recognises the essential role of Aboriginal community controlled health organisations in meeting the mental health and wellbeing and care needs of Aboriginal people in Victoria.

(6) The Parliament supports the development of future reforms which further Aboriginal self-determination within mental health and wellbeing services in Victoria.

...

18 Least restrictive principle

Mental health and wellbeing services are to be provided to a person living with mental illness or psychological distress with the least possible restriction of their rights, dignity and autonomy with the aim of promoting their recovery and full participation in community life. The views and preferences of the person should be key determinants of the nature of this recovery and participation.

...

27 Cultural safety principle

(1) Mental health and wellbeing services are to be culturally safe and responsive to people of all racial, ethnic, faith-based and cultural backgrounds.

(2) Treatment and care is to be appropriate for, and consistent with, the cultural and spiritual beliefs

and practices of a person living with mental illness or psychological distress. Regard is to be given to the views of the person's family and, to the extent that it is practicable and appropriate to do so, the views of significant members of the person's community. Regard is to be given to Aboriginal and Torres Strait Islander people's unique culture and identity, including connections to family and kinship, community, Country and waters.

(3) Treatment and care for Aboriginal and Torres Strait Islander peoples is, to the extent that it is practicable and appropriate to do so, to be decided and given having regard to the views of elders, traditional healers and Aboriginal and Torres Strait Islander mental health workers.

...

New Zealand

Mental Health (Compulsory Assessment and Treatment) Act, 1992 No 46 (excerpts only)

5 Powers to be exercised with proper respect for cultural identity and personal beliefs

(1) This section applies to—

(a) a court, tribunal, or person exercising a power under this Act in respect of a person; and

(b) a court or tribunal conducting proceedings under this Act in respect of a person.

(2) The power must be exercised, or the proceedings conducted,—

(a) with proper recognition of the importance and significance to the person of the person's ties with his or her family, whanau, hapu, iwi, and family group; and

(b) with proper recognition of the contribution those ties make to the person's wellbeing; and

(c) with proper respect for the person's cultural and ethnic identity, language, and religious or ethical beliefs.