Façade of Safety:

Gender-based violence in BC's involuntary mental health system

Dedication

This publication is dedicated to Shareen Nimmo, whose fierce leadership was and is foundational in shaping Health Justice as an organization. Shareen's expertise, bravery, and generosity helped us see the need for this project, influenced our thinking, and supported others to share their experiences. Shareen is pivotal in paving a pathway for members of the Health Justice team to be open about their own experiences of involuntary treatment, turning their oppression into resistance and advocacy, which enables them to lead projects like this one. She encourages us to work with humility, honesty, and openness, and her contributions are present daily in our work.

Content note

This publication and Health Justice's work engages with many topics that can be difficult to read or hear about, including sexual violence, mental health distress, mental health treatment, detention, seclusion and restraint, policing, and discrimination. These may bring up past negative experiences or memories with the healthcare system or 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 need any support, you can find a list of available resources on our website: healthjustice.ca/content-note-policies.

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This publication is part of a series of publications launched by Health Justice that will set out a path for BC to improve its mental health and substance use health 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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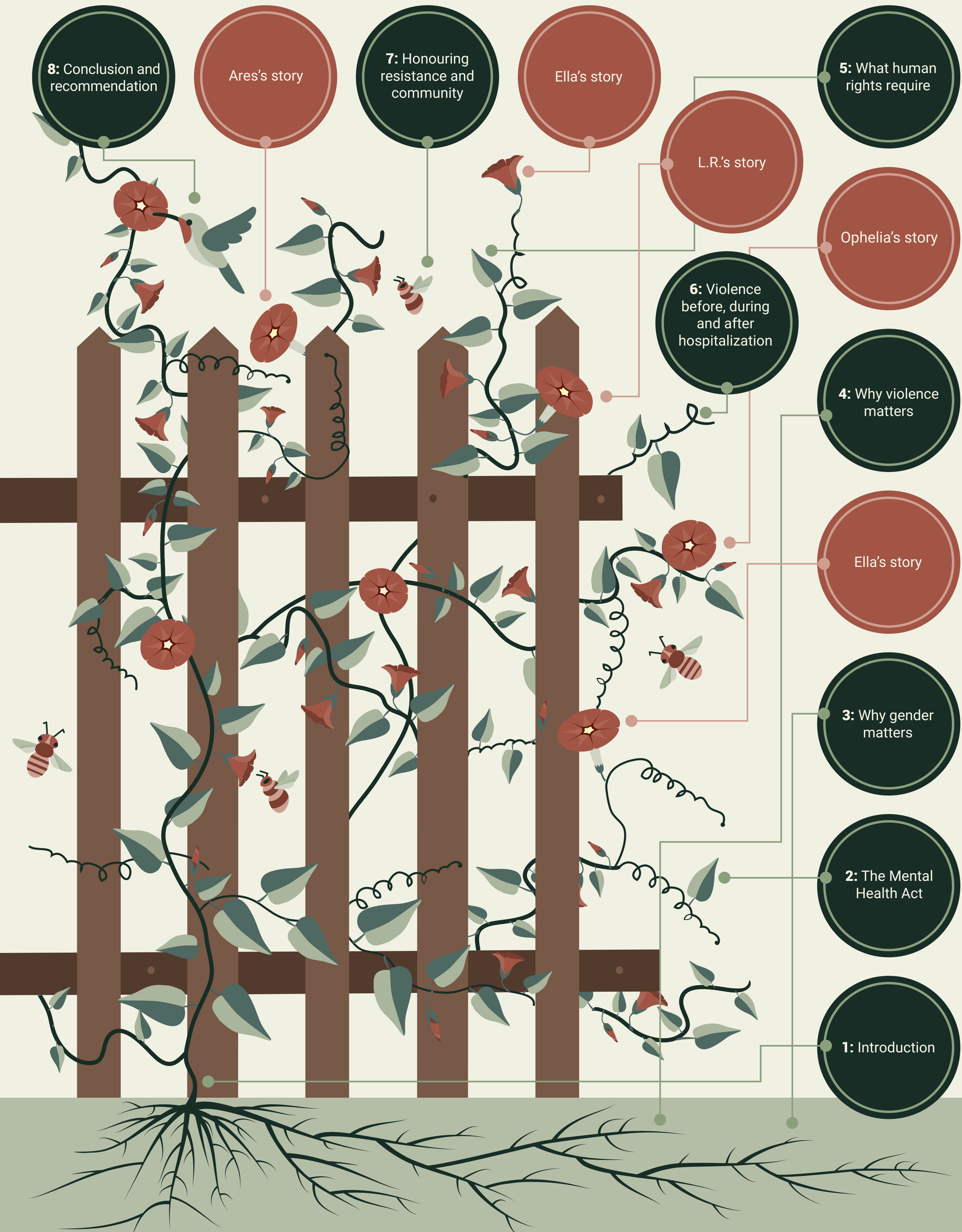
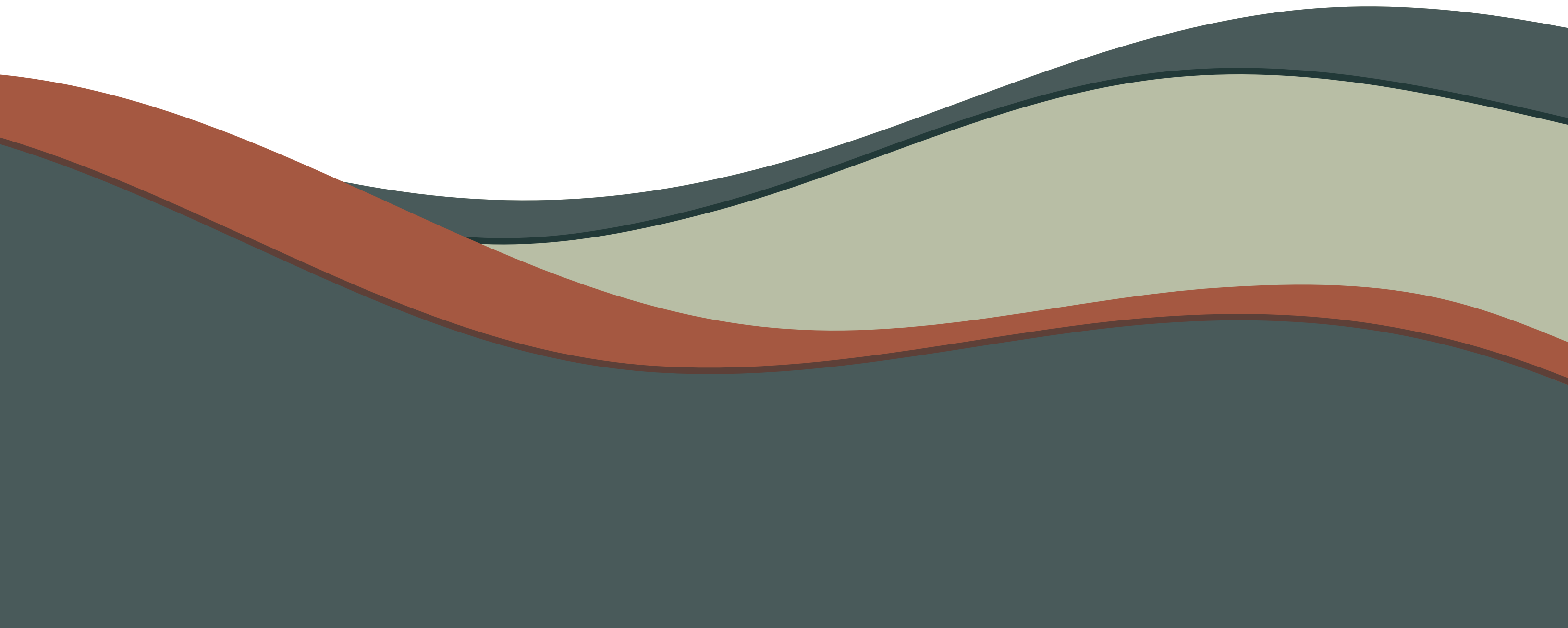
Interactive menu



Contents

Interactive menu **5**
Introduction **12**
About Health Justice 13
Why we did this work 13
Our process 14
Acknowledgment of Indigenous territories, legal orders, practices, and expertise 16
Acknowledgment of foundational expertise 17
How this publication is organized 17
Centring Story: Ella **19**
The Mental Health Act **22**
What we mean by gender **26**
Why gender matters in mental health law and services **30**
History of pathologizing the failure to comply with gender and sexual norms 32
Eugenics, white supremacy, and the mental health system 37
The gendered use of invasive psychiatric “treatments” 38
Despite the importance of gender, BC does not monitor gendered impacts 43
Centring Story: Ophelia Flowers **44**
Defining violence in this work **48**
Why violence matters in mental health law and services **51**
The assumption that detention and involuntary treatment are safe 51
Involuntary treatment creates a context with heightened risk of violence 53
Existing research on gender-based violence during involuntary treatment 56
Centring Story: Ares **59**
Human rights with respect to gender, violence, and involuntary treatment **62**
The rights to liberty and security of the person 63
The right to be free from violence 64
The right to adequate responses to violence 65
The right to equitable and non-discriminatory mental health services 66
State obligations during detention 67
Centring Story: L.R. **70**

Before hospitalization ... **73**
Weaponized gender stereotypes and gender-based violence ... 73
Dehumanization and violence from police ... 77
Violent apprehension of children ... 79
During hospitalization ... **82**
Violence and unsafety in emergency departments, psych emerg, and rapid-assessment units ... 82
The Mental Health Act and policies perpetuate gender-based violence ... 85
The Mental Health Act and involuntary treatment system fail to prevent or respond to gender-based violence ... 106
BC's involuntary treatment system is not trauma- and violence-informed ... 119
After hospitalization ... **133**
Unsafe discharge procedures ... 133
Continued surveillance and feelings of unsafety in the community ... 134
Trauma from involuntary treatment ... 136
Honouring resistance and community ... **139**
Conclusion and recommendation ... **143**



Summary

The Mental Health Act is one of the main laws in BC that authorizes civil detention in health settings and coercive health care. It is a law that grants enormous power over the people subject to it because it allows the health care system to detain a person in one of over 70 health care facilities across BC and to administer involuntary psychiatric treatment against a person's wishes.

Involuntary treatment does not impact all people and communities in the same way. Aspects of a person's identity and life experiences, including gender, sex, sexual orientation, Indigeneity, race, (dis)ability, migration status, or family status, can shape the way they experience it. Since its origin in 2020, Health Justice has continually heard from people with lived and living experience of involuntary treatment that BC's Mental Health Act creates significant gender-based impacts.

A person's gender, sex, gender identity, and gender expression—and specifically their experiences of discrimination and oppression related to their identities—impact their mental wellbeing. It also shapes what makes mental health services safe and accessible to them. Canada and BC are in a current wave of transphobia and gender-based hate that threatens the safety and wellbeing of gender-diverse people. In this context, it is imperative that BC take an intentional approach to address any gender-based harms and ensure its mental health services are gender inclusive.

Ensuring BC's mental health law proactively combats gender- and sex-based discrimination is also important because of the mental health system's long history of policing and pathologizing people who do not align with accepted gendered norms and subjecting them to invasive treatments. This history is deeply intertwined with BC's past and ongoing colonization and white supremacy, with roots in the eugenics movement. The legacy of that history is very much alive and impacts BC's mental health system today.

This report documents the gender-based impacts of the Mental Health Act faced by a group of people with lived and living experiences of involuntary treatment in BC (referred to as "Lived

Experience Experts"). These experiences are wide ranging and reflect the group's diverse, intersecting identities. They reveal strength and resistance in the face of multiple incidents of gender-based violence and discriminatory experiences during mental health detentions that were purported to keep them safe. These experiences include:

- The weaponization of gender stereotypes, sexuality, and power in the context of abuse;
- Violent police apprehensions and widespread use of seclusion, restraints, forced injections, and forced clothing removal;
- Failure to respect gender identity and withholding of gender-affirming treatments, clothing, and gear;
- Apprehension of and separation from children;
- Unaddressed power imbalances that heighten the risk of violence and harassment from staff;
- A lack of prevention of gender-based violence perpetrated by other patients;
- A lack of systematic responses to incidents of gender-based violence when they occur;
- Physical ward or unit designs that exacerbate risk of violence;
- Unsafe discharge procedures; and
- A failure to accommodate intersecting sex- and gender-based needs, including needs related to reproductive health care, access to tools that people often use to protect themselves from gender-based violence and harassment, and access to cultural supports.

A core objective of BC's Mental Health Act is to protect people from harm. This report documents how involuntary treatment does not always protect people from gender-based violence and harms despite this objective. Further, the report finds that:

- The Mental Health Act and related policies authorize gender-based violence by failing to (a) restrict the use of force and coercion or (b) expressly protect human rights related to gender, sex, and gender expression, in addition to other identity characteristics;
- The involuntary treatment system in BC does not adequately prevent gender-based violence or respond appropriately to it when it occurs; and
- Involuntary treatment in BC does not adhere to principles of trauma- and violence-informed care.

These findings also reveal significant human rights violations that may be occurring during detention and involuntary treatment in BC. These range from failures to adhere to existing judicial guidance on Charter compliance during state-authorized detention, to failures to accommodate intersectional gender-based needs, to failures to adhere to obligations set out in international human rights agreements.

Importantly, the experiences shared in this report also illustrate the resistance and resilience of people with lived and living experience of involuntary treatment. In the face of these human rights violations, Lived Experience Experts shared small and large ways they individually and collectively resisted gender-based violence and discrimination. From taking safety into their own hands, to actively confronting the gender bias they experienced, to finding community connection with peers, the Lived Experience Experts illustrated their knowledge and expertise about their own safety and wellbeing as well as that of their community.

HJ

Part 1: Introduction

- Health Justice's work focuses on provincial colonial laws that impact Indigenous people living on the traditional, ancestral, and unceded First Nation territories throughout BC.
- Health Justice brings together human rights, lived experience, cultural, clinical, family, and community-based expertise to inform our work.
- To respond to the need for a gender-specific analysis that was shared so clearly with us, Health Justice sought and received funding to support this work in a safe and ethical way.

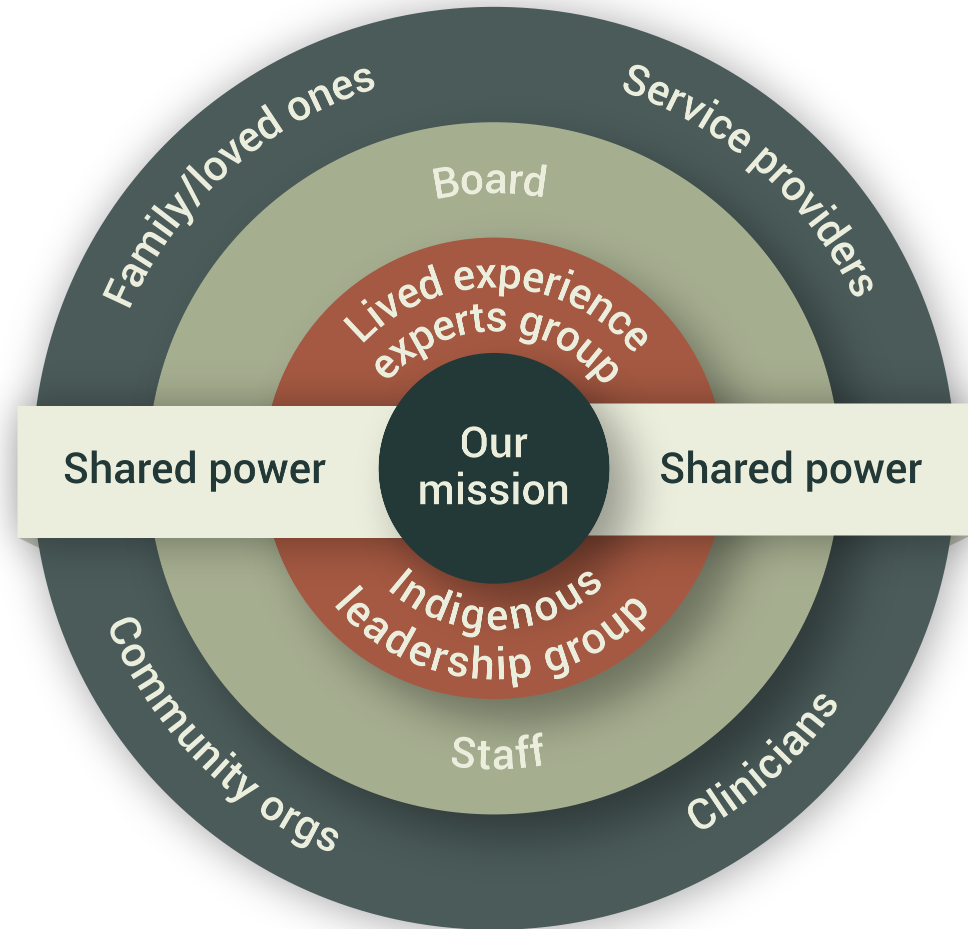
"Communities and individuals sharing their wisdom and insight have deeply shaped the ideas throughout this publication."

Introduction

Health Justice was established in 2020 to undertake research, education, and systemic advocacy to improve the laws and policies that govern coercive mental health and substance use health treatment in BC.

We work using 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.

We also engage with people with lived and living experience of detention and involuntary treatment via our staff team, interviews, focus groups, surveys, art-based reflections, and ongoing relationships. This project came about because of the experience and analysis shared with us through those processes.



Why we did this work

Experiences of detention and involuntary treatment under BC's Mental Health Act vary substantially from person to person, and differences in experience are often informed or impacted by the person's age, geographic region, race, class, sex, gender identity, gender expression, and numerous other factors. Although detention and involuntary treatment have been documented to harm people of all genders, cis and trans girls and women; trans, non-binary, and Two-Spirit people; and other gender-diverse people may experience disproportionate challenges and harms compared with cisgender men while detained under the Mental Health Act in hospitals and other facilities.

Since 2020, Health Justice has been working under the leadership of the Lived Experience Experts Group and the Indigenous Leadership Group. Both Groups have consistently identified multiple gender- or sex-specific impacts of detention and involuntary treatment under BC's Mental Health Act. These included experiences of:

- gender-based violence during psychiatric detention,
- interference with caregiving needs and the apprehension of children,
- separation of birth parents and infants during the crucial post-natal period, and
- lack of respect for gender identity and expression.

It quickly became clear that a gender-based analysis of involuntary treatment is missing from BC's mental health system and is crucial to improving that same system. In winter 2022, in support of our more general law reform work, Health Justice held Journey Mapping sessions where people with lived and living experience of detention and involuntary treatment under BC's Mental Health Act shared their experiences in one-on-one interviews. Once again, the experiences and expertise shared with us during the process confirmed that there are many ways gender, experiences of gender-based violence, and gender-related needs shape how involuntary treatment impacts the human rights of different people.

To respond to the need for a gender-specific analysis that was shared so clearly with us, Health Justice sought and received funding to support this work and, in particular, to provide adequate resources to ensure the work was done in a safe and ethical way that does not further traumatize people.

Our process

The core staff team on the project was made up of a Peer Researcher, with lived experience of detention and involuntary treatment, and a Law and Policy Researcher. The project was also supported at various points by additional staff, a summer legal student, a student policy researcher, and a cultural safety and trauma- and violence-informed practice advisor.

In addition to staff, the project was supported by Health Justice's governance groups—the Lived Experience Experts Group and the Indigenous Leadership Group—as well as a project Advisory Committee made up of experts in the connections between gender and human rights, substance use, mental health services, mental health policy, disability rights, and the needs of older adults.

A core part of the project was to centre the expertise of people with direct lived and living experiences of detention and involuntary treatment ("Lived Experience Experts," sometimes shortened to "Experts"). In support of this work, the project team developed an ethical framework, a cultural safety plan, and resource lists for participants. Most Lived Experience Experts who participated completed one-on-one interviews with the Peer Researcher working on the project to support safety and mutuality. Some participated by sharing previous written work about their experiences.

The Lived Experience Experts who participated in our engagement described themselves using various terms, including "cis woman," "female," "gender non-confirming," "heterosexual," "non-binary/agender," "non-binary/genderfluid," "queer," "queer gay transgender female," "transmasculine non-binary," "Two-Spirit," and "woman." Their ages at the time of their engagement ranged from 22 to 79, and for

two-thirds of the Lived Experience Experts, their last involuntary hospitalization had been within the past five years. Many have been hospitalized several times, and some were children or youth when they were first involuntarily hospitalized. More than 40% of our participants were Indigenous, and we also had Experts who identified as Black, white, and of Asian ancestry. Some of the participants came to Canada as immigrants or refugees. All of the people who were interviewed were comfortable speaking to us in English. Almost all identified as being disabled or having a disability.

We also developed an engagement survey for a small group of clinicians and front-line workers in the involuntary treatment system to understand their perspectives on the issues identified by Lived Experience Experts. This group consisted of people who described themselves as women, men, and non-binary clinicians with primarily nursing and social work backgrounds—some in practice leadership roles. Their survey responses, particularly about the training they receive and about workplace policies, informed some of our recommendations.

All of the expertise shared with us through our engagement work has informed this publication. Analysis and quotes from Lived Experience Experts, as well as clinicians working in the involuntary treatment system, are embedded throughout this publication. In addition, four story summaries are included to share the experience and expertise of people with lived and living experience in fuller context. These stories support a more holistic and embodied understanding of the lived experiences and the ways detention and involuntary treatment impacted the Experts' wellbeing and their rights.

In incorporating these words and ideas, we have made a concerted effort to prioritize informed consent. Authors of quotes and analyses have had opportunities to see, amend, and approve their words used in context and have consented to the inclusion of their thoughts and words in this publication. This consent process does not represent the end of participants' connection with our organization, however. We continuously strive to provide meaningful opportunities for involvement for those interested in maintaining their relationship with Health Justice.

In addition to the engagement work in the project, Health Justice carried out significant research to inform this work, including:

- Reviewing Canadian criminal and civil case law to understand when and how the legal system has responded to gender-based violence during detention and involuntary treatment;
- Reviewing BC Human Rights Tribunal decisions to understand when and how the Tribunal has responded to cases involving detention, involuntary treatment, and gender-based claims of discrimination;
- Analyzing international human rights agreements and related interpretation tools to understand Canada's human rights obligations;

- Researching mental health laws in other jurisdictions to understand how they respond to gender-specific needs; and
- Researching the history of gender-based bias, stereotypes, and discrimination in relation to mental health treatment.

Acknowledgment of Indigenous territories, legal orders, practices, and expertise

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. Currently in BC, over 200 distinct First Nations, 39 chartered Métis communities, and many First Nations, Métis, and Inuit people living away from home in communities across BC hold their own unique legal orders, justice systems, well-established health practices, concepts of health, and conceptions of gender.

Colonization, including land theft and the application of colonial laws, has disrupted these sovereign legal and health care systems, as well as understandings of gender, in numerous ways. The ongoing intentional displacement of communities from their traditional territories and the separation of children from their families and communities undermine protective factors and interrupt ways of sharing knowledge, families, communities, cultural land-based practices, and languages. Colonial binary and patriarchal understanding of gender have been and continue to be enforced through residential schools, day schools, and restrictions on how legal status can be passed down from a parent to their children.

Many of these colonial dynamics continue today in public systems, including the health and legal systems. Involuntary mental health and substance use health treatment, enforced by the colonial health and legal systems, can be experienced as another source of control over Indigenous people that pathologizes and punishes people for the impacts of colonialism.[1] These systems continue to predominantly rely on colonial and binary understandings of gender that force people into categories that may not reflect their culture or community's understanding of gender and sexuality. 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 resilience and resistance to those systems.

Health Justice is a virtual organization with a registered office address located on the traditional, ancestral, and unceded territory of the xʷməθkʷəy̓əm (Musqueam), Sḵwxwú7mesh (Squamish), and səlílwətaɬ (Tsleil-Waututh) Nations.

Acknowledgment of foundational expertise

All of the thoughts, ideas, and analysis in this publication have been built upon expertise and analysis that has been shared with us by experts with direct lived and living experience, Indigenous experts, clinicians, members of the project Advisory Committee, and other organizations. 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.

The work is also building on a long history of advocacy and organizing related to mental health detention, diagnosis, labels, and services, often carried out by people with lived or living experience. In addition, there is a long history of organizing and advocacy in relation to gender and human rights, gender-based violence, and gender-affirming law and policy that came before this project. We want to acknowledge that Health Justice did not start this work and that 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 acknowledgments. Communities and individuals sharing their wisdom and insight have deeply shaped the ideas throughout this publication, and throughout all of Health Justice's work.

How this publication is organized

In seeking to understand the impacts gender has on a person's experience of involuntary treatment, including gender-based violence, we begin with an overview of BC's Mental Health Act, followed by a definition of what we mean by gender, along with historical context for how understandings of gender and sex have affected mental health-related laws and service delivery—including through eugenics practices and pathologizing certain gender identities.

Next, we define how we've conceptualized violence in this project and explore some of the ways the power imbalances in an involuntary setting—one that purports to keep people safe—can create violent environments or exacerbate the impacts of violence.

We then offer a legal analysis of British Columbia's obligations to protect the human rights of people experiencing detention and involuntary treatment, as governed by the Canadian Charter of Rights and Freedoms, BC's Human Rights Code, and international agreements including the Convention on the Rights of Persons with Disabilities and the Convention to Eliminate All Forms of Discrimination Against Women.

The bulk of the publication then focuses on the experiences of the Lived Experience Experts who participated in our engagement. Their stories and insights informed our analysis and recommendations as they described their trajectories from before they were hospitalized—when many of them were apprehended under the Mental Health Act by police—to their experiences of gender-based violence and harassment during hospitalization, to the long-lasting impacts of their encounters with the involuntary mental health system even after they were released from the hospital.

We heard from Lived Experience Experts about the importance of highlighting their strength and resilience in the face of the violence they experienced, which we do before concluding the publication with a summary of our recommendations.

Centring Story: Ella

Ella is a queer woman of Asian descent in her early twenties. They have been hospitalized several times beginning when they were a child, where they received treatment for an eating disorder, mood, and trauma-related issues, with one of their stays lasting 8 months.

Her most consistent experience has been staff not listening to her as she expressed her needs. In one hospitalization, she begged her treatment team for psychological support but was moved to the medical unit where she was tube-fed against her will. The staff on the medical unit was ill equipped to support her mental health needs. When she asked to apply for a review panel hearing, her doctor discouraged her, telling her that by the time a hearing was scheduled, her current round of treatment would be over, so she might as well go through with it. She reluctantly agreed, not wanting to seem “difficult,” but found the forced tube feeding traumatizing and punitive.

When they became an adult, they were hospitalized in a mixed-gender unit where they recall being heavily medicated and unable to protect themselves as three male patients repeatedly and aggressively sexually harassed them. The harassment escalated to the point where they feared that one of the men would find them in the community when Ella was eventually discharged. Ella was especially distressed to learn afterward that the staff had been aware of the harassment but had done nothing to stop it or to protect them.

The harassment—and lack of staff intervention—culminated in a fourth man sexually assaulting her on the unit. The event was traumatic in and of itself, but Ella told us that what made her experience even more traumatizing was the staff response and their unwillingness to listen to her as she tried to tell them what she needed to feel safe.

Even though Ella kept telling staff that they would feel safest in her room, staff insisted they stay in the common area for mealtime, where they not only felt exposed and vulnerable but also had to endure other patients' probing questions about why they were upset and crying. The staff had told the person who assaulted Ella to go to his room, but his door

was unlocked, and Ella was always aware that he could walk out of his room and into the common area at any time.

Afterward, her care team didn't offer her any support to process the trauma of the sexual assault. When she asked her doctor for contact information for a local organization that helps women and gender-diverse people who have experienced violence, her doctor told her she could google it after she was discharged.

At one point Ella asked the nurses on the unit for the phone number to the Patient Care Quality Office, but they gave Ella the number to the Office of the Ombudsperson by mistake. When their care team discovered that they had tried calling the Ombudsperson, the staff confiscated their phone, cutting off contact with their outside support network, and noted in Ella's chart that they had used her phone to complain about their care. To this day, when they are hospitalized, they are not allowed access to their phone.

Ella told us that when her sexual assault happened, nursing staff were "scrambling. [...] It very much felt like they were running around with their heads cut off. They had absolutely no idea what to do." She would like to see facilities develop protocols and staff training to respond to these incidents in trauma-informed and person-centred ways.

Section Summary

Part 2: Mental Health Act Overview

- The Mental Health Act is one of the main laws in BC that authorize civil detention in health settings and coercive health care.
- The extraordinary power granted under the Act does not impact all people equally; it creates differential impacts based on core aspects of a person's identity and social location.
- To date, there has been little focus on the impact of the BC's Mental Health Act related to gender, sex, and sexual orientation.

"Multiple investigations and reviews of the Mental Health Act have documented widespread lack of compliance with human rights safeguards."

The Mental Health Act

The Mental Health Act is one of the main laws in BC that authorize civil detention in health settings and coercive health care. It is a law that grants enormous power over the people subject to it because it allows the health care system to detain a person in one of over 70 health care facilities across BC and to administer psychiatric treatment against a person's wishes.

The Act authorizes detention and involuntary treatment if a doctor or a nurse practitioner believes that four criteria are met. They must believe that the person:

i) has a mental disorder that requires psychiatric treatment and seriously impairs their ability to react to their environment or associate with others;
ii) requires psychiatric treatment in a facility or on extended leave (where they can live in the community but are still involuntary patients and must meet certain conditions);
iii) requires care, supervision, and control in a facility or on extended leave to protect them or other people or to prevent their mental or physical health from substantial deterioration; and
iv) is not suitable as a voluntary patient.[2]

The Act authorizes police to apprehend people and transport them to a physician or nurse practitioner for examination if the officer if satisfied from personal observations, or information received from third parties, that the person is acting in a manner likely to endanger that person's own safety or the safety of others, and is apparently a person with a mental disorder.[3]

Once a person is made an involuntary patient, staff working at designated facilities and mental health teams have significant and broad legal powers to make decisions impacting their rights. Three key powers grant authority to make decisions impacting involuntary patients:

- Section 31 of the Mental Health Act states that involuntary patients are "deemed" to have consented to any form of psychiatric treatment that staff at detaining facilities or mental health teams choose. Since the law creates a fiction that consent already exists, that means involuntary patients aren't assessed to see whether they are capable of making treatment decisions. Involuntary patients who are capable of making their own treatment decisions are not permitted to make their own decisions, and families and personal supporters are excluded from decision making on behalf of their loved ones. This does not happen for other forms of health care in BC. If an adult is assessed as mentally incapable of making a treatment decision for any other kind of health care, the people they trust and know them best act as supporting or substitute decision-makers.[4]

- Section 32 of the Mental Health Act states that every patient is "during detention, subject to the direction and discipline" of the facility staff. This means that patients can be solitarily confined in seclusion rooms, mechanically restrained with straps that tie them to their beds, or otherwise punished during their time in hospital. There are no limits on when, how, or why someone can be subject to these restraints, no review, and no requirement that the use of these powers be therapeutic or restricted to situations of imminent safety risk. Other conditions that involuntary patients experience in detention, such as access to visitors, access to methods of communication like a phone, and access to the outdoors are determined by staff with this broad grant of discretion.

- Section 37 of the Mental Health Act provides authority for staff at detaining facilities to release involuntary patients to the community under certain conditions, a situation known as "extended leave." In the community, people experiencing involuntary treatment on leave are generally under the supervision of a mental health team and still subject to the "deemed consent" model; if a person does not comply with the conditions of their leave, they can be apprehended and transported back to the facility to be detained again. This amounts to a de facto compulsory community treatment regime. There are no criteria or limitations on the conditions that can be imposed on involuntary patients, and someone suspected of violating their conditions of leave can be recalled back to detaining facilities.

This legislative approach is unique to BC, and multiple independent investigations and community reviews have identified widespread lack of compliance with mandatory legal safeguards,[5] violations of the Charter of Rights and Freedoms and international human rights law,[6] alarming growth in the use of involuntary treatment, and perpetuation of making people

with mental and substance-use health needs feel criminalized.[7] In addition, the extraordinary power granted under BC's Mental Health Act does not impact all people equally; it creates differential impacts based on core aspects of a person's identity and social location. For example, human rights concerns have been documented about the Act in relation to children and youth,[8] as well as Indigenous people and communities in BC.[9]

To date, there has been little focus on the impact of BC's Mental Health Act related to gender, sex, and sexual orientation. The Act is silent on its impacts or human rights obligations in relation to these aspects of a person's identity aside from one section, which is entitled "Admission of female person":

> *19 The person who requests or applies for the admission of a female person to a Provincial mental health facility must arrange for her to be accompanied by a near relative or a female person between the time of the request or application and her admission to a Provincial mental health facility.*[10]

This provision is a relic of BC's original mental health legislation, enacted in 1964, where it appeared with nearly identical wording.[11] It appears to be a throwback to outdated approaches to gendered propriety and safety that relied on the use of chaperons. We are not aware of any instances of it being used, and no Lived Experience Experts we engaged for this report shared any knowledge the section being used. Even if the section is in active use today, its impact is minimal and will be explored later in this report.

HJ

Section Summary

Part 3: What we mean by gender

- Gender is a socially constructed understanding of a complex combination of norms, roles, behaviours, and expressions.
- Colonial conceptions of gender reflect a binary understanding rooted in ideas that centre whiteness and narrow definitions of acceptable heterosexual masculinity.
- Binary conceptions of gender have resulted in inequity for cis and trans women and girls; Two-Spirit, trans, and non-binary people; as well as other gender-diverse people.

"Language that tries to encompass complex and nuanced understandings of identity and self are fraught and imperfect."

What we mean by gender

Gender is a socially constructed understanding of a complex combination of norms, roles, behaviours, and expressions.[12] For example, how we dress, how we speak, what role we play in our family, and how assertive we are can all be tied to socially enforced ideas of gender. Social construction of gender can change over time, from culture to culture, and from person to person.

Gender is different from the physical aspects of our bodies, like our organs, chromosomes, and hormones, which make up what we call biological sex. There is vast diversity in how society and an individual may understand their gender (for example, woman, man, cisgender, transgender, trans,[13] non-binary, genderfluid, agender, gender variant, transmasculine, transfeminine, etc.). We often think of sex categories as limited to male, female, and intersex, although that fails to account for the complex interconnections of people who may have sex characteristics that fall outside what is considered "normal" as they access gender-affirming treatments like hormones or surgery. Sexual orientation is a distinct concept that describes an enduring personal

GLOSSARY

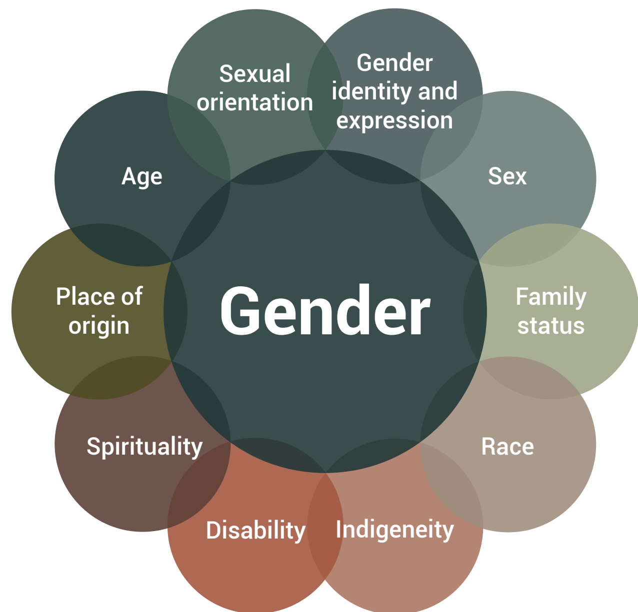
Gender: a socially constructed understanding of a complex combination of norms, roles, behaviours, and expressions.

Gender identity: our own internal sense of our gender.

Gender expression: how we express our gender outwardly.

pattern of romantic attraction or sexual attraction (for example, gay, lesbian, bisexual, aromantic, asexual, pansexual, etc.). However gender identity, expression, sex, and sexuality can intersect in complex ways.

Because gender is socially constructed, it is also deeply influenced by intersecting aspects of a person's identity.[14] For example, an individual's race, Indigeneity, (dis)ability, age, spirituality, or migration status may intersect with their gender and create specific ideas of what is considered "normal." For example, gender norms for women often include being compliant and submissive. A Black woman expressing strong emotion may be perceived not only through those gendered expectations but also through the lens of racist stereotypes about "angry Black women."[15] So she may be more likely to be perceived as "angry" and therefore perceived as behaving outside what is considered "normal" or "appropriate."



In addition, colonial conceptions of gender have typically reflected a binary understanding (boys and girls; men and women) rooted in patriarchal, Eurocentric ideas that centre whiteness and narrow definitions of acceptable heterosexual masculinity.[16] For example, women have been expected to be polite, caregiving, feminine, and submissive, while men have been expected to be assertive, strong, masculine, and dominant—although these expectations can vary based on factors like race and class.

These categorized, binary conceptions of gender (and sex and sexuality) have resulted in inequity for cis and trans women and girls; Two-Spirit, trans, and non-binary people; as well as other gender-diverse people. They have also led to an erasure of a nuanced understanding of gender beyond a limited binary. An example of the practical effects of this narrow view is that sex characteristics impacted by gender-affirming care, or a lack of alignment of sex characteristics with expected gender expression, can be viewed as abnormal. The health system, and mental health system in particular, has a long history of pathologizing people who do not conform to the current norms, social roles, and behaviours expected in relation to gender,[17] or erasing and ignoring their health needs and concerns.[18]

For First Nations, Métis, and Inuit people, these colonial conceptions and categories were imposed via colonial tools like residential schools that taught and enforced binary conceptions of gender.[19] The Indian Act created and compelled discriminatory patrilineal community membership that disenfranchised First Nations women from their communities.[20] In the face

of colonization, many First Nations, Métis, and Inuit people and communities continue to hold diverse and complex understandings of gender.[21] Two-Spirit identities, for example, reflect a nuanced range of cultural, gender, sex, and sexual identity that vary by community.[22] The enforcement of binary colonial approaches has undermined this complexity. Further, health research is often rooted in colonial conceptions of gender, which further erases Two-Spirit identities and experiences by omitting them from research.[23]

As set out above, participants in this project include people who experienced detention and involuntary treatment as cis and trans girls and women; trans, non-binary, and Two-Spirit people; as well as other gender-diverse people. Most of the impacts described in this report are due to a participant's gender, gender identity, or gender expression—or other people's responses to their gender, gender identities, and gender expressions—but some can be attributed to biological sex (for example, inappropriate reproductive healthcare related to menstruation, or discrimination in response to trans bodies and related sex characteristics). We have identified those when they come up.

Language that tries to encompass complex and nuanced understandings of identity and self are fraught and imperfect. We also recognize that understandings of labels and language may differ across people, place, culture, and time but can also be experienced as either affirming or denying a person's identity and dignity. This can be especially true in a time of increasing hate and discrimination based on gender, gender identity, gender expression, sex, and sexuality. In this project, we have done our best to be thoughtful and intentional by using terms people have used to describe themselves as individuals and by using inclusive and up-to-date language to describe groups, but we recognize that no term(s) will reflect every person's identity and understanding. If the terms or language used in this report do not match your own understandings or your identity, please know that it is not intentional and we are doing our best to keep learning.

Section Summary

Part 4: Why gender matters in mental health law and services

- The mental health system has a long history of pathologizing behaviour that does not conform to current social norms and expectations related to gender, sex, and sexuality.
- Many of the most invasive mental health treatments through history, some of which we find abhorrent today, have had differential impacts based on gender.
- BC must improve its data collection on gender in mental health services to monitor and evaluate any gender-based impacts.

"It is imperative that today's mental health system take steps to ensure gender-based discrimination in the mental health does not continue."

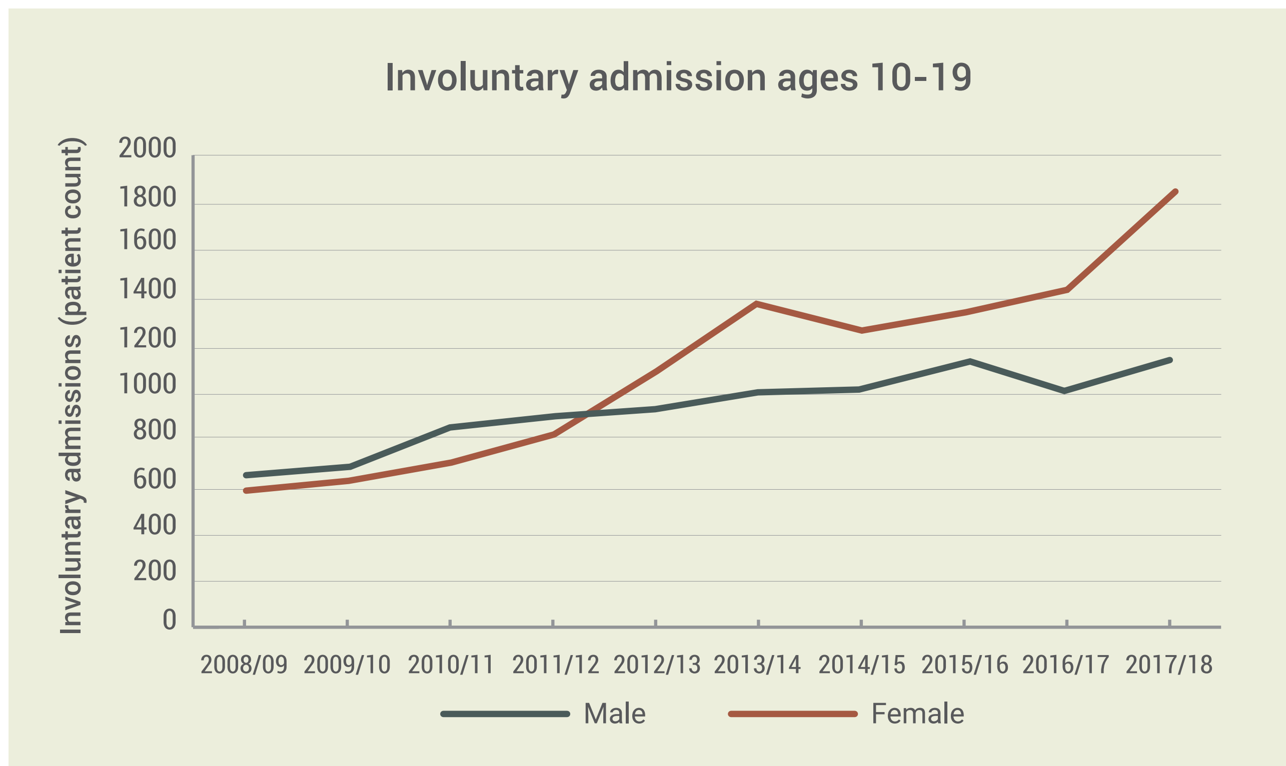
Why gender matters in mental health law and services

Experiences of involuntary treatment do not impact all people and communities in the same way. Aspects of a person's identity and life experiences, including gender, sex, sexual orientation, Indigeneity, race, (dis)ability, migration status, or family status, can shape the way they experience it. Chronic oppression and discrimination related to an aspect of a person's identity, like experiences of racism, colonization, failure to affirm gender identity, or patriarchal gender norms can create mental health inequities because of their negative impacts on wellbeing.

For example, immense mental health inequities are experienced by transgender people in Canada because of their experiences with discrimination, transphobia, harassment, and dysphoria (caused by socialized norms to adhere to gender expectations). That oppression leads to higher risk of suicide, self-harm, and depression.[24] It is also well established that gender-affirming relationships and health care positively impact the mental wellbeing of transgender people.[25] In the face of extreme anti-trans hate in Canada and the growing political willingness to curtail gender-affirming rights through provincial legislation by populist governments,[26] ensuring that all mental health services provide equitable and gender-affirming support is more important than ever.

BC has seen massive growth in the use of detention and involuntary treatment under BC's Mental Health Act in recent years. Between 2010/11 and 2020/21, involuntary admissions increased by approximately 83%.[27]

The fastest-growing group to experience detention and involuntary treatment is girls and young women. While accurate, reliable data is hard to come by, it appears that between 2008/09 and 2017/18 (the most recent data we have access to), involuntary treatment of girls and young women between the ages of 10 and 19 increased by approximately 222%.[28] Boys and young men in the same age group experienced an increase of 58% over the same period.[29] Over this entire 10 year period, BC's data recognizes only 5 involuntary admissions of a person between the ages of 10 and 19 with a "gender other than male or female," two admissions in 2013/14 and three in 2014/15.



Source: Ministry of Health, "FOI 2020-07130 Hospital Discharges with MH Diagnosis by Involuntary and Other" at page 7.

The disproportionate increase in the use of detention and involuntary treatment shows that the gender of children and youth is impacting their experiences with the Mental Health Act. Because this data appears to use binary sex categories but refers to "gender" in the data notes, it is unclear how the experiences of gender-diverse and intersex people are reflected. To the extent that they are reflected at all, it is also unclear if data reporting gender identity is based on a person's own description of their gender (versus staff perceptions or assumptions). Certainly, the very small number of patients reflected as having a "gender other than male or female" suggests gender-diverse identities are being largely erased in the data collection process. This is consistent with lived experience accounts in this project

and others. For example, two trans youth interviewed by the Representative for Children and Youth recalled that when they were detained under the Mental Health Act, their care teams did not appropriately support their transition journeys. One youth was denied access to hormone therapy and "felt stripped of her identity."[30]

Without a nuanced understanding of the history and context of gender in mental health treatment, it is easy to assume that girls and young women, based on the above data, simply have higher rates of individual mental health needs—and to ignore the systemic forces that create gender-based risks for their mental wellness and for the use of detention and involuntary treatment. Locating vulnerability in girls and young women or viewing them as somehow inherently "at risk" erases how structural gender inequity creates risk and how individuals resist those impacts.[31]

History of pathologizing the failure to comply with gender and sexual norms

A person's gender, gender identity, sex characteristics, and sexual orientation are not illnesses—they are fundamental parts of their identity that go to the heart of their dignity and humanity. However, the health system, and specifically the mental health system, has a long history of pathologizing behaviour that does not conform to current social norms and expectations related to gender, sex, reproduction, and sexuality.

Pathologization has typically occurred in two ways: (1) treating a person's behaviours or identities that do not conform to socialized gender expectations as an individualized medical problem or biological flaw in need of treatment or eradication; and (2) treating the distress a person experiences from the oppression because they do not conform to a narrow conception of gender as a medical problem or biological flaw in need of mental health treatment.

The following are just a few of the common examples of the ways the mental health system has (and continues to) pathologize aspects of gender, gender identity, and sexuality, framing the non-compliance with accepted social norms as a health problem.

a) Hysteria

Hysteria is identified as one of the first mental illnesses associated with women. In Ancient Egypt, hysteria was attributed to spontaneous movements of the uterus. Based on similar beliefs, hysteria in Ancient Greece is considered by some to be the origin of psychiatry.[32] In the 19th century, the label was used for an almost limitless array of symptoms. A woman considered hysterical may be labelled by physicians as "difficult, narcissistic, impressionable, suggestible, egocentric and labile" and an "idle, self-indulgent and deceitful woman, 'craving for sympathy', who had an 'unnatural' desire for privacy and independence."[33]

The diagnosis was eventually connected with the brain and understood as a psychological issue and not a physical one. In the late 1800s in BC's Provincial Hospital for the Insane, a diagnosis of hysteria was often treated with "a regime of 'moral control'" that included monitoring food

intake and elimination, as well as systems of reward and punishment that incorporated tools like restraints, solitary confinement, and loss of privileges.[34] When shellshocked soldiers from World War I started experiencing similar symptoms, the diagnosis became more gender neutral. Over time, the use of hysteria as a diagnosis declined, and it was removed from the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) in 1980.[35]

Some have argued that the concept of hysteria has persisted through various iterations of the DSM to the gendered application of histrionic personality disorder, somatoform disorder, and dissociative identity disorder diagnoses today.[36] One Lived Experience Expert who participated in this project described this very clearly:

> **They just see you as a hysterical… a hysterical woman. A hysterical, crazy woman, and this person doesn't need help. They've got a personality disorder. We don't know what it is, so we're just going to put this label on you and that's it.[37]**

This experience and others reported by Lived Experience Experts suggest that the gendered stereotypes at the heart of pathologizing "hysterical women" continue in BC's involuntary treatment system.

b) Transness and gender-diverse identities

Since at least the 1900s, people with gender identities or sexual orientations that do not align with social gender expectations and heterosexual, monogamous marriage have been labelled as deviant, linked to violence, and seen as risky to the broader population.[38] At the time, gender identity, gender expression, and sexual orientation were often conflated with "sexual deviance." Canada surveilled, policed, and criminalized these identities as the focus of national security concerns.[39] The mental health system was complicit in helping the RCMP develop psychological tests that attempted to "detect" people who did not conform to socialized norms.[40]

Through the late 1800s into the early 1900s, medical clinicians, often psychiatric professionals, began to frame gender identity as a biological flaw requiring treatment, instead of a moral failure.[41] As Susan Stryker notes, this move was a "two-edge sword" because it opened the possibility of access to gender-affirming medical treatment but forced a core aspect of a person's identity to be framed as an illness or biological flaw:

> *Far too often, access to medical services for transgender people has depended on constructing transgender phenomena as a symptom of a mental illness or physical malady, partly because "sickness" is the condition that typically legitimizes medical intervention.[42]*

Transness and gender-diverse identities have been and continue to be pathologized via the mental health system, although the form of pathologization has shifted over time. Before the DSM existed, the misalignment between a person's gender identity and assigned gender was pathologized, and many clinicians opposed gender-affirming treatment; instead, they considered this misalignment a delusion in need of treatment to eliminate.[43]

In 1980, pathologization was formalized when diagnostic labels for transsexualism, gender identity disorder of childhood (reflecting an ongoing focus on the gender identity of children that continues to this day), and atypical gender identity disorder were added to the DSM.[44] Confoundingly, the diagnosis of gender identity disorder of childhood had differing diagnostic criteria for children assigned boys and those assigned girls at birth, with broader criteria that included a "preoccupation with female stereotypical activities" only for those with an assigned gender of boy.[45] These differences continued until 2013 and are consistent with historical and ongoing concerns about effeminate boys as a threat to masculinity, the greater social acceptance (and therefore narrower pathologization) of behaviours that are associated with men and masculinity, and erasure or gatekeeping of transmasculine identities.[46]

In 2013, the DSM shifted from pathologizing a person's gender identity itself to pathologizing the suffering they experience because of their gender identity, moving to a diagnosis of "gender dysphoria," which was thought to be less stigmatizing.[47] While the DSM has not been updated since 2013, this approach continues today and is the subject of significant critique because it pathologizes as a mental health issue the suffering caused by the social structures that lead to someone's gender identity being marginalized as opposed to any health issue with the person themselves.[48] It also forces gender-diverse people to create a medical record of their identity that can follow them through a health care system that is often unequipped to provide appropriate, non-discriminatory care. The current diagnoses included in the DSM are also considered to be important to legitimizing the need for publicly funded gender-affirming health care in Canada, access to which is currently under attack in some provinces.[49]

Lived Experience Experts described how their gender identity is still pathologized in the current involuntary treatment system. For example, participants' concerns about the impacts of mental health treatments on the appearance of their body in relation to their gender were dismissed as symptoms of their eating disorder:

> **There have been times that I have tried to engage with staff about my experiences of gender dysphoria—especially in relation to my eating disorder treatment experiences—that my fear of my body changing with renourishment are not just around, quote-unquote, "the fear of being fat," rather the experience of dysphoria when I have more**

female characteristics appearing as well as a feeling of being "unsafe" in a more female-appearing body. In my experience, these conversations tend to be shut down and reduced to "just my eating disorder talking."[50]

Another Expert spoke about how they were prohibited from their gender-affirming health care based on one clinician's speculation that it was worsening their mental health symptoms when there was no evidence that was true. These experiences illustrate that when a person's gender identity does not align with the social norms and expectations tied to their assigned gender, that misalignment is pathologized.

c) Sexuality

Sexuality, and specifically behaviours or identities that run afoul of social norms that limit sexual relationships to heterosexual, monogamous marriage, have long been pathologized by the mental health system. Deeply interconnected and sometimes totally linked to understandings of gender, what is considered "normal" sexuality and sexual activity also varies across time and cultures. Social norms and expectations in these areas have often been circumscribed by binary ideas of gender where men and women exist in opposition to each other, with women's sexuality defined as subordinate and in service of men's sexuality and masculinity.[51] The accepted purposes of sexual activity were limited to reproduction or the sexual satisfaction of men.

Looking specifically at the various iterations of the DSM from 1952 to 2013, one can see a range of ways that sexual desire that is considered above "normal," sexual activity that is considered below "normal," pain issues, arousal issues, and erroneous physiological understandings have gone through shifting diagnostic labels.[52] For example, when frigidity was a diagnostic label, it was commonly attributed to women who did not reach orgasm; however, at that time, "marriage manuals indicated that sex ought to result in simultaneous orgasms as the climax of intercourse."[53] Similar trends can be seen with diagnoses related to gender identity that was considered abnormal.[54]

When the misogyny embedded in these gender and sexuality norms of the dominant white western culture intersects with anti-Indigenous racism, the potential for harm increases. The In Plain Sight report on Indigenous-specific discrimination in BC's health care system highlighted several ways that Indigenous women face "virulent misogynistic stereotypes"[55] from health care providers. For example, younger Indigenous women were "characterized as

Table 1: Summary of changes to DSM diagnoses related to sex, gender, and sexuality, 1952-2013 (expanded from Kleinplatz at 35).

Edition	Year	Changes to diagnoses about sexuality	Changes to diagnoses about gender identity
DSM	1952	Included involutional melancholia, frigidity, dyspareunia, nymphomania. Homosexuality listed under personality disorders.	No mention of gender identity.
DSM-II	1968	Homosexuality now listed under sexual deviations.	No mention of gender identity.
DSM-III	1980	Homosexuality removed. Nymphomania removed and a new diagnosis added of inhibited sexual desire and sexual aversion. Psychosexual dysfunctions added, which now include inhibited arousal and orgasm disorders in men and women, plus dyspareunia and vaginismus in women.	"Transsexualism," "gender identity disorder of childhood," and "atypical gender identity disorder" appear as diagnoses.
DSM-III-R	1987	Psychosexual dysfunctions renamed sexual dysfunctions. Inhibited sexual desire renamed hypoactive sexual desire disorder.	"Atypical gender identity disorder" replaced by "gender identity disorder of adolescence or adulthood, nontranssexual type" and "gender identity disorder not otherwise specified."
DSM-IV	1994	No significant changes.	"Transsexualism" changed to "gender identity disorder."
DSM-IV-TR	2010	No significant changes.	No significant changes.
DSM-5	2013	Sexual aversion removed. Dyspareunia and vaginismus removed and replaced by genito-pelvic pain/ penetration disorder. Female sexual arousal disorder and hypoactive sexual desire disorder replaced by female sexual interest/ arousal disorder. No similar collapsing of categories occurred for male sexual dysfunctions.	"Gender identity disorder" eliminated and replaced with "gender dysphoria."

sexually promiscuous. This led to girls being falsely assumed to be sexually active, to mistaken diagnoses of sexually transmitted diseases and to patients being treated in ways that left them feeling dirty and ashamed."[56]

Sexual orientation has also long been pathologized. As set out above, Canada has a long history of viewing anything other than heterosexuality to be deviant and a risk to both masculinity and people who were perceived as good, moral citizens (white heterosexuals complying with current gender norms).[57] In that vein, Canada has used state surveillance, policing, and

purported "science" to try to locate and eradicate this risk, with the mental health system working alongside these efforts through troubling psychological testing and experimentation.[58]

When "homosexuality" was initially included in the DSM in 1952, it was under the heading of personality disorders. It was referenced in a list of "sexual deviation" behaviours that included "homosexuality, transvestism, pedophilia, fetishism, and sexual sadism including rape, sexual assault, mutilation,"[59] sending a clear message about how the diagnosis was understood. While it was finally removed from the DSM in 1980, editions until 2013 continued including diagnoses based on distress connected to one's sexual orientation, moving to pathologizing the stress and toll of being someone with a marginalized sexual orientation.[60]

Lived Experience Experts in this project highlighted the ways involuntary treatment can allow for invasive and voyeuristic questioning about the details of their sexuality and who they have sex with—aspects of their life that had no bearing on their mental health needs at the time. For example, a doctor asked one Expert, who was receiving treatment for an eating disorder, whether she was a virgin, which she found irrelevant and inappropriate. A trans Lived Experience Expert fielded probing questions from their care team about their and their partner's genitals, which had no relation to the reasons for their hospitalization.

Eugenics, white supremacy, and the mental health system

In the late 1800s and into the early 1900s, a growing eugenics movement emerged in Canada and other areas of the British Empire. It focused on evolutionary "improvement" in the human population via controlled reproduction. In Canada, the eugenics movement was deeply rooted in discriminatory beliefs that resulted in the desire to maintain a strong, white, middle-class population free from disabilities and other perceived "defects." In the face of increasing immigration to support the expansion of settler resource extraction and economic development and to support World War I, fear rooted in white supremacy, racism, and ableism grew. Eugenic policies were developed to reduce the rate of reproduction of people who were deemed undesirable.

For example, people with mental health disabilities, labels, or diagnoses were considered biologically flawed, based on a strong belief that mental health needs were contagious or hereditary.[61] At the same time, provincial mental institutions in BC were dealing with ongoing issues of overcrowding, growing numbers of people detained in them, and a growing cost for their operations.[62] Through a lens of eugenics, this combination created a desire to reduce the growth (and, by definition, the reproduction) of people with mental health needs.

The eugenics movement in Canada is deeply connected to today's mental health system. The "mental hygiene" movement in Canada was formalized in 1918 via the National Committee on Mental Hygiene, which later became known as the Canadian Mental Health Association.[63] It was touted as focusing on preventing mental illness in the face of increasing demand on mental hospitals. However, its prevention priorities reflected understandings rooted in

eugenics, including preventing the hereditary spread of mental disease and implementing stricter immigration requirements to weed out unwanted newcomers.[64]

In 1925, BC's provincial government struck a Royal Commission on Mental Hygiene to study the reasons for the increase in people detained in provincial mental hospitals, causes and prevention of "lunacy," the ways "insane, mentally deficient and subnormal" people were entering BC, and the treatment of "subnormal" children.[65] One of the primary recommendations made by the Commission was to sterilize people detained in mental institutions so that they could be released into the community without any risk of "multiplication of the evil by transmission of the disability to progeny."[66] The report set out a recommended scheme for consent, where the individual could consent to sexual sterilization, and if they could not consent, their husband, wife, parent, or guardian could consent on their behalf. If none of those options for consent were possible, the provincial minister responsible for mental institutions could consent on the individual's behalf.[67] In practice, it appears that sterilizations were not always tied to discharge from a facility as these objectives would suggest; instead, sexual sterilizations were also performed on people who were never institutionalized, suggesting that motives also included simply sterilizing all people considered to be "defective" regardless of whether they were in a provincial mental institution or the community.[68] In 1933, BC implemented this recommendation by enacting the Sexual Sterilization Act, which remained in force until 1972.[69] It authorized the non-consensual sexual sterilization of people who, in the opinion of the superintendent of an institution, "would be likely to beget or bear children who by reason of inheritance would have a tendency to serious mental disease or mental deficiency." Requests had to be approved by a Board of Eugenics.[70]

As a result, sexual sterilization became a mental health "treatment" during this period. The gendered impacts of the law are explored further below.

The gendered use of invasive psychiatric "treatments"

Many of the most invasive mental health treatments throughout history, some of which we find abhorrent today, have had differential impacts based on gender. Women have been subject to these procedures in grossly disproportionate rates compared with men.

Most of the data presented below with respect to these practices is limited to a binary understanding of gender that conflates sex and gender, either due to the time period or a lack of adequate data collection in the mental health system. This limitation erases any impacts related to gender identity and expression in many of the examples.[71] However, given the clear pathologization of gender in the examples below, gender-diverse people would likely have been impacted by many of these assessments based on what was considered "normal" or "abnormal" based on social expectations of gender at the time. Much of the official recordkeeping is also

silent on race and Indigeneity, erasing any ability to understand the intersectional impacts of these procedures. However, where data is not available, there is no doubt that racialized and Indigenous people were likely to have been subject to the procedures at disproportionate rates due to racism and colonial bias.

a) Sexual sterilization

As set out above, from 1933 to 1973, the Sexual Sterilization Act was in force in BC, which authorized the non-consensual sterilization of people through requests from leaders of mental health institutions. There is limited detail available in terms of when and how the Act was used, but what is available illustrates it was very clearly gendered.

In 1945, the Essondale Report was completed, reviewing the use of sexual sterilizations authorized under the Act via the Essondale Provincial Mental Hospital (later renamed Riverview) between 1935 and 1943. The Report found:

- 89% of the sterilizations during that period were done to girls and women, and 11% to men, indicating a grossly disproportionate use on girls and women.[72]
- Men who were subject to sterilization were aged 22–48 while women were aged 13–44, indicating that girls and young women were subject to sterilization but boys and young men were not.[73]
- Reasons given for the sterilization of men included inability to support family, promiscuity, mental deficiency, violent tendencies, incest, and not wanting more children.[74]
- Reasons given for the sterilization of women and girls included promiscuity, post-partum depression, epilepsy, psychiatric problems, incorrigibility, and marked sexual tendencies.[75] For single women and girls, behavioural reasons given reflect a clear theme of noncompliance with gender norms, according to Gail van Heeswijk's analysis of the legislation:

> *The case notes for thirty three single women documented that these patients' behaviour, which was utilized to base their psychological assessment [sic]. Their behavior was described as follows: "sex delinquent," "sexual colouring to ideas," "sexual propensities," "already had one pregnancy," "talked freely of sex experiences," "illegitimate pregnancy," "already had an affair," "showing sexual tendencies," and "sexual propensities are quite marked."*[76]

The Essondale Report also assessed whether the sterilizations achieved their intended impacts and, therefore, whether the Sexual Sterilization Act was "successful." In concluding the Act was a success, the Report relied on several gendered and patriarchal understandings of gender and sexuality. As van Heeswijk writes:

The contrast between the successful and the unsuccessful cases was based in sexual behaviour. The man termed as successful was committed three more times to hospital, had numerous manic attacks, received social assistance, and quit his job. Women who were deemed successful had become married. The reasoning provided for the two unsuccessful cases was that they were still sexually active outside of marriage. This leads to the conclusion that these women were considered unsuccessful due to the fact that they did not fill the role expected of women, keeping sexual relations within marriage.[77]

Other cases were considered successful for reasons clearly tied to gendered social expectations; for example, a woman who was subject to sterilization was "reputed to be a scrupulous housekeeper" and therefore, the procedure was considered a success.[78]

Although data on race and Indigeneity were not reported at the time, control and coercion related to reproductive health and health more generally have been a historic and ongoing colonial tool.[79] We know that sterilization of Indigenous women and girls did take place at Essondale as well as in Indian hospitals,[80] which were part of racist segregation of the health system.[81] While the data erases the colonial impacts in BC, Indigenous women and girls were disproportionately affected by coercive sterilization in Alberta,[82] which had similar legislation. We also know that coercive sterilization practices of Indigenous women and girls have continued, being recently reported[83] despite the Sexual Sterilization Act's repeal in 1973.

b) Lobotomies

Lobotomies, or the intentional disconnection of the prefrontal cortex from the rest of the brain, is another example of a highly invasive procedure that was carried out disproportionately on women. Benefits were purported to include a reduction in "insomnia, nervous tension, apprehension, and anxiety." Risks included patients becoming markedly more docile and losing "some spontaneity, some sparkle."[84] The practice occurred in BC at Essondale/Riverview.[85]

It is widely accepted that lobotomies were carried out on women far more frequently than men, even though most people in mental institutions during periods studied were men.[86] Canadian or BC-specific data is not available, but it likely followed trends of the United States, where up to 75% of people subject to lobotomies were women.[87] This has been attributed to gender expectations of women and their role in society and the family:

At a time when women were expected to be calm, cooperative and attentive to domestic affairs, definitions of mental illness were as culturally bound as their treatments. A surgery that rendered female patients docile and compliant, but well enough to return to and care for their homes, had many proponents before the drug chlorpromazine, the first "major" tranquilizer, became available in 1954.[88]

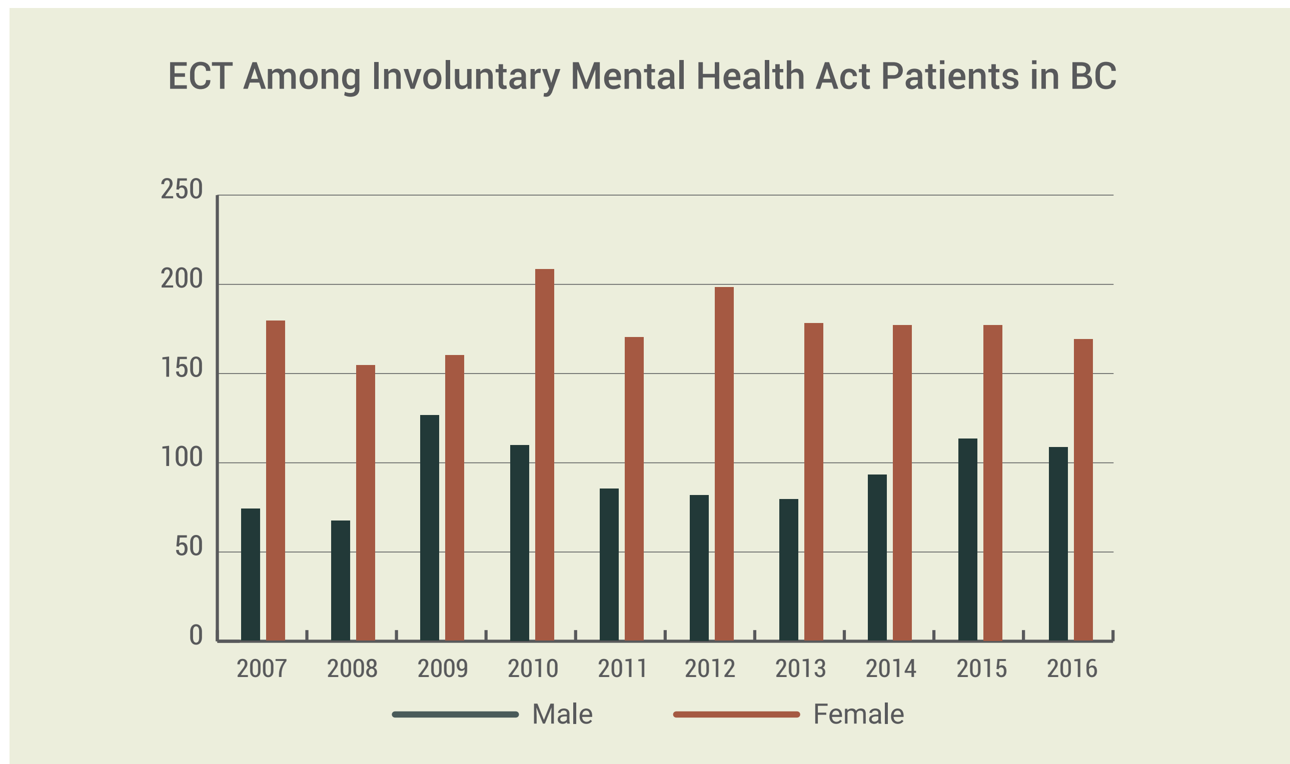
The use of lobotomies reflects the pathologization of relatively minor health issues that could be attributed to life stressors—and treating those issues with an incredibly invasive and disturbing procedure that results in compliance with gender norms reflects the mental health system's long history of policing gender.

c) Electroconvulsive therapy (ECT)

Electroconvulsive therapy (ECT) is a psychiatric procedure that involves passing electricity through a person's head to cause a convulsion or grand mal seizure. While there is debate, many classify ECT as a procedure that intentionally damages a person's brain, typically resulting in "signs of confusion, generalized cognitive impairment, loss of judgment, and emotional instability."[89] Research has shown that lasting effects include persistent and significant negative impacts on mental function, including memory and attention.[90]

In Canada, women are again the subjects of most ECT treatments:

> *One deeply troubling trend is the extent to which ECT is administered primarily to women and the elderly. In Canada and the US, approximately 70 percent of shock survivors are women and 45-50 percent are over 60 years old, with 10-15 percent being 80 years and older [sources omitted].*[91]



Source: British Columbia Ministry of Health, "Electroconvulsive Therapy among Mental Health Involuntary Hospitalizations in BC"

This aligns with the best data we have access to on the use of ECT during involuntary treatment in BC.[92] The data appears to be based on biological sex, which erases the impact of gender and gender identity.

Academic analysis attributes this gendered trend to the pathologizing of women's distress solely through symptoms, instead of trying to understand the underlying causes, which may be related to gendered norms and expectations themselves, experiences of gender-based violence, or oppression.[93] When treatments do not resolve these symptoms, because the structural or contextual causes have not been addressed, women are labelled as treatment resistant, and extreme procedures like ECT are pursued.[94] While erased in the data, if gendered norms impact the rates of ECT, gender-diverse people whose identities do not conform to the socialized definition of normal sex and gender are also likely disproportionately impacted.

d) Conversion therapies

Canada's mental health system also has a long history with conversation therapy—pseudoscientific treatments that attempt to suppress the expression of a socially disfavored status and impose a socially sanctioned cisgender and heterosexual standard.[95] These practices increased in the 1970s after the removal of homosexuality as a *DSM* diagnosis.[96] Conversion therapy practices primarily stem from beliefs that diverse sexual orientations and gender identities can and should be "fixed" or suppressed to conform to these standards.[97] There is wide consensus among medical experts that conversion therapy practices are ineffective and associated with poor health outcomes, notably including suicide ideation and attempts.[98] Conversion therapy is also more likely to be experienced by members of 2SLGBTQ+ communities who are also racialized, Indigenous, or economically insecure.[99]

While many people think of conversation therapy in a faith-based context or other situations outside of formal health services, these approaches have historically been and continue to be present in regulated health care settings.[100] Importantly, the denial of gender-affirming health care can be considered under the umbrella of conversation therapy,[101] and Lived Experience Experts in this project reported widespread occurrence of that denial during detention and involuntary treatment. Conversion therapy in a regulated health care setting also includes treatments like the prescription of psychotropic medications or other treatments to suppress sexual urges or preferences.[102] In 2021, Canada amended the Criminal Code to criminalize conversion therapy practices.[103]

It is clear from these examples of extreme procedures that the mental health system has a history of both pathologizing and disproportionately using invasive or harmful treatments on people whose identities do not align with existing gender norms and expectations, as well as those who experience suffering due to that misalignment.

Despite the importance of gender, BC does not monitor gendered impacts

Given the long history of the mental health system pathologizing aspects of a person's identity, including labelling their gender identity, gender expression, or sexuality to be mental health or biological problems, it is imperative that today's mental health system take steps to ensure that this trend does not continue.

However, despite gender having been identified in existing research as a key influence on involuntary patients' experiences,[104] we are not aware of any high-quality data collection, monitoring, or evaluation of how BC's mental health system, and particularly its detention and involuntary treatment system, impacts people based on their gender. Data that we have received through FOI requests seems to either rely on biological sex or conflate biological sex and gender. For example, one FOI request we received used the data heading of "Gender," but the data is divided by "M" and "F," presumably referring to male and female. There is a note on the data that says, "Cases with gender other than male or female are counted in total only." In the most recent year covered by the FOI-HLTH-2020-07130 response we received (2017/18), not one single patient was reported as having "gender other than male or female," indicating that likely both intersex people and gender-diverse people have their identities erased through this process.

This raises several questions:

- How does this data treat gender and sex, including all of the nuance and complexities that exist in different individual, cultural, or community understandings of these categories?
- In data collection, who defines a patient's gender and/or sex? Are patients asked their gender and/or sex, or do health care staff assume it? Is this data collected in an affirming way, or does it risk misgendering or de-gendering patients?
- How can the health system collect data in an affirming and transparent way that ensures a person's experiences of involuntary treatment related to gender and/or sex are not erased from existing data?
- How can BC create mental health law and data collection approaches that support accountability and evaluation, to ensure that all people receive mental health services that respect their gender and/or sex?

Later in this publication, we will share the many ways gender can and does impact people's experience of detention and involuntary treatment under BC's Mental Health Act. BC must improve its disaggregated data collection on gender to monitor and evaluate any efforts to mitigate these impacts, which are often extremely harmful to those who experience them.

Centring Story: Ophelia Flowers

Ophelia Flowers is a refugee and a trans woman. Someone called 911 because she was suicidal and stopped eating. The police responded in the middle of the night, and the first thing they told her was that she was under arrest. They handcuffed her and dragged her out of her home. Ophelia reported being mostly unresponsive because she hadn't eaten in almost six days.

The police then went through her house, waking all Ophelia's housemates and causing them to panic because police were in their home. One housemate tried to intervene and asked them to treat Ophelia less violently, but police ignored the request. Ophelia's neighbours eventually came out of their homes wondering what was happening because the police car was sitting outside her home with its lights flashing.

Ophelia was taken outside in handcuffs in front of her neighbours and housemates and placed inside the police car. The police then began talking to her roommates, while Ophelia sat alone with everyone looking at her. Ophelia assumed her neighbours thought she had committed a crime. She felt completely intimidated and scared because she could see police guns, pepper spray, and other weapons.

On another occasion, because of previous traumatic experiences, her precarious immigration status, and her lack of identity documents, Ophelia became fearful after receiving a call informing her that the police would be doing a wellness check. Based on her previous experience with police, she felt like she needed to flee her home to protect her own safety. Ophelia felt triggered and panicked. The experience caused her incredible distress and made her feel completely unsafe and terrified. She felt like she literally had to run. She remembers running through the streets in fear.

Ophelia doesn't have full memory of the events, but eventually she ran to a bridge and was running in traffic. The police attended with a van full of officers. Ophelia continued to panic

and tried to run away from them. The police chased her. Here is Ophelia's description of what happened when the police caught her:

> **And then when they reached me, all these cops—like, six or seven cops—came out from that van. And they didn't just only stop me. They just beat me. They beat me, they beat me, they beat me, they… they put me to the ground, they put their feet on my legs, they were crushing my chest with their weight. I wasn't able to breathe... it continued until the paramedics arrived.**
>
> **And that's something that I still remember, because I felt like I was about to die or to be violated or raped and then die, you know… and killed by these people. And they cuffed my hands and strapped me even. They keep insulting me. They call me by names.[105]**

An ambulance attended, and Ophelia was put in additional restraints using a strapped jacket along with handcuffs and gurney straps. She was transported with a police officer travelling with her, and she received no medical attention from the paramedic. The police officer continued to call Ophelia names, use profanity to tell her to shut up, and dropped his weight on her chest repeatedly, using something on the ambulance ceiling for leverage, until she passed out. Ophelia woke as she entered the emergency department, still escorted by police and restrained. She continued to call for help because she was being harmed, but no one intervened. The emergency staff did not check on Ophelia's health or attend to her while she was surrounded by police. She was transferred to another room with police and given injections that put her to sleep. Ophelia remembers groups of people grabbing and holding her while someone gave her the shots. Ophelia passed out.

Two or three days later, Ophelia woke up in the hospital. When she realized she was in the hospital, she immediately started thinking of ways to be discharged. She wanted them to understand she needed help, but not like this. Ophelia suspected the police thought that

she was a drug user. She was transferred to another assessment unit and held for four or five days. Staff did bloodwork and other tests that showed she had not consumed any drugs or substances. A staff member told her there had been a misunderstanding and that they would discharge her immediately. The next day, Ophelia was discharged with a taxi voucher. When she got home, she tried to process what she experienced.

If Ophelia could change the system, she would create a community crisis response that is peer led, so peers can be between the person in need of help and institutions like the police and health system. She knows it is hard to support people in distress or crisis, so having someone who relates to their experience with a sense of compassion would help ensure the police don't harm them, they get medical help, and they are not treated like a criminal. Ophelia said her long-term goal would be a compassionate and non-violent hospital system and defunding police, but that feels unthinkable right now. Ophelia hopes, though, the system will change radically to meet people's needs through compassionate and relatable services.

HJ

Section Summary

Part 5: Defining violence in this work

- Defining violence can be challenging; understanding the scope of what causes harm differs across time, geography, culture, and individuals.
- This project adopts a broad understanding of violence based on the World Health Organization definition.
- An understanding of violence that includes systemic causes acknowledges that broad social and political forces are often the root cause of interpersonal violence.

"Power in the involuntary treatment system can be wielded in many ways."

Defining violence in this work

Defining violence can be challenging; understanding the scope of what causes harm in a way that should be labelled violence differs across time, geography, culture, and individuals.[106] For some people, violence means direct and intentional physical harm. For others, experiences that may be less direct but that result in psychological, spiritual, or emotional harm may be just as or more damaging than direct physical violence. Some people understand violence as between individuals. Others experience law, policy, and societal norms as capable of inflicting violence. Differences of opinion in this area can be deeply personal and related to each person's experience with respect to the core parts of their identity and humanity.

This project adopts a broad understanding of violence. Because defining violence is so personal, we encouraged Lived Experience Experts to tell us how they define violence on their own terms. We shared examples based on different understandings of violence so that participants had the context to make their own determination.

In the context of health, the World Health Organization (WHO) defines violence as:

> *The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.*[107]

Types of violence identified by the WHO include physical, sexual, psychological, and deprivation or neglect.[108] It went on to clarify that "use of physical force or power" is intended to include acts that result from a power relationship, including threats and intimidation, and should be understood to include neglect and all types of physical, sexual, and psychological abuse.[109] Finally, the WHO makes clear that a perpetrator of violence does not need to intend to cause harm for an act to be considered violence.[110] Our Lived Experience Experts Group further noted that not only might an individual perpetrator not intend to harm, but they may not even intend to use the force or power made available to them by the system and yet still end up causing harm; however, the use of power and force are often built into their roles, particularly in the structure of involuntary treatment.

This approach aligns with an ecological model of understanding violence. Ecological models reflect the fact that many factors shape a person's health or experience of violence beyond their own physiology and individual context. Structural forces like colonization, inequity, discrimination, poverty, and more also shape their health. Lori Heise was one of the first in formal research to propose an ecological framework for gender-based violence in an effort to develop consensus as to its causes.[111] Heise underscored the need to add what was referred to as a "macro" level to ensure that structural and systemic causes of violence were reflected in the model.

In this project, an ecological model of violence is reflected in the fact that power in the involuntary treatment system can be wielded in many ways, including individual staff-patient interactions, but also unit and facility policies, health authorities' policies and directives, staff culture, social norms, and provincial laws like the Mental Health Act. Without minimizing individual interpersonal violence, an understanding of violence that includes systemic causes of violence acknowledges that broad social and political forces wield huge power in our lives and can cause great harm and are often the root cause of interpersonal violence.[112]

In this project, an assessment of structural violence allows us to see that many of the gendered impacts described by project participants may seem like individual events between a specific treatment team and patient, but both the cause and impacts are often rooted in complex layers of gender-based violence.

HJ

Section Summary

Part 6: Why violence matters in mental health law and services

- Many people believe that the purpose and scope of the Mental Health Act is to keep people safe, but we don't evaluate whether it is successful.
- The environment and circumstances of involuntary treatment create a high risk of violence and a lack of safety.
- If someone experiences gender-based violence during involuntary treatment and reports it, there is a strong chance they will not be believed.

"The layout of the environment put me at risk." – Lived Experience Expert

Why violence matters in mental health law and services

Violence and safety are key issues in the mental health system that should be primary considerations in the way services are designed and delivered. In the context of involuntary treatment, it is especially important because involuntary treatment is an intervention that is often used with the aim of keeping the people subject to it "safe," so investigating the extent to which that is true is crucial. In addition, the people who are subject to detention and involuntary treatment are at heightened risk of experiencing violence, so considerations of the extent of violence occurring during involuntary treatment, and ways to prevent violence, should be at the forefront of service design.

The assumption that detention and involuntary treatment are safe

To the extent that they are aware of the Mental Health Act and involuntary treatment in BC, many people believe that the purpose and scope of the law is about keeping people "safe," whether that be keeping the public safe from people who are perceived to be dangerous or keeping those experiencing detention and involuntary treatment safe themselves.[113] Because of deeply entrenched discrimination and bias about people experiencing mental health or substance use health issues, many people assume the Act is about protecting the public from people.

The Act authorizes detention and involuntary treatment beyond situations that involve immediate safety risk; however, several of the provisions of the Act do focus on safety and protection:

- Section 22 of the Act, which sets out the criteria that must be met for a physician or nurse practitioner to detain an individual as an involuntary patient and administer

involuntary treatment. In addition to the three other criteria, a person must require care, supervision, and control in a facility or on extended leave to **protect them or other people** OR to prevent their mental or physical health from substantial deterioration. The BC Supreme Court has confirmed that the reference to "protection" necessarily means the individual requires the health system to intervene to protect them from harm.[114]

- Section 28 of the Act authorizes police to apprehend a person if they are satisfied the individual is **acting in a manner likely to endanger that person's own safety or the safety of others**, and appears to be a person with a mental disorder.

Current provincial guidance at the time of writing interpreted what might be considered a risk to a person's safety very broadly:

> *The term "safety" here is not restricted to the potential of physical violence to self or others. For example, it also covers situations where the person's safety is endangered because of exposure to extremely cold weather conditions or gross self-neglect.*[115]

While the Mental Health Act has no stated purpose,[116] other government and health system interpretations often state that safety and protection of the person experiencing detention and involuntary treatment are core objectives. For example:

- "The **safe practice** of involuntary admissions under the B.C. Mental Health Act..."[117]
- "The Mental Health Act **protects people** who are unable to make decisions about their own mental health care due to their mental illness"[118]
- The Act is applied when "someone who is living with a mental illness needs treatment and **protection** for themselves/others"[119]

Court decisions considering the Act and offering guidance on how to interpret it have also focused on safety and protection, although there is again no consensus on the purpose of the statute. For example, the BC Supreme Court concluded based on the statutory framework in force in 1993, which has since been amended, that the purpose of the Act is "the treatment of the **mentally disordered who need protection and care** in a provincial psychiatric hospital."[120] [emphasis added]

Currently in BC, the Mental Health Act is commonly understood by the provincial government, health authorities, and courts to be at least in part aimed at ensuring the safety and protection of the person experiencing detention and involuntary treatment. It becomes paramount, then, to understand what we mean by safety and to evaluate whether detention and involuntary treatment actually achieve protection and safety for the people experiencing it. We know,

for example, that Indigenous women already experience BC's health services in general as unsafe, especially in settings like the emergency department and during hospital admissions, owing to misogynistic stereotypes in addition to racist one[121] —and layering the additional power imbalances and coercion inherent in detention and involuntary treatment would likely only intensify those feelings of unsafety.

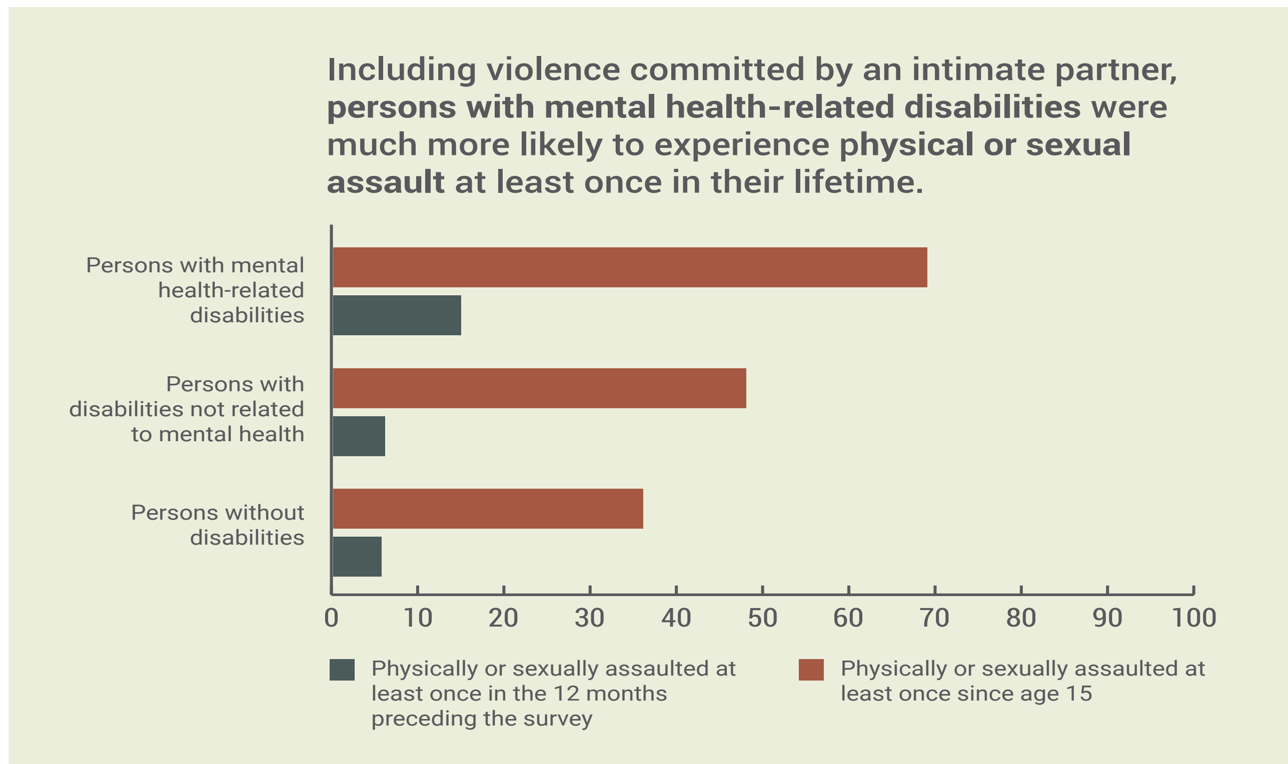
Unfortunately, there are few, if any, assessments of whether patients experience detention and involuntary treatment as safe, protective, and free from violence, particularly that centre the expertise of people with lived and living experience. Instead, conversations about violence and safety in the mental health system, and involuntary treatment specifically, often pit staff against patients and are based on the assumptions that patients are dangerous and create unsafety. Understanding the extent and impact of violence experienced by patients is necessary to assess how it impacts their own rights and wellbeing, as well as the wellbeing of staff working in the involuntary treatment system.

Involuntary treatment creates a context with heightened risk of violence

The second reason it is crucial to understand violence and safety during detention and involuntary treatment is because people experiencing it are at heightened risk.

a) People experiencing involuntary treatment are more likely to be victims

People likely to experience detention and involuntary treatment under the Mental Health Act are at increased risk of being victims of violence due to multiple overlapping inequities. For example, people with disabilities are more likely than people without disabilities to be victims of violence in Canada. Of people with disabilities, those with mental health-related disabilities experience the highest rates of violence.



Source: Statistics Canada, "Persons with mental health-related disabilities: Experiences of violent victimization in Canada, 2018".

Viewing violence through a gender lens is also revealing. Statistics Canada did not present data specific to trans, non-binary, or Two-Spirit people, or other gender-diverse people, but based on binary gender categories, the data shows that:

- women with mental health-related disabilities experience sexual assault twice as often as men with mental health-related disabilities;[122]
- women with mental health-related disabilities experience significantly higher rates of intimate partner violence than women without disabilities and women with other kinds of disabilities;[123] and

- women with disabilities who are members of the 2SLGBTQ+ communities and Indigenous women are more likely than other women with disabilities to experience intimate partner violence.[124]

Though not focused on mental health specifically, research on 2SLGBTQ+ communities' experiences of violence has found that trans, non-binary and Two-Spirit people, and other gender-diverse people, experience higher rates of physical and sexual violence than cisgender people in Canada.[125]

Taken together, this data suggests that cis and trans women and girls; trans, non-binary, and Two-Spirit people; as well as other gender-diverse people who experience involuntary treatment under BC's Mental Health Act, are more likely to be victims of violence than the rest of the population. This means they are more likely to have past experiences with trauma and be victims of violence during involuntary treatment. These disproportionate rates of violence and trauma are not caused by some inherent vulnerability in the people who experience it; instead, they are the result of structural economic and social inequities, including ableism and gender-based discrimination, that force people to live more precarious and less safe lives.

b) The power imbalance during involuntary treatment creates risk

The environment and circumstances of involuntary treatment create a high risk of violence and a lack of safety. The experience of being an involuntary patient under the Mental Health Act is one of extreme power imbalance and loss of autonomy. The treatment team staff hold immense power over you and are authorized to freely decide what will happen to your body in terms of psychiatric treatment, seclusion, restraint, access to outdoors, access to clothing, and communication with anyone outside the facility, with little accountability. Power imbalances like those created by the Mental Health Act can create a heightened risk of abuse and misconduct.[126]

In addition, this immense legal authority and the context of involuntary treatment remove common tools individuals might use to protect their personal safety in other contexts. For example, in a locked psychiatric unit, they cannot leave a situation of unsafety. They are also subject to forced psychiatric medication, which often includes sedatives, so their ability to be aware of their surroundings and avoid risk may be adversely impacted. They may have their phones confiscated and have limited ways to contact friends or family to accompany them or help ensure their safety. In this context, the risk of violence is incredibly high, and the Mental Health Act's authorization of sweeping powers to control the conditions of detention with minimal protections and accountability (for example, section 32 referenced above) removes tools that a person experiencing detention might otherwise use to increase their safety.

> **The layout of the environment put me at risk in a sense because I was forced to be in a free kind of flow of people**

that were men. […] You can't avoid certain patients, you can't avoid certain situations—you would feel cornered […] And the staff would make weird interpretations about… co-patient interactions, too, especially male–female ones, and they wouldn't understand or want to protect you. […] You can't get away if you want to, and you don't have choices in your movement.[127]

c) Reports of violence are more likely to be dismissed

Finally, if someone experiences gender-based violence during detention and involuntary treatment and reports it to facility staff, there is a strong chance they will not be believed. People who are labelled with mental health diagnoses are forced to also carry the discriminatory assumptions that go along with the diagnosis, including that they are not credible, they are not perceiving reality accurately, and they are incapable.[128]

Institutions like police and the criminal justice system often fail to take seriously and believe reports of gender-based violence even when the victim is not a person with a mental health-related disability.[129] It is hard to imagine that reports of gender-based violence from people experiencing involuntary treatment would not be subject to at least the same, and likely very heightened, dismissal of their experience and concerns.

For all of these reasons, it is crucial that we monitor and understand experiences of gender-based violence during involuntary treatment.

Existing research on gender-based violence during involuntary treatment

We searched the peer-reviewed and grey literature for existing research on gender-based violence in involuntary psychiatric settings. Our search spanned 22 years and yielded 36 relevant publications, mostly from Australia and the UK. They described impacts of gender-based violence that fell under these themes:

a) (Un)safety

Patients reported feeling unsafe sharing space in a locked ward with people who may behave unpredictably.[130] Many mixed-gender wards lacked private spaces, and women reported fearing male staff who invaded their privacy, forcibly medicated them, ignored or disbelieved them, or used seclusion and restraints in punitive ways.[131]

b) Various forms of violence

Patients reported experiencing violence that they defined as including derogatory comments, verbal aggression, physical aggression, intimidation, bullying and harassment, sexual assault, and rape.[132] Perpetrators tended to be male patients and male staff, with some cases of assault

being perpetrated by female patients.[133] Male perpetrators tended to cause physical injury, while women tended to engage in verbal assaults.[134]

c) Retraumatization

Some patients reported that forced treatment replicated dynamics from previous gender-based trauma.[135] Incidents of violence during hospitalization retraumatized patients who had experienced previous physical and sexual assault.[136]

d) Personnel failures

Patients reported that staff minimized the subtle forms of abuse experienced by women, with many holding misogynistic perspectives by labelling women "difficult and demanding."[137] Further staff failures resulted from an inadequate incident-reporting system.[138] Past traumas were often not factored into care plans.[139]

e) Systemic abuse

Patients reported feeling distressed, humiliated, and dehumanized by common practices including strip searches, surveillance, overmedication, seclusion, and physical restraint.[140] Discriminatory and degrading treatment by police and health services in a colonial context disproportionately affected Indigenous women.[141]

f) Denial of motherhood

Within the results of our literature search, no differential treatment options were offered to help mothers maintain relationships with their children. In one study, 57% of women patients had children; 68% percent of the mothers were permanently separated from at least one child before the age of 18 years; 11 of them had their child taken from them at birth while they were detained under mental health legislation; 50% of these child separations occurred during the mother's first episode of illness, and the mothers often had little or no subsequent contact with their children.[142]

g) Intersecting systems of oppression

One publication noted that patients who are women have been forced into service models developed for men.[143] Racialized women have found themselves isolated because of unwanted proximity to men, violating their religious beliefs.[144] Homophobia, racism, and ageism are often not included in violence risk-assessment tools and care plans.[145]

h) Gaps in research

The results of our literature search on gender-based violence in involuntary settings highlighted these gaps:

- The publications discussed gender as a binary, often equating sex with gender; almost no publications considered gender-diverse people in involuntary psychiatric settings.
- Only two studies were from Canada, and neither was conducted in BC.
- Other than studies focusing on Indigenous or trans experiences, most participants were cisgender white women 18 to 60 years old; missing perspectives include those of racialized or immigrant women, older adults, and children and youth.

Our literature search results informed the questions we included in the interview guide for our engagement with women and gender-diverse people with lived experience of detention and involuntary treatment under BC's Mental Health Act.

Centring Story: Ares

Ares is a white transmasculine person who has experienced consistent lack of respect for their gender identity and barriers to accessing gender-affirming health care during involuntary treatment.

Ares has never been asked their pronouns during detention and involuntary treatment. While they hope that things have improved since their last hospitalization, they expressed that imagining a level of gender sensitivity where staff would proactively ask them about their pronouns seemed almost absurd. They experienced being transgender as something they had to explain repeatedly to staff due a to lack of awareness and competency. Staff often asked inappropriate questions or made harassing comments related to a lack of knowledge about transgender people. Ares reported asserting they were a trans man because explaining being non-binary felt insurmountable.

Ares was also not allowed to access gender-affirming gear like a binder during involuntary treatment. Because their gender appeared ambiguous at the time, they felt this put them at risk during detention, including being asked questions like "what are you?" by other patients. They experienced frequent sexual harassment from other patients as well as staff, with some patients and staff targeting them for their perceived youthful appearance.

There were also no policies around where to place them, and staff didn't want to place Ares in a room with men or with women. During their first hospitalization, they were put in a seclusion room to sleep on the floor. Since then, they have often experienced being placed in unlocked seclusion rooms during detention because there were no gender-neutral bed options or spaces. Despite this, staff made no effort to protect Ares's identity, and would openly display their full legal ("dead") name on a whiteboard in a common area indicating their location on the ward, effectively outing them as transgender.

Ares also had to fight for access to testosterone during detention and involuntary treatment. Even though it was important for their wellbeing, one psychiatrist deliberately withheld it because he believed the hormone replacement therapy (HRT) was contributing to Ares's

psychosis. Ares felt access was being withheld under the guise of treatment based on inaccurate or speculative information, as this psychiatrist made a unilateral decision based on a single meeting and without consulting with Ares's endocrinologist. Ares recalls learning later that the same psychiatrist had a reputation for prohibiting access to HRT every time he had a transmasculine patient. Ares understood this to essentially be forcing people to detransition during involuntary treatment.

Ares also reported that, even when HRT was allowed during involuntary treatment, there were barriers to actually accessing it. Ares felt that staff were disorganized or just didn't prioritize ensuring access to their medication or understanding how to administer it. Ares felt it was random whether they would be given access to HRT in the hospital or not. Ares's hospitalizations were sometimes quite long, and they described bouncing between different facilities, where approaches to HRT were inconsistent. This meant they were never assured access to the health care they needed for their wellbeing.

Section Summary

Part 7: Human rights with respect to gender, violence, and involuntary treatment

- British Columbia is obligated to protect and respect the human rights of all people experiencing detention and involuntary treatment.
- These obligations arise from several sources, including the Canadian Charter of Rights and Freedoms, BC's Human Rights Code, and international agreements to which Canada has committed.

"BC has a duty to take all measures to eliminate gender-based violence."

Human rights with respect to gender, violence, and involuntary treatment

British Columbia is obligated to protect and respect the human rights of all people experiencing detention and involuntary treatment. These obligations arise from several sources, including the Canadian Charter of Rights and Freedoms, BC's Human Rights Code, and international agreements to which Canada has committed, including:

- the International Covenant on Economic, Social, and Cultural Rights,
- the International Covenant on Civil and Political Rights,
- the Convention on the Rights of Persons with Disabilities,
- the Convention to Eliminate All Forms of Discrimination Against Women,
- the Declaration on the Rights of Indigenous Peoples (adopted in BC through BC's Declaration on the Rights of Indigenous Peoples Act), and
- the Convention on the Rights of the Child.

In addition, more specific rights also apply, which are explored below.

The rights to liberty and security of the person

Under Canada's Charter of Rights and Freedoms, everyone is entitled to liberty and security of their person and the right not to be deprived of them unless the deprivation is done in accordance with fundamental justice.[146] BC's Mental Health Act directly impacts these rights via the detention and involuntary psychiatric treatment it authorizes, and those impacts must meet the requirements of principles of fundamental justice or they will violate the Charter.

> *The law has long protected patient autonomy in medical decision-making... This right to "decide one's own fate" entitles adults to direct the course of their own medical care (para. 40): it is this principle that underlies the concept of "informed consent" and is protected by s. 7's guarantee of liberty and security of the person [citations omitted].*[147]

The right to liberty includes the ability to make choices about your own life and your own bodily integrity—choices that are fundamental to a person's dignity as a human being.[148] The right to security of the person protects a person's physical and psychological integrity; state-enforced medical treatment is a primary example of a violation of bodily integrity.[149] It also includes protection from state-authorized psychological trauma or harm.[150] Exercising these rights involves navigating the power imbalance created when medical professionals hold expert knowledge about health care, but it is the individual's physical and psychological integrity that will be impacted. Informed consent, including the right of an individual to information and the risks, benefits, and alternatives to any treatment and the right to refuse or consent to it, is a long-established and protected right under section 7 of the Charter.[151]

The context of detention and involuntary treatment under BC's Mental Health Act, where the rights to liberty and security of the person are already infringed, creates a state- and statute-authorized power imbalance that can lead to disproportionate impacts on different communities, including cis and trans women and girls; trans, Two-Spirit, and non-binary people; as well as other gender-diverse people. The rights to liberty and the security of the person protect key human rights freedoms that are particularly important in the context of gender and sex:

- the right to choose whether to carry a fetus to birth;[152]
- the right to be free from state interference with the parent-child relationship and the right to nurture a child;[153]
- the right of a detained birthing parent to not be separated from their infant;[154]
- the right to choose to access safer working conditions for those engaged in sex work,[155]
- the right to reasonable warnings of heightened risk of sexual assault,[156]

- the right to live free from gender-based violence, and sexual assault in particular,[157] and
- the right to access timely and appropriate health care service free from state interference.[158]

The right to be free from violence

> *[The] right to a life free from gender-based violence is indivisible from and interdependent on other human rights, including the rights to life, health, liberty and security of the person, equality and equal protection within the family, freedom from torture, cruel, inhumane or degrading treatment, and freedom of expression, movement, participation, assembly and association.*[159]

To comply with its international human rights obligations, BC has a duty to take all measures to eliminate gender-based violence by any person, organization, or institution without delay.[160] These measures include:

- Repealing all laws that discriminate based on gender, or that enshrine, encourage, facilitate, justify, or tolerate any form of gender-based violence (this specifically includes laws that allow for non-consensual medical treatment of women with disabilities);
- Repealing all laws that prevent or deter people from reporting gender-based violence, including those that question or undermine their legal capacity;
- Adopting legislation prohibiting all forms of gender-based violence, harmonizing domestic law with international human rights conventions;
- Adopting and implementing effective legislative and other appropriate preventive measures to address the underlying causes of gender-based violence, including patriarchal attitudes and stereotypes.
- Examining gender-neutral laws and policies to ensure that they do not create or perpetuate existing inequalities and repealing or modifying them if they do so;
- Designing all public policies, programs, institutional frameworks, and monitoring mechanisms to aim at eliminating all forms of gender-based violence;
- Providing mandatory, recurrent, and effective capacity building, education, and training for members of the legal system, police, legislators, health care professionals, including those working in institutions, such as residential care homes, asylum centres and prisons, to equip them to adequately prevent and address gender-based violence.[161]

This includes taking steps to prevent violence and discrimination based on sex, gender, gender identity, and sexual orientation.[162] This obligation also includes paying special attention to the

aggravated forms of violence and discrimination experienced due to the intersection of gender and race, Indigeneity, age, disability, migration status, geography, and other identity factors.[163]

The right to adequate responses to violence

If gender-based violence does occur, BC has obligations under international human rights law to ensure there is an adequate state response that will take meaningful steps to protect victims of violence, ensure appropriate legal protections and effective legal remedies, and include legal procedures that are impartial, fair, and unaffected by gender stereotypes and discrimination.[164] People experiencing detention and involuntary treatment under BC's Mental Health Act are entitled to these rights.

To comply with international human rights agreements that Canada has signed, BC's responses to gender-based violence must include:

- Adopting appropriate and accessible avenues to protect a person who has experienced gender-based violence without requiring that they initiate legal action or complaints (this specifically includes people who experience gender-based violence in mental health detention);
- Investigating and applying appropriate legal or disciplinary sanctions, as well as ensuring reparations, in cases of gender-based violence;
- Protecting the privacy and safety of people who experience gender-based violence;
- Ensuring that all legal and complaint processes protect the privacy and strengthen the autonomy of people who experience gender-based violence;
- Ensuring people who experience gender-based violence have access to financial assistance and support services, including free or low-cost, high-quality legal aid; and
- Addressing factors that heighten the risk of serious forms of gender-based violence.[165]

The goal of these requirements is to ensure that BC is taking all measures available to protect someone who has experienced gender-based violence and provide access to a safe, accessible, fair, and unbiased avenue to seek justice that does not rely on the individual to initiate complex legal proceedings or put their safety at further risk.

These requirements have been flagged as especially important in situations where state law empowers individuals or organizations to exercise government authority, including in the health care system and in places of detention. In this context, detaining facilities defined under the Mental Health Act, and individuals who exercise legal authority under the Act, are obligated to comply with these responsibilities in the exercise of their authority under the

Act.[166] In addition, because BC has enacted the statute that authorizes the powers under the Act, any failures to adhere to these obligations are attributable to the provincial government under international law.[167]

The right to equitable and non-discriminatory mental health services

Equality rights, or the right to be free from discrimination, are protected in the Charter, BC's Human Rights Code, and international human rights agreements. Section 15 of the Charter ensures that all people are recognized at law as "human beings equally deserving of concern, respect, and consideration."[168] The Human Rights Code ensures that people can fully participate in society by prohibiting discrimination based on certain personal characteristics in specific areas of daily life, including public services like the mental health system.[169]

Both the Charter and the Human Rights Code adopt a "substantive" approach to equality, which recognizes that equality is not about treating everyone the same; instead, in order to be truly equal, people may need to be treated differently to reflect their different identities and needs.[170] Discrimination also does not need to be intentional: a neutral policy may inadvertently create discriminatory harms or impacts of different groups.[171]

Together, these human rights protections mean that people detained and subject to involuntary treatment under BC's Mental Health Act are entitled to not be discriminated against based on their gender, sex, gender identity, or gender expression under the law or in the way that services are delivered. The Act may be neutral on its face in terms of gender, sex, and gender identity, but if the law creates a negative impact or disadvantage in relation to gender, sex, or gender identity, it may be discriminatory. In addition, health authorities, detaining facilities, and staff in the involuntary treatment system have an obligation to accommodate gender- and sex-based needs in the delivery of services and the exercise of authority under the Act. For example, blanket rules or restrictions related to accessing personal clothing may be neutral on their face and apply to all people experiencing involuntary detention, but not having access to chest binders or gender-affirming clothing may have disproportionate impacts on the human rights and safety of people for whose gender is affirmed by these items. Not having access to bras or modest clothing may disproportionately impact people who have experienced sexual harassment. Similarly, facilities may have blanket policies restricting or regulating access to visitors that apply to everyone experiencing involuntary treatment, but these policies may have disproportionate impacts on a birthing or breast/chestfeeding parent who is separated from their infant.

International human rights law offers some guidance specific to mental health services that can help illuminate BC's human rights-based obligations when it comes to preventing and eliminating discrimination in the Mental Health Act, detention, and involuntary psychiatric treatment. The Special Rapporteur on the equal right to the highest attainable standard of health has noticed that mental health diagnoses are complex and have often been used to

pathologize diversity of gender, gender identity, gender expression, and sexuality; this can cause a person to "suffer more from discriminatory and inappropriate patterns of 'care' than from the natural effects of mental health conditions."[172] In addition, the Special Rapporteur noted that all mental health services must be culturally appropriate and acceptable to people with disabilities, adolescents, women, older people, Indigenous people, racialized people, refugees and migrants, and lesbian, gay, bisexual, transgender and intersex people.[173]

Finally, the Committee on the Elimination of Discrimination Against Women has noted that health services often fail to recognize that the mental health of women and gender-diverse people is disproportionately negatively impacted by structural factors, including gender discrimination, violence, poverty, dislocation, and other forms of social deprivation. As a result, the Committee calls on state governments like BC to ensure that health services are responsive to gender-based needs and respectful of human rights and dignity.[174]

State obligations during detention

State-authorized detention brings with it unique human rights responsibilities. While detention under the Mental Health Act may have different objectives than other forms of state-authorized detention (like incarceration in prison), the Supreme Court of Canada has been clear that the human rights triggered upon detention apply any time someone acting on behalf of the state places any significant physical or psychological restraint on liberty, no matter the duration.[175] Civil mental health detention under the Mental Health Act falls within this definition.

The extraordinary power to infringe on a person's liberty creates immense power imbalances between those with legal authority to detain and those who experience detention. That is true whether detention is related to the criminal justice, immigration, or health care systems. Charter case law, human rights case law, and specialized rules developed as part of international human rights law governing this area.[176]

All people subject to state-authorized detention experience this power differential, but structural inequity and discrimination can also lead to communities being disproportionately impacted. For example, BC has human rights obligations that may be particularly relevant to the experiences highlighted in this report tied to gender, gender identity, and sex:

- **Gender-informed approach to detention:** BC has an obligation to record and respect a person's self-identified gender identity[177] and ensure access to clothing that is not degrading or humiliating.[178] In addition, all people detained should have access to gender-sensitive, trauma-informed, and comprehensive mental health services,[179] and reasonable access to gender-affirming health care.[180]
- **Protection from gender-based violence during detention:** All staff in a detaining facility must undertake training on gender and human rights. In addition, all detaining

facilities must develop and implement clear policies and regulations on the conduct of facility staff aimed at providing maximum protection for people detained from any gender-based physical or verbal violence, abuse, and sexual harassment.[181]

- **Detained people should have the same access to health care as they would have in community:** for example, if a trans patient is taking gender-affirming treatment in the community, BC has an obligation to ensure that the treatment is available to them during detention.[182] This has also been confirmed via case law under the BC Human Rights Code, which confirmed that detaining authorities have a duty to accommodate the gender-affirming care needs of people experiencing detention unless it amounts to undue hardship.[183]

- **Limits on strip searches and clothing removal during detention:** It has been over 20 years since the Supreme Court of Canada established clear guidance on Charter requirements related to clothing removal in the criminal law context upon arrest.[184] Invasive removal of clothing and strip searches should only be undertaken if absolutely necessary and reasonable. They should not be conducted as a matter of course, and, whenever possible, the detained person should be given an opportunity to remove their own clothing. If clothing removal is necessary, it should be done in private, with as minimal force as possible, and by a staff member of the same gender as the detained person. In addition, clothing removal and strip searches should ensure that the person is not completely undressed at any time.[185] Clothing removal that occurs as a matter of course or fails to take the bodily integrity of the person experiencing it into consideration, it is likely to violate section 8 of the Charter.

- **Limits on seclusion/solitary confinement during detention:** In addition to general restrictions on the use of solitary confinement, including with respect to length of segregation, daily time out of segregation, and access to fresh air, there are also gender- and sex-specific human rights obligations related to BC's use of seclusion. Seclusion should not be used on pregnant people, or people breastfeeding or with infant children.[186] Canadian case law has also confirmed that the state authorization of solitary confinement for prolonged or indefinite periods (i.e., with no cap on the length of time), or use without independent review, may violate section 7 of the Charter if the principles of fundamental justice are not met.[187]

- **Access to family and children during detention:** Detained pregnant people are entitled to have their pre-natal and post-natal health needs met.[188] In addition, those who are caregivers to children must be authorized to make arrangements for the care of children during their detention.[189] Access to children and family must never be used as punishment and should be encouraged and supported.[190] Children must accompany the person being detained when it is in their best interests to do so.[191] This latter

point was confirmed in BC case law in the context of provincial corrections when the BC Supreme Court found that the cancellation of a mother-baby unit at Alouette Correctional Centre for Women that allowed incarcerated women to have their babies remain with them was a violation of the section 7 Charter rights of mothers and babies and the section 15 Charter rights of the mothers impacted.[192]

- **Sex-based hygiene needs during detention:** Detaining facilities must have services and supplies available to meet specific hygiene needs, particularly for those who are pregnant, breastfeeding, or menstruating.[193]

All of these rights should inform BC's approach to mental health detention. BC's mental health law can and should expressly acknowledge and protect these rights.

Centring Story: L.R.

L.R. shared her experience of being sexually assaulted by a detaining facility staff member over an extended period. She was detained for two months on a small unit that had only two nurses working at a time. When one would go on a break, the staff member would use it as an opportunity to harm L.R. without getting caught. L.R. was also not allowed to leave the unit unaccompanied; she was required to have a nurse with her. Her abuser would volunteer to accompany her and then would take her to areas of the hospital where there were no cameras and continue to abuse her.

L.R. was released on extended leave for a period, where she was still involuntary but was allowed to live in community with conditions tied to her eating disorder. She ended up readmitted to the same unit at the same facility, and the abuse continued.

Her abuser told L.R. that if she told anyone what was happening, no one would believe her because she was a psychiatric patient. He also told L.R. that everyone would know the abuse was her fault, and she would no longer be able to access health care. L.R. remembers him instilling a lot of fear in her to keep her quiet. During the abuse, L.R. continued to deteriorate, especially when her abuser was on shift. Her primary diagnoses related to an eating disorder and anxiety, but staff attributed L.R.'s increasing panic and erratic behaviour, which was significantly heightened when her abuser was working, to psychosis and put her on lithium.

One day he picked up a shift because another staff member called in sick. L.R. learned at five o'clock that he was coming in for a night shift and had what she describes as a meltdown. She walked off the unit, staff called security, and security followed L.R. as she went out and lay down flat on the highway. She explained that she could not bear to be alive knowing that she had to spend another night with her abuser. Eventually, more security guards came, picked her up, and brought L.R. to a seclusion room where her clothes were ripped off and she was forcibly injected. No one on staff ever noticed that L.R.'s behaviour was directly tied to the presence of her abuser on the unit.

L.R.'s abuser eventually began working elsewhere. L.R. did not intend to disclose the violence and abuse she experienced but eventually mentioned it in a conversation with another staff member. The staff member asked L.R. if she thought this admission would go better than her past ones, and L.R. recalls just blurting out what she had experienced. At that point, L.R. says, "everything blew up." L.R. recalls that staff wouldn't go near her after that or were always in groups of two or three. She knew they did not want to be alone with her, suggesting that she was the risk to staff. A doctor then told L.R. that if the report was true and "I wasn't lying about it," L.R. probably did something to bring it on. The doctor brought in a nurse who told L.R. that she was present for L.R.'s "protection." L.R. knew the nurse was there to protect the doctor's reputation.

L.R. also recalls staff asking why she would have allowed the violence to continue, implying that she would have reported it after the first or second time it occurred. She recalls that, at the time, that felt worse than the abuse itself. They created a lasting feeling that it was L.R.'s fault the violence had occurred.

In addition, L.R.'s abuser's best friend was also a nurse on the unit and continued to be after she disclosed the violence. L.R. then overheard the nurse contact her abuser by phone to tell him that L.R. had disclosed and went over details of her chart and current admission, all in violation of L.R.'s privacy rights. L.R. felt unsafe around this person and would cry and shake when he was near her. L.R. reported that he couldn't understand why she reacted like that, but it was because she knew that he sided with an unsafe person.

Eventually, L.R.'s abuser lost his license to practice nursing. She views that as an "in-your-face" to the psychiatrists, proof that it wasn't her fault and she wasn't "just crazy."

HJ

Section Summary

Part 8: Before hospitalization

- The circumstances under which women and gender-diverse people become involuntarily hospitalized under the Mental Health Act are often influenced by sexist, racist, ageist, and transphobic bias and stereotypes.
- Apprehensions under the Act often involve dehumanizing interactions with police and the devastating apprehension of children.

"They just ripped my van door open. They were pulling the kid out of her car seat. She was just a couple of months old." – Lived Experience Expert

Before hospitalization

What Lived Experience Experts shared with us shows that the circumstances under which women and gender-diverse people become involuntarily hospitalized under the Mental Health Act are often influenced by sexist, racist, ageist, and transphobic bias and stereotypes, in addition to the stigma that people with psychiatric diagnoses already face from some members of the public, police, and health care teams.

In this section, we share stories from Lived Experience Experts of:

1) their experiences of gender-based stereotypes affecting their encounters with the mental health system leading up to their involuntary hospitalization,
2) the fear, harassment, and violence they experienced when police apprehended them, and
3) the traumatizing apprehension of children.

Weaponized gender stereotypes and gender-based violence

The criteria for detention and involuntary treatment under the Mental Health Act are open to wide ranges of interpretation and can be used in ways that pathologize gendered stereotypes and non-compliance with gender norms.[194] For example, criteria for detention and involuntary treatment include decisions about things like whether someone's ability to react to their environment and associate with others is impaired, or whether they are in need of protection.[195] What is considered

to be a "normal" reaction is deeply contextual and shaped by a person's life experiences and identity. It is not an objective truth; many people hold different perspectives based on their own social location, culture, and experiences. Further, whether someone needs protection, and from whom, is also shaped by how the assessor views safety, danger, and risk. Socialized ideas about who is "at risk" or "vulnerable," and who deserves protection, shape these decisions.

When legal authority comes with such broad discretion to assess subjective and complex factors, it can easily be shaped by biases and discriminatory stereotypes, despite the best of intentions. For example, discretionary youth criminal justice diversion programs reflect racial bias by being less likely to exercise discretion to Black youth.[196] Police discretion informed by gender bias has been identified as one of the causes of reported sexual assaults being classified as unfounded.[197] Further, entrenched stereotypes and bias are often built into the very way we design systems and services.[198]

Many Lived Experience Experts reported that their first contact with the involuntary treatment system arose via a police apprehension. When police were called because of an abusive situation, they arrived with wide discretion. Experts reported that police would frequently deem the victim to be acting out of control and prioritize the abuser as more credible, without considering that a person's wellbeing might be negatively impacted because of the abusive situation itself.

> **Well, I find that my biggest and most consistent experience in all of this is feeling like, with the police, like I'm being treated like a hysterical woman […]. How else do I express that?**
>
> **In domestic violence situations, the victim is often presented as emotional and chaotic, and it's often the abuser who looks calm and collected and often law enforcement misses this; invalidating the victim's words because of how they are being said.**
>
> **This is often a gendered experience as well as a trauma survivor experience.**
>
> **Being in distress is distressing. Law enforcement has no skills in offering validation or de-escalation, and they create a situation of inevitable escalation as you frantically try to make yourself heard, thus, looking crazier.[199]**

An Indigenous Lived Experience Expert had an abusive mother who weaponized the involuntary treatment system as a tool of abuse. Her mother had taken her to various health care professionals since she was a child and persuaded them that she was mentally ill. The Expert

shared how her mother's perceived whiteness led to the police and health system believing her mother over her and other Indigenous family members who were not white-passing. Her mother would go on to repeatedly use the Expert's mental health diagnoses to have her detained under the Mental Health Act, including eventually weaponizing those diagnoses to get access to the Expert's children:

> **The three kids were small. And she wanted me and the kids to come live with her—like, it was a financial thing. She wanted money. And I didn't want to live with her. So she went to the doctor's and said that I had been diagnosed with bipolar disorder when I was a kid and I was manic again, which I wasn't. I was actually going to school and just raising my kids and trying to stay away from her.[…]**
>
> **I got locked up again after [child] was born. That was the time the cops showed up at my house because my mom had called the police and said that I was planning on killing myself and my kid. I hadn't even talked to her […] for months. I think she was mad because I wasn't letting her see [child] when [child] was born. Nobody even talked to me—they just came swooping in.[200]**

Other Lived Experience Experts were told that they had to be hospitalized for their safety, which they identified as evidence of paternalism informed by discriminatory beliefs connected to their gender.[201] Other Experts shared that gendered discrimination influenced the application of diagnoses like borderline personality disorder. For example, one Expert shared the ways that sex and gender shaped their diagnosis:

> **I have had multiple psychiatrists who've only met me in brief crisis situations (where I have no privacy, no control, no basic respect, no autonomy), diagnose me with BPD, even though that's not my experience, and I relate any symptoms that might present as BPD to medical and personal trauma, especially past emotional abuse To me, BPD is an inappropriate diagnosis to make in crisis settings, but because I have had suicidal ideation and attempts and appear female (even though I identify as non-binary) I just get the BPD diagnosis, which even my own psychiatrist doesn't agree with.**

Personally, I don't believe in BPD as a diagnosis, though I don't deny that the "symptoms" can exist across a spectrum that is also very context-dependent. That said, I fully respect that some people do identify with the diagnosis and find it helpful to have that diagnosis in order to access certain treatments. However, for me it is just stigmatizing and pathologizes responses that were once life-saving when they are understood in the context of attachment injury or trauma. My experience of being labelled with BPD is just that it functions as a modern day "hysteria" diagnosis, and I do not believe I would be diagnosed with it if I appeared male. I think I'd be more likely to be diagnosed with some form of neurodiversity (e.g. males tend to be diagnosed with autism more frequently) or other diagnoses that often are given more often to male-presenting persons.[202]

Several of the Lived Experience Experts we engaged were being treated for eating disorders, a diagnosis disproportionately given to girls and women as a result of gender norms that result in less diagnosis of boys, men, and masculine folks. They reported a seeming lack of coordination between their mental health and medical care, leading to multiple transfers between different units or a lack of psychiatric competence among the medical staff.

One admission [...] I was on a medical unit because I did have a medical issue. My blood sugars kept crashing, so they couldn't have me on a psych unit because I did have that medical component. But I was involuntary and couldn't leave that medical unit. And I think especially because of the medical unit, there was a lot of extra stigma around having me there and just lack of knowledge on how to handle the situations.[203]

Social and gender norms around weight and bodies also shape diagnosis. For example, another Lived Experience Expert reported not receiving eating disorder care when they needed it because medical staff were relying on their weight as a criterion for treatment:

When I struggled with an eating disorder, depending on your weight, they won't really help you with anything. So that's fucked up. Like, if you're at a specific weight, they don't help you with that kind of... I never got any resources outside of that to get any help.[204]

Both the Lived Experience Experts and the clinicians who participated in our engagement also reported a seemingly greater number of restrictions on and heightened control of patients diagnosed with eating disorders based on assumptions of what might cause harm or worsen mental wellbeing:

> **I have been to several inpatient eating disorder units, both voluntarily and involuntarily, and those were the only programs (outside psychiatric emergency services) where they regulate your time on your electronic devices. They regulate what access to devices you have and attempt to regulate what types of things you're looking at. Like, you cannot look at cooking things, you cannot look at diet things, what you read in magazines or watch on television is monitored.**[205]

> *My workplace had a "body positivity policy" which proscribed patients from wearing clothing that showed midriffs, thighs, tummies, etc. It ostensibly was put in place to prevent young women from comparing each other's bodies and engaging in eating disorder behaviour.*[206]

Mental health and policing services are public services, so they must be provided in ways that do not discriminate based on protected grounds of a person's identity, intentionally or unintentionally.[207] These include sex, gender, gender identity, and sexual orientation. In addition, those who are authorized to exercise discretion under the Mental Health Act have an obligation to do so in a way that does not discriminate. Further, the extent and scope of power authorized by the Mental Health Act brings with it an obligation for adequate oversight and accountability to ensure that the powers are not being used in discriminatory ways.

Dehumanization and violence from police

BC's Mental Health Act authorizes police to apprehend and transport a person for examination if a police officer is satisfied that the individual (a) is acting in a manner likely to endanger that person's own safety or the safety of others and (b) is apparently a person with a mental disorder.

Importantly, this power is granted to police if they are satisfied these criteria are met either based on their own observations or based on information they receive from others.[208] Reliance on police brings with it fear and trauma related to the historical and ongoing overpolicing of many communities—including Indigenous, racialized, and 2SLGBTQ+ communities—as well as to experiences of violence caused by police and police enforcement of racist and colonial policies.[209] Trauma and a reluctance to interact with police may also come from previous experiences of invalidation—for example, being disbelieved by police after reporting a sexual assault.[210]

With a few exceptions, most of the Lived Experience Experts we engaged had encounters with police for at least some of their hospitalizations. They described the humiliation of being

handcuffed when it wasn't necessary and the stigmatizing risks of having police cars, creating a disproportionate spectacle in front of neighbours and other onlookers, who might infer criminal activity. The experience led to an overall feeling of shame and criminalization, and created risk to one Expert's housing security:

> **Getting handcuffed in front of a fucking public crowd of people. That was humiliating. And they didn't need to. I was cooperating. Still to this day, I'm just like, "You don't need to fucking handcuff me. I would have willingly gone in the police car." Another time a police car was sent to me. They didn't cuff me. But in broad daylight. My landlords live above me. And I've begged them, begged them not to send a police car, and they did. And, like, that could impact people's housing, people's lives, right? And thank god my landlords didn't see, but yeah. Um, yeah, the other time, cuffed in public. That was not fun. And then you're brought in the hospital like that. And people make all sorts of assumptions about you. And they treat you accordingly.[211]**

Some Lived Experience Experts felt that, as physically smaller people who were not behaving violently at the time of their apprehension, they were not safety risks. They interpreted being handcuffed not as a safety issue but one of the police's asserting their power.

Other people with lived and living experience described the trauma and fear associated with police responses that were deeply interconnected with the mental health system and that made them feel violated or dehumanized. For example, one Lived Experience Expert described the combination of involuntary medication and clothing removal, combined with a lack of visibility, as an incredibly frightening experience:

> **Because of my drug-induced psychosis, I thought people were trying to hurt me. And they had drugged me with something, sedated me. And while I was in the hospital, they sedated me and then took me back to city cells and left me there for a day and a half in a room with no camera, completely stripped of all my clothes. And it was male officers involved.[212]**

The Expert noted how having a group of male officers involved created unsafety, which would be worsened for anyone who had previously experienced gender-based violence. Another Expert shared how little privacy and dignity is offered to people apprehended by police:

I forgot the one part about the police, too, was after when they did take my handcuffs off [in the emergency department] and they did, like, the… so humiliating to have the pat-down and have to lift up my bra and bend over to make sure I didn't have anything in my bra. Because they thought for sure I had a weapon. Like, that whole thing was just so dehumanizing. It shouldn't have been a police officer, they could have taken me into the… Can you imagine doing that out in the lobby? It was mortifying.[213]

There is ample evidence that police involvement in mental health calls, especially when they are unaccompanied by mental health professionals, can escalate into violence and even death for the person in crisis.[214] Further, the historic and ongoing overpolicing and discriminatory policing of specific communities means that the presence of police, and the weapons and risk of violence the police bring, create fear and trauma. People who need mental health supports are left feeling criminalized and dehumanized, which only negatively impacts their mental health.

In an effort to replace police as first responders to mental health calls, BC has committed to funding ten community-led peer-assisted care teams (PACTs) administered by CMHA BC and two teams coordinated by Indigenous-led organizations. These teams include one mental health professional and one trained peer worker with lived experience and attend mental health crisis calls without police presence.[215] The province should continue scaling up community-based non-police supports developed with people with lived and living experience to ensure that people across the province can access timely mental health crisis support without having to rely on the police.

Violent apprehension of children

For those who are the primary caregivers of children, police apprehension and involuntary treatment under BC's Mental Health Act can be intertwined with the traumatic and violent apprehension of children. One Lived Experience Expert, an Indigenous mother, described the way police responding to a purported mental health crisis resulted in the apprehension of her infant based on assumptions she was a risk to the child:

Violent. They were super violent, super overkill. Like that one time when they came and took [child] from me there was, like, five police cars parked in front of the house, lights flashing—you'd think I just killed somebody or robbed a bank. I didn't even know what was going on. I'd gone for a drive to clear my head and came back and they were there. They just ripped my van door open. They're were pulling the kid out of her car

> **seat. She was just a couple months old. Oh my god. I was so dramatic. Handcuffed me. And then that time they drove me to [Redacted] hospital and they… It's like, everyone in the [region] knows me—like, small town. They made me stand—they wouldn't even let me sit down—they made me stand in the waiting room of the hospital with the police officers standing right behind me. And for hours while people were just coming and going out of the emergency room. It was so fucking humiliating.[216]**

The Expert went on to describe another experience when her trauma-based reaction to apprehension of her children led to the police detaining her under the Mental Health Act. For this Expert, mental health services are deeply intertwined with the devastating loss of her children:

> **They came in and took the kids—ministry came in and ripped the kids out of the house. Took me in a cop car that time because of course I lost my shit when they took the kids—took me in a cop car and locked me up again. I don't even remember how long I was held that time, maybe three months. Three or four months. I came back out, couldn't have my kids back. That was really devastating. Then I think I got locked up a couple of more times.[217]**

Human rights-based research has shown that BC's child apprehension system can be biased against mothers and other caregivers of children who have disabilities.[218] The apprehension of children has well-documented and catastrophic impacts on the mental health and wellbeing of the parent they are removed from, especially mothers. For Indigenous women, who disproportionately experience child apprehension, the removal of children brings increased risk of attempted suicide.[219] For women who use drugs, removal leads to increased risk of overdose, with Indigenous women experiencing disproportionate risk.[220] In addition, fear and past trauma of child apprehension or the risk of apprehension can actively dissuade parents from seeking mental health supports in a proactive, voluntary manner to protect their families from that risk. Giving a person being apprehended under the Mental Health Act the opportunity to develop an emergency caregiving plan for any children in their care may prevent child removals that could worsen the person's mental wellbeing.

HJ

Part 9: During hospitalization

- During detention under BC's Mental Health Act, BC is obligated to ensure that people experiencing involuntary treatment are free from violence and services are equitable and not discriminatory.
- People with lived experience told us that the involuntary mental health system is itself violent and unsafe, and it responds poorly to incidents or threats of violence.
- People also reported widespread disrespect for gender identity and gender-affirming needs.

"I just get scared—what if someone on a power trip wants to do something bad?" – Lived Experience Expert

During hospitalization

During detention under BC's Mental Health Act, detaining facilities and the province have obligations to ensure that people experiencing detention are free from preventable violence, violent incidents are responded to adequately, and services are equitable and not discriminatory.

Lived Experience Experts shared with us that these obligations are not met in BC's involuntary treatment system. They told us of ways that:

1) The involuntary mental health system is itself violent and unsafe,
2) The system responds poorly to incidents or threats of violence, and
3) The system is not trauma and violence informed.

Lived Experience Experts encountered each of these broad categories of impacts in psychiatric units, which we delve into in detail below, but many Experts first became aware of them—in a particularly acute, overwhelming way—in emergency departments and rapid-assessment units, and that is where we begin.

Violence and unsafety in emergency departments, psych emerg, and rapid-assessment units

Emergency departments, psych emerg, and rapid-assessment units are where an initial examination and certification (completion of the initial form that authorizes detention) occurs

for many people with lived experience of involuntary treatment.[221] Because many hospitals do not have specialized psychiatric assessment units, people with lived experience who end up in these settings may interact with less specifically psychiatrically trained medical staff who are dealing with the chaos of triaging overrun facilities.

Many of the Lived Experience Experts we engaged told us that emergency, psych emerg, and rapid-assessment settings were among the worst parts of their hospitalization experience and were where, as cis and trans women and gender-diverse people, they felt the most unsafe. Experts described these settings as especially loud, chaotic, and devoid of privacy and opportunities to calm down and destimulate, which exacerbated their mental distress. Participants described feeling unsafe as they had to share a space with people of all genders, who were all in various stages of a health crisis, with minimal privacy. One person with lived and living experience described how this made them feel unsafe without accompanying support people:

> **I got sent to the hospital by ambulance, never really had no privacy, because they had curtains separating beds in emergency, and so to me, that wasn't no privacy. […] To me, it makes me feel like I need somebody with me all the time, especially if I go… and I end up going to emergency.[222]**

In these settings, rather than perform individualized risk assessments, staff often confiscate a person's clothing and belongings as a matter of course, including their phone, cutting off their contact with their outside support network and removing items that may be important to their identity or items that could help them self-soothe. Trans Lived Experience Experts also reported losing access to gender-affirming gear like binders while in psych emerg.

Several project participants said that the care they received in emergency, psych emerg, and rapid-assessment settings was inadequate. Sometimes they would have to wait days to see a doctor, only after which they could start earning some of their clothing, belongings, and privileges back. They didn't feel that staff had time to properly assess the full complexity of their health needs, as this Expert reported:

> **I have miles-long records, I'm sure. And in the psych ward, my psychiatrist gets to read those. They get to consult with my community clinicians and get a fuller picture going on. But at the [rapid-assessment/psych emergency unit], you kind of walk in and you say what's going on and they're very overworked there and understaffed and underqualified, perhaps some of the staff. But they have, like, 15 minutes to get a clear picture of you. And my doctor… my community**

clinician was actually so mad because they just completely missed the mark of what was going on with me.[223]

Lived Experience Experts also reported that staff at psych emerg would not listen to them when they were being evaluated for admission. Staff consistently dismissed someone's life circumstances as reasons for or contributing factors to their unwellness or crisis, and when making admission and treatment decisions, relied on collateral information from family members, chart notes from previous hospitalizations, or assumptions instead of speaking directly to the person and asking them for their expertise. For example, one Expert shared:

Yeah, that's a third, failed, attempt of hospitalizing me just because this nurse checked on my medical history or record of my previous hospitalizations and, you know, maybe she just thought, oh, maybe you're a criminal, you're unstable, you're trying to kill yourself, and it's, like, yeah, no, I'm trying here to get support and help. She ignored what I said and never even asked me what I need. Or "What are you looking for? What are you expecting?" Nothing. It was just straightforward, a transfer to the [assessment unit] and good luck with that.[224]

This person with lived and living experience also described how reaching out for help can lead to experiences that feel unnecessarily invasive and punitive. She went to an access and assessment unit to seek free counselling. She was locked in an interview room by staff so they could transfer her for admission to detain her. She was able to get out of the locked room and went home, only to have police attend and apprehend her. After being taken to the hospital and examined, the physician agreed she did not need hospitalization and she was released.

Emergency and psych emerg services also create barriers to meeting basic wellness needs, including accessing cultural supports or even literally having a bed available to sleep in. Lived Experience Experts reported that failing to respect their cultural needs and curtailing their rights felt less safe than other experiences:

I would say some of the biggest trauma that I've ever experienced was downstairs in psych emerg, and there's a lot of hostility. Nobody listens to you. Sometimes you don't have a bed to sleep on. If you ask for an Elder, or you're like, "This is very colonial," they're not going to do anything for you. They're not going to give you that option. Anytime I was asking for some things that I needed, they would… it seemed like I had less and less freedoms, like they would penalize me for

those things. And upstairs [the inpatient unit] is a little bit… the people just seem a bit, like… they just seem kinder, and I feel more safe if I'm upstairs [in the main psychiatric unit].[225]

This Expert described situations where they knew they needed mental health care but had to evaluate whether it was worth seeking out because they would have to "get through" the distress and trauma of being in psych emerg before they could be admitted to a psychiatric unit.

In many ways, psych emerg is a concentrated microcosm of the most traumatizing parts of the involuntary psychiatric system that escalates and amplifies distress rather than reduces it. Through the rest of this publication, we discuss how changes to the built environment of emergency and rapid-assessment settings to allow for more privacy, quiet, safety, and individualized care (page 115) could help these settings become less of a barrier for people deciding whether to seek mental health care.

Many of these harms persist in dedicated psychiatric units, although they may be more spread out. The following sections explore how the involuntary system perpetuates and responds poorly to gender-based violence, and how it fails to meet involuntary patients' needs in a trauma- and violence-informed way.

The Mental Health Act and policies perpetuate gender-based violence

BC's Mental Health Act and accompanying policies authorize broad power to use force, which is experienced as violence by involuntary patients. In other words, violence is part of the detention and involuntary treatment system by structural design, even when the system is operating according to the law and policy as it was intended.

a) Seclusion

For me, the seclusion rooms are traumatizing. You are trapped, you are captured. You are held in a cell. You feel like you're held in a dungeon or some guy's basement. You are confined. It's forcible confinement in order to control you.[226]

The quote from a Lived Experience Expert illustrates the feelings of confinement, punishment, and fear that can arise when they experienced seclusion while detained under BC's Mental Health Act. Many of the Experts who participated in this project described being placed into seclusion—which they sometimes referred to as "isolation," "solitary," or "incarceration"—and almost universally described a cold room with a mattress on the floor, a steel toilet, a heavy door with only a small window through which staff can observe the person, and no view of the outdoors. Every one of them found the experience profoundly traumatizing and harmful. One Expert describes how criminalizing and inhumane experiences can be:

> **So then they put me in the timeout room, they called it. And it's like how prisoners of war are tortured—there's a big fluorescent light, no furniture. They wouldn't shut the light off. I had no idea if it was day or night. How many days? Nothing. And then there was just a little window where they could watch me and they took all my clothes away. So I was a 14-year-old girl in there naked, and they could just watch me anytime they wanted.[227]**

This experience can be understood through the lack of legal protections offered by the law in BC. While not expressly mentioned in the law, the use of seclusion is authorized by BC's Mental Health Act with no limitations, restrictions, oversight, or procedural protections. Section 32 of the Act states that "[e]very patient detained under this Act is, during detention, subject to the direction and discipline of the director and the members of the staff of the designated facility authorized for that purpose by the director." The province's own guidelines on seclusion[228] say that it should be used as a last resort. There is no such limitation in the Act, though, and no publicly available information that suggests BC is monitoring facility or health authority compliance with the provincial guidance.

The current legal authorization of direction and disciplinary powers also means that tools like seclusion can be used for reasons that go far beyond urgent safety issues; this Expert noted that seclusion was used in situations when there is no immediate safety risk:

> **They didn't need to seclude me like they did. They could have talked to me. Because, I mean, it wasn't necessary. I wasn't actually, like, threatening violence to anyone. I wasn't being violent. I wasn't being violent to myself.[229]**

The experience of seclusion being used well before it could be considered a last resort was unfortunately common among a number of Lived Experience Experts. Experts noted that there were many opportunities for de-escalation or alternative approaches before they were placed into seclusion, sometimes repeatedly during a single hospitalization or for weeks at a time. Another Expert reported that seclusion seemed to be used as a matter of course: at each of her multiple hospitalizations, regardless of her mental state when she arrived at the hospital, she always spent the first several days in seclusion before being released into the main ward for the rest of her stay.

Case law and research establish that isolation and solitary confinement is detrimental to mental health.[230] One Lived Experience Expert shared the immense harms that can flow from the use of seclusion:

I wasn't suicidal at all when I went there, and I don't have a tendency towards suicidal ideation. [...] The way I was treated drove me to absolute sheer suicide... suicidal ideation and action when I was in the hospital, [...] after that incident, when I was secluded, I couldn't bear it anymore. It had driven me inside to a point of... I didn't know anymore. That was what did my brain in, was the seclusion room, and so their overuse of that, too, and the environment, for no apparent reason.[231]

Seclusion has been well established to be non-therapeutic, and its use increases rather than deters violence and aggression.[232] BC acknowledges this in its guidelines: "There is no evidence that seclusion contributes to healing or recovery, and there is strong indication that it can be harmful to the individual being secluded as well as to those who witness or deliver the intervention."[233] It is also well established from other jurisdictions with similar colonial histories to Canada that tools like seclusion are used disproportionately on Black, Indigenous, and other racialized people.[234]

Many places in the world have moved toward reducing the use of or abolishing seclusion. This is often in response to documented racism in its use[235] and in recognition that even having seclusion available as a "last resort" leads to its being inappropriately used because it is often the expedient option.[236] Law scholar Yvette Maker suggests several ways Victoria, Australia's plan to abolish seclusion within a decade could account for gender-based impacts, including ensuring that women and gender-diverse people with lived experience are involved in policy making toward this goal.[237]

Gendered aspects of the seclusion process left multiple Experts feeling particularly traumatized: they reported being stripped of their clothing and left naked, feeling terrified. When they expressed this fear, one Expert reported being forcibly injected with the assistance of security guards, who were large men. They expressed the ways in which experiences of seclusion and the force that can accompany it can create lasting scars that then require additional mental health supports to process:

They locked me in there and ignored me. And so I just started screaming and panicking because I was, like, trapped, and that was horrifying to me. And so then I was banging on the door and trying every possible way to get out and then they sent in security to stop me, and the security guards were very aggressive and, like, I'm a pretty small person, and these were two very giant men. So there was already a power difference there. And because I would not go and sit down on the bed,

> **the security guard literally pushed me over… like, slammed me to the ground. And told me to shut up and just go lay in the bed and then… because I just could not and would not calm down, the nurse came in to give me an injection, and then that security guard grabbed me so hard and so forcefully to hold me down, I, like, got bruising from it. And I just did not want that injection, and they wouldn't tell me what they were injecting me with. So I was freaking out about that. And so the nurse or someone tried to put their hand over my mouth to cover my screams, so I bit their hand, 'cause I was panicking… I was, like, what do I… like, I didn't know what to do, and they shouldn't have put their hand over my mouth. And so then the security guard just got more rough with me and was pushing me around. And, finally, they got the injection in and then because they had the door open, I tried to run out and then the security guard grabbed me by the back of the shirt and just, like, again pulled me down to the ground. And then, honestly, if I didn't move out of the way, I think he would have just stepped on me to get out of the room. So there was that, which took quite a lot of therapy to… not get over, but cope with the impacts of that experience.[238]**

While this experience is visceral and difficult to read, the importance of making visible the real impacts of seclusion is crucial. In addition to experiencing seclusion firsthand, Experts reported that it was used as a threat, sometimes overtly, to compel compliance or as punishment for behaviour that staff interpreted as inappropriate:

> **I was threatened with solitary confinement when I told one nurse that I was writing about my experience.[239]**

Because seclusion is a form of solitary confinement, it also brings with it several human rights obligations for the province and for state institutions, like health authorities, that authorize its use. For example, the United Nations Mandela Rules set out several requirements, which are typically referenced in relation to criminal detention but also apply to civil detentions like those under the Mental Health Act. Under the Mandela Rules, solitary confinement is defined as "confinement of prisoners for 22 hours or more a day without meaningful human contact," which applies to some of the experiences of psychiatric seclusion described by participants in this project. The Mandela Rules go on to set out specific requirements and limitations on the use of seclusion:

- Seclusion cannot be indefinite or prolonged (defined as lasting more than 15 days);
- The space someone is secluded in cannot be constantly lit or constantly dark;
- Seclusion should only be used in exceptional cases as a last resort, for as short a time as possible and subject to independent review;
- Seclusion should be prohibited in cases where the detainee has mental or physical disabilities when their conditions would be exacerbated by its use; and
- All people detained are entitled to at least one hour per day of access to fresh air.[240]

None of these obligations are protected in BC's Mental Health Act. These human rights obligations exist in recognition of the fact that seclusion or solitary confinement that does not meet these and other basic thresholds is tantamount to torture. Particularly relevant for BC's mental health law and system, prolonged use of solitary confinement that does not meet these minimum standards is well established to have detrimental mental and physical health impacts.[241] Canadian clinicians have also recognized the need to reflect on the role of psychiatric seclusion and lessons from the recent focus on the use of solitary confinement in the prison system.[242]

b) Restraints

Seclusion is frequently discussed alongside physical restraints and sometimes used together. One Lived Experience Expert described her experience in a published essay:

> **Restraint—limiting the freedom of limbs—is distinct from forced seclusion, although the terms restraint and seclusion are often used interchangeably in the psychiatric literature, or used together to refer to one total practice, a patient both tied to a bed and held in isolation. The words are linked in a single turn of phrase: restraint and seclusion, the simple conjunction joining the body's fixity together with the isolation from sustaining human bonds, signalling the violent yet legal coordination of corporal and mental immobility.**
>
> *****
>
> **You are still. You are still here**
>
> *****
>
> **It does not communicate. It cannot be shared. A form of madness. Language's end point, its zero hour. A hole. It is a**

room containing no one with the authority to be a witness, where there is no freedom of movement or ability to reach others. It is indefinite entrapment. It is the body held in place at it is not meant to be, as if human will, too, could be caught and fixed and silenced. It is the body stilled so that it does not disrupt others, does not interrupt the rhythm of human normalcy with any unusual speech or distracting movement, does not jar the actions and words of all those who might need to connect.[243]

Like the use of seclusion, BC's Mental Health Act is silent on the use of restraints, but the direction and disciplinary powers granted over all involuntary patients creates broad and sweeping legal authorization with no limitations or safeguards. Unlike seclusion, the province does not have guidelines to attempt to govern the use of restraints.

Lived Experience Experts described the fear and violence involved when they are subject to mechanical restraints, particularly when it involved multiple security officers or the forced injection of medication. The experiences they express reflect how untherapeutic and traumatic the use of restraints can be, and how triggering it can be for someone who has previously experienced gender-based violence:

I'd say my most significant experience of trauma in the hospital was being restrained by four male security officers, having my clothing removed by them, being heavily sedated with an injection in my gluteal muscles (which is not an intramuscular injection site that nurses are supposed to be using) and then put in five-point restraints for several days, and whatever they gave me—I have looked at my record, so I do know the medication they used; it nearly killed me at one point, and a code blue was called but—having people provide care to me while I'm not entirely unconscious but have a limited ability to rouse myself and, you know, attached to a bed in five-point restraints was horrific, especially in the context of previous sexual trauma. It took days to wean off that medication—I couldn't lift my head without fainting, and I developed extrapyramidal symptoms that were awful.[244]

Usually when they have me handcuffed, I'm usually pretty compliant. But this last time they had me handcuffed, my hands cuffed behind my back, and they had me laying belly

first flat on a stretcher. Meanwhile, I was strapped to this hospital bed. And all of a sudden, they're jabbing me some more times, and it's getting really freaking scary.[245]

Experts also reported being restrained with minimal privacy, which left them feeling like they were unable to protect themselves. When one Expert tried to loosen their restraints, and act of resistance and self-preservation, they experienced retribution and begged the staff to avoid further punishment—behaviour they later recognized as a gendered fawning trauma response:

So after they four-point restrained me, and I was in there, I fell asleep and then I woke up still in the four-point restraints, but I could tell there were people around me, and you could see the nurses' station from the bed. There's a curtain between you—that's it. There's no privacy in front of you. So anyone walking in front can see you. But I tried to wiggle out of the four-point restraints…and I wasn't wiggling out to misbehave, I was wiggling out to feel safe, to lay in bed and be able to roll over on my own accord... and they caught me and they ended up putting me immediately [into seclusion], no warning, no talk, no anything…I was, like, "I'll be good. I'll be good," you know, and it's so terrible to have to beg like that and to say, "I'll be good."[246]

Institutions and jurisdictions that have moved toward eliminating the use of restraints have found that eliminating restraint decreases the incidence of violence.[247] In addition, the use of restraints in other parts of the health care system is regulated, highlighting the gap in oversight under the Mental Health Act. For example, the Community Care and Assisted Living Act's Residential Care Regulation sets out circumstances where restraints can and cannot be used, a process that must be followed if they are used, required staff training, and required documentation.[248] Facilities are subject to inspections, and there are protections for those who report incidents of abuse.[249] BC's Mental Health Act has no such requirements or protections.

c) Forced clothing removal

Many Lived Experience Experts described their experience of being held down by security while their clothing was forcibly removed, often for the purpose of a forced injection of medication. Experts regularly reported having this experience when there was no urgent safety risk, including when they were proactively trying to calm themselves down or comply with requests:

For my last admission, I was admitted without an assessment but based on a community team's opinion without ever meeting me, only having talked to my landlord, who had

apparently heard me being loud. Once you are labelled, minor behaviours can build up to have your team or law enforcement deem you certifiable rather easily. So I wasn't doing great, but I wasn't certifiable, and for whatever reason they admitted me without an assessment in the ER. I said to the nurse "I haven't had an assessment. Can I please have a mental health assessment before you admit me?"

I was panicked, because I knew I was going into the involuntary system, and she said, "No," I was polite and reasonable but getting anxious and said, "I'm having a panic attack, can I just have one minute?" trying to breathe deeply and she said, "Change into your gown." Which increases anxiety, and I said, "Okay, can you give me a second?" and she said, "Okay, restrain her," and four security guards pushed me down. They ripped my clothes off, made me naked, and injected me.

And so that was my admission. Like, it was horrifying. And that certainly was horrific for me to be stripped down naked by this person in front of four security guards who were, you know, presenting as big male guys that I didn't know, and I was stripped in front of all of them.[250]

As explored earlier in this report, people who experience detention and involuntary treatment are more likely than others to be victims of violence, including sexual assault and intimate partner violence, as a direct result of gender inequality, and therefore more likely to have past trauma related to gender-based violence before their detention. For gender-diverse people who may be experiencing gender dysphoria, clothing removal might be especially traumatizing and harmful. While the experience of being stripped of clothing and forcibly medicated is harmful for anyone, people with previous experience of gender-based violence reported heightened fear and unsafety:

Of course everyone claims they provide trauma-informed care, but when you're in a fight or flight situation, and then you have, like, at least in my experience, having, like, four heavily muscled, uniformed men, like, hold you down, take off your clothing, to put you into hospital clothing and inject you with sedatives. If you don't have a history of trauma, that's traumatizing. But if you already have a history of trauma at the hands of men, then that just compounds things.[251]

Current legal restrictions and requirements related to clothing removal come from the policing and criminal justice context related to strip searches. Even when the express goal is punishment, forcible clothing removal must be justified in the specific situation and not be treated as a matter of course; people must be offered the choice of gender of the person carrying out the clothing removal whenever possible; the individual's privacy must be protected as much as possible; and no more staff than are necessary should be present for clothing removal.[252]

The restrictions exist because the forced removal of clothing has inherent impacts on privacy, bodily and psychological integrity, and human dignity.[253] Only one Lived Experience Expert shared that they had been given the choice of the gender of their care provider. Others reported that they were never offered a choice and that proactive requests are usually not accommodated. Several Experts compared the experience to sexual assault, including those who were survivors of sexual violence at the time of their detention, illustrating how violent the experience can be.

> **The brutality of security, their staff, and those guys are just ready to hurt you. They're just ready to hurt you. […] It's not okay to have six guys on you pinning you down, ready to pull your pants down and one guy actually smiling in your face. I forget what he was doing. Like smirking at me. […] And then the thing is, like, him mocking me with his face and then being carried and my pants being pulled down and jabbed without my consent not knowing what's going into my body, right? That's like… what do you call that when you've been violently sexually assaulted? It feels, like, so akin to that when you've got trauma to being, you know, nonconsensually anally raped and raped, period, and being drugged and raped. That was the context. […] My first sexual assault was being GHB'd and sexually assaulted. And so when you mix getting medicated with men, for me, it's like being sexually assaulted and you're getting in the butt, naked. […] It brings up the trauma. It's, like, "Oh my god, I'm being raped again." Like, without saying… without being raped, you're being raped. It's like a different kind of thing, but it brings up the same body memories.[254]**

It does not support the wellbeing of a person in crisis to experience a traumatizing and dehumanizing experience akin to sexual assault from the system that is purporting to help them. Participants' experiences shared in the project reflect the seriousness of the human rights involved in being able to control our own bodies and what happens to them, which engages the Charter rights to liberty and security of the person.

In particular, the reliance on security guards, often men in groups of four or more, were identified by Experts as unnecessary and violent. The practice of having groups of security and staff involved in the forced removal of clothing contradicts restrictions and guidance that applies in the criminal justice system and is an unnecessary interference with privacy and dignity. BC is in the process of increasing reliance on security guards in health care settings, with 320 new security guard positions added provincially.[255] One Expert described some ways to mitigate the escalating effects of security presence:

> **We're making some progress on understanding that police have no place in a crisis response team. I just wish there was also some effort underway with security. Like, can they not be in uniform, or can they not all be white cis dudes who are large and muscular and ready to go into the police academy when they're done this job? Or just not having them there if possible, because that really just escalates the situation most of the time, especially if somebody has trauma around men.[256]**

BC must question the need for the number of security guards that typically respond to involuntary psychiatric patients, and whether the training received by security guards is what is required to de-escalate these situations. BC's current approach is causing trauma and violence to those the mental health system is purporting to help.

d) Forced medication

> **I was so medicated and drugged up that it was hard for me to process anything that was going on. Or even just understand where I was physically—was it a fever dream? Like, I was just... I was very, very medicated and shouldn't have been.[257]**

Forced medication—and, in particular, forced injections—were a clear source of trauma or retraumatization for the Lived Experience Experts who shared their stories with us. Under BC's Mental Health Act, people who are subject to involuntary treatment are not permitted to consent to or refuse psychiatric treatment. Any legal tools they have chosen to govern their health care decisions if they are ever incapable of consenting or refusing health care, like representation agreements and advance directives, have no legal force.[258] Instead, BC uses a "deemed consent" model, under which involuntary patients are deemed to consent to any psychiatric treatment recommended by their treatment team.[259] As a result, Experts reported that designated facility staff did not seek consent prior to treatment, which felt stigmatizing:

No one has ever informed me of side effects in advance. No, I never had a choice of the medications—maybe when I took antidepressants for the first time when I was 16 I had a choice, before I was hospitalized involuntarily, and then after that, it was, like, "Sorry, you're crazy."[260]

Many Experts, including the one quoted above, were never told what they were injected with, and they were not told the risks and benefits of the medication, which increased their fear, panic, and lost sense of control. Some also reported serious side effects from medications, with staff often assuming that these effects were attributable to their mental health condition.

In addition, Experts experienced the use of forced injections as chemical restraints to control their behaviour or sedate them rather than as a treatment for their mental distress. Sedation can undermine someone's safety and ability to feel like they can protect themselves. For example, one Expert experienced an attempted sexual assault while she was in bed, under the effects of medication that contributed to the unsafe situation:

It was so sudden, too, like 'cause I was just kind of lying doped up in bed, too. That's part of it. You're even more vulnerable. Like, you can't think properly. You're in emotional distress plus all the drugs, so you can't really take care of yourself in the same way. And nobody's really taking care of you. You have to watch your back at all times.[261]

The forced injection of unknown medications is one of the most serious and significant incursions on the rights to liberty and bodily integrity authorized by law in Canada. The process of administering medication without consent, and particularly via use of force with multiple security and staff involved, is also disproportionately traumatic to detained people who have also experienced sexual violence: some Lived Experience Experts likened the experience of being held down and having their body penetrated against their will to their past experiences of sexual assault.

e) Failure to respect gender identity

As a result of transphobia and discrimination, transgender and gender-diverse people experience higher levels of mental distress, including depression, anxiety, and suicidality.[262] They are also disproportionately affected by violence and so are more likely to have a background of trauma.[263] In health care settings, transgender people are subject to misgendering, microaggressions, and overt harassment from health care providers, which can discourage them from seeking care and can exacerbate mental distress.[264] Transgender youth in Canada have self-reported contact with the involuntary mental health system at a much higher rate than cisgender youth.[265]

Human rights case law in BC is clear: the providers of public services have a duty to accommodate a service recipient's gender identity.[266] Case law confirms that failure to have a systematic approach to respecting and accommodating gender identity can amount to discrimination.[267] In addition, one of the most basic ways a human rights duty bearer can begin to respect and accommodate a person's gender identity is by using their identified pronouns and chosen name; failing to do so can cause shame, embarrassment, and negative impacts on their dignity.[268] In addition, it can out people and create dangerous situations for them.

The experiences of Lived Experience Experts illustrate the extent to which BC's mental health system has not yet shifted to accommodate people of diverse genders in basic ways. Out of all the Experts we interviewed, only one—a trans individual—was asked what pronouns she used, and even then the practice was inconsistent, with some staff members respecting her pronouns and chosen name and other staff members ignoring them. In addition, some staff continued using her deadname because it, along with her gender assigned at birth, were on her hospital bracelet. The Expert acknowledged that staff are overworked and carry out a difficult job, but also wanted their basic identity respected.

> **At the time, of course, I was dealing with my deadname. In that moment I didn't have the chance to change my name or my gender mark or anything, because I was a refugee claimant and had to provide my legal documents, so I was dealing with my deadname and also with the wrong personal information with the wrong gender mark. So that's another thing, you know. You have this hospital bracelet […] with all the wrong information, and the information would make you feel, like, more oppressed because people were always checking your wrist, you know, your label. And, yeah. It makes everything more uncomfortable or awkward in some of those situations. And even when I asked for the nurses to refer to me or address me with the right pronouns, some of them, they didn't care much. I know staff are busy and stressed, but that doesn't mean it's okay to disrespect or ignore people.[269]**

And, as we shared on page 59, one Lived Experience Expert told us that staff wrote their deadname on a whiteboard visible to everyone on the psychiatric unit, which was invalidating to the Expert's identity. In contrast, patient whiteboards could also present opportunities for affirmation: another Expert took it upon themself to add their pronouns to a whiteboard on the unit. However, not everyone would feel safe or empowered to take this action.

In addition, one Lived Experience Expert reported that the design of psychiatric units led to deeply inappropriate situations where staff did not know whether to place a non-binary patient in a shared room with a man or a woman. They resorted to placing the Expert in a seclusion room, often a site of distress and use of force, with the door unlocked.

These experiences shared by Experts align with what we heard from clinicians. One clinician told us that gender-affirming care is "often a tremendous gap in practice for clinicians."[270] Another mentioned that they "have noticed some staff seem to repetitively misgender a patient even immediately after they were corrected by a colleague."[271] Some health authorities also have access to online training modules related to gender-affirming care, but the clinicians who participated in our engagement all told us that this training was not mandatory.[272]

Unlike other places in the world, the Mental Health Act in BC does not create any obligations on detaining facilities or facility staff to respect the gender identity and expression of people experiencing detention and involuntary treatment despite the fact that failing to respect a person's identity can negatively impact their mental health.[273] However, BC's Human Rights Code requires that all services available to the public, including health care services, be provided in a way that does not discriminate on the basis of gender identity and expression. Unless discriminatory treatment is legally justified, failing to respect a person's identity amounts to discrimination in violation of the Code.

Some regions of BC have policies in this area, but there is no provincial coordination or oversight. For example, Vancouver Coastal Health has a trauma-informed practice guideline that says, "When documenting in the individual's record, discuss with the client any changes or updates regarding gender identification or markers and how they would like to be identified through their electronic record (i.e. names and/or pronouns)."[274] However, we are not aware of any monitoring or evaluation of compliance or implementation with this policy.

BC's mental health law could contain express statutory obligations that require detaining facilities to ensure that core aspects of a person's identity are respected in the mental health system. The law could also require that all regions and facilities either comply with province-wide standards for gender-affirming care or develop their own with minimum acceptable policy requirements, including co-development with trans and gender-diverse people with lived experience, and based on research evidence.[275] For example, requiring that staff explicitly ask all patients for their pronouns and chosen names—and use them in documentation like the patient file, hospital bracelet, and communication tools like whiteboards—is a simple but essential first step to providing gender-affirming care.[276] Staff introducing themselves with their pronouns or having pronouns on their name badges can also make the hospital setting safer for gender-diverse patients.

f) Withholding gender-affirming care, gear, and clothing

As set out above, as providers of a public service, designated facilities that detain and involuntarily treat people under the Mental Health Act have a legal obligation to accommodate gender identity needs to the point of undue hardship.[277] The specific right to access to gender-affirming care has been recognized in the jail context in a BC case where a trans woman was detained by the Vancouver City Police and they failed to recognize and accommodate her need for continuity in her gender-affirming care.[278] The failure to reasonably investigate or take seriously requests for gender-affirming care was found to be discriminatory, and the failure to have any policy or systematic approach to accommodating the gender identity-based needs of trans prisoners was found to amount to systemic discrimination. Delays in receiving access to gender-affirming care and gear can also amount to discrimination.[279]

From an international human rights perspective, BC has an obligation to ensure that all people who are subject to state detention have access to appropriate gender-specific health care equivalent to what they would have access to if not detained.[280] That health care, including mental health care, should be individualized and comprehensive. BC also has an obligation to ensure that a person's gender identity is not a barrier to realizing other human rights, including equitable access to health care.[281]

Despite this, Lived Experience Experts reported that detaining facilities regularly withhold or prohibit access to gender-affirming health care and gear during involuntary treatment. One Expert described never knowing what a facility's or clinician's policy or approach would be because they are different each time they are detained. Some facilities purport to allow access to gender-affirming medications, but there are bureaucratic delays in accessing them. For one Expert, a single clinician prohibited access to hormones because of an unconfirmed hypothesis that the medications might be worsening the Expert's mental health.

Another Expert described that, although the hospital could give her access to psychiatric medications, there were unexplained delays in providing her with the gender-affirming treatment she has been taking for a year, resulting in a barrier to basic continuity of care and medication:

> **They gave me everything else, you know—all my antidepressants, all my antipsychotics, all my things to reduce my psychosis episodes, or you know, any chance of mental breakdown. That was okay. But when I asked for my hormones, which are my estrogen and my testosterone blockers, they just say, "No, we're waiting for the call with the pharmacy. We haven't heard anything yet from them."**
>
> **[...]**

And in the end, I got my whole hormone therapy, but after, like, 12 days or 15 days, I can't recall exactly. But it was a long time. And then yeah, no, I felt super unstable, emotionally depressed, with ups and downs and really aggressive and violent emotion. Because I feel intoxicated when my testosterone gets higher, you know. I feel intoxicated. I feel violent. I feel distressed. I thought it was ridiculous the hospital said they couldn't get access. It's a hospital and these are my needs.[282]

A rapid change in medications during a period of crisis can exacerbate psychological distress and cause emerging physiological distress, as the Expert clearly identified. This very clearly does not adequately or responsibly support someone's health and wellbeing. The Expert went on to share that the lack of access to testosterone blockers contributed to an attempted suicide because of the distress it caused for her:

I tried to break through one of the windows in the building to just jump off and, yeah, they just call the security guards and they were real aggressive. They took me, they grabbed me and put me inside of the seclusion room. […] That gap of time [without hormones] is where I had this moment of violence where I was trying to kill myself and jumping off the building, you know. Because my hormones are not just a safety issue. It's a need, you know, for me, but the hospital, they never did anything about it. It took so long. I mean, for me, 10, 12, 15 days without the medication is like a rollercoaster—bad, bad things. Really, really bad things happen. Then they seclude me instead of providing what I need.[283]

Lived Experience Experts also shared their experiences of the involuntary treatment system restricting access to gender-affirming gear like binders. This restriction was detrimental not only to the Experts' sense of identity but also their sense of safety: some reported that having visible breasts put them at risk of intrusive questions and gender-based harassment.

In addition, regardless of gender identity, the confiscation of clothing, including undergarments, and forced reliance on hospital clothing, was raised repeatedly as something that made Experts feel deeply unsafe:

First of all, I felt really vulnerable having to wear hospital clothing, and that put me literally… I didn't want to speak about

> **it too much, but I just felt, like, being around men… you don't feel covered [...]. My body felt exposed. I didn't feel properly covered in a way that I felt comfortable ever.**[284]

Gender-affirming clothing can also be confiscated or restricted under the sweeping authority granted under the Mental Health Act. One clinician who participated in our engagement told us about a trans woman who had her clothing confiscated from her because the treating provider believed it was "hypersexual." But, according to the clinician, "I did not see anything in her chart or when observing her that suggested that she was relating to others in a way that was overtly sexual. [...] She did not have other clothes that aligned with her gender identity, and no real way of accessing clothing of this sort that would fit her."[285] The clinician coordinated with a social worker to find clothing donations that would affirm the individual's identity while being acceptable to the provider.

This is yet another example of how many facilities and treatment team members create barriers to gender-affirming care or gear with minimal justification or differing options across different staff. In this context, where there are clearly less intrusive or harmful options that could be pursued, there are serious concerns that failures to accommodate the gender identity of people experiencing detention and involuntary treatment may be found to be a violation of the Human Rights Code.

g) Pathologizing gender and sexuality

Under the guise of a psychiatric examination, many Lived Experience Experts experienced staff in the health care system asking invasive and deeply personal questions about their gender and sexuality. As set out above, the criteria for involuntary admissions can be interpreted in very broad and subjective ways. Trans and gender-diverse Experts reported several ways their hospitalization experience was affected by the often inappropriate reaction of staff and other patients to their gender expression, body, and sexuality.

> **From the very first interaction that I had at the hospital as a teenager, the very first time that I showed up there, was brought there by a guidance counsellor… that set the tone. [...] Even though they hadn't certified me, they wouldn't let me leave until I told everything that I had said to the mental health nurse to my parents. [...]. And then I was lectured about how I was a dramatic, terrible no-good kid, essentially. [...] Yeah, so "Your parents knew that you're just causing problems for them." Grilling me deeply about my horrible transgenderism, which is, like, a creepy sexual perversion. All the ways that I have sex and things like that. In great detail.**[286]

This Expert illustrates how gender identity can be pathologized and how that can set the tone for a person's relationship with the mental health system. The experience shows a continuation of the historical pathologization of transness, including deeming it to be immoral, perverse, or a manifestation of behavioural or mental health problems. At future hospitalizations, the Expert continued to face intrusive questions that were not relevant to their mental health:

> **I found that on subsequent occasions, most mental health practitioners at the hospital had a similar really inappropriate interest in how I had sex, in my genitals, in my partner's genitals and how my partners had sex and many very inappropriate things of that type, and what I enjoyed sexually, and just, like, really gross questions about my genitals and things like that, which had absolutely no relation to what was going on for me mentally.[287]**

Other Experts also experienced inappropriate questions about their sexuality posed by clinicians during examinations, which undermined their feelings of safety and led them to be less likely to share details of prior trauma or violence with involuntary treatment staff:

> **There was a doctor one time, and, like… the way he went about it was so weird. Just first of all, he started asking what my sexual identity is, which, I don't know, I thought was a little weird. And then, like, he started asking if I was a virgin. And that doesn't seem appropriate. And I feel really uncomfortable with you asking that, and I don't know how this pertains to this situation at all or benefits my medical care.[288]**

In addition, multiple Experts shared that their gender and sex was pathologized, leading to a rapid diagnosis of borderline personality disorder, and normal emotions were attributed to mental illness. These experiences connect back to the mental health system's history of pathologizing gender.

Experts also reported being treated differently because of an intersecting part of their identity. For example, one Expert felt she was detained because, as a white woman, she was seen to be in need of protection from herself and others, while racialized people might be refused services.[289] Another Expert reported that clinicians seemed hesitant to give her, a white professional, a diagnosis of drug-induced psychosis, which she felt was appropriate for her situation, while Indigenous women she knew were quickly labelled with that condition.

Finally, a clinician who participated in our engagement reported that they've witnessed a designated facility detaining pregnant people under the Mental Health Act to "protect the fetus"

and then calling child protection services to remove the baby from the parent after birth before discharging the parent from involuntary status. The clinician says, "This has been brought to leadership's attention many times, but not acted upon, even though this practice is illegal."[290] This is an example of a person's identity being narrowed to a pregnant person at risk to an unborn fetus with little focus placed on their human rights.

These experiences illustrate the impact of granting broad discretion and extraordinary power via the Mental Health Act with minimal systematic approaches to address the structural power imbalances that result. People experiencing detention and involuntary treatment are still subjected to gender-based assumptions and biases that impact their human rights and wellbeing.

h) Apprehension of and separation from children

The Mental Health Act is silent on family status, reproductive rights, caregiving responsibility, and access to children. BC does not have any facilities that are designed and equipped to have children accommodated alongside their caregiver during detention and involuntary treatment. Because of this, caregivers are often separated from children, and children may be apprehended by the Ministry of Children and Family Development during a detention.

As one Expert wrote in an account of her involuntary hospitalization for postpartum psychosis, "This condition is scary, confusing, and to be frank, complete torture, but the worst part of the ordeal was being separated from my newborn for nearly three weeks while I received care."[291] The experience of being separated from apprehended children was also experienced by other Experts, who reported that staff seemed to try to dissuade them from staying in regular contact with their children, which fails to respect the importance of parent-child connections to the health of the parent and child. There was never any acknowledgment of this part of their identity or how separation from their children impacted them:

> **My child was in care at the time, and I got told… I got told I could call at certain times. The foster home. I got told that… "Don't abuse this. Don't just call them up. Don't harass…" No, no, no, sorry. "Don't harass them." And I thought, my god. What kind of mother, what kind of person do you think I'm… I'm just gonna start harassing people now? You're accusing me of harassing… and I love my child and want to just… want this to… you know. That was another thing. They knew my child was in foster care and they never offered to help me with legal support or to offer anything. When I found myself with a social worker finally at the end, I had the social worker at the hospital plus an MCFD social worker, and they didn't offer me any legal support. I had to do that all by myself.**

Thank god I was hypomanic and did get my words out in a way that got me out of going to court all by myself. I argued for mediation instead of court, and the MCFD social worker agreed. The hospital worker said nothing to me or the MCFD social worker for the entire interview. Luckily, I'd been reading, I'd been figuring it out. But they never said to me, "[Name redacted], we understand… you've got…" And they never, ever incorporated that as part of my needs to say, "You've been separated from your child. How's this going for you? You must really be worried about your son." Like, they never considered that. "And is there anything that could help this situation?" It was like they turned it around on me that I was gonna do something wrong.[292]

Other Experts reported similar experiences, with information about and access to their children being withheld during involuntary treatment. This approach is in opposition to the international human rights standards that apply in state detention: people experiencing detention should be encouraged to stay in contact with their children, including via lengthy visits or staying together when possible.[293] The resulting impact is intergenerational and takes years to process and recover from:

I wasn't even allowed to call them, and the kids were old enough to talk to me on the phone, the bigger kids. No, I was allowed no contact. […] And it took years, even—like, not that many years ago, where I've been able to sit with the kids and tell them what really happened, because they all grew up still thinking that I had abandoned them. My [parent] said that I took off; they didn't even know I was locked up that second time. Or the third time. And then the one time when they came and took the kids, they had thought that it was because I was planning on murdering them. My [parent] used that a couple times, saying that I had planned to kill my kids and kill myself. I've never, ever.[294]

Parent–infant units, specialized wards where a person who has recently given birth can stay with their babies while they receive mental health treatment, was another specific concern that came out of the expertise shared during engagement for this project. One Lived Experience Expert describes being taken from her infant and held in seclusion, cold and leaking breastmilk, days after the birth of her child. She elaborates on how important a mother-baby unit would have been to her health and wellbeing:

I spent 17 excruciating days away from my newborn and my family. I was released with no psychiatric follow-up care except for one appointment with the same psychiatrist one month later, despite asking to be referred to BC Women's Reproductive and Mental Health Program.

Upon my release, my midwife referred me to the program. This is where I believe I should have been referred to on day one, but no one at the hospital bothered to look into more suitable care for me.

[...]

A mother and baby unit (Canada has none) and staff trained to treat perinatal mental health conditions would have made all the difference in my care. It would have spared me the separation from my son, the humiliation I felt, and the constant fear I had while being committed with male patients.[295]

This experience, and BC's failure to establish post-natal birthing parent–infant psychiatric units, mirrors the Charter case law related to incarcerated mothers and their infants.[296] In that case, the BC Supreme Court found that a decision to separate incarcerated mothers from their infants during the crucial post-natal bonding period without an assessment of the best interest of the child violated the section 7 and 15 Charter rights of the provincially incarcerated mothers and the section 7 rights of the babies.

Many of the factors that formed the basis for the Court's decision in that case likely apply in the situation of new birthing parents detained under the Mental Health Act: the separation interferes with a crucial period for attachment, bonding, and the physical and psychological benefits associated with breastfeeding regardless of the parent's ability to care for the infants.[297] The Court found the deprivation of section 7 rights violated the principles of fundamental justice because it was based on reasoning that did not consider the constitutional rights of the mothers and babies impacted, and there was a blanket exclusion with no investigation of whether there was a real risk of harm by allowing the parents and babies to remain together (the Court found the decision to cancel the program had no legitimate objective and it was arbitrary, overbroad and grossly disproportionate to a concern with respect to safety of the infants).[298] Finally, the Court also found that the decision to cancel the program violated the section 15 equality rights of the mothers impacted on the basis of their race, ethnicity, disability and sex, with much of the analysis

focused on intersections between gender and sex. In making this finding, the Court found that the decision to cancel the program was not based on real considerations of the safety of infants; instead, it was based on the stereotype that incarcerated women are unfit to mother,[299] furthering entrenching and exacerbating the historic disadvantage and inequality of incarcerated women and their children.[300]

The experience described above by a Lived Experience Expert mirror many of the considerations of the Court. Birthing parents with disabilities face clear historic and ongoing disadvantage, including deeply entrenched stereotypes that they are not fit or capable to parent.[301] The Mental Health Act does not set out any basis for a meaningful investigation of the safety or risk of allowing a birthing parent and infant to remain together during detention and involuntary treatment, or any consideration of the benefits and constitutional rights impacted by this blanket prohibition during the crucial post-natal bonding and attachment phase.

Research on birthing parent–infant units is mostly from the UK, Australia, and France, where they were established as early as the 1950s and are seen as a best practice[302] because the alternative of separating parents from their infants can disrupt bonding and cause long-term negative effects for both parent and child, with disproportionate effects on communities that have endured a history of infant and child apprehension, including Indigenous groups.[303] Studies of client satisfaction with these units found a preference for these units over general psychiatric wards, with women expressing the most satisfaction with their baby equipment, care advice, child development information, privacy, and accommodation of partner involvement. They were least satisfied with the extent to which they were involved in their own care plan, and one study found that "the women experienced returning home from the MBU [mother-baby units] as a significant life event and that women did not feel they had clear enough support plans post-discharge."[304] Studies of patient outcomes "suggest that the mental health of mothers who are admitted to MBUs improves significantly by the time they are discharged"[305] and "the research indicated improvements in maternal mental health, mother–infant relationship, and child development" after an admission to the MBU.[306]

BC has the opportunity to be a leader within Canada in perinatal mental health care for women and gender-diverse people. For example, BC Women's Hospital + Health Centre has a reproductive mental health program that offers support to birthing parents through pregnancy and up to 1 year postpartum,[307] and coupling this program with inpatient services that allow infants to remain with their birthing parents would provide comprehensive perinatal care that would support families after discharge. To ensure that birthing parents across the province could have similar access to perinatal mental health supports, facilities without specialized units could still dedicate rooms to accommodate infants together with their parent while the parent receives mental health support.

The Mental Health Act and involuntary treatment system fail to prevent or respond to gender-based violence

Gender-based violence in mental health facilities is not new, but it has received minimal research and advocacy attention in Canada. In 2018, the UK Care and Quality Commission issued a report on sexual safety on mental health wards.[308] The Commissioner reviewed reports covering a three-month period in 2017 and identified 1,120 of what it called "sexual safety" incidents, which include non-consensual nakedness, sexual assault, sexual harassment, and verbal sexual abuse. The Commission's findings echoed what we heard from Lived Experience Experts:

- Patients did not feel staff kept them safe;
- Clinical staff did not know what good practices entailed and had no guidance;
- Staff are unequipped to respond to sexual safety incidents;
- Mental health wards do not promote safety; and
- Staff likely under-report sexual safety incidents.[309]

Independent media investigations in the UK suggest that the number of reported incidents of sexual violence and abuse in psychiatric units in the country could be much higher, citing a lack of investigation and prevention.[310]

Similarly, in 2020 Australia's National Research Organization for Women's Safety issued a report looking specifically at ways to prevent gender-based violence against women in mental health inpatient units.[311] While the report does not adequately address gender diversity, it offers several guidelines to prevent gender-based violence:

- Ward design should be improved, including locking doors and safe gender spaces;
- Staff should be trained to provide prompt and assertive intervention when a risk of violence arises;
- When a violent incident occurs, victims should be offered rapid access to support services and ongoing support if they choose to report the incident;
- All incidents of gender-based violence should be reported (anonymously) and data should be publicly available; and
- Gender-based violence policies should be developed, implemented, and monitored for success; there should be oversight and timelines to ensure facility responses.[312]

These are just two examples of investigations and reviews into the extent and prevention of gender-based violence in mental health facilities. The sections below will explore the ways BC currently fails to prevent and respond to gender-based violence experienced by people subjected to detention and involuntary treatment under the Mental Health Act.

a) Power imbalance facilitates harassment and violence by staff

> **Because you have no control, you have no power in that. You're locked… you're a prisoner… you're held captive. And I just get scared—what if someone on a power trip wants to do something bad?[313]**

The quote from this Expert makes clear the extent of the power imbalance experienced by someone during detention and involuntary treatment. The UN Special Rapporteur on the right to the highest attainable standard of health has noted this extraordinary power imbalance in the mental health system and the ways it can facilitate or legitimatize human rights violations and misuse of power:

> *At the clinical level, power imbalances reinforce paternalism and even patriarchal approaches, which dominate the relationship between psychiatric professionals and users of mental health services. That asymmetry disempowers users and undermines their right to make decisions about their health, creating an environment where human rights violations can and do occur. Laws allowing the psychiatric profession to treat and confine by force legitimize that power and its misuse. That misuse of power asymmetries thrives, in part, because legal statutes often compel the profession and obligate the State to take coercive action.[314]*

This power imbalance is also the reason that the governing bodies of health professions place clear prohibitions on sexual and personal relationships with people receiving services from health care professionals, often taking a "zero tolerance" approach that prohibits even consensual relationships.[315] Members of health professions governed by the Health Professions Act have a mandatory reporting obligation if they have reason to believe another member might be committing sexual misconduct.[316] The BC Court of Appeal has confirmed that abusing a position of trust, power, or authority can result in coercion and vitiates any consent to sexual activity.[317]

It is a challenging reality to face, but unfortunately, professional conduct notices reflect that this power imbalance is sometimes weaponized by health care professionals who engage in inappropriate relationships with patients. For example, the BC College of Nurses and Midwives' complaints and discipline notices reflect a number of recent situations where registrants engaged in sexual relationships with current or very recent patients.[318] Further, Fraser Health Authority v Health Sciences Association of British Columbia is a labour relations arbitration decision involving the termination of a registered psychiatric nurse who entered into an

inappropriate sexual relationship with a mental health patient.[319] The risk of taking advantage of the coercive authority and power granted by the Mental Health Act is also clear from cases like R v Alsadi,[320] which involved a hospital security guard charged with the sexual assault of a woman while she was detained under the Mental Health Act.

At its core, gender-based violence is not about people being vulnerable victims—it is about unequal power relationships and especially those that are connected to gendered stereotypes and assumptions rooted in patriarchal values.[321] The Mental Health Act removes a person's ability to control what happens to their own body, possessions, relationships, and health, and it grants that power to actors in the mental health system under a law that establishes minimal restrictions or safeguards on the use of that power. In addition, the Mental Health Act reinforces entrenched stereotypes that cast doubt on the capacity of people with a mental disability. This worsens power differentials because people experiencing detention and involuntary treatment who experience violence or abuse are positioned to be less credible.

Lived Experience Experts affirmed this analysis, sharing the ways these unchecked power imbalances can lead to gender-based violence on the part of facility staff. Experts recounted being harassed or assaulted by staff members who held power over them, in a place that purported to keep them safe:

> **When I was younger, I had this one staff member that would sexualize me sort of, like, he would make… he would give me compliments that made me super uncomfortable. I was like 17 or whatever, and… I'll never forget the time—he was a psych assistant—he said… we went swimming, and he said, "You looked good out there in your swimsuit today, [Redacted]," and I'm like, "Oh my ick." I'm like, "What did you just say to me and how do I, like, even talk to you ever again?"[322]**

This was unfortunately not the Expert's only experience of violence. During a later detention, she was physically assaulted by a staff member, an experience that more than one Experts was forced to survive. On page 70 we shared a story of the experience of an Expert who was sexually assaulted over a long period of time by a facility staff member. Her trauma-based reactions when the staff member was working were attributed to her mental health diagnoses or punished using seclusion. When she did eventually disclose the violence, facility staff treated her as a risk to their professional reputation or discounted her reports. The abuser eventually lost his license to practice nursing, but to our knowledge there was no criminal proceeding or other punishment related to the violence.

Another Expert reported being warned about a psychiatrist who was known in the community for sexually assaulting patients:

I was also warned by other patients when I was detained that this same psychiatrist had a reputation for sexually assaulting patients. When I left the hospital I was able to confirm that his license had been previously suspended for sexual misconduct (I'm not sure if "suspended" is the exact right term—he had lost the right to practice previously, because he had been found to have pursued multiple relationships with female patients, but had ultimately been able to start practicing again) and that he was the focus of recent public accusations by people stating that he had behaved in sexually abusive ways towards them. The last I heard when I stopped receiving services at that hospital, he was still working there.[323]

The experiences shared by Experts illustrate the ways in which BC is not fulfilling its obligation to prevent gender-based violence during involuntary detention in the context of extraordinary, unchecked power imbalances.

It is worth noting that section 19 of the Mental Health Act appears to be aimed at supporting the safety of women by requiring them to bring a trusted support person or someone of their sex on the trip to a provincial mental health facility. However, the content of the section of the Act was created in 1964, and we are not aware of a single instance of its use in recent years. Further, it is extremely narrow in its scope. First, it appears to ignore the rights to safety of trans, non-binary, and Two-Spirit people and other gender-diverse people. Second, it applies only to provincial mental health facilities[324] and not to hospitals designated as observation or psychiatric units, where most people experience involuntary hospitalization. Finally, according to the *Guide to the Mental Health Act,*[325] the section does not apply when police or paramedics convey someone to a facility, meaning that it will not apply in the vast majority of situations where a person is being transported by someone who is not known to them personally.

b) Lack of prevention facilitates harassment and violence by other patients

I remember this guy. He was at least 70 years old, another patient, and he was saying how that… one day I would be his wife. I thought that was very inappropriate. And I was alone. I felt weird.[326]

This Lived Experience Expert's comment illustrated one example of the widespread experiences of harassment, unsafe situations, and violence experienced during interactions with other people detained under the Mental Health Act. Experts shared the extent to which this resulted in them feeling deeply unsafe, with little intervention even when harassment occurred in the presence of unit staff:

The last time I was on psych, there was one guy who just always would particular… like, he was a patient, and he'd always go after me, in the sense that he would come up to me and have his hood on… So it was, like, I don't know, that just made me feel extra uncomfortable because he was hiding. And he'd come up to me and I'd be sitting like this outside the nursing station waiting for medication, and he'd say things like, "I find it so attractive how weak you look." And other stuff like that. And so that… made me not want to leave my room. […] This guy would regularly walk up behind me and stroke his finger down my back. That just added to the feeling of not being safe around… safe on that unit because of that person.[327]

These experiences underpin how important it is not to minimize verbal sexual and gendered harassment because Experts also reported that harassment sometimes turned into physical violence with little warning, either directed at them or at others on the ward:

Yeah, so anyways, there's this guy, and he was super manic. This was my first hospitalization. And he became fixated on me. And, I mean, he was on another planet. And… he kept proposing marriage to me and stuff like that and just constantly harassing me. And this is actually violence to somebody else, but it was related to me. He saw another guy talking to me, and he punched him, like, straight-up sucker punched him in the face. And I did not feel safe at all. He kind of got shuttled out of the unit after that happened. And I don't know what happened to him.[328]

Under international human rights agreements, BC has an obligation to respond adequately to gender-based violence and to ensure that anyone who experiences it is offered safety and protection to avoid further violence. Experts reported that, although mental health facility staff did sometimes intervene in ways that made them feel safer, more often, staff did not do anything that meaningfully improved the Experts' feelings of fear and unsafety.

I didn't like it because there was a guy there that wouldn't leave me alone. And he kept saying the same things, repeating himself over and sitting there asking me questions over and over, and I couldn't get away from this guy. He kept bothering me all… the whole time I was there, it seemed like. And I told

them about him, and they said, "That's just how he is. You just get used to him." It's all they did. They didn't do nothing to try to help me with that or nothing, no.[329]

The design of the unit also impacted feelings of safety. For example, another Expert reported feeling frustrated because staff have ways to maintain their own safety, like working from behind Plexiglas in a nursing station, while she felt vulnerable and unprotected in the unit:

These things kept continuing, and they would just say to me, "Oh, he's just very disturbed." And I'm, like, "Okay, that doesn't help me. That doesn't protect me." […] And sometimes they even witnessed him doing it. And they just stand behind the nursing station, so it's, like, this Plexiglas and then the counter or whatever, so… they are protected behind their barrier while I'm out there. And they just watch it happening.[330]

While this is just one example, a study on removing Plexiglas barriers in nurses' stations found that nurses had mixed feelings about the change but that "Patients unanimously preferred the nurses' station without the barrier, reporting increased feelings of freedom, safety, and connection with the nurses after its removal."[331]

c) Ward design exacerbates risks of violence

They were gendered washrooms, but they were shared washrooms. So, yeah, anyways, I could hear this guy [in the men's washroom]. And he was talking to the other guys about how he was going to fuck me. […] And, yeah, this went on for a while. He was also just very aggressive in general, and he freaked me out […] I told the nurses this, that I heard him saying this, and he wasn't trying to hide the fact that he was saying this. And it's, like, I don't know really what they can do. They didn't transfer him to another ward at that time. It took them finding out that he was using, a bit later, for him to get sent to wherever he got sent to. […] Yeah, I told them, but they didn't really do anything, you know? And I was, like, fuck. Literally there's no barriers between people here, you know, and I have to fucking eat my three meals and shower in our fucking communal washrooms, where this disgusting guy is, you know? And I don't know, I don't even know what you're supposed to do in that situation. I don't think it was taken seriously.[332]

The experience shared by this Expert illustrates the importance of BC taking additional steps to prevent gender-based violence during detention and involuntary psychiatric treatment by improving the design of units/wards to support safety. Lived Experience Experts highlighted, in particular, ways that sharing rooms, bathrooms, showers, and common areas with other people who were also in crisis affected their sense of safety. For example, as one person shared:

> **I, to a certain extent, understand that there's a need for beds, but also the fact that they have people who are in psychiatric crises sharing rooms with up to three other people, I just think that's not appropriate, not helpful. Like, I don't know, especially for me, because, I just have trauma, as I'm sure a lot of people do, it… just the fact that the only thing separating me from other people is a curtain really feels so stressful. It's just like constantly in fear that I'm in danger.[333]**

This Expert's analysis of shared rooms was reflective of other expertise we heard. For one trans non-binary Expert, shared rooms resulted in inappropriate accommodation when they were forced to use a seclusion room as a sleeping space because there were no gender-neutral rooms available. In addition, every one of the clinicians who participated in our engagement mentioned shared rooms and washrooms as a structural factor exacerbating gender-based violence and harassment in involuntary settings.

These reports are consistent with research on the effect of environmental design on aggression: "Single bedrooms with private bathrooms may be the single most important design intervention for facilitating privacy access and reducing crowding stress and aggression in inpatient psychiatric wards. Considerable research on apartments and correctional facilities has shown that the number of persons sharing a bedroom or cell reliably correlates with higher crowding stress, reduced privacy, more aggressive behaviour, illness complaints, and social withdrawal."[334]

Connected to shared rooms, the overall lack of privacy during detention was identified by some Lived Experience Experts as another reason they felt unsafe and unprotected from violence during detention:

> **Privacy! That's huge. Not being able to use the bathroom without people watching or the door having to be propped open. It doesn't feel safe for a lot of folks. Me included. And yeah, I know why one-to-one is needed at times, but I do feel like sometimes it is over-prescribed. I've had multiple admissions where somebody is sitting within arm's reach, gawking. This act of surveillance can not only feel uncomfortable, but also be quite distressing.[335]**

Multiple Experts raised concerns about the lack of locks on room and bathroom doors. Many shared experiences of people entering their rooms or invading their space without consent. The need to feel safe while sleeping and at night was especially visceral. For example, one Expert shared waking up to a strange man touching her:

> **Once when I was sleeping, another patient came into my room and touched my foot and woke me up because there was no lock. Anybody could come in. [...] That was very scary. And he was a guy, too. I was really scared.**[336]

While many Experts acknowledged that the lack of locks was likely due to safety and to facilitate staff checks, they shared ways that rooms could be more private and secure while also ensuring those purposes are not undermined. For example, one Expert suggested locks on room doors but providing staff with the key.

Tensions between privacy and visibility/security were complicated topics in terms of the way they support and undermine safety. Many Experts reported that the lack of privacy and private space made them feel unsafe. Others reported that improved facility monitoring and ward design could have prevented the violence they experienced while detained (their abuser knew of areas in the facility that were not covered by cameras, for example). Another Expert told us that having people around, even strangers, made them feel safer when they were subject to physical restraints because they felt the visibility reduced the risk staff would hurt them or abuse their power. Further exploration is needed to understand, based on the leadership of people with lived and living experience, when visibility and monitoring increases safety or undermines it.

The final aspect of ward design that was mentioned earlier in this report is the idea of gender segregation or safe spaces on wards. The need for some kind of safer space is clear. For example, one Lived Experience Expert shared her perspective that there should be segregated wards:

> **Segregation of men, women.[...] I think as a woman speaking, I don't think men and... like, cis men or men period should be mixed with women, period. All right? This is not okay. It invites too much possibility of... even if it's not physical violence or all the other forms of violence. And how many women have had trauma from men from childhood on. We don't need to go to the stats. We know it. And that's just increasing distress and trauma. That's going to make anxiety worse, it'll make paranoia worse, it'll make, like, we could go... and we're going with psychiatric terms here. It can make delusions worse... It's just going to make anybody fearful. You're not going to feel safe, you're going to have to constantly watch your back.**[337]

The Expert went on to expand on this idea and clarify that her vision of segregated wards would include trans women, non-binary and genderqueer folks, and trans men. This recommendation aligns with something we heard from one clinician, who expressed that "Protected spaces for those that identify as women"[338] could help increase safety in involuntary settings.

International human rights agreements and Canadian case law in the prison context supports gender segregation, with flexibility to support trans and gender-diverse people. Some research shows that women-only wards do decrease the risk of sexual and physical violence against women and gender-diverse patients,[339] although women in these settings still experience violence from other women in the form of threats and intimidation.[340] Other research has found that some women would prefer being in a mixed-gender ward.[341] However, much of the research done in this area assumes a binary approach to sex and gender and fails to assess the impact of binary segregation on gender-diverse people.

A 2022 study from New Zealand involving both staff and service users suggests that focusing on gender segregation may be a red herring, the authors urging policy makers and providers to focus instead on trauma-informed and person-centred care that values autonomy, privacy, and safety, which would benefit all patients.[342] In other words, incidences of all violence, regardless of gender, would decrease in facilities that prioritized personhood and choice making.

It is likely possible to find a way to create safer spaces during involuntary detention that do not rely on strict binary sex and gender segregation. New guidance co-developed by the World Health Organization and the UN High Commissioner for Human Rights related to human rights-based mental health law recommends that legislation set out requirements that all facilities have "gender safe spaces"[343] that would be gender-inclusive but also offer a space to seek refuge from harassment and violence. This guidance is relatively new and emerging, and we are aware of few, if any, examples of the practice internationally. How exactly such a space would be designed and implemented would need to be co-developed with people with lived and living experience, in order to be piloted and evaluated for impact. BC should pursue ways to address the experience raised by Experts regardless of the complexity and emergent nature of the idea.

Finally, the systemic removal of personal phones and forced reliance on a shared ward phone left Experts feeling unsafe. Without private spaces to phone their outside support network, not only could staff hear their phone calls on shared ward phones, but one Expert shared an experience of the person sexually harassing them listening in to their calls, thereby undermining their right to be free from harassment:

> **The phones are in a public area as well. So people are listening to your phone conversations. Something that would happen to me was I would go to use the phone, and a dude who was sexually harassing me would come and hover while**

I was trying to use the phone, which is great. Just a garbage experience.[344]

Finally, some of the above issues are being addressed as newer facilities are built and some in-patient psychiatric units move toward features like single rooms with private bathrooms, a central staff station with visibility to rooms and common areas, and access to natural light, but the same cannot be said for psychiatric emergency settings. This was a key area where Lived Experience Experts flagged a lack of privacy and safety:

I remember in emerg, like, in psych emerg, that was terrifying because a lot of the men were… and I had no room, I had no bed. And the big scary bit was knowing a lot of them were coming off substances and probably unwillingly… and there would be explosive moments… I didn't know if any of that was going to come in my direction. It was terrifying. I've had violence happen to me from men in different ways, but not… in an intimate partner setting, but within the hospital context.[345]

In addition to implementing evidence-informed minimum standards for ward design in new facilities, prioritizing retrofits according to these standards at existing psychiatric units and in emergency settings may improve the experiences of people being examined for hospitalization and people being detained under the Mental Health Act.

d) No systematic response to gender-based violence when it occurs

As set out earlier in this report, BC has an obligation to respond adequately to gender-based violence if it occurs. This includes comprehensive actions to ensure the safety of a person who experiences violence and the availability of transparent, accessible, and effective complaints or legal processes.

However, Lived Experience Experts who experienced gender-based violence during detention reported that there were no systematic or coordinated responses. As we described on page 19 one Expert shared that, despite clear escalation, staff failed to respond effectively to harassment from multiple men while she was heavily medicated and unable to react, which then escalated to a sexual assault:

There was a point during the first couple weeks I was admitted that I had one male patient repeatedly and continually harass me. And soon it became a thing where I had two other guys contribute and also sexually harass me. I was just so out of it the entire time and unable to comprehend the level of risk I was in.

Eventually this culminated in a bigger incident occurring with yet another male patient taking advantage of my situation—a fourth one who assaulted me on the unit. And that was very, very traumatic for me. Especially in the sense with the thing, itself, being traumatic, but staff responses added additional layers of complexity to my response.[346]

This Expert illustrated the ways in which the staff and facility response to this incident failed to meet human rights obligations in numerous ways:

- First, staff failed to ensure the Expert's safety and protection: immediately after the incident, staff insisted that the Expert leave her room and stay in the common area, where she felt exposed and unprotected. Staff had sent the perpetrator of the sexual assault to his room, but there was nothing preventing him from leaving it and entering the common area. The Expert felt strongly that staying in her room would allow her to feel the safest, but staff would not respect her wishes. She was forced to remain in the common area, visibly upset, while other patients came out of their rooms for dinner.

- Second, staff failed to respond to escalating harassment and prevent the sexual assault: The Expert later learned that staff had been aware of the earlier sexual harassment, when she was experiencing the sedating effects of her medication and couldn't defend herself. The Expert felt that staff could have intervened and failed to ensure her safety.

- Third, the detaining facility had no policies or training to respond to gender-based violence: the Expert explained that after the assault, staff scrambled and did not know how to respond. The facility had no policy, procedure, or staff training related to sexual or gender-based violence. This caused additional distress for the Expert because she felt that staff should be the ones who know how to address the situation. The Expert felt this was not trauma-informed because she was forced to worry about the staff and facility's response in addition to the incident itself. The Expert felt strongly that the facility should have had a written protocol with clear steps to follow to respond to an incident of violence.

The failure to put in place policies and training so that facilities and staff are equipped to respond to violence was affirmed by a clinician who participated in our engagement. They highlighted the lack of this kind of policy:

Women and trans persons on the unit have experienced aggressive or shaming comments from co-patients. Staff often respond by asking one of the involved parties to separate or reduce interaction with the other patient, but it is not

consistent how this is implemented (e.g. sometimes the perpetrator is asked to go to their room, sometimes the victim is advised to ignore them or go to another space) and there is no clear policy on same.[347]

BC should consider amending the Mental Health Act to mandate that every detaining facility in BC have policies in place to prevent and respond to gender-based violence in the facility. The Act should also establish a timeline for the development of these policies and a monitoring and oversight role for the province to ensure policies meet minimum standards and are implemented.

e) Lack of accountability structures

I didn't know much about the psychiatric ward or how it worked. I didn't know where to take my complaints to.[348]

In this quote, this Expert illustrates the need for BC to ensure its response to gender-based violence during involuntary treatment includes legal and complaint processes that offer accessible, affordable, fair, and effective remedies. Further, BC has an obligation to ensure that these processes do not inadvertently reinforce or rely on gender or disability discrimination or bias.

Many Lived Experience Experts reported that they did not pursue any complaints or legal proceedings for a number of reasons:

- They did not know where or how to make a complaint. No Experts were informed by staff of the available processes.
- They feared retribution or punishment if they made a complaint. This was especially true for Experts whose children had been apprehended because they feared doing anything that might be used against them and create additional barriers to getting their children back.
- They did not think their complaint would be taken seriously or result in change:

It didn't really feel like an environment that was supposed to be safe. So it didn't, I think, occur to me to try to express my desire for safety when I had not had any experience of anyone taking my safety seriously. And certainly nobody expressed proactively to me, "Here's how you can let us know if you feel unsafe."[349]

Lived Experience Experts who did pursue accountability used many different avenues: Patient Care Quality Office (PCQO) complaints, Ombudsperson complaints, complaints to health professional regulatory bodies, and a meeting with an MLA. Most felt that the process they

pursued did not result in meaningful recognition of their experience, any individual remedy, or any systemic change.

In particular, Experts felt that the PCQO did not keep health care providers accountable because it is part of the health authority and is not independent. They experienced professional regulatory bodies like the College of Physicians and Surgeons as doctors who "protect their own," particularly in cases where it was an Expert's word against a doctor's. Finally, they experienced the Ombudsperson's office as deferring to the health authority's promise of a response, only to have the health authority not follow through on what it promised.

We asked the clinicians who participated in our engagement whether staff who were concerned about systemic problems at their facility had a way of reporting those concerns to leadership. One clinician responded that all staff are expected to take training on BC's Patient Safety Learning System (PSLS),[350] which is meant to foster "a culture of safety" by giving staff a tool to identify and report patient safety incidents. This clinician told us, "The downside of this system is that though it is expected that, for instance, every seclusion instance should have a PSLS associated with it, they are rarely filled out because it's clunky and time consuming. Additionally, though theoretically it could capture data on issues like lapsed certificates [which create the legal authority for involuntary status], absent Form 5s [which document deemed consent to a treatment plan], culturally unsafe care, iatrogenic harms of lengthy admissions, etc., the system is not really set up to count or prioritize response to these issues."[351]

Some of the Lived Experience Experts we interviewed believed that the province needs an accountability mechanism at a higher level, like a mental health advocate, that can provide neutral oversight:

> **I think there needs to be a neutral body of complaint and a very easy way and clear way that everybody upon admission is informed of that neutral person to go to when you need to go to for complaining and that they're entirely neutral and transparent. And that things actually happen as a follow-up as a result of whatever the complaint is. There is no way of really following up… The ombudsperson makes recommendations the government does not have to implement. Currently there is no neutral body within a hospital health authority or otherwise within the province… that can make solid permanent change.**[352]

This analysis was shared by a clinician who participated in our engagement, who highlighted the barriers involuntary patients face because of the power difference between them and their care team:

There needs to be a more accessible reporting system that involves 3rd party review. Complaints from clients do not often go above the staff or floor supervisor, as the clients are afraid that complaining too persistently will lead to retribution in their daily care. Many of these patients cannot tolerate a traditional reporting system where they have to engage in back-and-forth written communications. There needs to be an option for a 3rd party evaluator to visit the clients, transparently explain why they are a safe person, and proactively ask questions about topics that are not usually safe for the patients to bring up.[353]

BC did have a Mental Health Advocate Office from 1998 to 2001, which was not independent but operated very similarly to how the Seniors Advocate does today. The mental health advocate at the time, Dr. Nancy Hall, issued two reports of her investigations[354] that recommended systemic changes, many of which were never meaningfully implemented. The office was eliminated shortly after a change in government.

BC's involuntary treatment system is not trauma- and violence-informed

Gender-based discrimination and violence are structural factors that impact a person's health and wellbeing. They can also impact the way the person experiences their own mental health and what services will be safe, accessible, and responsive to their needs. In particular, cis and trans women and girls; trans, non-binary, and Two-Spirit people; as well as other people with diverse genders carry with them the ways that gender has shaped their relationships, health, wellbeing, and experience of public services. Experiences of interpersonal gender-based violence and ongoing structural violence caused by social norms and expectations of what is "normal" and "acceptable" in terms of gender and gender expression impact what services will meet their needs.

As the providers of a public service, the province, health authorities, and detaining facilities have an obligation under BC's Human Rights Code to ensure that mental health services, including involuntary treatment, are non-discriminatory on the basis of gender, gender identity, gender expression, and sex. As explained above, this requires more than just ensuring policy and practices do not expressly discriminate—it requires recognition that some people will need to be treated differently (accommodated) to prevent negative impacts related to their identities.

One way that can be accomplished in BC is by proactively designing services to be gender-responsive, or responsive and inclusive of all the ways that gender norms and expectations, gender-based violence, and gender-based discrimination can shape their experiences. This can ensure that services are safe and accessible for people of all genders. While the label of "trauma-informed" is overused to the point of losing its meaning, ensuring that mental health services are trauma- and violence- informed is one way to ensure that the services are sensitive and responsive to these gendered experiences. Many systemic investigations and reports have recommended ensuring that health services are trauma informed to meet gender-related

needs and in particular to provide accessible, safe services to people who have experienced structural violence, including intersecting gender-based violence.[355]

A trauma- and violence- informed framework (as opposed to a traditional trauma-informed framework) responds to critiques that trauma-informed approaches individualize trauma and harm and ignore the existence and impacts of structural violence and oppression.

> **Healthcare settings claiming that they are trauma-informed is absolutely meaningless to me because beyond a brief online course, there's nothing trauma informed about the care that's provided in involuntary psychiatric care. And probably other places in the hospital. Particularly for those who identify as marginalized individuals.[356]**

As this Lived Experience Expert notes, many models of trauma-informed care have become rote exercises in online training and checklists that focus on individual experiences of trauma, but they fail to recognize complexity and the fact that many experiences of trauma and violence are situated within structural violence and inequity. Similarly, other critiques of trauma-informed approaches centre risk, painting people as "at risk," locating the vulnerability in the individual instead of in systemic forces like colonialism, racism, and gender-based discrimination.[357]

Trauma- and violence-informed approaches resist this by expanding typical trauma-informed practice frameworks to include violence to account for the intersecting impacts of systemic and interpersonal violence and structural inequities—including violence, discrimination, and bias related to gender—on a person's life.[358] A trauma- and violence-informed approach differs from a traditional trauma-informed approach by having an explicit focus on:

- broad structural and social conditions, to avoid seeing trauma as happening only "in people's minds";
- ongoing violence, to avoid seeing trauma only as something that happened in the past;
- institutional and systemic violence, including policies and practices that perpetuate harm (system-induced trauma) because they are designed to satisfy the needs of the system rather than those of the person; and
- the responsibility of organizations and providers, supported by resources, policies, and systems, to shift services at the point of care, so that people do not have to work around services to get what they need.[359]

The EQUIP model of trauma- and violence-informed care has four core principles:

1) Understand trauma and violence, especially structural violence, its prevalence and its impacts on people's lives and behaviours;
2) Create emotionally, culturally and physically safe environments for people who access and provide services;
3) Foster opportunities for choice, collaboration, and connection; and
4) Provide strengths-based and capacity-building ways to support people who access services.[360]

While many health authorities and detaining facilities assert that they are committed to providing trauma-informed health care, there is little to no evaluation or oversight over whether that is actually the case. This section of the report will now go through these principles of trauma- and violence-informed care to analyze how BC's detention and involuntary psychiatric treatment system adheres to these principles, and by extension, the extent to which these services accommodate gendered needs.

a) Understand violence, including structural violence, and its impacts

> **It would be nice if they asked you about your trauma and about what you were scared of. They could even say, "Hey, what would make this experience go smoothly for you and for us?" If they really are so concerned about your safety and you being good, because they really are. They could say, "What would make this experience go smoother for you?"**
>
> **They don't ask your pronouns, they don't ask what would make you feel better, they don't ask you if you have any cultural preferences or customs.**
>
> **If they asked, "What's your trauma? What could… what would make this work? What would make you feel safe?" That would be a nice thing.**[361]

Lived Experience Experts, like the one quoted above, reported that staff they interacted with during detention and involuntary treatment seemed to have a lack of awareness of trauma and its impacts. Staff did not appear to understand how a person's behaviour could be influenced by previous experiences of trauma or violence. When disclosures of violence or trauma occurred, they were handled badly, and the Experts involved often felt unsafe or shamed in relation to their disclosure. For example, one Expert who was sexually assaulted by a staff member in a detaining facility requested never to be taken to that facility again. Despite her request, she

was transferred there and examined by a psychiatrist who seemed to have no understanding of the way her past experiences might be impacting her wellbeing or causing physical trauma responses like trembling. Another Expert reported trying to speak with a psychiatrist about their trauma only to have him focus on medication; there was no sign of validation or concern, which are part of a trauma- and violence-informed approach to health services:[362]

> **I tried to talk to the psychiatrist about past trauma and he only spoke of drugs. There was zero engagement with trauma or any psychological support. My symptoms are linked to past trauma, but the clinical staff had no grasp of that background whatsoever.[363]**

Experts' emotional reactions to what they were experiencing were also often pathologized as unacceptable instead of being met with affirmation, which would have validated their feelings. Crying or raising their voice was conflated with violence and sometimes punished with seclusion, physical restraint, or forced injection. One Lived Experience Expert expressed that they experienced this dynamic as rooted in gender stereotypes of women's emotional control:

> **Crying and then being violent are two different things. So if you're in distress, and you're crying and you're screaming and you're asking for help and you're overwhelmed, I feel like, I don't know, if you're a man, you get treated differently than if you were a woman.[364]**

Beyond individual interactions, BC, health authorities, and detaining facilities can comply with human rights obligations by (a) developing laws, policies, and processes that support a culture that is trauma- and violence-informed, and (b) ensuring adequate training.[365] International human rights frameworks offer significant guidance on what is required to support gender-based violence awareness in health care services. That guidance suggests that training should be mandatory and recurring and that it should include:

- How gender stereotypes and bias lead to gender-based violence and inadequate responses to it;
- Trauma and its effects, the power dynamics that characterize intimate partner violence and the varying situations of people experiencing diverse forms of gender-based violence, which should include the intersecting forms of discrimination; and
- Legal provisions that prohibit or protect against gender-based violence, the legal rights of victims/survivors, international standards and associated mechanisms and their

> responsibilities in that context, and steps for documenting incidents of violence, with respect for the privacy and free and informed consent of the person who experienced violence.[366]

In addition, staff should have to complete mandatory training on gender diversity and gender-affirming care, an area that clinicians identified as a major knowledge gap in the involuntary treatment system.

A clinician who participated in our engagement told us about a "sims" training program[367] developed in consultation with people with lived and living experience intended "to model how a collaborative and dignifying approach to care for people who use substances is superior to other approaches. They include [lessons] that show de-escalation of the involuntary patient, gender-affirming care, supporting a person who uses substances, access to perinatal care, etc."[368] Co-designing staff training with people with lived experience is a promising first step to actualizing a truly collaborative therapeutic relationship.

b) Create emotionally, culturally, and physically safe environments

Creating a welcoming and safe service environment is a key aspect of ensuring that health care services are trauma- and violence-informed. Several aspects of a person's identity can influence what they experience as safe and unsafe. The experiences of violence and discrimination outlined earlier in this report do not contribute to a safe environment. However, Lived Experience Experts identified additional gaps that left them feeling unsafe.

Cultural safety

Cultural safety and humility in mental health services is critical to making them less colonial. Some Indigenous Lived Experience Experts were never offered access to cultural support during detention and involuntary treatment. Others shared that cultural supports are sometimes available, but the practice is inconsistent:

> **It's just overt violence and taking my possessions and having decisions made for me—those things I can see it, physically, and then being treated poorly by the psychiatrist and not being listened to and not getting resources I need—like, I need an Elder. Why is there no Elder?[369]**

For Experts that did manage to access Indigenous cultural supports that were offered by a service independent from the health system, the services made them feel like someone outside the medical system was on their side and it offered some form of accountability:

> **And I only knew about them because somebody I went to treatment with, a girl, had used them to help her get her kids**

back. So that's how I knew, and then it was just so powerful when it was two ladies—they came in and they said, "Yeah, we see this all the time." And I was like, "Wow, it's not even really about me. This is what they do." Yeah, it just helped me feel like I wasn't just blowing in the wind, that I had people in my corner, and that there would be some sort of measure of accountability for whatever they did to me. There was eyes on them outside of the system—like, the medical system.[370]

Access to culturally safe health services, and respect for self-determined, community-specific health and wellness approaches, are core parts of implementing the Declaration on the Rights of Indigenous Peoples. BC's Mental Health Act does not include any right to cultural supports or cultural safety for Indigenous people experiencing detention and involuntary treatment.

Physical safety: non-psychiatric health needs

When you talk about menstrual protection, when you're wearing a hospital gown, and you're experiencing, um… I was begging them in the hospital: "Hey, do you mind? I've got this problem here with my bleeding. Do you mind helping me?" "No, you're here for psychiatric reasons."[371]

As illustrated by this Expert and others, non-psychiatric health needs are often left unaddressed or inadequately supported. In addition to the risks to physical safety already shared in this publication, Experts told us about the following:

- Experiencing heavy periods and the facility staff refusing to give access to the extra menstrual products, clothing, and supplements that would have helped;
- Having to bring in tampons because the hospital offered only pads and then having to ask male staff for access to those tampons;
- Having reproductive and post-natal needs like breastfeeding demeaned and not taken seriously;
- Having sexual health concerns that were impacting quality of life but that remained unaddressed; and
- Disclosing substance use during detention and then having their freedom curtailed by the facility's enforcing an abstinence-based approach.

These experiences illustrate the ways in which substance use, reproductive, and sexual health

needs are not being adequately met during detention. Regardless of detention status or status under the Mental Health Act, all people should have access to health care services that offer holistic and person-centred services.[372] In particular, BC has an obligation to ensure that people who are experiencing state empowered detention, like what is authorized by the Mental Health Act, have access to the same scope of health care services that they would experience if they were in community, free from detention.[373]

Emotional safety: shifting rules, lack of information, and isolation

A number of aspects of the experience of involuntary treatment undermined the emotional and psychological safety of the Lived Experience Experts who shared their expertise with us.

In particular, Experts reported experiencing the arbitrariness of hospital policies as a major source of distress. They often lost privileges for reasons they were not explained, and this unpredictability and loss of control exacerbated their feelings of trauma and eroded trust, as illustrated by this Expert:

> **I like to have a notebook with me as a comfort item, but with an ever-shifting set of rules of what is deemed safe to carry on me it never feels based in fact. Like, I could have a pencil sometimes, but not a pen. Other times, vice versa. Or I can't have either of those things and only a highlighter, which like, nobody carries a highlighter around. And rules change for me admission to admission and on different units. So, there's not one congruent set of rules that I know I can adhere to, it's never clear, making it more likely for me to "break" it and get penalized.[374]**

Many of the Experts described the phenomenon of having to guess the rules of the "game" so that they could get what they needed, comply with what they thought the treatment team wanted, or be discharged. While one might assume that the path to discharge from involuntary treatment is improvement in your mental health and wellbeing, that was not the experience many Experts shared. Instead, they described having to decipher what the system wanted from them and then do that. For some Lived Experience Experts, this expectation was gendered, appealing to the fawning trauma response that women are often socialized as "people pleasers" to offer. Paternalistic expectations to "be good" or "well behaved" were experienced as the pathway to getting out of detention:

> **The only hope you have in that place is to be really good, like a school kid, and do exactly what you need to do by their terms. And then maybe you'll get a pass or maybe you'll change your behaviour. Well, I already had that game in mind. I did**

> **everything they wanted to just to keep the peace and try to get out earlier.[375]**

Experts also reported that the lack of transparency and information also negatively impacted their emotional and psychological safety. Information about the reasons for their hospitalization, their diagnoses, and their treatment plan were regularly withheld, causing distress and generating a feeling of powerlessness and uncertainty.

> **I was really confused as to why I was there. And they never really talked to me and told me what was going on. They just kind of just left me there.[376]**

In addition to information about their own circumstances and health, Experts also reported that no one informed them of their rights. Some of the Lived Experience Experts experienced detention and involuntary treatment in the last few years, since the Ombudsperson's report Committed to Change was issued in 2019, which found widespread failure to comply with the constitutional and legal obligation to notify people of their legal rights upon detention.[377] Despite several years of work on improving compliance with the rights notification process, including the province and health authorities committing to changes, many Experts reported that they were either not informed of their rights or were given mixed messages about their rights. For example:

> **They give you this pamphlet that says, "Your rights under the Mental Health Act." [...] And it literally... the front cover says, "Your rights under the Mental Health Act." But then the nurses will directly say, "You don't have any rights. So just take this medication." [378]**

One Lived Experience Expert, who knew they were entitled to rights information, discovered after asking for it that the nurse responsible for their care was not aware of staff obligations to notify patients of their rights. The nurse had travelled to BC from elsewhere to fill a staff shortage and had not taken the same mandatory training on Mental Health Act rights as permanent staff had. As the province experiences more staff shortages in the health care system,[379] it may have to rely more on visiting staff who have this gap in knowledge. To close this gap, the province should ensure that all travel nurses and other visiting staff take the same mandatory training as permanent staff before they can practice.

This lack of compliance with legal obligations is also experienced as a withholding of information that would help people experiencing detention and involuntary treatment feel more in control and empowered. When Experts did try to exercise their rights, another opportunity for control

and empowerment during a traumatizing situation, they were met with punitive responses like the confiscation of their phone or threats of seclusion.

c) Foster opportunities for choice, collaboration, and connection

Not asking, not listening

BC's Mental Health Act already removes a person's autonomy and choice when it comes to psychiatric treatment decisions and many aspects of their life during detention. However, the law does not prohibit health care staff from engaging with a person to understand their experience and perspective on their own health and to make collaborative decisions together. A number of Lived Experience Experts told us that their hospitalization would have been far less traumatizing for them if they had simply been asked what they needed and given some choices.

> **I've also had situations where nurses have tried to tell me what they think would be helpful for me. And I've said, you know, "I have a lot of experience with being in the hospital and/or what works for me in community, and I appreciate that you're offering this feedback, but it's not as if I've never heard of mindfulness before. Like, I do know what's helpful for me, and this is why this is helpful or why this is unhelpful," and then have them say, like, "You are being resistant to treatment, you're not engaging with the program," and, yeah, I've had those be areas of argument where it's just, like, you may have knowledge of what works for you, but you are a patient, and you clearly can't know anything about yourself. So you just have to listen to what they say—shut up and comply, so to speak.[380]**

As explained by this Expert, asserting knowledge and expertise about their own health can be painted as non-compliance and refusal of treatment.

Virtually all Experts we spoke with told us some variation of staff not listening to them, not believing them, and not validating their concerns, with some explicitly describing the experience as "gaslighting," which women report experiencing from medical professionals far more frequently than men.[381] As we introduced on page 19, after one Expert was sexually assaulted by another patient, they kept trying to tell the staff what they would find helpful, but the staff did not respect their assertions:

> **I really just needed to feel safe and secure and be alone to regulate my emotions for a bit. That's what I really needed, but they would not let it happen. This made me believe the**

only option was to physically harm myself to cope. This could have all been mitigated or prevented if they listened to me and my needs when I asserted them.[382]

Another Expert shared that staff did not believe her when she told them her father was dying and needed her help. When someone eventually checked on her father, he had fallen and was injured. Staff eventually allowed her to visit him in a different section of the hospital because he refused to listen to hospital staff out of fear. The Expert could talk to him, and he allowed her to perform personal care tasks for him.

Many Experts shared the analysis that staff seemed to equate having a mental health diagnosis to a wholesale inability to make judgments, which led staff to dismiss and invalidate their views, perceptions, and opinions on what would best support their health. Experts felt that staff read their file and that became what was accepted as the universal truth about them, defining their interactions with staff. This reinforcement of bias and discriminatory stereotypes—that people with mental health issues are incapable or unable to participate in their own health care—is harmful and stigmatizing.

One Expert explained how even acknowledging the legitimacy and realness of their own feelings would have improved their experience.

Even that amount of change—of acknowledging the things that are bad, the practice of acknowledging the capability for choice and suffering, and meeting people there would have been something that made me feel a lot safer because the way that it was, was I felt like there was not a willingness to even understand my capacity to be a person who suffered or suffered for reasons that were understandable.[383]

Barriers to connections

The current approach to detention and involuntary treatment in BC disrupts a person's connections outside of the hospital instead of strengthening them, despite the fact that a strong support network benefits long-term health and wellbeing. Facilities typically control all communication with the outside world during detention, including access to visitors, telephone, internet, and passes to go outside or leave the facility. People experiencing detention and involuntary treatment often have to earn access to these things through compliance and good behaviour, a dynamic that one Expert explained can reinforce the feeling that involuntary treatment is punitive:

Some of them had really heavy restrictions on visitors. That just reinforced that I feel like I'm in jail… kind of thing. Yeah.

And then, there was one hospital that just was very stingy with passes. So that just really added to the being trapped, which I feel exacerbated the state of anxiety I was already in.[384]

Informal and formal caregiving and social support roles in community and family structures are often gendered. In addition, for people who experience ongoing gender-based violence or discrimination in their lives, their chosen family or social network may be primary sources of acceptance and inclusion. Prohibiting or controlling access to connections outside the detaining facility undermines these roles and supports.

In addition, access to phones and communication technology, or visibility to other people, are often tools people use to protect themselves because physical and social isolation heightens risks of gender-based violence. Being unable to contact the outside world and access trusted connections is experienced as a lack of oversight and accountability for the involuntary treatment system that makes Experts feel scared and at risk of being harmed, either by other patients or the involuntary treatment system itself.

Often the only way for Experts to connect with other people was to find community with fellow involuntary patients. Many Experts shared that this was a bright spot in their hospitalization experience, illustrating that a community of collective care is also present:

Being around people in community of others who are struggling with the same stuff is so lovely. That's the only thing that's gotten me through my experiences.[385]

Peer-based support and community that Experts reported sharing with other people also experiencing detention and involuntary treatment illustrates strength and compassion. It also shows that mutuality and listening can make people feel validated and visible in a way that helps them navigate the violence and harm of their involuntary treatment experience.

d) Strengths-based and capacity-building

I have never experienced more dehumanizing interactions than when I am a patient in mental health services. I don't really have words for the way that those interactions have gone.[386]

This quote illustrates the ways in which BC's approach to involuntary treatment can be deficit-focused and punitive. The last principle of trauma- and violence-informed care is ensuring that services are rooted in strengths-based and capacity-building approaches. This principle includes taking the time to recognize a person's strengths and tailor services to those strengths so that people can build their own capacity to navigate the impacts of

structural violence and triggers. [387]

Experiences of oppression, including gender-based discrimination or refusal to affirm a person's gender, often lead to internalized feelings of shame, internalized discrimination, and self-doubt.[388] Taking a strength-based approach can help counter these internalized inequities and help ensure services are gender affirming and responsive to gender-based needs in the context of structural violence and oppression.

Unfortunately, many Lived Experience Experts described detention and involuntary treatment as the opposite of strength-based and capacity-building. In fact, many of them used the term "dehumanizing" to describe their experience. Several of the Experts also described their experiences as punitive, as though they were treated like criminals and put in prison or jail. Other Experts shared that staff would sometimes deliberately provoke them, knowing how they might react, and use the reaction as justification for further punitive action:

> **Sometimes it feels as if I'm being baited, a trap. Like, whatever it is they're doing they know will cause me additional distress, and it almost feels like they want that level of distress so that they are able to then further justify other restrictive measures being put in place. It's a cycle that feels impossible to break free from.[389]**

This Expert's quote illustrates the ways in which the punitive and restrictive measures of involuntary treatment can directly undermine safety and trust in services and service providers. When asked what would have improved their hospitalization experience, several interviewees told us they just wanted to be recognized and treated as humans and with dignity:

> **To be respected as a human being instead of judged as a mentally ill person that doesn't know their own mind, that doesn't speak the truth, and to be treated with dignity and compassion.[390]**

Learning from positive experiences

> **I mean, I've been hospitalized at least 10 times. So I've had relationships with god knows how many staff, but there's a few that stand out to me. There was one. He was there my first time.. But he made probably the biggest impact on me. That was a very intense time. I was dealing with my diagnosis, and he shared with me that he had the same diagnosis and sort of told me a bit about—not going into gory details or**

whatever—but he told me his story. And that was insane for me because I was only 20 years old. And I was like, "Oh my god, this guy is a fucking [clinician], and he's dealt with this shit." That was so important to me. And he told some of the other patients as well. And it had an impact on all of us. It really did.[391]

Despite the negative experiences set out in this report, many of the Lived Experience Experts like the one quoted above shared stories of positive interactions with some staff as well. These accounts are a testament to the ways the involuntary treatment system can improve and become more trauma- and violence-informed. Some of the things that Experts assessed as having positive impacts included:

- Friendly staff who would take the time to talk to them;
- Staff who listened to them, including their gender-related needs, and conveyed that they believed the Expert;
- Staff who say hello, who are nice while doing examinations, and who try to make what Experts understand to be a "horrible job" more meaningful; and
- Staff who talked about their own lived experience of mental health and substance use diagnoses.

Many Experts also expressed recognition that facility staff are doing a hard job, they are often understaffed, they may be experiencing burnout, and they entered their professions because of a desire to help people.

Part 10: After hospitalization

- Being discharged from hospital can become another experience that is unsafe and creates fear and distrust.
- Involuntary hospitalization experiences can be so traumatic that people no longer voluntarily seek care for mental or physical health due to fear of the health system.
- Acknowledging that the involuntary psychiatric system does create harm is the first step to meaningful reforms that can reduce those harms.

“No one in the hospital ever spoke to me about the enduring psychological effects of surviving non-consensual treatment.” – Lived Experience Expert

After hospitalization

For the Lived Experience Experts who participated in our engagement, being released from the hospital was by no means the end of their negative experiences with the mental health system. Some were put at risk by unsafe discharge procedures, some continued to be surveilled and have their autonomy restricted through extended leave, and some found themselves in a cycle of rehospitalization. Most Experts reported long-lasting effects from the trauma of involuntary hospitalization, and some people lost support networks and drastically changed their life course as a result of their detention.

Unsafe discharge procedures

Discharge procedures should consider the safety and wellbeing of the person being discharged. However, that isn't always the case, and instead the discharge process can become another experience that is unsafe and creates fear and distrust. One Expert, an Indigenous woman who lives in a remote part of the province, had her clothes cut off of her when she arrived at the hospital. When the hospital discharged her, she had to walk home, alone, in the middle of the night, wearing only a hospital gown. Her experience illustrated the disregard for safety, and loss of control over one's own safety, that can be created by unsafe discharge procedures:

> **Four o'clock they would tell me I could go home, and they didn't provide no ride for me. I had to provide my own ride to get home. Four o'clock in the morning. [...] I had to walk home**

> **from the hospital because a taxi wouldn't take me unless I had money on me. […] I would have felt better if I had my clothes on me. Then if they're gonna let me go, like, four o'clock in the morning, then at least I will feel a bit more better, 'cause I have my own clothes on me. Instead of having to leave the hospital with a hospital gown on.**[392]

This experience illustrated an unacceptable level of risk that is exacerbated by the mental health system. When people are brought to the hospital against their will, sometimes without belongings they need, health authorities and facilities have an obligation to ensure that they have appropriate clothing and a safe way to get home when they're discharged.

Continued surveillance and feelings of unsafety in the community

Several Lived Experience Experts also reported that their autonomy continued to be undermined when they were placed on extended leave, which is when a person is released from hospital to live in the community but they are still subject to involuntary treatment. They typically have conditions they have to comply with, or they can be recalled back to hospital without their consent. Experts on extended leave understood that the police could be called at any time to take them back to the hospital and that their perspective or views would not be respected. They saw this as a continuation of the paternalistic surveillance they experienced while they were in the hospital, and the conditions they had to meet as an extended enforcement of social and behavioural norms. For example, one Expert shared:

> **But they forgot to give me my next appointment for my shot. And when that happened, I had police knocking on my door. It was, like, wow. They had arrested me and brought me to the hospital for my shots. And then I got my shot and they just let me go. I mean, how barbaric is that, right? Like, I just kind of been losing faith in the health care system. […] I had to snap back at one of the workers that were trying to tell me about my next appointment to get my shot, and I asked her, "Well, what if I don't show up?" She's, like, "Well, then I'm gonna have to call the RCMP and one way or another, [Redacted], you're gonna get it." So holy shit, man. That's fucking scary.**[393]

Experts also reported that even if they were not released on extended leave, the constant threat of police apprehension, detention, and involuntary treatment was used to gain their compliance. One Expert reported being made voluntary but was told they could not leave the facility or they would be detained again, an exercise of coercion that undermines both autonomy and access to the procedural safeguards set out in the Mental Health Act.

So it's just this wraparound experience of everything around me is kind of the Act. Or the threat of the Act. And, you know, when there's a point where you're on long-acting injections, and you have to go to the place where you would be detained to get your injection and the person who is sometimes involved in the hospital in your detention is giving you your long-acting injection, and you're being… Like, it's all tied together. [...] It was always people who were sort of involved in this surveillance. And it just felt like all of the time I was being watched. And I had no choice ever. So that was something that made me feel very unsafe.[394]

Avoidance of health care

Several of our Lived Experience Experts reported that their involuntary hospitalization experiences were so traumatic that they no longer voluntarily seek care—for mental or physical health. In other words, the involuntary psychiatric system created a barrier limiting their access to care—one that may disproportionately affect people at intersecting systems of oppression. For example, the In Plain Sight investigation into anti-Indigenous discrimination in BC's health care system found that as a result of colonization Indigenous women had higher health needs than Indigenous men,[395] meaning that any barriers to care would deepen inequity by preventing them from getting the help they need.

One Lived Experience Expert explained how, when they know they need care, they have to carefully consider whether contact with the traumatizing involuntary mental health system is worth it for the help they eventually receive. The involuntary treatment system has essentially left them with inequitable access to health care services:

You lose autonomy over your body… Like, you just have no freedoms. You feel like you're institutionalized, which you basically are, and, yeah, it's like, "Do I want to help that bad?" Like, you're risking putting yourself through more trauma. [...] And I feel sad for a lot of people who are looking for help and they get to that point where it's a really big, like… It's really big to go to the hospital for the first time and then to have your feelings and your experience to be invalidated by both your experience with the psychiatrist, the staff, the people who work there, it's very hard to be turned away in a moment of a lot of pain is really hard. It's a hard experience to have. Yeah, so I've experienced a lot of trauma when it comes to the

hospital. And yeah, it's not easy. It's not easy, and I feel bad for people who… Like, there's a higher chance you'll have a bad experience than a good experience.[396]

One Expert, who was sexually abused by a staff member at a facility, has traumatic associations with that hospital and, coupled with the stigma she faces from her small community, now travels long distances just to get health care, again creating barriers to equitable access to health services.

Well, and that whole experience… even still affects the way I receive health care now for even medical problems. There's just a lot of stigma attached to me because of that. I live in a really small community, so everybody at the hospital knows it's me. And so, yeah… I don't receive good treatment, and I always end up having to go drive an hour and a half to the next city to receive medical care.[397]

Trauma from involuntary treatment

No one in the hospital ever spoke to me about the enduring psychological effects of surviving non-consensual treatment. I do not think they considered them.[398]

This Expert illustrates the ways that detention and involuntary treatment can leave the people who experience it harmed, but those harms are unacknowledged and made invisible. By far the most persistent theme throughout our engagement was just how traumatizing our Lived Experience Experts found their hospitalization. The effects of seclusion and restraint, forced injections, dehumanizing and invalidating staff interactions, and loss of autonomy don't simply vanish after discharge. Many Experts described having to recover from their hospitalization and having worse mental health symptoms as a result of the trauma of their experiences:

When I got home, I was a shell of myself. I have since been diagnosed with post-traumatic stress disorder from the experience and struggle with thoughts of suicide.

Each day, I claw to the surface and decide to fight.

This experience has forever changed me. I share this story despite a deep sense of shame and stigma to highlight the disgraceful state of our perinatal mental health system.[399]

Other Experts expressed concern about the lack of support and continuity they were offered after the traumatic experience of detention:

> **There is no support. There is no, for example, following up with counselling that the hospital provides. Nothing. I was on my own, and because of all these different situations, probably violent situations, and also my mental health really deteriorates. It triggered a really severe eating disorder that I'm dealing even nowadays.[400]**

One of the clinicians who participated in our engagement acknowledged the overwhelming challenge of "treating people with trauma in the same place that produces trauma... so you have patients who are detained for a condition that is secondary to trauma/toxic stress (whether that's a situational crisis, someone with a diagnosis like schizophrenia being triggered into a relapse by something horrific) being detained in a super stressful environment where they have no control and there's also all sorts of inputs that announce that the space is unsafe (i.e., lots of strangers, screaming, they don't have keys to any of the locks, no privacy)... and then all of these inputs overwhelm their coping so they engage in internalizing behaviours (hiding in their room, mutism, etc.) or externalizing behaviours (fawning behaviour like [...] sex, aggression against others, including maybe racist or gender-based violence)."[401]

It can be hard to reconcile that a system meant to help people is directly causing them harm. But the Lived Experience Experts we engaged have given myriad examples of how the involuntary psychiatric system traumatizes and retraumatizes patients. Acknowledging that the involuntary psychiatric system does create harm is the first step to meaningful reforms that can reduce those harms.

Section Summary

Part 11: Honouring resistance and community

- In the face of the violence and discrimination experienced during detention and involuntary treatment, people with lived experience have found ways to resist this harm and support each other.
- Finding community with other people who were experiencing the same coercion, force, and violence caused by the involuntary treatment system can help validate experiences and affirm each other's dignity and humanity.

"I owe any life-saving encounters with mental health care to the people who are going through it themselves." – Lived Experience Expert

Honouring resistance and community

In the face of the violence and discrimination experienced during detention and involuntary treatment in BC, communities have also found ways to resist this harm and support each other. Many of the Lived Experience Experts who shared their experiences for this project told us of the ways they personally or collectively found small and large ways to resist the violence, harm, and loss of autonomy they experienced. For example:

- Some Experts continued to ask for what they needed, sometimes day after day during their detention, resisting the assumption that they were not experts in their own health and wellbeing and asserting their own autonomy and knowledge. This included asking for access to cultural supports, counselling, specialized services, more intensive community mental health services, and staff intervention to help prevent violence and harassment.
- Other Experts exercised their autonomy by learning what they needed to do to keep themselves safe and reduce the length of their detention. They described trying to be overly kind, cooperative, and compliant with staff, or finding ways to process their anger and frustration, with the clear goal of self-preservation.
- Some Experts reported learning to carefully control how much information they provided with facility staff, including the fact they use drugs, their previous experiences with violence and trauma, or anything they felt that could be used to undermine their autonomy or credibility.

- Some Experts processed their experiences of gender-based violence and discrimination by confronting staff about those experiences, writing letters to clinicians who had previously dismissed their reports of violence, or requesting to access their chart and notes after their detention to make meaning of what had happened to them.
- Finally, other Experts reported actively pushing back on clinicians who did not believe their experiences of gender-based violence during involuntary treatment or who made them feel like their experiences were symptoms related to their mental health. They identified this disbelief as discriminatory and resisted it by expressly stating that these experiences were not okay to clinicians who held power over them.

In addition to individual acts, the community of people with lived and living experience of involuntary treatment often take active roles in keeping other members of the community safe. For example, one Lived Experience Expert shared an experience where someone tried to warn others and take action against a clinician who was known in the gender-diverse community for perpetrating violence and harm:

> **At one point, someone spray painted the front of this hospital with the words "STAFF AT [HOSPITAL] SEXUALLY ABUSED ME" in huge red letters, so that it was impossible to miss when you entered; I think it was removed within a day or so, and I don't believe anything was ever done. I heard staff at the hospital discuss the graffiti as an obviously delusional act. I saw this psychiatrist both in inpatient and outpatient contexts and found it very disturbing to interact with him knowing the way he had treated me, my friends, and others, seemingly completely openly.**[402]

More directly, many Experts shared that peers, people who shared their own lived experience or people who were also experiencing detention and involuntary treatment, were important supports for them. Many described their peers as being key to the survival of their experiences, like this Expert:

> **I owe any life-saving encounters with mental health care to the people who are going through it themselves. They have had the biggest impact on supporting and healing me. And there's nothing like that sense of community. I think I've survived certain admissions because of the people I've encountered who are also in care. Of course there are some clinicians who make a difference as individuals, but the system itself is designed in really harmful ways that**

> **reinforce Western colonial, sanist, ableist, heterosexual, cis, white, patriarchal values.**[403]

Importantly, many Experts described that it was not mutuality around experiences related to mental health that they felt connected them to others—it was finding community with other people who were experiencing the same coercion, force, and violence caused by the involuntary treatment system. This mutuality can help validate experiences and affirm each other's dignity and humanity.

Finally, Lived Experience Experts also reported taking steps to keep others safe from gender-based violence and harassment during their own involuntary treatment. One Expert described being horrified when a young woman experiencing serious physical health issues was transferred to a psychiatric unit involuntarily. The Expert took steps to look out for her and spend time with her in an effort help keep the young woman safer:

> **I knew immediately this is not a place for her because… I mean, she had a shocking and traumatic experience, of course, but why are you bringing her here with other people who are super violent, and not only that, men who can sexually harass her or try to get into her room in the middle of the night. I mean, 19, 18 years old, really young. And it really blows my mind. But the only thing I did until she got discharged, I just checked on her every day, every time I could. I had conversations, or we'd draw or paint stuff—you know, have fun—trying to make more, in a way, doable experience for her.**[404]

These examples illustrate the ways people experiencing detention and involuntary treatment in BC's involuntary treatment system resist the violence and harm they encounter by building a supportive community with each other.

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Section Summary

Part 12: Conclusion and recommendation

- BC should undertake an independent statutory review process to develop a framework for a modernized provincial mental health law.
- This process should be rooted in the leadership people with lived and living experience of involuntary treatment.
- It should also comply with BC's obligations under the UN Declaration of the Rights of Indigenous Peoples.

"Now is the time for BC to take action to ensure the safety and accessibility of its mental health services."

Conclusion and recommendation

The experiences of people subject to detention and involuntary treatment under the Mental Health Act set out in this report, and the impacts of those experiences on their human rights and dignity, are serious and distressing. At a time of intense needs related to mental health services and the onslaught of transphobic public and political commentary, now is the time for BC to take action to ensure the safety and accessibility of its mental health services.

In order to address the human rights issues and violence identified in this report, BC should **undertake an independent statutory review process to develop a framework for a modernized provincial mental health law.**

This process should be rooted in the leadership and direction of people with lived and living experience of involuntary treatment, and it should comply with the self-determination and free and prior informed consent required under the UN Declaration of the Rights of Indigenous Peoples and the Declaration on the Rights of Indigenous Peoples Act. The review should expressly adopt a human rights–based framework to ensure that the new law complies with all international human rights agreements ratified by Canada, the Charter, and BC's Human Rights Code.

To address the specific issues documented in this report, the statutory review and law reform process must include the following actions:

(1) **Recognize and protect the right to equal access to mental health services that respect a person's gender and sex, and the right to be free from discrimination on the basis of gender, gender identity, gender expression, and sex, as well as other intersecting aspects of identity.**

This could include, but is not limited to:

a. Prohibiting the use of detention, involuntary treatment, seclusion, or restraint, on the basis of someone's gender, sex, or gender expression (in addition to other protected characteristics);
b. Ensuring access to and continuity in gender-affirming treatment during detention;
c. Ensuring reproductive and sex-based health care needs are met during detention;
d. Requiring that facilities and service providers respect a person's gender identity and expression, including pronouns and chosen name;
e. Developing and ensuring access to a specialized province-wide perinatal psychiatric program for birthing parents and infants to remain together during crucial bonding periods, including specialized units and remote specialist support and private rooming policies for areas of the province without access to specialized units;
f. Respecting and protecting the intersection of gender, sex, caregiving, and family status by facilitating access to children and other family members and preventing the apprehension of children because their caregiver is experiencing detention and involuntary treatment; and
g. Developing and implementing gender-affirming data collection approaches to be able to evaluate and monitor the gendered impacts of detention and involuntary treatment.

(2) **Implement provincial oversight over gender-based violence prevention and response in detaining facilities.**

This could include, but is not limited to:

a. Requiring that all mental health services be provided in a trauma and violence-informed way that includes consideration of both individual and structural violence;
b. Developing a province-wide standard that sets out minimum requirements for facility-specific policies to prevent gender-based violence and respond to it when it occurs;
c. Developing minimum standards for discharge procedures to ensure safe clothing, transportation, and continuity of services;
d. Employing provincial oversight to monitor the implementation and effectiveness of these standards and policies;

e. Creating a process for reporting incidents of violence that is independent from the facility and health authority; and
f. Collecting, monitoring, and publicly reporting data related to incidents of gender-based violence.

(3) Reduce or eliminate the gender-based harm connected with the use of physical force, seclusion and restraint, clothing removal, and forced injections.

This could include, but is not limited to:

a. Continuing the development of non-police community mental health crisis response services to replace police as the primary responders;
b. Developing restrictions on, or working to eliminate, the use of seclusion and restraints during police apprehension, detention, and involuntary treatment, including using these practices as a last resort and only using the least restrictive measure;
c. Developing data collection and reporting standards and procedural safeguards related to any use of seclusion and restraint;
d. Ensuring that any clothing removal occurs only as a last resort and meets at least the minimum standards set out in the criminal law for Charter compliance; and
e. Revisiting provincial guidelines that mandate the attendance of multiple security guards regardless of whether that level of non-health staff response is required or warranted.

(4) Develop provincial minimum facility standards to support gender- and sex-related human rights and to reduce the risk of violence and conflict.

This could include, but is not limited to:

a. Developing provincial standards for psychiatric units, psychiatric emergency departments, and psychiatric assessment units that ensure access to single, private rooms;
b. Developing provincial standards for psychiatric units that ensure access to private washrooms;
c. Leading practice in response to emerging guidance by co-developing, piloting, and evaluating "gender safe spaces where service users can spend time away from others whose presence can lead to them feeling unsafe, or to potential revictimization, harassment or abuse;"[405] and
d. Establishing specialized units and telehealth support to meet the needs of birth parents and infants and allow them to remain together during treatment.

(5) Develop a human rights-based approach to accessing personal belongings, clothing, and communication technology.

This could include, but is not limited to:

a. Ensuring that access to personal belongings, clothing, and communication technology is restricted only as a last resort and is never restricted as a default practice or a behavioural modification tool;
b. Ensuring that all people experiencing detention and involuntary treatment have access to safe and appropriate clothing and gear based on their sex- and gender-based needs during hospitalization and upon discharge; and
c. Recognition that access to personal belongings, clothing, and communication technology can prevent violence, increase safety, and accommodate gender- and sex-based needs.

(6) Develop and implement mandatory, province-wide training for all staff using powers authorized under the Mental Health Act. Training should be co-developed with people with lived and living experience of involuntary treatment and evaluated and updated regularly.

This training should include, but is not limited to:

a. evidence-based de-escalation;
b. best practices in gender-affirming care;
c. preventing and responding to gender-based violence; and
d. non-discrimination and the duty to accommodate gender and sex-related needs.

(7) Develop a robust, independent process for systemic monitoring and oversight of compliance with human rights during detention and involuntary treatment.

This could include, but is not limited to:

a. Authorizing proactive inspections for the monitoring, evaluating, and reporting on efforts to reduce gender- and sex-related harms related to detention and involuntary treatment;
b. Authorizing independent investigation of reported incidents of violence and discrimination against people experiencing detention and involuntary treatment; and
c. Developing a transparent process to monitor the gender- and sex-based impacts of detention and involuntary treatment, in addition to impacts related to other protected characteristics.

Endnotes

[1] Health Justice, *"Pathologize the systems and not the people": Decolonizing BC's mental health law.*

[2] Mental Health Act, s. 22.

[3] Mental Health Act, s. 28.

[4] Health Care (Consent) and Care Facility Admission) Act, s. 2.

[5] Ombudsperson of British Columbia, *Committed to Change*.

[6] Johnston, *Operating in Darkness*.

[7] Carnegie Community Action Project, *No Pill for this Ill.*

[8] Representative for Children and Youth of BC, *Detained*.

[9] Downtown East Side Women's Centre, Red Women Rising; Health Justice, *"Pathologize the systems and not the people": Decolonizing BC's mental health law*.

[10] Mental Health Act, s. 19.

[11] An Act Relating to Mental Health, s. 18.

[12] See for example, The Trans Language Primer, "Gender"; World Health Organization, "Gender and Health"; Trans Care BC, Glossary; QMUNITY, Queer Terminology from A to Q; Canadian Centre for Diversity and Inclusion, Glossary of Terms; Canadian Institutes of Health Research, "What is gender? What is sex?"; Ontario Human Rights Commission, "Appendix B: Glossary for understanding gender identity and expression."

[13] Whereas some people use the terms "trans" and "transgender" interchangeably (see, for example, The Trans Language Primer), others see differences in scope and meaning of these two words (see, for example, Kapitan, "The Radical Copyeditor's style guide for writing about transgender people"). We are using "trans" here to err on the side of a more inclusive term.

[14] Crenshaw, "Mapping the margins: Intersectionality, identity politics, and violence against women of color"; see also Clark, "Red intersectionality and violence-informed witnessing praxis with Indigenous girls," which explores how the concept of intersectionality has been part of Indigenous analysis before contact.

[15] Ashley, "The Angry Black Woman: The Impact of Pejorative Stereotypes on Psychotherapy with Black Women," p. 28.

[16] Hunt, *An Introduction to the Health of Two-Spirit People*, p 9; Honkasalo, "When boys will not be boys," p. 274.

[17] Hunt, "Embodying Self-Determination: Beyond the Gender Binary."

[18] Bauer et al., "'I don't think this is theoretical; this is our lives': how erasure impacts health care for transgender people."

[19] Hunt, *An Introduction to the Health of Two-Spirit People*, p. 9; Hunt, "Embodying Self-Determination: Beyond the Gender Binary," pp. 25–27.

[20] Hunt, *An Introduction to the Health of Two-Spirit People*, p 9; Hunt, "Embodying Self-Determination: Beyond the Gender Binary," pp. 25–27.

[21] Hunt, *An Introduction to the Health of Two-Spirit People*, p. 7.

[22] Hunt, *An Introduction to the Health of Two-Spirit People*, p. 7.

[23] Hunt, "Embodying Self-Determination: Beyond the Gender Binary," pp. 29–31.

[24] Mental Health Commission of Canada, "Transgender people and suicide."

[25] Mental Health Commission of Canada, "Transgender people and suicide."

[26] Black, "Alberta law professors believe province's planned transgender policies violate Charter rights"; Jabri-Pickett, "Canadian province changes LGBT policy in schools to 'recognize role of parents'"; Cecco, "Canada province uses constitutional override to advance pronoun legislation."

[27] Ministry of Attorney General, Request for Proposals: Mental Health Act Rights Advice Service, Appendix D (Opportunity ID 8138); Ombudsperson of British Columbia, *Systemic Investigation Update: Report on the Implementation of Recommendations from Committed to Change*, p. 30. (Note that data sources are not always consistent in the way they define and count admissions, and data standards have changed in recent years, so comparisons over time are approximations.)

[28] Health Justice, *A Path Forward: Human rights-based guiding principles for BC's mental health law and services*, p. 20.

[29] Health Justice, *A Path Forward: Human rights-based guiding principles for BC's mental health law and services*, p. 20.

[30] Representative for Children and Youth of BC, *Detained*, p. 45.

[31] See, for example, Clark, "Shock and awe: Trauma as the new colonial frontier."

[32] Tasca et al., "Women and hysteria in the history of mental health," p. 110.

[33] Ussher, "Diagnosing difficult women and pathologizing femininity: Gender bias in psychiatric nosology," p. 63.

[34] Kelm, "Women, families and the Provincial Hospital for the Insane, British Columbia, 1905–1915," p. 178.

[35] Tasca et al., "Women and hysteria in the history of mental health," p. 116.

[36] Ussher, "Diagnosing difficult women and pathologizing femininity: Gender bias in psychiatric nosology," pp. 64–66; Kleinplatz, "History of the treatment of female sexual dysfunction(s)," p. 31; Eriksen &

Kress, "Gender and diagnosis: struggles and suggestions for counselors"; Gasperoni, *From Hysteria to Histrionic Personality Disorder: Gender Bias in Mental Health Diagnosis*.

37 Lived Experience Expert interview.

38 McLaren, *Twentieth-century Sexuality: A History*, pp. 87–88; Honkasalo, "When boys will *not* be boys."

39 Hooper, "Queering '69: The Recriminalization of Homosexuality in Canada"; Kinsman & Gentile, *The Canadian War on Queers*.

40 Kinsman & Gentile, *The Canadian War on Queers*, pp. 168–69.

41 Stryker, *Transgender History*, p. 36.

42 Stryker, *Transgender History*, p. 36-37.

43 Beek et al., "Gender incongruence/gender dysphoria and its classification history," p. 6.

44 Beek et al., "Gender incongruence/gender dysphoria and its classification history," p. 6.

45 Beek et al., "Gender incongruence/gender dysphoria and its classification history," p. 6.

46 Bryant, "Making gender identity disorder of childhood."

47 Beek et al., "Gender incongruence/gender dysphoria and its classification history," pp. 9–10.

48 Davy & Toze, "What is gender dysphoria? A critical systematic narrative review."

49 Black, "Alberta law professors believe province's planned transgender policies violate Charter rights."

50 Lived Experience Expert interview.

51 Kleinplatz, "History of the treatment of female sexual dysfunction(s)," p. 32; Honkasalo, "When boys will *not* be boys," p. 274.

52 Kleinplatz, "History of the treatment of female sexual dysfunction(s)," p. 35.

53 Kleinplatz, "History of the treatment of female sexual dysfunction(s)," p. 35.

54 American Psychiatric Association, "Gender Dysphoria Diagnosis."

55 Turpel-Lafond, *In Plain Sigh*t, p. 73.

56 Turpel-Lafond, *In Plain Sight*, p. 74.

57 Hooper, "Queering '69: The Recriminalization of Homosexuality in Canada"; Kinsman & Gentile, *The Canadian War on Queers*.

58 Kinsman & Gentile, *The Canadian War on Queers*, pp. 168–69.

59 McHenry, "'Gay Is Good': History of Homosexuality in the *DSM* and Modern Psychiatry," p. 4.

[60] McHenry, "'Gay Is Good': History of Homosexuality in the *DSM* and Modern Psychiatry," p. 5.

[61] Kelm, "Women, families and the Provincial Hospital for the Insane, British Columbia, 1905–1915."

[62] British Columbia Mental Health and Addiction Services, *Riverview Hospital: A Legacy of Care and Compassion*, pp. 24, 28, 32, 44.

[63] Canadian Mental Health Association, "Our History."

[64] Kurbegovic & Leung, "CNCMH: Canadian National Committee for Mental Hygiene."

[65] Province of British Columbia, Report of the Royal Commission on Mental Hygiene, p. 6.

[66] Province of British Columbia, Report of the Royal Commission on Mental Hygiene, p. 7.

[67] Province of British Columbia, Report of the Royal Commission on Mental Hygiene, p. 7.

[68] van Heeswijk, *"An Act Respecting Sexual Sterilization": Reasons for Enacting and Repealing the Act*, at 48, 63.

[69] Sexual Sterilization Act.

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