The Collapse of Patient Rights in BC Psychiatry

An Urgent and Evidenced Call to Action

June 9, 2026

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This citizens' report presents objective data from a variety of published sources to reveal critical conflicts of interest and breaches of law within BC's involuntary psychiatric system.

While the BC Ombudsperson's *Committed to Change* investigation sets the stage in regard to the normalized disrespect of existing mandatory protocols, this report demonstrates additional failures of ethics which are ongoing via loopholes specific to this province's Mental Health Act, and via lack of oversight from authorities over the clinical programs themselves.

The evidence is clear that psychiatric intervention programs in BC have extended their scope to include non-psychotic persons, including 'monitoring' in the community and the overriding of consent in regard to medication. This has gone unchallenged since at least 2010, and there is evidence that the program administration and the program assessment board have been headed by the same individuals. This arrangement has been unsupervised by authorities and has accelerated into the following alleged human rights crisis for the persons under their 'care':

In addition to the 'community monitoring' and forced drugging of non-psychotic adults, the evidence presented strongly suggests that children ages 13-15 in involuntary psychiatric care in BC have been included in antipsychotic drug research without informed or voluntary consent. The drugs being administered are known to be damaging to children and are not approved by Health Canada for use in under-18s. These drugs are being prescribed and administered by nurses, and enforced by social workers, who are not educated in their use or their effects.

Several facilities across the province with dedicated, specialized units for children and youth have failed to refer any patients, or "not in meaningful numbers", to the Independent Rights Advice Service, created in 2024 for the purpose of advising psychiatric patients of their rights. As a result, only 0.5% of involuntary children under 16 had their case heard before the Mental Health Review Board in 2024/2025. The remaining 95.5% of these 2,400+ children in '24/25 were given no avenue for possible release except to comply with the demands of the program.

These programs have wholesale refused to report injury and death data of the children in their care, including their involuntary patient cohort, despite the law requiring that data to be disclosed since 2006. *(See: Representative for Children & Youth December 2025 report)*

The program administrators are known to have self-declared financial conflict of interest from the same pharmaceutical companies whose drugs they apply to involuntary patients, including children. It is evidenced from both marketing and an internal conference document that program leaders actively promote the use of these sponsored drugs in their involuntary patients. Patient outcomes are not tracked after dismissal from the program.

It is of concern to the citizen authors of this document that the legalization of psychiatric MAID may grant yet more power to these programs which do not comply with existing law.

Table of Contents

Section 1: Established Facts

BC's Mental Health Act (MHA)

The Mental Health Act of BC[1] has a number of weaknesses in regard to patient rights, compared to the MHAs of other provinces. These weaknesses have been well documented by HealthJustice.ca.[2]

While the author of this document supports all recommendations put forth by HealthJustice.ca, for the purpose of this report, primary elements of concern are as follows:

Detainment by Nurses and/or Police

Section 22(1) of the MHA states that a person may be detained based on the opinion of a single nurse practioner, rather than exclusively requiring the assessment of a doctor:

> *The director of a designated facility may admit a person to the designated facility and detain the person for up to 48 hours for examination and treatment on receiving one medical certificate respecting the person completed by a physician or nurse practitioner in accordance with subsections (3) and (4).*

Section 28(1) states that the opinion of a single police officer is also grounds to apprehend. This is notable given that police officers are not trained in recognizing mental disorders nor differentiating them from other conditions which may affect behaviour, such as developmental or neurological differences.

> *A police officer or constable may apprehend and immediately take a person to a physician or nurse practitioner for examination if satisfied from personal observations, or information received, that the person*
>
> *(a) is acting in a manner likely to endanger that person's own safety or the safety of others, and*
>
> *(b) is apparently a person with a mental disorder.*

In fact, anyone may apply to a judge or justice of the peace, to allege that a person should be involuntarily committed. Section 28(3):

> *Anyone may apply to a judge of the Provincial Court or, if no judge is available, to a justice of the peace respecting a person if there are reasonable grounds to believe that section 22 (3) (a) (ii) and (c) describes the condition of the person.*

No Family Representative nor Advance Directive

Despite other provinces allowing a family member to act as a substitute decision maker for the involuntary patient, the "Near Relative" role in BC's MHA does not grant the relative any authority to consent or refuse treatment or drugs on the patient's behalf. Their role is only informational, to receive notifications of the patient's status.

Even should the patient plan in advance with the completion of a Representation Agreement[3] or Advance Directive[4], which allow for the pre-emptive recording of the patient's choices to be applied in

1 BC Mental Health Act | https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96288_01#section22
2 HealthJustice.ca Mental Health Act Reform | https://www.healthjustice.ca/mha
3 Representation Agreement | https://www2.gov.bc.ca/gov/content/health/managing-your-health/incapacity-planning
4 Advance Directive | https://www2.gov.bc.ca/gov/content/family-social-supports/seniors/health-safety/advance-care-planning

the case of their future incapacitation, these documents are explicitly excluded from the process of involuntary psychiatric hospitalization in BC, and provide no authority over the program director's treatment of the patient.

Adults (16+ years)

The "Deemed Consent" model pre-2026

The 'deemed consent' model was a provision in the Mental Health Act which allowed the involuntary detention of a patient to be used as proof of their incapacity to consent, and which allowed the director of a facility to 'consent' on a patient's behalf, regardless of actual patient capacity. Under this model, anyone who was detained by Mental Health services immediately lost their bodily right to refuse medication, without evaluation.

An explanation from HealthJustice.ca's article[5] about Bill 32:

> *Section 31 of the Mental Health Act states that involuntary patients are "deemed" to have consented to* ***any form of psychiatric treatment*** *that the treatment team at a detaining facility or community-based mental health team authorizes. Since the law creates a fiction that consent already exists, involuntary patients aren't assessed to see whether they are capable of making treatment decisions. This means involuntary patients who are capable of making their own treatment decision do not have the right to consent to or refuse the proposed treatment. It also means that if an involuntary patient is not capable of making the decision, health care providers do not have to seek consent from another source.*

Since the purpose of this report is to highlight the failures of patient protections, the present majority of which occurred while the deemed consent model was still in place prior to December 2025, we will be at times be referring to 'deemed consent' directly. References to 'deemed consent' in this document are not intended to suggest that the deemed consent model is ongoing in 2026. Rather, we seek to highlight the overreach of its use in years prior to its redaction, and address the effects of its legacy on psychiatric culture in BC.

Since the enactment of Bill 32 in December 2025, the 'deemed consent' model has been replaced with the expectation that the patient will be assessed for capacity before involuntary treatment, and that the treatment plan will be correctly recorded via Form 5.

Ineffective change in regard to Form 5

The changes enacted in Bill 32 now require a doctor to record the justification for treatment after involuntary hospitalization of a patient, however, this requirement only marginally enhances patient safety, due to there being no requirement to actually assess the patient prior to completing Form 5.

From HealthJustice.ca:

Most importantly, nothing in Bill 32 adds any legal requirement to consider the wishes, values, and views of a person experiencing involuntary treatment. *It also does not provide any legal requirement to include family members or the people a patient trusts to make decision if they are not able to do so.*

5 HealthJustice.ca *New Mental Health Act amendments: What you need to know* | https://www.healthjustice.ca/blog/bill32

Children (<16 years)

"Voluntary" admissions

Section 20(1) of the MHA states that a director may admit a child under 16 years of age as a "voluntary" patient at the request of the child's parent or guardian, even if the child themselves is not consenting.

This "voluntary" status obscures the nonconsent of the child in the record.

However, the MHA implicitly acknowledges the child's nonconsent, by allowing a "voluntary" child under 16 to apply for release by the Mental Health Review Board.

From the Representative of Children & Youth's *Putting Children and Youth at the Centre* Report:[6]

> *Persons who are involuntarily detained are eligible to apply to have their detainment reviewed by the Mental Health Review Board, as are children under 16 years who are voluntarily admitted with the consent of their parent under section 20. The fact that children under 16 who are admitted with parental consent are eligible to apply for review amounts to an acknowledgment that these "voluntary" admissions are in fact involuntary. These provisions under section 20, in effect, statutorily deem children under 16 years to be incapable chattel of their parents or guardians and are obviously incompatible with the provisions of the UNCRC, the mature minor doctrine and the Infants Act.*

Failure of the Infants Act

If a child is detained under the Mental Health Act *without* guardian approval, she will be held as an "involuntary" patient and, prior to Bill 32, was to be immediately subject to the 'deemed consent' model which denies the child the right to refuse medication.

In the case that a child's guardian has volunteered the child for a "voluntary" psychiatric hold, the Infants Act[7] should, in theory, allow a child under 16 the right to nonconsent of medical treatment. It states that an agreement or acquiescence to health care by an infant does not constitute consent unless the health care provider:

> *(a) has explained to the infant and has been satisfied that the infant understands the nature and consequences and the reasonably foreseeable benefits and risks of the health care, and*
>
> *(b) has made reasonable efforts to determine and has concluded that the health care is in the infant's best interests.*

However, the superceding right of the program director to shift the status of a "voluntary" child to 'involuntary' at any time, thereby allowing 'deemed consent' and the override of patient refusal even in children, renders the rights of the Infants Act ineffective. Furthermore, while a "voluntary" child may have the right to refuse medication in theory, the director retains the ability to deny the child's release until the child 'consents' to medication. This type of negotiated consent amounts to coercion, yet in such a case, the child would be recorded as having consented to the drugs.

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6 Representative for Children & Youth, *Putting Children and Youth at the Centre - Reforming and Modernizing the Mental Health Act for Children and Youth* | https://rcybc.ca/wp-content/uploads/2026/01/RCY-Mental-Health-Act-Reform-Jan2026.pdf

7 BC Infants Act | https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96223_01#part2

Early Psychosis Intervention Program (EPI)

The Early Psychosis Intervention Program in BC is structured around a number of concerning elements which can be found in their Standards & Guidelines[8], published in 2010 and still current as of 2026.

Of particular note to this urgent report is the age range of patients accepted to the EPI program:

Ages 13-35.

With the information presented in the previous section ("Voluntary" admission), we can identify an age range, 13-15, of patients in the Early Psychosis Intervention program who are at particular risk. A significant portion of these patients, despite being recorded as voluntary and/or consenting, are in fact neither voluntary nor consenting.

The BC Representative for Children & Youth (RCY) makes a comment about exactly this in their December 2025 report:

> *It should be noted that the numbers of truly involuntary hospitalizations are under-represented in these data and the number of truly voluntary hospitalizations are over-represented to an unknown degree, due to the anomalous provisions of section 20 Mental Health Act described earlier wherein a child under 16 years can be "voluntarily" admitted to a mental health facility without their consent.*
>
> *An indicator of this under-representation in truly involuntary status is found in the differences in involuntary detention rates for the two age groups: there is greater reliance on involuntary detention amongst youth who are 16 to 18 years old than those under 16 years – 64% versus 54% – presumably because de facto involuntary hospitalization of children under 16 years can be accomplished by way of a "voluntary" admission under section 20 with parental consent.*

This obfuscation of the childrens' nonconsent becomes increasingly noteworthy as we proceed.

When considering the scope of this concern, we can look again to the RCY:

> *These data include voluntary and involuntary hospitalizations combined. About one-half (52%) of the total hospitalizations involved children under 16 years; more than one in ten (11%) involved children under 12 years.*

Thus, a significant majority of hospitalizations of children(<16) are in this 13-15 age range.

In addition, from 2020/21 to 2024/25:

> *Involuntary hospitalizations comprised the substantive majority (59%) of hospitalizations [of children and youth] during that five-year period, which averaged 2947 involuntary hospitalizations per year.*

8 Standards and Guidelines for Early Psychosis Intervention (EPI) Programs | https://www.health.gov.bc.ca/library/publications/year/2010/BC_EPI_Standards_Guidelines.pdf

The next item of concern is recorded in Section II-B – the elimination of professional referral:

> *Individuals with early psychosis typically experience a number of steps before receiving appropriate care (44). One step can potentially be eliminated by accepting referrals from all sources and* ***not requiring a professional referral.*** (emphasis added)

Later in the same section:

> *The EPI program is responsive to all referrals. This response may include consultation, information, referral to other services, or an intake interview as appropriate.*

And again under "Minimum Standards":

> *(iii) Accept and process referrals from any source (self, professional, family, friend, etc.).*

Under the deemed consent model, this open-to-anyone referral system may remove the only barrier between a nonconsenting patient and being forced into taking medication: the initial assessment.

Detainment, Monitoring, and Medicating of Non-Psychotic Persons

The claims to be made in this chapter are direct quotes from the EPI guidelines. We will be examining section I-D *"Assessment and Monitoring of Persons At Risk for Emerging Psychosis"* .

> *After the screening assessment is completed, some individuals will be found to have clear psychotic symptoms and will be considered appropriate for entry into the program, while others will need to be referred to other services. In addition, there will remain a group of persons with ambiguous presentations – they may be displaying some changes indicative of an incipient psychosis (e.g., subtle cognitive changes, minor perceptual disturbances) or they may be experiencing a general decline in functioning coupled with risk factors for developing psychosis (e.g., family history). Some of these individuals may be thought to be at risk for developing psychosis. To facilitate early detection of psychosis, it will be important to closely assess and monitor this group of individuals.*

The guidelines continue:

> *Research is underway to determine the risks and benefits of a number of strategies for attempting to thwart any impending psychosis, including strategies based on cognitive therapy (39) and antipsychotics (40, 41). However, it is important to note that even when using the best current research criteria, approximately 60% of all identified at-risk individuals do not make the transition to psychosis within one year (42).*

The use of antipsychotics in "pre-psychotic" persons is clearly recorded as acceptable under the guidelines.

It is also surprising to this author that the last line of this paragraph seems to admit that the majority of referred patients subject to this monitoring program are ultimately confirmed to be non-psychotic even after one year. The assertion also seems to imply that the year-long monitoring of non-psychotic persons is a regular enough occurence to have generated this data regarding its prevalence.

This author questions the acceptability of an involuntary psychiatric program being granted the power to monitor non-psychotic persons in the community and meet them at their home, including *"monitor[ing] these individuals at least once a month for a minimum of six months"*. It is of particular concern that the onboarding process to this program does not require a professional referral, as outlined

in the previous section of this report, as this seems to erode any limit as to who may become subject to this lengthy involuntary monitoring.

Fairly, the guideline does state to *"avoid the use of antipsychotic medications until full threshold psychotic symptoms have been sustained for a week or more"*, which appears to provide some protection against our most severe concerns regarding the use of forced medication, however, the sentence continues, *"or there is rapid deterioration accompanied by psychotic-like symptoms"*.

It seems that this second statement undermines the first. Rapid, as in less lengthy than the previously-established 'week or more'? 'Psychotic-like', as in, not full-threshhold-psychotic?

It is not the intent of this report to claim any speculation as fact, however, the content of these guidelines does align with anecdotal patient/victim stories of being monitored or tracked in the community, even without having been hospitalized, or in the absence of acute mental health crisis. It is this author's concern that such testimonies may have been historically dismissed due to their anomalous nature, despite the EPI guidelines confirming the potentiality of such an outcome.

We can gain some more information about this aspect of the Vancouver EPI program specifically, from a 2014 study titled, "*Improving Metabolic and Cardiovascular Health at an Early Psychosis Intervention Program in Vancouver, Canada"* [9]

Here we have an idea of the types of professionals involved in the Vancouver EPI program, which serves ages 13-30:

> *Team members at the program include psychiatrists (including those with specialized experience in treating children and adolescents), psychiatric nurses, social workers, child and family therapists, occupational therapists, and case workers.*

While it's not possible to determine which tasks are delegated to each professional, another paper titled, *"Early Intervention for Psychosis in Canada What Is the State of Affairs?"* [10] states that "clinicians (e.g., case managers) of all programs spend on average about a third of their time in community outreach interventions." Community outreach interventions are described as including "home and community visits, liaising with community and vocational agencies, schools, and housing facilities".

The same paper indicates that about 30% of patients 'disengage prematurely' from EPI services, and the paper seems to disapprove of the release of patients due to "refusal of treatment or noncompliance to treatment (both pharmacological and nonpharmocological)". It suggests that the release of these individuals "might be explained by administrative constraints forcing closure of files in those cases, leading to premature termination of care," concluding the paragraph with, "Most programs use community treatment orders when necessary."

Our final element of this section is a considerably older survey from 2004, published by the BC Schizophrenia Society called "*A QUIET EVOLUTION: Early Psychosis Services in British Columbia"* [11]. This older study is included as relevant, because it demonstrates that the Vancouver Early Psychosis program, at its Vancouver C&Y facility dedicated to involuntarily held youth as young as 13, did at one point detain

9 Improving Metabolic and Cardiovascular Health at an Early Psychosis Intervention Program in Vancouver, Canada | https://pmc.ncbi.nlm.nih.gov/articles/PMC4155777/

10 Early Intervention for Psychosis in Canada What Is the State of Affairs? | https://pmc.ncbi.nlm.nih.gov/articles/PMC4813422/

11 A QUIET EVOLUTION: Early Psychosis Services in British Columbia | https://archive.bcss.org/documents/pdf/EarlyPsychosisStudy.pdf

non-psychotic children ("At Risk" of psychosis) and dose them with antipsychotics, without employing a phase-based approach. Three locations in BC treated "At Risk" patients with antipsychotic medications. (See Tables 9, 10, and 12 in the aforementioned survey)

The inclusion of this 2004 study is meant to demonstrate the plausibility of this outcome in this setting. This report's research effort was unable to locate similar data for recent years. The RCY expresses: *"Unfortunately, due to substantive changes in legal status data collection by the Ministry of Health, data on involuntary detentions for 2018/19 and 2019/20 is not available and the data for the most recent five years cannot be reliably compared to data preceding 2018/19, i.e., comparable long term trend data on involuntary hospitalizations of children and youth is no longer available."*

Diagnosis, Prescription, Administration of drugs by underqualified providers

According to this[12] Times Colonist article:

> *British Columbia is creating 200 new nurse practitioner positions in an effort to connect more residents with primary care providers. Nurse practitioners can either work on their own or as part of a team, diagnosing patients, ordering tests and prescribing medications.*

The EPI guidelines are clear that nurse practitioners are permitted to prescribe antipsychotics:

> *Ensure all EPI clients have access to a psychiatrist, family physician or nurse practitioner who can prescribe antipsychotics and other medication. If this individual is not a psychiatrist, he or she must have timely access to psychiatric consultation as needed.*

Child and adolescent psychiatry is a medical subspecialty, requiring dedicated training not replicated by the qualifications of a nurse practitioner. The use of long-acting antipsychotics in under-18s is already off-label and not approved by Health Canada, so the potential for nurse practitioners to be diagnosing, prescribing, and administering these drugs in this age group may indicate an elevated level of risk toward patients.

Breach of Law: Distinct Rights of Children

The Early Psychosis Intervention Standards & Guidelines state, in section II-A:

> *EPI programs should strive to overcome the difficulties created by the legal (rather than developmental or cultural) distinction of youth versus adult status and develop inclusive services for both (approximately those aged 13-35).*

It is of great concern to this author that an official BC Health guideline would "strive to overcome" any law meant to protect the rights of children. While it's not possible to identify which specific law(s) this refers to, it is easy to speculate that this may refer to the Infants Act, which when fully applied, grants the child's medical decisions authority over the program's.

This EPI policy is in direct conflict with the recommendations set forth by the Representative for C&Y:

> *That reform, in the Representative's view, requires a comprehensive review and revision that creates either separate, stand-alone mental health legislation for children and youth in BC, or a separate and distinct part of a comprehensively reformed Mental Health Act that specifically addresses the rights, unique needs and circumstances of children and youth.*

12 B.C. adding 200 nurse practitioners in bid to improve access to care | https://www.timescolonist.com/local-news/bc-adding-200-nurse-practitioners-in-bid-to-improve-access-to-care-4662410

Canadian Consortium for Early Intervention in Psychosis (CCEIP)

The Canadian Consortium for Early Intervention in Psychosis is a national professional network which provides mentoring, knowledge, and best-practice resources to EPI programs across Canada.

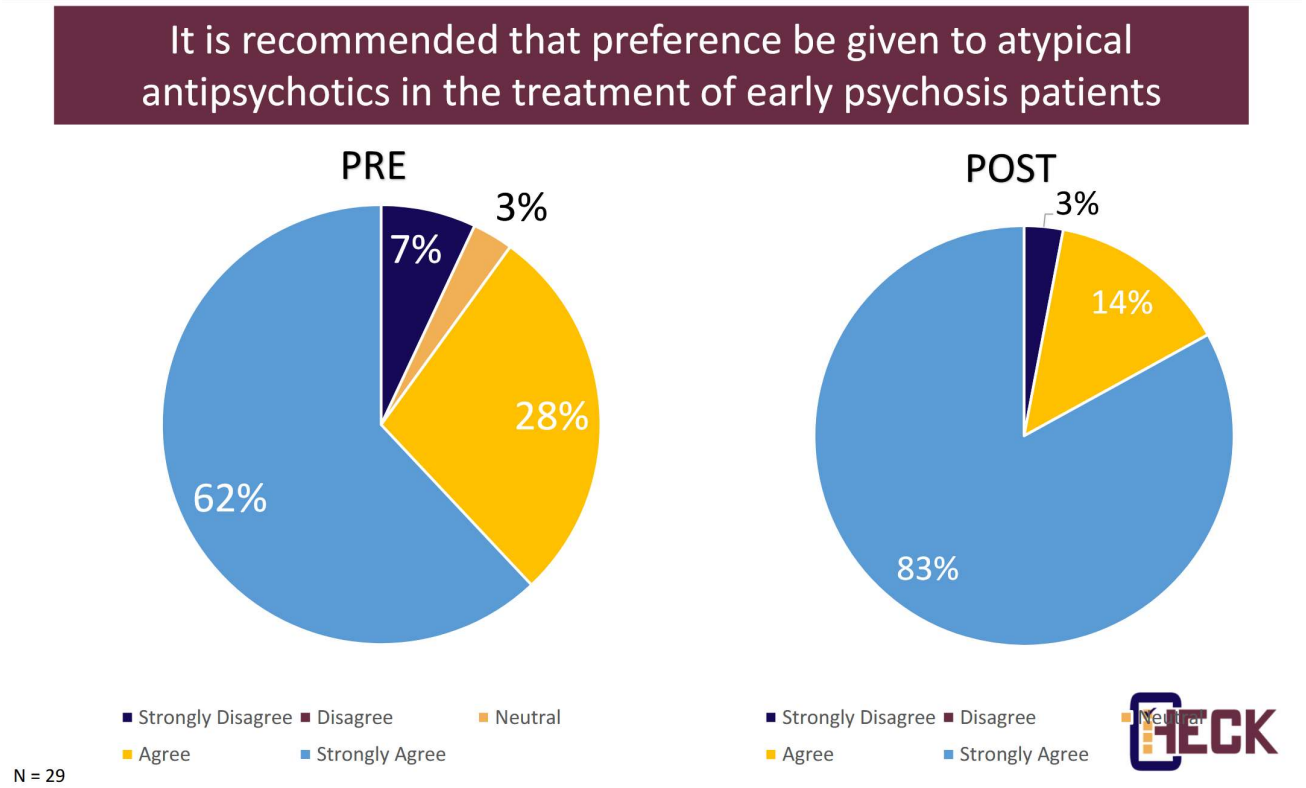
This section will examine a powerpoint document presented during an AGHPS event in 2018.[13] This powerpoint document was apparently presented to an audience of Canadian EPI team leaders.

CHECK program drug recommendations 2018

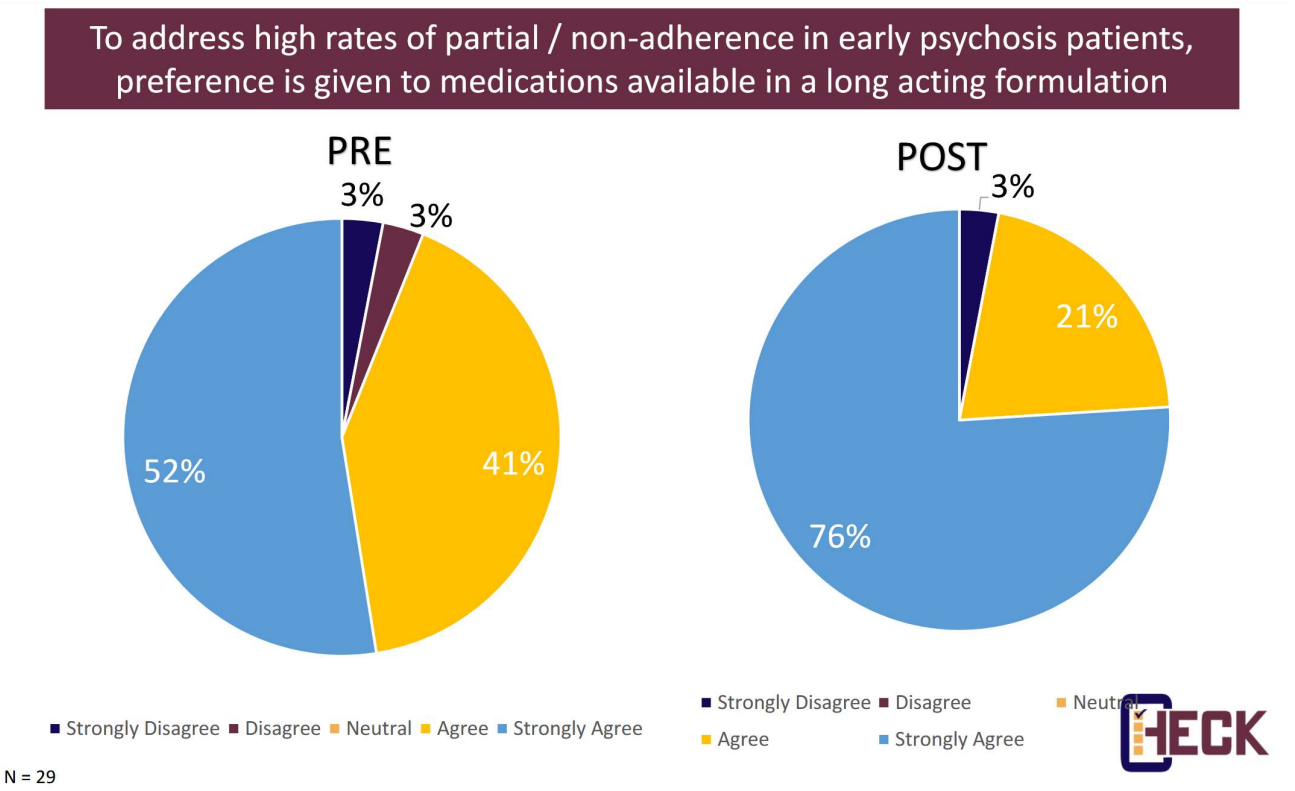
The CCEIP 2018 document contains a series of polls administered to its audience, taken before and after the presentation. Note that the N=29 surveyed represent 29 practicing EPI professionals, rather than patients.

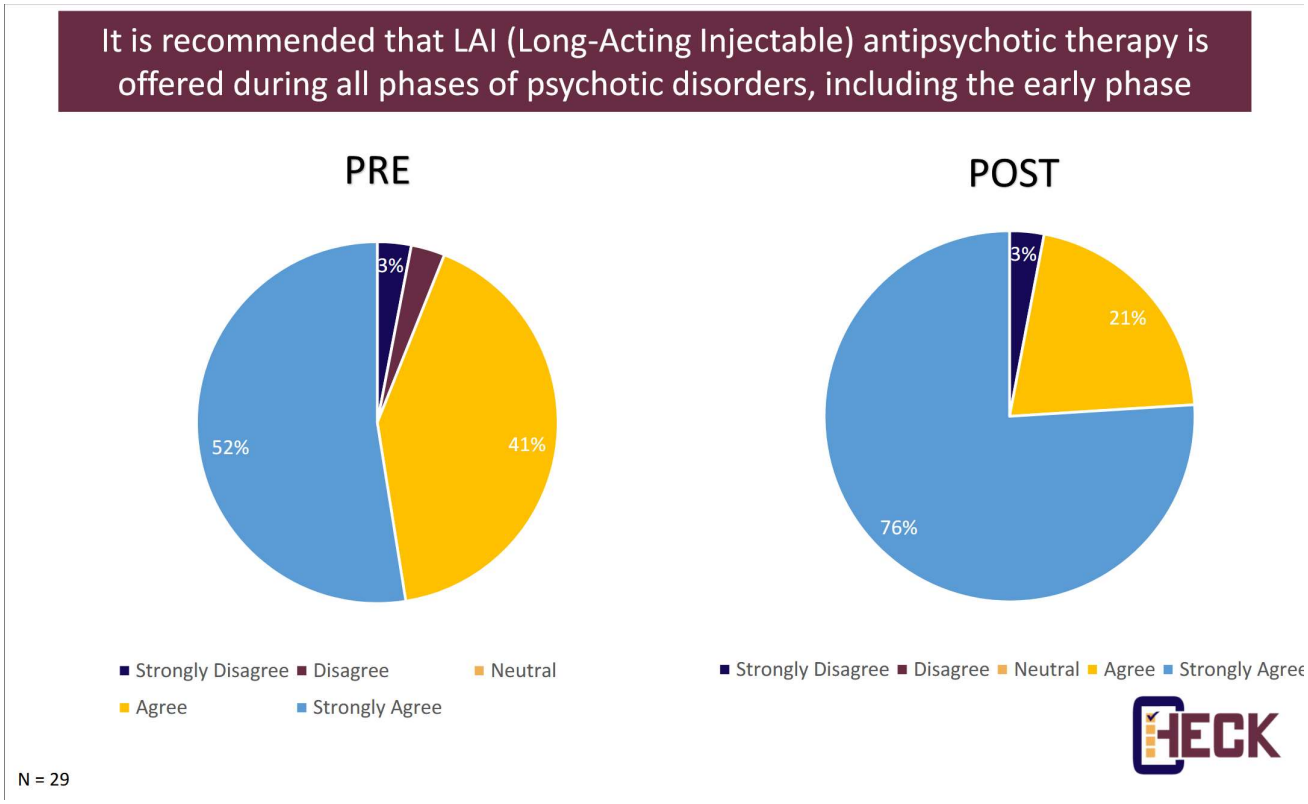
Each poll takes the form, *"Please indicate your level of agreement with the following statements on a scale of 1 (strongly disagree) to 5 (strongly agree):"*

It is demonstrated by the results of these polls that the effect of the presentation was an almost universal increase in the preference toward early-dosed long-acting injectible antipsychotics.



13 CCEIP 2018: Integrating Standards of Care into Clinical Practice for Early Psychosis | https://www.aghps.com/doc/OrderSetsHastingsThursday-1.pdf





Additional attachment: Tables from "*Short communication: Prevalence of long-acting injectable antipsychotic use in Canadian early intervention services for psychosis"* reveal the precise medications used by EPI programs, polled directly from EPI programs across Canada in 2016 and 2020, on pages 18, 19 and 20 of this report.

CCEIP Conflicts of Interest

This CCEIP presentation reveals three situations which indicate relevant conflicts of interest:

1) Self-disclosures by the presenter:

In the past 2 years Dr Hastings has received honoraria for services provided through creating (C), presenting (P) educational programs, participation on advisory boards (A), or work/conference related travel (T) from:

- *Janssen (C, P, A, T)*
- *Mylan (P)*
- *Otsuka-Lundbeck (P, A)*
- *Canadian Consortium for Early Intervention in Psychosis (C, P)*
- *Canadian Psychiatric Association (C, P)*
- *Schizophrenia Society of British Columbia, Victoria Branch (C, P)*
- *New Brunswick Psychiatric Association (C, P)*
- *Various Teaching and Non-Teaching Hospitals (nationally) (C, P)*

2) All four CHECK program faculty in this document were leaders or members of the CCEIP:

This suggests that the CHECK performance assessment of the CCEIP was performed by CCEIP members themselves:

The CHECK Program is an accredited performance assessment activity (section 3) as defined by the Maintenance of Certification Program of the Royal College of Physicians and Surgeons of Canada and approved by the Canadian Psychiatric Association (CPA).

Thomas Hastings, MD, FRCPC (Program Chair) - Director at Large, Canadian Consortium for Early Intervention in Psychosis - Lead Psychiatrist, Halton Region Early Intervention in Psychosis Program, Oakville, Ontario - Associate Clinical Professor, Department of Psychiatry, McMaster University, Hamilton, Ontario - Lecturer, Department of General Psychiatry, University of Toronto, Toronto, Ontario	Howard C. Margolese, MD, CM, MSc, FRCPC - Member, Canadian Consortium for Early Intervention in Psychosis - Medical Director, Early Psychosis and Schizophrenia Spectrum Program, McGill University Health Centre - Director, PEPP-MUHC (First Episode Psychosis Program) - Program Director, Clinical Pharmacology and Toxicology Residency Program, McGill University - Associate Professor, Department of Psychiatry McGill University, Montréal, Québec
Andrea Bardell, MSc, MD, FRCPC - Director at Large, Canadian Consortium for Early Intervention in Psychosis Early Psychosis Intervention Program, Victoria, British Columbia - Clinical Assistant Professor, Department of Psychiatry, University of British Columbia, Vancouver, British Columbia	Phil Tibbo, MD, FRCPC - President, Canadian Consortium for Early Intervention in Psychosis - Dr Paul Janssen Chair in Psychotic Disorders - Director, Nova Scotia Early Psychosis Program - Professor, Department of Psychiatry Dalhousie University, Halifax, Nova Scotia

3) The recommendation of the following antipsychotics, produced by companies in Point 1:

- Janssen Pharmaceuticals: Risperidone microspheres (LAI), Risperidone, Paliperidone, Paliperidone palmitate (LAI), Haloperidol decanoate (LAI)

- Otsuka: Aripiprazole, Aripiprazole monohydrate (LAI)

- Lundbeck (or Otsuka-Lundbeck): Flupenthixol decanoate (LAI), Zuclopenthixol decanoate (LAI), Aripiprazole monohydrate (LAI)

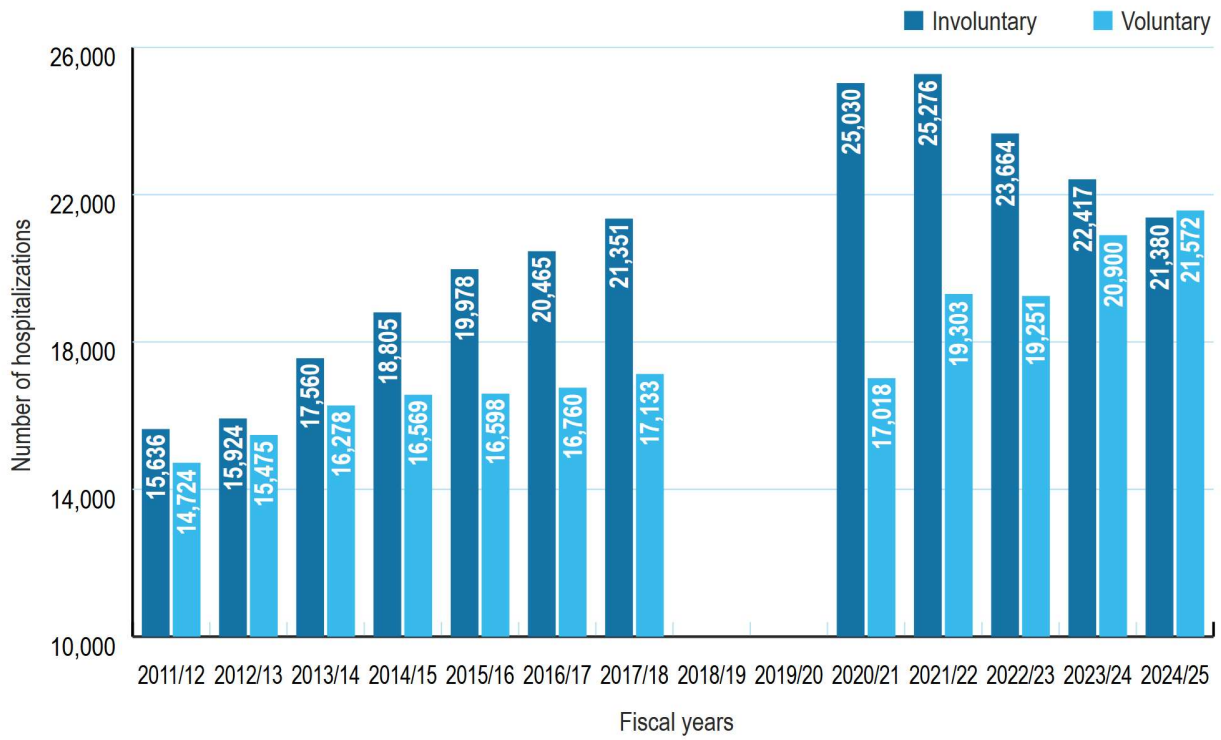
Involuntary Hospitalization in BC

Ombudsperson's Report, *Committed to Change,* 2026

The BC Ombudsperson has published commendable investigations into the state of patient rights under the BC Mental Health Act, the latest of which was released in January 2026.[14] This report proceeds under the assumption that the reader is familiar with the Ombudsperson's investigation.

Rates of Hospitalization

Figure 4. Hospitalizations under the *Mental Health Act* (MHA) at acute care hospitals or rehab facilities by MHA legal status and fiscal year, MHA disorder as most responsible diagnosis, 2011/12 to 2024/25



Note: The total hospitalization count for 2018/2019 is 39,674 (voluntary and involuntary patients combined) and for 2019/2020 is 40,782 (voluntary and involuntary patients combined) under Main Diagnosis category.

14 COMMITTED TO CHANGE: Protecting the rights of involuntary patients under the Mental Health Act | https://bcombudsperson.ca/wp-content/uploads/2026/01/OMB_Committed-to-Change_Report_Update_2026-WEB.pdf

Breach of Law: Missing Essential Forms

Figure 1. Percentage of patient files containing required forms, by form, all health authorities, July to September 2024

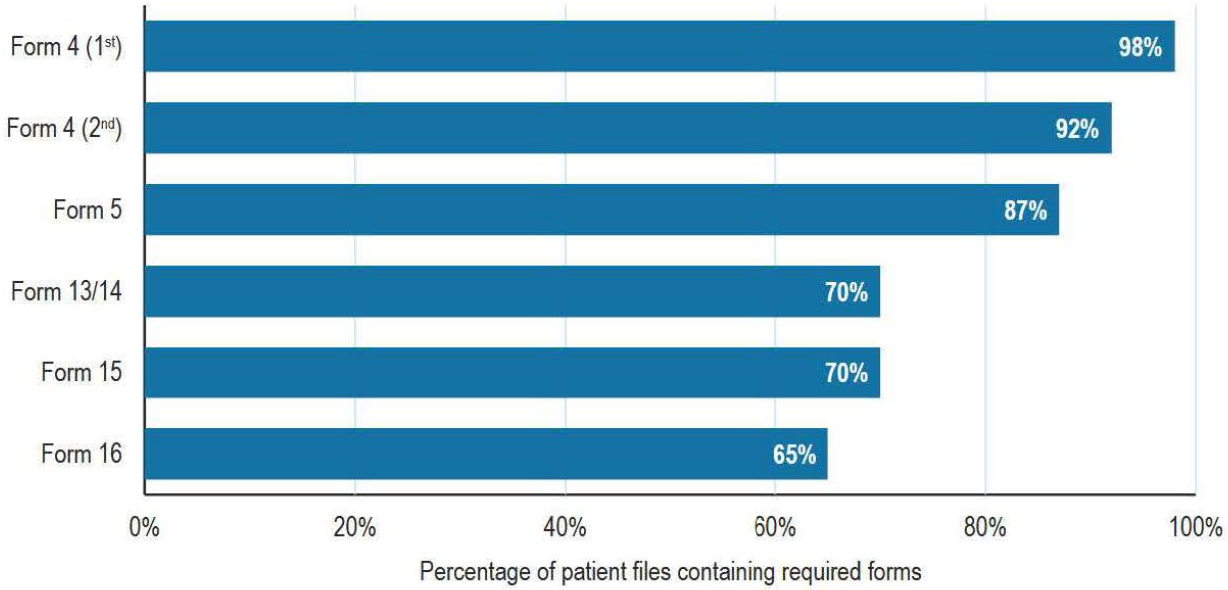
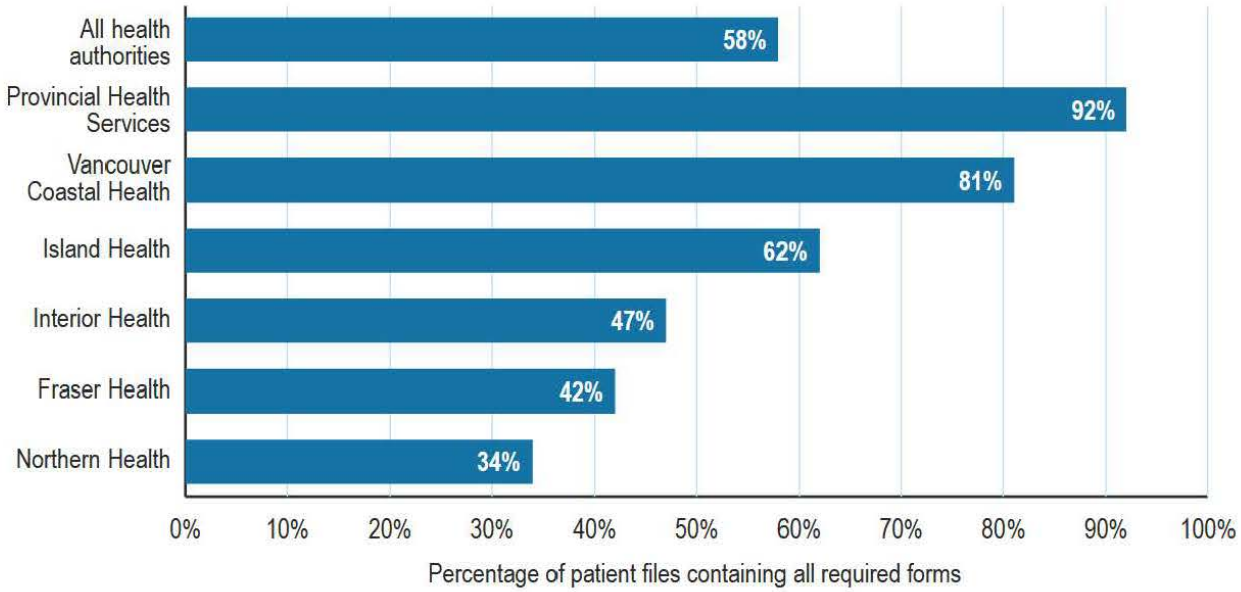


Figure 2. Percentage of patient files containing all required forms, by health authority, July to September 2024



Rates of Hospitalization

The Detained report found that the number of children and youth who were involuntarily committed to mental health facilities increased alarmingly in the 10 years between 2008/09 and 2017/18, almost tripling from 973 to 2,545 admissions. This increase for children and youth (162%) was also almost triple the rate of increase for involuntary committals of adults (57%) in the same time period.

[…]there has been far greater use of mental health hospitalizations of children and youth over the past seven years, as compared to the preceding decade; total hospitalizations in 2024/25 were more than double (112%) the number in 2008/09.

From *Trends in Involuntary Psychiatric Hospitalization in British Columbia: Descriptive Analysis*[15]*:*

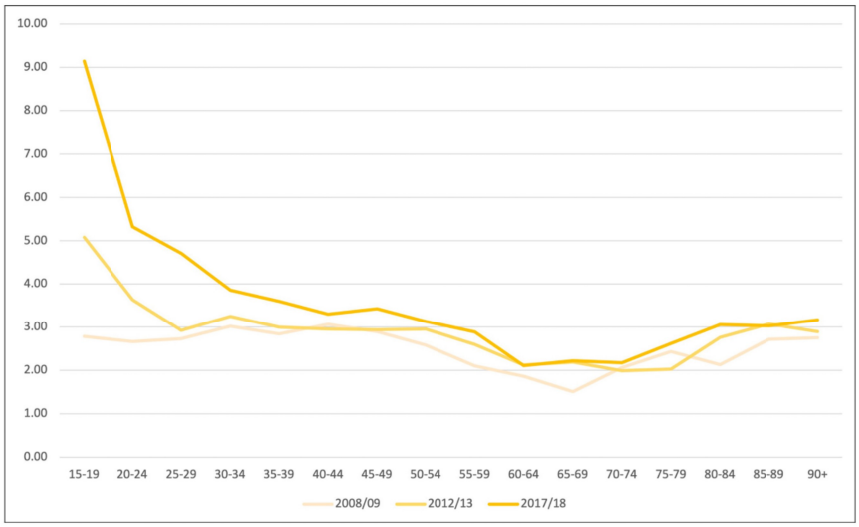


Figure 3. Involuntary hospitalizations by age among people with female sex/gender, per 1,000 population, for 2008/2009, 2012/2013, and 2017/2018. *Note:* Medical Service Plan registration forms only provide the options "M" and "F," however, the field is labelled "Gender." It is not possible to distinguish sex at birth, legal sex, and gender based on this information. We have opted to label this as sex/gender.

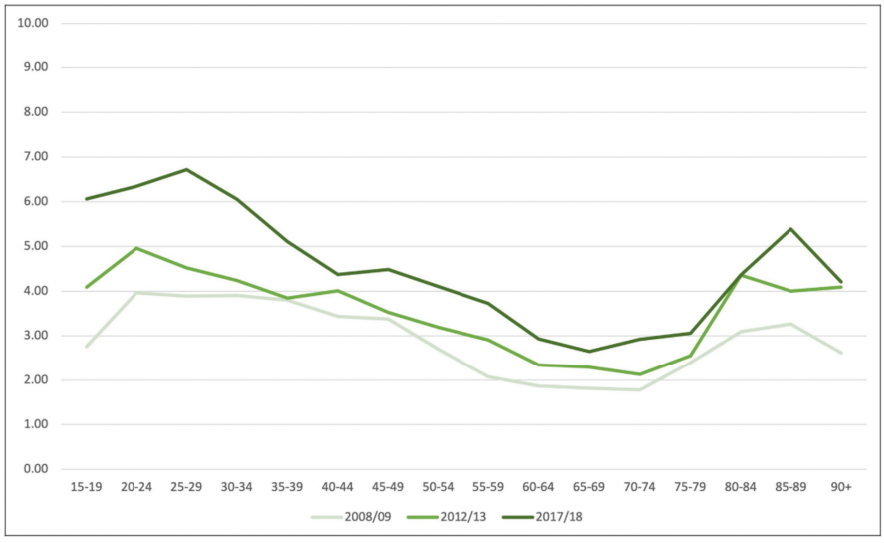


Figure 4. Involuntary hospitalizations by age among people with male sex/gender, per 1,000 population, for 2008/2009, 2012/2013, and 2017/2018.

15 Trends in Involuntary Psychiatric Hospitalization in British Columbia: Descriptive Analysis of Population-Based Linked Administrative Data from 2008 to 2018 | https://pubmed.ncbi.nlm.nih.gov/36200433/

Consent and Communication of Rights

> *On December 3, 2025, the amendments to the Mental Health Act came into force, creating a statutory obligation for staff of mental health facilities to inform patients of the availability of the independent right advice service, which will also be set out in statutory forms notifying patients of their rights under the Mental Health Act.*
>
> *[…]*
>
> *While this will be another step forward, it is noted that there is no mandatory training of healthcare staff to better support effective implementation. In the Representative's view, there should be mandatory training of relevant healthcare staff. Evidence of this need is illustrated by data provided by the independent rights advice service indicating that* ***several facilities across the province that have dedicated, specialized units for children and youth have not referred children and youth to the service at all or in any meaningful numbers.***
>
> *[…]in 2017/18, in the context of 2,545 cases of detained children and youth, there were only 21 [Mental Health Review Board] hearings involving children and youth. By comparison, recent data indicates these numbers have remained minuscule: in the context of 2,447 involuntary hospitalizations of children and youth in 2024/25, there were only 12 review board hearings involving children and youth.*

Regarding patient testimonies collected by the Society for Children & Youth:

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

Breach of Law: Unreported Injuries & Deaths

> *It is also imperative that health authorities routinely report critical injuries (e.g., suicide attempts, overdoses) and deaths of youth people who have been in receipt of mental health and substance use services to the Representative for Children and Youth so the Office is better positioned to monitor, review and, as necessary, investigate service provision to these young people.* ***Although the Representative for Children and Youth Act has been in place since 2006 and reporting of critical injuries and deaths has been legally required since that time, health authorities have not complied with this legal requirement****.*

Supplementary tables breaking down medication choices at EPI programs across Canada.[16]

Supplement 3: Profile of reported long-acting injectable (LAI) antipsychotic use by medication type, reported as total patient numbers.

	2016	2020
Haloperidol decanoate (Haldol LA)	1	2
Risperidone microspheres (Risperdal Consta)	17	2
Long-acting paliperidone (Invega Sustenna)	207	208
Long-acting paliperidone (Invega Trinza)	7	79
Flupenthixol decanoate (Fluanxol Depot)	11	8
Fluphenazine decanoate (Modecate Concentrate)	0	0
Long-acting aripiprazole (Abilify Maintena)	180	301
Pipotiazine palmitate (Pipotril)	0	0
Olanzapine tartrate (Zyprexa IM)	0	1
Zuclopenthixol decanoate (Clopixol Depot)	14	5

Note. *For 2016, data is based on responses from 12 (of 18) EIS programs that were able to provide detailed information regarding LAI formulation choices. For 2020, data is based on responses from 11 (of 12) EIS programs.*

16 "Short communication: Prevalence of long-acting injectable antipsychotic use in Canadian early intervention services for psychosis" | https://www.sciencedirect.com/science/article/pii/S0022395623003448

Supplement 4: Long-acting injectable (LAI) antipsychotic starting doses (mg) and maintenance doses (mg) as reported by participating early intervention services.

SURVEY YEAR: 2016						
		Mean dose (+/- SD)	Median dose	Minimum dose	Maximum dose	Number of clinics
STARTING LAI DOSE (mg)	Flupenthixol decanoate (Fluanxol Depot)	25.0 (7.1)	25.0	20.0	30.0	2
	Zuclopenthixol decanoate (Clopixol Depot)	125.0 (106.1)	125.0	50.0	200.0	2
	Long-acting aripiprazole (Abilify Maintena)	345.3 (49.8)	322.0	300.0	400.0	12
	Paliperidone palmitate (Invega Sustenna)	127.5 (34.6)	150.0	50.0	150.0	13
	Paliperidone palmitate (Invega Trinza)	197.0 (75.4)	212.5	100.0	263.0	4
	Risperidone microspheres (Risperdal Consta)	25.0 (0)	25.0	25.0	25.0	5
MAINTENANCE LAI DOSE (mg)	Flupenthixol decanoate (Fluanxol Depot)	44.0 (5.7)	44.0	40.0	48.0	2
	Zuclopenthixol decanoate (Clopixol Depot)	185.3 (120.6)	185.3	100.0	270.5	2
	Long-acting aripiprazole (Abilify Maintena)	372.2 (40.6)	400.0	300.0	400.0	11
	Paliperidone palmitate (Invega Sustenna)	106.1 (21.6)	100.0	75.0	150.0	12
	Paliperidone palmitate (Invega Trinza)	208.0 (87.9)	219.0	100.0	294.0	4
	Risperidone microspheres (Risperdal Consta)	41.2 (8.5)	41.9	31.3	50.0	4

SURVEY YEAR: 2020						
		Mean dose (+/- SD)	Median dose	Minimum dose	Maximum dose	Number of Clinics
STARTING LAI DOSE (mg)	Flupenthixol decanoate (Fluanxol Depot)	17.5 (3.5)	17.5	15.0	20.0	2
	Zuclopenthixol decanoate (Clopixol Depot)	125.0 (35.4)	125.0	100.0	150.0	2
	Long-acting aripiprazole (Abilify Maintena)	393.3 (19.1)	400.0	346.0	400.0	8
	Paliperidone palmitate (Invega Sustenna)	125.0 (25.0)	125.0	100.0	150.0	7
	Paliperidone palmitate (Invega Trinza)	308.2 (187.6)	274.5	100.0	525.0	6
MAINTENANCE LAI DOSE (mg)	Flupenthixol decanoate (Fluanxol Depot)	31.0 (12.7)	31.0	22.0	40.0	2
	Zuclopenthixol decanoate (Clopixol Depot)	200.0 (70.7)	200.0	150.0	250.0	2
	Long-acting aripiprazole (Abilify Maintena)	361.6 (52.2)	400.0	281.0	400.0	7
	Paliperidone palmitate (Invega Sustenna)	97.2 (26.6)	100.0	68.0	150.0	7
	Paliperidone palmitate (Invega Trinza)	314.8 (131.5)	263.0	184.0	525.0	5

Note. *For 2016, data is based on responses from 13 (of 18) EIS programs that were able to provide detailed information regarding LAI starting/maintenance dosages. For 2020, data is based on responses from 8 (of 12) EIS programs.*

Section 2: Four Paths to Involuntary Hospitalization

Children (<16 years)

In Parental Custody

1) A parent volunteers the child for involuntary commitment, admission to facility while the child is nonconsenting. Parents remain involved for care decisions after admission, unless the director makes the decision to override both the parents and the child by shifting the child's status to "involuntary". There is no formal protection against the application of this power except the rarely-accessed MHRB.

2) If the parent does not volunteer the child, but the program determines that the child should be committed, the child will be committed as "involuntary", and will not benefit from the protections of the Infants Act.

In Ministry Custody

The Ministry unilaterally decides as both health authority and acting guardian to commit the child, allowing the child to be recorded as "voluntary" in the program. The child has no third-party support to advise or collaborate on care decisions, except by making use of rights advice programs and applying for MHRB review, which in practice are only accessed by a miniscule percentage of children, due in large part to the children not being lawfully informed of their rights.

Adults (16+ years)

Living Independently

An adult may be "called in" for involuntary commitment by a community member, nurse practitioner, police, or doctor. If committed, they will be "involuntary", and prior to December 2025, were vulnerable to the 'deemed consent' model. If the Early Psychosis Program determines that commitment is not necessary, they may be monitored in the community for 6-12 months, estimated from EPI guidelines.

Dependent on Ministry Benefits

For the purpose of this document, "Ministry benefits" includes any form of dependence on Ministry authority, including child custody, subsidized housing, support of applications, financial assistance, etc.

An adult dependent on the Ministry faces the same avenue to involuntary commitment as an adult living independently. However, the Ministry-dependent adult is vulnerable to coercion at this stage.

Refusal to co-operate with a social worker or care worker, or refusal to attend an appointment deemed mandatory as part of Ministry process, puts the dependent-adult at risk of being categorized as non-compliant by Ministry gatekeepers. Especially in matters related to disability benefits, specialized housing, or child custody, refusal to 'comply' with a psychiatric order can be framed as a lack of effort to improve one's health or behaviour, and generate obstacles in Ministry process.

Ministry-dependent adults may find themselves in a position of "going along to get along" due to fear of losing essential benefits. Testimonies indicate that negotiation is normalized in Ministry process.

Section 3: After Hospitalization or Admission to EPI

Differences in Rights Upon Hospitalization

Adults (16+ years)

The Independent Rights Advice Service[17] lists that involuntarily hospitalized adults have the right to:

- meet with a Rights Advisor
- be told where you are
- be told the reasons why you've been made an involuntary patient
- be examined by a doctor
- have a review panel hearing
- apply to court
- right to a lawyer

The Mental Health Act specifies the following entitlements:

Detention beyond the initial 48 hours requires a second medical certificate (Form 4.2) by a different physician or nurse practitioner completed within that 48-hour period, authorizing continued detention for up to one month from admission.

Involuntary patients have the right to request a second medical opinion from another physician or nurse practitioner on the appropriateness of their psychiatric treatment (Form 11).

The initial period of detention authority is limited to one month; continued detention requires express renewal by further medical certificate(s).

Children (<16 years)

From the RCY report, *Putting Children and Youth at the Centre:*

In addition to being statutorily deemed incapable and subject to being detained with the consent of their parents/guardians, the liberty of children and youth under 16 is less protected than older persons insofar as:

- The two [section 20] criteria for admission of children under 16 years described above are far less stringent than the four [adult] criteria described earlier for involuntary detention.

- Detention of an involuntary patient beyond 48 hours requires a second medical certificate but that is not required with section 20 admissions of children and youth under 16 years.

- Persons who are involuntarily detained under section 22 have a right to request a second medical opinion, but children and youth who are admitted under section 20 do not have that right.

- The duration of initial detention of an involuntary patient is limited to one month unless the authority for detention is expressly renewed for further periods whereas the similar period for children under 16 years is longer (two months).

17 Independent Rights Advice Service: Involuntary Patients | https://irasbc.ca/involuntary-patients/

Ombudsperson: Missing Forms

The earlier section of this report, "Breach of Law: Missing Essential Forms" provides several tables which demonstrate the rates at which essential forms have been properly completed at facilities across BC. For the purposes of the present section, these percentages provide our scenario with a hypothetical likelihood that each corresponding right will be upheld.

Lack of Access to Mental Health Review Board

HealthJustice.ca provides a summary of the Mental Health Review Board's 2026 Annual Report.[18]

> *Making detentions reviewable with no automatic access has resulted in a safeguard that is* ***inaccessible in practice****. Combining recent data on the annual number of involuntary admissions with the number of review panel hearings, we learned that just* ***under 5% of adult detentions under the Mental Health Act last year involved a review panel hearing*** *(1). For children and youth, the numbers shrink drastically. Out of 2,447 involuntary hospitalizations of children and youth in 2024/25, there were only 12 review panel hearings, meaning* ***less than 1% of child and youth hospitalizations involved a review panel hearing****.*

Even if, in our scenario, we are one of the few who gets a hearing, for the 2024/25 year, only 9% of hearings resulted in a discharge from involuntary status. The number of review panels resulting in decertification has reduced by almost half in just 4 years.

> *It also means that the* ***vast majority of review panels (91%) last year decided that a patient's detention under the Mental Health Act should continue.*** *We know this percentage is impacted by the number of patients attending their hearings without legal representation as decertification rates are typically lower when a patient is not represented. However, this year,* ***more patients had legal representation than ever before****. This is an alarming trend that raises serious concerns about whether the accessibility of the review panel process for patients may have changed over time, or whether there is another explanation for why hearing outcomes are trending in this way.*

Special comment about the 2024/25 year with specific regard to children:

> *Last year, the Mental Health Review Board shared limited insights on how many applications and hearings involved children and youth that year. This year, the Annual Report is regrettably silent when it comes to children and youth.* ***There is no information on the number of applications or hearings involving children and youth*** *or how the Navigator position is impacting the accessibility of the hearing process. We strongly encourage the Mental Health Review Board to* ***improve its transparency*** *on this critical work.*

This data must be released in order to ensure that the rights and safety of children are being upheld.

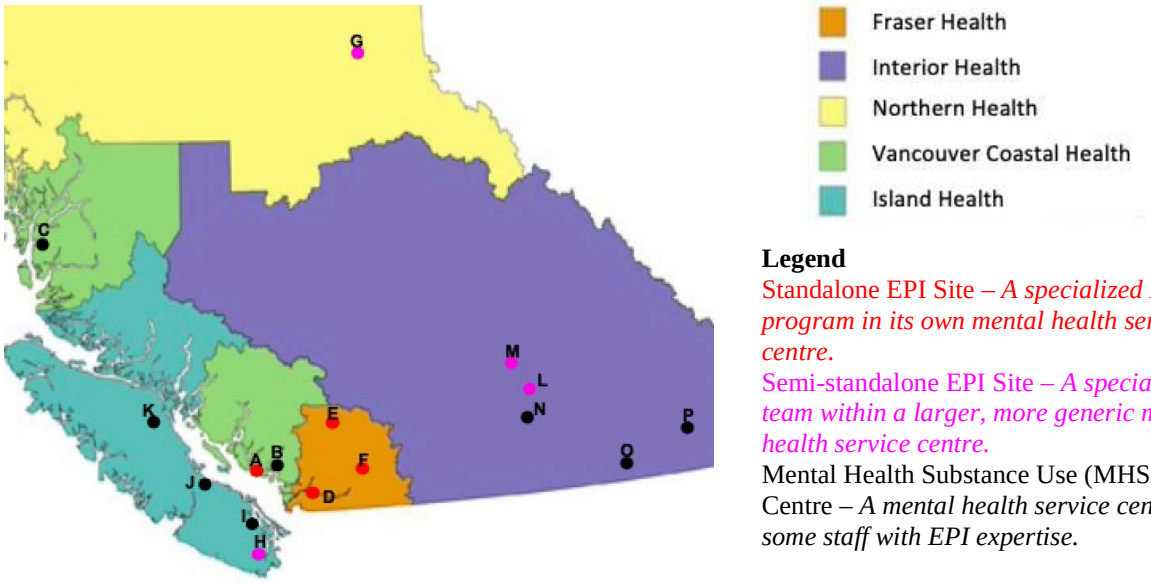
For our present scenario, this data indicates a severely low likelihood of access to the MHRB.

18 The Mental Health Review Board Has Released Its Annual Report, March 19 2026 | https://www.healthjustice.ca/blog/mhrb2425

Treatment to Expect

EPI Fidelity Assessment 2025

This Fidelity Assessment[19] is a February 2025 paper, analyzing the rates of adherence of BC's EPI programs to their stated guidelines. This data provides us a more detailed look at the goings-on in these programs, broken down by location in BC.



Legend
Standalone EPI Site – *A specialized EPI program in its own mental health service centre.*
Semi-standalone EPI Site – *A specialized EPI team within a larger, more generic mental health service centre.*
Mental Health Substance Use (MHSU) Service Centre – *A mental health service centre that has some staff with EPI expertise.*

Figure 1 – Mental health services that participated in the 2022 BC EPI fidelity assessment.

Site	Total Score (%)	Items Meeting Fidelity (%)	Essential Items† (%)	Fidelity Rating
A	68/84 (81%)	25/28 (89%)	17/17 (100%)	High Fidelity
B	42/84 (50%)	11/28 (39%)	7/17 (41%)	Moderate Fidelity
C	34/84 (40%)	12/28 (43%)	9/17 (53%)	Low Fidelity
D	64/84 (76%)	23/28 (82%)	14/17 (82%)	High Fidelity
E	52/84 (62%)	19/28 (68%)	11/17 (65%)	Moderate Fidelity
F	55/84 (65%)	20/28 (71%)	13/17 (76%)	Moderate Fidelity
G	61/84 (73%)	21/28 (75%)	16/17 (94%)	Moderate Fidelity
H	41/84 (49%)	12/28 (43%)	8/17 (47%)	Low Fidelity
I	29/84 (35%)	7/28 (25%)	5/17 (29%)	Very Low Fidelity
J	49/84 (58%)	18/28 (64%)	10/16 (63%)	Moderate Fidelity
K	38/84 (45%)	13/28 (46%)	9/16 (56%)	Low Fidelity
L	51/84 (61%)	16/28 (57%)	11/17 (65%)	Moderate Fidelity
M	42/84 (50%)	13/28 (46%)	7/17 (41%)	Moderate Fidelity
N	53/84 (63%)	18/28 (64%)	12/16 (75%)	Moderate Fidelity
O	27/84 (32%)	7/28 (25%)	4/16 (25%)	Very Low Fidelity
P	48/84 (57%)	15/28 (54%)	9/16 (56%)	Moderate Fidelity

†16 items for rural sites and 17 items for urban sites were designated as essential.

Table 1 – Total score, number of items meeting fidelity, number of essential items meeting fidelity and fidelity rating by site.

Note: this fidelity assessment excludes patients under 19 years of age.

19 A fidelity assessment of Early Psychosis Intervention Services in British Columbia, Canada | https://www.authorea.com/doi/full/10.22541/au.173974370.01817633/v1

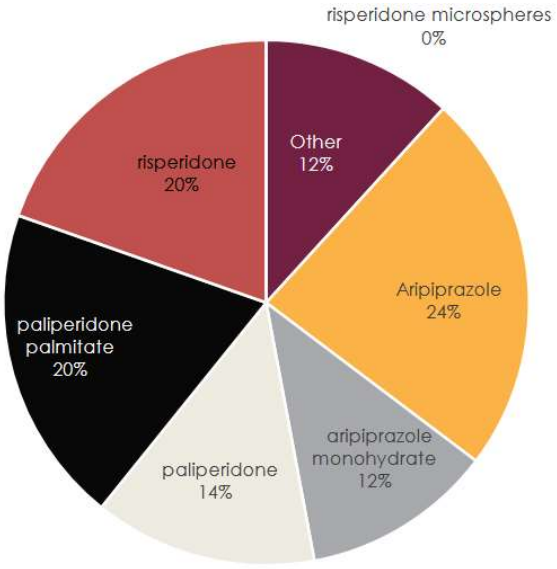
The EPI Fidelity Scale Items	% Sites Meeting Fidelity
Recognition and Access	
Education to Public and Service Providers†	38%
Well Defined Service Criteria†	94%
Epidemiological Benchmark from Provincial Standards†	63%
Timely Response†	94%
Assessments and Engagement	
Comprehensive Assessment Performed After Entry†	56%
Informed Consent and Decision Making/Empowerment†	75%
Family Engagement in Intake, During and as Service Advisor/Participant†	44%
Assess, Monitor or Treat Individuals at Ultra High Risk	44%
Ongoing Assessment of Potential Self-harm†	100%
Interventions and Required Services	
Best Practice Pharmacotherapy	69%
Side Effects and Physical Wellness Intervention†	56%
Clozapine is used for Treatment Refractory Positive Symptoms	44%
Psychological Therapy for Anxiety, Depression, Stress/Psychosocial Problems by Qualified Practitioners†	13%
Integrated Psychosis and Substance Use Treatment	38%
Functional, Vocational, Social Needs Interventions†	50%
Client Education†	44%
Family Education†	19%
Groups are Offered	50%
Outreach and Home Treatment	94%
Links to Inpatient Services†	81%
Service Structure and Staff	
Regular Client Reviews/Weekly Team Meetings†	75%
Multidisciplinary Team‡	63%
Sufficient Resources	38%
Minimum Client to FTE Staff Ratios†	56%
Staff Development	50%
Ongoing Clinical Supervision and Mentorship for Clinicians	25%
Ongoing Program QI and Evaluation	19%
Service Intensity	75%

†Essential item
‡Essential item for urban sites only

Table 2 – The EPI Fidelity Scale items and the percentage of sites meeting fidelity for each item.

Methods, CCEIP and EPI data

To the right, we have the polling results from the aforementioned CCEIP 2018 presentation, regarding N=68 order sets submitted, of Canada-wide EPI programs. This chart, along with the tables of 2016 and 2020 Canada-wide data on pages 18, 19, and 20 of this report, provide some insight as to what medications are used within EPI programs.



Prescribers: According to the minimum standards in section V-B of the EPI guidelines, only Urban EPI programs are required to have a psychiatrist on-site:

> *iii. Urban EPI programs: An urban EPI program must have psychiatrists involved for psychiatric assessment, to prescribe medication, and to monitor progress and medication side effects.*
>
> *iv. Rural EPI programs: A rural EPI program must have access to an individual who can prescribe antipsychotics and other medications.*

2016 Study: *"EIP in Canada: What is the state of affairs?" :*
To achieve the intensity of care needed for effective treatment, it is recommended that caseloads be kept low (15 to 1). However, patient to clinician ratios vary widely among surveyed clinics, from 19:1 to 50:1, with 7 programs having ratios between 20:1 and 30:1.
How long is a patient retained? *As of now, experts recommend durations varying between 3 and 5 years. All surveyed programs provide services for a period ranging from 2 to 5 years, with more than half having a duration of 2 or 3 years.*

Of 11 Canadian EPI programs surveyed, *"In 3 clinics, patients can be discharged before the end of the program if remitted from positive symptoms or having recovered sufficiently to be treated in a primary care setting."* We can infer that the remaining 8 locations polled did not allow for release with improved symptoms.

Electroshock therapy is a potential treatment for involuntary patients in BC. ECT is administered to involuntary patients under the same broad director-authorized psychiatric treatment framework (via Form 5) that covers other interventions.

Antipsychotics for children: Despite the 2025 fidelity report excluding children, we do have data that antipsychotic use in children has been on the rise since 1996. In "*A population-based study of antipsychotic prescription trends in children and adolescents in British Columbia, from 1996 to 2011"* [20],

> *From 1996 to 2011, overall AP (both first and second generation) prescription prevalence rate increased 3.8-fold (1.66 to 6.37 per 1000 population); second-generation AP (SGA) prescriptions increased 18.1-fold (0.33 to 5.98 per 1000 population). The highest increase in all AP prescriptions occurred in males aged 13 to 18 years (3.3 to 14.4 per 1000 population; 4.4-fold), followed by similar increases in males aged 6 to 12 years (2.3 to 8.6 per 1000 population; 3.7-fold) and in females aged 13 to 18 years (2.8 to 10.7 per 1000 population; 3.8-fold).*

20 A population-based study of antipsychotic prescription trends in children and adolescents in British Columbia, from 1996 to 2011 | https://pubmed.ncbi.nlm.nih.gov/23768264/

Extended Leave

Summarized from BC's Mental Health Act:

Section 37: The director of the designated facility may release a patient on leave if they believe it would benefit the patient **and** appropriate community supports exist to meet the conditions of the leave. This is documented on **Form 20** (Leave Authorization).

Section 39: The authority to detain the patient continues while on leave. The patient is still subject to the Act as if they were in hospital.

Coerced Medication as Condition for Leave

The program leader can offer the patient extended leave from the facility, under negotiated conditions.

In the case of a mandatory medication regimen, this includes reporting to a pharmacy and taking the medication in front of a provider, and/or the direct enforcement of medication at the patient's home.

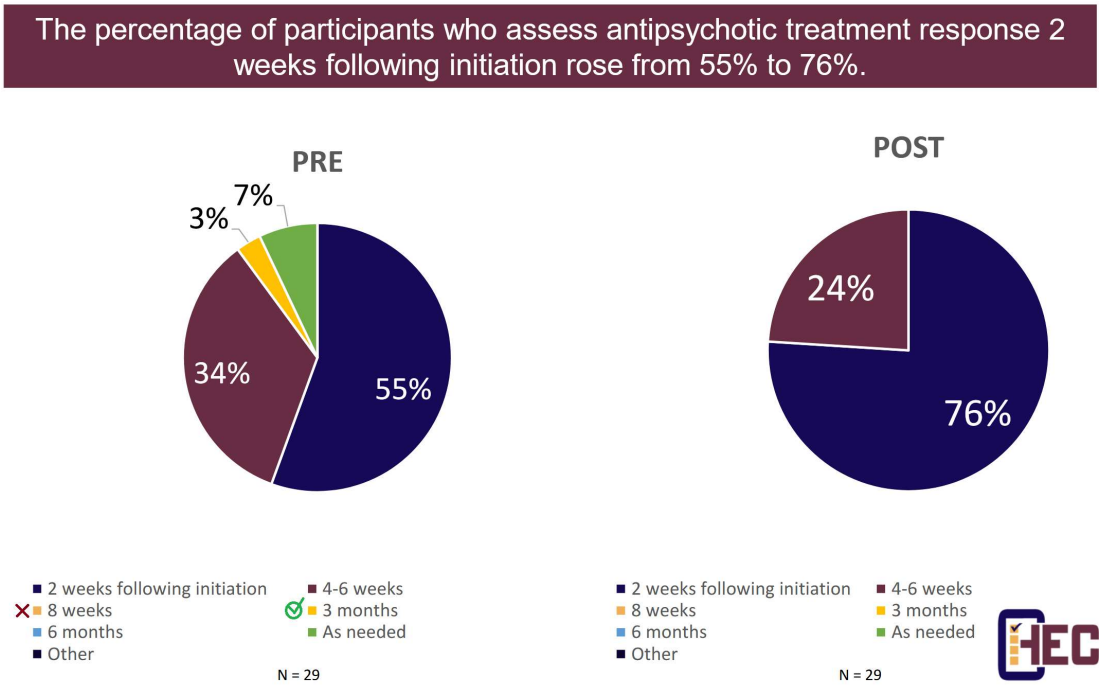
The patient on extended leave may be required to attend mandatory appointments with a program case manager, they may be disallowed from changing their home address, or from traveling out of reach of the program.

If the conditions of extended leave are not maintained, the patient can be recalled, including by police.

The offer of extended leave, or the threat to withhold it, can be used to coerce patients into medication.

Historical Lack of Monitoring for Side-Effects (CCEIP 2018 chart)

This poll from the CCEIP presentation shows that of N=29 EIP providers, prior to the 2018 presentation, only 55% were assessing the patent's treatment response to antipsychotics within 2 weeks of initial dosing. Three percent of providers only assessed every three months, and 7% of providers assessed "as needed". (Note that "6 months" is present in the poll, and unrepresented in the results.)



Special Concern A: Antipsychotic Drug Research in the EPI program

"Improving metabolic and cardiovascular health at an early psychosis intervention program in Vancouver, Canada", 2014

This study confirms that antipsychotic drug research was taking place in 2014 at the Vancouver EPI program, which accepts children as young as 13:

https://pmc.ncbi.nlm.nih.gov/articles/PMC4155777/

> *Furthermore, a number of ongoing research studies at the [Vancouver EPI] program* ***with a focus on the biological basis of metabolic dysregulation in patients treated with antipsychotic drugs*** *provide additional opportunities for patients to learn about their physical health.*

The paper also provides an overview of the potential damage caused by these drugs, including the especially high risk to youth.

> *Numerous studies have reported high rates of metabolic syndrome in atypical treated patients, with prevalence rates of over 50% for prediabetes or type 2 DM in some adult psychiatric inpatient settings (27–29). In the large head-to-head clinical trial of atypical antipsychotics, the Clinical Antipsychotic Trial of Intervention Effectiveness (CATIE) Study (a major, multi-center trial sponsored by NIMH) observed that 43% of patients treated with atypicals had metabolic syndrome. Controlling for BMI, CATIE men were 85%, and CATIE women 137% more likely to have metabolic syndrome than non-psychiatric subjects (30). Importantly,* ***evidence indicates that youth appear to be at higher risk than adults*** *for antipsychotic-induced weight gain and associated metabolic abnormalities (31–33), emphasizing the need for close monitoring of patients in EPI programs.*

"What is the state of affairs?" paper, which surveyed 11 'urban academic' EPI programs across Canada:

https://pmc.ncbi.nlm.nih.gov/articles/PMC4813422/

> ***All but one program conduct some research****, which is considered necessary to improve knowledge in the field and promote knowledge transfer. Nine EIS [Early Intervention Services] have produced peer-reviewed publications in the past 5 years (ranging from 8-88 publications);* ***all programs report some collaboration with other facilities on research projects.*** *Clinical research is conducted on various topics such as early psychosis outcome, epidemiology, psychopharmacology, neurobiology, and psychosocial and service-related research.*

Given the evidence of significant numbers of "false voluntary" children age 13-15 in BC's involuntary psychiatric programs, and given the widespread prevalence of "outcome, epidemiology, psychopharmacology, neurobiology, and psychosocial and service-related research" within Canada's, and therefore BC's, early psychosis intervention programs – programs which include coerced or mandatory medications for persons in their care – it is the mission of this author to call for an investigation into the safety and health outcomes of these children, as well as propose authoritative intervention to prevent children, especially mentally ill children with impaired capacity to consent, from being included in pharmacological research programs.

The refusal of these services to provide injury and death data to the Representative for Children & Youth, as is required by law, must be emphasized in this context.

This author advocates for immediate investigation, including the potential to halt such programs.

Special Concern B: Impending Legalization of Psychiatric MAID

At the time of this report, there is an ongoing federal policy debate regarding the potential to lift the exclusion of mental illness from the qualification for Medical Assistance in Dying on March 17, 2027.

For the sake objectivity, it must be emphasized that there is no true evidence which can predict the future. The impact and application of such legislation impossible to determine with certainty.

However, in the interest of justice, and for the sake of prioritizing the safe long-term outcomes of a generation of youth who have allegedly been mistreated by BC's Mental Health Act, this author calls for an indefinite pause on the eligibility of mental illness for MAID, and a pause on the approval of MAID for known iatrogenic harm or side-effects induced by antipsychotics.

At minimum, all missing health data regarding the injury and death of children in involuntary psychiatric care in BC must be located and publicized before these programs, including their research teams, are permitted to expand their reach in any way.

https://nmses.ca/events/event/psychiatry-grand-rounds-medical-assistance-in-dying-maid-a-primer-for-psychiatrists/

Section 4: Victim Testimonies