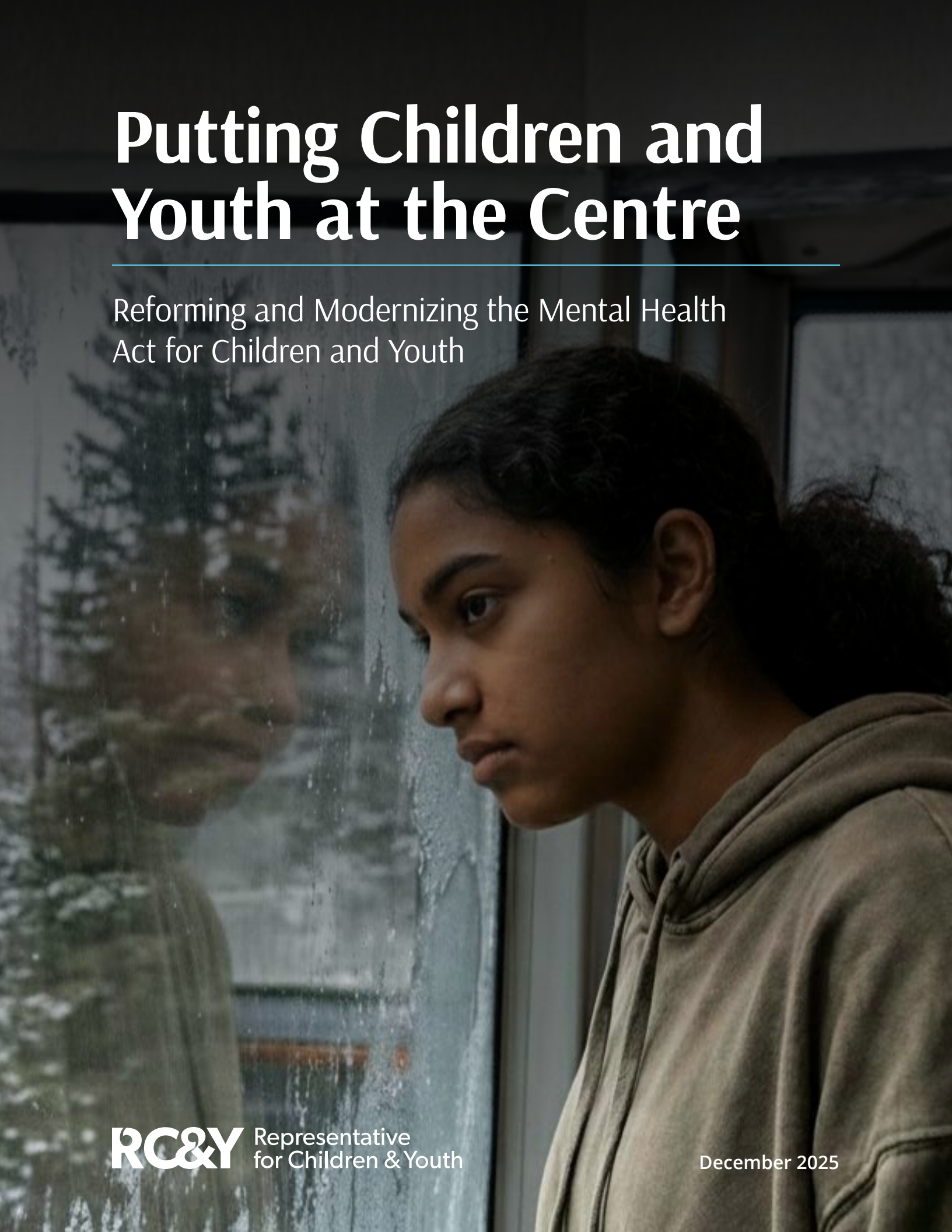
Putting Children and Youth at the Centre

Reforming and Modernizing the Mental Health Act for Children and Youth



RC&Y Representative for Children & Youth

December 2025

The Representative and staff, working throughout the province, would like to acknowledge that we are living and working with gratitude and respect on the traditional territories of the First Nations peoples of British Columbia.

We specifically acknowledge and express our gratitude to the keepers of the lands on the traditional territories of the Lheidli T'enneh peoples (Prince George) and the Lekwungen (place to smoke herring) people of the Songhees and Xwsepsum (Esquimalt) Nations (Victoria) where our offices are located. We also acknowledge our Métis and Inuit partners and friends living in these beautiful territories.

December 12, 2025

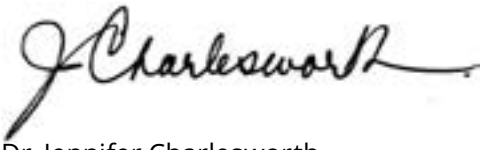
The Honourable Raj Chouhan
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, BC, V8V 1X4

Dear Mr. Speaker,

I have the honour of submitting the report, entitled *Putting Children and Youth at the Centre: Reforming and Modernizing the Mental Health Act for Children and Youth,* to the Legislative Assembly of British Columbia.

This report is prepared in accordance with Section 20 of the *Representative for Children and Youth Act,* which gives the Representative authority to make a special report to the Legislative Assembly if the Representative considers it necessary to do so.

Sincerely,



Dr. Jennifer Charlesworth
Representative for Children and Youth

pc: Ms. Kate Ryan-Lloyd
Clerk of the Legislative Assembly

Rohini Arora
Chair, Select Standing Committee on Children and Youth

Amelia Boultbee
Deputy Chair, Select Standing Committee on Children and Youth

Contents

Introduction

In the wake of the Vancouver Lapu Lapu festival tragedy in April 2025 that left 11 dead and many more injured, the Premier said there would be a review of the province's mental health legislation – the *Mental Health Act*[1] – to ensure it is working the way it is intended.[2] The terms of reference of that review have yet to be announced.

Prior to that, the province had appointed a chief scientific advisor for psychiatry, toxic drugs and concurrent disorders,[3] Dr. Daniel Vigo, who subsequently issued a guidance document to doctors and psychiatrists in March 2025, to provide clarification on how the *Mental Health Act* can be used to provide involuntary care for adults when they are unable to seek it themselves.[4] Government also previously announced the development of highly secure facilities for adults with long-term concurrent mental-health and addiction challenges under the *Mental Health Act* and in correctional facilities,[5] the first two of which were implemented in 2025,[6] which was followed several months later by an announcement of the development of two more facilities.[7]

It is notable that these commitments and initiatives almost entirely relate to adults[8] in the context of public and political concerns about crime, public disorder, encampments, the intersection of mental health and addictions with the toxic drug supply, and, in particular, involuntary care. Organizations such as the BC Division of the Canadian Mental Health Association,[9] Health Justice,[10] the Community Legal Assistance Society (CLAS) and others[11] have, however, championed a comprehensive review and modernization of the Act from a very different perspective, which relates to significant concerns about the inadequate attention in the legislation to the rights of individuals who are involuntarily detained such that BC has been characterized as "the most regressive jurisdiction in Canada for mental health detention and involuntary psychiatric treatment".[12]

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1 RSBC 1996, Chapter 288. https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96288_01

2 *BC premier announces review of mental health legislation in wake of Vancouver festival tragedy*, CBC News, April 30, 2025. https://www.cbc.ca/news/canada/british-columbia/b-c-premier-reviews-mental-health-legislation-1.7523191

3 *Advisor appointed to improve care for people with complex mental-health, addiction challenges,* British Columbia News, June 5, 2024. https://news.gov.bc.ca/releases/2024MMHA0028-000873

4 *BC improving care for people with mental-health, substance-use challenges*, British Columbia News, March 12, 2025. https://news.gov.bc.ca/releases/2025HLTH0015-000202. This was followed by the release of a similar guidance document respecting children and youth on December 5, 2025; see, New guidelines on *Mental health act* will help keep young people safe, December 5, 2025 https://news.gov.bc.ca/releases/2025HLTH0057-001209#:

5 *Province launches secure care for people with brain injury, mental illness, severe addiction*, British Columbia News, September 15, 2024. https://news.gov.bc.ca/releases/2024PREM0043-001532

6 *New beds improve care for people with complex mental-health disorders*, British Columbia News, June 3, 2025. https://news.gov.bc.ca/releases/2025HLTH0053-000534

7 CBC News, *Mixed reaction to BC premier's announcement of new involuntary care facilities*, September 27, 2025. Mixed reaction to BC premier's announcement of new involuntary care facilities | CBC News

8 In September 2024 government did commit to making changes to the law in the next legislative session "to provide clarity and ensure people, including youth, can and should receive care when they are unable to seek it themselves" (*supra*, note 4). The next legislative session began in February 2025 but the proposed legislative changes have yet to be introduced.

9 Canadian Mental Health Association, BC Division*, Involuntary Care Already Exists in BC, But Is It Working?* September 18, 2024. https://bc.cmha.ca/news/page/3/

10 Health Justice, *Framework for a review of the Mental Health Act*, 2025. https://www.healthjustice.ca/mhareview

11 *Open Letter from Community Groups on BC Mental Health Act Law Reform*, June 27, 2019**.** https://clasbc.net/our-work/law-reform/mental-health-law-reform/

12 Johnston, L. (2017, November 29). *Operating in darkness: BC's Mental Health Act detention system.* Community Legal Assistance Society, November 29, 2017, p.6. https://clasbc.net/operating-in-darkness-bcs-mentalhealth-act-detention-system/

With the exception of the recent release of Dr. Vigo's follow-up guidance document on how the *Mental Health Act* can be used for involuntary detention of children and youth, which will be discussed later, these commitments and initiatives almost entirely relate to adults. The unique needs and circumstances of children and youth[13] have been largely ignored, even though epidemiological research estimates that almost 100,000 children and youth in the province experience a mental disorder at any given time (see text box), more than 30,000 children and youth are served each year through the Ministry of Children and Family Development's (MCFD) Child and Youth Mental Health (CYMH) services[14] and as we will discuss, there are more than 4000 hospitalizations of children and youth under the *Mental Health Act* each year, more than half of which involve involuntary detention.[15] This lack of attention to children and youth echoes the provisions of the current *Mental Health Act* which, as we will also discuss, scarcely even recognizes children and youth and when that legislation does specifically address the unique circumstances of this especially vulnerable population, the provisions are severely wanting.

In the nearly five years since the Representative released her report on mental health hospitalizations of children and youth under the *Mental Health Act* – entitled *Detained, Rights of children and youth under the Mental Health Act*[16] ("Detained") – little progress has been made by government in implementing the recommendations in that report relating to improvements that will better respect the rights and interests of children and youth who are detained.[17] More generally, the Representative's follow up on government's responses to recommendations arising from ten previous RCY reports indicates that mental health services are the most frequent subject area for recommendations, yet it is the service area where government has been the least responsive to RCY recommendations.[18]

Prevalence of Mental Health Disorders Amongst Children

Children's mental health is crucial for the well-being of individuals and of populations. Yet rigorous epidemiological studies show high disorder prevalence with nearly 12.7% or 95,000 children aged 4–18 years being affected at any given time in British Columbia (BC). These studies also depict stark service shortfalls …

– Children's Health Policy Centre, Simon Fraser University, 2020, p.4[19]

As a follow-up to a key theme of the *Detained* report – listening to the voices of children and youth and promoting their active participation in processes that affect them – the Representative commissioned a series

[13] Unless otherwise specified, throughout this report "children and youth "and the shorter form "child" both mean persons under the age of 19 years, which is the age of majority in BC

[14] Ministry of Children and Family Development. The MCFD Reporting Portal states:
> A conservative estimate of the 2024/25 fiscal year total number of children and youth served including … (those) … not using CRIS is estimated at 31,000 provincially.

[15] To be discussed; see Figure 1 in the following section on Hospitalizations and Involuntary Detentions.

[16] Representative for Children and Youth. *Detained: Rights of children and youth under the Mental Health Act.* January 2021. https://rcybc.ca/reports-and-publications/detained/

[17] Representative for Children and Youth. *Detained: Rights of children and youth under the Mental Health Act RCY Annual Review Year 2*. Date Published: February 26, 2024 (amended March 25, 2024). rcybc.ca/wp-content/uploads/2024/04/2024.03.25-Detained-Year-2-Progress-Assessment-FINAL.pdf

[18] Representative for Children and Youth. *Annual Summary of Recommendations Monitoring Report 2023/24.*March 31, 2024. https://rcybc.ca/wp-content/uploads/2024/03/27.03.2024_FINAL_Annual-Monitoring-Summary_V6.pdf

[19] *Public Data Sources for Monitoring Children's Mental Health: A Research Report.* Children's Health Policy Centre, Faculty of Health Sciences, Simon Fraser University, 2020. https://childhealthpolicy.ca/wp-content/uploads/2020/12/Waddell-Datasets-2020.12.08.pdf

of reports from the Society for Children and Youth of BC ("SCY") relating to child and youth capacity and participation in legal and administrative proceedings, including healthcare decisions and the voluntary and involuntary civil detention of children and youth under mental health legislation. Three of those inter-related reports are appended to this report and are concurrently released on the SCY website.[20] These reports examine child participation rights and children's capacity primarily through the lens of the *United Nations Convention on the Rights of the Child* ("UNCRC")[21] and other international human rights instruments, review the relevant legal, social science and health science literature, and consider related legislation and select case law. These reports, the key findings of which will be briefly summarized below, are essential reading as they describe key elements of the framework, foundational principles and considerations that must inform reform of the *Mental Health Act* for children and youth. 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.[22]

The *Mental Health Act*

The *Mental Health Act* is the law in BC governing mental health interventions, allowing for voluntary admissions to a designated mental health facility as well as involuntary admissions and treatment of individuals, including children and youth, with a "mental disorder" under specific legislated criteria. The Act provides a framework for involuntary care while also outlining certain patient rights, including the rights to medical examinations, access to legal counsel, the ability to request a hearing with a review panel to challenge involuntary detention, and the right to meet with an independent rights advisor.

[20] https://scyofbc.org/. The remaining two reports on child participation and capacity in, respectively, family law and child protection proceedings are expected to be released in the near future.

[21] *United Nations Convention on the Rights of the Child*, United Nations 1989. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child

[22] This report is prepared under the authority of section 20 of the *Representative for Children and Youth Act*, RSBC, Chapter 29. Section 6 of the *RCY Act* describes the functions of the Representative, which include individual advocacy, reviews and investigations of deaths and critical injuries, and monitoring of designated or reviewable services and programs under the Act that are provided under an enactment or provided or funded by government. Section 1 of the Act includes mental health services to children, which are funded by government and in part are governed by the *Mental Health Act,* as designated and reviewable services. The Representative routinely provides individual advocacy services and receives reports of and reviews critical injuries and deaths in relation to mental health services for children, and monitors those services and programs. Section 20 of the *RCY Act* enables the Representative to make a special report to the Legislative Assembly if the representative considers it necessary. See, *British Columbia (Representative for Children and Youth) v British Columbia (Attorney General)*, 2019 BCSC 1888.

Highlights of the SCY Reports

Society for Children and Youth of BC

The Society for Children and Youth of BC is a provincial not-for-profit charity. Since 1974, the Society has focused on providing a strong voice representing children and youth. Its mission is to improve the well-being and resilience of children and youth in BC through the advancement of their civic, political, economic, social, cultural and legal rights. Using the UN Convention on the Rights of the Child as a foundation, SCY has a track record of creating and delivering programs that have motivated change in research, legislation, policy, and practice in Canada. The organization is comprised of three programming areas: the Child and Youth Legal Centre, Child and Youth Friendly Communities, and Child Rights Public Awareness.

SCY's approach to the commissioned research on child and youth capacity and participation in administrative and legal proceedings consisted of three stages. The first stage involved a literature review – predominantly from law, the social sciences, health sciences, and other disciplines – about child capacity, as well as legislation and select case law relevant to child capacity. The second stage involved interviews with children and youth about their experiences of capacity generally and as they related to the specific legal areas of inquiry, a survey of a larger number of children and youth, and hosting facilitated listening circles with groups of children and youth using key research questions. The final stage consisted of consultations with stakeholders and subject matter experts.

Children's Rights

The *United Nations Convention on the Rights of the Child (UNCRC)*, is a comprehensive, international human rights treaty adopted by the UN in 1989 that protects and promotes the rights of all children under 18. It recognizes children as individuals with their own rights and prescribes their civil, political, economic, social, health, and cultural rights, requiring signatory governments to ensure these rights are realized for all children, without discrimination. Having been ratified by almost every country, including by Canada in 1991, the UNCRC is the most widely ratified human rights treaty in the world.

The SCY reports embrace the UNCRC as a foundation, in particular Article 12 which states:

1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.[23]

The first SCY report – entitled*, Capacity: A Principled, Rights-Based Approach to Child Participation: Research Report on Child Capacity*[24] – is a primer on the research related to child capacity and participation and serves as a foundational review to inform the ensuing reports on child and youth capacity and participation in specific types of legal and administrative proceedings. SCY's key findings from this research are:

- There is no universally agreed upon definition of capacity although there are recurring themes throughout social science.

- Age alone is not a reliable indicator of capacity. Decision makers should not use age as the sole determinative factor of children's capacity.

- All children should be presumed to have capacity to express their views and preferences. Great harm is done to children who are not permitted to exercise their capacity to be heard in matters affecting them.

- Capacity can be understood as both a function of cognition, as well as an ability or a right one possesses. What it is varies depending on its context or function. Capacity can be a legal right.

- Capacity encompasses a variety of factors and develops at different rates. Children may possess more or less capacity in different contexts. The capacity to be heard is not the same as the capacity to be the decision maker.

- The UNCRC provides that a child need only be capable of forming a view in order for their view to be heard and considered. There is no further test of cognition or capacity that should stand in the way.

- Children and youth must be equitably supported to express their views and desires on matters affecting them, using methods that meet their level of capacity.[25]

The Representative notes in particular, the findings that all children should be presumed to have capacity to express their views and preferences and that great harm is done to children who are not permitted to exercise their capacity to be heard in matters affecting them. In contrast, the report notes that a growing body of evidence demonstrates that meaningful participation from children in decision-making promotes improved outcomes and well-being, even when the decisions made are not ultimately

[23] *Ibid.*
[24] Society for Children and Youth, *Capacity: A Principled, Rights-Based Approach to Child Participation: Research Report on Child Capacity,* 2024.
[25] *Ibid*, p.8.

in accordance with the child's views.[26] Another key finding of particular note is that the capacity to be heard is not the same as the capacity to be the decision maker, i.e., expressing a view should be differentiated from making a decision/choice.

Engagement with mental healthcare is, of course, a healthcare decision. The second appended SCY paper – entitled, *Child Capacity and Participation in Healthcare Decisions*[27] – specifically addresses child and youth capacity and participation in the context of decisions about healthcare by exploring the interplay of legal principles, provincial statutes and international conventions.

A key aspect of child and youth capacity and participation in a healthcare context is the "mature minor" doctrine, which has flowed from the common law, is reflected in BC's *Infants Act,*[28] and largely aligns with the provisions of the UNCRC. The mature minor doctrine recognizes the evolving capacity of children to make decisions for themselves, granting that autonomy to children and youth who are considered sufficiently mature to make their own choices about treatment, even when those choices do not align with their parent's/guardian's views. In BC, there is not a stipulated age for a child to be deemed to have the capacity to consent to healthcare. Instead, the *Infants Act* provides that a child may consent to their own healthcare if the healthcare provider is satisfied the child has the capacity to "understand the nature and consequences and reasonably foreseeable benefits and risks of the healthcare" and has concluded that the healthcare is in the child's best interests.[29]

Key findings from the SCY's report on child and youth capacity and participation in healthcare decisions are:

- Regardless of their decision-making abilities, all children and youth have a right to be heard and to express their views in decisions concerning their healthcare.
- As in adults, capacity of children and youth encompasses a variety of factors and develops at different rates. It is an evolving trait that may be more or less present in different contexts and can be assessed through a variety of models available to healthcare providers.
- Healthcare must be patient-centred, with the views and interests of the young patient meaningfully considered in the provision of services. The onus must be on the healthcare provider to find an effective strategy to communicate and connect with their child or youth patient.
- Dismissal and invalidation by healthcare providers, parents, and other adults contributes to significant negative impacts on children and youth including reduced self-esteem and confidence in their treatment plans.
- Children and youth would greatly benefit from neutral, third-party support in medical settings that focuses only on their interests, needs, and views.
- For many children and youth, making healthcare decisions can be an empowering experience, helping them develop individual agency.[30]

[26] *Ibid*, p.17
[27] Society for Children and Youth, *Child Capacity and Participation in Healthcare Decisions,* April 2024
[28] RSBC, c.223
[29] *Ibid*, section 17.
[30] *Supra,* note 25, p.8.

The Representative notes in particular the findings in relation to the negative effects of dismissal and invalidation of children's views, the benefits of independent support for children and youth, and the benefits for children and youth that flow from making healthcare decisions for themselves.

The third SCY report – entitled, *Child Capacity and Participation in BC's Mental Health System*[31] – examines the involuntary and voluntary civil detention of children and youth in BC under the *Mental Health Act*, as well as previous proposals to expand the scope of involuntary civil detention, and how the current and proposed legislative frameworks do or do not accord with the UNCRC and various other international treaties to which Canada is a signatory. The key findings from this report are:

- Although a child or youth's mental or cognitive capacity may fluctuate depending on the nature of their mental illness or disability, this does not impact their legal capacity. Their legal rights do not go away because of their perceived lack of cognitive or mental capacity.
- While children and youth with mental illness may not always make decisions deemed "good" by decision-makers and healthcare providers, their right to participate in decision-making through the expression of their views should not be ignored.
- It is important to work with a child and youth's capacity – meeting them where they are at rather than assuming they lack capacity.
- When a child or youth's capacity is denied or taken away, it can create a negative cycle that impacts their ongoing ability to make decisions for themselves and to maintain a sense of autonomy.
- It is important for children and youth to express their capacity to be heard; to share their opinions and views on their treatment. A legislative framework that presumes a lack of capacity is not consistent with a child's legal right to be heard.
- To respect a child or youth's capacity, it is essential that decision makers and care providers share appropriate information with them about their rights and communicate adequately with them about their treatment. This helps a child or youth to be able to understand, to the best of their abilities, the situation at hand and to use this information to form views and make appropriate decisions about their care.
- Institutionalization can harm the physical, mental, and cognitive development of children and youth, with lasting effects into adulthood. Involuntary mental health detention should be used sparingly, for the shortest time possible, and in select cases.
- Any proposed legislation and legislative amendments, such as the *Mental Health Amendment Act and Safe Care Act*, require thorough scrutiny for their impact on children and youth.[32]

[31] Society for Children and Youth, *Child Capacity and Participation in BC's Mental Health System,* 2025.
[32] *Ibid*, p.'s 8-9

The SCY's research included consultations with young people who had experience with the mental health system and who consistently reported ill-effects of their treatment during mental health detention or stabilization. Echoing the findings of the Representative's 2021 *Detained* report, the SCY report states:

> The voices of children and youth consistently highlight the negative impact of involuntary detention, revealing limitations in their ability to participate meaningfully in their mental healthcare. They report being ignored, disempowered, and stripped of decision-making capacity. Instances of isolation, fear, and inadequate communication with family members further compound their distress. The negative repercussions impact their education, violating fundamental rights and placing vulnerable populations at heightened risk.[33]

The report further concludes:

> The predominant finding of this paper concerns the current mental health framework which, while potentially beneficial for select individuals, is deeply flawed, proving to be traumatizing, harmful, disempowering, and disabling for many of the children and youth it affects. In addition, it operates in discordance with international treaties, notably the UNCRC, and other fundamental principles of justice and administrative law.[34]

These important themes will be explored from the Representative's perspective in more detail below.

[33] *Ibid*, p.39
[34] *Ibid*, p.39

The Detained Report: A Follow Up

The Representative's 2021 *Detained* report examined the administration of the system for involuntary detention of children and youth under the *Mental Health Act*, seeking to better understand how that legislation functions and to identify ways to strengthen safeguards, enhance opportunities for young people to have a say in their treatment and improve the experience and outcomes for children and youth.

The report utilized several sources of information, including RCY and external data, a review of the legislation, regulations and guidelines, interviews with key partners and, notably, in-depth engagement of young people who had experienced detention under the *Mental Health Act* to amplify the voices of youth with lived experience. The report was grounded on the provisions of the UNCRC and other international human rights instruments such as the *United Nations Convention on the Rights of Persons with Disabilities*[35] and the *United Nations Declaration on the Rights of Indigenous Peoples*[36] (UNDRIP), in particular that young people have the right to participate in making decisions about their care, to the extent that they are able.

The report was also grounded on the premise that given their immaturity and state of dependency, children and youth should have enhanced protections of their rights when they are facing deprivation of liberty, as is the case in the youth criminal justice system, which is matter we will explore in more depth in this report. This need for enhanced protection is even more crucial in a mental health context since the capacity of children and youth to understand and exercise their rights may be diminished by their mental state at the time of admission.

The report notes that while the intention of mental health detention is to keep young people in severe distress safe by providing effective stabilization and treatment, involuntary admission to secure facilities that at times can and do employ restraints and seclusion, is an extraordinarily powerful tool of the state that can be misused and cause unintended harm. Sometimes it is used well and indeed can be life-saving, but it should not be assumed that detention is always therapeutic and beneficial, as was sadly evident in the stories of detained young people who participated in the report. The fear and confusion expressed by youth who described their experiences in involuntary detention is troubling to read.

Although the *Mental Health Act* has some, albeit limited, protective safeguards – such as requiring the provision of information about rights, notification of a near relative, the opportunity to request a second medical opinion, periodic re-assessments, Mental Health Review Board hearings and access to legal counsel for those hearings – the report found that young people were apparently not being informed of nor supported to exercise their (limited) rights under the Act. As the report stated:

> 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 forced medication, not being involved in treatment decisions and a lack of

[35] United Nations, 2006. Convention on the Rights of Persons with Disabilities | OHCHR
[36] United Nations, 2007. UN Declaration on the Rights of Indigenous Peoples | OHCHR

> 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. (p.5)

The report also observed that while the involuntary detention of First Nations, Métis, Inuit and urban Indigenous children and youth under the *Mental Health Act* may be intended for their safety and protection, it can be seen and experienced as another link in a long chain of oppression imposed by the state on Indigenous peoples. This is exacerbated by the significant concerns about racism in the healthcare system[37] as well as the lack of culturally safe and relevant services and supports.

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.

The *Detained* report made 14 recommendations to a number of public bodies. To its credit, government has moved forward in implementing a key recommendation relating to providing independent rights advice to children and youth (and adults). In June 2022, amendments to the *Mental Health Act*[38] were passed by the Legislature, although those amendments and accompanying changes to regulations were only very recently brought into force.[39] These amendments enable the Attorney General to establish an independent rights advice service and require the director of a mental health facility to inform an involuntarily detained patient, including children and youth, to be informed of the availability of an independent rights service and to facilitate private contact with a rights advisor.

The independent rights service is being implemented in three phases. Prior to bringing the amendments into force, the Ministry of Attorney General established the independent rights service administratively by funding the Canadian Mental Health Association, BC Division (CMHA BC) to develop and implement the service, which has been active since February 2024. Staff from the service, who are lay individuals with lived experience, provide some outreach education to staff and patients at mental health facilities about the role and availability of the service, which is to explain rights under the *Mental Health Act* (see text box). Some youth-friendly rights advice educational materials have been developed. As well as adults, youth who have been involuntarily detained are eligible for the service, as are children and youth under the age of 16 who have been "voluntarily" admitted to a hospital or facility after their parent or guardian requested it under section 20. Meetings are typically requested online and held by video conference. Right advisors are not lawyers: they cannot advise on what children and youth should do, nor represent them at Mental Health Review Board hearings.

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[37] See, *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in BC Healthcare*, 2020. In-Plain-Sight-Addressing-Indigenous-specific-Racism-and-Discrimination-in-BC-Health-Care.pdf

[38] Bill 23 – 2022: Mental Health Amendment Act, 2022. https://www.bclaws.gov.bc.ca/civix/document/id/bills/billsprevious/3rd42nd:gov23-3

[39] BC Reg 456/2025 was authorized on October 2, 2025 and brought the amendments into force on December 3, 2025, while accompanying regulation changes are brought into force in stages on December 3, 2025 and March 18, 2026. See, Helping people understand their rights under the *Mental health act*, December 3, 2025, https://news.gov.bc.ca/releases/2025AG0070

Independent Rights Advice Service

Rights Advisors can

- Explain your rights under the *Mental Health Act* and answer any questions you might have.
- Explain the Mental Health Review Board review panel process. If you would like to request a review of your involuntary status and detention, a Rights Advisor can also help you apply.
- Tell you your options if you have concerns about your treatment. They can also help you ask for a **second medical opinion** on your treatment.
- Give you information about how to find a lawyer or other legal support.
- Help you find out if you are eligible for legal aid.

Rights Advisors cannot

- Represent individuals at a Mental Health Review Board hearing or court proceeding.
- Give legal advice or recommendations about what someone "should" do.[40]

This new rights advice service has been infrequently accessed by children and youth to date. Data provided by the CMHA BC indicates that in the 19-month period between February 2024 and September 2025, there were 48 rights advice meetings requested by young people under 19 years old, 44 of which were attended, i.e., less than 3 per month in the context of an average of more than 200 involuntary hospitalizations per month[41] of children and youth. Youth under 19 years represented 4 per cent of the total number of (adult and youth) meetings requested and 5 per cent of the meetings attended.

The small number of children and youth accessing the rights advice service may be a function of recent start up[42] and unfamiliarity, which may improve over time. Importantly, the second phase of implementation should promote more frequent access. 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.[43]

[40] Independent Rights Advice Service, https://irasbc.ca/what-to-expect/

[41] Ministry of Health reports an average of 218 involuntary hospitalizations of children and youth in 2023/24 and an average of 204 in 2024/25.

[42] CMHA BC data indicates that there no requests for meetings by children and youth in the first five months of the new service in 2024. In the first half of FY 2025/26 (April – September), there were still only a small number of meeting requests by children and youth, averaging 5 requests per month for a meeting with a rights advisor.

[43] CMHA BC, email communication, October 17, 2025

Even with a statutory requirement to inform involuntary patients of their rights, including the right to independent rights advice, the independent rights advice service is and will remain essentially reactive insofar as it responds to children and youth who reach out after they have been informed by mental health facility staff of the availability of the service. As such, the effectiveness of the system is dependent on hospital staff informing children and youth of their rights (including access to the rights advice service), on the child or youth understanding the need for rights advice and deciding to reach out to the service and request advice, and on the child understanding and acting on that advice. That seems a lot to ask of, for example, a 14-year-old with mental health challenges, especially one who does not have an independent advocate who, in addition to providing information, can walk along side of and directly support and assist them.

The third, prospective stage of implementation of the rights advice service involves automatic scheduling of meetings of eligible patients with a rights advisor (which can be waived by the patient). This third administrative stage is, however, subject to future funding approval in 2027, and is not guaranteed at this point. The Representative agrees that this proactive and assertive approach to rights advice is necessary, especially for immature young people with mental health challenges, and urges government to support funding, and to go even further by building into modernized legislation a requirement for a rights advice meeting to be scheduled at the outset of involuntary detention of children and youth,[44] In any event, access to this service by children and youth is a matter that warrants ongoing monitoring and future evaluation.

Mental Health Review Board

The Mental Health Review Board is an independent tribunal established under the *Mental Health Act*. The Review Board conducts review hearings on the involuntary admission of patients under the *Mental Health Act*, including children and youth.

In another step forward, the Mental Health Review Board ("the review board") has been very responsive to the Representative's recommendation to improve the hearing process for children and youth. Following an exemplary consultation process and advice from an advisory council, the Board developed, and in 2023 implemented, a detailed plan which included information and communication materials for young people and their families, a revised youth-centred hearing process, a training program, and established a Navigator position to act as a point person for all communications and coordination of hearings involving children and youth.[45]

The *Detained* report found that very few children and youth exercised their right to have their detention reviewed by the review board: in 2017/18, in the context of 2,545 cases of detained children and youth, there were only 21 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.

[44] The young person could, of course, choose to waive the automatically scheduled meeting.
[45] British Columbia Mental Health Review Board, *Practice Direction- Children and Youth Hearings*. May 1, 2023 mhrb-rules-of-practice-and-procedure.pdf

Table 1 describes the total number of review board hearings and those involving children and youth between 2017/18 and 2024/25. The number of review board hearings involving children and youth has been consistently very small throughout the time period, comprising an average of only about 2 per cent of all hearings. The number (12) and percentage (1.2%) of review board hearings involving children and youth actually reached its lowest point in 2024/25, the first full year of operation of the new independent rights advice service.

Table 1 Mental Health Review Board Hearings

Fiscal Year	Hearings of Under 19 Years	Total Hearings	% Under 19 Years
2017/18	21	878	2.4%
2018/19	12	820	1.5%
2019/20	16	811	2.0%
2020/21	21	970	2.2%
2021/22	15	990	1.5%
2022/23	21	946	2.2%
2023/24	22	937	2.3%
2024/25	12	990	1.1%

Source: Mental Health Review Board

Table 2 describes a similar picture with respect to applications by detained children and youth for legal representation from the Mental Health Law Program,[46] i.e., in every year of the time period, children and youth comprise less than 2 per cent of all applications for legal representation by persons detained under the *Mental Health Act*.

Table 2 Applications for Mental Health Law Program Representation

Fiscal Year	Under 19 Years	Total	% Under 19 Years
2017/18	8	831	0.96%
2018/19	11	1,336	0.82%
2019/20	22	1,389	1.58%
2020/21	26	1,538	1.69%
2021/22	25	1,696	1.47%
2022/23	18	1,658	1.09%
2023/24	26	1,891	1.37%
2024/25	27	1,890	1.43%

Source: Community Legal Assistance Society

[46] These are applications only, not actual representation. The number of applications are an indicator of awareness of rights. The number of applications is higher than the number of review board hearings because not every application for legal assistance is followed by a review board hearing. Involuntary patients may, for example, be decertified before the hearing or they may cancel their hearing for a variety of reasons, which may include agreement with the treatment team, that they find the hearing process too stressful, or other personal reasons.

The establishment of the rights advice service and improvements to the review board process are welcome steps forward. Nonetheless, the low rates of access to the rights advice service by children and youth and the continuing low rates of exercise of those rights evidenced by very small numbers of review board hearings is troubling. This is an area that, in the Representative's view, speaks to the need for more fulsome services and supports to inform children and youth of their rights and to exercise those rights, and to consideration of amendments that would, as recommended in *Detained*, statutorily mandate automatic scheduling of rights advice meetings and, similarly, mandate automatic early reviews and automatic periodic reviews thereafter by the review board rather than solely relying on the young person to take the initiative in making an application.[47]

Otherwise, a 2024 review by the Representative[48] indicated no progress or only some progress on the remaining 12 recommendations from the *Detained* report which, in brief, included:[49]

- Identify why involuntary mental health detention for children and youth is increasing and opportunities to reduce these admissions.
- Require the collection and reporting of standardized key data, including Indigeneity, pertaining to children and youth admitted under the *Mental Health Act*.
- Review and reconcile the section of the *Mental Health Act* that allows a child under 16 to be admitted on a voluntary basis at the request of their parent or guardian with the mature minor doctrine.
- Develop a process to enable a First Nations, Métis or Inuit child or youth to notify their community or Nation of their involuntary admission.
- Develop new informational materials provided to children and youth detained under the *Mental Health Act* that explain what is happening, their rights and options
- Ensure First Nations, Métis or Inuit children and youth who are detained under the *Mental Health Act* are offered services by staff who assist Indigenous patients.
- Amend the *Mental Health Act* to allow children and youth who are detained to retain personal items that do not pose a risk to their safety or the safety of others.
- Ensure First Nations, Métis, Inuit and urban Indigenous children and youth detained under the *Mental Health Act* receive trauma-informed, culturally safe and attuned mental health services
- Amend the *Mental Health Act* to ensure that for children and youth who are detained, the use of isolation (seclusion) and restraint are only used as a last report and in accordance with specified legislative or regulatory criteria.
- Conduct a review of the effectiveness of extended leave for children and youth who are detained and if effective review the need for additional legislative or regulatory criteria and oversight mechanisms.

[47] Statutorily mandated periodic reviews by the review board would not remove agency from the young person as long as the young person is also afforded the right to waive a mandated review.

[48] Representative for Children and Youth, 2024. *Detained: Rights of children and youth under the Mental Health Act RCY Annual Review Year 2*. 2024.03.25-Detained-Year-2-Progress-Assessment-FINAL.pdf

[49] For brevity, the detailed *Detained* recommendations are summarily described.

- Amend the *Mental Health Act* to create mandatory periodic reviews by the Mental Health Review Board of children and youth who are involuntarily detained and children under 16 who are admitted at the request of their parent, to ensure such reviews do not depend on the child or youth's knowledge or ability to request a review.

It is noted that several of the outstanding recommendations listed above involve amendments to the *Mental Health Act* which, in the Representative's view, should inform the development of 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.

Other outstanding recommendations from the *Detained* report are administrative in nature. The Representative notes in particular the lack of progress in collecting standardized data, including Indigeneity. For the *Detained* report, the Ministry of Health informed the Representative that it believes Indigenous children and youth are disproportionately involuntarily detained but was unable to verify the extent of the disproportionality with data. For the purposes of this report, the Representative requested updated data (discussed below) from the Ministry of Health, including the Indigeneity of children and youth admitted under the *Mental Health Act*. That data is still not available. It is unacceptable that five years after the Human Rights Commissioner's report on the need for disaggregated data on Indigeneity[50] as well as the *Detained* report, the urging of the First Nations Leadership Council,[51] and the In Plain Sight report on racism and discrimination in the healthcare system, there is still no data identifying the numbers of First Nations, Métis, Inuit and urban Indigenous children and youth who are detained under the *Mental Health Act*.

[50] Office of the Human Rights Commissioner, *Disaggregated demographic data collection in British Columbia: The grandmother perspective*, September 29, 2020. Disaggregated demographic data collection in British Columbia: The grandmother perspective | BC's Office of the Human Rights Commissioner

[51] First Nations Leadership Council, January 19, 2021. *Treatment Over Detention: Immediate Changes Required Regarding the Use of Involuntary Detentions for Youth under the Mental Health Act.*

Hospitalizations and Involuntary Detentions

Children and youth may be admitted to a designated mental health facility on a voluntary or involuntary basis. There are, in effect, two statutory regimes governing hospitalization of children and youth, one for those who are 16 years or older and the other for children under 16 years of age.

For youth who are 16 years or older, the rules for voluntary and involuntary admission are the same as they are for adults:

- **Voluntary admission**: A person aged 16 years or older may be voluntarily admitted to a mental health facility if they request admission and the director is satisfied that the person has been examined by a physician or nurse practitioner who is of the opinion that the person has a mental disorder.[52] A "voluntary" patient who is 16 or older must be discharged at the patient's request.[53]

- **Involuntary admission**: A person aged 16 years or older may be involuntarily admitted to a mental health facility if a physician or nurse practitioner who has examined the person issues a medical certificate certifying that the person:
  - has a mental disorder,
  - requires treatment in or through a designated facility,
  - requires care to prevent the person's mental or physical deterioration or for the protection of the person or others, and
  - cannot suitably be admitted as a voluntary patient.[54]

If a person, including a child, is involuntarily detained, treatment authorized by the director is deemed to be given with the consent of the patient.[55] This means that treatment, such as medications, may be administered to involuntary patients without assessing a patient's capacity to make their own treatment decisions and without consulting a substitute decision-maker. BC is only province in the country with such "deemed consent" provisions, which is a matter that is currently subject to a challenge before the BC Supreme Court on the grounds that these provisions infringe on liberty rights under the Canadian Charter of Rights and Freedoms.[56]

Bill 32 – the *Mental Health Amendment Act* (No.2), 2025 – was passed in the Legislative Assembly on December 2, 2025, in response to the pending court decision and is expected to be brought into force in the near future. Although these amendments repeal the deemed consent provisions and offer healthcare workers greater protection against liability in administering mental healthcare, they do not make any significant changes to the healthcare consent rights of involuntarily detained persons[57].

[52] A "Person with a mental disorder" is defined in section 1 *Mental Health Act* as "a person who has a disorder of the mind that requires treatment, and seriously impairs the person's ability to (a) react appropriately to the person's environment or (b) associate with others."
[53] Section 20 *Mental Health Act*
[54] Section 22 *Mental Health Act*
[55] Section 31 *Mental Health Act.* The deemed consent provisions also apply to persons who are discharged from hospital to the community on "extended leave", which is a form of release with stipulated conditions that are enforceable by requiring return to a designated mental health facility..
[56] Health Justice, May 27, 2025.*Charter challenge to deemed consent in BC: What does this mean?* Charter challenge to deemed consent in BC: Health Justice's intervention — Health Justice
[57] Health Justice, New *Mental health act* amendments: What you need to know, December 3, 2025. https://www.healthjustice.ca/blog

The only substantive provision of the *Mental Health Act* that differentiates children and youth from adults relates to voluntary admissions. Under section 20, a child under the age of 16 years who is assessed as having a mental disorder may be admitted to a mental health facility at the request of their parent or guardian as a "voluntary" patient, without the child's consent.[58] These provisions are starkly described in a revised form, which was recently authorized by Order-in-Council and was brought into force on December 3, 2025, notifying children under 16 years who are "voluntarily" admitted to a mental health facility of their rights:

FORM 14

NOTIFICATION TO PATIENT UNDER AGE 16, ADMITTED BY PARENT OR GUARDIAN, OF RIGHTS UNDER THE MENTAL HEALTH ACT.

REASONS FOR ADMISSION

You were admitted at the request of your parent or guardian and a medical doctor who examined you is of the opinion that

(a) you are a person with a mental disorder that seriously impairs your ability to react appropriately to your environment or associate with other people, and

(b) you require psychiatric treatment in a designated facility.

You do not have a choice about staying here. The staff may give you medication or other treatment, to which your parent or guardian has consented, for your mental disorder even if you do not want to take it.[59] (emphasis added)

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 criteria for admission of children under 16 years described above are far less stringent than the four criteria described earlier for involuntary detention.
- Detention of an involuntary patient beyond 48 hours requires a second medical certificate[60] 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[61] whereas the similar period for children

[58] If a parent or guardian does not consent to "voluntary" admission under section 20, a child under 16 years can still be involuntarily detained by applying the involuntary committal provisions of section 22 described above.

[59] BC Reg 456/2025; effective December 3, 2025. Order in Council 456/2025. It is accurate to say that these children do not have a choice about staying in hospital. It may be an over-statement, however, to suggest that all children admitted under section 20 may be required to take medication that their parent has consented to. The "deemed consent" provisions of section 31 of the *Mental Health Act* do not apply to children admitted under section 20 and in absence of any other provision addressing consent to treatment by this young age group, the provisions of the *Infants Act* governing the capacity of children to consent to healthcare should apply. Form 14.1 , which set out rights, including private access to a rights advisor, is also provided .

[60] Section 22(2) *Mental Health Act*.

[61] Section 24 *Mental Health Act*.

under 16 years is longer (two months).[62]

The absence of a requirement for a second medical certificate to authorize detention beyond 48 hours as well as the lack of an option to request a second medical opinion means that the only recourse for a child under 16 years admitted under section 20 is application for a hearing before the review board, which must be held within 14 days. This means that there is, in effect, no recourse for the first two weeks of detention and the recourse that is available through the review board is, as noted earlier, rarely exercised.

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.[63] 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*. In the Representative's view, these anachronistic provisions must be amended and brought into the 21st century. This is not to suggest that involuntary detention under the *Mental Health Act* should not be used for children under 16, which is obviously necessary in some circumstances. Those circumstances should, however, be conditioned by the principles set out in the UNCRC, the mature minor doctrine, and criteria that clearly set out appropriate grounds for involuntary detention, with appropriate safeguards to limit use to cases where involuntary detention is the only appropriate option and with timely and supported recourse to reviews of detention status.

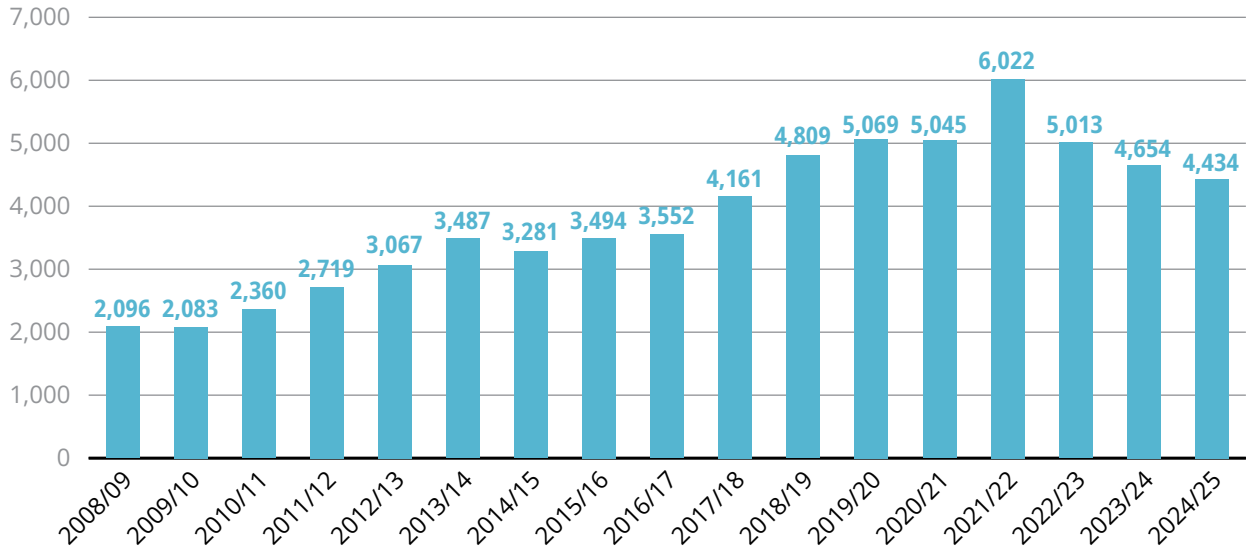
Figure 1 describes the total number of hospitalizations[64] under the *Mental Health Act* of children and youth between 2008/09 to 2024/25. These data include voluntary and involuntary hospitalizations combined. About one-half (52%) of the total hospitalizations involved children under 16 years; more than one in ten (11%) involved children under 12 years. There is a seemingly anomalous peak in hospitalizations in 2020/21 (a COVID year) and some decrease in the past two years. Otherwise, Figure 1 indicates that 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.

[62] Section 22(2*) Mental Health Act.*

[63] See section 21 *Mental Health Act*, which states that review panel proceedings apply to persons voluntarily admitted under section 20 " as though the patient had been admitted under section 22", which are the provisions for involuntary detention.

[64] These are hospitalizations, based on discharges during the course of a fiscal year. Note that the same unique individual may be admitted and discharged during the course of a year. Data does not include admissions to two MCFD -operated mental health facilities – the Maples Adolescent Treatment Centre ("Maples") and the Youth Forensic Psychiatric Services Inpatient Assessment Unit ("IAU"). Youth are admitted to IAU though the Youth Criminal Justice Act, whereas Maples is referral treatment centre that accepts voluntary admissions, with few exceptions.

Figure 1 Youth Mental Health Hospitalizations by Fiscal Year

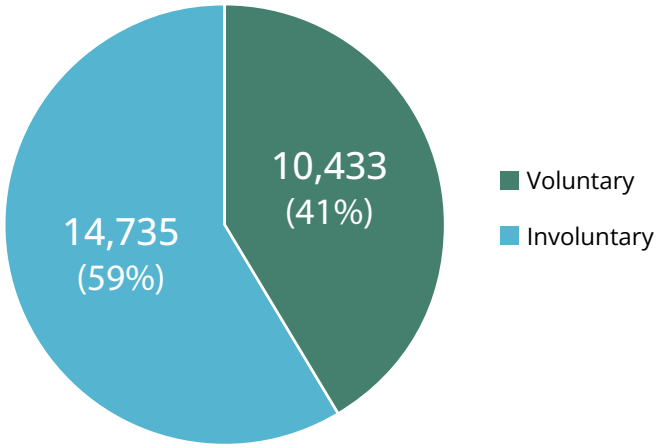


Source: BC Ministry of Health
"Youth" includes all patients under the age of nineteen years.

Turning to the critical issue of involuntary hospitalizations under the *Mental Health Act*, as noted, the *Detained* report described an alarming increase – 162% – in involuntary detentions between 2008/09 and 2017/18. This was a far greater rate of increase than the increase in voluntary hospitalizations of children and youth (+44%) and the increase in involuntary hospitalizations of adults (+57%) during the same period. 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.

Figure 2 describes the total number of voluntary and involuntary hospitalizations of children and youth in the past five years. Involuntary hospitalizations comprised the substantive majority (59%) of hospitalizations during that five-year period, which averaged 2947 involuntary hospitalizations per year. 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.

Figure 2 Voluntary and Involuntary Youth Mental Health Hospitalizations FY2020/21 to 2024/25 Totals



Source: BC Ministry of Health
"Youth" includes all patients under the age of 19 years.

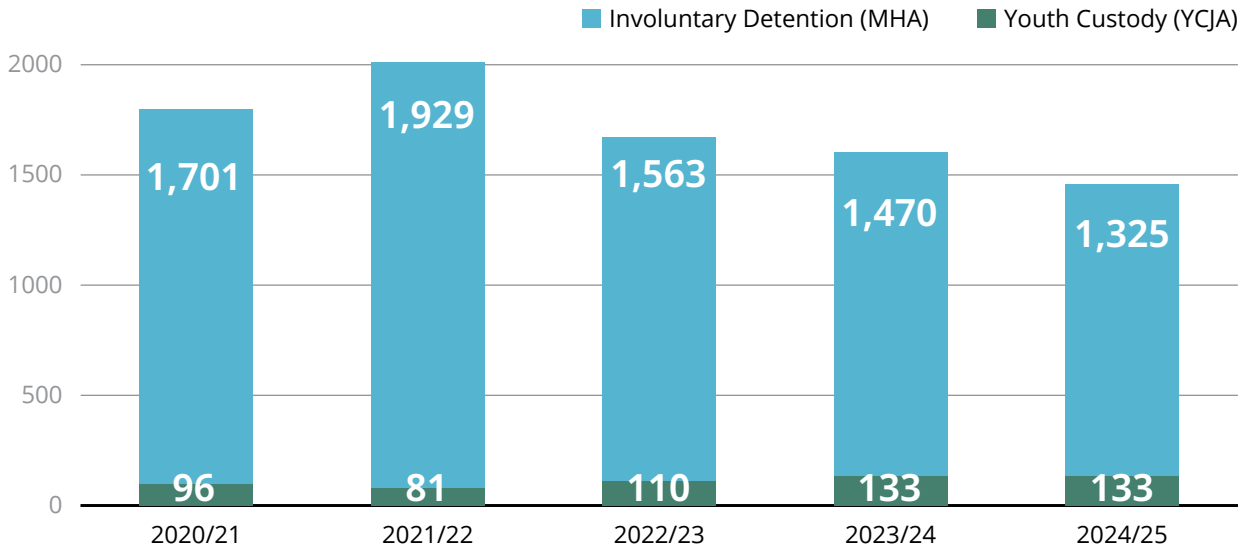
Involuntary detention under the *Mental Health Act* is perhaps the most intrusive measure the state can impose on an individual insofar as it deprives the person of their liberty, deprives the involuntary patient of the right to refuse treatment, and can lead to the use of restraints and seclusion in some circumstances while in detention. The only other legislative means of depriving young people of their liberty in BC is through the criminal justice system, specifically the federal *Youth Criminal Justice Act* (YCJA), which can result in a young person being committed to pretrial detention or sentenced to custody.[65] This raises a question about how these two legislative instruments for the deprivation of liberty of young people compare with respect to frequency of use. These data are available and presented in Figure 3, which compares the number of unique youth who have been involuntarily detained under the *Mental Health Act* to the number of unique youth who were committed to (pretrial or sentenced) custody under the YCJA in BC in each of the past five years. A unique youth is an individual youth who was admitted to mental health detention or to youth custody at least once during the year.[66] Since the age jurisdiction of the federal YCJA (12 to 17 years[67]) is different from the age jurisdiction of the provincial *Mental Health Act* (under age 19), children under the age of 12 and 18-year-olds have been removed from the mental health involuntary detention data, to make the two populations comparable in age groupings.

[65] S.C. 2002, c. 1. This is federal legislation that is administered by provinces, and has jurisdiction over a young person between the age of 12 and 17 years who is alleged to have committed or been found guilty of a Criminal Code or other federal statute offence In theory, a young person could also be committed to youth custody under the provincial *Youth Justice Act* (SBC 2003, Chapter 85), which has jurisdiction over provincial statute offences such as driving infractions, however, custody committals under that legislation do not occur in practice.

[66] Some youth from both population groups were admitted more than once during the year, however, they are only counted as one unique youth.

[67] Due to delays associated with police investigations and court processes, there are some youth over the age of 17 who are admitted to youth custody, however, as a matter of law they must have committed the alleged offence while under the age of 18.

Figure 3 Unique Youth (12-17) Involuntarily Detained (MHA) and Admitted to Youth Custody (YCJA) FY 2020/21 to 2024/25



As Figure 3 illustrates, the number of unique youth (12 to 17 years old) involuntarily detained under the *Mental Health Act* dwarfs the number committed to custody in every year. Throughout the entire five-year period, the total number of unique youth involuntarily detained under *the Mental Health Act* was fourteen (14.4) times the number committed to youth custody under the YCJA. Again, it should be noted that the number of youth who are truly involuntarily detained under the *Mental Health Act* is likely under-stated in these comparisons, given that admissions of youth under the age of 16 years under section 20 of the *Mental Health Act* are considered "voluntary" admissions. In short, the *Mental Health Act* is, by far, the principal mechanism for the deprivation of the liberty of children and youth in the province.

Locking Up Young People: A Comparison of Two Statutes

The fact that the *Mental Health Act* is, overwhelmingly, the primary legislative instrument for the deprivation of liberty of children and youth raises the question about how well that statute accords with the principles and safeguards set out in international human rights instruments respecting children and youth. The appended report by the Society for Children and Youth assesses how BC's mental health system aligns with the relevant requirements of the UNCRC as well as other international treaties, rules and guidelines such as the *United Nations Convention on the Rights of Persons with Disabilities*, the *United Nations Convention on the Rights of Indigenous Peoples*, the *United Nations Rules for the Protection of Juveniles Deprived of their Liberty, the International Covenant on Civil and Political Rights* and World Health Organization guidance. That analysis will not be repeated here but regarding summary the report concludes that BC's mental health system for children and youth, " … operates in discordance with international treaties, notably the UNCRC, and other fundamental principles of justice and administrative law."[68] The report further states:

> In summary, this paper underscores the urgent need for a comprehensive reevaluation and reform of the current mental health framework in British Columbia, emphasizing the importance of aligning with international standards and safeguarding the rights and well-being of the children and youth it affects.[69]

Moving beyond the international sphere, the comparison of rates of utilization of involuntary detentions of young people under the *Mental Health Act* and custody committals under the YCJA also invites a comparison of the key features, including the recognition of rights and safeguards for young people, in these two domestic statutes. Like the disparate rates of utilizations, the contrasts between two statutes are stark, the highlights of which are briefly described below:

Youth Specific:

The YCJA is separate legislation that is solely applicable to youth (12 to 17 years), establishing principles, criteria and procedures that are distinct from the adult system. In contrast, under the *Mental Health Act* young people are subject to the same criteria and processes as adults with the sole substantive exception of section 20 "voluntary" admissions of children under 16 to hospital with the consent of the parent.

Moreover, there are requirements in law to separate youth from adults in youth-specific pretrial detention and sentenced custody facilities,[70] which is not a requirement under the *Mental Health Act*. Children and youth are administratively separated from adults only in locations where there are child and youth specific designated facilities.[71]

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[68] *Supra*, note 31, p.39
[69] *Ibid.*
[70] Sections 30(3) and 84 YCJA.
[71] There are designated facilities at BC Children's Hospital in Vancouver, the Maples Adolescent Treatment Centre in Burnaby (operated by MCFD), Queen Alexandra Hospital in Victoria and specialized psychiatric units in Surrey, Kelowna and Prince George.

Recognition of Rights

The YCJA contains both a Preamble and a Declaration of Principle that applies throughout the Act. The Preamble to the YCJA expressly states:

> WHEREAS Canada is a party to the United Nations Convention on the Rights of the Child and recognizes that young persons have rights and freedoms, including those stated in the *Canadian Charter of Rights and Freedoms* and the *Canadian Bill of Rights*, and have special guarantees of their rights and freedoms[72] (emphasis added)

Further, the Declaration of Principle states the system must emphasize:

> … enhanced procedural protection to ensure that young persons are treated fairly and that their rights, including their right to privacy, are protected.[73] (emphasis added)

In contrast, the *Mental Health Act* does not similarly recognize the rights of young persons, nor provide special guarantees of rights and procedural protections in recognition of their state of development and maturity.

Agency and Participation

The YCJA states:

> young persons have rights and freedoms in their own right, such as a right to be heard in the course of and to participate in the processes, other than the decision to prosecute, that lead to decisions that affect them, and young persons have special guarantees of their rights and freedoms …[74]

In contrast to the *Mental Health Act*, the YCJA statutorily deems a young person to be capable of making their own decisions, independent of their parent or guardian. As examples, a 12-year-old can instruct counsel, enter a plea or apply for reviews of their sentences, independent of their parent or guardian.

Representation by Counsel

The YCJA guarantees in law the provision of publicly funded counsel at any stage of proceedings,[75] whereas publicly funded counsel is only provided in mental health proceedings if a young person is before the Mental Health Review Board, which, as noted earlier, is very infrequently accessed.

Consent to Treatment

In contrast to the "deemed consent" provisions of the *Mental Health Act* respecting consent to treatment and section 20 "voluntary" admissions to hospital of children under 16 years, the YCJA provides that in respect of sentences imposed on a young person, "…. nothing …. abrogates or derogates from the rights of a young person regarding consent to physical or mental healthcare"[76]

[72] YCJA, Preamble
[73] Section 3(1)(b)(iii) YCJA
[74] Section 3(1)(d)(i) YCJA
[75] Section 25 YCJA
[76] Section 42(8) YCJA

Principles of Minimum Intervention

The YCJA incorporates the principles of minimal intervention and the use of custody only as a last resort by establishing strict legislative criteria limiting the use of pretrial detention and sentenced custody,[77] while also providing that the court "shall not impose a custodial sentence .... unless the court has considered all alternatives to custody raised at the sentencing hearing that are reasonable in the circumstances, and determined that there is not a reasonable alternative"[78]

In contrast, the *Mental Health Act* is silent with respect to the use of involuntary detention as a last resort.

Community-Based Measures

The YCJA sets out a variety of non-custodial, community based options and promotes their use as alternatives to custody. In contrast, the *Mental Health Act* is almost entirely focused on hospitalization and is silent with regard to community based measures, with the exception of extended leave, which is a conditional release to community, or transfer to an approved home, which are only available to persons after they have been involuntarily detained.[79]

Role Of Parents

Although a young person is deemed to be capable of making decisions independent of their parent or guardian, the YCJA's Declaration of Principle states that, " ... parents should be informed of measures or proceedings involving their children and encouraged to support them." The Act further defines the role of a parent in respect of receiving notices, reports, and having the opportunity to participate in proceedings such as sentencing and review. In contrast, the *Mental Health Act* only speaks to the role of parents/guardians in respect of consenting to "voluntary" admissions under section 20, payments for care (section 11) and advice to "near relatives" (section 34.2), which includes a parent.

Seclusion and Restraint

Section 32 of the *Mental Health Act* provides that patients, including children and youth, who are detained, are subject to the "direction and discipline of the director and members of the staff of the designated facility", but is otherwise silent in defining and limiting the circumstances under which the most extreme forms of discipline and control can be exercised, i.e., the use of physical restraints and seclusion rooms. While there are administrative standards and guidelines for the use of seclusion, those standards do not, for example, do not specify a maximum limit on the duration of seclusion. In contrast, the *Youth Custody Regulation*, which has the force of law, provides a statutory right of review of disciplinary consequences, including hearing the views of the youth, defines and limits the use of physical restraints, and defines and limits, including duration, the use of seclusion (known as separate confinement).[80]

[77] See section 29(2) YCJA in respect of pretrial detention and section 39(1) in respect of sentencing to custody.

[78] Section 39(2) YCJA. Section 38(2)(d) YCJA also states "all available sanctions other than custody that are reasonable in the circumstances should be considered for all young persons, with particular attention to the circumstances of aboriginal young persons", while section 38(2)(e) requires the court to consider the "least restrictive sentence".

[79] See, sections 37 and 38 *Mental Health Act*.

[80] *Youth Custody Regulation*, BC Reg. 137/2005. Sections 12.1, 15 and 15.1. While statutory requirements may provide greater definition and assurances of compliance, it does not guarantee compliance. See, for example, a report by the Office of the Ombudsperson on misuses of separate confinement in BC youth custody centres, *Alone: The Prolonged and Repeated Isolation of Youth in Custody*, June 15, 2021. The regulations set a maximum cumulative limit of 72 hours, albeit that maximum may be extended with the approval of the Provincial Director.

The youth justice system affords youth specialized and distinct legislation with special guarantees of rights and enhanced procedural protections precisely because of their state of development and greater vulnerability than adults, and because their liberty is at risk. Yet the mental health system detains children and youth in vastly greater numbers without similar special legislation, guarantees and enhanced procedural protections. In fact, the converse is the case: under the *Mental Health Act*, youth who are 16 years or older are subject to the same provisions as adults, whereas children under the age of 16 actually have fewer rights and procedural safeguards than older persons.

The summary comparison of the two statutes described above illustrates how inadequate the Mental *Health Act* is with respect to addressing the unique needs, circumstances and rights of children and youth, and how anachronistic that legislation is, given that the YCJA was introduced into the Canadian Parliament nearly a quarter-century ago.[81] These comparisons should not be taken to suggest that the specific provisions of a (largely) judicial decision-making process can be transposed onto an administrative decision-making process like mental health proceedings, however, the relevant principles, rights and enhanced procedural protections certainly could and should be included in reformed and modernized mental health legislation for children and youth.

[81] The YCJA was introduced into Parliament as Bill C-7 in February, 2001 and brought into force on April 1, 2003.

Expanding Involuntary Care

Reform and modernization of the *Mental Health Act* will inevitably include consideration of broadening the criteria for involuntary care of both adults and youth, principally as a response to the tragic outcomes of the toxic drug crisis. While the declaration of the overdose crisis as a public health emergency is nearly a decade old, the debate about a broader legislative capacity – either by way of separate legislation or changes to the *Mental Health Act* – to protect and treat children from harms such as addiction and sexual exploitation through "secure care" or "safe care" has been a recurring and controversial theme for decades, at least since the Report of the Secure Care Working Group in 1998.[82]

In more recent years, government introduced the *Mental Health Amendment Act*[83] in 2020, which provided for involuntary "stabilization care" for young people under 19 years who had experienced substance use overdoses but this proposed legislation was withdrawn in the face of opposition from a variety of fronts, such as the Union of BC Indian Chiefs, BC Civil Liberties Association, Health Justice, RCY[84] and others.

In September 2024, government committed to making changes to the law in the next legislative session "to provide clarity and ensure people, including youth, can and should receive care when they are unable to seek it themselves".[85] The next legislative session began in February 2025 but the proposed legislative changes have yet to be introduced.

The recently released guidance by Dr. Vigo for physicians on the treatment of children and youth with substance disorder under the *Mental health act* is clearly intended to administratively broaden the use of involuntary detention and parent-authorized involuntary committals of children under 16 years under the current provisions of the legislation, without need for resort to amendments.[86]

In light of the likelihood that these guidelines will lead to expanded use of involuntary care of young people, or amendments promised by the Premier that may further promote greater use of involuntary care, it is necessary for the Representative to re-state and expand upon her position on this matter, which was initially set out in a statement in 2020 outlining significant concerns about the proposed *Mental Health Amendment Act.*[87]

To be clear, the Representative is not opposed to involuntary care of youth under the *Mental Heath Act*, which is obviously necessary in the right circumstances and under the right conditions, nor is she opposed to clarifying the grounds for involuntary care of youth in appropriate cases of concurrent mental health and substance use where there is imminent

[82] Secure Care Working Group (1998). *Report of the Secure Care Working Group*. BC: Minister of Children and Families. A brief history (up to 2019) by the British Columbia Law Institute describing legislative proposals for safe care in BC can be found at https://www.bcli.org/analysis-of-the-bc-safe-care-act-bill/. The *Secure Care Act* [SBC 2000, Chapter 28) received Royal Assent on July 6, 2000, but was never brought into force.

[83] BILL 22 – 2020, *Mental Health Amendment Act,* 2020 Legislative Session: 5th Session, 41st Parliament First Reading.

[84] See, Media Advisory of Press Conference: Bill 22 Stands to Increase the Opioid Crisis and Youth Deaths; Bill 22 Must be Withdrawn - UBCIC

[85] *Supra*, note 5

[86] *Supra*, note 4.

[87] Representative for Children and Youth, *Representative's Statement in response to government's proposed changes to the Mental Health Act*, June 23, 2020. Representative's Statement in response to government's proposed changes to the *Mental health act* | Office of the Representative for Children and Youth - RCYBC

and serious risk to the health and safety of young people and there is no other less intrusive means for effectively addressing that serious risk of harm.

In the Representative's view, however, expanding the scope of authority to detain youth under the *Mental Health Act*, whether administratively or through future legislative amendments, should only occur if four over-arching conditions are met, including:

A Robust and Accessible System of Voluntary Services

A robust and accessible system of voluntary, culturally appropriate, trauma-informed and evidence-based community -based treatment services must be the cornerstone of a system that incorporates involuntary care at the far end of the spectrum of care. A robust system with timely access is essential so that resort to involuntary care can be minimized rather than becoming the only available (and expensive) default mechanism in the absence of other alternatives, thereby avoiding or minimizing the potential anger, loss of trust and diminished likelihood of seeking help in future that can arise from forced treatment. Importantly, it is critical that a robust system of community-based supports for young people who are discharged from involuntary care be in place so they are well supported in their recovery, that gains made during treatment are not lost, or worse still, greater harms do not arise. In the latter regard, research has indicated that in some cases, involuntary treatment of persons with substance use disorders has been linked to negative health outcomes, such as increased risk of overdose or death post discharge.[88]

This begs the question: is there a robust and accessible array of community-based mental health services for children and youth currently in place in BC? Hardly so. Since the release in 2019 of government's ten-year plan for systemic enhancements to the mental health and substance use service system – known as *A Pathway to Hope*[89] – some strides have been taken to improve services to children and youth, especially with respect to Foundry programs[90] and school-based Integrated Child and Youth (ICY)[91] teams. Foundry centres and ICY teams are both integrated, multi-disciplinary services created to address gaps in the mental health and service system for children and youth, especially for cases of mild-to-moderate acuity that were previously unable to be well served. Foundry centres offer services to young people aged 12-24 and their families while ICY teams are based in school districts and serve children from 0 to 19 years. Foundry and ICY services are welcome steps forward, however, they are not systemically available.[92] At present, there are 19 active Foundry centres across the province, a virtual service, and announced plans to expand to a total of 35 service centres,[93] whereas there are active ICY teams in less than one-third (18 out of 60) of the province's school districts, noting that not all communities within those 18 school districts are served, two additional teams in the early phase of implementation.[94]

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[88] Canadian Centre on Substance Use and Addictions, *Evidence Brief: Involuntary Treatment for Severe Substance Use*, January, 2025. https://www.ccsa.ca/sites/default/files/2025-02/Involuntary-Treatment-Evidence-Brief-en.pdf

[89] June 25, 2019, BC Ministry of Mental Health and Addictions, *A Pathway to Hope: A roadmap for making mental health and addictions care better for people in British Columbia.* June 25, 2019.

[90] See, https://foundrybc.ca/about-foundry-services/

[91] See, BC Ministry of Health, *BC's Integrated Child & Youth Teams, Last updated on June 5, 2025. BC's Integrated Child & Youth Teams - Province of British Columbia*. Even in the largest urban centres, there are no ICY's in Vancouver and Victoria and one team planned for Surrey.

[92] See, https://foundrybc.ca/about-foundry-services/

[93] Ministry of Mental Health and Addictions, *Youth benefit from significant increase in mental-health, addiction care.* Updated March 4, 2024, https://news.gov.bc.ca/releases/2024MMHA0009-000280

[94] *Supra*, note 92. Supplementary information provided by MCFD, December 10, 2025.

Child and Youth Mental Health (CYMH) services, which principally involves community-based outpatient mental health services that are operated and/or funded by MCFD, are systemically available across the province. MCFD data indicates that there are large numbers of children and youth who are wait-listed for services, and for considerable periods. On December 31, 2024, there were 1,771 children and youth across the province who were wait-listed for CYMH services, with an average waitlist duration of more than four months (130 days). In the Northern region, the average waitlist duration was more than six months (194 days). Moreover, the average wait time across the province for the highest priority cases – described as "moderate risk of harm to self or others and-or high levels of distress, complexity and functional impact" – was more than three months (94 days). The average wait-time for these highest priority cases on Vancouver Island was more than seven months (219 days). Moreover, the average wait time to a first CYMH service in 2024/25 was slightly longer than in 2017/18, i.e., before the advent of *A Pathway to Hope*.[95]

Another critical service is "step up/step down" resources, which are staffed community residential resources[96] with appropriate clinical supports that can be an alternative to hospitalization in the first place or, importantly, can offer intensive support to transition from hospital to the community. The inadequacies – indeed, near absence – of dedicated mental health step up/step down community residential resources for youth has been the subject of reports, recommendations and plans in BC for more than twenty years,[97] with minimal to no progress during that time. A commitment to the establishment of step up/step down beds was made in government's plan, *A Pathway to Hope*, in 2019 and re-iterated with an investment of $13.4 million in the 2021 BC budget,[98] but there has been little follow through with the establishment of dedicated and readily available staffed residential resources.[99] It is noted that through RCY's individual advocacy function RCY Advocates routinely deal with cases of young people in hospital who are either held back in hospital due to a lack of appropriate placements or discharged to an inadequate community placement, an ongoing concern that has been underscored by recent discussions with representatives from BC Children's Hospital who describe children and youth, including those with mental health and complex needs, languishing in hospital due to a lack of community placements.

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[95] Data derived from MCFD Estimates Notes. The average number of days to first CYMH service in 2017/18 was 59.2 days compared to 59.8 days in 2024/25 (to December 31); the average number of days in the four years preceding 2024/25 were also greater.

[96] It is recognized that intensive non-residential services such as Assertive Community Treatment (ACT) teams and day programs can also be construed as a part of a continuum of step up/step down resources, however, the focus here is on community residential services.

[97] Examples of gaps in the availability of community residential step up/step down resources and recommendations or plans for improvement can be found in:
- Ministry of Children and Family Development*, Child and Youth Mental Health Plan for British Columbia*, February 2003
- A. Berland, *Promises Kept, Miles to Go: A Review of Child and Youth Mental Health Services in BC.,* Ministry of Children and Family Development, 2008
- Ministry of Health and Ministry of Children and Family Development, *Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use in British Columbia*, 2010
- The Federation of Community Social Services of BC and the Ministry of Children and Family Development, *Residential Review Project: Final Report*, 2012
- Representative for Children and Youth, *Missing Pieces: Joshua's Story*, 2017

[98] See, BC Ministry of Mental Health and Addictions, *A Pathway to Hope Progress Report*, August 2021

[99] MCFD reports that the Maples Adolescent Treatment Centre has established some short term, step up/ step down live-in treatment services with severe and enduring mental health needs. Up to five bed satellite services were established in Prince George and Vernon in 2024, serving 29 youth between November 29, 2024 and November 29, 2025. These services are obviously not systemically available. For context, there were 4434 hospitalizations of children and youth in 2024/25 in health authorities, excluding admissions to the Maples.

In recent years, the Representative has also documented in detail the inadequacies of mental health assessment and treatment services for highly vulnerable sub-populations of children and youth, specifically children in care[100] (2022), children and youth with neurodevelopmental conditions[101] (2023). and gender diverse youth[102] (2023). Little to no progress has been made in improving the service shortfalls and better addressing the needs of these highly vulnerable young people since release of those reports.

It is also noted that the ten-bed Carlisle Centre in North Vancouver for 13- to 18-year-olds, which was the only dedicated tertiary care treatment program in the province for adolescents with concurrent mental health and substance use disorders, was permanently closed in 2024 due to medical staff shortages.[103]

Enhanced Procedural Safeguards

This report, and the accompanying report by the SCY, have detailed the many shortcomings of the *Mental Health Act* in protecting the rights of children and youth, including insufficient procedural safeguards to ensure that the involuntary committal and deprivation of liberty of children and youth is limited to cases where it is necessary and for the shortest duration possible, with effective recourse to challenge detention decisions. If consideration is to be given to expanding or clarifying the criteria for involuntary detention of children and youth, or to undertake a wholesale modernization of the legislation, it is essential that much stronger safeguards be included, such as:

- Recognize and support the right of children and youth to participate in decisions affecting them and to be heard.
- Limit section 20 admissions by way of parental consent (without the consent of the child) only to circumstances where a child does not have the capacity to consent in accordance with the *Infants Act* and, similarly, to consent to treatment after admission, with advocacy and system navigation supports in place to better support the exercise of those rights.
- Establish criteria for involuntary detention that are no less stringent than the criteria for adults, incorporating the principles of least intrusive measures, for the shortest duration necessary, and requirements to consider all available alternatives.
- Require that detention can be extended beyond 48 hours only on the basis of a second medical opinion.
- Provide for automatic and immediate scheduling of access to the independent rights advice service upon admission.
- Provide for automatic scheduling and early hearings before the review board, with a statutory guarantee of publicly funded counsel, and periodic, automatically scheduled hearings thereafter.

[100] Representative for Children and Youth, A Parent's Responsibility: Government's obligation to improve the mental health outcomes of children in care, September 2022. https://rcybc.ca/wp-content/uploads/2022/09/RCY-ParentsResponsibility-Sept2002.pdf

[101] Representative for Children and Youth, Toward Inclusion: The need to improve access to mental health services for children and youth with neurodevelopmental conditions, April 2023. https://rcybc.ca/reports-and-publications/reports/toward-inclusion-the-need-to-improve-access-to-mental-health-services-for-children-and-youth-with-developmental-conditions/

[102] Representative for Children and Youth, The Right to Thrive: An Urgent Call to Recognize, Respect and Nurture Two Spirit, Trans, Non-Binary and other Gender Diverse Children and Youth, June 2023. https://rcybc.ca/reports-and-publications/right-to-thrive/

[103] Vancouver Sun, *During a toxic drug crisis, health authority is closing unique facility for Vancouver area youth with addictions,* February 15, 2024. https://vancouversun.com/health/exclusive-during-a-toxic-drug-crisis-this-unique-lifeline-for-youth-with-addictions-is-closing

- Narrowly define and limit the use of restraints and seclusion to circumstances where it is necessary for the prevention of serious and imminent harm, and the duration of the same, with appropriate review, oversight and reporting.

Indigenous Consultation and Support

Sadly, the legacy of colonization and residential schools has resulted in the most coercive powers of the state being applied to Indigenous children and youth to a vastly disproportionate degree.

An Indigenous child is about 19 times more likely to be brought into care than a non-Indigenous child.[104] Even though Indigenous youth comprise less than ten per cent of the general population, about one-half of the youth custody population is Indigenous.[105] Unfortunately, similar data is not available with respect to involuntary mental health hospitalizations but, as noted, the Ministry of Health has previously acknowledged probable disproportionality.

A broadening of the scope of authority to involuntarily detain under the *Mental Health Act* will undoubtedly have an outsized impact on Indigenous children and youth, and their families and communities.

The *Declaration on the Rights of Indigenous Peoples Act* requires the province, in consultation and cooperation with the Indigenous peoples in British Columbia, to take all measures necessary to ensure the laws of British Columbia are consistent with the *United Nations Declaration on the Rights of Indigenous Peoples (*UNDRIP*).*[106] It is noted that UNDRIP provides that all Indigenous

[104] Ministry of Children and Family Development, *2025/26 – 2027/28 Service Plan*, March 2025.
[105] Data provided by MCFD, October 24, 2025.
[106] SBC (2019] CHAPTER 44, section 3.

individuals have the right to the full enjoyment of all human rights and fundamental freedoms recognized in international human rights law, which would include the UNCRC, to which Canada is a signatory.

A Commitment to Research and Evaluation

As noted earlier, the *Detained* report documented a remarkable increase in involuntary hospitalizations of children and youth while as described earlier, total hospitalizations and involuntary detentions have remained at high levels in the ensuing years. Although the *Detained* report recommended that the Ministry of Health take steps to identify the conditions contributing to that increased use, that work has not been done. Involuntary detention of children and youth under the *Mental Health Act* is, overwhelmingly, the principal legislative instrument that deprives children and youth of their liberty, yet we know little – beyond simple frequency measures and some demographics – about, for example: how it is being used, why there have been changes in use, amongst which types of demographic and clinical sub-populations it is being used, where detained young people go after discharge, and what the outcomes are, including in particular, for involuntarily detained children and youth who have a substance use disorder. In the Representative's view, expansion of the use of involuntary detention requires much further research and evaluation.

It is noted that there is limited evidence on the effectiveness of involuntary treatment of persons with severe substance use disorders; most studies lack scientific rigour and most do not show significant improvement in reducing substance use.[107] If the state is going to deprive individuals of their liberty and commit considerable resources to involuntary detention, it is vital that we determine whether those measures are effective. As well, it is critical that there be ongoing monitoring and evaluation of the application and exercise of procedural safeguards to ensure that such intrusive measures are being fairly and appropriately applied.

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. The Representative has taken active administrative steps for the past eight years to promote reporting which, unacceptably, have resulted in little progress.

[107] *Supra*, note 86.

Concluding Remarks and Recommendations

The Representative fully agrees with the SCY's conclusions that the provisions of the *Mental Health Act* for children and youth are deeply flawed and fail to accord with Canada's obligations under the UNCRC and other international treaties, and simple procedural fairness. Due to their state of development and greater vulnerability, children and youth need greater procedural protections than adults but they currently actually have fewer protections, which in turn are inadequate for adults in the mental health system. We can and must do better.

The proposed review and modernization of the *Mental Health Act* presents an opportunity for British Columbia to move from being a laggard to a leader by either creating a separate *Mental Health Act* for children and youth, or a separate and distinct part of modernized mental health legislation that addresses the rights, unique needs and circumstances of children and youth. While this report focuses on rights and procedural safeguards, which are obviously vital, there are other key elements that should be incorporated into modernized mental health legislation for children and youth. The current legislation is almost entirely focused on hospitalization and is silent about the role and function of mental health services writ large and the intersections of those services with other child- serving systems. New legislation needs to address key aspects of the system of services such as mental health promotion, prevention, early intervention, and voluntary community-based services. As well, the Representative's July 2024 report, *Don't Look Away – How one boy's story has the power to shift a system of care for children and youth,*[108] underscored the need for cross-ministry and cross-service collaboration and communication to better support social and cultural determinants of health, which should be reflected and supported in new legislation.

It is noted that government is currently engaged in planning to transfer the administration of community-based CYMH services from MCFD, a child and family focused ministry, to the Ministry of Health and health authorities.[109] While this prospective change may have benefits such as better integration and coordination of mental health services for children and youth with other health services, especially youth substance use services, and more seamless transition from youth to adult mental health services, there are risks that child and youth mental health services will be subsumed and subordinated in a much larger adult mental health and health service system, with CYMH services becoming more adultified in nature. Separate and distinct mental health legislation for children and youth may help to buffer that dynamic.

The Representative recommends:

> The Ministry of Health include in the terms of reference of the forthcoming review and modernization of the *Mental Health Act,* a requirement that legislative proposals be considered that would establish either stand-alone mental health legislation for children and youth or a separate and distinct part of a modernized *Mental Health Act* that addresses the rights, unique needs and circumstances of children and youth.

[108] Representative for Children and Youth, *Don't Look Away – How one boy's story has the power to shift a system of care for children and youth,* July 16, 2024. https://rcybc.ca/hfaq/dont-look-away/

[109] See, Mandate Letter, Honourable Jody Wickens, January 16, 2025. https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/premier-cabinet-mlas/minister-letter/mandate_letter_jodie_wickens.pdf. There is parallel instruction to the Minister of Health.

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