BRITISH COLUMBIA • UKRAINE

Canadian Psychiatry Today:

An Overview of Practice in British Columbia and a Dialogue with Ukrainian Experience

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For Dad, with respect for his profession,
his experience and enduring interest in medicine.

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Preface. A Conversation Between Colleagues Across the Ocean

A person experiences psychosis for the first time. An older woman becomes confused after an infection. A man with an addiction needs pain treatment while trying to keep his job. A family prepares for a loved one's discharge. In each situation, the clinical decision continues beyond the consulting room: in the pharmacy, at home and at the next appointment.

British Columbia brings together Vancouver's university centres, regional hospitals and remote communities. Ukrainian psychiatry has its own network of clinical schools and institutions, from Kharkiv and Kyiv to Lviv, Odesa, Vinnytsia, Poltava, Bukovyna, Kherson, Donbas and Crimea. Their history records the search for ways to treat, teach and sustain a person's life beyond an acute episode.

If a patient from Vancouver received treatment in Ukraine, who would provide follow-up? If a Ukrainian family found itself in BC, which new services would enter its daily routine? A change in the setting of care brings familiar professional questions into view: the course of illness, physical health, relationships, independence and continuity of treatment.

The discussion begins with the organization and everyday practice of psychiatry in British Columbia. Fifteen hypothetical clinical cases then follow patients from their first contact to years of living with treatment, alongside an account of a psychiatrist's work in court. The Ukrainian section traces hospital and scientific traditions, contemporary reform and care during Russia's war against Ukraine. Comparisons of the two systems and clinical situations for mutual learning complete the conversation.

1. British Columbia: Who Organizes Care

Province, region and clinical team

Psychiatric care in British Columbia is organized at the provincial level. The Ministry of Health sets policy, budgets and accountability requirements. Five regional health authorities operate hospitals and much of the outpatient, outreach and community service network. The Provincial Health Services Authority, or PHSA, provides specialized services for the entire province, including forensic psychiatric care and treatment for particularly complex concurrent mental health and substance use disorders. The First Nations Health Authority, or FNHA, develops services for First Nations in partnership with communities and other organizations. [1]

Organization	Service area and place in the system
Vancouver Coastal Health	Vancouver, Richmond, the North Shore and coastal communities; general hospital, specialized and community care
Fraser Health	Communities east of Vancouver and the Fraser Valley; urban and suburban hospitals, local teams and regional programs
Island Health	Vancouver Island, nearby islands and part of the mainland coast
Interior Health	The southern interior, including the Okanagan and the Kootenays

Organization	Service area and place in the system
Northern Health	Northern BC, with long distances between communities and regional hospitals
PHSA	Provincial centres and programs receiving referrals from different regions
FNHA	Services, health programs and partnerships with First Nations communities

A family physician or *nurse practitioner*, an advanced-practice nurse authorized to diagnose and prescribe, often manages initial episodes of depression, anxiety and sleep disturbance. Primary care also monitors physical health, arranges laboratory testing and refers patients to psychiatry. The specialist may take on long-term treatment or provide a consultation followed by continued management in primary care. A community team adds nursing follow-up, social work, psychological care and support with everyday functioning. [2, 3, 4, 5]

In September 2026, the government reported that approximately **4.47 million residents, or 80% of the provincial population**, had a regular primary care provider. At the same time, **323,000 people** were on the Health Connect Registry, which connects patients with a family physician or nurse practitioner. This has direct practical consequences for psychiatry: ongoing prescriptions, blood pressure and metabolic monitoring, repeat referrals and discussion of new symptoms all require an accessible place for the next appointment. [6]

Routes into care

For an acute presentation, the hospital emergency department is an entry point. In Vancouver, adults aged 17 and over can self-refer to the Access and Assessment Centre; Greater Victoria has its own mental health and substance use access service. Early psychosis programs accept referrals from patients, relatives, physicians and other professionals. An older person with cognitive and behavioural changes may reach a specialized team through primary care. [3, 4, 5, 7]

Clinical work is distributed among these services according to its intensity. Emergency assessment determines whether admission is needed; an outpatient team supports treatment at home; a provincial centre accepts complex referrals requiring a longer course of specialized care. Red Fish Healing Centre, for example, combines treatment of severe mental illness and addiction within a single inpatient course. [2, 8]

There is no shortage of acronyms on this administrative map. Unfortunately, none of them works the night shift. 😳

An ordinary referral to a psychiatrist

In everyday outpatient practice, a referral begins with a clinical question: clarifying the diagnosis after several unsuccessful courses of treatment, assessing a possible bipolar course, or selecting treatment for a complex combination of symptoms. The family physician or nurse practitioner provides the history, risk assessment, previous medications with doses and durations, comorbidities and current patient contact details. The consultant reviews the request, assigns priority and communicates acceptance, a wait or a more suitable route. CPSBC's professional standard makes both parties responsible for this exchange. [9]

While the person waits, primary care continues treatment and reassessment. New suicidal intent, mania or rapidly deteriorating self-care changes the urgency: the physician contacts the consultant or redirects care to a crisis service. After the consultation, the report returns with a diagnostic formulation, treatment recommendations and an agreement about the next contact. For one patient, this means a single consultation followed by family physician care; for another, a series of specialist appointments or a transfer to a community team. [9, 10]

Within such a team, a nurse or social worker may coordinate the case: maintaining contact, arranging appointments, noticing missed treatment and addressing housing and financial difficulties. The psychiatrist is responsible for specialist assessment and treatment decisions within their part of the plan. Richmond Mental Health Team, for example, accepts adults aged 19 and over whose persistent mental health or substance use problems impair functioning and require several coordinated forms of support. [10]

Crisis care outside hospital

Since **30 November 2023**, Canada's **9-8-8** crisis line has operated around the clock by telephone and text. BC also has **310-6789** and **1-800-SUICIDE, or 1-800-784-2433**. The responder sustains the conversation, assesses immediate danger and helps identify the next step, involving emergency services when needed. [11]

Mobile responses follow several models. Vancouver's **Car 87**, established in 1978, pairs a police officer with a mental health professional. Community-based **CRCL, Crisis Response, Community Led**, formerly PACT, sends a professional together with a worker who has lived experience of a mental health crisis. The name changed in March 2025. During their

first two years, the teams responded to nearly 10,000 calls; 98.8% of responses involved no police. Coverage and hours depend on the local team; immediate danger is addressed through **9-1-1**. [12, 13]

Section 28 of the Mental Health Act permits police to take a person for medical examination when their behaviour gives grounds to believe that a mental disorder is likely to endanger that person or others. A subsequent decision to detain the person involuntarily requires the clinical assessment prescribed by law. This is the point at which police authority hands the matter over to a medical procedure. [14]

Who pays for consultation, therapy and medication

The Medical Services Plan, or MSP, pays for medically necessary physician services under provincial rules. Psychiatric consultations and physician-provided treatment are part of this system. The work of a psychologist, psychotherapist or counsellor can be funded through a public program's budget, employer-sponsored insurance, other targeted programs or the patient's own resources. This creates a practical difference between paying directly for private appointments and obtaining a place in a funded program with defined admission criteria and duration. [15]

Type of care	Funding route
Psychiatric consultation and treatment	MSP or contractual funding of physician services
Psychological care within a health authority team	The service's budget and program rules

Type of care	Funding route
Private psychological or counselling practice	Out-of-pocket payment, extended insurance or a targeted program
Medication after discharge	PharmaCare, extended insurance and out-of-pocket payment; coverage depends on the drug and the plan

Physician work is funded through fee-for-service arrangements and the Alternative Payments Program. The latter funds services through agreements with health authorities that engage physicians on contract or as employees, and through sessional agreements. One session is **3.5 hours**. These models can pay for case reviews, joint meetings and indirect patient care. They are particularly useful in team-based psychiatry, teaching hospitals and remote communities. [16]

Plan G is intended for people for whom the cost of psychiatric medication is a serious barrier to treatment. Subject to clinical and financial criteria, it covers 100% of the PharmaCare-recognized cost of listed drugs and pharmacy dispensing. Regular coverage is arranged for up to one year, followed by a renewal application. Urgent situations can receive three months of transitional coverage. In everyday practice, this adds a specific task before discharge: aligning the prescription, the funding plan and its renewal date. [17]

Plan Z fully covers listed opioid agonist treatment medications for residents registered with MSP. For some people whose MSP enrolment is incomplete, an exceptional coverage process is available through a physician or pharmacist. Funding and pharmacy dispensing therefore form

part of the clinical pathway alongside the choice of methadone or buprenorphine. [18]

From the provincial budget to the workplace

Nationally, CIHI projected combined public and private health expenditure of **399 billion CAD (approximately 119 billion CAD PPP) in 2025**[1], or **9,626 CAD (approximately 2,870 CAD PPP) per resident**, equivalent to **12.7% of GDP**. Provincial budgets are one of the public funding streams within that total. [19]

For **fiscal 2026/27**, BC Ministry of Health operating expenditure was budgeted at **36.12 billion CAD (approximately 10.8 billion CAD PPP)**. Regional services form the largest category; physician payments through MSP and PharmaCare run through separate streams. [1]

BC budget item, 2026/27	CAD	CAD PPP
Regional services	25.287 billion CAD	Approximately 7.55 billion CAD PPP

1. Canadian amounts are shown in CAD and CAD PPP. The defined CAD PPP unit expresses purchasing power at average Ukrainian prices: the stated CAD amount, exchanged at the NBU rate of 31.5383 UAH per CAD on 7 October 2026, represents the original amount's household purchasing power. World Bank national household-consumption parities for 2025 are 11.864623 UAH and 1.260483 CAD per international dollar, giving 9.412759 UAH per CAD and a multiplier of 0.29845487 for Canadian amounts. Example: 12,193 CAD is approximately 3,640 CAD PPP, or approximately 114,800 UAH in Ukrainian purchasing power. Ukrainian amounts remain in hryvnias; in comparisons they are divided by 31.5383. The same household-consumption scale is also applied to budgets. The original years of the amounts are retained, without inflation adjustment. [22, 23]

BC budget item, 2026/27	CAD	CAD PPP
MSP	8.91 billion CAD	Approximately 2.66 billion CAD PPP
PharmaCare	1.597 billion CAD	Approximately 477 million CAD PPP

Within a region, this money becomes staff shifts, ward operations, laboratories, outreach teams and care. **Fraser Health in 2023/24** received revenue of 6,383.3 million CAD (approximately 1.91 billion CAD PPP), including ministry contributions of 5.2 billion CAD (approximately 1.55 billion CAD PPP), and incurred expenses of 6,379.5 million CAD (approximately 1.9 billion CAD PPP). Acute hospital care accounted for 3.41 billion CAD (approximately 1.02 billion CAD PPP), long-term care for about 1.03 billion CAD (approximately 307 million CAD PPP), and community services for approximately 680.6 million CAD (approximately 203 million CAD PPP). The separate mental health and substance use category amounted to **453.49 million CAD (approximately 135 million CAD PPP), or 7.1% of the organization's total expenses**. [20]

Meanwhile, MSP pays medical practices' claims. For an outpatient psychiatrist, the volume of appointments and office costs are therefore linked to physician remuneration; for a community health authority team, approved positions, hours and contractual resources are decisive. A sessional or contractual agreement can provide time for home visits, joint discussions, work with the family and the handover of a complex patient. [21, 16, 20]

Paying for longitudinal family physician care

Since 2023, family physicians have been able to work under the **Longitudinal Family Physician, or LFP, model**. It pays for three components: time, patient encounters and the attached patient panel, taking complexity into account. Under the February 2026 schedule, direct and indirect office-based care are paid at 32.50 CAD (approximately 9.7 CAD PPP) per fifteen minutes, or 130 CAD (approximately 38.8 CAD PPP) per hour. Indirect work includes reviewing results, clinical documentation, preparing referrals and communicating with other professionals. [24]

For someone with bipolar disorder, this means that reviewing a lithium level, replying to the psychiatrist and coordinating a prescription also fall within paid working time. The model separately recognizes clinical administration and other care settings. A physician can plan longitudinal care for a panel of patients, combining appointments with the work between them. [24]

Geography as part of clinical practice

In Vancouver, a patient may receive assessment, admission and specialized outpatient treatment within one urban hospital complex. In a northern community, the local physician and nursing team more often provide longitudinal follow-up, with a specialist joining remotely or during an outreach visit. Physical examination, blood collection and medication dispensing remain local work. Distance affects the frequency of in-person appointments and who first notices a change in the person's condition.



Illustration: A family physician and patient in a small British Columbia community speak with a psychiatrist by video.

Program age limits also vary by region. Fraser Health's early psychosis program accepts people aged **13 to 30**, while Northern Health accepts those aged **12 to 45**. Northern specifies a target of first clinician contact within **48 hours** of referral. Interior Health offers self-referral and remote participation. In each model, the team arranges further assessment and the intensity of support according to the clinical presentation. [4, 25, 26]

The Rural Coordination Centre of BC offers remote psychiatric case discussions for primary care professionals. A community physician can discuss diagnostic uncertainty, medication response or the next treatment step. The consultation can also benefit subsequent patients in the local practice, because decisions are discussed together with their clinical reasoning. [27]

2. From Asylum to a Modern Network: British Columbia's History

Victoria, New Westminster and Essondale

The first provincial asylum opened in Victoria on 12 October 1872 in a former hospital building. By that evening, seven people had been transferred there from the local jail. In 1878, care moved to a new institution in New Westminster, initially home to about 37 patients. [28, 29]

Further expansion brought the psychiatric hospital to Coquitlam. In 1904, the province set aside approximately 400 hectares; a new institution opened on 1 April 1913, later known as Essondale. The name honoured Henry Esson Young, a physician and provincial minister who supported its construction. By the end of 1913, the hospital had 453 patients. An entire working settlement developed around the wards: a farm, workshops, staff housing, roads and support services. [30]

The large buildings combined acute treatment, residence over many years, elder care and support for people with intellectual disabilities. These functions gradually separated into different institutions. The New Westminster facility became Woodlands; Essondale and Crease Clinic developed in Coquitlam, and their histories later came together under the name Riverview. [31]

Year	Event on the future Riverview site
1913	Opening of the men's building, later named West Lawn

Year	Event on the future Riverview site
1924	Opening of the 300-bed acute care building, now Centre Lawn
1930	Transfer of 500 women from New Westminster to the new women's building
1949	Opening of a new Crease Clinic wing for the early stages of mental illness
1950s	Essondale's population reached approximately 4,630
2012	Transfer of the historic hospital's last patients

Chronology source: BC Housing's public history of the site. [32]

Overcrowding transformed everyday life: privacy was scarce, and beds filled attics and basements. The farm supplied the hospital with milk, meat and vegetables; its operations depended heavily on unpaid, often compulsory patient labour. A person could spend years both as a hospital resident and as a worker in its agricultural enterprise. [32]

Changes in clinical work

Social services were introduced in 1932, followed by a staff psychologist in 1937. Alongside hydrotherapy, clinicians used insulin comas and metrazol-induced seizures; ECT became widespread in the 1940s, and the first nine lobotomies were

performed in 1946. Chlorpromazine and reserpine entered treatment in the mid-1950s. [29]

Changes also affected ward routines and length of stay. During Crease Clinic's first year, 791 of 963 admitted patients returned to the community within the four months provided for by law. By March 1955, five open wards served 587 patients; in 1959/60, about 70% of Essondale's patients lived on open wards. Group psychotherapy, outpatient follow-up and vocational and daily-living rehabilitation developed. [29]

These changes required a different working day. A nurse observed behaviour and functioning, a social worker prepared for the person's return to the family, a physician reviewed treatment, and activities beyond the ward restored familiar actions. Life after hospital gradually moved to the centre of attention. Organizing that life would become the principal task of regional services.

Eugenic legislation and life after surgery

The sterilization law passed on 7 April 1933 took effect on 1 July. A three-person board comprising a judge, a psychiatrist and a social work professional reviewed applications from the institution's director. The premise was the presumed hereditary transmission of severe mental illness or intellectual disability. A unanimous board decision authorized the operation. [33]

The person was required to give written consent; when the board deemed the person incapable of making that decision, a spouse, parent or guardian could sign. If none of these people was present in the province, authority passed to the Provincial Secretary. The law also protected the surgeon from a civil claim for performing a properly authorized operation, while retaining liability for negligence in carrying it out. These provisions gave the institution decisive influence over a

patient's reproductive life. The law was repealed on 18 April 1973. [33]

Legal scholarship estimates that approximately 200 to 400 people were sterilized in BC.[2] In 2005, nine women who had undergone these operations at Riverview received a total of 450,000 CAD (approximately 134,000 CAD PPP) in settlement of their claims. The consequences of a hospital decision lasted for decades; legal recognition of the harm came after the law had been repealed. [34, 35]

From a single complex to regional services

In **1965**, Essondale and Crease Clinic were amalgamated as **Riverview Hospital**. In 1973, the hospital graduated its last class of psychiatric nurses, with training moving to colleges. West Lawn closed in 1983, and Colony Farm ceased operating as a working farm. Some functions of the large hospital settlement gradually passed to educational, municipal and community institutions. [36]

A provincial initiative in **1990** proposed moving much of the care to smaller specialized regional facilities while retaining a specialist centre on the Riverview site. Crease Clinic closed in 1992. The subsequent development of local inpatient units and residences required new staffing arrangements, transfer of clinical records and support for people for whom the hospital had been home for decades. [36]

2. Historical estimates depend on the preservation and coverage of records. This range appears in a 2021 McGill legal review. [34]

Transfers from Riverview: clinical and everyday outcomes

Regionalization unfolded over decades. Riverview's patient population fell while local services assumed acute treatment, long-term care and rehabilitation. Small residences opened on the site itself in 2001, 2006 and 2008: Connolly, Cottonwood and Cypress, each with roughly twenty places. Individual rooms and a more domestic environment replaced large shared wards. Riverview's last 40 patients moved to facilities in Surrey and Vancouver in 2012. [32, 30]

A prospective quasi-experimental study by Petersen and colleagues, published in 2013, followed 189 long-stay Riverview patients; 80% had schizophrenia-spectrum disorders. Some moved to specialized psychiatric residences, some to less structured community housing, and some remained in hospital. Most continued to receive care around the clock. [37]

Psychiatric symptoms remained broadly stable. Aggressive behaviour did not increase, although some socially inappropriate behaviours became more frequent. Neuropsychological impairments generally remained at their previous level, while some measures improved. Patients managed money, food preparation and storage, transport and work tasks more successfully; subjective quality of life improved significantly. During follow-up, one person spent time in a correctional institution, one in a forensic psychiatric facility, and one experienced a period of homelessness. These transfers combined continuing intensive care with greater opportunities in everyday life. [37]

Kwikwetlem land and new services

For the Kwikwetlem people, the slopes above the Coquitlam River offered refuge during floods and places for ceremony, hunting and gathering medicinal plants. Hospital construction changed the landscape and deprived the community of influence over the use of its traditional territory. In 2012, Kwikwetlem and BC Housing signed a protocol agreement for cooperation; in 2016, the Nation filed a land-title claim. [38]

On 10 March 2021, the province and Kwikwetlem announced a new name for the site, səmiq̓ʷəʔelə, meaning "place of the great blue heron," and the beginning of joint planning. The name was given as an act of restoring cultural presence and revitalizing language. Today, archaeological work, naming, art and site planning involve the Nation and its heritage protection requirements. [38]

On 12 October 2021, the 105-place Red Fish Healing Centre opened here, replacing the Burnaby Centre for Mental Health and Addiction. Provincial capital expenditure was 130 million CAD (approximately 38.8 million CAD PPP). The centre brought together treatment of severe mental illness and addiction, with individual rooms and space for rehabilitation, research, teaching and remote contact with families. Kwikwetlem participated in its design and treatment programs. The centre includes space for spiritual practices, and a carved pole by the Nation's artists stands near the entrance. [39]

Psychiatric care on this site evolved from a large institution with its own working estate to a combination of specialized treatment, small residences and connections with local services. Throughout that history, hospital routines, living space, human rights and the possibility of returning to everyday activities changed alongside treatment methods.

3. Everyday Clinical Practice: From Initial Assessment to Treatment

Acute care and psychiatry in a general hospital

At Vancouver General Hospital, or VGH, the acute psychiatric pathway begins in Psychiatric Emergency Assessment & Triage, shared with the emergency department. After initial assessment, a person may return to outpatient care, remain for brief observation or move to an inpatient psychiatric unit. The **Psychiatric Assessment Unit has 14 beds**, with a typical stay of about three days. At the Segal Family Health Centre, **75 inpatient beds** are distributed among brief intervention, mood disorders, general psychiatry and concurrent mental health and substance use disorders; the provider reports an approximate length of stay of 5 to 12 days. [2]

Consultation-liaison psychiatry serves patients on medical and surgical wards. The treating physician submits the request. The psychiatrist assesses mental state and clarifies diagnosis and treatment on the ward where the patient is receiving physical health care. This arrangement is particularly important in postoperative delirium, severe depression accompanying physical illness, or interactions between psychotropic and other medications. Medical interventions, nursing observation and psychiatric decisions are coordinated within a single admission. [2]

Alongside this hospital pathway, Vancouver has the Access and Assessment Centre, or AAC. It accepts city residents aged 17 and over with mental health and substance use concerns,

in person daily from **7:30 a.m. to 9:30 p.m.**, and by telephone from **7:30 a.m. to 10 p.m.** A nurse, social worker or another team clinician performs the initial assessment. Together with the patient and, when appropriate, relatives, the clinician identifies the next route: crisis support, a community service, addiction care or admission. When the need is urgent and admission is likely, a psychiatrist becomes involved at the first contact. Interpreters are available. [3]

A relative can telephone AAC, report changes in the person's condition and provide information relevant to assessment. Family physicians also have the RACE consultation line: psychiatric expertise is available on weekdays from 8 a.m. to 5 p.m. These two channels support different parts of the work: a person's request for help and professional discussion of their treatment. [3]

Psychotherapy: method, intensity and access

The 2023 CANMAT update on major depressive disorder, published in 2024, identifies cognitive behavioural therapy, interpersonal therapy and behavioural activation as first-line psychological treatments. The choice takes account of episode severity, previous response, patient preferences and availability. For severe and recurrent forms, combining or sequentially using psychotherapy and medication is important. [40]



Illustration: A patient and psychotherapist during an individual outpatient session.

Psychological care can have different intensities within a clinical pathway: independent work with materials, guided participation in a structured program, a group, or regular individual therapy. These involve different time commitments and different ways of working with symptoms. Behavioural activation restores specific activities to a day narrowed by depression; cognitive behavioural work adds examination of habitual interpretations; interpersonal therapy focuses on relationships, loss and changes in life roles. [40]

The free **BounceBack** program, delivered by CMHA BC, is intended for people aged 13 and over with mild to moderate depression, anxiety and stress. The telephone format offers **4 to 6 sessions** with a trained coach, together with workbook exercises. Coaching is available in English, French, Cantonese and Punjabi. The referring primary care professional retains clinical responsibility and receives information about participation and risks. The online version contains **20 modules** in English, with self-registration. [41]

Lau and Davis studied **25,338 closed referrals** from 2008 to 2014. Of these, 10,903 participants reached the first standard session, and 7,203 completed the program. A further 8,100 declined or lost contact before proceeding, 8,104 discontinued after screening or starting coaching, and 1,931 were assessed as requiring another form of care. [42]

Measure among BounceBack completers	Before the program	After the program
Depressive symptoms, mean PHQ-9	11.2	5.5
Anxiety symptoms, mean GAD-7	9.8	4.7
Life satisfaction, mean Q-LES-Q	43.9	52.0

Among **5,537** participants with initial scores indicating clinically significant depression and/or anxiety, **3,794, or 68.5%**, scored below the thresholds used on both scales after completion. Effect sizes for changes in PHQ-9 and GAD-7 were **1.13 and 1.08**, respectively. Completers were older on average than those who discontinued: 48.2 versus 43.7 years.[3] [42]

Medication treatment and the next appointment

The CANMAT/ISBD guideline for bipolar disorder organizes treatment by phase, including acute mania, bipolar depression and maintenance, and by a sequence of options

3. Analysis of routine data from 2008 to 2014, comparing scores before and after participation, without a control group or long-term follow-up. The table reports results for program completers.

that considers efficacy and tolerability. As acute symptoms subside, the work shifts to relapse prevention, monitoring adverse effects and restoring functioning. [43]

In practical care, the prescription is accompanied by a review date, a list of required tests and a named person responsible for reviewing them. After discharge, this may be an outpatient psychiatrist, family physician or team physician. The pharmacy receives the current prescription; the patient receives an understandable regimen and a contact for deterioration. After a change of dose or medication, the next appointment allows sleep, activity, mood, physical symptoms and tolerability to be considered together. In early psychosis, tolerability and return to education are especially important; in bipolar disorder, sleep and changes in activity; with clozapine, laboratory monitoring and physical health.

Who provides psychological treatment

A psychologist in BC is a regulated professional registered with the College of Health and Care Professionals of BC, or CHCPBC. Their work may include psychological diagnosis, psychometric assessment, psychotherapy and rehabilitation. In a hospital or community team, these activities are funded through the service's budget; in private practice, the fee is agreed with the patient. **Registered Clinical Counsellor, or RCC**, is a professional designation of the BC Association of Clinical Counsellors. Statutory regulation of psychotherapists through CHCPBC is scheduled to begin on **29 November 2027**. [44, 45]

In 2026, BCACC recommends **140 to 175 CAD (approximately 41.8 to 52.2 CAD PPP) for 50 minutes** of individual work, depending on the counsellor's experience; its upper benchmark for specialized services is 225 CAD (approximately 67.2 CAD PPP). For psychologists, BCPA has

recommended **245 CAD (approximately 73.1 CAD PPP) per hour** since 12 May 2025. An illustrative course of twelve sessions at 155 CAD (approximately 46.3 CAD PPP) would cost 1,860 CAD (approximately 555 CAD PPP); an employer insurance benefit or a place in a public program substantially changes the patient's share. [45, 46]

A distinct profession is the **registered psychiatric nurse, or RPN**, whose foundational education is specifically in psychiatric nursing. Alongside registered nurses, RPNs assess patients, monitor treatment response, sustain therapeutic engagement and work in hospital, community and outreach services. BCCNM regulates their practice. [47]

Electroconvulsive therapy

Modern electroconvulsive therapy, or ECT, is delivered under general anaesthesia with muscle relaxation. CANMAT considers it a particularly important option for the most severe depressive episodes, high suicide risk and physical depletion. Cognitive adverse effects and prevention of relapse after the acute course are part of treatment planning. [40]

The Neurostimulation Clinic in the Mental Health and Substance Use Wellness Centre at Royal Columbian Hospital in New Westminster can provide treatment to **up to 14 patients per day**. The pathway within the clinic includes nursing assessment and preparation, the procedure, monitored recovery in one of four spaces, and further time in a rest area before discharge. Referrals come from hospitals and community services; the regional ECT team coordinates access. [48]

At VGH's outpatient clinic, a psychiatrist submits the referral. An ECT psychiatrist and nurse assess the patient, reviewing previous treatments, physical illnesses and current medications. The program requires concurrent psychiatric follow-up throughout the course; procedures take place on Mondays, Wednesdays and Fridays. Patients must not drive on treatment days. Organizing a course therefore includes transport, support after anaesthesia, assessment of response and subsequent maintenance treatment.[4] [49]

Five years of psychiatric training

The University of British Columbia residency lasts **five years**, with training sites in Vancouver, Fraser, Prince George, Vancouver Island and the southern interior. The first year includes general medicine, neurology, paediatrics, emergency care, addiction and psychiatry. The second focuses on adult inpatient and outpatient work; the third comprises six months each of child and geriatric psychiatry. Consultation-liaison psychiatry, addiction, acute and persistent disorders, elective placements and independent responsibility then take a greater role. [50]

Psychotherapy has protected time: **two hours per week in the second year and four in the third and fourth years**. Training includes two supervised cognitive behavioural therapy cases, six months of group work, at least eight family sessions, interpersonal therapy and a two-year psychodynamic case with weekly supervision. Psychotherapy practice thus develops alongside hospital rotations and continues long enough for the resident to observe the evolution of the therapeutic relationship. [50]

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4. This pathway describes the VGH outpatient clinic. Its geographic and clinical eligibility criteria determine local access; general indications for ECT are set out in CANMAT.

The resident's timetable calls this protected time. Learning to protect it from the rest of the timetable gradually becomes a professional skill of its own. 🙂

Electronic records, prescriptions and information transfer

Before a consultation, a psychiatrist may open several information sources. **PharmaNet** contains records of medications dispensed by community pharmacies across the province. The hospital electronic record contains orders, administrations, investigation results and the course of admission. Fraser Health has been introducing MEDITECH Expanse in stages since 2023; Vancouver Coastal Health, PHSA and Providence are developing the shared CST Cerner system. A patient transferred from Surrey to Vancouver moves between different hospital platforms. [51, 52]

CareConnect allows authorized staff to view laboratory results, imaging, selected clinical documents and pharmacy data from multiple sources. Practical reconciliation still occurs at the level of the individual treatment: the last methadone dose dispensed, medication administered in hospital, the reason lithium was stopped or the date of a long-acting antipsychotic injection. The patient and pharmacy help establish actual medication use, while the discharge summary explains the changes made. [52, 53]

Primary care offices and private medical practices have their own electronic systems. Referrals, consultation reports and discharge summaries pass through available channels, including fax and electronic fax. The provincial **Digital Referrals and Orders** program is introducing electronic referral with progress tracking. The clinical value of this exchange is concrete: the physician can see who accepted the

request, and the patient receives a defined next contact. [52, 9]

How clinical work enters reporting systems

After an appointment, the physician submits an MSP claim with a service code and an **ICD-9-based** diagnostic code. The hospital separately codes the completed admission; BC data flow into the **Discharge Abstract Database, or DAD**, maintained by the Canadian Institute for Health Information, or CIHI. Diagnoses in this dataset use **ICD-10-CA**. These records support calculations of admission frequency, length of stay and service use. The clinical report, claim and statistical record describe the same episode at different levels of detail. [54]

The facility also retains Mental Health Act documents: certificates, treatment authorization, rights notifications and status renewals. Regional health authorities report service activity to the ministry. For example, the 2026/27 plan includes a **target of 46% continuous retention in OAT for at least twelve months**. For community bed-based addiction treatment and recovery programs, the forecast median wait in 2025/26 was **30.5 days**, with a **30-day** target for 2026/27. These times concern a defined group of programs, with acute withdrawal management counted separately. [1, 55]

Mandatory reporting beyond the treatment team

Under section 230 of the **Motor Vehicle Act**, a physician reports to RoadSafetyBC when a medical condition makes driving dangerous to the person or others and the patient continues to drive after being warned. The assessment connects diagnosis with function: attention, judgement, the risk of sudden loss of consciousness or marked sedation. The record retains the reasons for the conclusion and the substance of the discussion about driving. [56]

Section 14 of the **Child, Family and Community Service Act** requires everyone to report promptly to child protection services when there are reasonable grounds to suspect that a child needs protection. The **Coroners Act** requires reports of violent deaths, sudden unexplained deaths and other specified circumstances; the director of a designated psychiatric facility also has a specific duty to report a patient's death. Each report has a legally designated recipient and a specific basis. [56]

4. Care Across the Lifespan and for Complex Needs

First psychosis and early intervention

Early Psychosis Intervention programs, or EPI, provide specialized assessment, medication treatment, family work and support with education and employment. Fraser Health accepts young people aged 13 to 30 with a first psychotic episode or an early course requiring appropriate treatment; follow-up may continue for up to three years. Northern Health's age range is broader, from 12 to 45. Referrals can come from the family, a physician, another professional or the person themselves. [4, 25, 26]



Illustration: A young woman and her mother meet with a psychiatrist in an early psychosis intervention service.

A study by Riedlinger and colleagues, published in 2026, examined the organization of **16 services** using 2022 data.

Their catchment areas covered approximately **4.36 million residents**. Mean fidelity to the model studied was **56.1%** of the maximum score. Two services had high fidelity, nine moderate, three low and two very low. Dedicated EPI centres scored higher on average than general mental health and substance use centres. [57]

EPI component	Services meeting the criterion, out of 16
Ongoing assessment of self-harm risk	16
Timely response	15
Outreach and home-based treatment	15
Links with inpatient care	13
Support for functional, vocational and social needs	8
Psychological therapy for anxiety, depression and stress delivered by a trained professional	2
Family education	3

The clearest gap was between access to contact and the depth of continuing treatment. Most teams could respond and visit at home; psychological work, family education and clinical supervision were much less well supported. These differences

shape life after positive symptoms diminish: returning to classes, addressing anxiety and supporting relatives.[5] [57]

Youth services and the transition to adult care

Child and Youth Mental Health, or CYMH, services belong to the Ministry of Children and Family Development, MCFD. This network provides free, voluntary, specialized care for children and young people under 18. **Foundry** serves those aged **12 to 24**, bringing together mental and physical health care, substance use support, peer support and social services. In the same centre, a young person can discuss anxiety, contraception, education, work or housing difficulties. [58, 59]

The first six Foundry centres recorded **4,783 young people and 35,791 visits** from 2015 to 2018. Mental health and substance use care represented 57% of services used, and physical health care 25%. People most often heard about the centre from friends, at 44%, or family, at 22%. **58% of surveyed visitors said they would not have sought help anywhere without Foundry.** Girls and young people aged 15 to 19 attended particularly often; boys and the 20-to-24 age group were less represented. [59]

A later study of the network's expansion described **23,749 unique users and 110,145 services** across the respective in-person and virtual reporting periods. Virtual care supplemented local centres and made support available at a distance. [60]

Compass supports professionals treating children and young people under 25. In its first five years, from September 2018

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5. Team self-assessment using a research model-fidelity scale; adult services were surveyed. The findings describe the organization of care in 2022.

to September 2023, **2,336 professionals** registered. Family physicians accounted for 34.6% of contacts and paediatricians for 27.5%. Medication was discussed most often, in 60% of contacts; resource coordination in 32%; psychotherapeutic and behavioural interventions in 30%; and diagnostic clarification in approximately one quarter. A single contact could cover several questions. [61]

The provincial protocol for transition between child and adult care covers the period from age 17 to the 21st birthday. Handover includes planning with the young person, identifying the next service and exchanging clinical information. In practice, education, housing, family roles and program eligibility all change during these years. A handover meeting needs to preserve the accumulated knowledge of the illness course, treatment response and effective forms of support. [62]

The perinatal pathway has a separate consultation service. The **Provincial Reproductive Mental Health Outpatient Clinic at BC Women's** accepts referrals from physicians, nurse practitioners and midwives for pregnancy planning, conditions during pregnancy and up to eight months postpartum. A one-time preconception consultation may address lithium, an antipsychotic, previous postpartum psychosis and a monitoring plan. Continuing work is coordinated with the local team and maternity care. [63]

BC Children's Hospital provides specialized hospital care for children and adolescents: child and adolescent psychiatric units and a psychiatric emergency assessment area complement local services. For planned admission, the team gathers information from school and community providers; before discharge, it coordinates further work with the family, local physicians and CYMH. This cooperation is particularly

important when behavioural change simultaneously affects education, family life and safety. [64]

Intellectual disability and autism: supporting adult life

Community Living BC, or CLBC, funds social support for eligible adults aged 19 and over with intellectual disabilities; its Personalized Supports Initiative also covers defined cases of autism and fetal alcohol spectrum disorder with substantial limitations in adaptive functioning. Support may include daytime activities, employment assistance, respite for relatives and accommodation. Health services treat co-occurring psychiatric conditions. [65]

STADD coordination helps young people aged 16 to 24 move into adult services. Families encounter overlapping age boundaries: CYMH serves those under 18; Foundry serves ages 12 to 24; Compass advises professionals caring for people under 25; and CLBC support begins at 19. Transition planning aligns funding, daytime activity, communication and medical follow-up. [58, 59, 61, 66]

Developmental Disabilities Mental Health Services, or DDMHS, in Fraser and Vancouver Coastal supports people aged 12 and over with intellectual disabilities and mental health or complex behavioural problems. The initial psychiatric assessment usually takes two hours; work with the person and their support network may continue for up to 18 months. Referrals include a current physical examination, agreement from the family physician or nurse practitioner, and a psychological report. The team clarifies the roles of pain, communication difficulties, the environment and mental disorder, and coordinates treatment with the people providing daily support. [67]

Older adults: care at home and long-term care

Fraser Health's community program, mainly for people aged 65 and over, offers assessment, treatment, home visits, consultation in residential and long-term care facilities, and support for relatives. The person, a family member or a professional can make a referral. The team works with primary care; a home visit adds information about nutrition, medication use, mobility and the actual capacity to provide care. [5]



Illustration: An older woman speaks with a loved one and a professional during a home visit.

Vancouver's service accepts older adults with new mental health problems or a longstanding disorder complicated by ageing. People with progressive dementia and complex behavioural and psychological symptoms may receive its care at any age. [68]

The 2025 Canadian guideline on behavioural and psychological symptoms of dementia addresses agitation,

depression, anxiety, psychosis, risky sexual behaviour and medication review. Assessment connects a symptom with its course, the environment and its impact on the person and relatives. Pain, sleep disturbance, sensory difficulties and changes in familiar care become part of the clinical picture alongside cognitive impairment. [69]

For a transition to long-term care, the regional service assesses needs and urgency. On **31 March 2025**, **7,029 people** were on the provincial waiting list; their average elapsed wait was **287 days**. During that period, home support, respite for relatives and reassessment of needs constitute a distinct stage of care. [70]

Care developed by Indigenous peoples

The history of residential schools, family separation and discrimination affects trust in health institutions. The independent **In Plain Sight** review in 2020 surveyed **2,780 Indigenous people and 5,440 health care workers**. Among Indigenous respondents, 27% always felt that their needs were taken seriously, compared with 59% of other respondents; 23% reported feeling not at all safe when accessing mental health or substance use services. Stereotyped assumptions of intoxication affected the assessment of pain, neurological symptoms and reasons for seeking care. [71]

FNHA develops its own clinical and cultural pathways. Its **Virtual Substance Use and Psychiatry Service** provides specialized care to First Nations people and their family members by referral. Elders and traditional knowledge holders may join the support network. Patients can discuss their mental state and treatment in a setting that recognizes their connection with family, community and culture. [72]

In January **2026, the Sts'ailes Éyameth' Health Centre opened**, a partnership among the community, FNHA, Fraser Health and the province. In the North Fraser area, the centre combines clinical care with traditional healing practices and welcomes residents of different backgrounds. It provides a concrete way for communities to participate in organizing everyday services. [73]

The scale of need is especially visible in the toxic drug crisis. According to FNHA, **289 First Nations people died in 2025**, compared with 433 in 2024; mortality remained **5.4 times higher** than among other provincial residents. Almost half of those who died, **49.5%**, were under 40. FNHA's response combines harm reduction, clinical treatment, family support and community-led programs. [74]

Métis Nation British Columbia has its own mental health and harm reduction programs. Métis Counselling Connection, launched in 2021, helps MNBC citizens pay for counselling; coordinators assist in finding appropriate care. Inuit eligible for the federal **Non-Insured Health Benefits, or NIHB, program** have mental health counselling coverage. These pathways complement the regional health network while maintaining connections with their own communities and cultural practices. [75, 76]

Forensic psychiatry

The **Forensic Psychiatric Hospital in Coquitlam has 190 beds.** It serves people referred through the legal system, including those found unfit to stand trial or NCRMD, not criminally responsible on account of mental disorder. According to the provider, approximately 65% of forensic service clients and patients have concurrent severe mental illness and addiction. The team includes psychiatry, psychology, nursing, social work, occupational therapy and recreation. [77]

Continuing treatment is supported by **seven regional clinics** in Vancouver, Surrey/Fraser Valley, Victoria, Nanaimo, Kelowna, Kamloops and Prince George. They provide expert assessments, treat mental health and substance use disorders, and deliver opioid agonist treatment. Under a conditional discharge, the BC Review Board sets conditions for residence, supervision and treatment; the regional team supports compliance with them and the person's return to community life. [77]

5. Addiction, Rehabilitation and Life After Discharge

Substances that changed clinical work

The unregulated drug crisis has become one of the defining conditions of contemporary psychiatry in British Columbia. Preliminary BC Coroners Service figures for **2025 recorded 1,826 deaths**, approximately 21% fewer than the 2,315 in 2024. People aged 30 to 59 accounted for 69% of deaths, and men for 77%. **48% died in a private residence**, and 20% outdoors. A substantial share of crises therefore unfolds in the lives of people with housing, families and employment histories. [78]

Among those who underwent expedited toxicology testing, fentanyl was detected in 69%, fluorofentanyl in 54%, cocaine in 53% and methamphetamine in 52%; substances were frequently combined. Smoking was the most common route of use, at 65%, followed by intranasal use at 11% and injection at 9%. Clinically, this means frequent combinations of opioid dependence, stimulant use, psychotic symptoms, sleep disturbance and physical complications. [78]

Treatment of opioid and alcohol use disorders

The BC Centre on Substance Use, or BCCSU, guideline for opioid use disorder combines agonist treatment, psychosocial support, harm reduction and long-term follow-up. The choice of buprenorphine, methadone or slow-release oral morphine considers previous experience, tolerability, clinical condition and the feasibility of regular dispensing. Different buprenorphine formulations permit daily or long-acting treatment. After acute withdrawal, the next stage is retention

in care, with repeated assessment of craving, continued use, sedation and comorbid illness. [79]



Illustration: A patient receives medication at a community pharmacy during treatment for opioid dependence.

The range of prescribing professionals has expanded. Since September **2024**, specially certified registered nurses and registered psychiatric nurses, **RN/RPN CP-OUD**, can prescribe buprenorphine/naloxone, extended-release buprenorphine, methadone and slow-release oral morphine after the required training. This allows addiction treatment to be incorporated into nursing and community services. [80]

For alcohol use disorder, the Canadian guideline calls for assessment of severity, withdrawal risk and treatment goals. Naltrexone and acamprosate are first-line options for ongoing treatment; acute withdrawal management follows its own algorithm. Opioid use history and hepatic and renal function influence medication selection. A screening update in May 2026 proposed a simplified approach for primary care, where

a short consultation often begins with a physical complaint. [81]

Prescribed alternatives to unregulated substances have separate dispensing requirements. A December 2025 BCCSU bulletin describes the transition to witnessed dosing and the permitted exceptions. For the patient, this changes the daily schedule: travel to the dispensing location, timing that can fit around work, and the ability to maintain treatment. [82]

Decriminalization: a three-year pilot

From **31 January 2023**, a federal exemption allowed adults in BC to possess a combined total of up to 2.5 g of specified substances for personal use: opioids, cocaine, methamphetamine and MDMA. In May 2024, the conditions were narrowed, restricting the permitted locations. The **pilot ended on 31 January 2026**; the province retained funding for navigation and outreach workers engaged during it. [83]

OAT, naloxone, drug checking, overdose prevention sites and treatment of concurrent disorders continue in clinical practice. Their everyday tasks remain specific: reducing the risk of a toxic dose, maintaining contact, selecting treatment and helping a person continue it after a crisis. The legal framework for possession changed within this broader system of care. [79, 83]

Addiction in the general hospital

During an infection, after an injury or following surgery, pain and withdrawal require treatment alongside the physical reason for admission. BCCSU describes inadequate control of these symptoms, stigmatization and difficulties remaining in hospital as circumstances that may lead a person to leave before necessary care is complete. Medication reconciliation, continuation of appropriate agonist treatment, analgesia and

a discharge plan also support treatment of the infection or injury. [84]



Illustration: A physician and nurse beside a general hospital patient; care addresses physical illness and alcohol dependence.

Road to Recovery at St. Paul's Hospital has been developing since 2023. In autumn 2026, it operates **25 withdrawal management places, 20 transitional care places**, and an outreach follow-up team launched in autumn 2024. Entry is possible through Access Central, the rapid access addiction clinic, the emergency department and other Providence services. A nurse clarifies goals, substance use history and physical health; a physician joins when needed. While admission is pending, the team arranges outpatient support and, for eligible patients, same-day virtual care. [85]

Transitional places are for people awaiting a treatment program or long-term housing. After a return to the community, the outreach team maintains contact. If relapse

occurs, the intensity of care increases again according to the person's condition. [85]

Persistent concurrent disorders and rehabilitation

Red Fish Healing Centre has **105 beds** for people with severe concurrent mental health and substance use disorders. The usual program duration is **six to nine months**; care includes voluntary and involuntary admissions. Planning for community return begins early, identifying housing, medication, regional team contacts and the support required. [8]

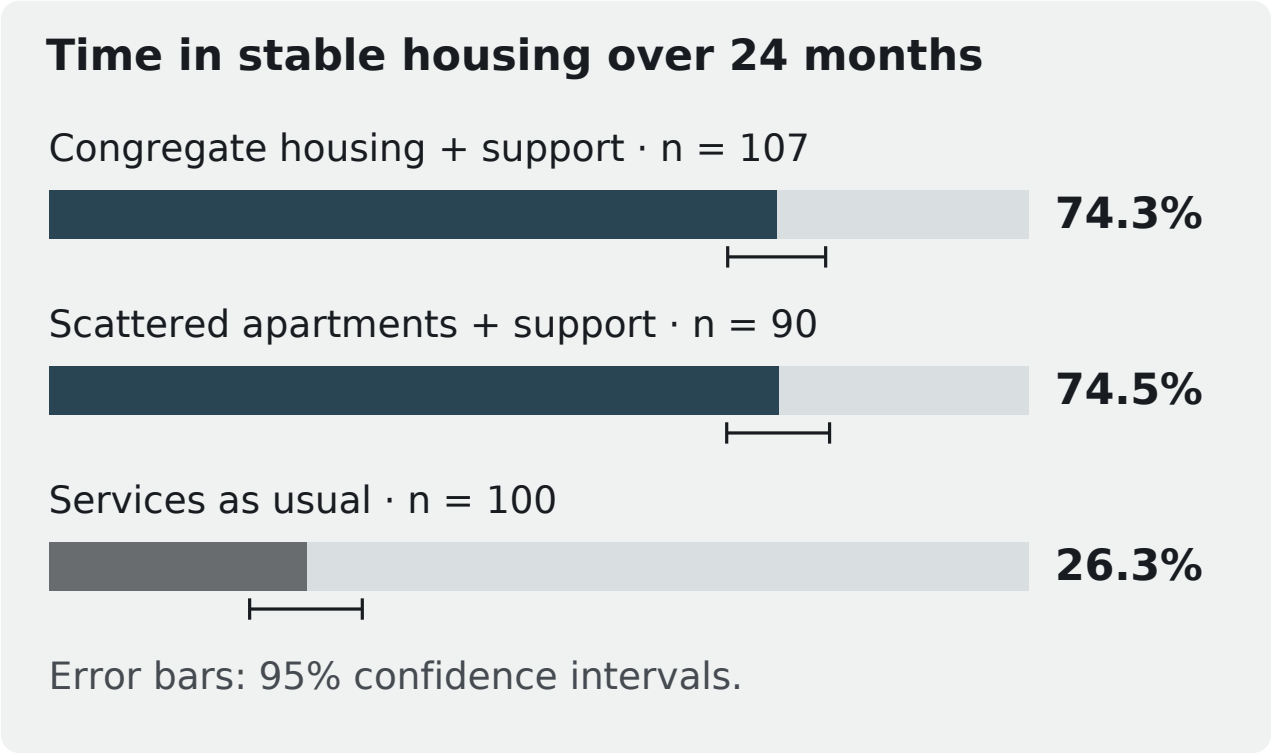
A **40-place Rehabilitation and Recovery Program** provides a subsequent stage. Medically stable people from Red Fish and Heartwood are referred in conjunction with their regional team; participation is voluntary. The program includes medical and psychiatric treatment, daily-living and social skills, employment and education support, addiction work and housing assistance. Its team includes physicians, nursing and social work professionals, vocational rehabilitation counsellors and recreation workers. [86]

Several levels of support lie between ordinary outpatient care and intensive outreach. A community team provides psychiatric treatment, psychological work and case coordination. **Intensive Case Management, or ICM**, in Fraser primarily serves people with severe substance use problems, often alongside homelessness and mental health concerns. The team helps them reach treatment, maintains contact and addresses housing and daily needs. Where a severe, enduring mental disorder requiring intensive psychiatric follow-up is the predominant problem, ACT may be the more appropriate pathway. [10]

Community **Assertive Community Treatment, or ACT, teams** support adults with severe, persistent needs where they live. Fraser Health describes outreach treatment and assistance with medication, physical health care, housing, daily-living skills and activities. The team's work may begin with a visit at home and continue by accompanying the person to a pharmacy or health facility. [87]

Housing and Housing First outcomes

In the Vancouver randomized trial by Somers and colleagues, **297 people** with longstanding homelessness, mental disorder and high support needs entered one of three pathways. An ACT team supported scattered-site apartments; a congregate housing complex provided round-the-clock support. Rent in both programs was capped at 30% of income. [88]



Housing First, Vancouver: 297 participants, two years of follow-up. Somers et al., 2017. [88]

In the complex with round-the-clock support, MCAS functioning, psychological community integration and

subjective recovery on RAS-22 also improved compared with usual services. Between-group differences in change were **5.81, 2.53 and 5.58 points**, respectively. For scattered-site housing, the study found no significant advantage on its secondary outcomes. There were also no significant between-group advantages in psychiatric symptom severity, substance use problems or quality of life. The strongest result shared by both models was therefore housing stability; some functional advantages accompanied the more intensive support within one complex. [88]

Family and everyday work after discharge

Relatives often first notice changes in sleep, spending, communication or self-care. Fraser Health describes how they can share these observations with the team; disclosure of the patient's confidential information occurs with consent or another applicable legal basis. Families can also receive general information about the illness, ways of providing support and resources for their own needs. [89]

The Red Fish handbook connects discharge with concrete agreements about accommodation, medication, upcoming consultations, financial and legal matters, and a safety plan. The person, relatives, hospital and regional team take part. For the family, the most tangible elements are the next appointment date, a reachable telephone number and a clear division of daily tasks. [90]

The hospital has a case coordinator. At home, the job often goes to whoever finds the missing prescription first. 😳

6. Rights, Workforce and Resources in Psychiatric Care

Involuntary admission and treatment

British Columbia's Mental Health Act connects involuntary admission with mental disorder, a need for treatment through a designated facility, the need to prevent substantial mental or physical deterioration or to protect the patient or others, and the inability to admit the person appropriately on a voluntary basis. The clinician sets out the grounds for the decision in a medical certificate. [14]

Stage	Procedure under the Mental Health Act
Initial detention	Up to 48 hours on a first certificate issued by a physician or nurse practitioner
Continuation	A second physician's certificate within those 48 hours; if a physician signed the first, a different physician completes the second
First period	Up to one month from admission
Renewal	A further month, then three months, followed by successive six-month periods with the required assessment
Review	A review panel for involuntary status, court mechanisms and a second medical opinion on treatment

On **3 December 2025**, section 31(1) on *deemed consent* was repealed. The director's authority to authorize treatment, including signing consent forms under section 8(a), was retained. When patients are informed of their rights, staff

explain the opportunity to meet an independent adviser and ask whether they want that contact. [14]

The **Independent Rights Advice Service, or IRAS**, provides free, confidential information about rights and how to exercise them. Advisers are independent of the treatment team. Those entitled to a meeting include patients admitted involuntarily under section 22 and children under 16 admitted at a parent's or guardian's request under section 20. The service helps people understand their status, review options and further legal steps. [91]

From its launch in February 2024 to **31 December 2025, IRAS received 1,565 requests and held 1,163 meetings**. Most work took place remotely by telephone or video; advisers also held regular in-person sessions at fourteen designated facilities. [55]

Capacity to consent and decisions involving relatives

For physical health treatment and other situations covered by the **Health Care (Consent) and Care Facility (Admission) Act**, the physician assesses whether the person understands the proposed care and appreciates how it relates to their own condition. In dementia, this assessment concerns a specific decision: an antibiotic, surgery, a diagnostic procedure or admission to a care facility. Remaining communication abilities, hearing support, interpretation and a suitable time for discussion help the person participate. [92]

When a patient requires substitute decision-making, a legally appointed representative or an appropriate relative from the statutory hierarchy acts. The physician checks the authority conferred by a **representation agreement** and, when needed, selects a **temporary substitute decision-maker**. If

no suitable person is available or a dispute arises, the law provides for involvement of the **Public Guardian and Trustee**. The representative considers the person's known wishes and values and their best interests. A family discussion about treatment for Mei, who has dementia, therefore has both a clinical and a defined legal structure. [92]

Medical assistance in dying

Canadian **medical assistance in dying, or MAID**, is governed by federal criminal law and includes separate assessment of eligibility and the voluntariness of the request. **As of 7 October 2026, mental illness as the sole underlying medical condition remains excluded; the law in force sets the end of this exclusion at 17 March 2027.** In June 2026, a majority of the joint parliamentary committee recommended making the exclusion indefinite. The debate concerns the ability to establish irremediability on sound grounds, the prognosis of an enduring disorder, access to treatment and protection of voluntary decision-making. [93]

Documents accompanying restrictions on liberty

In a **January 2026** report, the Ombudsperson summarized progress on 24 recommendations: **12 implemented, 8 in progress and 4 with no progress**. In an audit covering July to September 2024, a first certificate was present in 98% of reviewed records, a second in 92%, treatment authorization in 87% and rights notification in 70%. **58% of records** contained the complete set of mandatory forms. [55]

By region, a complete set was present in **34% of Fraser Health records and 92% of PHSA records**, the endpoints of the range. Completion of individual fields and the quality of clinical reasoning were assessed separately. Problems

concerned grounds for detention, the description of specific treatment, informing the person and notifying relatives. The findings connect legal procedure with an individual physician's decision and the patient's ability to challenge it. [55]

How patients and staff experience involuntary care

A 2026 study by Snow and colleagues drew on five focus groups involving **23 people** who had experienced involuntary treatment, and interviews with **11 clinical and 10 other staff members**. Data were collected from February to April 2023 in two health authorities. Participants described long waits for voluntary care, restrictive program criteria and housing difficulties that accompanied escalating crises and complicated discharge. [94]

During admission, patients felt they had insufficient involvement in treatment choices; available activities and therapeutic options were seen as limited. Loss of control, stigmatization and coercive interventions could undermine trust. Peer support from people with lived experience, however, helped establish contact and make sense of events. Staff also described stress: they had to make urgent decisions with limited voluntary and community care options. This creates a shared clinical problem of maintaining safety and therapeutic relationships while liberty is restricted. [94]

Admission rates over time

In the population study by Loyal and colleagues, involuntary admissions among people aged 15 and over increased from **14,195 in 2008/09 to 23,531 in 2017/18, a rise of 65.7%**. Police-involved apprehensions increased from 3,502 to 8,009,

or 128.7%. Voluntary admissions remained almost unchanged, at 17,651 and 17,751. [95]

In 2017/18, the most commonly recorded conditions among involuntarily admitted patients were mood disorders, at **25.1%**, schizophrenia, at **22.3%**, and substance use disorders, at **18.8%**. The last group had the largest ten-year increase, at **139%**. Population rates rose fastest among young women aged 15 to 24, by 162%; among men, pronounced increases occurred at ages 15 to 34 and 85 and over. [95]

Later Ombudsperson administrative data, using a different counting framework, show **21,380 involuntary and 21,572 voluntary admissions in 2024/25** with a relevant mental disorder as the primary diagnosis. These categories contained **15,580 and 14,408 unique patients**, respectively.[6] [55]

Distribution of psychiatrists and use of their services

On **28 February 2026**, the College of Physicians and Surgeons of BC registered **1,023 professionally active specialists certified in psychiatry**: 478 women, 543 men and two people whose sex was unspecified. The register includes different combinations of clinical, teaching and other professional work. [96]

Regional differences are clearer in the study by Rudoler and colleagues covering **2012/13 to 2021/22**. In 2021/22, the Vancouver region had approximately **45 psychiatrists per 100,000 adults**, compared with about **14** in less well supplied BC regions. The study distinguished any contact, one

6. The Ombudsperson's 2020/21 to 2024/25 series uses the primary-diagnosis category and updated ministry reporting. Loyal's ten-year study defines its population differently; the two series are analysed separately.

or two outpatient visits with the same psychiatrist, and ongoing care involving at least three visits per year. [97]

Use of psychiatric services in BC	Regional mean per 1,000 adults, 2021/22
Any contact with a psychiatrist	34.3
Consultation: 1 or 2 outpatient visits	14.4
Ongoing care: at least 3 visits	15.8

Across the three provinces studied, psychiatrist supply was more clearly associated with ongoing care ($\mathbf{R^2 = 0.411}$) than with consultation ($\mathbf{R^2 = 0.005}$). This helps explain why an expansion of specialist work may appear as greater care intensity for patients already receiving it. Access to an initial consultation also depends on referral arrangements and the structure of medical practice. [97]

How psychiatrists are paid

A psychiatrist's office is often an independent medical practice. Under **fee-for-service**, the physician submits MSP claims for services in the fee schedule; receipts cover premises, administration, equipment, software and other practice expenses. Hospital and community work also commonly involves sessional agreements, contracts for a defined volume of care and employment. One physician may combine several arrangements. [21, 98]

In **fiscal 2024/25, 901 psychiatrists** received total fee-for-service payments of 250.01 million CAD (approximately 74.6 million CAD PPP). The mean per physician was **277,485 CAD (approximately 82,800 CAD PPP) in annual gross payments**, 307 distinct patients and about 2,006 paid services. The report also records 174 days with paid work per physician.[7] Repeat visits and varying service durations produce very different working weeks for the same number of patients. [21]

Payment arrangement	Dated benchmark	What is paid for
MSP fee-for-service, 2024/25	Mean 277,485 CAD (≈82,800 CAD PPP) annually	Gross clinical payments to the practice
Service contract, 2024/25 range	304,978 to 381,222 CAD (≈91,000 to 114,000 CAD PPP) annually	Agreed volume of contracted work
Specialist session, 2026/27	747.22 CAD (≈223 CAD PPP) per 3.5 hours	Clinical or administrative work within the session
Forensic psychiatrist session, 2026/27	1,057.61 CAD (≈316 CAD PPP) per 3.5 hours	Specified forensic psychiatric work

7. Mean gross payments are calculated as 250,014,329 / 901 = 277,485.38 CAD (approximately 82,800 CAD PPP) annually. The dataset covers fee-for-service payments, including part-time practice. Contract receipts are counted separately. The service-contract range is for 2024/25; allocation of new funding under the subsequent agreement continued in 2026. [21, 98]

Sources: MSP, Doctors of BC and the BC Ministry of Health. [21, 98, 99]

Team salaries and income after expenses

Under the 2022 to 2025 nursing agreement, the **RN/RPN Level 3** base rate was **41.42 to 55.91 CAD (approximately 12.4 to 16.7 CAD PPP) per hour**, depending on seniority. At an illustrative 1,950 paid hours, this is **80,769 to 109,025 CAD (approximately 24,100 to 32,500 CAD PPP) annually**, before premiums and deductions. The provincial HSPBA schedule effective from the first pay period after 1 April 2026 sets **56.02 to 69.98 CAD (approximately 16.7 to 20.9 CAD PPP) per hour** for a P1 psychologist; the highest S4D level reaches **95.17 CAD (approximately 28.4 CAD PPP)**. The P1 range matches the cited Fraser Health neuropsychologist vacancy. At the same assumed working time, it corresponds to **109,239 to 136,461 CAD (approximately 32,600 to 40,700 CAD PPP) annually**.[8] [100, 101, 102]

8. Nursing rates use the agreement schedule that expired on 31 March 2025. On 24 July 2026, the NBA accepted special mediators' recommendations and ended collective job action; outstanding pay issues went to binding arbitration in the autumn. A new nursing schedule was still awaited on 7 October. The HSPBA psychologist schedule has a separate agreement and effective date, April 2026. Annual examples use 37.5 hours × 52 weeks. [100, 102]

Estimating personal income adds tax rules to these amounts. In the model of a psychiatrist receiving average MSP payments, office expenses are assumed to be 20%, or 55,497 CAD (approximately 16,600 CAD PPP) annually. This leaves business income of 221,988 CAD (approximately 66,300 CAD PPP). Federal and provincial taxes and Canada Pension Plan contributions under 2026 rules leave approximately **146,315 CAD (approximately 43,700 CAD PPP) annually**, or **12,193 CAD (approximately 3,640 CAD PPP) monthly**.[9] [103]

Example	Monthly income after tax and CPP/EI	Period of the underlying rate
Psychiatrist: mean MSP payments, 20% practice expenses	12,193 CAD (≈3,640 CAD PPP)	Payments 2024/25; taxes 2026
RN/RPN, 1,950 hours annually	5,141 to 6,804 CAD (≈1,530 to 2,030 CAD PPP)	2022 to 2025 agreement schedule

9. An illustrative working-age BC resident: basic tax credits, CPP and, for employees, EI; no other income, RRSP deductions, professional dues or contributions to an employer pension plan. The psychiatrist is self-employed and unincorporated; 20% expenses are an assumption of the example. Calculations use annual 2026 rules and are rounded. Actual payroll deposits depend on individual deductions. [103]

Example	Monthly income after tax and CPP/EI	Period of the underlying rate
P1 psychologist / neuro-psychologist, 1,950 hours annually	6,817 to 8,269 CAD (≈2,030 to 2,470 CAD PPP)	HSPBA, April 2026; Fraser vacancy

BC's average weekly earnings provide a local benchmark: **1,357.68 CAD (approximately 405 CAD PPP) in April 2026**, equivalent to about 70,600 CAD (approximately 21,100 CAD PPP) over 52 weeks. Mean gross fee-for-service payments to a psychiatrist are about 3.9 times that annual earnings figure; after the modelled 20% practice expenses, about 3.1 times. Personal taxes are still payable on that amount. [104, 21]

Funding and new treatment places

The **2026/27 to 2028/29** budget plan provides **more than 131 million CAD (approximately 39.1 million CAD PPP) in new funding over three years** for people with complex mental disorders, addictions and acquired brain injuries. Priorities include ACT expansion and specialized places for involuntary care in Prince George, Maple Ridge and Surrey. [105]

Project	Status, budget and capacity in autumn 2026
Surrey, King George Boulevard	Construction begun; up to 57 million CAD (≈17 million CAD PPP). 60 places; opening planned for spring 2028. [106]
Prince George	Project approved; up to 92 million CAD (≈27.5 million CAD PPP). Construction was planned to start in September 2026. Of 72 places, the first 24 were due by December 2027, the remainder by the end of 2028. [107]

Opening new buildings requires recruitment, shift arrangements and continuing community care. A bed in a budget table opens faster: it does not yet need a staff roster.

Clinical Cases: The Patient's Journey Through the System

Fifteen hypothetical clinical cases follow treatment from first contact to long-term follow-up: the physician's work, the patient's everyday life, family involvement and transitions between services.

Clinical Case No. 1. Postoperative Pain and Opioid Use Disorder

Injury and postoperative pain relief

Mark, 47, installs kitchen cabinets. He lives with his wife, Lisa, in a rented apartment in New Westminster; their adult daughter studies nearby. Before his injury, his working day consisted of stairs, heavy cabinets, travel between jobs and rather improvised lunches. He judged his health mainly by whether he could put on his work boots in the morning.

In March 2025, Mark falls awkwardly on the stairs at home and sustains a complex fracture around the ankle. He undergoes reduction and internal fixation. After surgery, he receives acetaminophen and a short course of oxycodone as needed; the other components of analgesia depend on his postoperative condition. Initially, oxycodone helps exactly where it is expected to: Mark can sleep, move his leg from the bed to the floor and get to the bathroom.

When renewing prescriptions, the physician assesses pain relief alongside mobility, sleep, actual medication use and tolerability. Mark's recovery is prolonged: medication helps him do his exercises, while a return to physical work recedes. [108]

Six weeks later, the wound has healed and the fixation is satisfactory, but installing kitchens is still a distant prospect. By evening, the ankle swells; movement is restricted and exertion increases the pain. The orthopaedic surgeon monitors healing. The family physician continues analgesia through small prescriptions. A physiotherapist sees Mark several times; the family cannot afford regular private sessions.

Each contact has its own logic. Yet no one has brought together sleep, actual tablet use, the family budget and return

to work. Lisa keeps three sheets of advice on the refrigerator. Clinically, this is already multidisciplinary care. Administratively, the refrigerator is still in charge. 🙂

Development of opioid use disorder

At first, Mark takes oxycodone before exercises or at night. Then he takes it before leaving home so that he will not think about his ankle. Later, he notices that a tablet makes it easier to answer customers' calls. Neither the debts nor the pain disappears, but for a while the feeling that he is letting everyone down at once retreats.

The prescribed quantity increasingly runs out. He takes more than agreed with the physician and requests a new prescription early. Twice he tries to reduce his use on his own. Sweating, yawning, abdominal discomfort and restlessness appear, together with increased pain. Within a few days, he returns to the previous pattern.

Physical dependence manifests through withdrawal. Assessment of opioid use disorder, or OUD, focuses on loss of control, craving and the consequences of use for work and relationships.[10] [108, 109]

In autumn, Mark buys tablets outside the pharmacy that are sold to him as oxycodone. At first, he explains that he could not get an appointment in time. Later, he spends part of his working day looking for tablets. He misses agreed measurement visits, conceals spending and declines family outings during which he could not take a tablet unnoticed. Lisa is angry about more than money: she no longer knows which answers she can trust.

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10. Tolerance and withdrawal arising solely during appropriate medical use of opioids do not count as OUD criteria. [109]

In January 2026, he agrees to seek help. One morning, his daughter asks him to drive her to class, and he realizes that he first has to find tablets. That reversal of priorities frightens him more than the word "addiction."

"I want to stop looking for them," he tells Lisa. "But if they simply take everything away, I don't know how I'll manage the ankle."

First contact with addiction medicine

Mark and Lisa attend Rapid Access to Addiction Care, or RAAC, in New Westminster. This Fraser Health service accepts direct presentations for assessment, initial stabilization and transition to ongoing community treatment. [110]

Their first contact is on a weekday. A nurse assesses intoxication, sedation and urgent needs, then arranges medical review. On weekends, the RAAC pathway begins with nursing assessment; physician access depends on clinical need and availability. [110]

The physician has a family medicine background and practises addiction medicine. She begins OUD treatment and later involves a psychiatrist to assess persistent mood symptoms.

Part of the discussion takes place without Lisa. Mark clarifies what he was embarrassed to say in front of his wife: the time spent searching, the strength of craving and the symptoms after a missed dose. With his consent, Lisa then returns and adds information about sleep, spending and missed commitments.

On examination, he is alert and coherent, with no psychosis or manic features. Sleep is fragmented, mood is low and guilt is prominent. Thoughts such as "I can't keep this up much longer" require direct clarification; he describes no suicidal

intent or plan. The physician also asks about alcohol, benzodiazepines, sleeping medication and previous overdoses. Mark reports no regular sedative use; recently, he has drunk alcohol only occasionally.

The pharmacy dispensing history is reconstructed through PharmaNet and reconciled with Mark's account of prescribed and non-pharmacy medication. Confirmatory urine testing detects fentanyl. Mark thought he was buying oxycodone; the treatment initiation plan now takes fentanyl exposure and the risk of precipitated withdrawal into account.

Liver and kidney function and medication interactions are reviewed, and HIV and hepatitis C testing are offered. Mark denies injecting drugs. His physical condition permits the selected treatment to begin. [111]

Distinguishing pain, physical dependence and OUD

The clinical plan addresses persistent postoperative pain, physical dependence and OUD. Each has its own goal: mobility and analgesia, control of withdrawal, reduced craving and restored everyday functioning.

Six behavioural features have emerged over recent months: taking more than intended; unsuccessful attempts to cut down; substantial time spent obtaining opioids; intense craving; repeated failure to meet work obligations; and continued use despite conflict with his wife. Together, these meet DSM-5-TR criteria for severe OUD. [109]

Mark can cooperate, has housing and support, and can attend repeated contacts. There is no acute indication for admission at assessment. The team begins outpatient treatment with frequent contact while medication is selected and adjusted.

The joint, imaging, scar, range of motion, sensation and response to loading are reassessed. The fracture has united, but localized pain and stiffness remain. Their relationship to

movement and the metalwork guides further orthopaedic investigation.

The most useful sentence of the appointment is delivered without ceremony: "We can treat the addiction and keep working out what is happening with the pain." Both problems now belong in one treatment plan.

Choosing OAT and starting treatment

Mark asks about a few days of "detox." The physician discusses sustained control of craving, protection against return to unregulated opioids and maintaining tolerance under medical supervision. The 2024 Canadian guideline recommends maintenance treatment for OUD; completing withdrawal alone increases the risk of resumed use and overdose. [112]

They discuss opioid agonist treatment, or OAT. The national guideline's two principal first-line options are buprenorphine and methadone. The choice considers previous experience, craving, tolerability, co-occurring conditions, personal preferences and the practical ability to obtain treatment. [112]

Mark chooses sublingual buprenorphine/naloxone. Its safety profile and the prospect of a more convenient dispensing routine matter to him. Methadone remains a fully appropriate alternative if the chosen option is ineffective or unsuitable. He has heard the name Suboxone, but the physician also writes down the generic names of both components. [113]

Buprenorphine initiation is planned according to the clinical course of withdrawal, taking the last fentanyl use into account. Starting a standard induction too early can precipitate withdrawal. They discuss standard initiation once sufficiently clear objective symptoms are present, and a gradual low-dose transition overlapping with another opioid.

Each approach requires an agreed schedule and accessible follow-up. [79]

Mark agrees to a standard induction with in-person assessment. At review, sufficiently marked objective withdrawal is present, assessed clinically and with COWS. Initiation proceeds without precipitated withdrawal. The dose is adjusted to craving, symptoms and tolerability; after titration, he takes 16 mg buprenorphine with 4 mg naloxone daily. [113]



Illustration: A middle-aged man and his wife discuss a written treatment plan with a physician at an outpatient appointment.

The morning search for tablets stops. Mark gradually returns the freed time to exercise and household tasks. Ankle pain, shame and lost income remain subjects for later appointments.

Pharmacy dispensing, family and everyday costs

After stabilization, a physician at an outpatient addiction clinic takes over OAT prescribing. RAAC agrees the first appointment date and medication coverage until then. The family physician continues general medical care and pain treatment. [110]

With active MSP coverage, PharmaCare Plan Z pays for Mark's medication. The family still faces travel costs, private physiotherapy expenses and earnings lost through reduced work. [18]

Initially, Mark attends the agreed pharmacy for witnessed dosing. The pharmacist knows whom to contact about a missed dose or unusual drowsiness. Mark knows where to call if he becomes ill or cannot attend. Later, the physician and pharmacist agree on some take-home doses with safe storage.

Work begins at seven, but the pharmacy opens later. The physician and pharmacist discuss collection times and take-home doses, considering sedation, other substances, storage and Mark's ability to follow the regimen. The BCCSU guideline provides for individualized assessment of take-home dose safety. [79]

Lisa asks whether she needs to supervise the tablets. They agree which signs of deterioration they will discuss immediately, what the team may tell Lisa with Mark's consent, and whom to contact about missed doses or drowsiness. Medical decisions remain with Mark and the clinical team.

Both are offered free Take Home Naloxone training: recognizing opioid poisoning, calling emergency services, supporting breathing and administering naloxone. They receive a kit for home. [114]

Lisa puts it in the agreed place. She is still angry about concealed spending; restoring trust will require more time and everyday agreements.

Psychiatric assessment after OAT begins

After several weeks, physical withdrawal no longer accounts for all of Mark's low mood. He is less restless but rarely leaves home without a reason. He says he has become "someone who only goes for treatment." The family physician arranges a psychiatric consultation.

The psychiatrist reconstructs the course of his mood before the injury and its changes alongside pain, intoxication and withdrawal. They clarify previous depressive or manic episodes, anhedonia, hopelessness, suicidal thoughts and daily functioning.

There is no history of mania or hypomania. On serial assessment, mood symptoms diminish as sleep stabilizes and activity resumes; a full persistent depressive syndrome does not develop. Mood and risk continue to be assessed at follow-up.

Mark agrees to psychological work on avoidance of movement, catastrophic expectations of pain and daily rhythm. OAT continues alongside it. Psychosocial care is matched to his capacity and willingness to participate. [112]

The psychiatrist sends the report to the family physician and addiction physician. They agree who monitors mood, who changes OAT and how they will exchange information after a new prescription.

Specialized care for persistent pain

The family physician refers Mark to the Jim Pattison Chronic Pain Clinic in Surrey. The service's published description includes physiotherapists, occupational therapists,

psychologists, pharmacists and social workers, as well as pain specialist consultations. Entry requires referral by a physician or nurse practitioner. [115]

The JPO referral is made after OAT has begun and stabilized, in accordance with the clinic's addiction-treatment criteria. Fraser Health's public handbook provides for the family physician to manage pain while specialist consultation is pending. [116]

While Mark waits, orthopaedic follow-up continues. The family physician clarifies permitted activity and reviews analgesia: acetaminophen, the possibility of a short ibuprofen course after assessing renal and gastrointestinal risks, and interactions with other medications.

At consultation, it becomes clear that Mark alternates between barely walking for several days and trying to catch up on everything in one day. Pain intensifies after a burst of activity, and he fears further injury. The physiotherapist works on graded loading; the occupational therapist examines cabinet lifting, kneeling, stairs and breaks. The psychologist helps restore activities Mark limits because he expects pain.

Mark also uses Pain BC materials and free support programs. These are combined with orthopaedic follow-up and physical rehabilitation. [117]

His first agreed goal is a task he can perform consistently: walking to the shop and back without spending the next two days recovering in bed. Short shifts on lighter duties follow. A colleague temporarily takes on heavy lifting while Mark prepares measurements and drawings. Machinery use and driving are discussed separately in light of his actual condition, drowsiness and medication changes.

Money remains tight in spring. Lisa takes extra shifts. A social worker helps with benefit applications and available

resources. Additional earnings and deferred spending allow the family to keep the apartment.

Resumed use and treatment review

In April, Mark takes on too much work. Pain and anxiety intensify sharply on two consecutive evenings. Craving returns at the end of the day after previously being almost absent. Once, he fails to reach the pharmacy in time; dosing resumes the following day after consultation. During that week, he buys unregulated tablets twice.

At the next appointment, this comes to light through more than a test: Mark describes what happened himself. His first question is whether he will now be removed from treatment. The physician clarifies recent doses, other substances, drowsiness, poisoning risk, mood and the precise timing of craving. The pharmacy confirms his dispensing history.

The team reviews OAT safety and effectiveness: dose adequacy, other sedating substances, medication storage and the feasibility of the pharmacy routine. Treatment continues after renewed fentanyl use, with more frequent contact. A positive urine test alone is not a reason to stop OAT. The physician interprets it alongside clinical assessment; take-home arrangements depend on storage safety, sedation, dosing regularity and support needs. [79]

Mark reports recurrent end-of-day craving even on days when he took his medication. After assessment and titration, the daily dose rises to 24 mg buprenorphine with 6 mg naloxone. He and the physician review pharmacy dispensing times, workload and access to the next contact so that the agreed routine is workable on working days. [113]

Lisa sees this episode as a return to concealment. At a joint meeting, Mark agrees to report increasing craving before money goes missing. Lisa speaks directly about financial

anxiety. They develop a shared response plan for the next deterioration.

Perioperative care during a further procedure

In summer 2026, the orthopaedic surgeon reassesses persistent focal pain and irritation over the metalwork. After confirming union and discussing expected benefit, they agree on elective removal of some fixation hardware. Mobility rehabilitation and treatment of residual pain will continue afterwards.

The incision is not Mark's greatest worry. "If they hear about the addiction, will they give me any pain relief at all?" Lisa fears the opposite: that another opioid prescription will undo the work already achieved.

The anaesthesiologist agrees on continuation of buprenorphine/naloxone, multimodal analgesia and an additional short-acting opioid when needed. The plan specifies monitoring of analgesia, sedation and breathing, and transition to outpatient prescriptions. This approach is described in BC guidance and the perioperative expert consensus. [79, 118]

During admission, regional analgesia and non-opioid medications are used. Hydromorphone is used briefly for breakthrough pain under clinical observation. Dosing is guided by effect, consciousness and respiration, taking tolerance and buprenorphine's action into account. [118]

The hospital confirms the last dose actually received with the pharmacy. They coordinate dispensing on the admission day and, before discharge, the next supply and prescription validity. Telephone reconciliation adds information about hospital administrations to PharmaNet. [53]

Discharge is planned for Friday. The nurse obtains pharmacy confirmation that the updated prescriptions have arrived and medication will be available over the weekend.

Hydromorphone is stopped after the brief postoperative period according to the agreed plan. OAT continues. The addiction physician and family physician receive information about the operation and analgesic changes. For Mark, the most important outcome is simple: he has undergone another procedure without concealing his addiction or being left without pain treatment.

Treatment outcome and continuing follow-up

By autumn, Mark works part-time. His ankle still limits some tasks, but he can plan a week without constantly searching for tablets. He reports no unregulated use in recent months, consistent with clinical observation and testing when indicated. He continues buprenorphine/naloxone, gradually rebuilds stamina and sleeps better.

"When can I manage without the medication?" he asks. He wants to free his day from treatment-related tasks. The physician discusses craving, stability at work, the previous return to use and the risks of stopping. For now, he chooses to continue OAT and review the decision later.

In a BC cohort study of 55,347 OAT recipients from 1996 to 2018, mortality was lower during treatment than during periods outside it. After fentanyl became widespread, mortality outside OAT increased, while mortality during treatment remained more stable. This gives sustained retention in care clinical importance alongside return to work and family life. [119]

Further dose changes will take account of craving, functioning, tolerability and Mark's preferences. If he moves,

the team will transfer prescribing information and connect him with a new provider.

Lisa judges the outcome somewhat differently. She can again agree ordinary expenses with her husband without checking every answer. Their daughter no longer has to establish each time whether Dad is able to help that day. Mark says he has regained not his old ankle, but the freedom to think about something else during the day.

Continuing treatment between countries

If Mark were treated in Ukraine, his pathway would combine orthopaedic follow-up with a methadone- or buprenorphine-based opioid substitution treatment program. Before another operation, the addiction specialist and anaesthesiologist would coordinate the last dose, its continuation and additional analgesia. Ukraine's Public Health Centre publishes information on substitution treatment sites and patient transfers, helping arrange care after relocation. [120]

In the opposite direction, from Ukraine to BC, the key elements would be a confirmed regimen and last dose, assessment by the local OAT prescriber, medication coverage and an agreed pharmacy. Avoiding a gap between the last dispensing at one location and the first at another preserves the stability already achieved.

Clinical Case No. 2. A First Depressive Episode in a Working Adult

Onset and initial consultation



Illustration: A woman stands by her apartment window, looking at the street after rain.

Emma is 36. She works as a librarian in Victoria, lives with her partner and sings in an amateur choir once a week. Over two months, her world gradually contracts. First she stops replying to friends, then misses rehearsals, and eventually notices that even a day off brings no relief. At work, she reads the same paragraph repeatedly. In the morning, she wakes earlier than necessary and lies awake considering her supposed professional inadequacy.

The reason for seeking help is ordinary: for the third time, she forgets to prepare materials for a children's event. Her family physician, who has known her for several years, schedules a separate, longer appointment. Emma calls it exhaustion. Her partner, present for the end of the conversation with Emma's

consent, describes changes at home: favourite activities have lost their appeal, and evenings together pass mostly in silence.

On examination, Emma is well groomed and engaged but answers more slowly than usual. Mood is persistently low, pleasure is almost absent, sleep and appetite are disturbed, and energy is limited. Her self-appraisal has become disproportionately harsh. She sometimes thinks it would be easier not to wake up but denies suicidal intent or a plan. The physician asks about previous attempts, available means, alcohol, her ability to seek help and support at home.

Her PHQ-9 score is 17; it will be repeated during treatment alongside assessment of functioning. Emma denies periods of increased energy with reduced need for sleep, unusual spending or disinhibition; there is no relevant family history. There are no psychotic symptoms, stimulant use or a new medication that would explain the changes.

Physical examination reveals no significant abnormalities. Fatigue and appetite changes prompt a complete blood count and thyroid testing: haemoglobin is 132 g/L and TSH 1.8 mIU/L. The history and mental state together are consistent with a first major depressive episode of moderate severity, without psychotic features.

Treatment choice and the first weeks

Emma would prefer to begin with psychological care but fears losing her job. After discussing the options, they choose gradually introduced sertraline and CBT-based interventions. The goals are to restore sleep, concentration, work capacity and enjoyment of familiar activities. [40]

Emma has a regular family physician, support at home and the option of temporarily reducing her workload. She joins the free BounceBack program, working through CBT materials

with telephone support from a trained coach. Her physician continues clinical follow-up and risk assessment. [41]

After the first week, Emma calls about nausea. The physician clarifies its severity, medication use and other symptoms; they agree to increase the dose more slowly. Over the following weeks, sertraline reaches 100 mg daily. The next contact is booked in advance.

Behavioural activation begins with short walks and one small task each day. Manageable activity gradually interrupts the cycle of inactivity, guilt and exhaustion. Later, Emma learns to notice the automatic conclusion, "If I've made a mistake, I'm not fit for the job."

At Emma's request, her partner regularly invites her to walk together. When she returns to choir rehearsal, she stays for half the session and a little longer the following week.

Remission, maintenance and completing treatment

By week six, sleep is better, passive thoughts of death have disappeared and PHQ-9 has fallen to 9; concentration and pleasure recover more slowly. After three months, Emma is working full-time again, scores 4 on PHQ-9 and can plan the next month without a sense of inevitable failure.

After remission, treatment continues for approximately nine months, taking recurrence risk and tolerability into account. CANMAT provides for 6 to 12 months of maintenance treatment for many patients and a longer course when relapse risk is higher. [40]

Sexual adverse effects persist longer than nausea and influence the decision about treatment duration. Once her condition is stable, the dose is reduced gradually. Brief dizziness after one reduction is assessed as a possible discontinuation symptom, and the next step is slowed. Follow-up examines anhedonia, early waking and self-blame.

At a later review, Emma is working, singing and has completed her antidepressant course. She recognizes early signs of deterioration and has an agreement to return to her physician.

Clinical Case No. 3. Generalized Anxiety, Panic Attacks and Financial Instability

Symptoms amid genuine uncertainty



Illustration: A father holding a phone watches his children do schoolwork; a television is on in the room.

Amir is 41. He lives with his wife and two school-aged children in Kelowna and works in logistics. After his hours are reduced, the family budget depends on both adults' variable earnings. Rent has risen, and summer visits to relatives are no longer affordable. Initially, his anxiety has an understandable focus: whether there will be enough money next month.

Over eight months, it moves far beyond checking bills in the evening. Almost daily, Amir expects trouble, tenses his shoulders, sleeps poorly and checks work messages even at night. He now worries about more than rent: the children's health, errors in documents and his own memory. His wife's reassurance helps for ten minutes before the next "what if" appears.

One day in a shop, he develops palpitations, trembling, breathlessness and fear of dying. The emergency department evaluates acute physical causes according to his symptoms and risks; investigations find no evidence of acute coronary syndrome. Amir returns home relieved, but within days begins to fear another attack. He avoids queues, stops travelling far from home and asks his wife to stay beside him in the supermarket.

Further assessment identifies persistent generalized anxiety disorder with panic attacks. The clinician clarifies the frequency of unexpected attacks, sustained fear of recurrence and avoidance, and their relationship to caffeine, alcohol, medication and physical symptoms.

Amir drinks several large coffees daily and denies cocaine or amphetamine use. He has had no manic episodes. GAD-7 is 16. TSH, the complete blood count and neurological examination show no significant abnormalities. Financial instability and its effects on sleep and treatment costs are discussed separately.

Finding continuing care

Since moving, the family has not obtained a regular family physician. Amir receives his initial prescriptions and medical notes at different appointments. Each time, he begins with the story about his heart because it seems the most medically convincing. One record emphasizes panic symptoms; another emphasizes insomnia. At every appointment, he explains the previous investigations and prescriptions again.

Ideally, one clinical team would follow treatment response and help him reach CBT of the required intensity. Private psychotherapy costs more than the family can pay regularly. His employer covers only a limited share. The suggestion to

"find a psychologist" leaves Amir choosing between treatment and current bills.

Regular sessions can be expensive. The British Columbia Psychological Association's recommended rate for 2025 to 2026 is 245 CAD (approximately 73.1 CAD PPP) per hour; private practitioners set their own fees. Four sessions at this rate would cost 980 CAD (approximately 292 CAD PPP). For Amir, even the portion left after insurance reimbursement competes with rent. [46]

Free materials can be opened in the evening, but by then Amir is exhausted and there is little quiet space at home. The physician assesses the suitability of BounceBack, designed for mild to moderate anxiety, while looking for regular psychological work on his marked avoidance. [41]

Treatment while waiting and subsequent CBT

At later appointments, repeat contact with the same physician becomes possible. She agrees on a low starting dose of sertraline and slow increases, as Amir closely monitors his heartbeat. They discuss initial anxiety, gastrointestinal adverse effects and delayed benefit; CBT is planned in parallel. [121, 122]

After gradual titration to 100 mg sertraline, attacks become less frequent. Avoidance of transport and shops persists, so functional goals need separate work. Amir also reduces caffeine.

Eventually, he begins a limited course of accessible CBT. The psychologist works on catastrophic interpretations of bodily sensations, checking and avoidance. Exercises progress gradually: a short journey, standing in a queue, returning to a task without checking his pulse again. Interoceptive exposure is used when appropriate after clinical assessment.

Homework is fitted around his changing shifts and reviewed at the next session. [121]

A social worker helps with available benefits and bills. Following their shared plan, his wife gradually reduces her accompaniment: first she waits outside the shop, then Amir shops alone.

Regaining independence

After six months, Amir travels to work again, shops independently and sleeps better. GAD-7 falls to 7. With income still unstable, he can now discuss expenses, make a necessary phone call and continue his day after bad news.

Maintenance treatment continues with periodic review. If sleep worsens again, Amir has his physician's contact details and a plan for returning to CBT exercises.

Clinical Case No. 4. Alcohol Use Disorder Without Severe Physical Complications

Identifying the problem at a routine appointment



Illustration: A cook prepares vegetables for the evening restaurant service; a colleague works nearby.

Peter is 52. He cooks in a small restaurant in Nanaimo, lives with his wife and repairs a boat with a friend on weekends. He visits his physician because of high blood pressure. He mentions alcohol without particular concern: a few cans of beer after a shift, sometimes more at weekends. The misunderstanding begins with the word "can." He usually means 473 mL of 7% beer: about 26 g of ethanol, or 1.94 Canadian standard drinks of 13.45 g each. [123]

Once volume and strength are clarified, actual consumption proves much higher than the initial estimate. Peter regularly drinks more than intended, has unsuccessfully tried to cut down, feels craving at the end of his shift and continues

despite conflict at home. Four behavioural criteria are consistent with moderate AUD. [81]

He has no history of seizures, delirium or morning drinking to relieve tremor. Previously, he managed several days without alcohol or severe symptoms. Before reducing consumption, the physician assesses withdrawal risk, physical illnesses, sedating substances, home support and access to reassessment.

There is no depressive or manic episode. Sleep is light, with early waking temporally related to evening drinking. Peter denies opioids, benzodiazepines and sleeping medications. ALT is 48 U/L with an upper reference limit of 40; bilirubin and albumin are within reference ranges, and eGFR is 88 mL/min/1.73 m^2. The physician plans to reassess liver tests during treatment.

Treatment goals and medication choice

Peter wants less craving, more control and better sleep. They agree on an initial goal of reduced consumption, criteria for evaluating progress and a possible later transition to abstinence.

In the absence of opioids and clinical contraindications, they choose naltrexone: initially 25 mg daily, then 50 mg as tolerated. Before prescribing, the physician also asks about codeine and other opioids in combination analgesics: naltrexone blocks their effects and can precipitate withdrawal in opioid dependence. Naltrexone and acamprosate are first-line medications for ongoing AUD treatment. [81]

Consumption decreases in outpatient care, with early follow-up; severe withdrawal does not occur. Mild nausea develops in the first days. Peter keeps a brief calendar of drinking, craving and sleep. One moment repeatedly appears:

the last half-hour of a shift, when fatigue coincides with the usual invitation from colleagues.

A counsellor works with this situation. Peter arranges to go home with a colleague who ends the evening without alcohol, and to eat dinner beforehand. At a family meeting, he and his wife agree to speak openly about craving and spending.

The course over a year

After two months, heavy drinking is less frequent, sleep improves and blood pressure is easier to control. After conflict at work, Peter again drinks far more than planned one evening. At his appointment, they examine the sequence of events, regularity of naltrexone use and the possibility of more frequent counselling.

In the fourth month, Peter chooses abstinence himself: he finds it easier to get through the evening without the first drink than to stop each time. Earlier work has helped identify risky situations and acceptable support.

A year later, his condition is stable. Naltrexone duration is reviewed in light of craving, tolerability and Peter's preferences. They retain an agreement for prompt reassessment if things worsen.

Treatment has taken place in the community from the start: the problem became visible during an appointment about blood pressure, and subsequent contacts combined physical health monitoring, AUD medication and work on familiar evening situations.

Clinical Case No. 5. A First Psychotic Episode in a Young Adult

Changes before the first contact

Raj is 22. He lives in Surrey with his mother and older sister, attends college and works part-time in an electronics shop. The latest semester begins with missed classes. His family attributes this to gaming at night; Raj says the instructors deliberately make assignments ambiguous. He increasingly checks the window and tapes over his laptop camera, then tells his sister that classmates are sending comments about his thoughts through his phone.

Over several weeks, sleep decreases, hygiene deteriorates and voices begin discussing him. Frightened, Raj mostly stays at home. One evening, he refuses food because he believes it has been switched. His sister helps him reach emergency care.

The initial record describes a psychotic syndrome with persecutory delusions, auditory hallucinations and functional decline. Assessment clarifies duration, earlier development, mood episodes and physical signs. Raj reports regular high-potency cannabis use; its role will be assessed through timing and the subsequent course after cessation.

In the department, Raj is oriented, attention is broadly sustained and consciousness does not fluctuate. There is no fever, new headache, seizure or focal neurological symptom. Basic investigations, substance use history and examination guide further work; clinical indications determine neuroimaging and specialized tests. Continuing observation is also needed to assess risk, nutrition and his ability to agree to treatment.

Acute treatment and early intervention

After several discussions, Raj agrees to a brief voluntary admission. He is offered risperidone at a low initial dose with gradual titration. They discuss drowsiness, motor adverse effects, prolactin and metabolic changes. Weight, blood pressure, glucose and lipid measures are recorded before treatment. These provide a baseline when, a month later, the patient says he feels "different."

Response to the first antipsychotic is assessed over an adequate course while actual use and tolerability are checked. With a partial response, the team clarifies these factors before changing medication. [124]

Contact with Fraser Health Early Psychosis Intervention is established before discharge. The program accepts people aged 13 to 30 with a first psychotic episode, including family referrals, and provides care for up to three years. Assessment also covers co-occurring substance use. [4]

The first outpatient contact occurs soon after discharge. Raj knows his coordinator's name, and his sister has her contact details. The discharge summary records symptoms, medication, risks, Raj's greatest fears and ways of building trust.

Clarifying the diagnosis

The voices become less frequent; the belief that he is being watched recedes more slowly. Raj stops cannabis and restores sleep. Psychotic symptoms persist beyond intoxication; the overall duration, functional decline and absence of a dominant mood episode later allow the diagnosis to be clarified as schizophrenia.

His mother asks about returning to education. The psychiatrist discusses retained abilities, attention difficulties

and gradual increases in workload. Raj's main concern is confidentiality. Together, they decide what he is willing to share with the college to obtain support.

Several months later, akathisia develops. Raj describes being unable to sit still; his sister interprets it as renewed agitation. Subjective inner tension, the need to move and examination help identify the adverse effect. The dose is reviewed, and later they agree to switch antipsychotics while monitoring psychotic symptoms.

Education, family and continuing support



Illustration: A young man carrying a backpack and folder walks along a college corridor with his sister.

An occupational therapist helps rebuild a daily schedule. Raj returns to one course; attention, stamina and pace are assessed through actual classes. Another course will be planned once he has adjusted to this workload.

Family meetings address early changes in sleep, tension and suspiciousness. His mother learns to respond to his fear calmly and briefly. Raj, his sister and the coordinator share responsibility for arranging appointments and agree on what information can be given to the family.

A year later, Raj studies part-time and works several shifts a week. Negative symptoms and cognitive difficulties still limit his pace. Appointments address the antipsychotic, sexual adverse effects, physical activity, relationships and contact with friends.

They separately consider a long-acting injectable formulation: visit frequency, convenience and Raj's preferences. Any reduction in maintenance treatment will require assessment of the previous course and relapse risk, with closer follow-up.

Preparation for transition after the three-year program begins early. Together with Raj and the psychiatrist, the coordinator will identify the necessary level of continuing support and the receiving team. [4]

Clinical Case No. 6. Longstanding Schizophrenia, Clozapine and Admission with Pneumonia

Previous course and partial stabilization

David is 54. His psychotic disorder began in young adulthood; over thirty years, there have been remissions, repeated admissions, several moves and changes of physician. He now lives in a supported apartment in the Fraser region. His sister visits weekly. He enjoys radio programs about gardening and tends several boxes of herbs on the balcony.

For years, earlier records used the word "resistant," although some unsuccessful courses had been interrupted by adverse effects or irregular dosing. Later, the team reconstructed the treatment history and confirmed two trials of different antipsychotics that were adequate in dose, duration and actual use, without sufficient response. Only then did clozapine have a clear clinical basis. Verifying the adequacy of previous trials is an important part of Canadian recommendations for treatment-resistant schizophrenia. [124]

Clozapine reduced the intensity of the voices and the frequency of crises. David still sometimes believes his neighbours are discussing him, but he can set the thought aside and go shopping. He needs support with complex daily tasks, money and regular treatment.

Consultation is provided by Fraser Health's Psychosis Treatment Optimization Program, an outpatient service for optimizing antipsychotic treatment, including clozapine. The local team, pharmacy and family physician provide everyday follow-up. [125]

Monitoring treatment

David takes a stable, individually selected clozapine dose. The team monitors absolute neutrophil counts through the Canadian medication monitoring system and reviews bowel movements, orthostatic symptoms, drowsiness, weight and glycaemia at appointments.

When asked directly, David reports infrequent bowel movements with considerable straining. The physician prescribes constipation treatment, and the nurse agrees with David on tracking stools, pain, distension and other signs of deterioration. Clozapine-associated gastrointestinal hypomotility can cause severe complications. [126]

His family physician also manages type 2 diabetes; HbA1c is 7.2%. Cigarette consumption is recorded whenever there is a substantial change in condition: tobacco combustion products induce clozapine metabolism, and stopping smoking can increase its concentration. Nicotine replacement therapy does not have this inducing effect. [127]

Acute physical illness

In February 2026, David coughs for several days, becomes weaker and stops his usual shopping. A support worker notices drowsiness and calls for medical help. In hospital, his temperature is 38.6 °C, oxygen saturation 89% on room air and respiratory rate 26 per minute. Chest radiography shows a right lower lobe infiltrate. He is admitted to a general medical ward with pneumonia and hypoxaemia.

Attention and orientation fluctuate; David confuses day and night and responds slowly. His sister describes an abrupt departure from his usual state. Acute onset and impaired attention direct assessment towards delirium associated with pneumonia.

The internist treats pneumonia and assesses oxygenation, hydration and glucose. The consultation-liaison psychiatrist establishes baseline functioning and clarifies possible medication contributions. The pharmacist checks actual use, recent doses, interactions and changes in smoking. David stopped smoking at home when he became ill and does not resume in hospital.

Infection and smoking cessation can raise clozapine concentrations. Because of drowsiness, the psychiatrist orders a clozapine level and reviews the dose. The internist continues to correct hypoxaemia, dehydration and metabolic abnormalities, while the pharmacist checks interactions. The three professionals agree on one plan. [126, 127]

Why a missed dose matters

Because of drowsiness, David missed several doses before admission. The team establishes the duration of the interruption: according to the Canadian monograph, after at least two days, treatment resumes at a low dose to reduce the risks of hypotension, bradycardia and syncope. [126]

His sister brings the pharmacy packs. These are compared with actual use and pharmacy information; after assessing toxicity and physical stability, the team plans retitration. They also monitor for returning psychotic symptoms during the transition.

As the pneumonia resolves, attention improves. David begins reading short newspaper items, remembers his plants and asks his sister to water them. She recognizes the familiar rhythm of his conversation.

Discharge and return to the community



Illustration: A man recovering from pneumonia walks along a hospital corridor holding the handrail, with a nurse beside him.

Before discharge, the team assesses walking, nutrition, daily-living skills and residual weakness. The occupational therapist finds that David needs help with several new prescriptions. Home support is temporarily increased.

The pharmacy receives the final clozapine regimen, blood-test plan and the clozapine prescriber's contact details. Changes in physical health treatment are sent to the family physician. Smoking cessation and a plan to reassess the dose if David resumes cigarettes are documented separately.

At the first follow-up, David wants to remain tobacco-free and accepts support. Actual smoking status continues to be reviewed alongside clozapine tolerability. Within several weeks, he is shopping again, and psychotic symptoms return to their previous controlled level.

Clinical Case No. 7. Bipolar I Disorder, Unstable Housing and Criminal Proceedings

Relapse of mania

Owen is 34. He works on construction sites in Vancouver and has spent recent months renting a room under a short-term arrangement. Bipolar I disorder has been known since his twenties: he had mania requiring admission and a separate depressive episode. Lithium kept him stable for several years, but after moving he missed blood tests and eventually stopped taking it. He had long viewed the early tremor and need for regular blood work as the price of a life that was already back on track.

He has a previous conviction for a property offence. Available records incompletely describe his mental state at that time; defence counsel clarifies its legal significance for the present case.

Before this presentation, Owen sleeps two or three hours nightly for ten days, feels little fatigue, speaks rapidly and interrupts. He takes out credit for tools for a business that does not yet exist, sends acquaintances proposals at night and believes he has acquired exceptional abilities to run a major project. Conflict with his landlord escalates: Owen damages a door and makes a threat. Neighbours call police.

Emergency assessment identifies mania with grandiose delusions and substantially impaired insight. Alcohol, stimulants, physical causes and the risk of further dangerous behaviour are assessed. Clinical and legal criteria support involuntary admission under the Mental Health Act; Owen is informed of his status, rights and the review process. [14]

Inpatient treatment and a separate legal process

Sleep is restored and antimanic treatment begins with quetiapine and lithium, taking his previous response into account. Renal function, electrolytes, calcium, TSH and interactions are checked before lithium. After titration and consistent dosing, the 12-hour post-dose concentration is 0.8 mmol/L. Clinical response and tolerability are assessed alongside the level. [43]

After two weeks, Owen sleeps longer, listens to questions and doubts his grand plans. Shame and fear emerge: he has lost the room, the debt remains, and police have submitted reports concerning property damage and the threat. Crown counsel assesses the material and decides whether to approve charges under BC's procedure. [128]

Owen asks his physician to describe the illness for court. The psychiatrist prepares clinical information within the scope of a proper request. Defence counsel considers separate questions: criminal responsibility at the time and his present ability to participate in proceedings. The NCRMD criterion concerns the capacity to appreciate the nature and quality of the act or know that it was wrong because of mental disorder. [129]

The case continues through the ordinary criminal process. Counsel explains defence options and release conditions: no contact with a particular person and no return to the previous address. The team takes these conditions into account when finding housing and planning discharge.

When clinical stabilization comes before a housing solution

Owen's housing was already unstable before admission. He cannot return to the room, and his sister has a small

apartment. She helps with paperwork and transport; the team seeks accommodation through housing services.

A social worker assists with an application through BC Housing's Supportive Housing Registration Service and contacts a homeless outreach service. At the same time, they seek somewhere for the immediate discharge; the longer-term application is considered according to need and availability. [130, 131]

In a 2025 qualitative study, 24 residents of supportive and complex-care housing in BC described long and variable waits, limited choice of location and adjustment to new housing rules. These difficulties also characterize Owen's situation: his clinical condition improves faster than a suitable address becomes available. [132]



Illustration: A man unpacks a travel bag in a small room in temporary accommodation.

Temporary supported accommodation is found before discharge. The first outpatient visit, blood tests and pharmacy are coordinated around that address. The longer-term housing application remains active.

One laboratory appointment has to be rescheduled because of transport. The nurse agrees a new date, informs the treating physician and helps combine the journey with the next appointment.

Continuing care and regaining responsibility

Owen gradually works through the financial consequences of mania. He finds it difficult to discuss the damaged door and the other person's fear. Psychotherapeutic work addresses shame, understanding the episode and realistic ways to repair its consequences within the court's conditions.

They develop an early-warning plan: reduced sleep, rapidly multiplying projects, spending and a sense of exceptional capability. With his consent, his sister knows whom to contact with observations. Maintenance planning includes monitoring lithium, renal function and thyroid function; they also discuss dehydration, interactions with some analgesics and changes to other medications. [43]

Quetiapine causes morning drowsiness. After stabilization, the regimen is reviewed alongside the return-to-work plan; driving and machinery safety are considered separately. Because his accommodation is temporary, the team agrees to maintain contact through the next move.

At the next assessment, criminal proceedings continue. Owen can now discuss decisions with his lawyer, attend the clinic and gradually resume work. The housing and legal parts of his life will need continuing support.

Clinical Case No. 8. Dementia, Family Care and Delirium During Physical Illness

Gradual functional decline



Illustration: An older woman, her husband, daughter, and a nurse discuss a weekly care schedule at home.

Mei is 79. She lives with her husband in Burnaby; their daughter lives nearby and visits several times a week. The family has established routines: Sunday lunch, walks along a familiar route and conversations with the grandchildren. Mei enjoys cooking, although over the past two years she has increasingly needed help with the sequence of preparing dishes.

At first, the difficulties seemed like forgetfulness: repeated questions, lost bills and confusion about dates. Later, she took her morning medication twice and could no longer manage paying for shopping. Her husband took over these tasks, so household life appeared almost unchanged for a long time.

Discussing who now did what revealed the actual decline in independence.

Assessment considers hearing, vision, language, education and previous functioning. Cognitive testing is supplemented by medication information, depressive symptoms, neurological examination, laboratory investigations and neuroimaging. The picture is consistent with dementia, most likely of Alzheimer type, with vascular risk factors.

They discuss donepezil, its expected symptomatic benefit, and gastrointestinal and cardiac adverse effects. At home, they arrange pharmacy packs, agreed supervision of dosing, help with finances and safe kitchen use. Behavioural symptoms and care needs are reviewed at subsequent appointments. [133, 134]

What family support involves

Her husband has osteoarthritis and needs respite; their daughter works. A home assessment covers available support hours, bathing, mobility, food and night-time sleep. It determines home support and respite options; contributions towards some services depend on income. [135, 136]

Her husband says he is managing, then admits that for almost a month he has left home only with Mei. Their daughter begins taking time off work. Care needs have gradually occupied the time previously available for rest and personal tasks.

The family and team agree on home help and daytime activity. Some support begins later than expected. During the interim, the daughter takes specified days, and regular respite is arranged for her father.

Acute change after a gastrointestinal infection

After several days of diarrhoea and reduced fluid intake, Mei suddenly becomes disoriented, cannot sustain a conversation, and alternates between falling asleep and trying to get up in the middle of the night. She stops recognizing her bedroom. Her husband knows her usual state and insists that this began quickly, rather than gradually over recent years.

In hospital, dehydration is identified: sodium is 149 mmol/L and creatinine 112 µmol/L, compared with a previous 72. Acute onset and fluctuating attention and activity are consistent with delirium superimposed on dementia. [137]

The medical team treats the cause and corrects fluid balance with laboratory monitoring. They review medications, pain, constipation, urinary retention and sleep. Glasses, a hearing aid, daylight and her daughter's familiar voice support orientation.

The psychiatrist helps assess delirium and behavioural difficulties. Environmental overload is reduced, with support for mobilization and orientation; together with correction of the physical illness, these measures prove sufficient. [137, 134]

Recovery after delirium

Sodium and renal function improve, and fluctuations in attention diminish. Mei still needs more help than before the infection. The team plans another functional assessment after further recovery.

The occupational therapist checks whether Mei can find the bathroom, stand safely, use a cup and follow a simple sequence. Her daughter describes familiar cues at home. These findings inform the discharge plan and the next home visit.

Mei returns home with increased support. Later, her night-time needs grow; she, her husband and their daughter begin considering long-term care with the team.

Waiting for long-term care

The waiting list affects the family's decisions. The Office of the Seniors Advocate report *Monitoring Seniors Services 2025*, released in 2026, records 7,029 people waiting as of 31 March 2025. Their mean elapsed wait was 287 days. [70]

While waiting, Mei's needs change, her priority is reviewed and the family receives the interim support available. Temporary assistance does not always match the family's ideal schedule. Small gaps are felt most keenly at this point in the larger system: one night without respite, one cancelled ride, one change of worker to someone who does not yet know Mei's habits.

When a suitable place becomes available, the family participates in the transition. Her husband continues bringing familiar tea, and her daughter brings photographs and music. Care changes address, but relationships continue. Follow-up includes nutrition, mobility, pain, sleep and understanding Mei's wishes as far as she can express them.

Clinical Case No. 9. Stimulant Use Disorder, Psychotic Symptoms, and Loss of Housing

From occasional to persistent use

Lucas, 28, worked in Vancouver's restaurant industry and shared an apartment with a friend. In his early twenties, he took MDMA at parties a few times a year. Later, cocaine appeared in his circle: first on weekends, then after exhausting shifts. Over several years, use became a recurring way to stay active and put fatigue out of mind.

Eventually, Lucas switches mainly to methamphetamine: it is available among people he knows and keeps him feeling active longer. Frequency of use, sleep deprivation, and spending increase together.



Illustration: A young man with a backpack and bag walks along a wet Vancouver street toward an overnight shelter.

Missed shifts, borrowed money, and conflicts lead to job loss. Rent arrears accumulate. When his friend moves out, Lucas

can no longer keep the apartment. For several months, he alternates between acquaintances' homes and, sometimes, a shelter. His address changes more often than the contact information in his medical record.

At his first presentation, Lucas wants to sleep and stop feeling watched. After several nights with almost no sleep, he hears footsteps, interprets chance conversations as threats, and changes his usual routes. A friend brings him to the emergency department.

Intoxication, psychosis, and the period after stimulant use

On examination, he has tachycardia, tension, suspiciousness, and exhaustion. The emergency physician assesses temperature, cardiovascular symptoms, hydration, and possible injuries, and asks about other substances. The psychiatrist compares the onset of psychotic symptoms with the timing of use; the course after stopping will help clarify the diagnosis.

A calm environment reduces overstimulation. Olanzapine is prescribed briefly for psychotic symptoms, with monitoring of consciousness and physical status. Observation continues after intoxication has resolved. [138]

After sleep, the voices and suspiciousness subside. Prolonged sleeping, fatigue, low mood, and strong cravings emerge. Lucas says he feels worse than on the day he came in. Suicidal thoughts, available support, and where he will stay next are reassessed.

Over the following weeks without methamphetamine, the psychotic symptoms disappear. There is no history of psychosis independent of substance use. The psychiatrist diagnoses stimulant-induced psychotic disorder in the context of severe stimulant use disorder. As remission and abstinence

continue, the psychiatrist reviews the need for olanzapine and a plan for gradual discontinuation; follow-up covers both recurrence of psychosis and renewed substance use. [139, 140]

Outpatient treatment and the housing barrier

Lucas starts accessible addiction counselling incorporating CBT. The BCCSU guideline also describes contingency management: systematic reinforcement of agreed changes, such as attendance or verified abstinence. At the beginning of Lucas's local care pathway, individual appointments and work on cravings and high-risk situations are available. [139]

He misses the first appointment after changing where he sleeps. His phone is out of charge, and the reminder went to an old number. With Lucas's consent, the team arranges an additional way to reach him through a support worker.

A housing worker helps with documents and an application for supportive housing. They look for a shelter for the next few nights while maintaining the longer-term plan. An outreach service helps with documents, finding housing, and access to local resources. [130, 131]

Residents of supportive housing in a BC study described affordable rents alongside difficulties with safety, neighbours, and limited choice. For Lucas, the environment matters clinically: he is looking for somewhere he can sleep and reduce daily contact with substance use. [132]

Risks of the unregulated market and returning to work

Lucas denies regular opioid use; there are no signs of OUD. Because of the risk of contaminants in unregulated substances, the team teaches him to recognize opioid

poisoning, provides naloxone, and discusses available drug checking and other harm reduction measures. [139, 114]

In the first months, Lucas returns to use after staying with a friend where methamphetamine is always available. At appointments, the team reviews sleep, cravings, symptoms, and the possibility of different accommodation; treatment contacts continue.

After obtaining a more stable temporary place, Lucas finds it easier to sleep and follow a schedule. He eventually starts working a few morning shifts. Morning shifts specifically: returning to his former nighttime environment would create another high-risk situation. Psychotherapy focuses on cravings, responses to setbacks, and rebuilding social connections that do not revolve around the substance.

By the end of the year described, he has not yet regained his previous income. Periods without use have become longer, psychotic symptoms have not returned, and contact with care continues. Clinical improvement is already apparent, although debts, housing uncertainty, and the risk of renewed use remain.

Clinical Case No. 10. Autism Spectrum Disorder First Recognized in Adulthood

Reason for seeking help and developmental history

Lin is 33. She works as a technical illustrator in Richmond, lives with her partner, and handles tasks with clear requirements well. After moving to an open-plan office, she starts missing work more often. Noise, unexpected conversations, and changes of plan leave her exhausted by evening. Lin seeks help for anxiety and a sense that she can no longer manage an ordinary workday.

Her initial account might suggest social anxiety or depression. Exploring her early life, however, changes the picture. Since childhood, she has found it difficult to understand indirect hints, sustain unstructured conversation, and tolerate certain sounds and textures. She spent hours on narrow interests, had a few close relationships, and learned to rehearse social situations in advance.

With Lin's permission, her mother adds to the developmental history, while school reports help trace early signs. Assessment covers social interaction, sensory features, repetitive patterns, adaptive functioning, and co-occurring disorders. [141]

Lin asks about Asperger syndrome, a term she knows from older literature. The physician relates this historical term to the current ASD diagnosis and describes her individual profile: preserved intellectual and professional abilities alongside substantial sensory and social difficulties.

Access to diagnosis and costs

A comprehensive assessment requires a professional experienced in adult autism. Lin chooses a private assessment, saves money, and schedules appointments

around work. Her supplementary insurance reimburses part of the cost.

On its adult diagnosis page, AutismBC gives an estimated private assessment cost of CAD 3,000 to 5,000 (≈CAD 895 to 1,490 PPP) and describes possible partial insurance coverage and help through local services or employment programs. A province-wide public pathway for adult diagnosis remains a gap identified in the organization's materials. [142][11]

While assessment continues, Lin works with a psychologist on anxiety, sensory overload, and changes to her work schedule. A few months later, the diagnostic conclusion clarifies the next goals.

Formulation and subsequent work

ASD without intellectual disability, with co-occurring anxiety, is confirmed. Lin feels relief and, at the same time, anger over years of advice to "be less sensitive." She discusses how to explain her needs to those close to her and at work.

The psychiatrist assesses co-occurring symptoms; there is no major depressive episode or psychosis. Care focuses on anxiety and adapting the environment. [141]

The psychologist makes sessions more concrete: written summaries, a predictable structure, and time to think. Lin works better with an example involving tomorrow's meeting than with general metaphors.

11. An estimate from the AutismBC page dated January 6, 2022, available in October 2026; an individual quote depends on the practitioner and the scope of assessment. [142]



Illustration: A woman works on a technical drawing at a drafting board in her home workspace.

With Lin's agreement, workplace accommodations include a quieter space, written priorities, advance notice of changes, and some remote work. She decides how much medical information to disclose. At home, she and her partner plan time to recover after a demanding day.

Diagnosis and eligibility for support

CLBC assesses eligibility for the Personalized Supports Initiative on the basis of diagnosis and significant limitations in adaptive functioning. Lin manages her household and finances and travels around the city independently; her assessment falls below the program's threshold of need. She receives ongoing support through workplace accommodations, psychological care, and community connections. [65]

A year later, Lin works more consistently, has a clearer schedule, and is less exhausted. After a busy day, she keeps the evening quiet. The new arrangements have reduced the daily effort required for work and social interaction.

Clinical Case No. 11. Autism with Intellectual Disability and the Transition to Adult Services

Preparing for adult life

Noah lives in Langley with his parents. At the start of the story, he is 17. He has autism and intellectual disability and communicates using individual words, gestures, and cards. He likes watering plants, listening to familiar recordings, and taking the same route to the park. With people who know him, he can clearly express agreement, refusal, and a preference between two activities.

Noah needs help with personal hygiene, meals, activities outside the home, and medical appointments. His mother has reduced her working hours; his father covers evenings. They want to broaden their son's activities and relationships beyond the family.

Planning begins before he finishes school. STADD coordinates transitions for eligible young people aged 16 to 24, while CLBC arranges support from age 19 once eligibility criteria are confirmed. A navigator helps gather assessments and coordinate the medical, educational, and social parts of the plan. [65, 66]

The plan records how Noah shows pain, reacts to noise and waiting, which prompts help with blood collection, and which tasks he performs independently. This information accompanies his medical history when handed over to new staff.

A new behavioural concern and a physical cause

Shortly before his nineteenth birthday, Noah starts refusing some foods, sleeps poorly, and hits his cheek with his palm. In a new setting, he pushes a worker's hand away more often. The initial referral describes "increasing aggression." His

parents add that the behaviour is new and especially noticeable while chewing.

The family physician performs a physical examination and arranges an adapted dental assessment. A painful tooth is found. After pain relief and treatment, Noah eats better and pushes the worker away less often.

Sleep and tolerance of the new schedule recover more slowly. Residual pain, sensory overload, communication, and anxiety are also assessed, with the circumstances of behavioural episodes recorded. [141]

In Fraser, DDMHS provides specialized care for people with intellectual disability and mental health difficulties or challenging behaviour. Referrals include supporting documents, a recent physical examination, and contact details for the family physician or nurse practitioner who will continue care after the specialized work ends. [67]

Clinical assessment adapted to communication

At the consultation, Noah has time to become familiar with the room. The clinician addresses him directly, offers a simple choice, and waits for an answer; his mother helps interpret gestures.

There is no psychosis or mania during assessment. The symptoms are associated with pain, disrupted sleep, and schedule changes. The team agrees on a sequence of activities, communication approaches, and conditions for falling asleep, then monitors the response. [141]



Illustration: A young man waters plants in a community garden; his mother and a support worker are nearby.

Staff use the same simple prompts and choice cards. Waiting before transport is shortened, and changes are announced in advance. His parents notice that Noah feels better when his day is predictable and filled with meaningful activities. His interest in plants gradually returns.

Starting adult services

CLBC confirms Noah's eligibility, but the full requested level of service does not start at once. Some daytime activities become available earlier, regular respite for his parents later. In the first months after school ends, long periods at home lack the usual support. The family temporarily fills these gaps itself.

CLBC's 2025/26 budget was CAD 1.8 billion (≈CAD 537 million PPP); an additional CAD 127 million (≈CAD 37.9 million PPP) was intended to expand services, including for an anticipated 1,200 new recipients. At the same time, CLBC

acknowledged a waiting list and allocated resources according to urgency of need. For Noah's family, this means services start in stages: daytime activities arrive before regular respite for his parents. [143]

His father asks for actual start dates and a named contact responsible for each service to be recorded. Until a worker's first shift, his parents provide daytime support.

Noah becomes familiar with two workers. When one leaves, the replacement initially works alongside an experienced colleague, using the same cards and prompts.

The longer view

At twenty, Noah gradually gains experience spending time outside the home. His family and team consider possible living arrangements that would provide the support he needs while preserving close relationships.

The result is visible in everyday things: less pain, clearer communication, engaging activities, and regular respite for his parents. An agreed medical plan helps staff recognize the next change in behaviour.

Clinical Case No. 12. Severe Alcohol Use Disorder with Psychotic Symptoms and Persistent Memory Impairment

History and condition on admission



Illustration: A man sits on a bench by a bus stop; a work bag and bottle stand on the ground beside him.

Tom is 58. He worked for many years as a mechanic in Kamloops. As work gradually declined, alcohol came to structure his day: mainly vodka, often 250 to 375 mL daily, with variable periods of lower consumption. He eats irregularly. His daughter lives nearby, brings groceries, and stays in touch, but does not always know how much he actually drinks.

Over recent months, Tom has several times heard voices accusing him of theft. During these periods, he generally knew where he was and could give a coherent account of events. The voices appeared during heavy drinking or abrupt

reductions. No prior history of prolonged independent psychosis emerges, although the timeline is initially incomplete.

His daughter brings him to hospital after a fall without significant injury. He is exhausted, walks unsteadily, and struggles to remember what has just been said. There is tremor and autonomic evidence of withdrawal after reducing alcohol. At this stage, he needs a general medical admission to assess injury, metabolic status, nutrition, and the risk of complicated withdrawal.

The emergency physician and consultation psychiatrist assess three processes: alcohol withdrawal, hallucinatory experiences, and cognitive-neurological deterioration. The timing of voices, clarity of consciousness, and fluctuations in attention help distinguish alcohol-induced psychosis from delirium.

Withdrawal and suspected thiamine deficiency

The physician prescribes lorazepam under the inpatient withdrawal protocol. Nursing staff regularly assess symptom severity, sedation, breathing, and haemodynamic status; these observations guide dose adjustments and reductions once the acute syndrome has resolved. [81]

Poor nutrition, ataxia, and memory impairment raise concern for Wernicke encephalopathy. The full classical triad may be absent; parenteral thiamine is given immediately without waiting for laboratory confirmation. The team corrects electrolytes, including magnesium, and plans nutritional restoration. If hypoglycaemia is present, glucose is given immediately, with thiamine administered as soon as possible. [144, 145, 146]

Liver tests are abnormal in the context of longstanding use. The differential assessment of cognitive and motor

impairment includes hepatic encephalopathy, injuries, vascular changes, and other deficiencies; further investigations depend on clinical findings.

What remains after the acute phase

Withdrawal resolves, and gait improves. With abstinence, psychotic symptoms fade. After stabilization, the team reviews the need for further antipsychotic treatment.

Several weeks later, Tom can sustain a conversation but forgets his daughter's morning visit and fills gaps with confabulations. Serial assessments after the acute phase support a persistent amnestic syndrome in the context of probable Wernicke-Korsakoff syndrome.

Repeated assessment focuses on learning new information, daily activities, and the ability to use prompts. Over the following months, recovery and the required level of support will be monitored.

Tom makes tea using a familiar sequence but loses track of the next step in a new task. The occupational therapist introduces simple external cues, a repeated schedule, and training for those close to him.

Long-term addiction treatment and supported living

With acceptable renal function and abstinence as the goal, acamprosate is selected. Several daily doses are coordinated with support workers who will help because of his memory impairment. [81]

His daughter continues working and visits regularly. Meals, medication, and rehabilitation of skills are organized in a supported setting. Decision-making capacity is assessed separately for treatment, accommodation, and finances.

He chooses music, clothes, and activities, recognizes those close to him, and enjoys talking about his former work. Some longstanding skills are better preserved than his ability to learn new information. This helps shape a day that contains more than memory checks and medication administration.

After several months, everyday functioning improves; help with new tasks and medication remains necessary. Tom abstains from alcohol, eats regularly, and maintains activities connected to longstanding skills.

Clinical Case No. 13. Depression and Opioid Dependence During Incarceration and After Release

Admission to the institution



Illustration: A woman spreads a blanket over a mat in a tent beside an urban park path.

Leah is 39. Before incarceration, she worked as a cleaner, then lost her job and moved between temporary accommodations. Between placements, she spent some time sleeping in a small tent in a city park, trying each evening to keep her bedding dry. In recent years she used illicit opioids, mainly a substance sold as fentanyl; two months before her arrest, she started methadone treatment. She is serving a sentence in a BC provincial correctional institution. This is an ordinary criminal proceeding, without an NCRMD finding.

At the initial medical assessment, Leah fears two things most: that methadone will be stopped and that reporting low mood

will automatically cost her all privacy. The nurse explains what information is needed for treatment and what safety circumstances may require disclosure to other staff. The assessment is a medical conversation, although the institution's regime is apparent in every organizational detail.

PHSA/BC Mental Health and Substance Use Services organizes health care in provincial correctional institutions. The team verifies pharmacy records, the last methadone dose actually taken, missed doses, and current tolerance. Leah is able to continue treatment without interruption. [147, 53]

A depressive episode

Suicide risk is assessed at first contact. At the same time, insomnia, anxiety, and tearfulness are explored: the experience of arrest, fear about housing, pain, changes in routine, and possible substance withdrawal.

The history reveals that persistent low mood, anhedonia, early waking, appetite loss, hopelessness, and thoughts that others would be better off without her had already lasted over two months before arrest. These symptoms persist after opioid treatment stabilizes. No periods of mania or hypomania are identified in the available history. Leah has no current intention to harm herself, but risk is reviewed when her condition changes, during conflicts, and as release approaches.

The clinical picture is consistent with a depressive episode in the context of opioid use disorder. The physician agrees on sertraline treatment with gradual dose increases, checks interactions, tolerability, and other medical factors. Brief structured psychological sessions are discussed separately. Their focus is practical: sleep, guilt, rebuilding contacts, and asking for help before a situation becomes critical. [40]

After several weeks, Leah sleeps better, reads, and concentrates on a letter to her sister. The institutional schedule helps with regular medication. Her greatest concerns are future housing and reconnecting after release.

Preparing for release

Release planning begins early. Her former room is lost; her sister can stay in touch. Together with Leah, the nurse and social worker clarify documents, health coverage, pharmacy, transport, prescriptions, and a place for the first night.

Community Transition Teams support the transition from provincial institutions to community care. BC Corrections' public description notes an extension of their support from 30 to 90 days. Leah agrees to this support and meets the worker who will help her after release. [148]

Before release, the team arranges contact with the physician who will continue methadone prescribing, a pharmacy, and the time of the first contact. A supply of other medication is arranged, and clinical information is transferred. Leah receives naloxone and refresher training on opioid poisoning. [114, 53]

The first week outside

On release day, a transition worker helps her reach temporary accommodation. The next morning, Leah receives methadone at the agreed pharmacy. However, the referral for ongoing depression treatment reaches a different service than expected; her old phone card no longer works. The appointment is delayed until the team worker establishes contact and confirms who is temporarily managing prescriptions.

A study by Erickson and colleagues describes transition difficulties: 19 women living with HIV after incarceration in

Metro Vancouver and six service providers discussed barriers to safe housing, addiction treatment, and rebuilding social connections. The interviews show how simultaneously seeking housing and care burdens the first days after release. [149]

Leah worries that one unsuccessful appointment means losing all help. The transition worker explains what happened and arranges another contact. For the physician, this means a few calls and correcting the handover; for her, it is the difference between continuing treatment and returning to her former circle to obtain illicit substances.

Three months and the following year

At three months, Leah receives methadone regularly, and depressive symptoms have decreased. Housing remains temporary. Before transition support ends, the team confirms the appointment date with an ongoing provider and transfer of prescriptions.

In a cohort of 1,535 people with 4,738 incarceration episodes in BC during 2015 to 2018, OAT during incarceration was associated with a lower hazard of non-fatal overdose in the first 30 days after release: adjusted hazard ratio 0.55 (95% CI 0.41 to 0.74). The association appeared both when previous OAT was continued and when it began in the institution: 0.49 and 0.58, respectively. [150]

Over the following year, Leah returns to part-time work. Anxiety increases during a housing move. Appointments monitor depression, sleep, treatment tolerability, and cravings; her sister remains a source of closeness and support.

In Ukraine, as of January 1, 2026, the Public Health Centre recorded 742 OAT recipients in branches of the criminal justice system's medical service. For a patient with the same course, the next step would be a coordinated transition to a civilian OAT site: confirmation of the dose, receiving facility, and dispensing date. [151]

Clinical Case No. 14. Postpartum Mania with Psychotic Symptoms

The first days after childbirth

Mara is 31. She lives with her partner in New Westminster and has given birth to their first child. Pregnancy passed without a known psychiatric episode. Previously, she worked as a music teacher. Her partner has taken leave, and his mother helps with meals and household tasks.

On the fifth day after delivery, Mara almost stops sleeping, even while her partner cares for the baby. She does not feel tired, talks continuously, develops several grandiose plans, and alternates between joy and sharp irritability. Two days later, she becomes convinced that ordinary phone messages contain special instructions about the baby's future. Her partner notices the abrupt change and arranges emergency assessment.

By the seventh postpartum day, a manic syndrome with psychotic symptoms has developed. Following emergency assessment, the course is consistent with a first manic episode of bipolar I disorder with postpartum onset. [152]

Emergency assessment and safety

The department checks physical and neurological status, blood pressure, temperature, medication, and substance use. Obstetric complications, infection, and endocrine and neurological causes remain in the differential; examination findings determine investigations. Mara has no fever, severe hypertension, focal neurological signs, or evidence of intoxication. Attention is sufficiently sustained for conversation, although her own ideas distract her easily.

The team assesses the content of psychosis, impulsivity, self-care, and safety of contact with the baby. Her partner

temporarily takes the primary caregiving role, with the grandmother helping at night. The family agrees with the team on visits and information sharing.

Mara agrees to assessment but, because of mania, denies needing to stay. The team assesses decision-making capacity and Mental Health Act criteria, completes the required procedure, and explains her rights. Mara remains on an acute psychiatric ward; the baby stays with family. Her partner maintains daily contact. [14, 152]

Treatment of the acute episode

Antimanic treatment begins with olanzapine; lorazepam is added briefly for acute agitation and restoration of sleep. After renal and thyroid function and other relevant measures are checked, lithium is added with concentration and tolerability monitoring. The clinical rationale draws on mania recommendations and separate perinatal guidance; the team selects the specific regimen. [43, 152]

Psychiatric, obstetric, and paediatric teams discuss medication, feeding, and possible infant monitoring. For the acute phase, the family chooses formula feeding: her partner takes nighttime feeds, allowing Mara longer sleep. Meetings also make room for her feelings about this decision.

During the first week, sleep improves partly, but marked psychosis persists; Mara eats little and cannot sustain a coherent conversation. Given the severity, the team discusses electroconvulsive therapy. The CANMAT perinatal guideline includes ECT among options for postpartum psychosis when rapid improvement is needed or other treatment is insufficiently effective. [152]

Electroconvulsive therapy within an actual care pathway

Referral to the Neurostimulation Clinic at the Mental Health and Substance Use Wellness Centre on the Royal Columbian Hospital campus in New Westminster is through a hospital or mental health service. The inpatient team coordinates assessment and treatment scheduling. [48]

The ECT team and anaesthesiologist assess Mara. They discuss benefits, alternatives, post-treatment confusion, and possible memory impairment; appropriate consent or legal authority is documented according to her condition and status. Concurrent medication, including lithium, is reviewed before the course.

Treatments take place under brief anaesthesia with muscle relaxation and subsequent observation. After several sessions, psychotic conviction weakens, eating improves, and conversation becomes more coherent. The course is adjusted according to response. Mara reports gaps in memory; important agreements are repeated and provided in writing.

Returning home



Illustration: A father holds a baby in the living room while the mother sleeps in the next room.

Before discharge, Mara can discuss her condition and participates in planning. Her partner shows a home schedule with sleep protected from nighttime interruptions. Contact with the baby resumes according to clinical improvement and safety assessment. The family receives clear early warning signs: a sharp reduction in the need for sleep, accelerated speech, and unusual certainty about special messages.

After discharge, a local psychiatrist and family physician continue care. If needed, Fraser Health or BC Women's perinatal mental health consultation services are involved, with the episode history and current plan transferred. [63, 153]

Over the following months, monitoring covers mood, sleep, renal and thyroid function, lithium levels, and tolerability of other prescriptions. Mara returns to short music lessons. Sometimes her partner checks too closely whether she has slept, and ordinary energy makes both anxious. A family meeting distinguishes support from constant surveillance: trust also needs rebuilding.

At one year, maintenance treatment is reviewed in light of the course, tolerability, and family plans. Mara will discuss any future pregnancy in advance with her psychiatrist and obstetrician, including relapse prevention and arrangements for sleep after childbirth.

Clinical Case No. 15. Schizophrenia, an NCRMD Finding, and Forensic Psychiatric Rehabilitation

The incident and the legal question

Daniel is 38. He has schizophrenia, previously worked in a warehouse, and lived near his sister. After stopping treatment, persecutory delusions intensified. During a severe relapse, he assaulted an acquaintance whom he believed posed an immediate threat, causing bodily injury.

After arrest, his mental disorder and current ability to participate in proceedings are assessed. A separate retrospective evaluation reconstructs his state at the time of the act using medical records, testimony, and other case materials.

After considering the evidence, the court finds him not criminally responsible on account of mental disorder, or NCRMD. Section 16 of the Criminal Code ties this finding to an inability, because of mental disorder, to appreciate the nature and quality of the act or know that it was wrong. [129]

Entering the forensic psychiatric system

Daniel enters the Forensic Psychiatric Hospital in Coquitlam under the jurisdiction of the BC Review Board. The clinical team plans treatment and rehabilitation, while Review Board dispositions determine the legal conditions of detention and leave. [154, 155]

Daniel still believes he acted correctly. His sister wants to visit but fears discussing the incident. The team explains the treatment plan and risk assessment; his lawyer helps Daniel understand legal decisions and prepare for the hearing.

After previous irregular medication use, Daniel and his physician select long-acting paliperidone once tolerability and suitability for the formulation are confirmed. Metabolic, movement-related, and prolactin-related effects are monitored. Regular injections accompany psychological and rehabilitation work. [124]

What happens between psychiatric reviews

Over months, voices and delusions diminish. Daniel begins to connect his earlier certainty with illness. Discussing the consequences is painful: on some days he can discuss the incident; on others, shame and fear make him withdraw.



Illustration: A man and an occupational therapist repot a plant during a hospital rehabilitation session.

Nurses observe sleep, responses to disappointment, interactions, and help-seeking. The psychologist works on interpretations of threat and early relapse signs. In occupational therapy, Daniel cares for plants, practising planning, attention, and cooperation.

Hypertension is treated alongside monitoring of weight, blood glucose, movement-related adverse effects, and sleep. Within the scope agreed with Daniel, his sister participates in meetings and receives information about support.

The BC Review Board hearing

The BC Review Board considers his condition, risk to the public, needs, and opportunities for reintegration. Daniel participates with his lawyer; the victim has statutory opportunities to receive information and express concerns. [156, 157]

The psychiatric report describes treatment progress, current and historical risk factors, protective circumstances, and the proposed plan. Assessment covers symptoms, substance use, reporting deterioration, housing, support, and the possibility of continuing treatment.

Initially, the Review Board maintains hospital detention. Later, gradual leave is introduced within the current disposition and delegated authority. The team observes behaviour in a less structured environment.

Section 672.54 of the Criminal Code provides for hospital detention, conditional discharge, or absolute discharge. Public safety is the paramount consideration; in the absence of a significant threat, a person found NCRMD receives an absolute discharge, subject to special statutory regimes. [158]

Gradual return to the community

Eventually, Daniel enters the community under specified conditions. Housing, an outpatient forensic psychiatric team, medication administration, and crisis contacts are arranged. His sister meets him regularly.

Daniel resumes public transport, shopping, and independent daily planning. Team contacts are initially more frequent. Returning insomnia or suspiciousness prompts early review and adjustment of care within the legal conditions.

In subsequent years, support and Review Board dispositions will change with his clinical condition and risk assessment. Rehabilitation encompasses treatment, relationships, activities, and gradually increasing independence.

The Psychiatrist in Court: A Summons to Testify

A subpoena after acute treatment

Several months after Owen's hospitalization in Case No. 7, his psychiatrist, Dr. Patel, receives a subpoena to testify in criminal proceedings. While on call, she assessed mania, documented mental status, and participated in treatment. She did not conduct an independent assessment of criminal responsibility.

She clarifies the subject of the summons, date, documents, and her role, obtaining medico-legal advice if needed. The subpoena requires attendance and compliance with the specified lawful requirements under section 700 of the Criminal Code. [159, 160]

Some scheduled appointments are moved while she is in court. A colleague handles urgent presentations by her patients and receives information about current treatment and issues requiring attention in the coming days.

Treating physician and independent expert

Dr. Patel testifies about her observations, information received, clinical conclusions, and treatment. The CMPA distinguishes the roles of treating physician, independent assessor, and expert; the subject of testimony determines which materials and opinions the court requires. [161]

An independent evaluation would separately define the questions, expertise, materials, and possible role conflicts. Here, Dr. Patel appears as the treating physician, drawing on care provided and clinical conclusions.

Preparing records and confidentiality

Before the hearing, she reviews contemporaneous notes: personal observations, Owen's statements, and reports from his sister and police. She prepares a chronology of assessments, symptoms, prescriptions, and treatment response.

Before a preliminary discussion with a lawyer, she checks patient consent or another proper legal basis for disclosure. She prepares documents within the scope of the lawful requirement; disputed disclosure questions in court are decided by the judge. [159, 161]

Owen worries that his physician will testify against him. She explains which clinical facts she will report and which questions the court decides. At their next appointment, they can return to his feelings about trust.

Questions in the courtroom



Illustration: A psychiatrist gives evidence at the witness table in a courtroom.

After identification and the required witness procedure, Dr. Patel answers questions. She uses ordinary language, explains terms, and distinguishes personal observation from information obtained elsewhere.

"What did you personally observe?" — "During assessment, he spoke rapidly, jumped between topics, reported needing very little sleep, and expressed grandiose beliefs. I did not personally witness the property damage."

"Does that condition prove that he is not criminally responsible?" — "My conclusion concerned a manic episode at assessment. The legal question of responsibility requires separately applying the legal test to his state at the time of the act. I did not conduct that evaluation."

"What supported your diagnosis?" — "The combination of sharply reduced need for sleep, accelerated thinking, grandiose beliefs, and behavioural change. Symptoms persisted across assessments and diminished with treatment. I reconstructed the circumstances of the offence from other people's accounts."

After testimony

After testifying, Dr. Patel returns to clinic. She records circumstances relevant to ongoing care in the clinical notes; the next meeting with Owen again focuses on mood, sleep, lithium, and everyday life.

7. Ukrainian Psychiatry: Regions, Hospitals, and Clinical Traditions

From custodial care to specialized services

Family care, monastic shelters, brotherhood hospitals, and municipal charitable institutions preceded specialized psychiatric hospitals. The Kyiv-Pechersk Patericon preserves accounts of mental suffering and care within the monastery. In the eighteenth century, people with severe mental disorders were accommodated in places including the Kyiv-Pechersk Lavra and Mezhyhiria Monastery. Municipal institutions gradually assumed responsibility for ongoing accommodation, operating expenses, and medical supervision. [162]

Records of the Kyiv Board of Public Welfare for **April 1790** describe a ward in Podil with **six patients: three men and three women**. In the early nineteenth century, care became concentrated in the former St. Cyril's monastery complex. This transition brought a permanent address, premises, staff, and administrative responsibility for people needing long-term care. [162]

During the nineteenth and twentieth centuries, several institutional traditions developed across present-day Ukraine. Austrian and later Polish university medicine influenced Lviv; Bukovyna experienced Austrian and Romanian periods; zemstvo services shaped large hospitals in the south and east. In the Soviet period, these networks formed a system of hospitals, dispensaries, academic departments, and research institutes. Local schools retained their own clinical interests and approaches to organizing work.

Lviv and Bukovyna

At Lviv's university clinical site in the late eighteenth century, a **47-bed** ward served people with neurological and mental illnesses. Construction of the Kulparkiv complex began in **1870**; the hospital opened in **1875**, receiving patients from a broad region. Buildings expanded under pressure from demand for long-term accommodation. [163, 164]

In **1903**, Henryk Halban, a pupil of Richard von Krafft-Ebing and Julius Wagner-Jauregg, became head of Lviv University's department of neurology and psychiatry. In the 1930s, the curriculum expanded to include child psychiatry and psychology. Hospital and dispensary networks grew after the war. In the early 1990s, Lviv departments worked on psychopharmacology, the course and treatment resistance of schizophrenia, alcohol-related psychoses, psychotherapy, and psychological assessment. [163]

In Chernivtsi, the first psychiatric hospital was built through public donations in **1833**. Another **50-bed** hospital opened in **1886**, funded through a lottery. A new pavilion complex admitted patients on **May 1, 1902**: five two-storey buildings had been erected in a year and eight months, and four more were added by 1907. Placement depended on the patient's condition; charitable funds paid for care of those without means. [165]

After wartime destruction, the Chernivtsi hospital resumed work in **1944** with **280 beds and two physicians**. A psychiatry department was established there in 1945. The subsequent network included a dispensary department, district psychiatrists, and children's services; the addiction service became separate in **1977**. Workshops and agricultural work held a substantial place alongside hospital treatment. [165]

Odesa: Dispensaries, day hospitals, and social work

Odesa's addiction dispensary was already operating in **1922 to 1928**. Its clinical context was the spread of morphine and cocaine in the port city. In **1930**, Hryhorii Markelov established a psychoneurological institute in a sanatorium for people with consequences of head injuries; its interests included borderline disorders and the autonomic nervous system. The institute's dispensary department opened in **1936**. [166]

The municipal dispensary restored in **1944** organized ongoing follow-up and social assistance, including housing and employment matters. A regional dispensary was established in **1952**. Therapeutic work workshops, outpatient forensic psychiatric assessments, and addiction, sexology, and gerontology clinics followed. [166]

The **1964** polyclinic was designed for **250 visits per shift**. In the late 1960s and early 1970s, two day hospitals with **100 places each** were established: one for mental disorders and one for neuroses. An adolescent day hospital, also with **100 places**, opened in **1972**. This network allowed treatment while living at home and distributed work among inpatient wards, the polyclinic, and district clinics. [166]

Vinnytsia and Poltava

Vinnytsia's psychoneurological hospital opened on **May 25, 1897, with 720 beds**. Since **1936**, it has borne the name of Oleksandr Yushchenko, associated with the biochemical approach in psychiatry. The opening of the medical institute in **1934** made the hospital a departmental clinical base, linking regional care with training students and physicians. [167, 168]

Vinnytsia's service turned to epidemiological work early: in **1929**, dispensary staff surveyed the populations of **three districts** to assess the number and characteristics of people with mental disorders. Chief physician R. Ya. Marianchyk's **1966** dissertation developed this approach through service planning and rehabilitation. Research into affective disorders, including depression with prominent physical complaints, later became another focus of hospital and departmental work. [167]

In Poltava, Oleksandr Maltsev led the hospital from **1886 to 1926**. A choir of patients and staff was organized as early as **1887**. Reading, musical evenings, and plays formed part of hospital life; productions in **1900** included *Natalka Poltavka* and *The Inspection*. In **1933**, occupational work involved 70% of patients. The 1960s saw a more open regime, self-care, outings, sports, and use of personal clothing and belongings. [169]

By the end of the Soviet period, prolonged stays had again become extensive. According to the Poltava account, in **1993, 23% of beds** were occupied by people hospitalized continuously for over two years, and **10%** by people who had lost housing and social ties. Thus the hospital provided treatment and a place to live when support outside was lacking. [169]

Kherson and Donbas: Work, family placement, and everyday surroundings

Kherson's services began with **ten beds** in the provincial hospital in the 1820s and 1830s. Psychiatrist M. Ya. Droznes transformed this unit into a psychiatric department in **1883**; it became a separate hospital in **1886**. The zemstvo built a colony in Hrafskyi Garden in **1889** and a new hospital in **1899**. [170]

By **1914**, the network had **1,600 places**: 800 in the central hospital, 150 in an agricultural colony, 320 in chronic wards, 150 in the open Arnaut family-placement service, and 180 across three closed placement services. Workshops, a library, theatre, choir, and orchestras operated. Patients without means received clothing and financial assistance on discharge. Family placement allowed some patients to live with families and adapt to ordinary daily life. [170]

The **Svato-Luch hospital** in Donbas admitted its first patients in **1914**. In Ukraine's modern network, it is known as the Svatove Regional Hospital for Psychiatric Care. [171] By 1941, its agricultural holdings included **500 hectares of arable land**, livestock farms, an orchard, and an apiary; sewing, shoemaking, and weaving workshops operated. Approximately **half the patients** participated in work. Similar workshops were established at the Donetsk hospital from its opening in **1935**. Farming supplied food and supported the institution, while activities structured patients' days. [172]

Crimea and the diversity of scientific schools

The Crimean academic tradition developed classical psychopathology and biological and behavioural research. Naum Balaban worked in clinical anthropometry in the 1930s. Anatolii Kornetov headed the department for **35 years from 1958**; his school is associated with clinical genetics of schizophrenia and changes in mental state over time. [173]

Interest in ethology, the systematic observation of behaviour, developed in the 1980s. Viktor Samokhvalov published a review in **1984**; international symposia and cooperation with ethologists, anthropologists, and physiologists expanded the research network. Alongside diagnostic interviews, attention

turned to nonverbal behaviour, interaction, and evolutionary explanations. [173]



Illustration: A Ukrainian physician reads old medical publications, comparing professional experience across eras.

Regional centres shared experience through departmental teaching, professional societies, conferences, and journals. The Kharkiv collections **History of Ukrainian Psychiatry (1994)** and **History of Saburova Dacha (1996)** brought together Ukrainian- and Russian-language contributions from colleagues in many cities. Within this professional network, clinical psychopathology, biological mechanisms, psychotherapy, dispensary follow-up, and rehabilitation were discussed side by side. [174]

8. Saburova Dacha, Kyrylivska Hospital, and Hlevakha

Kharkiv and Kyiv: Hospital, department, and research institute

Kharkiv's psychiatric hospital grew out of the municipal welfare system of the late eighteenth century. A special house for people with mental disorders appeared in 1796; general hospital services moved to the former Saburov estate in 1812, followed by psychiatric patients in 1820. In professional memory, the name "Saburova Dacha" gradually came to encompass a large hospital complex, clinical teaching, and research institutions. [175]

The university brought regular teaching and scientific publishing to this environment. In 1834, Petro Butkovskyi published the two-volume *Mental Illnesses Explained According to the Principles of Current Psychiatric Teaching*. Pavlo Kovalevskyi founded the *Archive of Psychiatry, Neurology, and Forensic Psychopathology* in 1883. In the 1920s, the hospital became a centre for psychoneurological institutes; the All-Ukrainian Psychoneurological Academy was established in Kharkiv in 1932. A large patient population linked clinical teaching with research into psychopathology, physiology, and service organization. [175]

Kyiv's tradition began with a small ward for people with mental illness in Podil in the late eighteenth century and developed within the former St. Cyril's monastery complex. The Kyrylivska charitable institutions officially opened in 1806. The hospital at today's 103 Kyrylivska Street became an enduring clinical base for municipal psychiatry; in the twentieth century it was known as the Pavlov Hospital, and today as the "Psychiatry" hospital. [162, 176, 177]

In 1885, Ivan Sikorsky headed Kyiv University's independent department of psychiatry and nervous diseases. His work covered general psychopathology and child development; the journal he founded, *Questions of Neuropsychiatric Medicine*, began publication in 1895. After psychiatry and neurology separated in 1920, Yevhen Kopystynskyi and Valentyn Hakkebush developed the clinical school. In 1921, Kopystynskyi prohibited straitjackets and tying patients down in his clinic; in 1929, he published a Ukrainian psychiatry textbook for feldshers. [178]

Hakkebush combined university work with a psychotherapy polyclinic and the Kyiv State Psychoneurological Institute, established in 1927. He studied neuroses, psychopathological consequences of brain injuries, and child and forensic psychiatric questions. In 1928, he introduced a course in forensic psychopathology. Alongside the large inpatient hospital, outpatient psychotherapy, specialized assessment, and teaching based on clinical cases were taking shape. [178]

Scientific connections between cities

Viktor Protopopov worked on organizing psychoneurological science in Kharkiv and, in postwar Kyiv, developed research into psychiatry and pathology of higher nervous activity. His school considered mental state alongside autonomic, metabolic, and general physical changes. With Yosyp Polishchuk, he studied nitrogen metabolism in schizophrenia; Petro Biriukovych's work concerned biochemical mechanisms of affective disorders. Protopopov also worked on postgraduate medical training and the development of dispensary services and psychiatric wards in general hospitals. [179]

After Kyiv's psychoneurological institute closed in 1948, much research concentrated at the Pavlov Hospital and academic

departments. Yakiv Frumkin developed clinical psychopathology and differential diagnosis; Liviia Bulakhova, child neuropsychiatry; and Vadym Bleikher, experimental psychological assessment of mental disorders. Bleikher's laboratory also trained psychologists. Semen Livshyts worked in forensic psychiatry, and Hryhorii Voronkov on the clinical features and classification of epilepsy. Detailed mental status descriptions, psychological experiments, biochemical laboratories, and expert assessments coexisted within the shared hospital environment. [180]

Occupation and the murder of patients

Nazi killings of patients occurred in waves. Olena Petrenko's archival research reconstructs the early segregation of Jewish patients: in early October 1941, 308 Jewish patients were shot at Kyiv's Pavlov Hospital. In Vinnytsia, 412 Jewish patients were killed during September and the first half of October. Further actions in late 1941 and throughout 1942 targeted the remaining patients. Hospitals lost people, staff, and the very possibility of continuing treatment. [181]

During the occupation, Oleksandr Oleksiiovych Ignatov remained chief physician and institute director at Saburova Dacha. According to his report reproduced in a 2012 publication, 470 patients were in the institution on December 18, 1941. That morning, they were taken away in trucks under the pretext of transfer to Poltava and murdered. Those removed also included patients with neurological and physical illnesses. In February 1943, during Kharkiv's brief liberation,

Ignatov headed an evacuation hospital for 600 wounded in the institute building; five physicians worked with him. [182][12]

His son Yurii survived the occupation as a teenager. Family memory preserves the decision to remain together in Kharkiv and Yurii's later wartime medical experience. Through the next generation, psychiatrist Mykhailo Yuriiovych Ignatov, this family history again became intertwined with the work of Saburova Dacha.[13]

Professional resistance to political abuse

Soviet punitive psychiatry used diagnosis, expert assessment, and special hospitals to isolate dissidents. The Dnipropetrovsk Special Psychiatric Hospital was one such place of imprisonment. In 1971, Semen Hluzman prepared an independent assessment of Petro Hryhorenko's case materials without examining him in person, substantiating his mental health. In 1972, Hluzman himself was arrested and sentenced to seven years in labour camps and three years in exile. His work restored clinical reasoning to the centre of a case in which the state opinion served political persecution. [183]

Intensive treatment of psychoses at Saburova Dacha

On July 21, 1975, Order No. 287 established an 80-bed department for exogenous psychoses at Kharkiv Hospital No. 15. It admitted people with acute alcohol-related and other

12. Ignatov's report is reproduced in the Petriuks' 2012 article. Its retrospective account also gives 480 patients as of December 16; the figure of 470 used here comes from the report itself for December 18.

13. Ignatov family information; Yurii Oleksandrovych's recollection of the decision to remain in Kharkiv also appears in the Petriuks' publication. [182]

exogenous psychoses and severe complications of alcoholism; planned stays were up to 21 days. In the early 1990s, 2,300 to 2,500 patients passed through annually, approximately one-tenth of hospital admissions. [184]

On December 30, 1992, Order No. 196 established a centre for intensive therapy and resuscitation in psychoses within the department. The centre provided round-the-clock clinical-biochemical and functional diagnostics, intensive care beds with a continuously present intensivist, and psychiatric and rehabilitation units. Placement reflected the required level of vital-function support. Treatments included psychopharmacotherapy and infusions, with hyperbaric oxygen, haemoperfusion, and controlled craniocerebral hypothermia also in the repertoire of the time. [184]

In a 1996 article, N. P. Yurchenko and Mykhailo Yuriiovych Ignatov summarized twenty years of work: over 36,000 people treated, four candidate-of-sciences dissertations, over one hundred publications, and over fifteen methodological recommendations. Clinical and neurophysiological data were recorded electronically. Over two to three years, the department developed and implemented a comprehensive approach to alcohol-related psychoses; the authors reported a 1.5- to 2-fold reduction in mortality. Rational psychopharmacotherapy and intensive treatment of physical complications were central to this work. [184]

The Kyiv regional hospital in Hlevakha

Regional Psychiatric Hospital No. 1 in Hlevakha began operating in 1957. In 1984, two of its departments formed a regional addiction dispensary; in 1998, the two institutions merged into the Kyiv Regional Psychiatric and Addiction Medical Association. Shared grounds and support services

brought specialized psychiatric and addiction work together. [185]

The complex developed notable services in geriatric psychiatry, treatment of neuroses, care for patients with infectious diseases, intensive care, and forensic psychiatry. It became a base for internships and postgraduate education, cooperating with Bogomolets National Medical University and research institutions. For Kyiv region, this concentrated several functions requiring specialized teams and technical resources in one regional institution. [185]

Institution	Historical centre	Role in the development of care
Saburova Dacha, Kharkiv	Hospital complex on the former Saburov estate	University psychiatry, psychoneurological institutes, specialized intensive care
Kyrylivska Hospital, Kyiv	Municipal complex at 103 Kyrylivska Street	Kyiv clinical schools, psychopathology, child and forensic psychiatry, municipal care
Regional hospital, Hlevakha	Regional institution founded in 1957	Care for Kyiv region, combined psychiatry and addiction medicine, specialized inpatient and teaching functions

Hospital continuity in the twenty-first century

Kharkiv National Medical University's course syllabus for the 2024/25 academic year lists Regional Clinical Psychiatric Hospital No. 3 among its clinical bases, alongside a military medical centre and research institute. In Kyiv, the "Psychiatry" hospital combines adult and child-adolescent inpatient services, physical and intensive care, outpatient services, and mobile teams; postgraduate teaching continues on site. [186, 177, 187]

Family participation is growing alongside hospital work. Kyiv's Psykhability initiative emerged from a group of relatives connected with medical-social rehabilitation at the hospital. Families support one another and help organize everyday life after hospitalization. [188]

On April 27, 2024, a Russian strike damaged Saburova Dacha's buildings. Suspilne documented destruction on the hospital grounds. Repairing premises, protecting people, and maintaining treatment during air-raid alerts were added to the clinic's usual responsibilities. [189]

9. Ukraine Today: How Care Is Organized

Who makes decisions and pays for treatment

Ukraine's current system combines national purchasing of health services with predominantly local hospital ownership. The Ministry of Health sets policy, standards, and regulatory requirements. The National Health Service of Ukraine (NHSU) contracts providers under the Medical Guarantees Program and pays for covered services. Regional councils and municipalities, as facility owners, make decisions about their networks and property; hospital management organizes staffing and clinical work. Social care, supported living, and employment assistance involve social protection authorities and local providers. [190, 191, 192]

The prewar starting point was strongly inpatient-oriented. WHO's situation analysis using 2020 data estimated that hospitals accounted for approximately 90% of mental health funding, with average stays of about 50 days. Reform shifts some work to primary care and community teams. Its policy sequence includes the 2017 concept through 2030, Ukraine's entry into WHO's Special Initiative in 2021, and the government's 2024 to 2026 plan. The first community teams studied began work in 2021. [193, 194, 195, 196]

Facility budgets and staff pay

Ukraine's **2026** state budget allocated **UAH 258.6 billion** to health care, including **UAH 191.6 billion** for the Medical Guarantees Program. A facility receives funds through its NHSU contract, prepares a financial plan, and distributes spending among wages, medication, food, utilities, and other

needs. Its owner may provide additional funding for infrastructure and local programs. [197, 190]

In the **first half of 2026**, median gross physician pay at Medical Guarantees Program facilities was **UAH 28,200 per month**; department heads received UAH 31,200 and nurses UAH 19,300. Median facility-director pay was UAH 50,800, and junior health support staff pay UAH 12,100.[14] Actual pay in a particular institution depends on revenue, staffing, workload, and management decisions. [198]

Staff category	Monthly gross pay	After 18% personal income tax and 5% military levy
Physician, median	UAH 28,200	UAH 21,714
Department head, median	UAH 31,200	UAH 24,024
Nurse, median	UAH 19,300	UAH 14,861

The tax model applies general deductions from gross salary. [199]

Average pay across all employees in Ukraine in **June 2026** was UAH 32,783; in health care and social assistance, UAH 22,274. The cited median physician salary was therefore approximately **86% of the national average**. This gap

14. Data cover all physicians in Medical Guarantees Program facilities; the cited publication does not identify psychiatrists separately. The source is a secondary account of NHSU figures in *Farmatsevt Praktyk*, dated October 2, 2026. Category medians and economy-wide average salaries have different statistical definitions. [198, 200]

affects vacancy appeal, additional employment, and hospitals' ability to retain experienced teams. [200, 198]

From first presentation to a specialized team

A family physician, general internist, or paediatrician assesses symptoms, physical health, substance use, and self-harm risk, begins care within their competence, and arranges the next contact. mhGAP training provides a structured approach to common mental, neurological, and substance-related disorders. For the psychiatrist, this can mean receiving a referral with a history, medication list, and initial investigation results already assembled. [201, 190]



Illustration: Participants in a rehabilitation session in a Ukrainian community work with a professional in a small workshop.

Specialized outpatient consultations are funded through the outpatient package. Mental health centres and mobile multidisciplinary teams operate under a separate package:

they develop an individual treatment and rehabilitation plan with the patient, visit at home, and involve relatives. People may approach them directly or through a referral from a family or treating physician. After discharge, a team can continue follow-up where the person lives and takes medication. [190]

Stage of care	Main work	Transition to the next stage
Primary care	Initial assessment, treatment of common conditions, physical health monitoring	Referral to a psychiatrist or team, agreed follow-up appointment
Specialized outpatient care	Diagnosis, psycho-pharmacotherapy, psychological care	Plan to monitor symptoms, tolerability, and functioning
Centre and mobile team	Team treatment, home visits, rehabilitation, family work	Links with primary care, social services, and inpatient services
Psychiatric inpatient care	Round-the-clock observation, diagnosis, and acute treatment	Discharge plan, prescription, handover to an outpatient clinician
Social support	Care, housing, assistance with daily life	Coordination of everyday needs with the medical plan

During deterioration, the pathway accelerates: self-presentation, referral, emergency transport, or transfer from another hospital leads to inpatient assessment. Under

additional purchasing conditions, the inpatient package covers intensive treatment of severe intoxication, alcohol withdrawal delirium, dangerous withdrawal syndromes, and other life-threatening conditions. Readiness to provide intensive care is reflected in funding. [190]

Electronic records, confidentiality, and reporting

Ukraine's **electronic health care system, eHealth**, has a central database to which facilities connect through medical information systems. Physicians record encounters, diagnoses, prescriptions, and results; electronic referrals and prescriptions accompany subsequent care. The NHSU uses entered information to verify contract performance and calculate payments under package rules. In inpatient psychiatry, the coded treated case affects payment, while other packages have their own units and formulas. [190, 202]

Patients may consult a psychiatrist or addiction specialist without an electronic referral at a facility with the appropriate NHSU outpatient contract. After consultation, the physician creates the necessary records, plan, and prescriptions. For someone who already knows their diagnosis and specialist, direct access shortens the path from deterioration to assessment. [203]

Additional sensitive-data access rules apply to mental health records in eHealth. Public eHealth guidance describes granting another physician access with the patient's written consent. In psychiatric practice, this requires agreement on what to share with the family physician: medication and dose, required tests, interaction risks, and follow-up date. Such exchange combines confidentiality with treatment of physical illnesses. [202, 204]

Separately, facilities complete **annual Form No. 10, "Report on Psychiatric Care Provided to the Population,"** approved by Ministry of Health Order No. 1504. Its instructions cover specialized institutions, departments, and licensed providers of all ownership types that provided psychiatric care, including for substance use disorders. The electronic record describes individual encounters; the aggregate form describes the volume and structure of care over a year. [205]

Involuntary hospitalization creates another documentary pathway: examination by a panel of psychiatrists within 24 hours and, where continued hospitalization is justified, an application by the facility to the court within the statutory period. The clinical description and justification for inpatient care become materials for judicial oversight. [204]

The network and actual service use in 2026

From January through May 2026, the NHSU registered 586,769 recipients of mental health services, including 84,139 children and adolescents. Outpatient consultations reached 378,523 people; centres and mobile teams served 87,314; more than 97,000 received primary mental health care and almost 98,000 inpatient care.[15] The largest numbers were registered in Dnipropetrovsk region, Kyiv, and Lviv, Odesa, and Kharkiv regions. [206]

As reported by the NHSU on June 19, the network included 2,591 primary care providers, 1,078 outpatient providers, 194 centre and mobile-care providers, and 138 inpatient providers. Primary care employed 22,901 physicians at 7,388 service locations. This geographically extensive level handles

15. One person could receive care at several levels; counts by service type overlap. [206]

early recognition, repeat contacts, and physical health care, while specialized teams concentrate on more complex conditions. [206]

The planned budget for the inpatient psychiatric package in 2026 was UAH 5.6 billion. Payment relies on treated cases, diagnostic weights, and readiness to provide the relevant scope of care. For a clinic, this links documentation, its patient mix, and available treatment capabilities to its financial plan. [207, 190]

Medication and treatment of opioid dependence

Outpatient medication provision follows a separate structure. The Affordable Medicines program reimburses specified medicines for mental and behavioural disorders and epilepsy. A psychiatrist or neurologist establishes the relevant diagnosis and treatment plan; a family physician may continue prescribing under that plan. An electronic prescription links the clinical decision with dispensing at a contracted pharmacy, while the current register determines brand availability and copayment. [208]

Opioid dependence is treated with maintenance substitution therapy using methadone or buprenorphine. A separate NHSU package funds treatment and support; the Public Health Centre maintains information on access points, transfer rules, and access during displacement. Daily dose stability, dispensing hours, travel to the site, and coordination with HIV, hepatitis, or tuberculosis treatment become part of long-term clinical care. [190, 120]

Patients' out-of-pocket costs

Public funding of psychiatric consultations and medication coexists with a private market. A Ukrainian review of **WHO Mental Health Atlas 2024** data estimates mental health at approximately **2.7%** of government health spending. It places patient out-of-pocket payments for outpatient care and psychological therapy in the **21% to 50%** category, and inpatient care and psychotropic medication at up to 5%.[16] [209]

Private appointments allow patients to choose a professional and time using their own budget. In October 2026, a consultation with one psychiatrist in Kyiv's Dobrobut network cost UAH 2,460; an initial consultation at Veselka in Lviv cost UAH 1,680, and a follow-up UAH 1,300. Family costs include repeated meetings, medication, travel, and, where needed, regular psychotherapy. [210]

16. The Atlas gives out-of-pocket payment categories, not a cash total of all Ukrainian household spending. The Ukrainian review presents the 2024 round of data; the individual clinic prices cited are dated October 2026. [209, 210]

Legislation and professional responsibility

Law No. 1489-III, "On Psychiatric Care," regulates psychiatric assessment, consent, confidentiality, hospitalization, and judicial oversight. Law No. 4223-IX, "On the Mental Health Care System in Ukraine," adopted January 15, 2025, and brought into operation February 7, 2026, encompasses a broader group: medical and psychological professionals, social services, education, employers, and communities. It establishes arrangements for prevention, psychosocial support, professional certification, and coordinated care. [191, 204]

Resolution No. 288 of March 4, 2026, established certification and continuing professional development procedures for mental health professionals; Resolution No. 681 of May 27 initiated formation of the National Commission. Alongside these new mechanisms, everyday clinical responsibility remains personal: the physician formulates a diagnosis, justifies treatment, records consent or the legal basis for intervention, and arranges follow-up. [211, 212, 204]

10. Psychiatric Care During Russia's War Against Ukraine

Changes in patient flow and staffing



Illustration: A physician consults a civilian patient in a frontline community clinic; backup power and communications equipment are nearby.

In the first months of Russia's full-scale invasion, some people lost access to their usual hospital, some left with family, and others were evacuated from inpatient care. Observations from 30 psychiatric institutions in 2022 capture this disruption: average monthly admissions per institution fell from 432.2 in January to 333.7 in April, then rose to 360.9 in July. Meanwhile, the average number of psychiatrists fell from 34.9 to 29.6, and nurses from 142.6 to 122.9. [213, 214]

A two-year follow-up tracked 25 hospitals participating in every wave. In this group, monthly admissions rose from 433.4 per institution in January 2022 to 552.0 in April 2024; over the same period, the average number of psychiatrists declined from 40.0 to 30.9. Beds changed from 435.8 to 415.0, without a statistically significant difference. A larger patient flow thus met a smaller medical workforce. [215][17]

By April 2024, displaced workers accounted for 21.7% of staff in the institutions studied. Patient transfers mainly originated in the east and south. Receiving hospitals assumed responsibility for continuing prescriptions, reconstructing records, and contacting relatives who might be in another region or abroad. [215]

Institutions in occupied territories and after evacuation

Russian occupation severed links among institutions, owners, families, and Ukrainian services. A National Social Service response published in June 2025 identified **15 psychoneurological residential institutions** remaining geographically under occupation; almost **3,000 people** had lived there on January 1, 2022. In Luhansk region, rapid occupation interrupted evacuation of **327 patients from Svatove Psychiatric Hospital**. Moving large groups requires

17. The 2025 article contains discrepancies among the abstract, text, and table for intermediate waves and two staffing categories. The consistent baseline and final figures from Table 1 are used here. The 2022 data from 30 institutions incorporate the published correction. [215, 214]

transport, accompanying staff, medication supplies, and prepared care placements.[18] [171]

Within a month after Kherson's liberation in November 2022, **257 patients** were evacuated from the regional psychiatric institution. Bakhmut's psychoneurological residential institution later resumed work in Poltava region with **100 beds**. Each move required restoring daily care: who dispenses medication, where records are kept, how families find their relatives, and who continues clinical follow-up. [171]

Symptoms in the civilian population

A September 2023 online survey included 2,050 adults. Screening criteria for at least one of seven disorders were met by 36.3%; 16.2% met criteria for two or more. Generalized anxiety, prolonged grief, and post-traumatic symptoms were most common. Financial difficulties and disruption of ordinary life following Russia's 2014 invasion were associated with several symptom groups. Forced displacement after the 2022 full-scale invasion was separately associated with complex post-traumatic symptoms. [216][19]

Screening condition	Proportion of participants, September 2023
Generalized anxiety disorder	15.2%
Prolonged grief disorder	11.4%

18. Data from state services and regional administrations in Suspilne's June 9, 2025 investigation. The population of the 15 residential institutions refers to early 2022; the relocated institution's 100 beds refer to March 2025. [171]

19. An online quota sample of adults; percentages represent positive screening on the questionnaires used. [216]

Screening condition	Proportion of participants, September 2023
Post-traumatic stress disorder	11.1%
Complex PTSD	9.2%
Depressive disorder	8.1%
Alcohol use disorder	8.1%
Cannabis use disorder	1.5%

Anxiety and depressive symptoms were more common among women; alcohol- and cannabis-related problems among men. Positive screening for any studied disorder was 41.7% in the east and 30.5% in the west. This profile combines traumatic experience, loss, economic anxiety, and substance use; clinical interviews often address several at once. [216]

Home visits and family work



Illustration: A mobile team visits a man at home in a Ukrainian city; his sister joins the conversation.

The initial experience of 14 community teams provides a detailed picture of work before the full-scale invasion. From April through December 2021, they supported 947 people with a mean age of 44. Schizophrenia-spectrum disorders predominated, accounting for 72.3% of those with relevant diagnostic data. On average, three of six recorded contacts took place in the community; home visits combined medication, psychosocial, and general medical care. [196]

Among 742 people with paired clinical assessments, 243 improved and 451 remained stable. Among 304 with paired WHODAS assessments, the median disability score fell from 62.50 to 58.33 over approximately ten weeks. More frequent

family work and support for community inclusion were associated with better functional change. Clinical improvement was less likely in the region affected by hostilities. [196][20]

The next development stage is mental health centres at general hospitals with outpatient and outreach work. An evaluation program published in 2026 plans to measure reach, clinical outcomes, professional adoption, and sustainability. In everyday practice, these questions are concrete: how many people maintain contact, how symptoms and functioning change, how often the team makes visits, and how it transfers a complex case to hospital. [217]

Reorganizing a regional ward

In Ward No. 8 of Kirovohrad Regional Psychiatric Hospital, average length of stay fell from 41.5 days in 2022 to 32.0 in 2023, 31.5 in 2024, and 19.6 in the first quarter of 2025. The discharge case mix also changed: schizophrenia-spectrum disorders fell from 54.94% to 15.15%, neurotic and stress-related disorders rose from 8.43% to 25.59%, and substance use disorders from 8.43% to 30.30%. [218]

Together, these changes imply a different pace of admission, diagnosis, and discharge. For the first quarter of 2025, the article reports mean stays of 35.72 days for organic disorders, 39.33 for affective disorders, and about six for substance use disorders. The overall average combines clinically distinct pathways. After a short treatment episode, post-discharge contact, continued addiction treatment, and rapid reassessment become especially important. [218]

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20. An observational study without a control group; clinical outcomes were available for 742 and paired functional assessments for 304 of 947 participants. [196]

Continuity of addiction treatment

On January 1, 2026, the Public Health Centre recorded 32,975 recipients of maintenance substitution therapy; 21,739 were treated in municipally owned institutions. Seven facilities in Donetsk, Zaporizhzhia, and Kherson regions continued caring for 1,616 people. The program operated through the simultaneous opening of new sites, patient transfers, and institutional reorganization. [151]

In 2025, the approaching front forced the Kostiantynivka site to close; patients transferred to Sloviansk. Patients from Dobropillia were referred to Kramatorsk and facilities in Pavlohrad and Dnipro. According to the Public Health Centre, transfers from the two closed Donetsk-region sites preserved treatment. In Krasnopillia, proximity to the front and shelling damage caused closure; other Sumy-region facilities continued care. [151]

During such moves, clinical continuity rests on confirming the last dose, arranging the next dispensing, and transferring information on concurrent medication. For someone with HIV or tuberculosis, the same pathway must preserve disease-specific treatment. The medication site becomes a daily source of stability that must move with the patient. [120, 151]

Military personnel, veterans, and physical rehabilitation

After injury, psychiatric care may develop within surgical and rehabilitation pathways. Pain, sleep disturbance, traumatic brain injury consequences, depression, and post-traumatic symptoms affect physical recovery and family relationships. WHO reported that by the end of 2024, multidisciplinary

teams from 28 non-specialized inpatient rehabilitation departments in eleven regions had received training. [219]

A Ministry of Veterans Affairs program also serves veterans and specified categories of family members: social-psychological support, specialized psychological care, and comprehensive medical-psychological rehabilitation. Providers in the official register can be approached directly or through physician referral; care is outpatient, inpatient, or remote. Psychiatric treatment under the Medical Guarantees Program and veterans' psychological support provide two possible entry points according to clinical need. [220, 190]

Rights and everyday treatment conditions

Article 14 of the Law on Psychiatric Care links involuntary hospitalization to severe mental disorder, a need for inpatient assessment or treatment, and immediate danger or inability to meet basic life needs. After admission, a panel of psychiatrists examines the person within 24 hours; where grounds exist, the facility applies to the court. Continued detention involves repeat examinations and judicial oversight. [204]

During a July 31, 2026 visit to Cherkasy Regional Children's Hospital, the National Preventive Mechanism documented an operating mental health centre, playroom, emotional decompression space, and equipped shelter. However, a room called an isolation room in the psychiatric ward was used for observation with a video camera contrary to regulatory requirements; medical staffing was insufficient. Equipment and protected space coexisted with specific problems of privacy and workload for the team on duty. [221]

Housing after hospitalization and evacuation

The strategy for deinstitutionalizing adult care through 2034 provides for community social services, including supported living. Its 2025 to 2027 operational plan links this to needs assessment, development of local services, and transition from large residential institutions to more individualized care. [192]

As of July 23, 2026, a pilot for internally displaced older people and people with disabilities included 91 providers; since August 2024, contracts had been signed with 675 recipients across two services combined: residential care and supported living. A separate 2026 plan envisaged about 3,000 supported-living recipients. In its 2025 report, Kharkiv region described starting this service for eight people at one centre and preparing premises in other municipalities. [222, 223]

After evacuation, accommodation determines the accessible pharmacy, route to the physician, and circle of people who can help. A stable address allows a team to arrange a visit, a family to distribute care, and the patient to rebuild an ordinary day. Long-term recovery consists of these repeated actions.

11. Two Systems, Shared Clinical Questions

What changes with the place of treatment

If the same patient changed countries, their history, symptoms, and medication response would travel with them. A new organization would form around these: a different entry point, division of medical and nursing work, payment system, housing support, and legal review. Clinical decisions would have to fit a new daily schedule.

Both systems grew alongside large psychiatric hospitals. In BC, redistribution of long-term care developed through regional inpatient units, housing programs, and community teams. Ukraine's network combines regional hospitals, a dispensary legacy, outpatient psychiatry, and new centres and mobile teams. Russia's war against Ukraine added mass displacement of patients and staff, institutional evacuations, and restoration of treatment after losing familiar care settings. [37, 190, 215]

Geography and first contact

In BC, regional health authorities organize networks around their territories' needs; PHSA concentrates selected provincial specialized functions. In Ukraine, the national purchaser, the NHSU, contracts local providers, predominantly municipally owned. For patients, the difference appears in who receives a referral, coordinates the next level of care, and ensures access near home. [1, 190]

A remote northern BC community and a small Ukrainian town share a clinical task: keeping follow-up locally accessible while involving specialists when needed. Compass brings

child and adolescent specialist advice to the clinician already caring for the patient. mhGAP expands primary care training in Ukraine, while centres and mobile teams add specialist contacts. The outcome depends on subsequent action: examination, tests, prescription adjustments, and the next appointment date. [61, 201, 190]

Paying for consultations, medication, and continuing treatment

MSP funds medically necessary physician care within its rules; outpatient medication goes through PharmaCare, while private psychological practice often requires supplementary insurance or personal payment. Ukraine's Medical Guarantees Program purchases a defined scope of services, and Affordable Medicines reimburses medication according to its register. In each system, physicians connect treatment choices with the actual ability to obtain them. [15, 17, 18, 190, 208]

For a person with depression, two amounts may matter: the medication copayment and the cost of regular psychotherapy. In BC, the professional association's recommended psychologist rate for 2025/26 is ≈CAD 73.1 PPP per hour. Free BounceBack or local programs provide another route depending on severity and need. In Ukraine, outpatient psychological and psychiatric care falls within the relevant NHSU packages; the local team and its contract determine the available scope. [46, 41, 190]

Money, working time, and team composition

Financial differences begin with budget size, then pass through fees, staffing, and the working day. The Ministry of Health of the single province of BC has ≈CAD 10.8 billion PPP for 2026/27. Ukraine's state health budget for 2026 is ≈CAD 8.2 billion PPP. In BC, some physician work is paid directly through MSP; in Ukraine, the main public route is through an NHSU contract with the institution.[21] [1, 197]

Measure	British Columbia	Ukraine
Payment for physician work	Fee-for-service, sessional, contracted activity, or salaried employment	Institutional salary; independent practice and private consultations have separate income
Starting monetary measure	Psychiatrist: average gross MSP payments ≈CAD 82,800 PPP annually, 2024/25	All physicians in Medical Guarantees Program facilities: median salary ≈CAD 894 PPP monthly, first half of 2026
Monthly estimate after expenses and taxes	Psychiatrist with modelled 20% office overhead: ≈CAD 3,640 PPP	Physician at the cited salary: ≈CAD 688 PPP

21. This compares one province's ministry budget with Ukrainian state expenditure, with different coverage of local, social, and private spending. BC Stats estimated BC's population at 5.65 million on April 1, 2026; war, occupation, and displacement complicate Ukraine's current population estimate. Amounts use a common CAD PPP consumption scale, defined in the Chapter 1 note. [23, 224]

Measure	British Columbia	Ukraine
Monthly nursing pay after taxes	RN/RPN model: ≈CAD 1,530 to 2,030 PPP	At the median salary: ≈CAD 471 PPP

Calculation methods and fee periods appear in Chapters 6 and 9. [21, 100, 103, 198, 199]

Within the local economy, gross MSP payments to a psychiatrist represent approximately **3.9 times average BC earnings**, or **3.1 times after modelled practice expenses**. Ukraine's median physician salary is **0.86 times the national average**. For a Canadian office, allocating paid time and operating expenses becomes a substantial organizational task; for a Ukrainian municipal hospital, the challenge is generating competitive pay from institutional revenue and retaining the team.[22] [21, 104, 198, 200]

Workload structure also differs. In Canadian fee-for-service data, a psychiatrist averaged **307 distinct patients annually** and about **2,006 services**. In 25 Ukrainian hospitals followed through April 2024, an average of 30.9 psychiatrists corresponded to 552 monthly admissions and 415 beds: approximately **18 new admissions monthly and 13.4 beds per psychiatrist**. The first measure describes billed contacts; the second, inpatient flow and existing staff. Both bring workforce discussions back to the working day:

22. The Canadian measure is average gross fee-for-service payments to psychiatrists; the Ukrainian measure is the median salary of all physicians in Medical Guarantees Program facilities. Local average earnings refer to April 2026 in BC and June 2026 in Ukraine. Ratios describe position within each labour market. Inpatient workload in the next paragraph is calculated by dividing group averages, with uneven distribution among physicians.

how many new histories to read, whom to reassess, and to whom care should be handed over. [21, 215]

When the history travels with the patient

If a patient continued treatment in Vancouver after hospitalization in Surrey, the team would reconcile the discharge summary, PharmaNet, available CareConnect documents, and family physician information. If the same change occurred in Ukraine, the next clinician would use their medical information system to access available eHealth records, electronic prescriptions, and the transferred report; sensitive psychiatric information would be accessed under the relevant rules. [51, 52, 54, 202]

In either pathway, a small set of accurate details becomes decisive: what the person actually takes, when the last long-acting injection or OAT dose was received, why treatment changed, and who will review the next test. Financial documentation also differs: the Canadian physician submits a separate MSP claim, while the Ukrainian electronic clinical record also supports verification of the NHSU package. [190, 54]

First psychosis and longstanding schizophrenia

After a first psychotic episode, Raj needs prompt contact, explanation of treatment to family, help with adverse effects, and a return to study. After thirty years of illness, David needs daily living support, clozapine monitoring, and coordination of physical health care. BC distributes these tasks among EPI, standard teams, intensive outreach, and specialist consultations. In Ukraine, an outpatient psychiatrist, centre, mobile team, and hospital undertake them according to the local pathway. [4, 87, 125, 190]

Evaluation of 16 BC EPI teams in 2022 found strong implementation of timely entry and outreach, with specialized psychotherapy and family interventions weaker components. In the Ukrainian observation of 14 teams, most recipients had schizophrenia-spectrum disorders, and about half of follow-up contacts occurred at home. Both examples reveal work between prescribing medication and returning to everyday life. [57, 196]

If a Ukrainian patient with longstanding illness entered BC care, a detailed history would inform the new team about effective doses, adverse effects, and early relapse signs. If a Canadian EPI participant moved to Ukraine, family agreements, educational accommodations, and psychotherapy would require separate handover. Clinical memory and distribution of team tasks thus complement one another.

Physical illness, intensive care, and ECT

For pneumonia in a patient taking clozapine, treatment depends on oxygenation, infection, medication dose, smoking cessation, and swallowing ability. In a large BC hospital, the general medical team manages physical illness, with the psychiatrist and pharmacist supporting psychopharmacotherapy. The Kharkiv centre described by Yurchenko and Ignatov in 1996 concentrated psychiatric, intensive care, laboratory, and rehabilitation components in one specialized setting. [184, 126, 127]

The shared function is to combine psychosis treatment with physical support around the clock. In Ukraine's current Medical Guarantees Program, intensive care for life-threatening conditions is included in the inpatient package's additional requirements. In an individual case, location depends on available staff, monitoring, laboratory facilities, and required general medical interventions. [190]

ECT offers another example of treatment's dependence on organization. In BC, the pathway includes referral, specialized assessment, anaesthetic care, and post-treatment observation; VGH operates on a specified weekly schedule, while Fraser's Neurostimulation Clinic operates at the Mental Health and Substance Use Wellness Centre on the Royal Columbian Hospital campus in New Westminster. Transferring this clinical situation to a Ukrainian hospital would require identifying the corresponding local centre and referral route, plus transport and accompaniment for an outpatient course. [48, 49]

Addictions and continuity of medication dispensing

Canadian OAT and Ukrainian maintenance substitution therapy share the pharmacological principle of long-term agonist treatment. In BC, a key link is the pharmacy that dispenses medication and reports missed doses or sedation to the OAT prescriber. Ukraine relies on OAT sites of different ownership types and defined dispensing and transfer rules. In 2025, relocation of Donetsk-region sites involved transferring patients to receiving institutions; in BC, Community Transition Teams support transition after incarceration. [79, 53, 120, 148, 151]

If a patient taking methadone crossed the border, the first practical action would be to verify the last dose, missed doses, and current tolerance. Next would come a locally authorized prescriber, available medication, and an agreed dispensing day. This sequence preserves treatment during relocation, hospitalization, or release.

Housing, care, and family participation

In a Vancouver randomized trial, two Housing First forms produced approximately 74% of days in stable housing over two years, versus 26% with usual care. Ukrainian supported-living pilots are developing within social care, including for displaced older people and people with disabilities. Their clinical importance appears through sleep, nutrition, medication storage, and regular contact. [88, 192, 222]

For Mei, who has dementia, the level of support depends on nighttime waking, safe mobility, and respite for her husband. For Noah, who has autism, it depends on communication, predictable activities, and trained workers. If these families changed countries, the first matter to coordinate would be the actual weekly schedule: home-help hours, transport, daytime activities, and emergency contact. That schedule reveals how much care remains with relatives.

Legal decisions and professional time

Clinical situation	British Columbia	Ukraine
Involuntary hospitalization	Mental Health Act certification, rights notification, status review	Psychiatric panel examination and judicial oversight under the Law on Psychiatric Care
Challenging detention	Lawyer, Mental Health Review Board, independent rights information through IRAS	Representation, court application, rights-protection mechanisms
Mental disorder in a criminal case	Criminal Code criteria, including NCRMD, Review Board jurisdiction	Forensic psychiatric assessment and court-ordered compulsory medical measures

In BC, the first medical decision and subsequent review follow their own sequence of certificates and hearings. In Ukraine, the specific law connects involuntary hospitalization with panel examination and court application. For physicians in both settings, the working material is equally concrete: symptoms, behaviour, risk, ability to meet basic needs, alternatives, and change over time. [14, 91, 129, 158, 204]

Team time also has a different structure. Canadian consultation and outreach programs require coordination among separate services. The Ukrainian study of 25 hospitals documented rising admissions alongside declining physician numbers in 2022 to 2024. In both settings, transferring

necessary information, identifying a responsible clinician, and planning follow-up turn individual interventions into continuous treatment. [215]

Moving countries and restoring treatment

For a Ukrainian continuing treatment in BC, the first meeting often begins by reconstructing the history: international medication names, doses, effects of previous courses, discharge summaries, and past adverse effects. Professional interpretation helps distinguish subtle differences among anxiety, obsessions, experiences of persecution, and memories of real danger. **Provincial Language Services** arranges interpretation in over 200 languages, free to patients and families. [225]

If someone from Ukraine sought help after losing housing and separation from family, the Canadian pathway would also need to address sleep, physical illnesses, work, and living conditions. **VAST** provides psychological and group support in BC for refugees who have experienced war, persecution, or torture. In the other direction, returning to Ukraine would require a brief clinical summary, current medication plan, and contact with the next clinician. The experience of two systems meets here in one person's life. [225]

12. Four Comparative Situations for Mutual Learning

Comparative situation 1. Consultation for a local physician

A nineteen-year-old student in a small town has persistent depressive symptoms, misses classes, and responds poorly to initial treatment. Her local physician reconstructs the dose, duration, and actual use of medication, and asks about hypomanic episodes, substances, and suicide risk. She needs discussion of the next step and the urgency of an in-person consultation.

If the patient lived in BC, the physician could contact Compass, which supports professionals caring for children and young people under 25. She would submit a specific clinical question, receive advice, and continue local follow-up. In a study of Compass's first five years, September 2018 to September 2023, medication questions accounted for about 60% of contacts. [61]

In a Ukrainian town, initial assessment could draw on mhGAP, with specialist contact through an outpatient psychiatrist or mental health centre. The family physician would continue physical health monitoring and available follow-up visits; the psychiatrist would clarify diagnosis and treatment. [201, 190]

If Compass's consultation function were introduced into this Ukrainian pathway, the main change would be the physician's access to specialist discussion. Its practical result should remain in the record: an agreed change, review date, and signs requiring urgent reassessment. If the student moved, this plan and confirmed contact with a new physician would preserve work already done. A well-transferred history saves

the patient another job interview for the position of being herself. 🙂

Comparative situation 2. Returning to education after first psychosis

A twenty-two-year-old man returns home after first psychosis. Voices have almost disappeared, but he reads slowly, feels embarrassed to meet classmates, and reports inner tension after his antipsychotic. His family wants to know whether he can finish the semester.

In Fraser Health, an eligible patient could join EPI for up to three years. The psychiatrist would review medication tolerability, a coordinator maintain family contact, and an occupational therapist help choose an academic workload. Evaluation of BC teams found timely entry and outreach better implemented than some psychotherapy and family components. The actual plan would therefore depend on the local team. [4, 57]

In Ukraine, an outpatient psychiatrist could work with a centre or mobile team: treating akathisia, visiting at home, assessing sleep patterns, and meeting family. The initial Ukrainian team study predominantly included people with schizophrenia-spectrum disorders; work took place both at the service and at home. [190, 196]

If the Canadian participant moved to Ukraine, a reduced workload and contact person would need separate agreement with the educational institution. If the Ukrainian patient entered EPI, a detailed medication-response history would let the team continue an effective regimen and focus on functional goals.

After three months, either pathway could assess the same events: how many classes he attends, whether he completes

assignments, how he sleeps, what he says about medication, and how often family seeks crisis help. After three years, the long-term pathway would need consideration. For the time-limited Canadian program, this means handover to another provider; for Ukrainian outpatient care, maintaining the necessary intensity and social connections.

Comparative situation 3. Psychosis and a dangerous physical condition

A patient with severe alcohol dependence develops delirium, hyperthermia, tachycardia, and marked dehydration after reducing consumption. Frequent observation, laboratory monitoring, withdrawal treatment, correction of physiological disturbances, and investigation for infection are needed. Emergency decisions unfold over hours.

The Kharkiv centre for intensive therapy and resuscitation in psychoses described in 1996 combined round-the-clock laboratories, intensive care beds with an intensivist, and psychiatric and rehabilitation units. In the early 1990s, its predecessor admitted 2,300 to 2,500 patients annually. Organizing care around physiological severity allowed observation intensity to change within a specialized setting. [184]

In a large contemporary BC hospital, this patient would enter general medical care or, depending on severity, intensive care. Psychiatry and addiction medicine would contribute to delirium treatment and subsequent planning. In a current Ukrainian pathway, these capabilities may be concentrated in a multidisciplinary hospital or a psychiatric institution meeting NHSU's additional intensive-care requirements. [190, 81]

An integrated specialized centre keeps psychiatric observation alongside intensive care. A general hospital brings physical-health specialists around the patient on its ward. These models could be compared through the first hours: time to laboratory assessment, intensive-care availability, repeated transfers, and continuity of prescriptions.

Once delirium resolves, the task changes again: nutrition, memory, long-term addiction treatment, and accommodation. Here, the intensive team hands the patient to outpatient care, preserving the history of the acute illness and its consequences.

Comparative situation 4. Stable housing after hospitalization

A person with a longstanding psychotic disorder has completed acute treatment and needs help with medication and daily living. Their previous room is lost. In the Ukrainian scenario, they evacuated from an unsafe city; in the Canadian scenario, they lost their tenancy during relapse.

In BC, the team could combine an application for supportive housing with temporary accommodation and outreach. In the Vancouver Housing First study, stable housing occupied about three-quarters of the two-year period; both studied forms substantially outperformed usual care on this measure. [88, 130, 131]

In Ukraine, the pathway would involve the medical team, social protection services, and a local supported-living or care provider. For a displaced person, documents, prescriptions, and family contact would be restored simultaneously. The social-service pilot and regional projects are developing such accommodation in particular communities. [192, 222, 223]



Illustration: A woman and her adult daughter settle into a home in Ukraine; a support worker discusses everyday matters with them.

On the first morning after moving, the patient finds their medication, prepares breakfast, and knows when a worker will arrive. They have personal space, a phone, and the opportunity to go out on their own business. After a month, the team sees which tasks they manage independently and where support should change.

If the Canadian housing pathway operated during Russia's war against Ukraine, it would also require shelter and readiness to relocate care after another evacuation. If the displaced Ukrainian settled in BC, transition would require restoring a prescription, local insurance coverage, and team contact at the new address. The shared clinical result would be sustained housing and treatment, and with them the ability to plan an ordinary day.

13. Clinical Continuity

Psychiatric care unfolds across several timescales. Delirium changes decisions within an hour. Antidepressant response is followed over weeks. Returning to study or work after psychosis takes months; life with a longstanding disorder requires memory of earlier years. A system connects these timescales through people who pass responsibility and knowledge of the patient to one another.

Riverview's history leads from a large institution to questions of housing, support, and freedom of everyday choice. Kharkiv's intensive-care centre leads to comprehensive treatment of a patient whose psychosis and physical danger unfold together. Kyiv's clinical schools, regional dispensaries, and today's mobile teams trace another long line: following illness over time, inside and outside hospital.

In present-day BC, specialized programs create many entry points: first psychosis, perinatal episodes, addiction, older age, and forensic psychiatric rehabilitation. Transitions between them need as much attention as individual consultations. In Ukraine, developing new services is accompanied by the daily task of preserving care during Russia's war against Ukraine: transferring a patient, finding medication, restoring family contact, and arranging an appointment in a new city.

On rounds, this broad history becomes precise questions. When did this person last receive clozapine? Who will dispense methadone tomorrow? Will the patient's husband get any sleep tonight? What helps this young man return to classes? The answers combine psychopathology, pharmacology, everyday living, and organization: the very combination an experienced psychiatrist works with daily.

Across the ocean, this work is readily recognizable: seeing the person attentively, following changes in condition, and maintaining the thread of treatment. In different hospitals, in different languages, and in different years, colleagues take it up again.

Short Glossary

CAD PPP — purchasing power in Canadian dollars at Ukrainian prices. A notional CAD amount that, after conversion at the fixed NBU exchange rate, would buy in Ukraine as much as the original amount buys in its own country. Canadian amounts are multiplied by 0.29845487; Ukrainian amounts in comparisons are divided by 31.5383. The price basis is the World Bank's national consumption purchasing-power parities for 2025.

ACT — Assertive Community Treatment. Intensive multidisciplinary community care: outreach, treatment, and support for everyday functioning with complex, longstanding disorders.

CANMAT — Canadian Network for Mood and Anxiety Treatments. A Canadian professional and scientific network developing clinical guidelines for mood disorders.

CLBC — Community Living British Columbia. A provincial organization funding support for adults with intellectual disability and certain other groups under defined eligibility criteria.

Consultation-liaison psychiatry. Psychiatric consultation and collaboration with other medical specialties, principally in general hospitals.

CRCL — Crisis Response, Community Led. Community mental health crisis-response teams, formerly called PACT.

CYMH — Child and Youth Mental Health. Child and adolescent services of the Ministry of Children and Family Development, MCFD.

DDMHS — Developmental Disabilities Mental Health Services. Specialized care for people with intellectual disability and mental health or complex behavioural problems.

ECT — Electroconvulsive Therapy. Treatment inducing a controlled seizure under general anaesthesia and muscle relaxation.

EPI — Early Psychosis Intervention. Specialized treatment, family work, and support for education and employment early in psychosis.

FNHA — First Nations Health Authority. The First Nations health organization in British Columbia, supporting clinical services, community programs, and culturally appropriate care.

Housing First. Providing stable housing with support as an early step in care for people experiencing homelessness.

ICM — Intensive Case Management. Intensive community care coordination, including for addiction and housing instability.

IRAS — Independent Rights Advice Service. Independent explanation of rights for people hospitalized under British Columbia's Mental Health Act.

LFP — Longitudinal Family Physician. A payment model for continuing family physician care, incorporating time, contacts, and attached patients.

MAID — Medical Assistance in Dying. Medical assistance in voluntarily ending life under federally established eligibility criteria.

mhGAP — Mental Health Gap Action Programme. WHO's program for developing care for mental, neurological, and substance use disorders in non-specialist services.

MHSU — Mental Health and Substance Use. A common designation for BC services.

MSP — Medical Services Plan. British Columbia's provincial program funding specified health services, including medically necessary physician care.

NCRMD — Not Criminally Responsible on Account of Mental Disorder. A Canadian legal finding of absence of criminal responsibility because of mental disorder; subsequent dispositions are made by a court or Review Board.

OAT — Opioid Agonist Treatment. Treatment of opioid dependence with agonists such as methadone or buprenorphine; the corresponding organized Ukrainian program is maintenance substitution therapy, known by the Ukrainian abbreviation ZPT.

OUD — Opioid Use Disorder. A diagnostic category encompassing loss of control, craving, and clinically significant consequences of opioid use.

RCC — Registered Clinical Counsellor. A professional designation of the BC Association of Clinical Counsellors.

Recovery. Personal recovery: meaningful life, relationships, activity, and the ability to influence one's future while receiving treatment for a longstanding disorder.

RPN — Registered Psychiatric Nurse. A nurse whose entry-level professional education is in psychiatric nursing.

eHealth; medical information system. Ukraine's electronic health care system and the information system through which a facility works with electronic records.

NPM — National Preventive Mechanism. Independent monitoring of places of detention within the human rights protection system.

NHSU — National Health Service of Ukraine. The national purchaser of health services under the Medical Guarantees Program.

Supported living. A social service combining community accommodation with help in daily living, self-care, and participation in society.

Rehabilitation. Assistance in restoring or maintaining functioning, independence, and participation in life.

References

The source base was checked in October 2026. Clinical statements draw on guidelines and research; service organization draws on public provider descriptions, official reports, and legislation. Archival, encyclopedic, and professional publications in Ukrainian, Russian, and English supplement the historical sections. Journalism provides supporting evidence for specific events.

The bibliography identifies each work's observation period and main content. Links lead to publicly available pages, texts, or bibliographic records. Illustrations were created for this edition using generative AI.

Ukrainian- and Russian-language reference titles are translated into English for this edition; linked originals retain their published wording.

[1] British Columbia Ministry of Health. 2026/27–2028/29 Service Plan. February 2026. Source.

The 2026/27 to 2028/29 plan: responsibilities of the ministry, regional organizations, and PHSA, priorities, and development indicators.

[2] Vancouver Coastal Health. Psychiatric Inpatient Services at Vancouver General Hospital. Source.

VGH inpatient care: 75 beds, typical stays of 5 to 12 days; consultation psychiatry on medical and surgical wards.

[3] Vancouver Coastal Health. Access and Assessment Centre at VGH. Source.

Vancouver's initial assessment pathway for people aged 17 and older, crisis care, and onward referral.

[4] Fraser Health. Early Psychosis Intervention. Source.

Fraser Health's early psychosis program: ages 13 to 30, access routes, treatment, and support for up to three years.

[5] Fraser Health. Older Adult Community Mental Health Program. Source.

Fraser Health community geriatric psychiatry: home visits, assessment, and primary care collaboration.

[6] Government of British Columbia. One million people connected to primary care in B.C. since 2018. 16 September 2026. Source.

Government primary care attachment data: 4.47 million attached people and 323,000 registered in the Health Connect Registry in September 2026.

[7] Island Health. Victoria Mental Health & Substance Use Access Services. Source.

Greater Victoria access services: assessment, brief intervention, and referral.

[8] BC Mental Health and Substance Use Services. Red Fish Healing Centre. Source.

Specialized centre for severe concurrent mental disorders and addictions: 105 places, usual stays of 6 to 9 months.

[9] College of Physicians and Surgeons of BC. Referral-Consultation Process. Professional Guideline. Source.

Referrer and consultant responsibilities: clinical question, receipt confirmation, priority, waiting, reporting results, and subsequent plan.

[10] Vancouver Coastal Health. Adult community mental health teams; Fraser Health. Intensive Case Management Teams. Source; Additional material; Additional material.

Standard community teams, case coordination, psychiatry, and rehabilitation. Fraser ICM primarily addresses severe addiction; ACT addresses severe mental disorder and intensive long-term needs.

[11] Crisis Centre BC. Crisis Lines; 9-8-8 and the Crisis Centre of BC. Source; Additional material.

Round-the-clock crisis support: 9-8-8, 310-6789, and 1-800-SUICIDE; Canada's 9-8-8 launched November 30, 2023.

[12] Canadian Mental Health Association, BC Division. CRCL: Crisis Response, Community Led. Source; Additional material; First two years: results.

CRCL, formerly PACT: renamed March 18, 2025. Nearly 10,000 contacts in its first two years, 98.8% of responses without police involvement; crisis support from age 13.

[13] Vancouver Police Department. 1978: Car 87 program begins. Source.

History of joint police and mental health professional outreach; on-site assessment and intervention.

[14] BC Mental Health Act, RSBC 1996, chapter 288. Source; Amendment history.

Official consolidated Mental Health Act: admission criteria and periods, treatment, extended leave, and patient rights; version checked in October 2026.

[15] BC Ministry of Health. MSP coverage and exclusions. Source; Additional material.

Official MSP payment rules for physician consultations and other medical services.

[16] British Columbia Ministry of Health. Alternative Payments Program. Source.

Contract and sessional physician payment; 3.5-hour sessions and funding of indirect clinical work.

[17] BC PharmaCare. 7.7 Psychiatric Medications (Plan G). Source.

Regular, transitional, and exceptional psychiatric medication coverage; application and renewal.

[18] Province of British Columbia. Plan Z (Assurance). Plan Z rules.

Plan Z rules: agonist-treatment medication coverage and exceptional funding while MSP registration is pending.

[19] Canadian Institute for Health Information. National Health Expenditure Trends, 2025: snapshot. Source.

Forecast total Canadian public and private spending for 2025: CAD 399 billion (≈CAD 119 billion PPP), CAD 9,626 (≈CAD 2,870 PPP) per capita, 12.7% of GDP.

[20] Fraser Health Authority. Financial Statements, year ended 31 March 2024. Source.

Audited statements: revenue CAD 6,383.3 million (≈CAD 1.91 billion PPP), expenditure CAD 6,379.5 million (≈CAD 1.9 billion PPP); mental health and substance use CAD 453.485 million (≈CAD 135 million PPP). A separate regional budget.

[21] British Columbia Ministry of Health. Physician Resource Report 2015/2016–2024/2025. October 2025. Source; Additional material.

Physicians and fee-for-service services, 2015/16 to 2024/25.

[22] National Bank of Ukraine. Official CAD exchange rate on October 7, 2026. Primary NBU data; Source; Additional material.

Official exchange rate of UAH 31.5383 per CAD 1; primary NBU data and two public republications. The rate defines the currency unit for CAD PPP comparisons.

[23] World Bank. World Development Indicators: PA.NUS.PRVT.PP, households and NPISHs final consumption expenditure PPP. Ukraine and Canada, 2025. Ukraine: primary data; Canada: primary data; Indicator definition.

2025 parities: UAH 11.864623 and CAD 1.260483 per international dollar. Their ratio is UAH 9.412759 per CAD 1. This national consumer-price scale underlies the common CAD PPP conversion.

[24] Medical Services Commission. Longitudinal Family Physician Payment Schedule. 23 February 2026. Source.

Payment for direct and indirect care time, clinical administration, contacts, and attached patients under LFP; February 2026 rates and rules.

[25] Early Psychosis Intervention BC. Northern Health Early Psychosis Intervention. Source.

Northern EPI: active primary care liaison and a target of first clinician contact within 48 hours.

[26] Interior Health. Early Psychosis Intervention. Source.

Early psychosis intervention organization in Interior Health, including remote participation.

[27] Rural Coordination Centre of BC. RTVS psychiatric case reviews. Source.

Professional psychiatric case discussions for rural physicians through Real-Time Virtual Support.

[28] Eugenics Archive, Erna Kurbegovic. Victoria asylum; Open School BC. Institutional timeline. Source; Additional material.

Archival educational chronology of early BC institutions: Victoria, 1872; New Westminster, 1878.

[29] Foulkes RG. British Columbia Mental Health Services: Historical Perspective to 1961. Canadian Medical Association Journal. 1961;85(11):649–655. PMID 13701008. Source.

A 1961 historical review: social work, psychology services, shock therapies, psychosurgery, and the beginning of psychopharmacology.

[30] Coquitlam Public Library. Riverview Hospital. Coquitlam History. Source.

Local historical chronology: hospital opening in 1913 and transfer of the final 40 patients in 2012.

[31] City of Coquitlam Archives. “British Columbia. Riverview Hospital,” authority record RH-2017-3. Source.

Archival description of Essondale/Riverview: foundation, renaming, and organizational changes.

[32] BC Housing / səmiq̓ʷəʔelə. The History of səmiq̓ʷəʔelə. Source.

History of the grounds, buildings, living conditions, and transition to smaller specialized residences.

[33] British Columbia. Sexual Sterilization Act, 1933, c. 59; repeal legislation, 1973, c. 79. Source; Additional material.

Primary BC legislation: the 1933 sterilization law and its 1973 repeal.

[34] McGill Journal of Law and Health. De Jure and De Facto Discrimination: Sterilization and Eugenics in Canada. 24 November 2021. Source.

Legal review of compulsory sterilization, including a historical estimate of the number affected in BC.

[35] Kurbegovic E. British Columbia opens the Hospital for the Mind. Eugenics Archive. Source.

Historical account of Essondale/Riverview, compulsory sterilization, and settlement of nine women's claims in 2005; references to archival and journalistic sources.

[36] City of Coquitlam. Riverview Hospital heritage timeline; BC Legislative Assembly, Public Accounts Committee, follow-up on the 1994 audit. Source; Additional material.

Chronology of institutional merger in 1965, transfer of nursing education to colleges in 1973, and West Lawn closure in 1983; audit of transition to community care.

[37] Petersen KL, Nicholls TL, Groden D, et al. Redevelopment of tertiary psychiatric services in British Columbia: a prospective study of clinical, social, and residential outcomes of former long-stay inpatients. Schizophrenia Research. 2013;149(1–3):96–103. PubMed; DOI.

Prospective follow-up of 189 former long-stay Riverview patients: housing pathways, clinical status, living conditions, and quality of life. Publication abstract available.

[38] Kwikwetlem First Nation. səmiq̓ʷəʔelə/Riverview. Source.

Kwikwetlem's own history: connection to səmiq̓ʷəʔelə and participation in decisions about its future use.

[39] British Columbia Ministry of Mental Health and Addictions; PHSA. People with mental illness, addictions benefit from new treatment centre. 29 October 2021. Source.

Red Fish opening announcement, October 12, 2021: 105 places, CAD 130 million capital funding (≈CAD 38.8 million PPP), Kwikwetlem participation in design and programs.

[40] Lam RW, Kennedy SH, Adams C, et al. CANMAT 2023 update on management of major depressive disorder in adults. Canadian Journal of Psychiatry. 2024;69(9):641–687. Source; DOI; Additional material; Source.

Canadian major depressive disorder guideline: assessment, psychotherapy, pharmacotherapy, neurostimulation, and maintenance.

[41] CMHA BC. BounceBack information for service providers. Source.

Free BounceBack program: CBT materials, telephone coaching, and eligibility.

[42] Lau MA, Davis S. Evaluation of a cognitive behavior therapy program for BC primary care patients with mild to moderate depression with or without anxiety: Bounce Back, 2008–2014. BC Medical Journal. 2019;61(1):25–32. Source.

BounceBack evaluation, 2008 to 2014: among completers, mean PHQ-9 fell from 11.2 to 5.5 and GAD-7 from 9.8 to 4.7.

[43] Keramatian K, Chithra NK, Yatham LN. The CANMAT and ISBD Guidelines for the Treatment of Bipolar Disorder: Summary and a 2023 Update of Evidence. Focus. 2023;21(4):344–353. DOI: 10.1176/appi.focus.20230009. PubMed; Source.

CANMAT/ISBD 2023 update: mania, bipolar depression, and relapse prevention.

[44] College of Health and Care Professionals of BC. Psychology; Regulating Psychotherapy. Source; Additional material.

Psychologists are regulated by CHCPBC. Statutory regulation of psychotherapists is scheduled to begin November 29, 2027.

[45] BC Association of Clinical Counsellors. Fee Guide 2026. Source.

Recommended individual 50-minute session fees: CAD 140 to 155 (≈CAD 41.8 to 46.3 PPP) for early experience, CAD 155 to 175 (≈CAD 46.3 to 52.2 PPP) for experienced counsellors; specialized care up to CAD 225 (≈CAD 67.2 PPP).

[46] British Columbia Psychological Association. BCPA Recommended Rate 2025–2026. Source.

Recommended hourly rate CAD 245 (≈CAD 73.1 PPP), approved May 12, 2025; practitioners set individual fees.

[47] British Columbia College of Nurses and Midwives. Registered Psychiatric Nurses. Source.

A distinct regulated nursing profession with entry-level education in psychiatric and mental health nursing.

[48] Fraser Health. Neurostimulation Clinic. Source.

Fraser Health neurostimulation clinic: ECT referral, anaesthesia, recovery, and ongoing psychiatric follow-up.

[49] Vancouver Coastal Health. ECT Clinic at VGH. Source.

ECT at VGH: referral indications, outpatient arrangements, and coordination with the treating psychiatrist.

[50] UBC Department of Psychiatry. Residency Program in Psychiatry. Source.

UBC's five-year residency: clinical rotations, psychotherapy training, and supervision.

[51] Fraser Health. Advance electronic health record; Clinical & Systems Transformation. About CST. Source; Additional material; Additional material.

Public descriptions of hospital electronic systems: phased Fraser MEDITECH Expanse implementation from 2023; shared CST Cerner at VCH, PHSA, and Providence.

[52] Provincial Health Services Authority. CareConnect: Clinical Data Available; Digital Referrals and Orders. Source; Additional material; Additional material.

Public description of available clinical information, PharmaNet, and transition from fax exchange to electronic referrals.

[53] BCCSU. Providing Care in Acute Care Settings: Opioid Agonist Treatment Maintenance. 2024. PDF.

BCCSU, 2024: verification of the last OAT dose, missed doses, hospital administrations, and handover to community pharmacies.

[54] British Columbia Ministry of Health. MSP physician claims; CIHI. Hospital Mental Health and Substance Use Data Users Guide, 2023–2024. Source; Additional material.

MSP claims use ICD-9-based diagnostic codes; the BC hospital data source in the CIHI report is DAD, coded using ICD-10-CA.

[55] BC Ombudsperson. Committed to Change: Systemic Investigation Update. Special Report 62, January 2026. Source.

Ombudsperson, January 2026: implementation of 2019 recommendations, mandatory-form review, and involuntary admission indicators.

[56] British Columbia. Motor Vehicle Act, s.230; Child, Family and Community Service Act, s.14; Coroners Act, ss.2–4. Source; Additional material; Additional material; Additional material.

Mandatory reporting grounds concerning unsafe driving, child protection, and specified categories of death; separate responsibilities of psychiatric facility directors.

[57] Riedlinger S, Ehmann T, Tamburri S, Lang DJ. “A Fidelity Assessment of Early Psychosis Intervention Services in British Columbia, Canada.” Early Intervention in Psychiatry. 2026;20(7):e70202. PubMed; Additional material; DOI.

Self-assessment of 16 EPI services using 2022 data, published in 2026. Model-component implementation was 56.1%; structured family interventions were particularly uncommon.

[58] Province of BC / MCFD. Child & Youth Mental Health. Source.

MCFD child and youth service: voluntary access, assessment, psychotherapy, and family work.

[59] Mathias S, Tee K, Helfrich W, et al. “Foundry: Early learnings from the implementation of an integrated youth service network.” Early Intervention in Psychiatry. 2022. PubMed; Additional material; DOI.

Early results from six Foundry centres: 4,783 young people, 35,791 visits; 58% of respondents said they would have sought no help without the centre.

[60] Barbic S, Mallia E, Wuerth K, et al. “Implementing Foundry: A cohort study describing the regional and virtual expansion of a youth integrated service in British Columbia, Canada.” Early Intervention in Psychiatry. 2024. PubMed; DOI.

Cohort description of Foundry expansion: regional centres, virtual care, and characteristics of youth presentations.

[61] Tsang VWL, Lin MCQ, Huang N, et al. “Compass—Canada’s first child psychiatry access program: Implementation and lessons learned.” PLOS ONE. 2025;20:e0323199. PubMed; Additional material; DOI.

Compass, 2018 to 2023: 2,336 registered professionals; approximately 60% of consultations concerned medication.

[62] MCFD, Ministry of Health and Health Authorities. Youth Mental Health Transition Protocol Agreement. 11 June 2015. Source.

A 2015 interagency protocol for transition from child and youth to adult services.

[63] BC Women’s, Provincial Reproductive Mental Health Outpatient Clinic referrals. Source.

BC Women's: referral criteria and outpatient consultation for reproductive mental health disorders.

[64] BC Children’s Hospital. Referral for Inpatient Psychiatry Units; Psychology Residency Brochure 2026–2027. Source; Additional material.

Provincial child and adolescent units, emergency psychiatric assessment, and discharge coordination with schools and local services.

[65] Community Living BC, eligibility for support. Source.

CLBC eligibility for intellectual disability support and the Personalized Supports Initiative for people with autism or fetal alcohol spectrum disorder.

[66] Community Living BC, Services to Adults with Developmental Disabilities. Source.

STADD transition coordination for eligible young people aged 16 to 24.

[67] Fraser Health, Developmental Disabilities Mental Health Services. Source.

Fraser Health DDMHS: specialized psychiatric care for people with intellectual disability and complex mental health or behavioural needs.

[68] Vancouver Coastal Health. Vancouver Older Adult Mental Health and Substance Use Services. Source.

Vancouver geriatric psychiatry: complex mental disorders, dementia symptoms, and home-care collaboration.

[69] Hatch S, Seitz D, Bruneau MA, et al. Canadian clinical practice guidelines for assessing and managing behavioural and psychological symptoms of dementia. Canadian Geriatrics Journal. 2025;28(1):91–102. DOI; Additional material.

Canadian guideline summary on behavioural and psychological symptoms of dementia: assessment of causes, interventions, and family participation.

[70] Office of the Seniors Advocate BC. Monitoring Seniors Services 2025. Published March 2026. Source.

Provincial monitoring: 7,029 people waiting for long-term care on March 31, 2025; average accumulated waiting time in this queue was 287 days.

[71] In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in BC Health Care. November 2020. Source.

Independent 2020 review: surveys of 2,780 Indigenous people and 5,440 staff; racism, trust, and care experiences.

[72] First Nations Health Authority. Virtual Substance Use and Psychiatry Service. Source.

FNHA remote psychiatry and addiction consultations, referral, and culturally appropriate care.

[73] Government of British Columbia. Declaration Act Action Plan, action 4.08; progress report 2025/26. Source.

Éyameth' Health Centre opening in January 2026 and partnership among Sts'ailes, FNHA, Fraser Health, and the province.

[74] First Nations Health Authority. 10 years of the toxic drug public health emergency; healing and hope for the future. 15 April 2026. Source.

2025 data: 289 First Nations deaths, age distribution, and mortality-rate ratios. FNHA counting covers people with First Nations status according to the registers used.

[75] Métis Nation British Columbia. Métis Counselling Connection; Mental Health & Harm Reduction. Source; Additional material.

Counselling coverage for MNBC citizens and mental health coordination; launched in 2021.

[76] Indigenous Services Canada. Non-Insured Health Benefits: Mental Health Counselling Benefits Guide. Source.

Federal counselling coverage for NIHB-eligible people, including Inuit; regional culturally appropriate care agreements.

[77] BC Mental Health and Substance Use Services. Forensic Psychiatric Hospital; Forensic Psychiatric Regional Clinics & Programs. Source; Additional material.

BC forensic psychiatric network: a 190-bed hospital and seven regional clinics.

[78] BC Coroners Service. BC Coroners Service shares 2025 data into unregulated drug-toxicity deaths. 19 February 2026. Source.

Preliminary 2025 annual totals: deaths, age, location, route of use, and expedited toxicology. Substances in toxicology categories can overlap.

[79] BCCSU. A Guideline for the Clinical Management of Opioid Use Disorder, 2023 update. Source; Additional material; Full PDF.

BCCSU provincial opioid dependence guideline: agonist treatment selection, induction, titration, pain, co-occurring conditions, and inpatient treatment.

[80] BC Centre on Substance Use. Provincial Opioid Addiction Treatment Support Program: Frequently Asked Questions. Source.

Training and expanded OAT prescribing authority for certified RN/RPN CP-OUD from September 2024.

[81] BCCSU/CRISM. Canadian guideline for high-risk drinking and alcohol use disorder. Source; Source.

Canadian guideline for high-risk drinking and alcohol use disorder; resource page includes a May 2026 screening update.

[82] BCCSU. Updated Prescribed Alternatives Policy—Implications for Clinical Practice. Source.

December 2025 clinical bulletin: witnessed consumption rules for prescribed alternatives to unregulated substances and specified exceptions.

[83] British Columbia Government. Decriminalization pilot: status, 14 January 2026; ten years of the toxic-drug emergency, 13 April 2026. Source; Additional material; Additional material; Report to Health Canada, February 2026; Provincial summary, 2026.

Pilot ran January 31, 2023 to January 31, 2026, without extension. A dated review of harm reduction and treatment measures.

[84] BCCSU. Providing Care in Acute Care Settings: Substance Use—What You Should Know. Source.

BCCSU 2024 practical resource on addictions in general hospitals: acute illness, treatment continuation, and discharge handover.

[85] Providence Health Care. Road to Recovery. Source.

Road to Recovery: acute addiction care, subsequent treatment stages, and support after inpatient care.

[86] BC Mental Health and Substance Use Services. Rehabilitation and Recovery Program. Source.

A voluntary 40-place transitional rehabilitation program for eligible BCMHSUS specialist-service patients.

[87] Fraser Health. Assertive Community Treatment. Source.

Fraser Health ACT: active multidisciplinary outreach for people with complex, longstanding needs.

[88] Somers JM, Moniruzzaman A, Patterson M, et al. “A Randomized Trial Examining Housing First in Congregate and Scattered Site Formats.” PLOS ONE. 2017;12:e0168745. PubMed; Additional material; DOI.

Vancouver randomized trial of 297 participants: stable housing occupied 74.3% to 74.5% of 24 months in two Housing First models versus 26.3% with usual care.

[89] Fraser Health. Mental health confidentiality. Source.

Practical Fraser Health account of consent, confidentiality, and clinical information sharing with families.

[90] BC Mental Health and Substance Use Services. Red Fish client and family handbook. Source.

Public Red Fish patient and family handbook, January 2022 edition: stays, family participation, and transition preparation.

[91] Independent Rights Advice Service. Official website; government announcement of service rollout in 2025. Source; Additional material.

Independent Rights Advice Service: access procedures and rollout in 2025.

[92] British Columbia. Health Care (Consent) and Care Facility (Admission) Act, RSBC 1996, c. 181. Source; Additional material.

Capacity to consent, representation, temporary substitute decision-makers, prior wishes, and patients' best interests.

[93] Parliament of Canada. MAID: mental disorder as the sole underlying medical condition. Special Joint Committee report, June 2026; Act SC 2024, c. 1. Source; Additional material.

Current temporary exclusion until March 17, 2027; June 2026 parliamentary committee recommendation for indefinite exclusion. Current law is distinguished from a proposed change.

[94] Snow ME, Salmon A, Banjo J, et al. “Backed into a Corner”: Lived experiences of receiving and providing involuntary psychiatric treatment under British Columbia's Mental Health Act. PLOS ONE. 2026;21(6):e0329049. Source; DOI.

Qualitative study: 23 patients, 11 clinical and 10 other staff. Coercion, communication, trust, and participation in decisions.

[95] Loyal JP, Lavergne MR, Small W. “Trends in Involuntary Psychiatric Hospitalization in British Columbia: Descriptive Analysis of Population-Based Linked Administrative Data from 2008 to 2018.” Canadian Journal of Psychiatry. 2023. PubMed; Additional material; DOI.

Linked administrative data, 2008/09 to 2017/18: trends in voluntary and involuntary admission episodes in BC.

[96] College of Physicians and Surgeons of BC. Annual Report 2025/26. Source.

Registration report as of February 28, 2026: 1,023 professionally active physicians certified in psychiatry.

[97] Rudoler D, Kaoser R, Lavergne MR, et al. Regional Variation in Supply and Use of Psychiatric Services in 3 Canadian Provinces. Canadian Journal of Psychiatry. 2025;70:511–523. Source; DOI.

Administrative data from BC, Manitoba, and Ontario, 2012/13 to 2021/22. Psychiatrist distribution and regional measures of any contact, consultation, and longer-term care; Table 2 averages are calculated across regions.

[98] Doctors of BC. Alternative Payments; 2024/25 Service Contract Rates. Source; Additional material.

Contract payment types. Psychiatry range comes from the dated 2024/25 table; allocation of additional funding under the 2025 agreement continued in 2026.

[99] British Columbia Ministry of Health. Sessional Rates, 2025/26–2028/29. Source.

Payment per 3.5-hour session in 2026/27: specialist CAD 747.22 (≈CAD 223 PPP), family physician CAD 633.47 (≈CAD 189 PPP), forensic-service specialist CAD 1,057.61 (≈CAD 316 PPP).

[100] BC Nurses’ Union / CFNU. Nurse Wage Comparison Charts; BC Nurses to End Province-wide Job Action, 24 July 2026; President’s Message, 29 September 2026. Source; Additional material; Additional material.

RN/RPN Level 3 scale under the 2022 to 2025 agreement: CAD 41.42 to 55.91 (≈CAD 12.4 to 16.7 PPP) hourly. On July 24, 2026, NBA accepted mediators' recommendations and ended job action; pay issues proceeded to binding arbitration in autumn. Rates retain the previous agreement's date.

[101] Fraser Health. Neuropsychologist: public vacancy, requisition 129198. Source.

Employer-published range CAD 56.02 to 69.98 (≈CAD 16.7 to 20.9 PPP) hourly. A specific-position example; hourly scale reviewed October 7, 2026.

[102] Health Sciences Association of BC. HSPBA 2025–2029 Wage Schedule O: Psychologist. Effective first pay period after 1 April 2026. Current psychologist scale.

Psychologist P1: CAD 56.02 to 69.98 (≈CAD 16.7 to 20.9 PPP) hourly; S4D maximum CAD 95.17 (≈CAD 28.4 PPP). Scale includes changes to selected categories from April 2026.

[103] Canada Revenue Agency; British Columbia Ministry of Finance. Personal income tax and payroll parameters, 2026. Source; Additional material; Additional material.

Official rates and thresholds for reproducible after-tax income examples, CPP, and EI. Calculations use BC's annual 5.60% rate, not the temporary second-half withholding rate.

[104] Statistics Canada. Payroll employment, earnings and hours, and job vacancies, April 2026. 25 June 2026. Source.

Average weekly employee earnings in BC in April 2026: CAD 1,357.68 (≈CAD 405 PPP). Used as the local scale for pay comparisons.

[105] BC Ministry of Finance. Budget and Fiscal Plan 2026/27–2028/29. 17 February 2026. Source.

Budget plan, 2026/27 to 2028/29: including CAD 131 million (≈CAD 39.1 million PPP) in additional three-year allocations for severe mental disorder and addiction treatment.

[106] BC Government. Beginning construction on mental-health, substance-use treatment facility in Surrey. 4 September 2026. Source.

Surrey construction start, September 2026: 60 places, CAD 57 million budget (≈CAD 17 million PPP), planned opening in 2028.

[107] BC Government. Adding involuntary care facilities in Surrey, Prince George. 10 July 2026. Source.

Prince George complex plan: 72 places, CAD 92 million budget (≈CAD 27.5 million PPP), phased opening in 2027 to 2028.

[108] Health Canada. Opioid use disorder and treatment. 2024. Read resource.

Health Canada: clinical features of opioid dependence, treatment options, and coexistence with chronic pain.

[109] BCCSU. DSM-5-TR Diagnostic Criteria for Opioid Use Disorder. 2023. PDF.

DSM-5-TR criteria: diagnostic threshold, severity, and the tolerance/withdrawal exception for appropriate medical opioid use.

[110] Fraser Health. Rapid Access to Addiction Care (RAAC) Clinic. Service description.

New Westminster RAAC: self-referral, initial stabilization, and handover to continuing treatment.

[111] BCCSU. Patient Assessment for Opioid Agonist Treatment. 2017. Assessment form.

BCCSU pre-OAT assessment form: substances, mental and physical status, interactions, and social circumstances.

[112] Yakovenko I. et al. Management of opioid use disorder: 2024 update to the national clinical practice guideline. CMAJ. 2024;196:E1280-E1290. Bibliographic record and abstract.

National 2024 update: buprenorphine and methadone as first-line treatments; long-term care and accessible psychosocial support.

[113] BCCSU. 2023 OUD Clinical Summary Resources. Clinical guide.

BCCSU 2023 concise clinical guide: agonist treatment induction, titration, and maintenance regimens.

[114] BC Centre for Disease Control. Harm Reduction & Substance Use Services: Take Home Naloxone. BCCDC program.

Take Home Naloxone: free kits, training, and family participation in overdose response.

[115] Fraser Health. Jim Pattison Chronic Pain Clinic. Clinic description.

Jim Pattison multidisciplinary chronic pain clinic: consultations, education, and referral through a physician or nurse practitioner.

[116] Fraser Health. Pain Services Referral Guide. 2025. Source.

Fraser Health public pain-service referral guide, 2025: selection, consultation cycle, and care while waiting.

[117] Pain BC. Find help for chronic pain. Pain BC resources.

Pain BC telephone support, groups, educational resources, and navigation for people with chronic pain.

[118] Kohan L. et al. Buprenorphine management in the perioperative period: educational review and recommendations from a multisociety expert panel. Regional Anesthesia & Pain Medicine. 2021;46:840-859. Bibliographic record.

Multidisciplinary expert recommendations: continuing buprenorphine during surgery, multimodal analgesia, and coordinated discharge.

[119] Pearce L. A. et al. Opioid agonist treatment and risk of mortality during opioid overdose public health emergency: population based retrospective cohort study. BMJ. 2020;368:m772. Study abstract.

Cohort of 55,347 OAT recipients in BC, 1996 to 2018: mortality during and outside treatment and changes during the toxic opioid crisis.

[120] Public Health Centre, Ministry of Health of Ukraine. Maintenance substitution therapy; frequently asked questions. Overview; Frequently asked questions.

Public Health Centre: Ukrainian OAT organization, methadone, buprenorphine, and use of buprenorphine/naloxone from 2024.

[121] Katzman M. A. et al. Canadian clinical practice guidelines for the management of anxiety, posttraumatic stress and obsessive-compulsive disorders. BMC Psychiatry. 2014;14(Suppl 1):S1. Source.

Canadian 2014 anxiety guideline: diagnostic assessment, psychotherapy, and pharmacotherapy.

[122] CAMH. Anxiety: Pharmacotherapy. Source.

CAMH clinical guide: anxiety pharmacotherapy, gradual titration, and response assessment.

[123] Canadian Centre on Substance Use and Addiction. Canada's Guidance on Alcohol and Health: Final Report. 2023. Full report.

Canadian 2023 report: alcohol risks and standard-drink definition, 17.05 mL or 13.45 g of pure ethanol.

[124] Remington and colleagues, Guidelines for the Pharmacotherapy of Schizophrenia in Adults, 2017. Source.

Canadian 2017 guideline: schizophrenia pharmacotherapy, assessment of treatment resistance, and maintenance.

[125] Fraser Health, Psychosis Treatment Optimization Program. Source.

Fraser Health's specialized psychosis treatment optimization program, including clozapine.

[126] CLOZARIL (clozapine). Canadian Product Monograph. 3 July 2025. Source.

Canadian clozapine monograph, July 3, 2025: haematological monitoring, interactions, infections, and retitration after interruption.

[127] CAMH. Psychosis: Pharmacology — Maintenance Treatment. Source.

CAMH psychosis maintenance treatment; effects of tobacco smoke and smoking cessation on clozapine metabolism.

[128] BC Prosecution Service, adult criminal-court process. Source.

BC Prosecution Service: adult criminal proceedings and Crown counsel's charge-approval role.

[129] Canada, Criminal Code, section 16. Source.

Criminal Code section 16: the NCRMD legal test concerning capacity to appreciate the nature of the act or its wrongfulness.

[130] BC Housing, Homeless Outreach Program. Source.

BC Housing outreach work on housing, income, documents, and institutional transitions.

[131] BC Housing, Supportive Housing. Source.

BC supportive housing: living models, staff assistance, and applications through the Supportive Housing Registration Service.

[132] Smith-Carrier T., Dahlquist-Axe H., Prindiville D., Marshall C. A. Exploring the bounds of consumer choice in supported housing: A reflexive thematic analysis of data generated from supportive housing tenants in British Columbia, Canada. PLOS Mental Health. 2025;2:e0000505. Source.

Thematic analysis of interviews with 24 supportive-housing residents: choice, access, and daily life.

[133] BC guideline, Cognitive Impairment: Recognition, Diagnosis and Management in Primary Care, 2014. Source.

Provincial 2014 guideline: recognizing cognitive disorders, diagnosis, and primary care management.

[134] Canadian Coalition for Seniors' Mental Health. Canadian Clinical Practice Guidelines for Assessing and Managing Behavioural and Psychological Symptoms of Dementia. 2024. Source.

Full CCSMH guideline: behavioural and psychological symptoms of dementia, causes, non-drug interventions, and pharmacotherapy.

[135] British Columbia, Home Support. Source.

BC home-support rules: needs assessment, personal assistance, and cost sharing.

[136] British Columbia, Caregiver Respite/Relief. Source.

Respite for family caregivers: home assistance, day programs, and short stays.

[137] Canadian Coalition for Seniors' Mental Health. Delirium Pocket Card. 2024 edition. Source.

CCSMH clinical pocket tool, 2024 edition: delirium recognition, investigation of causes, and management.

[138] BCCSU, Managing Acute Stimulant Intoxication and Withdrawal, 2024. Source.

BCCSU 2024 clinical resource: stimulant intoxication, acute assessment, and withdrawal.

[139] BCCSU, Stimulant Use Disorder clinical resources. Source.

BCCSU practical stimulant use disorder update: clinical management and psychosocial interventions.

[140] ASAM/AAAP. Clinical Practice Guideline on the Management of Stimulant Use Disorder. 2024. Source.

Reassessment of stimulant-induced psychosis; gradual antipsychotic discontinuation after remission and individualized care for co-occurring disorders.

[141] NICE, Autism spectrum disorder in adults, CG142. Source.

NICE CG142, updated 2021: adult autism assessment, environmental adaptation, and co-occurring disorder care.

[142] AutismBC. Getting an Autism Diagnosis as an Adult. 6 January 2022; public page accessed October 2026. Source.

AutismBC, 2022: adult autism diagnosis, navigation, and the then-cited private assessment cost of CAD 3,000 to 5,000 (≈CAD 895 to 1,490 PPP).

[143] Community Living BC. Province invests in CLBC-funded services in its 2025 budget. 7 March 2025. Source.

CLBC 2025/26 budget: CAD 1.8 billion (≈CAD 537 million PPP), an increase of CAD 127 million (≈CAD 37.9 million PPP); approximately 1,200 anticipated new recipients and unmet demand.

[144] Day G. S., del Campo C. M. Wernicke encephalopathy: a medical emergency. CMAJ. 2014;186:E295. DOI: 10.1503/cmaj.130091. Source.

CMAJ clinical publication: recognizing Wernicke encephalopathy and immediate parenteral thiamine.

[145] Emergency Care BC. Wernicke’s Encephalopathy: Diagnosis and Treatment. Source; Withdrawal protocol.

Emergency Care BC: emergency assessment and treatment of Wernicke encephalopathy.

[146] ASAM. Clinical Practice Guideline on Alcohol Withdrawal Management. 2020. Source.

Thiamine, correction of deficiencies, and withdrawal management; glucose and thiamine may be administered together or in either order according to clinical need.

[147] PHSA, BC Mental Health and Substance Use Services. Source.

Public BCMHSUS description: specialized and forensic psychiatric care and provincial correctional health services.

[148] British Columbia, integrated transitional and release planning. Source.

Provincial post-release transition arrangements: Community Transition Teams and support for up to 90 days.

[149] Erickson M. et al. “They Give you a bus Ticket and They Kick you Loose”: A Qualitative Analysis of Post-Release Experiences among Recently Incarcerated Women Living with HIV in Metro Vancouver, Canada. Violence Against Women. 2024;30:2935–2958. Online 2023. Source.

Interviews with 19 women living with HIV and six providers: housing, addictions, and interruptions in post-release care.

[150] Receipt of OAT in BC provincial correctional facilities and nonfatal overdose after release, PLOS ONE, 2024. Source.

Cohort of 1,535 people and 4,738 releases in 2015 to 2018: OAT in provincial institutions and non-fatal overdose risk within 30 days of release.

[151] Public Health Centre, Ministry of Health of Ukraine. Analytical report on implementation of maintenance substitution therapy in Ukraine. 2025; as of January 1, 2026. Report.

Records of 32,975 recipients, site networks, evacuation transfers, co-occurring diseases, and medication dispensing. Private-sector data cover facilities submitting monthly reports.

[152] Vigod and colleagues, CANMAT 2024 perinatal guideline, published 2025. Source.

CANMAT 2024 perinatal guideline, published 2025: postpartum psychosis, medication, lactation, and ECT.

[153] Fraser Health, Reproductive Mental Health. Source.

Fraser Health specialized assessment and treatment recommendations for reproductive mental health disorders.

[154] BC Mental Health and Substance Use Services. Forensic Psychiatric Services: Patient, Family and Partner Handbook. Source.

Public forensic psychiatric service handbook for patients, families, and partners: inpatient care, treatment, and community transition.

[155] BC Review Board, About the Board. Source.

BC Review Board authority over NCRMD and fitness to stand trial.

[156] BC Review Board, The Hearing Process. Source.

Review Board hearings: participants, representation, evidence, and review of dispositions.

[157] BC Review Board, Information for Victims. Source.

Victim participation in Review Board hearings and notification of dispositions.

[158] Canada. Criminal Code, section 672.54: Dispositions. Source.

Criminal Code section 672.54: court or Review Board dispositions, public safety, conditional and absolute discharge, and hospital detention.

[159] CMPA, Subpoenas: What are a physician’s responsibilities?, revised May 2023. Source.

CMPA, May 2023 revision: physicians' obligations after receiving a subpoena, records, and confidentiality.

[160] Canada, Criminal Code, section 700. Source.

Criminal Code section 700: content and requirements of criminal subpoenas.

[161] CMPA, Testifying: What it involves and how to do it effectively, revised September 2022. Source.

CMPA, September 2022 revision: preparing testimony and roles of treating physicians and independent experts.

[162] Benesko O. I., Seliukov H. I. A look into the early history of Kyiv psychiatry. In: History of Ukrainian Psychiatry, ed. I. I. Kutko, P. T. Petriuk. Kharkiv, 1994;1:16–17. Source.

Historical account of Kyiv psychiatric care: early institutions and development of hospital care.

[163] Vlokh I. Y., Danylenko Yu. M., Bondar R. M., Zakal Yu. P., Hul L. H. Main stages in the development of psychiatric care in western Ukraine. In: History of Ukrainian Psychiatry, ed. I. I. Kutko, P. T. Petriuk. Kharkiv, 1994;1:30–31. Source.

Western Ukrainian regional history: Kulparkiv, university psychiatry, and service development under different administrations.

[164] Heritage Bureau, Lviv. 95 Kulparkivska Street. Source.

Architectural history of Kulparkiv: construction from 1870 and hospital opening in 1875.

[165] Seleznev E. I., Kasko A. F. Development of psychiatric care in Bukovyna. In: History of Ukrainian Psychiatry, ed. I. I. Kutko, P. T. Petriuk. Kharkiv, 1994;1:121–122. Source.

Bukovyna: early hospital care, the specialized institution of 1902, and staffing and beds after the Second World War.

[166] Brusentsov A. I., Kravchenko N. F. Organization of outpatient psychiatric care in Odesa region. In: History of Ukrainian Psychiatry, ed. I. I. Kutko, P. T. Petriuk. Kharkiv, 1994;1:25–27. Source.

Odesa region: 1920s dispensary care, the psychoneurological institute, and development of day and outpatient services.

[167] Kovalenko I. V., Pshuk N. G. History of the Vinnytsia Regional Psychoneurological Hospital named after Academician A. I. Yushchenko. In: History of Ukrainian Psychiatry, ed. I. I. Kutko, P. T. Petriuk. Kharkiv, 1994;1:64–65. Source.

Vinnytsia hospital: clinical, scientific, and educational history, district surveys, and links with the medical institute.

[168] Vinnytsia Regional Psychoneurological Hospital named after Academician O. I. Yushchenko. Historical overview. Source.

Institutional history: opening May 25, 1897 with 720 beds, clinical work, and teaching.

[169] Lytvynenko V. I. History of social rehabilitation at Poltava Psychiatric Hospital. In: History of Ukrainian Psychiatry, ed. I. I. Kutko, P. T. Petriuk. Kharkiv, 1994;1:103–105. Source.

Poltava hospital: cultural life, work, social rehabilitation, and long-stay problems in the early 1990s.

[170] Chechin N. M., Avakina I. I. History of Kherson Regional Psychiatric Hospital. In: History of Ukrainian Psychiatry, ed. I. I. Kutko, P. T. Petriuk. Kharkiv, 1994;1:137–138. Source.

Kherson hospital: the balance of hospital wards, colony, and family placement in the early twentieth century.

[171] Suspilne. Left under occupation: hundreds of residents of psychoneurological institutions and psychiatric hospitals were never evacuated. 2025. Source.

Journalistic investigation publishing responses from the National Social Service and regional administrations. A secondary source on loss of institutional control and tracing patients under occupation.

[172] Abramov V. A. History of the rehabilitation approach in the Donbas psychiatric service. In: History of Ukrainian Psychiatry, ed. I. I. Kutko, P. T. Petriuk. Kharkiv, 1994;1:15–16. Source.

Rehabilitation history in Donbas, including Svato-Luch hospital and work workshops.

[173] Samokhvalov V. P. Psychiatric science in Crimea: trends, history, and prospects. In: History of Ukrainian Psychiatry, ed. I. I. Kutko, P. T. Petriuk. Kharkiv, 1994;1:119–121. Source.

Crimean psychiatric science before 1994: academic tradition, biological research, and clinical ethology.

[174] News of Ukrainian Psychiatry. Electronic reprints of History of Ukrainian Psychiatry (1994) and History of Saburova Dacha (1996). Source; Additional material.

Electronic archive of Ukrainian historical-psychiatric collections from 1994 and 1996, with full author texts.

[175] Petriuk P. T., Sosin I. K., Kutko I. I., Petriuk A. P. Chronology of Saburova Dacha's leadership in national psychiatry. News of Ukrainian Psychiatry. 2011. Source.

Professional chronology of Saburova Dacha: early hospital, academic departments, Kovalevskyi's journal, and Kharkiv research institutions.

[176] Kalnytskyi M. B. Kyrylivska Hospital. Encyclopedia of Modern Ukraine. 2013. Source.

Encyclopedic history of Kyrylivska Hospital: grounds, buildings, and stages of psychiatric care development.

[177] Kyiv Medical Portal. Municipal non-profit enterprise, Clinical Hospital "Psychiatry," 103 Kyrylivska Street. Source.

Municipal description of Kyiv's "Psychiatry" hospital: structure, specialized functions, and contact information.

[178] Naprieienko O. K., Protsyk V. O. Foundation of Kyiv clinical psychiatry. In: History of Ukrainian Psychiatry, ed. I. I. Kutko, P. T. Petriuk. Kharkiv, 1994;1:106–108. Source.

Kyiv clinical psychiatry: university department, journal, outpatient work, and institutes of the 1920s.

[179] Kryzhanivskyi O. V., Kryzhanivska L. O. The outstanding contribution of Academician V. P. Protopopov's school to Ukrainian psychiatry. In: History of Ukrainian Psychiatry, ed. I. I. Kutko, P. T. Petriuk. Kharkiv, 1994;1:78–80. Source.

Retrospective on V. P. Protopopov's school: pathophysiology, clinical work, and service organization.

[180] Kruk I. V. Prominent representatives of postwar Kyiv psychiatric schools. In: History of Ukrainian Psychiatry, ed. I. I. Kutko, P. T. Petriuk. Kharkiv, 1994;1:81–82. Source.

Postwar Kyiv schools: clinical psychopathology, child psychiatry, psychiatry of physical illness, and teaching.

[181] Petrenko Olena. Mass murder of Jewish patients in psychiatric clinics during the Nazi occupation of Ukraine. Ukraina Moderna. 2020;28:86–109. Source; DOI.

Archival research on Nazi murders of Jewish patients: Kyiv, Vinnytsia, and mechanisms of selection and killing.

[182] Petriuk P. T., Petriuk A. P. Psychiatry under Nazism: German occupiers' shooting of Saburova Dacha patients. Report 8. Mental Health. 2012;4:109–115. Source.

Historical article reproducing Oleksandr Ignatov's report on the occupation of Saburova Dacha and hospital restoration.

[183] Rapp Iryna. Hluzman Semen Fishelevych. Virtual Museum of the Dissident Movement, Kharkiv Human Rights Protection Group. 2005; updated 2016. Source.

Kharkiv Human Rights Protection Group biography: Semen Hluzman's independent assessment of Petro Hryhorenko and persecution of the psychiatrist.

[184] Yurchenko N. P., Ignatov M. Yu. Centre for intensive therapy and resuscitation in psychoses at Kharkiv City Clinical Psychiatric Hospital No. 15: history and main development directions. In: History of Saburova Dacha. Advances in Psychiatry, Neurology, Neurosurgery, and Addiction Medicine. Kharkiv, 1996;3:125–128. Source.

Report by the centre's founders: 80 beds in 1975, round-the-clock intensive care, and over 36,000 patients in twenty years.

[185] Kyiv Regional Psychiatric and Addiction Medical Association. History of the association's foundation. Source.

Institutional chronology: Kyiv regional psychiatric hospital in 1957, addiction dispensary in 1984, merger in 1998.

[186] Kharkiv National Medical University. Clinical Psychology curriculum, 2024/25 academic year. Source.

Kharkiv National Medical University 2024/25 curriculum: clinical bases and clinical psychology training arrangements.

[187] Shupyk National Healthcare University of Ukraine. Department of Psychiatry, Psychotherapy, and Medical-Psychological Disciplines. Source.

Official department page at Shupyk National Healthcare University of Ukraine: clinical bases and postgraduate education.

[188] Psykhability / Psychability. Organizational history and activities. Source.

History of the Psychability family initiative: support for relatives, group work, and community participation.

[189] Suspilne Kharkiv. Psychiatric hospital building damaged by a Russian missile in Kharkiv during the night of April 27. April 27, 2024. Source.

Suspilne report on damage to Kharkiv's psychiatric hospital from the Russian missile strike of April 27, 2024; supplementary journalistic evidence.

[190] National Health Service of Ukraine. Medical Guarantees Program 2026 guide. Source.

Medical Guarantees Program 2026 guide: package contents, team and facility requirements, psychiatric care, and maintenance substitution therapy.

[191] Verkhovna Rada of Ukraine. On the Mental Health Care System in Ukraine. Law No. 4223-IX of January 15, 2025. Source.

Law No. 4223-IX: an intersectoral mental health system, brought into operation February 7, 2026.

[192] Ministry of Social Policy of Ukraine. Deinstitutionalization; Cabinet of Ministers of Ukraine. Strategy through 2034, Order No. 1315-r of December 24, 2024. Source; Additional material.

Adult care strategy through 2034: community services, supported living, and changes to residential institutions.

[193] WHO. Ukraine: WHO Special Initiative for Mental Health — Situational Assessment. 2020 data; published 2021. Source; Additional material.

WHO situation analysis using 2020 data: the hospital model, funding, workforce, and length of stay before reform.

[194] Cabinet of Ministers of Ukraine. Mental health development concept through 2030, No. 1018-r, December 27, 2017; implementation plan for 2024 to 2026, No. 572-r, June 21, 2024. Source; Additional material.

State policy: mental health concept through 2030 and its 2024 to 2026 implementation plan.

[195] WHO. Special Initiative for Mental Health: Ukraine. Source.

WHO development of primary and community care in Ukraine through the Special Initiative for Mental Health.

[196] Ladyk-Bryzghalova A, Zemp C, Rivest-Beauregard M, et al. “Clinical and functioning outcomes during the establishment phase of Ukraine’s community mental health teams: a descriptive analysis.” The Lancet Regional Health – Europe. 2025;58:101446. PubMed; Additional material; DOI.

Initial work of 14 community teams in 2021: 947 patients; clinical and functional changes in separate subsamples.

[197] Ministry of Finance of Ukraine. Health care in the 2026 budget. Source.

State expenditure including transfers: UAH 258.6 billion; Medical Guarantees Program: UAH 191.6 billion. Planned annual allocations.

[198] Farmatsevt Praktyk. Billions in funding and physicians' actual incomes: distribution of the NHSU budget among regions and professionals. October 2, 2026. Source.

Secondary account of NHSU first-half 2026 data: category pay medians and city averages. Used as a benchmark; primary salary extracts for individual psychiatric institutions require further verification.

[199] State Tax Service of Ukraine. Salary payment and taxes, 2026. Source.

Salary deductions: 18% personal income tax and 5% military levy; employers separately pay the unified social contribution at the general 22% rate.

[200] Debet-Kredyt, reporting State Statistics Service data. Average wages in Ukraine in June 2026. July 31, 2026. Source; State Statistics Service announcement.

Secondary publication of official statistics: average gross salary UAH 32,783; health care and social assistance UAH 22,274. Date and statistical measure retained.

[201] Kopchak O, Pinchuk I, Ivnev B, et al. “Reforming Undergraduate Psychiatry Training in Ukraine.” Journal of Medical Education and Curricular Development. 2020;7:2382120520924000. PubMed; Additional material; DOI.

Reform of undergraduate psychiatry education in Ukraine: practical skills, mhGAP, and primary care links.

[202] State Enterprise Electronic Health. How access to patient medical data in eHealth works. December 2023. Source; Additional material.

Role-based access and separate permissions for sensitive data, including psychiatric records; interaction of the central database and medical information systems.

[203] National Health Service of Ukraine. Which physicians veterans can consult without an electronic referral. August 11, 2026. Source.

Current explanation of general Medical Guarantees Program rules: direct psychiatrist and addiction-specialist access at appropriately contracted NHSU facilities.

[204] Verkhovna Rada of Ukraine. On Psychiatric Care. Law No. 1489-III of February 22, 2000, current consolidated text. Source.

Specific psychiatric care law: rights, consent, hospitalization, panel examination, and court procedure.

[205] Ministry of Health of Ukraine. Order No. 1504 of November 30, 2017. Form No. 10 and instructions. Source; Additional material.

Annual psychiatric care report, registered April 10, 2018 as No. 426/31878. Official registration and accessible full regulatory text.

[206] National Health Service of Ukraine. More than half a million patients have received mental health services since the start of 2026. June 19, 2026. Source.

NHSU January to May 2026 summary: 586,769 care recipients, access pathways, and provider network.

[207] National Health Service of Ukraine. Medical Guarantees Program: what changes in 2026. December 31, 2025. Source.

Medical Guarantees Program 2026: announced package changes and UAH 5.6 billion in planned inpatient psychiatric funding.

[208] Ministry of Health of Ukraine. Affordable Medicines: rules, list updates, and prescribing for mental and behavioural disorders and epilepsy. Source; Additional material; Additional material.

Affordable Medicines: prescribing, treatment plans, electronic prescriptions, and medication access for mental disorders and epilepsy.

[209] Hanna F. Mental Health at a Glance: WHO Atlas 2024, Ukraine Spotlight. Source.

Ukrainian WHO Atlas profile: 5.7 psychiatrists and 23.2 psychiatric nurses per 100,000; government mental health spending approximately 2.7% and UAH 111.4 per capita. Presentation also covers network development in 2023 to 2025.

[210] Dobrobut, Kyiv; Veselka, Lviv. Public psychiatric consultation fees. Accessed October 7, 2026. Source; Additional material.

Two private-price examples: a specific Kyiv appointment and a Lviv clinic fee. Individual provider prices at the review date.

[211] Cabinet of Ministers of Ukraine. Resolution No. 681 of May 27, 2026; accompanying Ministry of Health announcement. Source; Additional material.

Resolution No. 681, May 27, 2026: formation of the governance mechanism provided by the mental health system law.

[212] Cabinet of Ministers of Ukraine. Resolution No. 288 of March 4, 2026 on certification and continuing professional development. Source.

Resolution No. 288, March 4, 2026: professional certification and continuing professional development.

[213] Pinchuk I, Goto R, Kolodezhny O, et al. “Dynamics of hospitalizations and staffing of Ukraine’s mental health services during the Russian invasion.” International Journal of Mental Health Systems. 2023;17:20. PubMed; Additional material; DOI.

Observation of 30 hospitals early in Russia's full-scale invasion: admissions and staffing in 2022; read with the 2025 correction.

[214] Pinchuk I et al. Correction: Dynamics of hospitalizations and staffing of Ukraine’s mental health services during the Russian invasion. International Journal of Mental Health Systems. 2025;19:1. Full text; DOI.

January 7, 2025 correction: July admissions were 360.9 per institution; table and figures in the 30-hospital study corrected.

[215] Pinchuk I, Yachnik Y, Goto R, Skokauskas N. Mental health services during the war in Ukraine: 2-years follow up study. International Journal of Mental Health Systems. 2025;19:11. Full text; DOI.

Three observation waves across 25 hospitals: admissions, staffing, and displacement of staff and patients in 2022 to 2024. Comparisons use consistent baseline and final data from Table 1.

[216] Martsenkovskyi D, Shevlin M, Ben-Ezra M, et al. “Mental health in Ukraine in 2023.” European Psychiatry. 2024;67:e27. PubMed; Additional material; DOI.

September 2023 online quota survey of 2,050 adults: 36.3% screened positive for at least one studied disorder.

[217] Madkour ME, Schwientek AK, Yasenok V, et al. “Community-based mental health centers in Ukraine – protocol for a mixed methods evaluation study using the RE-AIM framework.” Frontiers in Public Health. 2026;14:1740963. PubMed; Additional material; DOI.

Mixed-method evaluation protocol for community centres using RE-AIM: reach, implementation, acceptability, and sustainability.

[218] Yaroslavtsev S. O. The war's impact on inpatient psychiatric service indicators: experience of a regional psychiatric hospital. Ukrainian Bulletin of Psychoneurology. 2025;33(2). Source; DOI.

Ward No. 8 in Kropyvnytskyi: changes in admission case mix and length of stay from 2022 through the first quarter of 2025.

[219] WHO Europe. Three years of war: rising demand for mental health support, trauma care and rehabilitation. 24 February 2025. Source.

Rehabilitation, team training, and barriers for displaced people; summary of WHO work and 2024 needs assessments.

[220] Ministry of Veterans Affairs of Ukraine. How veterans and their families can obtain free psychological support. Source.

Official account of three care levels, eligible groups, provider register, and access routes; checked October 2026.

[221] Ukrainian Parliament Commissioner for Human Rights / NPM. Monitoring visit to Cherkasy Regional Children's Hospital. July 31, 2026. Source.

NPM visit to Cherkasy Regional Children's Hospital, July 2026: new centre, care conditions, staffing, and human rights concerns.

[222] Ministry of Social Policy of Ukraine. Approximately three thousand people will receive supported living in 2026 under the "money follows the person" principle. July 23, 2026. Source.

Experimental social-service funding as of July 23, 2026: 91 providers, 675 contracts for residential care and supported living combined.

[223] Ministry of Social Policy of Ukraine. Implementation in 2025 of the operational action plan for the adult care deinstitutionalization strategy through 2034. Source.

Administrative report for 2025 on adult care deinstitutionalization: regional services and completed community transitions.

[224] BC Stats. Quarterly Population Highlights, issue 26-01. Reference date 1 April 2026; released 17 June 2026. BC Stats bulletin.

BC population estimate on April 1, 2026: 5,646,420. Dated provincial population scale for the budget-comparison chapter.

[225] PHSA. Provincial Language Services; Vancouver Association for Survivors of Torture, VAST. Public services. Source; Additional material; Additional material; Additional material.

Professional interpretation in BC public health care and psychological support for refugees who experienced war, persecution, or torture.