



A Guide to Part 3 of the BC Adult Guardianship Act

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Why was this guide written?

In fall 2021 the BC government announced it is [reviewing the adult abuse and neglect response framework](#) under the Adult Guardianship Act (“AGA”). [Part 3 of the Adult Guardianship Act](#) (“AGA, Part 3”) is designed to help adults who may be experiencing abuse or neglect and who are unable to seek support and assistance because of a disability or health condition. The review is an important opportunity to consider how AGA, Part 3 is working and how we can make improvements in this province.

It is clear that a systemic, independent investigation is needed to inform our understanding of law and practices under AGA, Part 3. The AGA was passed by the BC legislative assembly in 1993 and came into force in 2000. Since that time there has been extremely limited information available to the public about how the law has been applied by the responsible designated agencies. In 2019 a court decision was published that found that a designated agency had unlawfully detained an adult and violated her constitutional rights while conducting an AGA, Part 3 investigation and response. There have been calls from community since that time for the BC government to commit to a systemic, independent investigation into AGA, Part 3 to create transparency with practices that have occurred in investigations and responses and whether other adults have experienced rights violations.

While further information has not yet been published about the process the BC government is following in conducting its review, there is significant interest and concern among many communities who may be impacted by AGA, Part 3. There are publications and descriptions of AGA, Part 3 that have been produced by the Public Guardian and Trustee and designated agencies that explain what the intended benefits are of actions taken in investigations and responses. Health Justice was asked by many community-based organizations to help explain the law and how practices that take place under it have been impacting adults who experience investigations and responses. This project is a response to those requests.

This plain language guide was written to help communities who want to participate in the government’s review process learn more about the current law and some of its impacts. The guide also considers whether and how Indigenous perspectives, laws, systems of care, and rights are factored in with the AGA. It was generated with legal research and input provided through in-depth interviews with people who have experiences with AGA, Part 3. Those interviews included:

- three adults who have been the subject of an investigation and response under AGA, Part 3;

- one family member who supported an adult who was the subject of an investigation and response under AGA, Part 3; and
- two clinicians who have professional experiences with investigations and responses under AGA, Part 3.

These interviews offered incredible insights into how adult abuse and neglect investigations and responses can play out on the ground but do not reflect the full range of AGA, Part 3 practices. This project and this guide are not a replacement for a systemic, independent investigation into the full range of practices that have occurred in AGA, Part 3 investigations and responses.

All interview participants were offered choices about whether they wanted their perspectives, stories, and words to be presented in this guide and how they would want that done. While the guide highlights some of this content explicitly with stories and quotes, all of the expertise and analysis that has been shared with us has grounded and informed this work. All the stories are presented using a pseudonym chosen by the participant or Health Justice. Identifying information has been removed from all the interviews because this guide aims to use individual perspectives to illustrate systemic issues in the BC adult abuse and neglect response framework, rather than critiquing any specific settings, teams, or individuals. We took particular care to ensure that while we presented the valuable perspectives from clinicians who have professional experiences of AGA, Part 3 there was no information published about the adults who lived that experience without their consent. The perspectives expressed in the interviews are those of the participants, not of Health Justice.

The foundational content for this publication was written by Carly Teillet. The interviews with adults with lived experiences with AGA, Part 3 were conducted by two peer researchers, Anita David and Rory Higgs. The interviews with clinicians and a family member were conducted by a clinician, Natania Abebe, or Health Justice staff. This publication has contributions, edits, and formatting by Health Justice staff.

Health Justice gratefully acknowledges the expertise, analysis, and work of everyone involved.



Rose's Story

"Adult Guardianship is supposed to be there to protect you, but it smothered me."

Rose's experience with the Adult Guardianship Act began when she was found unresponsive from alcohol consumption. She had been struggling with alcoholism at the time and was diagnosed with an acquired brain injury. She has been detained under the Adult Guardianship Act off and on and in different places for years.

"A lot of the time, it was necessary for me to be protected. But as I got better, and you know, put the bottle down, not drinking and stuff like that... In the beginning, I think it was an emergency and as an emergency, emergencies pass. That emergency when I was drinking and had the acquired brain injury and all that, that I understand the government getting involved, but not years and years and years after."

"Everything was decided through the courts, but not just the courts, this place. The facility itself. ... My goal is to live independently. And this is assisted living. And I've been under it for so long that I know the next step should be for me, through the court, is to allow me to

live independently."

In addition to being detained under Part 3 of the Adult Guardianship Act, Rose also had control of her finances taken away against her will through a different legal process that put the Public Guardian and Trustee in control of her finances and how much of her own money she can access. The combined effect of these legal interventions makes her feel that she has no freedom and no control over her own life.

"Every aspect of the Adult Guardianship has affected everything about me. Like...I didn't know who I was. For the longest time. I didn't know where I fit in, you know... I'm a mom. And I barely get to exercise that gift. [My kids] are growing up. You know, and not in front of my eyes."

"My experiences, I would say 80% of them were negative...It was like I didn't have a life anymore and being suicidal because of it was quite scary. But that's how negative the Adult Guardianship was for me."

What is Part 3 of the Adult Guardianship Act?

There are several laws in BC that create a structure for how government and organizations provide services to adults. AGA, Part 3 is designed to help adults who may be experiencing abuse or neglect and who are unable to seek support and assistance because of a disability or health condition.

What about Indigenous laws and systems of care?

The system of care for adults set out in AGA, Part 3 does not include or recognize Indigenous laws or Indigenous concepts of health, guardianship, or care. Canada and the province of BC made commitments to change their laws to uphold and respect the individual and collective rights of Indigenous people recognized by the [*United Nations Declaration on the Rights of Indigenous Peoples*](#). AGA, Part 3 needs to be changed in partnership with Indigenous Nations to reflect this commitment.

All adults, including adults who need support and assistance, have human rights

Everyone in BC has the right to receive health care and services without discrimination and to be treated in a dignified way. The law protects an adult's right to freedom and to make choices about which services and health care to receive. Whenever any adult's rights to freedom and to make choices about their health care may be taken away, important safeguards come into effect.

Relevant section of AGA, Part 3: Section 45

When investigations or actions are taking place under AGA, Part 3, an adult's rights must still be respected. For example, AGA, Part 3 says that adults who need support and assistance have the same rights to give or refuse consent to health care and admission to a care facility that all other adults in BC have.

Indigenous rights

In addition to human rights and fundamental liberties, Indigenous adults hold both individual and collective Indigenous rights. Article 24 of the *United Nations Declaration on the Rights of Indigenous Peoples* says that Indigenous people have the right to their traditional medicines and health practices. Indigenous people also have the equal right of all Canadians to enjoy the highest standard of physical and mental health, and to access social and health services without discrimination.

Relevant sections of AGA, Part 3: Sections 2, 3

Principles that guide the application of AGA, Part 3

The AGA has principles that guide the approach to delivering services and using the powers set out in the law:

- All actions and decisions should prioritize and respect the choice (self-determination) and independence (autonomy) of adults. This includes the right to receive the most effective but least restrictive and intrusive form of support, assistance, or protection when adults need help.
- All adults are entitled to live the way that they wish and to accept or refuse support, assistance, or protection as long as they understand those decisions and do not harm others.
- Every adult is presumed to be capable of making decisions about their personal care, health care, and finances unless it is demonstrated that an adult is incapable of making a decision. The way an adult communicates cannot be grounds for deciding that they are not capable of making a decision.

What is abuse, neglect, and self-neglect?

The AGA defines abuse, neglect, and self-neglect:

Relevant section of AGA, Part 3: Section 1

- **abuse** means the deliberate mistreatment of an adult that causes the adult physical, mental, emotional, or financial harm. Abuse could include a physical assault, overmedication, going through an adult's mail to decide what mail they are allowed to

see or keep (censoring mail), or not letting an adult have visitors.

- **neglect** means actions are not taken by another person to provide necessary care or assistance to the adult and the failure to act causes or could cause physical, emotional, mental, or financial harm.
- **self-neglect** means actions are not taken by an adult to care for themselves and the failure to act causes or could cause physical, emotional, mental, or financial harm.

Abuse, neglect, and self-neglect can happen whether an adult lives on their own, with family members, or in a facility like a hospital.

Colonial western standards of care

It is important to pause and consider the terms abuse, neglect, and self-neglect. There is a colonial western standard of care that prioritizes certain types of acceptable care that is only achievable for people with a certain income or in certain situations. Failing to meet the western standard of care can be considered abuse or neglect. People from different nations and cultures have different ways of living, practices of care, living arrangements, nutrition, and traditional health practices that a western standard may not understand or may dismiss.

Another issue with western concepts of abuse and neglect is that it focuses the responsibility only on specific people, like caregivers, and does not take into consideration the ways that the structures and systems of western medical and social services fail many marginalized communities.

BC's adult abuse and neglect response framework could be improved to better recognize these complexities. In particular, AGA, Part 3 needs to be changed in partnership with Indigenous communities to reflect the BC government's commitment to uphold and respect the individual and collective rights of Indigenous people recognized by the *United Nations Declaration on the Rights of Indigenous Peoples*.

Who responds to a report of abuse, neglect, or self-neglect and what happens?

Anyone who believes an adult is being abused or neglected can make a report to a designated agency.

Relevant sections of AGA, Part 3:
Sections 46-49, 61

A **designated agency** is an organization or institution chosen to be responsible for taking actions under AGA, Part 3. The legislation does not say who the designated agencies are, but provides power to the Public Guardian and Trustee to choose designated agencies through regulation. The designated agencies currently are Fraser Health Authority, Interior Health Authority, Northern Health Authority, Vancouver Coastal Health Authority, Vancouver Island Health Authority, Providence Health Care Society, and Community Living British Columbia. At the time this guide was written there were no Indigenous-led designated agencies.

A designated agency must investigate if they receive a report or have a reason to believe an adult is being abused or neglected. They can take many different actions during an investigation, including interviewing the adult and collecting information from other people in the adult's life.

At the end of the investigation the designated agency decides whether the adult is being abused, neglected, or if there is self-neglect, and if the adult needs support or assistance. If they decide the adult does not need support and assistance, they take no further action. If the designated agency believes the adult needs support and assistance, they can take a number of actions, including referring the adult to services or applying to court for an order to keep a person who abused the adult away.

Relevant sections of AGA, Part 3:
Sections 51-53

The designated agency could also create a plan with support and assistance services that are offered to help the adult respond to the abuse, neglect, or self-neglect. The designated agency must involve the adult as much as possible in creating the plan and must spend the time to explain the offered services in a way that the adult understands. If the adult says yes (consents to the services) then the services can be provided.



Lack of clarity and consistency in interpretation and application

A clear theme that came through in the interviews with clinicians who had professional experiences with AGA, Part 3 was the lack of clarity and consistency in designated agencies about how to apply the law, who applies it, and who it gets applied to.

There is little guidance in the law that defines who exercises powers and responsibilities under AGA, Part 3. While the legislation provides responsibilities and authority to designated agencies, AGA, Part 3 does not identify a role for specific service providers, like doctors or social workers. However, both clinicians reported that a practice has developed within designated agencies where AGA, Part 3 is generally viewed as being in the domain of social workers. While many factors likely went into social workers becoming viewed as primarily responsible for interpreting and applying AGA, Part 3, the clinicians offered some reflection on the need they had identified among their profession of social work to carve out an exclusive area of expertise for social workers that might have influenced the way that AGA, Part 3 has been used.

Both clinicians had taken all training available to them on AGA, Part 3 provided by the designated agencies in which they were employed, but had the sense that training requirements may be different in different settings or across different designated agencies. They reported seeing variation in how AGA, Part 3 was interpreted and applied across different settings and situations. Sometimes they observed AGA, Part 3 used in situations where they thought it was too intrusive and outside the scope of the legislation and, conversely, not used in other situations where they thought that the adult met the legislative criteria and it should have been used.

“I think that risk management is a bit of a subjective thing. And I have been on wards where there’s a very high risk tolerance, and I’ve been on wards where the risk tolerance is essentially zero. So it will very much depend on the staff involved how much power is used against patients.”

Both clinicians pointed out how challenging it can be for front line workers to identify who to raise concerns with and to feel confident enough to raise those concerns when a clinician feels like the AGA, Part 3 may be being misused. When they tried raising concerns with supervisors or leadership about AGA, Part 3 practices they felt their concerns were not effectively addressed.

Maeve's Story

"...his voice, and right, and his choice, were not being respected and heard."

Maeve supported a family member who was detained in hospital for over four months while he was the subject of an investigation and response under AGA, Part 3. She recalls how difficult it was to get communication with him in hospital or get any information from the designated agency, even though Maeve is his representative authorized in a representation agreement. No one told her family what factors led up to the decision to detain him in hospital or how to question the conclusions that had been made, no one told them that he had rights, and no one referred them to a lawyer or external supports.

It wasn't until Maeve made a freedom of information request to obtain her family member's health records that she learned what was happening under AGA, Part 3 and "just doing that alone helped us all feel empowered." Even before they received the records she recalls when she spoke to her family member about making the request "everything shifted for him, he went from that place of despair and panic and uncertainty and to a place of having a shred of hope that, you know, at least

I was making some gains in trying to understand what was going on."

Once the records were disclosed, Maeve saw the dynamics with staff shift and they were treated with more credibility because they were better informed. They learned that the designated agency had concluded that her family member was self-neglecting because of the conditions in his home. From her perspective, these conditions were reflective of the way he had chosen to live his entire life, not indicative of any new health issues or challenges. She felt that the approach of "risks that need to be mitigated" overlooked her family member's choices to live unconventionally, the way he wanted to. "I think those risks were definitely louder and used more vehemently, than...those real baseline markers for whether a person has capacity or not...for me, it seemed like the system that he was now under was imposing these societal norms and expectations on them to live in a certain way...you fail, because you are who you are."

Maeve's Story

Maeve believes if there had been better up-front communication, her family member's detention in hospital might not have happened or would not have lasted as long. At first, nobody was asking why he was saying no to being in a facility to try to understand what his resistance was based in, instead, "they made an assumption that we didn't know any better or we weren't able to comprehend or something and there was just this missing piece, this disconnect." They advocated for the designated agency to take a trauma-informed, rights-based approach, which in the end they felt they received in collaborative conversations that brought the adult, family, and staff together as a team.

After Maeve's family member was released, she saw his fear and distrust of interacting with health or social services in case it resulted in him being detained again. He described the Adult Guardianship Act "hanging over him,

like a big threat and a big fear" and would delay seeking health care for serious physical health needs out of fear. Trust has slowly been rebuilt by having experiences with health and social service providers who respect his choices for which services he accepts and which services he refuses. When he says no to a service offered, they respect that decision and offer it again in the future.

Maeve thinks that better training and monitoring in designated agencies could have spared her family the distress and trauma of the prolonged detention. Without deep and ongoing training about what living with disability and complex health issues can be like, and what it means to take an equitable, trauma-informed, and rights-based approach, it is easy to fall back on prejudices, stereotypes, and expectations that do not see people first.

Relevant sections of AGA, Part 3:
Sections 53-54

What if the adult says NO to the services?

Services must not be provided to an adult who says no (refuses consent to the services). But, if a designated agency thinks that an adult does not understand the decision to say no to the suggested services, they can arrange through the Public Guardian and Trustee for the capacity of the adult to be assessed.

If the assessment decides the adult does not understand the decision to refuse the proposed services, a designated agency can apply for a court order to force the services to be delivered against the wishes of an adult.

The impact of systemic racism on accepting services

There are many reasons why adults might not think suggested services are right for them. One is that many people have experienced discrimination and human rights violations in health and social service systems. For example, people with physical or mental disabilities, older people or elders, women, and 2SLGBTQIA+ people may be subject to stereotypes about being less capable of making their own decisions. [Anti-Indigenous racism, discrimination, and stereotyping are widespread in the BC health system.](#) Indigenous-specific racist stereotypes commonly include thinking that Indigenous patients are regularly intoxicated, irresponsible, and less capable.

Indigenous people and people who experience other forms of discrimination may mistrust, avoid, or say no to offered services as a result. Stereotypes and assumptions can negatively influence decisions made at every step in health and social service systems, leading to adults being forced into services against their wishes.

Higher levels of intervention with more marginalized adults

Clinicians reported that they have most commonly seen AGA, Part 3 being used with elderly populations; however, there were clear exceptions to that. For example, one clinician reported observing a facility rely on AGA, Part 3 to detain pregnant women to prevent them from using substances during their pregnancy. Since they were released as soon as they gave birth and the baby was apprehended, the clinician's perspective was that the detention was motivated to protect the fetus, rather than the adults experiencing the intervention, a practice that the clinician has seen taking place under the [Mental Health Act](#) in the past.

A clear theme that emerged from the clinicians was that marginalized adults were more likely to experience higher levels of intervention under AGA, Part 3. The clinicians identified that racialized people, Indigenous people, and people who use substances were populations they were concerned were being disproportionately impacted:

“I think it’s the more marginalized you are, they’re going to use something more intrusive, where she didn’t really have that many rights, like AGA you don’t have to do all the documentation, the Mental Health Act as much and you don’t need a second professional.”

The clinicians identified that the AGA, Part 3 was applied primarily in a way that focused on minimizing risk and ensuring safety by the standards of staff at the designated agencies. It was unclear that the AGA, Part 3 intervention facilitated access to support or services in the health care system or more broadly.

“So I think the paternalism behind health care for the AGA Act runs very deep. And I think it’s well intentioned, the idea that we would keep people safe from harm. That’s generally the intention of all health care is to help people and to care for them, but that sometimes the best intentions of how a person should live their life can become harmful when it’s used in a coercive manner.”

“I think it’s mostly used to protect, I don’t know what treatment they’d get, like, say if they were abused, or financially or physically, emotionally, I don’t know what therapy they’d get. To be honest, there was no focus on support, it was more about safety. And it was paternalistic.”

One clinician expressed concern that use of the AGA, Part 3 may increase given current public discussions calling for further increases to involuntary treatment and interventions for substance users in particular.

How can a court order an adult to receive services?

When an adult refuses suggested services, the designated agency can apply to court for an order to force the adult to receive the services against their wishes. The court will hold a hearing to decide whether the order should be granted.

At the hearing the **BC Provincial Court** decides three main questions:

**Relevant sections of AGA, Part 3:
Sections 54-57**

1. is the adult being abused or neglected or self-neglecting?
2. is the adult unable to seek support and assistance because of a disability or health condition that affects their ability to make decisions about the situation?
3. does the adult need or would they benefit from the services proposed in the plan?

When making an order the court must follow the principles of the AGA and only make orders that are the most effective but least restrictive or intrusive. The court can order:

- that the adult be forced to receive specific support and assistance services without their consent;
- that the adult must be admitted to a hospital, facility, or other place without their consent (detention);
- that someone who has abused the adult stop living with the adult, stop communicating with the adult, or follow other restrictions about their relationship.

The court ordered support and assistance plan can only be in effect for one year or less, and the designated agency can only apply once to have it renewed for a maximum period of two years.

What about an emergency?

In an emergency, AGA, Part 3 says the designated agency has power to act without the process and oversight normally required by a court application. AGA, Part 3 defines an **emergency** as a situation where a designated agency believes that the adult is being abused or neglected, the adult appears to be incapable of understanding decisions about services, and it is necessary to act immediately to save an adult's life, prevent serious physical, or mental harm or protect their property.

**Relevant section of AGA, Part 3:
Section 59**

In this emergency situation, the designated agency may enter a home or property without a court order or a warrant and use reasonable force to remove an adult from that location, take adults to a place designated agency staff consider safe, or provide emergency health care. The designated agency also has power to "take any other emergency measure" necessary to protect the adult from harm.

Some designated agencies have interpreted "any other emergency measure" in section 59 to include the power to involuntarily admit and detain an adult in a facility against their will without the authorization of the court. All three adults interviewed for this guide reported that they had

been detained in a facility against their will without a court order.

It is controversial and unclear whether designated agencies have the authority to involuntarily admit and detain adults in facilities under the “any other emergency measure” in section 59. In one court case, [AH v Fraser Health Authority](#), a judge found that a designated agency had acted outside the bounds of their emergency measure powers and had unlawfully detained an Indigenous woman for nearly a year and violated her rights. The courts have not decided yet whether designated agencies are allowed to detain an adult at all under the “any other emergency measure” provision in section 59, and if so, for what length of time.

Clinicians Report

Overlaps and interchanges with the Mental Health Act

Clinicians reported that applications of AGA, Part 3 often overlap and interchange with the [Mental Health Act](#). All but one of the designated agencies are health authorities that also operate facilities that have authority as designated facilities under the Mental Health Act. The Mental Health Act states clearly that police are authorized to apprehend people and bring them to facilities and facilities are authorized to involuntarily admit and detain people. Detention under the Mental Health Act is indefinite. That means it can continue as long as health care providers continue to complete Mental Health Act certificates that were created by government through regulations to make a procedure for authorizing further detention. In contrast, AGA, Part 3 does not provide authority to police to apprehend and transport people to facilities, does not have certificates created by government through regulations to make a procedure for detention, and involuntary admission and detention in a facility is only listed in the Act as something a court can order after a hearing, as discussed above.

Despite these differences, it appears that some language or approaches from the Mental Health Act are being mirrored or transplanted across to the adult abuse and neglect response context. For example, although there are no certificates to make a procedure for detention under AGA, Part 3, the [Verdict at a Coroner’s Inquest](#) stated that an adult was detained through a “certification” process under section 59 of AGA, Part 3. One clinician interviewed reported that the internal documents created by designated agencies to record decisions made about adults who were detained relying on section 59 were made to look similar to the Mental Health Act certificates. The document created by some designated agencies to [record a section 59 intervention](#) and the document [to inform adults subject to a section 59 intervention of their rights](#) use words like “certificate”, list the title and citation of the legislation at the top, and in many ways have similar language and layouts as the Mental Health Act certificates.

Clinicians Report

One clinician expressed that there are emergency situations where it is important for a designated agency to be able to act quickly to protect an adult from harm. However, both clinicians reported observing designated agencies detaining adults in facilities for prolonged lengths of time, such as several months or approximately a year, relying on the emergency powers of section 59. One clinician noted the role that security guards play in enforcing detention in facilities.

“I see a lot of security guards stationed outside of someone’s door, the term for that we call a sitter, which I find extremely condescending, but it would be essentially like a babysitter, you know, sits outside of the room and just make sure they don’t leave.”

The clinicians also identified practices such as detaining an adult simultaneously under the Mental Health Act and section 59 of AGA, Part 3, the same adult being sequentially detained under the two Acts at different points in time, and staff turning to the AGA, Part 3 as a sort of catch all when a viable mental health diagnosis could not be found to support a detention under the criteria of the Mental Health Act by viewing an adult as self-neglecting and in need of help.

“Often when the AGA Act is applied, the Mental Health Act is also applied, which I don’t understand. They’ll just sort of throw every coercive tool they have at somebody in case something is challenged.”

In addition, both clinicians reported that it was unclear to them in practice whether and how adults who were detained by designated agencies relying on the emergency powers of section 59 were informed of their rights or connected with a lawyer. They noted that it was possible adults had been notified of their rights and connected with a lawyer on detention without their knowledge, but neither had seen an adult detained under section 59 connected with an advocate or lawyer.



Lewis' Story

“...that’s my biggest complaint. They don’t listen to the patients.”

Lewis is an elderly man who is retired following a long and accomplished career. He has many complex health issues, including experiencing strokes. He lives with a family member who also has disabilities and health challenges and they do their best to support each other.

Lewis was getting regular health supports for a chronic health condition at home, but when home health support staff couldn't come to his home for three weeks, he had to go to hospital instead. Once he was there, he was held in hospital against his will for several months under the Adult Guardianship Act. He first found out he was being detained when he heard nurses speaking about him with each other and then asked a nurse if he was apprehended under the Adult Guardianship Act and what that meant. Health care providers at the hospital didn't adequately explain what the law was or why he was being held against his will and he had to do a lot of investigation on his own.

He believes that part of why he was detained under the Adult Guardianship

Act was a social worker reporting concerns about his living conditions. Lewis doesn't have issues with social workers in the hospital, but when social workers came to his home he felt like they were looking for reasons to judge him and the way he lives: “... they basically search your house for something that they can find wrong to put you in a care home.”

Lewis has been an advocate in many different capacities through his life and it's important to him to investigate and resist injustice. He is critical of an agenda he sees to move elderly people out of their homes and into care homes. Too often this is done for convenience and financial reasons that have nothing to do with what the individual wants. Lewis recalls other people in the hospital that wanted to leave and go home and hearing them screaming that they didn't want to go into a care home. He knows from experiences people in his family have had that people in care homes can be physically abused or mistreated and die from flu and COVID-19.

While he was detained in hospital Lewis was approached by a health care

Lewis' Story

provider who worked at the hospital with forms to initiate the process for Medical Assistance in Dying. He found that shocking and refused because he did not want to end his life. He was glad he had family members to talk to about that and make sure they knew his wishes for his care.

Some of the patients in the hospital where Lewis was detained had family and friends who played an important role in advocating for them to be able to return home. Like others, Lewis's family was also a big support in getting him released so he could return home. Lewis's main takeaway from his experience is that the health care

system listens to family members of patients more than patients themselves: "...the doctors, the nurses don't listen to the patient. The patients have no say."

Now he's regained his freedom, Lewis warns other people about the Adult Guardianship Act and cautions people about the risks of letting social workers into your home. Lewis lives with constant worry that if he dies, his family member could be taken into the system and will suffer. He believes that there should be more investigation and public conversation about the Adult Guardianship Act because there is so little awareness and understanding about how it's being used with people.

Where can impacted adults get help?

While there are a lot of uncertainties in the applications of AGA, Part 3, it is clear that any time someone is detained for any reason, the [*Canadian Charter of Rights and Freedoms*](#) guarantees the detained person basic rights, including the rights to:

- be told immediately the reasons for detention;
- be told immediately about the right to a lawyer and to be provided with help to contact a lawyer;
- challenge detention in a court application called habeas corpus; and
- a fair detention process and a fair hearing.

Adults who have been detained or who are facing a court application to order support and assistance services can apply for legal aid funding for legal advice and representation from a lawyer:

[Legal Aid BC](#)

1-866-577-2525

Adults who are experiencing an investigation or response under AGA, Part 3 may also be able to connect with information and support through these organizations:

[Seniors First BC](#)

1-866-437-1940

[Disability Law Clinic](#)

1-800-663-1278

[Alzheimer Society BC](#)

1-800-936-6033

[Inclusion BC](#)

1-844-488-4321

