CHAPTER ONE: INTRODUCTION

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I. Introduction

A. Purpose and Scope of the Guide

Facing criminal prosecution is especially difficult for anyone whose ability to understand the proceedings, to communicate effectively with counsel, to give instructions, and to make decisions is impaired by mental disability, whether in the form of mental illness, mental handicap, brain injury or other conditions or diseases.

For lawyers, providing effective representation for mentally disabled clients can be one of the greatest challenges of practicing criminal law. A client's disability can affect the solicitor-client relationship at all stages of the process. This is a complex area of the law, which underwent a significant change following the 2005 amendments to the *Criminal Code*.[1] Although there is much material in various resources about the criminal law and clients who are mentally disabled, there was no single accessible source that could be used by those who seek general orientation and guidance in order to provide quality representation.[2] Thus, the Research Centre undertook this review with the ultimate aim of producing a guide that would be of assistance primarily to lawyers and judges, but also to mentally disabled people, families, and community groups. The 2016-17 Edition updates the significant developments in the legislation and caselaw that have occurred in the past several years.

The goal of this publication is to provide an overview of the basic legal issues faced by a mentally disabled client and his lawyer, some of the ethical dilemmas and representation issues that may occur, the role of the police and the prosecution in diverting mentally disabled offenders out of the criminal justice system, sentencing options, prison conditions and treatment issues. The guide also discusses human rights issues as they arise in the context of mentally disabled offenders and it strives to highlight areas that may require more detailed research. In the course of the guide, emphasis will be placed on various practical aspects of representation such as taking instructions from a mentally disabled client, the options open to a mentally disabled accused and some of the possible

[1] RSC 1985, c C-46. All references are to this legislation unless otherwise specified.
[2] Archibald Kaiser, "Legal Services for the Mentally Ill: A Polemic and A Plea" (1986) 35 UNB Law Journal 89 at 92-93.

consequences of choosing these options.

Therefore, the focus of the guide is to provide information about the legal, practical and ethical difficulties faced by a mentally disabled accused and his/her lawyer. With this goal in mind, we have organized the guide generally to reflect the various stages of contact with the criminal justice system experienced by a mentally disabled client. However, there are some issues, such as capacity, which arise in several stages of the criminal justice system. This topic will be discussed in a separate section. Therefore, the materials are divided into sixteen chapters that loosely reflect the various stages encountered.

- The first sections deal with pre-trial issues, such as background information about terminology and identification of mental disabilities, capacity, confessions, remands for observation, fitness and diversion.

- The next sections deal with issues encountered at trial, such as the use of expert evidence and the exemption from criminal responsibility on account of mental disorder (formerly the insanity defence) and related issues.

- Finally, the last section of the guide deals with post-trial issues such as sentencing, incarceration and treatment.

There are some issues or topics that will arise in several places in the guide. For example, in early 1992, Parliament amended the provisions of the *Criminal Code* that dealt with how a mentally disabled person was to be treated in the criminal justice system. These provisions were further amended in 1997 and again in 2005.[3] Because practitioners may encounter clients who were involved under the old regime, wherever possible, the guide describes the former system and how it impacted upon mentally disabled people. These former provisions are clearly indicated and will be incorporated into the discussions of the various stages encountered by the client.

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[3] The following are amendments made to Part XX.1 of the *Criminal Code* as cited in *Tremeear's Criminal Code* (Toronto: Carswell, 2014 at 1394-1467): Section 672.11; s.672.12, s 672.191; s 672.24; s 672.38; s 672.5; s 672.51; s 672.53; s 672.55; s 672.6; s 672.67; s 672.71; s.672.72; s 672.78; s 672.83; s 672.9; s 673; s 675; s 676; s 676.1; s 677; s 679; s 680; s 682; s 682(3) (repealed); s 683; s 689; s 691. The 2005 amendments were made pursuant to Bill C-10, 2005 and proclaimed on May 19, 2005. Further amendments were made in 2014 See: Bill C-14, *Not Criminally Responsible Reform Act,* which amended or added sections 672.1(1), 672.11, 672.21(3), 672.47(4) and (5), 672.5(1), 672.5(5.2), (13.3), (15.2), (15.3), (16), 672.51(1), 672.54, 672.5401, 672.541, 672.542, 672.56(1.1), 672.64, 672.75, 672.76(2)(a), 672.81(1.4), 672.81(1.5), 672.84, 672.88(1), and 672.89(1).

Interspersed throughout the guide will be discussion of the impact of the various human rights instruments, including the *Canadian Charter of Rights and Freedoms*,[4] the *Alberta Human Rights Act*,[5] and various international human rights laws. The *Charter* and the international human rights instruments may have some direct and fairly clear application to the legal rights of mentally disabled accused. Additionally, some of these instruments specifically prohibit discrimination on the basis of mental disability.[6]

In some cases, the impact of the anti-discrimination provisions of these instruments will be complex. On the one hand, these anti-discrimination provisions were introduced with the clear goal of integrating mentally disabled persons into the mainstream of Canadian life, by eliminating the risks of discriminatory treatment. On the other hand, recent legal decisions have indicated that the true elimination of discrimination may require variations in treatment. This is especially the case where the operation of government systems has an adverse impact on mentally disabled persons. Therefore, obtaining results that are equal may not necessarily be accomplished by treating each person exactly the same as every other person.

In some situations, treating mentally disabled clients in the same fashion as all other persons will be appropriate and fair. In other situations, it may be necessary to accord special treatment to mentally disabled persons in order to attain equality. Therefore, one underlying issue throughout most of the guide will be whether there are options open to those dealing with the client that would result in him/her receiving equal treatment.

B. Need for a Guide on Mentally Disabled Offenders

Why are offenders who are mentally disabled the focus of special attention at this time? There are three general areas of concern: the social trend away from institutionalizing mentally disabled persons, the changing criteria for involuntary admissions to hospitals and

[4] Part I of the *Constitution Act*, 1982, being Schedule B of the *Canada Act 1982* (UK), 1982, c 11 (hereinafter *Charter of Rights*).
[5] RSA 2000, c A-25.5 (hereinafter HRA), formerly known as the *Individual's Rights Protection Act* and also the *Alberta Human Rights, Citizenship and Multiculturalism Act*. See Bill 44 Human Rights, Citizenship and Multiculturalism Amendment Act, 2009 which changed the name of the Act to the *Alberta Human Rights Act*. The Bill was enacted as RSA 2000, c A-25.5.
[6] *Charter*, s 15(1) and *HRA*, which prohibits discrimination in notices, public accommodation, tenancy, employment etc.

the special impact that the criminal justice system has upon mentally disabled persons.

1. Social Trends Away From Institutionalizing Mentally Disabled Persons

There has been a general shift away from institutionalizing both mentally ill and mentally disabled persons. For example, in 1991, the Government of Alberta adopted a policy that would result in Albertans currently in mental institutions being moved back into their communities for care.[7] This shift to de-institutionalization did not come without a cost. Currently, there are too few community supports in place to care for people with mental illness.[8] Advocates for the mentally ill claim hospital programs for the mentally ill are closing down faster than community resources can take their place. The Province's plan for de-institutionalization was expected to take years.[9] The Province currently has three designated mental health institutions—Southern Alberta Forensic Psychiatry Centre in Calgary, Claresholm Centre for Mental Health and Addictions, and Villa Caritas in Edmonton. The aim is for the treatment provided in these institutions to be replaced (for some patients) by other day treatment plans and community residential services.

Similarly, the Michener Centre in Red Deer, an institution that assists persons with mental disabilities, saw its population drop from over 2000 to 250 in the past twenty years.[10] In fact, in May 2013, the Associate Minister of Services for Persons with Disabilities announced the closure of the Michener Centre.[11] This is the result of the move to

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[7] S Alberts, "Mentally Ill to Leave Institutions—Patients Near Own Homes" *Calgary Herald* (April 3, 1992) A1.

[8] S. Scott and N. Naidoo-Hill, "Stranded on the Street" *Calgary Herald* (September 6, 1996) A6. See also Derek Wilken, "No Homes for the Helpless" *Calgary Herald* (December 5, 1997) C1, which discusses the housing difficulties associated with de-institutionalization of the mentally ill. See also: Barbara Wickens, "Unwell and Untreated", *Maclean's Magazine* (August 10, 1998) 44-45

[9] M. Stewart, "Mentally Ill are suffering from patchwork care" *Calgary Herald* (March 1, 1998) A3. In summer of 2009, the Alberta Health Services announced a plan to close down 246 beds out of the available 400 beds at the Alberta Hospital in Edmonton, and move patients to community settings over three years. A major public outcry resulted. The Government of Alberta consequently commissioned an advisory committee to examine the concerns raised. The advisory committee recommended: that 146 of those beds be left open, that the geriatric ward be closed and that over 100 patients be moved to Villa Caritas Hospital. According to the committee 'All other functions at Alberta Hospital would remain the same pending the outcome of a long-term, long-range look at all mental health needs'. See 'Decision Reversed to close some Alberta Hospital beds' *CBC News* (January 18, 2010).

[10] See A Cryderman, 'Michener Centre still Connecting with Red Deer Community' *Red Deer Express* (21 October, 2010).

[11] Licia Corbella, "Corbella: Reasons for closing Michener are defective", *Calgary Herald* (8 April 2013), online: Calgary Herald

community living.[12] De-institutionalization of mentally disabled persons has resulted in dramatic numbers of persons being moved into community residential settings—supervised residences, foster homes, group homes and independent living situations.[13] In the United States, where de-institutionalization has been the practice for some years, large numbers of mentally ill and mentally disabled persons are living on the streets and are being incarcerated in jails. Nearly three in 10 American jails are “surrogate mental hospitals”, holding seriously mentally ill people who have not been charged with crimes.[14] In 1991, 81.1 per cent of the jails in Kentucky held mentally ill persons not facing criminal charges.[15] Further, a 2006 report of the Bureau of Justice Statistics (BJS) showed that more than half of inmates held in American prisons and jails, including those facing criminal charges, have mental disorders.[16] A 1995 study in the United States reported that 1 in 13 psychiatric patients are arrested every year after admission to psychiatric treatment. Also noted in the report is that between one-third and one-half of all psychiatric patients have been arrested at some point in time.[17] A 2009 study concluded that the rate of serious mental illness cases among male inmates across US jails and prisons was 14.5% and 31.0% for female inmates.[18] Another American study noted that approximately 350,000 seriously mentally ill people find themselves in a position where they are either: awaiting charge, trial, or psychiatric

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http://www.calgaryherald.com/opinion/oped/Corbella+Reasons+closing+Michener+defective/8107681/story.html .

[12] C Bridges, "Michener Centre: Will it Be Allowed to Die?" (August 1992) Status Report—Premier's Council on the Status of Persons with Disabilities 6.

[13] J.D. Munro, "Epidemiology and the Extent of Mental Retardation" (1986) 9(4) Psychiatric Clinics of North America 591 at 606 (hereinafter Munro).

[14] "Mentally Ill Held in Jails Says Report" *Calgary Herald* (September 10, 1992) C5. See Human Rights Watch, ‘Mental Illness, Human Rights and US Prisons’ online: <http://www.hrw.org/news/2009/09/22/mental-illness-human-rights-and-us-prisons>

[15] "Mentally Ill Held in Jails Says Report" *Calgary Herald* (September 10, 1992) C5. Since this article, the Kentucky Department of Corrections has constructed the Correctional Psychiatric Treatment Unit (CPTU) in response to the ever-increasing number of mentally ill inmates within the system. In 1998, the CPTU opened and accepted the first of 150 inmates. More information on this project can be accessed through <www.corrections.ky.gov/instfac/adultinst/DMH.htm>.

[16] See Doris James and Lauren Glaze, "Mental Health Problems of Prison and Jail Inmates" Bureau of Justice Statistics, September 2006.

[17] See Linda Teplin, Karen Abram, & Gary McClelland, “Prevalence of Psychiatric Disorders among Incarcerated Women: I. Pretrial Jail Detainees” (1996) 53 Archives of General Psychiatry 505.

[18] See Henry Steadman et al, “Prevalence of Serious Mental Illness among Jail Inmates” (2009) 60 (6) Psychiatric Serv 762.

assessment in American prisons.[19]

In Canada, the available statistics are equally alarming.[20] In 1989, there were about 500 persons with schizophrenia in a Canada-wide penitentiary population of 12,500.[21] A 1992 report by the Correctional Service of Canada indicated that one in 10 prisoners had experienced a psychotic disorder.[22] In June 2011, the Office of the Correctional Investigator of Canada released a report that indicated that 38.4% of the prison population is mentally ill.[23] In the 2011-2012 report, 36% of the inmates had been identified at admission as requiring psychiatric or psychological follow-up.[24]

While de-institutionalization may be desirable, there have been some problems in implementing community programs to deal with persons who have left treatment facilities and are currently living in the community.[25] When individuals who have been treated or housed in institutions are re-integrated into the community, they may not have the support that they require in order to adapt to their new environment. Anecdotal evidence suggests the increase in the number of mentally ill people in contact with the legal and criminal justice systems in Canada over the past decades is due, in part, to the increasing numbers of homeless persons. According to the Canadian Council on Social Development, statistics on

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[19] Recent estimates suggest that over 350, 000 offenders with mental illness are currently confined in America's prisons and jails. "Nation's Jails Struggle With Mentally Ill Prisoners" *NPR* (September 4, 2011). See also E. Fuller Torre, Sheriff Aaron D. Kennard, Sheriff Don Eslinger *et al*, *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States* (May 2010), online: Treatment Advocacy,< http://treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf>.

[20] See Jake Rupert, "Mentally Ill Wait in Jail for Justice to be Done", *Ottawa Citizen* (November 10, 2004). Mentally Ill Held in Jails Says Report" *Calgary Herald* (September 10, 1992) C5. See also: Fred Adler, "Jail as Repository for Former Mental Patients" (1986) 30(3) International Journal of Offender Therapy and Comparative Criminology 225. See also Nathan Stall, " Imprisoning the Mentally Ill" (2013) 185(3) Canadian Medical Association 201.

[21] "Schizophrenia: Where Rights Run Into Realities" *Globe and Mail* (15 October 1992) A6.

[22] Correctional Investigator Canada, "Correctional Investigator Canada", http://www.oci-bec.gc.ca/rpt/pdf/annrpt/annrpt20102011-eng.pdf "Inmate Mental Disorders on Rise, Study Claims" *Calgary Herald* (January 21, 1992); Seena Fazel & John Danesh, "Serious mental disorder in 23 000 prisoners: A systematic review of 62 surveys" (2002) 359 The Lancet 9306, 545-550.

[23] See Correctional Investigator Canada, http://www.oci-bec.gc.ca/rpt/pdf/annrpt/annrpt20102011-eng.pdf See also: Canadian Journal of Public Health "A Health Care Needs Assessment of Federal Inmates in Canada" Volume 95, Supplement 1 March/April 2004.

[24] Correctional Investigator Canada, < http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20112012-eng.pdf >

[25] J Arboleda-Flórez, "Two Solitudes: Mental Health and Law" 1(2) Journal of Forensic Psychiatry 143 at 157 (hereinafter Arboleda-Flórez). See also: M. Borzecki and J.S. Wormith, "The Criminalization of Psychiatrically Ill People: A Review with a Canadian Perspective" (1985) 10(4) Psychiatric J of the Univ of Ottawa 241 at 242 (hereinafter Borzecki and Wormith). There is, however, some indication that the Canadian situation may be somewhat less severe than in the United States because some funds have been directed towards short-term inpatient and outpatient care.

homelessness indicate that up to 50% of homeless men and 75% of homeless women in Canada have a mental illness and are in need of treatment.[26] An earlier report from the City of Toronto showed that 30 to 35 per cent of homeless people in Toronto suffered from mental disorders, while 75 percent of homeless single women suffer from mental illness.[27]

Also, the incarceration of mentally disordered individuals is disturbing when considering the incidence of physical and sexual abuse by other inmates, partly due to the passive nature of the mentally ill inmates. Further, the stigma[28] attached to mental disabilities in society may cause communities to oppose group homes and other housing projects designed to fill the gap created by de-institutionalization.[29] As a result of this lack of support and society's attitudes, mentally disabled individuals may engage in behaviour that is considered socially disruptive or unacceptable. If there are no community services available to assist them, or if they are not diverted into some type of treatment facility, these individuals may find themselves in the criminal justice system.[30] According to Dr. Gary Chaimowitz, correctional facilities have become "the institution of last resort for people with serious mental illness."[31]

Unfortunately, for the most part, once a person is in prison, his/her mental illness may be left untreated and may even deteriorate. Thus, a significant number of persons with mental disabilities can get caught in a cycle between the hospital (or institution), the community and the judicial or penal system.[32]

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[26] Canadian Council on Social Development "Forging Social Futures" CCSD Canadian Social Welfare Policy Conference 2005, University of New Brunswick, Fredericton, NB June 16-18, 2005.

[27] See City of Toronto, 'Taking Responsibility for Homelessness: An Action Plan for Toronto. Report of the Mayor's Homelessness Action Task Force' (January 1999) available online: City of Toronto, < http://www.toronto.ca/pdf/homeless_action.pdf>. See also G.B. Miller, "Finding a More Humane Treatment for Mental Illness" *[Toronto] Globe and Mail* (September 24, 1992) A19. See also "The Mentally Ill and the Criminal Justice System: Innovative Community-Based Programs 1995" Ottawa: Mental Health Division, 1995.

[28] See: A. George, Canadian Mental Health Association, Stigma and Community Reintegration: The Perspective of Mental Health Service Consumers (October, 1992).

[29] "Neighbours Fail to Stop Housing Project" *Calgary Herald* (May 8, 1992) B8.

[30] Studies disagree as to whether there is an increase in the prevalence in prisons and jails of persons with prior psychiatric inpatient care. See: Borzecki and Wormith; James Ogloff et al, "Preventing the Detention of Non-criminal Mentally Ill People in Jails: The Need for Emergency Protective Custody Units" (1990) 69 Nebraska Law Rev 434 at 442 - 444.

[31] Nathan Stall, " Imprisoning the Mentally Ill" (2013) 185(3) Canadian Medical Association 201.

[32] F. Allodi, H. Kedward & M Robertson, "Insane But Guilty': Psychiatric Patients in Jail" (1977) 25(2) Canada's Mental Health 3 at 4. Some estimate that people with schizophrenia make up about 20 percent of the

2. The Changing Criteria for Involuntary Hospital Admissions (Civil Commitments)

The movement toward de-institutionalization has been generally coupled with a changing of the criteria for involuntary admission to mental hospitals. This has a particular impact on mentally ill individuals. In most Canadian provinces, the government provides power to physicians to detain individuals considered mentally ill who do not co-operate in their hospitalization or treatment.[33] Until recently, the grounds for involuntary commitment were basically the same in each province:

(1) the person is mentally ill,

(2) the person is dangerous to self,

(3) the person is dangerous to others,

(4) a ‘welfare’ clause, as found in some jurisdictions, such as the person is in need of care, or treatment, or is gravely disabled, and

(5) the person cannot be admitted otherwise (does not accept the need for admission).[34]

Currently, some provincial mental health laws use the following grounds for involuntary commitment. First, the person must be suffering from a mental disorder. Second, the person is likely to cause harm to themselves or others or to suffer substantial mental or physical deterioration or serious physical impairment, and third, the person is unsuitable for admission to a facility other than as a formal patient. These latter provisions were intended to broaden the criteria for involuntary commitment.

In the past, a mentally ill person could be involuntarily admitted against his/her will if he/she was simply in need of treatment. Today, for the most part, dangerousness/harm to self or others is a pre-requisite for involuntary admission. Therefore, some mentally ill persons who may have been admitted to hospitals involuntarily in the past will not currently be admitted this way because they do not manifest the required levels of dangerousness or harm. The historical narrowing of requirements for involuntary commitment was not

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prison population. See: B. Livingstone, "Schizophrenia Group Exceeds Funding Target" *Calgary Herald* (November 2, 1989) B7.

[33] Arboleda-Flórez, at 152.

[34] Arboleda-Flórez, at 152. See: Alberta's *Mental Health Act*, RSA 2000, c M-13, s 2.

necessarily undesirable. In fact, many would argue that the requirements for involuntary commitment should be even stricter.[35] However, the perhaps unintended results of stricter requirements are that some mentally ill persons are no longer being committed to hospitals and therefore find themselves in greater jeopardy of contact with the criminal justice system.

The traditional medical route for obtaining psychiatric treatment is no longer available for some mentally ill persons. In the past, many of these individuals would have been treated without any involvement of the criminal justice system. Some of mentally ill individuals who used to be committed involuntarily may find themselves in hostels and shelters or on the streets. Unfortunately, family, police or other social agencies are diverting patients who reject voluntary psychiatric admission and who do not meet the requirements for involuntary hospitalization to the criminal system.[36] Because of these narrow criteria for admission, some individuals or agencies will attempt to use the legal system in order to obtain psychiatric care for their family member or client.[37] Consequently, the criminal justice system is becoming increasingly involved in situations where the mentally ill accused is charged mostly with nuisance offences such as disturbing the peace, vagrancy or trespassing.[38]

There are also individuals who have difficulty gaining access to treatment and who are referred to as the “forfeited patients”.[39] First, there are those who, although too disruptive or dangerous for the psychiatric ward to handle, are not dangerous enough for involuntary committal. Second, there are those who are alcoholic and considered too disruptive by psychiatric staff.[40] Third, some treatment facilities have fairly narrow criteria for admission and therefore those with criminal records, pending criminal charges or other difficulties will not be accepted.[41] If these individuals are socially disruptive, yet are not

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[35] See, for example: Allan Borovoy, *When Freedoms Collide* (Toronto: Lester & Orpen Dennys Ltd., 1988) at 182 - 199.
[36] Brian Hoffman, "The Criminalization of the Mentally Ill" (1990) 35 Can J Psychiatry 166 at 166 (hereinafter Hoffman). See also: "Detained Man Had Suffered Delusions" *Calgary Herald* (20 May 1993) A16.
[37] Hoffman, at 166.
[38] Hoffman, at 166.
[39] Borzecki and Wormith, at 243.
[40] Borzecki and Wormith, at 243.
[41] Borzecki and Wormith, at 243.

admitted to psychiatric facilities, they will become part of the criminal justice system because the system "cannot say no".[42]

3. Specific Areas of Concern with Mentally Disabled Persons in the Criminal Justice System

The final reason for drawing attention to the situation of mentally disabled persons who are involved in the criminal justice system is that there are several special areas of concern. The criminal justice system may have a particularly harsh impact on individuals who are mentally disabled. Most of these issues are discussed in detail in the guide but are highlighted below.

(a) Mental Disability May Influence or Cause the Crime

Crimes committed by mentally disabled persons may be the result of or highly influenced by their mental illness or mental handicap. For example, mentally ill persons may be acting under the influence of delusions or hallucinations or may show poor judgment or lack of impulse control. Similarly, mentally disabled individuals may have difficulty ascertaining the consequences of their actions, may be used by others to commit criminal acts.[43] It is also possible that friendly social overtures by mentally disabled persons may be misinterpreted as attempted assaults, leading to rebuffs, anger and retaliation.[44] Consequently, identification of a possible mental disability may be very important to the client and may determine his experience with the criminal justice system.

A study conducted by scientists at the University of Montreal shows that subjects with major mental disorders or mental handicaps are more likely to be convicted of a crime than persons with no disorder or handicap.[45] While 30% of male subjects without a mental

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[42] Borzecki and Wormith, at 243. See also: Linda Teplin, "The Criminalization of the Mentally Ill: Speculation in Search of Data" (1983) 94 Psych Bull 54.
[43] See: *R v Harris*, [1993] AJ No 50 where the accused used a person of limited intellectual capacity to purchase traveller's cheques, report them lost, cash the traveller's cheques and then attempt to obtain a refund for the "lost" cheques. In this case, the mentally disabled person was not charged, but the accomplice was charged and convicted of attempted fraud for being the brains behind the scheme.
[44] H.A. Prins, "Mad or Bad—Thoughts on the Equivocal Relationship between Mental Disorder and Criminality" (1980) 3 International Journal of Law and Psychiatry 421 at 421 - 433.
[45] R. Kotulak, Chicago Tribune, "Brain Damage in Kids 'Epidemic'" *Calgary Herald* (May 22, 1993) B5 (hereinafter Kotulak).

disorder or handicap had been convicted of a crime, almost 50% of male subjects with a major mental disorder (schizophrenia, major depression, paranoia or other psychoses) and just over 50% of male subjects with an "intellectual handicap" had been convicted of at least one crime.[46] Similarly, while approximately five per cent (5%) of females with no disorder or handicap had been convicted of at least one crime, just under 20% with a major mental disorder and approximately ten per cent (10%) with an "intellectual handicap" had been convicted.[47]

Even where individuals are identified as having a mental disability, there are some persons with whom neither the criminal justice system nor the mental health system is willing to cope. These persons may enter into a "cyclical process of repeated transfers between health and correctional facilities"[48] and therefore they do not receive the help and support that they need. As a result, it is necessary to examine the relationship between the person's mental disability and her criminal activities, and to be aware of related practices and policies of persons in the criminal justice system and the mental health system.

(b) Less Awareness of Legal and Human Rights

Mentally disabled persons may be less aware of their legal rights than are non-disabled persons.[49] Therefore, they will be less able to insist upon receiving their rights at all stages in the criminal process. Special efforts must be made by advocates to ensure that mentally disabled persons receive fair treatment once involved in the criminal justice system.

(c) Involvement of Other Parties—Impact on Solicitor-Client Relationship

Generally, because the client has a mental disability, there are other significant players in that person's life. These include family, social workers, medical personnel and other organizations that assist clients with disabilities. Sometimes, these individuals and

[46] Kotulak, at B5.
[47] Kotulak, at B5. The statistics with regard to substance abusers are even more alarming. Over 90% of male and over 60% of female substance abusers had been convicted of at least one crime.
[48] R.J. Menzies, "Where They Go and What They Do: The Longitudinal Careers of Forensic Patients in the Medicolegal Complex" (1987) 29 Can J of Criminology 275 at 277.
[49] K. Biersdorff, D Young & James Ogloff, "Legal Rights: Advocating for Understanding" (1992) Manuscript, Vocational and Rehabilitation Research Institute, Calgary, Alberta.

agencies may be of invaluable assistance to the client and the lawyer. For example, an awareness of community resources may be extremely important in developing an alternate plan (e.g., sentence) for the mentally disabled offender.[50] Lawyers could draw on the support provided by these individuals and groups to make the most effective use of the resources available in the community. Further, supportive individuals may be very helpful in explaining the nature and consequences of the person's mental disability.[51]

Conversely, the role of some outside individuals can cause difficulties. For example, the accused's family members may be very supportive of the lawyer's strategies or they may be overly intrusive. There may be repercussions in the family if the lawyer discourages the mentally disabled client from discussing the case fully and frankly with her family. The lawyer may have serious concerns because family members are not in a privileged relationship with the client. Although everything that the client discusses with her lawyer in preparation for a criminal case is protected from being disclosed, information shared with others is likely not protected, or privileged. This means that a family member could be asked by the prosecution to testify about anything relevant he/she has been told by the client. This is particularly difficult for the mentally disabled accused who derives support from the family member, yet is not able to discuss his/her case with that person. Because the parents of mentally handicapped persons may be accustomed to making decisions for their son or daughter, they may not be satisfied with playing a minor role in his or her defence.[52]

Further, it is a current trend, in particular concerning individuals who are mentally handicapped, for advocates to insist on their clients being treated like all other persons. This concept is referred to as normalization. Lawyers sometimes want to proceed with defences related to the person's mental abilities but are met with opposition from advocates who want the client to be treated like all other accused. This may cause the lawyer some concern.

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[50] Chapter 15 of this guide contains a list of support agencies throughout the province.
[51] See: Neil Mickenberg, "The Silent Clients: Legal and Ethical Considerations in Representing Severely and Profoundly Retarded Individuals" (1979) 31 Stanford Law Review 625 at 633.
[52] Chapter Three, Solicitor and Client Issues, deals with some of the ethical difficulties faced by lawyers and mentally disabled clients.

(d) Consequences of Lawyer's Strategies

Lawyers representing mentally disabled clients are faced with choices that would not normally arise with a non-disabled client. The results of choosing some of these options may have serious consequences for the mentally disabled client. Lawyers may lack information about the long-range effects of exercising some of the options available.

Some of the issues unique to representing mentally disabled individuals include the implications of diverting a criminal charge toward the civil process. In some cases, it may be preferable to risk a criminal conviction to avoid the uncertainties of civil detention. However, the stress surrounding contact with the criminal justice system can be particularly difficult for mentally disabled persons to manage. Because the client is under stress, this could affect the client's communication with the lawyer in preparing the case and during the trial. Further, incarceration may be particularly difficult and stressful for a mentally disabled client. Finally, the mentally disabled person's criminal record may affect the availability of treatment and housing after he/she finishes serving his/her sentence.

These are just some examples of the various issues that might arise as a result of representing a mentally disabled client. Therefore, effective representation of a mentally disabled client requires special considerations.

(e) Special Needs and Circumstances of Mentally Disabled Persons in Prison

If convicted of an offence and sentenced to serve a term in prison, a mentally disabled person may face some especially difficult circumstances. Mentally disabled persons may have special health needs that may be particularly difficult to meet in custody. Mentally handicapped offenders generally do not receive appropriate services or rehabilitation programs when involved in the criminal justice system.[53] According to a 1983 Alberta Government report, “[i]n prison, mentally handicapped individuals are readily victimized by their fellow inmates and, further, are not able to benefit from rehabilitation programs to the same degree”.[54] Similarly, the 2011 Report of the Office of the Correctional

[53] Alberta Social Services and Community Health, *The Klufas Report on Services to Disabled Persons* (1983) at 59 (hereinafter *Klufas Report*).
[54] Klufas Report, at 62.

Investigator also notes the high incidence of abuse by fellow inmates and excessive use of force incidents, potentially involving application of physical restraint by prison officials.[55]

Mentally ill persons may also be subjected to harsh conditions and suffer from lack of appropriate treatment while in prison. Mentally disabled inmates may be abused by other inmates or their mistreatment may be the result of the realities of the prison setting (e.g., lack of appropriate facilities and treatment). Unlike some patients who are involuntarily committed under various Mental Health Acts, incarcerated individuals who are mentally ill can refuse treatment. Many prisons are ill-equipped to deal with persons who are mentally ill and in need of treatment, but are not dangerous. These individuals are sometimes placed in isolation for their own protection, but do not receive the treatment that they may need.

Further, mentally ill persons may be at a higher risk of suicide while incarcerated. A report released by the Solicitor General of Canada in 1976 indicates that inmates in Canadian institutions are six times more likely to commit suicide than the general population.[56] According to the Centre for Suicide Prevention, inmates on remand and those serving sentences in penitentiaries have extremely high rates of suicide compared with the general population. The World Health Organization indicated that those awaiting trial are seven and a half times more likely to attempt suicide. Those that are already sentenced are six times more likely to attempt suicide compared to the general population.[57] In a 1992 study conducted by the Research and Statistics Branch of Correctional Service of Canada, researchers calculated the federal prisoner suicide across more recent time periods. After reaching a high of 19.7 suicides per 10,000 (i.e., 197 per 100,000 inmates) during 1984 to 1985, the rate has decreased slightly over the last years. The Research and Statistics Branch of Correctional Service of Canada reported that in 2004-2005, there was a reduced rate of

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[55] In the 2011-2012 report there are 814 reported "use of force" incidents, see, Correctional Investigator Canada, http://www.oci-bec.gc.ca/rpt/pdf/annrpt/annrpt20102011-eng.pdf

[56] Canada, Solicitor General, *Suicide in Incarcerated Settings Statistical Handbook: Selected Aspects of Criminal Justice* (Ottawa: Ministry of the Solicitor General, 1976) as cited in Julio Arboleda-Flórez and H. Holley, "Predicting Suicide Behaviours in Incarcerated Settings" (1989) 34 Can J Psychiatry 668 at 668.

[57] Robert Olson, *Prison Inmate Suicide –Why It Matters* (Centre for Suicide Prevention, 2012), online: Centre for Suicide Prevention http://suicideinfo.ca/LinkClick.aspx?fileticket=ocUQ3DmX17Q%3D&tabid=600. (Olson).

10.8 deaths by suicide per 10,000 inmates (i.e., 108 per 100,000 inmates). However, a rate of 8.4 per 10,000 was reported in 2010.[58] According to the Office of Correctional Investigator of Canada, over 60% of the deaths in custody were suicides.[59] There were 66 suicides of inmates in federal custody between the years 2003 and 2008. This includes 20 suicides of inmates released on parole.[60] Between 2009 to 2012, there were 28 reported suicides. These figures do not include deaths that occurred on remand or in provincial penitentiaries.[61]

Additionally, persons with mental illnesses also are at a higher risk for suicide than the general population. In fact, approximately 10% of schizophrenic patients end their lives by committing suicide.[62] Approximately one per cent of the general population commits suicide.[63] Consequently, a person with schizophrenia is ten times more likely to commit suicide. Therefore, the risk of suicide is quite high for those inmates who have mental illnesses, especially those with schizophrenia.[64] According to the 2011 report of the Office of Correctional Investigator of Canada, "the practice of placing mentally ill offenders or those at risk of suicide or serious self-injury in prolonged segregation must stop".[65]

There are some international and Canadian human rights instruments that could apply to mentally disabled inmates. For example, section 12 of the *Charter of Rights* provides that "Everyone has the right not to be subjected to any cruel and unusual treatment or punishment." A person who has a mental disability might argue that because he lacks the ability to fend for himself in a general prison population, if he is incarcerated,

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[58] Correctional Investigator Canada <http://www.oci-bec.gc.ca/rpt/annrpt/annrpt20092010-eng.aspx#2.2>
[59] See Office of Correctional Investigator, *Deaths in Custody* (2007), online: Office of Correctional Investigator <http://www.oci-bec.gc.ca/rpt/oth-aut/oth-aut20070228-eng.aspx>
[60] Jenelle Power & DL Riley, *A Comparative Review of Suicide and Self-Injury Investigative Reports in a Canadian Federal Correctional Population* (Correctional Service Canada Research Branch, 2010), online: Correctional Service Canada <http://www.csc-scc.gc.ca/research/005008-0221-eng.shtml>.
[61] Olson.
[62] Canada, Correctional Service of Canada, *Prisoner Suicide: Retrospective Report on Inmate Suicides* (Ottawa: The Correctional Service of Canada, 1996-1997).
[63] Alec Roy, "Depression, Attempted Suicide and Suicide in Patients with Chronic Schizophrenia" (1986) 9(1) Psychiatric Clinics of North America 193 at 200 (hereinafter Roy) at 200.
[64] Less is known about the suicide rate for individuals with mental handicaps, although studies indicate that their suicide rate is similar to that of the general population. See: Munro, at 615. See also: R. Bland, S. Newman, R. Dyck and H. Orn, "Prevalence of Psychiatric Disorders and Suicide Attempts in a Prison Population" (1990) 35 Can J Psychiatry 407.
[65] Correctional Investigator Canada, http://www.oci-bec.gc.ca/rpt/pdf/annrpt/annrpt20102011-eng.pdf

he is subjected to cruel and unusual treatment or punishment.

Further, some of the international human rights laws legally bind the government of Canada and individuals can complain to the United Nations Human Rights Committee about cruel, inhuman and degrading treatment under certain circumstances. For example, Article 5 of the *Universal Declaration of Human Rights*[66] provides that “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.” There is a similar provision in the *International Covenant on Civil and Political Rights.*[67] Canada has ratified both the Covenant and the *Optional Protocol to the International Covenant on Civil and Political Rights,* which provide a mechanism for consideration of complaints that a nation has violated the Covenant. [68] This means that after exhausting all available legal remedies in Canada, an individual could complain to the United Nations Human Rights Commission about cruel or inhuman treatment in the prison setting.

Although Canada has adopted the language of the Convention in a number of its domestic laws,[69] these international rules are still frequently used to support an argument that an individual's *Charter* rights have been violated. To support an argument that a mentally disabled person has been subjected to cruel and unusual punishment, he/she might rely upon the provisions of the *Standard Minimum Rules for the Treatment of Prisoners*[70] adopted in 1955 by the first United Nations Congress on the Prevention of Crime and the Treatment of Offenders and approved by the Economic and Social Council of the United Nations.[71] A small number of Canadian legal decisions have relied upon articles from

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[66] GA Res 217 (III), UNGAOR, 3d Sess, Supp No 13, UN Doc A/810, (1948) 71.

[67] (1976) 993 UNTS 3, acceded to by Canada in May, 1976, article 7.

[68] (1976) 999 UNTS 171, acceded to by Canada in May, 1976.

[69] For example, Section 69 of the *Corrections and Conditional Release Act* (CCRA), SC 1992 c 20 provides that “no person shall administer, instigate, consent to or acquiesce in any cruel, inhumane or degrading treatment or punishment of an offender who is or has been incarcerated in a penitentiary”. This section prohibits the use of corporal punishment as a disciplinary sanction. See also 269.1(4) of the *Criminal Code* RSC 1985, c C-46, which bars the use of any statement obtained by torture for any purpose except as evidence that it was in fact obtained by torture. Even the *Anti-Terrorism A*ct, SC 2001 c 41, forbids inhuman or cruel treatment in the investigation of terrorism or interrogation of terrorism suspects. The Preamble to the *Act* recognizes that terrorism is a matter of national concern but that this concern must be addressed while continuing to respect and promote the values reflected in, and the rights and freedoms guaranteed by, the *Canadian Charter of Rights and Freedoms* (the *Charter*).

[70] Approved by ECOSOC Res 663C (XXIV) and 2076 (LXII).

[71] Canada was a member of the Economic and Social Council at the time the resolution was adopted and voted in favour of its adoption. However, Canada did not incorporate this legislation into domestic law. There may be a

this international document in support of arguments about prisoner treatment.[72]

Several rules from the *Standard Minimum Rules for the Treatment of Prisoners* (Revised)[73] deal directly with the issue of mentally disabled prisoners. They state:

> Rule 25
> 1. Every prison shall have in place a health-care service tasked with evaluating, promoting, protecting and improving the physical and mental health of prisoners, paying particular attention to prisoners with special health-care needs or with health issues that hamper their rehabilitation.
> 2. The health-care service shall consist of an interdisciplinary team with sufficient qualified personnel acting in full clinical independence and shall encompass sufficient expertise in psychology and psychiatry. The services of a qualified dentist shall be available to every prisoner.
> …
> Rule 27
> 1. All prisons shall ensure prompt access to medical attention in urgent cases. Prisoners who require specialized treatment or surgery shall be transferred to specialized institutions or to civil hospitals. Where a prison service has its own hospital facilities, they shall be adequately staffed and equipped to provide prisoners referred to them with appropriate treatment and care.
> 2. Clinical decisions may only be taken by the responsible health-care professionals and may not be overruled or ignored by non-medical prison staff.
> …
> Rule 76
> 1. Training referred to in paragraph 2 of rule 75 shall include, at a minimum, training on:…
> (d) First aid, the psychosocial needs of prisoners and the corresponding dynamics in prison settings, as well as social care and assistance, including early detection of mental health issues.
>
> **B. Prisoners with mental disabilities and/or health conditions**
> Rule 109
> 1. Persons who are found to be not criminally responsible, or who are later diagnosed with severe mental disabilities and/or health conditions, for whom staying in prison would mean an exacerbation of their condition, shall not be

possible argument that because these provisions have been followed by many countries over a long period of time, they have become part of customary law and are therefore morally binding if not legally binding.

[72] See: Re: *Application under s. 83.28 of the Criminal Code* [2004] 2 SCR 248; *R v Swain* [1991] 1 SCR 933; *Collin v Kaplan* (1982), [1983] 1 FC 496 (TD); *Stanley v RCMP* (1987), 8 CHRR D/3799 (CHRT); *R v KRP* [1994], BCJ No 2405; and *Trang v Alberta (Director of the Edmonton Remand Centre)* [2001], AJ No 1124.

[73] United Nations, *Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules)* (17 December 2015) A/RES/70/175 (hereinafter Nelson Mandela Rules).

> detained in prisons, and arrangements shall be made to transfer them to mental health facilities as soon as possible.
> 2. If necessary, other prisoners with mental disabilities and/or health conditions can be observed and treated in specialized facilities under the supervision of qualified health-care professionals.
> 3. The health-care service shall provide for the psychiatric treatment of all other prisoners who are in need of such treatment.
> …
> Rule 110
> It is desirable that steps should be taken, by arrangement with the appropriate agencies, to ensure if necessary the continuation of psychiatric treatment after release and the provision of social-psychiatric aftercare.

Therefore, the international community has recognized that mentally disabled persons should be considered for special treatment in the penal system and that all persons should be treated without cruel and unusual punishment.

C. Defining Mental Disability

1. Definitions of Mental Disability

One slightly perplexing problem facing the practitioner is that there are a number of definitions of mental disability. Some legal instruments provide definitions and some agencies utilize certain categories and descriptions. However, this is a generally confusing area.

A second issue that frequently arises is that of terminology. Certain terms are more in favour than others. However, there is no general agreement as to the appropriate terminology and what it means. In recognition of these difficulties, we have set out to provide several options and will indicate which options we have adopted in the guide.

(a) Definitions in Legislation

(i) *Criminal Code* and other Legal Definitions

The *Criminal Code* provides an exemption from criminal responsibility in section 16 for those persons who are not criminally responsible on account of mental disorder. “Mental disorder” means a “disease of the mind”, as defined in s 2 of the *Criminal Code*. There are numerous legal decisions that provide guidance as to what is a “disease of the

mind".[74] Unfortunately, the legal decisions have not been historically helpful in providing guidance as to whether persons with mental handicaps are included in the term "disease of the mind".

Further, a person may be found unfit to stand trial. This means that the person is:

> [U]nable on account of mental disorder to conduct a defence at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so, and in particular, unable on account of mental disorder to
>
> (a) understand the nature or object of the proceedings,
>
> (b) understand the possible consequences of the proceedings, or
>
> (c) communicate with counsel. [75]

There are numerous legal decisions that interpret whether or not a person is fit to stand trial. Consequently, a fair amount of guidance is available on the fitness issue.

Unfortunately, aside from these terms that have specific legal meanings, the term "mental disability" does not have a generally accepted meaning.

Courts have examined a person's mental abilities in several situations. In most cases, the legal inquiry is not focused upon whether a person has a mental disability. Rather, the court is usually looking at whether the disability prevents the person from understanding the nature and consequences of a particular action or choice.[76] It is useful to emphasize *functioning* because a person's capacity to function in certain circumstances may be different from his ability to function in other circumstances. In the non-criminal legal setting, courts will look at a person's legal capacity to cope with a particular situation and not whether the person can cope in all situations at all times. For example, courts may find that a person has the legal capacity to marry but not to make a will.[77] Similarly, in the criminal setting, a person may be found fit to stand trial, but may have difficulties choosing between complex options for plea bargaining, for example.

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[74] These decisions are discussed at length in Chapter Six, The Exemption for Mental Disorder.
[75] *Criminal Code*, s 2.
[76] Gerald Robertson, *Mental Disability and the Law in Canada* 2d (Calgary: Carswell, 1994) at 2.
[77] *Re McElroy* (1978), 93 DLR (3d) 552 (Ont Surr Ct).

(ii) Human Rights Instruments

"Mental disability" is mentioned as a ground for protection from discrimination in several international, national and provincial human rights laws. For example, it is one of the enumerated grounds in section 15 of the *Charter of Rights and Freedoms*. However, "mental disability" is not defined in many of these acts. Courts are left to develop precedents that interpret the legislation.

One notable exception is the *Alberta Human Rights Act (HRA)* which provides a fairly comprehensive definition in paragraph 44(1) (h):

> 44(1) (h) "mental disability" means any mental disorder, developmental disorder or learning disorder, regardless of the cause or duration of the disorder.[78]

This definition of mental disability is fairly broad and includes mental illnesses or disorders, developmental disorders and learning or language disorders. It has the advantage of focusing on one's inability to function under various circumstances.

(iii) Mental Health Instruments

The provinces have enacted various mental health laws that deal with various aspects of involuntary committal and other issues pertinent to persons who are mentally disabled. Alberta's *Mental Health Act* outlines several requirements for the involuntary admission of a patient.[79] One requirement is that the person is "suffering from a mental disorder".[80] Mental disorder is defined in s 1(g) as:

> 1. In this Act,
>
> (g) 'mental disorder' means a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs
>
> (i) judgment,
>
> (ii) behaviour,

[78] RSA 2000, c A-25.5.
[79] RSA 2000, c M-13.
[80] s 2(g).

(iii) capacity to recognize reality, or

(iv) ability to meet the ordinary demands of life.

It is likely that this definition will be quite strictly interpreted because its application could result in the involuntary committal of a person.

Similarly, there are provisions under the *Adult Guardianship and Trusteeship Act* that provide for the appointment of a guardian of the person.[81] The court looks at whether the appointment of a guardian will be in the best interests of the person in respect of whom the application is made. Some factors the court will consider include the physical, mental, social, vocational, residential, educational or other needs both present and future and generally the person's ability to care for him/herself and to make reasonable judgments with respect to these matters.[82] Mental disability, however, is not defined in this Act.

(b) Definitions and Terminology From Other Sources

(i) Mental Health Agencies

There is no consensus among mental health agencies as to definitions or categories of mental disabilities. Several groups rely upon the World Health Organization's definition and description of disabilities. The World Health Organization classification system describes impairments, disabilities, handicaps and disorder:

> Disorder is a clinically recognizable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions. Social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder...
>
> Impairment is a loss or abnormality ... of structure or function.
>
> Disability is a restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being.
>
> Handicap is the disadvantage for an individual ... that prevents or limits the performance of a role that is normal ... for that

[81] SA 2008 c A-4.2.
[82] *Adult Guardianship and Trusteeship Act*, SA 2008, c A-4(2) s 4.

individual.[83]

The American Psychiatric Association in its *Diagnostic and Statistics Manual - IV* ("DSM-IV") defined mental disorder as:

> [A] clinically significant behavioural or psychological syndrome or pattern ... associated with present distress (e.g. pain) or disability (i.e. impairment of functioning) or with a significantly increased risk of suffering, death, pain, disability or an important loss of freedom... Must not merely be an expectable and culturally sanctioned response to a particular event, e.g. death of a loved one. Neither deviant behaviour nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual as described above.
>
> Forensic Note 1: [T]he clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a "mental disorder", "mental disability", "mental disease", or "mental defect".
>
> Forensic Note 2: ...diagnosis does not carry any necessary implication regarding the individual's degree of control over the behaviours...Even when diminished control over one's behaviour is a feature of the disorder, having the diagnosis in itself does not demonstrate that a particular individual is/was unable to control his or her behaviour at a particular time.
>
> Forensic Note 3: [T]he test and criteria sets included in DSM-IV will require reconsideration in the light of evolving new information.[84]

The American Psychiatric Association in its *Diagnostic and Statistics Manual - V* ("DSM-V") defines mental disorder as:

> A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that

[83] See World Health Organization, *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines* (World Health Organization 1992) 4-5.
[84] (Fourth Edition) (1994) American Psychiatric Association.

> reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.[85]

It is very difficult to choose a specific definition or description of mental disability. This task is complicated by the lack of consistency in terminology chosen and used by various mental health agencies and other sources.

(ii) Advocacy Groups

Some agencies or groups differentiate between mentally ill persons and mentally handicapped persons. Others talk about persons with chronic mental illnesses, brain injuries or intellectual impairments. “Mental disability” includes intellectual impairment or psychiatric illness.

Some advocates are quite detailed in their choice of terminology and definitions. Some suggest that the term “person with a mental handicap” or “person with an intellectual disability” be used to describe a person instead of “retarded” or “mentally retarded”.[86]

Advocates have even pressed for a new spelling of “disabilities”, because they perceive that the prefix “dys” is more appropriate than “dis”. “Dis” means “not” as in “not able”, whereas “dys” means “difficulty” as in “difficulty functioning”. A change to the “dys” prefix would signal a more positive attitude towards persons with disabilities.[87]

(iii) Style Guides

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[85] (Fifth Edition) (2015) American Psychiatric Association.
[86] "People are Not Conditions" *Globe and Mail* (October 16, 1992) C8.
[87] Self-Advocacy Network, Calgary, Alberta, "Dysability vs. Disability". Note: the Self Advocacy Network is no longer in existence; however “People First” is an advocacy group in Calgary and act as advocates for people with developmental disabilities. The Independent Living Resource Centre is another organization that provides some advocacy for people with disabilities.

The *Globe and Mail* published a style guide that is intended to help writers present accurate and clear information to their readers. Their guide devoted a fair bit of discussion to the proper terminology to use when referring to disabled and mentally disabled individuals.

First, the style guide recommended that the words disabled and disability be used as general terms rather than handicap and handicapped.[88] Second, it is important to avoid labelling people with disabilities as *the disabled* or *the mentally ill*.[89] Third, they do not advise the use of euphemisms that are advocated by some support groups because clarity is sacrificed. For example, words and phrases such as "exceptional" and "mentally disabled" should not be used to describe mentally handicapped people because they are too vague.[90] Fourth, "mental illness" or "mentally ill" should be used rather than "insane" or "crazy".[91] Fifth, "brain injured" is preferred over "brain damaged".[92]

One somewhat controversial decision is their choice of "retarded" or "mentally retarded" over some other possible terms. The authors of the style guide recognize that some groups are offended by this choice of terminology, but argue that the terms "developmentally disabled" and "developmentally challenged" are too vague.[93] They recommend that "retarded" be replaced with "functions at a Grade 4 level" or similar phrases wherever possible.[94]

2. Our Choices of Definitions and Terminology

Every attempt has been made in this guide to be both sensitive and clear in our choices of terminology and definitions. We have relied mostly upon the definition of mentally disabled provided in the *HRA* because it is sufficiently broad to cover the individuals discussed in the guide. Consequently, we have chosen the terms "mentally

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[88] J.A. McFarlane and W. Clements, *The Globe and Mail Style Book* (Toronto: Info Globe, 1990) at 81. (hereinafter *Globe and Mail Style Book*). The latest edition of this guide, the 9th edition was published in 2003 and is available online, http://v1.theglobeandmail.com/servlet/story/STYLEBOOK.20041110.style_2290/Stylebook/Entertainment/

[89] *Globe and Mail Style Book*, at 81.

[90] *Globe and Mail Style Book*, at 81.

[91] *Globe and Mail Style Book*, at 82.

[92] *Globe and Mail Style Book*, at 82.

[93] *Globe and Mail Style Book*, at 83.

[94] *Globe and Mail Style Book,* at 83.

disabled persons" or "mental disability" in generally referring to all persons who may have one of the conditions or illnesses outlined in the *Act*. This covers persons with mental illness, persons with mental handicaps or intellectual impairments, persons with brain injuries and some persons with other developmental disabilities.

We have made several specific choices. First, we have chosen "mentally ill persons" or "persons with mental illness" when referring to people who have conditions such as schizophrenia and other physiological and psychiatric conditions that may be treated. Second, we refer to "mentally handicapped" persons when discussing individuals who face social and environmental consequences due to intellectual impairment or developmental difficulties. It should be noted that the United States some older sociological and legal materials refer to persons with mental handicaps as "mentally retarded" or as having "mental retardation". From time to time in the guide, when discussing materials and cases from the United States, these phrases may appear. Third, we refer to individuals who have experienced injuries or illnesses that impair capabilities that they once had and that may be regained through rehabilitation as "brain injured".

Finally, the *Criminal Code* refers to persons with a "disease of the mind" and persons with "mental disorders". Consequently, when we are discussing certain provisions of the *Criminal Code*, we refer to "mentally disordered persons" or "persons with a mental disorder".

D. Recognizing That a Person Has a Mental Disability

One of the first difficulties faced by a lawyer who has been retained to assist a person charged with a criminal offence is identifying whether the person has a mental disability that may have affected her behaviour or that may affect the solicitor-client relationship. It is not possible to provide a comprehensive guide to each form of mental disability. However, the following materials are intended to alert legal practitioners to some of the common manifestations of mental disabilities and how to best compensate for them during interactions with the client. These materials were prepared by or in consultation with persons who have experience and expertise in the area.

1. Mental Illness—Generally

Mental illnesses are described as disorders of thought, mood and perception.[95] The thought disorders that lawyers might commonly encounter include delusional or paranoid syndromes. Delusional individuals suffer from irrational beliefs that cannot be challenged by contradictory information. Those suffering from this kind of thinking are often convinced that they are famous people, are being persecuted or are capable of extraordinary accomplishments.[96] There are four common types of delusions:

A. **Delusions of reference**: where clients feel that everything happening around them, no matter how coincidental or apparently unrelated, actually is directed at or refers to them.

B. **Delusions of persecution**: where clients feel that persons or groups are plotting their downfall and destruction, when in fact those persons are indifferent or even positive toward them.

C. **Delusions of grandeur**: where clients perceive themselves as incredibly gifted, influential or important.

D. **Delusions of control**: where clients believe their thoughts and/or behaviour are being controlled by electric currents, radio waves, voices or spirits.[97]

One form of delusion is paranoia—where a person shows a tendency toward unfounded suspicions of people and situations. Those with paranoia may think that others are plotting against them or ridiculing them.[98] Other thought disorders include difficulty in memory or in concentration.

Perceptual disorders include persons suffering from hallucinations. Persons who are hallucinating see, hear, smell, taste or feel things that are not there.

Disorders of mood, also called affective disorders, include depression and manic states. One common affective disorder, sometimes called manic depression, occurs when a

[95] This overview provides only the most common mental illnesses. Please refer to the Glossary (Chapter 16) for further information on specific mental illnesses or disorders.
[96] Schizophrenia Society of Alberta, *Schizophrenia: Youth's Greatest Disabler*, 1990 at 40 (hereinafter Schizophrenia Society of Alberta).
[97] G Lindzey, CS Hall & RF Thompson, *Psychology,* 2d (New York: Worth Publishers, 1978) at 536.
[98] Schizophrenia Society of Alberta, at 42.

person experiences mood swings from high elation to deep depression. Some people only experience the manic form and others the depressed phase. Manic persons may be continually agitated, exhibit non-stop speech, and have grandiose projects or ideas. They may give away or spend large amounts of money. They may appear to have boundless energy and may go for days without sleep.[99]

Depression takes various forms and persons suffer depression with different levels of intensity. Severely depressed persons appear to get almost no satisfaction out of life, are unmotivated and extremely self-critical. Depressive states may be so severe as to restrict all activity and speech, and may be associated with suicides or attempted suicides.

Persons with personality disorders are considered to be chronically poorly adjusted. They may experience the inability to feel anxiety, shame, or guilt or may experience an inability to understand the feelings of others or to form close relationships.

Some strategies for recognizing individuals with mental illness and techniques for better client service are discussed below under "Schizophrenia", as this is a common mental illness that lawyers may encounter.

2. Schizophrenia

(a) Description

Schizophrenic disorders probably constitute the largest single group of serious mental disorders. Their incidence has been estimated at one per cent (1%) of the population.[100] Glenda Jones observed that "[s]chizophrenia is a major, chronic incurable disease affecting more people than many other major illnesses."[101] Common symptoms are personality changes, withdrawal, severe thought and speech disturbances, hallucinations, delusions and bizarre behaviour.[102] Schizophrenia is a chronic illness that has varying degrees of severity. It is often confused with multiple personality disorder. People who have

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[99] JP Houston, H Bee, E Hatfield and D Rimm, *Invitation to Psychology* (New York: Academic Press, 1979) at 580.
[100] Canada, Health and Welfare, *Schizophrenia: A Handbook for Families* (Ottawa: Minister of National Health and Welfare, 1991) at 10 (hereinafter Canada, Health and Welfare, 1991). See also: The Schizophrenia Society of Canada, http://www.schizophrenia.ca.
[101] Glenda Jones, Schizophrenia Society of Alberta, Letter re Legal Aid Changes, November 25, 1992.
[102] Schizophrenia Society of Alberta, 1990, at 42.

schizophrenia, “split mind”, do not have split personalities, but experience a split between what is perceived, what is believed and what is objectively real.[103] Schizophrenia usually first presents itself in young people between 15 and 30 years of age, although the illness may develop as late as age 40.[104] It occurs in all races, cultures, social classes and sexes.

There are several theories as to what causes schizophrenia. One of the leading theories is that it is caused by a chemical imbalance in the brain that affects neurotransmitters (the substances that allow communication between nerve cells) or by an excess or lack of dopamine (a chemical in the brain). Other possible causes include birth defects and brain inflammation. Some research has uncovered a genetic link to the disease,[105] and the likelihood of developing schizophrenia is increased if one or both parents have the disorder. Schizophrenia has a very profound effect on the individual and his family members.

Schizophrenia is not curable, but anti-psychotic drugs and psychotherapy assist greatly in controlling the illness. Approximately one-third of persons who have schizophrenia have only one psychotic episode and never experience it again. Approximately one-third manage their illness very well with medication. Another one-third do not respond to treatment for a variety of reasons.[106]

There are several different types of schizophrenia.

Disorganized Type: The disorganized type exhibits disorganized speech and/or behaviour (speech or behaviour that has little or no connection to physical or social context, or even the context what the individual has already said), along with flat or incongruent affect.[107] These symptoms will often present themselves in the form of poor concentration, moodiness, confusion and strange ideas. The person's speech is frequently incoherent, difficult to understand and rambling. The person may show no emotions or inappropriate emotions.[108]

Paranoid Type: Paranoid schizophrenia is characterized by delusions and

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[103] Canada, Health and Welfare, 1991, at 11.
[104] Canada, Health and Welfare, 1991, at 10.
[105] Canada, Health and Welfare, 1991, at 50.
[106] Schizophrenia Society of Alberta, Calgary Chapter, Information handout.
[107] *DSM-IV-TR Mental Disorders: Diagnosis, Etiology & Treatment*, 2004, at 648.
[108] Schizophrenia Society of Alberta, 1990, at 9.

hallucinations. The person may also have an exaggerated sense of self- importance or may exhibit anger, anxiety, argumentativeness, jealousy and occasional violence.[109]

Catatonic Type: With the catatonic type of schizophrenia, the person seems markedly withdrawn from her environment. She/he may not speak or move or may maintain a rigid posture. On the other hand, the individual may engage in physical activity that seems purposeless and that is not influenced by her environment.[110]

Undifferentiated Type: Persons who have undifferentiated type of schizophrenia have an illness that either cannot be classified into any of the foregoing categories or that matches the criteria for more than one type of schizophrenia. These individuals usually exhibit major psychotic symptoms, such as delusions and hallucinations.[111]

Residual Type: Finally, some individuals have one recognizable episode of schizophrenia but do not have on-going psychotic symptoms, nor do they exhibit other signs of the illness such as withdrawal, eccentric behaviour, illogical thinking or inappropriate emotions. They are said to have residual type schizophrenia.[112]

Because of the nature of the illness, about one half of persons with schizophrenia abuse drugs or alcohol.[113] Although people with schizophrenia may feel that the drugs or alcohol will reduce their symptoms, in reality they are often made worse. Thus, persons with schizophrenia may also have addiction problems.

There is a myth or misconception that people with schizophrenia are violent. In fact, many people with schizophrenia are withdrawn and timid. Indeed, ninety-five per cent of murders committed every year are committed by people who are sane.[114] If, however, a person with schizophrenia was prone to violence to begin with, schizophrenia might exacerbate those tendencies.

Unfortunately, a number of individuals with schizophrenia find themselves in trouble with the law. Offences range from shoplifting, mischief, assault, refusing to pay for a meal that was ordered, to much more serious charges such as aggravated assault, arson or

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[109] Schizophrenia Society of Alberta, 1990, at 9.
[110] Schizophrenia Society of Alberta, 1990, at 9.
[111] Schizophrenia Society of Alberta, 1990, at 9.
[112] Schizophrenia Society of Alberta, 1990, at 9.
[113] Per Glenda Jones, Schizophrenia Society of Alberta.
[114] Schizophrenia Society of Alberta, 1990, at 30.

murder.[115] The symptoms of schizophrenia are made worse by stress and tension.[116] Therefore, the anxiety surrounding contact with the criminal justice system, including the initial charging procedures, time spent in the remand centre, the experience in mental health facilities when undergoing court ordered observation, and the uncertainty of outcomes are very difficult for persons with schizophrenia. Upon arrest, these persons may not be immediately recognized as having schizophrenia. Because of the nature of the illness, incarceration can be particularly devastating. It is important that individuals with schizophrenia have lawyers who understand the problems of schizophrenia and its impact on the individual.

Also, because of the stigma attached to mental illness in our society and because of the nature of the illness, persons with schizophrenia often seek to hide their symptoms or to deny that they are ill at all.[117] Therefore, it is possible that lawyers and other persons in contact with the individual will not recognize that the person is mentally ill.

(b) Recognition of Schizophrenia

In some situations, family members, physicians or police personnel may inform a lawyer that an individual has schizophrenia. However, it is possible that a client may arrive at the lawyer's office without the lawyer having any background information. If a lawyer suspects that the client may have schizophrenia, he could refer the client to a schizophrenia specialist or could contact the Schizophrenia Society of Alberta for further information about the illness.

The most common signs that a person with schizophrenia may exhibit include: hallucinations (especially auditory hallucinations),[118] delusions, disorganized and fragmented thoughts, and altered sense of oneself (thinking one's body is separated from the person), lack of motivation, blunted feelings (inability to express emotion), depression, and social withdrawal.[119] Other symptoms include: marked change in personality, a

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[115] Canada, Health and Welfare, 1991, at 43.
[116] Schizophrenia Society of Alberta, 1990, at 6.
[117] Schizophrenia Society of Alberta, 1990, at 6.
[118] DSM-IV-TR Mental Disorders: Diagnosis, Etiology & Treatment, 2004, at 640.
[119] Canada, Health and Welfare, 1991, at 9 - 10.

constant feeling of being watched, difficulty in controlling one's thoughts, hearing voices or non-existent sounds, isolation, reclusive behaviour, use of words that make no sense, sudden excesses such as extreme religiosity, deterioration and abandonment of personal hygiene, and agitation.[120]

Schizophrenia may affect a lawyer-client relationship. Several aspects of schizophrenia make it difficult for the lawyer to obtain appropriate instructions and to discuss a case with a person who is suffering the effects of the illness. People with schizophrenia often display forgetfulness or inability to concentrate. This may make it quite difficult to obtain instructions from the client and to ensure the client understands all of his/her options. The lawyer may notice that the client responds inappropriately to certain questions—either the verbal response seems garbled or unusual in some way or the person displays inappropriate emotions. Because the client may have experienced hallucinations or delusions, it may be difficult for the lawyer to ascertain the exact facts of the incident in question. The client may have difficulty sitting still or may not move at all. He/she may be quite preoccupied—especially if he/she is hearing voices. Some people with schizophrenia do not like to be touched because of sensitivity. For such individuals, shaking the person's hand may not be desirable.

Further, the circumstances under which the client finds herself (charged with a criminal offence) may exacerbate her mental illness. The client may appear very paranoid and may even accuse her lawyer of being part of the system that is persecuting her. Persons with schizophrenia may feel threatened by the legal process and by lawyers. This may lead to inappropriate hostility on the part of the client. The stressful nature of legal proceedings may also negatively affect the client's illness. The client may make irrational statements. Further, because denial may be present, the client may be very adept at hiding the illness from the lawyer. She/he may feel that hiding the illness is necessary for her very survival.

Sometimes the medications prescribed for people who have schizophrenia cause side effects. These side effects include drowsiness, slowness, blurred vision, nervousness and other physical symptoms. Persons with schizophrenia who are on medication may be

[120] Schizophrenia Society of Alberta, 1990, at 7 - 14.

mistakenly presumed to be uninterested in their case because they appear lethargic or seem to lack motivation due to side effects.[121] Furthermore, the side effects of their medication may cause persons with schizophrenia to act as if they are ingesting street drugs.

(c) Interview Techniques That May Assist in Dealing with a Client Who Has Schizophrenia

If a person is experiencing a psychotic episode (a crisis), a lawyer may not be able to work with that person on a legal matter. However, the lawyer likely should recommend that the client attend her physician. It is not possible to reason with acute psychosis. If the lawyer or staff member thinks that the client is experiencing a psychotic episode, certain steps may be followed. It is desirable not to express irritation or anger with the person. The person should not be threatened or shouted at or criticized. One should not stand over the person if he/she is seated—it is better to be seated also. It is best to avoid direct, continuous eye contact or touching the person. It is advisable to decrease other distractions and to speak quietly, firmly and simply. It may be necessary to telephone the police or a family member.[122]

If the client is not experiencing an acute episode, but exhibits behaviour that indicates that she/he may have a mental illness, some of the following pointers may be of use. Attempts should be made to reduce the stressful aspects of being involved in the criminal process. Because the wait for trial is quite stressful for some persons with schizophrenia, perhaps efforts could be made to reduce the wait as much as possible. Other tactics might include an increased number of meetings so as to inform the client of the progress in his/her case.

It may be necessary to educate oneself about the person's illness through reading or discussion with an expert in the area. If the client is willing to discuss his/her condition, it may be desirable to ask him/her how she/he is affected by schizophrenia and how one might compensate for the difficulties. If the client has a specialist, he/she may grant the

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[121] Canada, Health and Welfare, 1991, at 27. More information about Schizophrenia is available online: Schizophrenia Society of Canada, <www.schizophrenia.ca>.
[122] World Schizophrenia Fellowship, *Schizophrenia: Dealing With a Crisis* (Toronto: 1992).

lawyer permission to discuss his/her illness with that physician in order to gain information about it. Sometimes the client has parents or other family members who are deeply concerned about the client and who have insight into the client's mental illness. These family members may or may not be able to provide assistance to the client's case because of problems with confidentiality. However, it may be appropriate to discuss the client's general condition (with her written instruction) with the relatives in order to gain some insights.[123]

There may be ways to compensate for some of the more common difficulties experienced by persons with schizophrenia. To compensate for loss of memory, lawyers might summarize discussions and instructions and reduce them to writing for the client. It may be necessary to repeat instructions. Because some clients with schizophrenia have very poor sleep habits, it may be necessary to schedule meetings later in the day. If there are concentration problems, meetings may have to be shorter. Clients may have to be encouraged to write out questions ahead of time in order to prepare for meetings. Corresponding with the client may be difficult if the client does not have a fixed address. Arrangements may have to be made to accommodate this difficulty.

Clients with schizophrenia do not like to be called “crazy” or other demeaning names. It is important to be sensitive to their illness. Many people with schizophrenia would likely not be encountering the criminal justice system were it not for their illness. The stigma attached to mental illnesses makes it more difficult for clients to discuss aspects of schizophrenia with others. They likely would be more willing to discuss these factors in a non-threatening, respectful environment.

3. Mental Handicaps or Intellectual Impairments

(a) Description

Persons with mental handicaps have a wide range of abilities and disabilities. Some mentally handicapped individuals may be quite dependent and require a great deal of support, while others may need only minimal assistance in specific areas. The technical

[123] See earlier discussion about the role of others.

definition of mental disability or handicap is: having general intellectual functioning that is significantly below average, coupled with deficits in adaptive behaviour, which are manifested in the developmental period.[124] This means that in addition to difficulties with intellectual functioning, the person also has problems in adapting to her environment.

A person who has a mental handicap may be impacted in his:

* ability to communicate
* self care skills
* social skills and ability to read social cues
* learning styles, rates and abilities
* functional abilities at school, work and recreation
* health and physical abilities

The effects of a cognitive disability on speech and language development may be so mild that the person has no speech difficulties or only minor articulation errors. Conversely, the effects may be so severe that the person may have very limited functional speech. Some people with mental handicaps may lack expressive language (speaking, writing, gesturing), but will have receptive language (ability to understand what is said to them or to read).

Although there are numerous classification systems for mentally handicapped individuals with varying criteria for determining levels of mental handicap, there is general agreement about the mentally handicapped person's reduced ability to learn and to acquire knowledge as compared to “normal” persons.[125] Often, persons with mental handicaps will have problems with short-term memory, in abstracting and generalizing from experience and will possess other sensory and perceptual handicaps.[126]

Courts often rely upon I.Q. (intelligence quotient) scores in order to determine whether a person can be held responsible for his actions. A person's I.Q. is determined by dividing his mental age by his chronological age and multiplying by 100. Thus, if a person aged 35 had a mental age of 35, his I.Q. would be 100. An I.Q. of 100 represents an average

[124] This is the definition used by the American Association of Mental Deficiency.
[125] The Calgary John Howard Society, *The Mentally Handicapped Offender: A Guide to Understanding*, 1983 at 13 (hereinafter the Calgary John Howard Society).
[126] The Calgary John Howard Society, at 13.

performer.[127]

A person's mental age is determined by her/his responses to questions on a test such as the Stanford-Binet. This mental age is read to imply that the person performed at a level equal to an average person of that chronological age.[128]

Both the I.Q. tests and the mental age measurement have been criticized. I.Q. tests are said to be culturally biased, measuring primarily what a person has learned and not his potential to learn. The concept of mental age is considered inappropriate because it does not address a person's ability to function socially. Neither test is said to accurately reflect a person's full potential.[129]

Another factor in determining a person's mental handicap is his/her level of adaptive behaviour. In order to determine one's adaptive behaviour, the tester interviews people who know the individual and makes observations of the person in day-to-day situations. Thus, the tester can look at the person's ability to engage in general life problem solving.[130] There are varying opinions on what exactly constitutes a deficit in adaptive behaviour, so this area also has some difficulties.

In some cases, a person with a mental handicap may have a guardian appointed for him under the *Adult Guardianship and Trusteeship Act.*[131] The powers of the guardian to make decisions for the client and to instruct the lawyer will vary according to the court order that appointed the person as guardian. This may add some stress to the situation as the lawyer will be dealing with two individuals. This difficulty is discussed at length earlier in this chapter under Third Parties, and in Chapter Two, Diversion.

(b) Recognition of a Person with a Mental Handicap

It may be readily apparent from a person's physical appearance, speech or social

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[127] The Calgary John Howard Society, at 15.
[128] The Calgary John Howard Society, at 16. See also, David Cairney & David Steiner, *Mental Disorder in Canada* (Toronto: University of Toronto Press, 2010) and Orville Endicott, *Persons With Intellectual Disability Who Are Incarcerated For Criminal Offences: A Literature Review* (Correctional Services Canada, 1991), online: Correctional Services Canada < http://www.csc-scc.gc.ca/research/r14e-eng.shtml>.
[129] The Calgary John Howard Society, at 16.
[130] The Calgary John Howard Society, at 16 - 17.
[131] The *Adult Guardianship and Trusteeship Act* (AGTA) SA 2008, c A-4(2) came into force on October 30, 2009, replacing the *Dependent Adults Act* (DAA), RSA 2000, c M-13.

skills that the person has a mental handicap. However, there may also be situations where there are no immediate indicators that a person has special needs. Further, the identification of a mentally handicapped person based on physical appearance is usually not reliable.[132]

Family members, medical personnel, social workers and community workers who assist people who have mental handicaps may be the most helpful in identifying the person's disability. However, the client also has a right to confidentiality even though support persons are involved.[133] Also, when a mentally handicapped person initially meets with a lawyer, he/she may not be accompanied by a support person or relative. Consequently, the lawyer must initially ascertain for him/herself whether the person may have a mental disability and the extent of that disability.

If a lawyer believes that a person may have a cognitive handicap, he could help determine whether this might be the case by asking increasingly abstract questions to ascertain the client's most appropriate level of conversation. Mentally handicapped persons tend to have problems with orientation to time and space. It may therefore be prudent to ask them questions about time and space at the initial meeting (e.g., "How long have you been waiting?").[134]

The purpose of asking these questions is for the lawyer to become better attuned to the client's abilities. It is important for the lawyer to be aware of the mentally handicapped client's situation so that the lawyer is able to provide services that meet that client's needs.

(c) Interview Techniques That May Assist in Dealing with a Client Who Has a Mental Handicap

The following pointers on effective communication with mentally handicapped persons were adapted from the Calgary John Howard Society's *The Mentally Handicapped Offender: A Guide to Understanding* and Seattle Rape Relief, *Project Action*.

1. Try to keep your surroundings free from distractions. Keep background noise to a minimum. For example, turn off the radio and shut the window to reduce street sounds.

[132] The Calgary John Howard Society, at 13.
[133] The issue of client confidentiality is discussed in Chapter Three, Solicitor and Client Issues.
[134] The Calgary John Howard Society, at 13.

2. Establish eye contact before you begin to speak, and maintain it for as long as possible. It may help to say the person's name occasionally at the beginning of a sentence.
3. Speak expressively with the appropriate gestures, facial expressions and body movements.
4. Communication with a person who has limited receptive language may be aided by visual cues. These could be drawings or visual aids or the communicator could physically demonstrate the activity about which he is speaking.
5. One may need to speak slower or to enunciate one's words more clearly. However, do not exaggerate the inflection or tone of one's voice. This is patronizing and it calls attention to the speaker rather than what is being said.
6. Speak in "here and now" concrete terms when you need to. It may also be helpful to emphasize key words within a question. Repeat important statements and use different ways of saying the same thing if the listener does not seem to understand.
7. Check frequently to be sure the person understands. It may be pointless to ask, "Do you understand?" Instead, ask the person to repeat what has been said or ask a question that requires a specific answer.
8. One may need to ask open-ended and either-or questions rather than questions that can be answered "yes" or "no". Many people with cognitive disabilities answer yes-no questions to reflect what they truly mean, yet sometimes people with cognitive disabilities have a tendency to say "yes" because they think it is the right answer. If this is a concern, let the person describe the situation, give a choice of answers and reassure him that it is acceptable to say "yes" or "no" without negative consequences. Examples of appropriate question styles:

Open-ended: "Tell me what happened this morning."

Either-or: "Did this problem happen today or yesterday?"

9. Do not pretend to understand. It is better to ask the person to repeat what he/she has said than to agree with something you do not understand. If you do not receive a completely comprehensible answer, build from a particular point that you can confirm. For example, ask, "Am I getting this right? This morning someone bit your arm."

10. Be patient. Do not anticipate the speaker's response and finish sentences for him.
11. When one notes signs of fatigue or nervousness, one may want to ask if the person wants to take a break. Some brief time away may allow the person to feel more focused or more relaxed.
12. Treat adults with cognitive disabilities as adults, not as children. For example use their proper names (Bill does not automatically become Billy). Also, talk to the person with a cognitive disability, not about her.
13. Use language that the person understands. Role-playing and analogies are often too abstract for a person with a mental disability. Explain legal terms in a way that is clear. For example, instead of referring to “recognizance”, tell the person that he must come back to the court building on Tuesday. Be specific and concrete. Sharing information with support people will allow the information to be repeated with the client at a later time. Repetition increases understanding.
14. Prepare the person for what it might be like to be in court. Instead of explaining it, take her or arrange for someone to take her to the courthouse. Allow her to experience court in session. People with mental handicaps have difficulty imagining what situations will be like and frequently require experimental preparation.
15. Be clear with instructions for meeting times, court dates, etc. Writing them down may be helpful for the client and his support people. Calling to remind the person of important dates may be necessary.
16. Discuss travel arrangements for meetings, court dates, etc. Is the person using public transportation and does he/she know bus routes? Is he/she using a taxi and does he/she have a special needs taxi card?

Sometimes, when under stress, a person with a mental handicap may act inappropriately. If this occurs, discussing the person's behaviour with support people or guardians may be the most helpful in determining what action to take.

It should be noted that a mentally handicapped offender may try to use his/her disability to his/her advantage. He/She may feel that since he/she is handicapped, he/she is

not subject to the same rules as everyone else. Advocates suggest that involving support persons in explaining the situation to the person may be of assistance.

An article from the Deputy Public Defender in California, U.S.A., makes note of various interviewing techniques to use when dealing with the mentally retarded, many of which have been discussed. However, two additional areas were discussed: over-compliance and resistance.[135] People with mental retardation will frequently give responses to gain acceptance, to please or acquiesce people in positions of authority. Consequently, lawyers must remember not to lead the client into certain responses. It may also be the case that people with mental retardation may be resistant to answering questions due to fear of appearing incompetent. The following is a list of clues to watch for when interviewing a potentially resistant client:[136]

* silence
* verbalized hostility
* changing the subject
* answering questions with short, clipped responses
* insignificant content.

The Public Defender also points out in the article the importance for lawyers who suspect that their client may have an intellectual disability to get a court order not allowing anyone to enter the jail to talk with the client about the case. He states that most mentally handicapped clients will speak with anyone and may ultimately make incriminating statements that will harm their case.[137]

4. Alzheimer's Disease

(a) Description

Alzheimer's Disease is a progressive, degenerative disease that attacks the brain and

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[135] William J Edwards, Advanced Interviewing Skills - Clients with Mental Retardation/Intellectual Disabilities (Indio, California: Eastern County Operations County Administrative Center, 1998) at 3 ("Edwards, Advanced Interviewing Skills").
[136] Edwards, Advanced Interviewing Skills, at 3.
[137] Edwards, Advanced Interviewing Skills at 1.

results in impaired memory, cognition, judgment and behaviour. In this disease, the nerve endings in the brain that carry messages become tangled and die. The ventricles (space in the middle of the brain) become smaller and the cortex (surface of the brain) shrinks or decreases. The death of nerve cells in the brain results in a gradual loss of function until total care and hospitalization are required. This disease attacks approximately 300,000 Canadians a year and is the fourth leading cause of death in adults. Most sufferers are elderly, but the disease can strike in the 40s and 50s. Alzheimer's is the most common form of dementia.[138]

Early symptoms of Alzheimer's include memory loss (short term memory first), difficulty with routine tasks (e.g., balancing a bank book), impaired judgment (e.g., unsafe driving), disorientation in space and time, personality changes, the loss of language skills and the loss of impulse or inhibition control skills. Associated with these symptoms is often a denial that the person has a problem. The person might become quite angry at any suggestion that there is something wrong with her/him. The disease's progression may vary from two to twenty years. In the later stages, motor skills decline and the person becomes totally helpless, requiring care in a hospital until her death. A person with Alzheimer's may also have vision and hearing problems that are common in the elderly.

Some persons with Alzheimer's are able to maintain a “social façade” in familiar social situations for short periods. This means that the person is able to act “normally”. For example, a woman may be able to serve tea and carry on a pleasant, superficial conversation without a clue as to whom he/she is talking, thinking he/she is somewhere else in another time. Because of this, others who do not see the person on a regular basis may accuse the family caregiver of unnecessarily initiating guardianship or institutionalization.

Since the person's short-term memory is affected first, the past may remain clear to that person, while current events vanish. The person may repeat questions, phrases or body movements. This is because they do not remember that they have asked the question or made the statement before.

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[138] Severe impairment or loss of intellectual capacity and personality integration.

In many cases, guardianship and trusteeship become necessary for persons with Alzheimer's Disease as they become unable to look after themselves and their affairs.

Family members who may be involved with the person who has Alzheimer's may not only be suffering from the stress of coming to terms with the disease, but also from the physical and emotional strain of caring for the person. Denial, fear and shame are common components of family reaction to the disease.

(b) Recognition of Alzheimer's Disease

Diagnosis of Alzheimer's Disease is quite difficult, especially in the early stages. A lawyer may find him/herself in the position of being the first person to raise the question of Alzheimer's Disease to the family or to the court. It may be necessary to refer the client to a physician so that other possible conditions that may be causing the symptoms of dementia can be ruled out. Until very recently, the only definitive clinical test for Alzheimer's Disease was a brain autopsy; however, at specialized centres, doctors can now diagnose the disease correctly up to 90% of the time.[139] Doctors use several tools to diagnose “probable” Alzheimer’s Disease including:

- Questions about the person’s general health, past medical problems and ability to carry out daily activities;
- Tests to measure memory, problem solving, attention, counting and language;
- Medical tests such as tests of the blood, urine and spinal fluid; and
- Brain scans.[140]

There is also a test involving a biopsy that can assist in diagnosing Alzheimer's Disease.

The early stage of Alzheimer's Disease will likely be the most difficult for the lawyer to deal with because Alzheimer's can be undiagnosed for several years. Further, the

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[139] US National Institute of Health and the National Institute on Aging: Alzheimer’s Disease Education and Referral Centre (ADEAR), online: National Institute on Aging, <http://www.nia.nih.gov/> (“US National Institute on Aging”).

[140] US National Institute on Aging.

individual or his/her family may deny the disease or not understand its symptoms. Family members may have noticed that the person is forgetful or confused or vague at times, and attribute the behaviour to old age.

If no family or close friends are in close contact with the person, the solicitor may be the first person to notice behavioural changes, perhaps when updating a will or dealing with financial matters. These behavioural changes may consist of forgetting dates, losing documents or appearing at appointments dishevelled or without proper clothing on a cold day. Further, a normally staid, law-abiding person may be facing charges of shoplifting, creating a disturbance or other inappropriate behaviour in public. Conversely, an elderly person may be accusing his/her caregiver of theft. These behaviours could all be symptoms of Alzheimer's Disease.

(c) Interview Techniques That May Assist When the Client has Alzheimer's Disease

When communicating with a person who has Alzheimer's Disease, it is important to remember that the person cannot force himself to remember or to concentrate. His/her damaged brain is not capable of wilfully controlling his behaviour or learning or of retaining or communicating messages. Persons with Alzheimer's Disease are not deliberately vague, stubborn, suspicious or unpleasant.

In addition, the following suggestions might improve communication:

1. Do not argue or attempt to use logic to explain something or to contradict an incorrect or inappropriate statement. Persons with Alzheimer's Disease are not capable of processing that information.
2. Meet with the client alone. Otherwise, the accompanying person could answer all of the lawyer's questions and the client may agree with all of the answers, whether they are correct or not. Further, meeting with the client alone gives the lawyer a better idea of the client's abilities, not to mention obtaining the client's answers. Once the lawyer assesses the client’s capacity to give legal instructions, he/she can decide how to proceed.
3. Always first identify yourself and state your purpose or function.
4. Use short, specific, familiar words and simple sentences.
5. Speak slowly, using a relaxed manner and a normal tone of voice.

6. Ask only one question or give one direction at a time and allow a longer period for a response. If no response is given, try repeating the question or direction.
7. Use open-ended questions. Using questions that require only a “yes” or “no” answer increases the risk of receiving an inaccurate answer.
8. Maintain eye contact. If the person is in a wheelchair, station yourself at his/her seated eye level.
9. If the person's attention wanders, a gentle touch on the hand or shoulder may redirect attention.
10. Keep the room environment as simple and non-distracting as possible.
11. If the person cannot find the word he/she needs in a phrase, or if he/she uses an inappropriate word, suggest the word for which he/she might be searching and confirm with him/her whether this is the correct word.
12. Some people may be able to read fluently, but will not comprehend the meaning of the words. Always ask questions to confirm whether they have comprehended what they have read.
13. Use proper names in sentences rather than pronouns (e.g., avoid “he”, “she” or “they”).
14. If the person stops in the middle of a sentence because she/he is distracted or cannot think of the correct word, try repeating her/his last sentence or phrase.
15. Be aware that the person may understand more than he/she can express.
16. If the person becomes agitated or upset, try to divert or to redirect his/her attention to something pleasant.
17. While words may no longer be understood, body language and non-verbal cues may be used.

It is important to remember that a person with Alzheimer's Disease is an adult who should be treated with dignity and respect. Even if she/he displays childlike behaviour, it is important to respond to him/her as an adult.

5. Brain Injuries

(a) Description

A brain-injured person does not fall into the category of mentally handicapped or mentally ill.[141] Brain-injured persons experience some of the difficulties encountered by both groups. Sometimes, authorities do not recognize people with brain injuries have this mental disability and thus, many may have been mistakenly placed in psychiatric facilities or prison.[142]

A serious brain injury usually results in loss of consciousness that lasts varying lengths of time.[143] Brain injuries are often the result of accidents or assaults, although they may occur any time oxygen to the brain is cut off, such as in drowning, heart attack, infection or other cause.[144] When a brain injury is the result of a work injury or a car accident, the injured person may suffer brain injuries from more than one cause. This may complicate her/his condition.[145]

Persons with brain injuries may experience learning disabilities or emotional, behavioural or physical changes. Many persons with brain injuries maintain their intelligence, but have difficulty utilizing it because of thinking and mental processing difficulties.[146] All brain injured clients encounter lessening of cognitive functioning—the conscious process of the mind by which we are aware of thoughts and perception, including all aspects of perceiving, thinking and remembering.[147] Some of these cognitive difficulties may result in poor problem solving ability, poor social judgment and poor emotional control.[148]

After a brain injury, a person's brain goes through a process of natural healing, which is called spontaneous recovery.[149] Although this type of healing usually takes place during the first six months after a person is injured, it can occur at any time and in any

[141] G Smith, *Lawyer's Guide for Successful Interaction with Brain Injured Clients* (Calgary: Easy Street Community Rehabilitation Campus, 1992) at 1 (hereinafter G. Smith, 1992). See also: Alberta Brain Injury Network, Alberta Brain Injury Network Survival Guide Calgary: 2001.
[142] G Smith, 1992, at 1.
[143] G Smith, 1992, at 1.
[144] G Smith, 1992, at 1.
[145] G Smith, 1992, at 1.
[146] G Smith, 1992, at 1.
[147] G Smith, 1992, at 2.
[148] G Smith, 1992, at 2.
[149] G Smith, 1992, at 2.

deficit area.[150] Therefore, persons with brain injuries are rehabilitated to help them regain functional abilities. The various forms of rehabilitation include programs that promote learning, improve skills, and empower the client to take control of his life and to adapt and compensate for difficulties.[151]

(b) Recognition of Brain Injury

The following discussion provides information about some of the difficulties that a brain-injured client might face and offers some insight into recognition of this condition. As with other forms of mental disability, it is often relatives or others who provide the lawyer with information about the client's condition. The client may indicate that he/she has been in an accident and suffered a brain injury, but one aspect of brain injury in some cases is denial of any difficulty related to the injury. As a result, the lawyer may have to make further inquiries.

Brain injuries may affect a person in several ways: cognitively, emotionally and physically. Brain injuries almost always affect the client's cognition. This means that she/he may experience difficulty concentrating. He/she may appear easily distractible and may exhibit some bizarre or irrelevant behaviour.[152] Second, the client may have difficulties with his/her memory. He/she may have difficulty with his/her recent memory (current working memory) or remote memory (past memory). The client may appear to be fabricating some parts of his/her story because he/she does not remember all of what occurred. He/she may forget appointments or may ask the same questions repeatedly.[153]

The client may have communication difficulties. These include slurred speech, no speech, slow speech and quiet speech.[154] She/he may appear to have difficulty thinking of the words that he/she wants to say. She/he may appear to jump from topic to topic. Additionally, a person with a brain injury may appear to have poor listening skills. She/he may have difficulty understanding what you are saying, especially if it involves new

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150 G Smith, 1992, at 2.
151 G Smith, 1992, at 2.
152 G Smith, 1992, at 3.
153 G Smith, 1992, at 4.
154 G Smith, 1992, at 6.

concepts or information.[155] She/he may interrupt frequently.

Other cognitive difficulties that may appear in a brain-injured client are difficulties in problem solving, judgment and flexibility. He/she may not perceive or judge situations correctly and therefore may not act in his/her best interest. He/she may appear to have a very low self- esteem and may have hygiene or other health problems.[156]

One potentially serious consequence of a brain injury is that the person may lack insight into the changes that have occurred since her/his injury. She/he may perceive that others have a problem, but that she/he is perfectly fine. It is important to remember that this difficulty is the result of a cognitive problem. In other words, the injury to the brain has caused changes in the person's actions and reactions. Because of the decreased social awareness, brain injured persons may appear quite self-centred. This is especially so if they have experienced frontal lobe damage. They may demand attention and have a lack of empathy for others.[157] A person with such an injury may be very impatient with your administrative assistant if you are not immediately available to discuss the case with her/him. In fact, some of the person's behaviours may be quite inappropriate, both sexually and socially.[158]

In addition to the cognitive difficulties, the brain-injured person may also suffer emotional or psychiatric difficulties. One common emotional response to a brain injury is to deny its effect on one's abilities. This is exacerbated by the person's organic injury that may also cause him to think that nothing is wrong. The person may avoid activities that are difficult or those that he cannot perform.[159] He may blame others for his difficulties.

The brain-injured client's denial may complicate the lawyer's task, especially if he/she is exploring possible defences that involve arguing lack of intent to commit the offence or sentence options. Further, denial may result in the client being placed in prison rather than in rehabilitation if he/she is in court for anti-social behaviours. She/he may refuse assessment or a judge's suggestions to attend rehabilitation programs. She/he may

[155] G Smith, 1992, at 6.
[156] G Smith, 1992, at 9.
[157] G Smith, 1992, at 10.
[158] G Smith, 1992, at 11.
[159] G Smith, 1992, at 12.

fail to recognize that her/his behaviours may be related to the head injury.[160]

A brain-injured person may suffer psychiatric difficulties as a result of the injury. If a client has suffered organic brain damage, he/she may exhibit hallucinations or delusions.[161] The brain injury may cause obsessive-compulsive behaviour (the excessive drive to do things over and over) or it may cause manic depression.[162] The person may appear quite moody or grouchy. He/she may appear quite sensitive because of lack of ability to perceive situations correctly and other causes.[163]

As with clients with other mental disabilities, brain injured persons may not be able to cope with undue stress. Unfortunately, contact with the criminal justice system is stressful. Lawyers can help to alleviate the stress by dealing with or discussing those aspects of the criminal justice system that the client finds the most stressful.

Clients with brain injuries may experience post trauma response. This means that they experience flashbacks of their injury, sleep disturbances, and other reactions. The client may discuss the event excessively.[164] This difficulty may cause the client to abuse drugs and alcohol or to be suicidal. It may also cause a great deal of fatigue.[165]

Brain injured clients may also experience a variety of physical problems. They may have loss of motor control that includes paralysis, poor balance, abnormal muscle tone and other physical problems.[166] They may experience vision, hearing or other perception problems.[167] Brain-injured persons may experience chronic pain syndrome and this may cause them to become withdrawn or to have difficulty sleeping.[168] Other physical problems suffered by brain-injured persons include diabetes, seizures and sleep disorders.[169]

(c) Interview Techniques That May Assist in Dealing with a Client Who Has a Brain Injury

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[160] G Smith, 1992, at 13.
[161] G Smith, 1992, at 13. See previous discussion of hallucinations and delusions under Mental Illness—Generally.
[162] G Smith, 1992, at 13. See previous discussion of psychiatric difficulties under Mental Illness—Generally.
[163] G Smith, 1992, at 13.
[164] G Smith, 1992, at 14.
[165] G Smith, 1992, at 15.
[166] G Smith, 1992, at 15 - 16.
[167] G Smith, 1992, at 16 - 17.
[168] G Smith, 1992, at 18.
[169] G Smith, 1992, at 18.

There are some techniques, which may assist a lawyer when dealing with a person who has some of the cognitive, emotional and physical difficulties associated with brain injuries. To assist a client who has concentration problems, it may be useful to choose a very quiet environment for meetings, in order to lessen distractions. It may be necessary to re-direct the conversation back to the issues at hand if the client becomes distracted. It may also be necessary to ensure that the client has understood one piece of information before you go on to discuss another.[170] This may require some ingenuity because merely asking a client if she understands the information may not elicit an accurate response.

If the client has memory difficulties, the lawyer may wish to summarize meetings and instructions in written or tape form. The lawyer may ask the client to repeat back what he/she has discussed with the lawyer. If necessary, a significant relative or other person may be informed about meeting times and dates.[171] If the client has a significant memory difficulty, he/she may telephone the lawyer's office frequently to refresh his/her memory about the case. It may be necessary to ask the client to call the office at a designated time each week in order to reduce multiple repeat telephone calls.[172]

If the client has difficulty with time management and planning, the lawyer may have to provide very explicit instructions about court appearances and other dates. Checklists or other organizing devices may be of assistance. Again, a significant relative or other caregiver may be of assistance in ensuring that the client arrives in court at the appropriate time, dressed for the occasion.[173]

Because the client may have poor time management skills, he/she may not appreciate that a lawyer and his support staff have time constraints themselves. As a result, he/she may contact support staff frequently, interrupting their work. It may be of assistance to tell the person that one has a certain amount of time to speak with him/her (e.g., five minutes) and then one must get back to his/her work.[174]

If the client has communication difficulties, it may be especially important to ensure

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[170] G Smith, 1992, at 3.
[171] G Smith, 1992, at 3.
[172] G Smith, 1992, at 5.
[173] G Smith, 1992, at 6.
[174] G Smith, 1992, at 6.

that he/she has understood questions and discussion. If the lawyer feels that the client is confabulating in order to fill in areas that the client does not recall, it may be advisable to question him/her further in order to assess the information that the lawyer is receiving.[175] The lawyer may have to pursue further clarification of facts. Charts or written instructions may be used in order to best assist the client to understand the information a lawyer is relaying.[176] Further, it may be necessary to proceed at a slower pace than normal in order for the client to process the information and respond to it.[177]

Because the client may have decreased social awareness, the lawyer may encounter behaviours that she/he considers inappropriate. The lawyer might approach these behaviours (e.g., shouting at the receptionist for putting him on hold) with honest and supportive feedback. One suggestion is to give an "I" message: "I'm having trouble with our interruptions. What do you suggest we do to help remind you to stop talking?"[178] If plans are going to be changed or there is a delay, it may be helpful to explain the reasons to the client.[179]

It is quite difficult to deal with a client who lacks insight into his/her difficulties or is denying that they exist. It may be useful to provide concrete information and facts in order for the client to draw the conclusion that others' perceptions of her behaviour are accurate. Head-injury specialists and counsellors may be of some assistance in dealing with the person's denial.[180]

There are some procedures that may compensate for the brain-injured client's physical difficulties. If the client has vision problems, ask him/her where one should sit or stand in order to be in his field of vision. Compensation may have to be made for hearing difficulties as well.[181]

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[175] G Smith, 1992, at 7 - 8.
[176] G Smith, 1992, at 8.
[177] G Smith, 1992, at 8.
[178] G Smith, 1992, at 11.
[179] G Smith, 1992, at 11.
[180] G Smith, 1992, at 12.
[181] G Smith, 1992, at 18.

6. Fetal Alcohol Spectrum Disorders

(a.) Description

According to Kellerman, "fetal Alcohol Spectrum Disorders (FASD) are a spectrum of lifelong physical, mental and neurobehavioral birth defects associated with alcohol consumption during pregnancy. FASD ranges from full Fetal Alcohol Syndrome (FAS), to Prenatal Exposure to Alcohol (PEA). Other terms for FASD include Fetal Alcohol Effects (FAE), Alcohol Related Neurodevelopmental Disorder (ARND), and Alcohol Related Birth Defects (ARBD)."[182] All include problems in many areas of neurological functioning and social adaptation. Some may also have visible physical indicators.

FAS is diagnosed on a number of criteria: facial features, small birth weight, central nervous system dysfunction, and a history of prenatal exposure to alcohol. When not all of the criteria are present, an individual may be diagnosed as FAE or ARND. Even though the physical characteristics are missing or the maternal history is unavailable, the adaptive abilities of a person with FAE may be just as diminished as those of a person with FAS, and the effect on him or her may be magnified because lack of visibility may lead to failure to diagnose and thus, to unrealistic expectations.

Damage occurs to the foetus when its mother drinks alcohol because the metabolism and elimination of alcohol are approximately half the adult rate, and due to the free flow of alcohol through the placenta, concentrations are at least as high in the foetus as in the mother's blood.[183] While there are indications of links between volume and frequency of consumption, there are no conclusive correlations between the amount of alcohol consumed, the pattern of consumption and the damage to the foetus, but it appears that different types of fetal damage occur at different times during the pregnancy resulting in a wide range of symptoms.[184]

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[182] Teresa Kellerman, "Fetal Alcohol Syndrome Disorders" online: Come Over To, <http://come-over.to/FAS/LawEnforcement.htm> [hereinafter Kellerman]

[183] Fred J Boland, et al, "Fetal Alcohol Syndrome: Implications for Correctional Service" (Correctional Service of Canada, July 1998), online: Correctional Service of Canada, <http://www.csc-scc.gc.ca/text/rsrch/reports/r71/r71e_es.shtml> [hereinafter Corrections Canada].

[184] Corrections Canada at 8. "Niccols (1994) has proposed several different stages of embryo development during which alcohol damages the central nervous system differentially; from conception to the first weeks of pregnancy alcohol acts as a cyotoxic agent causing cell death and chromosomal abnormalities; From four weeks

Infants and young children with FASD may present a range of the following characteristics:

- small stature
- sleeping and feeding difficulties
- birth defects such as hearing deficits, heart problems, kidney problems, tumours and skeletal abnormalities including smaller skull circumference and distinctive facial features
- delays in development of speech, poor articulation, slow vocabulary acquisition and sentence patterns
- poor judgment – difficulty in recognizing danger
- difficulty following directions
- destructive behaviour and tantrums
- distractibility , hyperactivity
- over friendliness – lack of fear of strangers, need for physical contact
- poor coordination and motor skills
- intellectual impairment and learning disability
- memory difficulty – both in registering and retrieving information
- impaired reasoning from cause to effect, difficulty predicting and understanding consequences, difficulty separating fact from fantasy
- adaptive and social behaviour difficulties – easily influenced, immaturity, problems with changes in routine, life choices and appearance of capability without actual skills.[185]

By the time individuals with FASD have reached the age where they are encountering the justice system, they may not be quite so visible. They may often catch up

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to ten weeks in utero exposure leads to abnormal cell migration, cell loss and damage, disorganized cell tissue structure, and microcephaly; and from eight to ten weeks of pregnancy neurotransmitter production is interfered with leading to suppression of growth hormones, and abnormal formation of neural synapses resulting in neurological deficits. Streissguth (1997) further adds that the greatest period of vulnerability in the brain is uncertain; it seems that all trimesters during pregnancy are critical for development."

[185] Ministry of Children and Family Development, Government of BC, "Community Action Guide: Working Together for the Prevention of Fetal Alcohol Syndrome" (Victoria: Ministry for Children and Families, 1998) [hereinafter Community Guide]. See also "Preventing FASD and FAS": online: Alberta Health Services, http://www.albertahealthservices.ca/AddictionsSubstanceAbuse/hi-asa-women-info-prevent-fasd.pdf .

in growth; they may develop superficial conversational talent, which may influence others to wrongly assume they have stronger linguistic skills than they actually do.[186] Even when youth with FAS hear speech they may ignore the messages they receive, and/or their reception and retention of information may be fragmented. Kellerman notes that quite often, an individual's ability to process information fluctuates dramatically depending on a variety of factors, "such as how his meds are working, what he had to eat, how stimulating the environment is, how well he slept the night before, how much stress he is experiencing, etc."[187]

In general adolescent and adult persons with FASD may show primary indications like the following:

- intellectual impairment and low academic achievement
- pronounced difficulties with impulsiveness, poor ability to generalize and to anticipate and respond to consequences
- difficulty in organizational skills and logic
- poor motivation and passivity
- tendency to lie, steal and cheat
- difficulty in setting boundaries, easily misled, unable to respond to others' feelings or needs
- low self-esteem and depression
- susceptibility to suicide, drug and alcohol abuse, unplanned parenthood,
- physical and sexual abuse, legal problems
- difficulty in independent living, getting and keeping a job.[188]

Not coincidentally, many of these traits are the precursors of delinquency and lead to lifestyles that require continued criminal activity for maintenance, like money for alcohol or drugs and/or the continuing approval of support persons.

The question of diagnosis is compounded by the ambiguity of the disorder; it is

[186] Corrections Canada at 20.
[187] Kellerman.
[188] Community Guide.

neither a mental illness nor a brain injury, although it has components of both. Unlike mental illnesses like schizophrenia, FAS is not responsive to chemical treatment, and unlike brain injuries, there is no question of rehabilitation and repair. FASD damage is permanent. Further, FASD is frequently accompanied by other disorders, for instance: Attention Deficit Hyperactivity Disorder, depression, Reactive Attachment Disorder, bipolar disorder, Obsessive Compulsive Disorder, Pervasive Developmental Disorder, Asperger syndrome (autism symptoms except language difficulties), Tourette syndrome, mental retardation, or developmental delays,[189] all of which mask FASD. The effects of FASD can be exacerbated by other risk factors such as poverty, abuse or neglect, alcoholism in the home and low parental education.

Because FASD has only been formally recognized since 1973, those most skilled in its diagnosis are the paediatricians who have grown up with it. The Community Guide notes that: "[a] diagnosis of FAS can only be made by a qualified physician."[190] Assessment reports contain medical, historical, legal, psychological and social elements, and therefore, require a multidisciplinary approach and specific training to complete. Accurate assessment is vital to help all personnel in the justice system treat persons with FASD appropriately.[191]

Difficulty of diagnosis poses a significant problem in the justice system.[192] Correctional Service Canada estimates that, although there are no national Canadian statistics, the incidence of FAS is between 1-2 cases per 1000 in Canada, as it is worldwide.[193] The incidence of FAE is even more unknown and therefore, more likely to be misdiagnosed and mishandled within the justice system. A 1999 British Columbia study

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[189] Kellerman.

[190] Community Guide. Also Carol Byrne BA, MSc, MD, a Consultant Psychiatrist with the Island Mental Health Support Team, who wrote: "As a psychiatrist I believe that only physicians with expertise in diagnosing FAS should be assessing persons for FAS. Developmental paediatricians have the background and developmental approach that is needed in diagnosing FAS (in adults and children). Psychiatrists generally have not been trained to recognize/diagnose FAS/ARND which surely must lead to the diagnosis being missed…" From *R v Gray,* [2002] BCJ No 428 (BC Prov Ct Crim Div) ("R v Gray"), quashed by *R v Gray,* 2002 BCSC 1192.

[191] Julianne Conry and Diane Fast, "Fetal Alcohol Syndrome and the Criminal Justice System" (2000 Maple Ridge: Law Foundation of British Columbia) at 26 [hereinafter Conry].

[192] For a comprehensive discussion of the complex dilemma which arises for the court system when a client is not properly diagnosed see Trueman J's decision in *R v Gray*. Note this case has been overruled on other grounds.

[193] Corrections Canada, at 13.

revealed that: "23.3% of youth remanded to a forensic psychiatric inpatient assessment unit were found to have FAS/FAE."[194] In an adult prison study in 2007, ten per cent (10%) were diagnosed with FASD in the screening of 91 offenders. Eighteen per cent (18%) of these offenders are under the "possible" category. Those in the "possible" category show evidence of central nervous system deficits, but evidence of alcohol history to confirm or rule out the diagnosis is lacking.[195]A 2011 report estimates that youths in Canada with FASD are 19 times more likely to be incarcerated than youths without FASD in a given year.[196]

A classic case of failure to recognize FASD appears in *R v WD*[197] in which a 13 year-old boy, who had been diagnosed with FAS at 29 weeks and had obvious severe symptoms, interacted with five lawyers and appeared on twelve charges with no one investigating his disability.

Failure to receive accurate diagnosis has significant consequences for sufferers of FASD ranging from unreasonable expectations to being incarcerated for a crime of which they have little or no understanding. Because persons with FASD have poor adaptive skills, they may be perceived as difficult and lacking in motivation: their impulsivity and desire to please make them ready targets for others with anti-social tendencies. In court, they may come across as lacking remorse; they may plead guilty to anything and everything either to get the process over with or because they do not understand.[198] They may jeopardize probation by failing to report to their probation officer due to time confusion, feeling unsafe in her office or something else taking priority; a good example is the youth who stole a car so he could get home on time to meet his curfew.[199] Recognition of FASD is important to sentencing because spending time in jail can be very detrimental; incarcerated persons with FASD are frequent victims of physical and sexual abuse; they seldom understand either institutional or social rules, and most importantly, they do not have the capacity to learn

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[194] Conry at 371.
[195] P MacPherson & AE Chudley, FASD: Screening & Estimating Incidence in an Adult Correctional Population (Paper delivered at the 2nd International Conference on Fetal Alcohol Spectrum Disorder, Victoria, 7-10 March 2007).
[196] S Popova et al, Fetal Alcohol Spectrum Disorder Prevalence Estimates in Correctional Systems: A Systematic Literature Review (2011) 102(5) *Can J Public Health* 336-40.
[197] *R v WD* [2001] SJ No 70.
[198] Conry at 37, "False Confession"
[199] Conry at 85.

from consequences, so the experience is meaningless as a deterrent. On the other hand, a conditional sentence in a facility with 24-hour supervision and consistent rules can promote significant improvement over time.

(b) Recognition of FASD

Frequently persons with FASD will not be aware of their condition or understand that knowledge of it might be relevant to legal counsel. Others may suspect that they have some disability, but try to hide it. Persons with FASD tend to develop a great deal of skill in telling people what they think they want to hear and will usually respond 'Yes' when asked if they understand. They may agree to, or make suggestions, which are clearly not in their best interests. Their narratives may be fragmented with both temporal and logical gaps. They may answer the same question differently within minutes of each other.

Individuals with FASD may exhibit inappropriate behaviour; they may be either too friendly with excessive touching or may appear remote and hostile. They may lack inhibitions about sharing personal information. Hyperactivity and short attention spans are common, leading to fidgeting. These symptoms often mean that the individual will not appear to take their legal matter seriously. Persons with FASD may miss appointments and have no satisfactory explanation or the sense that they need one. Literal interpretation of language is also very common,[200] as are illogical cause-and-effect conclusions. They frequently exhibit noticeably bad judgment. Memory deficiencies may lead them to confuse a number of events, and the desire to please may lead them to confabulate or fill in fictional events to create a story that appears to satisfy counsel.[201]

The social histories of persons with FASD have many common elements, which may serve as clues to their condition. There is a high likelihood of present alcohol and drug abuse, previous encounters with the law and troubles in both school and employment. They may have financial difficulties and demonstrate lack of understanding of the value of goods and services. Their pasts may include incidents of violence, sexual and physical abuse or abandonment, foster care or adoption, poverty, problems with relationships and

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[200] Conry at 18.
[201] Conry at 22.

inappropriate sexual behaviour. Of course, of most significance is ascertaining whether the mother abused alcohol during pregnancy. A combination of risk factors makes some aboriginals as much as 10 times more likely than the general population to have FASD.[202] There is no aboriginal genetic or racial connection to FASD, just a reflection of social conditions, and variation among communities reflects cultural trends related to drinking.[203]

(c) Interview Techniques That May Assist In Dealing with a Client who has FASD

Representation of a client who exhibits the characteristics of FASD poses some important ethical and practical issues. Even though an adult client may have an IQ in the normal range, he/she may be functioning at the moral and social level of a six-year old and may have no concept of the consequences of her actions. Should he/she be punished for a crime he/she does not understand? A person with FASD may be a danger to the public but not be able to control her impulses or may be used as a scapegoat by a peer. Should he/she be incarcerated when there is no hope that he/she will understand why or be able to learn from the experience? Should he/she be placed in jail where he/she is almost certain to be a victim?

From a practical standpoint, the issue of whether or not a client has sufficient capacity to instruct counsel must be determined. It is also crucial for the lawyer to determine whether an assessment for FASD should be made. Counsel may have the best opportunity to help a client with FASD get the individualized attention[204] he/she needs. The suggestions below may be helpful in conducting such interviews.

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[202] Corrections Canada at 13.

[203] Community Guide, and Corrections Canada at 14: "[I]n the Navajo communities the prevalence was 1.6 cases per 1000, for the Pueblos it was 2.2 cases per 1000, and for the Southwest Plains the incidence was 10.7 cases per 1000. This latter group had higher rates of abusive drinking than the others and mothers had lower social adjustment, high risk lifestyles and a higher mean age of birth. … Native communities in Yukon Territory and British Columbia found that the prevalence of FAS and FAE combined was 46 cases out of 1000 in the Yukon and 25 cases out of 1000 in British Columbia".

[204] Conry, per Vickers J (BCSC) at xiv –xv, "I argue for a process that asks 'why' at a much earlier stage in the process of criminal justice. Early questions by defence counsel should not be limited to the issue of guilt or innocence. Other vital information should include: Why did this individual exhibit antisocial criminal behaviour? And how do we provide programs to meet his or her needs to ensure the negative behaviour is not repeated? In short, how does the criminal law meet the goal of public protection and safety while, at the same time, safeguarding constitutional guarantees and addressing individual needs?"

1. Include a support person.

Even though a client has the right to exclude anyone from the interview, if at all possible, it is beneficial to have a support person present, even for adults with FASD. Because of their on-going association, parents, caregivers, support persons or friends can assist in interpreting how the client understands or does not understand what is happening. They may be able to fill in sequential blanks in fact scenarios or in previous relevant events (for example, in previous brushes with the law or learning disabilities at school). They may well know the character of companions and how the client came to be associating with them. Such people may also be a valuable resource for family history, whether they are birth parents or subsequent parents.

2. Make the environment safe.

Kellerman notes: "[i]ndividuals with FASD are overly sensitive to environmental stimulation like noise or crowds. When they feel overwhelmed, they may withdraw and shut down, or they may act in an aggressive manner."[205] Turn off any music or bright lights and minimize the number of people with whom the client must talk. Establishing a pattern for each visit (such as making each visit as similar as possible to prior visits or on the same day each week, or same location) helps to promote a feeling of security. Keep the relationship business-like; feeling too safe can lead to inappropriate personal revelations and behaviour. People with FASD have trouble interpreting social cues accurately. Avoid touching the client.

3. Keep it simple.

People with FASD are more suggestible than the average person, so it is important to avoid leading questions. Try to use open questions so the client provides the content. When asking questions requiring 'yes' or 'no,' keep the wording and demeanour as neutral as possible.[206]

It is important to structure questions simply and to check frequently for understanding.

[205] Kellerman.
[206] Conry at 31.

It isn't enough to ask, "Do you understand?"; comprehension must be evaluated by having the content summarized in the client's words. Avoid negative questions and double negatives. Do not combine questions; for example, in *R v Sawchuk* "the accused, who had FAS, was asked, 'Do you understand? Do you want to call Duty Counsel or any other lawyer?' Mr. Sawchuk responded, 'No.' The Court tried to determine whether he meant, 'No, I don't understand,' or 'No, I don't want to call Duty Counsel'. Then again he may have meant 'No, I have a lawyer and I don't need any other lawyer'.[207] Present small bits of information at each sitting. It may be necessary to schedule more, shorter meetings. Provide both verbal and written summaries and instructions to the client.

4. Pay attention to voice.

Conry states that: "[p]eople with FAS/FAE are more likely [than normal] to react to changes in intonation, and thus a clear, calm voice in normal speaking tones should be used".[208] Avoid expressive gestures and voice fluctuations because clients with FASD will change what they perceive as a negative response and give a positive one. Their lack of ability to correctly interpret social cues makes this process very stressful and inaccurate.

5. Be patient.

Allow the client plenty of time to answer, if rushed he/she may feel pressured and shutdown. Because persons with FASD are most likely to answer 'yes', questioners should be careful about pursing a point and then stopping as soon as they receive the desired response.[209] Think of a variety of ways to pose a question: even the difference between 'Did you see *a* car?' and 'Did you see *the* car?' may elicit a different response.[210] Clarify why the answer was different. Review at the beginning of each session may be necessary because of memory deficits and the tendency to confabulate to fill in gaps. Repetition during subsequent meetings may help to even out discrepancies arising from different moods, physical states, anxiety levels, etc.

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[207] Conry at 19 from *R v Sawchuk* [1997] MJ No 186 at para 42 (QB).
[208] Conry at 36.
[209] Conry at 32.
[210] Conry at 32.

6. Consider videotaping.[211]

Creating a videotape of each session may help to interpret what works for an individual with FASD and what does not. Over a number of sessions it may be possible to determine the most frequent response to important questions. Furthermore, body language may reveal significant areas of discomfort. If possible, a support person may be enlisted to help interpret videos to get the closest approximation of truth. Videotapes are also an important permanent record for the client because, unlike written records, they do not solely rely on language skills for understanding.

If videotaping is not agreeable to the client, extensive notes may serve the same purpose and help to identify discrepancies and suggest which areas need to be revisited.

7. Educate yourself about FASD in general and this client in particular.

Always keeping in mind the best interest of the client and his rights, ask for permission to get medical records and any previous court records. Get permission to talk to parents, relatives, and others who can help. Concerned third parties may be under the impression that they cannot change anything or that their input is not allowed or welcome.[212]

New information about FASD is emerging all the time; do not hesitate to consult professionals on the topic. First Nations now have elders who are trained in all aspects of the disorders and have a unique perspective, particularly with respect to sentencing. A bibliography of recent case law is included at the end of this chapter; many of the judgments are thorough and insightful with respect to the intersection between FASD and the justice system.

II. Criminal vs. Civil Detentions and their Differential Impact on the Accused

When a lawyer first encounters a person with a mental disability, the lawyer may have to canvass with the client the different forms of detention that the client may be facing. Therefore, it is useful to examine the general procedures followed where a person

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[211] The suggestion for videotaping as an aid to interviewing comes from suggested accommodations for witnesses with language difficulty suggested in the *Nova Scotia Protocol for the Prosecution of Cases Involving Persons with Special Communications Needs* (Province of Nova Scotia, 1991).
[212] Conry at Chapter 10.

with a mental disability comes into contact with the civil authorities as compared to the criminal process.

A. Civil Commitment

1. Voluntary Admission

A person may be voluntarily admitted to a mental health facility as an inpatient or an outpatient if he/she requests or consents to admission. This procedure is sometimes referred to as informal admission.[213] There is not much legislative guidance as to voluntary admission procedures.[214]

In order to be admitted as a voluntary patient, the person must give valid consent. He must be capable of giving consent to his admission.[215]

Another decision that is voluntary under an informal admission is whether or not to accept treatment. This differs from involuntary committal where, under certain circumstances, treatment decisions may be made for a formal patient.[216]

Voluntary patients may discharge themselves from the hospital or cease attending outpatient clinics. This right is the same as the right of medical patients to discharge themselves, even against the advice of physicians.[217] Although they might be subjected to persuasion and even coercion in order to induce them to stay, voluntary patients have the right to leave a hospital whenever they wish.

2. Involuntary Admission

(a) Procedure

If a person refuses to be voluntarily admitted or treated as an outpatient, he/she may be involuntarily admitted. This procedure is sometimes referred to as formal admission or civil commitment.[218]

The procedures governing involuntary admission are outlined in various Mental

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[213] Robertson, at 370.
[214] Robertson, at 370.
[215] Robertson, at 370-371.
[216] See: s 28 of the *Mental Health Act*, RSA 2000 c M-13 (hereinafter *Mental Health Act*).
[217] Robertson, at 374.
[218] Robertson, at 377.

Health Acts across the country. In Alberta, the *Mental Health Act* sets out the procedure. Where an individual resists voluntary commitment, he may be involuntarily committed in one of three ways.

First, a physician may examine the client and determine that he/she is suffering from a mental disorder and is likely to cause harm to themselves or others or to suffer substantial mental or physical deterioration or serious physical impairment. If a physician examines the person outside the facility and determines that the person is suffering from a mental disorder, is likely to harm themselves or others and is unsuitable for admission to a facility other than as a formal patient, the physician can issue an Admission Certificate.[219]

Second, a police officer or a member of the person's family (or the general public) may lay "an information" before a provincial court judge (of the Family and Youth division in Alberta).[220] The information, a legal document, would contain details about the person's condition and behaviour. A judge is also permitted to ask for oral testimony about the person. If the judge determines that the person is in a condition likely to cause harm to themselves or to others and that there is no other way to arrange an examination, the judge can issue a warrant so that the person mentioned in the warrant may be apprehended for an examination.[221] The warrant is authority for a police officer to apprehend the person named in the warrant and to convey that person to a facility for examination. Most individuals are involuntarily committed as a result of family members or police officers swearing an information in this fashion.

Finally, a police officer may make an emergency apprehension of the person. In this case, the police officer will be the first contact between the individual and the system. A police officer is permitted to apprehend a person and convey him/her to a facility for examination if the officer has reasonable and probable grounds to believe that the person is suffering from a mental disorder, the person is likely to cause harm to themself or to others, the person should be examined in the interests of his/her own safety or the safety of others

[219] *Mental Health Act*, RSA 2000, c M-13 s 2. See the appendix to this chapter for the form.
[220] *Mental Health Act*, s 10.
[221] *Mental Health Act*, s 10(2).

and it would be dangerous to proceed to obtain a warrant for the person's apprehension.[222] An example of an emergency situation would be if the police encountered a mentally disabled person lying in the middle of a busy street where he/she could get hurt.

Once the person is conveyed to a designated mental health facility (as listed in the regulations), a physician will examine that person and determine whether or not she/he should be admitted as a formal patient. If the physician determines that the person should be formally admitted, the physician issues an admission certificate[223] that authorizes the apprehension and detention of the person for up to 24 hours from the time that she/he arrived at the facility.[224]

After the person has been observed and assessed for the 24-hour period, a second physician decides whether to issue an admission certificate. The combination of two admission certificates is sufficient to commit the person for a period of one month from the date that the second certificate was issued.[225] A person cannot be formally detained unless one of the admission certificates is issued by a member of the facility's staff.[226]

A renewal certificate can extend an involuntary patient's confinement.[227] The first period of renewal is for up to one additional month of confinement; the second period for an additional month; the third renewal and subsequent renewals may cover a period up to six months.[228] The criteria for issuing renewal certificates are that the person is suffering from a mental disorder, is dangerous to herself or to others and the person is unsuitable to continue at a facility other than as a formal patient.[229]

When an involuntary patient's admission or renewal certificate expires and is not renewed, the patient is entitled to be discharged because the legal authority for continued confinement has terminated.[230] Further, once a formal patient no longer meets the

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[222] *Mental Health Act,* s 12.
[223] The authority to apprehend a person expires after 72 hours from the time that the certificate is issued.
[224] *Mental Health Act,* s 4.
[225] *Mental Health Act*, s 7.
[226] *Mental Health Act*, s 7.
[227] *Mental Health Act,* s 8.
[228] *Mental Health Act,* s 8.
[229] *Mental Health Act*, s 8. This criterion is the same as that for the initial physician's certificate and the formal admission.
[230] Robertson, at 398.

requirements for the issuance of an admission or renewal certificate, the physician must cancel the certificate.[231]

An involuntary patient or someone acting on the patient's behalf can apply to the Review Panel to review the confinement.[232] The Panel consists of five members: two lawyers, one psychiatrist, one physician and one member of the general public.[233] A formal patient, his/her guardian or a person acting on his/her behalf may apply to a review panel for the cancellation of admission or renewal certificates.[234] All formal patients' confinement will be reviewed by the review panel after six months continuous confinement even if there has been no application for review by or on behalf of the patient.[235]

Orders or written decisions of the Review Board may be appealed to the Court of Queen's Bench within 14 days of their receipt.[236]

(b) Treatment

One admission certificate authorizes the facility to care for, observe, examine, assess, treat, detain and control the person named in the certificate for up to 24 hours.[237] Once an informal patient is the subject of two admission certificates, the facility has the authority to observe, examine, assess, treat, detain and control the person named in them for one month (or for the duration of the renewal periods).[238] A formal patient who is considered mentally competent to make treatment decisions may refuse treatment.[239] The review panel is permitted to override this decision under certain circumstances.[240] Alternatively, when a formal patient is found by a physician to be mentally incompetent to make treatment decisions, those decisions may have to be made by a guardian who is appointed under the *Adult Guardianship and Trusteeship Act* or, if no guardian has been appointed for the formal patient, her nearest relative as defined in the *Mental Health*

[231] *Mental Health Act*, s 31(2).
[232] *Mental Health Act*, s 37.
[233] *Mental Health Act*, s 34(1) and (4).
[234] *Mental Health Act*, s 38.
[235] *Mental Health Act*, s 39.
[236] *Mental Health Act*, s 43.
[237] *Mental Health Act*, s 4(1)(b).
[238] *Mental Health Act*, s 7 and s. 8(3).
[239] *Mental Health Act*, s 26 and s. 29.
[240] *Mental Health Act*, s 29(2) and (3).

Act.[241] There are certain safeguards placed into the system, but it is clear that an involuntary patient may be subjected to treatment he/she does not wish to take.

The Board of a treatment facility is permitted to grant leaves of absence to patients who are the subject of an admission order. Under a leave of absence, formal patients are released into the community in order to re-integrate or to receive outpatient treatment.[242] The individual might take advantage of halfway houses or other community based facilities. However, until the admission order expires, a person who is subject to an order is still liable to be returned to the facility.[243] This situation must be changed if the formal patient no longer meets the criteria for the issuance of admission certificates.[244]

B. Criminal Detentions—Part XX.I of the *Criminal Code*

The various details regarding the encounters of a mentally disabled person with the criminal justice system are outlined throughout the guide. However, an overview of the system is useful so as to compare the criminal detention with civil detention.

1. Arrest

When a police officer is called to a disturbance, he/she has the discretion under the *Police Act*[245] not to charge the individual. However, if the officer has reasonable grounds to believe that the mentally disabled person has committed a criminal offence, the officer will likely arrest that individual. In Calgary, when the mentally disabled individual is conveyed to the police station, the arresting officer makes a notation on the arrestee's file that there needs to be an assessment of the individual.

Alternatively, the officer may determine that the person has not committed an offence and is not likely to harm him/herself or others, therefore likely would not qualify for involuntary admission under the *Mental Health Act*. However, there may be pressure on the officer to take some kind of action from family members or those involved in the incident. One option is for the officer to call in the Police and Crisis Team (PACT) in order to assist the

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[241] *Mental Health Act*, s 28.
[242] *Mental Health Act*, s 20.
[243] *Mental Health Act*, s 20(4).
[244] *Mental Health Act*, s 31(2).
[245] RSA 2000, c P-17 s 38.

family in finding the proper resources for the troubled person.[246] In many situations, however, the family is aware of the available resources and wants further action taken. Also, there may be no family members available to ensure that the person seeks assistance. Under these circumstances, the police officer may proceed to charge the individual with an offence, despite the fact that the individual has a mental disability. For example, one mentally disabled individual apparently makes a practice of going into banks handing notes to tellers, in which he demands that the teller hand over a small amount of money and call the police. This person is not likely to harm himself or others, and would likely not be admitted under the involuntary committal procedures. However, if he becomes enough of a burden, the police are called and may charge the individual with a minor offence.[247]

Once the person is charged with an offence, he/she is taken to the police station. The police officer or other person then swears out an information and a hearing is held before a justice. When a person is arrested, with or without a warrant, he/she must be taken before a justice without unreasonable delay and within 24 hours. Once the accused appears before a justice, he/she has the right to a bail or judicial interim release hearing. At this hearing, it may become evident to the justice that the accused has a potential mental disability or other psychiatric problem. Also, the arresting officer may have noted on the arrest report that the accused should be assessed. If this happens, the matter is remanded to the next sitting of the provincial court (usually the same day) and the accused's name will be noted on a special list as requiring an assessment.

When the accused is taken into custody and is awaiting trial or other hearing at the Remand Centre, there are hospital wards or separate wards in the larger centres. Psychiatrists visit the wards perhaps two or three times a week to visit those accused identified as having psychiatric difficulties. If the accused are held in the general population, they may be subjected to ill treatment at the hands of the other inmates.

[246] The Police and Crisis Team (PACT) is designed to help mentally disabled persons to access police services. See Police and Crisis team, 'Success Story: Police and Crisis Team' online: < http://justice.alberta.ca/programs_services/safe/history/Pages/PACT.aspx>.

[247] Dr. Tweddle, Alberta Hospital Edmonton, Criminal Trial Lawyers Association, *Three Short Snappers and the Post-Sentence Process*, November 21, 1992, Edmonton, Alberta.

2. Remand for Assessment

If the accused is noted as having a potential difficulty, a psychiatrist or other medical specialist may examine an individual to determine if he/she needs to be assessed. The courts, lawyers and psychiatrists sometimes refer to an assessment as a remand for observation. Under the previous *Criminal Code* provisions, a court usually remanded a person for psychiatric observation after receiving a written statement from a medical practitioner stating that there was reason to believe that the accused was mentally ill.[248] The amended *Criminal Code* provisions (s 672.11) require the court to have reasonable grounds to believe that the evidence obtained by an assessment is necessary to determine such matters as whether or not the accused is fit to stand trial. This section does not insist on the evidence of a duly qualified medical practitioner, nor does it specify what evidence is necessary in order to have a reasonable belief. However, it is usually the practice that a medical practitioner examines the accused in order to provide an opinion as to whether the accused should be remanded for an assessment.[249] An accused may be ordered to undergo an assessment at any stage of the proceedings, including during his/her trial.

Once it is determined that the accused needs to be assessed, he/she may be detained in custody for the assessment or may be released into the community and assessed on an outpatient basis. These provisions of the *Criminal Code* require that the accused not be detained in custody for an assessment except under limited circumstances.[250] However, it seems that in practice most individuals are being detained in custody for their assessment.[251]

Under the previous regime, in Calgary, the practice was to remand a person for 30 days' observation at a hospital. In Edmonton, the practice was to remand the person for 14 days' observation. In many cases, this continues to be the practice, although the new provisions require a shorter length of time for assessing fitness to stand trial (5 days, unless

[248] See: former *Criminal Code* s 615. By virtue of s 10(1) of the Transitional Provisions, any previous orders made under this section remain in force until s 672.64 (capping provisions) comes into force.
[249] Dr Cdasky, Alberta Hospital Edmonton, Criminal Trial Lawyers Association, *Three Short Snappers and the Post-Sentence Process*, November 21, 1992, Edmonton, Alberta.
[250] s 672.16, *Criminal Code*, RSC 1985, c C-46.
[251] T Glancy, Criminal Trial Lawyers Association, "The New Insanity Provisions", *Three Short Snappers and the Post-Sentence Process*, November 21, 1992, Edmonton, Alberta.

the accused consents to a longer period of up to 30 days).[252] By virtue of the *Mental Health Act*, the Helen Hunley Forensic Pavilion at the Alberta Hospital Edmonton and the Southern Alberta Forensic Psychiatry Centre in Calgary are the designated facilities for performing the assessments.[253] However, any medical practitioner who is entitled to practice medicine in Alberta may also perform an assessment.

An assessment order cannot direct that psychiatric or other treatment be carried out or direct that the accused submit to such treatment.[254] If the psychiatrist wishes to treat the accused while he/she is subject to an assessment order, this may be done only under the *Mental Health Act.*[255]

3. Trial on the Fitness Issue

After the accused is assessed, the person who made the assessment usually submits an assessment report to the court. If an assessment report concludes that an accused is not fit to stand trial or if the court has reasonable grounds to believe that the accused is unfit to stand trial, a court may recommend that there be a trial on the issue of fitness.[256] If the accused is not represented by counsel under these circumstances, the court must order representation for her/him.[257] If it is determined that an accused is fit to stand trial, the proceedings will continue as if the issue of fitness had never arisen.[258]

4. Accused Found Unfit to Stand Trial

Where the verdict is that an accused is unfit to stand trial, the plea is set aside and the jury is excused.[259] Then, the accused or the prosecutor applies for a disposition hearing held by the court and the court makes a disposition (sentence).[260] If the court makes no disposition, a Review Board consisting of five members appointed by the Lieutenant

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[252] *Criminal Code*, 672.14(2)
[253] See *Mental Health Act,* s 13 and *Mental Health Regulation*, Alta Reg 19/2004, s 1(2).
[254] *Criminal Code*, s 672.19.
[255] *Mental Health Act*, s 13.
[256] *Criminal Code*, s 672.23.
[257] Criminal Code, s 672.24.
[258] Criminal Code, s 672.28.
[259] Criminal Code, s 672.31.
[260] *Criminal Code*, s 672.45.

Governor of Alberta[261] must hold a hearing and make a disposition no later than forty-five days after the verdict of unfit to stand trial was rendered.[262] The Review Board will make its own determination as to whether the accused is fit to stand trial at the time of its hearing. If the Review Board determines that the accused is fit to stand trial, the accused will be sent back to court and the court must retry the fitness issue and render a verdict. Under some other exceptional circumstances, the chairperson of a Review Board may also send an accused back to court for a re-trial of the fitness issue.[263] If the Review Board determines that the accused is unfit to stand trial, it will make a disposition.[264]

The *Criminal Code* specifies what types of dispositions may be made by the Review Board or the court. The factors to be considered include the need to protect the public from dangerous persons, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused.[265] Additionally, the disposition chosen must be the least onerous and the least restrictive to the accused. Where the accused has been found unfit to stand trial, the court or the Review Board must choose between a conditional discharge and a hospital detention order.[266]

If the accused has been found unfit to stand trial and the court has not made a disposition under s. 672.54, the court may direct that the accused be treated for a period of up to 60 days.[267] A treatment order may only be made where a medical practitioner has testified that the treatment should be administered to the accused for the purpose of making the accused fit to stand trial. There are also other conditions that must be met before the court may order treatment.[268] The court must not direct that the accused be subjected to psychosurgery (brain surgery) or electro-convulsive therapy (shock treatments).[269]

[261] See sections 672.38 to 672.44 for specifics dealing with Review Boards.
[262] *Criminal Code*, s 672.47(1).
[263] *Criminal Code*, s 672.47(5).
[264] *Criminal Code*, s 672.47(1).
[265] *Criminal Code*, s 672.54.
[266] *Criminal Code*, s 672.54.
[267] *Criminal Code*, s 672.58. See also: *R v Conception*, [2014] 3 SCR 82, where the SCC upheld a finding that while this section and 672.62(1) engage the right to liberty and security under *Charter* s 7, the process did not violate the principles of fundamental justice.
[268] *Criminal Code*, s 672.58.
[269] *Criminal Code*, s 672.61.

A verdict of unfit to stand trial does not prevent the accused from being subsequently tried when he becomes fit to stand trial.[270]

If the accused has been found unfit to stand trial, section 672.33 provides for a review by the court within two years and every two years thereafter. The review is held to decide whether there is sufficient evidence to put the accused on trial. The Crown must show that it could prove the case against the accused if there were a trial. If the Crown cannot satisfy the court that it has a case against the accused, the accused must be acquitted.[271]

5. Accused Found Fit to Stand Trial

If the accused is found fit to stand trial, a different procedure is followed. The trial proceeds as normal. The accused may decide to rely on the defence provided in s 16 of the *Criminal Code* for persons who are suffering from a mental disorder at the time of the offence. Mental disorder is defined in s 2 as "a disease of the mind". The accused will be presumed not to suffer from a mental disorder and will have the burden of proving on a balance of probabilities that he/she was suffering from a disease of the mind at the time of the offence. If the accused is successful under s 16, she/he will receive a verdict that she/he is not criminally responsible on account of mental disorder.

6. Accused Found Not Criminally Responsible on Account of Mental Disorder

Once the accused has been found not criminally responsible on account of mental disorder, the court may on its own motion, and shall, on application by the accused or prosecutor, hold a disposition hearing.[272] If the court does not make a disposition, the Review Board must make one within 45 days.[273] The court may extend the time to hold the hearing to a maximum of 90 days after the verdict is rendered.

When making a disposition, the court or Review Board must take certain factors into consideration. These include: the need to protect the public from dangerous persons, the

[270] *Criminal Code*, s 672.32.
[271] *Criminal Code*, s 672.33.
[272] *Criminal Code*, s 672.45.
[273] *Criminal Code*, s 672.47.

mental condition of the accused, the reintegration of the accused into society and the other needs of the accused.[274] The disposition must be the least onerous and least restrictive to the accused. If the accused is not a significant threat to the safety of the public, the accused may be discharged absolutely. Other possible dispositions are a conditional discharge or an order directing that the accused be detained in custody in a hospital subject to conditions.[275]

If the accused receives a hospital detention order, the court or Review Board must issue a warrant of committal that authorizes the police and hospital personnel to detain the person.[276] In Alberta, an accused found not criminally responsible on account of mental disorder would serve a hospital detention disposition at the Alberta Hospital Edmonton[277] or in the Southern Alberta Forensic Psychiatry Centre.[278] He/She might serve a community disposition in Edmonton, Calgary or Claresholm, reporting on an outpatient basis to programs such as the Forensic Assessment Outpatients Service at the Peter Lougheed Hospital**.** Unlike a the situation where a person has been found unfit to stand trial, the court (or Review Board) cannot direct under s. 672.54 that the accused receive or submit to any psychiatric or other treatment.[279] However, a psychiatrist or other medical practitioner could pursue treatment of the offender under the provincial *Mental Health Act.*[280]

The proposed capping provisions that were to apply to a person found unfit to stand trial would have also applied to a person found not criminally responsible on account of mental disorder.[281] The premise was that the Review Board would review every disposition once every twelve months, unless the accused is absolutely discharged.[282] At the review hearing, the Review Board would make any disposition that it considered to be appropriate

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[274] *Criminal Code*, s 672.54.
[275] *Criminal Code*, s 672.54.
[276] *Criminal Code*, s 672.57.
[277] Dr. Tweddle, Alberta Hospital Edmonton, Criminal Trial Lawyers Association, *Three Short Snappers and the Post-Sentence Process*, November 21, 1992, Edmonton, Alberta.
[278] Southern Alberta Forensic Psychiatry Centre. Online: http://www.albertahealthservices.ca/info/service.aspx?id=1921.
[279] *Criminal Code*, s 672.55.
[280] *Mental Health Act*, s 13.
[281] This regime for the capping of dispositions was proposed by s 672.64 to 672.66 in Bill C-10. They were however repealed before they came into force.
[282] *Criminal Code*,s 672.81.

in the circumstances.[283] However, these proposed capping provisions were repealed before they came into force.[284] Current procedures ensure that only persons who continue to pose a threat to the public are detained. Those who pose no significant threat to the safety of the public will receive an absolute discharge.[285]

Section 672.72 permits any party to appeal to the court of appeal against any disposition (sentence) made by a court or review board. The court has broad powers outlined in s. 672.78, including making a disposition, or referring the matter to the court or Review Board for rehearing.

Under certain circumstances, the accused or Crown may wish to appeal a verdict of unfitness to stand trial or a verdict of not criminally responsible on account of mental disorder. The right to appeal these verdicts depends upon whether the Crown proceeded under summary conviction (minor offence) or by way of indictment (more serious offence). The appeal provisions are discussed at length elsewhere in the guide.

7. Accused Found Guilty

Where an accused is unsuccessful in arguing that he is not criminally responsible on account of mental disorder, he/she may be found guilty of the offence. Although he/she might have been found fit to stand trial, he/she might continue to suffer from a mental disability when he/she is incarcerated in a provincial correctional centre or federal penitentiary.

Some provincial correctional centres do not have separate psychiatric wards. However, the Fort Saskatchewan Correctional Centre contains an Assessment and Treatment area that is run like a psychiatric ward. Psychiatrists from the Alberta Hospital Edmonton and the Forensic Assessment and Outpatient Services visit the centre twice a week to conduct clinics.[286] As a result, mentally disabled prisoners often find themselves being incarcerated at this facility.

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[283] *Criminal Code*, s 672.83.
[284] They were repealed by SC 2005, c 22 s 24.
[285] *Winko v British Columbia (Forensic Psychiatric Institute)*, [1999] 2 SCR 733 at para 3.
[286] Dr. Tweddle, Alberta Hospital Edmonton, Criminal Trial Lawyers Association, *Three Short Snappers and the Post-Sentence Process*, November 21, 1992, Edmonton, Alberta.

Mentally disabled persons who are sentenced to federal institutions may also find themselves in the general population or in isolation for their own protection. The provisions in the *Corrections and Conditional Release Act*[287] require that the Correctional Service of Canada provide every inmate with essential health care (including mental health care) and reasonable access to non-essential mental health care.[288] The provision of essential health care must conform to professionally accepted standards.[289] The inmate must consent to any treatment offered in the institution.[290]

It is not clear whether these sections will change the current treatment system. Currently, a psychiatrist visits the institution on a regular basis to assist the inmates. If necessary, inmates are referred to a Regional Psychiatric Centre, such as the one in Saskatoon.[291]

Occasionally a federal prisoner will receive treatment in the Alberta Hospital Edmonton. By agreement with the government of Alberta, serving federal prisoners may be transferred to the Alberta Hospital Edmonton for treatment under a *Mental Health Act* certificate.[292] However, they must meet the requirements for involuntary committal (likely to harm self or others) before they will be admitted.[293]

III. Conclusion

When a lawyer encounters a client charged with a criminal offence whom he/she suspects has a mental disability, several issues arise. First, the lawyer must recognize the disability and gain some knowledge about how the person is affected by his/her disability. Second, the lawyer may have to examine several pieces of legislation in order to determine if his/her client fits the definition of mental disability or mental disorder contained therein.

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[287] *Corrections and Conditional Release Act*, SC 1992, c 20 (hereinafter Corrections and Conditional Release Act).
[288] *Corrections and Conditional Release Act*, s 86(1).
[289] *Corrections and Conditional Release Act*, s 86(2).
[290] *Corrections and Conditional Release Act*, s 88(1)(a) and (b).
[291] Dr Tweddle Alberta Hospital Edmonton, Criminal Trial Lawyers Association, *Three Short Snappers and the Post-Sentence Process*, November 21, 1992, Edmonton, Alberta.
[292] *Corrections and Conditional Release Act*, s 16.
[293] Dr Tweddle, Alberta Hospital Edmonton, Criminal Trial Lawyers Association, *Three Short Snappers and the Post-Sentence Process*, November 21, 1992, Edmonton, Alberta.

Then, the lawyer and his/her client will have to examine the impact that ethical and tactical decisions will have on the mentally disabled client. Finally, the lawyer may have to examine some alternatives to the traditional criminal justice system and canvass with the client whether these are more desirable under the client's circumstances.

Appendix

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Sample of Jurisprudence Relating to FASD

This case list does not claim to be all-inclusive, but is a representative sample of the approach the Courts are taking to different elements of the issue.

***R v Abou,* [1995] BCJ No 1096 (BC Prov Ct)** Barnett, Prov Ct J – 24 yr old woman, mentally handicapped and FAS repeatedly charged with assault, shows emerging understanding of syndrome, a truly sad but classic case, example of a very explicit case management report and probation order

***R v CJM,* [2000] BCJ No 2714** (BC Prov Ct) Trueman, Prov Ct J – 26 yr old accused of robbery- had frequent periods of incarceration in past, commentary on primary and secondary effects of FAS and misinterpretation of sufferers, discussion on lack of appropriate resources in justice system and community

***R v DEK*, [1999] AJ No 1357** (AB Prov Ct) Fraser, Prov Ct J – 18 yr old accused of sexual assault – shows full reliance on FAS assessment report and acknowledges Gladue principles.

***R v Harris*, [2002] BCJ 1691 (BCCA)** Levine, JA – 45 yr old with 62 previous convictions, defendant raised question of possibility of FAS, discusses difficulty of access to

assessment and when conditional sentences are appropriate

***R v Gray,* [2002] BCJ No 428** (BC Prov Ct Crim Div) Trueman Prov Ct J (quashed *R v Gray,* 2002 BCSC 1192) – trafficking cocaine, Charter s 15 - questions of sentencing, competence, unsuitability of incarceration for FAS offenders – thorough discussion of the diagnosis dilemma.

***R v JH*, [2002] BCJ 313** (BC Prov Ct Crim Div) Trueman Prov Ct J - 43-year old man sentenced for two counts of break and enter and one count of breach of probation. Accused suffered from FAS and from the time he was 16 years of age had been embroiled in the Criminal Justice System. A jail sentence was not imposed and the accused was given a conditional sentence instead of incarceration which enabled authorities to learn how to rehabilitate JH. (This decision was varied: *R v Harris*, 2002 BCCA 152. The sentencing judge erred in principle in diagnosing Harris as suffering from FAS or ARND as she had little evidence of his background or abilities. However, it could not be said that the conditional sentence was unfit).

***R v Makinaw*, [2002] AJ 1529** (AB Prov CT Crim Div) Bridges, Prov Ct J – guilty plea to arson – discounted possibility of FAS after reading psychiatrist report – reliance on traditional assessment.

***R v LEK*, [2000] 153 CCC (3d) 250** Lafond, J addressed lack of jurisdiction under YOA to order suitable treatment – court can't instruct administration to provide services or how to allocate resources – advised highest level of supervision for duration of probation

***R v LE M*, [2001] MJ No 62** (MB Prov Ct) Giesbrecht, Prov Ct J – differentiates between the needs of offenders with AFSD and others, intensive supervision and appropriate intervention no matter what cost.

R v RF, **[2002] SKPC 137***,* (SK Prov Ct) Whelan, Prov Ct J. – defendant makes argument that FAS is ‘disease of mind’ making incapable of appreciating nature and quality of actions – not accepted, had had sufficient degree of awareness to pass standard low threshold – discussed difference between ‘knowing’ and ‘appreciating’.

R v SLP**, [2002] SJ 311** (SK Prov Ct) Whelan, Prov Ct J – includes letter written by defendant which demonstrates typical language and reasoning deficits, recommends “Fetal Alcohol Syndrome: Implications for Correctional Service” published by Correctional Service of Canada as required reading for everyone associated with justice system.

R v TJ**, [1999] YJ 57** (YT Terr Ct) Lilles, Terr Ct J – 22 year-old male with physical size and demeanour of 12 yr old, found ‘unfit to stand trial’ on sexual assault charge, includes summary of primary and secondary FASD symptoms, outline of legislation relevant to finding of UST. (Negative treatment)

R v Wald**, [2002] SJ 222** (SK Prov Ct) Whelan, Prov Ct J – accused diagnosed with FAS shortly after birth, raised issue of fitness to stand trial – description of different test instruments and FAS symptoms, discrepancy between I.Q. and adaptive functioning.

Mental Health Act (Alberta) Forms

Form 1

Admission Certificate

Mental Health Act

Section 2

I, (print name of physician) of (address), certify that I personally examined (print name of person examined) of (home address) on (date) at (time) at (place of examination).

In my opinion the person examined is

(a) suffering from mental disorder,

(b) likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, and

(c) unsuitable for admission to a facility other than as a formal patient.

(Note: All three criteria above must be met.)

I have formed my opinion

(a) on the following facts observed by me:

(b) on the following facts communicated to me by others:

(Note: (a) and (b) must be completed.)

□ The person is not in a facility and is to be conveyed for examination to (name of facility) at (address of facility).

(Place an X in the box if conveyance is required.)

(date of issue)

(time of issue)

(signature of physician)

(printed name of physician)

Form 2

Renewal Certificate

Mental Health Act

Section 8

I, (print name of physician) of (address), certify that I personally examined (print name of person examined) on (date) at (time) separately from any other physician.

In my opinion the person examined is

(a) suffering from mental disorder,

(b) likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, and

(c) unsuitable to continue at a facility other than as a formal patient.

(Note: All three criteria above must be met.)

I have formed my opinion

(a) on the following facts observed by me:

(b) on the following facts communicated to me by others:

(Note: (a) and (b) must be completed.)

The person was examined at (name of facility)

(date of issue)

(time of issue)

(signature of physician)

(printed name of physician)

Form 3

Order to Return a Formal Patient to a Facility

Mental Health Act

Section 20(4) or 21(1)

To all or any peace officers in Alberta:

(name of formal patient), a formal patient, is absent without leave pursuant to the *Mental Health Act*.

You are hereby ordered to return the formal patient to (name and address of facility).

Admission certificates (or renewal certificates) expire on (date).

Dated this _____ day of _______, 20__.

(signature of representative of

board of facility) ____________

(printed name of representative)

Form 4

Certificate of Transfer into Alberta

Mental Health Act

Section 24(1)

I have reasonable and probable grounds to believe that (full name of person) may come or be brought into Alberta and is

(a) suffering from mental disorder,

(b) likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, and

(c) unsuitable for admission to a facility other than as a formal patient.

(Note: All three criteria above must be met.)

Pursuant to section 24(1) of the *Mental Health Act*, I authorize a peace officer or (name of person authorized) to apprehend and convey (full name of person) to a facility for examination.

(date of issue) ________________

(s
ignature of the Minister of Health
or person designated by the
Minister of Health) ____________

(
printed name of Minister
of Health or designated person) ___

Form 5

Transfer of Formal Patient to a
Jurisdiction Outside Alberta

Mental Health Act

Section 25

It appears to me

□ that (name of formal patient) has come or been brought into Alberta and that his/her care and treatment is the responsibility of (name of other jurisdiction).

or

□ that it would be in the best interests of (name of formal patient) to be cared for in (name of other jurisdiction).

(Choose one and place an X in the appropriate box.)

Therefore, I authorize that (name of formal patient) be transferred to (name of other jurisdiction).

(date of issue)__________________

(signature of the Minister of Health
or person designated by the
Minister of Health)_____________

(printed name of Minister
of Health or designated person)___

Form 6

Memorandum of Transfer
to Another Facility

Mental Health Act

Section 22(1)

Arrangements have been made with the board of (name of facility to which the patient is to be transferred) to transfer (name of formal patient), a formal patient in (name of facility in which patient is presently detained), to (name of facility to which the patient is to be transferred).

Dated this ___ day of _____, 20__.

(signature of representative of
board of sending facility)

(printed name of representative)

Form 7

Information

Mental Health Act

Section 10

This is the information of (name of informant) of (address of informant) who says that he/she has reasonable and probable grounds to believe that (name of person) of (address of person) is

□ suffering from mental disorder, and likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, or

□ is subject to a community treatment order and is not complying with the order.

SWORN BEFORE ME at the ______ of)
_______, in the Province of Alberta, the)
____ day of ____________, 20__________.)
___________________________________) (signature of informant)
(Judge of The Provincial)
Court of Alberta)) (printed name of informant)

Form 8

Warrant

Mental Health Act

Section 10

To all or any peace officers in Alberta:

(name of informant) has brought before me an information on oath that (name of person) of (address of person)

- ☐ is suffering from mental disorder, and likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, or
- ☐ is subject to a community treatment order and is not complying with the order.

I am satisfied that (name of person)

- ☐ is suffering from mental disorder, and likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment, or
- ☐ is subject to a community treatment order and is not complying with the order,

and that an examination can be arranged in no way other than by apprehension.

This is to order you to apprehend (name of person) and convey him/her to a facility for an examination.

Brief reasons:

Dated this ___ day of _____, 20__ at ___________________________.

(signature of Judge of The

Provincial Court of Alberta) ___________ (printed name of Judge of The

Provincial Court of Alberta) ___________

(clerk of the Court)

(date of filing) ____

Form 9

Extension of Warrant

Mental Health Act

Section 11

To all or any peace officers in Alberta:

(name of Judge of The Provincial Court of Alberta) issued a warrant dated _ to apprehend (name of person).

The warrant has not been executed.

(name of peace officer), (badge number) of (detachment),

□ has appeared before me to apply for an extension of the warrant.

or

□ has applied for an extension of the warrant by telephone or other means of telecommunication, and it appears on the oath of (name of peace officer) that it is impracticable to appear before me personally and that there are reasonable grounds for dispensing with an information presented personally and in writing.

(Choose one and place an X in the appropriate box.)

This order therefore extends the duration of the warrant for a period of 7 days from the day on which the warrant expires.

Dated at (place) on the ___ day of ___________________________,
20__ at (time) .

(signature of Judge of The

Provincial Court of Alberta)

(printed name of Judge of The

Provincial Court of Alberta)

(clerk of the Court)

(date of filing)

Form 10

Statement of Peace Officer
on Apprehension

Mental Health Act

Section 12

(name of person apprehended, if known) was apprehended on (date) at (time).

He/She was apprehended at (describe place and address).

I have reasonable and probable grounds to believe that

(a) the person apprehended is suffering from mental disorder,

(b) the person apprehended is

□ likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment,

or

□ subject to a community treatment order and is not complying with the community treatment order,

(c) the person apprehended should be examined in the interests of his/her own safety or the safety of others, and

(d) the circumstances are such that to proceed under section 10 of the *Mental Health Act* would be dangerous.

(Note: All four criteria above must be met.)

The grounds for my belief are:

Dated this ___ day of _____, 20__.

(signature of peace officer) ___

(printed name of peace officer)

(badge number) ____________

(detachment) ______________

Form 11

Certificate of Incompetence to
Make Treatment Decisions

Mental Health Act

Section 27

Part One

(To be completed by a physician)

I, (name of physician), am of the opinion that (name of formal patient) is not mentally competent to make treatment decisions.

The reasons for my opinion are as follows: ____________________.

Dated this ___ day of ______, 20__.

signature of physician) _____

(printed name of physician) __

Part Two

(To be completed by the board of a facility)

To: (name of formal patient) of __(address)_________________

And: (name of patient's guardian or agent, if any) __ of __(address)_

And: (name of nearest relative, unless patient objects) of __(address)_

Take notice that (name of formal patient) is entitled to have the physician's opinion about his/her competence to make treatment decisions reviewed by a review panel by sending to the chair of the review panel an Application for Review Panel Hearing, in Form 12.

Dated this ____ day of _______, 20__.

(signature of representative

of board of facility)__________

(printed name of representative)

Form 12

Application for Review Panel Hearing

Mental Health Act

Sections 27(3), 29(2), 33 and 38(1) and (1.1)

To: (print name of chair of the review panel)
(address of chair) ____________________________________

I, (printed name of applicant) of (printed address of applicant), bearing a relationship of (self, relative, guardian, agent, physician, other) to (name of patient or person who is subject to a community treatment order), apply

□ under section 27(3) of the Act for a review of the attached Certificate of Incompetence to Make Treatment Decisions,
dated ____________________________________
and signed by ____________________________________.

□ under section 29(2) of the Act for an order directing that the following treatment (nature of treatment) be administered to (name of formal patient).

□ under section 33 of the Act for an order transferring (name of patient) back to (name of correctional facility).

□ under section 38(1) of the Act for cancellation of admission certificates or renewal certificates issued on (date of issue).

□ under section 38(1.1) of the Act for cancellation of the community treatment order (issued/amended/renewed) on (date of issue/amendment/renewal).

(Choose one and place an X in the appropriate box.)

Dated this ___ day of _______, 20__.

(signature of applicant)

Notice

Mental Health Act

I (do) (do not) object to my nearest relative being informed of the review panel hearings.

(signature of patient or person who is subject to community treatment order)

(printed name of patient or person who is subject to community treatment order)

Form 13

Notice of Hearing Before Review Panel

Mental Health Act

Section 40

Application received by the review panel (date)____________

Take notice that a hearing will be held

(Choose one and place an X in the appropriate box.)

□ under section 27(3) of the Act for a review of the physician's opinion in the attached Certificate of Incompetence to Make Treatment Decisions relating to ____(name of formal patient)____ dated ______ and signed by _.

□ under section 29(2) of the Act for an order directing that the following treatment __(nature of treatment)__ may be administered to __(name of formal patient)__.

□ under section 33 of the Act for an order transferring (name of patient) back to a correctional facility.

□ under section 38(1) of the Act for cancellation of admission certificates or renewal certificates relating to (name of formal patient).

□ under section 38(1.1) of the Act for cancellation of the community treatment order (issued/amended/renewed) on (date of issue/amendment/renewal).

□ under section 39 of the Act for

(Choose one and place an X in the appropriate box.)

□ cancellation of renewal certificates relating to (name of formal patient), or

□ cancellation of the community treatment order relating to (name of person who is subject to the community treatment order).

The review panel will hear the application on __(date)__ at __(time)__ at __(place)__.

(date of issue)

(signature of chair of review panel)

(printed name of chair)

(address)

Form 14

Decision of Review Panel
Regarding Mental Incompetence
to Make Treatment Decisions

Mental Health Act

Sections 27(3) and 41

The formal patient (does) (does not) object to the nearest relative, (name of nearest relative), receiving notice of the decision.

The review panel has heard and considered the application of (name of formal patient) and has decided

□ to cancel the attached Certificate of Incompetence to Make Treatment Decisions dated ___________ and signed by ____.

□ to refuse to cancel the attached Certificate of Incompetence to Make Treatment Decisions dated ___________ and signed by ____.

(Place an X in the appropriate box.)

Date of decision: ____

This decision may be appealed to the Court of Queen's Bench within 14 days after receipt of this decision.

(signature of chair of review panel)

(printed name of chair)

Form 15

Decision of Review Panel
Regarding Treatment

Mental Health Act

Sections 29(2) and 41

The formal patient (does) (does not) object to the nearest relative, (name of nearest relative), receiving notice of the decision.

The review panel has heard and considered the application of (name of board representative or physician) and has decided

- □ to make an order authorizing the following treatment (nature of treatment) to be administered to (name of formal patient).

- □ to refuse to make an order authorizing the following treatment (nature of treatment) to be administered to (name of formal patient).

(Place an X in the appropriate box.)

Date of decision: ____

This decision may be appealed to the Court of Queen's Bench within 14 days after receipt of this decision.

(signature of chair of review panel)

(printed name of chair)

Form 16

Decision of Review Panel Regarding Transfer
Back to a Correctional Facility

Mental Health Act

Sections 33 and 41

The formal patient (does) (does not) object to the nearest relative, (name of nearest relative), receiving notice of the decision.

The review panel has heard and considered the application of (name of applicant) and has decided

□ to order that (name of patient) be transferred back to (name of correctional facility).

□ to refuse to make an order.

□ to cancel the admission certificates or renewal certificates, if any.

□ to refuse to cancel the admission certificates or renewal certificates for the following reasons: __.

(Place an X in the appropriate box(es).)

Date of decision: ____

This decision may be appealed to the Court of Queen's Bench within 14 days after receipt of this decision.

(signature of chair of review panel)

(printed name of chair)

Form 17

Decision of Review Panel Regarding Admission
Certificates, Renewal Certificates or
Community Treatment Orders

Mental Health Act

Sections 38(1) and (1.1) and 41

(name of formal patient or person who is subject to the community treatment order) (does) (does not) object to the nearest relative, (name of nearest relative), receiving notice of the decision.

The review panel has heard and considered the application of (name of applicant), bearing a relationship of (self, agent, guardian, other) to (name of formal patient or person who is subject to the community treatment order), and has decided

□ to cancel the admission certificates or renewal certificates relating to the person named above.

□ to refuse to cancel the admission certificates or renewal certificates relating to the person named above for the following reasons: ____________________________________.

□ to cancel the community treatment order relating to the person named above.

□ to refuse to cancel the community treatment order relating to the person named above for the following reasons: ____.

(Place an X in the appropriate box.)

Date of decision: ____

This decision may be appealed to the Court of Queen's Bench within 14 days after receipt of this decision.

(signature of chair of review panel)

(printed name of chair)

Form 18

Decision of Review Panel Regarding Renewal
Certificates and Community Treatment
Orders (Deemed Application)

Mental Health Act

Sections 39 and 41

(name of formal patient or person who is subject to the community treatment order) (does) (does not) object to the nearest relative, (name of nearest relative), receiving notice of the decision.

The review panel has heard and considered an application deemed by section 39 of the Act to have been made by (name of formal patient or person who is subject to community treatment order) and has decided

□ to cancel the renewal certificates relating to the person named above.

□ to refuse to cancel the renewal certificates relating to the person named above for the following reasons:
____.

□ to cancel the community treatment order relating to the person named above.

□ to refuse to cancel the community treatment order relating to the person named above for the following reasons:
____.

(Place an X in the appropriate box.)

Date of decision: ____

This decision may be appealed to the Court of Queen's Bench within 14 days after receipt of this decision.

(signature of chair of review panel)

(printed name of chair)

Form 19

Issuance of Community Treatment Order

Mental Health Act

Section 9.1

PART I
Issuing Psychiatrist's Examination

Name of person: ____

Address (if known): ____

Phone (if known): ____

Date of Birth: __________ Personal Health Care Number: ________

I, (print name of psychiatrist or designated physician) of (business address), (phone number), am:

□ a psychiatrist;

OR

□ acting as a designated physician pursuant to section 9.7 of the *Mental Health Act*, and I confirm I have consulted with a psychiatrist prior to the issuance of this community treatment order,

and I am the issuing psychiatrist of this community treatment order.

I certify that I personally examined this person on (date) at (time) at (place of examination) with the following results:

1. The person examined

(a) in my opinion, is suffering from mental disorder,

(b) has

□ during the immediately preceding 3-year period, on 2 or more occasions, or for a total of at least 30 days,

□ been a formal patient in a facility,

□ been in an approved hospital or been lawfully detained in a custodial institution where there is satisfactory evidence that while there the person would have met the criteria set out in section 2(a) and (b) of the *Mental Health Act* at the time or those times,

□ both been a formal patient in a facility and been in an approved hospital or lawfully detained in a custodial institution where there is satisfactory evidence that while there the person would have met the criteria set out in section 2(a) and (b) of the *Mental Health Act* at the time or those times,

or

□ within the immediately preceding 3-year period, been subject to a community treatment order,

or

□ in my opinion while living in the community, exhibited a pattern of recurrent or repetitive behaviour that indicates the person is likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community,

(c) in my opinion, is likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community, and

(d) is able to comply with the treatment or care set out in this community treatment order.

2. The facts on which I formed the above opinions are as follows: ____.

3. I am satisfied that the treatment or care set out in Part III of this community treatment order exists in the community, is available to the person and will be provided to the person.

____________________________ _____________________

(signature of issuing psychiatrist) (date and time)

PART II
Second Examination by Physician

Name of person: ____

Address (if known): ____

Phone (if known): ____

Date of Birth: _________ Personal Health Care Number: ________

I, (print name of physician) of (business address), certify that I personally examined this person on (date) at (time) at (place of examination) with the following results:

1. The person examined

(a) in my opinion, is suffering from mental disorder,

(b) has

□ during the immediately preceding 3-year period, on 2 or more occasions, or for a total of at least 30 days,

□ been a formal patient in a facility,

□ been in an approved hospital or been lawfully detained in a custodial institution where there is satisfactory evidence that while there the person would have met the criteria set out in section 2(a) and (b) of the *Mental Health Act* at the time or those times,

□ both been a formal patient in a facility and been in an approved hospital or lawfully detained in a custodial institution where there is satisfactory evidence that while there the person would have met the criteria set out in section 2(a) and (b) of the *Mental Health Act* at the time or those times,

or

□ within the immediately preceding 3-year period, been subject to a community treatment order,

or

□ in my opinion, while living in the community, exhibited a pattern of recurrent or repetitive behaviour that indicates the person is likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community,

(c) in my opinion, is likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community, and

(d) is able to comply with the treatment or care set out in this community treatment order.

2. The facts on which I formed the above opinions are as follows: ____.

3. I am satisfied that the treatment or care set out in Part III of this community treatment order exists in the community, is available to the person and will be provided to the person.

_______________________________ ___________________

(signature of physician) (date and time)

PART III
Treatment and Care Plan

Name of person: ____

Address (if known): ____

Phone (if known): ____

Date of Birth: _________ Personal Health Care Number: ________

The person who is subject to this community treatment order must

1. take the following medications (which may be adjusted where indicated by clinical need):

□ ____,

or

□ see attached list.

2. attend the following appointments with, accept telephone contact or home visits from or receive treatment or care from the following provider(s) or the provider's designate:

Provider Name: ___________ Contact Phone Number: _________

Profession/Role: _______________________________________

Description of Treatment or Care:

____

____

Location (if applicable): ______________________________________

Date/Time or Frequency (if applicable): _______________________

___________________________________ ______________

(signature of provider or person authorized by regional health authority) (date)

(Where treatment or care is provided by a regional health authority provider, a person authorized by the regional health authority must sign the Plan before it is issued. Where treatment or care is provided by a provider other than a regional health authority provider, that provider must sign the Plan before it is issued.)

Reporting obligations

In accordance with the *Community Treatment Order Regulation*, providers of treatment or care to the person who is subject to this community treatment order are required to report any failure by the person who is subject to the community treatment order to comply with the Treatment and Care Plan by

(a) completing Form 27, and

(b) submitting the completed Form 27 to the appropriate regional health authority within 24 hours of the time at which the provider became aware of the failure to comply.

PART IV

Person Responsible for Supervision of Community Treatment Order

Name of person: ____

Address (if known): ____

Phone (if known): ____

Date of Birth: __________ Personal Health Care Number: ________

The person responsible for the supervision of this community treatment order is

□ the issuing psychiatrist, or

□ (name of physician who is responsible for the supervision of community treatment order)

I, (print name of physician) of (business address), (phone number), am responsible for the supervision of this community treatment order.

____________________________ ________

(signature of issuing psychiatrist or supervising physician) (date)

PART V
Consent

Name of person: ____

Address (if known): ____

Phone (if known): ____

Date of Birth: __________ Personal Health Care Number: ________

□ **Consent by person who is subject to community treatment order**

I, ____, am the person subject to this community treatment order and I consent to the issuing of this community treatment order.

____

(signature)

____

(date)

□ **Consent by substitute decision-maker**

I, (print name of substitute decision-maker) am the person authorized under section 28(1) of the *Mental Health Act* to make treatment decisions on behalf of the person who is subject to this community treatment order and I hereby consent to the issuing of this community treatment order.

____

(signature of substitute decision-maker)

____

(date)

□ **No consent**

I, the issuing psychiatrist, have not obtained consent to the issuing of this community treatment order. I am of the opinion that the person who is subject to this community treatment order has, while living in the community, exhibited a history of not obtaining or continuing with treatment or care that is necessary to prevent the likelihood of harm to others, and the issuance of a community treatment order is reasonable in the circumstances and would be less restrictive than retaining the person as a formal patient.

____

(signature of issuing psychiatrist)

Form 20

Renewal of Community Treatment Order

Mental Health Act

Section 9.3

Name of person:____

Address (if known): ____

Phone (if known):____

Date of Birth: _________ Personal Health Care Number: ________

I, (print name of psychiatrist or designated physician) of (business address), (phone number), am:

□ a psychiatrist;

OR

□ acting as a designated physician pursuant to section 9.7 of the *Mental Health Act* and I confirm I have consulted with a psychiatrist prior to the renewal of this community treatment order,

and I am the issuing psychiatrist in relation to the renewal of this community treatment order.

I certify that I personally examined this person on _(date)_ at _(time)_ at _(place of examination)_ with the following results:

1. The person examined

(a) in my opinion, continues to suffer from mental disorder,

(b) is currently subject to a community treatment order,

(c) in my opinion, is likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community, and

(d) is able to comply with the treatment or care set out in this community treatment order.

2. The facts on which I formed the above opinions are as follows:

____.

3. I am satisfied that the treatment or care set out in Part III of this renewal exists in the community, is available to the person and will be provided to the person.

____________________________ _____________

(signature of issuing psychiatrist) (date and time)

PART II
Second Examination by Physician

Name of person: ____

Address (if known): ____

Phone (if known): ____

Date of Birth: __________ Personal Health Care Number: ________

I, (print name of physician) of (business address), (phone number), certify that I personally examined this person on (date) at (time) at (place of examination) with the following results:

1. The person examined

(a) in my opinion, continues to suffer from mental disorder,

(b) is currently subject to a community treatment order,

(c) in my opinion, is likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community, and

(d) is able to comply with the treatment or care set out in this community treatment order.

2. The facts on which I formed the above opinions are as follows:

____.

3. I am satisfied that the treatment or care set out in Part III of this renewal exists in the community, is available to the person and will be provided to the person.

_______________________________ _____________

(signature of physician) (date and time)

PART III
Treatment and Care Plan

Name of person: ____

Address (if known): ____

Phone (if known): ____

Date of Birth: __________ Personal Health Care Number: ________

The person who is subject to this community treatment order must

1. take the following medications (which may be adjusted where indicated by clinical need):

□ ____

OR

□ see attached list.

2. attend the following appointments with, accept telephone contact or home visits from or receive treatment or care from the following provider(s) or the provider's designate:

Provider Name: ___________ Contact Phone Number: _________

Profession/Role: ____

Description of Treatment or Care:

____

Location (if applicable): ______________________________________

Date/Time or Frequency (if applicable): ________________________

___________________________________ _________

(signature of provider or person (date)

authorized by regional health authority)

(Where treatment or care is provided by a regional health authority provider, a person authorized by the regional health authority must sign the Plan before it is issued. Where treatment or care is provided by a provider other than a regional health authority provider, that provider must sign the Plan before it is issued.)

Reporting obligations

In accordance with the *Community Treatment Order Regulation*, providers of treatment or care to the person who is subject to this community treatment order are required to report any failure by the person who is subject to the community treatment order to comply with the Treatment and Care Plan by

(a) completing Form 27, and

(b) submitting the completed Form 27 to the appropriate regional health authority within 24 hours of the time at which the provider became aware of the failure to comply.

PART IV

Person Responsible for Supervision of
Community Treatment Order

Name of person: ____

Address (if known): ____

Phone (if known): ____

Date of Birth: __________ Personal Health Care Number: ________

The person responsible for the supervision of this community treatment order is

□ the issuing psychiatrist, or

□ (name of physician who is responsible for the supervision of community treatment order)

I, (print name of physician) of (business address), (phone number), am responsible for the supervision of this community treatment order.

____________________________ ___________

(signature of issuing psychiatrist or supervising physician) (date)

PART V

Consent

Name of person: ____

Address (if known): ____

Phone (if known): ____

Date of Birth: __________ Personal Health Care Number: ________

□ **Consent by person who is subject to community treatment order**

I, ____, am the person subject to this community treatment order and I consent to the renewal of this community treatment order.

____

(signature) (date)

□ **Consent by substitute decision-maker**

I, (print name of substitute decision-maker) , am the person authorized under section 28(1) of the *Mental Health Act* to make treatment decisions on behalf of the person who is subject to this community treatment order and I hereby consent to the renewal of this community treatment order.

____

(signature of substitute decision-maker)

____

(date)

□ **No consent**

I, the issuing psychiatrist, have not obtained consent to the renewal of this community treatment order. I am of the opinion that the person who is subject to this community treatment order has, while living in the community, exhibited a history of not obtaining or continuing with treatment or care that is necessary to prevent the likelihood of harm to others, and the renewal of the community treatment order is reasonable in the circumstances and would be less restrictive than retaining the person as a formal patient.

____________________________ _________

(signature of issuing psychiatrist) (date)

Form 21

Community Treatment Order

Amendments to Community Treatment Order

Mental Health Act

Section 9.4

Name of person: ____

Address (if known): ____

Phone (if known): ____

Date of birth: ________ Personal Health Care Number _______

I, (print name of psychiatrist or designated physician) of (business address), (phone number), am

□ a psychiatrist;

or

□ acting as a designated physician pursuant to section 9.7 of the *Mental Health Act* and I confirm I have consulted with a psychiatrist prior to the amendment of this community treatment order,

and I am the issuing psychiatrist of this amended community treatment order.

I amend the community treatment order for this person by

□ amending the name of the person responsible for supervision of the community treatment order as follows:

Effective on the date below I, (print name of physician) of (business address), (phone number), am responsible for the supervision of this community treatment order.

______________________________ ______________

(signature of supervising physician) (effective date)

□ amending the treatment and care plan as follows:

The person who is subject to this community treatment order must

1. take the following medications (which may be adjusted according to clinical need):

□ ____

OR

□ see attached list.

2. attend the following appointments with, accept telephone contact or home visits from, or receive treatment or care from the following provider(s) or the provider's designate:

Provider Name: ______ Contact Phone Number: ______

Profession/Role: ________________________________

Description of Treatment or Care:

_

Location (if applicable): ______________________________

Date/Time or Frequency (if applicable): _______________

____

(signature of provider or person (date)

authorized by regional health authority)

(Where treatment or care is provided by a regional health authority provider, a person authorized by the regional health authority must sign the Plan before it is issued. Where treatment or care is provided by a provider other than a regional health authority provider, that provider must sign the Plan before it is issued.)

3. the person who is subject to the community treatment order is no longer required to .

I have explained the above amendment(s) to

□ the person who is subject to this community treatment order,

or

□ the substitute decision-maker for the person who is subject to this community treatment order.

______________________ _________

(signature of psychiatrist or designated physician) (date)

Reporting obligations

In accordance with the *Community Treatment Order Regulation*, providers of treatment or care to the person who is subject to this community treatment order are required to report any failure by the person who is subject to the community treatment order to comply with the Treatment and Care Plan by

(a) completing Form 27, and

(b) submitting the completed Form 27 to the appropriate regional health authority within 24 hours of the time at which the provider became aware of the failure to comply.

Form 22

Community Treatment Order

Cancellation or Expiry

Mental Health Act

Section 9.5

Name of person: ____

Address (if known): ____

Phone (if known): ____

Date of Birth: _________ Personal Health Care Number: ________

□ Cancellation of community treatment order

I, (name of psychiatrist or designated physician) of (business address), (phone number), am:

□ a psychiatrist,

or

□ acting as a designated physician pursuant to section 9.7 of the *Mental Health Act*, and I confirm I have consulted with a psychiatrist prior to the cancellation of this community treatment order,

AND

I cancel this person's community treatment order because this person no longer meets the criteria specified in section 9.1(1)(b) to (d) of the *Mental Health Act*.

□ Expiry of community treatment order

This person's community treatment order has expired.

Continued treatment recommendation (if applicable):

I recommend continued treatment and care as follows:

____

(signature of physician) (date and time)

Notice:

You are no longer subject to a community treatment order effective on the date and time written above. However, this form may contain information about treatment and care that your health care provider is recommending you continue to receive.

Form 23

Community Treatment Order

Apprehension Order

Mental Health Act

Section 9.6

To all or any peace officers in Alberta:

Name of person: ____

Address (if known): ____

Phone (if known): ____

Date of birth: ____

To all or any peace officers in Alberta:

I, (name of psychiatrist or designated physician) of (business address), (phone number), am:

□ a psychiatrist;

OR

□ acting as a designated physician pursuant to section 9.7 of the *Mental Health Act*, and I confirm I have consulted with a psychiatrist prior to the issuance of this apprehension order,

and I have reasonable grounds to believe that (name of person who is subject to community treatment order) has failed to comply with his/her community treatment order. The reasons for my belief are as follows:

____.

I am satisfied that efforts that are reasonable in the circumstances have been made to

(a) inform the person who is named in this order that the person has failed to comply with the person's community treatment order,

(b) inform the person of the possibility that I may issue an order for apprehension and assessment of the person if the person continues to fail to comply with the community treatment order, and of the possible consequences of that assessment, and

(c) provide reasonable assistance to the person to comply with the community treatment order,

and that the person continues to fail to comply with his/her community treatment order.

This authorizes you to

(a) apprehend the person who is named in this order and to convey the person to (name of facility) for an examination,

(b) take reasonable measures, including the entering of premises and the use of physical restraint, to apprehend the person who is named in this order and to take the person into custody for the purpose of conveying the person to the facility, and

(c) while the person is being conveyed to the facility, to care for, observe, detain and control the person.

____ ____________________

(signature of psychiatrist or designated physician) (date and time)

This apprehension order expires 30 days after the date of issue.

Form 24

Community Treatment Order

Examination on Apprehension

Mental Health Act

Section 9.6

Name of person: ____

Address (if known): ____

Phone (if known): ____

Date of birth: ______ Personal Health Care Number: ___________

I, (print name of psychiatrist, physician or designated physician) of (business address), (phone number), am:

□ a psychiatrist,

OR

□ acting as a designated physician pursuant to section 9.7 of the *Mental Health Act*, and I confirm I have consulted with a psychiatrist respecting this community treatment order,

OR

□ a physician,

and I certify that I personally examined this person on (date) at (time) at (place of examination) and have determined that

□ the person's community treatment order should be cancelled and the person should be released without being subject to a community treatment order (*also complete Form 22*),

OR

□ the person's community order should be continued and amendments to it are not necessary,

OR

□ the person's community treatment order should be continued but amendments to it are necessary (*also complete Form 21*)

OR

□ the person's community treatment order should be cancelled and admission certificates issued in accordance with sections 2 and 6 of the *Mental Health Act* (*also complete Form 1*).

______________________________ _____________

(signature of psychiatrist, physician (date and time)

or designated physician)

Form 25

Community Treatment Order

Designation of Physician

Mental Health Act

Section 9.7

I, (name of person authorized by board or regional health authority to make this designation) of (name of regional health authority), pursuant to section 9.7 of the *Mental Health Act*, designate the following physician to act in the place of a psychiatrist for the purpose of issuing, renewing, amending or cancelling a community treatment order or issuing an apprehension order when no psychiatrist is available to carry out those functions:

(name of designated physician) ________________________________

____

(signature of person authorized by
board or regional health authority)

____

(date)

I acknowledge this designation and the requirement to consult with a psychiatrist prior to exercising this authority.

____

(signature of designated physician)

Form 26

Community Treatment Order

Written Statement

Mental Health Act

Section 14(1.1)(a)

TO:

(Name of person) ____

Address (if known): ____

Phone (if known): ____

Date of Birth: _______ Personal Health Care Number: ___________

□ You are now subject to a community treatment order *(attach Form 19)* pursuant to section 9.1 of the *Mental Health Act*. The reason for issuance of the community treatment order is:
____.

□ The attached community treatment order has been renewed *(attach Form 20)* pursuant to section 9.3 of the *Mental Health Act*. The reason for the renewal of the community treatment order is:
____.

□ Your community treatment order has been amended *(attach Form 21)* pursuant to section 9.4 of the *Mental Health Act*. The reason for the amendment of the community treatment order is:
____

______________________________ ______________
(signature of issuing psychiatrist) (date)

____

(phone number)

Important Information:

You have a right to apply to a review panel for cancellation of this community treatment order.

You may apply for cancellation of this community treatment order by filing an application with the chair of your review panel. An application may be filed by you, your agent, your guardian or another person on your behalf.

____
Name of chair of appropriate review panel

____
Address of appropriate review panel

Form 27

Community Treatment Order

Non-compliance Report

Mental Health Act

Section 9.1(2)(f)

Name of person:____

Address (if known): ____

Phone (if known): ____

Date of Birth: _______ Personal Health Care Number: ___________

The person who is subject to this community treatment order has failed to comply with the following requirements of the treatment or care plan on the dates specified:

Date: _____________ Treatment or Care: _____________________

Date: _____________ Treatment or Care: _____________________

_________________________________ __________

(signature of treatment or care provider) (date)

____

(print name of treatment or care provider)

____
(phone number)

Reporting obligations

In accordance with the *Community Treatment Order Regulation*, providers of treatment or care to the person who is subject to this community treatment order are required to report any failure by the person who is subject to the community treatment order to comply with the Treatment and Care Plan by

(a) completing Form 27, and

(b) submitting the completed Form 27 to the appropriate regional health authority within 24 hours of the time at which the provider became aware of the failure to comply.