

Fitness to Stand Trial and Dementia: Considering Changes to Assessment to Meet Demographic Need

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ABSTRACT

Fitness to stand trial assessments conducted by forensic mental health specialists occur on a regular basis. The same standard has traditionally been used for close to thirty years. This paper examines an interesting case of a fitness assessment for a lawyer who was charged with a crime, which brings light to some facets of fitness assessments. Historically, it has been less common for individuals to be found unfit to stand trial related to Major Neurocognitive Disorder (Dementia) as compared to Psychotic Disorders. This lawyer's medical conditions are discussed as well as their implications for an individual's ability to be fit to stand trial. The criteria used in different legal decisions have varied in different cases. The variation has appeared to be related, at least in part, to the different diagnoses that may be impacting an individual at the time of their involvement with the legal system. We consider here the different interpretations of criteria related to fitness to stand trial, including the ability to communicate with counsel. Potential changes to fitness assessments will also be examined, including the idea of using standardized tools. The importance of these issues is made evident by the fact that Major Neurocognitive Disorder is becoming more prevalent, and these issues will likely be apparent more frequently in the future. A multi-disciplinary team approach may be an ideal way to examine the future direction of fitness assessments, including the involvement of allied health professionals.

I. INTRODUCTION

Fitness to stand trial assessments conducted by forensic mental health specialists occur on a regular basis. The same standard has traditionally been used for close to thirty years. This paper examines an interesting case of a fitness assessment for a lawyer who was charged with a crime, which brings light to some facets of fitness assessments. We have not used the name of this person within the article and instead refer to him as Mr. L.

Historically, it has been less common for individuals to be found unfit to stand trial related to a Major Neurocognitive Disorder (Dementia) as compared to Psychotic Disorders. This lawyer's medical conditions are discussed, as well as their implications for an individual's ability to be fit to stand trial. The importance of these issues is made evident by the fact that with gains in longevity, those with Major Neurocognitive Disorder are living longer and increasingly interacting with the law. As individuals diagnosed with Dementia typically have different challenges relating to fitness to stand trial, it is imperative that the standard for fitness adequately addresses the symptoms of Dementia.

The criteria used to assess fitness to stand trial have varied in different cases. The variation has appeared to be related, at least in part, to the different diagnoses that may be impacting an individual at the time of their involvement with the legal system. We consider here the different interpretations of criteria related to fitness to stand trial, including the ability to communicate with counsel. Considering the impact and potential consequences of the findings derived from fitness assessments, it is vital for the best standard to be utilized in every assessment completed. Similarly, the same interpretation of criteria is necessary to ensure fair treatment for all defendants in the justice system.

Potential changes to fitness assessments will also be examined in this paper, including the idea of using standardized tools for evaluation. Results in research evaluating the use of standardized tools in other areas are supportive of this option. In addition, a multi-disciplinary team approach may be an ideal way to conduct fitness assessments, including the involvement of allied health professionals. One potential role for allied health professionals could be to aid in educating individuals regarding fitness. Ultimately, consideration of the need to change the

assessment process may help to serve the courts more effectively, as well as defendants that have been diagnosed with a mental illness.

II. BACKGROUND

The history of considering the mental state of defendants in legal systems dates back thousands of years.¹ Much of the history around fitness to stand trial was explained in a paper by Brown (2019). The specifics of laws have varied, but the overarching theme has remained the same. It is not fair for those standing trial to be held accountable for their actions if they do not understand what is happening in court, or if they are suffering from delusions related to their matter. In Ancient Greece, Aristotle wrote about special consideration being necessary for someone being deemed not culpable for actions related to madness.² Prins wrote about how the views of those living in Ancient Rome were evident by the phrase *satis furore ipso puniter*, roughly translating to the notion that an individual was sufficiently punished by their mental disorder.³ Walker described the progression of the concept of fitness to stand trial being observed over a thousand years ago in England.⁴ At that time, persons unable to understand the nature of an offence were deemed to lack the intent necessary for guilt (*mens rea*) and were released to their families as opposed to receiving punishment. Later, trial by jury and eventually King's courts were instituted. The accused were confronted before a jury and required to plead "guilty" or "not guilty." Grubin explained that anyone not entering a plea was described as "standing mute."⁵ In such a scenario, a jury had to determine whether the accused was "mute of malice" (malingering) or "mute by the visitation of God" (deemed unable to plead and therefore excused from the proceedings). Hale and Emlyn explained that those thought to be malingering were starved and had heavy stones

¹ Penelope Brown, "Unfitness to plead in England and Wales: Historical development and contemporary dilemmas" (2019) 59:3 *Med Sci & L* 187 at 188.

² *Ibid.*

³ *Ibid.*, citing Herschel Prins, *Offenders, Deviants or Patients? An Introduction to Clinical Criminology*, 5th ed (London: Routledge, 2015).

⁴ *Ibid.*, citing Nigel Walker, *Crime and insanity in England*, vol 1 (Edinburgh: Edinburgh University Press, 1968).

⁵ *Ibid.*, citing Don Grubin, *Fitness to plead in England and Wales* (East Sussex, UK: Psychology Press, 1996).

placed on their chest until they either answered or perished, known as “*peine forte et dure*.”⁶

Crotty wrote about the history of mental disorders and the law.⁷ There was generally a poor understanding of mental illness until the 20th century, and many symptoms were explained by demons or religious experiences. Archaic terminology was used to describe diseases of the mind. Mental illness acquired later in life was explained by the term “insane.” Someone thought to have a fluctuating presentation, appearing sane at times yet seeming to suffer from a mental illness at others, was deemed a “lunatic.”

Brown (2019) further outlines how in the 17th century, the scholar Hale suggested a model much closer to our current legal framework in Canada.⁸ Hale focused on a more nuanced view of mental illness and did not equate the presence of a mental disorder with automatically being unable to plead guilty or not guilty. It was thought by Hale that the conditions causing a mental disturbance limit fitness to stand trial could change over time and that the ability to plead was a temporary determination and subject to review.

The first laws regarding insanity in the *Criminal Code of Canada* were instituted in 1892.⁹ These laws were based on an English case involving a man, Daniel M’Naughton, in 1843.¹⁰ In the context of experiencing paranoid delusions, M’Naughton killed a man he thought was the prime minister. The Code indicated that an individual found unfit to stand trial was to be detained “at the pleasure of the Lieutenant Governor.”¹¹ Amendments to the code in 1968 allowed an advisory board to be formed, at the discretion of the Lieutenant Governor, to review the cases of those in custody. Options available for those in custody included remaining in custody, absolute discharge, and discharge with conditions.

Even within Canada, the criteria for fitness to stand trial has been defined in different ways. There is a presumption of fitness under s.

⁶ *Ibid*, citing Matthew Hale & Sollom Emlyn, *Historia Placitorum Coronae: The History of the Pleas of the Crown* (Philadelphia, PA: Robert H Small, 1847).

⁷ *Ibid*, citing Homer D Crotty, “History of Insanity as a Defence to Crime in English Criminal Law” (1923-1924) 12:2 Calif L Rev 105.

⁸ *Ibid* at 188-89.

⁹ Graham D Glancy & John McD Bradford, “Canadian landmark case: *Regina v. Swain*: translating M’Naughton into Twentieth Century Canadian” (1999) 27:2 J Am Acad Psychiatry L 301 at 301.

¹⁰ *Ibid*.

¹¹ *Ibid* at 302.

672.22 of the *Criminal Code of Canada*,¹² and the burden of proof is on the party that raises the issue.¹³ S. 2 of the *Criminal Code of Canada* defines being unfit to stand trial as being unable on account of a 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.¹⁴

Each of the criteria for fitness is typically evaluated by asking an individual a series of questions to elicit their understanding of each concept. The ability to understand the nature or object of proceedings could be assessed by asking an accused person about their charges, the key individuals that work in a courtroom, the roles of those individuals, and the purpose of the court proceedings. It is important for the individual to realize that there are two opposing sides (defence and prosecution), as well as a deciding party (the judge).

Understanding the potential consequences of court proceedings can be measured by first asking an individual if they are aware of the different pleas available to them in court. The accused person is also typically asked about the likely outcomes if they were to be found either guilty or not guilty. Important outcomes that are reviewed with an individual usually include the possibility of a jail sentence, time served, probation, a fine, or community service. Another question asked would be about the meaning of taking an oath in court and the potential consequences if they were found to be lying under oath.

The ability to communicate with counsel can be measured in different ways. It is unusual for mental health professionals to be present to witness interactions between accused persons and their legal counsel. Possible proxies used to determine someone's ability to communicate with their lawyer include asking if the accused knows who their lawyer is, how to contact them, if they have spoken with them, or how their experience has been with their lawyer so far. Another question asked around this topic could be what someone's plan is for dealing with their charges, and

¹² RSC 1985, c C-46, s 672.22.

¹³ *Ibid*, s 672.23(2).

¹⁴ *Ibid*, s 2.

consequently, if they know who would be able to assist them in this task. More detailed questions about an individual's understanding of more complicated concepts are often not directly assessed. These concepts include ideas such as the burden of proof or reasonable doubt.¹⁵

In addition to determining whether an accused person passes the threshold of being fit to stand trial based on the three criteria above, the assessor must consider the mental health status of the accused and how any symptoms present affects the current functioning of the individual. The evaluator must consider the defendant's physical and mental health status and appreciate how any disease shown by the accused may be causing mental health symptoms. After assessing the individual, the duly qualified medical practitioner will provide a fitness assessment report indicating whether they believe someone is fit or unfit to stand trial. Other allied health professionals may be involved in parts of the assessment process. The assessment will be forwarded to the court, defence, and prosecution. Ultimately, a judge renders a finding of unfitness, but the role of the medical team as amicus to the court is to help provide medical information to assist in the court's understanding of the accused's mental functioning.

Fitness assessments often occur during a one-time assessment. In Manitoba, the majority of assessments are provided on an outpatient basis by the Adult Forensic Mental Health Program. They typically occur in correctional facilities or the Law Courts building if an individual is in custody or during an outpatient appointment at Health Sciences Centre in Winnipeg. In some cases, individuals will be admitted to PX3, the Inpatient Forensic Unit at Health Sciences Centre in Winnipeg, for the purposes of completing a fitness assessment.¹⁶ If a person is found unfit to stand trial, and it is thought that their state of unfitness is related to a mental disorder, a treatment order can be made. Most mental disorders can be treated non-invasively in a short timeframe. In the case of a treatment order being provided by the court, the individual can be provided medical care as an inpatient, and their mental state can be optimized. In Manitoba, persons under a treatment order are admitted to PX3. The order has a number of stipulations, including a 60-day limit for

¹⁵ Hy Bloom & Richard D Schneider, *Mental Disorder and the Law: A Primer for Legal and Mental Health Professionals*, 2nd ed (Toronto: Irwin Law, 2017) at 89-91.

¹⁶ Hygiea Casiano & Sabrina Demetriooff "Forensic Mental Health Assessments: Optimizing Input to the Courts" (2020) 43:3 Man LJ 249 at 252.

treatment and ongoing re-assessment of fitness. The least intrusive and least restrictive treatment must be administered, meaning that psychotropic medication is often used, while psychosurgery and Electroconvulsive Therapy (ECT) are avoided.¹⁷ In order for a treatment order to be made, the benefits of treatment must outweigh the risks. Accused persons found unfit following a treatment order, or thought unable to be rendered fit, are diverted to the Criminal Code Review Board (CCRB). If someone is permanently unfit, they can have a stay of proceedings. Such a determination would likely happen after the completion of a risk assessment, at the discretion of a judge. Risk assessment tools can be divided into short-term and longer-term tools used to aid in predicting violence.¹⁸

The current standard for fitness to stand trial is based on *R v Taylor* (1992), a case involving a lawyer diagnosed with Paranoid Schizophrenia who suffered from delusions regarding the legal community.¹⁹ Schizophrenia describes a chronic mental illness where individuals experience symptoms of psychosis. Psychosis is a word used to describe delusions (fixed, false beliefs), hallucinations (usually auditory but can also be visual or tactile in nature), disorganized thinking, grossly disorganized motor behavior, and negative symptoms (such as avolition, a decrease in expressing emotions, and a decrease in speech). The term “Paranoid Schizophrenia” is terminology used in a previous version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The term Schizophrenia is still used, but the diagnosis no longer requires further specification by subtypes such as paranoid.

In *R v Taylor*, Taylor had been suspended from the practice of law.²⁰ He had stabbed the counsel for the Law Society and was arrested for aggravated assault. He experienced a number of delusions about hospitals, the legal system, and even witnesses from his case. Taylor believed that there was a conspiracy against him. He had fired a number of lawyers appointed as his counsel. After a psychiatric assessment was ordered, he was found unfit to stand trial. One issue raised was that Taylor might

¹⁷ Bloom & Schneider, *supra* note 15 at 106–08.

¹⁸ Taanvi Ramesh et al, “Use of risk assessment instruments to predict violence in forensic psychiatric hospitals: a systematic review and meta-analysis” (2018) 52 *Eur Psychiatry* 47 at 47–49.

¹⁹ 1992 CanLII 7412 at 9, 11 OR (3d) 323 (ON CA) [*Taylor*].

²⁰ *Ibid* at 16–17.

misinterpret evidence given by witnesses during the proceedings. Other concerns included that his paranoia would interfere with his ability to instruct counsel in a manner that would be in his best interests, or even to co-operate with counsel at all.

Taylor appealed the finding of unfitness, and the Ontario Court of Appeals found that the “limited cognitive capacity” test should have been used to assess for fitness to stand trial rather than the “analytic capacity” test.²¹ The “analytic capacity” test requires an individual to make rational decisions that are beneficial to them and in their best interests. In the “limited cognitive capacity” test, an individual would be found unfit to stand trial related to delusions only if the delusions distorted their “rudimentary understanding of the judicial process.”²² This determination of the test for fitness to stand trial has been adopted in Manitoba and elsewhere.

The case discussed here involves a lawyer that was found unfit to stand trial for a different reason, specifically Dementia. The accused was diagnosed with Parkinson’s Disease and later Major Neurocognitive Disorder, commonly referred to as Dementia. In our discussion, we will use the current terminology of Major Neurocognitive Disorder when possible. We may use the previous nomenclature of Dementia if it was used in the information we are referencing. Mr. L was found unfit to stand trial related to a number of deficits in the required criteria. One key factor related to him being found unfit to stand trial was his ability to communicate with counsel. The decision regarding his fitness discussed varying interpretations of this term in legal cases over time. In addition to examining different standards for the ability to communicate with counsel, this case has other interesting features worth discussing. One such reason is the disease of the mind that rendered him being found unfit. From an epidemiologic perspective, the most common traits of individuals referred for fitness assessments include being male, single, unemployed, living alone, and having a psychiatric history.²³ Bloom and Schneider list the most common mental disorders encountered in this context as being Psychotic Disorders (e.g. Schizophrenia), Neurocognitive Disorders (e.g., Major Neurocognitive Disorder), and Mood Disorders

²¹ *Ibid* at 27–28.

²² *Ibid* at 21.

²³ Bloom & Schneider, *supra* note 15 at 94.

(e.g., Mania in Bipolar Disorder or Depression with Psychosis).²⁴ In our team's experience, seeing individuals diagnosed with Psychotic Disorders for fitness assessments is much more common than individuals diagnosed with Major Neurocognitive Disorders. Even though the bar for fitness is meant to be a low one, the symptoms of certain diagnoses (such as Major Depressive Disorder) may contribute to individuals who are unfit for trial being missed.²⁵ This article will examine the specifics of Mr. L's case, as well as the varying interpretations of the criteria for fitness to stand trial over time. Finally, potential future directions in fitness assessments will be examined.

III. CASE REVIEW

Our program is comprised of mental health specialists. We are responsible for completing court-ordered assessments. Our evaluations typically focus on two issues - whether someone is fit to stand trial and criminally responsible for their charges. At times, we are asked to address both issues. We first came into contact with Mr. L for the purpose of completing a fitness assessment.

Pertinent events surrounding the case date back to 2013. At that time, Mr. L was a 65-year-old married Caucasian man who had previously been working as a lawyer in estate law. In December of that year, he voluntarily withdrew from the practice of law, pending an investigation into the misappropriation of trust funds for which he had acted as executor. In 2015, a discipline hearing was held, and he was disbarred. The Law Society of Manitoba reported this matter to the Winnipeg Police Service in 2016. The Winnipeg Police Service was also provided with a joint statement of agreed-upon facts from The Law Society of Manitoba and Mr. L's counsel, recommending that Mr. L be disbarred and stricken from the list of barristers and solicitors of The Law Society of Manitoba. Mr. L was interviewed by police in June 2017 and November 2018. He reported that he was unable to recollect the events he was questioned about on both occasions. He was later charged with theft over \$5000, fraud over \$5000, false pretences, and criminal breach of trust. Following the charges, Mr. L's lawyer hired a forensic psychiatrist working in private practice to complete an assessment regarding the potential effects of a jail sentence

²⁴ *Ibid.*

²⁵ *Ibid* at 98-99.

given Mr. L's physical and mental health. During the interview, it became apparent that Mr. L did not fulfill all criteria required for being fit to stand trial. These concerns were raised by Mr. L's defence counsel, and a fitness assessment was ordered by the court.

Our team assessed Mr. L in November 2019. At that time, he was 71 years old. The information made available to us included a letter to the Chief of Police, an investigative brief, an arrest report, an information sheet completed by a constable, a neuropsychological assessment, a letter from Mr. L's psychologist to his family physician, a letter from Mr. L's family physician to his lawyer, a letter from Mr. L's neurologist to his lawyer (dated June 2019), and a private assessment completed by a forensic psychiatrist.

The letter from the neurologist stated that Mr. L had been diagnosed with Parkinson's Disease in 2015 after presenting with a tremor. Other neurological symptoms included urinary urgency, occasional urinary incontinence, constipation, hyposmia (impaired ability to smell), and daytime sleepiness.

A neuropsychological assessment had been conducted. This assessment uses various tools to evaluate cognitive functioning.²⁶ These tools are performance-based and compare an individual's score to reference groups with similar demographics.²⁷ Mr. L had a neurological assessment completed in May 2018. He displayed difficulties with working memory and delayed recall recognition. He scored 19/30 on a Montreal Cognitive Assessment, a decline from 23/30 in July 2017 as seen with his neurologist. It was noted that Mr. L's life partner described a gradual decline in his memory with a maintained ability to administer his own medications. Medical chart notes indicated that his assessment profile was consistent with Mild Cognitive Impairment associated with Parkinson's Disease. The report mentioned that the pattern of cognitive functioning was not suggestive of Alzheimer's Disease. This could be explained by the fact that there had only been minor changes in cognition and his level of functioning.

In 2016, Mr. L had been referred for counselling with a psychologist related to a diagnosis of Major Depressive Disorder. His depressive symptoms appeared to be related to his disbarment and legal situation. At

²⁶ Philip D Harvey, "Clinical applications of neuropsychological assessment" (2012) 14:1 *Dialogues Clin Neurosci* 91 at 91-92.

²⁷ *Ibid.*

an appointment with the psychologist in January 2019, Mr. L had been unable to recall his disbarment or the details around his charges. A letter to his family physician from his psychologist, written shortly after that appointment, explained that there had been a loss of episodic, autobiographical, and working memory. A loss of memory with respect to more emotionally neutral information was also seen. It was noted that Mr. L was functioning at the level of Major Neurocognitive Disorder (NCD) due to Parkinson's Disease and possibly vascular causes. Mr. L's cognitive assessments remained within the range for Mild Neurocognitive Impairment, but his psychologist based the diagnosis of a Major Neurocognitive Disorder on the significant change seen from previous functioning and the "collapse" of his memory.

The letter from his family physician written in June 2019 described Mr. L's complicated medical history. His psychiatric history involved diagnoses of Depression, Anxiety, and Cognitive Impairment. Over time, the cognitive impairment had gradually worsened. His medical history included diagnoses of Parkinson's Disease (PD), Coronary Artery Disease (CAD), Arrhythmia, Complete Heart Block (CHB), Cerebrovascular Accident (also known as a CVA or stroke), Ankylosing Spondylitis (AS), Guillain-Barre Syndrome (GBS) with residual neuropathic pain, Diabetes Mellitus Type 2 (DMII) with small vessel disease (Diabetic Retinopathy and Foot Ulcer), Ulcerative Colitis (UC), Perianal Abscess, Angina, and Hypertension. We will discuss each of Mr. L's medical conditions but will first review his answers related to fitness in order to gain context.

The private forensic psychiatry assessment was completed in the fall of 2019. Mr. L was aware of the roles of the defence lawyer and the judge but had difficulty explaining the role of the crown. He was not able to process the fact that he had been charged with an offence for more than a few minutes during the assessment. Although Mr. L had retained some working memory, he was not able to retain information regarding the circumstances that led to his charges. Regarding communication with counsel, the report noted that Mr. L could communicate with others but was limited by what he was able to process. In other words, he would not be able to instruct his counsel regarding information presented at trial if he could not retain or process it. The report explained the medical illnesses affecting Mr. L's cognitive functioning, including Parkinson's Disease and Atherosclerosis. Atherosclerosis was defined as a complication of Diabetes Mellitus Type II that resulted in Cardiovascular Accident and

Cardiac Disease. The presence of decreased blood flow through the brain was noted, along with a subsequent likely diagnosis of Vascular Dementia. It was explained that his severe memory problems were likely related to Vascular Dementia and Parkinson's Disease, and consistent with a mental disorder. The decline in memory present based on interview and collateral information was deemed to be in keeping with Dementia. The chronic, irreversible, degenerative nature of the condition was underlined, along with the implication that it would not be possible for Mr. L to return to a state of fitness.

At the time of our assessment, Mr. L was noted to be slow to respond to questions. He was unable to recite his charges after they were explained numerous times. He demonstrated an awareness of the key professionals in the courtroom and their roles. He was able to explain the concept of taking an oath, as well as the potential consequence of a jail sentence. He knew both pleas available and explained that an individual would be able to return home if they were found not guilty. With respect to potential outcomes of being found guilty, he was only able to list a jail sentence. When asked questions to assess his ability to communicate with counsel, Mr. L stated that he had friends that were lawyers. He described his defence counsel as a personal friend and was not aware that he was being represented by this person.

Mr. L brought a list of medications to the appointment. His exact medication regimen was unclear due to conflicting information from different sources. Mr. L reported taking Bisoprolol 7.5 mg PO daily, Levocarb 25/100mg 9 tablets/day, Amlodipine 10 mg PO daily, Metformin 500 mg PO twice daily, Gliclazide MR 30 mg 4 tablets/day, Tamsulosin CR 0.4mg PO daily, Gabapentin 200 mg 8 tablets per day, and Hydromorphone 2 mg tablets as needed. The mechanisms of action for these medications, as well as their potential impact on cognition, are discussed below.

Cognitive testing was completed in our assessment by a forensic psychologist working within our program. It was determined that Mr. L's immediate memory index was in the extremely low range, at approximately the 1st percentile. His language index was in the 16th percentile, far below what would have been expected of a highly educated individual who had worked as a lawyer. A Repeatable Battery for the Assessment of

Neuropsychological Status (RBANS) test was completed with Mr. L.²⁸ It can be used to evaluate for abnormal cognitive decline in older adults.²⁹ Mr. L displayed deficits in delayed recall. He performed better on verbal memory recognition tasks and was able to retain some information presented in a verbal format.

A Test of Memory Malingering (TOMM) was also administered. It is a memory test used to aid in separating feigning or the exaggeration of memory impairment from real impairment. It involves learning trials and the retention of 50 items. Mr. L's Test of Memory Malingering showed no evidence of feigning, as adequate effort was put forth during that test. A determination of adequate performance on the Test of Memory Malingering is not proof that an individual is not malingering. It is possible for an individual to feign or malingering on the interview but to score adequately on the Test of Memory Malingering. A more sophisticated patient could conceivably identify the purpose of the test, as the administration would involve switching from an initial narrative conversation to a test of memory.

The medical expert involved in evaluating an individual before the courts is tasked with the process of considering each possible medical condition present and its impact on mental functioning. Our team determined that although Mr. L was able to retain some information in verbal format, there had been a significant decline from his premorbid functioning and the neuropsychological assessment from 2018. In order to gain a better understanding of how Mr. L's medical history contributed to his finding of being unfit to stand trial, we will further discuss his medical conditions.

The main diagnosis contributing to Mr. L's state of being unfit to stand trial was Major Neurocognitive Disorder, with several other medical conditions acting as contributing factors. Hypoxia (low oxygen), metabolic dysfunction (problems with the production of energy), and cerebrovascular hemodynamics (blood flow to the brain) are three categories of mechanisms contributing to the development of Major Neurocognitive

²⁸ Christopher Randolph et al, "The Repeatable Battery for the Assessment of Neuropsychological Status (RBANS): Preliminary Clinical Validity" (1998) 20:3 J Clin Exp Neuropsychol 310 at 312-13.

²⁹ *Ibid.*

Disorder.³⁰ Risk factors present for Mr. L in the form of hypoxia included ischemia and decreased cerebral blood flow related to the Cerebrovascular Accident and Complete Heart Block. Under the category of metabolic dysfunction, Mr. L had been diagnosed with Diabetes Mellitus Type II (the body has an impaired response to insulin). A significant risk factor present under the classification of cerebrovascular hemodynamics was Hypertension (pressure from the blood against blood vessel walls is too high).

Major Neurocognitive Disorder is defined as “a syndrome of insidious onset and progressive decline of cognition and functional capacity from a premorbid level, that is not attributable to motor or autonomic symptoms.”³¹ A diagnosis of Major Neurocognitive Disorder requires the presence of a significant cognitive decline in one or more cognitive domains.³² The six cognitive domains are complex attention, executive functioning, language, learning and memory, social cognition, and perceptual-motor/visuospatial function.³³ Our assessment of Mr. L suggested impairments in a number of these domains. The deficits noted in Mr. L that were especially relevant to being found unfit to stand trial were declines in complex attention (difficulty retaining information), as well as learning and memory (especially impacting memory of more recent events).³⁴

Although the various types of Major Neurocognitive Disorder can all have significant impacts on cognition, it is important to remember that an individual with Major Neurocognitive Disorder can still be found fit to stand trial. Dependent on the state of Major Neurocognitive Disorder, a person may retain some ability to learn through repetition, though in the long term those items learned tend to be unlearned. The information that is newest tends to be lost first as someone struggles with memory loss

³⁰ Limor Raz, Janice Knoefel & Kiran Bhaskar, “The Neuropathology and Cerebrovascular Mechanisms of Dementia” (2016) 36:1 J Cereb Blood Flow Metab 172 at 178.

³¹ Joana Meireles & João Massano, “Cognitive Impairment and Dementia in Parkinson's Disease: Clinical Features, Diagnosis, and Management” (2012) 3:88 Front Neurol 1 at 5.

³² American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed (Arlington, VA: American Psychiatric Association, 2013).

³³ *Ibid* (Section II: Neurocognitive Disorders: Major Neurocognitive Disorder).

³⁴ Julie Hugo & Mary Ganguli, “Dementia and Cognitive Impairment: Epidemiology, Diagnosis, and Treatment” (2014) 30:3 Clin Geriatr Med 421 at 429.

attributed to Major Neurocognitive Disorder. A case-by-case evaluation of the specific deficits present in an individual is required in order to determine the overall impact of a disease on a person. Psychiatrists, with their advanced training in medical disease and medication treatment, can provide a unique perspective to help the courts disentangle the roles that each medical and mental health condition plays in the presentation of accused persons.

Dementia is an umbrella term encompassing all the different types of Major Neurocognitive Disorder.³⁵ The four main types are Alzheimer's Disease (AD), Dementia with Lewy Bodies (DLB), Vascular Dementia (VaD), and Frontotemporal Dementia (FTD).³⁶ Raz notes that other important types include Dementia associated with Parkinson's Disease and Mixed Dementia.³⁷ Mixed Dementia refers to the presence of more than one of the previously mentioned types of Major Neurocognitive Disorder.

Alzheimer's Disease, including that it is the most common neurodegenerative disease.³⁸ Dementia in Alzheimer's Disease requires a decline in memory and at least one other domain.³⁹ According to Hugo, Alzheimer's Disease is characterized by a progressive loss of neurons and synapses (spaces between neurons where information is transmitted) and the accumulation of certain proteins (amyloid plaques and neurofibrillary tangles) in the brain.⁴⁰ The cognitive decline present in Alzheimer's Disease has an insidious onset, and problems with memory and executive functioning will typically present prior to problems in other domains.⁴¹

Vascular Dementia is the second most common cause of Major Neurocognitive Disorder and refers to problems caused by impaired blood flow to the brain.⁴² It is often seen in combination with Alzheimer's Disease. Vascular Dementia generally impacts the complex attention and

³⁵ Aida Adlimoghaddam, Banibrata Roy & Benedict C Albensi, "Future Trends and the Economic Burden of Dementia in Manitoba: Comparison with the Rest of Canada and the World" (2018) 51:1-2 *Neuroepidemiology* 71 at 71.

³⁶ Raz, Knoefel & Bhaskar, *supra* note 30 at 174.

³⁷ *Ibid* at 174-75.

³⁸ *Ibid* at 174.

³⁹ Hugo & Ganguli, *supra* note 34 at 431.

⁴⁰ *Ibid*.

⁴¹ *Ibid*.

⁴² Raz, Knoefel & Bhaskar, *supra* note 30 at 176.

executive functioning domains.⁴³ The progression in cognitive decline often follows a stepwise pattern, corresponding with vascular events such as a Cerebrovascular Accident.⁴⁴

Parkinson's Disease results from the degeneration of dopaminergic (or dopamine-related) neurons in a specific part of the brain involved in movement and rewards (the substantia nigra).⁴⁵ The core symptoms of Parkinson's Disease are bradykinesia (slow movement), rigidity, resting tremor, and stooped posture. Pertinent to the case discussed here, approximately 75% of individuals diagnosed with Parkinson's Disease will be diagnosed with a Major Neurocognitive Disorder at some point.⁴⁶ Dementia associated with Parkinson's Disease often impacts the domains of memory, executive, and visuospatial functioning.⁴⁷ It involves the accumulation of the same neuropathological proteins (Lewy bodies) as those seen in Lewy Body Dementia.⁴⁸ Diagnosis is based on which symptoms are evident first, those associated with Major Neurocognitive Disorder or Parkinsonisms (physical symptoms of Parkinson's Disease). In order to use this nomenclature system, one group of symptoms must present a year prior to the appearance of the other group of symptoms. An individual with symptoms of Major Neurocognitive Disorder appearing first is classified as Lewy Body Dementia. If Parkinsonisms present earlier on in the course of the disease, the diagnosis will be Parkinson's Disease with Dementia.

Frontotemporal Dementia is characterized by marked changes in behaviour and social conduct.⁴⁹ Other changes seen can include emotional blunting and loss of insight. Age of onset is typically from 45 to 65 years old. Frontotemporal Dementia typically involves atrophy (loss of neurons) of the temporal and frontal lobes of the brain.

The diagnosis of Major Neurocognitive Disorder is typically based on symptoms and changes reported by the individual and their family

⁴³ Hugo & Ganguli, *supra* note 34 at 432.

⁴⁴ *Ibid.*

⁴⁵ Janice M Beitz, "Parkinson's Disease: A Review" (2014) 6 *Front Biosci (Schol Ed)* 65 at 65.

⁴⁶ American Psychiatric Association, *supra* note 32 (Section II: Neurocognitive Disorders: Major or Mild Neurocognitive Disorder Due to Parkinson's Disease).

⁴⁷ Hugo & Ganguli, *supra* note 34 at 433.

⁴⁸ Raz, Knoefel & Bhaskar, *supra* note 30 at 175.

⁴⁹ Jee Bang, Salvatore Spina & Bruce L Miller, "Frontotemporal Dementia" (2015) 386:10004 *Lancet (British Ed)* 1672 at 1672.

members or care providers, as well as more objective measures such as cognitive screening tools including the Montreal Cognitive Assessment (MOCA) or Mini Mental Status Examination (MMSE). Both tools involve a series of questions or tasks for an individual to complete and are marked out of 30. The Montreal Cognitive Assessment includes questions divided into visuospatial/executive, naming, memory, attention, language, abstraction, delayed recall, and orientation. A score of 26 out of 30 or greater is considered to be within normal limits. It is a more sensitive test and tends to pick up deficits earlier on in the disease course than the Mini Mental Status Exam. Prior to being diagnosed with Major Neurocognitive Disorder, an individual may initially be diagnosed with Mild Cognitive Impairment (MCI or Minor Neurocognitive Disorder). Mild Cognitive Impairment involves a lesser degree of cognitive decline and typically higher scores on cognitive testing.

The diagnosis of Major Neurocognitive Disorder requires changes in Instrumental Activities of Daily Livings (IADLs) – tasks such as grocery shopping, cooking, managing finances, cleaning, transportation, and managing medications.⁵⁰ In Mild Cognitive Impairment, an individual's ability to carry out these tasks would be preserved. Ongoing re-assessment over time of symptoms in individuals with Mild Cognitive Impairment or Major Neurocognitive Disorder is recommended. Although some individuals may actually report an improvement, approximately 10 – 15% of individuals diagnosed with Mild Cognitive Impairment will progress to Major Neurocognitive Disorder every year.⁵¹ The expected duration of survival of individuals can vary a significant amount, depending on other risk factors such as age or other medical co-morbidities present.

Several medical conditions present likely contributed to Mr. L's presentation and finding of being unfit to stand trial. Individuals diagnosed with Parkinson's Disease can experience related medical conditions such as Major Depressive Disorder, Anxiety Disorders, Major Neurocognitive Disorder, and autonomic dysfunction (such as orthostasis, meaning low blood pressure upon moving from lying down to standing). Major Depressive Disorder has a bi-directional relationship with Major

⁵⁰ Hui Jun Guo & Amit Sapra, *Instrumental Activity of Daily Living* (Treasure Island, FL: StatPearls Publishing, last modified 27 November 2020), online: <www.ncbi.nlm.nih.gov/books/NBK553126> [perma.cc/K3UL-6BF7].

⁵¹ Sima Ataollahi Eshkoo et al, "Mild cognitive impairment and its management in older people" (2015) 10 *Clin Interv Aging* 687 at 687-88.

Neurocognitive Disorder⁵² and could have contributed to a worsening of his cognitive decline. Coronary Artery Disease, also known as Ischemic Heart Disease (IHD), is caused by an obstructed coronary blood flow due to the formation of atherosclerosis.⁵³ Over time, it can lead to Myocardial Infarctions (heart attacks). Studies have shown as high as 35% of individuals with Coronary Artery Disease also have some degree of cognitive impairment.⁵⁴ Potential mechanisms raised for this relationship have included ischemic insults to the brain related to cardiac ischemic events, as well side effects of medications used to treat cardiac conditions. Angina describes a type of chest pain and is a symptom of Coronary Artery Disease. Complications indicating the presence of Vascular Disease included Atherosclerosis, Cardiovascular Accident, and Coronary Artery Disease.⁵⁵

Complete Heart Block can be life-threatening, and Mr. L required admission to a Coronary Care Unit (CCU) and the insertion of a pacemaker. Arrhythmias can vary greatly in severity but can also be life-threatening. Treatments can include medications or cardioversion. Cardiovascular Accidents can be quite debilitating. There can be a long rehabilitation process in order to re-learn skills such as walking or talking. Evidence of Mr. L's Cardiovascular Accident was visualized as a lacunar infarct (small infarct caused by the occlusion of a single branch of an artery in the brain⁵⁶) within the left medial thalamus on Magnetic Resonance Imaging (MRI).

A number of other conditions in Mr. L's medical history likely had less of a direct impact on his cognition. Ankylosing Spondylitis is a form of arthritis that can be associated with chronic pain.⁵⁷ Medical chart notes

⁵² Mary Ganguli, "Depression, cognitive impairment and dementia: Why should clinicians care about the web of causation?" (2009) 51 Suppl 1(Suppl1) *Indian Journal of Psychiatry* S29 at S29-S34.

⁵³ Nasser T Balbaid et al, "The Relationship between Cognitive Impairment and Coronary Artery Disease in Middle-aged Adults" (2020) 12:1 e6724 *Cureus* 1 at 2.

⁵⁴ *Ibid* at 6.

⁵⁵ Stanford Medicine, "Vascular Disease" (11 September 2017), online: *Stanford Health Care* <stanfordhealthcare.org/medical-conditions/blood-heart-circulation/vascular-disease.html> [perma.cc/W8KF-FLK6].

⁵⁶ Jamily Oliveira-Filho, "Lacunar Infarcts" (last modified 7 May 2021) online: *UpToDate* <www.uptodate.com/contents/lacunar-infarcts> [perma.cc/C6FA-AT8A].

⁵⁷ Judith A Smith, "Update on Ankylosing Spondylitis: Current Concepts in Pathogenesis" (2015) 15:489 *Curr Allergy Asthma Rep* 1 at 1.

indicate Mr. L was taking pain medications related to this condition. Guillain-Barre Syndrome (GBS) is a rare neurological condition where the body's immune system attacks part of the nervous system, causing muscle weakness.⁵⁸ Severity can vary from mild cases to paralysis to the point of an individual requiring breathing support. Most people recover, even if they have had a serious disease course. Ulcerative Colitis is a type of Inflammatory Bowel Disease that can cause symptoms such as bloody diarrhea, abdominal pain, urgency, and tenesmus (the sensation of needing to have a bowel movement).⁵⁹ It typically has a chronic course, and treatment is based on the severity of symptoms present. A perianal abscess is defined as a collection of pus, and treatment depends on the severity of symptoms. Some of the neurological symptoms described by Mr. L's neurologist, such as urinary urgency and incontinence, can be uncomfortable but there are medications available to treat them.

Mr. L was prescribed a number of medications, as listed above. With regards to Major Neurocognitive Disorder, there are pharmacological treatments available that can help to halt or slow down the progression of the disease. However, it is an irreversible neurodegenerative condition. Mr. L was not taking any medications aimed specifically at targeting the symptoms of Major Neurocognitive Disorder but several of the medications he was prescribed treated some of his risk factors for it. Bisoprolol and Amlodipine are antihypertensive medications that can be used to treat Hypertension and certain cardiac issues. Metformin and Gliclazide are Antidiabetic agents. Tamsulosin is an Alpha 1 Blocker that can be used in the treatment of urinary symptoms, such as frequency or urgency. These symptoms can be seen in males with prostate enlargement (Benign Prostatic Hyperplasia or BPH). Gabapentin is an Anticonvulsant medication that can also be used in pain management. Hydromorphone is an Analgesic. Levocarb, also known as Carbidopa and Levodopa, is an Anti-Parkinson agent.

Based on the information outlined above, our team found that Mr. L was unfit to stand trial. We recommended that an alternative disposition

⁵⁸ "Guillain-Barré Syndrome Fact Sheet" (last modified 16 March 2020), online: *National Institute of Neurological Disorders and Stroke* <www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Fact-Sheets/Guillain-Barr%C3%A9-Syndrome-Fact-Sheet> [per ma.cc/EL82-BAQM].

⁵⁹ Joseph D Feuerstein & Adam S Cheifetz, "Ulcerative Colitis: Epidemiology, Diagnosis, and Management" (2014) 89:11 *Mayo Clin Proc* 1553 at 1553.

be considered, as there were no medications that would render Mr. L fit to stand trial. Following the completion of our report, the crown questioned if the difficulties with memory that were reported were entirely accurate. A second report was prepared to address these concerns. The possibility of declaring Mr. L unfit to stand trial and then being admitted to hospital under the Criminal Code Review Board (CCRB) was raised as a possibility for two main reasons. The first reason was that a more thorough and detailed report could be completed including collateral information from staff working with Mr. L twenty-four hours a day. The second reason was that repeated education around his charges could be provided during admission to hospital. The report noted that there were some instances where Mr. L demonstrated remaining memory skills, including spontaneously remembering to take his medications at the appropriate time during an interview, retaining knowledge of one of his charges after an hour during one assessment, and recalling seeing the hospital psychiatrist from a previous assessment.

A hearing was conducted in spring 2020 regarding Mr. L's fitness to stand trial. Expert testimony was provided by the forensic psychiatrist in private practice, the forensic psychiatrist based in the hospital, and the forensic psychologist working in the hospital. Cross-examination of the psychiatrist that authored the private assessment included questions around the possibility of feigning deficits to avoid a more serious sentence as the possibility was not explicitly included in the report. There were a number of reasons identified by the private psychologist that suggested that feigning was less likely. These included the presence of objective signs of Mr. L's numerous medical conditions, the consistency in various sources of collateral information, and the fact that fitness was not raised as an issue by the defendant or his counsel. In addition, it was discussed that maintaining a lie or feigning memory deficits would be difficult to maintain - especially with various professionals and in different contexts over a number of years.

Mr. L's ability to communicate with counsel was addressed in the hearing. Mr. L had been observed having a brief social interaction with his lawyer the morning of the hearing. Based on this interaction, it was clear that Mr. L was able to communicate in the colloquial sense of the word. We saw Mr. L interacting with his lawyer in a friendly manner. When we asked Mr. L about his lawyer, he told us that his lawyer was a good friend. He did not mention that they had a working relationship. During his

testimony, he recalled meeting with his lawyer earlier that day. Expert testimony did not indicate whether the interaction witnessed that day suggested that Mr. L would be able to understand more complicated legal concepts related to providing a defence. A discrepancy in Mr. L's memory was raised by the Crown. Mr. L was able to remember numerous details about his previous practice, however he reported being unable to recall the details of his disbarment and charges. A possible explanation raised in testimony by the forensic psychologist included an explanation that the specific deficits present in a person can vary depending on the part of the brain affected. Another possible explanation for the discrepancy was the emotional salience of the charges, as opposed to more neutral topics.

Different interpretations of the ability to communicate with counsel were mentioned in the decision provided by the judge. The decision reviewed two divergent lines of cases with different interpretations for the meaning of the ability to communicate with counsel, as had been done recently in *R v Daley*.⁶⁰ The first interpretation of this criteria, not favoured by the judge in the decision, is explained in *R v Jobb* as "limited to an inquiry into whether an accused can recount to his or her counsel the necessary facts relating to the offence in such a way that counsel can then properly present a defence."⁶¹ The more detailed criteria for fitness to stand trial is explained in *R v Morrissey*⁶², but also extended to the decision in another case.⁶³ *R v Morrissey*⁶⁴ and *R v Eisnor*⁶⁵ were two cases that involved domestic partners being killed before the defendants turned the gun on themselves.

In both situations, the defendants reported amnesia or a lack of memory of the events leading up to the shooting. In *R v Morrissey*, it was noted that communication with counsel refers to the ability to "seek and receive legal advice"⁶⁶ and that there should be "meaningful presence and meaningful communication."⁶⁷ The main fitness-related issue in these cases was memory, however, the deficits were related to amnesia rather

⁶⁰ 2007 SCC 53 [*Daley*].

⁶¹ 2008 SKCA 156 at para 39 [*Jobb*].

⁶² 2007 ONCA 770 at paras 24–42 [*Morrissey*].

⁶³ *R v Eisnor*, 2015 NSCA 64 [*Eisnor*].

⁶⁴ *Morrissey*, *supra* note 61 at para 4.

⁶⁵ *Eisnor*, *supra* note 62 at para 2.

⁶⁶ *Morrissey*, *supra* note 61 at para 29.

⁶⁷ *Ibid* at para 36.

than a neurodegenerative disease. In *R v Morrissey*, there were memory deficits related to past events, but the ability to process new information was present. In that case, Morrissey was deemed to be able to communicate with counsel.⁶⁸ It was noted that *R v Morrissey* and *R v Eisnor* had favoured the same definition of ability to communicate with counsel. In both cases, the defendants were able to hear, respond, and understand the court proceedings such that they could instruct counsel even without remembering the events surrounding the shootings.

Another case with more similarities to Mr. L was *R v Amey*.⁶⁹ Amey had been diagnosed with Dementia. He also experienced delusions which were thought to be multifactorial in nature. After initially being found unfit to stand trial related to short-term memory impairment, he was admitted to hospital. He requested a second opinion and was later found fit to stand trial after experiencing improvement while in hospital. He was found fit to stand trial by the review board, but again unfit to stand trial when he was returned to the court system.⁷⁰ The decision by the court stated that memories of information presented at trial was important in a person's ability to instruct counsel. The language used by the court included the term "meaningful," again with respect to communication.⁷¹ Another trial was held again a year later, where Amey demonstrated the ability to facilitate his memory and communication in the trial process by taking and referencing notes of testimony provided. He was eventually found fit to stand trial.⁷² There was also a mention by a psychiatrist that Amey had an interaction with his lawyer the day of the trial. In that interaction, it was noted that Amey acknowledged the possibility of a guilty verdict.⁷³

Mr. L's testimony in the hearing was included in the judge's decision. A note was made of his overall presentation, including the presence of a flat affect and tremor, both signs of Parkinson's Disease. He often responded to questions by saying, "I don't think so" or "I don't know what that means." He was able to understand the meaning of charges such as theft or fraud. He showed deficits when asked about being charged. He

⁶⁸ *Ibid* at para 16.

⁶⁹ 2009 NSPC 29 [*Amey* 2009].

⁷⁰ *Ibid* at paras 1–9.

⁷¹ *Ibid* at para 36.

⁷² *R v Amey*, 2010 NSPC 100 at paras 22–31 [*Amey* 2010].

⁷³ *Ibid* at para 24.

recalled being told he had been charged with theft the day of the trial but stated that he was unaware of being charged with fraud. At one point, he demonstrated a general awareness of the reason for the hearing by stating that people were saying that he was “mentally defective.” However, near the end of the trial when he was asked about it, he reported being unaware of the reason for the hearing. He also stated that he was not aware of the other three charges he was facing.

At the end of the hearing, the judge opined that the collateral sources of information were consistent with Mr. L’s presentation in court, including the memory deficits present.

Following the decision of Mr. L being found unfit to stand trial, he was placed under the purview of the Mental Health Review Board. An assessment was completed regarding his disposition. On interview, Mr. L had a similar presentation to the previously documented assessments. He said that he was unaware that he had been charged and appeared to be unable to retain information presented to him. A risk assessment found that Mr. L was at a low risk of offending. He was discharged to reside at his home address and attend regular follow-up appointments.

IV. DISCUSSION

With respect to the case of Mr. L, there were a number of salient issues present during his assessment that factored into the determination of him being unfit to stand trial. First, he displayed deficits in his ability to understand the object and nature of proceedings. Although he had an awareness of some of the aspects of court, he was not able to process the fact that he had been charged. As a result, he was not able to apply his general knowledge about court proceedings to his specific case. Additionally, he was employed as a lawyer for many years but was unable to list any potential sentences for a guilty verdict other than a jail sentence. Again, he was unable to connect this possibility with his own sentence as he did not appear to be able to absorb the fact that he had been charged. Finally, it was deemed that he did not have the ability to communicate with counsel. The decision in his case considered previous interpretations of the ability to communicate with counsel. The limitations present in terms of processing information and the ramifications on Mr. L’s ability to instruct counsel were highlighted. Overall, the importance of meaningful

communication and the ability to participate in court proceedings was highlighted.

As discussed above, there have been a number of cases in Canada evaluating fitness to stand trial in the context of memory deficits. This case is unique in that it involves an individual with Major Neurocognitive Disorder who was previously employed as a lawyer. An individual diagnosed with Major Neurocognitive Disorder may or may not be found fit to stand trial. However, it is reasonable to assume that a lawyer who had not experienced symptoms of psychosis or other severe and persistent mental illness would usually be found fit to stand trial. If there were memory deficits, it would be expected that short-term memory would be affected prior to long-term memory.⁷⁴ Long-term memories would include an understanding of court proceedings and the potential consequences. This case highlights how significant and diverse the impact that Major Neurocognitive Disorder can be on fitness to stand trial, as it demonstrates the dramatic change from Mr. L's previous legal knowledge. In addition, the inability to communicate with counsel is surprising, as Mr. L would have communicated with lawyers countless times throughout his career. A reasonable expectation would be that such crystallized procedural knowledge would have been maintained, given that remote autobiographical memories are stored long-term.⁷⁵ He had extensive education and experience related to the workings of the legal system, yet was deemed unfit to stand trial based upon deficits in all three major criteria set out in the Taylor standard. Other case law discussed in his decision referenced individuals who had significant differences in comparison to our case. *R v Taylor* differed in that it involved a lawyer with delusions but without memory deficits.⁷⁶ The *R v Morrissey*⁷⁷ and *R v Amey*⁷⁸ cases involved memory deficits related to amnesia, not Major Neurocognitive Disorder. In the decision on Mr. L, there was no mention of previous cases in which an individual with significant legal knowledge was found unfit to stand trial related to Major Neurocognitive Disorder.

⁷⁴ Craig E Hou, Bruce L Miller & Joel H Kramer, "Patterns of autobiographical memory loss in dementia" (2005) 20:9 Intl J Geriatric Psych 809 at 810.

⁷⁵ *Ibid.*

⁷⁶ *Taylor*, *supra* note 19 at 7-9.

⁷⁷ *Morrissey*, *supra* note 61 at para 16.

⁷⁸ *Amey* 2009, *supra* note 68 at para 65.

Although the legal knowledge and experience of the man discussed in this case is relatively unusual in fitness assessments, his difficulties with memory and communication related to his medical conditions are not.⁷⁹ There are approximately 50 million people with Major Neurocognitive Disorder worldwide, and 10 million new cases each year.⁸⁰ The number of Manitobans with a diagnosis of Major Neurocognitive Disorder is projected to increase by 20.7% from 2015 to 2025, by 68.16% from 2015 to 2035, and by 125% from 2015 to 2045.⁸¹ It is estimated that 40,700 Manitobans will be diagnosed with Major Neurocognitive Disorder by 2038.⁸² Previous studies in Canada have determined that the majority of court-ordered assessments (approximately 68%) are regarding fitness.⁸³ From 2014 to 2018, the number of individuals in Manitoba requiring a fitness assessment increased by 30%.⁸⁴ There is no reason to suggest that this pattern will change, especially as our elderly population continues to grow.⁸⁵ As the population ages, it is instead expected that the number of individuals diagnosed with Major Neurocognitive Disorder requiring fitness assessments will increase. Neurodegenerative diseases can cause dysfunction of neural structures involved in judgment, executive function, emotional processing, sexual behaviour, violence, and self-awareness.⁸⁶ Such dysfunctions can lead to antisocial and criminal behaviour that appears for the first time in the adult or middle-aged individual or even later in life.⁸⁷

In addition, Diehl-Schmid et al. (2013) studied those with dementia and noted that between 12% to 56% of the sample had engaged in criminal behaviour, with differences based on the type of dementia

⁷⁹ *Ibid.*

⁸⁰ "Dementia: Key Facts" (21 September 2020), online: *World Health Organization* <www.who.int/news-room/fact-sheets/detail/dementia> [perma.cc/M33K-N8PN].

⁸¹ Adlimoghaddam, Roy & Albensi, *supra* note 35 at 73.

⁸² *Ibid.*

⁸³ Maurice Moyses Ohayon et al, "Fitness, Responsibility, and Judicially Ordered Assessments" (1998) 43:5 *Can J Psychiatry* 491.

⁸⁴ Casiano & Demetrioff, *supra* note 16 at 252.

⁸⁵ Manitoba Health, Seniors and Active Living, *Population Report* (1 June 2019), online (pdf): *Government of Manitoba* <www.gov.mb.ca/health/population/pr2019.pdf> [perma.cc/9VV2-72ZY].

⁸⁶ Madeleine Liljegen et al, "Criminal Behavior in Frontotemporal Dementia and Alzheimer Disease" (2015) 72:3 *JAMA Neurol* 295 at 296.

⁸⁷ *Ibid* at 295.

diagnosed.⁸⁸ It was presumed that the behaviour was caused by the degenerative disease, as none of the individuals had displayed criminal behaviour prior to the study.⁸⁹ Further research could examine the impact on the demographics of individuals in the justice system over time. One option to reduce uncertainty and variability in interpretations of criteria is to consider the application of a standardized screening tool to assess fitness to stand trial.

Considering that there have been varying interpretations of the ability to communicate with counsel over time, it would be pertinent to examine whether a specific screening tool to assess fitness to stand trial could be more useful to the medical practitioners called upon to aid the legal system. This is an important consideration given that wide variability exists in the comprehensiveness of competency evaluation reports.⁹⁰ It was noted in the same study that mental health examiners seemed to put more weight on a defendant's knowledge and ability to participate in trial than on their ability to appreciate and reason.⁹¹ Previous research has argued that competency assessment instruments may help to ensure that clinicians adequately address the relevant areas in competency assessments.⁹² One paper from England discussed the development of a standardized screening tool for evaluating fitness to stand trial that could potentially be adapted to other commonwealth countries.⁹³ In considering relying on an assessment tool, a potential drawback to having criteria for evaluating fitness to stand trial that are too specific would be that some of the nuances of tailoring questions could be lost. However, the authors of the article explicitly stated that such a tool was not meant to replace clinical assessment; rather, it was designed to be used as an adjunct in determining "a standardised, reliable and valid way of determining

⁸⁸ Janine Diehl-Schmid et al, "Guilty by Suspicion? Criminal Behavior in Frontotemporal Lobar Degeneration" (2013) 26:2 *Cognitive & Behav Neurol* 73 at 75.

⁸⁹ *Ibid* at 76.

⁹⁰ Patricia A Zapf et al, "Have the Courts Abdicated Their Responsibility for Determination of Competency to Stand Trial to Clinicians?" (2004) 4:1 *J Forensic Psychol Prac* 27 at 40.

⁹¹ *Ibid*.

⁹² Jodi L Viljoen, Gina M Vincent & Ronald Roesch, "Assessing Adolescent Defendants' Adjudicative Competence: Interrater Reliability and Factor Structure of the Fitness Interview Test-Revised" (2006) 33:4 *Crim Just & Behavior* 467 at 484.

⁹³ Penelope Brown et al, "Fitness to plead: Development and validation of a standardised assessment instrument" (2018) 13:4 *PLoS ONE* e0194332.

whether individuals are able to participate effectively in court proceedings.”⁹⁴ The fact that the *Morrissey*⁹⁵ standard has been used by multiple judges suggests that a standardized screening tool could be considered as another means to help assess fitness to stand trial that could be applied more broadly.

In terms of the operationalization of a potential standardized assessment screening tool, it would be important to reflect on the benefits of having a multidisciplinary team approach. Fitness assessments could involve a group of qualified professionals in addition to psychiatrists. The team could include Psychiatrists, Psychologists, Occupational Therapists, and Social Workers. Roles that these allied professionals could play include cognitive testing and tests for malingering by Psychology, functional assessments by Occupational Therapists (to understand the abilities in independent activities of daily living) and Social Workers to gather collateral information on functioning in the community. For those found unfit to stand trial but with the potential to be restored to fitness, education can be an option. The inpatient team, including Nurses, Occupational Therapists, and Community Forensic Mental Health Specialists, participate in educating those who are unfit to stand trial while they are hospitalized. The formalization of their involvement could be considered in a more standardized approach. The team could use the screening tool to help inform them about issues that warrant further review by the designated health professional. The creation of a new screening tool to assess fitness to stand trial is not required, as validated screening tools exist and are in use today.

The Fitness Interview Test (FIT) has been used as a screening instrument for fitness to stand trial.⁹⁶ The FIT-R is a semi-structured interview that assesses the three criteria specified in the Criminal Code of Canada.⁹⁷ It was originally developed for fitness assessments in Canada,

⁹⁴ *Ibid* at 11.

⁹⁵ *Morrissey*, *supra* note 61.

⁹⁶ Patricia A Zapf, Ronald Roesch & Jodi L Viljoen, “Assessing Fitness to Stand Trial: The Utility of the Fitness Interview Test (Revised Edition)” (2001) 46:5 *Can J Psychiatry* 426 at 428.

⁹⁷ *Ibid* at 426.

but later revised to include nuances in the law from the United States of America.⁹⁸

Zapf et al. (2001) explain that the Fitness Interview Test is divided into three separate sections to assess these issues separately.⁹⁹ The first part examines the defendant's understanding of the nature and object of court proceedings by reviewing their understanding of the nature and severity of their charges, the arrest process, the roles of key professionals in a courtroom, the two pleas available, and legal processes and procedures. The next section looks at their appreciation of the possible consequences of court proceedings, their plea options, and their understanding of the likely outcome. The final section deals with their ability to communicate with counsel. This ability is examined through their ability to communicate facts to their lawyer, relate to their lawyer, participate in their defence, plan a legal strategy, manage their behaviour in a courtroom, provide relevant testimony, and to challenge the testimony of witnesses. As it is a screening tool, the goal is to rule out individuals that are unambiguously fit to stand trial. In other words, the aim would be for a low percentage of individuals that were found fit to stand trial with the screening tool later having an assessment with the opposite finding. In two studies by Zapf et al., the false negative was quite low at 2%.¹⁰⁰ That is to say, 2% of those determined to be fit to stand trial according to the Fitness Interview Test were later found to be unfit to stand trial. The false positive rate has been higher in these studies, ranging from 11% to 24%. The false positive rate describes the proportion of individuals initially found unfit to stand trial by the screening tool who were later determined to be fit to stand trial.

Screening tools are often designed to have higher rates of false positives compared to false negatives. False positives do not have consequences that are as serious as false negatives, as those individuals would simply be flagged as requiring further assessment. Viljoen et al. (2006) found that the interrater reliability of items and sections of the Fitness Interview Test, Revised Edition (FIT-R) was good overall, and the correlations of the summary scores for sections between raters was

⁹⁸ Gregory DeClue, Book Review of *Fitness Interview Test-Revised (FIT-R): A Structured Interview for Assessing Competency to Stand Trial* by Ronald Roesch, Patricia A Zapf & Derek Eaves, (2006) 34:3 J Psychiatry & L 371 at 378.

⁹⁹ Zapf, Roesch & Viljoen, *supra* note 95 at 427.

¹⁰⁰ *Ibid* at 430.

between 0.82 and 0.91.¹⁰¹ In other words, individual raters provided very similar scores for the various sections.

Another study looked at the use of a different 22-item screening tool, the MacArthur Competence Assessment Tool, to assessing fitness to stand trial in individuals in England and Wales.¹⁰² In that study, inmates with or without diagnoses regarding mental health were examined.¹⁰³ It showed good internal consistency and interrater reliability on the scale, with correlation between psychiatrists at 0.77. The MacArthur Structured Assessment of the Competencies of Criminal Defendants (MacSAC-CD) was initially created by Hoge et al.¹⁰⁴

It is not clear to us that the use of either of the standardized tools mentioned would have made a difference to the final outcome in our case. All of the forensic assessments completed for Mr. L found that he was unfit to stand trial. However, it is important to note that there were discrepancies between the reports in our case with respect to the different criteria for being considered fit to stand trial. After our initial fitness assessment, the crown questioned the veracity of the memory problems that had been reported. There was consideration of admitting Mr. L to the Inpatient Psychiatric Unit for further observation and assessment, a resource-intensive option that is not considered lightly. The main discrepancy in viewpoints of the assessors was about Mr. L's ability to communicate with counsel. The other cases that we have discussed have shown that the definition of the ability to communicate with counsel has varied over time, although the standard used to determine fitness has not. Most importantly, standardized tools could help to ensure that defendants are treated fairly, even if there are different clinicians completing their fitness assessments.

In medicine, determining the specific question being asked can result in a consultation that is more effective and helpful.¹⁰⁵ Similarly, a reasonable goal of forensic assessments, and standardized assessments in

¹⁰¹ Viljoen, Vincent & Roesch, *supra* note 91 at 467.

¹⁰² Akintunde A Akinkunmi, "The MacArthur Competence Assessment Tool-Fitness to Plead: A Preliminary Evaluation of a Research Instrument for Assessing Fitness to Plead in England and Wales" (2002) 30:4 J Am Acad Psychiatry L 476 at 477.

¹⁰³ *Ibid* at 476.

¹⁰⁴ Steven K Hoge et al, "The MacArthur Adjudicative Competence Study: Development and Validation of a Research Instrument" (1997) 21:2 L & Hum Behav 141.

¹⁰⁵ Lee Goldman, Thomas Lee & Peter Rudd, "Ten Commandments for Effective Consultations" (1983) 143:9 Arch Intern Med 1753 at 1753.

general, is to have high levels of inter-rater reliability. The two standardized tests described above both have this quality. With respect to all three major criteria involved in assessing one's fitness to stand trial, there is a certain degree of variability present in the specific interpretation by different individuals. A previous study found that "Manitoba's forensic clinicians were using standardized criteria that were very similar to 1992 Criminal Code revisions of fitness."¹⁰⁶ A future project could examine whether this is still the case today. Previous research in the United States evaluating the accuracy of forensic examiners found that "mental health experts' intrinsic ability to discriminate between competent and incompetent defendants is high (though not perfect)."¹⁰⁷ In addition to examining the quality and consistency of assessments, it is vital to determine what standard is most useful to those ordering and using the assessments.

V. CONCLUSION

Fitness assessments are the most common forensic court-ordered evaluation.¹⁰⁸ Today in Manitoba, the *R v Taylor* (1992) case is accepted as the standard within the forensic psychiatric community. There have been a number of other cases since *Taylor* that have involved deficits in memory and its impact on fitness to stand trial. Other cases adopted an interpretation of the ability to communicate with counsel in more specific terms. It is reasonable to re-evaluate the standard for fitness to stand trial that has been used for nearly thirty years,¹⁰⁹ as interpretations of the individual criteria have varied. Different regions and countries have looked at standardized assessment tools in the hopes of achieving more accurate fitness assessments. Research looking at some of these standardized tools has shown positive results. The case discussed here highlights some of the variations in fitness criteria that have been adopted in the past. Given the discrepancy in the interpretation of fitness to stand trial, and specifically the ability to communicate with counsel, it may be

¹⁰⁶ R Gail Robertson et al, "Clinical and Demographic Variables Related to "Fitness to Stand Trial" Assessments in Manitoba" (1997) 42:2 Can J Psychiatry 191 at 191.

¹⁰⁷ Douglas Mossman et al, "Quantifying the Accuracy of Forensic Examiners in the Absence of a 'Gold Standard'" (2010) 34:5 L & Hum Behav 402 at 411-12.

¹⁰⁸ Casiano & Demetriooff, *supra* note 16 at 263.

¹⁰⁹ See *Taylor*, *supra* note 19.

time to consider examining the adoption of additional forensic screening instruments. A review of the criteria for fitness to stand trial could help to reduce individual bias and ensure fair treatment for individuals whose fitness to stand trial is questioned. This is especially true in the context of a growing aged population.

The case discussed here demonstrates a unique example of someone being found unfit to stand trial related to his diagnosis of Major Neurocognitive Disorder. Mr. L's legal experience provided perspective on the severity and breadth of the effects of being diagnosed with Major Neurocognitive Disorder. In the coming years, being found unfit to stand trial related to Major Neurocognitive Disorder may become more common. In anticipation of such upcoming changes, consideration should be given to evaluating the definitions and interpretations we are using. More discussion between legal and mental health professionals could be helpful. For example, if the mental health team were aware of which of the three prongs to be considered for unfitness were the concern of the legal team, this could aid in planning for the activation of involvement by allied health professionals for such things as education about fitness to the accused person. In addition, the plan to observe and directly evaluate patients while counsel interacts with their clients could be considered in situations where narrow delusions surrounding the lawyer were occurring.

Future collaboration by mental health professionals and legal professionals would be beneficial in determining the best standard for fitness assessments. The provision of increased communication and adoption of screening tools can help all those who serve the population of mentally ill defendants.