SUBMISSION TO THE GOVERNMENT OF CANADA:
DEPARTMENT OF JUSTICE

Transformation of the Criminal Justice System

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INTRODUCTION

The Dementia Justice Society of Canada appreciates the opportunity to participate in the Transformation of the Criminal Justice System public consultation. We commend the Government of Canada for its commitment to this important initiative, particularly as it relates to identifying and addressing gaps in services for Indigenous Peoples and those with mental health concerns throughout the criminal justice system.

Dementia Justice is a federally incorporated non-profit society dedicated to advancing the rights, needs and dignity of people with dementia who are, or are at risk of becoming, involved with the criminal justice system. We strive to achieve our objectives through public advocacy, awareness-raising, education, and interdisciplinary legal and policy research.

Dementia has been called one of the greatest societal challenges of the 21st century. The Alzheimer Society of Canada estimates that 564,000 Canadians currently live with dementia, and that 25,000 new cases are diagnosed every year.[1] If nothing changes, there could be 937,000 people in Canada with the condition in 15 years.[2] Among Indigenous populations specifically, it is estimated that dementia rates are 34 percent higher than the non-Indigenous population.[3] For people aged 60 and older with an intellectual disability, the incidence of dementia is estimated to be up to five times higher than older adults in the general population.[4]

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[1] Alzheimer Society of Canada, "Dementia numbers in Canada" (18 January 2017), online: <http://www.alzheimer.ca/en/about-dementia/what-is-dementia/dementia-numbers>.
[2] *Ibid*.
[3] Kristen M Jacklin, Jennifer D Walker & Marjory Shawande, "The Emergence of Dementia as a Health Concern Among First Nations Populations in Alberta, Canada" (Jan/Feb 2013) 104:1 Can J Pub Health e39 at e42.
[4] A Strydom et al, "Incidence of dementia in older adults with intellectual disabilities" (June 2013) 34:6 Res Dev Disabil 1881.

In recent years, dementia and its profound impact on the lives of Canadians has attracted increased attention. However, one area that has received little focus is the intersection of dementia and the criminal justice system. But as the population ages and dementia rates increase, this issue can no longer be neglected. People with dementia are present at all stages of the criminal justice system—from initial police contact to fitness to stand trial assessments to the aging prison population. The time is now to transform the criminal justice system in a manner that responds to this vulnerable population's needs. We appreciate this opportunity to share our thoughts and ignite further discussion on this area of pressing and understudied importance.

In this submission, we identify five broad, thematic priority areas which we believe can help shape the development and implementation of a comprehensive approach to dementia and criminal justice in Canada. These priority areas are:

1. Awareness, Education & Training;
2. Prevention;
3. Diversion;
4. Treatment, Care & Housing; and
5. System Integration.

This submission proceeds as follows. In Part A, we provide a brief overview of dementia and its responsive behaviours. In Part B, we outline the intersection between dementia and the criminal justice system, including some of the ways in which responsive behaviours can increase one's risk of falling on the wrong side of the law. In Part C, we discuss the five priority areas. In Part D, we offer an idea for the way forward, namely the development and implementation of a national *Dementia and Criminal Justice Action Framework*.

PART A: DEMENTIA OVERVIEW

WHAT IS DEMENTIA?

Dementia is not one specific disease. Rather, the word "dementia" is an umbrella term used to describe a collection of symptoms that are caused by a variety of disorders affecting the brain.

Depending on the subtype of dementia, symptoms may affect memory, thinking, problem-solving, language and social capabilities severely enough to interfere with the person's ability to perform everyday activities. Symptoms may also include changes in mood or behaviour.

Alzheimer's disease is the most common cause of dementia. It is progressive, which means that it gets worse over time. It is also irreversible, although treatment may help manage symptoms.

Other types of progressive and irreversible dementias include vascular dementia (e.g., caused by strokes); Lewy body dementia; and frontotemporal dementia (FTD). People may also have mixed dementia, which is a combination of two or more dementias, such as Alzheimer's disease and Lewy body dementia. They may also have other mental and physical health conditions.

Other disorders linked to dementia include Huntington's disease; traumatic brain injury; Creutzfeldt-Jakob disease; and Parkinson's disease.

Some causes of dementia or dementia-like symptoms can be reversed when the condition is treated. These include but are not limited to medication side effects; vitamin deficiencies; dehydration; thyroid problems; low blood sugar; and some infections and immune disorders.

Excessive alcohol use can also lead to symptoms of dementia. For some people in the early stages, alcohol-related dementia may resolve with treatment and if they abstain from drinking.

Dementia is not an inevitable part of aging. However, growing older is an important risk factor. After age 65, the risk for Alzheimer's disease, for example, doubles approximately every five years.[5] In Canada, it is estimated that one in 20 Canadians over age 65, and one in four over age 85, have Alzheimer's disease.[6]

Dementia does not just affect older people. When symptoms start before age 65, it is called young-onset dementia. Young-onset dementia is relatively rare, affecting an estimated two to eight percent of the dementia population.[7] The Alzheimer Society of Canada estimates that 16,000 Canadians under 65 are living with dementia.[8]

As dementia progresses, different models are used to describe its stages.[9] While stages overlap and vary depending on the subtype of dementia, a commonly accepted model identifies three stages: mild, moderate, and severe:

> **Mild**. People in the mild or early stage of dementia may experience some mild memory and thinking problems, such as word-finding difficulties. They are still able to function relatively independently and require minimal assistance from caregivers. They may have some awareness of their changing abilities.
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> **Moderate**. People in the moderate or middle stage experience a further decline in cognitive and functional abilities, and need assistance with several daily activities, such as grocery shopping, house-cleaning, dressing, bathing, and toileting. They may still retain some insight into their condition.

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[5] Alzheimer Society of Canada, "Risk factors" (18 December 2015), online: <http://www.alzheimer.ca/en/About-dementia/Alzheimer-s-disease/Risk-factors>.
[6] *Ibid*.
[7] Alzheimer Society of Canada, "Young onset dementia" (28 June 2017), online: <http://www.alzheimer.ca/en/About-dementia/Dementias/young-onset-dementia>.
[8] *Supra* note 1.
[9] See e.g. Alzheimer Society of Canada, "Stages of Alzheimer's disease" (1 April 2016), online: <http://www.alzheimer.ca/en/About-dementia/Alzheimer-s-disease/Stages-of-Alzheimer-s-disease>; B.C. Ministry of Health, *The Provincial Dementia Action Plan for British Columbia: Priorities and Actions for Health System and Service Redesign* (November 2012), online: <http://www.health.gov.bc.ca/library/publications/year/2012/dementia-action-plan.pdf> at 10.

Severe. The severe stage is also called the late or advanced stage. In this stage, people experience a considerable loss of cognitive and functional abilities, eventually becoming unable to communicate verbally. They cannot be left unsupervised, and need assistance with all activities of daily living. As death nears, the focus becomes end-of-life comfort care.

RESPONSIVE BEHAVIOURS

The behavioural and psychological symptoms of dementia (BPSD) are one of its most challenging and distressing aspects. While estimates vary widely, and depend on the setting (e.g., care home versus community-dwelling) and the subtype of dementia, it is estimated that up to 90 percent of people with dementia experience at least one BPSD over the course of the disease.[10]

BPSD is an umbrella term that refers to "a heterogeneous group of non-cognitive symptoms and behaviours that occur in people with dementia."[11] BPSD include but are not limited to agitation and restlessness; repetitive statements and questions; elation; verbal outbursts, including swearing and screaming; physical aggression, such as grabbing others; wandering and exit-seeking; disinhibition, including sexually disinhibited behaviours; anxiety; depression; apathy; delusions; and hallucinations.

In the past, the behaviours associated with dementia were framed as problematic, difficult and inappropriate.[12] But "[t]his negative terminology characterizes the behaviours from the point of view and experience of the person trying to manage it, without a positive focus on the person [who is living with dementia]."[13]

Therefore, the preferred term is "responsive behaviours." This modern and person-centred language recognizes "that most, but not all, behaviour is a response to a cue or trigger experienced by the person with dementia," and is "the person's best attempt to respond to their current situation and communicate their unmet needs."[14]

Responsive behaviours may trigger a criminal justice response. Police may be called, and in some cases, charged may be laid. Depending on the severity of the person's mental condition, charges may be stayed; the individual may be found unfit to stand trial; or they may be found not criminally responsible on account of mental disorder (NCRMD) and diverted to a Review Board. In other cases, they may be found guilty and sentenced, including to a lengthy prison term.[15]

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[10] See e.g. J Cerejeira, L Lagarto & EB Mukaetova-Ladinska, "Behavioral and Psychological Symptoms of Dementia" (2012) 3 Front Neurol 73.

[11] Brian Lawlor, *Editorial*, "Managing behavioural and psychological symptoms in dementia" (December 2002) 181:6 Brit J Pscyhiatry 463 at 463.

[12] B.C. Ministry of Health*, Best Practices Guideline for Accommodating and Managing Behavioural and Psychological Symptoms of Dementia in Residential Care: A Person-Centred Interdisciplinary Approach* (25 October 2012), online <http://www.health.gov.bc.ca/library/publications/year/2012/bpsd-guideline.pdf> at 7.

[13] *Ibid*.

[14] *Ibid*.

[15] See e.g. *R v Brooks*, 2017 ONSC 439 (life in prison with no parole eligibility for 10 years).

PART B: DEMENTIA & THE CRIMINAL JUSTICE SYSTEM

Similar to those with other mental health concerns, most people with dementia will not come into conflict with the criminal justice system. However, people with dementia are present at all of the system's stages. Some have dementia at initial contact, such as when arrested by police. Others develop dementia as they grow older while in a forensic setting, correctional institution, or while on parole. This section looks at three environments where dementia and the criminal justice system may intersect: prisons; communities-at-large; and care homes.

Aging prison population

The aging prison population and increasing number of inmates living with dementia have garnered some recent attention. Most notably, in his office's 2010-2011 annual report, Howard Sapers, former Correctional Investigator of Canada, drew special attention to the plight of aged offenders, and stated that the most common mental health disorders among this group are depression; anxiety; Alzheimer's disease and other forms of dementia; and late-life schizophrenia.[16] He also observed that the responsive behaviours associated with dementia may manifest in the correctional environment:

> Offenders that may be suffering from age-related degenerative diseases characterized by memory loss or distorted thinking, such as dementia and/or Alzheimer's, often exhibit behaviours that are considered maladaptive in the correctional setting. Symptoms may include disruptive or difficult behaviour, anxiety, paranoia, major depression, self-injury and/or the refusal/inability to follow prison rules and routines.[17]

The symptoms associated with dementia may also bring inmates into conflict with one another. For instance, "a person living with dementia that is repeatedly 'calling out' and/or wandering may become targeted or victimized by other inmates."[18] As dementia becomes more prevalent, these types of inmate-to-inmate interactions may become an increasing concern.[19]

Community-dwellers

Dementia is not just a concern for correctional institutions. People with dementia who live in the community may also come into contact with the criminal justice system. Some may be community-dwelling offenders on parole who are serving their sentence under supervision in the community. Others may be people who experience the criminal justice system for the first time, and in some cases, their alleged criminal behaviour may be a warning sign of dementia.

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[16] Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator 2010-2011* (29 June 2011), online: <http://www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20102011-eng.aspx>.
[17] *Ibid*.
[18] Alzheimer Society of B.C., submission to Dementia Justice on criminal justice initiatives (August 2017) at 1 (on file with Dementia Justice).
[19] See *ibid*.

For instance, depending on the subtype of dementia, a person with the condition may be at an increased risk for driving offences; shoplifting (e.g., due to forgetting to pay, disinhibition); trespassing (e.g., due to wandering); or sexual offences, such as indecent exposure.[20] In rare cases, a person with dementia may be charged with a very serious crime such as murder.[21]

Care home residents

It is estimated that almost 80 percent of people with dementia in institutionalized care environments experience the behavioural and psychological symptoms of dementia.[22] Sometimes this can manifest as resident-to-resident or resident-to-staff aggression. Incidents range from relatively minor, such as slapping, to serious violence, such as using a piece of furniture or assistive device (e.g., a cane) to hit someone. Victim injuries also range from relatively minor to serious, and in rare cases, the violence may be deadly.

PART C: PRIORITY AREAS

This section sets out five broad priority areas which we believe can help shape the development and implementation of a comprehensive approach to dementia and criminal justice in Canada.

The list is not presented as closed and exhaustive; rather, our aim is to provide a reference point to stimulate further discussion and systemic action on this emerging and growing challenge.

1. AWARENESS, EDUCATION & TRAINING

In an aging society, a transformed and modern criminal justice system requires a strong awareness of dementia and its responsive behaviours. Without this knowledge among all segments of the system, accused persons, offenders and inmates with dementia may not be identified as someone who is living with the disease, and it may also contribute to, *inter alia*, missed opportunities for pre-arrest and court diversion programs, or proper linkages with appropriate supports and services designed for people with dementia.

While there is a need to build and improve awareness about all types of dementia and their responsive behaviours, it is particularly important that attention is paid to lesser-known and young-onset dementias, such as behavioural-variant frontotemporal dementia (bvFTD). Unlike the "typical" image of someone living with dementia, people with young-onset may only be in their 40s or 50s, still be working at a job, and still be physically fit.

[20] See e.g. Madeleine Liljegren et al, "Criminal Behavior in Frontotemporal Dementia and Alzheimer Disease" (March 2015) 72:3 JAMA Neurol 295.
[21] See e.g. Gabriele Cipriani et al, "Violent and criminal manifestations in dementia patients" (2016) 16 Geriatr Gerontol Int 541 at 544.
[22] Lawlor, *supra* note 11 at 463.

Signs and symptoms of bvFTD include apathy; disinhibition; loss of interest in socialization, self-care and personal responsibilities; and socially inappropriate behaviours.[23] Some other symptoms include inappropriate joking; irritability; restlessness; easily provoked violence; craving affection and sexual contact; impulse buying; stealing; hoarding; and inattentive and careless driving.[24] People exhibiting these behaviours often lack insight into their changed behaviours, and others can perceive them as inconsiderate; self-centred; hostile; and aggressive.

Early bvFTD symptoms are not easily recognized, so other explanations such as depression, psychosis, and alcohol dependency may be suggested, especially by those who have no previous knowledge of the person.[25] Thus bvFTD is often misdiagnosed as another condition and can go undiagnosed for a long time.

Prior to diagnosis, a person with bvFTD may experience "significant family disruption, legal involvement, and problems in the workplace because of socially inappropriate behaviors."[26] Behaviour may continue to be severely disruptive in an institutionalized care environment, especially if the person is otherwise healthy and non-frail.[27]

A small but growing amount of psychogeriatric research has studied the relationship between criminal violations and bvFTD, and evidence suggests that new-onset criminal behaviour may be an early warning sign of the disease.[28]

These findings reinforce the importance of building and improving awareness of dementia throughout the criminal justice system, especially among frontline police officers, Crown counsel, and defence lawyers. It is also important to build and improve awareness among others in the system, including but not limited to judges, duty counsel and legal aid services; mental health court workers; probation and parole officers; and correctional institution staff.

Some dementia education and training initiatives in Canada and elsewhere are underway. In Rhode Island, for example, the Alzheimer's Association has partnered with the Drug Enforcement Agency and Department of Corrections to provide dementia education and training to prison wardens and clinicians, to enable them to provide appropriate responses within the correctional environment.[29] Some dementia organizations in Canada, such as Alzheimer Society of B.C. and the Alzheimer Society of Muskoka, have also provided education for correctional staff and inmates. These initiatives may provide a strong foundation for establishing programming that can be rolled out across Canada.

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[23] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed (Arlington: American Psychiatric Association, 2013) at 615 [DSM-5].

[24] Lars Gustafson, "Frontotemporal dementia" in Robin Jacoby & Catherine Oppenheimer, eds, *Psychiatry in the Elderly*, 3rd ed (New York: Oxford University Press, 2002), 533 at 554-55.

[25] *Ibid* at 554.

[26] DSM-5, *supra* note 23 at 617.

[27] *Ibid*.

[28] See e.g. Liljegren et al, *supra* note 20.

[29] Rhode Island General Assembly, Rhode Island's State Plan on Alzheimer's Disease & Related Disorders (n.d.), online: <http://act.alz.org/site/DocServer/RI_State_Plan__Sept_2013_.pdf/931185879?docID=26222> at 42.

2. PREVENTION

Reducing the risk of people with dementia coming into conflict with the criminal justice system requires multi-sector engagement, involving all levels of government, private and non-profit organizations, and community members. Combined with greater awareness about dementia, prevention efforts can help minimize the risk that someone with the condition will be arrested in circumstances where other responses may be more appropriate, such as a referral and linkage to community dementia support services. These programs may provide a range of assistance, such as helping the person with dementia, their family members, and caregivers understand and manage the person's responsive behaviours at home and in the community.

One promising initiative is the Safe Pathways partnership between the Guelph Police Service and the Alzheimer Society Waterloo Wellington.[30] Launched in 2015, this program aims to reduce the likelihood that people with dementia will enter the criminal justice system due to responsive behaviours, with the overall goal of improving the quality of life for people with dementia and their caregivers. It has a special focus on persons with FTD. The project also consists of creating a support system for those already in the criminal justice system.

Safe Pathways is a collaborative community approach, reminding us that it is not just frontline police officers and mental health workers who play a role in prevention. As elder and dementia care shifts away from institutions and into the community, members of the general public can also make a difference. For instance, through initiatives such as dementia-friendly communities, local shop owners can learn to spot the signs of dementia, and respond to problems such as shoplifting and opening food packages in stores, with more empathetic measures, such as calling a family member to bring their loved one safely home.

Another exemplary preventative initiative is Behavioural Supports Ontario (BSO), a program created in 2011 to help care providers identify triggers that can lead to responsive behaviours before they start.[31] In its 2017 budget, the Ontario government committed an additional $10 million to the program, and is working toward having a BSO resource in every long-term care home in the province.[32] Such programming may have the collateral benefit of reducing the number of persons with dementia who become involved with the criminal justice system.

3. DIVERSION

In some cases, a person with dementia whose behaviour beings them into contact with police may be a suitable candidate for pre-charge diversion. In other cases, post-charge diversion may be appropriate. For instance, depending on the alleged offence and circumstances, an accused person with dementia may be suitable candidate for a specialized therapeutic court, such as a mental health court, or another diversion measure out of the traditional criminal justice system.

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[30] Alzheimer Society Waterloo Wellington, *Safe Pathways*, online: <http://www.alzheimer.ca/en/ww/Safe-Pathways>.

[31] Behavioural Supports Ontario, online: <http://www.behaviouralsupportsontario.ca>.

[32] Government of Ontario, *2017 Ontario Budget*, Budget Papers (2017) at 38.

Anecdotal evidence suggests that one of the most common types of crimes coming through the therapeutic courts involving accused persons with dementia are general assaults. The person often has no previous criminal record. Incidents tend to arise in the community, such as at a gas station or corner store, whereby the person with dementia may become upset with the cashier. The ensuing anger and aggression by the person with dementia leads to the criminal charge.

In its recent report*, Delaying Justice is Denying Justice*, the Standing Senate Committee on Legal and Constitutional Affairs found that diversion initiatives for people with mental illness "need to be more widely available to Canadians."[33] While the report does not specifically refer to dementia, existing diversion measures may hold promise for persons with the syndrome. However, because of the unique needs of persons with dementia, further research is needed on the ability and potential of these diversion programs to address this vulnerable population's needs. Some modifications may be required to respond to their special circumstances.

Moreover, to work effectively, triage responses not only require the ability to recognize that someone may have dementia and is exhibiting responsive behaviours, but there also needs to be adequate resources and the right level of police and Crown discretion. One difficult area is domestic violence. As noted by the Advocacy Centre for the Elderly (ACE) in Ontario:

> Owing to mandatory charging policies around domestic violence and mandatory reporting in long-term care and retirement home settings, the dementia-related cases of domestic violence are being filtered through the criminal justice system. The system, however, has very few suitable resources to address the needs of these accused.
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> For example, these accused are often held in jail for extended periods of time owing to the fact that there is nowhere available to safely house them. They may not be able return to their homes where they have allegedly assaulted their spouses for safety concerns about their spouse. At the same time, it may have been the spouse who was the primary caregiver and who continues to be the accused's decision-maker for health related purposes. It may take significant periods of time to place them in a long-term care home or hospital that can accommodate their health needs.[34]

As people with dementia are living at home longer, mandatory policies related to domestic violence have the potential to impact an even greater number of Canadians with dementia, as

[33] Standing Senate Committee on Legal and Constitutional Affairs, *Final Report*, "Delaying Justice is Denying Justice: An Urgent Need to Address Lengthy Court Delays in Canada" (Chair: Hon. Runciman), online: <https://sencanada.ca/content/sen/committee/421/LCJC/Reports/Court_Delays_Final_Report_e.pdf> at 143.

[34] Advocacy Centre for the Elderly, Letter re: Consultation on Development of a Domestic Violence Strategy (21 September 2015), online: <http://www.advocacycentreelderly.org/appimages/file/Ltr%20re%20LAO%20Domestic%20Violence%20Strategy%2021Sep2015.pdf> at 3.

well as their family members. As such, it is important to revisit these policies and examine their collateral consequences on persons with dementia and their families.

4. TREATMENT, CARE & HOUSING

Once in the criminal justice system, people with dementia are at risk of languishing in inappropriate settings that are ill-equipped to manage their treatment, care, and housing needs. The following passage by ACE details some of the housing placement challenges in Ontario that an accused person with dementia may face following an alleged assault:

> [W]here the accused has behavioural problems, the accused will be more difficult to place in long-term care even if the accused has been designated a crisis (priority) placement by a community care access centre. ACE has had clients who have been refused by long-term care homes after they are accused of assault, claiming that the home does not have the nursing expertise to deal with the person's needs. In that instance, the accused may have nowhere to stay if they are not acutely ill enough to go to a hospital or a psychiatric facility.
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> If the alleged assault took place in a long-term care home, bail conditions may be set that do not permit the accused to return to the home. These bail conditions can result in an accused losing their accommodation. The *Long-Term Care Homes Act* [in Ontario] provides that a long-term care home shall discharge a resident if they are absent for more than 21 days, unless they are on a medical absence, in which case they can be absent for 30 days, or a psychiatric absence, in which case they can be absent for 60 days. At times, the bail conditions will provide that a long-term care home should supervise the accused person to ensure that the accused is kept away from the victim or vulnerable persons in the home. However, it is not appropriate to place the long-term care home in this position.
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> Where there has been a violent incident in a long-term care home, the home may seek to discharge the accused, claiming that the following conditions for a discharge under the legislation have been met, specifically, that "the resident's requirements for care have changed and that, as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident". As noted above, if a person is discharged and loses his/her accommodation in a long-term care home, it can be very difficult to again place him/her.[35]

Similarly, people with dementia who are unfit to stand trial, NCRMD, or otherwise awaiting assessment may languish in forensic environments, which may not have programs tailored to meet their needs and may house other residents whose behaviour can be disturbing for the

[35] *Ibid* at 3 [footnotes omitted; emphasis added].

individual.[36] Options become limited when care homes decline to put persons with a criminal history on their waitlists.[37]

Within the correctional environment, meeting the treatment and care needs of inmates with dementia is also a challenge that will likely intensify in the coming years. Speaking about the impact that aging has on corrections, Mr. Sapers observed: "In managing the growing wave of older offenders, it would be wise to avoid some of the mistakes we have already made along the way in regards to the mentally ill. Just as prisons today have become the new asylums, we do not want the prisons of tomorrow to become the new geriatric facilities."[38]

Further, persons with dementia may also face housing vulnerability when transitioning from the correctional setting into long-term care or the larger community. As the population ages and dementia prevalence increases, it will be important to study the challenges of finding appropriate housing for persons with dementia who have spent time in prison.[39]

5. SYSTEM INTEGRATION

Effectively responding to the intersection of dementia and criminal justice requires collaboration among multiple systems, including the justice system, the health and long-term care system, and the private and non-profit community services sector. Otherwise, the siloed approach will continue to put people with dementia at risk of falling through service gaps.

This was the fate of 70-year-old Joe McLeod, who "fell into a deep, dark hole".[40] His tragic story lead to the 2014/2015 Frank Alexander Inquest in Manitoba. It is discussed here at length because it contains many lessons to be learned, and it offers recommendations that have the potential to be implemented in other jurisdictions across the country. The following summary is based on some of the testimony provided at the inquest.

Mr. McLeod, who has passed away, had Alzheimer's disease. On September 7, 2010, while at home, Mr. McLeod did not recognize his wife and asked her to leave. Mrs. McLeod picked up a wedding photograph and showed it to him; however, he pushed her out of the door and she fell. The picture frame broke and cut her chest. She began bleeding profusely. Police were called.[41]

Mr. McLeod was taken to hospital, and cleared medically. Police indicated to family that he could either go home or to the Winnipeg Remand Centre (WRC). Family was scared to take him home, so Mr. McLeod was taken to the WRC, and charged with a domestic violence assault. Due to his

[36] See e.g. *Lee (Re)*, [2016] ORBD No 2601 at 24.
[37] See e.g. *Fournier (Re)*, [2015] ORBD No 200 at para 11.
[38] Howard Sapers, "Population Aging and the Challenges for Corrections" (29 March 2011), Ting Forum on Justice Policy, Simon Fraser University.
[39] See e.g. Rhode Island General Assembly, *supra* note 29.
[40] Report on Inquest and Recommendations of Judge Michel Chartier (26 May 2015), online: <http://www.manitobacourts.mb.ca/site/assets/files/1051/frank_alexander_inquest_final.pdf> at para 266.
[41] *Ibid* at para 55.

circumstances, he was placed in the WRC's medical ward, which is not equipped to handle the health care needs of people with dementia.[42]

Family and a concerned friend contacted provincial politicians. The then-leader of the Manitoba Liberal Party eventually told family that he would help get Mr. McLeod out of the WRC and into a personal care home (PCH). On September 20, 2010, a press conference was held with the objective of putting public pressure on officials to get Mr. McLeod into a PCH.[43]

A bail hearing then took place, and the court ordered a forensic assessment. A few days later, Mr. McLeod had a placement in a PCH. On October 8, 2010, he was released, and family took him to the PCH. He was in the WRC for almost 30 days.[44]

PCH staff were aware that Mr. McLeod had come from the WRC, but according to family, at the time of admission, there was no discussion of the event which led him there. A few days later, a care plan was made. He was placed in a room with another gentleman, but it soon became clear that the roommate was making Mr. McLeod angry. Mr. McLeod was moved to a single room.[45]

Mr. McLeod continued to have altercations with others. Two incidents required the attendance of the police. The first, in February 2011, involved pushing, shoving and grabbing others.[46]

The second, in March 2011, involved Mr. McLeod allegedly pushing another resident, Frank Alexander, who ultimately passed away from his injuries. Police were notified of the incident, and Mr. McLeod was taken to the Public Safety Building and charged with aggravated assault, which was later upgraded to manslaughter.[47]

Mr. McLeod was taken to the Health Services Centre (PX3) for assessment, where he saw the then-Director of Forensic Psychiatry for Manitoba. At the Inquest, the psychiatrist testified that PX3 is not designed to deal with and treat people with dementia.[48]

Mr. McLeod was eventually found unfit to stand trial, and as a result, he was transferred to the locked ward at the Selkirk Mental Health Centre.[49]

In the Inquest Report, the Court noted that "it is evident that there is a clear under appreciation of the degrees of complexities when dealing with persons with dementia generally and

[42] *Ibid* at paras 58, 60-61, 244 & 250.
[43] *Ibid* at paras 63-64.
[44] *Ibid* at paras 65-66.
[45] *Ibid* at paras 68-70.
[46] *Ibid* at paras 71 & 75.
[47] *Ibid* at paras 20 & 76-77.
[48] *Ibid* at paras 77 & 211-12.
[49] *Ibid* at para 20.

Alzheimer's disease specifically."[50] To help prevent deaths similar to Mr. Alexander's, the Court made several recommendations, including but not limited to:

- There must be a substantial increase in the number of behavioural unit beds dedicated to people with violence or aggressive tendencies.[51]
- A system needs to be designed to track situations in which people with dementia living at home refuse assistance, so there can be regular follow-up.[52]
- There needs to be better communication among all stakeholders. In Mr. McLeod's case, prior to his admission to the PCH, "no one really seemed to know what to do with him."[53]
- The Department of Health should develop a coordinated protocol with the Departments of Justice and Corrections to accommodate persons with dementia who are charged. Specifically, the "protocol ought to address where such an individual should be housed, how such a person should be assessed (both from a healthcare perspective and from a justice perspective) and what arrangements could be made to accommodate both the healthcare and justice systems."[54]
- While police cannot be expected to "care" for people with dementia, and while there was nothing the police in Mr. McLeod's case could have done differently, police forces "should give some consideration to incorporating an educational component into their respective training programs relating to persons afflicted by dementia."[55]

In response to the Inquest Report, the Manitoba government released a Recommendation and Implementation Plan, and established a multi-sector implementation team, with representatives from Manitoba Health; Manitoba Justice; the Selkirk Mental Health Centre; regional health authorities; personal care homes; the Alzheimer's Society of Manitoba; law enforcement agencies; and legal experts.[56]

In 2015, a process flow chart was produced for referral, assessment, panelling (i.e., the approval process for long-term care eligibility in Manitoba), and placement for persons with dementia who have correctional involvement.[57] It includes health authority contact information for use by Corrections, and a mechanism for information-sharing among Corrections, health authorities, and the courts.[58]

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[50] *Ibid* at para 254.
[51] *Ibid* at para 255.
[52] *Ibid* at para 260.
[53] *Ibid* at para 261.
[54] *Ibid* at para 267.
[55] *Ibid* at para 281.
[56] Government of Manitoba, *Frank Alexander Inquest: Recommendation Implementation Plan*, (n.d.), online: <https://www.gov.mb.ca/health/documents/fai_report.pdf> at 3.
[57] "Winnipeg Regional Health Authority Protocol with Department of Justice/Corrections (Draft)" (on file with Dementia Justice).
[58] A/Director of Health Services, Department of Corrections, Manitoba Government, *Advisory Note for Minister of Justice*, Subject: Alexander Inquest (22 September 2015) (on file with Dementia Justice).

Tragedies like the one involving Mr. McLeod have occurred, and may again occur, across Canada. While the Frank Alexander Inquest recommendations are specific to Manitoba, many of the ideas and changes have applicability across the country. The Transformation of the Criminal Justice System initiative provides an opportune time to ensure that all Canadians with dementia, no matter their province or territory, benefit from the lessons learned in Manitoba, as well as other jurisdictions which have struggled with and learned from similar tragedies.

PART D: THE WAY FORWARD

While there is considerable work to be done to improve how the criminal justice system manages people with dementia, there is a strong foundation is build from. As indicated in this submission, there is already some good work being done—by the Guelph Police, the Alzheimer Society Waterloo Wellington, the Alzheimer Society of B.C., the Alzheimer Society of Muskoka, the legal experts at ACE, and many others. The Frank Alexander Inquest, and the changes that followed, also provide important insights into the intersection of dementia and the criminal justice system.

Building on this work, we propose that the federal government bring together all stakeholders to develop a national *Dementia and Criminal Justice Action Framework* (Action Framework). The aim of this pan-Canadian framework would be to identify and close gaps in services and supports, identify and implement promising approaches and best-practices, with the ultimate goal of ensuring public safety and improving the quality of life for people with dementia who come into conflict with the criminal justice system. This Action Framework could be one aspect of Canada's future comprehensive national dementia strategy.[59]

CONCLUSION

Now more than ever, a transformed and modern criminal justice must be able to meet the unique needs of people with dementia. Ignoring this challenge is not a reasonable option. By addressing the priorities in this submission, and through the development and implementation of an Action Framework, Canada will be at the international forefront of recognizing and responding to the intersection of dementia and the criminal justice system.

Most importantly, we believe that a responsive justice system has the potential to enhance public safety and improve the quality of life of people who are affected by this terrible disease.

For questions or further information, please contact:

Heather Campbell, Director
Dementia Justice Society of Canada
Ottawa, Ontario
Email: dementiajustice@outlook.com
Website: www.dementiajustice.com

[59] *National Strategy for Alzheimer's Disease and Other Dementias Act*, SC 2017, c 19.