BRITISH COLUMBIA REVIEW BOARD

IN THE MATTER OF PART XX.1 (Mental Disorder) OF THE CRIMINAL CODE R.S.C. 1985 c. C-46, as amended S.C. 2005 c. 22

REASONS FOR DISPOSITION
IN THE MATTER OF

STEVEN HEER

HELD AT: **Forensic Psychiatric Hospital**
Port Coquitlam, BC
February 28, 2017

BEFORE:	**CHAIRPERSON:**	**B. Walter**
	MEMBERS:	**Dr. S. Iskander, psychiatrist**
		M. Majedi

APPEARANCES:
ACCUSED/PATIENT: Steven Heer
ACCUSED/PATIENT COUNSEL: A. Glouberman
DIRECTOR AFPS: Dr. E. Wang, P. Gill
DIRECTOR'S COUNSEL: D. Lovett, QC
ATTORNEY GENERAL: L. Hillaby

INTRODUCTION

[1] On February 28, 2017, the British Columbia Review Board ("BCRB") convened an annual hearing to review the disposition of Steven Heer, the accused, who is now 32 years of age.

[2] We are entitled to accept some, none or all of the evidence before us. While we have considered all of the evidence on record in this case, we only recite that which is necessary to our decision.

PSYCHIATRIC HISTORY

[3] In 2009, in the context of significant academic stress, Mr. Heer bumped a number of people on campus over a period of some months. His conduct was apparently sufficiently aggressive that it lead to charges. These were dealt with by mental health services. These incidents appear to mark the onset of Mr. Heer's mental illness.

[4] In late 2010, early 2011, Mr. Heer experienced a five week hospital admission in Edmonton, under Alberta's *Mental Health Act*, after an episode of aggression involving his sister, arising from paranoid ideation about her actions. The family also reported concerns about other odd, paranoid ideation, based on Mr. Heer's belief that he was being followed. His symptoms resolved with treatment and he was discharged from hospital on January 17, 2011, with a diagnosis of schizophrenia.

[5] Mr. Heer was apparently medication compliant. His dosage of Risperidone was being medically reduced in July 2011. He stopped medication without informing others he says because it was being reduced anyway. His family began to notice signs of decompensation.

[6] There is no history of alcohol or drug use.

INDEX OFFENCE

[7] On August 18, 2011, Mr. Heer was charged with Second Degree Murder, contrary to s.325 of the *Criminal Code* ("*the Code*"). The victim of the index offence was Mr. Heer's father.

[8] Mr. Heer drove his motor vehicle into his father in full view of witnesses. As the victim attempted to gain access to his home, the accused drove into him a second time, striking him in the pelvic area. Mr. Heer backed the vehicle and struck his father a third time. He then exited the vehicle, kicked and punched the victim while his wife tried to

protect him. Shortly thereafter, the accused left the scene in another vehicle. His father died at the scene. Mr. Heer was apprehended in an acutely psychotic state and hospitalized.

[9] Mr. Heer disclosed that he was experiencing auditory and visual hallucinations of a command nature at the index offence. Mr. Heer admitted that he had discontinued his medications in July 2011, eighteen days before the index offence.

VERDICT

[10] On September 7, 2012, a year after the index offence, Mr. Heer was given a verdict of NCRMD by the Alberta Court of Queen's Bench.

PROGRESS AFTER TREATMENT

[11] Under treatment with depot antipsychotic medication Mr. Heer's mental state stabilized. He has been described as organized and free of positive symptoms of schizophrenia since at least January 2012.

[12] Mr. Heer's progress in hospital, under disposition of the Alberta Review Board ("ARB"), was described as "mixed". On February 5, 2013, his community access was restricted due to an AWOL or AWOL attempt. There was no evidence of accompanying mental state deterioration. Even at that relatively early stage in his treatment and recovery, Mr. Heer appeared to be somewhat impatient, frustrated or angry at the pace of his progress. His presentation was described as superficial, even deceitful, aloof and egocentric, though he was neither hostile, oppositional, nor violent. He was free of significant negative symptoms. His "trustworthiness", limited insight and negative attitude were of concern: *Ex. 9*.

[13] Prior to Mr. Heer's February 21, 2014 ARB appearance, his treatment providers, on the basis of his overall demeanour and engagement, began to question the presence of narcissistic personality traits in addition to his schizophrenia.

[14] On August 29, 2014, Mr. Heer was transferred to BC under s.672.86(1) of the *Code*, and admitted to FPH. On admission, Mr. Heer was apparently surprised to be placed on a secure assessment unit at FPH. He believed that he would be afforded the level of security and privileges that he had achieved in Alberta and that he would be close to conditional discharge. There was noted pressure from the accused and his family to increase his privileges and to have him progress more rapidly. His family appeared to

minimize both the impact of the index offence and any concerns identified by his Alberta treatment team, in particular with respect to the possibility or potential of future risk. However, Mr. Heer presented with no problematic behaviours.

[15] At FPH, Mr. Heer's schizophrenic symptoms remained in remission. Nevertheless, his discharge was considered premature. His treatment team favoured a more gradual approach to his reintegration. Mr. Heer's insight was termed reasonable and he was able to verbalize his need for ongoing treatment compliance. He was described as a moderate risk of significant future violence.

[16] Mr. Heer was detained following his first appearance before the BCRB on October 16, 2014.

[17] During the following six months, the accused demonstrated some examples of questionable judgement. He somewhat grudgingly accepted limits on his self-initiated plans and decisions. Dr. Tomita's opinion definitely confirmed the presence of narcissistic personality traits, based on Mr. Heer's superficial attitude, and some manipulative behaviours. His social judgment was considered to be impaired. His transparency, vis-à-vis his treatment team, was questioned. This affected the team's confidence that he would disclose stress or problems. Interestingly, his future risk was seen to be directly related to the rate of increases in his freedoms. He appeared to downplay his potential risk and to view "the system" as a hindrance to his progress. His narcissistic reaction to frustration or disappointment was, itself, considered a risk factor, independent of his psychotic illness which remained in remission.

[18] As of June 8, 2015, Mr. Heer was discharged subject to conditions by the BCRB. The Board expressed its concerns about the accused's tendency to "over-reach", risking stress and possible destabilization; his entitled, demanding presentation; his limited insight into his treatment needs; his poor social judgment; his difficulty in accepting imposed limits, and his overall transparency or openness.

[19] Prior to Mr. Heer's discharge in June 2015, he was placed on visit leave to his mother's home. As a result of concerning news about Ms. Heer's health and worries about how Mr. Heer would respond emotionally, his early return for up to two months was requested. By June 5, 2015, Mr. Heer was feeling better and on June 10, his discharge proceeded according to plans. Mr. Heer was initially seen as an outpatient, on a weekly basis. He presented as pleasant and co-operative. His initial placement was with his

mother but by mid-October he was permitted overnights at a condominium owned by his family.

EVIDENCE AT THE FEBUARY 28, 2017, HEARING

[20] As of the date of the current hearing, Mr. Heer has resided on his own, on a full time basis, since December 2016. He began driving in February 2016 and has purchased a car. His family has no concerns about his driving. Mr. Heer's family remains unconditionally supportive of him and his mother is not hesitant to express or convey any concerns about his functioning.

[21] Mr. Heer's diagnosis of schizophrenia and narcissistic personality traits are now well established. Mr. Heer remains free of positive and negative psychotic symptoms. He acknowledges that he could relapse to delusional thinking if he were to discontinue his depot medication. He sees benefit from it and says he would not discontinue it unilaterally.

[22] Mr. Heer's compliance with treatment and with his reporting requirements has been issue-free. He is in no way resistant to treatment. His progress on discharge has been largely positive and further good progress is expected.

[23] Mr. Heer has made several attempts to gain employment. He has experienced job losses at grocery stores as well as at two other office-based positions, possibly as a result of routine, employment-related record checks. Despite his strong motivation to work he coped with these setbacks or disappointments adequately. Mr. Heer is now connected to a temporary employment agency. He continues to seek employment that he considers more appropriate to his abilities. Ms. Gill testified that Mr. Heer has advised that he might wish to change his name once discharged absolutely to avoid such record-related job losses in the future.

[24] Dr. Wang considers Mr. Heer's "impression management" – needing to present himself in an overly positive light – as an area of ongoing concern; one which may be related to potential risk should it result in an under-reporting of issues relating to the his mental state. He tends to diminish or dismiss concerns about his personality style, but Dr. Wang considers this an area of some importance as it may affect how Mr. Heer copes with stress, as well as how he assesses his own mental state and accepts feedback.

[25] During the past year, Mr. Heer has been able to be somewhat more disclosive of his internal processes. He accepts the serious nature of the index offence. He is able to

express regret and the desire not to harm anyone in the future. He was open to delaying his eagerly awaited discharge to community living consistent with his family's advice. Mr. Heer's family, especially his mother, is well informed about his illness, support his adherence to treatment and notably sought treatment and support even prior to the index offence, unfortunately without success.

[26] In an effort to advance his progress or chances of absolute discharge, Mr. Heer has initiated a relationship with a private family physician, Dr. Sawal. Mr. Heer has been seeing Dr. Sawal since September 23, 2016. Mr. Heer has disclosed his illness and his forensic history to Dr. Sawal and will provide him with past and future assessments. Dr. Sawal is willing to administer Mr. Heer's prescribed injectable medication and to refer him to a private psychiatrist. Dr. Sawal intends to see Mr. Heer every two weeks to monitor his mental state and will also communicate with his mother and extended support network.

[27] In his assessment of Mr. Heer's risk of further harm to others, Dr. Wang emphasized Mr. Heer's ongoing low insight and the possibility of problems in coping with destabilizing stress. Dr. Wang continues to believe that Mr. Heer requires legally mandated supports and services to manage his risk, on the basis that, if he were to become acutely psychotic, he could engage in serious violence against someone with whom he is delusionally preoccupied, most likely, family members or employers.

[28] Dr. Wang raises the possibility that Mr. Heer could decompensate to such a state, even while compliant, if his medication were to lose its effectiveness. With respect, Dr. Wang provided no research to support the probability of this eventuality and certainly no evidence which would render it probable in respect of Mr. Heer personally. Indeed, it strikes us that the statement could apply to any and every mentally ill person to an extent that would foreclose ever granting anyone an absolute discharge. As evidence this sort of information would improperly impose a legally impermissible onus to disprove threat on an accused. We accord no weight to the statement: see for example **DH v. British Columbia (Attorney General);** [1994] BCJ 2011:

> With respect, I think the Review Board placed an unreasonable interpretation on the words "significant threat". The phrase implies a consideration of possible future events, but the evidence must take the Board beyond mere speculation. In **Orlowski**, supra, the risk of harm was obvious.
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> The Board's interpretation here places an impossible burden on a person in the appellant's position: he must negative any future possibility that he

> may become a significant threat, no matter how remote that possibility may be. That ascribes to "significant threat" a meaning that the words cannot reasonably bear and amounts to a reversible error in law: *paras 21, 22.* (emphasis added)

[29] On a positive note, Dr. Wang's assessment indicates that Mr. Heer remains free of violence or violent ideation. He now lives and functions largely independently, and his narcissistic traits have not destabilized him. Nevertheless, Dr. Wang continues to express residual concerns that Mr. Heer's personality style may affect assessment of his mental state and that his over-confident attitude may cause him to underestimate stressors or their impacts. Under certain circumstances, Dr. Wang fears that these features could conspire to persuade Mr. Heer to discontinue treatment, whereupon he would deteriorate. He also reiterates Mr. Heer's previous physician's concerns about their "deceitful", dismissive, and entitled interactions, a description he believes is consistent with, and the product of, Mr. Heer's narcissistic traits.

[30] Dr. Wang appears to relate Mr. Heer's lack of "psychological mindedness" and his "concrete thinking" to possibly residual symptoms of his schizophrenia. Despite this characterization, Mr. Heer was in fact able to navigate through and respond in a sophisticated manner to complex questions during this hearing. We also consider whether Mr. Heer's response style may represent a mechanism to distance himself from the horrific circumstances and emotions associated with his index offence.

[31] In any event, before he can confidently support Mr. Heer's absolute discharge, Dr. Wang would like to see him establish a more collaborative and transparent relationship, one which gives the treatment team confidence that Mr. Heer is able to accept and to follow feedback (as he has in fact done to date).

[32] In his testimony, Mr. Heer was able to state that he suffers from paranoid schizophrenia and, perhaps in a somewhat rote or learned manner, to describe some of its symptoms. He agrees, and does not appear to dispute, that he will need to stay on medication for life. Mr. Heer says that, if absolutely discharged, he would follow the recommendations of his physician and the psychiatrist to whom he is being referred. He is willing to talk to such a psychiatrist in greater depth as he feels he does not get the sort of "real" feedback he would like from his current treatment regime. He would also prefer physicians who share his cultural heritage and beliefs.

[33] Mr. Heer sees his family, including his sisters daily and his brother-in-law on weekends.

[34] Mr. Heer says that he first became ill around 2009 when he became “overly stressed” in relation to carrying a heavy course-load. He said he was “rushing around” and “bumping into people” on his university campus. An estimated nine incidents of bumping occurred over the span of several months. Mr. Heer indicated that when he made physical contact with an individual on campus, he would recognize what had occurred but did not feel the need to apologize because he somehow believed himself to be “better than” they were. Mr. Heer had difficulty identifying a clearer link between specific psychotic symptoms and the events that led to charges and subsequent diversion to mental health resources. He agrees that he was not formally diagnosed until 2011.

[35] Mr. Heer ceased his medications eighteen days prior to the index offence. He had suspicions about his psychiatrist but says that he stopped his medication based on the tragically erroneous belief that, because his (bumping) charges were stayed, he did not need to continue to take them and did not realize the risk of such non-compliance. His thinking and behaviour became more disorganized and he developed extremely delusional beliefs about his father. He has never experienced such thoughts while medicated.

[36] Mr. Heer was able to speak about the index offence with great precision and detail, despite what he describes as disturbing, unpleasant symptoms at the time. He reiterated that he saw his father as a demon and intended to free him from possession. He was in a zombie-like state at the time of his offence. He was quickly overwhelmed by command hallucinations. He described the impulse to act upon the commands as immediate.

[37] Mr. Heer says that he has sought employment or jobs which involve minimal stress. He does not consider a return to school as a current option because of the stress and relapse risk it could engender. He sees his involvement with FPS as an obstacle to employment.

[38] Mr. Heer insists that he has always accepted his treatment team’s direction and that he has also responded to the suggestions which arose at his last hearing. He insightfully agrees that he was not ready to manage his own health last year.

[39] Mr. Heer regrets the index offence and will not become non-compliant with medication again. He does not wish to hurt his family or put others in jeopardy by

becoming ill again. He identifies signs of relapse as lack of attention to his hygiene and disorganized thinking. He does not readily accept his narcissistic personality features; he commented that half of the world is narcissistic. Mr. Heer attributes pride in his appearance and grooming to his Sikh religion and cultural background. He acknowledges that he is perhaps not psychologically minded and does not fully understand himself. He cited no other “weaknesses”.

[40] Mr. Heer’s mother’s testimony tried to put her son’s presentation and apparent narcissism into context as being consistent with his upbringing. She appears informed and educated about her son’s illness and cited some symptoms corresponding to relapse. She described what appear to have been sincere attempts to connect her son to treatment including approaching the courts and police when Mr. Heer first became ill, unfortunately to no avail. Ms. Heer does not believe her son would cease taking his medication in the future and says he always follows his treatment team’s recommendations.

ANALYSIS AND DISPOSITION

[41] The Board’s decision making is governed by s.672.54, and s.672.5401 of the *Criminal Code* (as amended) which provide:

> When a court or Review Board makes a disposition under subsection 672.45(2), section 672.47, subsection 672.64(3) or section 672.83 or 672.84, it shall, taking into account the safety of the public, which is the paramount consideration, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused, make one of the following dispositions that is necessary and appropriate in the circumstances:
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> (a) where a verdict of not criminally responsible on account of mental disorder has been rendered in respect of the accused and, in the opinion of the court or Review Board, the accused is not a significant threat to the safety of the public, by order, direct that the accused be discharged absolutely;
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> (b) by order, direct that the accused be discharged subject to such conditions as the court or Review Board considers appropriate; or
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> (c) by order, direct that the accused be detained in custody in a hospital, subject to such conditions as the court or Review Board considers appropriate.
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> **672.5401** For the purposes of section 672.54, a significant threat to the safety of the public means a risk of serious physical or psychological harm to members of the public — including any victim of or witness to the offence,

> or any person under the age of 18 years — resulting from conduct that is criminal in nature but not necessarily violent.

[42] The Board must first determine whether Mr. Heer poses a significant threat to public safety as defined in s.672.5401. In doing so, the Board does not, and is not permitted to conduct its own assessment of the accused's risk. Rather, it evaluates the evidence of threat that it receives in the context of a hearing, to determine whether the threshold is met.

[43] We first consider Mr. Heer's history of violence or aggression. On the evidence before us, we find there have been two episodes: the "bumping" of strangers in 2009 and the episode involving his sister, both of which we consider aggressive though not at the more serious pole of the violence spectrum. In retrospect, these likely unfolded in the context of Mr. Heer's emerging schizophrenic illness. The fatal index offence was ultimately violent. It occurred while the accused was floridly and acutely psychotic and non-compliant. Mr. Heer has demonstrated the capacity for serious criminal violence.

[44] Mr. Heer's diagnoses are well established and supported by professionals. The key to controlling Mr. Heer's risk is obviously the maintenance of his mental stability.

[45] Mr. Heer's mental state has been stable and his psychotic symptoms have been in remission since at least January 2012, five years ago. He has, throughout, accepted both his illness and its need for treatment. Nevertheless, he has demonstrated a single episode of non-compliance for 18 days with tragic results. His family's efforts to get help were unsuccessful.

[46] Mr. Heer has shown no evidence of non-compliance with medication since the index offence. Despite his presentation, vis-à-vis his treatment providers, and clear desire to move beyond this scheme, Mr. Heer has, on the evidence been entirely compliant. He is, despite his communication style, able to verbalize his reasons to comply and to adhere to treatment indefinitely. He acknowledges that non-compliance could cause him to relapse to psychosis. He genuinely wants to avoid this. He has also, in the main, been pleasant, co-operative and accepting of advice and expectations. He has, over the past year, become more open about his thinking with his treatment team.

[47] As of December 2016, some four months now, Mr. Heer lives and cares for himself entirely. He has the unflinching support of his close family, who appear willing to

monitor his mental state and have demonstrated that they will not hesitate to enlist help and support as necessary.

[48] Mr. Heer has experiences a series of job losses which, given his self-image and aspirations could be expected to cause him stress. He has nevertheless tolerated these incidents with equanimity. He also coped with the emotional stressor of his mother's health scare, which could have delayed his long-awaited discharge from hospital, in a manner that was insightful. That said, his subjective description of his life as entirely stress-free may be an overstatement.

[49] The outstanding issue of concern is Mr. Heer's personality construct: his identified narcissistic traits and their potential risk implications. Mr. Heer's treatment team is concerned that his personality traits, of which he is somewhat dismissive, could jeopardize his commitment to treatment on a voluntary basis, although there is no evidence that he has disregarded their advice. We are left with at least the suspicion that narcissistic traits, even short of a disorder, may be associated with heightened risk, possibly due to a resulting sense of entitlement, lack of empathy, or self-justification. This dynamic inspires caution.

[50] Under the circumstances, we somewhat cautiously conclude that Mr. Heer could continue to pose a significant threat justifying our jurisdiction for a further period of time.

[51] It is not our intention to place the burden of disproving his potential risk on Mr. Heer's shoulders. He has demonstrated impressive progress and more is anticipated.

[52] However Mr. Heer has only recently become wholly independent. We consider it prudent to extend our supervision for a period of time to enable Mr. Heer to behaviourally demonstrate his verbal commitment to remain treatment adherent.

[53] Further, Mr. Heer has undertaken arrangements for his ongoing medical supervision. He has, however, not yet identified a psychiatrist who will agree to monitor his mental health. We were provided with no information as to who this might be or when a referral might occur. It strikes us that this will be an important aspect of any management plan going forward.

[54] Therefore, while we have no basis to consider anything but the current status quo is either necessary to the protection of the public, nor appropriate in terms of furthering his reintegration, we consider it prudent to require Mr. Heer to provide the Board at his next

hearing, with a report from his new psychiatrist that demonstrates that this professional has accepted Mr. Heer as a patient; that Mr. Heer has disclosed his personal, psychiatric and forensic history; and that this physician is able and willing to monitor Mr. Heer's mental state and supervise his treatment.

[55] For that reason, we have determined to continue Mr. Heer on a disposition of discharge subject to conditions, for a further period of six months or less if appropriate.

Reasons written by B. Walter, in concurrence with Dr. S. Iskander and M. Majedi