SUPREME COURT OF NOVA SCOTIA
(FAMILY DIVISION)

Citation: *Nova Scotia (Community Services) v. C.R.*, 2019 NSSC 84

Date: 20190318
Docket: SFHCFSA-108201
Registry: Halifax

Between:

Minister of Community Services

Applicant

v.

C.R.

Respondent

LIBRARY HEADING

Judge:	The Honourable Justice Carole A. Beaton
Heard:	February 1, 4, 5, 6 and 7, 2019 in Halifax, Nova Scotia
Written Decision:	March 18, 2019
Subject/Key Terms:	*Children and Family Services Act*
Summary:	The Applicant seeks permanent care of the Respondent's child.
Issues:	(1) Is the child in need of protective services? (2) Is a permanent care order in the child's best interests?
Legislation:	*Children and Family Services Act*, S.N.S. 1990
Cases Considered:	*Nova Scotia (Minister of Community Services) v. S.C.*, 2017 NSSC 336 *Nova Scotia (Minister of Community Services) v. A.R.*, 2018 NSSC 86 *S.A.D. v. Nova Scotia (Community Services)*, 2014 NSCA 77

Result:

1) The child remains in need of protection services.

2) Permanent care is the only order suitable to properly address the child's best interests.

THIS INFORMATION SHEET DOES NOT FORM PART OF THE COURT'S DECISION. QUOTES MUST BE FROM THE DECISION, NOT THIS LIBRARY SHEET.

SUPREME COURT OF NOVA SCOTIA
FAMILY DIVISION

Citation: *Nova Scotia (Community Services) v. C.R.*, 2019 NSSC 84

Date: 20190318
Docket: SFHCFSA-108201
Registry: Halifax

Between:

Minister of Community Services

Applicant

v.

C.R.

Respondent

Restriction on publication:

Publishers of this case please take note that s. 94(1) of the *Children and Family Services Act* applies and may require editing of this judgment or its heading before publication.

Section 94(1) provides:

No person shall publish or make public information that has the effect of identifying a child who is a witness at or a participant in a hearing or the subject of a proceeding pursuant to this Act, or a parent or guardian, a foster parent or relative of the child.

Judge:	The Honourable Justice Carole A. Beaton
Heard:	February 1, 4, 5, 6 and 7, 2019 in Halifax, Nova Scotia
Written Release:	March 18, 2019
Counsel:	Elizabeth Whelton, Q.C. for the Applicant Linda Tippett-Leary for the Respondent

By the Court:

Introduction

[1] Sadly, in many child welfare proceedings the Court hears allegations of the disturbing conditions of some children – situations of physical or emotional abuse, inadequate housing, poor nutrition, lack of health care or hygiene, parental substance abuse, domestic violence and the list goes on. To be blunt, in some previous cases the evidence militating in favour of a permanent care order has been so overwhelming that the decision was almost made "easy", to the extent that any Court's task of removing a child(ren) permanently from the custody of a parent(s) could ever be so characterized. This case is very different from those.

[2] There is no dispute between the Applicant Minister and the Respondent parent that the Respondent is a capable and loving parent who can meet the needs of and perform the daily tasks required to care for the child, J. When in the Respondent's care, J. has been clean and well fed, residing in appropriate accommodations, meeting developmental milestones, followed by a family doctor, and socially stimulated through attendance at daycare and other community-based activities, with funds set aside in an RESP for J.'s future education. The Respondent's capacity to appropriately parent J. should otherwise have gone unnoticed by the Applicant, and ultimately by the Court, except for one factor – the Respondent's mental health.

[3] The Applicant seeks a final disposition order of permanent care and custody of the child pursuant to s.42(1)(f) of the *Children and Family Services Act*, SNS 1990, c.5. The Respondent seeks the return of the child, under the supervision of the Applicant, pursuant to s. 42(1)(b) until the end of the statutory deadline in this proceeding, which is June 11, 2019. The burden of proof on a balance of probabilities rests with the Applicant to persuade the Court the child remains in need of protective services and that a permanent care order is in the child's best interests.

[4] The Applicant argues the Respondent's mental health condition presents a risk of future harm to J. such that the child cannot be adequately protected absent a permanent care order. The child, presently three and half years of age, has twice been in care since birth, which the Applicant asserts is primarily due to the Respondent's unwillingness to adhere to a course of prescribed treatment. Both apprehensions of the child came about when the Respondent's mental health

deteriorated to the point the Respondent's very paranoid, anxious and irrational thoughts and behaviors came to the attention of police, in chaotic episodes where the Respondent's mental health crisis left him/her unable to focus on the presence of or needs of the child.

[5] The Respondent argues that his/her mental health condition has now been stable for some time, and there is still time left in this proceeding (between now and June) for the Applicant to monitor the Respondent's compliance with prescribed treatment, concurrent with the Respondent's safety plan developed for the child. The Respondent relies on a post-apprehension record of attendance at appointments with mental health care providers and compliance with a medication regime, along with support from friends and out-of-province family as demonstrating that any perceived risk to the child can be addressed over the long term without resorting to a permanent care order.

Issues

[6] The first question is whether the child remains in need of protective services. If the conclusion is the child is no longer in need of protective services, then the matter is at an end; the proceeding must be dismissed, and the child returned to the Respondent. If the Court concludes the child remains in need of protective services, then I must consider through the lens of the best interests of the child (s.3 (2) of the *Act*), which of those orders possible under s.42(1) of the *Act* will be in the child's best interests.

[7] The Applicant's evidence and submissions focussed on the ongoing need of the child for protective services owing to the substantial future risk to the child posed by the Respondent's inability or unwillingness to manage his/her mental health condition, and the resultant necessity of a permanent care order as being in the child's best interests.

[8] The Respondent's evidence and submissions were heavily focused on the latter issue – that if the child remains in need of protective services, that can be best addressed through the least intrusive measure of having the Applicant continue to monitor the Respondent's adherence to treatment concurrent with returning the child to the Respondent's care, but under a supervision order only until the statutory timeline is exhausted.

Brief History of the Proceedings

[9] J. was born in November 2015 and was residing with the Respondent in their home. The child was taken into care in March 2016 at age 4 months and the Respondent was involuntarily hospitalized for a period of time. The child was found in need of protective services in June 2016 and placed with the Respondent's mother, who had relocated to this province. The grandmother was required to supervise the Respondent's contact with J. and all three resided together. In October 2016 the grandmother left Nova Scotia and J. was placed in the Respondent's care under a supervision order; the Respondent was taking medication by injection and was under the care of a mental health team which included regular contact with a psychiatrist.

[10] By early 2017 the Respondent had chosen to switch from injections to oral medication; that spring the Respondent was also referred to a psychologist (but did not pursue that care). The child was in daycare and the Respondent completed family skills programming and was pursuing employment. In early July 2017, the proceeding was terminated.

[11] By December 2017 the Respondent was no longer taking prescribed medication nor accessing mental health services and therapy, and the child was no longer in daycare. This second proceeding commenced with apprehension of the child and the Respondent was again involuntarily hospitalized for a period of time. Eventually discharged under a Community Treatment Order ("CTO") pursuant to the *Involuntary Psychiatric Treatment Act,* the Respondent then had no choice but to receive medication by injection. The Respondent was also re-connected with mental health professionals, with whom treatment continues at this time.

[12] The child has been in the temporary care and custody of the Applicant for the duration of this second proceeding. At first disposition the child was found in need of protective services pursuant to s.22(2)(g) of the *Act* (risk of emotional abuse). The Respondent continues to exercise regular, supervised access at home and in the community, which by all accounts has gone very well. Most of J.'s life has been spent supervised by or in the care of the Applicant.

Evidence and Current Circumstances

i. The Applicant's Evidence

[13] The Court heard the expert evidence of the Respondent's former psychiatrist, Dr. E. Dini, treating psychiatrist, Dr. T. Pellow, treating psychologist,

Dr. C. DeFreitas, and treating family physician, Dr. P. Somers. From among the evidence of those witnesses certain themes emerged:

i. The Respondent is intelligent, articulate (both as demonstrated in the Respondent's evidence) and resourceful. Since first being diagnosed with a mental health condition many years ago, the Respondent has for periods of time been hospitalized, and at other times been able to function in the community, living independently and employed.

ii. The Respondent is unwilling to accept the medical diagnosis of a permanent and irreversible delusional disorder, maintaining instead that the correct diagnosis is depression and/or post-traumatic stress disorder. As a result, the Respondent demonstrates a lack of insight about the diagnosed condition.

iii. The Respondent's ability to function independently in the community is and will remain contingent on engaging in all aspects of the care plan(s) identified by treating physicians and professionals, including taking prescribed medication. The medication is crucial to allowing the Respondent to carry on day-to-day in spite of the delusional thinking.

iv. The Respondent has historically been resistant to treatment at various periods, including not attending appointments with mental health professionals, unilaterally ending relationships with physicians, and not taking prescribed medication or being resistant to medication due to concerns about side-effects.

v. Since the birth of J. the Respondent has twice "gone off" the prescribed medication, which culminated both times in the Respondent's mental health deteriorating to a point where the Respondent's delusional thinking was profound and disturbing.

vi. The Respondent has worked hard to try to make progress in discrete areas such as employment and is generally attentive to matters of physical health. The Respondent's thinking around conspiracy theories and paranoia is exacerbated when in conflict with authority figures and by times this has impacted the Respondent's efforts to pursue goals.

vii. After learning the Minister intended to seek permanent care of J. during this proceeding, the Respondent instructed health care

providers not to provide any further information/records to the Applicant.

viii. Within days prior to the hearing of this matter, the CTO previously imposed by Dr. Dini binding the Respondent to a treatment plan was discontinued. Among other matters, it had required the Respondent to take prescribed medication for the diagnosed mental illness, and failure to do so would alert the treating physician.

ix. The discontinuance of the CTO coincided with the Respondent's mother, who had acted as statutory decision-maker for the Respondent under the CTO, advising the Respondent's treating psychiatrist that she would only continue in her role as statutory decision-maker pursuant to the Personal Directives Act. (The Applicant only became aware of this development during the hearing).

x. Various of the expert witnesses expressed uncertainty about the implications of the Personal Directives Act for the Respondent's future obligation to adhere to treatment but were clear that absent a CTO the Respondent was not bound to take medication, and there was no longer a mechanism to monitor whether the Respondent did so.

[14] The Respondent's mental health social worker, J. Thornhill, testified as to her willingness to continue working with the Respondent in future regardless of their limited contact in recent times. (In the past the Respondent had only wanted to see her when at appointments with the psychiatrist, and not for the purpose of assisting with any other goals).

[15] The child protection social worker, Ms. Brooks, testified as to the history of the proceeding and the Applicant's concerns that the child is at risk of future harm because of the Respondent's historical non-compliance with a prescription medication regime, ongoing abuse of certain over-the-counter medication, termination of relationships with prior physicians and lack of insight into the mental health diagnosis. The worker questioned how the Applicant could be confident the Respondent would properly care for J. in the future given a "pattern" of only complying with treatment for certain periods of time, and only as long as needed to satisfy the Applicant during the previous child welfare proceeding, with that concern having been heightened by the recent removal of the CTO.

ii. The Respondent's Evidence

[16] The Respondent called evidence from friends G.D.-G. and C.L., who both form part of the safety plan for the child identified by the Respondent as mitigating any potential of future risk to J. while in the Respondent's care. Both friends testified as to the history of their respective relationships with the Respondent and recounted their individual understandings of the Respondent's past mental health challenges and hospitalizations, and the need for the Respondent to take medication. They too spoke to the Respondent's day-to-day ability to parent J. as acknowledged by the Applicant's witnesses.

[17] While both individuals impressed the Court as sincere and well-meaning, their evidence was vague regarding important aspects of the Respondent's condition. I formed the conclusion neither is sufficiently informed so as to appreciate fully the potential for risks to the child that the Respondent's mental health condition presents. Neither witness was able to definitively articulate at what point or under what circumstances the Respondent's safety plan for J. might need to be activated. Neither party appears to fully grasp what a deterioration in the Respondent's mental health could mean for the safety or well-being of the child.

[18] The Respondent was cross-examined at some length, and to his/her credit readily acquiesced to the Applicant's counsel in some instances. For example, the Respondent agreed there have been past periods during which medication was not taken despite having been prescribed, the longest period having been for a year, around 2014-15. The Respondent was also careful to frame answers to some questions in such a way as to avoid compromising his/her position on the central issue of future risk to the child. For example, at times the Respondent avoided direct questions about whether he/she was accepting of the diagnosis of delusional disorder, explaining that rather than focussing on belief or acceptance, his/her approach going forward will be to avoid discussing the specific past event that forms the foundation or core of the delusional thinking.

[19] At other points in the evidence the Respondent very cogently explained away, minimized or occasionally denied any of a lengthy list of historical events and social or professional interactions that sharply illustrated what has occurred when the Respondent's mental health has deteriorated in the past. For example, the Respondent was critical of local police for having previously identified the Respondent as mentally ill, which the Respondent believes therefore negatively informs and frames all their interactions with the Respondent, and critical of certain former physicians who have failed to properly diagnosis and/or treat the Respondent.

[20] The central thrust of cross-examination related to the question of the connection between the Respondent's ability to assure future compliance with a course of prescribed treatment, and in particular medication, and any risk to the child given the Respondent's "track record" in this regard. The Respondent spoke well and was able to communicate a clear position, however the Court is left less than confident by that evidence that future risk to the child connected to any failure of the Respondent to adhere to treatment (therapy and medication) can be properly managed.

Issue No. 1 – Does the child remain in need of protective services?

[21] The Court must be persuaded on a balance of probabilities that a "substantial risk" is posed to the child. In *Nova Scotia (Minister of Community Services) v. S.C.*, 2017 NSSC 336, Jollimore, J. summarized the test for assessment of substantial risk:

> 35. "Substantial risk" is a real chance of danger that is apparent on the evidence: subsection 22(1) of the *Children and Family Services Act*. It is the real chance of physical or emotional harm or neglect that must be proved to the civil standard. That future physical or emotional harm or neglect will actually occur need not be established on a balance of probabilities: *MJB v. Family and Children Services of Kings County*, 2008 NSCA 64 at paragraph 77, adopting *B.S. v. British Columbia (Director of Child, Family and Community Services)*, 1998 CanLII 5958 (BCCA), at paragraphs 26 to 30.

[22] I do not need to be persuaded the risk will occur. At this time, the circumstances which existed at the time the protection finding was made continue. There remains a real possibility that, as has happened in the past, the Respondent will not adhere to treatment in the future, which would pose a considerable and substantial risk to the child's well-being. The Respondent's own evidence helps to support the conclusion that it is more probable than not that the future will not look substantively different than the past, in terms of the Respondent's willingness to adhere to a plan of treatment that is essential to functioning as a care-giver to the child. Having been persuaded the child remains in need of protective services owing to the existence of a substantial risk, I turn to the second issue

Issue No. 2 – Is a Permanent Care Order in the child's best interests?

[23] As noted by Jesudason, J. in *Nova Scotia (Minister of Community Services) v. A.R.*, 2018 NSSC 86:

> The preamble to the *Children and Family Services Act* ("CFSA"), recognizes that children have a sense of time that's different from adults and that services provided and proceedings taken under the CFSA must respect the children's sense of time. Furthermore, decisions made under the CFSA must not be dictated by feelings of sympathy for parents whose circumstances are extremely challenging. Rather, the paramount consideration for decisions is the best interests of the Children: section 2(2). (*sic)*

[24] The Court is alive to the reality that the Respondent is not unlike many other parents in experiencing mental health challenges. The problematic aspect is not the Respondent's mental health diagnosis. Rather, is the very real potential that failure to adhere to treatment would create serious risks for the child. The Court does not seek perfection in parenting and parents can often perform their role in the face of many obstacles to be managed if not, in some cases, overcome.

[25] The Respondent's future adherence to treatment is critical to the best interests of the child. Without it, the expert evidence has confirmed the inevitability of a severe deterioration in the Respondent's condition; such a deterioration would have serious consequences for the young child residing alone with the Respondent. At currently less than four years of age, J. could not be expected to be capable of communicating sufficiently to anyone about any deterioration of the Respondent's condition in adequate time to avoid serious compromise to the child's safety and/or well-being. Given J.'s age that would continue to be the case for some time to come.

[26] The expert evidence made it very clear the Respondent's mental health condition will never be overcome, only managed. It is in the management, which requires on-going adherence to a treatment plan, that the concern lies. The Respondent does not have to accept or agree with his/her diagnosis but does need to comply with the course of prescribed treatment, if only for the health and safety of and in the best interests of the child. The Court is left unassured, on the whole of the evidence, that needed compliance will be maintained in the future, which leaves the child keenly exposed to future risk of harm.

[27] The Court cannot risk the child's future well-being in the face of the evidence; I am unpersuaded that protection–like concerns would be less than probable of arising in the future. To that extent, I note the factual circumstances in this case are very different from those in *Nova Scotia (Minister of Community Services) v. S.C. (Supra),* where both parents' mental health conditions did not impede "good enough" parenting. As noted by Jollimore, J. in that decision:

> [39] The Minister's argument on this point was framed as the rhetorical question, "What are the prospects that she [Ms. C] will get help in the future?" This is an appropriate way to frame the issue. Parents who have poor mental health are not deprived of their children: parents whose poor mental health puts their children at risk and who do not seek needed treatment are. As well, this framing acknowledges that mental health conditions may be chronic and not capable of once-and-for all-resolution.

[28] Here, the word "seek" found in the above passage is substituted for the word "maintain". The child J. is obviously well-loved by the Respondent, but sadly vulnerable to the Respondent's condition. The Respondent's mental health puts the child at risk because while the Respondent has adhered to treatment by times, that adherence has not been sustained over the duration of J.'s life, and it is highly questionable for the future.

[29] While the Respondent has sometimes adhered to treatment in the past and might do so in future, that "might" or "probably" is not a chance the Court can take without seriously compromising the child's best interests, based on the history of the Respondent's management of his/her condition both prior to and since the birth of the child, as detailed in both the evidence of the expert witnesses who testified and to an extent in the Respondent's own evidence on cross-examination.

[30] In coming to my conclusions, I am mindful of the Court of Appeal's observation in *S.A.D. v. Nova Scotia (Community Services)*, 2014 NSCA 77 regarding the correlation between past history and future risk:

> [82] The trial judge found (para 30) that "the best predictor of future behaviour is past behaviour". That was Mr. Neufeld's testimony (above para 55) and was supported by the evidence of Ms. Boyd-Wilcox (above paras 49, 53). <u>There is no legal principle that history is destiny. But a trial judge may, based on the evidence in a particular case, find that past behaviour signals the expectation of future risk</u> **…** [emphasis added]

[31] At points during cross-examination the Respondent was able to articulate a commitment to a future treatment regime, but during the course of this second proceeding concerning the same child the Respondent has also ended a key physician-patient relationship, articulated a desire to secure an alternative diagnosis and articulated a desire to change the method of administering medication to one that would require no outside monitoring. All of those behaviours or views have also been features of past deteriorations in the Respondent's mental health and the stability of his/her condition.

[32] In closing argument, counsel for the Applicant submitted the Respondent's safety plan involves not only friends and out-of-province family, but also the Respondent's medical team. However, the evidence illustrated that by times the Respondent appears to have seen that team, or certain members of it, as obstacles. Coupled with a somewhat vague and inadequate safety plan for the child, the Court is concerned that the Respondent is saying what the Respondent perceives needs to be said in the hope of influencing a desired outcome to this proceeding.

Conclusion

[33] The evidence of the Applicant leads me to conclude, on a balance of probabilities, that the child remains in need of protective services on any or all of the three grounds set out in s.22(2)(b), (g) and (k) of the *Act* (risk of future physical harm, risk of future emotional abuse and risk of neglect). The evidence persuades me it is more probable than not that in future the Respondent would unilaterally decide to abandon any medically prescribed treatment plan, be it taking medication, regular engagement with physicians and care providers or both, thereby posing a danger to J.'s well-being. I have concluded on the whole of the evidence put before the Court that the child's best interests dictate that potential future risks to the child's safety and security not be managed by adopting a "wait and see" approach to the probability of a deterioration in the Respondent's ability to manage his/her condition.

[34] Even if the Respondent could parent between now and June 11th with certain boundaries or restrictions to safeguard the child's best interests, I am not left sufficiently confident on the evidence before me that those boundaries or restrictions would be adhered in the future. The Court's concern is for when the Respondent is left to self-manage with autonomy any conditions or restrictions the Court could impose between now and the end of the proceeding, such as a requirement that the Respondent take all medications as and when prescribed. The expert evidence of Dr. Dini was that lack of insight into one's condition is a hallmark of those with a delusional disorder and the Court is concerned about the risk to J. of any future unwillingness of the Respondent to follow prescribed treatment.

[35] I am of the view the least intrusive measure possible is a permanent care order. The evidence persuades me the circumstances justifying a permanent care order are unlikely to change before the expiration of the statutory timeline. It is in the best interests of J., who has spent the majority of his/her short life under the

supervision or care of the Applicant, and who measures time very differently from adults, to gain permanency as soon as possible. I note there has been no other possible placement alternative (s.42(3)(a)) put before the Court for consideration. Regardless of the parties' respective positions, which in effect left the Court with an "all or nothing" choice for J., the *Act* requires me to keep the best interests of the child squarely in focus, no matter how severe the fall-out of the decision for the Respondent. Counsel for the Applicant shall prepare the Order.

Beaton, J.