IN THE SUPREME COURT OF NOVA SCOTIA
(FAMILY DIVISION)
Citation: Nova Scotia (Health) v. C. R., 2005 NSSC 74

Date: 20050408
Docket: S.F.H. No. 034880
Registry: Halifax

Between:

Minister of Health

Plaintiff

v.

C. R.

Defendant

Editorial Notice

Identifying information has been removed from this electronic version of the judgment.

Judge:	The Honourable Assoc. Chief Justice Robert F. Ferguson
Heard:	March 29 & 30, 2005, in Halifax, Nova Scotia
Written Decision:	April 22, 2005
Counsel:	John Underhill, for the Plaintiff Fergus Ford, for the Defendant

By the Court:

[1] C. R. is fifty-two years old and the Defendant in an application by the Minister of Health dated October 25, 2004, pursuant to Section 10(2) of the *Adult Protection Act* in which the Minister seeks:

> "1. A declaration that the defendant, C. R., is an adult in need of protection, pursuant to Section 9(1) of the *Adult Protection Act*.;
>
> 2. A declaration that the defendant, C. R., is not mentally competent to decide whether or not to accept the assistance of the Minister of Health, pursuant to Section 9(3)(a) of the *Adult Protection Act*; and
>
> 3. An Order authorizing the Minister of Health to provide the defendant, C. R., with services, including placement in a facility approved by the Minister of Health, pursuant to Section 9(3)(c) of the *Adult Protection Act*."

[2] The Minister had made a similar application dated October 5, 2004, though not pursuant to Section 10(2) of the *Act*. In this application, reference was made to the appointment of a litigation guardian. The parties, in answer to the first application, appeared on October 18, 2004, and a hearing was scheduled for December 6 and 7, 2004. There was agreement that Ms. R. could instruct counsel and a litigation guardian was not a requirement. At the time of this appearance, Ms. R. was a formal patient in the Nova Scotia Hospital. On October 13, 2004, a decision of the Review Board held in conjunction with Section 65(1) of the *Hospitals Act* determined her status as formal patient be terminated. Ms. R. left the hospital a short time after the court appearance on October 18, 2004. This decision of Ms. R. triggered the current application pursuant to Section 10 of the *Adult Protection Act* that authorizes the Minister to bring about "the immediate removal of the person to such place as the Minister considers fit and proper for the protection of the person and the preservation of his life, and a person so authorized may take reasonable measures to remove the person whose life is in danger." This authority was exercised in this instance and Ms. R. was removed from her home and placed in the Nova Scotia Hospital. A hearing was held on October 25, 2004, (one day after the current application was issued) and an order was issued stating, in part:

> "AND UPON THE ABOVE DETERMINATIONS having been made on a preliminary basis, in order to comply with the provisions of Section 10(3) of the *Adult Protection Act*, until the Plaintiff's application pursuant to Section 9 of the *Adult Protection Act* can be heard on December 6 and 7, 2004;
>
> AND UPON THE PARTIES HAVING AGREED, and the Court having further determined, that the above determinations are being made without prejudice to the right of the Defendant, C. R., to challenge the Plaintiff's application pursuant to Section 9 of the *Adult Protection Act*.
>
> AND RESERVING to the Defendant, C. R., the right to cross-examine with respect to all documents on file herein;
>
> NOW UPON MOTION:
>
> 1. IT IS HEREBY DECLARED, pursuant to Section 9(1) of the *Adult Protection Act*, that the Defendant, C. R., is an adult in need of protection as defined in Section 3(b)(ii) of the *Adult Protection Act*.
>
> 2. IT IS FURTHER DECLARED, pursuant to Section 9(3)(a) of the *Adult Protection Act*, that the Defendant, C. R., is not mentally competent to decide whether or not to accept the assistance of the Minister of Health.
>
> 3. IT IS HEREBY ORDERED, pursuant to Section 9(3)(c) of the *Adult Protection Act*, that the Minister of Health shall be and is hereby authorized to provide the Defendant, C. R., with services, including placement in a facility approved by the Minister of Health.
>
> 4. IT IS FURTHER ORDERED THAT this that (sic) this (sic) matter shall be and is hereby adjourned to Monday, the 6th day of December, 2004 at the hour of 9:30 o'clock in the forenoon for the hearing of the Plaintiff's application pursuant to Section 9 of the *Adult Protection Act*."

[3] The application did not proceed as scheduled on December 6 and 7, 2004, and it was rescheduled to March 30 and 31, 2005.

[4] Ms. R. opposes this application.

RELEVANT LEGISLATION

[5] The following sections of the *Adult Protection Act*:

“3(a) ‘adult’ means a person who is or is apparently sixteen years of age or older;

(b) ‘adult in need of protection’ means an adult who, in the premises where he resides,

(i) is a victim of physical abuse, sexual abuse, mental cruelty or a combination thereof, is incapable of protecting himself therefrom by reason of physical disability or mental infirmity, and refuses, delays or is unable to make provision for his protection therefrom, or

(ii) is not receiving adequate care and attention, is incapable of caring adequately for himself by reason of physical disability or mental infirmity, and refuses, delays or is unable to make provision for his adequate care and attention.

. . .

9(1) Where on the basis of an assessment made pursuant to this Act the Minister is satisfied that there are reasonable and probably grounds to believe a person is an adult in need of protection, he may apply to a court for an order declaring the person to be an adult in need of protection and, where applicable, a protective intervention order.

. . .

9(3) Where the court finds, upon the hearing of the application, that a person is an adult in need of protection and either

(a) is not mentally competent to decide whether or not to accept the assistance of the Minister; or

(b) is refusing the assistance by reason of duress, the court shall so declare and may, where it appears to the court to be in the best interest of that person,

(c) make an order authorizing the Minister to provide the adult with services, including placement in a facility approved by the Minister, which will enhance the ability of the adult to care and fend adequately for himself or which will protect the adult from abuse or neglect;

. . .

10(1) Where on the basis of an assessment made pursuant to this Act the Minister is satisfied that there are reasonable and probabl grounds to believe that

(a) the life of a person is in danger;

> (b) the person is an adult in need of protection and
>
> (c) the person is not mentally competent to decide whether or not to accept the assistance of the Minister or is refusing the assistance by reason of duress,
> the Minister may authorize the immediate removal of the person to such place as the Minister considers fit and proper for the protection of the person and the preservation of his life, and a person so authorized may take reasonable measures to remove the person whose life is in danger.
> . . .
>
> 12 In any proceeding taken pursuant to this Act the court or a judge shall apply the principle that the welfare of the adult in need of protection is the paramount consideration."

[6] Section 65(1) of the *Hospitals Act*:

> "65(1) Subject to subsection (2), a review board shall review the file of a patient within one month of the request in the prescribed form by
>
> (a) the patient;
>
> (b) a person, other than the patient, authorized by the patient to act on his behalf;
>
> (c) the administrator of the facility where the person is a patient;
>
> (d) the medical director of the facility where the person is a patient;
>
> (e) the administrator of psychiatric mental health services; or
>
> (f) the Minister."

[7] The following testified:

- Dr. Brent Browster, a psychiatrist
- Angela Boyd, an occupational therapist
- Shaun O'Neil, an adult protection worker
- F. H., the Defendant's son
- John Thompson, a social worker with the Nova Scotia Hospital
- Donna Pettipas, an adult protection worker
- C. R., the Defendant

Eleven exhibits were tendered.

TESTIMONY

[8] John Thompson testified briefly as to the protocol at the Nova Scotia Hospital and the options available to a patient when declassified as a formal patient, specifically, the opportunity to remain as a voluntary patient or to leave on their own if they wished.

[9] Shaun O'Neil testified as to his involvement in this application for the brief period of time Ms. Pettipas was on personal leave.

[10] Angela Boyd provided the court with the results of a cognitive competency test completed by Ms. R. on July 21, 2004. It is dated July 26, 2004, and states, in part:

> "The CCT samples a wide range of cognitive skills and items that are reality based, representing situations most basic to survival, and varying from overlearned concrete living skills to abstract problem-solving and safety judgement. The CCT adopts a practical approach by simulating daily living situations in evaluating cognitive skills that are required to maintain safe and independent living. The CCT was completed with C. on July 21, 2004.

[11] Further, the Summary states:

> "The CCT was completed with an average score of 92% suggesting C. is able to maintain safe, independent living related to cognitive skills. Further assessment will be completed to analyze (sic) the pattern and quality of her performance on specific activities of daily living. Further assessment will also evaluate the necessity for community supports to ensure she maintains her current level of function."

[12] Ms. Boyd further provided an occupational therapy report pertaining to Ms. R.. The assessment occurred on July 20, 21, and 22, 2004, and is dated July 30, 2004. It states, in part:

> "C. R. is a 52-year-old female with a history of chronic schizophrenia differential diagnosis of schizoaffective disorder. Dr. Browster referred her for a functional

assessment to determine her functional abilities and the supports required upon discharge."

[13] Under Summary and Recommendations:

"Ms. R. presents as a pleasant, very conversational woman. Her cognitive skills are suggestive of independent living, with a score of 92% on the CCT. Her demonstrated performance on completion of meal planning, grocery shopping and kitchen assessments would also suggest she would be able to maintain independent living within the community. She demonstrated however very questionable judgement, delusional thoughts and limited insight during the assessment process. For example, writer arrived for an appointment with the client and she was in her housecoat. Ms. R. went to her room to change where she proceeded to take off her housecoat and stand nude in her room while she was looking for clothing to wear, with the door of her room open. She also reported to writer she feels her current difficulties are more related to medical/physical problems as opposed to mental health illness and she does not feel the medication she is taking is improving any symptoms. Finally she stated during the assessment process on several occasions God advised her the weather would improve when she was discharged from hospital and upon discharge from hospital she would continue her work as a healer for God. Given the chronic nature of her illness, her reported beliefs, her previous non-compliance with medication as well as her past demonstrated erroneous decision-making, she is at high risk for functional impairments within the community. Without support in the community to monitor her status, she will likely relapse and her functional status will decline and she may again place herself in unsafe situations.

Despite her positive performance on several assessments with writer, given a holistic appraisal of all issues, it appears a **supportive living environment** would be most appropriate for Ms. R. at this time. This supportive living environment would assist with addressing all the following issues:

Assistance with medication management - daily assistance with medication to ensure she is taking prescribed medication as well as monitoring and follow-up with a community psychiatrist to assist with medication monitoring and compliance issues.

Encouragement to complete basic self-care tasks/household management and developing a structured daily/weekly routine., e.g. shower every morning upon wakening, check day planner following shower, clean bathroom in apartment on Monday, wash dishes immediately following supper every day, etc. C. can be consulted to

further discuss meaningful activities and a realistic structure of these activities.

Assistance with healthy eating choices and with meal planning tasks – A degree of stress was experienced at the grocery store and C. was somewhat unorganized within the store, possibly given the store was not familiar. In a familiar environment she could assist with grocery shopping tasks, with assistance with planning for healthy eating choices.

Assistance with cooking skills, preparing meals that do not have to be cooked and education regarding preparing meals appropriately on low/medium heat – Ms. R. could assist with cooking tasks in a supportive living environment while accessing support from staff to prevent the risk of burning food.

Consultation with a dietician – It appears she makes unhealthy eating choices given her diabetes. Further education regarding healthy eating may or may not be of benefit however in a supportive living environment her diabetes could be monitored to ensure her blood sugar levels are not dangerously elevated due to unhealthy eating choices.

Possible social skills training – Despite her demonstrated performance on the picture interpretation subtest of the CCT (evaluating social skills), given her past history of inappropriate interactions she may benefit from a review of verbal and nonverbal communication and discussion of more complex social interactions. Role-playing could be completed to assist Ms. R. with developing the skills required to interact with members of the community and make appropriate decisions regarding people she is in contact with in the community.

Assistance with involvement in leisure activities – Currently Ms. R. does not engage in any structured activity. Performance in structured activity would decrease the likelihood of engagement in non-productive activity.

Managing finances and carrying out financial transactions – Despite her appropriate performance on the financial portion of the CCT subtest, based on her reported ability to manage her finances as well as family reports she gives money to strangers, Ms. R. would benefit from assistance with budgeting and management of financial affairs.”

[14] F. H. testified as to his love and concern for his mother. He wrote a letter on September 17, 2004, outlining these concerns. The letter listed his concerns accordingly. Referring to his mother, she

> "– does not take her medications when it isn't 'given' to her
> – keeps a poor diet and regularly skips meals
> – wanders * Street all day and night (when very ill)
> – does not always dress appropriately for the weather
> – often wanders the streets with no shoes
> – is so lonely that often brings complete strangers home to live with her
> – routinely forgets her stove and leaves it on after she's left the apartment
> – goes without sleep for days at a time
> – she is incapable of keeping her apartment at a basic level of cleanliness and I am even concerned of the potential fire hazzard especially when she falls asleep with a cigarette"

[15] Mr. H. acknowledged that these concerns existed over an extended period of time, that he is a recovering addict and he does not currently reside with his mother.

[16] Dr. Brent Browster, as previously noted, is a psychiatrist. He signed the medical observation form on October 17, 2004, in which he stated that Ms. R., in his professional opinion, was an adult in need of protection as per the *Adult Protection Act*. He testified he was still of that opinion at trial. In a document dated September 17, 2004, he provided additional reasons for his conclusion. It stated, in part:

> "C. R. is a 52 year-old female who is currently a formal inpatient at the Mayflower Unit of the Nova Scotia Hospital. She has suffered chronically from what is most likely a Schizoaffective Disorder (Bipolar type). When she is severely ill there are major problems with disorganized and erratic behaviour. She becomes so disorganized in her thinking that it is difficult to have a coherent conversation with her. As well, she has grandiose and religious delusions, and at times has claimed to hear the voices of God and Satan. She believes that she is religiously special, which may explain in part why she downplays her problems. Even when optimally treated with appropriate medications in hospital, Ms. R. is never without these symptoms, though they may be significantly improved. Any improvement obtained in hospital is lost rather quickly upon discharge because of C.'s persistent failure to remain on her treatment and difficulties co-operating with psychiatric follow-up, even when that follow-up involves outreach to her home. For the vast majority of her life, Ms. R. has refused to recognize that she is

psychiatrically ill, and therefore hasn't recognized the need for ongoing treatment. This lack of insight extends as well to her medical illnesses, particularly her diabetes, and demonstrated by her flagrant disregard for a diabetic diet and her inability to comply with the VON when they attempted to come and help prepare her medications and test her glucose levels.

. . .

"Many of the above noted concerns have also been noted by clinical staff that have worked with Ms. R. in the past, including Pam Chisholm and Christina Leblanc (outreach mental health nurses who know her very well). These nurses and Dr. Patriquin (C.'s family physician) are especially concerned about her serious deficits in insight and judgement and they are fully in support of this application for Adult Protection. Dr. Curtis Steele, who has been C.'s outpatient psychiatrist for at least the past 15 years also gave unquestioning support to requesting Adult Protection. He feels that Ms. R.'s cognitive faculties have deteriorated in recent years to the point that she is often not competent to make decisions about living at risk. Given our own observations during C.'s admission to the Nova Scotia Hospital this time (May 2004 to present), we are not surprised by the reports we have received. Especially while very ill, the patient was disinhibited and inappropriate with others, and she was quite disorganized in her thinking and behaviour. Even while at her best, C. has continued to deny she has a mental illness and she has been clear that she doesn't think she needs medication. She has disregarded her diabetic diet to the point that it has not been possible to adequately control her diet with medication alone, and insulin has been introduced. This serious step has been taken despite countless attempts at education by the clinical staff. It should also be noted that diabetes is a risk factor for stroke and heart disease especially if poorly controlled. There is evidence that C. is already at high risk, as she apparently had a small stroke shortly after she was first admitted to our hospital. If she were left to manage this condition without a high level of supervision. Ms. R. would be at high risk for both acute and chronic complications of her diabetes.

C. completely dismisses any concerns raised about her ability to live independently or the need for more support. The failure to recognize her deficits and illness has also been pointed out in her Occupational Therapy Assessment and her Psychological Assessment done during this hospital admission. Both reports recommended supervised housing, in spite of Ms. R.'s ability to perform reasonably well in some areas. The Psychological assessment underlined her deficits in working memory, which were thought to at least partially explain her failure to comply with medication. We have observed that Ms. R. is unable to learn how to manage her medications on her own even while in hospital, again underscoring the need for ongoing close supervision in this area. While we would still have concerns about Ms. R.'s ability to care safely for herself even when

> properly medicated, such concerns would become extreme if she went off her medication, particularly given the degree and nature of her symptoms when her Schizoaffective Disorder is not well controlled. C.'s problems with poor working memory and her lack of insight into her psychiatric and medical conditions would make non-compliance a virtual certainty if she were to again live independently. As well, even though she is now a diabetic who has become dependent on insulin, it is doubtful that she would administer this medication herself, or let others give it on a regular basis if she isn't in a structured setting.
>
> . . .
>
> This patient's lack of recognition of her deficits, illness and level of risk, as well as her refusal to accept a supervised setting on discharge have necessitated this application to Adult Protection."

[17] Donna Pettipas is the adult protection worker, to use her word, that has been "assigned" to the Defendant. Her direct testimony was primarily contained in the three affidavits she provided to the court. She provided information beginning with Ms. R.'s attendance on May 17, 2004, at the emergency room in the Dartmouth General Hospital; her admission to the Nova Scotia Hospital; the assessment of the psychologist, Dr. Paul Freeman, conducted on July 23, 2004, and subsequent report dated September 13, 2004; the testing administered by Angela Boyd; the concerns expressed by Ms. R.'s son, F. H.; the reports of Dr. Browster; her personal interaction with Ms. R. and her ultimate conclusion of bringing forward this current application.

[18] Dr. Freeman's report which is before the court and dated September 3, 2004, stated, in part:

> "C. R. is a 52 year-old woman currently treatment (sic) in the Mayflower Unit of the Nova Scotia Hospital, diagnosed with schizophrenia. She was admitted to hospital on May 17, 2004, after arriving at Dartmouth General ER making bizarre demands of staff, exhibiting poor hygiene and dressed only in t-shirt and panties. Since her admission and stabilization of her medication regimen, Ms. R. has made some progress in her presentation, but continues to exhibit delusional and tangential thinking. In testing, she exhibited verbal intelligence in the low average-to-average range, but was (sic) generally poorer non verbal skill, especially in the area of speed of mental processing. Moderate deficits were also noted in working memory capacity. Her verbal skill and incidental learning of new information are indicative of independent living ability, in that she likely can learn new skills and routines, but working memory deficits and her own report of

> lapses in long term memory are more troublesome. It seem (sic) that the greater barrier to Ms. R.' (sic) capacity for independent living is her ability to maintain compliance to medication, and working memory deficits are significantly, if not entirely, responsible for this failure to comply. Even when medicated on the ward, Ms. R. has expressed confusion and frustration at the variety of medications, schedules and dosages she must take. Failure to comply has shown itself to lead to poor nutrition and self-care as well as bizarre, and even potentially dangerous behaviour.
>
> In my estimation, and consistent with the findings of the earlier OT assessment, Ms. R. likely is capable of living in supported-care environment, with careful attention to her self-care, nutrition and compliance with medication. My only major concern is that her apparently complete lack of insight into her illness, and the angry, belligerent behavior that results if anyone suggests that she is incapable of managing her own affairs. More intensive care may in fact turn out to be necessary if these difficulties cannot be overcome. Compliance may be improved if concerns of medical staff are expressed more in terms of the possible harmful effects of future CVAs (which may in fact be a significant risk factor), rather than specifically in relation to mental illness."

[19] The decision of the Review Board dated October 13, 2004, has been made available to the court. Both parties rely on this document as being supportive of their position regarding this application. This document stated, in part:

> "Pursuant to Section 65(1) of the Hospitals Act, the Review Board met on Monday, October 4, 2004, to review the file of Ms. C. R., a patient detained under a Declaration of Formal Admission in the Nova Scotia Hospital.
>
> . . .
>
> Section 42(3) of the Hospitals Act of Nova Scotia outlines the test for formal status. The board must determine, first, whether the patient suffers from a psychiatric disorder and second, whether she is a danger of her own safety or to the safety of others. In applying this test, the Board concluded that Ms. C. R. does suffer from a psychiatric disorder. The Board then considered whether or not, on the facts, she represents a danger, either to her own safety or to the safety of others.
>
> Ms. R. is a 52 year old single women (sic). She lives alone in an apartment in central Halifax. She has not worked for several years . . . She has a chronic history of mental illness extending back approximately 20 years. She has been admitted to psychiatric hospitals several times, at least once in each of the past 5 years. Her admissions have followed states of disorganization and erratic

behaviour. She has had psychotic symptoms such as grandiose and persecutory delusions and auditory hallucinations. She has been diagnosed with schizoaffective disorder, a combination of schizophrenia and bipolar illness. Her records show recurring evidence of poor insight and judgement. There is also frequent references to poor medication compliance, both for her psychiatric illness and diabetic illness. As well, she has shunned outreach services which have been available to her.

. . .

She has suffered from diabetes for some time. Prior to this hospitalization it had been treated with oral medication. However, since she was admitted it has been found that the injection of insulin is the appropriate way to treat her. Her sugar levels are monitored regularly. On May 28th she suffered, what appears to have been a cerebrovascular accident, i.e., a stroke. This was treated in a regular hospital.

She was made a formal patient on May 21, 2004. This status was renewed on June 21, 2004, and again on September 21, 2004.

She was found not to have capacity to consent for her treatment on her admission. This finding was confirmed on September 21, 2004. Her mother has since then been providing consent.

. . .

Dr. Wadhwa expressed the view that there is no risk of suicide or danger to others. However, she said that, if she did not take her medication for diabetes, she could be in serious life threatening trouble within 48 hours. Her mental health might be maintained without serious risk for 4 to 6 weeks without medication.

Dr. Wadhwa told of her discussion with Ms. R. respecting her capacity to consent. Ms. R. did not recognize that she had a mental illness nor could she understand any suggestion that she may have a chemical imbalance. Because of her condition she has no insight into her illness. This addresses the first and fifth factor mentioned in Section 52(2). Dr. Wadhwa was unable to engage in any meaningful discussion with her respective (sic) the other three factors. Thus, Dr. Wadhwa is of the opinion that Ms. R. does not have the capacity fo consent to her treatment.

Dr. Wadhwa admits that there is significant improvement in her condition, but the treatment team remains concerned with her ability to care for herself.

. . .

Dr. Neilson questioned her at some length about matters related to her capacity to consent. She denied she had any problem with thinking. Her medication only gives her a sour mouth and a dry throat. In answer to the question of what would happen, if she did not take her psychiatric medication, she said ‘nothing as long as I act properly and function in the community.’

She said that, if she was released, she would return to her apartment. The main test to which she would be put, she said, was whether she could avoid smoking, to which she has been severely addicted.

. . .

She clearly suffers from a psychiatric disorder. She is not a danger to the safety of others. The only question is wether she is a danger to her own safety. There is no indication that she is suicidal. There are two overriding concerns, one is whether she will take her medication for her diabetes and the other whether she will take her psychiatric medication. She understands that she has diabetes and understands the importance of taking the medication for it. With some monitoring and knowing of the support she has in the community, we think that she will be looked after in this regard. She refused to acknowledge her psychiatric illness and most likely will be non compliant in taking the medication prescribed for it. However, Dr. Wadhwa said that non compliance with it would take 4 to 6 weeks before her condition would be critical. She does have insight into when she should go to the hospital as evidenced by her behaviour on the day of admission and by her arranging with her pastor to be driven back to the hospital. If she returns to her home, she has her friends and neighbours who watch out for her. She needs some community support, a VON nurse to monitor her medication, etc.

. . .

She has been in an (sic) out of hospital several times. Between hospitalizations she some how (sic) gets along. She may be disorganized, maintain a messy apartment, lack regularity in her daily affairs, etc. However, she lives in a community where she has friends. There are people who care about her, like Pastor * and Ms. M.. There are community support agencies available to her. With them and her friends, we think she would be able to get along. There will be difficulties, but on balance we do not think they meet the test of a danger to oneself. We, therefore, determine that her status as a formal patient should be terminated. We very much urge Ms. R. to stay in the hospital as an informal patient until appropriate support arrangements can be put in place.

> We understand that an application to have her declared a person in need of protection is being made under the Adult Protection Act. If successful, it should assure the attention she needs. However, we emphasize that this is a matter quite apart from formal status under the Hospitals Act. Formal status must be justified by the tests provided under that Act and faithfully applied by any psychiatrists making declarations of formal status and by this Board when it reviews such declarations. It cannot be used as a stop gap pending some other proceeding without such justification."

[20] C. R. filed an affidavit and testified. She acknowledged having a medical health disorder, although not agreeing with Dr. Browster as to the specifics of such disorder. She acknowledged she is a diabetic. She disagrees with her son's description as to her lifestyle and any risk such lifestyle creates for her or the public. She points to the cognitive competency testing results as an indication she is able to maintain "safe independent skills related to cognitive skills." She stresses the Review Board's decision is an acknowledgement she is capable of living on her own.

[21] Ms. R., at 52, has a history of mental illness, sometimes described as chronic, extending over the past 20 years. She has, as of more recent date, become diabetic. As stated in the Review Board's decision, "she has been admitted to psychiatric hospital several times, at least once over the past five years." Apart from these admissions, she has lived independently on her own. She submits the evidence presented provides her with the right to continue to conduct her life in this manner. She suggests that one ill-advised trip to the Dartmouth General Hospital – if that be the case – on May 18, 2004, should not deprive her of the right to make her own decisions as to the conduct of her life. She submits her son's "list of concerns" are partly incorrect, for the most part overstated, refer to isolated events of many years past and are over relied on by those professionals who suggest she is an adult in need of protective services. In short, she notes she has suffered with mental illness for about 20 years and has been a diabetic for four or five years and, apart from short stints in the psychiatric hospital, has been able to make her own decisions and should be afforded that continuing opportunity.

[22] The evidence presented, including the testimony of Ms. R., overwhelmingly supports the views, concerns and recommendations made by Dr. Browster and other care givers who gave evidence in this application.

[23] The decision of the Review Board discontinuing her formal status was based on different criteria than is applicable to this application. The statements made in the conclusion reached by the Board as to Ms. R.'s health, mental and otherwise, her ability to recognize these problems and provide for them support a conclusion that she is an adult in need of protection.

[24] Angela Boyd's statement, in her summary of the results of the cognitive testing indicating Ms. R. is able to maintain an independent living lifestyle, is not without qualification. It acknowledges a further assessment would be completed. The occupational therapy report which followed qualifies the earlier findings significantly.

[25] Dr. Browster stated, in his professional capacity, Ms. R. was an adult in need of protective services. He offered reasons and explanations for his conclusion. I do not find these conclusions were arrived at by an over reliance on third-party information, particularly that of Ms. R.'s son. Dr. Browster, again in his professional capacity, stated Ms. R. was not medically competent to decide whether or not to accept the assistance of the Minister. I find he has provided sound reasons for this conclusion. The evidence provided by the other witnesses, including Ms. R., are supportive of Dr. Browster's conclusions.

[26] Ms. R., at times, acknowledges she has mental health problems and, on other occasions, she refers to an instance when her mother was responsible for placing her in a hospital for what Ms. R. believed was a form of exhaustion and, ultimately, found to her chagrin that she was receiving treatment for mental problems. I am convinced she has no realization as to the depth of her mental health problems and the necessity of following the prescribed medication regime.

[27] Ms. R. is aware she is a diabetic. It currently should treated by an injection of insulin. Ms. R. is unable to inject herself with insulin. Further, I conclude she is unable or unwilling to monitor her condition as to be aware of when and where such medication is required. Ms. R. may, over the past number of years, have functioned on her own with her mental illness and diabetes. The evidence suggests her illnesses may have increased in severity or, if not, her illnesses are having a more detrimental affect on her life than they have been in the past. In any event, I find, if allowed to live on her own, she would not be receiving adequate care and attention and would not make provision for such.

[28] I find, as required in the application, that Ms. R. is an adult in need of protection. I further find she is not mentally competent to decide whether or not to accept the assistance of the Minister and I order the Minister to provide Ms. R. with services; specifically, the opportunity to reside in a small options home with the services as described in that submission.

J.