Consent and Capacity Board
Commission du consentement et de la capacité
Ontario

25-2460-01

IN THE MATTER OF
the ***Health Care Consent Act***
S.O. 1996, chapter 2, schedule A,
as amended

AND IN THE MATTER OF
SR
A PATIENT AT
ROYAL OTTAWA MENTAL HEALTH CARE
OTTAWA, ONTARIO

REASONS FOR DECISION

PURPOSE OF THE HEARING

SR was a patient at Royal Ottawa Mental Health Care. His attending physician had found him incapable to consent to certain treatment. The Consent and Capacity Board (the "Board") convened at SR's request to review the finding of incapacity.

DATES OF THE HEARING, DECISION AND REASONS

The hearing took place on August 27, 2025 by videoconference. The Decision was released the next day, on August 28, 2025. Reasons for Decision ("Reasons") (contained in this document) were requested by SR at the hearing. The Reasons were released on September 2, 2025.

LEGISLATION CONSIDERED

The *Health Care Consent Act* ("*HCCA*"), including sections 4 and 32

PARTIES & APPEARANCES

SR, the applicant, represented himself.
Dr. Tabitha Rogers, the health practitioner, was represented by counsel, Paige Miltenburg.
Both parties attended the hearing.

PANEL MEMBER

Suzanne Clapp, senior lawyer and presiding member

PRELIMINARY MATTERS

Incapacity to Consent to Treatment

Dr. Rogers' finding of incapacity to consent to treatment related to treatment with antipsychotic medications.[1] At the outset of the hearing it was conceded that SR passed the first branch of the legal test for capacity, and it was only the second branch of the test that was the focus of the hearing.

Applicant Self-Representation and *Amicus*

The parties attended before the Board for the first time with respect to this matter on July 29, 2025. At that time, Legal Aid Ontario had appointed Melissa Lukings to act as counsel for SR. Ms. Lukings (and SR) provided notice of a number of preliminary matters in advance of July 29th, including that SR wished to represent himself and that Ms. Lukings would be asking to be appointed as *amicus curiae* ("*amicus*"). The presiding member at that hearing agreed that SR had an absolute right to represent himself, but did not appoint Ms. Lukings as *amicus*, and stated the following in the Board's Order of July 29, 2025 (at paragraphs 10 and 11):

[1] The Board held a hearing related to SR's capacity to consent to treatment on or around January 29, 2025, and issued a Decision confirming a finding of incapacity to consent to treatment with antipsychotic medications. The initial hearing of this matter was therefore postponed to July 29, 2025 in order to comply with subsection 32(5) of the *HCCA*.

> "10. The purpose of appointing *amicus* in Board cases is to ensure that there is neutral and objective counsel available to assist the Board and to ensure that the applicant has a fair hearing process. *Amicus* may often ask questions of witnesses and make submissions. However, *amicus* takes instructions from the panel. *Amicus* is not legal counsel to the applicant, even if a panel instructs them to protect that person's interests.
>
> 11. The presiding member was of the view that Ms. Lukings was not sufficiently at arms length from the applicant to take on the role of *amicus* in the circumstances. This was not a case where counsel had been appointed but had no substantive solicitor-client dealings apart from attending a hearing to notify the Board of their client's wish to self-represent. In this case, Ms. Lukings actively acted in the role of counsel, took instructions and made submissions for [SR]."

At the hearing on August 27, 2025, SR revisited the issue of the appointment of *amicus*, and requested an adjournment. He stated that he had not been successful in finding a lawyer to act in that role. SR was reminded that *amicus* was appointed by the Board (not the applicant). Given that the issue of *amicus* had been discussed on July 29, 2025, it had not been raised at the second attendance before the Board on August 18, 2025, there had already been two adjournments, and I was prepared to proceed with the hearing in the absence of *amicus*, I did not want to delay the hearing any further by granting another adjournment.

It was clear that SR continued to want to represent himself. At the hearing on August 27, 2025, all parties, including SR, agreed that I would ask questions of the witnesses in advance of SR, so that SR could get a sense of what issues I was interested in, and perhaps cover some of the questions he wished to ask.

Summons to Witness

The Board issued Summons to Witness at the request of SR for the following three people:

1) Dr. Alexandra Baines (out-patient psychiatrist) - Dr. Baines retained counsel (Brooke Smith on August 18th and Emily Bradley on August 27th) and ultimately gave evidence on August 27, 2025[2];

[2] Dr. Baines only attended the hearing to provide her evidence, therefore no order for the exclusion of witnesses was required.

2) Dr. Andrea Bardell (prior attending physician at The Ottawa Hospital – Civic Campus) - Dr. Bardell advised the Board by email that she was out of the country and did not attend any of the hearing dates; and
3) Jennifer Kutten (pharmacist) - Ms. Kutten was represented by Ms. Miltenburg. By the August 27th hearing date SR had advised that he did not require Ms. Kutten as a witness.

At the hearing on August 27, 2025, SR confirmed that Ms. Kutten was not needed, but stated that he had asked that Caitlin Sigg (spiritual care provider) be summonsed in relation to the *Charter* issues he raised.

I advised the parties that I would make a determination as to whether the evidence of the proposed witnesses was relevant and necessary after I heard the evidence of Dr. Rogers. At that time, I heard submissions from Ms. Bradley regarding the relevance of Dr. Baines' evidence. She submitted that Dr. Baines had not been involved in SR's care since January 2025 (when the current admission began), and she had no information about SR's current health status or capacity. Ms. Miltenburg did not take a position on the proposed additional witnesses. SR maintained that the evidence of Dr. Baines, Dr. Bardell, and Ms. Sigg was required.

After having heard Dr. Rogers' evidence, and considering the narrow issue before me and the Board's obligation to conclude hearings in a timely manner, I decided that the evidence of Dr. Baines was relevant, but that it was not appropriate to delay the hearing for the evidence of Dr. Bardell or Ms. Sigg. Dr. Baines had been involved in SR's care in the past, including as his out-patient psychiatrist when he was living in the community. She was directly involved in his care when SR decided to taper and then discontinue Clozapine. I determined that Dr. Baines' evidence was likely relevant to the issue of whether SR was able to appreciate the reasonably foreseeable consequences of a decision about taking treatment or not taking it, based on her history with him. I found that evidence from Dr. Bardell was not required because the document package provided by Dr. Rogers included clinical notes and records from SR's admission (including when Dr. Bardell was involved), and Dr. Rogers was able to speak to the issue of capacity at the time of the hearing. In terms of Ms. Sigg, the evidence was that SR had only met

with spiritual care at the hospital briefly, and SR had not met with Ms. Sigg for several months. I concluded that evidence from Ms. Sigg was not necessary or relevant such that the hearing should be delayed.

Preliminary Issues Raised by SR

A number of additional preliminary issues were raised by SR at the July 29, 2025 and August 18, 2025 attendances before the Board. Many of these issues appeared to have been resolved prior to the August 27, 2025 hearing date, including access to a computer and other resources on the unit and the provision of noise-cancelling headphones. On August 18, 2025, SR requested an adjournment of the hearing until January 2026 in order to ensure that all medications had cleared from his system, as he maintained that this was required in order to facilitate his ability to conduct the hearing. The presiding member on August 18th declined to adjourn the hearing for that length of time, but all parties agreed to an adjournment to August 27th for allow for a longer hearing (see the Board's Order of August 18, 2025).

A number of preliminary issues raised by SR remained outstanding at the August 27, 2025 hearing as follows:

1) *Charter* issues – SR consistently maintained that his right to freedom of religion as protected by section 2(a) of the *Canadian Charter of Rights and Freedoms* (the "*Charter*") was being violated by the *Mental Health Act* ("*MHA*") and the *Health Care Consent Act* ("*HCCA*"). In his document entitled "Today's Final Draft for Tomorrows Hearing w/ the CCB" dated August 17, 2025 ("Prepared Statement")(Exhibit 3) SR also submitted that other *Charter* protected rights were being violated. SR specifically requested that the Board rescind the Form 33 (finding of incapacity), his involuntary status, and other Orders that had been made by the Board (related to a Form D application) as a result of these violations. SR had been informed that the Board does not have the jurisdiction to make determinations as to whether or not legislation is *Charter* compliant, nor to grant relief under the *Charter*. I reiterated this at the hearing on August 27th, but advised that the Board must take *Charter* values into account when making a

decision, and that I would be doing that in this matter (discussed further below in these Reasons).

2) Criminal Charges – SR stated that it was his opinion that he had been the subject of aggravated assault and "medical battery" at Royal Ottawa Mental Health Care and that Dr. Rogers' was obstructing justice by not allowing him to go to the police station or court house (these points were also made in SR's Prepared Statement). SR was reminded that criminal matters were outside the jurisdiction of the Board.

3) Reading of Prepared Statement – SR asked to read his Prepared Statement (Exhibit 3) because he has Attention Deficit Hyperactivity Disorder (ADHD). While the Prepared Statement dealt with many issues that were outside the scope and jurisdiction of the hearing, and there were portions that I did not think were necessary to be read, SR was ultimately allowed to read the entire Prepared Statement at the hearing during his evidence.

4) Substantive Issues – SR raised issues in his Prepared Statement that I viewed as more substantive than preliminary issues, and decided that I would consider them in my discretion when making the decision on the issue of capacity to consent to treatment. These included allegations that Dr. Rogers was prejudiced against SR, and that there were "gross factual inaccuracies" in the evidence submitted by Dr. Rogers.

Other Proceedings

I was informed at the hearing that SR had appealed a Decision of the Board related to his involuntary status earlier in the current admission. There had also been a Form D application (application for directions under section 35(1) of the *HCCA*) brought by Dr. Rogers, and a Decision of the Board which SR had appealed. Both appeals remained outstanding. SR's Prepared Statement also indicated that SR had made a complaint to the Ombudsman about the Board. SR often referred to these issues and other proceedings during the hearing (they were also

discussed in SR's Prepared Statement) and it was reiterated that this hearing only related to the issue of incapacity to consent to treatment.

THE EVIDENCE

The evidence at the hearing consisted of the oral testimony of Dr. Tabitha Rogers, Dr. Alexandra Baines, and SR, and the following three Exhibits:

1) Package of documents submitted by Dr. T. Rogers, including: CCB Summary dated July 26, 2025 ("Summary"); *MHA* Forms; and clinical notes and records (22 pages);

2) Package of documents submitted by SR, including: police record check; driving record; screening test for Dissociative Identity Disorder; document re: Clozapine withdrawal symptoms; articles re: No-touch Torture and Mind Invasive Technology; Code White instructions; excerpt from Fiona Barnett's Eyes Wide Open (handwritten); Emergency Use of Restraints Policy from the Royal Ottawa Hospital; handwritten notes and submissions; document re: strategies for dealing with ADHD; excerpts from "a little one of Christ Jesus"; Advance Directive of SR dated July 7, 2024; *Charter of Rights and Freedoms*; and excerpts from gotquestions.org (50 pages); and

3) Document submitted by SR entitled "Today's Final Draft for Tomorrows Hearing w/ the CCB" by SR dated August 17, 2025 ("Prepared Statement") (20 pages).

There was hi-lightning, underlining, and handwritten notes as part of Exhibit 2. I asked SR to advise if he had made those markings on the documents and written the handwritten notes, but he was unable to confirm this as he was not sure that I had the same document that he had submitted, and he could not be sure that the document had not been tampered with. SR provided his Prepared Statement in the chat of the videoconference, and read it at the hearing. I confirmed that it was the same document that I marked as Exhibit 3.

SR also provided a link to a video in the chat, however I declined to mark it as an Exhibit as it was my understanding that SR had received multiple communications from the Board about how to submit Exhibits appropriately to the Board.

INTRODUCTION

SR was a 36-year-old man who had lived at home with his parents prior to being admitted to hospital on January 20, 2025. He had completed a college program and was financially supported by the Ontario Disability Support Program (ODSP). SR had a longstanding history of treatment resistant schizophrenia and multiple psychiatric hospitalizations. He had been followed in the community by Dr. Alexandra Baines. SR was brought to The Ottawa Hospital – Civic Campus (the "Ottawa Civic") by police on January 20, 2025. He was detained on an involuntary basis and was found incapable of consenting to treatment by Dr. Andrea Bardell on January 22, 2025 (Exhibit 1, page 7). SR was transferred to Royal Ottawa Mental Health Care (the "Royal Ottawa") on February 25, 2025, and remained there as an involuntary patient at the time of the hearing. Dr. Tabitha Rogers made a further finding of incapacity on July 23, 2025 (Exhibit 1, page 4). SR applied to the Board to have the finding of incapacity reviewed (first on July 4, 2025 and again on July 23, 2025).

THE LAW

On any review of incapacity to consent to treatment under the *HCCA*, the onus of proof at a Board hearing is always on the health practitioner to prove the case. The standard of proof is proof on a balance of probabilities. The Board must be satisfied on the basis of cogent and compelling evidence that the health practitioner's onus has been discharged. There is no onus whatsoever on the patient. The Board must consider all evidence properly before it. Hearsay evidence may be accepted and considered, but it must be carefully weighed.

<u>Capacity to Consent to Treatment</u>

Under the *HCCA*, a person is presumed to be capable to consent to treatment (s. 4(2)) and the onus to establish otherwise lies with the health practitioner. The test for capacity to consent to treatment is set forth in s. 4(1) of the *HCCA*, which states:

> *A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance*

> *service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision* (emphasis added).

In the seminal case of *Starson v. Swayze*, [2003] S.C.R. 722 ("*Starson*"), the Supreme Court of Canada reviewed the law of capacity to consent to treatment. The Court noted that the right to make one's own treatment decisions is a fundamental one that can only be displaced where it is established that a person lacks mental capacity to do so. The person's "best interests" are not a consideration in determining the question of capacity to consent to (or refuse) treatment. Capable people have the right to take risks, to make decisions which others consider unwise, and to make mistakes. The presence of mental disorder should never be equated with a lack of capacity.

ANALYSIS

After carefully considering the evidence, the submissions of the parties, and the law, I decided that there was clear and compelling evidence presented at the hearing to conclude that SR was incapable of consenting to treatment with antipsychotic medications. Reasons for this Decision are set out below.

Capacity to Consent to Treatment

Relevant Background

The clinical records in Exhibit 1 indicated that SR had a history of depression and mania starting at age 13, with psychotic symptoms emerging in his later teens. His symptoms included significant paranoia, suicidal thoughts, and pronounced fluctuations in mood. Between June 2020 and July 2021, SR had six psychiatric admissions. It was noted that there was a pattern where SR was frequently admitted on a Form 1 or voluntarily, stayed a few days and agreed to restart a low dose of medication in hospital, and then gradually discontinued the medication when he left the hospital with a resultant worsening of symptoms. The symptoms also began to impact his behaviour to a more significant degree and his home life became increasingly volatile (Exhibit 1, pages 17-18). SR was hospitalized at the Royal Ottawa for approximately 18 months commencing in July 2021, and the following excerpt was taken from the Discharge Summary from that hospitalization:

> "…a trial of paliperidone resulted in partial improvement in symptoms though with ongoing significant mood instability, severe auditory and tactile hallucinations and an entrenched paranoid and delusional system. A trial of clozapine resulted in more significant improvement in symptoms despite ongoing hallucinations and delusional beliefs. He was able to repair his relationship with his parents and work towards his goal of living in the community close to them and working on developing a small business with his father" (Exhibit 1, page 18).

Following this admission, SR was followed by Dr. Baines in the community. SR's parents reported that SR did fine for the first six months and was quite happy and content. Despite always having some delusions and hallucinations while on Clozapine, SR's parents reported that SR would socialize with the family, watch television with them, and there were no safety issues. However, SR gained 200 pounds and started having metabolic syndrome with diabetes and high blood pressure. He refused medications for diabetes or weight gain. The family discussed the issue with Dr. Baines and SR began tapering the Clozapine, ultimately discontinuing it near the end of 2024. SR's parents reported that following the discontinuation of the medication, the intensity of SR's delusions increased and he told his parents that his body and mind were being controlled by electronics (Exhibit 1, page 12 and 14). The following description of the circumstances leading up the current admission was taken from the admission documentation from the Ottawa Civic dated January 20, 2025:

> "Yesterday he grabbed a knife and told his father that the voices are telling him to stab himself and then told his parents that he does not have any control on the knife and they are controlling him and forcing him to stab his parents. [SR's mother] shared that she locks her bedroom door at night to be safe" (Exhibit 1, pages 12-13).

Upon admission to the Ottawa Civic, SR was noted to be "floridly psychotic" and was responding to command hallucinations and acting on delusions of control in a very hostile and aggressive manner. He had delusional ideation that his body was controlled by "MK ultra" and he believed that he had been a victim of ritual satanic abuse since he was a baby. He was adamant that he never wanted to take any medications as he felt all medications were a "sin to Jesus." He refused to speak with spiritual care. SR was found incapable of consenting to treatment on January 22, 2025 and consent was obtained from the Public Guardian and Trustee (SR's parents were not comfortable acting as substitute decision-makers) to start Invega Sustenna. SR was reported to have tolerated this medication well with some improvement noted

in his thought process organization. At the time of the transfer to the Royal Ottawa on February 25, 2025, it was noted that SR had "very poor insight into his illness" (Exhibit 1, pages 14-15).

SR was transferred to the Royal Ottawa on a Form 4 (Certificate of Renewal). His admission diagnoses were: Schizoaffective disorder, Bipolar type; Generalized anxiety disorder; Cannabis use disorder, Moderate, In sustained remission; Alcohol use disorder, Mild, In sustained remission; Attention-deficit/hyperactivity disorder, Predominantly inattentive presentation; and Obesity (Exhibit 1, page 20). The clinical records indicated that SR immediately identified himself as Christian, and spoke about an "advanced wish" he had given Dr. Baines a year ago. SR believed that he had symptoms of Clozapine withdrawal, and maintained that no one should ever give him medication. SR talked about being saved "by the grace of God alone" and believed that psychotropic medications (or "pharmakeia") affected his cognition and ability to do things (Exhibit 1, page 16).

Did the evidence establish that SR was unable to understand the information relevant to making a decision about the treatment in question?

Dr. Rogers' Summary stated that SR had the cognitive capacity to understand information provided to him, and that he was aware of the diagnosis of Schizoaffective disorder, treatment plan with antipsychotic medications, and common side effects of the medications (Exhibit 1, page 2). Dr. Rogers testified that SR was "definitely a very bright individual." This was supported by SR's evidence where it was clear that he was intelligent and able to understand information that was relevant to making a decision about treatment with antipsychotic medications. Based on this evidence, and the presumption of capacity, I concluded that the evidence did not establish that SR was unable to understand the information relevant to making a decision about the treatment in question.

Did the evidence establish that SR was unable to appreciate the reasonably foreseeable consequences of a decision or lack of decision about the treatment in question?

Evidence of Dr. Tabitha Rogers

Dr. Rogers' Summary stated the following about the reasonably foreseeable consequences:

> "[SR] does not appreciate that stopping medication (Clozapine) has lead to his current admission to hospital. He denies that he pulled a knife on his father and threatened to harm him. He denies that he has hallucinations and delusions which are the symptoms of his illness. Most seriously he has had delusions of control where he feels he has no control over his actions" (Exhibit 1, page 2).

The Summary stated the following about SR's inability to appreciate the reasonably foreseeable consequences:

> "[SR] denies he has Schizoaffective disorder and believes that he is Ex MK ultra (experiment subject), that he currently is undergoing no touch torture, that Satan is influencing is life, and God has chosen him as his disciple. [SR] has asked that we refer him to Urology for Castration. He believes his parents subjected him to Rape at age 3 and that at this age he murdered a man. He repeatedly makes threats of conditional suicide if we are to treat his mental illness. He believes he has Dissociative Identity Disorder, and does not appreciate he is displaying the symptoms of Schizoaffective disorder. Currently, [SR] is Manic, he has pressured speech, flight of ideas, delusions and hallucinations. He is sleeping 3 to 4 hours a night. He is refusing all medications and has been offered ECT treatment to which he also refuses. His decisions are under the influence of delusional beliefs and auditory hallucinations" (Exhibit 1, page 2).

Dr. Rogers testified that she had been SR's most responsible physician since March 22, 2025. SR had received one dose of a long-acting injectable antipsychotic medication (Invega Sustenna) at the Ottawa Civic, and a second dose on March 11, 2025 at the Royal Ottawa. Dr. Rogers explained that SR had not received any antipsychotic medication since then (he had also not received any PRN's (as needed medication)) because she brought a Form D application to the Board regarding SR's Advanced Directive which stated that SR did not want any pharmakeia at all, and SR's appeal of the Board's Decision on that matter remained outstanding.

Dr. Rogers assessed SR's capacity to consent to treatment and issued a Form 33 on July 23, 2025 (Exhibit 1, page 4). She had last formally assessed SR's capacity on August 15, 2025, and she read her note from that day into the record. This note included the following: when asked why he was in the hospital SR stated that both of his parents told Dr. Baines that he had taken a knife to their throat, but SR denied this; SR believed that he was medically battered at the Ottawa Civic;

SR denied that he had Schizoaffective disorder and stated that he had Dissociative Identity Disorder from satanic ritual abuse, being raped at age three, and being forced to kill a man at age three; SR claimed he had Williams Syndrome and believed the test done at the hospital was a false negative or that the result had been edited; SR claimed he was a victim of no-touch torture and was focused on diagnoses of Generalized anxiety disorder, ADHD, and chronic PTSD from being an ex MK ultra slave; SR was asked whether he understood the diagnosis of Schizoaffective disorder and he said that he did but he refused to elaborate on the symptoms; SR refuted all evidence related to symptoms of delusions and hallucinations; and SR maintained that he was functioning well and could be discharged to a shelter and find his own housing. Dr. Rogers testified that while SR was aware that he had experienced side effects of Clozapine, he was unable to appreciate that it had also provided him with benefits. Although SR agreed that he was able to attend college while on Clozapine, he did not provide an answer as to what he attributed that high level of functioning to if it had not been the medication. Dr. Rogers stated that SR was unable to appreciate the benefits of antipsychotic medications at the current time because he did not believe he was ill. Dr. Rogers attempted to assess SR's capacity again the day before the hearing, but SR refused to participate.

It was Dr. Rogers' opinion that SR remained incapable to consent to treatment at the time of the hearing. Dr. Rogers testified that SR was manic, with symptoms including flight of ideas, delusions, and lack of sleep (sleeping approximately three hours per day). She stated that SR did not agree that he suffered from Schizoaffective Disorder. He continued to believe that he was the subject of no-touch torture, satanic ritual abuse, and that he had Williams Syndrome - which is a genetic syndrome that interferes with emotions. Dr. Rogers explained that SR was tested for Williams Syndrome at the hospital and the result was negative, however SR refused to accept this result. Dr. Rogers explained that she was proposing treatment with a long-acting injectable antipsychotic medication. Although Clozapine was likely the best medication to treat SR's illness, she acknowledged that SR had experienced serious side effects when treated with Clozapine, and they would explore alternative forms of medication as a result.

When asked why it was her opinion that SR failed the second branch of the test for capacity, Dr. Rogers reiterated that SR was preoccupied with his delusional systems (that were religious,

persecutory, referential, and grandiose). When asked about SR's religious delusions, Dr. Rogers explained that SR believed that he had a special relationship with God, that he was on a spiritual conquest, and that he received messages from different places. Dr. Rogers stated that she considered whether this was in keeping with religious views that were not influenced by delusions. Although SR had not allowed her to speak with his parents, Dr. Rogers testified that she had received communication from SR's parents which stated that SR was not overly religious or preoccupied with religion when he was growing up. It was her understanding that SR grew up in a Christian household where religion was important, but they also appreciated medical treatment and would not forgo medication due to religious beliefs. Dr. Rogers testified that it was her opinion that SR's current preoccupation with religion, to the point that it was the essence of SR's whole existence, was not at all in keeping with the person he was growing up or the family values he had. However, given the importance of religion in SR's life, Dr. Rogers had encouraged SR to meet with spiritual care at the hospital. She explained that Caitlin Sigg was a Chaplain at the hospital, but it was her understanding that SR had not met with spiritual care in several months (she had not seen anything in the chart) because SR believed that they supported pharmakeia and would coerce him.

Dr. Rogers also testified that it was very difficult to have a rational conversation with SR about his illness and the proposed treatment because he was so preoccupied with his allegations of assault and infringement of his *Charter* rights. She stated that SR had no appreciation of how well he did when he was on medication, and he believed that he was doing well now. SR did not realize the impact that his delusions had on his life, or how disruptive he had been on the unit. Dr. Rogers stated that SR remained "quite impaired" and noted that he had written on all four walls of his room with a marker and had asked for castration. SR had also recently been moved to another unit because he had been so intrusive, threatening, and difficult to manage (with respect to both staff and co-patients).

Dr. Rogers was asked specifically why SR was not making a capable decision to not accept antipsychotic medications based on the side effects he had experienced while taking Clozapine. Dr. Rogers explained that although it appeared that SR had been concerned about side effects when he was presumed capable of consenting to treatment, he was not currently talking about

side effects because he was so preoccupied with having no illness that required treatment. SR believed his primary problems were ADHD and Williams Syndrome. It was Dr. Rogers' opinion that SR's decision-making was being affected by his delusions. She also stated that SR was not accepting any treatment for any condition, including refusing Vaseline for a cut on his foot.

Dr. Rogers was also asked about whether it was the case that SR did not accept the diagnosis of Schizoaffective disorder, but explained his symptoms or manifestations of illness in a different way. Dr. Rogers responded that SR did not recognize the core psychotic symptoms that they were trying to treat. SR believed that his only issue was inattentiveness due to ADHD and he just needed structure and routine. Dr. Rogers also testified that SR truly believed that he had been subject to no-touch torture, that he had been an MK ultra slave, that his parents had exposed him to satanic rituals, and that he had murdered a man at age three. When asked whether these things could be true (as opposed to delusional), Dr. Rogers responded that SR was not alive in the 1960s when MK experimentation was alleged to have occurred at Harvard, it was unlikely that a three year old could have murdered a man, and based on the collateral history she had received about SR's upbringing, it was her opinion that it was more likely that these were delusional beliefs.

SR had prepared some questions to ask Dr. Rogers (and the other people that he had summonsed) and these were included in his Prepared Statement. In response to these questions, Dr. Rogers explained what Schizoaffective disorder was, what the symptoms were, and that antipsychotic medications were the primary treatment. She agreed that psychiatry involves both art and science, but stated that when there is a conglomeration of symptoms, there is a clear prognosis and trajectory with treatment. Dr. Rogers agreed that all medications prescribed in psychiatry are psychotropic. Dr. Rogers explained what Clozapine was intended to treat, how it worked, and why there were side effects. She acknowledged that some of the side effects were serious, but noted that the risks go down the longer a person is on the medication. She stated that it was very unlikely that a person could be killed by Clozapine. Dr. Rogers also explained what may occur when someone stops taking Clozapine, including cholinergic rebound, restlessness, and emergence of psychotic symptoms. She also acknowledged that some people did not have complete eradication of symptoms while on Clozapine, but they are able to function in the

community. SR asked Dr. Rogers about the benefits of pharmakeia, and she responded that in SR's case he was able to go back to school, socialize with friends, live independently, and function well.

In response to further questions from SR, Dr. Rogers agreed that SR was a Christian because he told her that. She agreed that she was not present at the time of SR's admission to hospital in January 2025 and had not assessed him at that time, and stated that she obtained her information from the Admission Note. Dr. Rogers denied that she had threatened SR with ECT, that she was prejudiced against SR, or that she was trying to cause him harm or inject him against his religion. Dr. Rogers stated that she thought that SR could "do a lot better than he was doing now." Dr. Rogers agreed that it was not a crime to be "weird or intense", and did not disagree that SR had never been charged with a crime and had a clean driving record. She also agreed that a "fundamental difference of opinion" is not mental illness, even if there are professionals or a power imbalance involved. Dr. Rogers maintained her opinion that SR was experiencing delusions that were affecting his decision-making. She explained that while people can involve their religion in decision-making, in SR's case it was her opinion that it was influencing every decision and was not his baseline level of functioning.

Evidence of Dr. Alexandra Baines

Dr. Baines testified that she first met SR a number of years ago, before the COVID-19 pandemic, when he was a voluntary patient in a psychosocial recovery program. SR had had treatment with multiple antipsychotic medications for his mood and psychotic symptoms, and had poor functioning despite treatment. Prior to the pandemic, SR was considered capable of consenting to treatment and was in and out of the hospital over a period of six to twelve months as a result of discontinuing medications. This led to an extended hospitalization beginning in 2021, and SR was found incapable of consenting to treatment at that time. Dr. Baines testified that SR was "highly distressed by his symptoms" and he assented to a trial of Clozapine while in the hospital. This improved SR's level of distress, enabled him to rebuild his relationship with his parents, and develop a plan to move back in with them (prior to the hospitalization they were not willing to support SR at home given his level of illness). SR developed friendships and was discharged.

Dr. Baines testified that SR lived at home with his parents for one and a half to two years and did well. He volunteered in the community, was engaged with life, attended appointments, and was presumed capable of consenting to treatment.

Dr. Baines testified that SR was very sensitive to weight gain with all antipsychotic medications, and there were ongoing discussions about the side effects of the medication and treatments that could be taken to decrease them. It was not Dr. Baines' recommendation that SR decrease the Clozapine, but SR and his parents had met with their family doctor as well as an internal medicine doctor and were concerned about the side effects. SR did not want to take more medication just to reduce side effects when he felt he could stop the Clozapine. Dr. Baines testified that there were no clear guidelines about how to decrease Clozapine, but it should be done gradually to avoid rebound psychosis. Dr. Baines stated that she was clear in her discussions with SR that the risk of relapse was 95% or greater, and likely closer to 100% for him given his history. She stated that SR proceeded to gradually reduce the Clozapine (often not following her recommended schedule), and the last time she was involved with SR was likely in December 2024.

Dr. Baines was asked about the benefits of Clozapine for SR. She responded that while SR experienced hallucinations throughout his treatment, the severity of them decreased, and SR was not as distressed by them. She stated that there were also significant improvements in his ability to organize his thoughts, actions, and activities of daily living, as well as his engagement in community life. Dr. Baines also stated that SR's acute and severe mood instability and lability completely resolved.

Dr. Baines testified that SR acknowledged the diagnosis of Schizoaffective disorder when she treated him, and that he had a childhood diagnosis of ADHD. He did not mention Williams Syndrome to her. Dr. Baines stated that no-touch torture and MK ultra experimentation were always part of SR's beliefs. When asked about SR's religious beliefs, Dr. Baines testified that they were not prominent in the first few years that she was involved in his care, but that they were more prominent during the last hospital admission. Although SR had expressed that he was interested in more faith-based treatment, Dr. Baines stated that the intensity of SR's beliefs

increased with the severity of his mental illness. She opined that SR's religious beliefs were more related to a delusional belief system, and added that when SR was treated with medication, he did not identify religion as a reason not to take medication.

SR asked Dr. Baines similar questions as he had asked Dr. Rogers, including questions about what Schizoaffective disorder was, whether psychiatry was a "hard science", how Clozapine treats mental illness, and what the side effects and "withdrawal" symptoms were for Clozapine. Dr. Baines explained that there was a significant body of evidence related to consistent patterns of symptoms that lead to a diagnosis of Schizoaffective disorder, however she acknowledged that there was a lack of clear understanding about the biological pathway (noting that this was not unique to psychiatry). She testified that approximately 35% of people on Clozapine continue to experience some symptoms, but over the longer term studies have shown that there is a significant improvement in functioning, ability to live in the community, and a reduction in mortality (even with partial response and side effects). Dr. Baines also testified that she believed that SR was a Christian because he told her that. She agreed that it was not a crime to be "weird or intense."

Evidence of SR

SR read his Prepared Statement as his oral evidence (Exhibit 3). He answered some questions posed by Ms. Miltenburg and I. When asked whether antipsychotic medications had ever helped him, SR responded no. He did not agree that there had been any improvement in his condition or functioning (as noticed by other people) when he was on medication. He declined to answer my question about what caused those changes in his life if it had not been the medication. When asked if he required hospitalization at the current time, SR responded "absolutely not." He stated that if he was discharged today, he would go to a shelter, get an apartment as soon as possible, and commence studies in the fall. SR testified that he went to church "very frequently" when he was growing up. He last went to church during the current hospitalization when he went to a church that other patients went to. He explained that he was "chased out by a member of the congregation." SR could not remember what it was that he was doing that caused the member of the congregation to chase him out of the church, but thought he may have encouraged the

member to reconsider certain views. When asked why he viewed taking pharmakeia as a sin because he was Christian, SR responded that he would leave that for the courts.

I noted that SR's documentary evidence included articles about Clozapine withdrawal symptoms, no-touch torture, "Light of Mind Invasive Technology", and ADHD (Exhibit 2).[3] It also included an excerpt from SR's online independent publication launched in May 2025 ("a little one of Christ Jesus") which stated that SR was a born again Christian (saved by grace through faith alone), an ex-MK Ultra slave, a psychiatric prisoner, a satanic ritual abuse survivor, a no-touch torture survivor (various mind invasive technologies), a gang-stalking survivor, and a victim of EEG Heterodyning. It also stated that SR believed that he had Williams Syndrome (Exhibit 2, page 40). SR stated numerous times throughout the hearing that he had ADHD, Williams Syndrome, and that he had been subjected to no-touch torture. It was also clear from SR's questioning of Dr. Rogers and Dr. Baines, that it was his opinion that they had prescribed or were proposing medication (pharmakeia) for a disorder that was not well understood (Schizoaffective disorder) and that the medication had the potential to kill him.

Analysis

In the seminal case of *Starson v. Swayze*, [2003] S.C.R. 722, the Supreme Court of Canada said this about the issue of capacity:

> "While a patient need not agree with a particular diagnosis, if it is demonstrated that he has a mental "condition", the patient must be able to recognize the possibility that he is affected by that condition....a patient is not required to describe his mental condition as an "illness", or to otherwise characterize the condition in negative terms. Nor is a patient required to agree with the attending physician's opinion regarding the cause of that condition. ***Nonetheless, if the patient's condition results in him being unable to recognize that he is affected by its manifestations, he will be unable to apply the relevant information to his circumstances, and unable to appreciate the consequences of his decision***." (at pp. 761-762 Emphasis added)

I accepted the evidence provided by Dr. Rogers that SR was suffering from Schizoaffective disorder, with symptoms which included delusions (religious, persecutory, referential and grandiose), mania, flight of ideas, disruptive behaviour, and lack of sleep. I found Dr. Rogers'

[3] It was unclear where these articles were from or when they were written.

evidence to be reasonable and credible (and did not find that she was prejudiced against SR), and it was supported by the clinical records provided and the opinion of a number of other doctors who had treated SR in recent years (including Dr. Baines.) SR's oral and documentary evidence, and his behaviour during the hearing, also corroborated Dr. Rogers' evidence. Although SR believed that he had other diagnoses (ADHD, Williams Syndrome) or had other explanations for some events in his life (no-touch torture, ex-MK ultra slave, satanic ritual abuse), the evidence was clear that SR was unable to recognize that he was experiencing psychotic symptoms of a mental disorder, including delusional religious beliefs. Despite being an involuntary patient and there being numerous issues with his behaviour in the hospital, SR believed that he was absolutely fine at the time of the hearing and could be discharged into the community without difficulty.

I carefully considered the fact that SR had experienced serious side effects when taking Clozapine in the past and that he may have been refusing antipsychotic medication as a result of that experience. However, the evidence was clear that at the time of the hearing SR did not believe that he was experiencing the manifestations of a mental condition at all, or that he required hospitalization or psychiatric treatment. He was also refusing all treatment, not just psychiatric medications. Further, while SR was able to identify side effects, or harmful effects of antipsychotic medication, he was unable to appreciate that there were benefits to antipsychotic medication. Specifically, he denied that Clozapine had been of any benefit to him, despite compelling evidence provided by his parents and Dr. Baines that his mental condition and functioning had improved significantly. I found that SR's mental condition prevented him from appreciating that he was suffering from the manifestations of a mental condition (specifically Schizoaffective disorder), and as a result he was unable to evaluate information concerning medications or treatment as it related to his own circumstances, and was unable to appreciate the reasonably foreseeable consequences of a decision or lack of decision about the proposed psychiatric treatment.

In coming to my Decision, I also carefully considered the *Charter* value of religious freedom, and SR's forceful and consistent allegations that his *Charter* rights had been infringed. In coming to this conclusion, I considered the cases submitted by Ms. Miltenburg, and agreed that

the facts and issues were similar to this case.[4] The following paragraph from the Ontario Court of Appeal decision in *S.H. v. Prakash*, 2023 ONCA 459 was particularly instructive (at paragraphs 17-18):

> "[17] On the findings, the religious nature of some of the appellant's beliefs and explanations for his conduct had no impact on the question of incapacity as defined in s. 4(1) of the Act. The appellant's inability to appreciate that his beliefs and actions may be the product of a mental condition rendered him unable to appreciate the reasonably foreseeable consequences of taking or refusing the treatment. Characterizing the beliefs manifested as a consequence of his mental condition as religious could not affect the ultimate finding of incapacity once the court concluded the appellant was incapable, on account of his mental condition, of appreciating that his beliefs and conduct may be a manifestation of that mental condition.
>
> [18] Counsel for the appellant correctly points out that *Charter* values can play a role in capacity determinations. ***The high value Canadian society places on the fundamental right to freedom of religion dictates that the CCB and the courts must proceed cautiously before characterizing a professed religious belief as a manifestation of a mental condition. The evidence must offer clear and cogent support for both the conclusion that the beliefs are a manifestation of a mental condition and the conclusion that the condition has rendered the individual incapable of recognizing that his beliefs may be the product of a mental condition.*** Decisions of the CCB demonstrate that it has regularly undertaken this analysis in the past: *C.R. (Re)*, 2023 CanLII 24871 (Ont. CCB); *G.S. (Re)*, 2021 CanLII 152914 (Ont. CCB); and *E.P. (Re)*, 2013 CanLII 49102 (Ont. CCB). We are satisfied that that onus was met on this record." (Emphasis added)

In this case, I found that there was clear and cogent evidence that supported the conclusion that SR's religious beliefs at the time of the hearing were a manifestation of his mental condition, and that his mental condition rendered him incapable of recognizing that his beliefs may be the product of a mental condition. I accepted the evidence that SR grew up in a Christian family where religion was important. I also accepted that SR's current beliefs were sincere. However, the evidence was that SR's religiosity did not affect his views about medication and treatment of his mental condition until he became unwell. As he became more and more unwell, his views about religion became more prominent to the point that they took over every aspect of his life. SR's parents told Dr. Rogers that their religion did not preclude treatment with medication, and Dr. Baines testified that when SR was relatively well, he did not speak about refusing medication as a result of his religion, or that pharmakeia was a sin (I also noted that SR would not answer

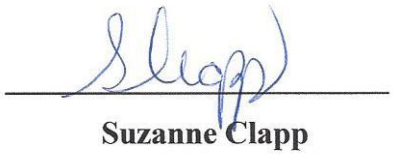
[4] *SH (Re),* 2024 CanLII 39695 (ON CCB); *M.L. v. Meng*, 2023 ONSC 4775.

the question at the hearing about why taking pharmakeia was a sin). The evidence was clear that SR was unable to recognize that his thought process and beliefs were potentially a manifestation of his mental condition. Further, SR was exhibiting other symptoms of a mental condition that were not related to religion, including flight of ideas, lack of sleep, and disruptive behaviour. For all of these reasons, I accepted the evidence and the opinion of both Dr. Rogers and Dr. Baines that SR's religious beliefs were delusions caused by his mental disorder and were influencing his decision-making.

RESULT

For the foregoing reasons, I confirmed the finding that SR was incapable of consenting to treatment with antipsychotic medications.

Dated: September 2, 2025



Suzanne Clapp
Presiding Member