Court of King's Bench of Alberta

Citation: Black v Alberta, 2023 ABKB 123

Date:
Docket: 2301 01360
Registry: Calgary

Between:

Ophelia Black

Applicant

- and -

His Majesty the King in Right of Alberta

Respondent

Reasons for Decision
of the
Honourable Justice Colin C.J. Feasby

Introduction and Overview

[1] Ophelia Black is addicted to opioids. Her addiction has nearly killed her several times. Until recently, she was being treated for her condition by physicians from the Opioid Dependency Program Clinic ("ODP Clinic") at the Sheldon M. Chumir Health Centre ("Chumir Centre") in downtown Calgary. Ms. Black has been prescribed hydromorphone, a potent opioid often used for pain management. She picks up the hydromorphone at her local pharmacy and administers it in her home by crushing the tablets, dissolving them and injecting the solution intravenously. This treatment has allowed Ms. Black to escape street-sourced opioids, which are often contaminated, and to establish a more stable and healthy lifestyle.

[2] The *Mental Health Services Protection Regulation,* Alta Reg 114/2021 ("*Regulation*") and *Community Protection and Opioid Stewardship Standards* (*"Standards"*) provide that, as of March 4, 2023, certain narcotics may not be prescribed to individuals for opioid dependency for use outside a treatment facility. In Calgary, the only such facility is the ODP Clinic. This will mean that Ms. Black can no longer get her medicine from her local pharmacy and consume it at home, which she says will prevent her from following the treatment protocol prescribed by medical professionals. The Chumir Centre is located far from her home and the ODP Clinic is closed from 7pm to 7am, a period during which Ms. Black takes some of her medicine.

[3] Ms. Black asserts that the changes to her treatment required by the *Regulation* and the *Standards* infringe her constitutional rights, specifically her *Charter* s. 7 rights to life, liberty, and security of the person, her *Charter* s. 12 right not to be subjected to cruel and unusual treatment, and her *Charter* s. 15 right to equality. She asks the Court to issue an interim injunction granting her an exemption from the *Regulation* and the *Standards* that would allow her to continue her treatment until the final determination of this proceeding.

[4] Alberta submits that Ms. Black does not have a right to any specific kind of medical treatment for her severe opioid use disorder. Alberta says that it is entitled to make decisions concerning available medical treatments based on a range of factors including cost, effectiveness, and patient and public safety. According to Alberta, the *Regulation* and the *Standards* are a well-considered response to the opioid crisis and it is not the Court's place to intervene. Alberta argues that the Court lacks expertise in health policy and should defer to the decision-making of democratically elected representatives.

[5] Alberta denies that any of the rights infringements alleged by Ms. Black raise a serious issue to be tried. Ms. Black's treatment regimen, according to Alberta, is not approved and is unsafe. Further, Alberta submits that there are safe treatments available to Ms. Black and that her circumstances are the result of her own choices. Alternatively, Alberta states that, to the extent that there are any rights infringements, they are justified by the need to maintain patient and public safety. Alberta contends that consumption of potent opioids outside a supervised facility poses an unreasonable risk to patients. Alberta further argues that prescribing potent opioids to individuals with severe opioid use disorder for use outside a supervised facility creates an intolerable risk that the drugs will be diverted for illicit use by individuals other than the patient to whom the prescription was given.

[6] The present case arises in the context of changing government policy concerning the treatment of opioid use disorder. The Court's job is not to opine on the wisdom of government policy. McLachlin CJC made this point in ***Canada (Attorney General) v PHS Community Services Society***, 2011 SCC 44 at para 105:

> The issue of illegal drug use and addiction is a complex one which attracts a variety of social, political, scientific and moral reactions. There is room for disagreement between reasonable people concerning how addiction should be treated. It is for the relevant governments, not the Court, to make criminal and health policy. However, when a policy is translated into law or state action, those laws and actions are subject to scrutiny under the *Charter*. The issue before the Court at this point is not whether harm reduction or abstinence-based programmes are the best approach to resolving illegal drug use. It is simply whether Canada has limited the rights of the claimants in a manner that does not comply with the *Charter* [citations omitted].

[7] The questions in the present application are whether it is sufficiently clear on the record before the Court at this stage of the litigation that Alberta has infringed Ms. Black's *Charter* rights, that Ms. Black will suffer irreparable harm if the injunction is not issued, and that the balance of convenience weighs in favour of granting an interim injunction to allow her to continue her treatment regimen until the case is decided on its merits.

Procedural History and Evidence Before the Court

[8] This matter originally came before the Court on February 7, 2023 with Ms. Black seeking an interim interim injunction on the belief that changes affecting her treatment mandated by the *Regulation* and *Standards* had come into effect on February 3, 2023. Shortly before the application was to be heard, the Deputy Minister of Health issued a letter to the ODP Clinic clarifying that the changes to the *Regulation* and the *Standards* preventing use of designated narcotics outside approved facilities are to come into effect on March 4, 2023.

[9] Once the misunderstanding concerning the effective date of the *Regulation* and the *Standards* was straightened out, the court appearance was converted into a Rule 4.10 Case Conference to deal with scheduling. A litigation plan setting out deadlines for the delivery of affidavit evidence by both sides and completion of questioning over the balance of the month of February was agreed to by the parties and directed by the Court. Subsequently, the parties consented to orders directing the production of medical records and certain records concerning the opioid treatment program. This schedule and the production orders allowed for the development of a robust evidentiary record.

[10] Ms. Black filed the following evidence:

(a) Affidavit of Ophelia Black affirmed on February 3, 2023 (the "First Black Affidavit");

(b) Affidavit of Ophelia Black affirmed on February 6, 2023 (the "Second Black Affidavit");

(c) Affidavit of Ophelia Black affirmed on February 10, 2023, (the "Third Black Affidavit");

(d) Affidavit of Dr. Helen Bouman sworn on February 1, 2023 (the "Bouman Affidavit");

(e) Affidavit of Dr. Sahil Gupta sworn on February 10, 2023 (the "Gupta Affidavit"); and

(f) Supplemental Affidavit of Dr. Sahil Gupta sworn on February 26, 2023 (the "Gupta Reply Affidavit").

[11] Alberta filed the following evidence:

(a) Affidavit of Kenton Puttick, sworn on February 21, 2023 (the "Puttick Affidavit");

(b) Affidavit of Dr. Sharon Koivu, dated February 21, 2023 (the "Koivu Affidavit");

(c) Affidavit of Dr. Nathaniel Day, dated February 21, 2023 (the "Day Affidavit"); and

(d) Affidavit of Emily Oswald, dated February 28, 2023 (the "Oswald Affidavit").

[12] The following questioning transcripts were filed:

(a) Dr. Helen Bouman, February 23, 2023;

(b) Ophelia Black, February 24, 2023;

(c) Dr. Nathaniel Day, February 24, 2023;

(d) Kenton Puttick, February 24, 2023; and

(e) Dr. Sharon Koivu, February 27, 2023.

[13] The parties also filed responses to undertakings given at the various questionings. Accordingly, the record before the Court at this point is quite comprehensive, akin to what might be available on a summary trial.

Background

The Applicant

[14] Ms. Black is 21 years old. She says that she has struggled throughout her life with mental health. During her late adolescence, she experienced physical and sexual abuse at the hands of an older man, who introduced her to hard drugs as a way of imposing control over her.

[15] Ms. Black was assaulted during what she calls a "non-consensual intimate encounter." She required hospitalization for her injuries. While in hospital, she was given intravenous hydromorphone, which dulled her pain and allowed her to feel calm and sleep peacefully despite her recent trauma.

[16] Upon discharge from the hospital, Ms. Black was prescribed hydromorphone to manage her ongoing pain. The older man she associated with continued physically and sexually abusing her and demanded that she provide him with her hydromorphone medication.

[17] Eventually, she was unable to secure a renewal of her hydromorphone prescription. Without hydromorphone, she experienced significant withdrawal symptoms and she turned to using street-sourced opioids including morphine, heroin, and fentanyl.

[18] Ms. Black's life came to be dominated by her need to purchase and consume street-sourced opioids. This destructive cycle prevented her from holding down a steady job or pursuing education. She accumulated significant personal debt and declared bankruptcy. Ms. Black states that she "overdosed numerous times and nearly died on multiple occasions."

The Regulation and the Standards

[19] The *Regulation* and the *Standards* came into force on October 5, 2022. However, s. 56(1)(b) of the *Regulation* defines "transition period" as "the period beginning on the coming into force of section 15 and ending 150 days after section 15 comes into force." The result is that the *Regulation* and the *Standards* become effective on March 4, 2023, as discussed above.

[20] Part 2 of the *Regulation* sets out a framework for narcotic transition services ("NTS"), which are defined as "services to treat opioid use disorder and includes the use of one or more designated narcotic drugs, but does not include the use of designated narcotic drugs if medically indicated for the purpose of stabilizing a person suffering from opioid withdrawal during the patient's admission to an approved hospital for other indications."

[21] The *Regulation* governs the prescription and dispensing of designated narcotic drugs for opioid use disorder. Designated narcotic drugs include "any full agonist opioid drug with the

exception of methadone or slow release oral morphine." Hydromorphone, the drug prescribed to Ms. Black, is a designated narcotic drug under the *Regulation*.

[22] The *Regulation* provides that, with only limited exemptions, a licence is required to provide NTS and that only a regulated health authority may apply for a licence. For practical purposes, Alberta Health Services ("AHS") is the only provider of NTS in Alberta.

[23] NTS may be offered only in facilities that are "equipped and staffed to immediately recognize serious adverse reactions, including potentially fatal respiratory depression and seizures, and to initiate immediate treatment and resuscitation measures if needed" (s. 17). As noted above, the only place NTS is offered in Calgary is at the ODP Clinic.

[24] Section 18 of the *Regulation* precludes pharmacies from dispensing designated narcotic drugs: "(i) if the prescription does not include the medical indication for which the drug is being prescribed, (ii) directly to the patient, or (iii) for a purpose other than administration of the drug by or under the in-person supervision of an authorized regulated member." It also requires that doctors administer designated narcotic drugs only at a licenced facility, an approved hospital, or a facility designated under the *Mental Health Act* or under the *Regulation*. Significantly, however, s. 14 exempts doctors and pharmacies from the *Regulation* when they are prescribing or dispensing "a designated narcotic drug for the purpose of treating a medical condition *other than opioid use disorder*...." [emphasis added].

[25] The *Standards* provide at s. 2 that a patient is eligible for NTS if

> (a) the patient has been unable to initiate or stabilize on
>
> (i) buprenorphine, and
>
> (ii) methadone or slow-release oral morphine,
>
> (b) the patient is able and willing to attend at the place the narcotic transition services will be provided as needed to receive the narcotic transition services,
>
> (c) the patient has a history of drug use with opioids and severe opioid use disorder (Diagnostic and Statistical Manual of Mental Disorders, 5th edition [DSM-5]),
>
> (d) the patient shows signs of current opioid drug use confirmed by patient report, signs of drug use and opioid-positive urine toxicology screen, and
>
> (e) the patient and, if applicable, the patient's substitute decision maker agree to the terms of and sign the service agreement.

[26] Once a patient has been assessed and determined to be eligible for NTS, s. 7 of the *Standards* requires that an initial treatment plan be developed within 48 hours. The patient is then required under s. 15 to sign a service agreement, the minimum contents of which are set out in Schedule 1 to the *Standard*s.

[27] The *Standards* require a service provider (in practice, AHS) to provide psychiatric assessment (s. 20), mental health services and addiction counselling (s. 21), and referrals to other health, recovery support, and social services not directly provided by the service provider (s. 23).

[28] Section 28 of the *Standards* provides that AHS "shall ensure that a designated narcotic drug is not prescribed, administered, dispensed or sold in a formulation that may be taken by a patient out of the facility or other location at which narcotic transition services are provided."

[29] The *Standard*s also require AHS to ensure "best efforts are made to transition patients from designated narcotic drugs to opioid agonist treatment services that use opioid agonist drugs other than designated narcotic drugs...." (s. 30).

[30] The *Regulation* and *Standards* do not provide for exemptions to be made for any patients to account for their individual circumstances.

[31] Alberta provided an affidavit from Mr. Kenton Puttick, who until recently was the Director of the Legislation and Policy Unit in the System Enhancement and Legislation Branch of the Ministry of Mental Health and Addiction and was involved in the development of the *Regulation* and the *Standards*. In questioning on his affidavit, Mr. Puttick was asked about a memorandum sent by the Alberta Medical Association to the Deputy Minister of Mental Health and Addictions on October 8, 2022 referencing "Modifications to the new Narcotic Transition Services". That memorandum reads, in part, as follows:

> *3) Creating a case-by-case exemption system for clients who are stable and on carried doses of opioids expanding upon the current case evaluation system.*
>
> PRO: Providing a unique case exemption option will ensure the ongoing stability of highly complex clients who are currently stable to maintain and build on their recovery. While the current regulations allows for complex cases to not necessarily be transitioned to methadone, Kadian, or buprenorphine, it still requires clients to be daily dosed and witnessed in the brick-and-mortar ODP facility. For currently stable clients who are working/attending school/no longer have contact with other unstable clients/have barriers to travel into downtown, this move to ODP dosing could destabilize them and put them at increased risk of relapse to illicit fentanyl. Medicine requires flexibility and creating an exemption for stable clients will support clients in their continued recovery.
>
> Rural communities in particular would benefit from potential case by case carries to deal with transportation and geographic barriers.
>
> CON: While this would go against the current proposed regulations, the exemption program would ensure it's [*sic*] limited to select clients after appropriate evaluation by addiction medicine specialists and reduce the risk of poor outcomes related to opioid prescribing. It also continues to limit prescribing shorter-acting opioids to a select number of practitioners and providers experienced in addiction medicine.

[32] Mr. Puttick indicated that he recalled there having been some discussion of an exemption system or a process to grandfather in certain patients. No exemption has been offered to Ms. Black that would allow her to continue her current treatment regimen.

Alberta Opioid Treatment Programs

[33] A standard of care for injectable opioid agonist treatment ("iOAT") is described in N. Fairbairn et al, "Injectable opioid agonist treatment for opioid use disorder: a national clinical

guideline" CMAJ 2019 September 23; 191: E1049-56. The authors of the national clinical guideline conclude at E1055:

> Individuals with severe opioid use disorder who inject opioids may not adequately benefit from oral opioid agonist treatment medications, for a variety of reasons. This guideline provides a framework for how to build a clinical practice of injectable opioid agonist treatment and recommends that this treatment should be considered for individuals with severe, treatment-refractory opioid use disorder and ongoing illicit injection opioid use. For those individuals determined likely to benefit from injectable opioid agonist treatment, both diacetylmorphine and hydromorphone should be considered appropriate treatments. Finally, injectable opioid agonist treatment should be provided as an open-ended treatment, with decisions to transition to oral opioid agonist treatment made collaboratively with the patient.

[34] On January 16, 2020, the government of Alberta announced that it would terminate the iOAT programs on March 31, 2021. A lawsuit seeking to enjoin that termination was commenced on September 30, 2020: ***TAM v Alberta***, 2021 ABQB 156. On November 16, 2020, Alberta indicated that it would permit existing iOAT patients to continue to receive iOAT after March 31, 2021, but treatment would be delivered at ODP clinics instead of through a standalone iOAT program. Doctors were not allowed to offer new patients iOAT even at ODP clinics.

[35] Alberta began to offer iOAT to new patients again in Fall 2022 after the *Regulation* and *Standards* were adopted. In Calgary, iOAT is now offered only through the ODP Clinic. The ODP Clinic is open daily from 7am to 7pm; however, Dr. Day gave evidence that, in practice, patients may receive iOAT only between 7:15 am and 6:45 pm.

[36] Despite not having any express power to do so under the *Regulation* and *Standards*, Alberta granted to AHS a temporary exemption from certain parameters for the purpose of allowing AHS to manage the needs of patients receiving iOAT in the community through a mobile service. Dr. Day explained that, as of the time of his questioning, the patients receiving mobile iOAT have been transitioned to ODP clinics and that Alberta is covering the cost of transportation for the patients to the ODP clinics where necessary. Mr. Puttick and Dr. Day confirmed that no further exemptions for AHS have been contemplated.

[37] Dr. Day testified in his questioning that AHS is "anticipating that with the [March 4, 2023] deadline that's coming up, that there'll be new cases that come forward particularly for people out of the community who may have been receiving hydromorphone in the community." He later explained that special accommodations for patients are reviewed "on an individual basis." Since the commencement of this proceeding a month ago, AHS has not offered Ms. Black the accommodation she seeks to allow her to continue her current treatment regimen.

Ms. Black's Treatment Regimen

[38] Ms. Black sought help for her opioid addiction at Safeworks, the supervised consumption site at the Chumir Centre. From there, she found her way to the ODP Clinic, hoping to find a way to free herself from street-sourced opioids.

[39] Ms. Black explains that she tried several treatments for her opioid addiction, including sobriety, suboxone, and methadone.[1] She says that her attempts at sobriety drove her to use other substances such as crystal meth and caused her to experience suicidal ideation. Suboxone and methadone did not work for her; they did not stop her cravings for opioids and left her in an unstable and distraught mental state. Ms. Black reverted to street-sourced opioids to manage her condition.

[40] Ms. Black was diagnosed with severe opioid use disorder and her treating physicians at the ODP Clinic determined that she required stronger opioids to manage her condition and prevent her from using street-sourced opioids. She was prescribed hydromorphone tablets to be taken orally, though, as noted above, she instead dissolves and injects them.

[41] When Ms. Black is ready to inject hydromorphone at home, she contacts the National Overdose Response Service ("NORS"). NORS is a peer support program that stays in contact with the person injecting opioids until it is clear that the person has not overdosed. NORS will contact emergency services if an overdose occurs. Alberta offers a similar service through a phone app called Digital Overdose Response System ("DORS") that may be used by those consuming illicit opioids.

[42] Since she started following the treatment regimen more than 20 months ago, Ms. Black says that she has reduced her number of daily doses from six or seven to three. Ms. Black stated in her affidavits that she injects twice during the day and once in the middle of the night. During her questioning, she stated that she has updated her schedule and now injects in the early morning, at approximately midday, and in the evening. She prefers this new schedule as it obviates the need to get up in the middle of the night and allows her to work over the dinner hour.

[43] Dr. Bouman is an addiction medicine physician at the ODP Clinic at the Chumir Centre. Ms. Black was under her medical supervision from May 2021 until early February 2023, during which time Ms. Black received medication and psychological and social supports through the ODP Clinic. Dr. Bouman confirms Ms. Black's description of her treatment regimen. She stated this in her affidavit:

> Since her admission to the ODP Clinic and this Treatment Regime, Black has done well. She informs me and I believe true that she has substantially decreased her use of street-sourced opioids such as fentanyl.
>
> I believe that as a result of the Treatment Regime, Black has experienced an improvement in her physical, mental and social health, Black's current Treatment Regime is the only treatment she is able to accept at this moment. Black has demonstrated her commitment to her Treatment Regime, which is a safer and better alternative to toxic street-sourced opioids.

[44] Dr. Bouman elaborated on her affidavit evidence in re-examination:

> A ...Some patients are deeply entrenched in their addiction and use intravenous drugs and, you know, are not able to stop that. So we meet the patients where they're at. And there are many forms of treatment. We try

[1] Alberta has questioned whether Ms. Black was ever prescribed methadone. For the purposes of this injunction application, nothing turns on whether she was treated with methadone.

and choose together the most appropriate form of treatment. Our overall goal is to reduce the harms associated with illegal fentanyl use or illicit fentanyl use and also to, you know, provide them wrap around care where they're engaged with the team on multiple levels. You know, and to this end we did succeed with Ophelia.

Q What do you mean you succeeded with Ophelia?

A So, Ophelia was, you know, prescribed hydromorphone tablets under very strict circumstances, right? She had many requirements that she had to meet in order to maintain her prescription, and she did that for, you know, the year and a half, 20 months that we were working together. So, for example, at the very beginning of her treatment, she was required to attend weekly appointments to, you know, confirm that we were on the right track. She had daily attendance at the pharmacy. She had to pick up her medications every day. So, we engaged the pharmacist in terms of monitoring Ophelia to ensure that she was alert and, you know, coherent at each pickup. We required frequent random urine drug screen. The random urine drug screens were required to be negative for fentanyl. So, we wanted to ensure that our medications were, in fact, doing what, you know, they were intended to do. They were eliminating her use of street fentanyl. She was also highly encouraged to engage with all the psychosocial supports that we have available at ODP. And she did that quite successfully. She met with a therapist on many occasions. She had over 40 visits with various medical and psychological professionals at ODP at the time that she was with our clinic.

So compared to other patients, I would say this was a highly successful interaction, right? We reduced her use from illicit fentanyl, and we improved her medical and psychological supports.

Q And in terms of -- you mentioned that you have to meet patients where they're at. Where is Ophelia at?

A Ophelia is a young, you know, woman suffering from severe opioid use disorder. And she is firmly entrenched in her intravenous drug use. That is not my choice, right? My choice is to sort of continually encourage and support patients as they transition from a dangerous substance use to safer and safer forms of therapy and eventually to get off of it altogether, right? At this point in a 21-year-old woman's life we're not there, yet, right? Our hope is to keep her alive so that she lives into her 30s and 40s and that at that time perhaps, you know, she may be at a less intensive form of substance use.

[45] Dr. Bouman testified that she was aware of the risks of injecting dissolved hydromorphone tablets and that she advised Ms. Black of those risks.

Alberta's Criticism of Ms. Black's Treatment Regimen

[46] Alberta's witnesses criticize Ms. Black's treatment regimen. They assert that hydromorphone tablets are approved by Health Canada only for oral use and note that there is a

separate hydromorphone preparation for injection. Dr. Koivu's evidence is that there are dangers associated with injecting hydromorphone tablets. There are non-medicinal ingredients in those tablets that do not dissolve easily and can cause many serious problems when injected into the bloodstream including endocarditis, stroke, and a range of infections. Dr. Koivu's opinion is that injection of oral hydromorphone tablets is "misuse" and that risk of death from infection may exceed risk of death from overdose. During questioning, Dr. Koivu conceded that Ms. Black's treatment regimen was safer than using street-sourced opioids.

[47] Dr. Gupta disagreed with Dr. Koivu's evidence, saying that "Tablet-based injectable opioid agonist therapy is recognized within the addictions medical community in Canada and, in my opinion, Dr. Koivu's views do not reflect a complete or comprehensive perspective of the efficacy of the treatment option." To support his opinion, he pointed to Tablet Injectable Opioid Agonist Treatment ("TiOAT") programs in British Columbia and Ontario. He also highlighted a study published in the Canadian Medical Association Journal in 2022 that observed significant declines in emergency department visits, hospital admissions, and health care costs for patients in a London, Ontario safer opioid supply program using, among other things, TiOAT: T. Gomes et al, "Clinical outcomes and health care costs among people entering a safer opioid supply program in Ontario" CMAJ September 19, 2022 194 (36) E1233-E1242.

[48] Dr. Bouman explained that, despite the risks associated with injecting hydromorphone tablets, it "is a safer alternative to provide her pharmaceutical grade tablets of known strength and quantity that she can use in a predictable fashion as opposed to buying street-sourced opioids, which are not pharmaceutical grade and not of uniform quantity and dosage." Her evidence was that treatment of opioid addicts sometimes requires doctors to choose a treatment option that, while not ideal, is less harmful than the alternative of street drugs.

[49] The evidence is that Dr. Bouman did not prescribe oral hydromorphone for injection, but was aware that Ms. Black was injecting it. At this point, there is no legal impediment to Ms. Black's treatment regimen. It is unconventional and perhaps unsafe, but legal. Dr. Bouman acknowledged this, but explained that it was the only realistic option given that, as of March 31, 2021, Alberta would not allow new patients in the iOAT program:

> At the time of her admission to the clinic in May of 2021, we were not allowed to admit her to the iOAT program. We were no longer allowed to take new patients on. So, this was the safest form of treatment.... But in these extreme circumstances of a very young girl who had ... multiple overdoses, who was determined to continue using intravenously, who had all the social supports and the ability to follow through with our relatively stringent admission criteria, we felt this was the best option available to us at the time.

[50] Dr. Bouman testified that Ms. Black now can be offered iOAT at the ODP Clinic. When it was thought that the *Regulation* and *Standards* were effective on February 3, 2023, Ms. Black was encouraged to enroll in the NTS program where she could receive iOAT during clinic hours. When Alberta clarified that the changes required by the *Regulation* and *Standards* were effective on March 4, 2023, Ms. Black changed clinics so that she could continue with her existing treatment regimen of picking up oral hydromorphone tablets daily from her local pharmacy.

[51] As of March 4, 2023, neither the ODP Clinic nor any other clinic will be allowed to prescribe hydromorphone tablets for use outside of an approved facility for the purpose of treating opioid use disorder, regardless of whether the tablets are intended to be consumed orally

or injected. The *Regulation* and *Standards* make Ms. Black's treatment regimen illegal as of March 4, 2023.

Application to Strike the Koivu Affidavit and Questioning Evidence

[52] Counsel for Ms. Black urged the Court to strike the affidavit of Dr. Koivu and opposed her qualification as an expert. He submitted that Dr. Koivu was partisan because she purports to give "voice to the voiceless" by raising public awareness of the dangers associated with injecting drugs formulated for oral consumption. He further asserted that much of her evidence was based on anecdotal observations and her personal experience of living near a safe consumption site and that she failed to give a complete picture of the use of tablet hydromorphone for injection in safe consumption programs in Canada. Some of this critique rings true, but on an interim application it would be a mistake to apply an overly high standard. The evidence from Dr. Koivu was compiled in a matter of days and it is understandable if it is not of the caliber that might be expected at a trial.

[53] I accept both Dr. Koivu and Dr. Gupta as experts. As I noted at the oral hearing, I do not consider their opinions any more valuable than the other medical witnesses. Both Dr. Day and Dr. Bouman are what the Court of Appeal described as witnesses with expertise: ***Kon Construction Ltd v Terra Nova Developments Ltd***, 2015 ABCA 249 at para 35. I note that on the critical medical questions in issue on this application, the medical witnesses are in substantial agreement.

***Charter* Injunctions**

[54] Where "rights or freedoms, as guaranteed by this *Charter*, have been infringed or denied", courts are empowered by s. 24(1) to grant "such remedy as the court considers appropriate and just in the circumstances....". Courts have interpreted this authority to include the power to grant interim relief prior to the final determination of whether rights or freedoms have been infringed or denied: ***RJR-Macdonald v Canada (Attorney General)***, [1994] 1 SCR 311 at 332.

[55] The Supreme Court of Canada adopted the tri-partite test used in civil matters (see ***American Cyanamid Co v Ethicon Ltd***, [1975] AC 396 (HL)) for use in determining whether to grant injunctions under the *Charter*: ***Manitoba (AG) v Metropolitan Stores Ltd***, [1987] 1 SCR 110, 1987 CanLII 79; ***RJR***; ***Harper v Canada***, 2000 SCC 57. The test requires the applicant to establish:

(a) a serious issue to be tried;

(b) irreparable harm; and

(c) that the balance of convenience favours the granting of the injunction.

[56] Paperny JA, writing for the majority of a five-judge panel in ***AC and JF v Alberta***, 2021 ABCA 24, described the serious issue to be tried test as a low threshold and made two additional important points. First, the parts of the test are not watertight compartments. At para 30, she observed that "[e]ven weak cases may be entitled to interlocutory relief if the other aspects of the test weigh heavily in that direction...". Second, citing the extra-judicial writing of Sharpe JA (Robert J Sharpe, "Interim Remedies and Constitutional Rights" (2019) 69 UTLJ 9), she

accepted that where an applicant can demonstrate a strong case in the first part of the test, that "likelihood of success" may be "weighed in the balance": para 29, citing Sharpe at 14. The approach outlined by Justice Sharpe and adopted in ***AC and JF*** was deployed by the Ontario Court of Appeal in the context of a stay application in ***Toronto (City) v Ontario (Attorney General)***, 2018 ONCA 761 at para 20.

[57] In ***Metropolitan Stores***, an early *Charter* injunction case, it was submitted that a presumption of constitutionality should be considered in the first stage of the tripartite test. Prior to the *Charter,* courts applied a presumption of constitutionality in various ways: Joseph Eliot Magnet, "The Presumption of Constitutionality" (1980) 18 Osgoode Hall LJ 87. In ***Metropolitan Stores***, however, Beetz J at paras 15 and 16 rejected a presumption of constitutionality in the context of *Charter* injunctions on two grounds. First, he concluded that an irrebuttable presumption of constitutionality would mean that an injunction could never be granted. Further, a rebuttable presumption of constitutionality effectively would require a trial on the merits at an interim stage. Second, he concluded that "there is no room for the presumption of constitutional validity" because of the character of the *Charter*. By this, it seems, he meant that a presumption of constitutionality was inconsistent with the *Charter*'s rights-protecting function. Accordingly, the evaluation of whether there is a serious issue to be tried must be made without a thumb on the scale in favour of the state.

[58] The second part of the injunction test asks whether the applicant will suffer irreparable harm if the injunction is not granted. The Supreme Court of Canada explained in ***RJR*** at 315 that "'[i]rreparable' refers to the nature of the harm suffered rather than its magnitude. It is harm which either cannot be quantified in monetary terms or which cannot be cured, usually because one party cannot collect damages from the other." Paperny JA in ***AC and JF*** at para 55 observed that "[t]he harm engendered by the failure to grant interlocutory relief is generally assessed from the standpoint of the person seeking to benefit from that interlocutory relief." While irreparable harm is assessed from the standpoint of the person seeking to benefit from the interlocutory relief, it must be demonstrated with evidence, not just asserted.

[59] The third part of the test, balance of convenience, requires "a determination of which of the two parties will suffer the greater harm from the granting or refusal of an interlocutory injunction, pending a decision on the merits": ***Metropolitan Stores*** at para 36. The Court held in ***RJR*** at 342 that, "[i]n light of the relatively low threshold of the first test and the difficulties in applying the test of irreparable harm in *Charter* cases, many interlocutory proceedings will be determined at this stage."

[60] The determinative issue in *Charter* injunctions at the balance of convenience stage is often the public interest. ***RJR*** and ***Harper*** have come to be understood to stand for the proposition that a Court must presume that the government entity whose statute, regulation, or other action is challenged represents the public interest and that the government is not required to provide evidence of that. In ***RJR*** at 349, Sopinka and Cory JJ explained that a plaintiff also may be acting in the public interest, but must demonstrate it with evidence.

[61] This public interest presumption rests on a democratic rationale; until there is a decision on the merits, the people's elected representatives should be presumed to be acting lawfully. Slatter and Watson JJA stated in ***Alberta Union of Provincial Employees v Alberta***, 2019 ABCA 320 at para 17 that "in the short term the elected legislators must be allowed to legislate except in the clearest of cases." See also ***Metropolitan Stores*** at para 56.

[62] In practice, however, the public interest presumption can function as a backdoor presumption of constitutionality. This was acknowledged by Slatter JA, writing for himself and Watson JA, concurring in ***AC and JF*** at paras 114-122. He stated at para 115, "[t]here may not be a presumption of constitutionality, but there is an assumption that governments act constitutionally." Similarly, he held at para 119 that "the balance of convenience analysis should assume that the Legislature does not deliberately cross constitutional boundaries."

[63] Schutz and Pentelechuk JJA in ***PT v Alberta***, 2019 ABCA 158 at para 76, citing ***RJR***, explained that the public interest presumption is rebuttable. Sopinka and Cory JJ in ***RJR*** held at 349: "[i]n order to overcome the assumed benefit to the public interest arising from the continued application of the legislation, the applicant who relies on the public interest must demonstrate that the suspension of the legislation would itself provide a public benefit."

[64] The balance of convenience is sometimes said to require a second assessment of the merits to determine whether the applicant has made out a clear case. In separate concurring reasons in ***Hak c Procureure générale du Québec***, 2019 QCCA 2145, Bélanger JA and Mainville JA took a similar approach. Both judges dismissed an appeal from a lower court decision declining to grant an injunction suspending Quebec's law banning displays of religious symbols by public service employees pending determination of a *Charter* challenge on its merits. Bélanger JA wrote at paras 91-93:

> The harm the Attorney General of Quebec would suffer if a stay were ordered would be harm to the public interest. The Attorney General has rightly invoked the presumption that the legislative measure is in the common interest. At this stage of the proceedings, the Court must proceed on the assumption that the Act serves a valid public purpose. Unless it is clear that the enactment does not have a valid public purpose, the courts must assume it does.
>
> It follows from this principle that courts will not suspend a statute passed by a legislature without having performed a full constitutional review. Consequently, a stay will only be ordered in clear cases.
>
> We must recognize that, <u>despite the presence of serious issues, this is not a clear case in which we can, at this point in time, state that the Act is unconstitutional</u>... [emphasis added; footnotes omitted].

[65] The most recent statement of the clear case standard in this Province is found in ***Moms Stop the Harm Society v Alberta***, 2022 ABCA 35, where the Court held at para 36 that "interlocutory judicial intervention is not warranted unless the decisions made by the government are so obviously unreasonable that the *Charter* is engaged, and the challenged policy cannot be justified."

[66] There is confusion in the law as to what is meant by a clear case. Bélanger JA in ***Hak*** appears to interpret "clear case" as referring to the merits, as does the Court in ***Moms Stop the Harm***. These decisions suggest that there is a second merits evaluation at the balance of convenience stage. In contrast, Newbury JA in ***Cambie Surgeries Corporation v British Columbia (Attorney General)***, 2019 BCCA 29 at para 49 dismissed the idea that the clear case standard applies to the merits stage of the inquiry and said instead that "it informs the court's task in assessing the second factor of the analysis, irreparable harm."

[67] Paperny JA in ***AC and JF*** held at para 37 that "[t]he law remains as set out by the Supreme Court in the leading cases of ***RJR-MacDonald***, ***Harper*** and ***CBC***." A close analysis of ***Harper*** shows that the clear case standard refers to the balance of convenience, nothing more. The words "clear case" come from para 9 of ***Harper,*** which is a discussion about public interest and the balance of convenience, so the most reasonable interpretation of the words "clear case" is that it refers to the balance of convenience. In other words, for an injunction to be granted, the balance of convenience must clearly favour the applicant. If "clear case" referred to the merits, that would mean that applicants have to show a clear case instead of a serious issue to be tried. To interpret the words "clear case" as referring to the merits would mean that ***Harper*** overruled ***RJR***. There is no suggestion in ***Harper*** that this was the Court's intention. Indeed, this conclusion is compelled by Paperny JA's observation in ***AC and JF*** at para 30 that "[e]ven weak cases may be entitled to interlocutory relief if the other aspects of the test weigh heavily in that direction...."

[68] The requirement for an applicant to demonstrate that the balance of convenience clearly favours the granting of an injunction should not be confused with the point that Paperny JA in ***AC and JF*** adopted from Justice Sharpe. The different parts of the tripartite test are not watertight compartments. A strong showing by a party at the merits stage may tip the scales in favour of that party in the overall result. This does not require a second merits analysis under the guise of ascertaining a "clear case" as part of the balance of convenience. Nothing that I have said here is inconsistent with a court, after completing the tripartite analysis, considering the overall balance to determine whether the case is an appropriate one for an injunction before exercising its remedial discretion.

[69] I am bound by the decision of the Court of Appeal in ***AC and JF*** and the decisions of the Supreme Court of Canada in ***Metropolitan Stores***, ***RJR***, and ***Harper***. Accordingly, I will apply the tripartite test set out above in para 55 and, at the third stage of the test, will presume Alberta to be acting in the public interest and apply the clear case standard from ***Harper***.

Serious Issue to be Tried

Charter s. 7 – Deprivation of Life, Liberty, and Security of the Person

[70] The question before the Court in the present application is not whether Ms. Black has a standalone right to a particular form of treatment that is protected by *Charter* s. 7. McLachlin CJC and Major J held in ***Chaoulli v Quebec (Attorney General)***, 2005 SCC 35 at para 104: "[t]he *Charter* does not confer a freestanding constitutional right to health care. However, where the government puts in place a scheme to provide health care, that scheme must comply with the *Charter*." The question in the present application is whether there is a serious issue to be tried that the limits on Ms. Black's treatment regime imposed by the *Regulation* and the *Standards* comply with the *Charter*.

[71] *Charter* s. 7 demands that the Court ask two questions. First, is there an interference with the right to life, liberty, or security of the person? Second, is the interference in accordance with the principles of fundamental justice? The second question, in turn, requires the Court to identify the relevant principles of fundamental justice and determine whether the deprivation is in accordance with such principles: ***R v Ndhlovu***, 2022 SCC 38 at para 49 and ***Carter v Canada (Attorney General)***, 2015 SCC 5 at para 55.

[72] Ms. Black contends that her rights to life and security of the person are engaged because the changes in her treatment required by the *Regulation* and the *Standards* may result in her returning to street-sourced opioids, putting her at risk of death or serious harm. The Supreme Court of Canada in ***Carter*** held *per curiam* at para 62 that "the right to life is engaged where the law or state action imposes death or an increased risk of death on a person, either directly or indirectly." The question of whether obstacles preventing drug addicts from accessing safe injection facilities engage the rights to life and security of the person was decided in ***PHS***. McLachlin CJC, writing for the Court, held at para 93: "[w]here a law creates a risk to health by preventing access to health care, a deprivation of the right to security of the person is made out. Where the law creates a risk not just to the health but also to the lives of the claimants, the deprivation is even clearer" [citations omitted].

[73] The right to security of the person has been interpreted to protect both physical and psychological integrity: ***R v Morgentaler***, [1988] 1 SCR 30 at 37; ***Rodriguez v British Columbia (Attorney General)***, [1993] 3 SCR 519 at 588. Both in ***Morgentaler*** (Dickson CJC writing for the majority at 59) and in ***Chaoulli*** (McLachlin CJC and Major J at para 118; Deschamps J at paras 43 and 45; and Binnie & LeBel JJ at para 206), the Supreme Court of Canada held that significant obstacles to obtaining necessary health care engage the rights to life and security of the person.

[74] Alberta submits that it should have a free hand to determine health policy and that it has determined that potent opioids should be administered as treatment for severe opioid disorder only in approved facilities. Alberta contends that the *Regulation* and the *Standards* do not deprive Ms. Black of effective treatment because her need for treatment is adequately addressed by the provision of iOAT at the ODP Clinic at the Chumir Centre. Alberta, in its written brief, said: "[t]he Applicant's choice to deprive herself of effective treatment does not engage section 7 of the *Charter*." Alberta further asserted that "any burden that is created, such as the travel required to access NTS services, is a result of the Applicant's place of residence or her personal lifestyle choices." Alberta's position is that Ms. Black's complaint is really that the new treatment regimen required by the *Regulation* and *Standards* is inconvenient to her and that this is not sufficient to engage *Charter* s. 7.

[75] Alberta relies on ***Lewis v Alberta Health Services***, 2022 ABCA 359, where a patient was removed from the organ transplant list because she refused to comply with a rule requiring all transplant candidates to have the COVID-19 vaccine. The Court of Appeal dismissed the applicant's *Charter* s. 7 claim, holding at para 45: "[i]t is one thing to assert that the state is unlawfully prohibiting one from accessing life-saving treatment; it is quite another for Ms. Lewis to selectively choose which treatment criteria she will comply with."

[76] The Court in ***Lewis*** concluded at para 28 that the vaccine requirement was not government action; accordingly, the Court held at para 36 that "the *Charter* has no application to the COVID-19 vaccine requirement". As such, the paragraph in ***Lewis*** relied upon by Alberta is *obiter dicta*.

[77] Moreover, ***Lewis*** is distinguishable from the present case. In this case, the *Regulation* and *Standards* remove discretion from doctors to prescribe potent opioids to patients for use outside approved facilities; this is clearly government action. In ***Lewis***, medical personnel using their professional judgment to set transplant criteria were found not to be government agents. The Court of Appeal held at paras 32-33:

> We conclude that setting [organ] pre-transplantation criteria is the result of myriad clinical and medical factors, including the collective judgment of numerous specialized medical and other personnel acting in concert to determine the standard of care for all patients on the [organ] transplant waitlist, including Ms Lewis. In our view, the respondent physicians' decisions made in respect of Ms Lewis are quintessentially clinical, made to maximize the best use of a scarce resource and the best possible outcome for Ms Lewis, with the greatest chance of a life free from life-threatening complications, through science-based and medical consensus-based management of all possible identifiable risks.
>
> The record amply supports the conclusion the Program referral, intake, and allocation processes are informed solely by clinically and medically appropriate information and optimal standard of care; nothing the Program team decided ceded their medical opinions about the best interests of Ms Lewis to government policy, government mandates, or otherwise. This included their clinical and medical decision that a pre-transplant COVID-19 vaccine is required [emphasis added].

[78] Quite apart from ***Lewis***, it is important to address Alberta's argument that Ms. Black's predicament is the result of her own choice and, accordingly, that there is no *Charter* s. 7 issue. It is clear from the evidence of all the doctors who testified for Alberta and Ms. Black that the nature of opioid use disorder is that it drives people to make bad choices, including choices that foreseeably could result in serious harm and death. To say that Ms. Black's treatment choice is voluntary is to ignore her condition. Justice Valente in ***The Regional Municipality of Waterloo v Persons Unknown and to be Ascertained***, 2023 ONSC 670 considered a similar argument in the context of homeless people camped on municipal property. He concluded that a "choice" to live in an encampment rather than a shelter that did not meet their needs was not really a choice at all. He concluded at para 106 that this sort of choice "does not negate a claim that one's section 7 *Charter* rights have been breached. In my view, the overriding context in the matter before me is not one of freedom in the exercise of autonomous choice."

[79] The Supreme Court of Canada has held that unreasonable treatment choices forced on patients can sometimes engage *Charter* s. 7. In ***R v Smith***, 2015 SCC 34, the Court considered whether an exemption from the *Controlled Drugs and Substances Act*, SC 1996 c 19 for medical marijuana contravened *Charter* s. 7 because it was limited to dried marijuana. The evidence before the Court was that smoking marijuana was problematic for some medical marijuana users, that some patients could only use edibles or topical oils or creams, and that edibles and topical oils or creams were more effective for others. The Court held *per curiam* at para 18 that, "by forcing a person to choose between a legal but inadequate treatment and an illegal but more effective choice, the law also infringes security of the person."

[80] Alberta is correct that mere inconvenience in receiving necessary medical treatment does not amount to a *Charter* s. 7 violation. The government is not required to build hospitals or clinics on every corner for the convenience of citizens. Courts are often reluctant to find breaches of *Charter* s. 7 when government decisions allocate scarce resources. But, to be clear, Alberta has not advanced a financial justification for its policy choice in the present case. Further, as noted earlier, there is a significant body of caselaw standing for the proposition that significant obstacles to necessary healthcare may contravene the *Charter* s. 7 rights to life and security of

the person. The question at the trial of this matter will be whether the impediments Ms. Black faces are mere inconveniences or significant obstacles to necessary treatment.

[81] Alberta and Ms. Black agree that the *Regulation* and *Standards* require changes in Ms. Black's form of treatment (injection rather than tablet hydromorphone), location of treatment (only at the Chumir Centre), and timing of treatment (only during ODP Clinic hours rather than according to her prescribed dosing schedule). Ms. Black states that these changes will drive her back to street-sourced opioids. Based on her evidence, I accept that, if an injunction is not granted, it is probable that she will revert to street-sourced opioids. At this interim stage, I cannot accept that this is a choice on Ms. Black's part; it may be part of her condition. Dr. Gupta's evidence is that patients "often disengage from treatment of opioid use disorder the more barriers are erected to access treatment." Ms. Black in her questioning explained that her only lapse over 20 months of treatment occurred when she was out of town, was unable to obtain her medicine from a local pharmacy and was compelled by her withdrawal symptoms to obtain and use street-sourced opioids. That resulted in an overdose and a hospital admission. The evidence of both Ms. Black and Alberta is that street-sourced opioids are dangerous and that use of them brings with it substantial risk of adverse health outcomes, including death.

[82] Ms. Black lives in the Bridlewood area deep in the southwest quadrant of Calgary adjacent to the Spruce Meadows show jumping facility. She says that travelling to the Chumir Centre multiple times per day is burdensome. Because treatment using designated narcotic drugs is offered only in downtown Calgary, Ms. Black and others requiring that treatment must travel downtown from wherever they reside. Since these patients will be taking a potent opioid, it must be assumed that they will not be operating a motor vehicle, meaning that they must have family or other support for transportation, take public transit, or use a taxi or ride sharing service. Alberta has said that taxi chits are available at the ODP Clinic for patients and has now clarified that Ms. Black would be eligible to receive taxi chits to cover the expense of travelling to and from the clinic as required for her treatment. Even with the cost of travel taken care of, Ms. Black objects to attending the ODP Clinic because much of her day will be consumed with travelling to and from downtown, leaving little time for her to engage in employment, education, or other activities. As she put it in her questioning: "I'm ready to ... go back to school, to have a career. And if I'm spending four hours a day in a taxi going back and forth to the ODP, then I won't be able to go back to school or have a career. And that's not something I want to miss out on."

[83] For purposes of this application, I find that there is a serious issue to be tried in respect of the first requirement of *Charter* s. 7 arising from the changes to Ms. Black's treatment required by the *Regulation* and *Standards*. There is also a serious issue to be tried in respect of whether the resulting daily travel is merely an inconvenience or a significant obstacle to necessary care as in ***Morgentaler***.

[84] If a protected right is found to be engaged, the *Charter* s. 7 inquiry then proceeds to the question of whether the right has been denied in accordance with the principles of fundamental justice. The Supreme Court of Canada observed in ***Carter*** at para 72 that, although it "has recognized a number of principles of fundamental justice, three have emerged as central in the recent s. 7 jurisprudence: laws that impinge on life, liberty or security of the person must not be arbitrary, overbroad, or have consequences that are grossly disproportionate to their object." Arbitrariness and overbreadth are potential issues in the present application.

[85] An arbitrary law is one that imposes limits having no rational connection to its objective: ***Canada (Attorney General) v Bedford***, 2013 SCC 72 at para 111. The objective of the *Regulation* and the *Standards* is to implement a system of treatment for individuals with opioid use disorder that, at the same time, ensures public safety. In my view, the restriction on prescription of potent opioids to individuals with severe opioid use disorder for consumption outside approved facilities is plausibly connected to the objective of the *Regulation* and *Standards*. Requiring consumption in approved facilities with supervision can be argued, in the abstract, to promote patient safety and prohibiting prescription of potent opioids to individuals with severe opioid use disorder for use outside approved facilities ensures that those drugs are not diverted to users other than the patient. Conversely, it may be arbitrary to require a treatment that can be safely and economically delivered in a patient's home to be delivered only in a treatment facility, causing significant inconvenience or hardship to the patient.

[86] At trial, determining whether there is a rational connection will require consideration of the evidence. Alberta relies on Dr. Koivu's evidence to the effect that treatment in facilities is safer than self-administration of treatment at home and that there is a substantial risk of diversion if patients are prescribed potent pharmaceutical grade opioids for self-administration at home. Dr. Gupta takes issue with Dr. Koivu's evidence on the question of safety and the Court will have to consider Ms. Black's track record of safe treatment at home while under the care of the ODP Clinic.

[87] Further, it is not clear that Dr. Koivu's anecdotal evidence of drug diversion in London, Ontario, without more, establishes a risk of significant diversion of prescribed opioids into the illegal drug trade in the conditions currently prevailing in Alberta. Certainly, patients like Ms. Black who pick up only one day's worth of medicine at a time pose a low risk of diversion. Presumably at trial, Alberta would adduce the evidence concerning drug diversion to illegal markets that it relied on in developing the *Regulation* and *Standards*. At this point in the litigation, however, the only evidence concerning Alberta's evaluation of the risk of drug diversion was given by Mr. Puttick in his questioning:

> Q Did the Ministry have evidence of diversion necessitating this regulatory change?
>
> A The Minister reviewed evidence that diversion is a risk with these drugs and heard from the expert panel that diversion is a common enough occurrence with these drugs in other jurisdictions where they provide them without the protections of witness dosing....
>
> Q But there was no evidence of diversion in Alberta context?
>
> A I don't recall seeing evidence of a diversion within the Alberta context.

[88] ***R v Smith*** at para 27 shows that courts require evidence to substantiate a rational connection when the government's asserted concern is diversion of legal drugs into illegal markets.

[89] Based on the foregoing, in my view, there is a serious issue to be tried as to whether the *Regulation* and *Standards* are arbitrary.

[90] Karakatsanis and Martin JJ for the majority in ***Ndhlovu*** explained at para 77 that "[a] law is overbroad when it is so broad in scope that it includes some conduct that bears no relation to its purpose, making it arbitrary in part. In other words, overbreadth addresses the situation where

there is no rational connection between the purpose of the law and some, but not all, of its impacts" [citations omitted]. Put differently, a law is overbroad when it catches more individuals or conduct in its net than is required to accomplish its purpose.

[91] ***Ndhlovu*** is a recent example where a law was found to be overbroad and therefore unconstitutional. The *Criminal Code* required mandatory lifetime registration on the national sex offender registry for all individuals convicted of a sex offence, regardless of the individual's risk to reoffend. Mr. Ndhlovu was judged to be a low risk to reoffend. Karakatsanis and Martin JJ held at para 10: "The two challenged provisions, therefore, suffer from the same constitutional defect. They both use categorical and unyielding proxies that are too broad, resulting in the measures casting too wide a net. To the extent they require the registration, sometimes for life, of offenders who demonstrate no increased risk of reoffending, they threaten the liberty interests of offenders in a manner which is overbroad and violates s. 7 of the *Charter*." The law at issue in ***Carter*** also was found to be overbroad. In that case, the purpose of the law was to prevent people from choosing suicide in a moment of weakness. The Court held at para 86 that it also prevented individuals who were not vulnerable from taking their own lives.

[92] The *Regulation* and the *Standards* distinguish between individuals prescribed potent opioids as part of NTS (*i.e.*, those with severe opioid use disorder) and individuals prescribed the same drugs for any other purpose. Moreover, individuals with severe opioid use disorder are treated uniformly as a class. Is there a serious issue that, by treating severe opioid users in this manner, the *Regulation* and the *Standards* catch more individuals in their net than required to accomplish their purpose?

[93] Ms. Black has been prescribed potent opioids for use outside a supervised facility for 22 months with only the one incident described above. Dr. Bouman's evidence, quoted at length above in para 44, is that "strict circumstances" applied to Ms. Black's hydromorphone prescription. She was required to attend weekly appointments at the ODP Clinic, was able to pick up only one day's worth of medicine at a time from the pharmacy, was required at each visit to the pharmacy to check in with the pharmacist so that her condition could be ascertained, and was subjected to frequent random drug screening to ensure that she was not taking street-sourced fentanyl. Ms. Black's treatment shows that, under appropriate conditions, some individuals with severe opioid use disorder may be prescribed potent opioids for use outside an approved facility in a way that is tolerably safe for the patient and poses minimal risk to the public.

[94] Accordingly, I find that there is a serious issue to be tried as to whether the *Regulation* and the *Standards* are overbroad contrary to the principles of fundamental justice.

Charter s. 12 – Cruel and Unusual Treatment

[95] *Charter* s. 12 provides: "[e]veryone has the right not to be subjected to any cruel and unusual treatment or punishment." The purpose of *Charter* s. 12 is "to prevent the state from inflicting physical or mental pain and suffering through degrading and dehumanizing treatment or punishment. It is meant to protect human dignity and respect the inherent worth of individuals": ***Quebec (Attorney General) v 9147-0732 Québec inc***, 2020 SCC 32 at para. 51.

[96] The Court explained in ***R v Hills***, 2023 SCC 2 at paras 34-35 that there are "two prongs" in the "well established analytical approach under s. 12." The first prong looks at "the amount or quantity of punishment imposed" and asks whether "its particular effects make it grossly

disproportionate and thereby constitutionally infirm: ***Hills*** at para 35. This is not relevant to the present application.

[97] The second prong of *Charter* s. 12 "protects against the imposition of punishment and treatment that are cruel and unusual because, by their very nature, they are 'intrinsically incompatible with human dignity'": ***Hills*** at para 36 quoting ***R v Bissonnette***, 2022 SCC 23 at para 60. This is the prong of *Charter* s. 12 invoked by Ms. Black.

[98] The present application raises a threshold issue that must be dealt with before considering the second prong of *Charter* s. 12: has Ms. Black been subject to "treatment" by Alberta as that term is used in *Charter* s. 12?

[99] The principles of constitutional interpretation dictate that the word "treatment" must have a meaning independent from "punishment": ***Hunter v Southam Inc***, [1984] 2 SCR 145 at 146; ***R v Big M Drug Mart Ltd***, [1985] 1SCR 295 at 344; ***R v Ali***, 2019 ONCA 1006 at para 68. Most *Charter* s. 12 cases deal with punishment, not treatment. The few cases that do touch on "treatment" indicate that it is distinct from punishment but still must involve some form of administrative control over the subject.

[100] Sopinka J, writing for the majority in ***Rodriguez***, said at 611 that he was "prepared to assume" that "'treatment' within the meaning of s. 12 may include that imposed by the state in contexts other than that of a penal or quasi-penal nature." He went on to say that something imposed by a general law, such as the *Criminal Code*, could not be a "treatment" unless the subject was "in some way within the special administrative control of the state." He concluded that simply because "a particular prohibition" affects someone in a specific situation does not mean that the person is subject to treatment "at the hands of the state" for the purposes of *Charter* s. 12. He illustrated his point at para 182 with hypothetical examples:

> The starving person who is prohibited by threat of criminal sanction from "stealing a mouthful of bread" is likewise not subjected to "treatment" within the meaning of s. 12 by reason of the theft provisions of the *Code*, nor is the heroin addict who is prohibited from possessing heroin by the provisions of the *Narcotic Control Act*, R.S.C., 1985, c. N-1. There must be some more active state process in operation, involving an exercise of state control over the individual, in order for the state action in question, whether it be positive action, inaction or prohibition, to constitute "treatment" under s. 12. In my view, to hold that the criminal prohibition in s. 241(b), without the appellant being in any way subject to the state administrative or justice system, falls within the bounds of s. 12 stretches the ordinary meaning of being "subjected to ... treatment" by the state.

[101] The Court in ***Canadian Doctors for Refugee Care v. Canada (Attorney General)***, 2014 FC 651 held that reduction in health care coverage for refugee claimants amounted to cruel and unusual treatment. Justice MacTavish held at para 610: "in the unusual circumstances of this case, I am prepared to find that the decision of the Governor in Council to limit or eliminate a benefit previously provided to a discrete minority of poor, vulnerable and disadvantaged individuals coming within the administrative control of the Government of Canada subjects these individuals to 'treatment' for the purposes of section 12 of the *Charter*."

[102] The question in the present application is whether there is a serious issue that Ms. Black is subject to administrative control such that the changes in the *Regulation* and the *Standards*

could be considered cruel and unusual treatment. She asserts that administrative control is established because people with severe opioid use disorder are vulnerable and Alberta is, by reason of the *Regulation* and the *Standards*, the monopoly supplier of treatment for severe opioid use disorder. She argues that the circumstances in the present case are analogous to those of the refugee claimants in ***Canadian Doctors for Refugee Care***.

[103] I disagree. In my view, there is no serious issue to be tried pursuant to *Charter* s. 12. Monopoly supply of health care services is not sufficient to establish administrative control of the kind contemplated by Sopinka J in ***Rodriguez***. If it were, *Charter* s. 12 potentially could apply to health care delivery for all residents of Canada. Sopinka J was clear that *Charter* s. 12 does not apply to laws or programs of general application. As noted above at para 73, constitutional claims concerning access to healthcare traditionally have been advanced pursuant to *Charter* s. 7: see, for example, ***Morgentaler***, ***Rodriguez***, ***Chaoulli***, and ***Carter***.

Charter s. 15 – Equality

[104] Alberta submits that Ms. Black has not sufficiently pleaded *Charter* s. 15 which is "fatal to her claim." While Ms. Black filed an Amended Statement of Claim that expanded her pleading of *Charter* s. 15, I agree that the s. 15 claim could have been pleaded with more particularity. Under normal circumstances, Alberta might be justified in seeking a remedy based on the grounds that s. 15 is inadequately pleaded. The Court could direct that Ms. Black provide further and better particulars or strike the pleading with leave to amend. There is no suggestion that Ms. Black is out of time to bring her claim, so any relief would not be an obstacle to her pursuing the claim.

[105] The present circumstances – an interim injunction application – do not afford the luxury of normal litigation practice. It is unrealistic to adjourn this Application to permit Ms. Black to remedy the deficiency in her pleadings. Ms. Black gave Alberta notice that she was pursuing a *Charter* s. 15 claim in both her Amended Statement of Claim and in her Application. I have essentially case managed this matter over the past month leading up to this Application and it has always been clear to me that s. 15 was in issue and the general outline of Ms. Black's position with respect to s. 15 was obvious. Accordingly, I conclude that the s. 15 claim is properly before me and that there is no prejudice to Alberta. I also note that Alberta raised this issue for the first time in its brief when it could have been raised earlier. The parties demonstrated no hesitation over the last month in raising with me any other issues they encountered.

[106] *Charter* s. 15 provides:

> 15 (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

[107] Since ***Andrews v Law Society (British Columbia)***, [1989] 1 SCR 143, the assessment of claims under *Charter* s. 15(1) has focused on upholding substantive equality. McIntyre J wrote at 165 that "a law expressed to bind all should not because of irrelevant personal differences have a more burdensome or less beneficial impact on one than another." Section 15(1) aims to prevent distinctions that are discriminatory and have adverse impacts on groups identified by the grounds enumerated in s. 15(1) or analogous grounds: ***R v Kapp***, 2008 SCC 41 at para 16. The analysis under s. 15(1) does so by looking at the "actual impact of the impugned law, taking full account

of social, political, economic and historical factors concerning the group": ***Withler v Canada (Attorney General)***, 2011 SCC 12 at para 39.

[108] Whether an impugned law substantively violates a person's right to equal protection and benefit of the law is assessed in two stages. The first stage asks whether the law creates a distinction, on its face or in its effect, based on enumerated or analogous grounds: ***Kapp*** at para 17; ***Quebec v Alliance du personnel professionel***, 2018 SCC 17 at para 25 [***Alliance***]; ***Fraser v Canada (Attorney General)***, 2020 SCC 28 at para 27. The second stage asks whether the effect of a distinction found under the first stage is to create an arbitrary or discriminatory disadvantage by imposing burdens on or denying benefits to the identified group "in a manner that has the effect of reinforcing, perpetuating or exacerbating their disadvantage": ***Kahkewistahaw First Nation v Taypotat***, 2015 SCC 30 at para 20; see also ***Withler*** at para 35; ***Alliance*** at para 25; and ***Centrale des syndicats du Québec v Quebec (Attorney General)***, 2018 SCC 18 at para 22.

[109] Where, as here, adverse impact discrimination is alleged, the claimant bears the onus of demonstrating that the impugned law creates or contributes to a disproportionate impact on the identified group: ***R v Sharma***, 2022 SCC 39 at paras 31, 40-45; ***Withler*** at para 64. Demonstrating a disproportionate impact necessitates a comparison between the effect on members of the protected group and members of the unaffected group: ***Sharma*** at para 31; ***Andrews*** at 164; ***Fraser*** at para 55. In certain cases, the impact may be obvious and claimants are not required to adduce statistical evidence to confirm the disproportionality: ***Taypotat*** at para 33.

[110] Whether a disproportionate impact imposes burdens or denies benefits in a manner that reinforces, perpetuates, or exacerbates the disadvantage of the identified group can be assessed by looking for arbitrariness, prejudice, or stereotyping in the impugned law's effect: ***Sharma*** at para 53; ***Fraser*** at para 78. I note that the arbitrariness analyses under *Charter* ss. 7 and 15 are distinct. Whereas s. 7 is concerned with whether the law is arbitrary for imposing limits that have no rational connection to the law's objective, s. 15(1) asks whether the law creates a distinction that has the effect of perpetuating an arbitrary disadvantage: ***Quebec (Attorney General) v A***, 2013 SCC 5 at para 331 [***Quebec v A***]; ***Taypotat*** at paras 16, 18, 28, and 34. I also note that a claimant need not prove that a distinction promotes an arbitrary disadvantage, prejudicial notions, or stereotypes to establish an infringement of s. 15(1); rather, those things may be indicative of discrimination: ***Sharma*** at para 53; ***Fraser*** at para 80.

[111] With respect to distinctions that perpetuate an arbitrary disadvantage, the ***Sharma*** majority noted: "A distinction that does not withhold access to benefits or impose burdens, or that is based on an individual's actual capacities, will rarely be discriminatory": para 53, citing ***Andrews*** at 174-175. Rather, discrimination grounded in the furtherance of an arbitrary disadvantage may result from a law's failure to account for the "actual capacities and needs of the members of the group" (***Taypotat*** at para 20) or, for example, where the distinguishing characteristic of the group is irrelevant to the benefit of which they have been deprived (***Quebec v A*** at para 221).

[112] The discriminatory impact of the perpetuation of prejudicial or stereotypical attitudes toward a protected group is particularly acute in the case of those with mental or physical disabilities. Writing for the majority in ***Ontario (Attorney General) v G***, 2020 SCC 38 at para 62 [***Ontario v G***], Karakatsanis JA observed the following:

> The stereotyping, exclusion, and marginalization experienced by persons with disabilities is also visited on those with mental illnesses.... The prejudicial idea that those with mental illnesses are inherently and perpetually dangerous, along with other stigmatizing, prejudicial notions, has led to profound disadvantage for individuals living with mental illnesses. [citation omitted]

[113] Once an infringement of s. 15(1) is established, the burden of justification under s. 1 shifts to the state: ***Miron v Trudel***, [1995] 2 SCR 418 at 141. In ***Sharma***, however, the majority held that the broader legislative context must be considered in the discrimination analysis, thus reintroducing to the second stage of the s. 15(1) analysis elements that arguably resemble justification. The Court held at para 59 that "the objects of the scheme, whether a policy is designed to benefit a number of different groups, the allocation of resources, particular policy goals sought to be achieved, and whether the lines are drawn mindful as to those factors" are all relevant considerations to the discrimination analysis under s 15(1).

Stage 1: Do the *Regulation* and *Standards* create a distinction based on enumerated or analogous grounds?

[114] The *Regulation* and *Standards* are directed at individuals like Ms. Black with severe opioid use disorder. The *Standards* stipulate at s. 2(c) that, to be eligible for narcotic transition services, a patient must have "a history of drug use with opioids and severe opioid use disorder". Further, pursuant to s. 4 of the *Standards*, eligibility is to be determined by or under the supervision of an "addiction medicine physician". The distinction drawn by the *Regulation* and *Standards* is most obvious in the specific exemption for the prescription and dispensing of designated narcotic drugs for treatment of individuals with conditions other than opioid use disorder.

[115] Addictions to less serious drugs have been found by courts not to be a disability for the purposes of *Charter* s. 15. For example, in ***R v Malmo-Levine***, 2003 SCC 74, the Supreme Court held at paras 184-185 that an inclination to consume marijuana does not constitute a personal characteristic for the purpose of attracting the protection of s. 15. Similarly, in ***McNeill v Ontario (Ministry of Solicitor General & Correctional Services)***,1998 CanLII 14947 (ONSC) at paras 32-33, O'Connor J held that nicotine addiction does not constitute a disability as it "does not interfere with a person's physical, social, or psychological functioning."

[116] McLachlin CJC, writing for the Court in ***PHS*** observed in the context of *Charter* s. 7 that "injection drug users are a historically marginalized population that has been difficult to bring within the reach of health care providers." Also in the context of a *Charter* s. 7 claim, Cronk JA in ***Canada (Attorney General) v Bedford***, 2012 ONCA 186 at para 356, aff'd without comment on this point 2013 SCC 72, noted that drug addiction is a form of disability.

[117] In ***Simons v Ontario (Minister of Public Safety)***, 2020 ONSC 1431 at para 80, Belobaba J, in the context of a claim that failure to provide safe injection equipment for inmates with addictions violated ss. 7 and 15 of the *Charter*, found that drug addiction constitutes a disability for the purposes of s. 15(1).

[118] Slatter JA, in the context of a claim under provincial human rights legislation in ***Wright v College and Association of Registered Nurses of Alberta (Appeals Committee)***, 2012 ABCA 267, concluded at para 51 that an opioid addiction qualified as a disability:

> Addictions are often accepted as being a form of disability. They differ in some respects from other disabilities, in that they sometimes involve an element of volition. Sometimes persons inappropriately and voluntarily consume various substances, leading to addictions. In other cases the initial use may be medically prescribed, or otherwise blameless, but other circumstances subsequently lead to misuse and addiction. Further, an addicted person can (in theory at least) decide to stop using the addictive substance. Some addictions are very powerful, some persons have insufficient willpower, and in many cases even the willing addict will be unable to overcome the addiction [citation omitted].

[119] For the purposes of *Charter* s. 15(1), "volition" is not a relevant consideration — a distinction can be discriminatory even if it arises from the choices made by a claimant or affected group: ***Fraser*** at para 86; ***Quebec v A*** at paras 334-336.

[120] Applying the evidence before me at this stage of the litigation to the standard in ***McNeill***, I am satisfied that there is a serious issue to be tried whether Ms. Black's opioid addiction significantly interferes with her physical, social, and psychological functioning. Further, I am satisfied for the purposes of this application that Ms. Black's opioid addiction engages the enumerated ground of mental or physical disability. That is not to say that claimants must prove such interference for their addiction to qualify as a disability, but the fact that the interference is made out in the instant case makes it clear that there is at least a serious issue to be tried with respect to whether there is a distinction based on an enumerated ground.

[121] I am further satisfied that the current evidential record demonstrates that the *Regulation* and the *Standards* create a *prima facie* distinction that has a disproportionate impact on Ms. Black. Ms. Black's current form of treatment was developed through consultation with her professional medical care providers. Though Alberta's witnesses criticize that treatment regimen, the evidence of Dr. Gupta and Dr. Koivu is consistent that this method of consuming hydromorphone is part of the spectrum of options available in some parts of Canada for treating severe opioid use disorder.

[122] As of March 4, 2023, section 18 of the *Regulation* will prevent Ms. Black from accessing hydromorphone tablets at a local pharmacy. The exemption under section 14 of the *Regulation,* which allows doctors and pharmacies to dispense "a designated narcotic drug for the purpose of treating a medical condition other than opioid use disorder", creates a clear distinction between individuals with opioid use disorder and individuals prescribed designated narcotic drugs for other purposes. The distinction is further exacerbated by the requirement that persons with opioid use disorder must attend the ODP Clinic at the Chumir Centre to receive treatment, whereas non-opioid addicts who are prescribed a designated narcotic drug can continue to obtain those drugs from local pharmacies and self-administer them at home. This distinction may impose a significant burden on those with opioid use disorder.

[123] I am therefore satisfied that the distinction imposed by the new legislative scheme may disproportionately affect members of a protected class, being those persons with opioid use disorder, such as Ms. Black, whose current treatment regimens will be significantly disrupted by the changes.

Stage 2: Does the distinction under the new legislative scheme create an arbitrary or discriminatory disadvantage?

[124] I am satisfied on the evidence adduced at this preliminary stage of the litigation that there is a serious issue to be tried that the foregoing distinction may have the effect of imposing an arbitrary or discriminatory disadvantage on those with opioid use disorder, such Ms. Black. First, the distinction effectively withholds access to stable patients' current treatment plans in instances where those treatment plans involve obtaining prescribed designated narcotic drugs from a pharmacy and self-administering them at home. Second, the distinction imposes additional burdens on those with opioid use disorder by forcing them to travel to the Chumir Centre for treatment, perhaps multiple times per day. Withholding access to certain benefits and imposing additional burdens on a protected class or otherwise failing to address their legitimate treatment needs may constitute discrimination: ***Sharma*** at para 53; ***Taypotat*** at para 20.

[125] Further, in citing the protection of the public from drug diversion and preventing the harms associated with the misuse of narcotics in their justification of the new legislative scheme, Alberta is telling the public that those with opioid use disorder are not trustworthy and pose a greater risk of drug diversion and misuse than non-addicts who are prescribed designated narcotic drugs. Expressing this view through policy risks perpetuating the disadvantage of those with opioid addictions — a historically marginalized population — by reinforcing the stigma that they are inherently dangerous and untrustworthy: ***Ontario v G*** at para 62; ***PHS*** at para 10.

[126] I am satisfied that the distinction imposed by the new legislative scheme may create an arbitrary or discriminatory disadvantage, thus engaging s. 15(1) of the *Charter*.

Charter s. 1 Justification

[127] To assess whether there is a serious issue to be tried, consideration must also be given to s. 1 of the *Charter*: ***Harper*** at para 4; ***Ingram v Alberta (Chief Medical Officer of Health)***, 2020 ABQB 806 at paras 3-32; and ***Toronto International Celebration Church v Ontario (Attorney General)***, 2020 ONSC 8027 at para 18. *Charter* s. 1 provides that rights are guaranteed "subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."

[128] The first stage of the *Charter* s. 1 analysis asks whether the law in question addresses a pressing and substantial objective: ***R v Oakes***, [1986] 1 SCR 103 at 138-139. As I am required to assume that Alberta is acting in the public interest, it seems incongruous to question whether Alberta has a pressing and substantial objective in adopting the *Regulation* and the *Standards*. Accordingly, at this preliminary stage, I assume that Alberta has a pressing and substantial objective.

[129] The second stage of the *Charter* s. 1 analysis, often called the proportionality analysis, asks three questions: (1) is there is a rational connection between the government's objective and the means chosen to achieve that objective? (2) does the law minimally impair the right in question? and (3) do the salutary effects of the law outweigh its deleterious effects? For a brief statement of the proportionality analysis, see ***Carter*** at para 94.

[130] Question 1 in the proportionality analysis replicates the arbitrariness analysis under *Charter* s. 7, which also asks whether there is a rational connection between objective and means. The balancing of effects in Question 3 is similar to the balancing required under the third

part of the tripartite injunction test. Since this is an interim injunction application and time is of the essence, I will address only Question 2, often referred to as the minimal impairment test.

[131] McLachlin J, as she then was, in ***RJR-MacDonald Inc v Canada (Attorney General)***, 1 [1995] 3 SCR 199 (***RJR #2***) described the minimal impairment test at para 160:

> As the second step in the proportionality analysis, the government must show that the measures at issue impair the right of free expression as little as reasonably possible in order to achieve the legislative objective. The impairment must be "minimal", that is, the law must be carefully tailored so that rights are impaired no more than necessary. The tailoring process seldom admits of perfection and the courts must accord some leeway to the legislator. If the law falls within a range of reasonable alternatives, the courts will not find it overbroad merely because they can conceive of an alternative which might better tailor objective to infringement. On the other hand, if the government fails to explain why a significantly less intrusive and equally effective measure was not chosen, the law may fail [citations omitted].

[132] McLachlin CJC restated the minimal impairment test more succinctly in ***Alberta v Hutterian Brethren of Wilson Colony***, 2009 SCC 37 at para 55: "[t]he test at the minimum impairment stage is whether there is an alternative, less drastic means of achieving the objective in a real and substantial manner."

[133] Alberta bears the burden at trial to show that the impugned measures are the least drastic means for achieving its objective: ***Ndhlovu*** at para 126. The government cannot rely on "assertion and conjecture" but instead must "call evidence that shows less infringing measures would fail to substantially achieve the measure's objective": ***Ndhlovu*** at para 126. On an interim injunction, the evidential record is incomplete, but it is nevertheless inappropriate to dispense with the government's evidential burden on the basis of an assumption. This is especially true in the present case where the pre-hearing schedule provided ample time to adduce evidence and ample evidence was adduced. Alberta is required to produce evidence – presumably the evidence it considered prior to making the *Regulation* and the *Standards* – that less infringing measures would not achieve its purpose.

[134] Martin and Karakatsanis JJ in ***Ndhlovu*** rejected the assertion that mandatory registration of all sex offenders on the national sex offender registry was the least drastic means available to the government to achieve its objective. The Court pointed to a less drastic alternative that had existed prior to the challenged provision being adopted, where the registration requirement was in the discretion of the sentencing judge. The Court considered the discretion of sentencing judges to exclude sex offenders assessed to be at low risk of re-offending from listing on the national sex offender registry to be an adequate safeguard of rights that did not impinge on the government's ability to substantially achieve its objective.

[135] The present case is analogous to ***Ndhlovu***. Now, before the changes required by the *Regulation* and *Standards* on March 4, 2023, prescription and dispensing of potent opioids to individuals with severe opioid use disorder for use outside an approved facility is in the discretion of doctors and pharmacists. The *Regulation* and the *Standards* remove that discretion from doctors and pharmacists just like the impugned law in ***Ndhlovu*** removed discretion with respect to enrolling convicts on the sex offender registry from judges. I am not persuaded by the evidence adduced by Alberta at this stage of the litigation that doctors and pharmacists, operating

pursuant to their professional ethical obligations, fail to provide a sufficient safeguard for both patients and the public.

Conclusion on Serious Issue to be Tried

[136] After reviewing the evidence adduced by both parties, Ms. Black's rights claims and Alberta's potential justification arguments under *Charter* s. 1, I conclude that at this stage of the litigation there are serious issues to be tried.

Irreparable Harm

[137] The question of irreparable harm is straightforward. Ms. Black deposed that if she is unable to continue with her current treatment regimen, she will be driven by her addiction back to street-sourced opioids. Nothing in the evidence causes me to question Ms. Black's statement. Indeed, the evidence of the medical witnesses for both Ms. Black and Alberta support the conclusion that where the treatment regime for an individual with severe opioid use disorder is disrupted, a reversion to street-sourced opioids is a genuine risk. The evidence from both Ms. Black and Alberta is that street-sourced opioids are dangerous. Many users of street-sourced opioids die every year in Alberta, to say nothing of other serious harms suffered by opioid users as a direct or indirect consequence of their drug use.

[138] Alberta submits that Ms. Black will not suffer irreparable harm because she has a "back-up plan", which is to use NTS at the ODP Clinic. The passage in Ms. Black's questioning transcript relied on by Alberta appears to be Ms. Black relaying statements made to her by a care provider at the CUPS clinic encouraging her to look at NTS as a back-up plan if her court application is not successful. Ms. Black's repeated evidence is that going to the NTS program at the ODP Clinic is likely to result in her reverting to street-sourced opioids because of the practical barriers involved. As noted above, this risk is substantiated by the evidence of the medical witnesses concerning the reaction of severe opioid users to barriers to treatment. Indeed, it is consistent with the concerns expressed by the Alberta Medical Association to Alberta following the pronouncement of the *Regulation* and *Standards*.

[139] I have no difficulty concluding that Ms. Black has satisfied the irreparable harm requirement.

Balance of Convenience

[140] The balance of convenience is a weighing of harms to each party. As I have set out earlier in these Reasons, the law is clear that I must assume that the government represents an element of the public interest and that it will be harmed by an injunction suspending operation of the relevant sections of the *Regulation* and the *Standards* pending trial.

[141] Counsel for Ms. Black submits that because she is seeking an exemption only for herself, there will be little impact on the public interest. The law is clear, however, that where an applicant seeks an exemption that would make it difficult for the court to refuse the same remedy to other litigants, a court should conduct the balance of convenience analysis as if the applicant were seeking a suspension of the law pending trial: ***Metropolitan Stores***, at para 80; ***Springs of Living Water Centre Inc v The Government of Manitoba***, 2020 MBQB 185 at para 33; ***Trca v Alberta (Director of Saferoads)***, 2022 ABQB 85 at para 24. Accordingly, I will proceed with the balance of convenience analysis on the basis that Ms. Black is asking for suspension.

[142] The public interest presumption does not require a judge to refrain from a critical assessment of the public interest asserted by a government actor. As Beetz J explained in ***Metropolitan Stores*** at para 15, applications for interlocutory relief under the *Charter* do not lend to a detailed analysis of the merits of the alleged infringement that would be required to rebut the presumption. Hence the need for some scrutiny of the public interest asserted by Alberta. Moreover, not all harms to the public interest are the same. Recognizing that irreparable harm speaks to the nature of the harm and not its magnitude, to engage in the balancing of convenience required by the tripartite test, both the nature and magnitude of the harms asserted by both parties are important considerations: ***Prophet River First Nation v British Columbia (Forests, Lands and Natural Resource Operations)***, 2015 BCSC 2662 at para 18; ***First Street Foods Ltd v Mitchell & Mitchell Stores Limited***, 2020 ABCA 303 at para 22. This, in turn, requires an evaluation of the nature and magnitude of the harm to the aspect of the public interest represented by the government. Put in simple terms, the law requires the court to assume the existence of harm to the public interest; it does not require the court to assume that such harm is of any gravity.

[143] Having considered the objects of the broader regulatory scheme and the benefits that the amendments are designed to confer on different groups, I am satisfied that, even if the impugned provisions are suspended, Alberta will still be able to substantially implement NTS through the *Regulation* and the *Standards*. Dr. Day's evidence given during questioning is that after the *Regulation* and *Standards* were adopted in October 2022, AHS determined there were only a small number of people, perhaps 30, who were receiving iOAT outside approved facilities. All these individuals have transitioned to NTS at ODP clinics. Even a suspension of the impugned provisions would not result in a significant number of patients being outside the regulatory regime. An injunction preserving the *status quo* pending trial by suspending the operation of the relevant provisions of the *Regulation* and *Standards* would not pose a significant roadblock for the implementation of Alberta's policy agenda for opioid use disorder treatment. Accordingly, the harm to Alberta's ability to pursue its policy objectives is not significant.

[144] As set out earlier, the relevant provisions of the *Regulation* and the *Standards* have two objectives: patient safety and public safety. I must assume that both will be harmed by an injunction that suspends operation of the relevant sections of the *Regulation* and the *Standards* pending trial. But again, I am required to assess the nature and extent of this harm.

[145] Suspending provisions restricting the ability of doctors to prescribe and pharmacists to dispense potent opioids to individuals with severe opioid use disorder for use outside an approved facility would leave in place the *status quo* under which doctors and pharmacists exercise their discretion in accordance with their professional ethical obligations. The existence of these professional gatekeepers controlling access to potent opioids indicates that the magnitude of the harm to the public interest that should be assumed is not significant.

[146] Ms. Black also claims that the public interest favours her position. She says that she and people like her may resort to using street-sourced opioids if the relevant provisions of the *Regulation* and the *Standards* go into effect. Earlier in these Reasons, I accepted her evidence that reversion to street-sourced opioids was a genuine risk. I further accepted that death or other serious harm was a foreseeable outcome if she reverted to street-sourced opioids. Ms. Black's interest in avoiding death or serious harm is not just self-interest. Canadian society has a public interest in the well-being of its members. Indeed, the inviolability of life is a fundamental value in Canadian society (***Rodriguez*** at 595; ***Carter*** at para 63) and legislation or state action that has

the effect of jeopardizing the right to life is not easily justified: ***Bedford*** at para 109; ***PHS*** at paras 136-140; ***United States v Burns***, 2001 SCC 7 at paras 103 and 133. The public interest favours preventing Ms. Black and anyone similarly situated from being exposed to the real risk of death that would result from the operation of the relevant provisions of the *Regulation* and the *Standards*. Ms. Black also contends that an injunction that would keep her and those similarly situated from consuming illicit drugs in the streets is consistent with the objective of promoting public safety.

[147] Both Alberta and Ms. Black represent aspects of the public interest. Both parties claim that their preferred outcome will protect patients and the public. I do not find the harm to the public interest if an injunction were to issue to be significant whereas I conclude that the harm to the public interest and to Ms. Black if an injunction does not issue is potentially grave. After weighing the competing aspects of the public interest represented by Alberta and Ms. Black, I conclude that the balance of convenience clearly favours Ms. Black.

Conclusion

[148] In exercising my remedial discretion, I must consider the overall balance. The evidence at this stage of the litigation shows that Ms. Black has a strong position that her constitutional rights have been infringed, that she will suffer irreparable harm, and it is clear that the balance of convenience weighs in her favour. I am satisfied that this is an appropriate case in which to grant an injunction.

[149] Ms. Black has asked the Court that the injunction take the form of an exemption pursuant to *Charter* s. 24(1) pending trial from the provisions of the *Regulation* and *Standards* that prohibit prescription and dispensing of designated narcotic drugs for use other than at approved facilities. She has not asked the Court to suspend the operation of those provisions generally.

[150] The reality is that, while the *Regulation* and the *Standards* affect Ms. Black, she is not directly subject to them. Rather, they apply to the service providers who provide care to Ms. Black. Accordingly, for an exemption to achieve its purpose, it must apply to those service providers. Therefore, I order that, pending resolution of this matter at trial or further order of the Court, section 28 of the *Standards*, s 18 of the *Regulation*, and such other provisions that may prevent Ms. Black from receiving her current treatment regimen do not apply to service providers giving treatment (*i.e*., prescribing or dispensing designated narcotic drugs) to Ms. Black. In addition, should Ms. Black choose to return to the ODP Clinic, this exemption also shall apply to the doctors in the ODP Clinic regardless of the AHS or ODP Clinic policy referred to by Dr. Bouman in her questioning.

[151] Put another way, pending resolution of this matter at trial or further order of the Court, the discretion of Ms. Black's service providers to determine her best course of treatment is to be exercised in consultation with her and in accordance with their professional responsibilities and judgment unfettered by the *Regulation*, the *Standards* or any limiting policies. For the avoidance of doubt, this does not confer upon Ms. Black a right to continue her current treatment until that time. It merely permits her service providers to treat her in the interim period without the limitations imposed by the *Regulation*, *Standards* and policies. As was the case in ***Lewis***, if Ms. Black's service providers, in the exercise of their professional medical judgment, determine that her course of treatment should be altered, this Court will not interfere with that determination.

[152] If the parties are unable to agree on costs, they may make submissions of 5 pages or less supported by a draft bill of costs within 30 days of the date of these Reasons.

Heard on the 1st day of March, 2023.
Dated at the City of Calgary, Alberta this 2nd day of March, 2023.

Colin C.J. Feasby
J.C.K.B.A.

Appearances:

Avnish Nanda, Nanda & Company
for the Applicant

Nate Gartke & Ryan L. Martin, Alberta Justice, Constitutional & Aboriginal Law
for the Respondent