CITATION: The Neighbourhood Group et al. v. HMKRO, 2025 ONSC 1934
COURT FILE NO.: CV-24-00732861-000
DATE: 20250328

ONTARIO
SUPERIOR COURT OF JUSTICE

APPLICATION UNDER Rule 14.05 of the *Rules of Civil Procedure*

BETWEEN:	)	
	)	
THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES, KATHARINE RESENDES and JEAN-PIERRE AUBRY FORGUES	)	*Carlo Di Carlo, Rahool Agarwal, Spencer Bass, Olivia Eng, Avnish Nanda Camila Franco,* for the Applicants
	)	
Applicants	)	
	)	
– and –	)	
	)	
HIS MAJESTY THE KING IN RIGHT OF ONTARIO	)	*S. Zachary Green, Andrea Bolieiro and, Emily Owens*, for the Respondents
	)	
Respondent	)	
	)	
	)	
	)	
Interveners	)	*Emily Hill and Christa Big Canoe*, for the Intervener Aboriginal Legal Services of Toronto
	)	
	)	*Andrea J. Sanche and Harleen Pentlia*, for the Interveners Leslieville Neighbours for Community Safety and Niagara Neighbours for Community Safety
	)	
	)	*Selwyn Pieters and Demar Kemar Hewitt*, for the Intervener Black Legal Action Center
	)	
	)	*Sean LaPrairie and Ryan Peck*, for the Interveners HIV Legal Network and HIV & AIDS Legal Clinic Ontario
	)	
	)	*Andrew Max and Tabir Malik*, for the Intervener Harm Reduction Service Providers Coalition

)	
)	*Amita Vulimiri and DJ Larkin*, for the
)	Interveners Harm Reduction Policy
)	Coalition
)	
)	*Fred Fischer and Cara Davies*, for the
)	Intervener Board of Health for the City of
)	Toronto Health Unit
)	
)	*Mariam Moktar and Greta Hoaken*, for the
)	Interveners Barbara Hall and John Sewell
)	
)	**HEARD:** March 24-25, 2025

REASONS ON APPLICATION FOR INJUNCTIVE RELIEF

CALLAGHAN J.

[1] The Applicants seek an interlocutory injunction restraining the application of s. 2 of the *CCRA*, which is to come into force on April 1, 2025, pending the release of this court's decision on the merits of this case.

[2] For the reasons that follow, I am satisfied that the three-part test has been met and injunctive relief in the form of exemptions for all existing supervised consumption sites ("SCSs") is appropriate in this case.

Background

[3] In response to the rising drug epidemic, the concept of SCSs was developed whereby users could consume drugs in a supervised environment where, among other things, they could be helped if they were to overdose. To facilitate SCSs, in 2017, the federal government introduced amendments to the *Controlled Drugs and Substances Act*, S.C. 1996, c. 19 ("*CDSA*") to allow for the possession of otherwise illegal drugs in SCSs, now reflected at s. 56(1) of the *CDSA*.

[4] Since 2018, 23 SCSs in Ontario have been granted exemptions. Ten are in Toronto and the rest are scattered around the province. The SCSs provide a clean and supervised location for people to consume their own drugs in the presence of trained staff. The SCSs also provide clean drug paraphernalia, such as needles, to make the consumption of drugs safer. As the drug supply on the street is highly variable and altered drugs can be deadly, the SCSs also facilitate drug testing services which provide a dual purpose: they warn the user of the dangers of the contents of their drugs so they can avoid drug dealers using unwanted or dangerous additives, and they provide society at large with knowledge and surveillance as to the ever-changing supply and alteration of street drugs. As discussed below, the people who use SCSs are amongst the most marginalized people in society. SCSs also act as a gateway to other health and social services. This is particularly

so as most SCSs are operated by social service organizations that are already engaged in assisting marginalized people in their respective communities with wraparound services like housing, employment, mental health, and others.

[5] In December 2024, the Ontario legislature passed the *Community Care and Recovery Act, 2024*, S.O. 2024, c. 27, Sch. 4 (the "*CCRA*"). Section 2 of the *CCRA* mandates that SCSs are not permitted to be established or operated within 200 metres of a childcare facility or school. Any SCS within that radius is mandated to close. If a school or daycare opens within 200 metres of an existing SCS, that SCS must also close. The *CCRA* is to come into force on April 1, 2025. On that date, ten SCSs will be required to close: five in Toronto and one in each of Kitchener, Hamilton, Guelph, Thunder Bay, and Ottawa.

[6] Section 3 of the CCRA mandates that any municipality or local board seeking an exemption under s. 56(1) of the *CDSA* from Health Canada must first obtain the approval of the Ontario Minister of Health.

[7] In the within application, the Applicants challenge sections 2 and 3 of the *CCRA* which they assert violate sections 7 and 15 of the *Canadian Charter of Rights and Freedoms* (the "*Charter*"). They further assert that the enactment of the CCRA is *ultra vires* the province and is inoperative because the sections frustrate the *CDSA*.

[8] The application was subject to a scheduling order which set the hearing dates for March 24 and 25, less than a week before the April 1, 2025 date on which the *CCRA* is slated to come into force. There are eight interveners to the application. There are 76 affidavits filed, including ten experts. The record spans more than 6,000 pages. The written arguments and appendices of the parties and interveners total over 300 pages.

[9] The constitutional issues in this application are complex. My decision will require some time. Thus, I have reserved my decision on the *Charter* and other constitutional issues and the judgment will be released in the coming months. However, because the in force date of the legislation is April 1 at which point some SCSs will have to close, the Applicants request this interlocutory relief which is opposed by the Respondent.

The Applicants

[10] The individual Applicants are two users of SCSs, Katharine Resendes and Jean-Pierre Aubry Forgues. They have both testified as to their struggle with opioid addiction and their use of SCSs. They have testified that SCSs are a safe place to consume drugs. They rely on the services offered by the SCSs including supervised consumption of drugs and reversal of overdoses, clean drug paraphernalia such as needles, testing of the drug supply to ensure a safe product, and referrals and access to other health and social services. They both described their inability to abstain from opioids due to their addictive nature and severe withdrawal symptoms, and their fears of death by overdose—a risk they feel is mitigated by the services provided at SCSs. They described how fentanyl exploded on the street drug scene 5 or 6 years ago, and how it is more powerful and addictive than heroin. They also explained that the street drug supply is unreliable and frequently contains unwanted, often dangerous additives such as animal tranquilizers. They described their

own experiences with overdoses and how they have been fortunate not to die, as happened to some of their friends. They detailed their attempts at abstaining from opioid use, but how the highly addictive nature of opioids frustrate their attempts at abstinence. They both described overdoses they have experienced, and credited SCSs with saving their lives and protecting their health.

[11] Ms. Resendes lives in Toronto. She has been using heroin since she was 20. She has attempted to stop but the withdrawal symptoms were too painful and the cravings for heroin were overwhelming. She eventually entered a treatment program with methadone which decreased her consumption. While she no longer requires heroin every day, she is still a regular consumer. She also uses fentanyl. She started using fentanyl because the street drug supply moved away from heroin in favour of fentanyl, making heroin hard to find. She has overdosed and has required hospital treatment for an overdose. She has been diagnosed with substance use disorder and has lived with the condition for some 16 years. She has come to rely on SCSs, which not only provide a safe place to consume drugs and reverse any overdoses but test the safety of her drug supply and assist her in correcting dangerous consumption habits such as reusing needles. She explained that with the closure of SCSs in Toronto, she will lose access to SCSs and will revert to her old practices including consuming drugs in unsupervised settings, reusing needles (often leading to illness and infection), and not properly discarding needles. Because of her substance use disorder, which is a chronic, relapsing condition, she knows she will not be able to stop consuming drugs. She is afraid that because she will be taking these drugs alone, she is at a greater risk of dying from an overdose. In her words: “Even knowing the dangers, the compulsion that I feel to use drugs still overwhelms me sometimes.”

[12] Mr. Forgues, a resident of Kitchener, explained his addiction and its origins in childhood. He explained how he has tried to stop his opioid use many times but only to return to taking drugs in greater amounts. He now knows that his inability to stop was a condition of his opioid use disorder. He explained that the symptoms of withdrawal are debilitating such that he would want to die. He went on to explain that the symptoms include severe migraines and body pain so severe that it felt “like my skin was being ripped off my body”. He has overdosed on numerous occasions. He too began taking fentanyl—though by chance, as it was in the heroin he bought. That was in 2018. He explained the enhanced high from fentanyl. While he was aware that fentanyl could be deadly, it was found in “all opioids bought on the streets” as well as in non-opioids such as crystal meth. The presence of fentanyl “changed everything”. He started to overdose regularly, yet he was unable to stop consuming. He explained how SCSs transformed his life. They provided a safe, monitored space for him to use substances under the care of trained professionals, along with clean, sterile equipment to consume them. He stated that the SCS he attends, Kitchener Consumption and Treatment Services (“Kitchener CTS”), has reversed countless of his overdoses and “near deaths”. He states that “the only reason that I am still alive and am so far along in my journey of recovery is because I accessed supervised consumption services offered by Kitchener CTS”. The Kitchener CTS also referred him to a treatment option where he connected with a physician who is assisting in treatment where he takes prescribed drugs. In saying that, he recognizes that he has a chronic disorder, that relapsing is part of the disorder, that he has relapsed and will relapse in the future. During these relapses, he has “intense withdrawal symptoms that I need to address immediately”, and he uses street-sourced opioids. As he put it, “I try my best not to succumb to [these urges], but I am not always successful”. He expressed concern that if the Kitchener CTS closes, when he relapses in the future, there is a “strong likelihood of me overdosing and dying”.

[13] The Applicant, The Neighbourhood Group Community Services ("TNG") provides social services to, among others, marginalized and homeless people. Through its various predecessors, it has provided services to those living in poverty in Toronto since 1911. As a long-established social service and outreach organization, TNG owns its own building on Augusta Street in Kensington Market. TNG's predecessor, St. Stephen's Community House, bought the building 24 years ago as landlords did not want to host services for the homeless, making renting difficult. Due to concerns raised by the community of drug users in the area, including the concern over those that had overdosed in public spaces such as local parks, TNG was encouraged to open an SCS. In 2018, TNG received an exemption under the CDSA. It opened the Kensington Market Overdose Prevention Site ("KMOPS"), an SCS, at its existing building on Augusta Street. KMOPS is within 200 metres of a child care centre (which it operates) and therefore is caught by s. 2 of the *CCRA* and, but for any interlocutory relief, must close on April 1, 2025.

Safe Consumption Sites

[14] Rising overdose and death rates due to opioids since the mid-2010s led governments, civic leaders, and experts to conclude that Canada is in a public health crisis relating to opioid use. It is for this reason that in 2017, the federal government amended the *CDSA*. At the time of the amendment, the Minister of Health described Canada as "facing a national public health crisis related to opioids, characterized by ever-increasing rates of harm, overdose and death". The purpose of the amendment was to remove the criminal sanction for drug possession within SCSs so people could bring drugs there for consumption without fear of criminal repercussions. The minister commented that when properly established, the SCSs "will save lives and improve health". SCSs were said to be part of an evidence-based approach to drug use where harm reduction was part of the national strategy in response to the crisis.

[15] There are 23 SCSs in Ontario. They are largely operated by community-based organizations in areas where they can serve the homeless, under-housed and otherwise marginalized members of their community. Providing SCS services is generally one of many social and health services they provide their clients. Health Canada reports that between January 2017 and August 2024, there were a total of 1,180,815 supervised consumption site visits (average of 21,867 per month) in Ontario.

[16] The vast majority of SCS clients are from marginalized communities. The Applicants specifically challenge the *CCRA* on the basis that it breaches s. 15(1) of the *Charter* on the grounds of disability. It is not disputed that a great number of SCS users suffer, like Ms. Resendes and Mr. Forgues, from substance use disorder, a recognized psychiatric disorder. Substance use disorder includes cognitive, behavioural, and psychological symptoms and can apply to a wide range of substances. There can be horrible withdrawal symptoms upon cessation of drug use, including severe pain, sweating, palpitations, nausea, vomiting, diarrhea, and feeling as though you are going to die. People with substance use disorder become trapped in a cycle of using drugs to avoid the unbearable withdrawal symptoms.

[17] The Applicants raise other forms of marginalization that they say intersect with the disability of substance use disorder and which impact the users of SCSs. For example, the Applicants point to studies that report that in Toronto, 90.5% of SCS users are homeless or unstably

housed, 38% were recently incarcerated, and 33.6% are Indigenous (despite Indigenous peoples representing only 0.5-3% of Toronto's population). In Thunder Bay, it is said that approximately 70% of SCS users are Indigenous. In Toronto, it said that 30.9% of all SCS clients are women, 18.6% belong to a sexual minority group, and 17.1% engage in sex work. One intervener states that three of the SCSs slated to close in Toronto are in communities where the racialized population is predominantly Black.

[18] Since 2016, more Ontarians have died from drug overdoses than from COVID-19. The Chief Coroner for Ontario recorded 10,601 opioid-related deaths from 2016 to 2021, with numbers steadily increasing since 2018. From 2015 to 2023, Toronto has seen a 283% increase in opioid-related deaths, with 137 deaths in 2015 and 525 deaths in 2023. SCSs in Toronto reported 2,296 overdoses at sites in 2023 (out of a total of 94,872 client visits), with no deaths. No one has ever fatally overdosed at an Ontario SCS.

[19] The Applicants observe that the death rate does not account for those who survive an overdose but suffered irreversible damage, such as brain damage from the lack of oxygen during the overdose. There are said to be other societal costs to overdoses, such as paramedic calls and emergency room visits. In Toronto in 2023, paramedics responded to an average of 400 suspected opioid overdose calls per month (24 per month were fatal).

[20] In practice, SCSs not only combat overdoses and prevent opioid-related deaths but provide a clean environment with clean drug paraphernalia, such as needles. It is recognized that the availability of a clean environment and clean drug paraphernalia reduces the risk of transmission of injection-related diseases such as HIV, hepatitis C and bacterial infections.

CCRA and Closures

[21] The *CCRA* limits SCSs from operating within 200 metres of a school or daycare. The Respondent asserts that *CCRA*'s purpose is "to reduce the exposure of children and youth to concentrated disorder near SCSs". While the *CCRA*'s purpose is debated by the Applicants, the Respondent and some local community members point to the negative impact to children and youth of being exposed to the disorderly conduct by the clients and others in and around SCSs. Some of the disorderly conduct relayed in the affidavits filed by the Respondent includes people passed out in front of schools, urinating and defecating in public, confrontational behaviour by intoxicated people, drug transactions outside SCSs, drugs being consumed outside SCSs, and discarded needles, pipes, and drugs in the vicinity of schools and daycares. Some affiants also point to the tragic shooting death of an innocent mother near an SCS when a drug deal went sideways. The Respondent identifies these incidents and others as the types of "disorder" that the *CCRA* seeks to prevent within 200 metres of daycares and schools.

[22] Of the ten SCSs which are to close because of the *CCRA*, five are in locations where they are the only SCS in the municipality. For example, the sole SCS in Thunder Bay is operated by Elevate, a non-profit social service group assisting those living with HIV, hepatitis C, and substance use related issues. Elevate's SCS will close because of the *CCRA* and the nearest next SCS is in Winnipeg, some eight hours away by car. Thunder Bay's SCS services 1,100 clients per month. It is estimated by staff that 65% suffer from substance use disorder. With the shuttering of

the only SCS in town, Elevate is bracing for a rise in overdoses and "overdose-caused mortality". Indeed, it is so concerned about the likelihood of clients dying, that it is preparing to provide grief services to manage the impact on families and staff who they believe will inevitably deal with clients who overdose and die.

[23] In the case of KMOPS, TNG says it does not have the resources to move. As noted, TNG has owned the building currently housing KMOPS for 24 years. As it is, KMOPS is only open for a few hours a day given its current budget, which does not include having to pay rent. TNG states that even if it had the resources, it would be difficult to make any long-term financial commitments in circumstances where they may be required to move in 30 days if a daycare or school opened within 200 metres.

[24] When KMOPS stops operating, the Applicants assert that clients will either go back to using drugs in public (as they are mostly homeless) and risk unsupervised overdoses or they will have to try to use another SCS. There is a debate, given the symptoms of substance use disorder and other attributes such as homelessness, as to how far these users will travel to attend another SCS. I need not address that debate here. It is enough to observe that even in Toronto, where five SCSs will remain, the evidence is there is not the capacity to absorb all those who will no longer have access to one of the five closed SCSs in Toronto.

[25] The lack of capacity is attested to by the Executive Director of Street Health Community Nursing Foundation ("Street Health"), a community-based organization in Toronto working with the homeless and under-housed that operates an SCS which will not be shuttered. It is within three kilometres of three SCSs that will close. Street Health believes at most it can expand its capacity by only 10-20%. This is said to be totally inadequate to absorb the three SCSs closing nearby. From March 2020 to May 2024, the three that will close served 29,781 clients and had 139,139 visits. In contrast, Street Health in that time served 3,132 clients and had 7,954 visits. More poignant is the fact that the three to be closed dealt with 3,892 non-fatal overdoses in that period and Street Health dealt with 223. The Applicants assert that the capacity to deal with those displaced due to closures, assuming they will travel, is not available in Toronto. They say the result will be, among other things, more unsupervised consumption, more unsupervised overdoses, and more deaths. Like Elevate, the Executive Director states that Street Health is planning to offer grief services and counselling to community members in the expectation that there will be a number of people in their community who die as a result of the closures.

[26] There are no applications before Health Canada for any new exemptions. Any attempt to move an SCS would take months by the time an organization located a new site, took the steps to apply for an exemption for a new site, and for the application to be vetted and approved. As such, the Applicants submit there is no prospect of any new SCS adequately filling the void left by any of the closed SCSs, whether in Toronto or outside of Toronto, in the coming months.

Legal Principles and Application

[27] The Applicants seeks an interlocutory injunction staying the operation of the *CCRA* until such time as the court has had an opportunity to fully consider this matter. An injunction at this stage pits the legislator's ability to legislate in the public interest against the potential breach of

the Applicants' constitutional rights. This arises, as the Supreme Court noted, "simply because the courts cannot move quickly enough" to release a decision on the *Charter* issue at stake in the application: *Harper v. Canada (Attorney General)*, 2000 SCC 57, [2000] 2 S.C.R. 764, at para. 5. That is the case here. As noted by Sopinka J. in *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1994] 1 S.C.R. 311, the weighing of a *Charter* claim requires careful analysis. Given the record that has been amassed on this case, a decision is neither advisable nor possible before the *CCRA* comes into force on April 1, 2025. As such, the Applicants seek to enjoin the impact of the *CCRA* until a decision may be reached.

[28] The Supreme Court in *RJR* described the competing interests in an interlocutory injunction such as this in the following way (at pp. 333-334):

> On one hand, courts must be sensitive to and cautious of making rulings which deprive legislation enacted by elected officials of its effect.
>
> On the other hand, the *Charter* charges the courts with the responsibility of safeguarding fundamental rights. For the courts to insist rigidly that all legislation be enforced to the letter until the moment that it is struck down as unconstitutional might in some instances be to condone the most blatant violation of *Charter* rights. Such a practice would undermine the spirit and purpose of the *Charter* and might encourage a government to prolong unduly final resolution of the dispute.

[29] For this reason, the public interest is of greater significance when considering the traditional test for an injunction. However, as reflected in the discussion in *RJR,* upon a proper consideration and weighing of all the factors, a court may grant either a suspension or exemption of the legislation for a period that allows the court to consider the entire record and arrive at a decision. Nonetheless, the request must still satisfy the test set out in *RJR* and *Harper*.

The Test

[30] Section 101 of the *Courts of Justice Act*, R.S.O. 1990, c. C.43 provides that an interlocutory injunction may be granted where it appears to a judge to be just or convenient to do so. In addition, where a *Charter* remedy is sought, as is the case here, s. 24(1) of the *Charter* permits the court to grant an interlocutory injunction "to preserve the rights of the parties pending a final resolution of constitutional rights": *RJR*, at p. 332.

[31] The three-part test for granting an interlocutory injunction was originally set forth in *Manitoba (A.G.) v. Metropolitan Stores Ltd.*, [1987] 1 S.C.R. 110, and later adopted in *RJR*. While the balance of convenience portion of the test is modified where the request is to exempt or suspend legislation, the test is largely the same as in civil matters. The test requires me to determine:

a) Whether there is a serious issue to be tried;

b) Whether irreparable harm will be suffered by the moving party if the injunction is not granted; and

c) Whether the balance of convenience favors granting or refusing the injunction.

[32] In applying the test, the onus is on the Applicants to establish the above criteria.

a. Serious Question to be Tried

[33] At the first stage, the applicant must demonstrate a serious question to be tried. The threshold at this stage is low. As the Supreme Court explained in *RJR* at p. 348:

> Whether the test has been satisfied should be determined by a motions judge on the basis of common sense and an extremely limited review of the case on the merits … A motions court should only go beyond a preliminary investigation into the merits when the result of the interlocutory motion will in effect amount to a final determination of the action, or when the constitutionality of a challenged statute can be determined as a pure question of law. Instances of this sort will be exceedingly rare. Unless the case on the merits is frivolous or vexatious, or the constitutionality of the statute is a pure question of law, a judge on a motion for relief must, as a general rule, consider the second and third stages of the *Metropolitan Stores* test.

[34] The Respondent does not contest that the Applicants have met the serious issue standard. I agree. In my view, the Applicants have raised a serious issue as to whether their right to life and security will be infringed with the introduction of the *CCRA*. There are a host of cases establishing that legislation which impacts the health or life of a person may engage s. 7 of the *Charter.* As expressed by Justice Abella in *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44, [2011] 3 S.C.R. 134, at para. 93:

> Where 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: Morgentaler (1988), at p. 9, per Dickson C.J., and pp. 105-6, per Beetz J.; Rodriguez v. British Columbia (Attorney General), [1993] 3 S.C.R. 519, at p. 589, per Sopinka J.; Chaoulli, at para. 43, per Deschamps J., and, at paras. 118-19, per McLachlin C.J. and Major J.; R. v. Parker (2000), 188 D.L.R. (4th) 385 (Ont. C.A.). Where the law creates a risk not just to the health but also to the lives of the claimants, the deprivation is even clearer.

[35] In this case, there is a serious issue as to whether the *CCRA*, by effectively shuttering ten SCSs, creates a risk to the health and lives of the individual Applicants and those similarly situated. As discussed, SCSs provide both lifesaving and health benefits and, as a result, there is a serious issue whether this legislation violates s. 7 of the *Charter*.

[36] To be clear, I am not required to and am not opining on the ultimate merits of this application. Indeed, the Applicants raise other grounds which they claim are serious, including the deprivation of liberty and a breach of s. 15(1) of the *Charter*. Similarly, while it has not contested that a serious issue has been raised, the Respondent contests that the law deprives the Applicants of life, liberty, or security of the person, that it violates the principles of fundamental justice, and

that it breaches s. 15(1). Given the Supreme Court's direction not to go beyond a preliminary analysis, it is not necessary for me to go further than saying I agree that the Applicants have established a serious issue that the rights to life and security of the person under s. 7 may have been violated, requiring a final adjudication by the court.

b. Irreparable Harm

[37] At the second stage, the Applicants must convince the court that they will suffer irreparable harm if the relief is not granted. 'Irreparable' refers to the nature of the harm rather than its magnitude: *RJR*, at p. 341. A harm is irreparable if it "could not be remedied if the eventual decision on the merits does not accord with the decision on the interlocutory application": *RJR*, at pp. 341 and 348.

[38] While the jurisprudence does not require absolute certainty in establishing that irreparable harm would occur, the evidence must establish an increased risk that goes beyond speculation and satisfies the balance of probabilities: *Thibault v. Ontario (Attorney General)*, 2024 ONSC 3168 (Div. Ct.), at para. 57; *Muslim Association of Canada v. Attorney General of Canada*, 2022 ONSC 7284, at para. 17.

[39] Courts have recognized that "a risk of personal injury" is sufficient to show irreparable harm: *Cycle Toronto v. AG Ontario,* 2025 ONSC 1650, at para. 46, citing *Toronto Standard Condominium Corp. No. 2395 v. Wong*, 2016 ONSC 8000, at para. 32. Indeed, even financial damage may constitute irreparable harm: *RJR*, at p. 342.

[40] In *Harm Reduction Nurses Association v. British Columbia (Attorney General)*, 2023 BCSC 2290, leave to appeal refused, *British Columbia (Attorney General) v. Harm Reduction Nurses Association,* 2024 BCCA 87, discussed in more detail below, the Chief Justice found that a "high degree of probability" that "at least some" of the alleged irreparable harms would occur was sufficient at this stage of the *RJR* test: at para. 89. In that case, it was found that drug users would be compelled in response to the challenged legislation to consume drugs alone, increasing the risk of a fatal overdose. Moreover, in *PHS*, the Supreme Court considered the possible closure of a Vancouver SCS and found that the closure would threaten the health and lives of the SCS's users: at paras. 19 and 136. As such, courts elsewhere have already grappled with and concluded that the closure of SCSs, and its increased risk of unsupervised drug use, threatens the health and lives of users.

[41] Nonetheless, it is important to consider the facts of this case and the context in which the legislation is coming into effect: *Harm Reduction Nurses Association*, at para. 65. The evidence establishes that Ontario is facing an opioid crisis. This court has taken judicial notice of same: *R. v. Charles*, 2021 ONSC 5907, at para. 20; *R. v. Otto*, 2019 ONSC 6446, at para. 36. As the Respondent's expert Dr. Koivu put it: "We are in a serious drug crisis". Like British Columbia, as outlined in *Harm Reduction Nurses Association*, the drug situation remains dire in Ontario. We have and continue to be in a public health emergency as it relates to the use of opioids in Ontario.

[42] In introducing the exemptions in the *CDSA*, the federal Minister of Health emphatically stated that SCSs save lives and improve health. This was echoed by Health Canada which

concluded "supervised consumption services save lives and benefit communities". A 2018 Ontario government report stated that the data suggested that SCSs reduce deaths from overdoses. Based on the evidence adduced and for the purpose of the interlocutory relief, I accept that SCSs provide supervision from trained workers who can reverse overdoses, which reduces the likelihood of fatal overdoses. Most people who use SCSs are homeless or unstably housed, so their alternative to SCSs is to consume drugs without supervision and in public places. I am also satisfied that through the provision of clean, unused needles, SCS clients are at much lower risk of contracting bloodborne diseases such as hepatitis C or HIV when they consume drugs at an SCS.

[43] The evidence further establishes that the clients of the SCSs slated to close do not have access to ready substitutes. This applies to both those municipalities where there is only one SCS, such as Thunder Bay and Kitchener, as well as Toronto, where there is insufficient capacity in the remaining SCSs and the prospect of relocating, at least in the time it will take to release a decision, is unrealistic.

[44] Mr. Forgues lives in Kitchener, where the only SCS will close. Ms. Resendes lives in Toronto, where other sites will remain open, but it is clear that the remaining sites will not accommodate all those who had been attending the closed sites. Accordingly, I am satisfied that if the SCSs are closed, the Applicants will be at risk of not having access to an SCS. As a result, both will consume drugs without supervision and, in doing so, will be at greater risk of overdose and death. They will also be at greater risk of bloodborne diseases, such as hepatitis C and HIV. In my view, the requirement of irreparable harm to these Applicants is satisfied.

c. Balance of Convenience

[45] The third and final stage requires an assessment of the balance of convenience. This stage often determines the result in applications involving *Charter* rights: *RJR*, at pp. 348-349. At this stage, the court essentially considers which of the parties will suffer the greater harm from the granting or refusing injunctive relief: *Cycle Toronto*, at para. 63.

[46] Where the requested relief involves still-valid legislation such as the *CCRA*, the court must have regard to the fact that the injunction will have the effect of denying the public of an enactment that was duly passed by the elected legislature. It is assumed that the impugned legislation serves a public benefit. The court's role at this interlocutory stage is not to "second-guess the wisdom of the policy or to question whether it really serves the public interest. It is assumed to do so": *Cycle Toronto*, at para. 78. To rebut that presumption, the applicant bears the onus of demonstrating that the suspension or exemption of the legislation would itself provide a public benefit: *RJR*, at pp. 348-349.

[47] It is important to distinguish between a suspension and an exemption order when considering the balance of convenience. These public interest considerations will carry less weight in exemption cases than in suspension cases: *RJR*, at p. 348-349. An exemption is where certain people are exempt from the impact of the new law, whereas a suspension stays the implementation of the law. The public interest in favour of the legislation is said to be less important in exemption cases, as the law would still be generally enforceable. Nevertheless, the public interest must not be discounted in exemption cases; it continues to be a pressing concern, especially in cases

involving wide application of the impugned legislation: *Thibault v. Attorney General of Ontario*, 2024 ONSC 3168 (Div. Ct.), at paras. 68-69, citing *Metropolitan Stores*, at p. 146.

[48] While an exemption for some or all of the SCSs would allow the legislation to take effect for futures SCSs, given the limited number of existing SCSs to be affected by the *CCRA*, I accept that this part of the test should be dealt with as a suspension case: *Metropolitan Stores*, at p. 146; *Black v. Alberta*, 2023 ABKB 123, at para. 141.

[49] The Respondents submit that the *CCRA* will protect vulnerable children and youth. As mentioned, I am not concerned with whether it will actually have such an effect; I must assume that it will: *Harper*, at para. 9, citing *RJR*, at pp. 348-349. This assumption weighs heavily in my assessment of the balance of convenience, and I will only grant the injunction if the Applicants convince me that it will do more for the public interest by protecting rights: *Harper*, at para. 9; *RJR*, at pp. 348-349.

[50] Having acknowledged that the public good derived from the legislation is a significant factor, the government does not have a monopoly on the public interest. Other factors come into play and must be balanced against the legislation and its impact. The public interest includes "both concerns of society generally and the particular interests of the identifiable groups": *RJR*, at p. 344. As such, harms to others not a parry to this application may be considered when addressing the balance of convenience.

[51] While the Applicants are at greater risk of overdose and death, so are the other users of SCSs. This would include those who will no longer have access to an SCS and those who compete for the limited spots remaining in Toronto. The result will be an increase in unsupervised consumption. It is foreseeable that many more will overdose, and some of those will die. In addition, it is foreseeable that there will be an increase in the spread of bloodborne diseases. Death and disease that would have been prevented will now not be prevented, because those who would have used an SCS will now consume drugs in less safe settings.

[52] The other health and social services provided by SCSs and for which SCSs are a gateway will no longer be accessed at the same rate. Given the number of users that are affected by substance use disorder, homelessness, and other marginalized characteristics, the impact will be felt by the most vulnerable.

[53] The impact on the users of SCSs is a matter of public interest. Not surprisingly, the Supreme Court has stated "[t]he sanctity of life is one of our most fundamental societal values": *Carter v. Canada (Attorney General)*, 2015 SCC 5, [2015] 1 S.C.R. 331, at para. 63. It is also the case that the public interest values preventing disease and avoiding further marginalization of those with disabilities and other vulnerable people. These are significant public interests which must be weighed against the public interest of the *CCRA*.

[54] My task is not unique. I am not the first judge to grapple with these issues, although each case must be determined on its specific facts.

[55] In British Columbia, Chief Justice Hinkson in *Harm Reduction Nurses Association* addressed the impact of legislation causing *CDSA* exemptions to be removed, putting drug users at greater risk. In that case, the province of British Columbia as part of its public health response to the opioid crisis sought and obtained a three-year exemption decriminalizing personal possession. The province later passed legislation prohibiting people from consuming certain illegal substances in certain public areas, subject to the broad discretionary powers held by the Lieutenant Governor in Council to designate additional areas. Persons who breached the legislation could have their drugs seized. According to the Chief Justice, this would result in a range of harms including withdrawal or the user resorting to cheaper, lower-quality drugs from unknown suppliers which could lead to adverse health impacts including but not limited to death. The Chief Justice further concluded that to avoid detection, users would consume their drugs alone, decreasing the likelihood of obtaining life-saving care if they overdosed. Many of the same impacts will occur here. Other negative impacts were also cited. In the end, the Chief Justice had regard to the "social harms associated with public illegal drug use" but he concluded that in the context of the ongoing public health emergency relating to opioids, the balance favoured the injunction: *Harm Reduction Nurses Association*, at paras. 98-99, 103.

[56] In Alberta, Justice Feasby in *Black v. Alberta*, dealt with a regulation that restricted the use of certain opioids that had been used to treat opioid dependent persons. The regulation restricted the use of those drugs to treatment facilities. The applicant had been using the drugs but would no longer have access unless she was in a facility. The evidence was that the applicant and others like her would resort to using street drugs, which were inherently more dangerous. Like this case, His Honour "accepted that death or other serious harm was a foreseeable outcome if [the applicant] reverted to street-sourced opioids": at para. 146. Justice Feasby found, in those circumstances, that the public interest favoured the injunction: at para. 147. See also *Laska v. Wellington North*, 2021 ONSC 8236 where a municipal by-law that prevented the cultivation of cannabis for medicinal purposes was enjoined from being enforced because of the adverse impact on the applicant.

[57] Like British Columbia and Alberta, the current opioid crisis in Ontario is exceptional. The closing of SCSs will cause significant harm across the province, including the loss of life. In my weighing of the competing public interests, I accept that the *CCRA* will address the public disorder with which it is concerned, thus protecting children and youth. Nonetheless, I find that the balance rests with granting an exemption for the existing 23 SCSs for a period of time. Exempting the existing SCSs will have a substantial public benefit of preventing serious health risks and deaths which, in my view, outweighs the harm caused by the continued public disorder.

[58] In exempting the existing SCSs, I am cognizant of the Supreme Court's comments at p. 347 of *RJR* that it is preferable to limit the scope of the applicants' request to minimally interfere with the public good arising from the challenged legislation. In this case, the SCSs that are not slated to close are nonetheless in a precarious position: if a school or daycare opens within 200 metres of their site, they will have to close within 30 days. In cities with more than one SCS, such as Toronto, the burden on the existing SCSs would be significant. The loss of each additional SCS will exacerbate an already tenuous situation. Obviously, the same goes for the SCSs which are the only one servicing their communities. The *CCRA* will still prevent new SCSs from opening and operating within the 200-metre buffer zones around schools and daycares. The exemption also has no application to the remainder of the *CCRA*.

[59] The exemption is for a limited period. I have already heard this case on its merits. The injunction will only last until a decision is rendered, with an additional 30 days to allow the Applicants to seek a further injunction at the appellate level if necessary.

Disposition

[60] Accordingly, I hereby exempt all existing SCSs from the provision of section 2 of *CCRA* until 30 days after the release of my decision in this matter. Costs will be addressed following the delivery of my reasons on the application and in accordance with a timetable that will be set at that time.

Callaghan J.

Released: March 28, 2025