COURT OF APPEAL OF ALBERTA

Form AP-5
[Rule 14.87]

Registrar's Stamp

COURT OF APPEAL FILE NUMBER:	
TRIAL COURT FILE NUMBER:	2103 11484
REGISTRY OFFICE:	EDMONTON
PLAINTIFF/APPLICANT:	MOMS STOP THE HARM SOCIETY and LETHBRIDGE OVERDOSE PREVENTION SOCIETY
STATUS ON APPEAL:	Appellant
DEFENDANT/RESPONDENT:	HER MAJESTY THE QUEEN IN RIGHT OF ALBERTA
STATUS ON APPEAL:	Respondent
DOCUMENT:	**EXTRACTS OF KEY EVIDENCE**

Appeal from the Decision of
The Honourable Mr. Justice R.P. Belzil
Dated the 10th day of January, 2022

EXTRACTS OF KEY EVIDENCE OF THE APPELLANT

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Prepared by counsel for the Appellants

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Form 49
[Rule 13.19]

COURT FILE NUMBER	2103 11484
COURT	COURT OF QUEEN'S BENCH OF ALBERTA
JUDICIAL CENTRE	EDMONTON
PLAINTIFFS	MOMS STOP THE HARM SOCIETY and LETHBRIDGE OVERDOSE PREVENTION SOCIETY
DEFENDANT	HER MAJESTY THE QUEEN IN RIGHT OF ALBERTA
DOCUMENT	**AFFIDAVIT**

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AFFIDAVIT OF T.F.

Sworn on August 24, 2021

I, T.F., of Calgary Alberta, SWEAR AND SAY THAT:

1. I am a resident of Calgary who consumes crystal meth and am sometimes exposed to opioids through my use of crystal meth, including fentanyl ("**substances**"). I access supervised consumption services at the Safeworks Safe Consumption Site ("**Safeworks**") in Calgary daily to ensure that I do not overdose and die as a result of my substance use. As a result of my experience as a substance user who accesses supervised consumption sites to consume substances safely, I have personal knowledge of the matters set out in this affidavit, except to such matters based on information and belief.

Personal Background and Use of Safeworks

2. I am 37 years old.

3. I was born and raised in Calgary, which is where I live today.

4. I have accessed safe consumption services through Safeworks since October 2020.

5. When I first attended Safeworks, I had just been released from jail and had nowhere to go. I was robbed of my personal possessions and had no housing. I needed a safe place to be to use substances and receive the support I needed to get my life back on track.

6. I was reluctant to access supervised consumption services at Safeworks. I had misconceptions of the site because it was run by Alberta Health Services ("**AHS**"). I thought it would be a cold and unwelcoming place. I was scared I would face discrimination and marginalization due to my substance use.

7. I have faced a lot of discrimination in the health care system in Alberta as a result of my substance use. I once told a doctor who was prescribing me Vynanse for my attention deficit hyperactivity disorder that I use substances. As soon as I disclosed this to the doctor, they became reluctant to refill my prescription because they believed I would abuse it. I felt like they thought I was lying about my condition to get access to the medication. In the end, I did not receive the quality of care I deserved and it was a demeaning experience. This was directly tied to my doctor becoming aware of my substance use.

8. It has been my experience that many health care providers do not provide adequate health care screening and treatment once you disclose to them that you use substances. These experiences make me feel that my life does not have the same value as others because I am a street involved substance user. I feel worthless after these experiences and that my life doesn't matter. These experiences make me want to use substances more to avoid having to feel the way these interactions make me feel.

9. I did not like that feeling and I have tended to avoid seeking medical treatment for my health care needs for the risk of similar experiences happening. I have experienced the same form of discrimination and poor treatment in other health care settings after disclosing that I use substances. As a result of the treatment I have received, I have avoided seeing health care providers for minor or major health issues, and instead, self-medicate or simply ignore health problems.

10. However, things were different at Safeworks. Safeworks provides a safe, monitored, hygienic, and low barrier space to consume substances. It also provides a space to use substances where I do not run the risk of being arrested for having and consuming them. Safeworks and its staff accept me for who I am and provide me a deep sense of belonging to the community that works and accesses the site's services.

11. Safeworks has provided me a safe place to consume substances, with staff trained to take care of me in the worst case scenario of an overdose. I have overdosed numerous times at Safeworks and the staff were able to revive me and ensure that there was no lasting impacts.

12. Safeworks is also a place where I can get other medical care from providers I trust, and who see me as a human being and not just as someone who uses substances. It has made me feel like my life matters. I was able to get a new social worker through Safeworks, connect with a care team, access dental care, and get assistance with obtaining my identification, as well as just having access to basic necessities like food and clothing. Safeworks has even helped me find stable housing. It has allowed me to belong to a community of people who are rooting for my success.

13. The Safeworks site is also highly accessible at its location at the Sheldon M. Chumir Health Centre. I can catch the bus from anywhere in the city and be downtown in a matter of minutes, which to me is safer than consuming substances in public on the street, or in a private home.

14. Safeworks has made me feel that my life matters and that I am more than my substance use. At Safeworks, I found a support system and community that holds me accountable for my life and health without stigma. The staff know that approaching drug use from a harm reduction standpoint, rather than just handing out pamphlets and handshakes to a revolving door of substance users, is a more accessible and helpful way to ensure people can manage their substance use. For some people, that means consuming substances in a supervised and secure manner, while for others it means seeking treatment in the form of recovery therapy or more interventionist treatment options, such as opioid agonist treatment.

15. My experience with supervised consumption sites is that it provides the foundation for people to come to terms with their substance use, lessen its negative impacts, and empower people in their efforts to figure out what to do next. The services I have received from Safeworks has made me safer and healthier.

16. Without Safeworks or access to supervised consumption services I would be dead. I know this because I have overdosed many times at Safeworks and would have died if the Safeworks staff was not there to revive me. I know of many others who have died of overdoses because they did not access supervised consumption sites to use their substances. I know that my continued survival depends on on-going access to supervised consumption services.

17. I only attend Safeworks because it accepts me for who I am and creates an environment where I can exist without stigma or discrimination and fear that my substance use will be held against me in some manner. I have a strong sense of trust in Safeworks that it accepts and understand me, and would never do anything to betray that trust. The services I access here is built around my experiences and circumstances and not one imposed on me, which has been the case when accessing services from other health providers in Alberta. If Safeworks stops being a safe and welcoming space and starts to force me to do things I don't want to do, I will return to consuming substances on the street because the stigma is worse than the risk of overdosing and dying.

18. People who do not use substances may not understand why I would risk dying rather than accessing supervised consumption services at a place I did not trust that makes me feel shitty and that my life is worthless. But those people do not know what it is like to live as a street-involved substance user, including what it feels like to be made to feel that you are worthless and that our lives do not matter. There have been experiences in my life where I have wanted to die from consuming substances because the feelings and stigma are too much too handle. I know others in my situation feel and have done the same. We would rather risk dying than have to experience the shame and stigma of living as a street involved substance user in our society.

<u>Proposed Changes by the Alberta Government</u>

19. I have been informed by the lawyers of the Plaintiffs in this action and believe true that the Government of Alberta is requiring supervised consumption service operators to collect the

Personal Health Number ("**PHN**") of those accessing supervised consumption sites in Alberta, and to record, store, and share this and other personal and identifying information to others in the health care system. I have also been told by the lawyers of the Plaintiffs in this action and believe true that we will be asked to provide this information on attending a supervised consumption site in Alberta, and although we may not be turned away if we refuse to provide this information, it is something that will be requested upon accessing services at a site and will be information that can be disclosed to others.

20. I have further been told by the lawyers of the Plaintiffs in this action and believe true that this personal information will be stored in the electronic medical records system of safe consumption service operators and may be shared with AHS' broader health care record collection system, which means anyone who has access to the system can determine who is accessing safe consumption services in Alberta. Even if this information is not shared through AHS' electronic medical records system, it will be stored somewhere for others to access and know the personal and identifying information of those who access safe consumption services in the province.

21. Providing PHNs and identifying information are not required to access supervised consumption services at Safeworks right now. All we provide is our initials or a name that we like to go by, and even then, people provide fake initials and names because we do not want anyone knowing our real names because we do not know what they will do with that information. The services are provided in a manner that preserves anonymity and confidentiality, which prevents our information from being shared with others, particularly other health care providers.

22. Knowing our PHN and personal information does not impact the delivery of the supervised consumption services that we need. At no point have I ever been required to provide this information to Safeworks and it has not impacted the services I have been able to receive or my general experience at the site. There is no need to demand this information from supervised consumption site users for them to access the services.

23. I do not want the fact that I use safe consumption services to lead to the police arresting me with substances in and around Safeworks and other supervised consumption sites. I fear that this information will also be made available to health care providers at walk-in clinics or at the hospital which will result in me being denied me the quality of health care that I deserve.

24. I believe that if my visits to a supervised consumption site are collected, logged in relation to my PHN and personal information, and disclosed to others in the health care system, then this information would follow me as I have other interactions with the health care system and can be accessed by other health care providers without my consent. I fear that this information could undermine the quality of health care I receive and cause me real harm. It could lead me to experience the same interactions in the health care system that caused me to initially disengage from seeking health care through official channels.

25. I refuse to provide Safeworks or any other supervised consumption services provider any personal identifying information, including my PHN. I will never provide this information to a supervised consumption services provider. I will never attend a supervised consumption site that demands this information because it may try to get this information through other means and then share these details with other people in the health care

system. I do not and will not trust a supervised consumption operator that would request this information based on my experience as a substance user in the health care system, especially one that would share it with others in the health care system and maybe even the police. The fact that they are requesting this information and are storing it to share with others is my biggest concern. I don't trust the formal health care system based on my experience with it as a substance user, where I have been marginalized and discriminated against, provided a lower quality of care due to my status as a substance user, and been made to feel that my life does not matter.

26. I would never attend a supervised consumption site that collected and shared that information with others out of the risk that they would do the same with me if somehow they learnt that information or I provided it to them by mistake. It would severely undermine my trust in the supervised consumption service provider and I would no longer access their services. I would rather use substances on my own and in unsafe settings than be forced to provide this information to a supervised consumption services provider. If this requirement is imposed on all supervised consumption site operators in Alberta through the guidelines, then I will no longer attend them. They will cease to be an appropriate place for me to use substances safely.

27. I would rather take the risk of using substances in an unsupervised, unsafe manner than attend a supervised consumption site that collects and share this information with others in the health care system. I know that means that I am more likely to die if I do not continue to access supervised consumption services while using substances but I would rather take that chance than access supervised consumption services from a provider that collects and shares this information with others, forming part of my health care records and experience with the health care system for years to come.

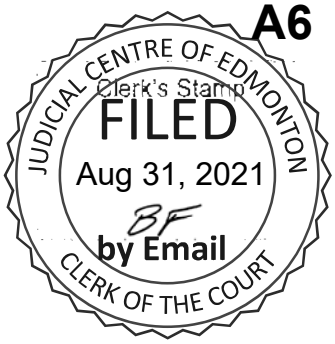
SWORN BEFORE ME at Calgary, Alberta,)
this 24 day of August, 2021.)
)
)
)

Patrick Keeler
PATRICK KEELER
A Commissioner for Oaths
in and for the Province of Alberta
My Commission Expires November 24, 2023
Appointee #0752382

T.F.

TAB 2

A6



COURT FILE NUMBER	2103 11484
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DEFENDANT	HER MAJESTY THE QUEEN IN RIGHT OF ALBERTA
DOCUMENT	**AFFIDAVIT OF TIMOTHY SLANEY**

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AFFIDAVIT OF TIMOTHY SLANEY

Sworn on August 30 2021

I, Timothy Slaney, of the City of Lethbridge in the Province of Alberta, MAKE OATH AND SAY THAT:

1. I am a director for the Lethbridge Overdose Prevention Society ("**LOPS**"), one of the Plaintiffs in this action, and as such I have personal knowledge of the matters set out in this affidavit, except to such matters based on information and belief.

2. The information that I provide in this affidavit is based on my role as LOPS' litigation representative in this action, and also on my lived experience as an opioid user in recovery who accessed support services through Aids Outreach Community Harm Reduction Education Support Services ("**ARCHES**") in Lethbridge and later as a harm reduction specialist and outreach worker for the organization.

3. LOPS is also seeking public interest standing in this proceeding to represent the interest of substance users impacted by the new regulations the Defendant Her Majesty the Queen in Right of Alberta ("**HMQA**") imposed on accessing supervised consumption services in Alberta.

Background

4. I began using substances at the age of 13. I would use a variety of opioids as well as amphetamines, and I managed to sustain my substance use in a way that allowed it to go largely undetected. I was functional. I held a job. I did not look like a substance user or "drug addict". I managed to afford substances through my employment, and I was able to purchase safe consumption supplies online, including clean needles.

5. However, by 2017 my consumption had reached the point that I was no longer able to function at work or to pass as "normal." I looked like someone who used illicit substances. I could no longer afford safe consumption supplies after my hours were cut at my job because of my increasingly erratic behaviour and appearance. I later lost my job completely after my situation and circumstances deteriorated as a result of my substance use. It started to become difficult for me to bluff my way into getting prescriptions refilled and consumption supplies through pharmacies.

6. I was consuming opioids and speed balls (heroin and cocaine) multiple times a day and reusing needles. My health was deteriorating quickly, and I was having significant substance induced mental health episodes. I overdosed a number of times. I quickly realized that I needed support for my substance use or my health would continue to deteriorate and I would die.

7. My circumstances led me to ARCHES, a non-profit organization that provides harm reduction-oriented support to substance users in Lethbridge. ARCHES quickly became one of the only bright spots in my life. I started visiting ARCHES daily for both consumption supplies and meaningful human interaction and a growing sense of community.

8. It is lonely being an opioid user or someone living with opioid use disorder. Many of my friends and family abandoned me or did not know how to respond to my condition. Strangers and others in the community, including acquaintances I knew before, did not want to engage with me and often looked at me like a threat or not worth their time. It is an extremely dehumanizing experience, and I lost a lot of self-worth and confidence.

9. When I started attending ARCHES, I began to have brief but meaningful interactions with staff members and others present at the facility. ARCHES was the only place where I felt like my substance use was accepted and not judged. I could be honest to myself and the staff at ARCHES, and it was met with positivity instead of hostility and judgment. The interactions I had were very different than the ones I was experiencing day to day. They made me feel like a human being again and started to restore my confidence.

10. ARCHES also provided me access to clean supplies for my substance use. This was important because I developed serious and lasting medical issues because I would reuse needles and other equipment for substance use. Reusing needles has caused permanent damage to my heart. In the past I would also have frequent skin infections and heavy tracking from where I would inject opioids. All of this could have been avoided if I accessed clean supplies from ARCHES at the start of my substance use.

11. However, I was initially reluctant to attend ARCHES. Like many substance users, I had significant shame and fear about my substance use. I did not want to share it with others because I felt that I would be stigmatized and discriminated against for being a substance user. I was also fearful that the police would somehow find out that I was using illicit substances if I attended ARCHES or other organizations that supported substance users. I could face significant jail time and be harassed by the police in the future. It took a lot of time and courage to reach a point where I could attend ARCHES.

12. The only reason that I initially agreed to attend ARCHES and decided to continue to access its services was because it provided its users harm reduction services in an anonymized and confidential manner. Anonymity and confidentiality are the foundation for any effective program that seeks to engage and support people who use substances. The stigma, discrimination, and fear of criminalization dominates the interactions that most people who use substances have with others, including health care providers. I was very concerned about sharing personal information or any of my personal details being shared with others because of the serious impact it would have on me.

13. Being a substance user is an isolating and shameful existence. Most people who use substances, me included, feel shame 90 percent of our lives. The notion of coming to a place where the staff consider you less than human, as a burden for using substances is a triggering experience. It makes me feel so uncomfortable in my own skin that I would rather take my chances using substances on the street, and face overdose and death, than access services where the staff constantly remind me of the shame that drove me towards substance use in the first place.

14. Being identified as a substance user in the health care setting, to police, or in the broader community is an invitation for abuse and discrimination. It is dehumanizing and isolating. It pushes substance users away from accessing health care, speaking with the police, or engaging in other agencies and care providers that are delivering services to support substance users. Many substance users are so concerned about revealing their personal information to service providers, and that this information will be shared with others, that they knowingly put themselves in harm's way to avoid accessing critical and sometimes lifesaving snpport.

15. I had that same concern with ARCHES when I first heard about it and was reluctant to attend and access its services for a long period of time, despite being assured that it offered

support in an anonymous and confidential manner. I was a bit paranoid because of negative interactions I had in the health care system and with the police after being identified as a substance user. I have had doctors and nurses refuse me health care or provided me terrible health care upon discovering that I was a substance user. I have had paramedics and other emergency responders search my wallet and belongings looking for illegal substances while attending to me when I needed medical care. I think they did this so that they could charge me for drug possession even though I needed medical care. These experiences would feed my shame and embarrassment as a substance user, and erode my confidence and sense of worth. They would also fuel my substance user and create obstacles to accessing support and ensuring I was consuming substances safely.

16. I would have not used ARCHES' services if it requested any personal information from me or otherwise delivered services in a manner that was not otherwise anonymous and confidential. Even if this information was simply requested and not required, I would still not access its services. This is how much of a concern that I had about being outed as a substance user and for that information to be shared with others.

17. Fortunately, ARCHES followed best practices for the delivery of harm reduction services, and employed a model of care and support built around anonymity and confidentiality.

18. When I started attending ARCHES, it was only distributing safe consumption supplies. It did not provide supervised consumption services or operate a supervised consumption site. I was using mostly alone at home at the time. In 2018, I ended up suffering a major overdose while using on my own, which prompted me to try to seek treatment for my opioid use.

19. Around the time of the overdose, ARCHES referred me to methadone clinic. I trusted ARCHES and felt like I was ready to start methadone treatment and signed up for the program they suggested to me. Methadone treatment saved my life and helped me manage my substance use. The only reason that I started on methadone was because ARCHES offered me a path to it and I had slowly developed a bond with its staff and programming. I knew ARCHES had my best interests in mind and had enough trust in the organization that I decided to try the methadone treatment option.

From ARCHES' Client to Employee

20. ARCHES was the only organization of its kind in Lethbridge. It provided harm reduction services in a manner that centered substance users. However, there was a vocal and organized group of folks in the community that opposed harm reduction as a way to engage and treat substance users. These people were targeting substance users and trying to stop the delivery of harm reduction-oriented care to substance users. Given my experience as a substance user that benefited so much from ARCHES' services, specifically access to free safe consumption gear and methadone treatment, I started Lethbridge Supports Harm Reduction. Lethbridge Supports Harm Reduction is a Facebook page to raise awareness of

the benefits of harm reduction and create a space to build community among substance users and harm reduction supporters for greater acceptance of this model of care.

21. ARCHES learned about my efforts and decided to hire me as a harm reduction specialist and outreach worker with ARCHES. By this time, ARCHES had been authorized to provide supervised consumption services in Lethbridge and established a supervised consumption site with 21 consumption booths. Thirteen of the booths were for individuals who injected and insufflated the substances they used and the remaining eight were for those who inhale their substances.

22. As a harm reduction specialist, I assisted in the consumption room at ARCHES and was responsible for providing non-medical care and support to substance users, with the exception of dispensing naloxone to reverse an overdose. In this role, I would check substances for impurities or other concerns, offer safe consumption equipment, provide site users access to health information, and reverse overdoses. While I was able to determine that someone was overdosing and attempt to rouse them without input from other staff, nurses or paramedics would make the ultimate decision on which treatments to administer to substance users in the event of a medical emergency.

23. In my role as an outreach worker, I was charged with identifying substance users in the community and ensure that they were using safely by providing them with safe consumption supplies and building to trust with them so that they would access ARCHES' supervised consumption services rather than consuming substances unsafely on their own. I was also responsible for providing support and harm reduction services to substance users who were too behaviorally complex to be able to access ARCHES' support while they were consuming on their own and intervening if there was an overdose.

24. In my role as a harm reduction specialist and outreach worker for ARCHES, I have worked with numerous substance users and reversed countless overdoses. Through these roles, and based on my personal experience, I have come to appreciate how critical anonymity and confidentiality are to engaging people to make safe choices around the consumption of substances.

25. Substance users have real fear and paranoia over being identified as a substance user, particularly in the health care system and police, and will avoid accessing supervised consumption services if there is any indication that a provider wants to collect a substance user's personal information or if they will share this information with others.

26. My job at ARCHES was to impress upon our site users that we did not collect, store, or disseminate this information. ARCHES knew that if we did, or even asked site users for any personal information, they would likely disengage and use substances unsafely, increasing the risk of overdose death aud other harms. In almost every conversation I had with substance users about accessing supervised consumption services through ARCHES, the question was whether the services would be provided in an anonymous and

confidentially manner. If they were not, substance users would not access ARCHES' services.

27. Anonymity and confidentiality are hallmarks of the effective delivery of supervised consumption services to substance users and ensuring they consume substances safely. This is how ARCHES was structured and what led them to have the largest and most active number of clients of any supervised consumption site in North America. Operating in this manner ensured high engagement and made ARCHES and the supervised consumption services it offered a real and viable option for a large number of substance users in Lethbridge.

Substance Users in Lethbridge are Overwhelmingly Indigenous

28. The vast majority of substance uses in Lethbridge are Indigenous people, mainly from the First Nations' located near the city, which are the Piikani Nation and Kainai Nation. From my experience as a former substance user in Lethbridge, harm reduction specialist and outreach worker, and work with LOPS, I would say approximately 70% of substance users accessing harm reduction services are Indigenous. I spent most of my time with ARCHES and LOPS working with Indigenous substance users and ensuring they had the support and assistance required to consume substances in a safe manner, including through the delivery of supervised consumption services.

29. Indigenous substance users are subject to the most severe effects of substance use. They are frequently without the care and support that non-Indigenous substance users in Lethbridge have, as their family and support systems are not located in the city. Based on my experience, they are more likely to experience fatal and non-fatal overdoses, and be subject to a range of harms associated with street sourced substance use.

30. Indigenous substance users also face additional barriers to care, including racism and discrimination from health care providers and the police in Lethbridge. When visiting hospitals on substances or in search of substances, rather than stabilize or treat them, I have heard firsthand that many substance users have had health care providers call the police on them and have been arrested. Indigenous people face the brunt of this form of conduct and often in the most extreme forms. This leads to serious distrust and major barriers that must be overcome to deliver harm reduction and supervised consumption services to Indigenous substance users in Lethbridge.

31. A significant portion of my work with ARCHES and LOPS was to reduce the barriers that Indigenous substance users face in accessing harm reduction and supervised consumption services. Indigenous substance users have more distrust of state actors and health care providers, and are reluctant to access support if personal details are requested and stored by service providers. They fear that the information they provide and identified as substance users can be used to criminalize them, deny access to quality health care, lead to children and other dependents being apprehended, and other harms. From my experience,

anonymity and confidentiality are foundations to eradicating the barriers and stigma Indigenous substance users face in accessing supervised consumption services.

ARCHES's Closure, LOPS' Opening

32. I worked at ARCHES from the opening of its supervised consumption site in February 2018 until its closure in August 2020. From August 2020 onwards, there has been only one authorized supervised consumption site in Lethbridge. It is a mobile unit set up by Alberta Health Services ("**AHS**").

33. The AHS mobile supervised consumption site offers only two injection booths for consumption. It is staffed by AHS health care providers. There is a sense on behalf of substance users that the AHS mobile unit is an extension of the traditional health care system and that their information is collected if they access its services.

34. The closure of ARCHES and opening of the AHS mobile unit led to a major gap in supervised consumption services in Lethbridge. Insufflation and inhalation were popular form of consumption at ARCHES. Insufflation means individuals snort substances. Inhalation refers to substances being smoked by individuals. Both are common forms of substance consumption in Lethbridge and occurred frequently at ARCHES. Insufflation and inhalation may have been the most popular forms of substance consumption at ARCHES.

35. Although ARCHES had eight inhalation booths, the AHS mobile unit has none. It also has only two injection booths, which cannot accommodate insufflation and inhalation substance use. The AHS mobile unit cannot provide supervised consumption services to those who insufflate or inhale substances, or even handle the volume of injectable substance use that occurs in Lethbridge.

36. Substance users will not access supervised consumption sites if it they are not catered to their method consumption and if there is not enough space to accommodate them when they want to consume their substances. Substance users will not alter their method of consumption or wait around for booths to open if they want to consume substances. The compulsion to use is so strong that individuals will not wait to consume substances and will instead use in unsafe manners.

37. The AHS mobile unit has another barrier to access since it is government run. Many substance users, particularly Indigenous substance users have experienced a great deal of racism and discrimination while accessing formal healthcare in Lethbridge. There were numerous instances of emergency room staff calling police on substance users that had nodded off in the emergency room. The AHS mobile unit also had the same staff who would call the police on substance users who showed up to the emergency room. For this reason, many substance users in Lethbridge did not trust the AHS mobile unit and will not

access it because of its affiliation with the formal health care system and fear that they may face discrimination or identify them as substance users to other health care providers.

38. I would not access the AHS mobile unit personally as a substance user for this same reason. The AHS mobile unit and staff members do not have the best interests of substance users in mind.

39. The limitations of the AHS mobile unit, and that fact that it is an AHS run supervised consumption site has led to large scale abandonment and disengagement of supervised consumption services in Lethbridge. The lack of insufflation and inhalation consumption booths, limited capacity, and stigmatizing and triggering environment at the AHS mobile unit led to a surge of substance consumption in public parks and people in Lethbridge. There was a surge in overdose deaths, reaching levels we had never seen before.

40. At the same time, the supply of substances in Lethbridge became increasingly toxic. Although the opioid supply was poisoned with synthetic opioids, they were combined with other substances, such as a crystal meth and other things, meaning that people were overdosing on opioids even if they did not mean to consume opioids. Many people died as a result. It was a crisis point and the AHS run supervised consumption site was unable to address the needs of the community.

41. In September 2020, I joined a group of former ARCHES' site users, employees, and volunteers to form an organization that would offer overdose prevention services to substance users in Lethbridge. We called ourselves Lethbridge Overdose Prevention Society, or LOPS, and registered as a society. LOPS modeled itself after opioid prevention societies that sprung up across Canada as quick and targeted responses to the overdose crisis in small centers where there was no effective or formal access to supervised consumption services, or where the needs of a particular community of substance users was unmet.

The Moral Framework and Work of LOPS

42. LOPS is based on and committed to the ethical and moral framework of harm reduction. Harm reduction is a philosophy, worldview, and approach to medical care that in the context of substance use is focused on ensuring approaches to addressing the opioid epidemic are centered around services and policy that protects the life, health, and dignity of people who use substances and their communities. This approach is grounded in the understanding that substance use disorder is a health condition, and the overarching aim of any policy is to secure and maintain the lives of those who live with the condition or use substances.

43. LOPS' purpose and direction are rooted in its commitment to harm reduction and ensuring that its work conforms with this framework. The mission of LOPS is to improve the quality of life for people in Lethbridge who use substances, particularly street source opioids,

through the provision of safe and compassionate harm reduction practices. The organization is community-driven, with an emphasis on peer support, and creating a judgement-free environment for people to receive quality care and support with dignity and respect.

44. LOPS, as a group of former substance users and individuals who have worked with people who use substances, including medical professionals, knows the adverse impacts of substance use intimately. The harms associated with substance use are extremely severe, and often fatal, but are entirely preventable. Many of LOPS' directors and members have lost loved ones, or have overdosed or contracted diseases from substance use, which is true in my case. LOPS knows that another reality is possible for substance users in Lethbridge, and want to ensure that it can be achieved through the delivery of effective and low barrier supervised consumption services to them.

45. As the overdose crisis worsened in Lethbridge, the founders of LOPS could not stand by and watch our family members, friends, neighbours, and broader community members die preventable deaths. LOPS was created to fill the gap created by ARCHES' closure and the AHS mobile unit's limitations. We wanted to do whatever we could to save and improve the lives of substance users, confronting whatever difficulties and challenges along the way. The overdose epidemic in Lethbridge was too severe and wide encompassing to let things persist as they were.

46. The primary goal of LOPS is "to provide a space for people to administer their previously obtained drugs with sterile equipment in a setting where volunteer can observe and intervene in overdoses as needed." LOPS operates "a low threshold, health care service where people can consume pre-obtained drugs in a hygienic environment under the supervision of trained volunteer and receive basic health care, harm reduction teaching and counselling as well as referrals to external health and social services." LOPS is a welcoming and supportive environment for substance users in Lethbridge. Our aim is to ensure that no substance user in Lethbridge consumes substances in an unsafe manner. Attached as **Exhibit "1"** to this affidavit is a copy of the LOPS' operational manual that sets out its mission, policies, protocols, and guidelines.

47. LOPS got to work right away in the parks and areas in and around Lethbridge. We fundraised our budget and started buying the supplies we needed to provide supervised consumption services, including tents, needles, and other items. By October 2020, LOPS was operating a pop-up overdose prevention tent in Lethbridge, moving through out the community as needed, and engaging substance users in the community who otherwise would not access supervised consumption services through the AHS mobile unit for a variety of reasons. If LOPS was not around, these individuals would have used on their own and in an unsafe manner, and in many cases, overdosed and died.

48. LOPS delivers supervised consumption services to substance users in Lethbridge in a manner that conveys to them that their life matters. Through the method that LOPS delivers supervised consumption services, it ensures that each substance user is aware there are people who love, support, and are rooting for them on their journey. LOPS does not advocate a specific path that substance users take, but in both the services it provides and how it provides them, we communicate to each substance user that there is hope of a better future and that we are with every step of the way.

49. LOPS does this because many of its directors and members are substance users or are former substance users and we know how important this message is for substance users. The only reason I engaged with ARCHES and eventually accessed methadone treatment is because of the messages and support I received when I received during my interaction with its staff, building trust and confidence to the point where I decided to stop using street sourced opioids and enter treatment. It changed my life for the better and LOPS wants to give that same encouragement to other substance users as they live with their substance use.

LOPS Commitment to Harm Reduction and Helping Substance Users

50. LOPS has faced a range of hostility from certain segments of Lethbridge who do not believe that any harm reduction services should be provided to substance users, including supervised consumption services in the context of the overdose crisis.

51. LOPS' staff and volunteers, including myself, have been verbally harassed and physically assaulted during the delivery of supervised consumption services in Lethbridge numerous times. Substance users are also harassed, threatened, and assaulted in an attempt to dissuade them from accessing our services.

52. At the same time, the Lethbridge Police Service ("**LPS**") began to use municipal bylaws to prevent LOPS from operating in the community. The LPS has specifically targeted me as part of its campaign to stop LOPS from delivering supervised consumption services to substance users in the city. In September 2020, shortly after LOPS began operations, I was issued 17 bylaw infractions related to having a tent in a city park to holding activities on city property without a permit. The infractions came with fines that totaled thousands of dollars that LOPS and me could not afford to pay. The LPS' aim was to shut us down through the issuance of municipal infractions and associated penalties.

53. However, neither LOPS nor I were deterred by the tactics employed by the small group of opponents to harm reduction in Lethbridge and the LPS' efforts to prevent the delivery of LOPS' supervised consumption services. LOPS continued to operate in Lethbridge despite the threats, harassment, intimidation, assaults, and bylaw infractions.

54. LOPS persisted in its work because of the need in Lethbridge's substance use community and our commitment to harm reduction. LOPS and its members, including myself, could

not sit on the sidelines and watch our community members die when we could stop the deaths. For LOPS to do nothing would be in violation of its founding principles and the ethical and moral framework that informed all that it did. It would infringe the conscience of the organization, its directors, and its members. There was no way that LOPS would do nothing when we as a collective could stop the dying and harm related to substance use in Lethbridge.

55. I was personally even more motivated to continue the work LOPS was doing. I also knew that the LPS' tickets were a veiled attempt to stop the delivery of supervised consumption services to substance users in Lethbridge.

56. I challenged the infractions the LPS charged me with in court and had them all dismissed. Neither LOPS nor I are subject to any further bylaw infractions.

57. LOPS and its directors are bound by our commitment harm reduction and delivering supervised consumption services in Lethbridge, including being exposed to harassment, violence, and bylaw infractions. Every time we are able to reverse an overdose, we know that the risks associated with delivering supervised consumption services in Lethbridge are worth it. We will continue to provide them as long as there is a need.

LOPS' Federal Exemption to Provide Supervised Consumption Services

58. LOPS commenced operations before securing an exemption from the federal government pursuant to section 56.1 of the *Controlled Drug and Substances Act*. We did not have time to go through the administrative hoops because so many people were dying and they needed help right away. There was a desperate need for supervised consumption services and LOPS filled that gap immediately. From a practical perspective, LOPS did not need an exemption to provide supervised consumption services, although it would protect ourselves and the individuals we served from being prosecuted for the crimes associated with illicit substance possession and use. But, we could not wait for this approval, as the epidemic was so severe in Lethbridge and we needed to move quickly.

59. However, since LOPS' founding, it has been working closely with the federal government to complete our section 56.1 of the *Controlled Drug and Substances Act* exemption application and provide our volunteers and site users protection from criminal prosecution. LOPS has met most of the requirements and is ready to submit its application. Attached as **Exhibit "2"** to this affidavit is a copy of the application LOPS submitted to Health Canada for an exemption pursuant to section 56.1 of the *Controlled Drug and Substances Act*. LOPS is seeking an exemption as an overdose prevention service provider and has prepared an application for a section 56.1 exemption pursuant to the "Urgent Public Health Need" stream, which is an expedited and distinct application process for overdose prevention sites.

60. LOPS has not submitted its application to the federal government for a section 56.1 exemption under the *Controlled Drug and Substances Act* because of the announcement made by the Defendant Her Majesty the Queen in Right of Alberta ("**HMQA**") in April 2020 that it will be adopting an additional set of regulations that supervised consumption service providers must follow to be granted authorization to provide these services in Alberta. Attached as **Exhibit "3"** to this affidavit is a copy of the Recovery-Oriented Overdose Prevention Services Guide (the "**Guidelines**").

The Guidelines Impose Barriers on Substance Users for Accessing Care

61. The Guidelines impose a requirement on supervised consumption providers that they collect and store the person health care number ("**PHN**") and other identifying information of substance users, which can then be shared with other health care providers and potentially police agencies. This requirement represents a transition in the delivery of supervised consumption services in Alberta from a model based on anonymity and confidentiality to an integrated model where this information can be accessed by others without the consent or authorization of substance users. Not only does this approach undermine the privacy interests of site users, but based on my personal experience and the outreach that LOPS has engaged in to determine substance user feedback to the approach, it will erect major barriers for substance users accessing supervised consumption services in Lethbridge and across Alberta.

62. Individuals who access supervised consumption services do not want to be identified as substance users. There is the fear of stigmatization and discrimination in the health care system and broader community, and of targeting by police agencies. Substance users will avoid accessing supervised consumption services if these requirements are imposed because providing PHNs and other identifying information will mean that their substance use can be tracked. This information can be shared without their consent, and from their perspective, for purposes that can harm them.

63. LOPS' solicitor informs me and I believe true that under the Guidelines, it is possible for a supervised consumption provider to disclose the personally identifying information of substance users to the police directly or through another health care provider without the substance user's consent. This is extremely concerning because substance users are handling and consuming illicit substances. Substance users will not attend supervised consumption sites in Alberta if there is a chance that site operators can share this information with police agencies directly or indirectly without their consent or knowledge.

64. Even if disclosing this personally identifying information is not mandatory to access supervised consumption services in Alberta, the request and risk of disclosure is enough to create a barrier to access. The understanding that a supervised consumption service provider is asking and storing this information creates significant distrust and apprehensions if it is acting in the best interests of substance users. Without trust and

ensuring that substance users have low barrier access to the supervised consumption services, most will disengage and return to consuming substances in dangerous and unsafe manners.

65. The fear that substance users have of being discriminated against in the future for accessing supervised consumption services is based on my own lived experience and from the knowledge and insight I have gained by working with ARCHES and LOPS. I have experienced first-hand in the health care system after being identified as a substance user. I was treated in a suspicious manner and not provided adequate health care. This is why I avoided seeking medical attention for my substance use until I gained the confidence to seek methadone treatment through ARCHES. The anonymous and confidential nature of the delivery of harm reduction services it allowed me to get the help I needed on my terms and at my own pace.

66. For this reason, LOPS will not collect personal health information or any personal identifiable information of site users. Site users are reluctant to give out personal identifiable information for fear of it being used against them in the future in the manner set out above. LOPS has heard this fear expressed by its directors, members, and the substance users it serves, and it does not want this concern to serve as a barrier to accessing supervised consumption services and leading substance users to consume substances unsafely on their own during the midst of the overdose crisis. With the rates of overdose deaths rising dramatically month over month, especially for Indigenous people in Alberta, including in Lethbridge, there is far too much at stake to impose additional barriers to accessing supervised consumption and other harm reduction services.

67. There is also no need to collect this information. It has no bearing on the ability of a supervised consumption site to provide services to a substance user. The demand for this information is not connected with the ability to provide substance users with supervised consumption services. ARCHES, LOPS, and countless other supervised consumption service providers deliver these services without the need to record or collect this information. Alberta will be the only jurisdiction in Canada that requires this information if the Guidelines are adopted.

The Guidelines Ban Overdose Prevention Sites in Alberta

68. The Guidelines will prevent overdose prevention service providers like LOPS from operating in Alberta. Overdose prevention sites deliver supervised cousumption services in emergency situations or in under-resourced areas in a swift and immediate manner with limited infrastructure and resources. Overdose prevention service providers meet substance users where they are at and operate in temporary locations and often in public spaces. They are not meant to be permanent and intended to meet the demands of the community of substance users they are supporting.

69. The federal government recognized the value of overdose prevention sites to help substance users as part of its approach to addressing the overdose crisis and created an expedited and distinct process for them to obtain a section 56.1 exemption under the *Controlled Drug and Substances Act*. The application is entitled "Subsection 56(1) Exemption from the Controlled Drugs and Substances Act for Urgent Public Health Need Sites" (**"OPS Application"**). It is meant for overdose prevention service providers to provide urgent public health responses to prevent overdoses or other health harms to substance users. LOPS has worked with the federal government to obtain a section 56.1 exemption through this stream, including completing an OPS Application.

70. A personal information record collection and storage system that is integrated with an electronic medical records system is not viable given the infrastructure of an overdose prevention service provider and the *ad-hoc* manner in which they operate. It requires servers, computers, and electronic medical record collection programs. It requires a fixed, secure, and indoor location for these items to be stored. There needs to be significant financial investment to secure both and cannot be maintained by an overdose prevention service provider who is addressing urgent public health needs of substance users and often in the community where substance users can be found.

71. The Guidelines are geared towards supervised consumption providers that operate in a fixed location and already have clinical infrastructure. It is not meant for overdose prevention service providers that are under-resourced and built for more swift and immediate action, meeting substance users where they are and on their terms. It is neither practical nor viable for overdose prevention service providers like LOPS to have the record collection and storage infrastructure that the Guidelines mandate.

72. In addition, LOPS operates on a small budget entirely funded by community donations. The organization does not have the financial capacity to put in place a system of collecting the personal information of site users, storing them in an electronic medical system for records, and sharing them with HMQA. LOPS simply cannot afford to put in place and operate the infrastructure needed to meet this regulation.

73. LOPS operates on an *ad-hoc* and grassroots basis that allows for immediate deployment. If the organization hears that substance users in Lethbridge need supervised consumption services in a specific location in the city, it will direct its efforts there until the population is served. Then, LOPS will go to other locations in the city, ensuring that as many substance users and pockets of substance users can consume substances without fear of being exposed to any adverse impacts. LOPS cannot transport an electronic medical records system infrastructure and all the associated components with it as it moves from location to location in Lethbridge.

74. The Guidelines do not meet the realities of overdose prevention service providers and how the federal government has approached them to help address the overdose crisis through

the creation of a separate and expedited process to obtaining exemptions pursuant to section 56.1 of the *Controlled Drug and Substances Act*. The requirements that supervised consumption service providers have large scale, integrated electronic medical record systems means that grassroots overdose prevention sites can never obtain authorization to deliver supervised consumption services in Alberta. Grassroots organizations like LOPS can never fulfill this requirement.

The Guidelines will Harm Substance Users, LOPS

75. For the reasons set out above, the Guidelines will deter substance users from accessing supervised consumption services in Alberta. The requirement that PHNs and other identifying information be collected, stored, and shared with others, even if there is an ability to opt out, will impose major barriers to accessing supervised consumption sites that will lead to large number of substances users to engage or refuse to access these services.

76. Once substance users disengage or refuse to access supervised consumption services, they will use substances in an unsupervised, unsafe manner that will increase their likelihood of being exposed to harm from street sourced substance use. This includes the risk of overdoses and acquiring diseases from substance use, particularly Indigenous substance users, who are more acutely impacted by the overdose crisis.

77. Personally, if I were to relapse and return to street sourced opioid use, I would rather consume opioids with friends or alone rather than access a supervised consumption site that did not operate on a model of anonymity and confidentiality. The ability to opt out is not sufficient because I have navigated life and the health care system as a substance user and know what it feels like to be stigmatized and discriminated against as a substance user. I would rather take my chances using alone than at a supervised consumption facility that allows for the personal details of substance users to be stored and shared with others without consent, including other health care providers and police agencies.

78. The Guidelines also prohibit overdose prevention sites to open in Alberta, particularly community based and grassroots oriented overdose prevention service providers. This will limit the ability to provide supervised consumption services to substance users across the province, including in rural communities and smaller municipalities, to particularly vulnerable substance users, and in situations where supervised consumption services need to be deployed urgently and in community settings.

79. The prohibition and limits the Guidelines impose on overdose prevention sites mean that fewer substance users will have access to supervised consumption services in Alberta. Already vulnerable substance users will be further marginalized as a result of the Guidelines, leading to them consume substances in unsafe settings and being exposed to harms related to substance use, including an increased risk of overdose death.

80. Based on LOPS' experience delivering supervised consumption services as an overdose prevention society, and my lived experience as a substance user and worker with ARCHES and LOPS, I believe that the Guidelines will cause significant and irreparable harm to substance users in Alberta, including an increased risk of death and other adverse impacts associated with street sourced substance use.

Injunction: Undertaking as to Damages

81. LOPS undertakes to abide by any court order arising from an injunction being issued against HMQA in this matter, including being liable for any damages sustained by HMQA as a result of an injunction.

82. LOPS undertakes to prosecute this action to a conclusion and without delay.

SWORN BEFORE ME at Lethbridge, Alberta, this 30 day of August 2021.

Miranda P Hady
Lawyer

TIMOTHY SLANEY

TAB 3

COURT FILE NUMBER	2103 11484
COURT	COURT OF QUEEN'S BENCH OF ALBERTA
JUDICIAL CENTRE	EDMONTON
PLAINTIFFS	MOMS STOP THE HARM SOCIETY and LETHBRIDGE OVERDOSE PREVENTION SOCIETY
DEFENDANT	HER MAJESTY THE QUEEN IN RIGHT OF ALBERTA
DOCUMENT	**AFFIDAVIT OF ELAINE HYSHKA**
ADDRESS FOR SERVICE AND CONTACT INFORMATION OF PARTY FILING THIS DOCUMENT	NANDA & COMPANY 10007 – 80 Avenue Edmonton, AB T6E 1T4 Tel.: (780) 801-5324 Fax: (587) 318-1391 Email: avnish@nandalaw.ca File:

AFFIDAVIT OF ELAINE HYSHKA

Sworn on August 31, 2021

I, Elaine Hyshka, of the City of Edmonton, in the Province of Alberta, MAKE OATH AND SAY THAT:

1. I am a Canada Research Chair in Health Systems Innovation and an Assistant Professor at the University of Alberta's School of Public Health. Attached as **Exhibit 1** to this Affidavit is a copy of my *curriculum vitae*, which sets out my education, work experience, and academic research and service contributions.

2. My expertise is in improving how health systems and services respond to substance use, with a particular emphasis on preventing morbidity and mortality amongst structurally vulnerable populations. I completed a PhD in Public Health Sciences at the University of Alberta in 2016. My dissertation focused on estimating population need for substance use services amongst homeless and unstably housed people who use drugs.

3. I am the recipient of multiple competitive research grants (over $4.3 million as principal investigator in the past five years), and author of 54 peer-reviewed publications on substance use and health, including manuscripts published in top health sciences (*PLOS One, CMAJ*) and substance use (*Addiction, International Journal of Drug Policy, Drug and Alcohol Dependence)* journals.

4. The quality and impact of my academic scholarship has been recognized with 13 distinctions and awards over the past five years. As a Tier II Canada Research Chair, I am nationally regarded as an exceptional early career scholar with the potential to be an international leader in my field. I have also been awarded a *Trailblazer Award* for significant contributions to public health from the Canadian Institutes of Health Research, our national health research funding agency; an Alberta Health Services' *President's Excellence Award for Outstanding Achievements in Innovation*; and the *Brooklyn McNeil Award* from Harm Reduction International (UK), the global authority on harm reduction approaches to substance use.

5. I have authored 20 technical reports and have advised decision makers in municipal, provincial, federal, and American governments, health authorities, and civil society organizations. I currently serve as Co-Chair of the Harm Reduction Working Group for the Royal Society of Canada's COVID-19 Task Force; and Co-Chair of Health Canada's Expert Advisory Group on Safer Supply of Pharmaceuticals as Alternatives to Illegal Street Drugs.

6. Between May 2017 and November 2019 I was appointed Co-Chair of Alberta's Minister's Opioid Emergency Response Commission alongside the Chief Medical Officer of Health. Our mandate was to make recommendations on how to allocate ~$60 million of new funding to address Alberta's opioid overdose epidemic. This included reviewing and recommending proposals for funding to implement supervised consumption services in Calgary, Lethbridge, Edmonton, Grande Prairie, and Red Deer; and advising Alberta Health on its process for approving overdose prevention sites in the province.

7. I have been conducting academic research on supervised consumption services ('**SCS**') since 2012. In 2013, I published an invited policy case study outlining the implications of *Canada (Attorney General) v. PHS Community Services Society* for expanding access to SCS nationally.[1] Between 2014-2019, I was a member and scientific advisor of *Access to Medically Supervised Injection Services in Edmonton*, a community coalition of nonprofit agencies, healthcare providers, academic researchers, and municipal and provincial

[1] Elaine Hyshka, Tania Bubela, and T. Cameron Wild, 'Prospects for Scaling-up Supervised Injection Facilities in Canada: The Role of Evidence in Legal and Political Decision-Making', *Addiction* 108, no. 3 (March 2013): 468–76, https://doi.org/10.1111/add.12064.https://doi.org/10.1111/add.12064. Attached as **Exhibit "1"** to this Affidavit.

officials, which supported the implementation of three SCS in Edmonton. In this role, I conducted the *Edmonton Drug Use and Health Survey,* a City of Edmonton and Alberta Health-funded epidemiological research project that estimated the need for, and feasibility of, implementing SCS in the inner city.[2] Findings from this research informed the implementation of four SCS in Edmonton in 2018.

8. More recently, I have conducted an evaluation of Edmonton's Royal Alexandra Hospital supervised consumption service, and my research group is contracted to provide data management and analysis support to Edmonton's three community-based SCS. I have authored three peer-reviewed manuscripts[3,4,5] describing SCS in Alberta, and published a comprehensive review[6] examining the extent to which SCS internationally accommodate non-injection drug use (i.e. drug consumption via oral, intranasal, or inhalation routes). I also advised the Institute for Health Economics on their protocol for evaluating Alberta SCS. In 2020, I was the lead author of a Health Canada-commissioned national rapid guidance document outlining how to implement SCS in shelter settings during COVID-19.[7]

9. I am currently chairing the expert committee responsible for authoring the Canadian Research Initiative in Substance Misuse's ('**CRISM**') forthcoming national operational guidance for SCS. CRISM is a national research consortium focused on translational and implementation research targeting substance use and related harms, funded by the Canadian Institutes of Health Research ("CIHR") and Health Canada.

10. I am also Principal Investigator of a CIHR-funded team conducting a national survey of Canada's 37 federally-exempted SCS, with data collection commencing this fall. In September, we are launching whyscs.ca, a national repository of scientific information on SCS in Canada.

[2] Elaine Hyshka et al., 'Risk Behaviours and Service Needs of Marginalized People Who Use Drugs in Edmonton's Inner City: Results from the Edmonton Drug Use and Health Survey' (Edmonton, Alberta: University of Alberta, 7 January 2016). Attached as **Exhibit "2"** to this Affidavit.
[3] Kathryn A. Dong et al., 'Supervised Consumption Services for Acute Care Hospital Patients', *CMAJ* 192, no. 18 (4 May 2020): E476–79, https://doi.org/10.1503/cmaj.191365.https://doi.org/10.1503/cmaj.191365. Attached as **Exhibit "3"** to this Affidavit.
[4] Hannah L Brooks et al., 'Supporting the Full Participation of People Who Use Drugs in Policy Fora: Provision of a Temporary, Conference-Based Overdose Prevention Site', *International Journal of Drug Policy* 84, no. 102878 (October 2020): 1–5, https://doi.org/10.1016/j.drugpo.2020.102878. Attached as **Exhibit "4"** to this Affidavit.
[5] Brynn Kosteniuk et al., '"You Don't Have to Squirrel Away in a Staircase": Patient Motivations for Attending a Novel Supervised Drug Consumption Service in Acute Care', *International Journal of Drug Policy*, 19 May 2021, 103275, 10.1016/j.drugpo.2021.103275**.** Attached as **Exhibit "5"** to this Affidavit.
[6] Kelsey A. Speed et al., 'To What Extent Do Supervised Drug Consumption Services Incorporate Non-Injection Routes of Administration? A Systematic Scoping Review Documenting Existing Facilities', *Harm Reduction Journal* 17, no. 1 (7 October 2020): 72, https://doi.org/10.1186/s12954-020-00414-y. Attached as **Exhibit "6"** to this Affidavit.
[7] CRISM, 'Supporting People Who Use Substances in Shelter Settings during the COVID-19 Pandemic: National Rapid Guidance', 17 May 2020, https://crism.ca/wp-content/uploads/2020/06/CRISM-Guidance-Supporting-People-Who-Use-Substances-in-Emergency-Shelter-Settings-V1.pdf. Attached as **Exhibit "7"** to this Affidavit.

11. I have been retained by Nanda & Company as an expert witness to provide an understanding of the potential impacts of the new *Recovery-oriented Overdose Prevention Services Guide* on SCS and people who use substances in Alberta. On the basis of my education, credentials, research, publications, and other relevant experience, I have personal knowledge of the information set out in this affidavit, except to such matters based upon information and belief.

12. I certify that I am aware of my duty as an expert witness to assist the court, and not to be an advocate for any party. I have made this affidavit and have given this written testimony in conformity with that duty. If I am called to give further testimony, it will be in conformity with that duty.

Canada's drug poisoning epidemic

13. Canada has been experiencing an unprecedented drug poisoning epidemic, which killed 21,174 Canadians between 2016 and 2020.[8] This mortality is so severe that it is reversing a four decade trend of increasing life expectancy in Canada.[9]

14. The dramatic increase in drug poisoning deaths has largely been driven by the introduction and proliferation of novel synthetic opioids. Fentanyl, an opioid more potent than heroin or morphine, is the main chemical amongst a growing number of clandestinely-produced opioid analogues in circulation.[10]

15. Fentanyl and other analogues are illegally manufactured and distributed as counterfeit opioid or benzodiazepine pills; loose powders mixed with various cutting agents (e.g. caffeine); or as adulterants in other illegal drugs such as heroin, methamphetamine, or cocaine.[11,12] Potency and toxicity of these products varies from batch to batch. As a result, in illegal markets (such as Alberta's) where synthetic opioids dominate, it is extremely difficult for people who use drugs (i.e., opioids, methamphetamine, or other substances) to know exactly what they are purchasing, or to accurately predict the potency of the drug

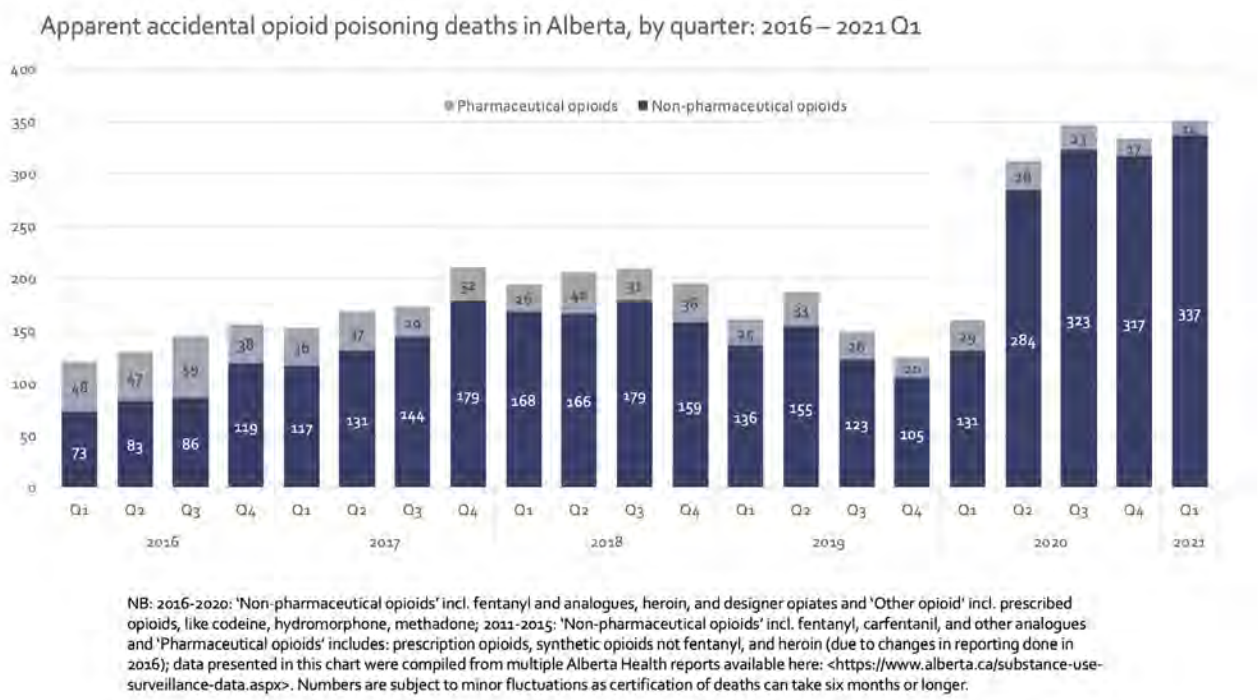
[8] Public Health Agency of Canada, 'Apparent Opioid and Stimulant Toxicity Deaths: Surveillance of Opioid- and Stimulant-Related Harms in Canada', June 2021. Attached as **Exhibit "8"** to this Affidavit.
[9] Statistics Canada, 'The Daily — Changes in Life Expectancy by Selected Causes of Death, 2017', 30 May 2019, https://www150.statcan.gc.ca/n1/daily-quotidien/190530/dq190530d-eng.htm. Attached as **Exhibit "9"** to this Affidavit.
[10] Benedikt Fischer, Michelle Pang, and Wayne Jones, 'The Opioid Mortality Epidemic in North America: Do We Understand the Supply Side Dynamics of This Unprecedented Crisis?', *Substance Abuse Treatment, Prevention, and Policy* 15, no. 1 (17 February 2020): 14, https://doi.org/10.1186/s13011-020-0256-8.https://doi.org/10.1186/s13011-020-0256-8. Attached as **Exhibit "10"** to this Affidavit.
[11] Fischer, Pang, and Jones, 'The Opioid Mortality Epidemic in North America'. Attached as **Exhibit "10"** to this Affidavit.
[12] Daniel Ciccarone, 'The Triple Wave Epidemic: Supply and Demand Drivers of the US Opioid Overdose Crisis', *International Journal of Drug Policy* 71 (September 2019): 183–88, https://doi.org/10.1016/j.drugpo.2019.01.010.https://doi.org/10.1016/j.drugpo.2019.01.010. Attached as **Exhibit "11"** to this Affidavit.

they are consuming.[13,14] This volatility places people using illegal drugs at high risk of drug poisoning.

16. Since 2016, Alberta and British Columbia have been the two Canadian jurisdictions most grievously impacted by drug poisoning fatalities.

17. Figure 1 illustrates Alberta's recent death statistics. In 2020, an unprecedented 1152 Albertans died from an apparent accidental opioid poisoning, up from 623 deaths the year prior.

Figure 1



NB: 2016-2020: 'Non-pharmaceutical opioids' incl. fentanyl and analogues, heroin, and designer opiates and 'Other opioid' incl. prescribed opioids, like codeine, hydromorphone, methadone; 2011-2015: 'Non-pharmaceutical opioids' incl. fentanyl, carfentanil, and other analogues and 'Pharmaceutical opioids' includes: prescription opioids, synthetic opioids not fentanyl, and heroin (due to changes in reporting done in 2016); data presented in this chart were compiled from multiple Alberta Health reports available here: <https://www.alberta.ca/substance-use-surveillance-data.aspx>. Numbers are subject to minor fluctuations as certification of deaths can take six months or longer.

Source: Chart compiled from data accessed via: Government of Alberta. Alberta substance use surveillance dashboard: Apparent accidental opioid poisoning deaths. Government of Alberta; August 10, 2021. [NB: totals are subject to minor fluctuations as certification of deaths can take six months or longer].

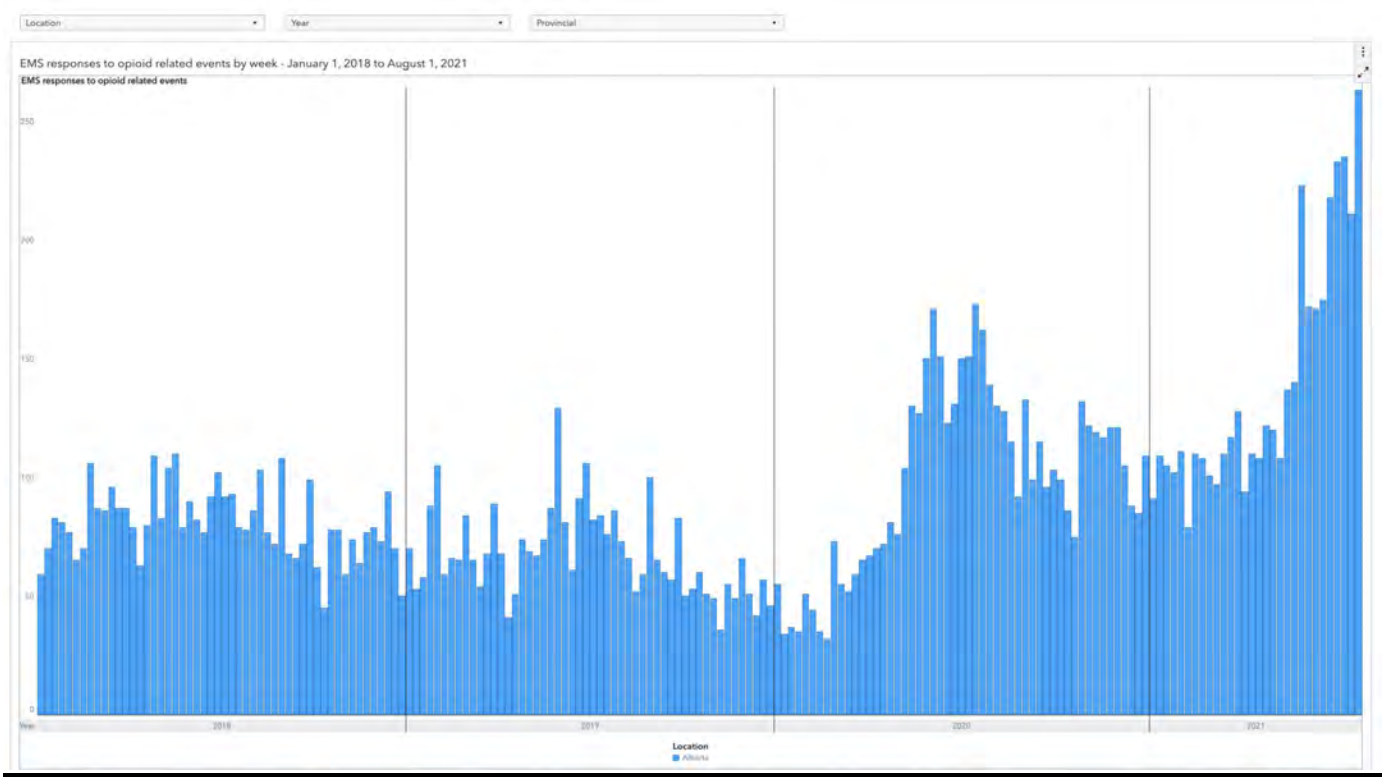
18. The provincial opioid poisoning death rate was 25.6 per 100,000 population in 2020 (compared to a national average of 17.2 per 100,000 population), and fentanyl was implicated in 89% of Alberta's opioid poisoning deaths.[15]

[13] Fischer, Pang, and Jones, 'The Opioid Mortality Epidemic in North America'. Attached as **Exhibit "10"** to this Affidavit.
[14] Ciccarone, 'The Triple Wave Epidemic'. Attached as **Exhibit "11"** to this Affidavit.
[15] Public Health Agency of Canada, 'Apparent Opioid and Stimulant Toxicity Deaths: Surveillance of Opioid- and Stimulant-Related Harms in Canada'. Attached as **Exhibit "8"** to this Affidavit.

19. Figure 2 illustrates recent Emergency Medical Services calls for opioid-related events in Alberta. The province marked the worst week on record at the end of July 2021, with 265 ambulance calls recorded.[16]

Figure 2

Emergency Medical Services (EMS) responses to opioid related events in Alberta by week -- January 1, 2018 to August 1, 2021



Source: Government of Alberta. Alberta substance use surveillance dashboard: Provincial EMS responses by week. Government of Alberta; August 10, 2021.

First Nations people in Alberta are at high risk of drug poisoning morbidity and mortality

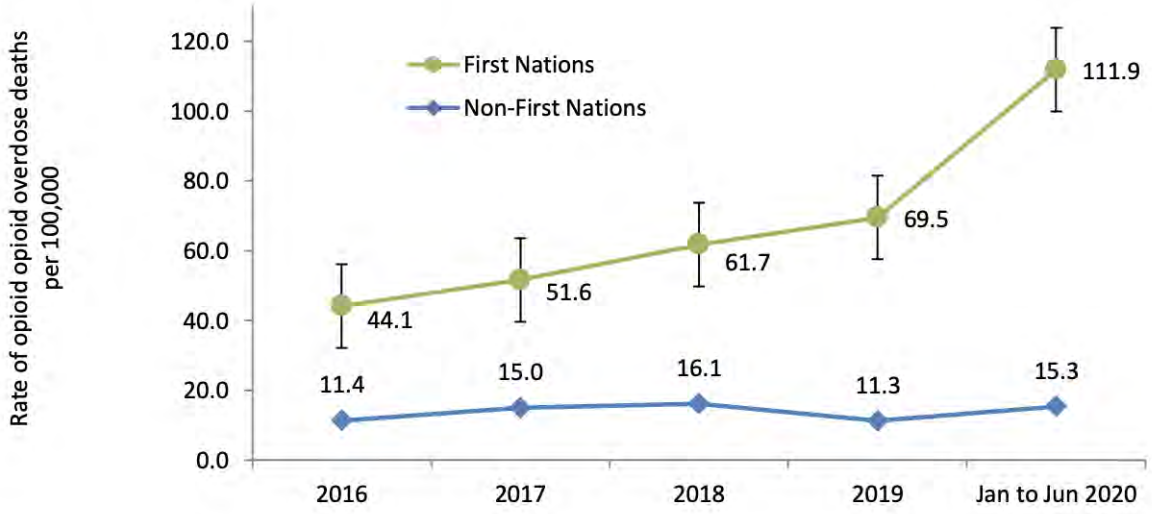
20. Drug poisoning deaths occur across the population but some are much more at risk than others. In particular, First Nations people in Alberta are far more likely to die of opioid poisoning than members of the general population. Available data from 2020 indicate that the rate of apparent accidental opioid poisoning for First Nations people was 111.9 per 100,000 population, compared to a rate of 15.3 for non-First Nations people in Alberta (Figure 3).[17]

[16] Government of Alberta, 'Substance Use Surveillance Data - EMS', n.d., https://www.alberta.ca/substance-use-surveillance-data.aspx. Attached as **Exhibit "12"** to this Affidavit.
[17] Government of Alberta and The Alberta First Nations Information Governance Centre, 'Alberta Opioid Response Surveillance Report: First Nations People in Alberta (June 2021)', 2021, 24. Attached as **Exhibit "13"** to this Affidavit.

Figure 3

Apparent accidental opioid poisoning deaths (fentanyl & non-fentanyl opioids)

Figure 1: Rate of apparent accidental opioid poisoning deaths per 100,000 by First Nations status and year. January 1, 2016 to June 30, 2020.



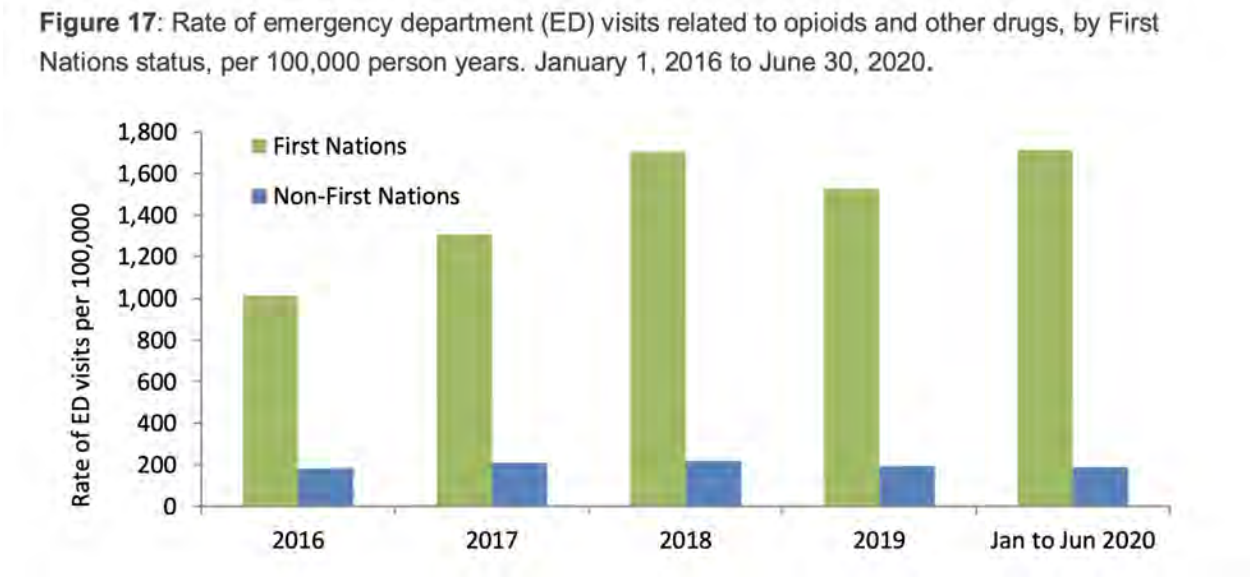
Source: Government of Alberta and The Alberta First Nations Information Governance Centre. Alberta opioid response surveillance report: First Nations People in Alberta. Edmonton: Government of Alberta; June 2021. 24 p.

21. Amongst First Nations people, 66% of opioid poisoning deaths occur in males, and the largest number of deaths have been for those aged 25-29. Amongst non-First Nations decedents, 80% were male and the largest number of deaths occurred amongst those aged 35 to 39.[18]

22. First Nations people in Alberta are also far more likely to require care at an emergency department for opioid or other drug-related care. In 2020, the rate of emergency department visits was 9 times higher for First Nations people than non-First Nations people in Alberta (Figure 4).[19]

[18] Government of Alberta and The Alberta First Nations Information Governance Centre. Attached as **Exhibit "13"** to this Affidavit.
[19] Government of Alberta and The Alberta First Nations Information Governance Centre. Attached as **Exhibit "13"** to this Affidavit.

Figure 4



Source: Government of Alberta and The Alberta First Nations Information Governance Centre. Alberta opioid response surveillance report: First Nations People in Alberta. Edmonton: Government of Alberta; June 2021. 24 p.

Harm reduction as an approach to reducing drug-related morbidity and mortality

23. In Canada, provincial and federal governments have implemented an array of interventions over the past 5 years aimed at reducing drug poisoning morbidity and mortality, including several that align with a harm reduction approach.

24. Harm reduction is both a philosophy and set of strategies that aims to assist people who use legal and illegal psychoactive substances to live safer and healthier lives by providing care that is not contingent on abstinence or reductions in drug use.[20] In doing so, harm reduction prioritizes the human rights and health of people who use drugs and advances a value neutral perspective on drug use.

25. According to sociologist Helen Keane, it is this refusal of moral judgement "that has made harm reduction such an effective and innovative strategy in a field overwhelmed by moral discourse," because "suspension of moral judgement combined with the objective of protecting health gives harm reduction unique critical leverage when faced with governmental strategies which allow moral qualification to obstruct the duty to provide care."[21] (pg. 551)

[20] Bernadette Pauly, 'Harm Reduction through a Social Justice Lens', *International Journal of Drug Policy*, Values and Ethics in Harm Reduction, 19, no. 1 (1 February 2008): 4–10, https://doi.org/10.1016/j.drugpo.2007.11.005. Attached as **Exhibit "14"** to this Affidavit.

[21] Helen Keane, 'Moral Frameworks, Ethical Engagement and Harm Reduction: Commentary on "Ethical Challenges and Responses in Harm Reduction Research: Promoting Applied Communitarian Ethics" by C. L. Fry, C. Treloar & L. Maher', *Drug*

26. There is no single definition that accurately captures harm reduction's diverse meanings, but several key principles[22] underpin its philosophy, including:

- *Pragmatism* - accepting that some level of psychoactive substance use is inevitable and normal in a society;
- *Humanistic values* - drug use is neither condemned or supported, regardless of level of use or mode of intake, moralistic judgement is suspended and the dignity and rights of drug users are respected;
- *Focus on harms* - the extent of an individual's drug use is of secondary importance to the harms associated with their use; and
- *A hierarchy of goals* - the immediate focus is on addressing the most pressing health and social needs of the person.

27. Although these principles can be traced back centuries,[23] the development of specific harm reduction strategies for illegal drug use occurred mainly in response to rising rates of HIV/AIDS amongst people who inject drugs during the 1980s,[24] when it became clear that criminalization of illegal drug use was insufficient to deter use and stop the spread of infectious disease amongst this population.[25] This is because fear of police detection often resulted in unwillingness to carry sterile injecting equipment, leading to syringe borrowing and lending, rushed or less cautious injections, improper syringe disposal, and concealing drug use—all practices which put people who inject drugs at increased risk for HIV/AIDS and other health harms.[26,27]

28. Moreover, stigma resulting from engaging in a criminalized activity marginalizes people who use drugs and often separates them from both formal health and social services and informal support networks.[28,29] As a result, harm reduction was initially implemented via illegal grassroots practices (bleach provision, syringe distribution) by and for people who

and Alcohol Review 24, no. 6 (November 2005): 551–52, https://doi.org/10.1080/09595230500404152. Attached as **Exhibit "15"** to this Affidavit.

[22] Diane Riley et al., 'A Brief History of Harm Reduction', in *Harm Reduction in Substance Use and High-Risk Behaviour*, ed. Riley, Diane and Pates, Richard (Wiley-Blackwell, 2012). Attached as **Exhibit "16"** to this Affidavit.

[23] Riley et al. Attached as **Exhibit "16"** to this Affidavit.

[24] Patricia G. Erickson, 'Introduction: The Three Phases of Harm Reduction. An Examination of Emerging Concepts, Methodologies, and Critiques.', *Substance Use & Misuse* 34, no. 1 (1999): 1–7. Attached as **Exhibit "17"** to this Affidavit.

[25] Catherine A. Hankins, 'Syringe Exchange in Canada: Good but Not Enough to Stem the HIV Tide.', *Substance Use & Misuse* 33, no. 5 (April 1998): 1129–46. Attached as **Exhibit "18"** to this Affidavit.

[26] Daniel Werb et al., 'Effects of Police Confiscation of Illicit Drugs and Syringes among Injection Drug Users in Vancouver.', *The International Journal on Drug Policy* 19, no. 4 (2008): 332–38. Attached as **Exhibit "19"** to this Affidavit.

[27] Elaine Hyshka et al., 'Needle Exchange and the HIV Epidemic in Vancouver: Lessons Learned from 15 Years of Research', *International Journal of Drug Policy* 23, no. 4 (1 July 2012): 261–70, https://doi.org/10.1016/j.drugpo.2012.03.006. Attached as **Exhibit "20"** to this Affidavit.

[28] Hyshka et al., 'Needle Exchange and the HIV Epidemic in Vancouver'. Attached as **Exhibit "20"** to this Affidavit.

[29] Don C. Des Jarlais, Samuel R. Friedman, and Thomas P. Ward, 'Harm Reduction: A Public Health Response to the AIDS Epidemic among Injecting Drug Users', *Annual Review of Public Health* 14 (1993): 413–50, https://doi.org/10.1146/annurev.pu.14.050193.002213. Attached as **Exhibit "21"** to this Affidavit.

use drugs and their allies, many of which preceded integration of these interventions into formal healthcare systems. A strong tradition of peer involvement in harm reduction is still evident today. [30,31]

29. In countries where harm reduction was pioneered - including the United Kingdom, Netherlands, and Canada - syringe exchange programs which sought to decrease needle sharing and increase connections to health and social support amongst people who inject drugs, became a central component of early harm reduction efforts.[32] As harm reduction interventions spread and were associated with demonstrable reductions in injection-related risk behaviours and HIV incidence, the approach expanded to include additional interventions, including SCS.[33]

Supervised consumption services (SCS)

30. SCS are a harm reduction strategy that provide a safe and clean environment for people to consume pre-obtained illegal drugs and be monitored by staff with first aid or medical training. The first officially-sanctioned SCS was established in 1986 in Berne, Switzerland in response to high rates of HIV, and an increase in drug-related deaths and public drug use.[34] According to Harm Reduction International, there are now over 130 SCS operating in 12 countries worldwide.[35]

31. SCS developed primarily as a strategy to mitigate health harms associated with public drug use. People who use drugs in public spaces, such as alleys, parks, bathroom stalls and other settings, are at increased risk of experiencing negative health outcomes due to: unsterile conditions and reduced access to sterile drug use equipment; rushed or risky consumption practices associated with fear of being interdicted by police or disrupted by others; and reduced access to emergency care in the event of a drug poisoning or accidental

[30] Neil Hunt, Eliot Albert Albert, and Virginia Montanes Sanchez, 'User Involvement and User Organising in Harm Reduction', in *Harm Reduction: Evidence, Impacts, Challenges.*, ed. Tim Rhodes and Dagmar Hedrich, EMCDDA Monographs (Luxembourg: Publications office of the European Union, 2010). Attached as **Exhibit "22"** to this Affidavit.
[31] Samuel R. Friedman et al., 'Harm Reduction Theory: Users' Culture, Micro-Social Indigenous Harm Reduction, and the Self-Organization and Outside-Organizing of Users' Groups', *The International Journal on Drug Policy* 18, no. 2 (March 2007): 107–17, https://doi.org/10.1016/j.drugpo.2006.11.006. Attached as **Exhibit "23"** to this Affidavit.
[32] Catherine J Cook, Jamie Bridge, and Gerry V. Stimson, 'The Diffusion of Harm Reduction in Europe and Beyond.', in *Harm Reduction: Evidence, Impacts, Challenges*, ed. Tim Rhodes and Dagmar Hedrich, EMCDDA Monographs (Luxembourg: Publications office of the European Union, 2010, 2010). Attached as **Exhibit "24"** to this Affidavit.
[33] Cook, Bridge, and Stimson. Attached as **Exhibit "24"** to this Affidavit.
[34] Schäffer Dirk, Stöver Heino, and Weichert Leon, 'Drug Consumption Rooms in Europe: Models, Best Practices and Challenges', 2014, https://idhdp.com/media/399959/drug-consumption-in-europe-final-2014-1.pdf. Attached as **Exhibit "25"** to this Affidavit.
[35] Harm Reduction International, 'The Global State of Harm Reduction 2020' (London, 2020), https://www.hri.global/files/2020/10/26/Global_State_HRI_2020_BOOK_FA.pdf. Attached as **Exhibit "26"** to this Affidavit.

overdose.[36,37,38] SCS also provide an alternative for people who are able to use drugs in a private and secure space, but who wish to avoid using alone, which is a major risk factor for fatal drug poisoning.[39]

32. SCS typically offer sterile drug use equipment (e.g. syringes, needles, cookers, tourniquets, alcohol swabs, acidifiers, pipes, sharps containers) and safe disposal facilities, education about safer drug use, and direct provision of, or referral to, healthcare, substance use treatment, and/or other services.[40]

33. In the event of a drug poisoning, SCS provide emergency medical care including stimulation, oxygen, and if indicated, naloxone (opioid poisoning reversal medication).[41] They are also able to call for EMS transport to hospital in the event of a severe drug poisoning that requires more intensive emergency care. While virtually all SCS accommodate drug injection, many facilities internationally also accommodate drug inhalation or smoking.[42]

Scientific Evidence on SCS

34. Research demonstrates that SCS engage a particularly vulnerable subpopulation of people who use drugs who are at high risk of negative health outcomes. This includes people who use drugs and are homeless or unstably housed; those who inject in public;[43,44,45] those who

[36] Kristina T. Phillips and Michael D. Stein, 'Risk Practices Associated with Bacterial Infections among Injection Drug Users in Denver, CO', *The American Journal of Drug and Alcohol Abuse* 36, no. 2 (March 2010): 92–97, https://doi.org/10.3109/00952991003592311. Attached as **Exhibit "27"** to this Affidavit.
[37] Campbell Aitken et al., 'The Impact of a Police Crackdown on a Street Drug Scene: Evidence from the Street', *International Journal of Drug Policy* 13, no. 3 (1 September 2002): 193–202, https://doi.org/10.1016/S0955-3959(02)00075-0. Attached as **Exhibit "28"** to this Affidavit.
[38] Thomas Kerr et al., 'A Micro-Environmental Intervention to Reduce the Harms Associated with Drug-Related Overdose: Evidence from the Evaluation of Vancouver's Safer Injection Facility', *International Journal of Drug Policy* 18, no. 1 (January 2007): 37–45, https://doi.org/10.1016/j.drugpo.2006.12.008. Attached as **Exhibit "29"** to this Affidavit.
[39] Keith Chichester et al., 'Examining the Neighborhood-Level Socioeconomic Characteristics Associated with Fatal Overdose by Type of Drug Involved and Overdose Setting', *Addictive Behaviors* 111 (1 December 2020): 106555, https://doi.org/10.1016/j.addbeh.2020.106555. Attached as **Exhibit "30"** to this Affidavit.
[40] Hyshka, Bubela, and Wild, 'Prospects for Scaling-up Supervised Injection Facilities in Canada'.https://doi.org/10.1111/add.12064Hyshka, Bubela, and Wild. Attached as **Exhibit "1"** to this Affidavit.
[41] Hyshka, Bubela, and Wild, 'Prospects for Scaling-up Supervised Injection Facilities in Canada'. Attached as **Exhibit "1"** to this Affidavit.
[42] Speed et al., 'To What Extent Do Supervised Drug Consumption Services Incorporate Non-Injection Routes of Administration?' Attached as **Exhibit "6"** to this Affidavit.
[43] Jo Kimber et al., 'The Sydney Medically Supervised Injecting Centre: Client Characteristics and Predictors of Frequent Attendance during the First 12 Months of Operation', *Journal of Drug Issues* 33, no. 3 (July 2003): 639–48, https://doi.org/10.1177/002204260303300306. Attached as **Exhibit "31"** to this Affidavit.
[44] Evan Wood et al., 'Do Supervised Injecting Facilities Attract Higher-Risk Injection Drug Users?', *American Journal of Preventive Medicine* 29, no. 2 (2005): 126–30, https://doi.org/10.1016/j.amepre.2005.04.011.https://doi.org/10.1016/j.amepre.2005.04.011. Attached as **Exhibit "32"** to this Affidavit.
[45] Evan Wood et al., 'Summary of Findings from the Evaluation of a Pilot Medically Supervised Safer Injecting Facility', *Canadian Medical Association Journal* 175, no. 11 (21 November 2006): 1399–1404, https://doi.org/10.1503/cmaj.060863. Attached as **Exhibit "33"** to this Affidavit.

have difficulty injecting safely; those who report a history of injection-related infections; and those with a lack of knowledge of safer injection practices.[46,47]

35. Systematic reviews, which critically appraise and collate findings from multiple research studies, have demonstrated that SCS reduce the risk of drug poisoning death.[48,49,50] In Vancouver, researchers observed a 35% decline in drug poisoning fatalities in the area around a supervised consumption service after it opened, compared to only a 9% reduction in other areas of the city during the same period.[51] Globally there have been no recorded fatal drug poisonings in any supervised consumption service.[52]

36. Regular SCS use is also associated with reductions in unsafe drug use practices including public drug consumption, rushed use, and borrowing, lending, reusing, and unsafe disposal of drug use supplies.[53,54] For example, a meta-analysis of three studies found that SCS use was associated with 69% reduction in the odds of syringe sharing.[55] This is important because syringe sharing and other unsafe drug use practices increase the risk of HIV and HCV incidence, skin and soft tissue infections, drug poisoning, and other negative health outcomes.[56,57]

[46] Danya Fast et al., 'The Perspectives of Injection Drug Users Regarding Safer Injecting Education Delivered through a Supervised Injecting Facility', *Harm Reduction Journal* 5, no. 1 (2008): 32, https://doi.org/10.1186/1477-7517-5-32. Attached as **Exhibit "34"** to this Affidavit.
[47] Allison M. Salmon et al., 'Injecting-Related Injury and Disease among Clients of a Supervised Injecting Facility', *Drug and Alcohol Dependence* 101, no. 1–2 (2009): 132–36, https://doi.org/10.1016/j.drugalcdep.2008.12.002. Attached as **Exhibit "35"** to this Affidavit.
[48] Mary Clare Kennedy, Mohammad Karamouzian, and Thomas Kerr, 'Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: A Systematic Review', *Current HIV/AIDS Reports*, no. 14 (2017): 161–83, https://doi.org/10.1007/s11904-017-0363-y. Attached as **Exhibit "36"** to this Affidavit.
[49] Chloé Potier et al., 'Supervised Injection Services: What Has Been Demonstrated? A Systematic Literature Review', *Drug and Alcohol Dependence* 145 (December 2014): 48–68, https://doi.org/10.1016/j.drugalcdep.2014.10.012.https://doi.org/10.1016/j.drugalcdep.2014.10.012Potier et al. Attached as **Exhibit "37"** to this Affidavit.
[50] Timothy W. Levengood et al., 'Supervised Injection Facilities as Harm Reduction: A Systematic Review', *American Journal of Preventive Medicine*, 1 July 2021, https://doi.org/10.1016/j.amepre.2021.04.017. Attached as **Exhibit "38"** to this Affidavit.
[51] Brandon DL Marshall et al., 'Reduction in Overdose Mortality after the Opening of North America's First Medically Supervised Safer Injecting Facility: A Retrospective Population-Based Study', *Lancet (London, England)* 377, no. 9775 (2011): 1429–37, https://doi.org/10.1016/S0140-6736(10)62353-7. Attached as **Exhibit "39"** to this Affidavit.
[52] Levengood et al., 'Supervised Injection Facilities as Harm Reduction'. Attached as **Exhibit "38"** to this Affidavit.
[53] Kennedy, Karamouzian, and Kerr, 'Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: A Systematic Review'. Attached as **Exhibit "36"** to this Affidavit.
[54] Potier et al., 'Supervised Injection Services'. Attached as **Exhibit "37"** to this Affidavit.
[55] M.-J. Milloy and Evan Wood, 'Emerging Role of Supervised Injecting Facilities in Human Immunodeficiency Virus Prevention', *Addiction (Abingdon, England)* 104, no. 4 (April 2009): 620–21, https://doi.org/10.1111/j.1360-0443.2009.02541.x. Attached as **Exhibit "40"** to this Affidavit.
[56] Salmon et al., 'Injecting-Related Injury and Disease among Clients of a Supervised Injecting Facility'.https://doi.org/10.1016/j.drugalcdep.2008.12.002. Attached as **Exhibit "35"** to this Affidavit.
[57] Thomas Kerr et al., 'The Role of Safer Injection Facilities in the Response to HIV/AIDS among Injection Drug Users', *Current HIV/AIDS Reports* 4, no. 4 (7 November 2007): 158, https://doi.org/10.1007/s11904-007-0023-8. Attached as **Exhibit "41"** to this Affidavit.

37. Frequent attendance at SCS has also been associated with increased participation in substance use treatment programs,[58] and initiation of withdrawal management,[59] and methadone treatment.[60,61,62,63] In Vancouver, among SCS participants, people who regularly attend the SCS were approximately 70% more likely to enroll in withdrawal management programs[64] and 30% more likely to initiate any form of substance use treatment and achieve subsequent declines in frequency of injection drug use after initiating treatment.[65]

38. Given these and other positive health outcomes, it is not surprising that longitudinal cohort research has demonstrated that frequent SCS use (i.e., at least once per week) is associated with reduced risk of all-cause mortality for people who inject drugs on Vancouver's downtown eastside.[66]

39. Beyond public health benefit, peer-reviewed research to date indicates that SCS are cost-saving;[67] do not increase substance use or prolong substance use trajectories;[68] do not increase crime;[69,70] and are associated with objective declines in public drug use and/or improperly discarded injection supplies.[71,72]

[58] Vendula Belackova et al., '"Beyond Safer Injecting"—Health and Social Needs and Acceptance of Support among Clients of a Supervised Injecting Facility', *International Journal of Environmental Research and Public Health* 16, no. 11 (2019): 2032, https://doi.org/10.3390/ijerph16112032. Attached as **Exhibit "42"** to this Affidavit.
[59] Evan Wood et al., 'Rate of Detoxification Service Use and Its Impact among a Cohort of Supervised Injecting Facility Users', *Addiction* 102, no. 6 (2007): 916–19, https://doi.org/10.1111/j.1360-0443.2007.01818.x. Attached as **Exhibit "43"** to this Affidavit.
[60] Kora DeBeck et al., 'Injection Drug Use Cessation and Use of North America's First Medically Supervised Safer Injecting Facility', *Drug and Alcohol Dependence* 113, no. 2–3 (January 2011): 172–76, https://doi.org/10.1016/j.drugalcdep.2010.07.023. Attached as **Exhibit "44"** to this Affidavit.
[61] Jo Kimber et al., 'Process and Predictors of Drug Treatment Referral and Referral Uptake at the Sydney Medically Supervised Injecting Centre', *Drug and Alcohol Review* 27, no. 6 (2008): 602–12, https://doi.org/10.1080/09595230801995668. Attached as **Exhibit "45"** to this Affidavit.
[62] M.-J. S. Milloy et al., 'Inability to Access Addiction Treatment and Risk of HIV Infection among Injection Drug Users Recruited from a Supervised Injection Facility', *Journal of Public Health* 32, no. 3 (2010): 342–49, https://doi.org/10.1093/pubmed/fdp089. Attached as **Exhibit "46"** to this Affidavit.
[63] Wood et al., 'Rate of Detoxification Service Use and Its Impact among a Cohort of Supervised Injecting Facility Users'. Attached as **Exhibit "43"** to this Affidavit.
[64] Wood et al., 'Summary of Findings from the Evaluation of a Pilot Medically Supervised Safer Injecting Facility'. Attached as **Exhibit "33"** to this Affidavit.
[65] DeBeck et al., 'Injection Drug Use Cessation and Use of North America's First Medically Supervised Safer Injecting Facility'. Attached as **Exhibit "44"** to this Affidavit.
[66] Mary Clare Kennedy et al., 'Supervised Injection Facility Use and All-Cause Mortality among People Who Inject Drugs in Vancouver, Canada: A Cohort Study', ed. Alexander C. Tsai, PLOS Medicine 16, no. 11 (26 November 2019): e1002964, https://doi.org/10.1371/journal.pmed.1002964. Attached as **Exhibit "47"** to this Affidavit.
[67] Kennedy, Karamouzian, and Kerr, 'Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: A Systematic Review'. Attached as **Exhibit "36"** to this Affidavit.
[68] Potier et al., 'Supervised Injection Services'. Attached as **Exhibit "37"** to this Affidavit.
[69] Kennedy, Karamouzian, and Kerr, 'Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: A Systematic Review'. Attached as **Exhibit "36"** to this Affidavit.
[70] Potier et al., 'Supervised Injection Services'. Attached as **Exhibit "37"** to this Affidavit.
[71] Kennedy, Karamouzian, and Kerr, 'Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: A Systematic Review'. Attached as **Exhibit "36"** to this Affidavit.
[72] Potier et al., 'Supervised Injection Services'. Attached as **Exhibit "37"** to this Affidavit.

History of SCS in Canada

40. In 1994, in response to a growing provincial drug poisoning epidemic, British Columbia's Provincial Chief Coroner formed a task group that published the 'Cain Report,' which included a recommendation that Vancouver explore the opening of a supervised consumption site. The following year, IV Feed--a group of people who use drugs and their allies--opened and operated an unsanctioned site known as the 'Back Alley,' which accommodated around 100 people who inject drugs per evening. The site was closed by police a year later.[73]

41. Efforts to establish SCS in Vancouver picked up again between 2000 and 2001 when the municipal government released a policy endorsing implementation of two facilities, and a community coalition of people who use drugs, healthcare professionals, researchers, and families developed a formal proposal to implement SCS in the city. Around the same time another unsanctioned supervised consumption site, the '327 Carrall Street Safe Injection Facility,' opened and operated for 184 days prior to being closed following pressure from police and policymakers.[74]

42. In 2002, nurses at Vancouver's Dr. Peter Centre, a specialized subacute care facility for people living with HIV, began supervising illegal drug injections for their program participants, an activity that they interpreted as falling under their formal scope of practice. This was later affirmed by their provincial regulatory college, which found that nurses had an "ethical obligation"[75] (pg. 2) to engage in this practice given the real risk of harm that could arise from unsupervised drug consumption.[76] The Dr. Peter Centre would continue to provide SCS without a formal federal exemption for the next fourteen years.

43. On September 21, 2003, Insite, the first legally sanctioned supervised consumption service in Canada opened in Vancouver's downtown eastside. The operator, Portland Hotel Society, worked with the regional health authority and Health Canada to secure a 3-year pilot exemption from the federal Minister of Health under section 56 of the *Controlled Drugs and Substances Act* (**"CDSA"**).[77] In Canada, such an exemption is required to ensure SCS staff and clients are not prosecuted for drug possession or trafficking offences.

44. Insite's exemption was contingent on participation in a rigorous scientific evaluation of the facility. The evaluation was conducted by researchers affiliated with the British Columbia

[73] Thomas Kerr et al., 'Supervised Injection Facilities in Canada: Past, Present, and Future', *Harm Reduction Journal* 14, no. 1 (December 2017), https://doi.org/10.1186/s12954-017-0154-1. Attached as **Exhibit "48"** to this Affidavit.
[74] Kerr et al., 'Supervised Injection Facilities in Canada'. Attached as **Exhibit "48"** to this Affidavit.
[75] Kerr et al. Attached as **Exhibit "48"** to this Affidavit.
[76] Kerr et al. Attached as **Exhibit "48"** to this Affidavit.
[77] Kerr et al. Attached as **Exhibit "48"** to this Affidavit.

Centre for Excellence in HIV/AIDS and the University of British Columbia. They found that Insite was achieving its objectives of reducing drug poisoning and infectious disease transmission risks, and connecting people accessing the service to substance use treatment and other healthcare, without increasing substance use, crime, or other negative impacts.[78]

45. Despite these positive peer-reviewed research findings, Insite encountered difficulty renewing its section 56 exemption. In 2006, the last year of their pilot exemption, the Conservative Party of Canada came to power after forming a minority government. Prime Minister Stephen Harper, speaking during the election campaign, would not publicly commit to extending Insite, indicating that his party's drug policy would focus on enforcement, treatment, and prevention instead.[79]

46. The new federal Minister of Health claimed that science on Insite was mixed and would go on to make disparaging remarks about the facility in the media, describing it as "an abomination"[80] (pg. 237) at the International AIDS Conference in 2008. His position was based in part on a quasi-scientific critique commissioned by the Royal Canadian Mounted Police, and written by Dr. Colin Mangham, an anti-harm reduction advocate. The report, published on a website funded by the Drug Free America Foundation, questioned the validity of Insite's evaluation.[81] This report has since been discredited.[82,83]

47. Instead of renewing Insite's exemption, the Minister granted a temporary extension and directed Health Canada to convene an Expert Advisory Committee to externally review the evaluation findings. The committee confirmed Insite's public health benefits and lack of negative community impact in 2008.[84] But by mid-2007, fearing the facility would be shut down as part of an anti-harm reduction policy agenda, the Portland Hotel Society, Dean Wilson and Shelley Tomic (two Insite clients), and the Vancouver Area Network of Drug Users initiated a court action to secure the facility's continued operation.[85]

48. The case was ultimately heard by the Supreme Court of Canada. In an unanimous decision the Court found that Insite prevented drug poisoning deaths and risky drug injection

[78] Kerr et al. Attached as **Exhibit "48"** to this Affidavit.
[79] Neil Boyd, 'Lessons from INSITE, Vancouver's Supervised Injection Facility: 2003–2012', *Drugs: Education, Prevention and Policy* 20, no. 3 (1 June 2013): 234–40, https://doi.org/10.3109/09687637.2012.755495. Attached as **Exhibit "49"** to this Affidavit.
[80] Boyd, 'Lessons from INSITE, Vancouver's Supervised Injection Facility'. Attached as **Exhibit "49"** to this Affidavit.
[81] Elaine Hyshka et al., 'Canada Moving Backwards on Illegal Drugs', *Canadian Journal of Public Health / Revue Canadienne de Sante'e Publique* 103, no. 2 (2012): 125–27. Attached as **Exhibit "50"** to this Affidavit.
[82] Hyshka, Bubela, and Wild, 'Prospects for Scaling-up Supervised Injection Facilities in Canada'. Attached as **Exhibit "1"** to this Affidavit.
[83] Boyd, 'Lessons from INSITE, Vancouver's Supervised Injection Facility'. https://doi.org/10.3109/09687637.2012.755495**.** Attached as **Exhibit "49"** to this Affidavit.
[84] Boyd, 'Lessons from INSITE, Vancouver's Supervised Injection Facility'. Attached as **Exhibit "49"** to this Affidavit.
[85] Hyshka, Bubela, and Wild, 'Prospects for Scaling-up Supervised Injection Facilities in Canada'. Attached as **Exhibit "1"** to this Affidavit.

practices, without increasing public disorder, and concluded that the Minister's decision to not renew its exemption violated the section 7 *Charter* rights of clients and staff.[86]

49. The Court ordered the Minister to immediately reverse his decision and instructed that future section 56 SCS exemptions should be granted if, as with Insite, "the evidence indicates that a supervised injection site will decrease the risk of death and disease, and there is little or no evidence that it will have a negative impact on public safety."[87] (pg. 192) The Court further specified five factors that must be considered in making the decision, including:

- *evidence, if any, on the impact of such a facility on crime rates,*
- *the local conditions indicating a need for such a supervised injection site,*
- *the regulatory structure in place to support the facility,*
- *the resources available to support its maintenance,*
- *and expressions of community support or opposition.*[88]

50. The federal government responded to the Supreme Court of Canada's ruling by passing *Bill C-2 (Respect for Communities Act)* in what was by then a Conservative majority parliament. The legislation, adopted in June 2015, amended the *CDSA* to introduce a new section 56.1, which created a specific exemption regime for SCS and outlined 26 criteria that applicants must meet prior to having their application considered.[89] The excerpted text below delineates these criteria [emphasis added]:

> *(3) The Minister may consider an application for an exemption for a medical purpose under subsection (2) that would allow certain activities to take place at a supervised consumption site only after the following have been submitted:*
>
> *(a)* ***scientific evidence demonstrating that there is a medical benefit*** *to individual or public health associated with access to activities undertaken at supervised consumption sites;*
>
> *(b) a* ***letter from the provincial minister who is responsible for health*** *in the province in which the site would be located that*
> *(i)* ***outlines his or her opinion*** *on the proposed activities at the site,*
> *(ii)* ***describes how those activities are integrated within the provincial health care system****, and*
> *(iii)* ***provides information about access to drug treatment services, if any, that are available*** *in the province for persons who would use the site;*

[86] Hyshka, Bubela, and Wild. Attached as **Exhibit "1"** to this Affidavit.
[87] Canada (Attorney General) v. PHS Community Services Society, No. File No.: 33556. (Supreme Court of Canada 12 September 2011). Attached as **Exhibit "51"** to this Affidavit.
[88] *Canada (Attorney General) v. PHS Community Services Society*. Attached as **Exhibit "51"** to this Affidavit.
[89] 'Bill C-2: Respect for Communities Act', Pub. L. No. C–2, 62-63-64 (2015), https://parl.ca/DocumentViewer/en/41-2/bill/C-2/royal-assent. Attached as **Exhibit "52"** to this Affidavit.

*(c) a **letter from the local government of the municipality** in which the site would be located that outlines its opinion on the proposed activities at the site, including any concerns with respect to public health or safety;*

*(d) a description by the applicant of the **measures that have been taken or will be taken to address any relevant concerns outlined in the letter referred to in paragraph (c)**;*

*(e) **a letter from the head of the police force** that is responsible for providing policing services to the municipality in which the site would be located that outlines his or her opinion on the proposed activities at the site, including any concerns with respect to public safety and security;*

*(f) a description by the applicant of the **proposed measures, if any, to address any relevant concerns outlined in the letter referred to in paragraph (e)**;*

*(g) **a letter from the lead health professional, in relation to public health, of the government of the province** in which the site would be located that outlines their opinion on the proposed activities at the site;*

*(h) **a letter from the provincial minister responsible for public safety** in the province in which the site would be located that outlines his or her opinion on the proposed activities at the site;*

*(i) a **description of the potential impacts of the proposed activities at the site on public safety**, including the following:*

*(i) **information, if any, on crime and public nuisance** in the vicinity of the site and information on crime and public nuisance in the municipalities in which supervised consumption sites are located,*
*(ii) **information, if any, on the public consumption of illicit substances** in the vicinity of the site and information on the public consumption of illicit substances in the municipalities in which supervised consumption sites are located, and*
*(iii) **information, if any, on the presence of inappropriately discarded drug-related litte**r in the vicinity of the site and information on the presence of inappropriately discarded drug-related litter in the municipalities in which supervised consumption sites are located;*

*(j) **law enforcement research or statistics, if any,** in relation to the information required under subparagraphs (i)(i) to (iii);*

*(k) relevant information, including **trends, if any, on the number of persons who consume illicit substances in the vicinity of the site** and in the municipality in which the site would be located;*

*(l) relevant information, including **trends, if any, on the number of persons with infectious diseases that may be in relation to the consumption of illicit substances** in the vicinity of the site and in the municipality in which the site would be located;*

(m) relevant information, including ***trends, if any, on the number of deaths, if any, due to overdose —*** *in relation to activities that would take place at the site — that have occurred in the vicinity of the site and in the municipality in which the site would be located;*

(n) ***official reports, if any, relevant to the establishment of a supervised consumption site,*** *including any coroner's reports;*

(o) ***a report of the consultations held with the professional licensing authorities for physicians and for nurses*** *for the province in which the site would be located that contains each authority's opinion on the proposed activities at the site;*

(p) ***a report of the consultations held with a broad range of community groups*** *from the municipality in which the site would be located that includes*
(i) ***a summary of the opinions of those groups*** *on the proposed activities at the site,*
(ii) copies of all written submissions received, and
(iii) ***a description of the steps that will be taken*** *to address any relevant concerns that were raised during the consultations;*

(q) ***a financing plan*** *that demonstrates the feasibility and sustainability of operating the site;*

(r) ***a description of the drug treatment services available at the site****,* ***if any,*** *for persons who would use the site* ***and the information that would be made available to those persons in relation to drug treatment services available elsewhere;***

(s) relevant information, including ***trends, on loitering in a public place*** *that may be related to certain activities involving illicit substances,* ***on trafficking of controlled substances and on minor offence rates*** *in the vicinity of the site, if any;*

(t) ***information on any public health emergency*** *in the vicinity of the site or in the municipality in which the site would be located that may be in relation to activities involving illicit substances as declared by a competent authority with respect to public health, if any;*

(u) ***a description of the measures that will be taken to minimize the diversion of controlled substances*** *or precursors and the risks to the health and the safety and security of persons at the site, or in the vicinity of the site, including staff members,* ***which measures must include the establishment of procedures***
(i) to ***dispose of controlled substances****, precursors, and any thing that facilitates their consumption, including how to transfer them to a police officer,*
(ii) ***to control access to the site****, and*
(iii) ***to prevent the loss or theft of controlled substances*** *and precursors;*

(v) ***a description of record keeping procedures for the disposal, loss, theft and transfer of controlled substances and precursors*** *— and any thing that facilitates their consumption — left at the site;*

(w) ***the name, title and resumé, including relevant education and training, of the proposed responsible person in charge, of each of their proposed alternate responsible persons, and of each of the other proposed key staff members****;*

(x) ***a document*** *issued by a Canadian police force* ***in relation to each person referred to in paragraph (w), stating whether, in the 10 years before the day on which the application is made, in respect of a designated drug offence or a designated criminal offence****, the person was*
(i) convicted as an adult,
(ii) convicted as a young person in ordinary court, as those terms were defined in subsection 2(1) of the Young Offenders Act, chapter Y-1 of the Revised Statutes of Canada, 1985, immediately before that Act was repealed, or
(iii) a young person who received an adult sentence, as those terms are defined in subsection 2(1) of the Youth Criminal Justice Act;

(y) ***if any of the persons referred to in paragraph (w) has ordinarily resided in a country other than Canada*** *in the 10 years before the day on which the application is made,* ***a document issued by a police force of that country*** *stating whether in that period that person*
(i) was convicted as an adult for an offence committed in that country that, if committed in Canada, would have constituted a designated drug offence or a designated criminal offence, or
(ii) received a sentence — for an offence they committed in that country when they were at least 14 years old but less than 18 years old that, if committed in Canada, would have constituted a designated drug offence or a designated criminal offence — that was longer than the maximum youth sentence that could have been imposed under the Youth Criminal Justice Act for such an offence;

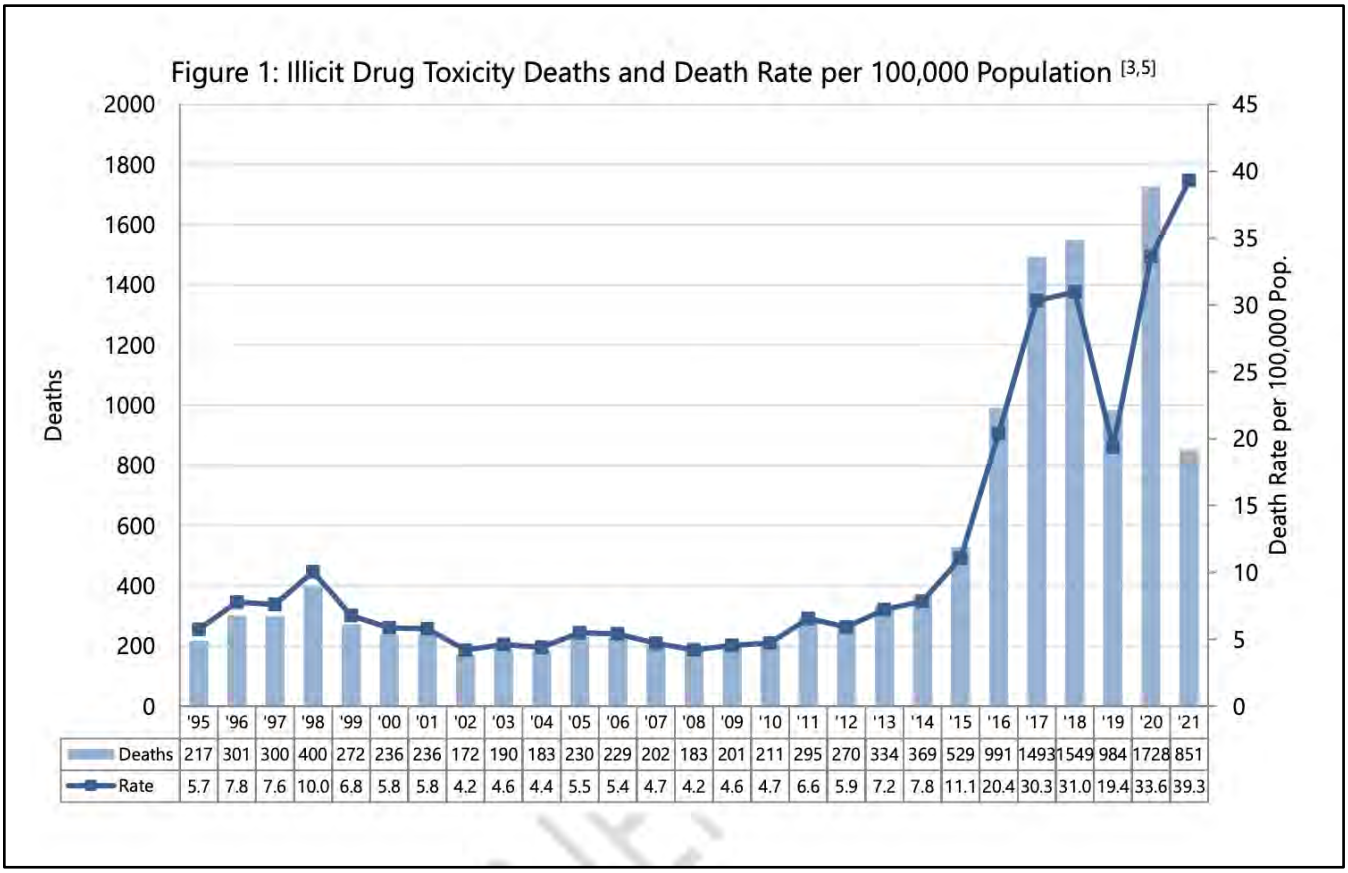
(z) ***any other information that the Minister considers relevant*** *to the consideration of the application; and*
(z.1) any prescribed information that is submitted in the prescribed manner.

51. This new legislation proved to be a significant barrier to securing exemptions and no new SCS exemption applications were approved until 2016.

52. Two factors precipitated the eventual expansion of SCS in Canada. The first was increasing rates of drug poisoning deaths in various parts of the country. For example, between 2011--when the Supreme Court of Canada released its *PHS Community Services Society ruling*--and 2016, when Vancouver's second federally-sanctioned SCS was approved (at the Dr. Peter Centre), the provincial illegal drug poisoning death rate more than tripled, and the number of deaths increased from 295 to 991 (Figure 5).[90]

[90] British Columbia Coroners Service, 'Illicit Drug Toxicity Deaths in BC: January 1, 2011 - May 31, 2021', 1 January 2011. Attached as **Exhibit "53"** to this Affidavit.

Figure 5



Source: British Columbia Coroners Service. Illicit Drug Toxicity Deaths in BC: January 1, 2011 – May 31, 2021. June 29, 2021. Victoria: Government of British Columbia. 26 pp. Available from: https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicit-drug.pdf

53. The second factor supporting the expansion of SCS was the election of a Liberal Party of Canada majority government in November 2015, led by Prime Minister Justin Trudeau, who had previously voiced support for SCS and harm reduction.[91]

54. The new government approved a long-pending federal exemption application from the Dr. Peter Centre (which had been offering SCS without a formal federal exemption since 2002) in January 2016, and renewed Insite's exemption in March 2016.

55. These SCS exemptions notwithstanding, many prospective applicants (often small non-profit organizations or informal community coalitions) continued to experience difficulties

[91] Annie Foreman-Mackey and Cecile Kazatchkine, 'Overdue for a Change: Scaling up Supervised Consumption Services in Canada — Canadian HIV/AIDS Legal Network' (Canadian HIV/AIDS Legal Network, 11 December 2018), http://www.aidslaw.ca/site/overdue-for-a-change-scaling-up-supervised-consumption-services-in-canada/?lang=en. Attached as **Exhibit "54"** to this Affidavit.

meeting the arduous administrative burden imposed by the previous federal government's SCS legal regime.

56. To address this challenge and facilitate the opening of more SCS, the government repealed the *Respect for Communities Act* and introduced *Bill C-37* (*An Act to Amend the CDSA*), which "did not remove section 56.1 of the *CDSA* (which creates a specific exemption regime for [SCS] for a medical purpose), but replaced previous onerous legislative requirements with simpler, streamlined requirements." [92] (pg. 4)

57. These requirements mirror the five factors set out by Supreme Court of Canada in *PHS Community Services Society*, and include information "regarding the intended public health benefits of the site and information if any, related to

> *(a) the impact of the site on crime rates;*
> *(b) the local conditions indicating a need for the site;*
> *(c) the administrative structure in place to support the site;*
> *(d) the resources available to support the maintenance of the site; and*
> *(e) expressions of community support or opposition."* [93] (pg. 44)

58. Additional Bill C-37 amendments removed language stating that SCS exemptions should only be granted in "exceptional circumstances,"[94] (pg.2) and allowed the Minister to start reviewing applications prior to the submission of all required materials. To enhance transparency around SCS decision-making, the bill also set out a requirement in law that the Minister provide their exemption decision publicly in writing, and include reasons in the case of a refusal.[95]

59. The new legislation came into effect in May 2017 and five months later, the number of exempted SCS had increased from 2 to 24. As of August 30 2021 there were 37 federally-exempted SCS operating in Canada.[96]

[92] Foreman-Mackey and Kazatchkine, 'Overdue for a Change: Scaling up Supervised Consumption Services in Canada — Canadian HIV/AIDS Legal Network'. Attached as **Exhibit "54"** to this Affidavit.
[93] 'Bill C-37: An Act to Amend the Controlled Drugs and Substances Act and to Make Related Amendments to Other Acts' (2017), https://www.parl.ca/DocumentViewer/en/42-1/bill/c-37/royal-assent. Attached as **Exhibit "55"** to this Affidavit.
[94] Bill C-2: Respect for Communities Act, 2. Attached as **Exhibit "52"** to this Affidavit.
[95] Foreman-Mackey and Kazatchkine, 'Overdue for a Change: Scaling up Supervised Consumption Services in Canada — Canadian HIV/AIDS Legal Network'. Attached as **Exhibit "54"** to this Affidavit.
[96] Health Canada, 'Supervised Consumption Sites: Status of Applications' (Ottawa, ON: Government of Canada, 13 January 2021), https://www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/status-application.html. Attached as **Exhibit "56"** to this Affidavit.

The Advent of Overdose Prevention Sites (OPS)

60. In addition to ministerially-exempted SCS, beginning in late 2016, overdose prevention sites ("**OPS"**) were established in some parts of the country, originally without formal authorization.[97]

61. OPS are SCS that are lower budget, more temporary in design (e.g. implemented in the absence of purpose-built space), frequently staffed by volunteers, and focused primarily on preventing drug poisoning deaths.[98] As a result, they may provide fewer ancillary supports, such as HIV testing or counselling, relative to federally-exempted SCS. In Canada there are legal subtleties that distinguish OPS from SCS but in practice this distinction is not necessary or meaningful, and OPS are best viewed as part of the continuum of diverse SCS models[99] (p. 12).

62. Canada's first overdose prevention site, the 'Overdose Prevention Society' opened in Vancouver in fall of 2016 without a federal exemption or approval from any level of government.[100] It was co-founded by two activists (Ann Livingston and Sarah Blyth) in response to increasing drug poisonings at the open market on Hastings Street. Rather than continuously responding to frequent calls for emergency assistance in and around the site, the pair set up a pop-up tent canopy with space to consume drugs, stocked it with medical and harm reduction supplies, and staffed it with volunteers trained in rescue breathing, naloxone administration, and emergency first aid.[101]

63. As B.C.'s drug poisoning crisis worsened, additional OPS 'popped up' in other parts of the neighbourhood,[102] and led to the British Columbia Minister of Health enacting a ministerial order on December 9, 2016 that supported

> *the implementation of these sites across the province--again, without seeking a federal ministerial exemption (for services being characterized as [OPS] rather than [SCS]). The order was issued under the province's Health Emergency Services Act and Health*

[97] Foreman-Mackey and Kazatchkine, 'Overdue for a Change: Scaling up Supervised Consumption Services in Canada — Canadian HIV/AIDS Legal Network'. Attached as **Exhibit "54"** to this Affidavit.
[98] Foreman-Mackey and Kazatchkine. Attached as **Exhibit "54"** to this Affidavit.
[99] Foreman-Mackey and Kazatchkine. Attached as **Exhibit "54"** to this Affidavit.
[100] Foreman-Mackey and Kazatchkine. Attached as **Exhibit "54"** to this Affidavit.
[101] Jill Slattery and Nadia Stewart, 'Pop-up Safe Injection Site Opens in Vancouver Downtown Eastside | Globalnews.Ca', *Global News*, accessed 8 August 2021, https://globalnews.ca/news/3002250/pop-up-safe-injection-site-opens-in-vancouver-downtown-eastside/. Attached as **Exhibit "57"** to this Affidavit.
[102] Yvette Brend, 'Activists Bring More Pop-up Injections Sites to Vancouver's Overdose "battle Zone" | CBC News', *CBC*, 21 November 2016, https://www.cbc.ca/news/canada/british-columbia/drug-overdose-vancouver-bc-pop-up-battle-zone-insite-injection-blue-hue-1.3860193. Attached as **Exhibit "58"** to this Affidavit.

> *Authorities Act, in the context of a public health emergency declared in April that year. Since then, more than 20 OPS have opened in BC.*[103] (pg. 11)

64. The British Columbia government stated that this "extraordinary measure"[104] (pg. 1) was taken in the interest of urgent action that was not possible under the *Respect for Communities Act* s.56(1) SCS legal regime.

65. In response, the federal government announced they would be amending the *CDSA* to speed up the process and reduce the burden on SCS exemption applicants, and tabled Bill C-37 in Parliament a shortly after.[105]

66. In August 2017, Canadian Association of People Who Use Drugs, a peer-run non-profit organization, released, *This Tent Saves Lives*, a guide to opening an OPS in your community.[106] Activists and volunteers outside of BC also set up "non-authorized" OPS in Ottawa and Toronto, which operated for several months without federal, provincial, or municipal approval.[107]

67. In December 2017, Health Canada announced a formal pathway for authorizing OPS on an emergency basis, stating that provinces and territories could request a 'class exemption' under s. 56(1) of the *CDSA* for operating OPS "in the public interest."[108] (pg. 7). Characterizing these sites as OPS, or "Urgent Public Health Need Sites" as Health Canada formally refers to them, enabled applicants to respond quickly to escalating drug poisoning risks and avoid submitting the full scope of materials required to secure an SCS exemption under s. 56.1.[109]

68. Health Canada's OPS application form requires:

- a description of the proposed services to be offered;
- the area where the site(s) will be located, and the proposed hours of operation.

[103] Foreman-Mackey and Kazatchkine, 'Overdue for a Change: Scaling up Supervised Consumption Services in Canada — Canadian HIV/AIDS Legal Network'.http://www.aidslaw.ca/site/overdue-for-a-change-scaling-up-supervised-consumption-services-in-canada/?lang=en. Attached as **Exhibit "54"** to this Affidavit.
[104] The Canadian Press, 'B.C. Enacts Ministerial Order to Create Overdose Prevention Sites', *Macleans.Ca*, 13 December 2016, sec. Canada, https://www.macleans.ca/news/canada/b-c-enacts-ministerial-order-to-create-overdose-prevention-sites/. Attached as **Exhibit "59"** to this Affidavit.
[105] Peter Zimonjic and Matthew Kupfer, 'Liberals Say Laws to Make Safe Injection Sites Easier to Open on Way | CBC News', *CBC*, 12 December 2016, https://www.cbc.ca/news/politics/safe-injection-sites-goodale-philpott-1.3892687. Attached as **Exhibit "60"** to this Affidavit.
[106] Sarah Blythe et al., 'This Tent Saves Lives' (Canadian Association of People Who Use Drugs, 31 August 2017), https://capud.ca/node/131.https://capud.ca/node/131Blythe et al. Attached as **Exhibit "61"** to this Affidavit.
[107] Foreman-Mackey and Kazatchkine, 'Overdue for a Change: Scaling up Supervised Consumption Services in Canada — Canadian HIV/AIDS Legal Network'. Attached as **Exhibit "54"** to this Affidavit.
[108] Foreman-Mackey and Kazatchkine. Attached as **Exhibit "54"** to this Affidavit.
[109] Foreman-Mackey and Kazatchkine. Attached as **Exhibit "54"** to this Affidavit.

- information and/or evidence to support the urgent public health need in the region, location, area, or community.
- description of the role of the applicant's organization in determining the location and number of OPS, oversight, application process and requirements
- and confirmation of the funding source.[110]

69. OPS applicants also have the option of appending additional materials including supporting reports, data, and letters from key stakeholders (community leaders, elected officials, landlord, local law enforcement, etc.).[111]

70. Qualitative research[112,113,114] indicates that OPS are often lower-barrier or easier-to-access than permanent, federally exempted SCS. This is because some federally-mandated SCS policies and procedures have inadvertently excluded subpopulations of people who use drugs with distinct needs or preferences. Examples here include people who require assistance from peers to inject drugs (e.g. due to medical conditions or disabilities), people who smoke or inhale drugs (i.e. only one SCS in Canada currently accommodates this mode of consumption), and those who want to share or split their drugs with a partner or friend.[115,116,117]

71. While Health Canada has taken recent steps to minimize some of these barriers (i.e. by authorizing peer-assisted injecting, and splitting and sharing within ministerially-exempted SCS), OPS continue to fill a critical care gap for even more marginalized subpopulations of people who use drugs, i.e. those who avoid formal healthcare services and systems due to prior negative experiences of stigma or discrimination, fears of criminalization, and/or a reluctance to disclose their substance use to healthcare providers.[118,119]

[110] Controlled Substances and Cannabis Branch, Office of Controlled Substances, Health Canada, 'Application Form - Subsection 56(1) Exemption from the Controlled Drugs and Substances Act for Urgent Public Health Need Sites', June 2019. Attached as **Exhibit "62"** to this Affidavit.
[111] Controlled Substances and Cannabis Branch, Office of Controlled Substances, Health Canada. Attached as **Exhibit "62"** to this Affidavit.
[112] Ryan McNeil et al., '"People Knew They Could Come Here to Get Help": An Ethnographic Study of Assisted Injection Practices at a Peer-Run "Unsanctioned" Supervised Drug Consumption Room in a Canadian Setting', *AIDS and Behavior* 18, no. 3 (2014): 473–85, https://doi.org/10.1007/s10461-013-0540-y. Attached as **Exhibit "63"** to this Affidavit.
[113] Kora DeBeck et al., 'Public Crack Cocaine Smoking and Willingness to Use a Supervised Inhalation Facility: Implications for Street Disorder', *Substance Abuse Treatment, Prevention, and Policy* 6, no. 1 (2011): 4, https://doi.org/10.1186/1747-597X-6-4. Attached as **Exhibit "64"** to this Affidavit.
[114] Craig L Fry, 'Injecting Drug User Attitudes towards Rules for Supervised Injecting Rooms: Implications for Uptake', *International Journal of Drug Policy* 13, no. 6 (1 December 2002): 471–76, https://doi.org/10.1016/S0955-3959(02)00076-2. Attached as **Exhibit "65"** to this Affidavit.
[115] McNeil et al., '"People Knew They Could Come Here to Get Help"'. Attached as **Exhibit "63"** to this Affidavit.
[116] DeBeck et al., 'Public Crack Cocaine Smoking and Willingness to Use a Supervised Inhalation Facility'. Attached as **Exhibit "64"** to this Affidavit.
[117] Fry, 'Injecting Drug User Attitudes towards Rules for Supervised Injecting Rooms'. Attached as **Exhibit "65"** to this Affidavit.
[118] Ehsan Jozaghi and Vancouver Area Network of Drug Users, 'Exploring the Role of an Unsanctioned, Supervised Peer Driven Injection Facility in Reducing HIV and Hepatitis C Infections in People That Require Assistance during Injection', *Health & Justice* 3, no. 1 (28 August 2015): 16, https://doi.org/10.1186/s40352-015-0028-0. Attached as **Exhibit "66"** to this Affidavit.
[119] McNeil et al., '"People Knew They Could Come Here to Get Help"'. Attached as **Exhibit "63"** to this Affidavit.

72. In addition to creating a more expeditious exemption process for OPS in Canada, Health Canada has also allowed provincial governments to request a 'class exemption' under section 56 of the CDSA, which authorizes them to unilaterally approve OPS, under certain terms and conditions.[120] At the onset of the COVID-19 pandemic, Health Canada also proactively granted these class exemptions to the provinces and territories allowing them to temporarily authorize and operate OPS as a means for:

- *reducing the administrative burden of having organizations applying for a supervised consumption site, or temporary overdose prevention site;" and*
- *creating new spaces, as may be needed, or adjusting existing supervised consumption sites to respect public health guidance*.[121]

73. This policy development further entrenched OPS as the most expedient way to create or expand SCS capacity in response to shifts in local drug poisoning epidemiology.

Implementing SCS and OPS in Alberta

74. The first formal efforts to open federally-exempted SCS in Alberta began in 2012 with the formation of the *Access to Medically Supervised Injection Services in Edmonton* (**"AMSISE"**) community coalition. AMSISE was chaired by Shelley Williams, the Executive Director of HIV Edmonton, a non-profit organization dedicated to making life better for people living with, or affected by, HIV and AIDS.

75. The coalition included over 20 other representatives from Alberta Health Services, community agencies, people and families with lived experience of substance use, healthcare providers, law enforcement, municipal and provincial government, and academic institutions.

76. A main objective of AMSISE was to address HIV, drug poisoning, and other harms associated with drug use in Edmonton's inner city. To that end, the coalition undertook multiple initiatives to understand the feasibility of implementing SCS including: creating a business case; conducting a design charrette; conducting community and stakeholder engagement; and helping secure funding for the Edmonton Drug Use and Health Survey to measure need for, and perspectives on, SCS amongst the local population of people who use drugs.

[120] Foreman-Mackey and Kazatchkine, 'Overdue for a Change: Scaling up Supervised Consumption Services in Canada — Canadian HIV/AIDS Legal Network'. Attached as **Exhibit "54"** to this Affidavit.
[121] Health Canada, 'Questions and Answers - Provincial/Territorial Class Exemptions: For Supervised Consumption Site Operators', 21 April 2020, https://www.drugpolicy.ca/wp-content/uploads/2020/04/Qs-and-As-Class-Exemption-April-20-2020-SCS-FINAL.pdf. Attached as **Exhibit "67"** to this Affidavit.

77. I conducted the Edmonton Drug Use and Health Survey[122] in 2014 as a doctoral researcher at the University of Alberta's School of Public Health. The Principal Investigator of the research was my PhD supervisor, Dr. Cameron Wild, a Professor in health promotion and socio-behavioural sciences and the lead of the Canadian Research Initiative in Substance Misuse's Prairie Node. This survey is to my knowledge, the largest ever quantitative study of injection drug use in Edmonton.

78. The Edmonton Drug Use and Health Survey was designed to better understand the health status and service needs of people who use drugs, particularly those residing in the inner city area (including Boyle Street, McCauley, Central MacDougall, and Downtown neighbourhoods).

79. We recruited 324 people who use drugs from in and around three inner city agencies (Boyle Street Community Services, Boyle McCauley Health Centre, and the Bissell Centre) between April and October 2014 using snowball sampling and street outreach methods. Study eligibility included being at least 15 years of age, reporting regular illegal drug use (at least once per month), and immersion in the street drug scene (two or more days per week spent in the inner city).[123]

80. Eligible participants completed an interviewer-assisted structured survey that contained 121 single and multi-item measures and took on average 50 minutes to complete. The survey instrument was divided into four sections covering: (1) sociodemographic information; (2) substance use, associated risk behaviours, and experiences of harm, (3) participants' health services utilization and unmet healthcare needs; and (4) acceptability of potential new interventions designed to reduce the burden of disease associated with illegal substance use. Participants were provided a cash honorarium for their time and expertise and the University of Alberta's Research Ethics Board approved our study protocol.[124]

81. Of 320 participants included in the final analysis, 206 (65%) were male, 202 (65%) identified as Indigenous, and most were middle-aged with a mean age of 42 years.

82. The sample was street-involved with 290 (91%) spending most of each day in the inner city and 57% reporting unstable housing. In terms of drug use, 247 (77%) reported using

[122] Hyshka et al., 'Risk Behaviours and Service Needs of Marginalized People Who Use Drugs in Edmonton's Inner City: Results from the Edmonton Drug Use and Health Survey'. Attached as **Exhibit "2"** to this Affidavit.
[123] Elaine Hyshka, Jalene Tayler Anderson, and T. Cameron Wild, 'Perceived Unmet Need and Barriers to Care amongst Street-Involved People Who Use Illicit Drugs', *Drug & Alcohol Review* 36, no. 3 (May 2017): 295–304, https://doi.org/10.1111/dar.12427.https://doi.org/10.1111/dar.12427Hyshka, Anderson, and Wild. Attached as **Exhibit "68"** to this Affidavit.
[124] Hyshka et al., 'Risk Behaviours and Service Needs of Marginalized People Who Use Drugs in Edmonton's Inner City: Results from the Edmonton Drug Use and Health Survey'. Attached as **Exhibit "2"** to this Affidavit.

illegal drugs four or more time per week, 297 (91%) reported injecting drugs in the past six months,[125] and 282 (89%) participants reported non-injection drug use in the past six months. All but one participant met clinical criteria for problematic drug use, and 62% (n = 180) met clinical criteria for drug dependence.[126]

83. Overall, the main survey findings documented high rates of comorbid mental health conditions and drug-related risk behaviours. Participants reported difficulty accessing sterile injection equipment and other harm reduction supports, and unmet healthcare needs were very common.[127,128]

84. The survey included several questions regarding the potential offering of SCS in Edmonton, described as "a legally operated indoor facility where people go to inject pre-obtained drugs under the supervision of medically trained workers. People inject there under safe and sterile conditions, and have access to all sterile injecting equipment."[129] (pg. 41).

85. Amongst participants reporting injection drug use in the previous six months, 242 (91%) were willing to access SCS. Participants were asked about potential SCS locations, whether they would use a mobile service, and how far they would be willing to travel to access an SCS. The majority (76%, n = 188) were not willing to travel more than 1 kilometre to access such a site.[130]

86. Participants also answered several questions regarding willingness to use SCS if certain rules were enforced. Figure 6 provides details on participants' views. Overall, the rule with the lowest level of support was if SCS required that people accessing the service show government identification.[131]

[125] Hyshka, Anderson, and Wild, 'Perceived Unmet Need and Barriers to Care amongst Street-Involved People Who Use Illicit Drugs'. Attached as **Exhibit "68"** to this Affidavit.
[126] Hyshka et al., 'Risk Behaviours and Service Needs of Marginalized People Who Use Drugs in Edmonton's Inner City: Results from the Edmonton Drug Use and Health Survey'. Attached as **Exhibit "2"** to this Affidavit.
[127] Hyshka et al. Attached as **Exhibit "2"** to this Affidavit.
[128] Hyshka, Anderson, and Wild, 'Perceived Unmet Need and Barriers to Care amongst Street-Involved People Who Use Illicit Drugs'. Attached as **Exhibit "68"** to this Affidavit.
[129] Hyshka et al., 'Risk Behaviours and Service Needs of Marginalized People Who Use Drugs in Edmonton's Inner City: Results from the Edmonton Drug Use and Health Survey'. Attached as **Exhibit "2"** to this Affidavit.
[130] Hyshka et al. Attached as **Exhibit "2"** to this Affidavit.
[131] Hyshka et al. Attached as **Exhibit "2"** to this Affidavit.

Figure 6

Edmonton Drug Use and Health Survey participants' views on potential SCS rules (n = 261)

"Would you use a supervised injection facility in Edmonton if…"	Yes	No
Injections are supervised by trained staff who can respond to overdoses	95%	5%
"No smoking crack" inside the facility	93%	7%
Have to hang around for 10-15 minutes after injecting so your health can be monitored	90%	10%
30-minute time limit for injections	86%	14%
Have to register each time you use it	84%	16%
May have to sit and wait until an injection space opens up	84%	17%
Not allowed to share or split drugs	82%	18%
Not allowed to assist each other with injections	78%	22%
Video surveillance cameras on site to protect users	71%	29%
Must live in the neighbourhood	40%	60%
Required to show identification	**36%**	**64%**

Adapted from: Hyshka E, Anderson J, Wong J-A, Wild TC. Risk behaviours and service needs of marginalized people who use drugs in Edmonton's Inner City: Results from the Edmonton Drug Use and Health Survey. January 7, 2016. Edmonton: University of Alberta School of Public Health (decimals rounded; emphasis added).

87. I compiled these and other survey findings into a comprehensive report[132] that was submitted to Alberta Health (one of the funders of the survey research).

88. AMSISE also used the findings to inform the development of its SCS proposal. Details of the proposal and the broader survey findings were shared with dozens of community stakeholders and multiple municipal, provincial, and federal key decision-makers.

89. AMSISE's efforts culminated in the provincial government ('**HMQA'**) granting the coalition $230,000 in October 2016 to conduct a formal community consultation and finalize site selection, undertake required renovations, and prepare a federal SCS exemption application.

[132] Hyshka et al. Attached as **Exhibit "2"** to this Affidavit.

90. This grant ultimately led to the implementation of three small-scale SCS integrated into pre-existing health and social service agencies that were already serving people who use drugs.

91. The sites included the Boyle McCauley Health Centre (a community-based, primary care clinic); Boyle Street Community Services (a community centre and drop-in serving unstably housed and homeless people); and the George Spady (an overnight shelter and detoxification facility). A fourth SCS was also implemented at Edmonton's Royal Alexandra Hospital for inpatients only (no public access).

92. These four SCS received federal s. 56.1 exemptions and opened in Edmonton in 2018 with funding from HMQA.[133]

93. Shortly after the three community-based SCS were exempted, the Chinatown Area Business Association sought a judicial review of the exemption decision in Federal Court. In a 2019 ruling, Justice Mosley dismissed the application finding that the minimal requirements of procedural fairness owed to the Chinatown and Area Business Association were met.[134]

94. In addition to awarding funding to AMSISE in October 2016, HMQA allocated $500,000 (through the Alberta Community Council on HIV) to groups in seven other cities (Calgary, Red Deer, Grande Prairie, Lethbridge, Medicine Hat, Ft. McMurray, and Edson/West Yellowhead) to conduct the Alberta Drug Use and Health Survey, which directly replicated my Edmonton Drug Use and Health Survey, and conduct SCS needs assessments in their own communities.

95. Ultimately these needs assessments led to grant proposals and HMQA funding to operate fixed site SCS in Calgary (AHS' Sheldon M. Chumir Health Centre; opened October 2017) and Lethbridge (ARCHES, opened February 2018); and a mobile SCS in Grande Prairie (Northreach; opened March 2019).

96. Shortly after first approving funding for SCS in Alberta, HMQA commissioned a third-party provincial evaluation of these services. The Institute of Health Economics in Edmonton was tasked with examining the impact of SCS on both people who use drugs, and residents and businesses in the surrounding communities.[135] The Institute for Health

[133] Minister's Opioid Emergency Response Commission, 'Minister's Opioid Emergency Response Commission Recommendations to the Minister - Updated July 5, 2018', 5 July 2018. Attached as **Exhibit "69"** to this Affidavit.
[134] Chinatown & Area Business Association v. Canada - Judgment and Reasons (Federal Court 27 February 2019). Attached as **Exhibit "70"** to this Affidavit.
[135] Minister's Opioid Emergency Response Commission, 'Minister's Opioid Emergency Response Commission Record of Discussion: August 17-18, 2021', 17 August 2017. Attached as **Exhibit "69"** to this Affidavit.

Economics is an independent, not-for-profit organization with a mission to consistently provide relevant, timely and impactful evidence that supports informed health system policy and investment decisions by public and private partners.

97. In Red Deer, after the municipality, HMQA, and other stakeholders hit an impasse on a permanent SCS location, a temporary OPS was established (under a provincial OPS class exemption) by Turning Point in October 2018 and is still operating as of this writing.

98. During 2018, two other temporary OPS operated briefly under the HMQA's class exemption. One in Standoff after the Blood Tribe declared a local state of emergency and reported a spike in drug poisoning events,[136] and another at the Edmonton Convention Centre during a national conference on substance use.[137]

99. HMQA also funded HIV Community Link (a non-profit operating in Calgary and parts of Southern Alberta) to construct a fixed site SCS in Medicine Hat and commission a new mobile SCS bus to be deployed in underserved areas of Calgary. These SCS were under construction when a new provincial government was elected in April 2019. Efforts were also ongoing in Red Deer to establish a permanent SCS there.

100. As a condition of their provincial grant funding agreements, SCS operators provide regular reports of client demographics, utilization patterns, and adverse events to HMQA. To date, the data collected by HMQA show that from opening until June 30, 2021, SCS in Alberta have supervised 964,400 visits and responded to 12,353 potentially life-threatening drug poisoning events.[138] No deaths have occured in any of these SCS.

Shifting SCS and OPS policy in Alberta

101. The election of the United Conservative Party government in 2019 marked a shift in SCS and harm reduction policy in Alberta.

102. In the run up to the election, Premier Jason Kenney told the Lethbridge Herald[139] that he doubted the scientific evidence supporting SCS and indicated that he would oppose more SCS in Alberta if elected:

[136] Yolande Cole, 'Blood Tribe to Get Temporary Overdose Prevention Site as State of Emergency Continues', *Calgaryherald*, accessed 12 August 2021, https://calgaryherald.com/news/local-news/blood-tribe-to-get-temporary-overdose-prevention-site-as-state-of-emergency-continues. Attached as **Exhibit "71"** to this Affidavit.
[137] Brooks et al., 'Supporting the Full Participation of People Who Use Drugs in Policy Fora'. Attached as **Exhibit "4"** to this Affidavit.
[138] Government of Alberta, 'Substance Use Surveillance Data'. https://www.alberta.ca/substance-use-surveillance-data.aspxGovernment of Alberta. Attached as **Exhibit "72"** to this Affidavit.
[139] Tim Kalinowski, 'Kenney Opposes Consumption Sites', *Lethbridge Herald*, 28 February 2018. Attached as **Exhibit "73"** to this Affidavit.

> "the real question isn't how can we help people poison themselves? The real question is: how the hell are these synthetic, foreign-produced drugs hitting the streets in Alberta? Why aren't we massively increasing funding for the Canada's Border Service Agency to interdict the importation of deadly drugs from China and elsewhere?"[140] (pg. 1)

103. The United Conservative Party's 2019 election platform also promised to:

> - *only endorse new supervised consumption sites if there have been extensive consultations with affected communities, including residents and business owners, and if there is a robust evidence-based analysis of the socio-economic impact of a potential drug consumption site;*
> - *only endorse new overdose prevention sites if they have clear plans to provide treatment services;*
> - *conduct an evidence-based socio-economic analysis of the impact of existing drug consumptions* [sic] *sites.*
> - *consult with local communities, police, municipalities, and others on the location of existing sites to determine if they are optimal, or if better locations could be found that would reduce the impact of crime, discarded needles, and other negative social and economic impacts on local neighbourhoods*.[141] (pg. 54)

104. In June 2019, HMQA announced a moratorium on funding new SCS in Alberta, and paused the opening of two new SCS in Medicine Hat and Calgary. Around the same time, the government also quietly cancelled the Institute for Health Economics' ongoing SCS evaluation before it could be completed.

105. In July 2019, Hon. Jason Luan, Associate Minister of Mental Health and Addictions expressed skepticism of the peer-reviewed scientific research supporting SCS, stating:

> *these reviews never reference the impact to the surrounding community & business. They only focused on the benefits of harm reduction to the users. How much of the so called 'evidence-based research' is funded by the multi billion dollar Pharma industry? Full disclosure is needed.*[142] (pg. 2)

106. It should be noted that systematic reviews of multiple scientific studies that examine the impacts of SCS on crime and public disorder have found no objective evidence of negative

[140] Kalinowski. Attached as **Exhibit "73"** to this Affidavit.
[141] United Conservatives Alberta, 'United Conservatives Alberta Strong & Free - Getting Alberta Back to Work', n.d., https://static.unitedconservative.ca/2020/07/Alberta-Strong-and-Free-Platform-1.pdf. Attached as **Exhibit "74"** to this Affidavit.
[142] David Bell, 'Deleted Tweet about Big Pharma by Associate Minister for Addictions "laughably Absurd," Says Scientist | CBC News', *CBC*, 17 July 2019, https://www.cbc.ca/news/canada/calgary/deleted-tweet-by-associate-minister-jason-luan-draws-condemnation-1.5215730. Attached as **Exhibit "75"** to this Affidavit.

impacts on the surrounding community.[143,144] Further, authors of peer-reviewed studies are required to disclose funding sources and potential conflicts of interest prior to publishing. To my knowledge, no scientific studies of SCS (which monitor consumption of illegal street drugs, not pharmaceutical drugs taken as prescribed) have been funded by the pharmaceutical industry.

107. In August 2019, HMQA appointed an 8 person committee to examine the social and economic impacts of current and proposed SCS in Alberta. The objectives of the review were to:

- *minimize the adverse social and economic impacts of existing supervised consumption sites (SCS) on local neighbourhoods;*
- *help inform decisions around the establishment of future SCS and reduce the potential for negative social and economic impacts;*
- *and help inform a provincial policy that outlines required criteria for provincial funding of SCS.*[145] (pg. 2)

108. A number of pertinent topics were deemed out-of-scope by HMQA, including:

- *the merits of supervised consumption sites as a harm reduction tool;*
- *the utility of these services in each community;*
- *establishing supervised consumption services outside of the current or proposed sites;*
- *provincial funding for supervised consumption services;*
- *other social issues such as housing and homelessness*.[146] (pg. 1)

109. These exclusions precluded an analysis of the benefits of SCS in Alberta and consideration of other factors which may be driving public complaints regarding social disorder in the neighbourhoods where SCS have been implemented.

110. Members of the SCS review committee had backgrounds in law enforcement, real estate, economics, criminology, addictions medicine, and lived or family experience of alcohol and drug use. However, their biographies did not contain any experience or expertise specific to operating SCS or implementing harm reduction approaches to illegal drug use.

[143] Kennedy, Karamouzian, and Kerr, 'Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: A Systematic Review'. Attached as **Exhibit "36"** to this Affidavit.
[144] Jonathan P. Caulkins, Bryce Pardo, and Beau Kilmer, 'Supervised Consumption Sites: A Nuanced Assessment of the Causal Evidence', *Addiction*, August 2019, add.14747, https://doi.org/10.1111/add.14747. Attached as **Exhibit "76"** to this Affidavit.
[145] Government of Alberta, 'Supervised Consumption Services Review', accessed 12 August 2021, https://www.alberta.ca/supervised-consumption-services-review.aspx. Attached as **Exhibit "77"** to this Affidavit.
[146] Government of Alberta, 'Supervised Consumption Sites Review - Backgrounder', n.d., https://www.alberta.ca/assets/documents/supervised-consumption-services-backgrounder.pdf.https://www.alberta.ca/assets/documents/supervised-consumption-services-backgrounder.pdfGovernment of Alberta. Attached as **Exhibit "78"** to this Affidavit.

111. The panel was chaired by Rod Knecht, Edmonton's former Chief of Police, who had previously expressed ambivalence towards SCS. In a February 2017 op-ed published in the Edmonton Journal, he wrote that he had concerns that SCS implemented with too much focus on

> *enabling the illicit use of drugs at the expense of treatment falls drastically short of the care that an addict needs. It also risks jeopardizing community compassion due to the resulting scourge of discarded needles, increased criminal activity, social disorder, and neighbourhood degradation. Should a facility be realized, surrounding residents should not have to worry about the safety of their vehicles, sanctity of their homes, or the quality of their lives.*[147] (pg. 5)

112. The committee adopted "a mixed method research approach, which included the collection of both quantitative and qualitative data,"[148] (pg. 2) and examined seven operating SCS (four in Edmonton, one in Calgary, one in Grande Prairie, and one in Lethbridge), one operating overdose prevention site (in Red Deer); and three proposed SCS in Medicine Hat, Calgary, and Red Deer.

113. In March 2020, the Government released the committee's report, which outlined a number of concerns related to SCS in Alberta. At the press conference announcing the release, Hon. Jason Luan, Associate Minister of Addiction and Mental Health summarized the report's findings: "from increases in social disorder, to discarded needles ... what we see is a system of chaos."[149] (pg. 2)

114. The report's main findings are collated in the Executive Summary and provided verbatim below:

- *Serious questions had been raised concerning the level and adequacy of the consultation process some site operators used to obtain their site exemptions under Section 56.1 of the Controlled Drugs and Substances Act.*
- *While there were no deaths recorded among people who used drugs at the SCS sites, death rates in the immediate vicinity of the SCS locations increased. Opioid-related calls for emergency medical services (EMS) also increased in the immediate vicinity following the opening of the sites.*
- *In many cases, "adverse events" (even if non-life threating* [sic] *or minor) are reported as overdoses, and the term "reversal" is used even when the response was a simple*

[147] Rod Knecht, 'Police Chief: Safe Injection Sites in Edmonton Must Offer Rehabilitation | Edmonton Journal', 18 February 2017, https://edmontonjournal.com/opinion/columnists/opinion-safe-injection-sites-must-offer-rehabilitation. Attached as **Exhibit "79"** to this Affidavit.
[148] Government of Alberta, 'Impact: A Socio-Economic Review of Supervised Consumption Sites in Alberta', March 2020, http://www.deslibris.ca/ID/10103999. Attached as **Exhibit "80"** to this Affidavit.
[149] Hannah Kost, '"A System of Chaos": Supervised Consumption Services Review Committee Releases Findings | CBC News', *CBC*, 5 March 2020, https://www.cbc.ca/news/canada/calgary/ucp-supervised-consumption-site-review-committee-announcement-findings-1.5486579. Attached as **Exhibit "81"** to this Affidavit.

administration of oxygen. This leaves the public with an inference that without these sites thousands of people would fatally overdose or no longer be alive. Comparatively rare cases resulted in the use of naloxone. As a result, the committee became concerned with issues of transparency and accountability with the regards to the way overdose reversals are tracked and reported. The committee finds this misleading and the ambiguity and faulty reporting cannot responsibly make such a determination.

- *Non-opioid substance use, specifically methamphetamine use at some SCS sites, increased substantially and numerous residents complained about aggressive and erratic behaviour of substance users leaving the sites.*
- *Except for Edmonton, crime, as measured by police calls for service, generally increased in the immediate vicinity in contrast to areas beyond the immediate vicinity of the sites. Residents complained about the lack of response to calls for service by police. Site users and operators typically believed that the Section 56.1 exemption allowed for a no-go zone for police within the proximity of the site. Evidence suggested a level of "de-policing" near some sites.*
- *Needle debris was a substantial issue with many residents complaining about used and unused needles, broken crack pipes and other drug-related paraphernalia being discarded in the vicinity of the sites and in public areas near the sites.*
- *A striking observation was the advocacy in favour of these sites, by SCS staff, at every town hall meeting, particularly the two Edmonton town hall meetings.*[150] *(*pg. iii)

115. The Committee also noted that they "heard reports of inadequate oversight and the lack of accountability mechanisms at the sites," identified a "lack of focus on referrals to detoxification and treatment resources," and that "stakeholder feedback predominantly suggested that SCS have had a negative social and economic impact on the community." Finally, they noted that the SCS were "inappropriately favouring harm reduction."[151] (pg. iii)

116. I and other academic experts have reviewed and critiqued the Committee's report. We have identified serious methodological errors, and determined that many of the report's conclusions are not substantiated by the evidence contained therein.[152,153,154] Below, I highlight some of these specific concerns.

[150] Government of Alberta, 'Impact: A Socio-Economic Review of Supervised Consumption Sites in Alberta'. Attached as **Exhibit "80"** to this Affidavit.
[151] Government of Alberta. Attached as **Exhibit "80"** to this Affidavit.
[152] KG Card, B Pauly, and K Urbanoski, 'A Brief on Methodology: Using Proximity Analysis to Study the Impact of Substance Use Services on Local Neighbourhoods' (Canadian Institute for Substance Use Research, 2020), https://static1.squarespace.com/static/5eb1a664ccf4c7037e8c1d72/t/5ec3081ba170291f46b51294/1589839917584/Proximity+Analysis.pdf. Attached as **Exhibit "82"** to this Affidavit.
[153] Signatories, 'OPEN LETTER: Calling on the Alberta Government to Retract Supervised Consumption Site Report', 18 March 2020, https://www.drugpolicy.ca/open-letter-calling-on-the-alberta-government-to-retract-supervised-consumption-site-study/. Attached as **Exhibit "83"** to this Affidavit.
[154] James D Livingston, 'Supervised Consumption Sites and Crime: Scrutinizing the Methodological Weaknesses and Aberrant Results of a Government Report in Alberta, Canada', *Harm Reduction Journal* 18, no. 1 (2021): 1–5. Attached as **Exhibit "84"** to this Affidavit.

117. Although the report is formatted to look like a scientific study, none of the purported data sources (surveys, town halls, public submissions, EMS or police calls, overdose statistics, costing information, and SCS records) are presented in a way that meets minimal criteria to be considered scientifically credible, and the report's findings have not been peer-reviewed.

118. The report's conclusions rely heavily on anecdotal information obtained from qualitative data collected at town halls and via email submissions. Many contradictions in the results suggest that whatever data analysis was conducted (no qualitative analytic procedures are described) was not a systematic or rigorous synthesis of all views presented. For example, the Executive Summary states that "a striking observation was the advocacy in favour of these sites, by SCS staff, at every town hall meeting" (pg. iii) but the document presents extremely negative findings, with almost no discussion of the positive views shared with the Committee.

119. The Committee conducted an online survey of 13,700 respondents on their perceptions of their local SCS. However, it is unclear what if any procedures were used to verify whether these respondents lived, worked or owned a business surrounding an existing or proposed SCS in Alberta. No procedures for preventing participants from completing the survey multiple times were described.

120. Further, the Committee's survey asked residents to accurately pinpoint events and trends that occurred up to 2 years prior, around the time of the opening of SCS in their communities. As criminologist Dr. Jamie Livingston has outlined in his peer-reviewed critique[155] of the report, such questions are prone to well known cognitive errors, and subject to recall and recency bias, accordingly "a large body of literature demonstrates that people tend to misperceive and overestimate crime-related issues and trends," (pg. 2) and strongly cautions against asking participants to recall such events from more than six months prior.[156]

121. Even if we place these concerns aside and take the survey responses at face value, the survey data appended to the report often conflict with statements made in the body of the report. For example, in Edmonton the majority of survey respondents reported a decrease (64%) or no change (19%) in needle debris following the opening of the SCS in their neighbourhood,[157] (pg. 137) yet the report concludes that

[155] Livingston. Attached as **Exhibit "84"** to this Affidavit.
[156] Livingston. Attached as **Exhibit "84"** to this Affidavit.
[157] Government of Alberta, 'Impact: A Socio-Economic Review of Supervised Consumption Sites in Alberta'. Attached as **Exhibit "80"** to this Affidavit.

> *Consistent with most other locations in the province, residents of Edmonton complained of excessive amounts of needle debris (Safeworks distributed 2.3 million needles in 2008) and increases in crime and social disorder.*[158] (pg. 31; NB: Safeworks is located in Calgary, it is unclear why it is mentioned in the Edmonton section of the report].

122. The report's more objective data sources were not handled more rigorously. In many cases, the timeframe for analysis of police, EMS, and overdose administrative data was not sufficient to distinguish positive or negative impacts of SCS *vis-a-vis* historical trends.

123. For example, as researchers at the University of Victoria's[159] Canadian Institute for Substance Use Research have summarized, the

> *crime data was reported comparing 2017 to a partially completed year (2018), without any adjustments for changes in policing activities. The comparison units varied from city to city and analysis to analysis. One comparison used a 250 meter buffer and compared it to both the city centre and the rest of the city; one compared a 50 to 500-meter buffer vs. a 500+ meter buffer (inclusive of the rest of the city); a third analysis compared a 500 meter buffer to a 501-2000 meter buffer; a fourth analysis used police beats instead of the buffer approach. Only the years (or partial years) immediately prior to or after the opening of these sites were considered. It is unclear why consistent methodologies were not used [...] Given these methodological limitations and the fact that these results differ from previous studies, findings from this review are suspect.*[160] (pg. 9)

124. Despite this heterogeneity in analysis approaches, the report to concludes that

> *reported crime has increased slightly throughout the Province over the past few years. As indicated, however, the evidence suggests that calls for service near the SCS sites have increased disproportionately for most Alberta cities in comparison to the rest of the community. The only exception is the City of Edmonton which reported a slight decrease in calls for service while calls increased in the rest of the city.*[161] (pg. 20)

125. It is not possible to draw conclusions like this reliably without appropriate statistical analysis.[162] Yet the report did not employ inferential statistics (e.g. time series, bivariate, or multivariate analyses) to measure accurately the size and significance of observed differences, or whether any apparent increase or decrease in any given outcome was plausibly linked to the SCS and not the product of random chance or confounding factors.

[158] Government of Alberta. Attached as **Exhibit "80"** to this Affidavit.
[159] Card, Pauly, and Urbanoski, 'A Brief on Methodology: Using Proximity Analysis to Study the Impact of Substance Use Services on Local Neighbourhoods'. Attached as **Exhibit "82"** to this Affidavit.
[160] Card, Pauly, and Urbanoski. Attached as **Exhibit "82"** to this Affidavit.
[161] Government of Alberta, 'Impact: A Socio-Economic Review of Supervised Consumption Sites in Alberta'. Attached as **Exhibit "80"** to this Affidavit.
[162] Livingston, 'Supervised Consumption Sites and Crime: Scrutinizing the Methodological Weaknesses and Aberrant Results of a Government Report in Alberta, Canada'. Attached as **Exhibit "84"** to this Affidavit.

126. Further, the report's finding of an apparent increases in police calls for service around the SCS, conflicts with statements in the Executive Summary that police and operators view SCS as 'no-go' zones, and that there is a phenomenon of 'de-policing' where residents are reluctant to call police in the zones around SCS.[163] (pg. 3)

127. In other cases, inappropriate administrative data were analyzed, such as the decision to include alcohol-related deaths into calculations of drug poisoning death rates around the SCS (SCS do not monitor alcohol consumption).

128. Economic analyses of operating costs across sites do not take into account basic differences in the SCS models that drive costs. Characteristics like operating hours, facility size, mix of health professionals on staff, and differences in services provided within each SCS were not factored into comparisons of relative operating costs across sites. Instead, the report suggests that the variability of these costs was due to accounting errors and recommended that each SCS be subject to twice-yearly financial audits.

129. The report criticizes the adverse event and overdose classification system used by SCS staff, suggesting that overdoses that require administration of oxygen are "non-life threatening or minor." The report also states that "preventing overdose deaths does not seem to apply to amphetamine use."[164] (pg. 14) Neither of these assertions are medically accurate.

130. The sole administration of oxygen is an appropriate measure when managing an opioid poisoning event, and can help to reduce severity of the event and avoid a situation where naloxone would be indicated.[165,166]

131. Any drug has the potential to cause acute drug toxicity and other negative health outcomes, and SCS are designed to minimize harms associated with use of a wide range of illegal drugs. Further, many people who use drugs are polysubstance-using and in 2020, 53% of opioid poisoning decedents in Alberta also had methamphetamine in their system at the time of death (Figure 7; second bar from top). Drug checking studies show that unregulated stimulants, such as methamphetamine, can be contaminated with fentanyl and other

[163] Government of Alberta, 'Impact: A Socio-Economic Review of Supervised Consumption Sites in Alberta'. Attached as **Exhibit "80"** to this Affidavit.
[164] Government of Alberta. Attached as **Exhibit "80"** to this Affidavit.
[165] British Columbia Centre for Disease Control, 'BC Overdose Prevention Services Guide - 2019', n.d. Attached as **Exhibit "85"** to this Affidavit.
[166] Alberta Health Services, 'Intramuscular Naloxone Administration: Suspected Opioid Poisoning (Overdose)', Document #: HCS-247-01 (Clinical Operations Executive Committee, Executive Director, Communicable Disease Control, 2 December 2019). Attached as **Exhibit "86"** to this Affidavit.

synthetic opioids.[167] Thus, excluding people who use methamphetamine from SCS would be counter to the public health objectives of these services.

Figure 7

Source: Government of Alberta. Alberta substance use surveillance dashboard: Polysubstance use among acute substance related deaths. Edmonton: Government of Alberta; August 10, 2021.

132. Finally, the report does not meet typical academic or scientific conventions for the disclosure of real or perceived conflicts of interest among authors. For example, the Committee's budget included $202,500 for honoraria,[168] but whether the expert committee was financially compensated for their work on the report, or reimbursed for travel or meals is not discussed in the front matter or elsewhere in the document.

133. These and other flaws prompted 42 scientists and scholars (myself included) from academic institutions across North America, to formally request that HMQA retract the SCS review report.[169] This request was based on the concern that the report does not meet basic quality standards for an evidence-based evaluation or study, is misleading, and could result in the closure of life-saving services.

[167] Kenneth W. Tupper et al., 'Initial Results of a Drug Checking Pilot Program to Detect Fentanyl Adulteration in a Canadian Setting', *Drug and Alcohol Dependence* 190 (1 September 2018): 242–45, https://doi.org/10.1016/j.drugalcdep.2018.06.020. Attached as **Exhibit "87"** to this Affidavit.
[168] Alanna Smith, 'Prime Rib Dinners, "Double-Dipping": UCP-Appointed Panel Exceeds Travel, Meal Budget by $10K', *Calgaryherald*, 21 September 2020, https://calgaryherald.com/news/politics/disgusting-abuse-of-taxpayer-money-ucp-appointed-panel-exceeds-travel-accommodation-budget-by-thousands. Attached as **Exhibit "88"** to this Affidavit.
[169] Signatories, 'OPEN LETTER', 18 March 2020. Attached as **Exhibit "83"** to this Affidavit.

134. HMQA declined this retraction request, and instead has acted on the report's findings via subsequent decisions to close SCS in the province. These closures are occurring in the context of escalating and unprecedented drug poisoning morbidity and mortality (Figure 1 & 2).

Constraining access to SCS in Alberta

135. Following the release of the report, HMQA formally cancelled the two new SCS planned for Medicine Hat and Calgary.

136. Acting on an anonymous tip[170] (pg. 2) HMQA further announced a financial audit of Alberta's largest and busiest SCS, operated by the non-profit organization ARCHES in Lethbridge. The goal of the audit was to investigate "disturbing allegations of financial irregularities."[171] (pg. 2)

137. The provincial government contracted Deloitte to conduct the audit, and the firm reported that it was unable to account for $1.5 million of provincial funding. In responding to these findings, Associate Minister Luan told the media "the picture that was discovered was so awful [...] this is at the expense of when the most vulnerable people's lives are at risk."[172] (pg. 4-5)

138. HMQA turned the audit findings over to police, and officially terminated ARCHES' SCS funding agreement.

139. Instead of identifying another organization to assume operations of ARCHES' site, HMQA closed the facility on August 30, 2020, and replaced it with a two-booth mobile supervised consumption site delivered out of a retrofitted van and operated by Alberta Health Services.

140. Unlike the ARCHES site, which was the largest and busiest site of its kind in Canada and accommodated as many as 800 people per day prior to the pandemic, the van is not designed to serve large volumes of visits or equipped to supervise drug inhalation/smoking. This is problematic because a significant proportion of fatal opioid poisonings in Alberta are attributed to smoking.[173] Additionally, many of the substance use treatment and other

[170] Joel Dryden, 'Province Sends Auditors to Lethbridge Supervised Consumption Site, Citing Anonymous Tip | CBC News', *CBC*, 5 March 2020, https://www.cbc.ca/news/canada/calgary/arches-jason-luan-lethbridge-supervised-consumption-site-1.5487577. Attached as **Exhibit "89"** to this Affidavit.
[171] Dryden, 'Province Sends Auditors to Lethbridge Supervised Consumption Site, Citing Anonymous Tip | CBC News'. Attached as **Exhibit "89"** to this Affidavit.
[172] Kirby Bourne and Eloise Therien, 'Government Pulls Grant Funding from Lethbridge Safe Consumption Site Citing Fund Mismanagement | Globalnews.Ca', *Global News*, accessed 12 August 2021, https://globalnews.ca/news/7184155/arches-lethbridge-grant-funding-safe-consumption-site/. Attached as **Exhibit "90"** to this Affidavit.
[173] Alberta Health, *Opioid-Related Deaths in Alberta in 2017: Review of Medical Examiner Data*, 2019, https://open.alberta.ca/dataset/f9912915-bd4f-4b57-93bf-2a963cb99038/resource/a2857fb6-6663-491c-b9df-686e348bb456/download/070519-me-chart-review-final.pdf. Attached as **Exhibit "91"** to this Affidavit.

health and social supports previously offered by ARCHES are not available out of the mobile service.

141. On December 22, 2020 the Lethbridge Police Service and Alberta Justice Specialized Prosecutions Branch held a media event to announce the conclusion of their investigation into ARCHES.

142. In a statement to the media, investigators noted that "through a lengthy and comprehensive investigation, in which special prosecutions was provided with regular updates on its progress, Lethbridge Police were able to uncover records which accounted for the funding in question."[174] (pg. 4) The Chief of Police declined to provide specifics of the investigation, but indicated that prosecution would not be in the public interest.

143. Despite these findings, ARCHES SCS remains closed. The most recent data available on drug poisoning deaths in Alberta indicate that Lethbridge's death rate was 83.9 per 100,000 person years in May 2021, more than double the provincial average of 32.4 per 100,000 person years. These statistics suggest an urgent need to expand drug poisoning prevention and response efforts in that city (including through the provision of additional SCS).

144. HMQA has also taken steps to reduce SCS capacity in other cities.

145. In October 2020, Edmonton's busiest SCS at Boyle Street Community Services was temporarily relocated to the Tipinawâw shelter at the Edmonton Convention Centre as part of the municipal pandemic response for unstably housed and homeless populations.[175] While there, the service operated under HMQA's provincial OPS class exemption.

146. In April 2021, HMQA announced that the Boyle Street Community Services supervised consumption site would not be returning to its normal site after the closure of Tipinawâw. Instead, it would be permanently closed.

147. Although the nearby George Spady Centre site has increased its hours and expanded SCS from 3 to 4 booths, the Boyle Street closure still represents a net reduction in service capacity in Edmonton, with four fewer booths operating between 8 a.m. and 8 p.m. everyday.[176] Since the closure of the facility, Boyle Street staff have responded to a

[174] Alanna Smith, 'Lethbridge Police Investigation of ARCHES Finds Records for "Unaccounted Funds"', *Calgaryherald*, 22 December 2020, https://calgaryherald.com/news/local-news/lethbridge-police-investigation-into-arches-finds-records-for-unaccounted-funds. Attached as **Exhibit "92"** to this Affidavit.
[175] Caley Ramsay, 'Advocates Raise Concern over Closure of Edmonton Supervised Consumption Site: "It's Puzzling"', *Global News*, 28 April 2021, https://globalnews.ca/news/7818759/edmonton-boyle-street-supervised-consumption-site-closed/. Attached as **Exhibit "93"** to this Affidavit.
[176] Ramsay, 'Advocates Raise Concern over Closure of Edmonton Supervised Consumption Site: "It's Puzzling"'. Attached as **Exhibit "93"** to this Affidavit.

significant increase in drug poisoning events on the street outside its facility,[177] suggesting that demand for SCS in Edmonton currently exceeds supply.

148. Finally in May 2021, Postmedia reported that HMQA was planning to make additional changes to SCS in Calgary, Grand Prairie, and Red Deer.[178]

149. Shortly after, HMQA confirmed that it intends to shut down the Sheldon M. Chumir site in Calgary, but stated that they plan to offer SCS out of two smaller facilities in that city instead. Locations have yet to be announced.

150. If prior SCS policy changes in Lethbridge and Edmonton are any indication, it is reasonable to assume that this closure will result in reduced SCS capacity in Calgary. Specific timelines and plans for SCS in Red Deer and Grande Prairie have yet to be confirmed.[179]

HMQA's new 'Recovery-Oriented Overdose Prevention Services Guide' (New Requirements)

151. Beyond reorganization and reductions in SCS capacity, HMQA has introduced a new mandatory licensing scheme for SCS and OPS that adds significant administrative burden for providers.

152. On June 2 2021, HMQA announced that it would be introducing mandatory licensing requirements for SCS and OPS providers under the provincial *Mental Health Services Protection Act* and *Mental Health Services Protection Regulation*.[180] These new requirements are elaborated in HMQA's *Recovery-Oriented Overdose Prevention Services Guide* ("**New Requirements**").[181]

153. In addition to securing a federal exemption via (1) an exemption from Health Canada under 56(1) or 56.1 of the *CDSA*, or (2) authorization from HMQA under its section 56(1) class

[177] Anna Junker, 'Potent Drugs, Limited Places to Go Contributing to Overdose Spike in Edmonton, Says Boyle Street Community Services', *Edmontonjournal*, 4 June 2021, https://edmontonjournal.com/news/local-news/local-reaction-to-55-opioid-related-calls-over-two-days.Attached as **Exhibit "94"** to this Affidavit.
[178] Alanna Smith, '"Defies Logic": UCP to Close Supervised Consumption Site at Sheldon Chumir and Replace with Two Locations', *Calgaryherald*, 27 May 2021, https://calgaryherald.com/news/local-news/it-is-going-to-kill-people-ucp-to-close-calgarys-only-supervised-consumption-site. Attached as **Exhibit "95** to this Affidavit.
[179] Smith, '"Defies Logic"'.https://calgaryherald.com/news/local-news/it-is-going-to-kill-people-ucp-to-close-calgarys-only-supervised-consumption-siteSmith. Attached as **Exhibit "95"** to this Affidavit.
[180] Government of Alberta Minister of Health, 'Mental Health Services Protection Act - Mental Health Services Protection Regulation - Appendix - (Section 27) O.C. 163/2021, A.R. 114/2021', 2 June 2021, https://www.qp.alberta.ca/documents/Orders/Orders_in_Council/2021/2021_163. Attached as **Exhibit "96"** to this Affidavit.
[181] Government of Alberta, 'Recovery-Oriented Overdose Prevention Services Guide', April 2021. Attached as **Exhibit "97"** to this Affidavit.

exemption,[182] the regulation requires that all SCS and OPS providers in the province of Alberta also hold a licence from HMQA.

Duplicating existing regulations and practices

154. Although HMQA states that the New Requirements are necessary to encourage "consistency of services and policies at SCS and OPS in Alberta," much of the document is duplicative of existing regulations and practices, by mandating activities that either already occur within Alberta SCS, or are already Health Canada requirements.

155. The New Requirements include a list of "mandatory" (pg. 5) services that all SCS and OPS must provide, including:

- *In-person supervision of illicit drug use by trained staff*
- *Emergency care in response to an adverse event*
- *On-site or defined pathways to addiction treatment and recovery-oriented services, including mental health supports.*
- *On-site or defined pathways to a variety of wrap-around services, including but not limited to primary care, housing and other social supports.*
- *Services that reduce harm, including:*
  - *education on the consequences of illicit drug use, less harmful consumption practices, and how to use naloxone*
  - *provision of take-home naloxone*
  - *provision of sterile consumption supplies for use on site*
  - *monitoring for and removing discarded consumption supplies (e.g., needles and other drug use equipment) from public spaces surrounding the site*[183] (pg. 5)

156. All of these mandatory elements are already current practice for SCS or OPS in Alberta.

157. Supervision of drug use, emergency medical care, and harm reduction services (sterile supplies, naloxone kits, and safer drug use education) are the minimum constituent components of all SCS delivery.

158. Alberta SCS also already include access to wraparound addiction, mental health, primary care, and social supports either directly through healthcare providers employed onsite (such as nurses, addiction and mental health counsellors, peer support workers, social workers,

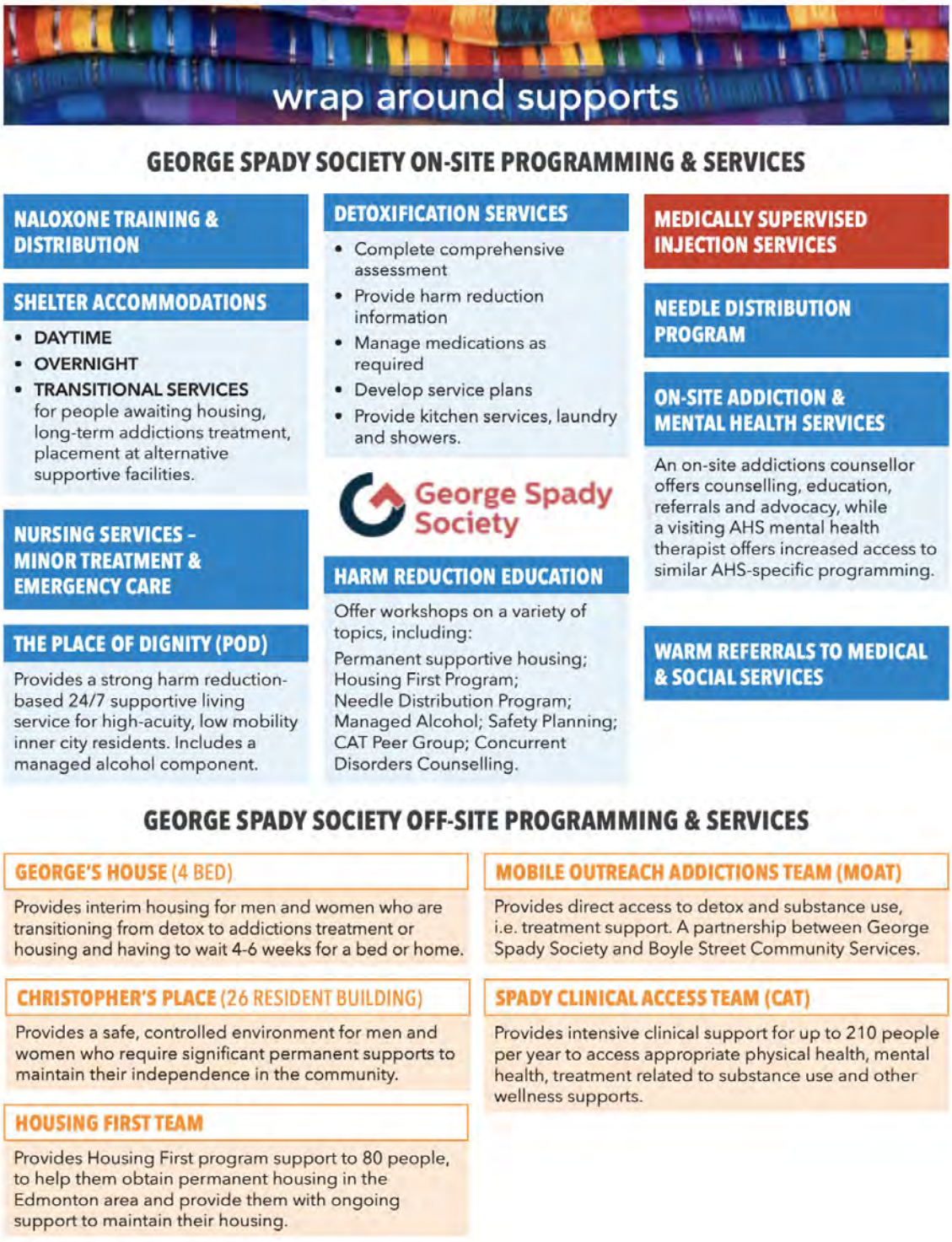
[182] Government of Alberta Minister of Health, 'Mental Health Services Protection Act - Mental Health Services Protection Regulation - Appendix - (Section 27) O.C. 163/2021, A.R. 114/2021'. Attached as **Exhibit "96"** to this Affidavit.
[183] Government of Alberta, 'Recovery-Oriented Overdose Prevention Services Guide'. Attached as **Exhibit "97"** to this Affidavit.

or paramedics) or through pre-defined referral pathways to service providers off-site[184,185] (including through warm hand-offs where possible).

159. Figures 8 & 9 outline wraparound supports provided by the George Spady Centre and the Boyle McCauley Health Centre as examples of the range of supports already available through SCS in Alberta.

[184] Alberta Health Services, 'Supervised Consumption Services - Beyond the Headlines', Beyond the Headlines, 1 February 2019, https://www.albertahealthservices.ca/Blogs/BTH/Posting330.aspx#.YRfwN4hKga5. Attached as **Exhibit "98"** to this Affidavit.
[185] Alberta Community Council on HIV, 'A Community-Based Report on Alberta's SCS Effectiveness', n.d. Attached as **Exhibit "99"** to this Affidavit.

Figure 8



Source: AMSISE. Wrap around supports: George Spady Society. Available from https://crismprairies.ca/amsise/. Accessed August 12, 2021.

Figure 9

BOYLE McCAULEY HEALTH CENTRE ON-SITE PROGRAMMING & SERVICES

MEDICAL SERVICES
- Primary health care
- In clinic/Home visits
- Immunizations
- **Supervised injection services**
- On-site opiate replacement therapy (Suboxone/Methadone)
- Hepatitis/HIV treatment
- Diabetes education and treatment
- Smoking cessation

OTHER SPECIALTY SERVICES
- Acupuncture
- Chiropractor
- Optometry
- Pediatrician
- Footcare

WOMEN'S HEALTH PROMOTION PROGRAM

NALOXONE TRAINING & DISTRIBUTION

DENTAL SERVICES
- Low barrier/ Sliding scaling Fees

WOUND CARE CLINIC

BM BOYLE McCAULEY HEALTH CENTRE HC

STREETWORKS NEEDLE DISTRIBUTION & HIV PREVENTION PROGRAM

MENTAL HEALTH & ADDICTION SERVICES
- Access to psychiatrist
- Counselling, advocacy & referrals to detoxification, day and residential drug treatment

SOCIAL SERVICES

Support and Advocacy for:
- Access to housing/Shelters
- Financial/Legal
- Addiction services
- Basic needs

HEALTH ADVOCATE PROGRAM

SHOWER FACILITIES / HYGIENE PRODUCTS

DYNALIFE DIAGNOSTIC LABORATORY SERVICES

BOYLE McCAULEY HEALTH CENTRE OFF-SITE PROGRAMMING & SERVICES

KINDRED HOUSE

Drop-in/Resource Centre for those involved in the sex trade

HAART HOUSE

Drop-in for Anti-Retroviral medications, meals, social activity for those living with HIV

COMMUNITY NURSING STATION

Walk-in nursing clinic, located at **Herb Jamieson Centre**

PATHWAYS TO HOUSING

Assertive community treatment program for chronically homeless individuals with serious mental health/addiction/medical and social issues

NURSE PRACTITIONER-LED HEALTH CLINICS

MIYOWAYAWIN CLINIC
Partnership with Native Healing Centre

YOUTH HEALTHCARE CLINIC
Partnership with I-Human Youth Society

WOMEN'S HEALTH CLINIC
Partnership with Women's Emergency Accommodation Centre (WEAC)

Source: AMSISE. Wrap around supports: Boyle McCauley Health Centre . Available from https://crismprairies.ca/amsise/. Accessed August 12, 2021.

160. While some lower-budget OPS may not provide onsite access to addiction treatment or a large array of wrap-around supports, volunteers and staff in these sites are typically knowledgeable of local substance use service offerings and can provide informal advice and support to people in their care.

161. Further, SCS and OPS routinely partner with external service providers to streamline participants' access to health and social support. For example, before it closed, ARCHES SCS partnered with Alberta Health Services' Virtual Opioid Dependency Program to connect participants directly to opioid agonist treatment (buprenorphine, methadone, or slow release oral morphine) initiation and maintenance through telehealth.

162. Beyond these mandatory services, a number of the administrative processes set out in the New Requirements also duplicate current practice or existing Health Canada and HMQA rules and regulations.

163. Alberta SCS and OPS already either provide access to a washroom for participants or inform clients of other options for washroom access, and all have staff safety and security plans[186] in place (the latter are a formal requirement for Health Canada-exempted SCS).

164. Alberta SCS and OPS already have policies and procedures for facilitating safe disposal of syringes and other drug use equipment, this includes robust efforts to collect this debris in and around their sites. According to the Alberta Community Coalition on HIV (a provincial organization comprised of SCS and harm reduction service providers):

> *All SCS facilities are actively participating in the provincial Needle Debris program, which dedicates resources to respond to the needle debris issue around SCS locations. Each [SCS] now has staff and peer workers regularly involved in needle pick-up service on a daily or weekly basis around their facilities, providing safe supplies and sharp containers to clients, and responding quickly to reports about needle debris from community members. SCS staff continue to educate clients about the impact of drug debris on the ground and proper disposal.*[187] (pg. 15)

165. Health Canada already requires an up-to-date floor plan for federally-exempted SCS as part of the application and renewal process.[188]

[186] Health Canada, 'Apply to Run a Supervised Consumption Site: What You Need before You Start', 28 January 2019, https://www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/apply/before-you-start.html. Attached as **Exhibit "100"** to this Affidavit.
[187] Alberta Community Council on HIV, 'A Community-Based Report on Alberta's SCS Effectiveness'. Attached as **Exhibit "99"** to this Affidavit.
[188] Health Canada, 'Apply to Run a Supervised Consumption Site'. Attached as **Exhibit "100"** to this Affidavit.

166. SCS and OPS typically have to have established policies and/or procedures respecting: client care; SCS eligibility; staff and volunteer roles and training; and handling adverse and critical incidents either as a condition of their federal exemption or operational funding.

167. All SCS and OPS sites routinely collect and report anonymous utilization statistics including basic participant demographics, substances consumed, number of unique participants, number of visits, number of adverse events, and service referrals. This anonymous information is collated and reported monthly to Health Canada and HMQA according to standards set by each authority.

168. Further, renewal of federal exemptions is contingent on the submission of reports on activities, and for SCS this includes positive and negative community impacts in the vicinity of the sites.

Hindering SCS and OPS provision

169. Although much of the New Requirements are redundant, there are some aspects that represent a significant departure from current SCS and OPS practice and regulation in Canada. These new rules make it more difficult for providers to engage people who use drugs, and are likely to lead to reduced access to SCS in Alberta.

170. First, the regulation states "a service provider who offers or provides supervised consumption services is prescribed as a service provider requiring a license."[189] (pg. 3)

171. Although other provinces have released guidelines or guidance for SCS providers, these documents are either non-binding or only mandatory for facilities receiving provincial funding.[190,191,192] For example, Ontario has made provincial SCS funding contingent on adherence to mandatory provincial guidelines. But it does not require any person or organization who provides SCS to be provincially authorized or licensed, and a privately-

[189] Government of Alberta, 'Mental Health Services Protection Regulation - Mental Health Services Protection Act - Extract - Alberta Regulation 114/2021', 2 June 2021, https://www.qp.alberta.ca/1266.cfm?page=2021_114.cfm&leg_type=Regs&isbncln=9780779824922. Attached as **Exhibit "101"** to this Affidavit.
[190] British Columbia Centre for Disease Control, 'BC Overdose Prevention Services Guide - 2019'. Attached as **Exhibit "85"** to this Affidavit.
[191] British Columbia Centre on Substance Use, 'Supervised Consumption Services: Operational Guidance' (Vancouver, BC: BCCSU, 2017), https://www.bccsu.ca/wp-content/uploads/2017/07/BC-SCS-Operational-Guidance.pdf. Attached as **Exhibit "102"** to this Affidavit.
[192] Ontario Ministry of Health and Long-Term Care, 'Consumption and Treatment Services: Application Guide', October 2018, 23. Attached as **Exhibit "103"** to this Affidavit.

funded, federally-exempted SCS is currently operating in Toronto without provincial support or sanction.[193]

172. Under the New Requirements, people and organizations aiming to provide SCS in Alberta will have to seek a federal SCS exemption *and* a provincial licence prior to offering services. Those without private funding will also have to apply to the provincial or federal government for funding.

173. Based on the six years I spent participating in the AMSISE coalition and my past research on the harm reduction services sector,[194] I believe that this will deter most, if not all, non-profit organizations, people who use drugs and their allies from providing SCS or OPS. This is problematic because Alberta's drug poisoning epidemic has never been more acute, and more SCS are urgently needed to prevent avoidable deaths in our province.

174. Second, the New Requirements reposition SCS and OPS within an abstinence-based framework that is antithetical to harm reduction. HMQA defines a "recovery-oriented system of care" (pg. 5) as one that supports "individuals, families, and communities to achieve a life free of illicit drugs."[195] (pg. 5) By requiring all SCS in Alberta to "exist within this broad continuum of services,"[196] (pg. 5) the New Requirements encourage moral judgement of illegal drug use and undermine the value neutral approach at the core of harm reduction.

175. SCS are health interventions that provide care to people who use drugs, and reduce their risk of dying or being gravely harmed. They provide this care irrespective of whether the people they serve are seeking abstinence from illegal drug use or not. This is important because our research has found that many SCS-eligible people who use drugs in Alberta are not willing to engage in care for substance use disorders, even if they perceive a need for it.[197] As a low-barrier service, SCS are able to engage and support this population until such a time that they can engage in additional substance use services. This makes SCS complementary to, but distinct from abstinence-based treatment programs.

[193] Street Health, 'Overdose Prevention Site (OPS) — Street Health', accessed 14 August 2021, https://www.streethealth.ca/services/overdose-prevention-site-ops.https://www.streethealth.ca/services/overdose-prevention-site-opsStreet Health. Attached as **Exhibit "104"** to this Affidavit.
[194] Elaine Hyshka et al., 'Principles, Practice, and Policy Vacuums: Policy Actor Views on Provincial/Territorial Harm Reduction Policy in Canada', *International Journal of Drug Policy*, January 2019, https://doi.org/10.1016/j.drugpo.2018.12.014. Attached as **Exhibit "105"** to this Affidavit.
[195] Government of Alberta, 'Recovery-Oriented Overdose Prevention Services Guide'. Attached as **Exhibit "97"** to this Affidavit.
[196] Government of Alberta. Attached as **Exhibit "97"** to this Affidavit.
[197] Hyshka, Anderson, and Wild, 'Perceived Unmet Need and Barriers to Care amongst Street-Involved People Who Use Illicit Drugs'. Attached as **Exhibit "68"** to this Affidavit.

176. While harm reduction services support the choice to seek abstinence from illegal drugs, and facilitate connections to treatment and recovery services, abstinence is not the ultimate goal of a harm reduction.[198] Regulations that guide all SCS delivery must reflect this reality. Otherwise licensing may become contingent on an ability to demonstrate high rates of treatment referrals, uptake, and completion. Imposing such metrics is inappropriate and unrealistic, setting SCS providers up for failure or requiring them to pressure participants to attend treatment in violation of harm reduction best practice, and significantly increasing the likelihood that SCS participants will disengage.[199]

177. Third, in requiring SCS to ask for the personal health number (**'PHN'**) of participants, the 'New Requirements' shift SCS from a low-barrier, anonymous or confidential service, to a high-threshold, institutional model that is unprecedented amongst community-based SCS in Canada.

178. SCS in Canada are offered anonymously and confidentially (with the exception of services that are restricted to registered patients of a hospital or other inpatient or residential facility.)

179. This means that participants are not required to verify their identity as a condition of accessing the service in most settings. In Alberta, SCS collect basic demographic and pertinent health information (e.g. emergency contact, allergies, pre-existing health conditions) on a confidential and voluntary basis at intake or in subsequent visits as disclosed by participants.

180. Participants are assigned a unique code which they provide to the SCS at each visit. The code is typically a combination of initials and a birthdate, but these identifiers are not confirmed by staff. This enables SCS participants to access the service anonymously while still providing staff with basic information about their health and substance use patterns at each visit.

181. Should participants decide to seek additional healthcare services on or off-site that require identification or PHN, their personal identifiers are collected at that time, if required. If they don't have government-issued identification or a PHN, staff can assist participants in securing this documentation.

182. SCS do not routinely ask for or require government-issued identification as part of service provision because it is widely-recognized as a major barrier to care for people who use

[198] Mary Hawk et al., 'Harm Reduction Principles for Healthcare Settings', *Harm Reduction Journal* 14, no. 1 (2017): 70. Attached as **Exhibit "106"** to this Affidavit.
[199] Catie, 'Substance Use Treatment Referrals', Best Practice Recommendations for Canadian Harm Reduction Programs Part 2, n.d. Attached as **Exhibit "107"** to this Affidavit.

drugs.[200] This is confirmed by quantitative survey data collected from people who use illegal drugs in 8 Alberta cities (Figure 10), which indicate that most are not willing to access SCS if they are required to show identification.

Figure 10

Proportion of people who use drugs who would not be willing to attend SCS if required to show identification in Alberta

City where study was conducted	Percent and frequency of participants unwilling to attend SCS if required to show identification	Total number of survey participants
Red Deer	70% (174)	247
Calgary	65% (221)	339
Edmonton	64% (16)	253
Grand Prairie	56% (80)	143
Lethbridge	55% (117)	211
Medicine Hat	52% (93)	178
Edson	50% (19)	38
Fort McMurray	43% (21)	49

Source: Information in this table is based on analysis of data collected as part of the Edmonton Drug Use and Health Survey (2014) and Alberta Drug Use and Health Survey (2017-2018). The Alberta Drug Use and Health Survey was conducted by the Alberta Community Council on HIV in partnership with academic researchers at the University of Calgary and University of Lethbridge. My research team conducted the above analyses after obtaining the raw dataset from the Alberta Community Council on HIV, the Edmonton statistics come from Figure 6.

183. Unwillingness to access SCS that ask for or require government-issued identification is the product of multiple factors. A significant proportion of people who require SCS are

[200] Jessica Xavier et al., 'Rules and Eligibility Criteria for Supervised Consumption Services Feasibility Studies - A Scoping Review', *The International Journal on Drug Policy* 88 (February 2021): 103040, https://doi.org/10.1016/j.drugpo.2020.103040.https://doi.org/10.1016/j.drugpo.2020.103040Xavier et al. Attached as **Exhibit "108"** to this Affidavit.

unstably housed or homeless.[201] People who do not have stable housing frequently do not have healthcare cards or other forms of identification.[202]

184. Even when people who use drugs have access to identification or a PHN, many will not want to disclose it to an SCS site due to criminalization or discrimination that profoundly shapes the everyday lives of people who use drugs, including decisions to access or not access health care.

185. Collecting and linking PHN (or other unique identifiers) to SCS utilization records would create an identifiable, electronic record of ongoing illegal activity (e.g. dates and times of when someone was in a specific location and in possession of illegal drugs). This evidentiary record could be highly damaging if ever disclosed to police or other authorities (probation officers, child welfare agencies, employers, etc.), or to social contacts.

186. While people who attend federally-exempted SCS in Canada are not liable to criminal prosecution for drug possession, people who use drugs are often skeptical of this legal protection and report fears that accessing SCS will lead to interdiction from police.[203,204,205,206,207] This causes apprehension about sharing identifiable information with SCS service providers out of fear that this information may be disclosed to police or other officials without their knowledge or consent.

187. University of Alberta criminologist Dr. Marta Urbanik and Athabasca University criminologist Dr. Carolyn Greene conducted ethnographic interviews with 75 people who use drugs in Edmonton and Calgary.[208] Their research documented how perceptions of police surveillance are already a common barrier to SCS use. In a paper published in the *International Journal of Drug Policy,* they note that a

[201] Evan Wood et al., 'Service Uptake and Characteristics of Injection Drug Users Utilizing North America's First Medically Supervised Safer Injecting Facility', *American Journal of Public Health* 96, no. 5 (May 2006): 770–73, https://doi.org/10.2105/AJPH.2004.057828. Attached as **Exhibit "109"** to this Affidavit.
[202] Erika Khandor et al., 'Access to Primary Health Care among Homeless Adults in Toronto, Canada: Results from the Street Health Survey', *Open Medicine* 5, no. 2 (24 May 2011): e94–103. Attached as **Exhibit "110"** to this Affidavit.
[203] Marta-Marika Urbanik and Carolyn Greene, 'Operational and Contextual Barriers to Accessing Supervised Consumption Services in Two Canadian Cities', *International Journal of Drug Policy* 88 (1 February 2021): 102991, https://doi.org/10.1016/j.drugpo.2020.102991. Attached as **Exhibit "111"** to this Affidavit.
[204] Kosteniuk et al., '"You Don't Have to Squirrel Away in a Staircase"'. Attached as **Exhibit "5"** to this Affidavit.
[205] Geoff Bardwell et al., 'Implementation Contexts and the Impact of Policing on Access to Supervised Consumption Services in Toronto, Canada: A Qualitative Comparative Analysis', *Harm Reduction Journal* 16, no. 1 (2 May 2019): 30, https://doi.org/10.1186/s12954-019-0302-x. Attached as **Exhibit "112"** to this Affidavit.
[206] Alexandra B. Collins et al., 'Policing Space in the Overdose Crisis: A Rapid Ethnographic Study of the Impact of Law Enforcement Practices on the Effectiveness of Overdose Prevention Sites', *International Journal of Drug Policy*, 18 September 2019, https://doi.org/10.1016/j.drugpo.2019.08.002. Attached as **Exhibit "113"** to this Affidavit.
[207] Tara Marie Watson et al., '"This Is a Health Service. Leave It Alone": Service User and Staff Views on Policing Boundaries Involving Supervised Consumption Services', *Addiction Research & Theory*, 3 March 2020, https://doi.org/10.1080/16066359.2020.1730821. Attached as **Exhibit "114"** to this Affidavit.
[208] Urbanik and Greene, 'Operational and Contextual Barriers to Accessing Supervised Consumption Services in Two Canadian Cities'. Attached as **Exhibit "111"** to this Affidavit.

common contextual barrier [to SCS use] was the perception that SCS and the surrounding neighbourhoods are spaces of concentrated police surveillance (pg. 5). *Participants expressed concerns that police monitored individuals entering SCS to identify [people who use drugs], and some believed that undercover officers infiltrated the sites to collect intelligence on drug trafficking. As many participants reported selling drugs to finance their drug use, these perceptions were a notable hindrance to SCS access for SCS-users and Non-SCS-users:*

"Like I know some of my friends, they won't go there because they think it's a trap--They think, now they [SCS staff] know I do drugs and now the cops will know" (M, Non-SCS-user)

"The [police] fuckin' approved of the site. They said they wanted this site to be here to begin with. So, you know, you say you want this site built and then like you're coming down here, you're putting undercover cops in posing as addicts...in the site. Um asking people to buy drugs and then charging them" (M, SCS-user).

"The cops could also be fuckin' sittin outside stakin' it out, seeing who comes...They say they're not allowed, but fuck, how many times do cops bend the rules? Let's be realistic…" (F, SCS-user)

[...]

Some participants described trying to convince others that SCS are not collaborating with police, though they recognized these efforts may sometimes be futile:

"It's the paranoia of the cops…what most people don't know is when you go into the site, it's safety. The cops can't go in there. They [SCS] can't give no information to the cops in the site…I've told a couple of people and they're like, 'yeah, still, you never know'(F,SCS-user).[209] (pg. 5)

188. My research team documented similar fears in our peer-reviewed evaluation of the Royal Alexandra Hospital's SCS,[210] which records PHN to confirm patient registration. Under provincial law, hospitals in Alberta can only deliver clinical care to registered patients, precluding anonymous SCS provision in this setting, and deterring a subset of patients from accessing SCS. In our qualitative interviews with hospital patients multiple participants told us that

[209] Urbanik and Greene.https://doi.org/10.1016/j.drugpo.2020.102991Urbanik and Greene. Attached as **Exhibit "111"** to this Affidavit.
[210] Kosteniuk et al., '"You Don't Have to Squirrel Away in a Staircase"'. Attached as **Exhibit "5"** to this Affidavit.

> *they did not trust the intentions of the site, believing that it could be a "trap" with the ulterior motive of identifying and arresting [people who use drugs]. As 'Rachel' described upon hearing that the hospital provided an SCS for patients who use drugs, "I was like well, there's a catch here. Cops are going to [be] waiting or security's going to kick me out."* (pg. 4)

189. These pre-existing fears of criminalization are certain to be exacerbated by a sudden change in SCS provision that demands PHN upon entry to the SCS, even if a refusal to provide PHN or other identification does not result in an exclusion from service. Simply starting to ask for PHNs is likely to heighten concerns that SCS staff are collaborating with police, or that police are accessing SCS records, and deter people who use drugs from accessing these services. Indeed, prior research has documented that many people who use drugs are unwilling to engage in other life-saving health services due to fears that it could potentially lead to their arrest and incarceration.[211,212]

190. Beyond fears of police scrutiny, many people who use drugs are reluctant to have their substance use recorded on their personal health record. This is because they are worried that their substance use will be disclosed to other healthcare providers, and lead to negative, unilateral changes in their care.

191. Indeed, several patients we spoke with in our research on the Royal Alexandra Hospital's SCS told us that the site's routine practice of sharing patient SCS records with other hospital staff was a major deterrent to SCS use. As one participant, noted:

> *"Most people are afraid to go to the safe consumption site because they don't want [news of their drug use] to come back to their unit. I find that those people who don't want to use the site because they don't want people to find out they're using"*
>
> *Many participants expressed concern that if unit staff learned of their ongoing drug use, it could negatively impact their care. These fears were commonly based on past interactions with healthcare providers where they faced judgement and stigma from staff as a result of their drug use. "Kristin" described avoiding the SCS for this reason: "That's one reason why I won't go there . . . I'm really kind of afraid that they are going to look down on me again because of my use." Some were also worried that they might receive less timely care, that staff would be more avoidant or hands off, or that they could be moved to a different unit if they were to attend the SCS.*

[211] Karla D. Wagner et al., 'Post-Overdose Interventions Triggered by Calling 911: Centering the Perspectives of People Who Use Drugs (PWUDs)', *PLOS ONE* 14, no. 10 (17 October 2019): e0223823, https://doi.org/10.1371/journal.pone.0223823. Attached as **Exhibit "115"** to this Affidavit.

[212] Mohammad Karamouzian et al., 'Correlates of Seeking Emergency Medical Help in the Event of an Overdose in British Columbia, Canada: Findings from the Take Home Naloxone Program', *International Journal of Drug Policy* 71 (1 September 2019): 157–63, https://doi.org/10.1016/j.drugpo.2019.01.006.. Attached as **Exhibit "116"** to this Affidavit.

> *Others expressed concerns that they could face abrupt changes to medications they were receiving to treat pain or withdrawal.*[213] (pg. 4)

192. The New Requirements make disclosure of SCS use to other healthcare providers a realistic possibility, because they require participant consent processes to "not disallow access to information by other authorized service providers to deliver health services to the client" (pg. 13) or access by other "authorized custodians to track, in aggregate, the outcomes of [SCS]." (pg. 13) Requiring people who use drugs to disclose their PHN and sign a consent that does not allow them to opt out of data sharing will deter people who use drugs from accessing the SCS.

193. Even asking for PHN when it is not necessary can be a significant deterrent to harm reduction care. For example, in 2019, the Alberta College of Pharmacists had to issue a special bulletin[214] advising pharmacists not to ask people who use drugs for their PHN, after it was identified that this practice was deterring people from accessing naloxone kits at community pharmacies. According to the College

> *identification is not needed when requesting a kit and, when providing kits to these individuals, it is preferable not to ask for identification. Asking for ID may feel stigmatizing for those who might not want a naloxone kit noted on their profile and may dissuade them from obtaining this life-saving medication.*[215] (pg. 1)

194. In light of evidence that the routine collection of PHN or other personal identifiers will deter Albertans who use drugs from accessing SCS, it is not clear why HMQA is pursuing this policy decision.

195. Collecting a PHN at intake is not required to provide high quality SCS care. Alberta SCS staff already support people to access their PHN when they request assistance. An abundance of peer-reviewed research on Insite and other anonymous and confidential SCS[216,217,218] shows that participants are frequently connected to addiction treatment in facilities that do not compel identification or PHN at intake.

[213] Kosteniuk et al., '"You Don't Have to Squirrel Away in a Staircase"'.https://doi.org/10.1016/j.drugpo.2021.103275. Attached as **Exhibit "5"** to this Affidavit.
[214] Alberta College of Pharmacy, 'Community Based Naloxone: A Partnership to Save Lives', 23 January 2019, https://abpharmacy.ca/articles/community-based-naloxone-partnership-save-lives. Attached as **Exhibit "117"** to this Affidavit.
[215] Alberta College of Pharmacy, 'Community Based Naloxone: A Partnership to Save Lives'. Attached as **Exhibit "117"** to this Affidavit.
[216] Silvina C. Mema et al., 'Mobile Supervised Consumption Services in Rural British Columbia: Lessons Learned', *Harm Reduction Journal* 16, no. 1 (2019): 4, https://doi.org/10.1186/s12954-018-0273-3. Attached as **Exhibit "118"** to this Affidavit.
[217] Will Small et al., 'Access to Health and Social Services for IDU: The Impact of a Medically Supervised Injection Facility', *Drug and Alcohol Review* 28, no. 4 (2009): 341–46, https://doi.org/10.1111/j.1465-3362.2009.00025.x. Attached as **Exhibit "119"** to this Affidavit.
[218] Wood et al., 'Rate of Detoxification Service Use and Its Impact among a Cohort of Supervised Injecting Facility Users'. Attached as **Exhibit "43"** to this Affidavit.

196. PHN is also not required to meaningfully evaluate SCS or OPS. For studies where administrative data linkage to health records would be helpful (e.g. for measuring uptake into other health services that collect PHN), it is both feasible and ethical to make participant enrollment (and requisite collection of PHN) voluntary through an opt-in process that does not ask all SCS clients for identification upfront.

197. Further, in the interest of reducing access barriers and promoting health equity, many other health programs and services that target people who use illegal drugs, or other stigmatized populations in Alberta do not require a PHN. This includes: ambulance care, sterile injection and safer sex supply distribuition, naloxone kit dispensation and training, COVID-19 vaccination, birth control and sexual health care, virtual mental health support, suicide prevention, domestic violence counselling, or STI testing.

198. Even abstinence-based residential addiction treatment programs, which are the core component of Alberta's 'recovery-oriented system of care' do not collect PHN.

199. HMQA recently invested $140 million to provide universal, publicly-funded access to residential treatment beds[219] and introduced new licensing requirements for them under the *Mental Health Services Protection Act.*[220] However, according to *Getting Started: Licensing for Residential Addiction Treatment Facilities*[221] these providers are not required to collect PHN or any other personal health information from patients registered in their programs nor are they required to facilitate the sharing of this information with other healthcare providers along the continuum of care.

200. The third and final way in which the New Requirements significantly depart from current SCS practice and regulation in Canada is by requiring those who offer these services to collect the signatures of "local businesses, community associations, and nearby residents within a minimum 200-metre radius" (pg. 6) on a good neighbour agreement.

201. This requirement far exceeds even the original community consultation requirements under the repealed *Respect for Communities Act* that were streamlined by Bill C-37. It is also logistically challenging and time intensive. When AMSISE canvassed the inner city residents surrounding Edmonton's three community-based SCS, language barriers, shift work, and inaccessible multifamily dwellings made it very difficult to connect with all those residing or working in the vicinity of the services.

[219] Kathy Le, 'User Fee for Publicly-Funded Residential Addiction Treatment Beds Eliminated in Alberta | CTV News', *CTV News*, 6 November 2020, https://calgary.ctvnews.ca/user-fee-for-publicly-funded-residential-addiction-treatment-beds-eliminated-in-alberta-1.5178457. Attached as **Exhibit "120"** to this Affidavit.
[220] Government of Alberta, 'Getting Started - Licensing for Residential Addiction Treatment Service Providers', June 2019. Attached as **Exhibit "121"** to this Affidavit.
[221] Government of Alberta. Attached as **Exhibit "121"** to this Affidavit.

202. Even without these logistical challenges, the fact that SCS continue to be politically contentious in the province--with only 49% of Albertans in support[222]-- enforcing this requirement would preclude many SCS from securing a provincial license, and render access to life-saving health care for marginalized people who use drugs contingent on public approval.

203. Based on the reasons and evidence outlined above, it is my view that the New Requirements will do very little to enhance SCS or OPS provision in Alberta and instead cause real harm by either discouraging large numbers of people who use drugs from using SCS and OPS, or effectively precluding prospective operators from providing more of these services during an unprecedented drug poisoning epidemic.

SWORN BEFORE ME at Edmonton, Alberta, this 31st day of August 2021.

Avnish Nanda
Barrister and Solicitor
Commissioner for Oaths/Notary Public
in and for the Province of Alberta

ELAINE HYSHKA

[222] T. Cameron Wild et al., 'Public Support for Harm Reduction: A Population Survey of Canadian Adults', *PLOS ONE* 16, no. 5 (19 May 2021): e0251860. https://doi.org/10.1371/journal.pone.0251860. Attached as **Exhibit "122"** to this Affidavit.

TAB 4

Form 49
[Rule 13.19]

COURT FILE NUMBER	2103 11484
COURT	COURT OF QUEEN'S BENCH OF ALBERTA
JUDICIAL CENTRE	EDMONTON
PLAINTIFFS	MOMS STOP THE HARM SOCIETY and LETHBRIDGE OVERDOSE PREVENTION SOCIETY
DEFENDANT	HER MAJESTY THE QUEEN IN RIGHT OF ALBERTA
DOCUMENT	**AFFIDAVIT**

ADDRESS FOR SERVICE AND CONTACT INFORMATION OF PARTY FILING THIS DOCUMENT	NANDA & COMPANY ATTN: Avnish Nanda 10007 80 Avenue NW Edmonton, AB T6E 1T4 Tel: 780-801-5324 Fax: 587-318-1391 Email: avnish@nandalaw.ca

AFFIDAVIT OF BONNIE LARSON

Sworn on August 31, 2021

I, Bonnie Larson, of Calgary, Alberta, SWEAR AND SAY THAT:

1. I am a family physician with a Certificate of Added Competence (CAC) in addictions medicine, and supplementary residency training in health equity and global health, including addictions, mental health, HIV/Hepatitis C care, and corrections health.

2. I have worked with structurally vulnerable patients exclusively since beginning my practice in 2009, including patients who are Indigenous and those living in the inner city.

3. Prior to becoming a physician, I received a Masters of Arts degree in Anthropology specializing in health beliefs and worked in community development for four years. Since 2014, I have been the Program Director for the Global Health Equity Enhanced Skills Residency Program in the University of Calgary's Department of Family Medicine, a program that trains new family physicians in health equity for Calgary's most vulnerable patient populations, as well as overseas. Attached at **Exhibit "1"** is my *curriculum vitae*.

4. I practice accompaniment, an approach to care that seeks to meet patients where they are in order to provide care to patients at the highest risk of poor health outcomes. My practice is a unique outreach model in Calgary, where I have seen patients in many locations by working with outreach partners in Calgary including: Connect to Care; Calgary Allied Mobile Palliative Program; EMS Mobile Integrated Health community paramedics specializing in inner city populations; the Downtown Outreach Addictions Partnership ("**DOAP Team**"); Police and Crisis Team ("**PACT**"); harm reduction housing teams, and Calgary Police Service. These partnerships have allowed me to deliver care to patients who otherwise do not access mainstream healthcare, for example rough sleepers (i.e. patients who do not use the shelters) and supervised consumption service clients. I have provided care in patients' encampments, on the streets, in shelters, in Calgary's Supervised Consumption Site ("**Safeworks SCS**"), and Lethbridge's Overdose Prevention Site ("**LOPS**").

5. Between 2009 and 2020, in my capacity as a physician providing care out of CUPS Calgary, I provided outreach care to Alpha House shelter and detox facility, the Mustard Seed, and the Calgary Drop-In Centre.

6. I have led the Calgary Street Community Capacity in Research, Education and Development Collaborative ("**Street CCRED**") since 2015. Street CCRED is a community-campus partnership with the University of Calgary O'Brien Institute for Public Health. In that capacity I have participated in many community-driven service and research initiatives, including setting up our palliative program for the homeless, creating medical supports at the Calgary Drop-In Centre, leading the early homeless-serving community response to the pandemic, and building capacity in EMS community paramedicine to respond to mental health and substance use crises and their consequences in our community.

7. With these programs and community partners described above, I have worked in many harm reduction and other settings with thousands of patients with substance use disorders ("**SUDs**"), most of which are severe and intractable forms of SUD.

8. I participated in the Alberta College of Family Physicians Opioid Response Task Force from 2017 to 2019 and subsequently the Collaborative Mentorship Network for which I provide mentorship for other family physicians in their learning to treat opioid use disorder ("**OUD**"), specifically how to prescribe opioid agonist therapy.

9. I have advised several prospective SCS operators on their medical protocols in a volunteer capacity as well as assisted in applying for exemptions pursuant to section 56 of the *Controlled Drugs and Substances Act,* SC 1996, c 19.

10. I have trained instructors in community-based overdose response as well as helped to catalyze more formalized programs such as those now conducted by Westside Harm Reduction and St. John's Ambulance.

11. My expertise is clinical, applied, and empirical rather than solely research-based.

12. On the basis of my education, academic and professional credentials, research, and work experience, I have personal knowledge of the matters set out in the affidavit, except to such matters based on information and belief.

13. The information and opinion I provide below is based on my review of the Recovery-oriented Overdose Prevention Services Guide (the "**Guidelines**"), which the Defendant Her Majesty the Queen in Right of Alberta is requiring all supervised consumption service providers follow for the delivery of services in the province. I have not attached a copy of the Guidelines to this Affidavit as I have been informed by the solicitor for the Plaintiffs and believe true that the Court has been furnished with a copy of them.

A Profile of Vulnerable Substance Users

14. My patient population is extremely complex, however they all have one thing in common: they are all at a much higher risk of poor health outcomes, including death, than the general population. My current patient panel is 100% Indigenous; from 2009-2020 I estimate it comprised on average 65% Indigenous. All of my patients must navigate competing priorities that many in the general population never need to consider, such as poverty, housing and food insecurity, legal issues and child custody.

15. From 2009 to 2020 my patient population was either living with or had a history of acute or chronic homelessness.

16. Many of the patients I have cared for between 2009 to 2020 use drugs and I would estimate that I have cared for several hundred unique individuals who have used the Safeworks SCS since it opened. I have provided care for patients, alongside allied providers such as social workers, nurses, and paramedics inside and nearby/around the Safeworks SCS. I have also witnessed overdoses outside of the vicinity of the Safeworks SCS, including at shelters and various other locations.

17. There is a broad spectrum of substance use disorder, from mild (e.g. use that is sometimes hazardous to self or others, have neglected some of one's responsibilities, have been unsuccessful at quitting) to severe. Patients with the most severe SUD must consider their substance use in all decisions at all times of the day and night, anticipating the degree and timing of their impending withdrawal symptoms. For patients who are homeless or at risk of homelessness, this complex planning is layered atop their daily survival, as they navigate daily necessities, rising violence against people who are homeless, and access to resources and services.

18. Interaction with the health care system is among the most challenging for such patients and represent a risk to them of substance withdrawal; stigma, shame, and trauma (or re-traumatization); undesirable changes in their care plans; loss of resources or property; and opportunistic exposure to law enforcement and even inappropriate information sharing.

The Contextual Provision of Supervised Consumption Services

19. The provision of supervised consumption services in Alberta occurs in a broader social context that deeply stigmatizes, shames, and criminalizes drug use. Given that context, people who use drugs are afraid of being exposed as such, and will avoid situations that subject them to such stigma and societal shaming, as many people do. Anonymity, privacy and feeling welcome makes it far easier for my patient population to access any services, including emergency shelters and food programs, as well as other sensitive health services including contraception, access to free health supplies such as drug use equipment, biohazard containers (i.e. "sharps bins"), condoms and other safer sex supplies.

20. An individual with severe intractable disease is compelled to use their substance despite potentially harmful outcomes and consequences. However, people are still very rational and will do everything they can to survive and minimize the harms associated with their own drug use where those resources exist. My patients' health seeking behaviour reflects all the ways they try to minimize not only adverse physical harm, but also their mental health (including avoidance of trauma and shaming). Many, even those who do not have a diagnosed substance use disorder, will use a supervised consumption service in the current era of poisoned drug supply, in order to survive, if they do not put themselves at excessive risk in order to do so.

21. Many things that are barriers to care are not initially apparent until one either experiences the barrier oneself, or is told about it firsthand. I have been told by many patients in the course of caring for them about their experiences with barriers and negative experiences in the health care system generally, which has included supervised consumption and other harm reduction services.

22. The most basic of these arises from the severe stigma that drug use carries in our society. I myself experienced a feeling of worry and concern when I had to call Safeworks mobile outreach to request harm reduction supplies. I worried that my neighbours would see the van or that somehow someone would find out that it was me that was asking for supplies and make assumptions. I worried I would get in trouble. Despite being equipped with thorough knowledge of the entire health care system, including harm reduction, I was nevertheless concerned about confidentiality when accessing the service.

23. I thought about my patients, all of whom are less certain about the rules and expectations within the system than I am, and may have specific reasons for worrying about confidentiality. For example, they might have outstanding transit tickets, or a warrant. People fleeing domestic violence are concerned that an abusive person in their lives might be able to find them or their children. Parents who use drugs may fear reprisal from Alberta Children's Services. Refugee claimants think that the government has access to this information and will send them an invoice to pay for services or that it will adversely affect their claim. Undocumented migrant workers worry they will be found and deported if they use health services.

24. These are all reasons that without a safe and hygienic place for my patients to consume drugs, they will do it in hiding in poor conditions.

25. Patient- and relationship-centred care that is individualized and precise is a best practice when caring for structurally vulnerable patients. In this model, a particular trusted staff member often attaches to a specific patient where there is trust in the relationship. Any program should be flexible enough that each service provider must be able and willing to provide a range of services in order for the patient to receive standard of care. For example, an adult patient with a trauma history or even attachment disorder may find it impossible to engage with a social worker to have a treatment form filled out. However they might be able to sit with a specific nurse to fill out the entire form together, including the medical

portion. That way they only have to relate their vulnerabilities to a single provider whom they trust with their most personal information[1].

26. Principles of health equity determine that these accommodations should be made whenever possible, otherwise patients are at risk of not accessing care. In the case described above, the trusted provider being willing to shift outside their usual tasks in order to complete the treatment form can very well mean the difference between that patient getting to treatment, stopping their illicit drug use, and survival. The evidence behind having trusted providers extends to the general population and in fact the current standard of care for primary care access is known as 'the patient's medical home'. This concept is known to improve care, efficiency, and cost effectiveness of primary care in the general population and should be available to everyone, including people who use drugs.

27. In many ways, supervised consumption sites for my patients is their medical home, or service hub. Barriers to accessing supervised consumption services can mean barriers to their wraparound services, whether those are in-house and integrated or part of a network of referral pathways. These can include primary care, chronic disease i.e. diabetes care, dental care, HIV and chronic hepatitis treatment, as well as social services.

The Guidelines Erect Barriers to Accessing Supervised Consumption Sites

28. Placing undue burden on staff at services and programs that serve the structurally vulnerable to adhere to rigid guidelines, including it being mandatory to ask each patient for identification in whatever circumstances arise, increases the risk of staff moral distress, burnout, and turnover. Extremely high rates of burnout and staff turnover are well-known problems in the homeless-serving sector. This translates to worse patient care, even more so in these contexts with this patient population, than in the general population. For example, if a patient enters the supervised consumption site in withdrawal and is agitated because they are sick and therefore impatient, staff insisting on identification at that point will escalate the situation and cause the patient to lose trust and possibly leave to use their drugs in an alley or park. This will cause the staff person extreme concern for the patient and feelings of helplessness, which contribute to trauma, anxiety, lack of agency and early burnout. The patient might also come to harm if they leave, or be deterred from future attendance if they do not. Regardless, staff who are trained to deal with a situation like this must have flexibility and agency to use their specialized skills and knowledge of the patients in order to provide appropriate care.

29. If people don't have access to supervised consumption services, this will not deter them from using drugs, particularly those with moderate to severe SUD who are at greatest risk of death. It will only increase the risk and potential harms of doing so in unhygienic and less safe environments, not to mention the public harms to communities that arise from increased public drug consumption, neighbourhood disorder, and needle debris. This further harms my patients because they are blamed for all of those things.

[1] Neale, J., Sheard, L., & Tompkins, C. N. (2007). Factors that help injecting drug users to access and benefit from services: A qualitative study. Substance Abuse Treatment, Prevention, and Policy, 2(1), 31. https://doi.org/10.1186/1747-597x-2-31. **Exhibit "2".**

30. The implementers of the Guidelines assume that as long as services are technically available, no matter who, where, or how they are delivered, and no matter how siloed, that they have done their job and covered themselves against negligence. But the reality is very different. How a program is delivered, its capacity for establishing trusting relationships and for opportunistic care, makes all the difference in the world. A patient who is struggling with severe intractable OUD is usually not able to attend various appointments in various places delivered by various providers. The supervised consumption site provides a location where that person can be found (if they so permit and desire), can be met with by a physician such as myself, a community paramedic or specialized nurse (such as palliative care or mental health), probation or parole officer, housing or case worker, etc. Someone who is living in homelessness with severe OUD is going to have a very difficult time with the executive functioning that is required to get their life on track, and is in survival mode. The principle of harm reduction is to meet people where they are at, and the truth is that the SCS is the only place that many people will be able, out of immediate necessity to prevent severe illness, to attend on a regular basis.

31. Destabilizing precariously-stable patients negatively affects their health and puts them at risk for worse health outcomes including death. I have been told by patients who access supervised consumption sites that when they learned of the Guidelines, specifically that they will be required to give their personal information or that they will be asked often to agree to abstinence-based treatment referrals, they started to try to think of other ways to stay safe because these new requirements will deter their use of the service. They expressed fear and anxiety, and some have either decreased or stopped accessing supervised consumption services altogether because they say they will no longer feel safe at a site that is required to collect and potentially disclose their personal information to others, or that staff may be required to meet a quota of referrals to abstinence-based treatment, which many with severe OUD feel is unhelpful and potentially quite harmful.

32. I have many patients who know from experience - that is, they have tried “recovery-oriented” services in the past, sometimes many times, and it has not helped them. Many have also experienced life-threatening relapses (i.e. overdoses) when they leave abstinence-based treatment. There is high-quality evidence that abstinence-based treatment programs increase the risk of fatal overdose in OUD relapses; many of my patients have lost friends and family this way.

33. Service users additionally report that since the government is planning to close the Safeworks site, they will be abandoned and no longer be able to access the service so they have started to try to “wean” themselves off the service ahead of time. Some have reported that they know they “might die” after the changes are implemented, and/or the service is closed. Some cite the increase in overdoses and overdose deaths in Edmonton following the closure of the Boyle Street supervised consumption site.

34. As the lowest-barrier service for people who use drugs, supervised consumption sites and overdose prevention sites are ideal places and entry points for the co-location of other services, including primary care, housing, and crisis management. Increasing barriers at that entry point not only increases the likelihood that patients will not access the life-saving medical supervision for their drug use and access to harm reduction supplies, but also be barriers to accessing primary care, housing, income supports, mental health supports and crisis management to which supervised consumption sites provides a portal.

35. I have had many patients whom I have only been able to connect with because they access supervised consumption services. Often, these patients are in need of significant and urgent care for serious and even life-threatening conditions (for example, diabetic ketoacidosis, severe alcohol withdrawal, or severe infections requiring immediate treatment). Patients suffering even these conditions will still often not go to hospital or emergency departments, often due to having experienced racism and traumatic stigmatization in mainstream medical settings. Erecting additional barriers to access supervised consumption services will have downstream effects such as these patients not receiving care for these conditions before it is too late. This can result in increased disability and death in my patient population.

36. I have personally accompanied patients directly from the SCS to detox, and a portion of those on to long term treatment, whom I believe would not have accessed those services without having first accessed SCS. This occurs because an allied provider will have an encounter with a patient at SCS and then phone me, I will secure a bed in detox/safe withdrawal and have the patient brought over at which time I will assess and treat them. Often this involves starting them on opioid substitution treatment such as buprenorphine/naloxone and/or treating withdrawal symptoms. Over their course of treatment in detox I will ensure they have door-to-door placement at a treatment centre, any paperwork and income supports in place if needed, and their medical forms completed in order to attend the program. This illustrates functional, if labour intensive, referral pathways regardless of whether a patient presents an Alberta Health number at entry to supervised consumption site, for patients who reach disease remission; people who may have been deterred at that point-of-entry if they had felt unsafe/stigmatized/shamed or that their privacy could be compromised.

37. The morbidity that is a consequence of drug poisoning is often not minor and can result in severe injuries such as anoxic (lack of oxygen) brain injury, or severe frostbite/other environmental exposure injury, accompanied by all of each case's enormous societal costs. The range of health complications associated with opioid-induced hypoxia includes kidney failure, heart complications, neurologic consequences, seizures, nerve damage, temporary motor paralysis, fluid buildup in the lungs, stroke, and pneumonia from inhaling vomitus.[2] In my clinical practice, this is true. For every fatal overdose, many more overdoses occur whose sequelae range from loss of a digit due to frostbite to severe lifelong cognitive and physical impairment requiring 24/7 nursing care.

38. The less supervised consumption service availability we have, in this era of a highly poisonous drug supply, will directly translate to increased injuries such as these. Responding to a drug poisoning promptly and effectively reduces "down time" so that not only are overdose patients' lives saved, they are also far less likely to suffer severe injuries, the severity of which bear a linear relationship to response time and efficacy.

[2] Zibbell, J. et al. (2019). Non-Fatal Opioid Overdose and Associated Health Outcomes: Final Summary Report. RTI International. https://aspe.hhs.gov/reports/non-fatal-opioid-overdose-associated-health-outcomes-final-summary-report-0. **Exhibit "3".**

39. Furthermore, people who suffer multiple non-fatal overdoses are more likely to suffer hypoxic brain injury.[3] I have cared for many patients who have overdosed multiple times (I estimate as many as 100+), and given the cumulative effect of prolonged down time, they are likely to fare much better if their overdoses are responded to promptly and adequately at an SCS.

40. Patients report to me worries that their personal information could be shared with law enforcement or that they risk prolonged exposure time to law enforcement while walking to or from the supervised consumption sites, and I feel that may not be unfounded given the seemingly disproportionate criminalization of supervised consumption site users, specifically around the Sheldon Chumir site.

41. The wording in the Guidelines also suggests that information may be shared with others. This will not only undoubtedly create fear of accessing the service for patients but may also cause them to be at increased risk of criminalization.[4] It is also unethical for health care providers to share patients' personal information with anyone or any institution without either the express permission of the patient for that specific disclosure or a court order.

Vulnerable Substance Users will be Harmed if the Guidelines are Implemented

42. In my opinion, the implementation of "Recovery-oriented Overdose Prevention Services Guide" will cause increased morbidity and mortality amongst my patients via decreased access to life saving supervised consumption services. Many substance users, particularly the structurally vulnerable substance users that I treat and work with, will no longer access supervised consumption services in Alberta due to the requirement of providing personal identifying information, a loss of trust arising from the recovery focused approach, and other requirements set out in the Guidelines. Each and every time a patient is unable to access these essential services for the reasons described above, given the current context of an extremely poisonous illicit drug supply; harsh and disproportionate criminalization of drug use; and no alternatives to access a safer supply, each patient who does not use SCS when they use drugs are at high risk of death or disability due to the anoxic brain and other injuries and sequelae caused by the central nervous system (respiratory) depressants that ubiquitously contaminate the illicit drug supply in Alberta today.

SWORN BEFORE ME at Calgary, Alberta,)
this 31 day of August, 2021.)
)
)
)

SARAH RANKIN
Barrister & Solicitor
Province of Alberta

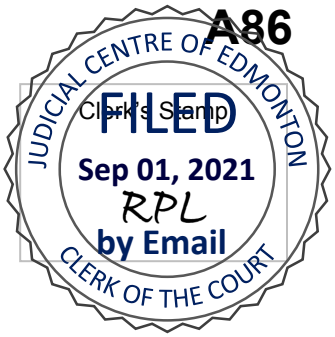
BONNIE LARSON

[3] Zibbell, J. et al. (2019). Non-Fatal Opioid Overdose and Associated Health Outcomes: Final Summary Report. RTI International. https://aspe.hhs.gov/reports/non-fatal-opioid-overdose-associated-health-outcomes-final-summary-report-0. **Exhibit "3".**

[4] Urbanik, M. M., & Greene, C. (2021). Operational and contextual barriers to accessing supervised consumption services in two Canadian cities. International Journal of Drug Policy, 88, 102991. **Exhibit "4"**.

TAB 5

A86



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JUDICIAL CENTRE	EDMONTON
PLAINTIFFS	MOMS STOP THE HARM SOCIETY and LETHBRIDGE OVERDOSE PREVENTION SOCIETY
DEFENDANT	HER MAJESTY THE QUEEN IN RIGHT OF ALBERTA
DOCUMENT	**AFFIDAVIT OF CLAIRE O'GORMAN**

ADDRESS FOR SERVICE AND CONTACT INFORMATION OF PARTY FILING THIS DOCUMENT	NANDA & COMPANY 10007-80 Ave NW Edmonton, AB, T6E 1T4 Tel.: (780) 801-5324 Fax: (587) 318-1391 Email: avnish@nandalaw.ca File: 406.00001

AFFIDAVIT OF CLAIRE O'GORMAN

Sworn on August 31, 2021

I, Claire O'Gorman, Calgary, Alberta, SWEAR AND SAY THAT:

Background

1. On the basis of my education, academic and professional credentials, research, work experience, and my role at the Safeworks Supervised Consumption Services at the Sheldon M. Chumir Health Centre ("**Safeworks**"), I have personal knowledge of the information set out in the affidavit, except to such matters based on information and belief.

2. Attached as **Exhibit "1"** to this Affidavit is a copy of my *curriculum vitae*, which sets out my education, work experience, teaching experience, academic research, and community engagement.

3. I am a licensed registered nurse in Alberta. My expertise is in public health, harm reduction, health equity, and community informed and led wellness.

4. I completed a Master's in Public Health from the University of British Columbia and my research focused on using the principles of community-based participatory research to engage in program planning and policy development around health care delivery with individuals with incarceration experience.

5. Most recently, I worked as a Knowledge Translation ("**KT**") Specialist at the National Collaborating Centre for Determinants of Health ("**NCCDH**"). Hosted by St. Francis Xavier University in Halifax, Nova Scotia, NCCDH is funded by the Public Health Agency of Canada and promotes the use of scientific research and other knowledge to strengthen public health practices and policies in Canada. As a KT Specialist, I have expertise in bringing together research and practice to ensure effective and informed decision making that reflects the interests of all stakeholders.

6. From 2015 to 2020, I worked as Program Coordinator and then Program Manager at Safeworks, an Alberta Health Services ("**AHS"**) harm reduction program that serves Calgary Zone and operates Calgary's first and only supervised consumption service.

7. My impact as a registered nurse has been recognized with distinctions and awards. I have been awarded the College & Association of Registered Nurses of Alberta Award in Administrative Excellence and the Canadian Nurses Foundation Sanofi Pasteur Award.

8. I am a Sessional Instructor at the University of Calgary, Faculty of Social Work, teaching a Harm Reduction professional development course. In 2018, I was a sessional instructor within the Certificate program *Working with Homeless Populations* and developed and delivered course materials on the Harm Reduction module. In 2014, I was a Sessional Instructor for the undergraduate course *Community Health Services* in the Faculty of Health Services at Simon Fraser University.

9. I am a contributing author to peer-reviewed publications on harm reduction initiatives, including Alberta's naloxone program, and on incorporating the perspectives of service users in the delivery of health services. I have authored reports on supervised consumption services and contributed to several Alberta Health Services policies, clinical guidelines, and resource documents regarding the delivery of supervised consumption services, opioid overdose procedures, and harm reduction guidance. I have given numerous presentations to and hosted workshops with provincial health service providers on best harm reduction practices, ethical community advocacy, health equity, social determinants of health, and supervised consumption services.

10. From 2012 to 2014, I served as Program Director at YouthCO HIV and Hep C Society, a youth-led HIV and Hepatitis C organization seeking to reduce stigma related to HIV and Hepatitis C in British Columbia. I led, trained, and coordinated staff and volunteers to

implement harm-reduction workshops, health promotion campaigns, needle-distribution, and peer-support services for youth.

11. In my various roles, I have investigated the impacts of policy and program delivery models on access to health services and subsequent impacts on health equity. I have also reviewed and studied the various regulatory models that exist in different jurisdictions in Canada regarding the delivery of supervised consumption services.

12. My history of researching, interacting with, listening to, and identifying the needs of people who use drugs, and using this information to establish effective models of delivering supervised consumption and other harm reduction services uniquely positions me to provide expertise on the effectiveness of different models of supervised consumption services.

Safeworks Calgary

13. In 2015, I was hired as program coordinator at Safeworks, which at the time was a small outreach-based harm reduction program under the umbrella of AHS' provincial sexually transmitted infection ("**STI**") services team that provided low-barrier STI testing and needle distribution for people who use illegal substances.

14. My role was to ensure that the programming developed by Safeworks reflected the interests and needs of people who use drugs in Calgary, and to ensure service uptake, especially in the context of increasing rates of drug-poisonings deaths in the Calgary Zone.

15. In 2017, as Safeworks program coordinator, I founded and co-chaired the Calgary Coalition on Supervised Consumption ("**CCSC**") alongside Leslie Hill, Executive Director of HIV Community Link. We solicited support from Dr. Katrina Milaney at the University of Calgary to conduct a needs assessment to inform service delivery planning to address rising rates of drug-poisoning deaths in Calgary. Research was conducted with over 300 people who use drugs in Calgary and identified the need for and feasibility of supervised consumption services in Calgary.

16. In 2017, Safeworks was identified as the AHS program best suited to implement supervised consumption services within the Sheldon M. Chumir Health Centre ("**SMCHC"**). As program coordinator, I helped to lead the program planning, community consultation, and implementation of Safeworks' supervised consumption site.

17. Safeworks was exempted by the federal government and funded by the provincial government to provide supervised consumption services. These services include, but are not limited to, establishing a fixed location where people can use substances in a monitored, hygienic, and non-criminalized setting, distribution of harm reduction supplies and naloxone kits, counselling, social services, and referrals to treatment for substance use disorder and other medical conditions.

18. Prior to the opening of Safeworks supervised consumption site, my role as program coordinator was to identify best practices and conduct stakeholder engagement, specifically consultation with people who use drugs to determine the service delivery model that would promote maximum service uptake within funding, regulatory, and capital restraints.

19. I consulted with Insite and the Dr. Peter Centre, which at the time were Canada's only authorized supervised consumption sites. I also studied the range of delivery models for needle exchanges in North America and determined the effectiveness of the different approaches and reviewed best practices to improve accessibility and uptake.

20. I met with and held numerous focus groups with people who use drugs in Calgary, including with the Calgary Chapter of Alberta Addicts Who Educate and Advocate Responsibly ("**AAWEAR"**). I wanted to hear directly from people who use substances about how Safeworks could best implement and provide supervised consumption services. I wanted to ensure that Safeworks would meet the needs of people who use drugs and ensure widescale uptake.

21. From these consultations and meetings that I had with supervised consumption site operators and people who use drugs, the research conducted, and my own academic and work experience, I determined that Safeworks needed to center people who use drugs and their needs in any programming offered and ensure that there was low barrier access to its supervised consumption services.

22. In order to achieve program accessibility and service-uptake, Safeworks needed to build trust with people who use drugs and offer a non-judgmental and welcoming space. The importance of a sense of community, non-judgmental support, and of "meeting people where they're at" was evident in both consultations and research findings.

23. The established supervised consumption site operators and people who use drugs in Calgary we consulted strongly recommended that anonymity and confidentiality be the core of any effective delivery model for supervised consumption services. It was clear through my consultations that such a request would prevent many people who use drugs from accessing its services.

24. As a result of these consultations, Safeworks adopted a model for delivering supervised consumption services that was based on anonymity and confidentiality. This was critical to ensuring that people who use drugs would access its services. In addition, we implemented several design and procedural recommendations to achieve low barrier model of care for delivering supervised consumption services that were rooted in the best harm reduction practices and prioritized the needs of people who use drugs. For example, inclusion of a "chill room" (also called the monitoring room), provision of snacks, and

overhead music were design elements that were incorporated to support a sense of community and help service-users feel welcome and comfortable in the space.

25. An anonymous and confidential delivery model that incorporated low-barrier access meant that anyone could obtain supervised consumption services at Safeworks without disclosing their identity or providing personal information.

26. Safeworks established a Microsoft access database uniquely designed for the delivery of supervised consumption services in an anonymous and confidential manner. Any data elements that are collected from participants for reporting or medical charting purposes is done so on a voluntary basis. Individuals can access supervised consumption services through an anonymous identifier or an agreed upon alternative identifier. There is no requirement that a service user provide any personal identifying information. Maintaining the confidentiality of service users was critical to ensuring that there would be uptake of Safeworks' supervised consumption services.

27. Safeworks developed additional policies, procedures, and programming to minimize the risks and improve the health outcomes of people who use substances. Safeworks made harm reduction supplies widely and easily accessible to anyone who needed them, outlined how substances could be used more safely, tested and provided counseling for transmissible diseases, and offered overdose prevention and response education.

28. As a result of the low-barrier, harm reduction-oriented policies adopted by Safeworks, there was significant uptake of services and noted service-user satisfaction. Safeworks became a safe and accessible space for people who use drugs where they were protected from many of the harms associated with substance use, and also gain self-worth, confidence, meaning, and membership into a supportive and nurturing community that encourages them to improve their health and social outcomes.

29. In 2019, I was promoted from program coordinator to program manager. As program manager, I was responsible for Safeworks' supervised consumption service programming, outreach programming, budgeting, human resources, and quality assurance and stakeholder engagement.

30. Safeworks was committed to ensuring that it was a low-barrier, accessible space for people who use drugs in Calgary, and it was my responsibility to ensure that services were patient-centered, evidence-based, and of high-quality. This involved addressing complaints of site users and staff members in a timely and effective manner, conducting daily on-site quality checks, and incorporating learnings from emerging evidence, data, and research. These duties included regular interactions with patients and community members to ensure that any barriers preventing individuals from accessing Safeworks were reduced.

31. In my role as program manager, I had access to data and reports generated by Safeworks. I became intimately familiar with Safeworks utilization statistics including: the number of

patients accessing the sites daily and monthly, general patient demographics, rate of drug overdoses, increases or decreases in site intake and access. Specifically, any significant drops in site intake would be scrutinized to ensure Safeworks was properly operating under the low-barrier model.

32. During my time at Safeworks, I developed and fostered relationship with other service providers and the harm reduction community in Alberta and nation-wide. I identified the best harm reduction practices and conducted ongoing consultations with people who use drugs, and integrated best practices and quality improvement measures into Safeworks' policies, procedures, and programming.

33. The Safeworks staff and I were acutely aware that continuing to ensure that it remained a safe, supportive, and accessible place for people who use drugs would mean the most number of people could access supervised consumption and wrap-around care during the overdose crisis. The risks related to inability to access supervised consumption, including the risk of overdose and death, informed the decisions we made.

The Importance of Low-Barrier Access

34. According to voluntary data that was collected from service users, the vast majority of individuals who access Safeworks' supervised consumption services experience homelessness and unstable housing, are disproportionately Indigenous, and many site users who are women-identifying are involved in survival sex work. The significant majority of site users are living in poverty. Lived experiences of trauma, mental health-related needs, and other chronic health conditions are common among people who access Safeworks.

35. Safeworks serves an extremely vulnerable and systemically marginalized population, who frequently report experiencing dismissiveness, discrimination, and a lack of compassion and poor care from health care and social service providers, and therefore do not trust that all health and social service providers are working in their best interests.

36. Many individuals who access Safeworks have a history of criminal charges or incarceration, most often related to drug-possession or petty-crime that is committed to acquire illegal substances. As a result, many supervised consumption site users are especially concerned about their information being shared with police or Child and Family Services.

37. Based on my experience at Safeworks, I know first-hand how important it is for supervised consumption services to provide non-judgmental and welcoming services for a population that is highly stigmatized and often discriminated against to establish trust and therapeutic relationships. It is critical that substance users are assured that they will face no negative consequences or judgment for using illegal substances and accessing supervised consumption services.

38. Supervised consumption services must be low barrier to ensure that people who use drugs will access them. This is an integral part of ensuring that supervised consumption sites play an effective and robust role in addressing the opioid overdose crisis.

39. The 2017 Alberta Drug Use and Health Survey in Calgary funded by the Alberta Community Coalition on HIV and conducted by Dr. Katrina Milaney asked people who use illicit substances in Calgary whether they would access supervised consumption services if they had to show identification. The study revealed that only 35% of over 300 respondents would access supervised consumption services if that requirement was imposed.[1] 65% of respondents said that they would not access supervised consumption services if this information was requested. This finding is consistent with what I heard from site users, stakeholder focus groups, and others whom I consulted in developing the supervised consumption service programming at Safeworks.

40. Safeworks and most supervised consumption sites in Alberta are structured in a manner that minimizes as many barriers to accessing supervised consumption services as possible. This includes adhering to a model of care that is premised on anonymity and confidentiality. This builds and maintains trust that other health care providers and police agencies will never be able to identify them as people who use drugs without explicit client consent. If supervised consumption sites never request or possess the personal identifying information of people who use drugs, there is no fear that this personal information will be disseminated shared with others.

41. As a result of the deliberate strategy employed by Safeworks to provide low-barrier, anonymous and confidential access to supervised consumption services, the site has had 203,418 client visits since it commenced operation (up to and including July 31, 2021). Safeworks staff have responded to over 3000 overdoses with no fatalities.[2]

The Guidelines Impose Barriers on People who use drugs in Alberta

42. The Recovery-Oriented Overdose Prevention Services Guide (the "**Guidelines**") will impose significant barriers on people who use drugs accessing supervised consumption sites in Alberta.

43. The Guidelines will transform how many supervised consumption site operators deliver these services in Alberta. Supervised consumption sites will transition from an anonymous and confidential community-based model for delivering supervised consumption services

[1] Milaney, K, Williams, N. "Nothing About Us Without Us": Results from the Alberta Drug Use and Health Survey in Calgary. October, 2017. HIV Community Link and University of Calgary. Attached to this affidavit as **Exhibit "2"**.

[2] Alberta Health Services. Safeworks Monthly Report, Supervised Consumption Services – July 2021. August 12, 2021. Retrieved from https://www.albertahealthservices.ca/assets/info/amh/if-amh-sup-con-chumir-2021-07.pdf Attached to this affidavit as **Exhibit "3"**.

to one that integrates the access and delivery of these services within the broader health care system.

44. People who use drugs will now be asked to provide their personal health care number ("**PHN**") and other identifying details to supervised consumption site operators for them to record, store, and share with others through electronic medical record systems. The Plaintiffs' solicitor informs me, and I believe true, that this information can then be shared with other health care professionals and even the police without the further consent of people who use drugs. This is also my understanding based on my review of the Guidelines, *Mental Health Services Protection Regulation*, *Mental Health Services Act*, and *Health Information Act*.

45. This will impose a major barrier for people who use drugs accessing supervised consumption services in Alberta. Although it is unclear if there will be an opt-out provision under the Guidelines, I believe the effects will be the same in either circumstance. Many, if not the majority, of people who use drugs, will disengage from accessing supervised consumption sites, fearing that their interaction with a site that collects and shares this information with others might lead to further stigmatization and even criminalization.

46. People who use drugs have legitimate concerns of supervised consumption services providers requesting, collecting, and sharing their personal information with other health care providers and the police. At Safeworks, both as part of my consultation efforts in developing the site's policies and throughout my time working there, the most common concern raised by service users was whether they would be outed as people who use drugs.

47. This population faces significant hostility and discrimination in the health care system and routinely engages in criminal activity through the consumption of illicit substances and may also sustain their substance use in the form of survival sex work and petty crime. Their experiences are substantiated by my own experiences: I have personally witnessed Safeworks service users face significant discrimination in the health care system that led to a lower quality of care and exposure to real harm, and there were a number of police operations near and immediately outside of Safeworks targeting people who use drugs that I had to personally intervene in in order to ensure services could remain accessible.

48. The concerns of people who use drugs around being identified as a substance user, and this information being collected and shared with others whom they do not want this information shared, is not irrational paranoia. It is grounded in the lived experience of people who use drugs and will be a barrier that prevents many from accessing supervised consumption services, particularly the most marginalized and vulnerable.

49. In the focus groups and discussions that I have had with people who use drugs, I was told repeatedly that collection of PHNs and other personal information of people who use drugs, even if voluntary, would impose a significant barrier for individuals accessing the sites.

People who use drugs informed me that they would no longer access supervised consumption services at Safeworks if this information was requested. The academic literature and my consultations made clear that the low barrier access to supervised consumption services required an anonymous and confidential model of delivery. The slightest indication that a supervised consumption site was recording, holding, and sharing this information would undermine the trust of people who use drugs and cause them to disengage from accessing supervised consumption services.

50. Verbal assurances of safety from staff are not enough to mitigate such fears. Individuals accessing these sites must be satisfied with the structures and procedures in place to keep them feeling safe and secure. Even with the perception that a supervised consumption service provider is engaging in a practice that may undermine the interests of people who use drugs, particularly around disclosure of their substance use, they will stop accessing services. This is a highly marginalized and vulnerable population that does not trust health and social care providers.

The Guidelines Will Harm People who use drugs

51. In my opinion, for the reasons set out above, the Guidelines will result in large numbers of people who use drugs to disengage or no longer access supervised consumption services in Alberta. The request for PHNs and other personal identifying details of people who use drugs, even on a voluntary basis, establishes a major barrier to accessing supervised consumption services. Many people who use drugs will rather consume substances on their own in an unsafe manner than access supervised consumption sites that do not deliver their services anonymously and confidentially, exposing them to the range of harms associated with street sourced substance use, including an increased risk of acquiring disease such as Hepatitis C and HIV, developing medical conditions such as heart failure and endocarditis, experiencing non-fatal overdoses, and dying from an overdose.

SWORN BEFORE ME at Calgary, Alberta,)
this 31 day of August 2021.)
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CLAIRE O'GORMAN

SARAH RANKIN
Barrister & Solicitor
Province of Alberta

TAB 6

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COURT FILE NUMBER	2103 11484
COURT	COURT OF QUEEN'S BENCH OF ALBERTA
JUDICIAL CENTRE	EDMONTON
PLAINTIFFS	MOMS STOP THE HARM SOCIETY and LETHBRIDGE OVERDOSE PREVENTION SOCIETY
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DOCUMENT	**AFFIDAVIT OF BERNADETTE PAULY**
ADDRESS FOR SERVICE AND CONTACT INFORMATION OF PARTY FILING THIS DOCUMENT	NANDA & COMPANY 10007 – 80 Avenue Edmonton, AB T6E 1T4 Tel.: (780) 801-5324 Fax: (587) 318-1391 Email: avnish@nandalaw.ca File:

AFFIDAVIT OF BERNADETTE PAULY

Sworn on August 31, 2021

I, Bernadette Pauly, of the City of Victoria, in the Province of British Columbia, MAKE OATH AND SAY THAT:

1. I am a Registered Nurse and Researcher with a Ph.D and recognized as a leading community engaged scholar in Canada in the area of health equity, harm reduction and substance use. I am a University of Victoria Provost Community Engaged Scholar, Island Health Scholar in Residence and recognized as a City of Victoria Honorary Citizen.

2. I have received numerous awards including the prestigious Ron Draper Award for Health Promotion, a University of Victoria Community Leadership Award and a BC Community Leadership Award. Attached as **Exhibit "1"** to this Affidavit is a copy of my *curriculum vitae*.

3. My expertise is in the impacts and outcomes of harm reduction services, populations who are homeless and impacted by poverty and harms of licit and illicit substance use, health equity and health services including access to health care for populations who use illicit and licit drugs.

4. My post-doctoral focus of study was health care ethics and policy. I have conducted ethical analysis of harm reduction services including SCS drawing on professional standards of healthcare ethics. This work has been published in peer reviewed nursing journals in Canada.

5. I have done evidence reviews of harm reduction services and informed national nursing and housing policy on inclusion of harm reduction services in healthcare and housing

6. I have reviewed and contributed to operational guidance outlining best practices in SCS and OPS including National SCS Guidelines as well as British Columbia provincial OPS guidelines.

7. I have conducted research on the implementation and impacts of overdose prevention sites with reports provided to Health Canada with recommendations for operation as well as publishing in peer reviewed journals on this topic.

8. Avnish Nanda of Nanda & Company has informed me and I believe true that the Defendant Her Majesty the Queen in Right of Alberta has adopted a set of guidelines that supervised consumption service providers must adhere to be authorized to operate in Alberta. Attached at **Exhibit "2"** to this Affidavit is a copy of the guidelines.

9. I have been retained by Nanda & Company as an expert witness to provide an understanding of the impacts the guidelines may have on people accessing supervised consumption services in Alberta, the ethics around adopting the measures set out in the guidelines, and British Columbia's approach to regulation overdose prevention sites in the context of the overdose crisis. These topics all fall within my research, writing, and work expertise.

10. I certify that I am aware of my duty as an expert witness to assist the court, and not to be an advocate for any party. I have made this affidavit and have given this written testimony in conformity with that duty. If I am called on to give further testimony, it will be in conformity with that duty.

11. On the basis of my education, credentials, research, publications, and other relevant experience, I have personal knowledge of the information set out in this affidavit, except to such matters based upon information and belief.

An Overview of the Research on Barriers to Accessing SCS/Harm Reduction

12. People who use illicit drugs face multiple barriers to accessing healthcare that include both interpersonal and structural barriers [1] [2] [3]. Barriers to accessing care are increased for persons who are living in poverty or homelessness and may be amplified for those who identify as Indigenous and or identify as LGBTQ2.

13. Such barriers are particularly problematic as people who use illicit drugs often have unmet healthcare needs and lack access to essential healthcare. These barriers may include lack of transportation, competing priorities such as the need to find food and fears related to treatment and quality of care.

14. A major barrier to care is concerns about being judged and/or punished for using drugs in spite of specific health care needs and the fact that drug use is often a response to trauma and coping with difficult life circumstances. Real and perceived judgements can result in avoiding or delaying care or leaving care early before treatment is completed.

15. Judgements or negative attitudes of health care providers are best understood as forms of stigma and discrimination in which those in positions of power have the ability to name differences, label, stereotype, and thereby stigmatize certain behaviors.

16. Stigma is often deeply embedded in healthcare systems and although judgements based on drug use are contrary to professional ethics of nurses and other health care providers, such stigma is perpetuated and reinforced by societal norms and current drug policies that criminalize drug use.

17. In our research on cultural safety and access to health care with people who use drugs, we identified that feeling criminalized or under surveillance acts as a barrier to healthcare and can be reflected in the attitudes of healthcare providers.[4] In fact, people who use drugs often do not feel safe to access healthcare and as result of long histories of systemic and ongoing trauma often have high levels of distrust of healthcare services.

[1] Iammarino, C., and Pauly, B. Harm reduction as an approach to ethical nursing care of people who use illicit substances: an integrative literature review of micro and meso influences. Drugs: Education, Prevention and Policy 2020. DOI: DOI: 10.1080/09687637.2020.1840515. **Exhibit "3"**.
[2] B. Wallace, K. MacKinnon, H. Strosher, C. Macevicius, C. Gordon, R. Raworth, Marcellus, L., Urbanoski, K. Pauly, B. Equity oriented frameworks to inform opioid overdose responses: A scoping review. JBI Evidence Synthesis 2021 Vol. 19 Issue 8 Pages 1760-1843 DOI: doi: 10.11124/JBIES-20-00304. **Exhibit "4"**.
[3] B. Pauly, J. McCall, A. Brown, J. Parker and A. Mollison. Toward cultural safety: Nurses' and patients perceptions of substance use in hospitals. Advances in Nursing Science 2015 Vol. 38 Issue 2 Pages 121-135. **Exhibit "5"**.
[4] B. Pauly, J. McCall, A. Brown, J. Parker and A. Mollison. Toward cultural safety: Nurses' and patients perceptions of substance use in hospitals. **Exhibit "5"**.

18. In research I have conducted, gaining trust and the development of trusting relationships is often identified as a key facilitator of access to healthcare[5] [6] [7] [8]. Supervised consumption sites and overdose prevention sites often provide a point of access to both harm reduction and health services including much needed primary care as well as referrals to other health and social services such as detoxification and treatment [9].

19. SCS and OPS are considered low barrier services because they embrace a harm reduction approach which aims to reduce harms of drug use including provision of a non-judgmental approach to drug use which is core to developing trusting relationships and facilitating access to healthcare.

20. Thus, supervised consumption sites and overdose prevention sites often provide a much needed point of access to healthcare and can be a first step in provision of essential health services as well as access to referrals for other health and social services.

Impact of PHN/Other Requirements on Barriers to Accessing SCS/Harm Reduction

21. Individuals who use illicit drugs and who may be living in unstable housing or experiencing homelessness are living in situations in which they are vulnerable to lose and theft of their belongings. This may be due to belongings being confiscated or impounded by police, bylaw or other security forces or due to theft of personal belongings due to lack of private spaces and locking doors.

22. Thus, it may be difficult to produce healthcare cards which can act as deterrent to the use of SCS if individuals believe they will require a healthcare card or if services specifically require that the card be produced in order to access healthcare services. While there are physical barriers that may interfere with the ability to produce a healthcare card, the perception that a card is required may also deter use for several reasons.

23. First, the person may not access the service believing they need a card, give a number or fear that refusing to give a PHN will impact the quality of their care. Second, they may not access the service for fear that their health information may be shared with police or justice system. In an SCS where illicit drugs are being brought onsite to use in a safer

[5] Pauly, B., Close to the street: Nursing practice with people marginalized by homelessness and substance use. In: Homelessness and Health in Canada, edited by S. Hwang and M. Younger. University of Ottawa Press 2014. **Exhibit "6"**.
[6] B. Pauly, B. Wallace, F. Pagan, J. Phillips, M. Wilson, H. Hobbs, Connolly, J. Impact of overdose prevention sites during a public health emergency in Victoria, Canada. PLoS ONE 2020 Vol. 15 Issue 5. https://doi.org/10.1371/journal.pone.0229208. **Exhibit "7"**.
[7] McCall and Pauly B., Sowing a seed of safety: Providing culturally safe care in acute care settings for people who use drugs. Journal of Mental Health and Addictions Nursing 2019 Vol. 3 Issue 1 Pages 1-11. **Exhibit "8"**.
[8]MacNeil, J., and Pauly, B. Needle exchange as a safe haven in an unsafe world. Drug & Alcohol Review 2011 Vol. 30 Issue 1 Pages 26-32. DOI: 10.1111/j.1465-3362.2010.00188.x. **Exhibit "9"**.
[9] Pauly, B., Wallace, B. et al. Impact of overdose prevention sites during a public health emergency in Victoria, Canada. **Exhibit "7"**.

environment, the requirement of having to provide a PHN could act as a deterrent to care even if they are not required to produce a PHN.

24. In other words, the knowledge that such information is being stored could be a barrier to accessing SCS services. There is an inherent risk of loss of anonymity and confidentiality which is an essential feature of SCS as a health service. Thus, safety concerns would prevent use of SCS and ultimately increase harms of drug use.

25. When people use alone or without access to clean supplies their risk of overdose, HIV, Hepatitis C, abscesses and other infections are increased. This can result in poorer health and increased costs from conditions which could be prevented as well as perpetuating a lack of access to other health and social care that could benefit the health and well-being of people who use drugs.

The Ethical Implications of the Proposed Approach

26. As described above the barriers to health care experienced by people who use drugs especially when they intersect with other marginalizing conditions such as poverty and homelessness or some aspect of one's identity that is already subject to discrimination such as cultural, or gender identifies are considered inequities.

27. Inequities are considered unfair or unjust because they are rooted in structural conditions such as policies that produce harm that are not fully under the control of individuals to mitigate.[10] These inequities in access to health care are both morally and ethically objectionable in that we embrace and ascribe a high level of importance and value to universal access to health care in Canada.

28. Supervised consumption sites as well as other harm reduction services mitigate some of the existing inequities in access to healthcare and provide a point of entry into the healthcare system for individuals who face significant barriers to accessing health services.

29. Further registered nurses and other health care professionals have specific obligations to address and reduce health inequities as well as inequities in access to healthcare. Specific examples of this can be found in Part II of the Canadian Nurses Association Code of Ethics[11] and commitments such as that of the Canadian Medical Association to further equity in professional practice.

[10] B. Pauly, Harm reduction through a social justice lens International Journal of Drug Policy 2008 Vol. 19 Issue 1 Pages 4-10. http://www.sciencedirect.com/science/article/pii/S0955395907002411. **Exhibit "10"**.
[11] Canadian Nurses Association, Code of Ethics for Registered Nurses. 2017. https://www.cna-aiic.ca/-/media/cna/page-content/pdf-en/code-of-ethics-2017-edition-secure-interactive.pdf. **Exhibit "11"**.

30. As such, introducing requirements such as a PHN can put nurses and other health care providers into a position of moral compromise and ethical tension. For example, if healthcare providers are required to obtain a PHN, they will have to weigh the risks and benefits of the need for care versus the requirements for care. In this scenario, they will be placed in a difficult position and the choice of following organizational policies and refusing care potentially in the face of urgent needs for care.

31. Healthcare providers are already under considerable moral strain in providing healthcare to people who use drugs in which they are often unable to address the broader structural conditions that produce trauma and harms in the first place and expend considerable energy and effort to create trusting relationships in a context of systemic distrust[12].

32. Adding requirements that increase barriers to care will do little to reduce existing inequities, will increase barriers to care and potentially increase ethical issues for providers. Thus, from an ethical perspective of professional responsibilities to address or reduce inequities, the proposed approach falls short and has unfortunate and unintended consequences of potentially increasing inequities in access to healthcare which is morally and ethically objectionable.

British Columbia's Regulation of Overdose Prevention Sites

33. In the wake of escalating overdose deaths and a declaration of a public health emergency due to overdoses, the province of British Columbia issued a Ministerial order for the establishment of overdose prevention sites. We analyzed this policy directive and identified that it provided for the establishment of low barrier overdose prevention sites that serve many of the same functions as supervised injection sites including provision of clear supplies, harm reduction education, prevention and early identification of overdose[13].

34. Part of the unique features of overdose prevention sites are being community driven and established in a manner that is acceptable and welcoming to people who use drugs.

35. BC Guidelines for the operation of these sites have been developed and clearly delineate that such sites should not be subject to policing, surveillance or requirements for access

[12] Pauly, B., Close to the street: Nursing practice with people marginalized by homelessness and substance use. **Exhibit "6"**.
[13] B. Wallace, F. Pagan and B. Pauly, The implementation of overdose prevention sites as a novel and nimble response during an illegal drug overdose public health emergency. International Journal of Drug Policy 2019 Vol. 66 Pages 64-72. . **Exhibit "12"**.

to services. Anonymity and confidentiality of client information is of utmost importance as outlined in these guidelines with specific reference to signing of confidentiality agreements by workers.

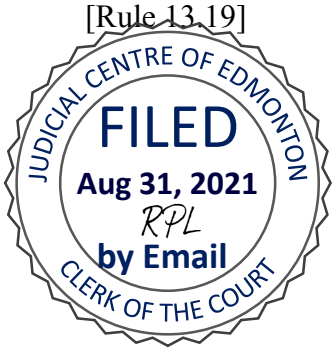
SWORN BEFORE ME at Victoria, British Columbia, this 31st day of August 2021.

BERNADETTE PAULY

David W. Wu
Barrister
Arvay Finlay LLP
360 – 1070 Douglas Street
Victoria, BC, V8W 2C4

TAB 7

Form 49
[Rule 13.19]



COURT FILE NUMBER	2103 11484
COURT	COURT OF QUEEN'S BENCH OF ALBERTA
JUDICIAL CENTRE	EDMONTON
PLAINTIFFS	MOMS STOP THE HARM SOCIETY and LETHBRIDGE OVERDOSE PREVENTION SOCIETY
DEFENDANT	HER MAJESTY THE QUEEN IN RIGHT OF ALBERTA
DOCUMENT	**AFFIDAVIT**

ADDRESS FOR SERVICE AND CONTACT INFORMATION OF PARTY FILING THIS DOCUMENT	NANDA & COMPANY ATTN: Avnish Nanda 10007 80 Avenue NW Edmonton, AB T6E 1T4 Tel: 780-801-5324 Fax: 587-318-1391 Email: avnish@nandalaw.ca

AFFIDAVIT OF SAHIL GUPTA

Sworn on August 31, 2021

I, Sahil Gupta, of Toronto, Ontario, SWEAR AND SAY THAT:

1. As a result of my education, training, credentials, work experience, and other details set out below, I have personal knowledge of the information set out in this affidavit, except to such matters based upon information and belief.

2. I have worked as an emergency medicine physician since 2018, and my clinical practice has had a focus on inner-city populations. marginalized peoples, and the treatment of those with substance use disorders. I have worked at three urban academic inner-city hospitals, including St. Paul's Hospital in Vancouver, B.C., Royal Alexandra Hospital in Edmonton, AB, and St. Michael's Hospital in Toronto, ON. Attached as **Exhibit "1"** to this Affidavit is a copy of my *curriculum vitae*.

3. I completed my residency in Edmonton, AB, and graduated as a specialist under the Royal College of Physicians and Surgeons of Canada in Emergency Medicine in 2018.

4. In June of 2018, I completed the Opioid Dependency Treatment course at CAMH in Toronto, ON, and began providing opioid agonist therapy ("**OAT**") to patients suffering from opioid addiction.

5. I also currently serve as the medical director at the COVID Recovery Site in Toronto, ON, and I also work with the Addiction Recovery and Community Health ("**ARCH**") team in Edmonton, AB as a locum physician. Both settings serve a large proportion of patients experiencing substance use disorders. I treat structurally vulnerable patients living with substance use disorder, and develop programs and policies to provide medical care to this unique population. Many of my patients regularly access supervised consumption services in Alberta and Ontario, and the medical care I provide are ancillary to the support they receive at supervised consumption sites.

6. I have been retained by Nanda & Company as an expert to review the regulations proposed by the Defendant Her Majesty the Queen in Right of Alberta ("**HMQA**") around accessing supervised consumption services in the province and their impact on substance users and those accessing supervised consumption services. The materials Nanda & Company has provided me to review include the guidelines prepared by HMQA that supervised consumption service providers in Alberta must follow (the "**Guidelines**"), and a service provider checklist and Q&A guide that outlines the operational changes that result from the regulatory changes (the "**Operational Documents**"). I believe these materials to be true and reflect HMQA's position on the regulations developed for providing and accessing supervised consumption services in Alberta. Attached as **Exhibit "2"** to this Affidavit is a copy of the Guidelines. Attached as **Exhibit "3"** is a copy of the Operational Documents.

7. I certify that I am aware of my duty as an expert witness to assist the court, and not to be an advocate for any party. I have made this affidavit and have given this written testimony in conformity with that duty. If I am called on to give further testimony, it will be in conformity with that duty.

Supervised Consumption Services: the Importance of Anonymity

8. Safe consumption spaces are places where people who use drugs can safely consume substances they have under supervision.

9. Safe consumption spaces have benefits both for the person using drugs including reduced overdose mortality, reduced HIV infection and for society, including safe syringe disposal and less public injecting.[1]

10. A core principle of these harm reduction and prevention programs related to drug use remains the principle of confidentiality and anonymity.

11. In the Canadian context, two types of safe consumption spaces exist - one usually run by healthcare organizations are known as supervised consumption sites ("**SCS**") and others run by community or peer organizations, known as overdose prevention sites ("**OPS**"). Both provide supervised consumption services.

[1] Stoltz JA, Wood E, Small W, Li K, Tyndall M, Montaner J, Kerr T. Changes in injecting practices associated with the use of a medically supervised safer injection facility. J Public Health (Oxf). 2007 Mar;29(1):35-9. doi: 10.1093/pubmed/fdl090. Epub 2007 Jan 17. PMID: 17229788, attached as **Exhibit "4".**

12. While both types of safe consumption spaces require trust building due to structural stigma that people who use drugs face, the burden is higher for SCS sites as healthcare spaces to establish a safe, welcoming space.

13. Anonymous participation in healthcare is also not unique to safe consumption spaces.

14. People facing stigma for their medical illness or behavior often choose not to participate in medical or preventative care.

15. Low barrier participation including anonymous and confidential participation allows engagement of people who would not otherwise engage in care. There are a number of examples in healthcare settings:

    a. Needle exchange programs, which offer safe supplies for people who use drugs, maintain a similar principle of anonymity for client participation into their programs.

    b. Clinics offer HIV and STI testing anonymously because of concerns of consequences of linking that information to their personal health records.

    c. Clinics offering care to undocumented persons allow anonymous participation to encourage people to attend who would otherwise be afraid of deportation.

16. From a medical and health care policy standpoint, safe consumption spaces should offer anonymous and confidential participation. This helps build trust with drug uses and keep a low-barrier space. An anonymous and confidential approach to accessing supervised consumption services is considered the best and most effective method to delivering these services to substance users, particularly substance users living with structural vulnerabilities.

The Regulatory Changes Impose Barriers to Accessing SCS Services

17. Asking people to provide personal health information, including their medical Personal Healthcare Number ("**PHN**") is a significant departure from a core principle in engaging in treatment for safe consumption sites.

18. Criminality of drug use remains a constant fear for people who use drugs.

19. People who use drugs are frequently brought to healthcare settings without their volition after an overdose.

20. Safe consumption sites rely on emergency services including police and ambulance services to transport patients to hospital in events of medical emergencies and serious overdoses.

21. Police presence is a barrier to engaging in care for people who use drugs and a barrier for people using SCS.[2]

[2] Bardwell, G., Strike, C., Altenberg, J. et al. Implementation contexts and the impact of policing on access to supervised consumption services in Toronto, Canada: a qualitative comparative analysis. Harm Reduct J 16, 30 (2019). https://doi.org/10.1186/s12954-019-0302-x, attached as **Exhibit "5".**

22. People fear being identified in healthcare settings like the emergency room, people being identified, being charged for possession of illegal substances, or being asked to appear for pending warrants.

23. Patients I care for in the emergency room are sometimes taken into custody for pending charges they may have.

24. Linking personal health information at SCS would increase the possibility of people who use drugs being identified, no longer making it a safe space due to fear of being persecuted or associated with criminality.

25. People using drugs carry the stigma of addiction, often exacerbated by a number of factors including but not limited to poverty, homelessness, negative experiences from previous healthcare interactions, interpersonal violence and childhood adverse events,.

26. In my clinical practice as an emergency physician, people who use drugs often are fearful of disclosing their drug use to healthcare providers.

27. Many people who use drugs delay coming to hospital and leave before their treatment is complete against medical advice.

28. Medical care for people who use drugs is complicated by concerns of stigma, discrimination, and challenges in accessing care.

29. Lack of anonymity of drug use was identified as a barrier for drug users to use hospital-based SCS in Alberta.

30. Patients choose not to disclose their drug use to medical providers for fear of associated stigma and impact of that information on their medical record in future interactions.

31. There is shame and fear associated with using substances, even more so in events such as overdose and relapse.

32. Asking for personal identifying information at SCS will turn people who use drugs away in fear of their healthcare providers finding out about their ongoing drug use.

33. Asking for people's PHN will link their attendance to their healthcare record.

34. Furthermore, based on the "Supervised Consumption Services - Information Session Q+A" the "Supervised Consumption Services - Information Session Q+A" found at Exhibit "3" to this Affidavit the "Consent for disclosure is only required when a custodian does not have authority under the *[Health Information Act*] to disclose an individual's health information without their consent." In a time of increased connectivity and digitization in Alberta, this would mean that every healthcare provider accessing a person's healthcare record would know about when that person did or did not attend a SCS based on "Event History" for that person's Alberta Netcare Portal.

35. Given the stigma and discrimination that people who use drugs face, linking attendance at SCS to a PHN would be damaging step to that person's agency and has many health and social consequences for that person.

36. People who use drugs fear institutions and authorities, often for good reasons due to historic and ongoing harms they face.

37. Based on details from the "Supervised Consumption Services - Information Session Q+A" found at Exhibit "3" to this Affidavit it is my understanding that collection of personal health information, whether or not that includes PHNs, will be encouraged as part of service delivery.

38. Even if people are not turned away from accessing SCS for refusal to provide personal health information, requiring service providers to ask clients about their PHN creates a distrust for SCS and puts up a barrier to access for this space.

39. Based on my expertise and clinical work experience working in healthcare with people who use drugs, and reviewing the requirements made of SCS service providers to collect personal health information and PHN from people who use drugs, it my opinion that it will cause major harms to people who use drugs in Alberta.

40. Collecting personal health information and PHNs at SCS has the potential for people to be identified, tracked, charged by law enforcement, or other healthcare providers finding out about their attendance at SCS. It links their substance use to other facets of their life.

41. Introducing these requirements will create the potential for SCS to no longer be safe spaces for people who use drugs.

42. It will create distrust from institutions that have worked hard to build the trust of people who are routinely disenfranchised and turned away from institutional care.

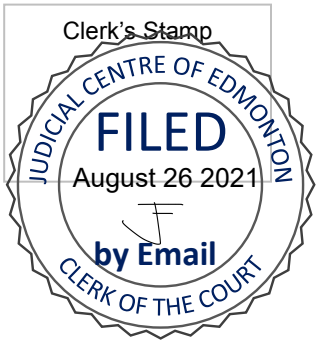
43. In my professional opinion, the proposed regulations will cause people who use drugs in Alberta to choose unsafe practices where they may use alone or unsupervised, rush their drug use, re-use supplies, or consume drugs in other unsafe manners. Drug consumption in this manner can lead to demonstrable harms including increased fatal overdose risks, increased non-fatal overdose risks, increased spread of bloodborne infections such as HIV and Hepatitis C, and bacterial infections such as infectious endocarditis and skin infections. If the regulations are implemented, it is likely that many drug users in Alberta will experience these harms, including an increased risk of death, by deciding to consume drugs in these unsafe manners rather than utilize supervised consumption sites in the province.

SWORN BEFORE ME at Toronto, Ontario,)
this 31 ST day of August, 2021.)
)
)
)

R. Ahya (LSO # 72991P)

SAHIL GUPTA

TAB 8



COURT FILE NUMBER	2103 11484
COURT	COURT OF QUEEN'S BENCH OF ALBERTA
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PLAINTIFFS	MOMS STOP THE HARM SOCIETY and LETHBRIDGE OVERDOSE PREVENTION SOCIETY
DEFENDANT	HER MAJESTY THE QUEEN IN RIGHT OF ALBERTA
DOCUMENT	**AFFIDAVIT OF DEVYN ENS**

ADDRESS FOR SERVICE AND CONTACT INFORMATION OF PARTY FILING THIS DOCUMENT	NANDA & COMPANY 10007-80 Ave NW Edmonton, AB, T6E 1T4 Tel.: (780) 801-5324 Fax: (587) 318-1391 Email: avnish@nandalaw.ca File: 406.00001

AFFIDAVIT OF DEVYN ENS

Sworn on August 26, 2021

I, Devyn Ens, of the City of Edmonton in the Province of Alberta, MAKE OATH AND SAY THAT:

1. I am a Paralegal at Nanda & Company, the law firm that is representing the Plaintiffs Moms Stop the Harm Society and Lethbridge Overdose Prevention Society, and as such, have personal knowledge of the matters set out in this affidavit, except to such matters based on information and belief.

2. The information that I provide in this affidavit is based on my review of the Hansard records from the Legislature of Alberta and Parliament of Canada and social media posts made by the Premier of Alberta and the previous Associate Minister of Mental Health and Addictions. I have attached true copies of the Hansard records and social media posts to this Affidavit.

3. Attached as **Exhibit "1"** to this Affidavit is a copy of sections of the Hansard records from the Legislature of Alberta that relate to supervised consumption services in Alberta and the impugned regulations set out in the *Mental Health Services Protection Regulations,* RSA 2018, Alberta Reg 114/2021 that are the basis for this lawsuit.

4. Attached as **Exhibit "2"** to this Affidavit is a copy of sections of the Hansard records from the Parliament of Canada that relate to the regulation of supervised consumption services and amendments made to the *Controlled Drugs and Substances Act*, SC 1996, c 19 in 2017.

5. Attached as **Exhibit "3"** to this Affidavit are copies of social media posts made by the Premier of Alberta Jason Kenney and previous Associate Minister of Mental Health and Addictions Jason Luan.

6. Attached as **Exhibit "4"** to this Affidavit is the Recovery-oriented Overdose Prevention Services Guide, released by the Government of Alberta in April 2021.

SWORN BEFORE ME at Edmonton, Alberta, this 26th day of August 2021.)

Avnish Nanda
Barrister and Solicitor
Commissioner for Oaths/Notary Public
in and for the Province of Alberta

DEVYN ENS

This is Exhibit "Z" referred to in the affidavit (or statutory declaration) of

Devyn Ens

sworn (or affirmed or declared) before me

this 26 day of August 20 21

A Notary Public in and for the Province of Alberta

Avnish Nanda
Barrister and Solicitor
Commissioner for Oaths/Notary Public
in and for the Province of Alberta

HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

House of Commons Debates

VOLUME 148 • NUMBER 177 • 1st SESSION • 42nd PARLIAMENT

OFFICIAL REPORT
(HANSARD)

Monday, May 15, 2017

Speaker: The Honourable Geoff Regan

HOUSE OF COMMONS

Monday, May 15, 2017

The House met at 11 a.m.

Prayer

PRIVATE MEMBERS' BUSINESS

● (1105)

[*English*]

ITALIAN HERITAGE MONTH

The House resumed from November 18, 2016 consideration of the motion.

Mr. Kevin Waugh (Saskatoon—Grasswood, CPC): Mr. Speaker, I wish to speak to Motion No. 64, Italian heritage month. As deputy critic for Canadian heritage for our party, I certainly support the motion.

The first Italian to land in Canada was the explorer Giovanni Caboto. That was back in 1497. He is better known to us as John Cabot. The first settlement of Italians in Canada did not occur, though, until 1865, when soldiers from areas of what is present-day Italy were recruited by the French army.

Italians also served with the British military in Lower Canada during the war of 1812. When their regiments were disbanded in 1816, some of the soldiers stayed in Canada, settling in Ontario and in the Eastern Townships.

The first significant wave of Italian immigration began in the early 1870s, until 1914. With the construction of the railroad in Canada, demand for workers was sensational. The second wave occurred between 1920 and 1930, and the greatest number of Italians came to this country between 1950 and the 1970s.

Leaving Italy, of course, was not easy for many of them. One Italian immigrant commented:

> I know that my father loved his family, his home and his country and the experience of leaving it all behind must have been heartbreaking, nonetheless he pressed on towards the Canadian shores to give his family a new...life.

Those who came to Canada after World War II came from a war-torn country to build a better life for their families. There were very few jobs in Italy, so a number of families decided to make the move to Canada. Many came to Canada with just a suitcase in their hand, and that was all they had.

Today, there are approximately 1.4 million Canadians of Italian descent. Of the 10,000 who live in Saskatchewan, the majority live in Saskatoon and Regina. About 3,000 make Saskatoon their home, and almost a third live in my riding of Saskatoon—Grasswood.

The Italian culture is rich in tradition. We all know that. When one of my Italian constituents was asked to describe what Italians are like, she replied, “We are very resilient, hard-working, and hospitable. We love to socialize. We believe in unconditional love, and family means everything to us. We are very proud of our culture.”

What was it like for a family to leave Italy and come to Canada? One member of the Saskatoon Italian community, Rosemarie Palidwor, shares her family's story: “My parents, along with other Italian families, immigrated to Canada, to Saskatoon, in the late 1950s and the early 1960s. They were young. They were motivated, and they wanted a better life. They were told that Canada was a 'land of opportunity', a place to put down roots and raise a family. With some Italians already in Saskatoon, they were sponsored, so, on borrowed money, they chose to leave Italy and take the journey to what they hoped would be the beginning of a wonderful new life.

“It was a cold day on November 22, 1959 when my parents arrived at Pier 21 in Halifax, after spending two long weeks on the ocean. To this day, my mother is still afraid of water and becomes seasick at the thought of being in a boat. My mother was four months pregnant with my sister at the time.”

“Upon arrival, it did not take long for excitement to turn into anxiety and much uncertainty: not being able to speak English, no means of transportation, and no jobs. The first few years were especially hard. A tight network of family and friends certainly helped my parents through the tough times. They were able to lean on this support group and begin to build the life they were hoping for.

“The prairie winters were long and very cold. Italian immigrants who were new to Saskatoon were taught how to make preserves for the winter months. Italians were resourceful, and they looked for ways to save money for their first house. Many families rented a garden plot of a dollar from the City of Saskatoon at the corner of 33rd Street and Avenue P. They planted lots of tomatoes. It was not uncommon for Italian gardens to have 200 tomato plants. They made a lot of delicious tomato sauce and canned the sauce for the winter months. Many families purchased freezers, which came in very handy throughout the year.

Warkentin
Waugh
Wong
Zimmer– — 75

Watts
Webber
Yurdiga

PAIRED

Members

Foote

Moore– — 2

The Speaker: I declare the motion carried.

● (1250)

[*English*]

RESUMING DEBATE

The House resumed from May 12 consideration of the motion in relation to the amendments made by the Senate to Bill C-37, An Act to amend the Controlled Drugs and Substances Act and to make related amendments to other Acts, and of the amendment.

Hon. Jane Philpott (Minister of Health, Lib.): Mr. Speaker, I am thankful for the wonderful opportunity to speak to the amendments adopted in the Senate relating to Bill C-37. This is an act, as we know, to amend the Controlled Drugs and Substances Act, and to make related amendments to other acts.

Before I begin, I thank my colleagues in the House and the Senate for their work on the bill to date, for reviewing this important legislation, and for recognizing the urgency of the issue. I particularly want to thank all my colleagues who supported getting the bill through the House as quickly as possible.

[*Translation*]

This bill, as proposed, will help our federal government and its partners to combat the existing opioid crisis and deal with the more general drug problem in Canada.

[*English*]

For that reason, I urge my colleagues to support the bill so it can be adopted without delay and to help protect the health and safety of Canadians and their communities.

It is clear that we are in the midst of a national public health crisis. Last year in British Columbia, more than 900 people died from illicit drug overdoses. If trends continue in 2017, we can expect 1,400 people in British Columbia to die this year as a result of overdoses.

However, British Columbia is not alone. In Alberta, close to 500 people died from overdoses in 2016.

[*Translation*]

We are also seeing signs that the opioid crisis is spreading to other parts of Canada.

[*English*]

For example, seizures of fentanyl have increased in almost every province over the last year.

Our government is responding. We are taking actions that are compassionate, collaborative, comprehensive, and evidence-based in our approach to drug policy. Our aim is to take a public health approach to addressing the opioid crisis and problematic substance use in general, while also ensuring law enforcement officials have the tools they require to keep communities safe.

[*Translation*]

That is why, last fall, the Minister of Public Safety and Emergency Preparedness and I announced the new Canadian drugs and substances strategy.

[*English*]

This new strategy replaces the previous approach by addressing problematic substance use as primarily a public health issue, restoring harm reduction as a key pillar of Canada's drug policy, alongside prevention, treatments, and enforcement, and supporting all those pillars from a strong evidence base.

[*Translation*]

Bill C-37 and the revised amendments our government proposed support this strategy by updating the law to focus on harm reduction measures.

[*English*]

Streamlining the application process for supervised consumption sites is central to this legislation.

[*Translation*]

Solid evidence shows that, when properly set up and maintained, supervised consumption sites save lives, and they do it without increasing drug use or crime in the neighbourhood.

[*English*]

To this end, Bill C-37 proposes to amend the current legislation in two ways. It will establish a streamlined application process that aligns with the five factors set out in the Supreme Court of Canada decision in 2011, in Canada vs. PHS Community Services Society. It will also improve the transparency by requiring decisions on supervised consumption site applications to be made public, including reasons for denying such an application.

[*Translation*]

We need to create an environment that encourages communities that want and need these sites to apply for them. I can assure the House that Bill C-37 and the revised amendments our government is proposing will ensure that communities that want and need these sites do not experience unreasonable delays in their efforts to save lives.

● (1255)

[*English*]

The first amendment specifies that should the Minister of Health choose to post a notice to seek further public input regarding an application, the public should have a minimum of 45 days to provide feedback.

Some members, and indeed members of the public as well, have questioned why we are accepting this Senate amendment. To be clear, the ministerial authority to post a public notice regarding an application for up to 90 days exists under the current legislation. Bill C-37, as introduced by our government, made that time period more flexible but retained the optional nature of the posting and the optional nature of an extra consultation. The only thing that would change with the Senate's amendment is that should a public notice for further consultation be posted, it must be posted for a minimum of 45 days.

Our government supports this amendment, as it would ensure that in the special cases where further community consultation was warranted, communities would receive a reasonable amount of time to provide comment on specific applications.

I will repeat that this consultation would not be required by legislation, and indeed, it would be the exception rather than the rule.

The second Senate amendment would give the Minister of Health the authority to establish citizen advisory committees for approved sites where deemed necessary.

Our government understands the intent of this amendment. It could be to bring together supervised consumption sites and community members. However, adding this oversight of supervised consumption sites, which is not used for any other health service as a legislated requirement, would further stigmatize their clients and potentially reduce the use of these critical facilities. As such, we respectfully disagree with this amendment.

The final amendment adopted by the Senate would require that clients of supervised consumption sites be offered an alternative pharmaceutical therapy before they consumed substances at the site. While the intention of this amendment may be to encourage the provision of evidence-based treatment options to people who use drugs, it is critical that the application process for supervised consumption sites not be hindered by additional federal requirements for immediate access to treatment services. This could impose an additional burden and make it more difficult to establish and operate supervised consumption sites.

As written, this amendment could result in charter challenges on the grounds that an individual's safety and security could be jeopardized if that person could no longer access the services offered at a supervised consumption site. It also represents significant jurisdictional issues, since it could be construed as regulating a health service or clinical practice.

In addition, repeated offers of pharmaceutical treatment could actually discourage people who are not yet ready to begin treatment from using supervised consumption sites. This would be counter to the aim of supporting communities that need these sites to save the lives of their community members.

For these reasons, our government proposes that we amend the wording to say “may” instead of ”shall” and remove subsection 2 of this amendment.

For all the reasons I just outlined, our government does not support the amendment to the motion moved by the member for Oshawa.

I also want to remind the House that this bill includes other important initiatives, because the opioid crisis is a complex problem that requires a comprehensive response.

The pathways to addiction are numerous, but they are connected through their origin in personal pain, whether that be mental or physical pain. These issues are all too often exacerbated by multiple social determinants of health, including poverty, homelessness, and lack of access to economic resources, making the reality of addiction and the path to recovery all the more difficult to navigate.

To add to this complexity, the drug environment in Canada has changed drastically in recent years. Strong drugs like fentanyl, carfentanil, and other analogs have made their way into Canada, and they are often being disguised as prescription drugs like Percocet or oxycodone, or they are mixed with other less potent street drugs, such as heroin or cocaine.

With that in mind, l would like to take this opportunity to specifically discuss the Senate amendments with respect to establishing supervised consumption sites.

● (1300)

This crisis is impacting high-risk, long-term drug users as well as recreational drug users who do not expect that the drug they are using could contain fentanyl. As we all know from the devastating local news reports across this country, the crisis is also affecting young people who are experimenting with drugs. That is why, in addition to important provisions regarding supervised consumption sites, Bill C-37 also includes proposals that would modernize the current legislative framework and create new law enforcement tools to confront the ongoing crisis.

For example, Bill C-37 proposes legislative measures to prohibit the unregistered import of pill presses to Canada. If passed, it would allow border officials to open international mail of any weight should they have reasonable grounds to suspect that the item may contain prohibited, controlled, or regulated goods. As well, it would grant the Minister of Health the necessary powers to quickly temporarily schedule and control a new and dangerous substance.

[*Translation*]

It is important to point out that Bill C-37 and the revised amendments our government is proposing are part of a suite of vital measures that our government has taken to combat the opioid crisis. For the benefit of the members, I think it is worth mentioning some of our government's other initiatives.

[*English*]

We have made naloxone available without prescription, and we have expedited the review of naloxone nasal spray to ensure that multiple formats are available to Canadians. We have granted exemptions to Insite and the Dr. Peter Centre to operate supervised consumption sites in Vancouver, and we have now issued exemptions for a total of three supervised consumption sites at fixed locations in Montreal and are expediting reviews for the approval of 18 additional sites in 10 cities: Montreal, Toronto, Vancouver, Surrey, Ottawa, Victoria, Edmonton, Calgary, Kelowna, and Kamloops.

[*Translation*]

Our government has also rescinded the prohibition on access to an important treatment option, prescription heroin, to treat more serious addictions.

[*English*]

We have finalized new regulations to control chemicals used to make fentanyl, making it harder to manufacture illegal substances in Canada, and we have supported the passage of the important Bill C-224, the Good Samaritan Drug Overdose Act, which I am pleased to say achieved royal assent on May 4. Finally, we are providing $100 million in federal funding to support the Canadian drugs and substances strategy, as well as an additional $10 million in emergency funding to British Columbia and $6 million in emergency funding to Alberta.

It is important that members understand that there is no single action that will end this opioid crisis immediately. There is no single law or policy that will do so. It requires comprehensive, urgent action. The adoption of the amendment our government is now proposing and making Bill C-37 law would be, however, a very important step forward in supporting a new approach to drug policy in Canada.

[*Translation*]

As proposed, this legislation would give our government and law enforcement agencies more effective tools to fight problematic substance use and provide more support to communities that are battling this crisis locally.

[*English*]

The amended legislation would also help our government work with partners to implement an evidence-based approach that is comprehensive and collaborative. Therefore, I encourage all members to support Bill C-37 and our approach to the Senate's amendment in order to protect Canadians and save lives. I thank my colleagues for their important work in this regard, and I thank you, Mr. Speaker, for the opportunity to discuss it.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Mr. Speaker, I agree that Bill C-37 has some very important initiatives to tackle this particular crisis, but I continue to be very concerned. As a former mayor and a former member of a local council, I know that anything we have tried to make sure was included that gave communities the ability to have a thoughtful process has been taken away, such as the initial removal of the need for council approval. In Kamloops, 100% of council agreed with it, but council members also had the right and the ability to say they wanted to move forward. That was stripped away.

We had a very thoughtful suggestion from the Senate that there be some advisory support. I think advisory support could do many things in terms of how cities deal with this issue, above and beyond the particular crisis. Again, that has been stripped away.

Why does the minister not trust local governments and local communities to have a part in the decision-making? It would appear that she does not trust them to be part of the solution.

● (1305)

Hon. Jane Philpott: Mr. Speaker, I want to reiterate this, because I am not sure everyone has fully comprehended the severity of this crisis in British Columbia. Based on the number of deaths that have occurred in the first three months of this year, if trends continue there will be 1,400 deaths from overdose in British Columbia. This is a serious matter. We see no end in sight, and we have to make sure we use all measures within our jurisdiction to respond to it.

As the member says, of course it is important to respond to the community to make sure there is a demand for these sites, that there is a need for these sites, and that there is appropriate community consultation. I trust that the member is aware that those were among the five factors the Supreme Court gave us. It required, even within Bill C-37, that the Minister of Health take them into consideration in recognizing the need for a site. Clearly, that need has to be demonstrated, and the community must have the opportunity for input. It is at the discretion of the Minister of Health to determine whether further consultation is required.

We know there is a huge demand for this. I speak on a very regular basis with people in these communities who are desperate to have supervised consumption sites.

Community consultation includes consultation with the members of the community who are seeing their friends, family members, and young people dying. They need the opportunity for input too. These are the members of society I hope members of this House will take into consideration when they are considering this bill.

As it relates to the matter of having a citizen oversight body, no other health facility has a legislative requirement for that. We know that some health facilities like to have community oversight bodies, but having a legislative requirement, as I said in my remarks, would further stigmatize a population whose members are dying because of the stigmatization of their community. It is important that we not introduce any further barriers to making sure we save people's lives.

Ms. Elizabeth May (Saanich—Gulf Islands, GP): Mr. Speaker, this will be the second time only in six years as a parliamentarian that I have voted for time allocation. I voted for it also on Bill C-37.

The question here is urgent. I agree with the minister, although I would say that this may be the classic case of the perfect being the enemy of the good. When lives are at stake, I do not think we can take the time to argue over improvements that, frankly, I would want to see made too.

We know that on the street, fentanyl is being found in 80% of the street drugs that are otherwise not identifiable as fentanyl. Can the minister give us any update on what is being done on the ground while we get this bill through the House as fast as possible?

Hon. Jane Philpott: Mr. Speaker, I thank the member for supporting time allocation in this case. I agree with her that this is an exceptional piece of legislation because there is a tremendous amount of urgency. I appreciate her upstanding perspective on how to address it, as she said, knowing that there may be ways this could be further improved but that time is of the utmost necessity, because people are dying.

The member has also reiterated, perhaps after reading it in the newspaper in the last couple of days, that there is evidence now in British Columbia that when we look at some of the drugs being sold on the street, over 80% of some drugs are now contaminated with fentanyl and some of its analogues.

We have always had challenges with problematic substance use in society. As I said earlier, it goes with things like poverty, homelessness, unresolved trauma, and the abuse people have experienced. This was made worse, as the member knows, by the unfortunate reality of the over-prescription of opioids based on deceptive pharmaceutical practices. This is an area we are working on as well with a number of medical educators and regulatory bodies.

What has made this crisis unprecedented are these new highly potent products. It affecting not just Canada but North America, and now we are seeing it even further around the world.

I am happy to tell the member about a number of initiatives. As I said, we are working with 42 organizations across the country, regulators and educators of health professionals, to make sure we understand the work that needs to be done to address over-prescription. We are, of course, also working with organizations across the country to expand access to treatment. I alluded in my notes to the fact that we have taken steps to allow products to come into the country. For example, there is the possibility of using pharmaceutical-grade diacetylmorphine as a treatment option, and we are encouraging multiple approaches to treatment.

There is so much being done, and I am happy to update any members who are interested.

● (1310)

Mr. Sukh Dhaliwal (Surrey—Newton, Lib.): Mr. Speaker, last summer, in light of the tragedies that have happened in Surrey, all members of Parliament were asked to an emergency summit, in fact the member for South Surrey—White Rock was also invited, as well as all the MLAs and local professionals. I brought that issue to our hon. minister. The hon. minister has taken steps since then on the harm reduction measures, balanced with an enforcement strategy.

However, critics in Surrey are asking me to tell the minister that we are not doing enough and we are not doing it fast enough. Would the minister be kind enough to tell the people in Surrey what the minister has done, and the plan to deal with this in a fast and efficient manner going forward?

Hon. Jane Philpott: Mr. Speaker, the member's question gives me an opportunity to speak to what is taking place in Surrey. Indeed, I was in Surrey not very long ago addressing this very issue.

Surrey is one of the municipalities where I saw a tremendous amount of collaboration from members of the community. I met with the mayor and with a number of health providers in that community to hear what they are doing.

One of the things I was very impressed with is that they have done exceptional work in terms of gathering data. For instance, they were able to share with me the number of overdoses that were determined to have taken place in Surrey last year. The emergency medical services in Surrey have evidence of over 2,000 overdoses that took place. Some very interesting information came out of the work that was done in Surrey. We found that these overdoses are not just taking place in the downtown core, but are taking place all throughout the city.

I could give the member all kinds of examples of other things that are being done which would reassure the people of Surrey, but while we are on the topic of data, perhaps I could share that one of my concerns is about the lack of good data across the country, and the tremendous need to co-operate with multiple orders of government and other agencies.

One of the things I have asked the Public Health Agency of Canada to do, for example, is to launch an epidemiologic study, and to do so immediately. That will give us better information in understanding who is taking drugs, what drugs are being taken, the causes of the overdoses in these communities, and where they are taking place. They will begin that work immediately. There are a number of other initiatives that we are taking to make sure we are working with coroners, medical examiners, Canadian Institute for Health Information, Statistics Canada, and multiple organizations, to get the data we need that will drive the change to save lives.

Hon. Kevin Sorenson (Battle River—Crowfoot, CPC): Mr. Speaker, I am pleased to participate in the debate on Bill C-37, legislation proposed by the Liberal government to help deal with the opioid crisis that is affecting too many communities across Canada.

I am not encouraged after hearing the minister's comments. She talked about 900 fatalities in British Columbia in the last year, 500 in Alberta, that 1,400 have died of overdoses. She said after quoting this that she sees no end in sight. That tells us the severity of what we are facing across Canada. However, it seems a little disappointing that the minister does not give a lot of answers to the problems that she sees. Bill C-37 does not contain enough answers. In fact, we believe there are some problems with Bill C-37.

Today, we are considering some amendments by my colleague, the official opposition health critic. It is my first entry into the debate on Bill C-37, although it is not the first time I have dealt with this. As a member of Parliament back in 2001-02, we had an opioid problem in the country. There was a committee struck, the Special Committee on the Non-Medical Use of Drugs. We travelled across Canada and to Germany, and I believe to France, Switzerland, and a number of other countries. We saw safe injections sites. At that time, they believed it was the answer to the opioid problem. They called them safe injection sites then, not supervised consumption sites. I guess the government feels that supervised consumption sites sells a little better.

I travelled with Randy White, a member of Parliament from Abbotsford. I think he would find it very disappointing that 16 years later we are still debating the same types of issues and have seen even greater problems since some of these safe injection sites have been incorporated into the landscape across our country.

I will take this opportunity to thank my colleague, the member for Oshawa, for all his hard work on the health file on behalf of his constituents and Canadians. As a doctor, he understands all aspects of the health file. For many years, we have benefited from his input, his comments, and knowledge. He has been on the committee for years as well. Today, he is asking the House, again, to consider the amendments to Bill C-37 that have been brought forward by the Senate of Canada. His amendment states:

> That the motion be amended by deleting all the words after the word "That" and substituting the following:
>
> "the amendments made by the Senate to Bill C-37, An Act to amend the Controlled Drugs and Substances Act and to make related amendments to other Acts, be now read a second time and concurred in."

The first amendment that the Senate brought forward ensures that there is a minimum consultation period of 45 days prior to the approval of an injection site.

The second amendment looks to establish a citizens advisory committee that is responsible for advising the approved injection site of any public concerns, including public health and safety issues. The amendment also looks to have the committee provide the minister with a yearly update on these matters.

The third amendment directs those working at the site to offer the person using the site some legal pharmaceutical therapy before that person consumes or injects illegal drugs.

It is disappointing that the minister is flatly refusing to accept the amendments from the Senate. I believe that many Canadians would feel that those amendments are fair, substantive, and reasonable. The Senate does not amend legislation from this House very often. The Senate takes very seriously any amendments that it would recommend to the House. Therefore, when senators do take the time to study and bring forward amendments, we should be paying attention to what they do. We should not discount it as quickly as the minister did.

The Senate tries to help the government and this House pass good legislation. It wants to help us ensure that the laws we pass accomplish what we want done. The Senate wants to help ensure that our legislation would not cause other harm, or place an unnecessary burden on Canadians.

● (1315)

There are many reasons for the Senate to return a bill to the House with amendments, and it is important that we accept suggestions and recommendations from the other place and agree to consider them seriously.

The first amendment asks for a minimum consultation period of 45 days prior to the approval of an injection site anywhere in Canada. The Senate knows that not all Canadians want injection sites in their local communities, or, as the minister calls them, supervised consumption sites. Anyone looking at community injection sites would understand why. Those who have been involved understand why. To discount the amendment out of hand is disappointing. The Senate is trying to inject a measure of democracy into Bill C-37 by providing communities with a chance to further consider proposals for injection sites. We hope that the Liberals will respect that.

The Liberals talk about inclusion, but we see the opposite. They talk about partnerships with other levels of government, but we see the opposite. Why will they not listen to Canadians? They promised to do politics differently. They said that under their rule, we would all live to our full potential as Canadians, whatever that means. They also promised to consult with Canadians. Now, when the Senate is suggesting that they consult with communities as to where a safe injection site is going to be put, they do not want to hear it. The Liberals do not want to hear from those communities or from those groups that would advocate for one site being a better place than another site.

The Liberals should learn to listen to the grassroots of communities and allow them to have their say. Under Bill C-37, communities should be encouraged to make comments, to offer suggestions, to consider proposals on where an injection site should be built, or if it should be built at all. That is what being community minded is all about. The government should not be afraid of local governments, citizens, community organizations, or anyone who has a differing opinion.

The first amendment wants to allow a local community, large or small, to have at least 45 days to study and prepare before the government opens an injection site. That is fair. The Senate believes it is reasonable, diplomatic, and democratic, but the Liberals say no. Far from delaying the approval of a new injection site, a courtesy to the community is about to be changed.

The second amendment wants to establish a citizens advisory group. Much like the first amendment in some respects, the Senate is trying to help the government with Bill C-37, and after great study on the subject, it felt that this amendment would do that. The Senate is recommending that a group be formed that will help communities deal with the challenges of establishing an injection site. That would be generous and very helpful.

Many Canadians do not know much about what happens at a safe injection site or a supervised consumption site. We want them to be aware of the opioid crisis that is facing Canada and what the Liberals see as solutions. Canadians only know the images that they see on the media, which depict the horrors, for example, of Vancouver's Downtown Eastside, what we used to call heroin districts and other things in the United States and Europe.

The constituents that I represent in Battle River do not want to become like the Eastside of Vancouver. In fact, I do not know of too many constituencies, rural or urban, that do. Being almost like a Bible belt in parts of Alberta, more time is probably spent praying for drug victims on those streets. They care very much. They feel badly when they see lives being ruined by the opioid crisis.

● (1320)

I believe the communities are there and want to help. We want to do the right thing. We want to address the crisis, even if it is in our own communities. As we can see from the statistics that the minister quoted of 900 deaths in B.C. last year and 500 in Alberta, it is in every community.

However, the Liberals are saying that we must do only what the Liberal politicians in Ottawa say we have to do, whether that is in Alberta or anywhere else, and by opposing amendment number two, the Liberals are denying Canadians the opportunity to be involved. The government does not want experts bringing their knowledge into communities and making recommendations and suggestions or amending anything. The Liberals are trying to dictate what every community in Canada must do when it comes to their supervised consumption sites. That is too bad, because wherever the opioid crisis raises its ugly head, in most communities, rural or urban, those communities would like to have some credible and knowledgeable assistance. Why do the Liberals not want that?

The government is saying that it knows what is best: one size will fit all. Imagine, as injections sites are brought into communities across Canada, that none of the lessons learned would be shared with those communities, none of the problems that have been dealt with successfully in certain communities would be available to other communities so that they would be able to benefit.

The Senate is simply trying to help the government with its bill. The Senate is trying to look out for communities, large and small, by having experts who know about the problems help communities grapple with them. That would be a good thing. We hope the government does not dig in its heels on these amendments. We hope that the minister is not just saying that we should do what she says because she knows best, but it seems that is what she is doing.

Canada has many different diverse communities. The operators of injection sites would appreciate being advised of community concerns and local health and safety issues. Not all injection sites would be able to operate the same way in every community.

There are many concerned citizens in every community in Canada. I have seen this in my own large geographical constituency. In every small town and village, there are folks who know very well how the local community operates, and we want to allow them to help. We do not want the Liberals to consider their efforts to be interference. We need everyone with knowledge and experience to work on the opioid crisis. We do not want to exclude the very people who can help us the most, the residents who know how things work in their communities. If the government proceeds with this program, every community could certainly benefit by having five to 10 volunteers within the immediate vicinity of the site at least consulted.

The third amendment that the Senate brought forward directs those working at the site to offer the person who is using this illegal drug some legal pharmaceutical therapy.

Much of the drugs that are being used are obtained illegally. In Senator White's speech in the other place, as a long-time police officer and city police chief, he talked about the day that an addict uses his drug as a day of crime, when he or she would go out and usually commit various crimes in order to raise enough funds to obtain the drug. If this plan is adopted, should we not give those people in those sites who would be using at least some counsel or therapy? Why would the government not listen to what the senators are calling for here? Is it not the most basic and simple thing to try to help those who are abusing opioids at the time they are actually going to use them? Is it not in the best interests of the addicts, and of our society, to help those individuals who are addicts to get off opioids? It sounds as though the Liberals are saying no.

● (1325)

The more people abuse themselves with harmful opioids, the more they will want to stop as their health declines. I have never met one who wants to keep going. They wish they could get out of the rut they are in. As their relationships with others disappear and their finances disappear, they are going to want help and they are crying for help. They will need to be rescued in order to save their lives.

They probably had a very difficult time getting drugs from some of these drug dealers. The drug abuse world is a violent, lawless world. Every time a drug abuse victim visits an injection site, we should be offering them an alternative. We should make saving that person's life a priority. Why would the Liberals not want that? It is unbelievable. It is almost as if the Liberals are trying to enable the continuing abuse of drugs by drug addicts. It is unfair. This is not the sunny ways the Prime Minister talked about. It is not helping everyone live to their full potential as Canadians, as the government said it wanted to do. What we see is mismanagement of the opioid crisis.

We should make it a criminal offence not to offer an alternative to someone who is so addicted to a drug that they need supervision when they inject that drug. Anyone in that position needs help. They may not accept the help being offered, but at least it should be offered to them. If everyone knows that the injection site is offering a way out, an alternative, then we have a better chance of saving lives.

I have heard some say that offering pharmaceutic therapy could erode the relationship between the drug abuser and the facilitator at the injection site. Really? Could offering a little counsel could lose the relationship between the two? I think the Liberals are off base on this.

The facilitator, as they call it, would be from the community. To the extent that the facilitator may not approve of the drug abuse, that facilitator would want to be ready to help if he or she is asked. I would say that is true in many parts, if not all parts, of Canadian communities, and I hope it would be true in our communities. That is the Canadian way. We are there to help. Is that not what the Prime Minister tells the world—that Canada is there to help? What part does he not get?

I see that my time is running short, so let me just say this: are there good things in Bill C-37? Not much, but we hope the Liberals will support the first amendment and include communities. We hope the Liberals realize communities need time to figure out how they will provide an injection site, and we hope the Liberals are willing to come up with something that could satisfy the third amendment.

There are other measures in Bill C-37. The bill gives the Canada Border Services Agency the authority to open international mail of any weight, should there be reasonable grounds. Perhaps this may sound like a good measure, but I think we had better be careful what we ask for here. In their hurry to find some solution, they may have eroded some of the rights of Canadians, and a lot will depend on the term "reasonable grounds". Allowing searches of packages and shipping and so on will slow down commerce. Do we mean "reasonable grounds" that there are drugs in there? I think there are already reasonable grounds for every package, if they want to use that, but again, it may not be exactly what they want to accomplish.

If passed, Bill C-37 could add prohibitions and penalties that would apply to possession, production, sale, importation, or transport of anything intended to be used in the production of any controlled substance, including fentanyl. That is a good measure.

I brought forward a private member's bill that offered to allow the minister to allow Canadians access only to specific narcotics that have tamper-resistance or abuse-deterrent formulations. The technology is there now. This measure would only be used when a particular drug is being abused with deadly results of the kind we saw with fentanyl. Oxycontin is available now as OxyNEO, a tamper-proof pharmaceutical, but the government voted against it.

Today the minister said that this is just one measure that will fight the opioid crisis. It is funny, though, that when pharmaceutical companies and United States governments under Obama and other states started going down that road, this minister said it was not in our best interests.

We should improve Bill C-37 so that it helps Canadians deal with the opioid crisis. We should support the amendments that are being debated, and we should support the amendment of the member for Oshawa.

● (1330)

Mr. Ken Hardie (Fleetwood—Port Kells, Lib.): Mr. Speaker, the response that needs to be asked is about the urgency of the situation. We want a 45-day consultation period, but in British Columbia's case, at the rate people are dying, 113 people would die just in the consultation period.

There was an opportunity in the House a few months ago to fast-track the bill and get things going so that safe injection and safe consumption sites could get up and running. That was blocked by the same party that wanted to do away with the one and only safe injection site in the Downtown Eastside of Vancouver, and that would be the Conservatives. Since then, 92 people in B.C. have died.

The implication is that these safe consumption sites would pop up in every nice community and small town across the country. I would ask the member whether it is not the case that these are needed where there are currently dirty needles on the ground and people shooting up in doorways, not in the member's community and, thankfully, not in mine?

● (1335)

Hon. Kevin Sorenson: Mr. Speaker, I take great offence to what the member said about our wanting to have a debate in this place. He almost alleged that people were dying only because we did not get those safe injection sites into their communities or have them coming to communities near them. It is not that way. Extra debate on an issue like this is not the reason people are dying.

Another point is that in 2001, members travelled to countries such as Germany on this very issue. The member said in his question that safe injection sites would clean up the situation of people shooting up in doorways and in parks. No one involved with safe injection sites believes that. If people go to safe injection sites, they will be supervised there, but if the member were to go around the safe injection site, as we did, he would still see people shooting up on sidewalks and needles in the park. He would still be warned about walking in sandals or barefoot through parks. He could not do it, because the truth is that people do not only go to the safe injection site.

If they know they will get a clean needle, they will typically go there, get a needle or two, and those needles will be disposed of the next time they shoot up. Typically, as members found out in Germany, Switzerland, and some other countries, the next time is not at the safe injection site.

We do have an opioid crisis. The government voted against a private member's bill, Bill C-307, that would have established tamper-resistant fentanyl. No, the government would not accept that. It was not designed to be the answer to all of the problems, but one little tool in the tool kit, exactly as the minister said, but she said that was not the government's plan.

We need to proceed. The Senate did a study. It brought in people from all across Canada, worked hard, and took its study very seriously. Now the Liberal government wants to reject the amendments from the Senate because it believes it knows that one size fits all. It is shameful.

Ms. Sheila Malcolmson (Nanaimo—Ladysmith, NDP): Mr. Speaker, shameful would characterize 10 years of Conservative inaction, followed by a year and a half of Liberal foot-dragging, followed by three months of Senate stalling, studying the exact same questions that were debated and rejected at committee, while people continue to die at rates way beyond other countries. In my community of Nanaimo, 13 people died just in the first three months of this year alone, and 28 people died last year. We are losing people at the same rate as Vancouver.

The west coast has been hit very hard by the opioid crisis for all kinds of reasons, such as over-prescription, access to west coast shipping, untreated pain, improper way of supporting people with PTSD. The causes are myriad, but the solutions have fallen completely to the front line: ambulance, paramedics, firefighters, social workers, NGOs that train people in naloxone. If the House cannot get it together and actually remove the barriers to the solutions that have been identified, that is shameful.

Specifically, the member is talking about the community consent amendment that the Senate has brought, an idea that was rejected at committee. Specifically the legislation already requires the Minister of Health to consider expressions of community support when they consider licensing a new site. Why on earth would the member continue to propose and support the Senate amendment, which just gets in the way of the approval of treatment facilities for addicted people?

● (1340)

Hon. Kevin Sorenson: Mr. Speaker, I do not question the member's concern on this. Obviously, all of us are concerned about the crisis. There were 900 fatalities in her province last year. She says that it has to be community consent. It is community consult. The amendment states that there be a 45-day consultation period with the community. It is not asking for a consensual agreement. The senate has asked that communities be given the opportunity of 45 days before safe injections sites are brought to their communities. Again, it is almost like the heavy hand of Ottawa coming down saying it knows best in every community across this land. I disagree with that.

However, I do agree that we need to look for ways we can adequately move forward and recognize the significance of what we see. This issue did not begin 10 years ago under our government. In 2001-02, I was on that non-medical drug committee when we travelled the country and the issue was there. We have new opioids being brought forward almost monthly. It might be a bit of an exaggeration, but if it is not OxyContin, it is fentanyl. If it is not that, it will be something else, many of which are concocted in the basements of homes and garages. Like Senator White, I hate to use the word “drugs”. They are poison in some cases.

The fact is that the safe injection site is not the answer to the problem. It may be an answer, but it is not the answer, especially a safe injection site that cannot give counsel to the individual, the third amendment. The shameful part is not bring forward measures that would simply keep the issue going as it is now, the status quo, but that seeing some effective changes.

I am disappointed the member is so anxious, it seems, to open these safe injection sites, but says we do not need counselling within them.

Mr. John Barlow (Foothills, CPC): Mr. Speaker, my colleague and I come from very similar constituencies in rural Alberta, and I have been inundated with letters from my communities. It is not whether they want a safe injection site. They want to have input and community consultation on not only whether they want one, but where it goes as well. I would like my colleague to talk about some of the feedback he is getting from his rural communities on this issue.

Hon. Kevin Sorenson: Mr. Speaker, the communities are engaged. I have been here for 17 years and I have brought forward a private member's bill, a rural riding, and typically we think of Downtown Eastside Vancouver and others, to deal with tamper-proof opioids. That shows how much community involvement there is.

My wife and daughter are registered nurses. My daughter has told me that we have to do something, that people are coming in, asking for the kit. They know the drugs they are taking, which are made in garages, will be laced with poisons.

The member is right, as much as I hate to admit it. It is not just happening in the big cities anymore. In rural ridings, especially with the economy in Alberta, which I think is a contributing factor, we see it more and more all the time. We need answers that will actually help.

● (1345)

Mr. David Lametti (Parliamentary Secretary to the Minister of Innovation, Science and Economic Development, Lib.): Mr. Speaker, I would like to thank each of the members of the House, the House Standing Committee on Health, the Senate, and the Senate Standing Committee on Legal and Constitutional Affairs for their work on Bill C-37.

I would also like to thank the minister as well as her current and previous parliamentary secretary for all the work they have done on this and the leadership they have shown.

The hon. members of the Senate have adopted some amendments to Bill C-37 around supervised consumption sites, particularly for supporting public consultation in the application process.

I welcome the opportunity to rise in the House today to speak to the amendments to Bill C-37, an act to amend the Controlled Drugs and Substances Act and to make related amendments to other acts.

[*Translation*]

As all my colleagues know, there is currently a troubling number of overdoses and fatalities associated with opioids and other substances in Canada. Far too often, we hear about new and powerful drugs that end up in our communities and heartbreaking stories of families and communities that lose loved ones to an overdose.

[*English*]

To help address the challenges associated with problematic substance use in Canada, Bill C-37 proposes important legislative changes to support a new Canadian drugs and substances strategy, a comprehensive, collaborative, and compassionate strategy composed of four pillars, which are prevention, treatment, harm reduction, and enforcement, each one built on a strong foundation of evidence.

These proposed legislative changes will help provide public health officials and law enforcement organizations in Canada with the tools they need to help communities in addressing problematic substance use, including live-saving harm reduction initiatives to help those struggling with opioid use disorder.

[*Translation*]

Bill C-37 was drafted to offer a real solution to the communities dealing with this crisis by eliminating, among other things, unnecessary obstacles to opening supervised consumption sites.

[*English*]

Should it receive royal assent, Bill C-37 will streamline the application process for supervised consumption sites by replacing the current 26 criteria set out in the Controlled Drugs and Substances Act with the five factors set out by the Supreme Court of Canada in its 2011 decision regarding Insite. These factors are: one, impact on crime rates; two, local conditions indicating need; three, regulatory structure in place to support the facility; four, resources available to support its maintenance; and, five, expressions of community support or opposition.

[*Translation*]

Reducing the number of criteria will alleviate the administrative burden on communities wanting to open a supervised consumption site without compromising the health and safety of those using the site, their clients, and the neighbouring community.

[*English*]

I want to underscore our government's position on the importance of community consultation in the establishment of supervised consumption sites, while also reducing the barriers for communities to establish life-saving services for their citizens. Our government recognizes and respects that there is a balance between a community's need for adequate time and appropriate channels to provide valuable feedback and the need to minimize unnecessary delays in the administrative process for critical harm reduction services.

In Bill C-37, our government is proposing an authorization process that respects the Supreme Court of Canada's decision and criteria, including the requirement that the minister of health must consider expressions of community support or opposition when reviewing applications for supervised consumption sites.

● (1350)

[*Translation*]

The proposed approach will give the communities the assurance that their voice will be heard and that every application is subject to a thorough review.

[*English*]

While supervised consumption sites have been shown to be effective in reducing the harms of problematic substance use, the Minister of Health needs to make informed decisions on future applications, which could include collecting additional information and hearing directly from community members when necessary.

Our government is committed to the protection of public health and the maintenance of public safety. Health Canada will do the necessary verification so that any potential site operates in a responsible manner and ultimately meets its stated objectives of saving lives and reducing harms.

In the amended bill, the minister would continue to have the authority to post a notice of the application and invite public comments. Such a provision could be used in cases involving extenuating circumstances where the minister feels that further community consultation is warranted.

Our government supports the Senate amendment to establish a minimum public comment period of at least 45 days, which will offer the public time to provide its feedback on site applications when the minister chooses to post the public comment period. Bill C-37 retains the previous maximum consultation period of up to 90 days.

[*Translation*]

The communities have an important role to play in the successful launch of a supervised consumption site. They have to work together on meeting the challenges and determining whether such a program is appropriate for their neighbourhood.

[*English*]

The support of the community within which the sites are located is a key element in a supervised consumption site's ability to have a positive and meaningful impact. This requires constructive dialogue among community members to find common ground and address potential concerns.

At the same time, our government also recognizes that stigmatizing problematic substance abuse can negatively impact the rates of which harm reduction services, such as supervised consumption sites, are accessed by those who need them. Adding measures for supervised consumption sites that are not applied to other health services add to the stigmatization of the sites and those in need and unnecessarily impact access to these critical services.

In addition, the advisory committee could be composed of individuals who do not have adequate qualifications to warrant their oversight of a health care service. As such, our government does not support the second amendment adopted by the Senate.

[*Translation*]

Now more than ever, it is important to help communities open supervised consumption sites in order to help address the underlying issues of problematic substance use.

The proposed changes will help us ensure that community members have the opportunity to make comments on applications for proposed centres, that federal legislation does not contribute to further stigmatizing these centres relative to other health services, and that there are no obstacles or unjustified delays to opening these centres where they are wanted and needed.

[*English*]

Because the need for supervised consumption sites is urgent in helping to save lives, it is imperative that the process not be overly burdensome so as to unnecessarily delay the establishment of potential sites. While our government recognizes the benefits and supports the use of alternative pharmaceutical therapy, the decision to offer additional services to clients should be made by each site based on the needs of its community. It is for this reason that our government does not support the amendment as currently written. We respectfully propose that the word "may" be substituted for "shall".

Health Canada would also support communities through the publication of a revised application form, available online, and simplified guidance to help site applicants through the process and clearly state what documentation is required to support the minister's consideration of the Supreme Court of Canada's factors. The application form would provide details on how to address these Supreme Court criteria. The criteria would be streamlined and modified to provide applicants with greater flexibility to consider their local context.

We cannot turn our backs on the preventable deaths occurring across the country. We must do our part, and that includes passing Bill C-37. I urge all members of the House to support our government's proposed legislative changes that would support communities rather than place unnecessary barriers in their path.

● (1355)

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Mr. Speaker, I want to ask specifically about this issue of people who go into supervised injection sites being offered an alternative in the context of going in. I understand this is one of the Senate amendments that the government is rejecting. It is also a part of previous legislation.

Those who defend supervised injection sites generally do so on the basis that there is still hope and still an effort to put people on a path to recovery, and yet the government seems allergic to having specific language in the legislation that would ensure that people were at least offered a step on that path to recovery. I wonder if the parliamentary secretary can explain this allergy. Why, when we have these supervised injection sites, should we not at a minimum insist that people be offered some kind of an alternative when they are going in?

Mr. David Lametti: Mr. Speaker, the problem is with making the requirement mandatory. Certainly in a local context, where there is local expertise and local need and those needs are being assessed, there is the possibility, as we are proposing in terms of an amendment to the amendment, to allow that kind of suggestion to happen without making it mandatory. It is in making it mandatory that potentially more delays are added to the system, that we add an extra layer of advising that may not be necessary and which in fact may be an impediment to quick and expeditious treatment.

As I mentioned in my remarks, there is also the question of expertise and adding another layer of assessment as to who is an expert in those alternative therapies.

Mr. Kevin Lamoureux (Parliamentary Secretary to the Leader of the Government in the House of Commons, Lib.): Mr. Speaker, it is important to recognize that the Minister of Health is looking at this as just one tool that is being used to combat that national public health crisis. We have invested literally $10 million in emergency funding in B.C. and millions of additional dollars in Alberta. There has been a great deal of consultation with the different stakeholders to make sure that the government is working with others in trying to minimize the crisis.

Could my colleague talk about the necessity of strong national leadership and how important it is that we work with the local levels of government and other stakeholders, in particular our first responders?

Mr. David Lametti: Mr. Speaker, we are in the middle of a crisis, and therefore, we need national leadership to coordinate the response across the country and to allow the appropriate level of resources to be targeted at the specific regions of the country that need it the most. That being said, we are trying to strike a balance with this legislation with local communities to help identify and work with us toward finding solutions and that includes first responders. Much of what we are doing in this legislation is listening to the suggestions that those people have made on the ground to us in terms of dealing with this crisis.

The Speaker: There will be six minutes and 19 seconds remaining for questions and comments following question period.

STATEMENTS BY MEMBERS

[*Translation*]

CITY OF LACHINE

Ms. Anju Dhillon (Dorval—Lachine—LaSalle, Lib.): Mr. Speaker, I rise today to wish the City of Lachine a very happy birthday. Some 350 years ago, France granted the Domaine Saint-Sulpice to explorer René-Robert Cavelier de La Salle. Over the centuries, this simple seigneury became the third parish on the island of Montreal, as well as serving as departure point for fur traders heading north, and later literally became Montreal's main industrial corridor thanks to the building of the canal.

● (1400)

[*English*]

If people are planning to visit Montreal to celebrate its 375th anniversary, they should be sure to stop by Lachine. All summer long, there will plenty of activities designed to mark our sesquarcentennial, celebrate our past, and look toward our future.

[*Translation*]

FAMILY

Mrs. Mona Fortier (Ottawa—Vanier, Lib.): Mr. Speaker, I am delighted to rise to pay tribute to all the hard-working mothers in Ottawa—Vanier and across the country.

[*English*]

Yesterday was Mother's Day, a day to pause and acknowledge the critically important role that mothers play in our lives.

[*Translation*]

I would also like to point out that May 15 is the International Day of Families.

[*English*]

As this government continues to invest in the rights of women and girls across the globe, I want to acknowledge the important work that Canadian organizations play in helping support families across the globe, with investments in children's education; safe, clean drinking water and sanitation; and unwavering support of reproductive health funding.

[*Translation*]

I am asking all members of the House to join me in recognizing Mother's Day and the International Day of Families.

ORAL QUESTIONS

[*Translation*]

NATIONAL DEFENCE

Hon. Rona Ambrose (Leader of the Opposition, CPC): Mr. Speaker, the Liberals' plan to overhaul Canada's defence policy is behind schedule and is creating uncertainty for our national security and our military.

We have just learned that the Trump administration will see Canada's new defence policy before Canadians do or, even worse, before the military.

Why is the Prime Minister going to discuss plans for our armed forces with President Trump before discussing them with Canada's military?

[*English*]

Hon. Harjit S. Sajjan (Minister of National Defence, Lib.): Mr. Speaker, defence policy was done by and for Canadians. We consulted them extensively, and that is why we want to release our new defence policy to them first. All along, in our defence policy review, we had a range of discussions with our allies, including the U.S. We learned a lot from them, particularly from those who engaged in the same review process in the most recent years. Our defence policy will be costed and fully funded.

Hon. Rona Ambrose (Leader of the Opposition, CPC): Mr. Speaker, I have a hard time believing that this defence minister actually designed and devised this defence policy himself. I know the chamber has not seen it, members of Parliament have not seen it, and the military has not seen it. Now the Prime Minister is meeting in secret with the Americans to get their okay. They know our defence plans before Canadians know them.

Why do Washington insiders get privileged access to Canadian defence policies before the Canadian public does and before the Canadian military does?

Hon. Harjit S. Sajjan (Minister of National Defence, Lib.): Mr. Speaker, Canadians across Canada as well as members of Parliament were involved with the consultations. We have spoken with our allies, we have spoken with experts on this, and we have done a thorough process that is fully costed and fully funded.

* * *

● (1420)

JUSTICE

Hon. Rona Ambrose (Leader of the Opposition, CPC): Mr. Speaker, Wynn's law could have literally saved the life of Constable Wynn. When an accused criminal is already facing over 12 other charges and a judge releases him on bail, we have a problem. The system failed, and we need to fix it. This is a common sense fix.

When will the Prime Minister start supporting Wynn's law and start putting the safety of Canadians first?

Hon. Jody Wilson-Raybould (Minister of Justice and Attorney General of Canada, Lib.): Mr. Speaker, I would like to say again that we have the deepest sympathies for Ms. MacInnis-Wynn and the family of the constable.

We are working diligently in terms of doing an overview of the criminal justice system, including bail reform. That is why, when I met with the provinces and territories, we agreed that one of the priorities in terms of how we move forward in criminal justice is to concretely and collaboratively look at bail reform. We agree with the principle of Wynn's law, or the bill, in terms of ensuring that all relevant information is available at bail hearings.

Hon. Rona Ambrose (Leader of the Opposition, CPC): Mr. Speaker, once again the Prime Minister is putting the needs of criminals and lawyers ahead of the needs of victims, but gutting Wynn's law is a new low. Wynn's law is not controversial. It is a common sense, simple answer to a real loophole in our system. If an accused wants to be released at a bail hearing, a judge should know whether this individual has a history of being dangerous to Canadians.

Why will the Prime Minister not start standing up for victims instead of criminals?

Hon. Jody Wilson-Raybould (Minister of Justice and Attorney General of Canada, Lib.): Mr. Speaker, again, we are undertaking a comprehensive review of the criminal justice system, including bail reform. That is why, when I met with my colleagues in the provinces and territories, we talked about what we could do to increase confidence in the criminal justice system in protecting victims and increasing public safety. We are moving forward collaboratively.

When the Province of Alberta, after the unfortunate and tragic death of Constable Wynn, put together a report, the report did not, when it came back, provide recommendations that are contained within Bill S-217.

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OFFICIAL REPORT
(HANSARD)

Monday, March 21, 2016

Speaker: The Honourable Geoff Regan

● (1450)

The Speaker: I am hoping we will keep showing respect for each other and listen carefully and not interrupt.

The hon. member for Charlesbourg—Haute-Saint-Charles.

[*Translation*]

Mr. Pierre Paul-Hus (Charlesbourg—Haute-Saint-Charles, CPC): Mr. Speaker, I understand my colleague's explanations, but I am going to ask the question again.

The European Parliament, the Pope, and even the Prime Minister's good friend President Obama have characterized the terrorist acts that ISIS is committing against religious groups in Iraq and Syria as genocide. All that the Minister of Foreign Affairs has done is weakly condemn those crimes.

Does the minister agree with the Obama administration? Will he confirm that this is indeed a genocide?

[*English*]

Ms. Pam Goldsmith-Jones (Parliamentary Secretary to the Minister of Foreign Affairs, Lib.): Mr. Speaker, I would like to repeat that Canada is a member of the International Criminal Court. The term genocide there means much more than the term genocide in terms of halting genocide, and the opposition should know that. This is absolutely serious. This is not the United States of Canada, and our strategy—

Some hon. members: Oh, oh!

The Speaker: Colleagues, we all know that each side gets to have its turn to speak: to ask questions and answer the questions. Let us let each other take their time. Even if you do not like the answers or the questions sometimes, let us show respect for this place.

The hon. parliamentary secretary has the floor.

Ms. Pam Goldsmith-Jones: Thank you, Mr. Speaker. Our anti-ISIL strategy, in fact, is an example of our strengthening conviction against the hideous crimes of ISIL. That is all I have to say.

* * *

HEALTH

Mr. Don Davies (Vancouver Kingsway, NDP): Mr. Speaker, there is a national epidemic of drug overdoses, and the Minister of Health has acknowledged that safe injection sites like Insite in Vancouver make sense and save lives. Public health officials in Toronto and cities across Canada are asking for federal help to open these desperately needed facilities. Yet, Liberals are refusing to repeal Conservative legislation that blocks communities from providing harm-reduction services.

Will the government stop stalling, make an evidence-based decision, and repeal the Conservatives' Bill C-2?

Hon. Jane Philpott (Minister of Health, Lib.): Mr. Speaker, as my colleague well knows, we are a government that bases our decisions on evidence. In terms of the matter of problematic substance use, we will address this on the basis of public health concerns as well as a focus on harm reduction.

I am very pleased that communities across the country have recognized that our government is supportive of supervised consumption sites, which have been known to save lives, prevent infections, and help people to access the health care system in a safe way. We will continue to work with communities to make these sites more available.

* * *

ETHICS

Mr. Erin Weir (Regina—Lewvan, NDP): Mr. Speaker, concerns have been raised about millions in federal funding for Regina's Global Transportation Hub. This crown corporation spent $21 million buying land at inflated prices from businessmen with cozy ties to the governing Sask Party. Two weeks ago, the President of the Treasury Board promised to look into this scandal. Even a former Sask Party MLA has called for a police investigation.

Will the minister now report what he found, and will he be referring this matter to the RCMP?

Hon. Scott Brison (President of the Treasury Board, Lib.): Mr. Speaker, I thank the hon. member for his question and also for his inquiry when I appeared before committee.

The reality is that the provincial government in Saskatchewan has actually engaged its auditor general to look into this matter. It is a provincial matter. We look forward to seeing the result of the auditor general's inquiry on the provincial side. The hon. member has played a role in provincial politics in Saskatchewan in the past. That is very good, but we would urge him to focus on his role as a member of Parliament and the federal issues that we are seized with today.

● (1455)

Mrs. Karen Vecchio (Elgin—Middlesex—London, CPC): Mr. Speaker, it has come to light that the Minister of Justice actively opposed the Site C dam project. The minister worked closely with Treaty 8 first nations to oppose it for years. Now with her role at the cabinet table, how can we be assured that she will stay neutral? The minister's mere presence will still have an influence.

Will the minister remove herself from the discussions on this project?

Mr. Jonathan Wilkinson (Parliamentary Secretary to the Minister of Environment and Climate Change, Lib.): Mr. Speaker, in the fall of 2014, the former government approved the project and set out a range of legally binding conditions with which the proponent must comply. BC Hydro must meet the requirements set out in the decision, and we are active in verifying compliance. We will continue to be proactive in that regard. We continue to reach out to indigenous groups to ensure that they are consulted and that we understand the concerns that are being brought forward.

Mrs. Karen Vecchio (Elgin—Middlesex—London, CPC): Mr. Speaker, Benjamin Bergen was the executive assistant to the current Minister of International Trade and her campaign manager. Now, he has begun lobbying the Liberals. His relationship with the minister gives him access to her and her cabinet colleagues. He has even stated that he has an extensive network among senior public sector officials that would be of benefit to their organization.

What is the Prime Minister going to do about yet another insider getting special access to Liberal ministers?

ADJOURNMENT PROCEEDINGS

TAB 9

entrenched powers. These claims raise a number of factual and legal issues that establish a range of serious questions that must be tried in the determination of this action.

1. The Doctrine of Paramountcy

i. The Anatomy of a Federal Paramountcy Claim

215. The paramountcy doctrine renders a provincial law inoperable when there is an inconsistency between valid federal and provincial laws.[317] The inconsistency can manifest as an operational conflict or a frustration in purpose between the laws.[318] Different frameworks are employed depending on the source of the conflict.

216. The frustration of purpose branch under the paramountcy doctrine "occurs where the operation of a valid provincial law is incompatible with a federal legislative purpose."[319] The impact of the provincial law may frustrate the purpose of the federal law, even though it does "not entail a direct violation of the federal law's provisions."[320] The party raising the frustration of purpose branch of the paramountcy doctrine "must first establish the purpose of the relevant federal statute, and then prove that the provincial legislation is incompatible with this purpose."

ii. The Federal Paramountcy Claim Advanced

217. The Plaintiffs allege that HMQA's framework for delivering and accessing supervised consumption services in Alberta frustrates the federal government's purpose behind section 56.1 of the *Controlled Drug and Substances Act*. Section 56.1 confers the federal government authority to grant supervised consumption site operators an exemption under the criminal law powers for individuals to consume and receive support in the consumption of illegal substances.[321] Supervised consumption service providers require a section 56.1 exemption to deliver their services and the review engages in a holistic view of the need and impact of services in a geographic area and to a specific population of substance users.

218. As set out above, section 56.1 has undergone numerous iterations in a short period of time, reflecting the ruling of the Supreme Court of Canada in *PHS* and the election of a government with

[317] *Canadian Western Bank v Alberta*, 2007 SCC 22 at ¶69, Plaintiffs' Authorities, Tab 19.
[318] *Orphan Well Association v Grant Thornton Ltd.*, 2019 SCC 5 at ¶65, Plaintiffs' Authorities, Tab 20.
[319] *Orphan Well Association v Grant Thornton Ltd.*, 2019 SCC 5 at ¶65, Plaintiffs' Authorities, Tab 20.
[320] *Orphan Well Association v Grant Thornton Ltd.*, 2019 SCC 5 at ¶65, Plaintiffs' Authorities, Tab 20.
[321] *Controlled Drugs and Substances Act*, SC 1996, c 19, s 56.1, Plaintiffs' Authorities, Tab 1.

a mandate to streamline and make it easier to deliver and access supervised consumption services in the face of rising overdose rates, particularly in Alberta and British Columbia.[322]

219. The version of section 56.1 that is in effect and at issue in this proceeding was enacted in 2017 after the federal government noted that the previous framework contained significant barriers to delivering and accessing supervised consumption services.[323] Evidence in the form of Hansard records and affidavit evidence establish that this was the federal government's purpose behind the amendments and reflects its current approach to supervised consumption services.

220. In the Parliamentary debates around the 2017 amendments, the government described the revisions as necessary to address the overdose crisis and restore "harm reduction as a key pillar of Canada's drug policy."[324] The amendments "support this strategy by updating the law to focus on harm reduction measures" by "streamlining the application process for supervised consumption sites."[325] To this end, the federal government removed the 26 factors to consider in approving a section 56.1 exemption and replaced them with "the five factors set out in the Supreme Court of Canada decision in 2011, in *Canada vs. PHS Community Services Society*"[326]:[327]

> Should it receive royal assent, Bill C-37 will streamline the application process for supervised consumption sites by replacing the current 26 criteria set out in the Controlled Drugs and Substances Act with the five factors set out by the Supreme Court of Canada in its 2011 decision regarding Insite. These factors are: one, impact on crime rates; two, local conditions indicating need; three, regulatory structure in place to support the facility; four, resources available to support its maintenance; and, five, expressions of community support or opposition…

221. The federal government in Hansard debates around the 2017 touted the changes as "a real solution to the communities dealing with this crisis by eliminating, among other things, unnecessary obstacles to opening supervised consumption sites."[328] The Minister of Health was concerned about "barriers to making sure we save people's lives" during the overdose crisis.[329]

222. The federal government was also specifically concerned that the requirements for delivering and accessing supervised consumption services should not exacerbate the stigma many

[322] Hyshka Affidavit #1 at ¶¶40-59.
[323] Hyshka Affidavit #1 at ¶¶40-59.
[324] Ens Affidavit at Exhibit "2".
[325] Ens Affidavit at Exhibit "2".
[326] Ens Affidavit at Exhibit "2".
[327] Ens Affidavit at Exhibit "2".
[328] Ens Affidavit at Exhibit "2".
[329] Ens Affidavit at Exhibit "2".

substance users face in accessing care to ensure that the sites "are accessed by those who need them."[330]

223. In support of the 2017 amendments, the federal government reiterated that the evidence is that supervised consumption sites "save lives, prevent infections, and help people to access the health care system in a safe way," and through the legislation, it committed "to make these sites more available" to address the overdose crisis contributing to significant loss of life in Alberta and British Columbia. [331]

224. The Plaintiffs have also tendered expert evidence from academics who research and publish on the regulatory requirements for delivering and accessing supervised consumption sites. Dr. Hyshka also describes the 2017 amendments to the section 56.1 framework as a deliberate effort to "facilitate the opening of more [supervised consumption sites]."[332] This also played into practice after the 2017 amendments were adopted; Canada went from 2 supervised consumption sites to 38, and at least 8 in Alberta alone when previously there were none.[333]

225. The federal purpose behind the 2017 amendments to the section 56.1 regime has also been litigated in the Alberta context in the Federal Court of Canada when community associations opposed the establishment of supervised consumption sites in Edmonton's inner-city. The Honourable Justice R. Mosely accepted that the 2017 amendments were intended by the federal government to make it easier to open and access supervised consumption services in Canada, particularly in provinces like Alberta that were in the grips of the overdose crisis (emphasis added):[334]

> Parliament responded to *PHS* by adding *CDSA* section 56.1 in 2015: *Respect for Communities Act*, SC 2015, c 22, s 5. The new provision imposed 26 conditions requiring information to be submitted with any application for an exemption. Among the conditions was a requirement to submit a report on consultations with a broad range of community groups from the municipality in which the proposed site would be located.
>
> **The 2015 amendments stipulated that an exemption relating to a supervised consumption site could only be granted in exceptional circumstances: only after 26 prescribed conditions had been met and**

[330] Ens Affidavit at Exhibit "2".
[331] Ens Affidavit at Exhibit "2".
[332] Hyshka Affidavit #1 at ¶¶53-59.
[333] Hyshka Affidavit #1 at ¶¶53-59.
[334] *Chinatown & Area Business Association v Canada (Attorney General)*, 2019 FC 236 at ¶¶23-27, Plaintiffs' Authorities, Tab 21.

> **after the Minister had considered a number of specified principles regarding the risks associated with illicit substance use**…
>
> Parliament considered the matter again in 2017. Section 56.1 was significantly amended by *An Act to amend the Controlled Drugs and Substances Act and to make related amendments to other Acts*, SC 2017, c 7, section 42, introduced as Bill C-37. **The changes, which were quickly adopted and came into force on May 18, 2017, removed the limitations on the Minister's discretion that had been imposed by the 2015 Act and substantially reduced the information required to be submitted to grant an exemption.** Information regarding the intended public health benefits of the site was still required…
>
> As stated by the Minister of Health in the House of Commons on May 15, 2017, **the intent of these amendments was to streamline the application process for supervised consumption sites so that "communities that want and need these sites do not experience unreasonable delays in their efforts to save lives." She noted that in the previous year, more than 900 people had died from illicit drug overdoses in British Columbia and close to 500 more had died in Alberta. The conditions required by the 2015 legislation had caused delays in establishing sites.** The new process, the Minister said, would "align with the five factors set out in the Supreme Court of Canada decision in 2011."

226. Justice Mosley also found that "the principal and mandatory focus of the legislation is on the question of whether an exemption would provide public health benefits."[335] That is the focus under section 56.1 of the *Controlled Drugs and Substances Act* after the 2017 amendments and were intended to address the range of other mandatory requirements that existed in the legislation prior, including broader community consultations. This requirement was removed in 2017 because it was "stultifying applications" for exemptions:[336]

> I think that it is clear from the legislative history evidence submitted by CDPC that the mandatory requirements imposed by the 2015 legislation were, in CDPC's words, "stultifying applications" for exemptions. Because of this and from a concern that drug users' *Charter* rights were at risk of being violated, mandatory consultation, as required by subsection 56.1(3) of the 2015 *CDSA*, was eliminated in Bill C-37 in favour of a requirement that the applicant for an exemption provide statements of community support or opposition. Absent the issuance of notice for public comments under *CDSA* section 56.1(4), the legislation provided CABA no right to

[335] *Chinatown & Area Business Association v Canada (Attorney General)*, 2019 FC 236 at ¶100, Plaintiffs' Authorities, Tab 21.
[336] *Chinatown & Area Business Association v Canada (Attorney General)*, 2019 FC 236 at ¶98, Plaintiffs' Authorities, Tab 21.

> further consideration of its position before the decisions to grant the exemptions were made.

227. The Regulations frustrate the federal purpose behind section 56.1 of the *Controlled Drug and Substances Act* by imposing a range of additional criteria that supervised consumption site operators have to satisfy in Alberta to deliver supervised consumption services. Most of the criteria is the same as the existing section 56.1 framework and requires operators to establish them again under HMQA's framework. However, there are several key requirements that exist under the HMQA framework that were *repealed* by the federal government in 2017 from the section 56.1 framework because they were identified as barriers to opening and accessing these services.

228. The clearest example of HMQA reinstating measures that previously existed under the section 56.1 framework but removed by the federal government in 2017 after determining that the measure was an unnecessary barrier in the process is the community consultation requirement. As noted by Justice Mosely, the mandatory community consultation provision incorporated in the section 56.1 framework in 2015 was removed in 2017 because it was considered a barrier in opening supervised consumption sites.[337] HMQA's consultation requirement is also far more onerous than the version repealed by the federal government, as it requires a proposed operator to collect signatures of all local businesses, community associations, and nearby residents within a 200-metre radius of the proposed site as part of a good neighbour agreement.[338]

229. The effect of HQMA's community consultation requirement is the same that the federal government attempted to mitigate through the 2017 amendments to the section 56.1 framework: it serves as a barrier to opening and making supervised consumption services more accessible.[339] It creates major challenges for operators being able to meet these requirements and dissuade them from engaging in the process, "stultifying" applications under the provincial licensing regime.

230. There are additional measures that were repealed by the federal government in 2017 under the section 56.1 framework for being barriers to delivering and accessing supervised consumption services that HMQA has reinstated in the Regulations. They include a criminal record and vulnerable sector check of individuals employed with supervised consumption operators, which

[337] *Chinatown & Area Business Association v Canada (Attorney General)*, 2019 FC 236 at ¶¶88-100, Plaintiffs' Authorities, Tab 21.
[338] Hyshka Affidavit #1 at ¶¶200-202.
[339] Hyshka Affidavit #1 at ¶¶169-203.

would preclude many with invaluable lived experience with substance use from delivering harm reduction and other support services.[340]

231. HMQA has also enacted new barriers to delivering and accessing supervised consumption services under the Regulations. According to the various experts retained by the Plaintiffs in this proceeding, the PHN and personal identification requirement, even if it consists of a voluntary request, will deter many substance users from accessing supervised consumption services in Alberta. This is due to the unique structural vulnerabilities of substance users, and the real fears many have around being identified in the health care system or by police as a substance user. Making the PHN and personal identification requirement mandatory or voluntary will have the same effect; people who otherwise need and access supervised consumption services will no longer attend these sites, which is consistent with the testimony of those with lived experience of substance use, such as T.F. and Slaney.

232. An additional barrier proposed in the Regulations that is at odds with the federal government's purpose and approach to section 56.1 approvals is the electronic medical record system requirement and other measures that would effectively prohibit grassroots, *ad-hoc* overdose prevention sites from operating in Alberta. As Slaney deposes on behalf of LOPS, the measures would make it impossible for community-based overdose prevention sites like LOPS from operating due to logistical and financial constraints.[341] In addition these overdose prevention sites move their operations from location to location based on need within a community, and do not have a permanent fixed location.

233. Transporting a secure electronic medical records system from park to park is not feasible for LOPS and other similarly situated overdose prevention sites. The requirement means that the HMQA framework does not allow grassroots, community overdose prevention sites to deliver supervised consumption services in Alberta. If that is the case, then it illustrates a striking discord with the federal government recognition that overdose prevention sites are critical to addressing the overdose crisis and creation of a formal pathway has existed since 2018 under the section 56.1 framework to allow these services providers to operate in an expedited manner.

[340] *Controlled Drugs and Substances Act*, SC 1996, c 19, s 56.1(3) (w), (x), (y) (version in existence from July 16, 2015 to January 12, 2016), Plaintiffs' Authorities, Tab 4.
[341] Slaney Affidavit at ¶¶68-74.

234. The federal government's purpose behind establishing the "Urgent Public Health Need Sites" application process for overdose prevention sites to receive authorization to deliver supervised consumption services would be thwarted if the regulatory requirements under HMQA's framework that effectively prohibits them from operating.

235. HMQA's purpose in pursuing the regulatory changes is either opposition to expanding access to supervised consumption services, which is supported by the provincial government's statements on the matter both inside and outside the Legislature.[342] Or in the alternative, the purpose behind the Regulations is to provide a uniform licensing regime for delivering and accessing supervised consumption services in Alberta.[343] However, there is evidence from HMQA that the measures are intended to help substance users recover from their afflictions through a recovery-oriented model of care.[344]

236. The Plaintiffs argument that Regulations frustrate the federal government's purpose in enacting the section 56.1 framework for supervised consumption services is arguable.

2. Section 2(a) of the *Charter*

i. The Anatomy of a Section 2(a) *Charter* Claim

> Everyone has the following fundamental freedoms:… freedom of conscience and religion.

237. LOPS alleges that HMQA's new measures breach its freedom of conscience right at section 2(a) of the *Charter of Rights and Freedoms*.

238. Freedom of conscience has not been subject to much judicial consideration, and virtually none by Alberta courts.

239. However, Justice Wilson's concurrence in *R v Morgentaler* provides a conceptual approach to the fundamental freedom:[345]

> Freedom of conscience and religion" should be broadly construed to extend to conscientiously-held beliefs, whether grounded in religion or in a secular morality and the terms "conscience" and "religion" should not be treated as tautologous if capable of independent, although related, meaning.

[342] Ens Affidavit at Exhibits "1", "3', and "4".
[343] Puttick Affidavit at ¶4.
[344] Affidavit of Coreen Everington, affirmed October 28, 2021 at ¶¶12-16.
[345] *R v Morgentaler*, [1988] 1 SCR 30 at page 37, Plaintiffs' Authorities, Tab 22.

240. There is also no recognized legal test to determine rights claims advanced under the freedom of conscience protection.

241. However, the Plaintiffs propose the following analytical framework to determine freedom of conscience claims at section 2(a) of the *Charter of Rights and Freedoms*, which is based on the work of Professors Jocelyn Downie and Françoise Baylis:[346]

a) the claimant's conscience claim has a nexus with specific ethical values, beliefs, or commitments that recommend or demand a particular act;

b) the claimant is sincere in its ethical values, beliefs, or commitments;

c) the claimant's conscience claim is the result of an exercise of ethical judgment from:

    1. the exercise of due diligence, and

    2. the avoidance of undue deference

d) the state action interferes with the freedom to act in accordance with the claimant's ethical values, beliefs, or commitments; and

e) the interference with the act that is grounded in the claimant's ethical values, beliefs, or commitments is more than trivial or insubstantial.

ii. The Section 2(a) *Charter* Claim Advanced

242. Harm reduction is an ethical and moral philosophy that LOPS embraces and informs all of its actions.[347] LOPS purpose and direction are to ensure that people who use substances are supported and receive safe and compassionate care in a judgment free environment; the emphasis is on providing substance users the care they need to continue to live notwithstanding their substance use rather than forcing them to pursue abstinence or reductions in their substance use.[348] This ethical worldview places the needs of a substance user at the forefront and emphasizes a

[346] Jocelyn Downie & Françoise Baylis, "A Test for Freedom of Conscience under the Canadian Charter of Rights and Freedoms: Regulating and Litigating Conscientious Refusals in Health Care" (2017) 11:1 McGill JL & Health S1: S26-S27, Plaintiffs' Authorities, Tab 38.
[347] Slaney Affidavit at ¶¶42-49.
[348] Slaney Affidavit at ¶¶42-49.

public health approach to substance use rather than a moralizing, recovery guided trajectory that only ends with no longer using substances.

243. Because of its commitment to harm reduction, LOPS formed and has consistently delivered supervised consumption services in Lethbridge where the overdose crisis is particularly acute. The organization has delivered these services in the face of harassment, violence, and quasi-criminal prosecution.[349] These obstacles have not deterred LOPS in fulfilling its mandate and helping substance users in Lethbridge survive the overdose crisis, demonstrating the sincerity of its beliefs.

244. LOPS was in the process of obtaining a section 56.1 exemption until HQMA enacted its Regulations that will prevent it delivering in a manner that accords with its harm reduction philosophy.[350]

245. For this reason, LOPS refuses to adopt the PHN requirement.[351] This means that it will be prohibited from providing supervised consumption services in Alberta, making it liable for significant regulatory fines, to the sum of $10,000.00 per day, but it is willing to accept the fines to fulfill the harm reduction principles that informs its worldview and guides its actions.

246. The Regulations infringe LOPS' freedom of conscience.

247. LOPS's freedom of conscience argument is neither frivolous nor vexatious, and is arguable on the record tendered for this application.

1. Section 2(b) of the *Charter*

i. The Anatomy of a Section 2(b) *Charter* Claim

> Everyone has the following fundamental freedoms: freedom of thought, belief, opinion and expression, including freedom of the press and other media of communication.

248. Freedom of expression allows parties to promote the search and attainment of truth, participation in social and political decision-making and the opportunity for individual self-fulfillment through expression.

[349] Slaney Affidavit at ¶¶50-57.
[350] Slaney Affidavit at ¶¶58-60.
[351] Slaney Affidavit at ¶¶65-67.

249. Freedom of expression is broadly defined and encompasses "any activity or communication that conveys or attempts to convey meaning."[352]

250. Canadian courts have developed the following framework for determining freedom of expression claims at section 2(b) of the *Charter of Rights and Freedoms*:

a) does the activity in question have expressive content, thereby bringing it within section 2(b) protection?;

b) does the method or location of this expression remove that protection?; and

c) if the expression is protected by section 2(b), does the government action in question infringe that protection, either in purpose or effect?

ii. The Section 2(b) *Charter* Claim Advanced

251. There is an expressive purpose to LOPS providing supervised consumption services to marginalized substance users in Lethbridge, constituting expression that pursues democratic, educational, health, and other valuable social aims (emphasis added):[353]

> LOPS, as a group of former substance users and individuals who have worked with people who use substances, including medical professionals, knows the adverse impacts of substance use intimately. The harms associated with substance use are extremely severe, and often fatal, but are entirely preventable. Many of LOPS' directors and members have lost loved ones, or have overdosed or contracted diseases from substance use, which is true in my case. LOPS knows that another reality is possible for substance users in Lethbridge, and want to ensure that it can be achieved through the delivery of effective and low barrier supervised consumption services to them.
>
> As the overdose crisis worsened in Lethbridge, the founders of LOPS could not stand by and watch our family members, friends, neighbours, and broader community members die preventable deaths. LOPS was created to fill the gap created by ARCHES' closure and the AHS mobile unit's limitations. We wanted to do whatever we could to save and improve the lives of substance users, confronting whatever difficulties and challenges along the way. The overdose epidemic in Lethbridge was too severe and wide encompassing to let things persist as they were.
>
> The primary goal of LOPS is "to provide a space for people to administer their previously obtained drugs with sterile equipment in a setting where

[352] *Libman v Quebec (Attorney General)*, [1997] 3 SCR 569 at ¶31, Plaintiffs' Authorities, Tab 24.
[353] Slaney Affidavit at ¶¶44-49.

> volunteers can observe and intervene in overdoses as needed." LOPS operates "a low threshold, health care service where people can consume pre-obtained drugs in a hygienic environment under the supervision of trained volunteer and receive basic health care, harm reduction teaching and counselling as well as referrals to external health and social services." LOPS is a welcoming and supportive environment for substance users in Lethbridge. Our aim is to ensure that no substance user in Lethbridge consumes substances in an unsafe manner…
>
> LOPS got to work right away in the parks and areas in and around Lethbridge. We fundraised our budget and started buying the supplies we needed to provide supervised consumption services, including tents, needles, and other items. By October 2020, LOPS was operating a pop-up overdose prevention tent in Lethbridge, moving through out the community as needed, and engaging substance users in the community who otherwise would not access supervised consumption services through the AHS mobile unit for a variety of reasons. If LOPS was not around, these individuals would have used on their own and in an unsafe manner, and in many cases, overdosed and died.
>
> **LOPS delivers supervised consumption services to substance users in Lethbridge in a manner that conveys to them that their life matters. Through the method that LOPS delivers supervised consumption services, it ensures that each substance user is aware there are people who love, support, and are rooting for them on their journey. LOPS does not advocate a specific path that substance users take, but in both the services it provides and how it provides them, we communicate to each substance user that there is hope of a better future and that we are with every step of the way.**
>
> LOPS does this because many of its directors and members are substance users or are former substance users and we know how important this message is for substance users. The only reason I engaged with ARCHES and eventually accessed methadone treatment is because of the messages and support I received during my interaction with its staff, building trust and confidence to the point where I decided to stop using street sourced opioids and enter treatment. It changed my life for the better and LOPS wants to give that same encouragement to other substance users as they live with their substance use.

252. There is nothing about the method or location of LOPS' expression that removes the protection.

253. The Guide and Regulation infringe LOPS' expression in the form of providing supervised consumption services to vulnerable substance users in Lethbridge by deeming it unlawful and subjecting it to significant regulatory fines.

2. Section 7 of the *Charter*

i. The Anatomy of a Section 7 *Charter* Claim

> Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

254. For a section 7 *Charter* claim to be successful, a claimant must demonstrate that their life, liberty, or security of the person interest has been deprived in a manner that fails to accord with the principles of fundamental justice.

255. "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."[354]

256. "Security of the person encompasses "a notion of personal autonomy involving… control over one's bodily integrity free from state interference" and it is engaged by state interference with an individual's physical or psychological integrity, including any state action that causes physical or serious psychological suffering."[355] While the life interest is concerned with the continuation of life, concerns around an individual's quality of life are engaged by the security of the person interest.

257. There are two dimensions to security of the person: "physical integrity" and "psychological integrity." An individual's psychological integrity is engaged where "state interference with an individual interest of fundamental importance" brings about "serious psychological incursions":[356]

> For a restriction of security of the person to be made out ..., the impugned state action must have a serious and profound effect on a person's psychological integrity. The effects of the state interference must be assessed objectively, with a view to their impact on the psychological integrity of a person of reasonable sensibility. This need not rise to the level of nervous shock or psychiatric illness, but must be greater than ordinary stress or anxiety.

258. The liberty interest is engaged "where state compulsions or prohibitions affect important and fundamental life choices."[357]

[354] *Carter v Canada (Attorney General)*, 2015 SCC 5 at ¶62, Plaintiffs' Authorities, Tab 25.
[355] *Carter v Canada (Attorney General)*, 2015 SCC 5, at ¶64, Plaintiffs' Authorities, Tab 25.
[356] *New Brunswick (Minister of Health and Community Services) v G(J)*, [1999] 3 SCR 46 at ¶60, Plaintiffs' Authorities, Tab 26.
[357] *Blencoe v British Columbia (Human Rights Commission)*, 2000 SCC 44 at ¶49, Plaintiffs' Authorities, Tab 27.

259. The deprivation of a section 7 *Charter* interest must occur in accordance with the principles of fundamental justice.

260. The Plaintiffs rely on the following established principles of fundamental justice:

a) **arbitrariness**: there is no rational connection between the state's interest and the limit it imposes on the section 7 *Charter* interests;[358]

b) **overbreadth**: the state, in pursuing its objective, takes away rights in a way that generally supports the object of the law, but goes beyond what is necessary to achieve its objective by denying the rights of some individuals in a way that bears no relation to the object;[359]

c) **gross disproportionality**: "the impact of the restriction on the individual's life, liberty or security of the person is grossly disproportionate to the object of the measure;"[360] and

d) **shock the conscience**: state action that is so disproportionate and excessive that it would shock the conscience of Canadians.[361]

261. However, there are principles of fundamental justice that can be recognized on an *ad-hoc* basis, "it must be a legal principle about which there is significant societal consensus that it is fundamental to the way in which the legal system ought fairly to operate, and it must be identified with sufficient precision to yield a manageable standard against which to measure deprivations of life, liberty or security of the person."[362]

262. In addition to the established principles of fundamental justice, the Plaintiffs advance a new principle of fundamental justice in this context:

a) **medical ethics and practice standards**: the state cannot alter or deny medical treatment that it provides to individuals in a manner that is inconsistent with the medical ethics and practice standards that apply in a particular situation.

[358] *Carter v Canada (Attorney General)*, 2015 SCC 5, at ¶83, Plaintiffs' Authorities, Tab 25.
[359] *Carter v Canada (Attorney General)*, 2015 SCC 5, at ¶85, Plaintiffs' Authorities, Tab 25.
[360] *Carter v Canada (Attorney General)*, 2015 SCC 5, at ¶89, Plaintiffs' Authorities, Tab 25.
[361] *United States v Burns*, 2001 SCC 7 at ¶¶67-69, Plaintiffs' Authorities, Tab 28.
[362] *R v Malmo-Levine; R v Caine*, 2003 SCC 74 at ¶113, Plaintiffs' Authorities, Tab 29.

ii. The Section 7 *Charter* Claim Advanced

263. The record establishes that if the PHN and identity requirements set out in the Regulations are implemented, barriers will be erected in the delivery and access to supervised consumption services in Alberta. The measures will reduce the availability of supervised consumption services by making it extremely difficult if not impossible for community overdose prevention sites to operate legally.

264. HMQA's measures will cause more Albertans to consume substances in unsupervised settings, increasing the risk substance users have of overdose death and other harms, including the spread of bloodborne infections such as HIV and Hepatitis C, and bacterial infections such as infectious endocarditis and skin infections.[363]

265. An increase in unsupervised substance consumption will deprive substance users of their right to life, liberty, and security of the person, by exposing them to these harms. The measures will discourage substance users from accessing supervised consumption services, which are life saving and sustaining medical and social supports. This intrudes on the ability of substance users to make fundamentally personal decisions, depriving them of their liberty interest. More concerningly, unsupervised substance use will cause substance users to die and suffer serious injuries, engaging their life and security of person interests.

266. The deprivation does not accord with the principles of fundamental justice. If HMQA's measures are intended to establish a uniform licensing regime or a recovery-oriented approach to substance use that provides options to individuals and incorporates harm reduction measures, then the purpose of the law is arbitrary, grossly disproportionate, and overbroad in its effects as it causes people to die and suffer other serious harms.

267. In the alternative, if this court finds that the purpose behind the Regulations is to deter access to supervised consumption services, then HMQA's measures would shock the conscience of Canadians because they would be directly contributing to the death and serious harms being inflicted on vulnerable substance users, and continuing to fuel Alberta's serious overdose crisis.

[363] O'Gorman Affidavit at ¶51; Pauly Affidavit at ¶24; and Gupta Affidavit at ¶43.

268. In all proposed purposes attached to the Regulations, HMQA's measures are contrary to the medical ethics and best practices for providing supervised consumption services to substance users, increasing their risk of death and other harms.

3. Section 8 of the *Charter*

i. The Anatomy of a Section 8 *Charter* Claim

Everyone has the right to be secure against unreasonable search or seizure.

269. Privacy is essential not only to human dignity but also the functioning of a democratic society. The right to privacy is protected at section 8 of the *Charter of Rights and Freedoms*; it protects people, not places.[364]

270. The protection exists in the criminal and civil context.[365]

271. The test for a section 8 *Charter* breach consists of the following steps:[366]

a) has there been a search or seizure; and

b) if so, was the search or seizure reasonable?

272. A search or seizure will be reasonable where it is (1) authorized by law; (2) the law itself is reasonable; and (3) the manner in which the search is carried out is reasonable.[367] This is a contextual determination based on the totality of circumstances in a case.

ii. The Section 8 *Charter* Claim Advanced

273. The demand for a PHN and personal identifying information by the state when accessing a supervised consumption site constitutes an effort to seize biographical information that is at the core of an individual's identity. Even if disclosure is voluntary, and people will not be turned away from accessing supervised consumption services if they refuse to provide this information, the request is a seizure for the purposes of section 8 of the *Charter*.

274. Supervised consumption services are critical medical and social supports that substance users require to live. HMQA, through the Regulations, is requiring that substance users disclose

[364] *R v Gomboc*, 2010 SCC 55 at ¶17, Plaintiffs' Authorities, Tab 30.
[365] See: *Hunter et al v Southam Inc*, [1984] 2 SCR 145, Plaintiffs' Authorities, Tab 31.
[366] *R v Caslake*, [1998] 1 SCR 51 at ¶10, Plaintiffs' Authorities, Tab 32.
[367] *R v Caslake*, [1998] 1 SCR 51 at ¶10, Plaintiffs' Authorities, Tab 32.

this private information to access lifesaving services. A substance user is placed in the position of providing this information or consuming substances in a manner that is likely to kill them.

275. The demand is unreasonable because the disclosure of a PHN or personal identifying information is not required to deliver or access supervised consumption services. This information is neither required to engage in program reviews or to track outcomes. There is no other jurisdiction in Canada that requires this level of disclosure of private information to access supervised consumption services. In Alberta today, this information is not required to deliver these supports.

276. However, even if there is some value in collecting this information, the harms outweigh any benefits because it will cause many substance users to no longer access supervised consumption services and consume substances in unsupervised settings. This will increase their likelihood of overdose death and other harms. HMQA's measures will further contribute to the overdose death crisis in Alberta and is unreasonable in the circumstances.

277. Transitioning from a delivery model for supervised consumption services premised on anonymity and confidentiality to one where individuals are asked for their PHN or personal identifying information constitutes an unreasonable intrusion on personal privacy that will deter substance users from accessing supervised consumption services in Alberta.

4. Section 12 of the *Charter*

i. The Anatomy of a Section 12 *Charter* Claim

> Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.

278. In the non-penal, civil context, "treatment" for the purposes of section 12 of the *Charter* has only been judicially interpreted four times over the course of the provision's nearly 40-year history.

279. In *Rodriguez v British Columbia (Attorney General)*,[368] Justice Lamer for the Majority held:[369]

> 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… [t]here must

[368] [1993] 3 SCR 519, Plaintiffs' Authorities, Tab 33.
[369] *Rodriguez v British Columbia (Attorney General)*, [1993] 3 SCR 519 ["***Rodriguez***"] at pages 611-612, Plaintiffs' Authorities, Tab 33.

> 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.

280. A state process that involves the government engaging in some form of positive action or inaction over an individual, or prohibiting them from doing something, is enough to trigger section 12 of the *Charter*. If that positive action (doing something), inaction (not doing something), or prohibition (banning something) is cruel and unusual, in the sense that it is "so excessive as to outrage standards of decency" or "grossly disproportionate to what would have been appropriate," then a section 12 *Charter* breach is made out.

281. However, in *Rodriguez*, the court held that since the appellant was challenging the impacts of a law of general application, in the sense that all individuals in Canada were subject to the same criminal code provisions against assisted dying, then the prohibition on medically assisted death did not constitute "treatment" for the purposes of section 12 of the *Charter*.[370] The was no special administrative control over the appellant that distinguished her experience from other individuals in Canada. There was no "active state process in operation" to engage her section 12 *Charter* rights to ground a breach.[371]

282. In contrast, refugee claimants in *Canadian Doctors for Refugee Care v Canada (Attorney General),*[372] were found to be subject to an active state process: "those seeking the protection of Canada are under immigration jurisdiction, and as such are effectively under the administrative control of the state."[373] The state process they are under as foreign nationals seeking legal status in Canada creates a dependency on the state, which affects their rights and interests. This engaged the section 12 *Charter* rights of refugee claimants (emphasis added):[374]

> 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.

[370] *Rodriguez* at pages 611-612, Plaintiffs' Authorities, Tab 33.
[371] *Rodriguez* at pages 611-612, Plaintiffs' Authorities, Tab 33.
[372] 2014 FC 651 ["***Refugee Care***"], Plaintiffs' Authorities, Tab 34.
[373] *Refugee Care* at ¶585, Plaintiffs' Authorities, Tab 34.
[374] *Refugee Care* at ¶590, Plaintiffs' Authorities, Tab 34.

283. In *Refugee Care,* determining whether a particular form of state conduct constitutes treatment for the purposes of section 12 of the *Charter* was an involved, contextual determination that required significant fact-finding and review by the court.

284. The court ruled in *Refugee Care* that the state treatment in that case rose to the level of being cruel and unusual because forcing vulnerable and marginalized individuals "to beg for life-saving medical treatment" was demeaning, signifying "that their lives are worth less than the lives of others."[375] This outraged the standards of decency and was grossly disproportionate to how refugee claimants should have been treated in the circumstances.

285. In a similar injunction application brought in the harm reduction context in Alberta, the court ruled that "the *Refugee Care* case does describe a path of legal reasoning which could lead to a finding that the withdrawal of medical care constitutes treatment for the purposes of s 12 of the *Charter*."[376]

ii. The Section 12 *Charter* Claim Advanced

286. The regulatory framework HMQA has adopted for delivering and accessing supervised consumption services constitutes "treatment" for the purposes of section 12 of the *Charter*. The state process at issue is prohibition and positive action: (1) HMQA has developed new requirements that overdose prevention sites must meet to deliver these services and (2) will require operators to request the PHN and other identifying details of substance users, which the record in this proceeding establishes will deter large numbers of substance users from continuing to access supervised consumption sites.

287. Substance users constitute a discrete minority of poor, vulnerable, and disadvantaged individuals who are within the control of HMQA through its regulation of supervised consumption services. The control arises from the fact that substance users rely on supervised consumption services for survival and HMQA has developed a regulatory framework that restricts both the delivery and access to these services.

288. HMQA's new regulatory framework will cause substance users to no longer access supervised consumption services in Alberta, placing them at greater risk of overdose death and experiencing other harms. The requirements achieve no demonstrable public benefit, are contrary

[375] *Refugee Care* at ¶688, Plaintiffs' Authorities, Tab 34.
[376] *TAM v Alberta*, 2021 ABQB 156 at ¶130, Plaintiffs' Authorities, Tab 35.

to the medical science and best practices in delivering supervised consumption services, and will worsen the already unprecedented overdose crisis. The conduct of the government and resulting harms are "so excessive as to outrage standards of decency" or "grossly disproportionate to what would have been appropriate."

289. The argument advanced in relation to the section 12 *Charter* breach is analogous to the situation of the claimants in *Refugee Care*. The claimants in *Refugee Care* sought continued access to health care coverage as their refugee claims were being decided. The court found that denial of such coverage to a discrete, marginalized group of people would cause harm, and be "so excessive as to outrage standards of decency" in Canada. Forcing vulnerable and marginalized individuals "to beg for life-saving medical treatment" was demeaning, signifying "that their lives are worth less than the lives of others."[377] On that basis, the court found the section 12 *Charter* claim in *Refugee Care* made out.

290. The Plaintiffs are advancing the same argument in this case: HMQA has created a regulatory framework for life-saving supervised consumption services that will stigmatize many substance users and prevent them from accessing these services, signifying to substance users in Alberta that their lives are not worth saving in the midst of the overdose crisis. The changes to delivering and accessing supervised consumption services in this context are so excessive and cruel that it outrages the standards of decency.

291. The section 12 *Charter* claim advanced in this action raises a serious issue to be tried.

5. Section 15 of the *Charter*

i. The Anatomy of a Section 15 *Charter* Claim

> 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.
>
> (2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

[377] *Refugee Care* at ¶688, Plaintiffs' Authorities, Tab 34.

292. For a section 15 *Charter* claim to be actionable, a claimant must demonstrate that:[378]

a) the state action imposes differential treatment based on protected grounds, either explicitly or through adverse impact; and

b) has the effect of reinforcing, perpetuating, or exacerbating disadvantage.

ii. The Section 15 *Charter* Claim Advanced

293. Substance use is a mental or physical disability, and HMQA's regulatory framework for supervised consumption services will restrict their availability and deter access to them, reinforcing, perpetuating, and exacerbating the disadvantage that substance users already experience in Canada.

294. Additionally, based on the record before this Court, the measures will have a disproportionate effect on Indigenous people in Alberta who are substance users, as they are overrepresented among those dying of overdoses and requiring medical interventions because of substance use.[379] In addition, based on the evidence of Slaney, O'Gorman, and Dr. Larson, Indigenous substance users are among the most marginalized and vulnerable substance users, most concerned about stigma and discrimination in the health care system, and more likely to be restricted and deterred in accessing supervised consumption services with the new measures due to the limits imposed on grassroots community overdose prevention sites and mandatory identity requests.[380] The evidence on record establishes that it is arguable that Indigenous substance users in Alberta will be disproportionately impacted by the new measures HMQA has announced for supervised consumption services.

295. The Plaintiffs' section 15 *Charter* claim is neither frivolous nor vexatious in the circumstances.

[378] *Fraser v Canada (Attorney General)*, 2020 SCC 28 at ¶81, Plaintiffs' Authorities, Tab 36.
[379] Hyshka Affidavit #1 at ¶¶20-22.
[380] Slaney Affidavit at ¶¶28-31, ¶37, ¶66, and ¶76; O'Gorman Affidavit at ¶34; and Larson Affidavit at ¶¶14-42.

6. HMQA's Regulatory Framework is *Ultra Vires*

i. The Anatomy of an *Ultra Vires* Claims

296. To determine if a law is *ultra vires*, a court must first determine the matter of the law, and then ascertain the purpose and effect of the law.[381]

297. The approach was outlined in *R v Morgentaler*, where Nova Scotia enacted a uniform licensing scheme for abortion services in the province.[382] However, the regulatory framework limited the availability of and who could access the procedure, and included significant regulatory sanctions if operators failed to abide by the requirements.[383] The sanctions consisted of regulatory fines between $10,000.00 and $50,000.00.[384]

298. After engaging in a pith and substance analysis, the Supreme Court of Canada determined that though Nova Scotia claimed that the measures "regulated the place for delivery of a medical service with a view to controlling the quality and nature of its health care delivery system," the framework was actually for "the prohibition of the performance of abortions with penal consequences."[385] The penal consequences were the significant fines, intended to punish those providing abortion services outside the designated process and locations prescribed in the provincial regulations.[386] This amounted to criminal law powers that fell under federal jurisdiction, resulting in the court declaring the regulatory framework "*ultra vires* in their entirety."[387]

299. In ascertaining the pith and substance of the law, the court found that it was "entitled to refer to extrinsic evidence of various kinds provided it is relevant and not inherently unreliable."[388]

ii. The *Ultra Vires* Claim Advanced

300. The Plaintiffs' claim is directly analogous to the one advanced in *R v Morgentaler*.

301. The regulation of supervised consumption services is a criminal law power. Operators require an exemption pursuant to section 56.1 of the *Controlled Drug and Substances Act*, a

[381] *R v Morgentaler*, [1993] 3 SCR 463 at pages 479-494, Plaintiffs' Authorities, Tab 23.
[382] *R v Morgentaler*, [1993] 3 SCR 463 at pages 468-478, Plaintiffs' Authorities, Tab 23.
[383] *R v Morgentaler*, [1993] 3 SCR 463 at pages 468-478, Plaintiffs' Authorities, Tab 23.
[384] *R v Morgentaler*, [1993] 3 SCR 463 at pages 468-478, Plaintiffs' Authorities, Tab 23.
[385] *R v Morgentaler*, [1993] 3 SCR 463 at pages 488 and 512, Plaintiffs' Authorities, Tab 23.
[386] *R v Morgentaler*, [1993] 3 SCR 463 at pages 511-512, Plaintiffs' Authorities, Tab 23.
[387] *R v Morgentaler*, [1993] 3 SCR 463 at page 516, Plaintiffs' Authorities, Tab 23.
[388] *R v Morgentaler*, [1993] 3 SCR 463 at pages 483-485, Plaintiffs' Authorities, Tab 23.

criminal law statute, to provide these services. The exemption allows individuals to consume and facilitate the consumption of illegal substances without the risk of criminal prosecution.

302. HMQA now seeks to regulate the delivery and access of supervised consumption services in Alberta. There are a variety of aims advanced by the parties for the framework's purpose: (1) limiting access to supervised consumption services; (2) establish a uniform licensing regime for supervised consumption service providers; and (3) pursue a recovery-oriented model of care for substance use.

303. HMQA is limiting who can provide supervised consumption services and establishing barriers for those accessing these services. Large numbers of substance users in Alberta, particularly the most structurally vulnerable substance users, will no longer access supervised consumption services and be exposed to an array of harms. Those who continue to provide supervised consumption services to this population of substance users, such as LOPS, will be subject to serious fines, including $10,000.00 per day in contravention of the Regulations. As the framework is drafted, that would mean that for every substance user who is not asked for their PHN or personal identifying information at intake at a supervised consumption site, the operator would be in breach of the Regulations and subject to a $10,000.00 fine.

304. The regulatory framework applies to all supervised consumption service operators in Alberta, including those who have already obtained an exemption under section 56.1 of the *Controlled Drug and Substances Act*. An operator must satisfy HMQA's requirements as well as the section 56.1 framework. The HMQA requirements include the same criteria at section 56.1 that Parliament removed from the framework after identifying them as a barrier to delivering and accessing supervised consumption services and contributing to the overdose crisis. It also adds additional barriers that will discourage vulnerable substance users from accessing these life saving services.

305. In Hansard debates and through statements released through official channels, the provincial government routinely criticizes supervised consumption services and calls for their closure. HMQA has on the government's direction already moved to close or limit supervised consumption services in Alberta. Proposed supervised consumption sites were cancelled in Calgary, Red Deer, and Medicine Hat; established sites were closed in Edmonton and Lethbridge, which was the largest and busiest facility in North America and shut down under allegations that

were proven to be untrue; and HMQA proposes additional closures citing nuisance, community stigma, and claims that these services are not effective in comparison to rehabilitation therapy.

306. Based on how the provincial regulation has been drafted, and the statements, policies, and conduct of the government in relation to the Regulations before and after their announcement in both the Legislature and broader public, the purpose of the framework is to prohibit or limit the availability of supervised consumption services with penal consequences. This purpose places the framework within the criminal law power, rendering it *ultra vires* pursuant to section 91(27) of *The Constitution Act, 1867*.[389]

E. Substance Users Will Face Immediate and Serious Harm if the Framework is Adopted

307. As set out by the Supreme Court in *RJR-MacDonald*, irreparable harm "refers to the nature of the harm suffered rather than its magnitude."[390] In addition, the Alberta Court of Appeal has directed chambers justices to assess irreparable harm from the standpoint of the applicant, based on their unique circumstances.[391] It is not an objective consideration, but rather situated in the lived experience of the party seeking the application, which in this case are marginalized substance users.

308. The affidavits tendered by the Plaintiffs set out a nuanced, thorough description of the physical, mental, and social harms they will face if the measures are implemented.[392]

309. Declining to access supervised consumption services because of HMQA's requirement that site operators request, collect, and disclose the personal identifying information of substance users is not a choice. In *Canada (Attorney General) v Bedford*,[393] a similar argument was advanced in the context of individuals engaging sex work, which was considered high-risk behaviour. The Attorney General submitted that sex workers "choose to engage in an inherent risky activity" that

[389] *The Constitution Act, 1867*, 30 & 31 Vict, c 3, s 91(17), Plaintiffs' Authorities, Tab 8.
[390] *RJR-MacDonald*, at page 341, Plaintiffs' Authorities, Tab 12.
[391] *AC and JF v Alberta*, 2021 ABCA 24 at ¶55, Plaintiffs' Authorities, Tab 13.
[392] T.F. Affidavit at ¶¶25-27; Slaney Affidavit at ¶¶75-77; Hyshka Affidavit #1 at ¶169-203; Larson Affidavit at ¶¶28-42; O'Gorman Affidavit at ¶¶48-51; Pauly Affidavit at ¶¶23-32; and Gupta Affidavit at ¶¶16-40.
[393] 2013 SCC 72.