Court of Queen's Bench of Alberta

Citation: TAM v Alberta, 2021 ABQB 156

Date: 20210225
Docket: 2003 15090
Registry: Edmonton

Between:

TAM, AFME, BB, CW, DWA, FP, GWF, GLC, KT, MSC and SPM

Plaintiffs

- and -

Her Majesty the Queen in Right of Alberta

Defendant

Reasons for Decision
of the
Honourable Mr. Justice G.S. Dunlop

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1. Overview

[1] On September 30, 2020, the Plaintiffs filed an application seeking an interlocutory injunction prohibiting the Defendant, the Province of Alberta, from denying Injectable Opioid Agonist Treatment (iOAT) to them, other existing patients and future patients until the final determination of this action. They also seek an interlocutory declaration that all existing patients are entitled to receive iOAT while this action is being determined and an order directing the Province of Alberta to provide iOAT to existing patients until the final determination of this action.

[2] By February 10, 2021, when the Plaintiffs' argued their application before me, it was clear that the Province has no plans to terminate iOAT for the Plaintiffs or any other patients

presently receiving it, but does intend to change the way it provides iOAT, effective March 31, 2021.

[3] The Plaintiffs claim that the planned changes will breach their constitutional rights, specifically:

- their rights to life, liberty, and security of the person, as protected by section 7 of the *Charter of Rights and Freedoms*;
- their rights not to be subject to cruel and unusual treatment by the state, as protected by section 12 of the *Charter of Rights and Freedoms*; and
- their entitlement to equality before and under the law and equal protection and equal benefit of the law, pursuant to section 15 of the *Charter of Rights and Freedoms*.

[4] The issues on this application are:

- what changes does Province intend make to the iOAT it provides?
- what effect will those changes have on the Plaintiffs?
- is there a reasonable issue to be tried that those changes will infringe the Plaintiffs' *Charter* rights?
- will the Plaintiffs suffer irreparable harm if an injunction is not granted?
- does the balance of convenience favour granting an injunction?

[5] I find that the planned changes and their effect on the Plaintiffs are minor. While there is an argument to be made that those changes will breach one or more of the Plaintiffs' *Charter* rights, the Plaintiffs have not established that they will suffer irreparable harm as a result of those changes. I also find that the balance of convenience favours denying an interim injunction. For those reasons, I dismiss the Plaintiffs' application.

2. Admissions

[6] During the hearing of this application on February 10, 2021 I asked the Defendant's lawyer whether the Province of Alberta admits certain facts, all of which she admitted on behalf of her client. Consequently, the following facts are established for the purpose of this application, by admission:

- Opioid Use Disorder (OUD) is a medical condition.
- The Plaintiffs have opioid use disorder.
- Oral Opioid Agonist Treatment (oOAT) is an effective treatment for opioid use disorder in some cases.
- Injectable Opioid Agonist Treatment (iOAT) is an effective treatment for opioid use disorder in some cases.
- The Plaintiffs have been receiving iOAT at clinics operated by Alberta Health Services (AHS) in Edmonton and Calgary.
- Each Plaintiff has received some benefit from iOAT.

[7] Some of the people who swore affidavits use the acronym “siOAT” which stands for Supervised Injectable Opioid Agonist Treatment. In the context of this application, siOAT means the same thing as iOAT. Also, sometimes “OAT” is used to refer to “oOAT”.

3. Opioid Use Disorder (OUD) and Treatment Options including iOAT

[8] Opioid use disorder may be diagnosed if a person meets two of the following criteria repeatedly over a twelve-month period:

- using a larger amount and over longer period than intended
- a persistent desire or unsuccessful attempts to cut down
- a great deal of time spent obtaining, using, or recovering from opioids’ effects
- craving
- inability to fulfil major role obligations
- continued use despite social or interpersonal problems
- important activities are given up
- use in physical hazardous situations
- continued use despite physical or psychological problem
- tolerance
- withdrawal

[9] The description above is set out in paragraph 9 of Dr. Krishna Balachandra’s first affidavit. Dr. Balachandra is a physician specializing in addictions medicine. He has been the Addiction Psychiatrist at the Edmonton iOAT clinic from March 2019 to the present.

[10] A similar description of opioid use disorder is set out in other affidavits submitted on behalf of the Plaintiffs and in paragraphs 6 to 8 of Dr. Charl Els’ affidavit, submitted on behalf of the Defendant.

[11] According to Dr. Balachandra, detoxification alone is not a recommended treatment for opioid use disorder; some form of medication therapy is required as well. The medications used are agonists which serve the same function as the opioids which are abused, but the agonists “differ in the long-term duration of effect which allows the person to avoid withdrawal and rehabilitate other aspects of their lives”. There are several agonists available:

- buprenorphine as first line
- methadone as second line
- slow release oral morphine as third line
- iOAT for those for whom the first three do not work

[12] John Cabral is the Assistant Deputy Minister, Health Service Delivery Division, Ministry of Health. He submitted two affidavits on behalf of the Defendant. His second affidavit, sworn January 8, 2021 includes the following background facts regarding iOAT in Canada:

- As of September 2017, the Providence Crosstown Clinic in British Columbia was the only place in North America where iOAT was offered.
- Health Canada approved hydromorphone for use by qualified medical professionals as part of iOAT in May 2019.
- As of January 2021, iOAT is still not widely available in Canada.

3.1 Is iOAT an emerging or an established treatment?

[13] Dr. Charl Els is an addiction psychiatrist and occupational physician, and serves as a Professor in several capacities at the University of Alberta. In his affidavit submitted by the Defendant, Dr. Els describes iOAT as an emerging treatment and notes that the recommendations in the national iOAT guidelines were either conditional or based on low-quality medical evidence. He also notes that the iOAT recommendations have remained outside the national guidelines for opioid use disorder, and he opines that iOAT is not considered standard of care in Canada.

[14] The Plaintiffs filed several affidavits which take issue with Dr. Els on these points, including one sworn or affirmed by Dr. Julie Bruneau. Dr. Bruneau is Canada Research Chair in Addiction Medicine, Professor in the Department of Family and Emergency Medicine at the Universite de Montreal, and Head of the Primary Care Department at the Centre Hospitalier de l'Universite de Montreal. She is also the Node Principal Investigator of the Quebec/Atlantic Node of the Canadian Research Initiative in Substance Misuse (CRISM). Her affidavit is submitted on behalf of CRISM to correct what she describes as misinformation in Dr. Els affidavit, and clarify CRISM's position on iOAT.

[15] It is not necessary for me to resolve the issues the Plaintiffs have raised with Dr. Els' evidence on these points. The Defendant admits that iOAT is an effective treatment for opioid use disorder in some cases and that each of the Plaintiffs has received some benefit from iOAT. It is not disputed by the Plaintiffs that Vancouver was the first place iOAT was offered in Canada, that it was introduced for the first time in Alberta in 2018, and that it is currently not available in many other places in Canada. For the purposes of deciding this application, it is not necessary for me to make any findings regarding iOAT's effectiveness or acceptance in the medical community beyond those admitted or uncontested points.

4. Alberta Health and Alberta Health Services (AHS)

[16] The Defendant is the Government of Alberta. The Department of Health, also known as Alberta Health, is a department of the Government of Alberta. Mr. Cabral describes Alberta Health and Alberta Health Services as follows (January 8, 2021 affidavit, paragraphs 4 and 5):

> 4. The Department of Health implements the Government of Alberta's vision and strategic direction for health. It is responsible for the overall design, strategic policy direction, legislation, and monitoring of the health system's quality and performance.
>
> …
>
> 5. Alberta Health Services ("AHS") is the primary provider of health services in Alberta and implements provincial policy and direction as set out by

Alberta Health. Alberta Health provides operational funding to AHS for health service delivery.

5. May 2017 to October 2018: Opioid Emergency Response and Opening of iOAT Clinics in Edmonton and Calgary

[17] In 2017 the Defendant passed the *Opioid Emergency Response Regulation* (Alta Reg 99/2017) which created the Minister's Opioid Emergency Response Commission (MOERC). The preamble to the Regulation reads:

> WHEREAS Alberta is experiencing an unprecedented rise in opioid-related overdoses and other harmful effects of certain uses of opioids, resulting in a public health crisis;
>
> WHEREAS the Government of Alberta, along with its partners, has implemented numerous measures to address this public health crisis;
>
> WHEREAS some of the measures previously implemented have included changes to the laws of Alberta, including the issuing of numerous extraordinary Ministerial Orders authorizing persons to engage in restricted activities aimed at preventing, combating or alleviating a public health emergency as defined in the Public Health Act, and the re-scheduling and de-scheduling of naloxone to increase Albertans' access;
>
> WHEREAS the number of overdoses continues to increase despite all of the measures taken to date, and overdoses and other harmful effects of certain uses of opioids urgently need to be addressed;
>
> WHEREAS numerous additional actions must be taken on an urgent basis and in a coordinated way to address this public health crisis as quickly and effectively as possible; and
>
> WHEREAS the rapid deployment of resources and actions that adjust to changing conditions are urgently needed to combat the opioid crisis;
>
> THEREFORE the Lieutenant Governor in Council enacts as follows:

[18] The Regulation tasked MOERC with providing recommendations to the Minister of Health for "urgent coordinated actions to effectively combat the opioid crisis" as well as facilitating or monitoring the implementation of the actions it recommended: Regulation, s. 4(2). MOERC was created on May 31, 2017. The Regulation expired on November 30, 2019: Regulation, s. 16.

[19] MOERC first considered iOAT in June 2017. Later that year, MOERC asked AHS to prepare and present a proposal for implementing iOAT. AHS presented its iOAT proposal to MOERC in September 2017 and MOERC recommended that the Minister support AHS's iOAT proposal and funding request. The Minister accepted that recommendation.

[20] Alberta Health and AHS entered into a grant agreement effective March 27, 2018 in which the Province agrees to fund "the planning for and implementation of a Supervised Injectable Opioid Agonist Therapy (siOAT) Program". The agreement specifies locations in

Edmonton and Calgary as the sites where the program would be implemented. The term of the Grant Agreement is March 27, 2018 to March 31, 2020.

[21] The iOAT program started in both Edmonton and Calgary in October 2018, but the Edmonton program operated from interim sites until July 2019 when it moved into a newly renovated clinic.

[22] The iOAT clinics operate 12 hours per day, 7 days per week. They are dedicated programs.

[23] The treatment provided at both clinics is described by Dr. Balachandra as follows at paragraph 16 of his first affidavit:

> Injectable opioid agonist therapy in Alberta consists of providing medical grade hydromorphone for patient to inject in a medically supervised facility up to three times per day and provide slow release oral morphine or methadone overnight to prevent withdrawal. However, the overall treatment concept encompasses more than that. The team consists of patients in recovery (peer support workers), pharmacists, nurses, social workers, and physicians. The team works collaboratively and with the patient to identify unique goals.

[24] A similar description is provided in other affidavits.

[25] The daily attendance of patients at the iOAT clinics provides an opportunity to treat other conditions, such as hepatitis C and sexually transmitted illnesses.

5.1 Is iOAT in Alberta a pilot study?

[26] Mr. Cabral was a member of MOERC. In paragraphs 14 to 20 of his affidavit sworn January 8, 2021, Mr. Cabral describes the subject of the March 27, 2018 grant agreement between Alberta Health and AHS as "a two-year pilot study". Dr. Kathryn Todd, who is the Vice President, Provincial Clinical Excellence with AHS and who was a member of MOERC, testified when she was questioned on her affidavit in this action that the AHS grant submission was a pilot project.

[27] Dr. Elaine Hyshka, who was one of the co-chairs of MOERC, at paragraphs 24 to 35 of her third affidavit, sworn January 22, 2021, disputes the description of iOAT in Alberta as a pilot study. Dianne Dyer, who wrote the iOAT proposal for the government and who was the provincial lead for the AHS iOAT program, states in paragraph 14 of her affidavit that she did not consider it a pilot.

[28] It is not necessary for me to determine whether the iOAT provided to the Plaintiffs beginning in 2018 was a pilot project or study. Clearly the agreement between the Province and AHS was for an initial period ending March 31, 2020, and it was extended to March 31, 2021. However, the Plaintiffs are not parties to the initial agreement or the extension and they are not bound by agreements between Alberta Health and AHS.

6. October 2018 – January 2020: Plaintiffs begin iOAT

[29] One of the Plaintiffs, GWF, receives iOAT at the Edmonton clinic. The other ten Plaintiffs are patients at the Calgary clinic. The Plaintiffs began receiving iOAT at different times, as follows:

TAM and SPM	October 2018
AFME	November 2018
CW and GLC	October 2019
KT	December 2019
DWA	January 2020

[30] I have no evidence regarding when BB, FP, GWF and MSC started receiving iOAT.

[31] Before receiving iOAT at the Edmonton or Calgary clinic, each patient, including each of the Plaintiffs, signed a Patient Agreement which included the following paragraphs:

> 2. I am aware that the iOAT program is a service that will be specially designed for me. My treating team may include some or all of the following: physician, nurse practitioner, registered nurses, social worker, pharmacist, and others. The team will work with me in a respectful collaborative way to address my priorities for care including medical care, funding, housing and prevention and treatment for health issues that I am experiencing such as wound infections, Hepatitis C, influenza etc.
>
> …
>
> 15. I understand that there may be many reasons, including safety considerations and interference with medical and psychiatric conditions, for iOAT to be discontinued and that the iOAT team will work with me to find alternative treatments.

[32] Patients, including the Plaintiffs, were not told when they started iOAT at the Edmonton or Calgary clinic that the treatment could be discontinued before they were ready to transition away from it: DC affidavit, paragraph 2; TAM affidavit sworn November 19, 2020, paragraph 3; Wilson affidavit sworn October 5, 2020, paragraph 13; Wilson affidavit sworn November 20, 2020, paragraph 12.

7. January 2020: Province announces closure of iOAT clinics effective March 31, 2021

[33] On January 16, 2020, Mr. Cabral sent the following email to Dr. Todd:

> Hi Kathryn, we've been advised that AHS will be ending the iOAT Pilot Projects as of March 31, 2020. This email is to confirm that the Minister Luan has approved a one-year extension of the AHS iOAT projects to March 31, 2021. The approval comes with the condition that the intake of new clients be ceased and the projects would focus on transitioning existing clients to the AHS opioid dependency programs. Funding for this program is approved and is not part of Health's savings initiatives.
>
> Let me know if you need any additional information and please provide confirmation these pilots will continue (with conditions noted above) until March 31, 2021.

[34] Alberta Health and AHS entered into an amending agreement effective March 10, 2020 which extended the term of the March 27, 2018 grant agreement to March 31, 2021.

[35] According to Dr. Balachandra, after the Province announced the iOAT programs would not continue beyond March 2021, patients began to disengage. One patient who was discharged died.

8. November 2020: Province announces continuation of iOAT (for existing patients) at ODP clinics

[36] On November 16, 2020 the Defendant's lawyer wrote to the Plaintiffs' lawyer advising that the Defendant would continue to provide access to injectable hydromorphone under medical supervision to any of the Plaintiffs and other patients who had not transitioned to oral opioid agonist treatment as of March 31, 2021. The letter describes this as the core service of iOAT. The November 16, 2020 letter says that the core service would be provided at the Opioid Dependency Program (ODP) clinics in Edmonton and Calgary and that the patients would receive wrap-around psychosocial and health supports there.

[37] In a second letter, on November 30, 2020, the Defendant's lawyer advised the Plaintiffs' lawyer as follows:

> My client appreciates that the hours of operation of the ODP clinics need to be extended, existing psychosocial supports enhanced and other necessary arrangements made, and it is, and has been, in the process of attending to these details.

[38] The November 30, 2020 letter continues:

> In response to your clients' concerns about access to wrap-around services, you should be aware that Alberta Heath, in December, 2019, announced it will increase patient access to supports like addiction counsellors and therapists at opioid dependency clinics. The news release can be found here: [web address] Alberta Health has been working with Alberta Health Services on this plan for a number of months, but the work is impacted due to the pandemic. This work is currently in progress and we anticipate the timeframe to complete this work is spring, 2021.

9. Planned Changes to iOAT Effective March 31, 2021

[39] Mr. Cabral describes the Defendant's intentions for iOAT after March 31, 2021 as follows in paragraphs 26 and 27 of his affidavit sworn January 8, 2021:

> 26. Since then [January 2020], Alberta Health has committed to continuing iOAT therapy for all current patients who have not transitioned to OAT as of March 31, 2021. The iOAT therapy will be merged into the Edmonton and Calgary ODP clinics. The continuation of iOAT therapy is open-ended and based on a care plan decided upon between the health care practitioner and the patient. This includes a transition between OAT and iOAT as deemed medically necessary.
>
> 27. This changes the siOAT therapy from a dedicated program into an embedded program and is reflected in the BC and national iOAT models of care. Clients will have access to the same suite of wrap around services, some being

> offered within the clinic setting with others being accessed through referrals form clinic staff to community settings. As indicated in the guidelines these wrap around services include addiction counselling, primary care, mental health care, chronic pain management and psychosocial services. Psychosocial services include housing, employment services, trauma therapy, and specialized services for women, youth and indigenous services.

[40] In questioning on his affidavit on January 20, 2021, Mr. Cabral gives the following testimony (p. 5, ll. 15 – 20):

> So this is not a proposal, so we are working to provide the same level of care for -- for all of the recipients that are in the iOAT program, and we're working to transition them to an ODP clinic, which, in most cases, will be in the exact same site that they're receiving the services today.

[41] Later in his questioning, Mr. Cabral testifies as follows (p. 8, l. 23 – p. 9, l. 15):

> For the most part, in conversations with Alberta Health Services, these clients will see very little change because they will be going, for the most part, to the same place that they are today.
>
> …
>
> And they will receive the same therapy as well as the same sort of wraparound services.
>
> …
>
> They might not receive it by the same people. So, for example, in the iOAT clinic, where there are specific nurses assigned to that, that could change, but they'll get the same services.

[42] Later in that questioning, Mr. Cabral testifies (p. 20, ll. 20 – 23):

> Q. Are you certain that as of right now, is the same level of primary care being offered in the ODP setting as the iOAT setting?
>
> A. Generally, no, it's not. …

[43] At page 27, Mr. Cabral testifies (ll. 2 – 7):

> In this case, Government is going to continue on the services for these individuals because the Government's decided that it's not fair to give them a particular treatment pathway and then take that away, so that's being continued.

[44] At page 33, ll. 22 – 24, and at p. 35, ll. 11 – 15 Mr. Cabral testifies:

> … a lot of the primary care that's provided, in particular to the Edmonton centre, is not at that clinic.
>
> …
>
> They don't have the capacity at the current Edmonton location to provide those primary services to the same degree that they do in Calgary. So they – they – they refer them to – to the Boyle Street Community Health Centre.

[45] At page 36, l. 10 – p. 38, l. 10, Mr. Cabral testifies:

> Well, but I want to be clear, it's not a proposal. It's what we're doing. So we're working through the logistics of that, which don't have an impact on the client. So the client will not notice any difference from -- from the services that they're getting.
>
> Again, I want to be clear what that means. They're going to get the same services. If someone was receiving hydromorphone two -- three times a day, 365 days a week -- 365 days a year, rather, they will continue to get that. That will not change. How we fund Alberta Health Services on the back end is -- has got no bearing on how we -- we provide those services to those individuals.
>
> …
>
> For the most part, all of the services that they're getting, they will continue to get after April 1st, they might be in a slightly different room. In the case of the Chumir, it probably will be in the same place. In the case of the Edmonton clinic, I understand they're moving the ODP clinic into what is the iOAT clinic, so it, too, will also be in the same -- in the same space within the Edmonton centre.
>
> …
>
> We're working with our colleagues at Alberta Health Services to work through the details around -- they have to do -- for example, they have to do some renovations, they have to -- to look at staffing, they have to extend hours, those sorts of things. So we're working through those details with them now.
>
> …
>
> We are committed, as is Alberta Health Services, to ensure a seamless transition as possible for -- for these clients. We -- we understand the seriousness of this for them, and we -- Government has committed that those services will continue.

[46] At p. 55, ll. 2 – 10, Mr. Cabral testifies:

> For the individuals that are in this program, they will continue to get the same services, both clinical and around psychosocial supports, April 1st, 2021. Those services will be primarily out of the ODP clinic, but could be referred to other settings as appropriate. Individuals will work with the care teams. The care teams will develop the plan and the approach, like they do today, and that will continue on after April 1st.

[47] Dr. Todd describes AHS's plan for iOAT after March 31, 2021 as follows in paragraphs 14 to 18 of her affidavit:

> 14. Since then [January 2020], Alberta Health informed AHS that siOAT clients may continue to receive siOAT within ODP clinics, as clinically appropriate. While one possible outcome of siOAT treatment is for siOAT clients to transition to a non-injectable opioid agonist treatment option, the siOAT treatment is open-ended. Clients may transition back from OAT to siOAT if clinically required.
>
> …

16. In preparation for the closing of the siOAT clinics, AHS has committed to transfer current clients in the siOAT program to ODP clinics to receive their injectable siOAT treatment and psychosocial support as applicable.

17. Integrating siOAT services with the ODP clinics will require some additional resources at the ODP clinics. Planning for these resources is currently underway, including increasing hours of service, staffing numbers and expertise, and clinical space to support delivery of care to siOAT clients.

18. AHS is committed to continuing to support current siOAT clients through the transition to ODP clinics including ensuring appropriate access to psychosocial supports.

[48] Mark Snaterse, AHS's Executive Director, Addiction and Mental Health, Edmonton Zone, describes AHS's plan for iOAT after March 31, 2021 as follows in paragraphs 17 to 26 of his affidavit:

17. In preparation for the closure of the clinic, AHS has committed to transfer current clients in the siOAT program to ODP clinics to continue their injectable siOAT treatment. There will be no interruption to injectable siOAT treatment upon the closure of the siOAT clinics for clients currently in the program.

18. Prior to March 31, 2021, each current siOAT client will receive information about the transition to treatment at the ODP clinic as part of their care planning. They will remain under the care of a physician at the ODP clinic and referrals to other care providers and wrap-around services will remain available as needed. Of course, the way in which a client's needs are addressed will vary depending on each individual and circumstances.

19. The type of wrap-around services available to siOAT clients at the ODP clinics will be similar to what is currently available. However, the level of support in the two programs differs and ODP clients may have to access some resources in the community rather than directly at the clinic.

20. Plans to integrate the iOAT and OAT patients are underway. In Edmonton, plans are being developed to move the ODP clinic into the space currently occupied by the siOAT clinic. In Calgary, plans are being developed to accommodate the siOAT patients at the Sheldon Chumir Health Centre.

21. The hours of operation of the ODP clinics will be extended to 12 hours per day, 7 days per week, including holidays. Appropriate security measures will be taken.

22. The supervision of injectable hydromorphone must meet the standards set by the College of Physicians and Surgeons of Alberta. iOAT patients will continue to have their injections supervised by health care providers who meet those standards.

23. Supervision of the injection will take place in a dedicated space in the ODP clinics. This issue is being addressed and an appropriate dedicated space should be available at the end of March 2021.

24. Primary care and wound care will be addressed through appropriate referrals.

25. AHS is exploring additional proposals to further increase the levels of service available to siOAT clients at ODP clinics.

26. AHS is committed to continuing to support current siOAT clients through the transition to ODP clinics at the closure of the siOAT clinics.

[49] Mr. Snaterse was questioned on his affidavit on January 20, 2021 and provides the following testimony (p. 37, l. 9 – p. 38, l. 3):

MR. NANDA: What aspect of the iOAT treatment is continuing in the ODP?

THE WITNESS: So for the -- for the clients in our iOAT clinic, the iOAT clinic will -- will come to an end. The care that they -- that they receive will continue within our ODP clinic. We're actually going to be relocating our ODP clinic into our current iOAT space. And then we're going to be augmenting that ODP team with additional resources, so that -- that they're still going to be -- they're going to be open extended hours, 7 days a week. We're still going to continue to have embedded pharmacy supports within the clinic that will support everybody within the ODP umbrella, including the iOAT, and continue to have access to physicians, psychiatry, nurse practitioners, nurses, social workers, addiction counsellors.

BY MR. NANDA:

Q. Onsite?

A. Yes.

[50] Later in his questioning on affidavit, Mr. Snaterse testifies (p. 48, l. 16 – p. 49, l. 24):

Q. Yeah, how about this, just to make it easier. Based on our discussion, there is injectable hydromorphone, the medication component of iOAT, there's some sort of primary care or health access, and then there's, like, psychosocial supports. I want you to explain to me what is currently offered in iOAT and what won't be offered in ODP past March 2021.

A. So -- I -- I think that the access to the -- the pharmacological treatments will -- will be the same. I think that the psychosocial interventions, you know, I think probably within our iOAT clinic, up until March 31st, I would say, probably the --the scope of psychosocial interventions has been a Cadillac service, quite robust.

After March 31st, we're absolutely going to continue to provide psychosocial interventions; we're not just becoming a prescription service only. But probably our -- our iOAT clients -- it probably won't be a Cadillac psychosocial service anymore. That's -- that's not the model within ODP, but it'll still be a very good car, not the Cadillac service.

And in -- in terms of primary care, I guess I'll come back to, we're always going to ensure that our clients receive the -- the primary care that they need, and the psychosocial services that they need. So -- so if -- if there is any change in what we can deliver under our roof within our walls, then that's still not going to stop

> us from getting people connected to the services that they need, whether it's primary care or income supports or employment supports or ID or whatever that service is.

[51] Some of the affidavits submitted by the Plaintiffs describe the Province's planned changes differently, but Mr. Cabral, Dr. Todd and Mr. Snaterse have the most direct knowledge of what the Province is planning. Based on their evidence, I find that the planned changes are minor, and consist of moving the iOAT program inside the OPD program, which in Edmonton will involve expanding the existing iOAT space so that OPD can move in there, and in Calgary will mean operating iOAT out of the existing OPD space. Psychosocial supports will continue, but on a reduced scale and some primary care will no longer be provided on site in which case referrals will be made. The other change from what was in place up to January 2020, is that new patients are no longer offered iOAT. The Plaintiffs are not affected by that, because they are existing patients.

10. Effect of the Changes on the Plaintiffs

[52] The affidavits submitted by the Plaintiffs up to October 8, 2020 address the anticipated harm to the Plaintiffs and other iOAT patients if iOAT were terminated in Alberta completely. That is understandable because until November 2020, the Province's announced intention was to end the iOAT programs on March 31, 2021. The landscape shifted in November 2020, when the Province announced it would continue iOAT for existing patients, but offer it out of the ODP clinics rather than from stand-alone iOAT clinics.

[53] The gist of the affidavits submitted up to October 8, 2020 is that if iOAT were cut off completely the Plaintiffs would return to using street opioids which are inherently dangerous because of their impurities and toxicity and the Plaintiffs and others presently using the iOAT program would be forced to engage in dangerous sex work or crime to pay for the street opioids. Both the street opioids themselves, and the activities forced upon the Plaintiffs to pay for them, would create substantial risks of serious injury and death. However, the risks of the Province terminating iOAT completely are not relevant to this application, because that is not what the Province plans to do, based on the evidence before me.

[54] Affidavits submitted by the Plaintiffs after November 16, 2020 address the anticipated harm of moving iOAT from the dedicated clinics into the more general ODP clinics, which reflects the new information contained in the November 16, 2020 and November 30, 2020 letters from the Defendant's lawyer.

[55] The Plaintiffs seek to stop the Province's planned changes until the trial of this action, so my focus is on the anticipated effect of those changes on the Plaintiffs.

10.1 Plaintiffs' Evidence

[56] Each Plaintiff provided an affidavit that was filed with the Statement of Claim and Application on September 30, 2020. In addition, TAM provided a second affidavit sworn November 19, 2020 and AFME provided a second affidavit sworn January 12, 2021.

[57] The Plaintiffs' affidavits filed September 30, 2020 do not address the effect on the Plaintiffs of continuing to receive injectable opioids after March 31, 2021 through the OPD clinics instead of at the iOAT clinics. Those affidavits focus on the effect of losing iOAT completely, which reflects the Plaintiffs' understanding of the Province's intentions at the time

they swore those affidavits. With two exceptions, none of the Plaintiffs' initial affidavits addresses what services other than the provision of injectable opioids the Plaintiffs have been using at the iOAT clinics.

GWF and MSC

[58] The two exceptions are GWF and MSC. GWF states in his affidavit that "the program provided the stability and medical conditions necessary for me to treat my Hepatitis C". He also says that in iOAT he was able to treat his asthma and chronic obstructive pulmonary disease and that the iOAT program helped him find housing. MSC also says he was able to cure his Hepatitis C through the iOAT program and that he was able to treat a blood infection and breathing problems in iOAT. There is no evidence that GWF and MSC would not be able to achieve the same benefits if they were to receive injectable opioids at the ODP clinics and some other services elsewhere, as the Province intends after March 31, 2021.

TAM

[59] TAM swore a second affidavit on November 19, 2020, in which he compares his experience receiving treatment at the Calgary iOAT clinic, from October 2018 to November 2020, to his experience receiving treatment at the Calgary OPD clinic, up to 2018:

> 4. In order to improve my health, I have needed to access not only specialty addiction medicine (such as IV hydromorphone) but also medical care (such as wound care, treatment of dental infection, treating chronic diseases). Because the iOAT program takes up so much of my day, if the medical care is not available at the same site as the IV hydromorphone, then this would be difficult for me to access and my health would deteriorate.
>
> 5. Calgary ODP does not treat any condition other than my opioid use disorder. While I was a patient there, they would refer me to another clinic if I had a dental infection or a skin infection. They were not able to provide any primary care onsite.
>
> 6. Calgary ODP is only open Monday to Friday during business hours. Calgary iOAT Clinic is open 7 days a week for 12 hours a day so that I can access my life-saving medication every day and stabilize my opioid use disorder.
>
> 7. I worry that the staffing at Calgary ODP will not be enough to meet my health needs. When I was a patient at Calgary ODP, I was only able to meet with my physician every 3 months. At Calgary iOAT Clinic my physician comes to the clinic twice a week. Because of my severe opioid use disorder, I require frequent access to staff with specialized iOAT knowledge and I worry that Calgary ODP will not be able to provide this level of access.

[60] In this affidavit, sworn on November 19, 2020, TAM compares iOAT as he experienced it to that point to his previous experience with the ODP clinic up to 2018. TAM does not address the enhancements to the ODP clinic which the Province announced after November 19, 2020, such as the extended hours and additional staffing described in the November 30, 2020 letter from the Defendant's lawyer to the Plaintiffs' lawyer.

AFME

[61] AFME, in her affidavit sworn January 12, 2021, describes her initial experience with iOAT and returning to using street opioids after the Defendant announced the termination of the Edmonton and Calgary iOAT programs:

> 3. When I heard about the closure of the injectable opioid agonist treatment program ("iOAT") in Calgary, which I have been a patient of for approximately 2 years, it felt like my legs were ripped out of underneath me.
>
> 4. I felt helpless, scared, and angry. I spent my entire life falling through the cracks of the system. From school to the child welfare system to the health care system. Throughout my life, I have been promised help and safety, only to have the system turn its back on me when I needed it most and expose me to all forms of abuse and harms.
>
> 5. When I started on iOAT, I had the same suspicions. But, the iOAT team worked hard to develop my trust. They talked and engaged me like a human being, and took time to understand my situation and ensured I was safe and welcomed in the clinical setting, something I have never experienced before in the health care system.
>
> 6. I developed strong bonds with the iOAT staff and other patients, and we became family. iOAT is the only real family I have ever known. I trusted them fully and felt like they were with me together in my journey to manage and overcome my opioid use disorder.
>
> 7. It was because of that bond that, for the first time in my life, I was able to take control of my opioid use disorder. My condition was stabilized and I stopped using street opioids entirely. I had found housing and was no longer working on the streets as a sex worker to support my opioid use. I stopped being charged with crimes I would commit to support my opioid use. I was no longer being attacked and confronted on the streets for sex, money, or drugs. I no longer had to fear of dying of an opioid overdose or catching a serious disease. I felt safer than I had ever been in my life.
>
> 8. iOAT provided me hope of a better life. That hope meant everything to me because I spent most of my life on the streets with opioid use disorder, doing whatever I could to survive and support my opioid use, and being exposed to all sorts of violence. I never had a sense that my life could get better and that I could take control of my condition before iOAT.
>
> 9. However, with the announced closure, that hope was taken from me. I felt that my initial suspicions about the system turning its back on me and leaving me when I was most vulnerable became true. The system didn't care about me and I was falling through the cracks once again.
>
> 10. I felt the announced closure of iOAT was a death sentence for me. I would either die of an opioid overdose or through a violent incident on the streets. Everything I had worked towards and built, that safer and healthier future I had envisioned, was robbed from me with the announcement.

> 11. After the news, I returned to using street opioids. I returned to street opioid use because I felt like the system had abandoned me again and that I knew that without iOAT I had no other option to manage my opioid use disorder aside from using street opioids. It would be safer for me to start using street opioids now rather than immediately after I was cut off from iOAT entirely in March 2021. For this reason, I gradually started introducing them into my consumption habits along with the medication I received through iOAT until street opioids became the primary basis of my opioid use.
>
> 12. In order to support my street opioid use, I returned to street sex work. Street sex work is extremely dangerous and not something I would do by choice. I do and have done it to support my opioid use. I stopped doing it when I was on iOAT, as I did not need to do the work to support my opioid consumption habit.

[62] In her first affidavit, sworn on August 8, 2020, AFME says nothing about having lost hope and returning to using street opioids paid for with street sex work. As of August 8, 2020, AFME's testimony was that she had cut her street opioid use and reduced her dose of opioids and was no longer sexually assaulted and exploited. Based on her two affidavits, I conclude that AFME returned to street sex work to support her use of street opioids sometime between August and December 2020.

[63] AFME does not say whether she regained any hope after the Province announced in November 2020 that she and the other existing patients could continue to receive iOAT through the OPD clinics after March 31, 2021. It appears from her affidavit that she returned to using iOAT opioids rather than street opioids in December 2020 or January 2021.

[64] AFME was engaged in street sex work in December 2020, when she was picked up by a man, taken to a remote location and raped by three men, which resulted in her contracting HIV. At some point after that, AFME returned to the Calgary iOAT clinic and resumed receiving iOAT there.

[65] AFME criticizes the Province's plan to offer iOAT from the OPD clinics in her second affidavit:

> 22. My lawyer informs me and I believe true that they want to provide iOAT patients access to injectable hydromorphone in a secure setting at the Opioid Dependency Program ("ODP") and that will ensure that iOAT patients aren't negatively impacted by the closure of the program in Alberta.
>
> 23. ODP can never provide what iOAT provided patients like me. ODP didn't work for me when I tried to use the program, largely because it couldn't cater to my unique needs. iOAT put in real effort to understand and help me address the sources of my opioid use disorder and built trust with me to undertake the treatment. iOAT is more than just access to injectable hydromorphone. It is about creating the conditions necessary to make patients feel safe and want to access the medical system, which has failed us so many times. It is about addressing the other things in our lives to ensure that we are avoiding the cravings and pressures to use street opioids and the harms associated.
>
> 24. At iOAT, you are not just another patient, but rather a family. The staff care and put in so much work to ensure that we are on our treatment path. The

> safety iOAT provided allowed me to address other aspects of my health. It made me trust the health care system for the first time in my life.
>
> 25. ODP has hundreds of patients and does not provide the same form of dedicated care. It is easy to fall through the cracks at ODP, as it is meant to cater to those with my degree of opioid use disorder. I know that I will relapse and continue to use street sourced opioids if l am transitioned to ODP.
>
> 26. I am back accessing services through iOAT. I have decreased my use of street opioids and am receiving care not only to address my opioid use disorder but also my HIV through the primary care and sexual health providers that operate at the clinic. The only reason that I am doing this is because the iOAT staff have reached out and I still trust them as individually. That is why I went to iOAT after I was raped instead of any other clinic. They know my circumstances and care about me, and want to help me. I need help because I think I will die if I am left on my own, and unable to access iOAT therapy and the supports the program provides.
>
> 27. If l were a patient of ODP and told them I was raped and needed sexual transmitted infection screening, I would not be able to accessible help there. That is because ODP doesn't include access to primary care services, like help for sexual health issues. Instead, ODP would refer to a different clinic. I would have to set up my own appointment and figure everything out. That wouldn't really be an option to me because of my experience and the trust issues I have with the health care system. The only reason that I asked for help after I was raped was because I trusted the people at iOAT and know that they care and want to help me.
>
> 28. However, I don't think I will continue to access treatment services after iOAT is shutdown. ODP will not work for me and I don't trust that this government will provide the necessary components of treatment in the ODP setting to actually help me. Simply offering injectable hydromorphone doesn't provide the treatment we received at iOAT.

[66] AFME also provides the following evidence about other iOAT patients, at paragraph 21 of her second affidavit:

> So many iOAT patients like me are failing treatment because of the government's announced closure of the program. It has caused havoc in our lives and will only get worse if it is allowed to shut down the program in its entirety.

[67] This evidence is unclear whether AFME is talking about the complete discontinuance of iOAT, or the change to provided iOAT through the OPD clinics. It is also unclear how many "so many" is.

10.2 Evidence of Medical Professionals Working at Edmonton and Calgary iOAT Clinics

Dr. Krishna Balachandra

[68] Dr. Balachandra's first affidavit, sworn September 9, 2020, describes the treatment provided at the Edmonton clinic and also describes opioid use disorder and its treatment. In his

second affidavit, sworn September 27, 2020, Dr. Balachandra reports the number of opioid related deaths from April to June 2020, and expresses his opinion that access to iOAT should be expanded. Dr. Balachandra's third affidavit is mostly opinion. I address that in section 10.3 of these reasons, below.

Dr. Susan Bornemisza

[69] Susan Bornemisza is a physician at the Calgary iOAT clinic. In her first affidavit, sworn September 22, 2020, she describes iOAT as an "alternative approach" and as "a recognized part of the continuum of care for those with opioid use disorder". In her second affidavit, sworn October 3, 2020, Dr. Bornemisza reports that the mental health of patients of the Calgary clinic has destabilized since the announcement of the impending closure in March 2020, and provides her opinion that the severity of this destabilization is "directly linked to the announcement of the closure of the Calgary iOAT Clinic and the threat of losing access to their life-saving medication". She also reports that Alberta Health Services and Alberta Health had instructed the Calgary clinic to gradually reduce the number of clients it served with the goal of having zero patients by March 2021, which required the clinic to transition patients out ahead of the recognized clinical guidelines, causing a further decline in patients' mental health.

[70] I address Dr. Bornemisza's opinion evidence in section 10.3, below.

Patty Wilson

[71] The Plaintiffs submitted four affidavits by Patty Wilson. Ms. Wilson is a nurse practitioner who has been working with "marginalized populations living with substance use disorders for 4 years." She worked as a nurse practitioner at the Calgary iOAT clinic from October 2019 to September 2020. Her first affidavit, sworn September 11, 2020, provides background information on iOAT generally and some facts about the Calgary iOAT clinic, including the fact that more people met the criteria for admission than could be admitted, resulting in a waitlist of potential patients, with only the most vulnerable actually receiving treatment.

[72] In her second affidavit sworn October 3, 2020, Ms. Wilson states that the Plaintiffs are the most stable of the existing patients of the Calgary clinic. She also states that the physical and mental health of the patients is rapidly deteriorating because "many are concerned over the closure of iOAT and don't believe that there are any alternatives aside from returning to street opioids to medicate their opioid use disorder". She reports that some of the patients are in the process of transitioning to street drugs. She reports that the mental health of one of the Plaintiffs "has declined rapidly over the government's insistence that the iOAT program will end in March 2021 and she has returned to using street opioids". Ms. Wilson attributes this Plaintiff's deterioration in part to the "looming iOAT closure deadline". Ms. Wilson reports that many iOAT patients increased their use of street-sourced fentanyl after the announcement of the closure of the Calgary iOAT clinic and she provides her hypothesis about the reasons for that. She reports that relapses are common among opioid use disorder patients, but that the consequences are more severe if the full spectrum of treatment, including iOAT is not available.

[73] Ms. Wilson notes the impact of the COVID-19 pandemic, causing a reduction in supports for persons suffering from opioid use disorder at the same time as an opioid epidemic rages in the province.

Dianne Dyer

[74] Dianne Dyer describes her involvement in the Alberta iOAT program in paragraph 3 of her affidavit:

> I wrote the proposal for government, oversaw the development and implementation of the program objectives and mandate, created and sought approval for policies, gathered expert advice and patient input from clinic managers and others to support program logistics, wrote regular progress reports for the AHS leadership, the AHS Board, and for Alberta Health, oversaw and reported on the capital developments, monitored the grant implementation steps and acted as the provincial contact for questions about the program in accordance with the expectations and roles defined by my AHS leadership

[75] Ms. Dyer describes what happened between March and July 2019, when iOAT was offered at the Edmonton ODP clinic as an interim measure until the dedicated iOAT site was ready for use:

> 27 In March 2019, the iOAT program started at the Edmonton Opioid Dependency Program (ODP) as an interim measure until the iOAT clinic could open. However, the care of the iOAT program population put a significant strain on the ODP program as the site was extremely busy with ODP patients and space was extremely limited to accommodate the iOAT population's complex needs. The site was only able to follow approximately 10-11 iOAT patients at a time. The ODP manager indicated that this was a particularly challenging and stressful time for staff and patients. The permanent Edmonton clinic site opened July 3, 2019 and the health care team and patients were grateful to have a space that could safely accommodate their complex needs for wraparound services and high-risk medical treatment.

[76] The Province's plan is to expand the existing iOAT space and move the ODP program, including the existing iOAT patients into that space after March 31, 2021. Consequently, I find that the experience in 2019 described by Ms. Dyer cannot be expected to reoccur with the Province's changes effective April 1, 2021.

[77] The Plaintiffs' clarified in oral submissions of their counsel on February 10, 2020, that Ms. Dyer is purely a factual witness; they do not seek to qualify her to give expert opinion evidence. Consequently, I place no weight on the opinions set out in paragraphs 34 and 35 of her affidavit.

10.3 Admissibility of Expert Opinion Evidence

[78] Rule 6.11 permits expert evidence on interlocutory motions such as this application, but the Rules do not describe a procedure for the introduction of such evidence on chambers applications. Topolniski, J addressed this in ***ANC Timber Ltd. v Alberta (Minister of Agriculture and Forestry)***, 2019 ABQB 653 at para 124:

> The *Rules* are silent about expert evidence on motions. (Perhaps they should be amended.) However, I conclude that any expert evidence ought to be introduced as it would at trial: the proposed expert's qualifications and scope of opinion should be precisely defined, and the substance of their opinion clearly expressed.

> Doing so will not only avoid surprise, it will also avoid any call for judicial sleuthing or intervention.

[79] I agree that the procedure for introducing expert opinion evidence on a chambers application should follow the same procedure as at trial. In particular, the party seeking to introduce an expert's opinion on a chambers application should set out either in the expert's affidavit or in a written submission the subject on which the expert is sought to be qualified. The usual form for this is "the Plaintiff asks the Court to qualify John Smith to give expert opinion evidence regarding". It would have assisted me in preparing for the oral hearing on February 10, 2021, to have that submission in advance.

[80] In a pre-hearing conference with counsel on January 26, 2021, I advised the parties that I would be seeking their submissions regarding Rule 8.16 at the February 10, 2021 hearing. Rule 8.16(1) reads:

> Unless the Court otherwise permits, no more than one expert is permitted to give opinion evidence on any one subject on behalf of a party.

[81] The Plaintiffs submit that Rule 8.16(1) does not apply to chambers applications because it is in Part 8 of the Rules which deals with trials. The Defendant submits that the purpose behind Rule 8.16 applies equally to trials and chambers applications.

[82] Yungwirth, J described the purpose of rules limiting the number of experts in ***Smith v Obeck***, 2018 ABQB 849 at paras 18 – 20:

> The purpose of this type of limitation appears to be to prevent the abuse, expense, and delay caused by the excessive use of expert evidence where unnecessary to assist the Court in arriving at a just result.
>
> Especially in these times of limited judicial resources, it is more important than it ever has been for the Court to limit procedures that waste those resources.
>
> However, this must be weighed and balanced against the right of the Plaintiff to put its best case forward

[83] I agree with the Plaintiffs that Rule 8.16(1) does not explicitly apply to chambers applications. I also agree with the Defendant that the purpose behind Rule 8.16 applies equally to chambers application. In this case the Plaintiffs submitted more than 20 affidavits containing opinion evidence, which exceeded 6,000 pages in total including exhibits. The question of an "excessive use of expert evidence where unnecessary to assist the Court in arriving at a just result", referred to in ***Smith v Obeck***, is a live issue here.

[84] In my view, following the reasoning in ***ANC Timber***, a party who wishes to introduce the evidence of more than one expert on a subject in a chambers application should follow the same procedure as applies at trial. That party should seek leave to do so, either in advance, or during the application, providing evidence and argument why it ought to be permitted.

[85] In this case, the Plaintiffs submitted during the oral hearing that each of their experts brings a distinct perspective to the questions on which they provided an opinion. I do not agree that that is a sufficient reason to have more than one expert opine on a subject, because it will usually be the case that different people will have different perspectives. If that were a sufficient reason, there would be no limiting rule at all.

[86] A limit on the number of experts whose evidence is adduced in a hearing, be it chambers application or trial, is a specific codification of the requirement that expert opinion evidence be necessary to assist the court before it is admitted. The first expert on a subject may be necessary, but the second, third and fourth will usually not be. However, given the fact that this issue was raised by me, and not by the Defendant, I will not address the admissibility of expert opinions based on the number of opinions provided on each subject. Instead I will do so on the basis of relevance, necessity and a properly qualified expert.

[87] In this case, there are two areas where expert opinion evidence may assist me:

- a description of opioid use disorder and the treatment options; and
- a prediction of the effect on the Plaintiffs of the changes in iOAT planned by the Province to take effect on March 31, 2021.

[88] Dr. Krishna Balachandra provided one of the first affidavits. He includes in it a description of opioid use disorder and the treatment options, including iOAT. I have referred to his evidence in section 3 of these reasons, above. Other affidavits provide similar descriptions. Those additional opinions on those points are repetitious and unnecessary.

[89] The most important factual issue on this application is what effect the planned changes will have on the Plaintiffs. In the next section of these reasons I will address the opinion evidence which the Plaintiffs have submitted on that issue.

[90] Dr. Nick Bansback provided an affidavit setting out his opinion regarding the cost effectiveness of iOAT. Some of the Plaintiffs' other experts did so as well. I will address those opinions in the Balance of Convenience section of these reasons, section 14, below.

10.4 Expert Opinion Evidence

[91] Some of the affidavits sworn or affirmed by medical professionals who worked at the Edmonton or Calgary iOAT clinic or were involved in the establishment of iOAT in Alberta contain both fact evidence and expert opinion evidence. In addition, the Plaintiffs filed ten affidavits of seven people who had no direct involvement with the Plaintiffs or the iOAT programs in Edmonton and Calgary. Those witnesses provide opinion evidence and they also provide some hearsay evidence regarding the Edmonton and Calgary clinics which duplicates evidence from witnesses with direct knowledge.

[92] Expert opinion evidence may be admissible if it is relevant, necessary and provided by a qualified expert: ***R v Mohan*** [1994] 2 SCR 9 at para 17 – 32. Rules of evidence may exclude an expert opinion and the Court may exclude expert evidence if its risks outweigh its benefits: ***White Burgess Langille Inman v Abbott and Haliburton Co***, 2015 SCC 23 at paras 23 - 25. No exclusionary rule applies in this case and I have decided not to exercise my discretion to exclude any evidence on a risk benefit analysis. However, expert opinion evidence that iOAT patients who are denied iOAT will resort to street opioids and dangerous activities to pay for street opioids, with consequent risks of injury and death, is of little use to me because the Province does not plan to eliminate iOAT.

[93] The Plaintiffs submitted 21 affidavits which include opinion evidence regarding anticipated harm to the Plaintiffs and other patients presently using the iOAT services in Edmonton or Calgary, as follows:

Affidavits containing direct fact evidence and opinion evidence

- Dr. Krishna Balachandra #1, sworn September 9, 2020
- Dr. Krishna Balachandra #2, sworn September 27, 2020
- Dr. Krishna Balachandra #3, sworn November 18, 2020
- Dr. Susan Bornemisza #1, sworn September 22, 2020
- Dr. Susan Bornemisza #2, sworn October 3, 2020
- Patty Wilson #1, sworn September 11, 2020
- Patty Wilson #2, sworn October 3, 2020
- Patty Wilson #3, sworn November 20, 2020
- Patty Wilson #4, sworn January 21, 2021
- Dr. Meera Grover #1, sworn September 23, 2020
- Dr. Elaine Hyshka #1, sworn October 1, 2020
- Dr. Elaine Hyshka #2, sworn November 22, 2020
- Dr. Elaine Hyshka #3, sworn January 22, 2021

Affidavits containing opinion evidence and no direct fact evidence

- Dr. Donald MacDonald #1, sworn September 23, 2020
- Dr. Haitham Kharrat #1, sworn September 17, 2020
- Dr. Haitham Kharrat #2, sworn October 4, 2020
- Dr. Haitham Kharrat #3, sworn January 22, 2021
- Dr. Rupinder Brar #1, sworn October 2, 2020
- Dr. Susan Boyd #1, sworn September 29, 2020
- Dr. Eugenia Oviedo-Joekes #1, sworn October 6, 2020
- Dr. Eugenia Oviedo-Joekes #2, sworn January 19, 2021

[94] Of those 21 affidavits, 14 provide opinions about the effect of eliminating iOAT completely, which is not what the Province plans. That evidence is irrelevant. Consequently, the opinion evidence in the following affidavits is inadmissible and I will make no further reference to it in these reasons:

- Dr. Krishna Balachandra #1, sworn September 9, 2020
- Dr. Krishna Balachandra #2, sworn September 27, 2020
- Dr. Susan Bornemisza #1, sworn September 22, 2020
- Dr. Susan Bornemisza #2, sworn October 3, 2020
- Dr. Meera Grover #1, sworn September 23, 2020

- Dr. Elaine Hyshka #1, sworn October 1, 2020
- Dr. Donald MacDonald #1, sworn September 23, 2020
- Dr. Haitham Kharrat #1, sworn September 17, 2020
- Dr. Haitham Kharrat #2, sworn October 4, 2020
- Dr. Rupinder Brar #1, sworn October 2, 2020
- Dr. Susan Boyd #1, sworn September 29, 2020
- Dr. Eugenia Oviedo-Joekes #1, sworn October 6, 2020
- Patty Wilson #1, sworn September 11, 2020
- Patty Wilson #2, sworn October 3, 2020

[94] That leaves the following affidavits which contain opinion evidence regarding the effect on patients, including the Plaintiffs, of changes to iOAT short of completely discontinuing it.

- Dr. Krishna Balachandra #3, sworn November 18, 2020
- Patty Wilson #3, sworn November 20, 2020
- Patty Wilson #4, sworn January 21, 2021
- Dr. Elaine Hyshka #2, sworn November 22, 2020
- Dr. Elaine Hyshka #3, sworn January 22, 2021
- Dr. Haitham Kharrat #3, sworn January 22, 2021
- Dr. Eugenia Oviedo-Joekes #2, sworn January 19, 2021

Dr. Krishna Balachandra

[95] Dr. Balachandra's third affidavit, sworn November 18, 2020, attaches as an exhibit the November 16, 2020 letter from the Defendant's lawyer to the Plaintiffs' lawyer, which is discussed in section 8 of these reasons, above. In his third affidavit, Dr. Balachandra offers his opinion that the Defendant's proposal set out in the November 16, 2020 letter "is not a workable or effective solution for the Plaintiffs, existing iOAT patients, or future iOAT patients." (paragraph 3). He goes on to explain that iOAT is more than just the provision of an injectable opioid under supervision in an appropriate facility (paragraph 4). He states that the Opioid Dependency Program (ODP) clinic where the Defendant proposes to provide injectable opioids operates only during the daytime and Monday to Friday, whereas the existing iOAT clinic is open longer hours and 7 days a week. He notes that daily dosages are recommended for iOAT (paragraph 6). Dr. Balachandra also states that the Opioid Dependency Program clinics do not have the resources to address the complete set of conditions iOAT patients typically have (paragraph 7). He also states that it is contrary to the best interests of the patients currently receiving treatment at the Opioid Dependency Program Clinics for iOAT to be administered there because the patients not receiving iOAT may be triggered to use opioids themselves (paragraph 8). Dr. Balachandra also says the Opioid Dependency Clinics are too small to provide iOAT (paragraph 9).

[96] Dr. Balachandra's opinion is based on the Province's planned changes as described in the November 16, 2020 letter. He did not have the benefit of the additional information provided in the November 30, 2020 letter or what is set out in the January 2021 affidavits and questioning transcripts of Mr. Cabral, Mr. Snaterse and Dr. Todd. In particular, Dr. Balachandra's evidence does not consider the implications of the OPD clinic in Edmonton moving into the iOAT space after it has been expanded, and the expansion of the hours and staffing of the OPD clinics, or the dedicated area inside the OPD clinics to be provided for iOAT. Of course, Dr. Balachandra's opinion in his November 18, 2020 affidavit is based on the information available to him then. Substantial additional information has since become available. Consequently, the factual foundation for Dr. Balachandra's opinion is not what has been established on the evidence before me. For that reason, his opinion regarding the effect on the Plaintiffs of the Province's planned changes is of no assistance to me.

Patty Wilson

[97] Ms. Wilson, in her third and fourth affidavits, provides her opinions regarding whether iOAT with the changes planned by the Province complies with the Canadian Research Initiative in Substance Misuse (CRISM) guidelines, whether it is ethical and whether it is likely to lead to patients relapsing and returning to using street opioids. Ms. Wilson is not a physician. She is a Registered Nurse and a nurse practitioner. Her affidavits, including her curriculum vitae, describe only 4 years of experience in nursing including only 11 months of experience with iOAT, all at the Calgary iOAT clinic. She is the Chief Fellow of the British Columbia Centre on Substance Use Disorder Addiction Nurse Practitioner 2020/2021 Fellowship. She anticipates completing that Fellowship program in 2021. It is clear from Ms. Wilson's affidavits that she is a passionate advocate for patients coping with severe opioid use disorder and that she has strong opinions regarding the benefits of iOAT and how it should be delivered. However, and with respect, I find that she does not have a combination of education and experience that would qualify her to give expert opinion evidence regarding the effect on patients of changes to the delivery of iOAT. To the extent her affidavits include opinion evidence, they are inadmissible.

Dr. Elaine Hyshka

[98] Elaine Hyshka is an Assistant Professor of Health Policy and Management in the School of Public Health at the University of Alberta. She describes herself in her first affidavit, sworn October 1, 2020 as an expert in "improving how health systems respond to substance use, with a particular emphasis on advancing health and social outcomes for structurally vulnerable populations who use illegal drugs". She is not a physician. Between May 31, 2017 and November 30, 2019, Dr. Hyshka and Alberta's Chief Medical Officer of Health co-chaired the provincial Minister of Health's Opioid Emergency Response Commission (MOERC).

[99] In her second affidavit, sworn November 22, 2020, Dr. Hyshka provides her opinion that "it is unlikely that iOAT patients' complex needs will be adequately addressed if the iOAT clinics are closed, and the patients are required to transition to the opioid dependency clinics for care either for the duration of the court proceedings or indefinitely". However, that opinion is based on a comment reported on a University of Alberta website on April 1, 2019 that the Edmonton ODP clinic did not have "the capacity to treat more than maybe 10 people because of space and staffing limitations". Dr. Hyshka's opinion on this point does not assist me because it does not consider the current iOAT space being expanded and the ODP clinic moving in there, with additional staff.

[100] Dr. Hyshka provided a third affidavit, dated January 22, 2021. In it, she asserts that the Province's plans for iOAT after March 31, 2021 are "tentative", "unclear", and "not clearly defined" and she states at paragraph 48:

> Although AHS has indicated that referrals to primary care and other services will be provided to iOAT patients transitioning to the ODP clinics, the specific referral pathways have not been described, i.e. which providers are willing to take iOAT patients and what processes are in place (such as dedicated hours, transportation support, or peer assistance), to ensure care is accessed and complex needs are addressed with minimal disruption to mediation administration.

[101] Dr. Hyshka offers these opinions at paragraphs 49 and 53 of her third affidavit:

> Inconsistent access to primary care, psychosocial support and social work assistance is therefore likely to place at least some iOAT patients at greater risk of relapse and discharge from the program, overdose and other negative health outcomes, including death.
>
> …
>
> The planned ODP model is untested, and not clearly defined. In contrast, all available evidence indicates that the Edmonton and Calgary iOAT clinics provide comprehensive care, are functioning effectively, and have achieved positive health, social, and societal outcomes. On this basis it is reasonable to **assume** that the transition from iOAT to ODP will cause at least some disruptions in care for patients. These disruptions **could** lead to destabilization of remaining patients (particularly those who are already struggling due to the uncertain future of iOAT, and challenges associated with the ongoing COVID-19 pandemic), and result in relapse and a return to street drug use.
>
> (emphasis added)

[102] Dr. Hyshka states in her third affidavit that she reviewed some of the affidavits filed by the Defendant, including those of Mr. Cabral, Mr. Snaterse and Dr. Todd. She does not state that she reviewed the transcripts of their questionings, which is understandable because those transcripts appear to have been prepared on January 22, 2021, the same day Dr. Hyshka swore her third affidavit.

[103] Dr. Hyshka's opinion regarding the risk to iOAT patients from the Province's planned changes to the program is speculative. She "assumes" there will be disruptions which "could" lead to destabilizations resulting in relapse and return to street drug use. Given the minor changes described by Mr. Cabral, Dr. Todd and Mr. Snaterse, I conclude that the risk of the dire consequences foreseen by Dr. Hyshka is low.

Dr. Haitham Kharrat

[104] Haitham Kharrat is a family physician whose "clinical practice has focused on inner-city populations, marginalized peoples, and the treatment of those with substance use disorders." Dr. Kharrat provides a similar opinion to Dr. Hyshka's in paragraphs 20 and 22 of his third affidavit:

> 20. For extremely vulnerable individuals living with severe opioid use disorder, such as the iOAT patients in Alberta, the co-location of access to iOAT

> medication and wraparound services, including primary care, is essential for the therapy to work to its maximal potential benefit on this unique patient population.
>
> …
>
> 22. Based on my review of the Defendant Her Majesty the Queen in Right of Alberta's proposed changes to the treatment regime that existing iOAT patients will receive after March 2021, I believe that those patients are likely to experience harms as there is inadequate details on the provision of wraparound services, including primary care, and how those services will be delivered to an extremely vulnerable and marginalized patient population of individuals living with severe opioid use disorder.

[105] Dr. Kharrat's third affidavit does not say what affidavits or other documents he reviewed regarding the Province's planned changes, which is the basis for his opinion. It is unlikely that he reviewed the transcripts of the questioning of Mr. Cabral, Dr. Todd and Mr. Snarterse, because those transcripts appear to have been prepared on the same day as Dr. Kharrat swore his third affidavit. Furthermore, Dr. Kharrat does not describe what harms he thinks the Plaintiffs may suffer as a result of the changes. Consequently, his opinion is of little assistance to me.

Dr. Eugenia Oviedo-Joekes

[106] Eugenia Oviedo-Joekes is a Professor in the School of Population Health at the University of British Columbia's Faculty of Medicine and she was a co-investigator or principal investigator on two iOAT studies in British Columbia known as NAOMI and SALOME.

[107] Her first affidavit provides a description of opioid use disorder and options for treatment, including iOAT, and she opines that iOAT saves lives and "has a small but very important role in the addiction treatment system".

[108] Dr. Orviedo-Joekes, in paragraph 13 of her second affidavit, sworn January 19, 2021 provides the following opinion:

> As stated above, the proposed approach will likely not work in the manner that it is currently structured and it is the patients who will suffer the potentially grave, serious, and irreparable consequences of implementing an unproven method of treating severe opioid use disorder during the height of the opioid overdoes epidemic. Patients who, according to the affidavits tendered by the Plaintiffs and HMQA, appear to be benefitting from the current treatment method. HMQA's intention to transition patients from iOAT to this alternative treatment regime creates the real possibility that existing iOAT patients will return to using street opioids and experience the range of health and social harms associated with street opioid use, including an increased risk of overdose death and acquiring diseases such as HIV and Hepatitis C.

[109] Neither Dr. Orviedo-Joekes nor any other witness explains why the Plaintiffs or anyone else with opioid use disorder would choose to use street opioids with all the associated risks and costs when prescribed opioids are available with none of those risks for free at an ODP clinic.

[110] Dr. Orviedo-Joekes states in her second affidavit that she reviewed the affidavits submitted by the Defendant, including those of Mr. Cabral, Mr. Snaterse and Dr. Todd. She does not state that she reviewed the transcripts of their questioning which provide additional detail

regarding the Province's plans. This is understandable because those questionings occurred the day after Dr. Orviedo-Joekes' swore her second affidavit.

[111] Dr. Orviendo-Joekes' understanding of what the Province plans is set out in paragraph 10 of her second affidavit:

> However, this is not what is being proposed by HMQA, as injectable hydromorphone will only be offered to existing iOAT patients and **will not be provided with a full range of wraparound services, including access to primary care**, an essential component to iOAT therapy. It also seems that others will not be able to apply for iOAT and that the services offered are not even tailored to the clients.
>
> (emphasis added)

[112] It is clear from the evidence of Mr. Cabral, Mr. Snaterse and Dr. Todd that the Province plans to over a full range of wraparound services, including access to primary care, although some of the primary care may be provided off-site. It is also clear that the services offered will be tailored to clients. Dr Orviedo-Joeke's opinions set out in her second affidavit are based on false premises and consequently do not assist me.

10.5 Conclusion Regarding the Effect of the Changes on the Plaintiffs

[113] All of the Plaintiffs will continue to be able to receive injectable opioids from the Province (via AHS) after March 31, 2021. The delivery of wraparound services and primary care may change. I have no evidence regarding what wraparound services and primary care eight of the eleven Plaintiffs have used through the iOAT clinics to date. GWF and MSC received treatment for Hepatitis C and lung and blood disorders. TAM received wound care, dental treatment and chronic disease treatment. I have no evidence that they will not be able to receive that primary care after March 31, 2021, although TAM states that, because the opioid injections take up so much of his day, it would be difficult for him to access treatment if he is not able to access it at the same place where he receives injectable opioids.

[114] AFME states that she returned to using street opioids because of the Province's announced intention to close iOAT completely. Several of the medical professionals provided evidence that this is true of other patients as well. The initial affidavits filed in September 2020 provide compelling testimony of the extreme risks associated with the use of street opioids. The Province no longer plans to cut off all access to iOAT, but some harm has been done to AFME and other patients who returned to street opioid use in the meantime. Some of that harm has been lessened by the Province's announcement in November 2020 that it would continue iOAT for existing patients out of the ODP clinics. While AFME does not attribute her return to the iOAT clinic in December or January to the Province's announcement, she has nevertheless returned. I have no evidence from any of the Plaintiffs other than AFME that they have returned to street opioid use.

[115] AFME states that she will return to using street opioids if the Province offers iOAT only through the ODP clinics. Dr. Oviedo-Joekes offered her opinion that if iOAT is embedded in the ODP clinics, there is a risk some patients will return to using street opioids. This evidence defies common sense. In the absence of an explanation why anyone would choose an expensive, potentially impure street opioid over a free, pharmaceutical grade one, I do not accept that the changes planned by the Province will cause anyone to return to street opioid use. Some may do

so for other reasons, but a causal connection between the Province's planned changes and iOAT patients returning to street opioid use has not been proven.

[116] On the evidence before me, I conclude that the changes planned by the Province may cause some of the Plaintiffs to have to travel further afield to obtain some primary care and other wraparound services. Faced with that inconvenience, some patients may be unable or unwilling to obtain some primary care and other wraparound services. Apart from that, nothing will change.

[117] Dr. Hyshka describes the iOAT program after the Province implements its planned changes as "untested". On the evidence before me, that appears to be true, but the changes the Province plans are minor. While any change carries a risk, I find that the risk to the Plaintiffs of the Province's planned changes is small.

11. The Three-Part Test for an Injunction

[118] To succeed on this application, the Plaintiffs must establish:

- a serious issue to be tried;
- irreparable harm if no injunction is granted; and
- that the balance of convenience favours an injunction.

RJR-MacDonald Inc v Canada (Attorney General), [1994] 1 SCR 110 at paras 81 – 85; ***AC and JF v Alberta***, 2021 ABCA 24 at paras 19 – 37

12. Serious Issue to be Tried

[119] This is an interlocutory application and not a final decision regarding the Plaintiffs' claims that their Charter rights will be breached. The issue for me is whether there is a serious issue to be tried; not whether the Plaintiffs will ultimately succeed in their action:

> The Charter protects fundamental rights and freedoms. The importance of the interests which, the applicants allege, have been adversely affected require every court faced with an alleged Charter violation to review the matter carefully. This is so even when other courts have concluded that no Charter breach has occurred. Furthermore, the complex nature of most constitutional rights means that a motions court will rarely have the time to engage in the requisite extensive analysis of the merits of the applicant's claim. This is true of any application for interlocutory relief whether or not a trial has been conducted.
>
> ***RJR-MacDonald*** at para 53

[120] The majority reasons in the recent decision of ***AC and JF***, put this part of the injunction test succinctly (at para 39):

> As articulated earlier, a serious issue to be tried does not mean anything other than that the case is neither frivolous nor vexatious; rather it is arguable.

[121] The Plaintiffs submit that the changes the Defendant plans to make to the iOAT therapy effective March 31, 2021 breach their ss. 7, 12 and 15 *Charter* rights.

12.1 s.7 Deprivation of Life, Liberty and Security of the person

[122] The Plaintiffs submit in their reply submissions at paragraph 56 that their section 7 claim is "for continued access to iOAT, lifesaving and life sustaining medical treatment for their severe opioid use disorder and the harms associated with the condition".

[123] This case is not like ***Providence Health Care Society v Canada (Attorney General)***, 2014 BCSC 936 or ***Canada v PHS***, 2011 SCC 44. In ***Providence***, the federal government stopped authorizing the use of a particular opioid, diacetylmorphine, used in iOAT, and in ***PHS***, the federal Minister of Health refused to extend an exemption from the application of the *Controlled Drugs and Substances Act* to a safe injection facility in Vancouver. In those cases, government action prevented people suffering from Opioid Use Disorder from either accessing iOAT or having a safe place to inject opioids. In this case, the Province is not preventing the Plaintiffs from doing anything; it is merely making minor changes in the iOAT it provides the Plaintiffs.

[124] The Supreme Court of Canada in ***Carter v Canada (Attorney General)***, 2015 SCC 5 at paras 62 and 64 describes how the rights protected by section 7 are engaged:

> In short, the case law suggests that the right to life is engaged where the law or state action imposes death or an increased risk of death on a person, either directly or indirectly. Conversely, concerns about autonomy and quality of life have traditionally been treated as security rights.
>
> …
>
> *(2) Liberty and Security of the Person*
>
> Underlying both of these rights is a concern for the protection of individual autonomy and dignity. Liberty protects "the right to make fundamental personal choices free from state interference": *Blencoe v. British Columbia (Human Rights Commission)*, 2000 SCC 44, [2000] 2 S.C.R. 307 (S.C.C.), at para. 54. Security of the person encompasses "a notion of personal autonomy involving ... control over one's bodily integrity free from state interference" (*Rodriguez*,at pp. 587-88 per Sopinka J., referring to *R. v. Morgentaler*, [1988] 1 S.C.R. 30 (S.C.C.)) 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 (New Brunswick (Minister of Health & Community Services) v. G. (J.)*, [1999] 3 S.C.R. 46 (S.C.C.), at para. 58; *Blencoe*, at paras. 55-57; *Chaoulli*, at para. 43, per Deschamps J.; para. 119, per McLachlin C.J. and Major J.; and paras. 191 and 200, per Binnie and LeBel JJ.).

[125] With one exception, there is no evidence before me of any risk to life, liberty or security of the person of any of the Plaintiffs resulting from the Province's changes to iOAT. The one exception is the evidence of AFME and Dr. Orviedo-Joekes that relocation of iOAT to the ODP clinics will cause AFME and other patients to resume using street opioids. Street opioid use is dangerous and if the Plaintiffs are able to prove a causal connection at trial then they may be able to establish a section 7 breach.

[126] The Province argues at paragraph 30 of its brief that "section 7 does not create a positive obligation on the government to provide health care, even where health care has been provided previously", citing cases from the Federal Court, the Ontario Superior Court of Justice

(Divisional Court) and the Ontario Court of Appeal. Those arguments may succeed at trial, but I am not prepared to make that determination in this case at this interlocutory stage.

[127] Based on the possibility that there may be a causal connection between the changes planned by the Province and a return to using street opioids by AFME and others, I find that the Plaintiffs' section 7 claim is not frivolous and vexatious.

12.2 s. 12 Cruel and Unusual Treatment

[128] To establish a breach of their section 12 rights, the Plaintiffs must prove two things: first, treatment or punishment imposed on them by the state and, second, that that treatment is cruel and unusual. The Plaintiffs do not allege that the Province has imposed any punishment on them, but they do claim that the changes in the iOAT program constitute cruel and unreasonable treatment. The Supreme Court of Canada in ***Rodriguez v. British Columbia (Attorney General)***, [1993] 3 SCR 519 at para 67 addresses the meaning of "treatment" for the purpose of section 12:

> In the present case, the appellant is simply subject to the edicts of the Criminal Code, as are all other individuals in society. The fact that, because of the personal situation in which she finds herself, a particular prohibition impacts upon her in a manner which causes her suffering does not subject her to "treatment" at the hands of the state. The starving person who is prohibited by threat of criminal sanction from "stealing a mouthful of bread" is likewise not subjected to "treatment" within the meaning of s. 12 by reason of the theft provisions of the Code, nor is the heroin addict who is prohibited from possessing heroin by the provisions of the Narcotic Control Act, R.S.C. 1985, c. N-1. **There must be some more active state process in operation, involving an exercise of state control over the individual, in order for the state action in question, whether it be positive action, inaction or prohibition, to constitute "treatment" under s. 12.**
>
> (emphasis added)

[129] The Plaintiffs submit that they are under the administrative control of the Province because the Province is providing them with potentially life-saving medical treatment, which makes them entirely dependent on the Province. They rely on ***Canadian Doctors for Refugee Care v Canada (Attorney General)***, 2014 FC 651 in which refugee claimants argued that their section 12 rights were breached when the government discontinued their access to health care. The Federal Court in ***Refugee Care*** distinguished the ***Rodriguez*** case, holding as follows at paras 587 and 590:

> Furthermore, Ms. Rodriguez was subject to a law of general application, albeit one that had an adverse differential impact on her because of her compromised physical condition. In contrast, in the present case, the decision to change the IFHP was not a neutral decision taken by the Governor in Council that has only incidentally had a negative impact on historically marginalized individuals who were covered under the former IFHP. Rather, the executive branch of government has in this case *intentionally targeted* an admittedly vulnerable, poor and disadvantaged group for adverse treatment, making the 2012 changes to the IFHP for the express purpose of inflicting predictable and preventable physical and psychological suffering on many of those seeking the protection of Canada.
>
> …

> For the purpose of my section 12 analysis, however, this intentional targeting of a vulnerable, poor and disadvantaged group distinguishes this case from the usual situation involving the assigning of priorities and the drawing of lines by government in relation to the availability of social benefit programs. In the unusual circumstances of this case, I am thus satisfied that the actions of the executive branch of government at issue here constitute "treatment" for the purposes of section 12 of the Charter.
>
> (emphasis in original)

[130] I do not have evidence in this case that the Defendant intentionally targeting iOAT patients for the express purpose of inflicting suffering. However, I accept 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*.

[131] In addition to establishing that the Province's planned changes to iOAT are treatment, the Plaintiffs must also establish that it is cruel and unusual. To meet that test, the Plaintiffs must show that the change to iOAT is more than merely disproportionate or excessive. It must be so excessive as to outrage standards of decency and abhorrent or intolerable to society: ***R v Boudreault***, 2018 SCC 58 at para 45.

[132] In ***Refugee Care***, the Federal Court held as follows at para 688:

> As I have already found, putting individuals affected by the 2012 cuts to the IFHP such as Mr. Ayubi, Mr. Garcia Rodrigues and Mr. Akhtar in the position where they have to beg for lifesaving medical treatment is demeaning. It sends the message that their lives are worth less than the lives of others. It is cruel and unusual treatment that violates section 12 of the Charter.

[133] While the evidence before me falls short of establishing the extreme situation found by the Court in ***Refugee Care***, I agree with the Plaintiffs submission that the Court in ***Refugee Care*** engaged in extensive analysis in reaching its decision, following a full hearing of the case. In contrast, the application before me is interlocutory, with the full hearing yet to be scheduled. At this point on the facts before me, and given the ***Refugee Care*** precedent, I find that the Plaintiff's claim based on a breach of their s 12 rights is not frivolous and vexatious.

12.3 s. 15 Equality

[134] Section 15(1) of the Charter reads:

> 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.

[135] The Supreme Court of Canada wrote in ***Fraser v Canada (Attorney General)***, 2020 SCC 28 at para 27:

> To prove a prima facie violation of s. 15(1) , a claimant must demonstrate that the impugned law or state action:
>
> > on its face or in its impact, creates a distinction based on enumerated or analogous grounds; and

> imposes burdens or denies a benefit in a manner that has the effect of reinforcing, perpetuating, or exacerbating disadvantage.

[136] The Plaintiffs' section 15 claim is based on patients with severe Opioid Use Disorder being denied effective treatment while those with mild or moderate OUD are provided with effective treatment. This claim relies upon the minor changes planned by the Province rendering iOAT ineffective for the Plaintiffs. The only Plaintiff who has given evidence on this point is AFME, who says in her affidavit that if the changes are made she will return to using street opioids with all their inherent dangers. The only other evidence I have that the changes will render iOAT ineffective is that of Dr. Orviedo-Joekes who opines that if the changes are made some of the patients, like AFME, will return to using street opioids. The problem with this evidence, as noted above, is that it is non-sensical on its face and comes without any explanation of why anyone would choose street opioids over pharmaceutical opioids.

[137] Even if the Plaintiffs provide additional evidence that establishes the link between the changes and patients returning to street opioids, they will face the arguments raised by the Province in its submissions, that s 15 of the *Charter* does not provide everyone with a right to the best possible health.

[138] At this interlocutory stage, I find that the Plaintiffs' s 15 claim is not frivolous and vexatious.

12.4 Conclusion on Serious Issue to be Tried

[139] I find that the Plaintiffs' claim based on breaches of their ss 7, 12 and 15 *Charter* rights is not frivolous and vexatious. They have established an arguable case, which is the first part of the test for an interlocutory injunction. However, the evidence before me falls far short of what will be necessary to establish their claim at trial. On this evidence, the Plaintiffs' claim is weak, which is relevant to balance of convenience.

13. Irreparable Harm

[140] The Plaintiffs submit that they risk serious harm and death if the Province makes its proposed changes. This is based their assertion that they will return to using street opioids, and that they will have less access to primary care. None of the Plaintiffs, except AFME and TAM have given evidence on these points. For nine of the eleven Plaintiffs I have no evidence from them that they will return to using street opioids or that they will be unable to access primary care if it is not available at the same location where they receive injectable opioids. TAM's evidence is that it will be more challenging for him to access primary care and AFME testifies that she will return to using street opioids.

[141] I must consider both the probability of the harm occurring and its magnitude. As Sharpe J writes in *Injunctions and Specific Performance*, looseleaf (Toronto: Thomson Reuters Canada Limited, 2019), at 2.418:

> Instead, the plaintiff should be required to establish a "meaningful risk of irreparable harm" or a meaningful doubt as to the adequacy of damages if the injunction is not granted". This assessment requires consideration of both the likelihood of harm occurring and the gravity of the harm. Assessing the "true overall risk of irreparable harm will always be a function of both the likelihood of the harm occurring and its size or significance should it occur". Irreparable harm

> and the assessment of the balance of convenience are very closely linked, in some cases where the balance of convenience strongly favours an injunction, conclusive proof of irreparable harm may not be required.

[142] On the evidence before me, none of the Plaintiffs will suffer any serious harm from the changes planned by the Province. The evidence does not establish a high probability that the changes will cause death or serious health consequences for any of the Plaintiffs. At worst, some, in particular TAM, may postpone or miss some primary care because of the combination of the time required to receive opioid injections and other challenges they face connected to their opioid use disorder. In addition, there is a possibility of minor inconvenience, such as having to go further afield to access some medical services than they presently do at the iOAT clinics. In combination, the likelihood of the harms and the magnitude of the harms do not amount to irreparable harm.

[143] Whereas in the first part of the interlocutory injunction test I am prepared to anticipate that the Plaintiffs may be able to establish a causal connection between the Province's planned changes and AFME and others returning to using street opioids, on the irreparable harm part of the test, the Plaintiffs must prove that connection, which, on the evidence before me, they have failed to do. I am not prepared to accept AFME's and Dr. Orviedo-Joekes' evidence on this point, because it does not make sense.

14. Balance of Convenience

14.1 Public Interest

[144] In *Charter* cases the public interest is a special factor which must be weighed in considering the balance of convenience: ***RJR-MacDonald*** at para 69. Both parties can invoke the public interest in support of their position and the public interest factor engages the interests of people who are not parties to the litigation: ***RJR-MacDonald*** at paras 71 and 72.

[145] Where a government has taken-action pursuant to its responsibility to promote the public interest, irreparable harm to the public interest is presumed to flow from a restraint of that public action:

> In our view, the concept of inconvenience should be widely construed in Charter cases. In the case of a public authority, the onus of demonstrating irreparable harm to the public interest is less than that of a private applicant. This is partly a function of the nature of the public authority and partly a function of the action sought to be enjoined. The test will nearly always be satisfied simply upon proof that the authority is charged with the duty of promoting or protecting the public interest and upon some indication that the impugned legislation, regulation, or activity was undertaken pursuant to that responsibility. Once these minimal requirements have been met, the court should in most cases assume that irreparable harm to the public interest would result from the restraint of that action.
>
> A court should not, as a general rule, attempt to ascertain whether actual harm would result from the restraint sought. To do so would in effect require judicial inquiry into whether the government is governing well, since it implies the possibility that the government action does not have the effect of promoting the

> public interest and that the restraint of the action would therefore not harm the public interest. **The *Charter* does not give the courts a licence to evaluate the effectiveness of government action, but only to restrain it where it encroaches upon fundamental rights.**
>
> ***RJR-MacDonald*** at para 76 – 77 (emphasis added)

[146] Much of the evidence in the Plaintiffs' affidavits goes to the merits of the government's decision to close the existing iOAT program. In particular, Dr. Nick Bansback's affidavit setting out his opinion that iOAT is cost-effective, when extended patient life-spans and reduced crime are considered, relates solely to the effectiveness iOAT. Several other affidavits submitted by the Plaintiffs contain similar comments. As set out in the words I have emphasized in the quotation above, the merits of the Province's decision to change the way it provides iOAT is not a question for me to determine.

[147] The Plaintiffs argue that because iOAT was established through the work Minister's Opioid Emergency Response Commission (MOERC), the continuation of iOAT is in the public interest as part of the response to the opioid crisis. That argument may have been persuasive when the Province planned to terminate iOAT entirely, but things have changed. The Province now plans minor changes to way it provides iOAT. The Plaintiffs have not established that those minor changes are contrary to the public interest.

[148] The Defendant, through Alberta Health and Alberta Health Services, is responsible for the health system and health service delivery in Alberta. Consequently, I assume that an injunction prohibiting the Province from implementing its planned changes to iOAT would cause irreparable harm to the public interest.

[149] The public interest favours denying an injunction.

14.2 Strength of the Plaintiffs' Case

[150] It is relevant for me to consider the strength of the Plaintiffs' claim in the balance of convenience: ***AC and JF*** at paras 27 – 30.

[151] For the reasons set out in section 12 above, the Plaintiffs' case is weak which weighs in the balance against an injunction.

14.3 Weighing Uncertainty in the Balance

[152] The Plaintiffs point to the fact that the Defendant's witnesses are not able to say precisely what wraparound services, particularly primary care, will be offered by the Defendant after March 31, 2021. The point in particular to Mr. Snaterse's testimony in which he admitted he did not know how various things would be done and to the absence of a funding agreement between Alberta Health and AHS. The Plaintiffs submit that this is fatal to the Defendant's position. I disagree. Uncertainty regarding future action is a common feature in injunction cases. No authority has been cited to me for the proposition that a defendant responding to an injunction application must prove exactly what it will do in the future, to avoid an injunction preventing any changes.

[153] The context of this case is important. The *Opioid Emergency Response Regulation*, enacted in 2017, recognized a public health crisis and created MOERC to recommend actions to address the crisis. The committee was formed in May 2017 and it first considered iOAT in June 2017. AHS presented its iOAT proposal to MOERC in September 2017. MOERC recommended

that the Minister accept AHS's proposal which the Minister did, and a grant agreement was entered into effective March 27, 2018. iOAT clinics were up and running in Edmonton and Calgary by October 2018. This was rapid government action to respond to a public health emergency which continued as iOAT was considered, planned and implemented and which continues today. The future is always somewhat uncertain, but it is particularly uncertain with respect to emerging public health emergencies. It is not surprising that the Province's witnesses were not able to say in January 2021 precisely how the planned changes to iOAT would be implemented or funded. This reality is reflected in the last sentence of the preamble to *Opioid Emergency Response Regulation*:

> WHEREAS the rapid deployment of resources and actions that adjust to changing conditions are urgently needed to combat the opioid crisis;

[154] In Injunctions and Specific Performance, loose-leaf (Toronto: Thomson Reuters Canada Limited, 2019), Sharpe, J describes at 1.750 – 1.790 some of the issues for a court in considering an application to restrain uncertain future action:

> What the court does look for is the information necessary to predict with confidence not only that the harm will occur but also other relevant circumstances which will then exist.
>
> …
>
> The problem occurs in cases where the definition of the plaintiff's right and degree of remedial protection it is to be afforded are not static but fall to be determined by potentially changed circumstances existing at the time the harm occurs.
>
> …
>
> A related matter is the weighing of the benefit the injunction confers on the plaintiff against the cost it imposes on the defendant. Again this assessment can be made only where the court has a firm grasp on the actual effect the harm will have on the plaintiff at the time it occurs and the cost alleviating or avoiding the harm will impose upon the defendant.
>
> …
>
> Another consideration is that making *quia timet* injunctions too readily available could stifle development and innovation. Change by some almost always threatens others, and legal rights take shape and colour depending on the actual circumstances.
>
> …
>
> Thus, the existing law reflects the notion that from the point of view of accommodating change and economic, industrial and social innovation, it is important to be able to postpone as long as possible, up to the point where harm is actually sustained, the award of injunctive relief.

[155] The fact that the Defendant is responding to the opioid public health emergency as it continues, while simultaneously responding to the COVID-19 pandemic, weighs against any restraint of government action regarding iOAT, particularly given the Province's commitment to

continue iOAT for the Plaintiffs and other existing patients, as articulated by its representative, Mr. Cabral.

14.4 Conclusion on balance of convenience

[156] The impact on the Plaintiffs of the Province's planned changes to iOAT will be minor. The harm to the public interest if an injunction were granted would be irreparable. The balance of convenience favours denying an injunction.

15. Disposition

[157] I dismiss the Plaintiffs' application. If the parties cannot agree on costs, the Defendant may submit a brief by March 31, 2021, the Plaintiffs may submit a brief by April 15, 2021, and the Defendant may submit a reply brief by April 30, 2021, following which I will release a written decision on costs. The reply brief may be up to 5 pages and the other briefs may be up to 10 pages, excluding tabs.

Heard on the 26th day of January and the 10th day of February, 2021.
Dated at the City of Edmonton, Alberta this 25th day of February, 2021.

G.S. Dunlop
J.C.Q.B.A.

Appearances:

Avnish Nanda and Manraj Preet Sidhu (Student at Law)
of Nanda & Company
for the Plaintiffs

Lillian Riczu and Nate Gartke
of Alberta Justice, Constitutional & Aboriginal Law
for the Defendant